Thailand AIDS Response Progress Report 2012
Reporting period: 2010-2011

Status at a Glance

(a) Inclusiveness of the stakeholders in the report writing process

The 2012 Thailand AIDS Response Progress Report covers the period 2010 and 2011. This report was prepared with the full collaboration and participation of all related sectors including government, civil society and international organizations.

The Department of Disease Control (DDC), Ministry of Public Health (MoPH), as secretariat of the National AIDS Committee (NAC), joined with the Thai National Coalition on AIDS (TNCA), the Thai Network of People living with HIV/AIDS (TNP+), and UNAIDS to coordinate the compilation of this report. Representatives from government, civil society, and international organizations were appointed to a technical task force charged with facilitating data collection and analysis for the overall report and receiving endorsement on their interpretation from key stakeholders.

Task force representatives worked with 13 working groups, each focused on specific required components of the report. Working groups included representation from 12 departments of the MoPH, 9 departments of other ministries other than the MoPH, 17 civil society organizations, and 8 international agencies. Working groups compiled and analyzed relevant information to produce a draft report for discussion and consultation with the larger assembly of program partners and key stakeholders.

Data collection for the National Commitments and Policy Instruments (NCPI) component of the Report was undertaken with the assistance of two technical specialists. In Part A (Government response), data was collected from 24 government departments (9 from the MOPH and 15 from other governmental entities). Data for Part B (NGO sector response) was compiled through consultative meetings among their constituency and their findings and recommendations were presented at consultative meetings referenced above which included representation from government, civil society and international organizations.

Two consultative meetings were convened during the Report development process. The purpose of the first meeting was to review initial findings among technical experts in each of the areas being reported on. In the second meeting, a total of 210 persons representing 28 government organizations, 26 civil society organizations, and eight international organizations from national and sub-national levels participated to review and endorse findings presented by the different working groups.

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(b) Status of the Epidemic

The spread of HIV in Thailand continues after the first diagnosed case nearly 30 years ago. From the first AIDS case report in 1984, the main driving force of the epidemic has been unsafe sex, and this has disproportionately affected women and men of reproductive age. Even though Thailand has had a National Strategic Plan since 1992 which helped the country succeed in rapidly slowing the spread of the virus during the decade that followed, HIV continued to spread during the first decade of the new millennium among the general population, with troubling trends in the key affected populations, including female sex workers (FSW), men who have sex with men (MSM), and people who inject drugs (PWID).

Despite the stable and slightly declining trend of HIV prevalence among pregnant women aged 15-24 years and male military recruits aged 20 -24 years, the risk behavior data in youth which reported an increase in sex-partner mixing without condom use could be contributing to the increased risk for STIs and unwanted pregnancy. The age distribution of STI patients in which the highest number of cases was in the 15-24 year age group, and the number of teenage deliveries per 1000 girls aged 15-19 years had increased from 33.7 in 1989 to 50.1 in 2010.

Among the higher risk groups, the trend of HIV prevalence during the past few years remained stable at around 2% for venue based FSW. The recent evidence from prevalence surveys among non venue-based FSW revealed higher HIV prevalence than venue-based FSW. This is especially worrisome since proportionally more of the non venue- based FSW are outside of the formal HIV prevention program than the venue- based FSW, and may not be receiving the same level of care and information about prevention of HIV and STIs.

The rapid spread of HIV among MSM has been observed from IBBS in 3 big tourist cities. In a 2010 survey, HIV infection among MSM remained high in Bangkok (31.3%). Lower prevalence was observed in Chiangmai and Phuket. HIV prevalence among MSM aged less than 25 years was at 12.1%. The trend of HIV prevalence among Transgenders was lower than MSM (around 10% in 2010), but the trend did not decline over the past years. Alike, the trend of HIV prevalence among MSW in the sentinel sites did not decline and was still high at 16% in 2010.

The prevalence of HIV among PWID attending detoxification centers is still high, at levels of 30% to 40%. The IBBS conducted in 2010, using respondent driven sampling (RDS) which represents PWID in communities, documented HIV prevalence among PWID at 21.9%.

The Asian Epidemic Model (AEM) and policy analysis were used to estimate new HIV infections as well as number of PLHIV for the purpose of planning for the ART program. It is estimated that 43,040 new infections will occur during 2012-2016. Among the estimated number of new infections, 62% will be through transmission among MSM, FSW and their clients and PWID; 32% will be through intimate partners and 6% through casual sex.

In sum, the epidemiological and behavioral data indicate that the number of new HIV infections in Thailand continues among key affected populations including MSM, FSW and PWID as well as certain subgroups of general population.

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(c) Policy and Programmatic Response

During 2010-2011, the last two years of the National AIDS Strategic Plan (2007-2011) the reviewing process was undertaken to review HIV/AIDS situations and implementation of policies, plans and program, and to assess remaining gaps and challenges for improving the HIV/AIDS responses as well as to identify next steps to be undertaken in order to reach the targets set.

