

THAILAND



Ending AIDS

THAILAND AIDS RESPONSE PROGRESS REPORT

2015



คณะกรรมการแห่งชาติ
ว่าด้วยการป้องกันและแก้ไขปัญหายาเสพติด
NATIONAL AIDS COMMITTEE

2015

THAILAND AIDS RESPONSE PROGRESS REPORT

Reporting Period: Fiscal Year of 2014



Introduction

Thailand has joined the commitment to the 2011 UN General Assembly Special Session on HIV to prevent and control the AIDS epidemic and pursue the strategy of 3 Zeroes: (1) Zero HIV new infection; (2) Zero AIDS death; and (3) Zero AIDS stigma and discrimination. The Thailand National Strategic Plan of HIV (2014-16) has set the 2016 targets to reduce new HIV infection by two-third, peri-natal transmission rate less than 2%, AIDS related deaths reduced by half, and discrimination to key populations and people living with HIV reduced by half. The National AIDS Committee (NAC) further approved the policy of ending AIDS epidemic in Thailand by 2030 as the national priority on November 28, 2014, and directed all related agencies at the national and sub-national level to mobilize efforts to achieving the objectives. In addition, Thailand has developed key measures and the operational plan for 2015-19 to support the ending AIDS policy. The measures have applied strategies of test and treat regardless of CD4 level with the focus to most affected areas and populations

This report is the product of active and participatory collaboration of government and non-government agencies, civil society organizations, academia, international agencies, and representatives of key populations and the Thailand Network of Positive People (TNP+) during fiscal year of 2014. Representatives from these agencies and individuals reviewed, analyzed and discussed the latest data on indicator targets as a basis for the findings reported herein. This progress report has been acknowledged by the NAC Sub-committee on Strategic Information.

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Acronyms

AEM:	AIDS epidemic model
AIDS:	Acquired immunodeficiency syndrome
ANC:	Antenatal care
ART:	Antiretroviral therapy
ARV:	Antiretroviral drugs
ASO:	AIDS-response Standard Organization
BATS:	Bureau of AIDS, TB and STIs
BOE:	Bureau of Epidemiology
BSS:	Behavioral surveillance survey
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
HIV:	Human immunodeficiency virus
HLM:	High level meeting
HSS:	HIV sentinel sero-surveillance
HTC:	HIV testing and counseling
IBBS:	Integrated biological and behavioral surveillance
IPSR:	Institute of Population and Social Research
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:	National AIDS Program: Database program for antiretroviral treatment of NHSO
NAPHA:	National access to antiretroviral 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

NSO:	National Statistical Office
PCM:	Provincial coordinating mechanism
PCR:	Polymerase chain reaction
PHAMIT:	The project entitled: Prevention of HIV and AIDS among Migrant Workers
PHIMS:	Peri-natal 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
UNHCR	United Nations High Commissions for Refugees
UNICEF:	United Nations Children's Fund
UN Woman	United Nations Entity for Gender Equality and the Empowerment of Women
USAID:	United States Agency for International Development
VCT:	Voluntary counseling and testing
WHO:	World Health Organization

