THAILAND
Ending AIDS

2014 THAILAND AIDS RESPONSE PROGRESS REPORT

THAI NATIONAL AIDS COMMITTEE

2014 THAILAND AIDS RESPONSE PROGRESS REPORT
REPORTING PERIOD: 2012-2013

SUMMARY REPORT

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Introduction

This 2014 Global AIDS Response Progress (GARP) Reporting is the 7th Thai review in the series beginning in 2002 according to the requirement of the 2001 UNGASS Declaration of Commitment on HIV/AIDS, 2006 Political Declaration on HIV/AIDS and 2011 United Nations Political Declaration on HIV/AIDS. The first five reports were bi-annual progress reports, while the 6th report (2013) was a mid-term review of progress in achieving the targets as set in the 2011 Political Declaration on HIV/AIDS. This report presents progress and achievements of implementation for the period of 2012 to 2013 against the ten targets and elimination commitments of the 2011 UN Political Declaration on HIV/AIDS, the indicators specified in the WHO/UNICEF Health Sector Response in HIV/AIDS and the targets of the Thailand National Strategic Plan on HIV.

This report is the product of extensive and inclusive collaboration among the networks of implementing partners, government, civil society, non-government organizations, technical specialists, international organizations, and representatives from the Thai Network of People Living with HIV/AIDS (TNP+). Individuals from these organizations worked in 13 task forces to compile, analyze, synthesize, and interpret the relevant data for the indicators in question and draft the narrative contents and recommendations. Consultants were contracted to collect and prepare National AIDS Spending Assessment (NASA) and National Commitments and Policy Instruments (NCPI). The draft reports of the task forces were reviewed in a plenary consultative meeting of stakeholders to provide more inputs and consensus to key findings and recommendations for future actions. This meeting included 125 participants from central and provincial organizations. A total of82 participants were from government agencies, 28 participants were from 13 Civil Society and NGO organizations, ten participants were from three international organizations, and there were five technical resource persons. The final draft was reviewed and approved by the national subcommittee on strategic information under the National AIDS Committee.

Contents

Acronyms

AEM	:	AIDS Epidemic Model
AIDS	:	Acquired immunodeficiency syndrome
ANC	:	Antenatal care
ART	:	Anti-retroviral therapy
ARV	:	Anti–retroviral drugs
ASO	:	AIDS-response Standard Organization
BATS	:	Bureau of AIDS, TB and STIs
BOE	:	Bureau of Epidemiology
BSS	:	Behavioral surveillance survey
CHAMPION	:	The project entitled: Comprehensive HIV Prevention among Most at Risk Populations by Promoting integrated Outreach and Networking
DDC	:	Department of Disease Control
DiC	:	Drop-in center
DOC	:	Department of Corrections
DOH	:	Department of Health
EWI	:	Early warning indicators
FSW	:	Female sex workers
Global Fund	:	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCT	:	HIV counseling and testing
HIV	:	Human immunodeficiency virus
HLM	:	High level meeting
HSS	:	HIV sentinel sero-surveillance
IBBS	:	Integrated biological and behavioral surveillance
KAP	:	Key affected population
KPI	:	Key performance indicator
LAO	:	Local administrative organization
M&E	:	Monitoring and evaluation
MHW	:	Migrant health worker
MW	:	Migrant worker
MICS	:	Multiple indicator cluster survey
MMT	:	Methadone maintenance therapy
MOL	:	Ministry of Labour
MOPH	:	Ministry of Public Health
MSDHS	:	Ministry of Social Development and Human Security
MSM	:	Men who have sex with men
MSW	:	Male sex workers
NAC	:	National AIDS Committee
NAMC	:	National AIDS Management Center

NAP	:	Software for treatment and care for PLHIV: National AIDS Programme
NAPHA	:	National access to anti-retroviral drug for people living with HIV and AIDS
NAS	:	National AIDS strategy
NASP	:	National AIDS strategic plan
NCPI	:	National commitment and policy instrument
NGO	:	Non-governmental organization
NHSO	:	National Health Security Office
PCM	:	Provincial coordinating mechanism
PCR	:	Polymerase chain reaction
PHAMIT	:	The project entitled: Prevention of HIV and AIDS among Migrant Workers
PHIMS	:	Perinatal HIV information monitoring system
PICT	:	Provider initiated counseling and testing
PLHIV	:	People living with HIV and AIDS
PMTCT	:	Prevention of mother-to-child HIV transmission
PWID	:	People who inject drugs
RDS	:	Respondent driven sampling
RIHIS	:	Routine integrated HIV information system
STI	:	Sexually transmitted infection
TB	:	Tuberculosis
TBCA	:	Thailand Business Coalition on AIDS
TG	:	Transgender people
TNP+	:	Thai Network of People Living with HIV/AIDS
TUC	:	Thailand MoPH-US CDC Collaboration
UNAIDS	:	Joint United Nations Programme on HIV/AIDS
UNGASS	:	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	:	United Nations Children's Fund
USAID	:	United States Agency for International Development
VCT	:	Voluntary counseling and testing
WHO	:	World Health Organization

STATUS AT A GLANCE

The number of new HIV infections, HIV related deaths, and people living with HIV (PLHIV) in Thailand have declined steadily over time, based on the model estimation. However, the pace of decline has slowed over the past years. Prevalence of HIV in the key affected populations also declines but remains much higher than in the general population. Access to prevention services has improved and saferbehaviors are practiced more consistently; however, the change is not high enough to significantly reduce new infection as targeted. Besides, incidence of STI shows signs of increasing, particularly in young people.

Much progress in the HIV response has been made during the past two years. Thailand has committed itself to ending AIDS by 2030 and set the respective targets. The Cabinet and National AIDS Committee (NAC) approved the national AIDS strategic plan (NASP) for 2014-16. The updated NASPhas reinforced the original 2012-16strategies and incorporated additional measures that will enable the country to achieve the ending AIDS targets by 2030.

Significant steps have been made towards ensuring financial sustainability of the response. Domestic resources have been mobilized, both from central budget, through the expansion of the HIV treatment fund of the National Health Security Office (NHSO) to cover prevention activities, and from local administrative organizations (LAO). Close monitoring of budget allocation and disbursement of the domestic resources, as well as advocacy for proper utilization and greater flexibility will be required to maintain the momentum of continuity.Capacity building and support for LAO in planning and resource mobilization for prevention interventions among the key affected populations and general population will require particular attention and support.

Thailand has continuedintensifying the focus on HIV prevention among the vulnerable populations of MSM, TG, MSW, FSW and their clients. A variety of strategies are being used to increase access to and uptake of combination prevention, STIservices, HCT, treatment and care. Prevention outreach activities were concentrated in 30 priority provinces for MSM, 43 provinces for sex workers and 19 provinces for PWID. The coverage of prevention services has improved but been still insufficientand HIV infection rate has not declined as much as intended, particularly in MSM and PWID. More attention is required to‘young KAP’ (under age 25 years) and non-venue-based FSW; surveys show that they have lower levels of knowledge and HCT than those over age 25 and those venue-based FSW.

There has been progress in the policy arena to facilitate the work with PWID; the signing of the order 19/2013 from the National Center to Fight over Narcotics and the associated implementation plan, which includes harm reduction for PWID on a trial basis in 19 provinces,isviewed as a critically important step that will facilitate scale up of comprehensive combination prevention for PWID.

Misconceptions and legal barriers, e.g., the provision that "injection drug use is a crime," and "distribution of needles is promotion of drug addiction", sex work is illegal, continue to be an obstacle to increasing demand for and uptake of services among key affected populations. Attitudes of service providers toward KAP require further improvement, and service systems need to be further adapted to address the needs of the target population who live in diverse and varied local contexts.

In general population and youths, there is no clear improvement in knowledge, condom use and STI in the national scale. Thailand will need new strategies and innovation in addition to current interventions with assured quality and continuation of efforts at scale to achieve results**.**Further effort is needed to improve attitudes toward condoms and normalize HIV, to increase HCT uptake in general population and condom use among regular partners.

Implementation of prevention and treatment for migrants has shown visible progress.During the report period, targeted interventions for migrants were implemented largelywith international financial support. However, in 2013, the MOPH announced a policy to provide health insurance (with ART coverage included) for cross-border migrant workers who are not covered by social security; the policy applies to both registered and unregistered migrants.

Thailand has high rate of coverage of quality PMTCT, it is likely to be one of the first countries in the world to achieve the target of reducing MTCT to under 2% by 2016. Increased use of couple counseling and testing services, increased coverage of HIV PCR testing among infants born to positive mothers, and increased coverage of cross-border migrants who are pregnant, HIV+, and attend Thai ANCwill be required to achieve the target and sustain the result.