In addition to the situation review and assessment, through partnership and collaboration of Government agencies (both health and non-health), Civil Society, academics, the development of national M& E system was proposed, and called for collective and synergistic efforts, especially among the line ministries to deal with the national HIV/AIDS response. With the consensus of stakeholders, the national strategic information and M&E Plan for HIV/AIDS 2012-2016 was developed in late 2011 as a comprehensive and consolidated effort to systematically plan for new generation of strategic information and national M&E for HIV/AIDS response toward achieving the "Getting to Zero" Goals in 2016.

Target 1: Halve sexual transmission of HIV by 2015

Population of reproductive age (15-49 years)

Estimates from application of the Asian Epidemic Model (AEM) suggest that one in three new HIV infections in Thailand in 2012 will occur in intimate partnerships, while a much smaller 6% of new infections will be among casual sex partners.

While the HIV sentinel surveillance system (HSS) does not include a representative sample of the general population of reproductive age, surveillance among three proxy groups is able to suggest trends of HIV spread among the general population. These include ante-natal care (ANC) clinic clients, in which declining trends in HIV infection have been noted; blood donors aged 20 – 24 years in which increasing levels of HIV infection have been noted; and military recruits (males) at the time of induction in which stable levels of HIV infection have been noted. Nevertheless, the results from behavioral surveillance of the working-age population indicating declining HIV knowledge over time, and inconsistent condom use - particularly among those with more than one sex partner and those who visit female or male sex workers remain concerns on HIV prevention among general population

In the past two years (2010-11) there have been attempts to expand HIV counseling and testing for couples in ANC clinics. The continuation of the ASO (AIDS Response Standard Organization) approach has put more emphasis on the quality for expanding the program. To be awarded for the ASO, it is required for workplaces to have their own policy in dealing with HIV issues, including prevention, referral for treatment and AIDS rights protection for their employees. An important area of policy improvement is that the National AIDS Committee (NAC) has announced the national guidelines for AIDS management in the workplace, modifying from the ASO, for both public and private worksites.

The important challenges that need to be addressed in the coming period is the need to increase the number of women coming to ANC clinics with their partner, and to apply and scale up the national guidelines for AIDS management in the workplace to achieve maximum, quality coverage of both government and private worksites.

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Youth

Youth are not represented directly in the national Health Surveillance Sentinel system. Thus, the group of pregnant women aged 15-24 years who appear at ANC clinics, along with new army inductees, is used as a proxy trend of HIV prevalence in the general youth population. When compared with the previous progress report for 2008-2009, data for the past two years show that there have been *declines* in HIV knowledge and understanding (less than 30% in every subgroup youth on surveillance), and increased risk behavior, in the youth population (e.g., having more than one sex partner at a time, low condom use).

During 2010-11, there were several achievements in prevention of HIV among youth including development of a national policy and associated strategy for reproductive health, which includes expansion of youth-friendly services, delivery of sex education in community, strengthening of life skills through school-based education.

Effective implementation of the national strategy is hampered, however, by incomplete implementation in three areas: (1) sex education in schools: Less than the recommended global standard of 30 hours per academic year are being provided in most schools; not all schools in different geographical locations are providing sex education; and to date there has been no evaluation of the effectiveness of the program of instruction in altering behaviors; (2) youth-friendly service delivery: Most centers still are not meeting felt needs of the affected population; and not all geographical locations are yet providing these services; and (3) youth under age 18 who desire HIV counseling and testing still require parental consent.

Female Sex Workers (FSW)

Data from the HIV Sentinel Surveillance survey among venue-based FSW found that HIV prevalence among these women has declined steadily over time: 2.8% to 2.2% to 1.8% in 2008, 2010, and 2011 respectively. HIV prevalence is lower among the younger age group, opposite to the findings of the IBBS of 2010 for non-venue-based FSW in Chiang Mai, Phuket and Chonburi. In that survey, the level of infection was highest among the age group under 25 years (2.6%). Correct answers to the five HIV/AIDS knowledge questions were rather low among this population (under 40% correct) and this has not changed over the prior five years. Fully 95.7% reported using condoms with their last customer; yet only 45.4% of FSW reported using condoms with a lover or husband. With financial and technical support from the Global Fund Round 8it was found that during 2008-2010, 81% of FSW had been tested for HIV and knew the results, as compared with only 57% during 2004-2007.

During 2010-11, HIV prevention implementation continued with the Global Fund Round 8 support and with support from government, civil society and the private sector through initiatives such as establishing drop-in centers, distribution of condoms and lubricant, and initiating the innovative Comprehensive Condom Programming (CCP) project, among others. These activities were implemented in an effort to increase access to HIV prevention services and expand coverage, increase quality of services, intensify outreach, build capacity for service providers and civil society workers, increase participation of stakeholders, mobilize resources and conduct network strengthening.

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Accomplishments in the past two years include increased coverage and quality of STI/HIV services, for instance under the Global Fund support, the coverage of STI clinics has reached 185 in 74 provinces in 2011, increased participation of community leaders, and mobilization of local resources, policy advocacy through the "sex work is work" campaign, and formation of the Subcommittee on Rights with representatives from female sex workers and other civil society agencies working in this area.

Yet there remain many challenges in increasing effectiveness of HIV prevention programming targeting female sex workers, including the complexity of data collection at national level on this population, multiple sources of surveillance data, and differing techniques of data collection which make it difficult to consolidate the data into a national picture of the situation. The referral system from outreach services provided by NGOs to VCT and STI services in hospitals needs to be improved. Local participation and involvement from local areas also remains weak. FSW who are non-Thai also lack access to free services and essential information which is reserved for Thai nationals. In this way, laws and regulations are still an obstacle to access to prevention and health care.