Summary: 2015 Thailand Global AIDS Response Progress Report

 <p>REDUCE SEXUAL TRANSMISSION</p>		<p>Target 1: Progress has been made but the scale and coverage are not enough to reach targets and have the desired impacts particularly in MSM and TG. More effort and resources are needed to rapidly expand the re-designed services and approaches to reach 90-90-90 targets in key population. Adjustment of HIV interventions to address specific needs and/or context is needed for non-Thais, young key population, and non-venue based key populations.</p>
 <p>PREVENT HIV AMONG DRUG USERS</p>		<p>Target 2: There has been progress on policy with better political support for harm reduction programs. While the drug use situation is fast evolving and diverse, harm reduction services, including opioid substitution therapy, and needle/syringe programs have to be rapidly implemented and addressed the needs of the local context.</p>
 <p>ELIMINATE NEW HIV INFECTIONS AMONG CHILDREN</p>		<p>Target 3: Thailand can be among the one of the first countries in the world to eliminate mother-to-child transmission of HIV. The MTCT rate was 2.1% in 2014, thus achieving the target ahead of the national target date. Validation towards elimination of MTCT is underway.</p>
 <p>15 MILLION ACCESSING TREATMENT</p>		<p>Target 4 Thailand was one of the first countries in the Asia and Pacific region adopting ambitious targets and providing anti-retroviral treatment to people with HIV irrespective of CD4 count. There is a need to focus on early detection and treatment for key populations as well as improving access to services for non-Thais.</p>
 <p>AVOID TB DEATHS</p>		<p>Target 5 Thailand has made considerable progress in alignment of HIV and TB programmes. The focus needs to be on improving ART in co-infected patients, monitoring and improving clinical practice to ensure early detection of HIV and/or TB, and prevention of leakage in treatment cascade.</p>
 <p>CLOSE THE RESOURCE GAP</p>		<p>Target 6 Thailand has mobilized more domestic resources to support the Ending AIDS policy. Continuous effort is needed to prepare for the transition to self-reliance and ensure sustainability of the HIV response with continued engagement of CSOs and communities in delivering appropriate HIV prevention for key populations.</p>
 <p>ELIMINATE GENDER INEQUALITIES</p>		<p>Target 7 Progress has been made on advocacy and mobilization of organizations, communities and networks on gender issues related to transgender populations, MSM and women living with HIV. Thailand needs to ensure the provision of gender-sensitive services especially for HTC, prevention, treatment and care through appropriate policies and quality-controlled implementation with meaningfully engagement of CSO and local communities.</p>
 <p>ELIMINATE STIGMA AND DISCRIMINATION</p>		<p>Target 8 Legal and policy barriers have been reduced including parental consent for HIV in young people, harm reduction, and migrants. Development and scaling up of stigma and discrimination reduction interventions in the health care setting is underway. Thailand is planning to normalize HIV as a key measure for enabling environment of sigma reduction</p>
 <p>ELIMINATE TRAVEL RESTRICTIONS</p>		<p>Target 9 Thailand has no travel restriction in place.</p>
 <p>STRENGTHEN HIV INTEGRATION</p>		<p>Target 10 The re-designed HIV/AIDS-related services can be an example for Global Health Integration through task-shifting and task-sharing in new partnerships between the public sector, civil society, and the private sector.</p>

2015 Thailand Global AIDS Response Progress Reporting

1. Overview of the AIDS Epidemic

HIV burden

Using the AIDS epidemic model (AEM) for adults (aged 15+ year) and Spectrum for children (aged less than 15 year), there were estimated 7,816 new HIV infections, 20,492 AIDS related deaths, and 445,504 persons living with HIV (PLHIV) at the end of 2014 in Thailand. Females account for 39% of total adult PLHIV and 47% of children living with HIV.