Thailand has performed well in extending ART to as many PLHIV as possible, with steady improvements in coverage over time. The criteria for initiating ART have been changed twice. The first change, from CD4 count of a 200 to 350 cells/cu mm, has been implemented nationwide as of October 1, 2012. In 2013, as part of its ending AIDS strategy, the country has endorsed provision of ART irrespective of CD4 count, to be implemented starting from October 1, 2014. Three national health insurance schemes (NHSO scheme, social security scheme and the government civil servants medical scheme)have been harmonized to ensure standardization and full accessto ART with greater efficiency

Policy and programme for HIV/TB integration shows good progress, with a high level of coverage on screening PLHIV for TB and screening for HIV among TB patients. However, the mortality rate among those with co-infection is still too high. This needs to be urgently addressed.

Thailand does not have sufficient data on thegender dimensions of programmes andservices; little systematic evidence exists of violence between spouses/partners, violence against women, and gender inequality as they relate to HIV infection in women.

Thailand has initiated development of asystem to collect data to measure the scope and progress of stigma and discrimination; the stigma and discrimination measurement tool is being finalized and shall be put in use in 2014. It is expected that the tool will be instrumental in informing action to reduce abuse, violence and remove obstacles to access to all service components.

Whilegreat progress has been achieved already in integrating HIV services into the routine system, Thailand still faces challenges in ensuring integration of care and assistance for vulnerable children and other children affected by AIDS. The sub-national system of social protections needs improvement, and the Joint key performance indicator system should be re-introduced in the government sector.

The stakeholders and partners contributing to the national programme effort have offered cases of good practices. They are relating to the areas of reaching MSM and SW, community services for PWID, migrant health workers, prisoners, empowerment of women living with HIV, children living with HIV, disclosure sero-status among youth and children, and reduction of disparity of ART provision.

Thailand has a costed plan for strategic information and M&E system for the National strategic plan of HIV. AStrategic Information Sub-committee under the National AIDS Committee oversees the implementationand monitors progress with the secretariat support from the National AIDS Management Center. The NAC has approved the AIDS ZERO PORTAL as a tool to enable policy makers and program managers in the public sector and civilsociety to monitor the situation and the HIV response down to facility level, usingweb-based visualization of up-to-date, comprehensive data. The PORTAL will be officially launched and go live in May 2014.

Thailand has been in good collaboration with international development partners such as UN agencies, US government agencies and the Global Fund. The assistance iswell harmonized with the current NASP and contributed appropriately towards achievement of the ten targets for 2012-13.

Thailand Global AIDS Response Progress Reporting 2014

1. Overview of the AIDS Epidemic

The number of new HIV infections, HIV-related deaths, and peopleliving with HIV (PLHIV) in Thailand have declined steadily over time, as per the model estimation using the Asian Epidemic Model (AEM) for adult age 15 years or older, and Spectrum for child age < 15 years. However, the pace of decline has slowed over the past years. The situation at the end of 2013 compared with previous years is shown in table below.

Table 1: Key figures of HIV estimation, Thailand

Estimated Number	2000	2005	2011	2013
New infections in adult people *	28,241	15,266	9,503	8,134
New infections in adult women *	15,716	7,237	2,919	2,235
Annual AIDS mortality in adult people *	55,079	30,805	19,511	20,962
Annual AIDS mortality in adult women *	12,036	7,153	6,133	6,282
Adult people living with HIV *	676,005	544,743	475,638	451,258
Adult women living with HIV *	217,860	212,351	204,767	193,965
New infections in children <15 years **	1,378	748	176	122
Annual mortality among children <15 years**	452	406	173	158
Children <15 years living with HIV**	7,836	11,065	9,709	8,430
Total population (million)	**60.6**	**63.1**	**64.1**	**64.5**

* Estimated from Asian Epidemic Model** Estimated from Spectrum

Status of the epidemic in target populations has beenmonitored using the HIV surveillance system, ad hoc surveys or studies of HIV infection and risk behavior, and routine case report of sexually transmitted infections (STI).

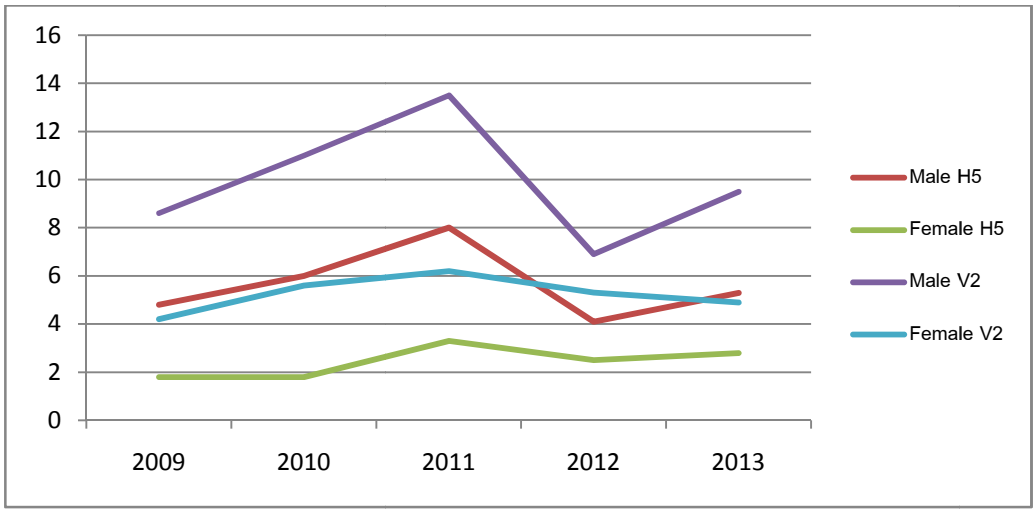
The HIV sentinel serosurveillance (HSS) among antenatal clinic (ANC) clients implemented in all 76 provinces since 1989 has shown a continuing decline of HIV prevalence while it reached peak in 1995 at 2.3%;HIV prevalenceremained at around 0.5-0.6% during 2009-2013. In 2013, the HIV prevalence among the 15-24 year-old age group ANC clients was 0.43%.

The HIV prevalence among all male army recruits (average age of 21 years) has remained at approximately 0.5% since 2005. At the same time, STI reported rates show an increasing trend among adults, especially those aged 15-24, from 62.1 to 93.2 per

100,000populationsbetween 2008 and 2012 respectively.

The Behavioral Surveillance Surveys (BSS) were conducted since 1995 to assess HIV risk behavior among 5th year high school students and 2nd year vocational college students in 24 of Thailand's 76 provinces. These surveys found that the proportion of reporting age at first sex under 15 years declined in 2012,when compared with the level in 2011, but increased only in vocational students in 2013 (Figure 1). AIDS knowledge did not improve significantly during the same time as the percent who could answer the five HIV/AIDS knowledge items correctly remained at 20% and 26% in 2012 and 2013 respectively.

Figure 1: Percent of Thai adolescents reporting first sex at age under 15 years during 2009-13 by sex and school grade



Source: Bureau of Epidemiology

In 2013, studies of condom use found that 56.4%, 37.5% and 28.7% of sexually active male, high school students reported using condoms for every episode of sex with FSW, another male, or girlfriend, respectively. The corresponding proportion for males, vocational college students were 63.0%, 40.9%, and 27.1% respectively. For sexually active female high school and vocational college students, 25.5% and 19.3% respectively reported using condoms for every episode of sex with their boyfriends.

The BSS of factory workers in 24 provinces age 15 to 49 years in 2013 found that 21.6% of male workers had sex with more than one partner in the previous year compared with 4.6% of female workers.

For migrant workers (MW), the Integrated Behavioral and Biological Survey (IBBS) was conducted in ten provinces in 2010 and 2012. The HIV prevalence of infection among the Burmese, Cambodian and Laos MW in 2012 was 1.0%, 0.9%, and 0.8% respectively. The corresponding prevalence was 1.2%, 2.5% and 0.5% in 2010 for the three nationalities respectively.

HIV prevalence among MSM is still high, especially among those living in large urban areas and international tourist destinations (e.g., Bangkok, Chiang Mai, Phuket, Pattaya). Median HIV prevalence in the 13 provinces where HIV IBBS of MSM is conducted was 7.1% in 2012 (compared to8.0% in 2010). Coverage of MSM with prevention services increased from 43.9% to52.6%, and the proportion of those having an HIV test and receiving the results in the past 12 months increased from 14.9% to 25.6%.

Prospective studies among MSM in Bangkok during 2006-2011, and in Chiang Mai during 2008 to 2009 found an HIV incidence rate at 5.9and 8.2 cases per100 person-year, respectively. Percentage of syphilis among MSM attending STI clinic was at 24.4% in 2013.