Men who have Sex with Men (MSM)

These three populations contribute to the sustained incidence of HIV in Thailand, with no indication of declines in the near future. From surveys in 2010 in three provinces (Bangkok, Chiang Mai, Phuket and Chiang Mai) it was found that HIV prevalence among MSM was 20.0%, followed by 17.7% among MSW and 10.4% among TG. There were significant differences in prevalence by age as well. For instance, HIV prevalence among MSM aged 25-29 was 32.4% while the rate among those in age group 15-24 was 12.1%.

When looking at the proportion reporting having had an HIV test in the prior 12 months and who knew their results, it was found that more male sex workers (51.4%) had been tested and knew their results, followed by transgenders (41.3%). The lowest rates were among men who have sex with men (29.2%). The proportion who reported receiving condoms and lubricant was highest among transgenders (7 out of 10 transgender respondents), although the rate of reported condom use at last sexual encounter (84.5%) in the past six months was highest among men who have sex with men.

During 2010-11, the government accelerated the expansion of HIV prevention interventions targeting these three populations utilizing multiple channels. There have simultaneously been measures implemented supporting treatment, care and support through collaboration with civil society and the private sector. The CHAMPION Project (HIV prevention among KAPs), with support from the Global Fund, has been implemented in 30 provinces, which has started in late 2010. The Department for Disease Control has strengthened related work in 47 provinces outside the CHAMPION target areas, mainly through condom distribution, condom points, supporting local initiatives by local NGOs in campaigning and awareness raising.

While there are many indications of accomplishments in trying to reduce HIV incidence among these three populations, implementation in the past two years has been difficult in certain respects. For example, with administrative decentralization efforts, many local communities either do not see this as a priority, or lack the capacity to effectively program HIV prevention activities for these populations. In addition, civil society leadership among these affected is at times weak, particularly

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in creating awareness and concern among community leaders regarding the need to support effective interventions and policies targeting these at risk groups. Strategic planning and quality improvement initiatives are also hampered by a lack of availability of strategic data. Poor quality of services offered consequently results in decreased motivation among affected populations to seek HIV prevention services. Stigma and discrimination against these populations also acts as a deterrent to demand for services and needs to be addressed.

Migrant workers

The 2010 IBBS was first implemented among migrants worked in six provinces (three coastal and three inland). The IBBS found that HIV prevalence varied by nationality (Cambodia 2.15%, Myanmar 1.16%, Lao PDR 0.51%) and type of occupation (seafood processing 2.34%, deep-sea fishing 1.96%, agriculture 0.7%). Comprehensive HIV knowledge was also found to be low in this population. Only one-fourth of migrant workers could answer all five HIV/AIDS knowledge questions correctly. High risk behavior among migrants was also elevated. 27.5% of migrant workers under the age of 25 years had more than one sex partner in the past 12 months (highest rate of multiple partners was among the group of fishing boat crew), use of condoms was low, and only 8% had benefitted from HIV counseling and testing and knew their test results.

Important achievements of the HIV prevention program for migrants “PHAMIT Project” during 2010-11 include the distribution of more than 1.5 million condoms per year, distribution of HIV risk reduction-related media to over 250,000 migrant workers, and HIV counseling and testing provided to over 4,000 migrant workers. 2,500 migrant workers were screened for STIs and those with positive diagnoses received appropriate case management.

Target 2: Reduce transmission of HIV among people who inject drugs by 50% by 2015

People who Inject Drug (PWID)

The 2010 IBBS conducted in Bangkok, Chiang Mai and Songkla found that HIV prevalence among people who inject drugs (PWID) was 21.9%. The HIV prevalence among those who inject heroin and/or opium who present for treatment at drug treatment and rehabilitation centers around the country has remained constantly high at levels ranging from 30% to 50% depending on location. While the self-reported use of sterile needles/syringes by PWID is rather high (77.8%), condom use and access to HIV prevention remains low(46.1%). The data show that females who inject drugs used sterile needles and condoms less frequently compared with male PWID, and an HIV prevalence in female was 30.8% compare to 24.2% among male injectors.

In 2010 the National AIDS Committee approved a harm reduction policy for ten comprehensive service packages for PWID. This policy was also presented to the National Narcotics Control Board and approved as an intervention option, with pilot implementation schemes to begin in ten provinces for the year 2011. In parallel, six complementary projects funded by international donors including the CHAMPION project funded by the Global Fund have being implemented in selected provinces. The negative consequence and law violation of needles and syringes program are still debated in Thailand, and during the current reporting period the MoPH, civil society, and international organizations have actively advocated for full implementation of all aspects of harm reduction, and availability of voluntary, community based treatment options

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There remain many challenges that need resolution in the coming months, especially the lack of understanding of concepts underlying and guidelines for harm reduction for PWID, the drug suppression and compulsory treatment policy which impacts on access to prevention services, quality of services provided, dependence on external grant funding for sustainability of current pilot approaches, and enduring stigma and discrimination which limits access to services.

Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths

Prevention of Mother-to-Child Transmission (PMTCT)

Assessment of PMTCT services during 2010-11 show that there has been no change in coverage when compared with the past three progress reports covering the previous six years. Among ANC clients who are HIV+, the proportion who receive ARV prophylaxis, and the proportion of HIV-exposed infants receiving ARV prophylaxis both continue to exceed 90%.

Over the past two years there have been important programmatic enhancements including prescription of HAART triple therapy for HIV+ pregnant women regardless of CD4 level, recommended HIV counseling and testing for partners of HIV+ pregnant women, and scale up of virological testing approaches for HIV early infant diagnosis. Simultaneously, measures to further spur improved coverage of specific PMTCT.

Services for pregnant women, their partners, and family members have been introduced, including the incorporation of new PMTCT related indicators into the national M&E system to be consistent with global recommendations, and improved software capability for data analysis related to PMTCT service delivery.

Remaining challenges associated with PMTCT include scaling up provision of PMTCT services for migrant workers who are not registered, increasing participation of male partners in HIV testing and counseling in ANC, reducing stigma and discrimination in clinics and communities which leads many HIV+ pregnant women to refuse to return for ANC services in subsequent pregnancies, improving data collection for selected PMTCT indicators, and improving clinical follow-up of children born to HIV+ mothers.

Target 4: Have 15 million people living with HIV on Antiretroviral Treatment by 2015

As of end 2011, 225,272 PLHIV were receiving antiretroviral therapy (ART) at 943 healthcare facilities nationwide of which 96% of were governmental hospitals. 97% of those on treatment were adults and 3% were children. Male to female ratio of patients on treatment was 1:1. Using the most recent WHO HIV treatment guidelines which recommend ART initiation at CD4 levels ≤350 cells/mm^3, ART coverage was calculated at 59% in 2010 and 65% in 2011. Coverage of ART among females is significantly higher than among men (82% vs. 54%). The number of patients newly initiated on ART has remained relatively stable over the past several years with 35,618 were reported in 2011. The number of children receiving ART has been continually decreasing over the past few years due to success of PMTCT program nationwide. This could be explained by a combination of PMTCT program success nationwide resulting in fewer new infections in children combined with a steady transition of pediatric HIV cases being transferred to adult care as they age.

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The retention rates of ART seem stable since 2009. The rates during 2010-2011 at 12 and 24 months following ART initiation was 83% and 80% respectively.

The overall death rate from AIDS-related causes was 8.8% in year 2011. The adult HIV-attributable death rate was higher than in children (8.9% vs. 4.2%); and the HIV attributable death rate among men was higher than among women (10.3% vs. 7.0%). A significant cause of higher rates of AIDS-related mortality is related to late diagnosis and/or entry into care and treatment. Treatment initiation only at an advanced AIDS stage remains a major problem in Thailand.

During 2011, only 3% of ART facilities (18 of 574 surveyed facilities) reported drug stock out experiences. Most of these occurred during the major 2011 floods in Thailand. Although the overall stock-out period was very short, about half of all affected patients had to either change their ART regimen or temporarily stop ART.

The Royal Thai Government has continually played a major role to continually increase access to ART services through initiatives including free access to HIV-related care, including treatment, and decentralization of care and treatment services. More than 90% of all people living with HIV/AIDS have their antiretroviral treatment financed by one of 3 governmental health security schemes including universal coverage; social security and civil servant medical benefit schemes. However, there are still some patients who are unable to benefit from any of these three schemes, including migrants. Treatment coverage for these populations is for the moment being supported by the Global Fund.

Civil Society organizations, particularly the Thai Network of PLHIV (TNP+) have played significant roles in providing psychosocial support to PLHIV and their families through the holistic care centers, which work closely with hospitals. The government has continually supported the TNP+ in their management of holistic care centers nationwide through funding from the National Health Security Office. To respond to antiretroviral medication shortages during the 2011 floods, the TNP+ together with AIDS ACCESS Foundation and in collaboration with the National Health Security Office, Department of Disease Control in the Ministry of Public Health, and the Thailand MoPH – US CDC Collaboration (TUC) developed and implemented an emergency response to help PLHIV in flooded areas access their medication and significantly reduce any treatment interruption.

In 2010, Thailand's national guidelines on HIV/AIDS diagnosis and treatment were developed and approved by the National AIDS Committee. The main revision from the previous guidelines was a treatment recommendation for earlier initiation of antiretroviral therapy (i.e. CD4 levels ≤350 cells/mm^3) and a phasing-out of stavudine (d4T) as part of the recommended first line regimen in favor of zidovudine or tenofovir. The national program under the Universal Coverage program has begun to implement the new treatment guidelines incrementally, starting with pregnant women with HIV.

Although the ART program in Thailand has been progressively scaled up in a continuous manner since the inception of the treatment program, the coverage of ART, based on the new treatment recommendations calling for earlier initiation of treatment in the disease cycle, has seen a decrease in effective coverage as more patients with HIV are not eligible for treatment. Current coverage is approximately two thirds of total need. Other challenges facing universal treatment coverage

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include a current lack of sustainable financing for populations not able to benefit from the current healthcare schemes, including migrants. Late entry into care remains another challenge with sixty per cent of PLHIV at the time of ART initiation registering CD4 levels of less than 100 cells/ mm^3. Harmonization and standardization of the treatment protocol for all health schemes, and strengthened quality of HIV counseling and testing in order to increase the proportion of patients entering treatment when they are first eligible, remain areas of priority in the next two years.