Table 1: Key figures of HIV estimation, Thailand

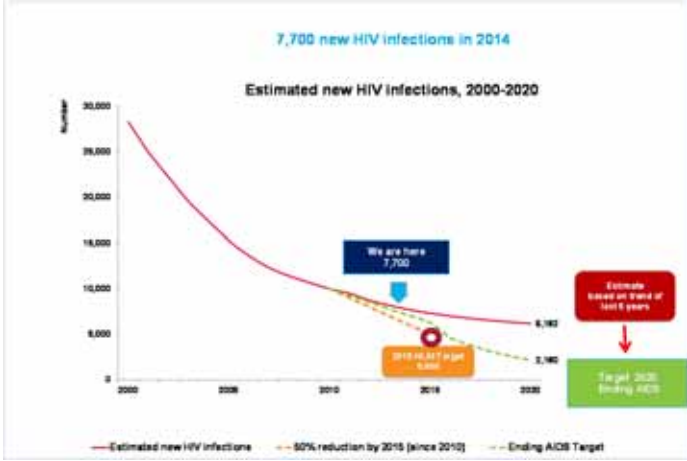
Estimated Number	2000	2005	2010	2012	2014
Total annual new infections	29,619	16,014	10,215	8,877	7,816
• New infections in all adults*	28,241	15,266	10,011	8,719	7,695
New infections in women adults *	15,716	7,237	3,294	2,576	1,944
• New infections in all children	1,378#	748#	204@	158@	121@
New infections in girl children	669#	363#	99@	76@	59@
Total annual AIDS mortality	55,531	31,211	20,670	20,477	20,492
• AIDS mortality in all adults*	55,079	30,805	20,422	20,270	20,325
AIDS mortality in women adults *	12,036	7,153	6,079	6,116	6,127
• AIDS mortality in all children	452#	406#	248@	207@	167@
AIDS mortality in girl children	221#	199#	133@	114@	94@
Total people living with HIV	683,841	555,808	493,932	471,811	445,504
• All adults living with HIV *	676,005	544,743	485,646	464,086	438,629
Women adults living with HIV *	217,860	212,351	199,978	198,013	172,454
• All children living with HIV	7,836#	11,065#	8,286@	7,725@	6,875@
Girl children living with HIV	3,843#	5,428#	3,998@	3,697@	3,262@
Total population (million)	60.6	63.1	63.9	64.5	65.1

* Estimation using the 'AEM', # Estimation using 'Spectrum' in 2013, @ Estimation using 'Spectrum' in 2014

New HIV infections in adults have declined but are insufficient to reach the national and HLM target

The number of adults who are newly infected with HIV is continuing to decline but at a slower pace. The reduction of new HIV infections during 2000-2010 was 65%. There were an estimated 7,700 HIV infections in 2014, a decline of only 23% from 2010. This falls short of the national target by two-thirds or the HLM target by half.

Figure 1 Estimated new HIV infections in adult population based on the current response



Closer to eliminating new HIV infections among children

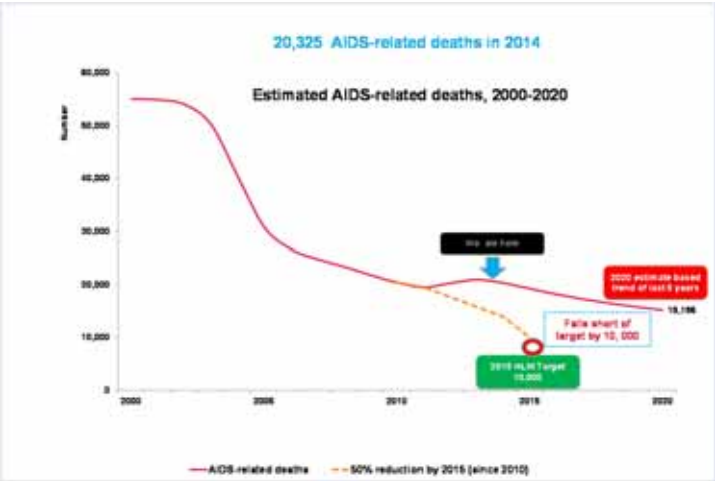
Progress in eliminating new HIV infections among children has been dramatic in Thailand. In 2014, 121 children were estimated to be newly-infected with HIV. This represents about 41% reduction compared to the level in 2010. The MTCT rate was estimated 2.1% in 2014, thus in line for achieving the 2016 target ahead of the National Plan. Thailand can be one of the first middle countries in the world to eliminate MTCT.

AIDS-related deaths remain unchanged in last 5 years

The estimated number of AIDS-related deaths sharply decreased by 63% between 2000 and 2010 (from 55,531 to 20,670); since then, the number of AIDS deaths has remained stable. In 2014, the estimated number of AIDS-related deaths was 20,492.

These data indicate that, since the early of 2000s, when the ART programme was expanded and rapidly scaled up, the Thai program has averted a significant number of AIDS related deaths since that time. Although ART coverage still increased during 2010-2014, many PLHIV learn about their positive status and receive ART very late in the course of disease. This reduces effectiveness of ART. In addition, coverage of screening co-infection such as tuberculosis has not been increased significantly. Thus, a significant proportion of PLHIV die within the first six months after diagnosis even though they have access to services and treatment.