HIV prevalence among venue-based FSW continues to decline, from 2.7% in 2010 to 2.2% in 2012. Reported condom use with clients remains high at 95.6% and 93.6% for the two years respectively. Only half of these FSW were covered with prevention services: 50.4% and 53.9% for 2010 and 2012. Similarly, 47.8% and 55.6% of FSW reported having an HIV test in the prior 12 months in 2010 and 2012 respectively.

For non-venue-based FSW, including those who seek clients in public spaces or other formats, the surveys in 5 provinces showed HIV and STI prevalence was distinctly higher than for the venue-based FSW except in Phuket (see table below).

Table II: HIV prevalence among "non-venue-based FSW" found by RDS with HIV prevalence among "venue-based FSW" found by HIV serosurveillance, 2007 and 2010

Sex worker category	2007		2010		
	Bang-kok	Chiang Rai	Chiang Mai	Phuket	Chon Buri
Non-venue-based [1](N)	20.0% (519)	10.0% (87)	5.0% (287)	1.4% (285)	1.2% (284)
Venue-based, direct establishment[2](N)	4.6% (264)	6.9% (72)	3.1% (128)	2.8% (284)	-
Venue-based, indirect establishment (N)	1.6% (314)	1.2% (573)	0.98% (205)	2.61% (274)	-

Source: Bureau of Epidemiology, Department of Disease Control, MOPH

1 IBBS using Rapid Driven Sampling (RDS) among non-venue based FSW

2 HSS or IBBS among venue based FSW

HIV prevalence among MSW declined from 16.0% in 2010 to 12.2% in 2012, but remains significantly higher than in most groups of FSW and general MSM population. Coverage of prevention services for MSW increased from 61.0% to 73.8%, while having an HIV test (and receiving results) in the past 12 months also increased from 49.0% to 52.4% in 2010 and 2012 respectively.

The Respondent Driven Sampling (RDS) method was used to study the population of PWID. HIV prevalence is still highest in this group compared to other key affected populations, and actually increased from 21.9% in 2010 to 25.2% in 2012. The proportion of PWID having an HIV test in the past 12 months increased from 40.7%in 2010 to 43.6% in 2012. The proportion of PWID reporting condom use at last sex was 49.0% and 80.4% of those reported using clean needles/syringes the last time they injected.

In sum, prevalence of HIV and STI in the key affected populations remains high and much higher than in the general population. Access to prevention services and prevention behavior is still not high enough to significantly reduce new infection. Despite the plateau in HIV prevalence among the general population, incidence of STI shows signs of increasing.

2.The National AIDS Responses during 2012-13 against ten targets of UN Political Declarations on HIV/AIDS and the Thailand National Strategic Plan

The Thai Cabinet and NAC approved the National AIDS Strategic Plan (NASP) for 2014-16 thatincorporates additional measures to the original strategies from 2012-16 in order to achieve the ending AIDS targets by 2030. The NAC also approved the budget framework to support the operational plan, which would require additional investment, and endorsed the expansion of the HIV treatment fund of the National Health Security Office (NHSO) to cover prevention activities.

The NAC also approved expansion of eligibility for anti-retroviral therapy (ART) for all PLHIV regardless of CD4 count to improve quality of life and ART efficacy. The plan calls for an expansion of comprehensive prevention with a standard package of services founded on human rights principles and gender sensitivity to ensure full coverage of the key affected populations in areas for accelerated intervention.

Civil society has played an important role in policy and programme advocacy on the expansion of health insurance for migrant workers and associated member. ART is included in the benefit package of migrant health insurance.

There will need to be additional resource mobilization among all sectors through a shared sense of ownership and an enabling policy and legal environment. To be successful, the program will need to rely heavily on accurate, strategic information for decision-making, and increase advocacy and efficiency of integration of quality implementation.

3. Country Progress towards the UN 2015 Targets

Target 1

HLM: **Reduce sexual transmission of HIV by 50% by 2015**
Thai NASP: **Reduce sexual transmission of HIV by two-third in 2016**

The data from the AEM projections for 2012 and 2013 show 90%of new adult HIV infections were transmitted from unprotected sex. Of all new infections, 4%were among MSM, MSW, and TG, 12%werein FSW and their clients, 33%-in discordant couples, and 4%- among those engaging in casual sex. Three target groups of population including key affected populations (MSM, TG, MSW, and FSW), youths and general population, and migrants were reviewed and identified future priority actions.

Key Affected Populations: MSM, TG, MSW and FSW

Thailand has been intensifying the focus on HIV prevention among the vulnerable populations of MSM (including TG), MSW, FSW and their clients. A variety of strategies are being used to increase access to and uptake of prevention services, STI, HCT, treatment and care. Most of the budget for prevention outreach comes from the Global Fund, and is concentrated in 30 priority provinces for MSM and 43 provinces for sex workers.

Over the past two years, there have been notable efforts to increase coverage of prevention services through innovative interventions. This includesre-design of service delivery models, expanded outreach to target population, improvement inservice linkages and referrals for prevention and treatment as needed, increasing demand for HCT, improving the standards and quality of services, ensuring that HCT outlets provide same-day results, implementing community-based HCT, and better management of condom distribution for men and women.

Theprogramme evaluation has found that the coverage of prevention services has remainedinsufficientthough the reported condom use at last sex was high. In addition, HIV infection rate has not declined as much as intended. Other vulnerable populations such as 'young KAP' (under age 25 years) and non-venue-based FSW have lower levels of knowledge and HCT than those over age 25 and those venue-based FSW.

Conclusions: Notable progress has been made in scaling up prevention programmes for key populations; however, the impact of these interventions is yet to be recorded. Lessons learned from implementation are helping to inform improvement and re-design of strategies to reachthe target population and achievesufficientcoverage withcombination prevention services and linking to treatment services.

Key Priority Actions

Activity	Time Frame
1. Develop mechanism and strategies to advance policy-to-action to increase area coverage, proper budget allocation, and increased the capacity of staff to work in a systematic and integrated way continuously	Mid of 2015
2. Expand outreach activities and increase demand for HCT, including through new models of service (i.e., community based-HCT)	2015- 2016
3. Conduct in-depth studies to better understand the most vulnerable populations, and research into innovative prevention interventions, and improve the quality and continuity of the evaluation and follow-up activities.	2015

Youths and General Population

Over the past five years, there has been noticeable progress in expanded coverage of prevention in the schools through more systematic sex education. More prevention activities in the school setting and community have been implemented through the Global Fund support and domestic source relating to the teen pregnancy prevention programme.

There have been improvements in youth health behavior in some locations where there have been intensive interventions on a continuous basis. Nevertheless, the scale of these improvements is yet too low to generate an impact that would be reflected in national STI incidence or unplanned pregnancy among youth. Youth-friendly sexual health services have been expanded nationwide, but this has not been able to adequately meet the needs of youth. The current prevention system is still not effectively reaching the more vulnerable youth.

For general population, the program has focused on safer sex, especially for workers in factories and other worksites. This included awareness raising, increasing motivation for prevention, improving attitudes about condoms, and implementing VCT outreach services. Despite these activities there has been no significant improvement in behavior. Knowledge of one's sero-status among the general population is still low, and condom use among those with more than one sexual partner has not increased.

Conclusion: There is no clear sign of improvement in knowledge, condom use and STI among general population and youths on the national scale. Thailand will need new strategies and innovation in addition to current interventions with assured quality and continuation of efforts at scale to achieve results**.** Further effort is needed to improve attitudes towardcondoms and

normalize HIV, to increase HCT uptake in general population and condom use among regular partners.

Key priority actions:

Activity	Time Frame
1. Increase coverage and ensure quality of sex education for all eligible schools, including informal education settings and youth groups outside the school settings	2014-2016
2. Increase accessibility and varieties of services of youth-friendly clinic, which meet adolescent's needs. Introduce innovations to increase access and awareness about risk, and make condoms and HIV testing easily available	2014-2016
3. Implement innovations to increase access to most vulnerable youth and youth with high risk for HIV ('Young KAP')	2014-2016
4. Accelerate mass media campaigns through a variety of channels to change the image of HIV infection so that it is seen as manageable, and increase motivation to know one's serostatus	2014-2016
5. Improve the image of condoms so that they are seen as a sexual health product for all, and promote condoms in factories and other worksites, communities and schools to increase access	2014-2016

Migrant Workers (MW)

Most of interventions for this population were supported by the Global Fund, such as the prevention activities under the PHAMIT Project in 36 provinces. In the past two years there have been efforts to increase access for HIV services for MW through a network of field outreach workers and MW health volunteers. This includes peer education about reducing risk behavior, distribution of prevention supplies to the more vulnerable populations such as fishing boat crew, workers in seafood processing factories, factory workers, construction workers, and MW who work in the agricultural sector. The programmewas able to access approximately 250,000 MW, with over three million condoms distributed to the MW population. Over 6,000 MW received HIV VCT, and nearly 3,000 MW received treatment for STIs.