Target 5: Reduce tuberculosis deaths in PLHIV by 50 per cent by 2015

Co-management of Tuberculosis and HIV treatment

Thailand is one of 22 high TB-burden countries in the world. Based on the TB program record, 90.8 cent of TB patients were tested and counseled for HIV in 2011. According to a HIVQUAL-T survey, there was an increase in TB screening among adults/children in HIV care from 97.0 to 98.9 percent in 2010-2011 over the prior report. Using the estimated number of TB/HIV co-infection cases based on the TB incidence rate among patients living with HIV as identified by WHO, 27.7 per cent of HIV-positive incident TB cases received treatment for both HIV and TB. Current national guidance on isoniazid preventative therapy (IPT) recommends considering IPT where feasible. This is particularly the case for children less than 5 years of age.

During 2010-11, achievements in the prevention and care of TB in patients with HIV include the allocation of funds by the National Health Security Office for TB prevention at provincial and community levels, and treatment of TB in 140 prisons. In 2010, the protocol for Thailand's second national TB prevalence survey was approved and is scheduled to be conducted in 2012.

Challenges associated with reduction of tuberculosis prevalence in patients with HIV include the need for improvement in quality of DOTS in order to ensure the success of treatment for tuberculosis, particularly in large cities such as Bangkok. There is also a need to strengthen integrated TB/HIV services, ensure greater application national guidelines for MDR-TB control including provision of training in the control and prevention of MDR-TB, and strengthen the M&E system related to tuberculosis control (particularly in the area of data collection from private hospitals, especially those in Bangkok).

Target 6: Reach a significant level of annual global expenditure (between $22 billion and $24 billion) in low-and middle-income countries

The National AIDS Spending Assessment notes that total expenditures on HIV and AIDS programs totaled 7,702 million baht (approximately US$ 253.4 million) in 2010 and 9,826 million baht (approximately US$ 323.2 million) in 2011. These figures were 0.08 % and 0.09% of the Gross Domestic Product (GDP) in 2010 and 2011 respectively, and 2.0% and 2.4% of all health expenditures in 2010 and 2011, respectively.

A sizeable percentage (82%) of expenditures came from domestic sources for both years. The government budget through the National Health Security Office (NHSO) provided for a significant portion of HIV/AIDS spending largely focused on care and treatment. With respect to AIDS-spending categories, care and treatment accounted for 74% of overall HIV-related spending. The amount of spending for the care and treatment category increased significantly from 5,676 million baht

(approximately US$ 186.7 million) from 2010 to 7,261 million baht (approximately US$ 237.2 million) in 2011. Prevention accounted for 13% of overall HIV-related spending for both years. A significant proportion of funding for prevention came from external sources (47% and 46% for 2010 and 2011 respectively), of which 90% and 93% for the two years came from the Global Fund Against AIDS, Tuberculosis and Malaria.

Spending on the enabling environment, which has been indicated as one key factor to achieve the zero stigma and discrimination goal in the National AIDS Strategy for 2012-2016, accounted for 1.3% and 1.4% of total HIV/AIDS spending in 2010 and 2011 respectively.

The country has recognized the needs of ensuring sustainable domestic funding for its HIV prevention activities, particularly to continue activities already initiated Global Fund support. Establishment of an HIV prevention fund has been indicated as a priority area in the National AIDS Strategy Plan for 2012-2016.

Target 7: Critical enablers and synergies with development sectors

National Commitments and Policy Instruments (NCPI)

There are six principal components to the 2012 policy indicators: (1) Strategic plan; (2) Political support and leadership; (3) Human rights; (4) Prevention; (5) Treatment, care and assistance; and (6) M&E.

National AIDS Strategic Plan

The National AIDS Plan for 2007-11 was developed with participation and collaboration by all relevant sectors, including Government, civil society and international organizations. The NAP was comprised of four strategies, with target populations, sites and clear issues to address identified. The goal for the end of the plan period was to reduce new infections by half of the projected baseline amount, provide full treatment coverage for people living with HIV/AIDS, and extending social support to families affected by HIV/AIDS.

Prior to the final two years of the plan period, there was a review of progress made to date and designation by the Prime Minister of HIV/AIDS as one of nine national cross-sectoral priority strategies to be addressed with an associated list of indicators to measure progress in achieving results across ministries. Each ministry was expected to allocate a portion of its budget to support the National AIDS Plan goals. Much of the allocated budget went for care and treatment. Near the end of the plan period, a draft National AIDS Plan for the 2012-16 period was produced which focuses on two principal areas: 1) Innovation and change (4 associated strategies); and (2) Consolidation and optimization (1 strategy). Each strategy has clear targets, and an associated two-year implementation plan accompanied by an M&E framework.