As of September 2013, a total of 2,151 HIV-infected MW were able to access ART through the NAPHA Extension Project funded by the GFATM. It is estimated that an additional unreached 700 MW were eligible for ART in 2013. Nevertheless, there have been improvements in policy to support access to treatment for MW, for example, the MOPH announcement in support of voluntary MW access to health insurance and expansion of rights,

including the right to ART. That said, there remain obstacles to ensuring coverage of this population. There are limitations of budget in support of this population in the coming years since many of the vulnerable MWdo not fall into the traditional target populations of the NASP.

Conclusion: Implementation of prevention for MW has shown progress during the report period, largely due to international financial support. The MOPH announced a policy to provide health insurance (with ART coverage included) for registered and unregistered cross-border migrant workers; effort will be required to make the insurance work smoothly and efficiently.

Key priority actions:

Activities	Time Frame
1. Increase the clarity of targets and implementation goals for MW under the NASP and implementation plans which reflects the sources of funding to ensure systematic implementation	2014
2. Review and revise laws and policies which inhibit improving the health status of the MW population, for example the Ministry of Labor policy which only allows benefits and insurance to be extended to legal MW, and restrictive regulations on the hiring of MW as full-time health volunteers	2014-2016

Target 2

HLM: Reducing HIV transmission among PWID by 50% by 2015
Thai NASP: Reducing HIV transmission among PWID by two-third by 2016

Prevention interventions with PWID in the past two years have been benefit from GFATM support and closer collaboration by all stakeholders including government, civil society, international organizations and peer leaders from the PWID. Key activities include extension of harm reduction programmes such as methadone maintenance therapy (MMT), clean needle/syringe exchangeprogrammes (NSP), and reduction of stigma and discrimination.

The overview of outcomes found that coverage of PWID is still well below target, and only 12 sets of clean needles/syringes have been distributed per PWID per year (against the target of 88 sets), condom use is still low (49%) and less than half have had an HIV test (44%).

Obstacles to accessing prevention services continue to revolve around the traditional issues such as legal barriers (e.g., the provision that "injection drug use is a crime," and "distribution of needles is promotion drug addiction"), persistent negative attitudes of service providers toward PWID, and service systems which do not address the needs of the target population who live in diverse and varied local contexts.

There has been progress in the policy arena to facilitate the work with PWID; the signing of the order 19/2013 from the National Center to Fight over Narcotics and the associated implementation plan, which includes harm reduction for PWID on a trial basis in 19 provinces,is viewed as a critically important step that will facilitate scale up of comprehensive combination prevention for PWID.

Conclusions: Thailand can integrate harm reduction into the prevention program as long as there is a strong and consistent support from the public sector to apply more flexibility to services, including improved attitudes of government staff toward PWID.These improvements include better access to PWID in their home communities through peer outreach and removing obstacles to PWID access to services.

Key priority actions:

Activity	Time Frame
1. Reduce prejudice and stigma against PWID by government personnel, especially public health service providers and law enforcement.	2014-2015
2. Modification of the service system for MMT and NSP to improve efficiency and effectiveness, and so that services are better aligned with the needs of the client	2014-2015
3. Emphasize delivery of the full package of integrated harm reduction interventions in the 19 pilot provinces, and assess outcomes of the first two years of implementation	2014-2015

Target 3

HLM: **Elimination of mother-to-child transmission (PMTCT) of HIV and significant reduction of AIDS Mortality**

Thai NASP: **Vertical transmission of HIV less than 2%**

PMTCT in Thailand has achieved high coverage and high quality. Nearly all Thai pregnant women receive some ANC from a clinical outlet and nearly all (99.7%) are screened for HIV. Fully 95.0% of HIV+ pregnant women receive PMTCT and virtually all (99.5%) of their infants receive ART prophylaxis. It is estimated that mother-to-child transmission (MTCT) rate decreased from 2.7% in 2012 to 2.3% in 2013.

Among sero-status women, 93.7% received some ANC in Thailand. Of those, 98.9% were screenfor HIV and 71.5% of the HIV+ received ARV for PMTCT, while 97.8% of their children received ART prophylaxis, and it is estimated thatMTCT rate among this population is 4.8%.

Despite the high coverage and quality of PMTCT, there is room for improvement. There needs to be an increase in couple counseling during ANC (currently only 38%), increase in use of infant HIV diagnosis using DNA PCR, providing continuous ART for the infant through the first year of life, and increasing PMTCT coverage for foreign pregnant women who are HIV+.

Conclusions: Given Thailand's extremely high rate of coverage of quality PMTCT, it is likely to be one of the first countries in the world to achieve the target of reducing MTCT to under 2% by 2016. That said, there still needs to be increased use of couple counseling and testing services, increased coverage of HIV PCR testing among infants born to positive mothers, and increased coverage of cross-border migrants who are pregnant, HIV+, and attend Thai ANC.

Key priority actions:

Activity	Time Frame
1. Expand couple counseling services in the ANC clinic to increase coverage, and assess services to improve quality	2014-2016
2. Modify the guidelines for PMTCT by including the regimen of TDF+3TC+EFV to be administered at the earliest possible time for all infected pregnant women, and continue ART for the mother in the post-partum period regardless of CD4 level	2014
3. Improve active case management in order to follow-up HIV+ post-partum women and their infants to keep them in the service system	2014-2016

Target 4

HLM: **Reach15 Million PLHIV with lifesaving antiretroviral treatment**

Thai NASP: **All PLHIV residents in Thailand receive social protection and access to quality treatment and care AIDS-related deaths reduced by half**

Over the past two years, Thailand has revised its policy on initiating ART by increasing eligibility from a CD4 count of 200 to 350 cells/mm^3as of October 2012. The intention was to initiate ART faster to improve efficacy and reduce AIDS mortality. In addition, in 2013, the NAC approved in principle the goal of eradicating the threat of AIDS by extending ART to all regardless of CD4 count, and more thorough identification of new cases to ensure they enter the treatment system at the earliest possible time after infection. This policy is effective starting October 1, 2014.

Using the criterion of a CD4 count of 350, it is estimated that 80% of eligible PLHIV received ART, with women receiving higher coverage than men (86% versus 75%) and children less than adults (71% versus 80%). If all PLHIV are to receive ART regardless of CD4 then the current coverage rate is 54%.

Despite the raising of the CD4 threshold to 350, PLHIV initiating ART still had very low CD4 counts in the report period (median count of 92 in 2012 and 111 in 2013). Of the total starting ART, 67% had CD4 counts under 200 cells.

In 2013, the retention rates for PLHIV in the treatment system at 12 and 24 months were 83% and 79%, while the mortality rates were 8% and 11% respectively. Follow-up of ART clients initiating ART in 2009 found that the retention rates at 12, 24, and 60 months were 83%, 79% and 75% respectively. The mortality rates were 8%, 10% and 16%, respectively. Surveillance of drug resistance shows a slightly rising trend from 1% in 2009 to 2% in 2013.

Conclusions: Thailand has performed well in extending ART to as many PLHIV as possible, with steady improvements in coverage over time. Quality of service is at a high level but plateauing.

Key priority actions:

Activity	Time Frame
1. Support expansion of HIV testing and improve the referral system to ART services at the earliest time after infection, especially in the key affected populations	2015
2. Improve quality and capacity of services in preparation for the expansion of treatment eligibilityto ART regardless of CD4 level	2014-2016
3. Improve the data system and M&E to inform planning (including staff capacity building and database linkages among related clinics (HCT-STI-ART-TB)	2015
4. Support urgent reforms in health security managementfor migrant population	2015

Target 5

HLM: **Reduce tuberculosis deaths in PLHIV by 50% by 2015**

Thai NASP: **TB deaths mortality among PLHIV reduced by half by 2016**

The integrated response to TB and AIDS in Thailand is consistent with guidelines and directions of the WHO which has stipulated three objectives: (1) To implement coordination mechanisms between the TB and AIDS response plans; (2) To reduce the threat of TB in PLHIV; (3) To reduce the threat of AIDS in TB patients.

Over the past two years there has been progress for this component in many areas. Thailand has promoted provider-initiated HIV testing and counseling (PITC) for TB patients as part of the national implementation guidelines with a target to test all registered TB patients for HIV. In 2013, 92% of TB patients were tested for HIV, with 15% testing positive. Based on the projected incidence of TB-HIV co-infection, 38.8% of cases received treatment for both TB and HIV. However, if the calculation is based on the total number of registered TB patients who are HIV+, then the co-infection treatment rate would be 59%.

Application of theHIVQual-Tsystem found that 97.9% of PLHIV coming for treatment were screened for TB at least once in 2013. Mortality for cases of TB-HIV co-infection was about 13%, or about twice the mortality of TB cases without HIV infection.

Conclusion: Thailand screens PLHIV for TB and screens for HIV among TB cases at a high level of coverage. However, the mortality rate among those with co-infection is still too high. This needs to be urgently addressed. New guidelines for care and treatment of PLHIV (2014) specify initiating ART regardless of CD4 level, and this should significantly increase those starting ART at an early stage of infection. In turn, that will reduce risk of TB morbidity and mortality.

Key priority actions:

Activity	Time Frame
1. Accelerate initiation of ART regardless of CD4 to help cases of TB-HIV co-infection to receive treatment at an earlier stage of disease	2014
2. Accelerate follow-up and coordination to fill gaps in coverage in all stages of implementation, especially in locations of high mortality and lower coverage of TB detection activities	2014

Target 6

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

Thai NASP: **By 2016 increase budget proportion for prevention in priority provinces**

Secured funds for prevention services among key affected populations in priority provinces is the national priority. In the past, much of the prevention budget for these target populations has come from external sources. In the past two years, Thailand has achieved progress by increasing the proportion of the domestic budget to support prevention activities at both national and provincial.

At the national level, there has been an expansion of funding to support the NAS plan for 2014-2016, including support from the AIDS Treatment Fund of the NHSO which can be used for prevention of HIV and STI in the key affected populations (e.g., HCT). The Department for Disease Control (DDC) of the Ministry of Public Health (MOPH) has increased its budget to prepare for implementing the strategy to end AIDS starting in 2015. At the sub-national level, the local administrative organizations (LAO) are allocating more budgets for procurement of condoms. Nevertheless, there remain challenges in the area of legal restrictions and regulations which limit the flexibility of the LAO to allocate budget. These restrictions need to be reviewed and removed.

Expansion of prevention activities by encouraging a sense of ownership of the response by the local stakeholders, and this is a key to success. Efforts are underway to build capacity at the sub-provincial level to produce plans and mobilize resources for an efficient response to AIDS. That said, there are not that many concrete AIDS plans and programmes developed from the local level. Most of the grassroots activity so far is in the form of welfare subsidies for PLHIV. At the same time, there are efforts to build capacity of the board members of the local Tambon (sub-district) health fund committee to improve efficiency of fund management.

Conclusion: Significant steps have been made towards ensuring financial sustainability of the response. Domestic resources have been mobilized, both from central budget, through the expansion of the HIV treatment fund of the National Health Security Office (NHSO) to cover prevention activities, and from local administration. Close monitoring of disbursement & utilization of the domestic resources, as well as advocacy for greater flexibility and sustainability in budget allocation will be required to maintain the momentum. Capacity building and support for LAO in planning and resource mobilization for prevention interventions among the key affected populations and general population will require particular attention.

Key priority actions:

Activity	Time Frame
1. Review and specify funding mechanisms which are sustainable and appropriate for prevention using government budget or other domestics sources	2015
2. Advocate for approval of national budget by the new cabinet and allocation of resources to the relevant agencies for efficient implementation	2015-2016
3. Advocate and accelerate capacity building for LAO at the provincial and sub-provincial to urgently expand coverage. Develop guidelines for implementation for the LAO on how to provide budget support for prevention. Improve the financial data system for AIDS at the provincial and sub-provincial levels through the NAC sub-committees. Promoting a sense of ownership of the response by the province and periphery	2015

Target 7

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

Thai NASP: **Human rights and gender specific needs are addressed in all HIV Responses**

Thailand does not have sufficient data on various dimensions of gender in services and program interventions,especially systematic evidence of violence between spouses/partners, violence against women, and gender inequality as they relate to HIV infection in women. The most recent data on spousal violence comes from a survey of married women in 2009, which found that 3% reported ever being physically abused by a spouse, especially those age 15-19 years. In addition, statistics of clients appearing at crisis centers in 2011 show that there was an average of 62 clients per day of women and children who were abused by the spouse or boyfriend.

Over the past two years, there have been attempts to draft three laws to improve protection ofrights of women, and gender equality. At present, these draft laws have been submitted to Parliament. Public campaigns have been launched to improve understanding of sexual rights and promote positive sex communication. Many of these campaigns are organized by NGOs and civil society and include the development of curricula and training in gender and sexuality for staff of agencies working with the key affected populations. In the area of services, there are projects to improve access to client-friendly and safe reproductive health services for ANC clinic clients, and counseling on HIV testing and hormone for transgender population who appear at drop-in centers.

Even though gender inequality is not a top priority for the country at present, couple violence, especially as it relates to HIV infection, must be addressed, first by assembling better data and evidence of the scope and scale of the problem. Helping create a new vision and recognition about gender issues and sexual violence will improve the environment for a more efficient response to AIDS.

Conclusion: This target cannot be achieved if the service providers and AIDS workers do not see the importance of gender issues and sexual abuse of women and TG populations. Overall, the NASP still lacks mechanisms for implementation in this area. There is also a lack of empirical data on gender-based violence at the national and provincial levels.

Key priority actions:

Activity	Time Frame
1. Integrate implementation of HIV and reproductive health services toaddress gender, sexual diversity, and sexual violence, including capacity building of service providers to align attitudes with the objectives	2014
2. Conduct a national survey and compile strategic information on gender inequality, violence against women, and spousal abuse in the context of HIV/AIDS	2015
3. Review and improve laws, regulations and policies to create an enabling environment for implementation of the response to AIDS in women	2016

Target 8

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

Thai NASP: **Expand the protective social and legal environment essential for HIV prevention and care**

In the past two years there has been a review of laws and policies thatimpede the elimination of stigma and discrimination against PLHIV and other affected persons, including the key affected populations. At least two laws were identified that needed revision, such as the law on drug abuse and the law on prostitution.

Progress in the policy arena has been achieved with support for greater access to ART for MW. The August 2013 announcement of the MOPH authorized the health insurance cards for all MW at a fee of 2,800 baht per year, with ART covered as a benefit. That said, actual implementation in the field remains a challenge.

Civil Society has helped to advocate reduction in antiretroviral drug prices to improve access to ART. There are strategies, measures and mechanisms in place to protect persons from rights violations, with public information dissemination about this in order to reduce stigma and discrimination against PLHIV. This public relations effort included radio spots, short film, training on human rights, HIV and the law for groups working with MW, and capacity building so that people know how to protect their own rights and assist others whose rights may be violated.

There now is development of tools and surveys to assess the scale of the problem of stigma and discrimination among the vulnerable populations and the service providers they interact with. These tools help to assess the situation in the health system to help bring services up to standard. Another tool, iMonitor, is being tested as an instrument for community monitoring and rapid responseto cases of abuse and violence against sex workers, and data on these activities should be available in 2014.

Conclusion: There remain some laws and policies that hinder access to HIV services among key affected population. The system to collect data to measure the scope of the problem of stigma and discrimination is under development and will be put in use already in 2014. It is expected that the tool will be instrumental in informing action to reduce abuse, violence and remove obstacles to access to all service components.

Key priority actions:

Activity	Time Frame
1. Review and propose the revision of laws and policies which hinder access to services	2015
2. Expandand strengthen the channels and process for public communication to encourage society to view HIV infection as a manageable condition just as other chronic illnesses are viewed since this will help reduce stigma and discrimination	2014-2015
3. Build capacity of peer leaders and networks of people living with and affected with HIV so that they are empowered to protect their own rights and participate in advocacy for human rights protections	2014-2015

Target 9

HLM: **Eliminate Travel Restriction**

Thai NASP: **Thailand has no travel restriction relating to HIV status**

Target 10

HLM: **Eliminate parallel systems for HIV-related services to strengthenintegration of the AIDS responses in global health and development efforts**

Thai NSP: **No specific target**

Thailand has already gone a long way to integrate HIV prevention and care into the routine system of health care, social services, education, and labor. However, integration of assistance for vulnerable children and other children affected by AIDS throughout the social protections system remains a challenge.

Over the past two years the CHILDLIFE Project (funded by the Global Fund) continued implementation in the 29 provinces with higher HIV prevalence. The Project promotes a collaborative approach among agencies and individuals in the service network, including government and community organizations. There are "Child Action Groups" to advance key activities at the grassroots level. The Project attempts to achieve comprehensive care for targeted children through three integrated systems: Community, health and social protections. Civil Society, through PLHIV networks, assists with interventions to reduce stigma and discrimination in the community, and disseminates educational media. There is a phone counseling hot line, and collection of data on the target population to inform strategic planning and decision-making.

Those agencies and individuals working on AIDS operate under a common strategy and goals. Government ministries were encouraged to collaborate in this effort through the Joint key performance indicator (KPI) system of measuring progress. This system was discontinued in 2012 after three years of implementation. Recently, the National AIDS Management center has requested the approval from NAC in 2013 to reinstitute KPI to help consolidated efforts from all government agencies toward the goal of ending AIDS.