Support from the political sector and leadership

During 2010-2011, the political sector, especially the Prime Minister, provided political support for implementation of the National AIDS Plan. The Prime Minister pushed for a Cabinet resolution approving guidelines for inter-ministerial integration on the HIV/AIDS strategy, and provision of budget support for full coverage of HIV-related services. In addition, there was high-level participation from senior leadership in technical forums and HIV/AIDS campaigns. Government and Civil Society developed draft policies to extend and improve quality health care coverage which were

then approved by national committees, including the policy for harm reduction for people who inject drugs. There was also support for full exercising of rights by establishing the subcommittee for the "support and protection of AIDS rights" under the National AIDS Committee. However, it has been felt that the national leadership and responsibility is still not clear in advancing the NAP. The concrete action on financial support for the accelerated HIV prevention plan had not proceeded.

Human rights

At present, Thailand has laws and regulations in place to protect the rights of the population and guard against discrimination, including against those affected by HIV/AIDS. In the past two years, there has been visible progress in the area of human rights in Thailand. There is now a master plan for human rights for the period 2009-2013 which includes support for and protection of rights and freedoms. With regard to AIDS rights, the subcommittee for the "Support and Protection of AIDS Rights" under the National AIDS Committee has been established. The NAS plan for 2007-2011 specified that protection of AIDS rights was to be an integral part of all implementation strategies. Under Article 30 of the Constitution, it is clearly specified that there be no discrimination against persons based on ethnicity, place of origin, gender, age, language, or religion. Nevertheless, enforcement of the laws is at times unevenly applied. On the other hand, there are laws which impeded implementation of AIDS policies and programs on prevention, treatment and care especially discrimination against some groups of population, for instance the drug law 1979, which consider drug users as criminals.

Prevention

Implementation of HIV prevention activities during the past two years has involved disseminating information, increasing knowledge among affected populations, and communicating about HIV with the general population through various channels. Affected groups have received special attention with special projects targeting youth, most-at-risk populations and migrant workers with specialized funding from organizations such as the Global Fund. But there are many areas that need improvement in order for HIV prevention activities to be more effective such as addressing and reducing stigmatization of certain population groups considered 'most at risk'. This has been difficult with the small budgets available to NGOs focused on this topic. Efforts also need to be applied to put the policy on harm reduction into implementation, expand client-friendly services at hospitals, and develop a better system of coordination between civil society and Government. There has been some improvement toward provincial integration of the National AIDS Plan strategies with provincial plans, but this has occurred in only a few provinces. Thus, integration of prevention into the routine services at the provincial level still needs improvement, and local communities need to be more aware and supportive of HIV/AIDS issues, including fostering of more positive attitudes if there is to be successful sustainability of the work.

Treatment, Care and Support

The combination of advocacy from civil society in the area treatment, care and support combined with Government implementation has resulted in considerable progress in terms of comprehensive coverage of services for the entire eligible population. From civil society's perspective, if it were to rate the progress in this area, the score would be 8 out of 10 points. During the past two years, the government has allocated a large budget through the National Health Security Office which has significantly increased equitable coverage and access to care and treatment. The challenge is to

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maintain the efficiency of treatment using the 1st line regimen, and prevent drug resistance. In addition, there is a need to find ways to provide treatment for foreign migrant workers.

Other areas of progress include: (1) Development and expansion of pediatric treatment, positive prevention, and the development of models of care and treatment through self-management; (2) Development of a progress monitoring information system for support of the NAP database including HIV-Qual-T, STI-Qual, and EWI tools. This includes capacity building of staff in the use of the data; (3) Planning for improvement and expansion of counseling services for hard-to-reach and vulnerable populations, and the general population; and (4) Coordination with Civil Society and the community to benefit greater PLA access to services and public welfare assistance.

The country has an implementation plan being supported by Round 10 of the Global Fund, and an implementation plan of the Ministry of Social Development and Human Security for the assistance of vulnerable children including children affected by HIV/AIDS. For the remaining challenges, there is a need to expand care and treatment, especially ART, in the context of revised guidelines which has led to a much larger treatment eligible population. Those who do not hold Thai citizenship such as migrant workers, undocumented Thais, and displaced persons are not eligible for state-sponsored ART, and mechanisms to ensure treatment access for these populations remains to be developed. In addition, problems of drug resistance to the 1st line ART regimens and improvement of quality services on non-discriminatory basis must be addressed.

Monitoring and evaluation (M&E)

In 2010, a new M&E national plan was developed for prevention of new infection in key affected population and an AIDS strategic plan was developed for 2012-16 which includes an M&E component as one the three core priorities of the plan.

In the past two years, Thailand has clearly mobilized agencies, plans and budget for M&E. But there are shortcomings in the area of staff capacity, amount of budget and management that is not yet unified. There is still a need for increased technical support and budget from international donors. There have been efforts to make M&E and surveillance more efficient so that the information can inform implementation planning and improve precision. This includes integrated government inspection which can stimulate the provincial AIDS committees to advocate more for prevention and conduct more monitoring of the implementation by the responsible agencies.

Participation of Civil Society

Civil Society groups in Thailand have participated quite actively in prevention and control of AIDS since the beginning of the epidemic over nearly 3 decades and increasingly play an important role in voicing needs of the people who are affected by HIV/AIDS. Many of the components of today’s NAP arose from the advocacy efforts of Civil Society, in particular, the establishment of a subcommittee of the NAC on the topic of “Support for Protection of AIDS Rights.”