Conclusion: Despite great progress in integrating HIV services into the routine system, Thailand still faces challenges in the area of care and assistance for vulnerable children and other children affected by AIDS. The sub-national system of social protections needs improvement, and the Joint KPI system should be re-introduced in the government sector.

Key priority actions:

Activity	Time Frame
1. Advocate for a joint integrated set of indicators on AIDS as a tool to promote inter-ministerial collaboration and a shared sense of ownership of the response to AIDS	2014-2016
2. Integrate the CHILDLIFE approach into the activities of the relevant ministries including participation of the community and implementing allies to improve policy and measures for services to children in Thailand	2014-2016

4. GoodPractices Case Studies

The stakeholders and partner agencies contributing to the National AIDS Programme effort have offered the following cases of good practices.

Case No. 1: ACHIEVED Project to improve access to men who have sex with men and female sex workers

The Planned Parenthood Association of Thailand has implemented a "good practice" model for accessing MSM and non-venue-based FSW to participate in HIV prevention activities. This effort has shown that reaching the more vulnerable MSM and FSW requires skills, experience and knowledge across a range of topics in order to generate trust among these hard-to-reach groups. Efforts to reach MSM need to work through the MSM network or designated contacts. To reach free-lance FSW, it is critical to have the cooperation of entertainment establishment owners where these FSW seek clients. Implementing interventions which are tailored to these key affected populations is important in order to motivate them to seek HCT. This can be facilitated through the deployment of mobile HIV VCT units and providing same-day results of HIV tests. Services must be client-friendly, absent of any form of stigma, and providing full protection of the confidentiality of the clients.

Case No. 2: Community-based Methadone Maintenance Therapy (MMT) as Harm Reduction for PWID

The PSI Foundation initiated a pilot project to provide community MMT for PWID living in remote locations and having difficulty accessing the government MMT services. The government MMT service was city-based and limited to 45 days of MMT. Thus, the recidivism rate in the government program was high. Implementing community-based MMT was possible through the collaboration of community leaders, PWID peer volunteers, and local public health staff. For example, the project used a strategy of drop-in centers in ChiangRai to draw in the population of hard-to-reach PWID. Results in the first six months of implementation show that 97 PWID enrolled in MMT with a relapse rate of 8% (compared to a 92% relapse rate in traditional programmes). These findings support an MMT therapeutic community approach to PWID to prevent relapse. Those who remain drug-free report improved quality of life, improved health, and ability to re-enter the workforce with acceptance by the community and employers.

Case No. 3: Empowerment of Positive Women and Access to Services for Reproductive Health and Sex Abuse

This case study focuses on the Positive Women's Network (PWN) and the Raks Thai Foundation (RTF) to recruit and train HIV+ women to serve as peer educators and conduct activities with other vulnerable women such as promotion of couple counseling in the ANC

setting, promotion of couple service-seeking, and referral to partner agencies for addressing HIV-related problems in the marriage. This approach has been accepted by hospital-based service providers in that the trained peer educators and their partners are allowed to access couples in need of assistance, particularly those under age 20 years, ethnic minorities, MW, and discordant couples. The goal is to insure that these pairs participate in activities to improve knowledge about HIV testing, self-risk assessment, and positive sex communication.

Case No. 4: Addressing Issues of HIV in the Prison Setting through Sustainable Collaborationat the Provincial Level:

Providing HIV VCT in the prison setting through the prison infirmary in Lampang Province in northern Thailand was achieved through the collaboration of the Department of Corrections, the Lampang Provincial Hospital and the Lampang Provincial Chief Medical Office. This program is a model of best practices in devising an approach to reduce HIV transmission among prisoners in an efficient and effective way. This project relied on existing resources and personnel, especially the members of the provincial network and demonstrated the feasibility of conducting prevention programmes in the prison setting just as effectively as those in the broader community.

Case No. 5: Creating a Quality Network for Monitoring Child PLHIV

Over the past five years, most of the pediatric cases of HIV received ART at regional and provincial hospitals. This increased the ART workload of these facilities, straining their ability to cope with the demand. What is more, the concentration of services in the major urban centers increased the cost of travel and time spent by rural PLHIV clients to keep appointments. In response, a new approach was introduced to link community hospitals with provincial hospitals to provide closer-to-home care. The model for this approach was tested in Chiang Rai and subsequently expanded to 12 other provinces with support from the Global Fund and the TUC. During 2011-13, this model was further expanded throughout the country to improve quality care for pediatric PLHIV. This model involves the collaboration of four regional learning centers including the Chiang Rai Provincial Hospital, the Sri Nakarin Hospital of KhonKaen University, thePrachomKlao Hospital, and HatYai Hospital. Staffs of these hospitals serve as mentors to the other facilities implementing this program.

Case No. 6: Counseling on Disclosure of Child and Youth HIV Aerostats

Informing HIV+ children and youth of their aerostats, especially for those approaching adolescence, is a delicate issue that needs to be managed properly and at the right time. BATS has collaborated with the NHSO, the TUC, and nurses counselors at hospital-based learning centers to develop a training curriculum to address this challenge. BATS has organized training sessions in counseling children and youth about their HIV+ sero-status for staff of 71 provincial hospitals. Preliminary evaluation of this effort has found that the

number of children/youth who know their HIV+ sero-status has increased. Most of the caregivers in the HIV+ child's family are relieved that this is known, and family relationships have improved as a result. This initiative has increased the ability of personnel to communicate about HIV/AIDS withfamily members and the community.

Case No. 7: Reduction of treatment disparities among Thai under the three Benefits Systems and among migrants

Even though the Thai health insurance scheme includes free ART for Thai nationals, HIV+ cross-border MW are not formally eligible for this subsidized care. Thus, Thailand has pursued efforts to expand access of subsidized ART to eligible MW in recent years. The MOPH issued a proclamation on August 13, 2013 which authorized MW to acquire health insurance in one form or another (i.e., through the Ministry of Labor or the MOPH). The benefits package included the right to HCT, PMTCT, and ART. While, in practice, there remain obstacles to accessing these benefits, efforts are being put in place to ensure smooth functioning of the MW insurance scheme.

As for disparities in access to ART among the three insurance systems (government civil servants, social security, and universal health insurance), Thailand has undertakento achieve unity of these systems and eliminate disparities through the integration of the three schemes so that each uses the same standard and criteria for service. In this way there is seamless transition across insurance schemes.

Case No 8: Migrant Health Workers increase migrants' access to health services and improve health outcomes

The Prevention of HIV and AIDS among Migrant Workers in Thailand Program, known as PHAMIT, provides HIV prevention services to migrants, helps recruit and train Migrant Health Workers (MHW) to provide translation and counseling to migrants in hospitals. Migrants are recruited through outreach activities in the community. Commonly, these people first become volunteers who pass through capacity building trainings on HIV and health and assist with outreach activities. Over time they display responsibility, commitment and the ability to communicate about HIV properly. Those who are appropriate are then recruited to be Migrant Health Workers at hospitals or Migrant Field Officers to work with the NGO. The MHW also acts as a vital linkage between the hospital and the migrant community. MHW played a significant role in these clinics. Through their linkage with networks of volunteers in the migrant community, MHW helps promote mobile clinics and also provide responsive services to combat outbreaks of diseases. For those migrants who initiate ART, MHW provide essential follow-up to promote adherence. In Ranong, the Provincial Public Health Office has used PHAMIT support and obtained local funding to train and hire around twenty MHWs who are currently placed in local hospitals around the province.

5. Support from International Development Partners

Thailand's international development partners use the current NASP as a guide to providing assistance toward achievement of the ten targets for 2012-13.

The Global Fund assistance is used to fill gaps and is concentrated on funding prevention interventions for the key affected populations of MSM, TG populations, sex workers, PWID, and prisoners, and funding for ART for MW. The report period encompassed the first two years of the Global Fund support for the CHILDLIFE Project in higher HIV prevalence provinces.

The Thai-US Collaboration and USAID were the key contributors of funding for technical assistance and strategic development, exploring innovative approaches to prevention for key affected populations, prisoners, and PMTCT, health promotion for HIV+ post-partum mothers and their infants, improving quality of ART for children and adults, prevention and management of TB-HIV co-infection, and improvements and expansion of the M&E system for national coverage.

The UN Joint Team on AIDS has developed a joint plan for assisting Thailand in the following three areas: (1) Support scale up of highimpact HIV prevention interventions in priority provinces; (2) Support forthe review of laws and regulations which impede access to services by the key affected populations, and advocacy for a national resolution to remove these obstacles to access; and (3) Support development and use of innovative strategic information tools to inform decision-making to improve of HIV response. Each member of the Joint Team has their own set of activities to support Thailand to achieve national goals.