In addition, Civil Society participated in or has representation in the strategy formulation for prevention and control of HIV/AIDS from the level of the National AIDS Committee, to the Committee for Inter-country Collaboration, the Task Force on Strategic Proposals, and the Task Force on National M&E.

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There are, however some obstacles identified and to be considered in strengthening the potential of the Civil Society to fully participate in policy planning and involvement in budgeting process. There is also a strong need for improvement in the system of technical assistance to Civil Society. The efficiency of management of concerned government organizations should be improved to enhance meaningful participation of Civil Society, for instance the preparation of documents in Thai and early appointment for consultation and the like.

Intimate Partner Violence

Thailand does not have updated data that could be used respond to target area 7.2 on Intimate Partner Violence (IPV). Only a few sources of information are available on the subject such as a Report from the Office of Women's Affairs and Family Development (OWAFD), Ministry of Social Development and Human Security (MSDHS), and the National Statistics Office 2009 Reproductive Health Survey. From these two major sources, only a small number of women reported IPV and mostly in terms of physical, not sexual abuse. The only reliable source of information on IPV is the national scale survey on Violence in Intimate Relationships and Women's Health (2003) undertaken by the Institute of Population Studies and Research, Mahidol University and Foundation for Women supported by WHO. Out of 2,818 ever-partnered women ages 15-49 interviewed in Bangkok and upper central provinces, nearly 50% of them reported having ever experienced physical or sexual violence by their intimate partners.

Despite the lack of up-to-date data on intimate partner violence, several national efforts were made during 2010-2011 to highlight and address the problem of intimate partner violence by government agencies and non-governmental organizations including the campaign led by the UN Women Goodwill Ambassador, Her Royal Highness Princess Bajarakitiyabha Mahidol, to include targets for ending violence against women in the Women's Development Plan (in the National development Plan 2007-2011), the development of the Joint Strategic Plan and Action Plan in Support of the Protection Against Domestic Violence Against Women Act (2009-2013), and the Ministry of Social Development and Human Security's implementation of policies and programs on Ending Violence Against Women (EVAW). The NGO Raks Thai Foundation and the Thai Positive Women's Network explored the intersection between HIV/VAW and a number of research projects were carried out to enhance knowledge on this particular issue.

During 2010-2011, under the leadership of Her Royal Highness Princess Bajarakitiyabha, Thailand has successfully initiated and facilitated the 2010 adoption by the UN General Assembly on the UN Rules for Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (known as Bangkok Rules). In addition under the leadership of Her Royal Highness Princess, Thailand contributed 622,189 actions taken by Thai individuals on EVAW as part of the "UN Women Say No-UNITE Campaign". At the same time, Justice Organizations developed guidelines supporting implementation of the Domestic Violence Act. The One Stop Crisis Center (OSCC) has planned to set up centers in 150 community hospitals nationwide in addition to the existing 783 OSCCs set up in 2009.

There remain gaps to be filled in this area starting from a lack of knowledge and understanding on the concept of gender issues and sexuality, improving data quality and research, and strengthening coordination among involved organizations. Many challenges also remain including effective

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implementation of the Domestic Violence (DV) Act, clearer structure and working mechanisms of OSCCs, strengthening the referral system for affected women, increasing accessibility to services for non-Thai women, improving understanding on vulnerability of HIV positive women, and strengthening national mechanisms to promote gender equality.

Care and support for Children Affected by HIV/AIDS

This population includes children who are HIV+ and/or children in families in which a father or mother is ill with or has died from AIDS. Data on this population provide for inconclusive analysis as there has been no systematic approach to data collection focused on this population. The number of children infected with HIV receiving ART is about 6,510. Many children affected by HIV/AIDS receive care and assistance in many areas from multiple government ministries such as the MOPH, the Ministry of Social Development and Human Security, and the Ministry of Education as well as from civil society and private or non-governmental institutions. Actual coverage levels or corresponding levels of quality are unknown due to limited data collection. A significant number of affected children are in the care of welfare institutions because their parents are poor and/or because of associated stigma and discrimination in caring for this population.

Important achievements in 2010-11 include successful application for funds from the Global Fund for a five-year period in the amount of $42 million to be used for programs of care and support for vulnerable children including children affected by HIV/AIDS in high HIV prevalence areas. The program includes integration and strengthening of health, social protection and community systems. Regarding treatment, there have been improvements recommended to the models for care of HIV+ children by the Sri Nakarin Hospital of Khon Kaen Province and the Chiang Rai Prachanukroh Hospital. There has been joint planning with the AIDS ACCESS Foundation to scale up application of the model throughout the country. In the National AIDS Strategy for 2012-16 it is specified that children affected by HIV/AIDS will be included as a core focus population whose needs will have to be addressed and responses evaluated.

An important remaining challenge as referenced above is that to date there has been a lack of quantitative and qualitative data about children affected by HIV/AIDS including coverage of services. Stigma and discrimination continue to impede access to services, and HIV+ children who are transitioning through adolescence who need treatment and care for psycho-emotional stress, as well as reproductive health care, still do not have sufficient access to these services.