6. Monitoring and Evaluation (M&E)

Over the past two years, there has been progress in M&E planning in accordance with the national AIDS strategy. ASub-committee on Strategic Information was appointed under the NAC (on April 27, 2012) to oversee implementation and monitor progress, including developmentof policy recommendations and support for efficient operations of the M&E system.

Thailand has had a well-establishedsurveillance system which tracks AIDS morbidity, mortality, risk factors and behavior. HIV incidence using BED techniques, prevalencesurveys, and integrated HIV and behavioral surveillance of the key affected populations and sero-status have been implemented. The behavioral monitoring and surveillance of resistance to ARV drugs represent an important database for tracking the status and evolution of the HIV epidemic. For projections, Thailand has relied on the Asian Epidemic Model (AEM) for the adult population and the SPECTRUM software for the child population. There are surveys and estimates of the hard-to-reach populations to help inform policy and plans at the national level.

To monitor effects of ART, Thailand has improved theNational AIDS ProgrammeDatabase (NAP) so that it is now referred to as NAP plus that contain ART database from three health insurance scheme.There is a GIS system linked with NAP plus to produce estimates of ART coverage and quality. Thailand has produced the NAP-DAR to enable service outlets to check the accuracy of data and analyze the data themselves. This should improve the quality and use of the data in the NAP plus system, resulting in better reports of progress toward indicator targets, and provide a more accurate picture of the actual situation.

ThePerinatal HIV Intervention Monitoring System (PHIMS) (version 3)began fullimplementation in 2013 which improves the coverage of the reporting system. The Routine Integrated HIV Information System (RIHIS) is being applied to produce higher quality information for the key affected populations. There is data for assessing the number of children needing assistance, and access to disadvantaged children in 19 provinces which receive funding from the Global Fund. The STI monitoring system has also been improved.

Evaluation and research studies during the report period are helping to inform changes in policy and improvements in implementation to increase efficiency. These studies include a cost-benefit analysis of alternative approaches to ending the AIDS in Thailand, an evaluation of HIV prevention among MSM, sex workers and PWID, an evaluation of HIV VCT, ART and care through the Holistic Centers, a study of sexual orientation and gender assessment of MSM,and a review of early infant diagnosis procedures.

There have been supporting the use of data in decision makingto improve quality of services at the implementation level on a regular basis. At the end of 2012, the HIVQual-T tool was integrated into the routine system as a means to monitor the quality of clinical services and as a basis for hospital accreditation.

In addition, there were innovations to improve access to and use of data through the AIDS ZERO PORTAL, which is a complete package with the core, essential data on HIV, which can be displayed at the national, provincial and facility levels.

Implementation of the ending AIDS strategy, with expanded provision of combination prevention, will present a new set of challenges for the national SI/M& E system. Greater integration of M&E data on prevention, care and treatment in aunifiedsystemwill be required to enable monitoring of continuum of care, from prevention to treatment to support. Accelerated expansion of the M&E system at provincial level will be needed to support decentralized service delivery and increased role of communities in service delivery.Revision of M&E personnel and budgetary provisions may be in order to support the strengthening of the national M&E system.

Overview indicator table

TARGET 1: Reduce sexual transmission of HIV

HLMTarget: Reduce sexual transmission of HIV by 50% by 2015
Thai NASP: Reduce new HIV infections by 2/3 by 2016

Targets		Indicators	GARP	UA	National target by 2016	2009	2010	2011	2012	2013
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				
		Percentage of high school students and vocational students (male and female) aged 16 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	High school students (male)			28.6%	28.9%	21.9%	25.2%	24.3%
			High school students (female)			30.3%	29.7%	23.5%	25.9%	23.7%
			Vocational students (male)			28.7%	23.2%	19.0%	20.1%	21.5%
			Vocational students (female)			30.9%	23.9%	18.1%	21.4%	23.0%
	1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	●	●		Data not available				
		Percentage of high school students (male and female) aged 16 who have had sexual intercourse before the age of 15	High school students (male)			4.8%	6.0%	8.0%	4.1%	5.3%
			High school students (female)			1.8%	1.8%	3.3%	2.5%	2.8%
			Vocational students (male)			8.6%	11.0%	13.5%	6.9%	9.5%
			Vocational students (female)			4.2%	5.6%	6.2%	5.3%	4.9%

Targets	Indicators		GARP	UA	National target by 2016	2009	2010	2011	2012	2013
	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				
		Percentage (%) of factory workers (male and female) aged 15 - 49 who have had sexual intercourse with more than one partner in the past 12 months	Factory workers (male)						16.2%	21.6 %
			Factory workers (female)						5.5%	4.6%
	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 their last sexual intercourse	●	●		Data not available				
		Percentage (%) of factory workers (male and female) aged 15-49 who have had more than one sexual partner in the past 12 months who reported the use of a condom during their last sexual intercourse.	Factory workers (male)						53.9%	49.0%
			Factory workers (female)						30.9%	16.7%
	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	●	●	0.3%	Data not available				
		Percentage (%) of factory workers(male and female)aged 15-49 who received an HIV test in the last 12 months and who know their results	Factory workers (male)						18.0%	23.7%
			Factory workers (female)						19.2%	25.2%
	1.6	Percentage (%) of young people (woman) aged 15-24 who are living with HIV	●	●	0.3%	0.58%	0.44%	0.44%	0.40%	0.43%
Female Sex workers	1.7	Percentage of sex workers reached with HIV prevention programmes	●	●	80.0%		50.45%		53.89%	

Targets	Indicators		GARP	UA	National target by 2016	2009	2010	2011	2012	2013
Female Sex workers	1.8	Percentage (%) of sex workers reporting the use of a condom with their most recent client	●	●	95.0%		95.56%		93.60%	
	1.9	Percentage (%) of sex workers who have received an HIV test in the past 12 months and know their results	●	●	90.0%		47.76%		55.60%	
	1.10	Percentage (%) of sex workers who are living with HIV	●	●	1.0%		2.69%		2.16%	
Male Sex workers	1.7	Percentage of sex workers reached with HIV prevention programmes	●	●	80.0%		61.00%		73.77%	
	1.8	Percentage (%) of sex workers reporting the use of a condom with their most recent client	●	●	99.0%		88.00%		98.18%	
	1.9	Percentage (%) of sex workers who have received an HIV test in the past 12 months and know their results	●	●	90.0%		49.00%		52.38%	
	1.10	Percentage (%) of sex workers who are living with HIV	●	●	10.2%		16.00%		12.20%	
Men who have sex with men	1.11	Percentage of men who have sex with men reached with HIV prevention programmes	●	●	80.0%		43.79%		52.65%	
	1.12	Percentage (%) men reporting the use of a condom the last time they had anal sex with a male partner	●	●	95.0%		80.22%		85.49%	
	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%		14.93%		25.58%	
	1.14	Percentage (%) of men who have sex with men who are living with HIV	●	●	6.0%		8.02%		7.13%	

Targets	Indicators		GARP	UA	National target by 2016	2009	2010	2011	2012	2013
	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	1,344,165
		Number of HIV+						22,339	21,907	22,122
		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	527,373
		Number of HIV+						17,464	16,984	17,031
	1.16.1	Percentage (%) of health facilities dispensing HIV rapid test kits that experienced a stock-out in the last 12 months. (new)		●						Data not available
	Sexually Transmitted Infections (STIs)									
	1.17.1	Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit		●					91.55%	95.78%
	1.17.2	Percentage of antenatal care attendees who were positive for syphilis		●					0.06%	0.05%
	1.17.3	Percentage of antenatal care attendees positive for syphilis who received treatment		●					93.10%	97.87%
	1.17.4	Percentage of sex workers (SWs) with active syphilis	Median					0.26%	0.00%	0.00%
			Mean					0.62%	0.54%	0.69%
	1.17.5	Percentage men who have sex with men (MSM) with active syphilis		●						24.36%

Targets	Indicators		GARP	UA	National target by 2016	2009	2010	2011	2012	2013
	1.17.6	Number of adults reported with syphilis (primary/secondary and latent/unknown) in the past 12 months (new)		●						2,273
	1.17.7	Number of reported congenital syphilis cases (live births and stillbirths) in the past 12 months (new)		●						Data not available
	1.17.8	Number of men reported with gonorrhea in the past 12 months (new)		●						6,409
	1.17.9	Number of men reported with urethral discharge in the past 12 months (new)		●						NA
	1.17.10	Number of adults reported with genital ulcer disease in the past 12 months (new)		●						NA

TARGET 2: Reduce transmission of HIV among people who inject drugs

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

Thai NASP: Reduce new HIV infections by 2/3 by 2016

Targets	Indicators		GARP	UA	National target by 2016	2009	2010	2011	2012	2013
	2.1	Number of Syringes distributed per person who injects drugs per year by needle and syringe programmes	●	●	88			9.79	11.52	12.02
	2.2	Percentage (%) of people who inject drugs who report the use of a condom at last sexual intercourse	●	●	95.0%	39.18%	46.02%		49.06%	
	2.3	Percentage (%) of people who inject drugs who reported using sterile injecting equipment the last time they injected	●	●	82.0%	42.02%	77.68%		80.45%	
	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%	39.99%	40.71%		43.65%	
	2.5	Percentage (%) of people who inject drugs who are living with HIV	●	●	21.0%	17.20%	21.87%		25.20%	
	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)		●	4,500		2,201	2,612	3,735	4,068
	2.7	Number of needle and syringe programme (NSP) sites Number of opioid substitution therapy (OST) sites (WHO)								
		2.7.1 Number of needle and syringe programme (NSP) sites		●		39	49	42	36	38
		2.7.2 Number of substitution therapy (OST) sites		●		49	Data not available	147	147	147

TARGET 3: Eliminate mother-to-child transmission of HIV

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

Thai NASP: Vertical transmission ofHIV less than 2%

Targets	Indicators		GARP	UA	National target by 2016	2008	2009	2010	2011	2012	2013
	3.1	Percentage(%) of HIV-positive pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission	●	●	98.80%	93.60%	95.00%	94.20%	93.98%	93.75%	95.15%
	3.1.1	Percentage (%) of women living with HIV who are provided with antiretroviral medicines for themselves or their infants during the breastfeeding period (new)	●								Indicator not relevant
	3.2	Percentage % of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	●	●	90.0%			75.80%	73.13%	77.23%	72.87%
	3.3	Estimated percentage (%) of child infections from HIV-infected women delivering in the past 12 months	●	●	2.0%			3.75%	3.04%	2.74%	2.30%
	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		●		99.70%	99.30%	99.50%	99.87%	99.14%	99.74%
	3.5	Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months		●	60.0%					32.30%	38.41%
	3.6	Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing		●			44.00%			85.56%	88.16%

Targets	Indicators		GARP	UA	National target by 2016	2008	2009	2010	2011	2012	2013
	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		●		96.50%	99.30%	99.40%	99.00%	99.17%	99.47%
	3.8	Percentage of infants born to HIV-infected women (HIV-exposed infants) who are provided with antiretroviral (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 co-trimoxazole (CTX) prophylaxis within two months of birth		●			35.90%		42.00%	51.99%	57.34%
	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	804,484

Target 4: Anti-Retroviral Treatment

HLM Target: Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015
Thai NASP: All PLHIV residents in Thailand receive social protection and access to quality treatment and care
AIDS-related deaths reduced by half

Targets	Indicators		GARP	UA	National target by 2016	2009	2010	2011	2012	2013
	4.1	**Receiving ART**								
	4.1.1	Percentage (%) of eligible adults and children currently receiving antiretroviral therapy	●	●	90 %					
		- (CD4 <200 cell/ml)				75.76%	71.80%	77.00%		
		- (CD4 <350 cell/ml)					59.10%	64.61%	69.96%	80.25%
		- any CD4 Level								53.55%
	4.1.2	Number of adults and children currently receiving ART				216,118	208,570	225,272	239,090	246,049
	4.2	**Retention of ART**								
	4.2a	Percentage (%) of adults and children with HIV known to be on treatment 12 months after initiating antiretroviral therapy	●	●	95.0%	85.14%	80.70%	83.12%	82.11%	82.70%
	4.2b	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)		●			79.80%	79.80%	78.89%	78.38%
	4.2c	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)		●			Data not available	Data not available	Data not available	75.91%
	4.3	Number of health facilities that offer antiretroviral therapy (i.e. prescribe and/or provide clinical follow-up)		●						
		- Adults				1,014	943	937	949	978
		- Pediatric							672	675

Targets	Indicators		GARP	UA	National target by 2016	2009	2010	2011	2012	2013
	4.4	Percentage of health facilities dispensing antiretroviral (ARVs) for antiretroviral therapy that have experienced a stock-out of at least one required ARV in the last 12 months (WHO)		●				3.14%	Data not available	3.55%
	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 (Not need in 2014)		●			89.00%	89.32%	92.47%	
	4.6	**HIV care**								
		Number of adults newly enrolled in pre-antiretroviral therapy (pre-ART) during the reporting period (Not need in 2014)		●					10,646	
		Number of adults newly enrolled in HIV care (pre-ART or ART) during the reporting period (Not need in 2014)		●					24,654	
	4.6a	Total number of adults and children enrolled in HIV care at the end of the reporting period (New)		●						407,046
	4.6b	Number of adults and children newly enrolled in HIV care during the reporting period (New)		●						52,521
	4.7	**Viral Load**								
	4.7a	Percentage of people on ART tested for viral load who have a suppressed viral load in the reporting period (new)		●						95.38%
	4.7b	Percentage of people on ART tested for viral load (VL) with VL level ≤ 1000 copies/ml after 12 months of therapy (new)		●						92.54%

Target 5: Reduce tuberculosis deaths in people living with HIV

HML Target: Reduce tuberculosis deaths in people living with HIV by 50% by 2015
Thai NASP: TB deaths among people living with HIV reduced by half

Targets	Indicators		GARP	UA	National target by 2016	2009	2010	2011	2012	2013
	5.1	Percentage (%) of estimated HIV-positive incident TB cases that received treatment for TB and HIV	●	●	50.0%	25.53%	26.07%	36.19%	27.84%	38.37%
	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) (Not need in 2014)		●			Data not available	Data not available	Data not available	
	5.2	Percentage of adults and children living with HIV newly enrolled in care who are detected having active TB disease (New)		●						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	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		●			94.98%	Data not available	Data not available	Data not available

Target 6 :Close the global AIDS resource gap and reach annual global Investment

HML Target: Close the global AIDS resource gap by 2015 and reach annual global Investment of US$22-24 billion on lowand middle income countries

Thai NASP: By 2016 increase budget proportion for prevention in priority provinces

Targets	Indicators		GARP	UA	National target by 2016	2008	2009	2010	2011	2012	2013
	6.1	Total AIDS spending (USD.)	●			208.1	210.2	244.0	325.4	282.9	287.3
		- Percentage of domestic sources (%)				85.4	93.3	85.2	85.7	89.8	89.4
	6.2	Total AIDS spending for prevention program (USD.)				45.1	28.8	32.0	43.7	47.3	49.0
		-Percentage of prevention spending out of total AIDS spending (%)				21.7	13.7	13.1	13.4	16.7	17.1
		- Percentage of domestic sources (%)				79.8	87.8	47.9	55.7	76.9	78.2
	6.3	Total AIDS spending for prevention program targeting on PWID, SW, MSM				NA	NA	NA	8.1	5.3	5.4
		- Percentage ofAIDS spending for prevention program targeting on PWID, SW, MSM out of prevention program (%)				NA	NA	NA	18.5	11.3	11.1
		- Percentage of domestic sources (%)				NA	NA	NA	2.3	8.8	13.8

Note: Exchange rates in 2008-2013 from the Bank of Thailand are used. The exchange rates in Thai Baht per 1 USD are as follows: 33.29, 34.29, 31.69, 30.49, 31.08, and 30.73 respectively.

TARGET 7: Eliminating gender inequalities

HMLTarget: Eliminating gender inequalities and gender-based abuse and violence and increase the capacity of woman and girl to protect themselves from HIV

Thai NASP: Human rights and gender specific needs are addressed in all HIV Responses

Targets	Indicators		GARP	UA	National target by 2016	2012	2013
	7.1	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from male intimate in the past 12 months	●				Data not available

TARGET 8: Eliminating stigma and discrimination

HML Target: Eliminating stigma and discrimination against people living with and affected by HIV through promotion oflaws and policies that ensure the full realization of all human rights and fundamental freedoms

Thai NASP: Expandthe protective social and legal environment essential for HIV prevention and care

Targets	Indicators		GARP	UA	National target by 2016	2012	2013
	8.1	Discriminatory attitudes towards people living with HIV	●		Reduce stigma and discrimination by 50 %		Data not available

TARGET 10: Strengthening HIV Integration

HML Target: Eliminate parallel system for HIV- related services to strengthen integration of the AIDS response in health and development efforts

Thai NASP: No specific target

Targets	Indicators		GARP	UA	National target by 2016	2012	2013
	10.1	Orphans school attendance (Percentage Current school attendance among orphans and non-orphans 10–14 years old, primary school age, secondary school age)	●				
		Part A: Children who have lost both parents					91.70%
		Part B: Children who are living at least one parent					97.70%
	10.2	External economic support to the poorest households (Proportion of the poorest households who received external economic support in the last 3 months)	●		TBD		80.19%