Table 1: Overview indicators

Core indicators for Global AIDS response progress reporting		Year of data collection						Remarks
		2006	2007	2008	2009	2010	2011	
Target 1 Reduce sexual transmission of HIV								
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	37.4					Data not available	The most recent data that is available regarding HIV prevention among the general population is from the 2006 National Household Survey.
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the aged of 15	4.8						
1.3	Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months	9.4						
1.4	Percentage of adults aged 15-49 who have had more than one partner in the past 12 months who report the use of a condom during their last intercourse*	50.9						
1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	19.1						
1.6	Percentage of young people aged 15-24 who are living with HIV	1.0	0.6	0.5	0.4	0.4	0.4	National estimates were derived from the HIV Sentinel Surveillance Survey, which reports a median figure of the averages for each province.

Core indicators for Global AIDS response progress reporting		Year of data collection							Remarks
		2005	2006	2007	2008	2009	2010	2011	
Target 1 Reduce sexual transmission of HIV									
Sex workers									
1.7	Percentage of sex workers reached with HIV prevention programmes - FSW (venue based)	Data not available					56.9		Thailand has adopted a standard definition for this indicator in its 2010 IBBS survey.
	- MSW	Data not available					61.7		Source: IBBS in three provinces (Bangkok, Chiang Mai, and Phuket)
1.8	Percentage of sex workers reporting the use of condom with their most recent client - FSW (venue based)	Data not available					95.7		Thailand has adopted a standard definition for this indicator in its 2010 IBBS survey. Data on consistent condom use is available from 2006-2010.
	- MSW	88.3		89.2			87.3		Source: IBBS in three provinces (Bangkok, Chiang Mai, and Phuket)
1.9	Percentage of sex workers who have received an HIV test in the past 12 month and know their results - FSW (venue based)	Data not available					50.4		Thailand has adopted a standard definition for this indicator in its 2010 IBBS survey.
	- MSW	44.3		54.2			51.4		Source: IBBS in three provinces (Bangkok, Chiang Mai, and Phuket)
1.10	Percentage of sex workers who are living with HIV - FSW (venue based)	3.8	2.6	3.6	2.8	1.9	2.2	1.8	Source: The HIV Sentinel Surveillance Survey reports a median figure of the HIV prevalence among provinces.
	- MSW	15.6		20.7			17.7		Source: IBBS in three provinces (Bangkok, Chiang Mai, and Phuket)
Men who have sex with men									
1.11	Percentage of men who have sex with men reached with HIV prevention programmes	Data not available					49.2		Source: IBBS in three provinces (Bangkok, Chiang Mai, and Phuket)
1.12	Percentage of men who have sex with men reporting the use of a condom the last time they had anal sex with a male partner	79.9		81.0			84.5		
1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 month and know their results	28.5		35.2			29.2		
1.14	Percentage of men who have sex with men who are living with HIV	19.2		24.5			20.0		

Core indicators for Global AIDS response progress reporting		Year of data collection						
		2006	2007	2008	2009	2010	2011	Remarks
Target 2. Reduce transmission of HIV among people who inject drugs								
2.1	Number of syringes distributed per person who injects drugs per year by needle and syringes programmes	Data not available				9.8		Source: IBBS in 3 provinces (Bangkok/surrounding areas, Chiang Mai, and Songkla) using RDS (weighted)
2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse					46.1		
2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected					77.8		
2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results					40.8		
2.5	Percentage of men who inject drugs who are living with HIV					21.9		
Target 3 Eliminate mother-to-child transmission of HIV								
3.1	Percentage of HIV positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission	90.1	95.9	93.6	95.0	94.2	94.0	
3.2	Percentage of infants born to HIV-positive women who receiving a virological test for HIV within 2 months of birth	No required				75.8	73.1	
3.3	Mother-to-child transmission of HIV						3.2	Source: Service reports using virological testing

Core indicators for Global AIDS response progress reporting		Year of data collection						
		2006	2007	2008	2009	2010	2011	Remarks
Target 4. Antiretroviral Treatment								
4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy - CD4 <200 cells/ml	41.0	52.9	67.1	75.8	71.8	77.0	Estimated number of adults and children advanced HIV infection using AEM (Asian Epidemic Model)
	- CD4 <350 cells/ml	-	-	-	-	59.1	64.6	
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy			79.3	83.7*	84.0*	83.1	* Revised from previous UNGASS report
Target 5. Reduce tuberculosis deaths in people living with HIV								
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	32.6	n/a	24.1	25.5	26.1	298	
Target 6. Reach a significant level of annual expenditure								
6.1	Domestic and international AIDS spending (million THB)	n/a	6,728	6,928	7,208	7,702	9,826	
Target 7. Critical enablers and synergies with development sectors								
7.2	Proportion of even-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the 12 months	No required					Data not available	Thailand currently plans to integrate IPV in its 2013 Reproductive Health Survey.
7.3	Current school attendance among orphans and non-orphans aged 10-14 - Orphans	95.5					Data not available	Updated MICs data will be available in late 2012 or early 2013.
	- Non-orphans	96.4					Data not available	
7.4	Proportion of the poorest household who received external economic support in the last 3 months	No required					Data not available	Data will be available at the end of 2012 or early 2013.