Figure 2 Estimated AIDS-related deaths based on the current response



2. Thailand National AIDS Strategy and Responses

Thailand has committed itself to ending the AIDS epidemic by 2030. The Cabinet and National AIDS Committee (NAC) approved the National AIDS Strategic Plan (NASP) for 2014-16. The updated NASP has reinforced the original 2012-16 strategies and incorporated additional measures that will enable the country to achieve the ending AIDS targets by 2030. The costed Operational Plan for Ending AIDS in Thailand for 2015-2019 has been developed and approved by NAC in November 2014. Thailand has implemented the new guideline of antiretroviral treatment by providing antiretroviral treatment to all HIV positive people regardless of CD4 nationwide since October 1, 2014.

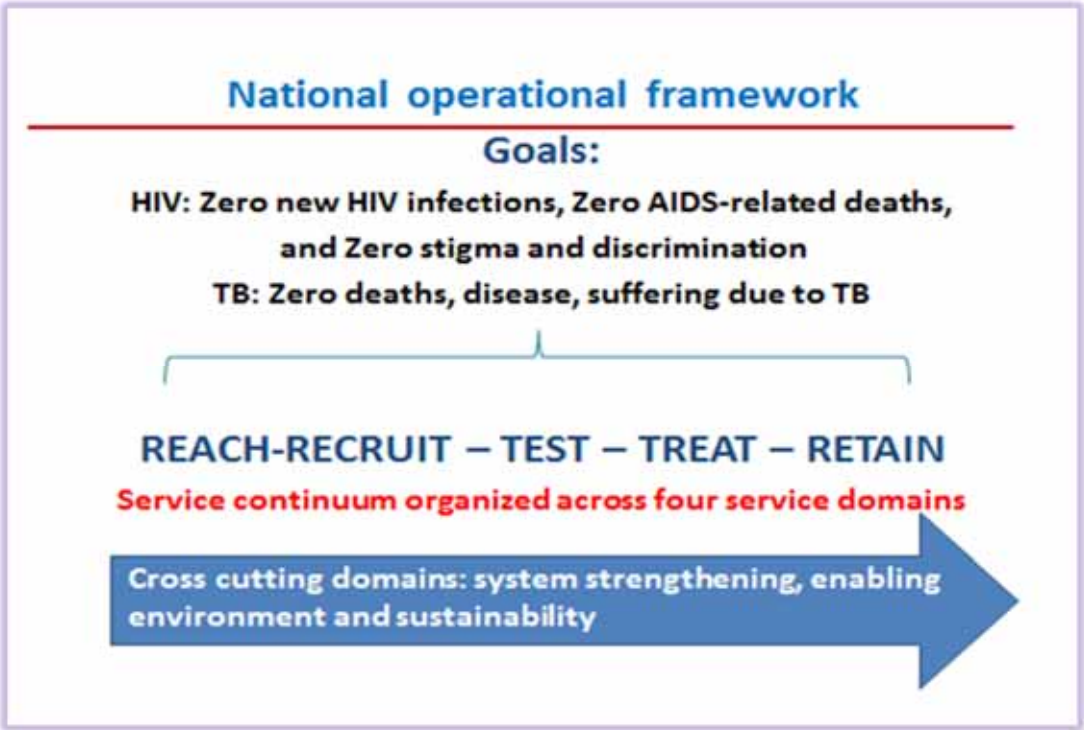
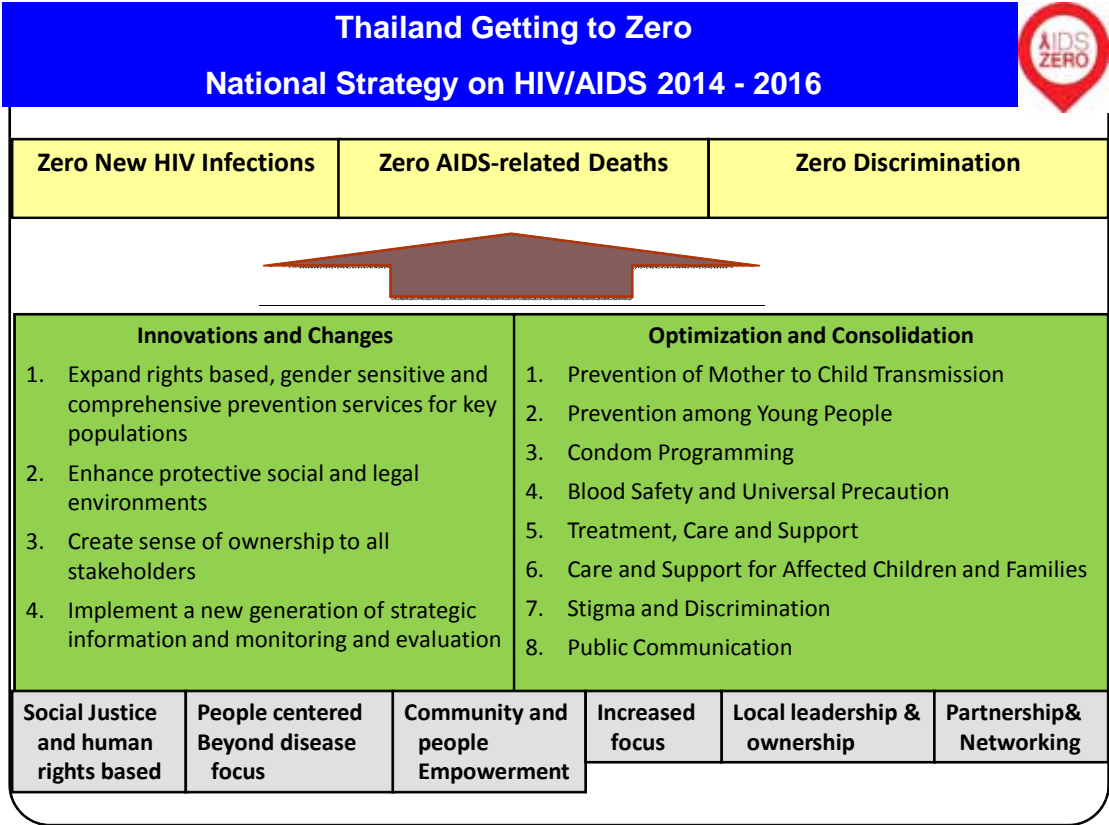
The NSP (2014-2016) presents two over-arching strategic directions; (i) innovation and change; and (ii) optimization and consolidation. It is based on the principles of promoting equality; implementation of people-centered approaches; clear target setting; creating national ownership and leadership; empowerment and increasing self-esteem; and working in partnership with government, private and non-governmental sectors. The Plan focuses on vulnerable populations of MSM, TG, MSW, PWID, FSW and their clients in 33 priority provinces.

The NSP (2014-2016) set ambitious targets: (i) new HIV infections reduced by two-thirds; (ii) vertical transmission of HIV less than 2%; (iii) universal access to social protection and quality care and treatment for PLHIV; (iv) AIDS related deaths reduced by 50%; (v) TB deaths among PLHIV reduced by 50%; (vi) laws and policies which impede access to prevention, treatment and care and other government health services revised; (vii) human rights and gender specific needs are addressed in all HIV responses; and (viii) number of discrimination and /or human rights violation cases occurring to PLHIV and KAPs reduced by 50%.

The Operational Plan (2015-2019) has been developed to elaborate critical activities to ensure the achievement of the long term ending AIDS goals by 2030. Main inputs were drawn from the recent knowledge of early antiretroviral treatment on prevention benefits(HPTN052), the evaluation studies, the national consultation on strategic use of ARVs, and the national consultation of the ending AIDS in Thailand through evidence based responses.

The Plan has identified 30 high burden provinces (including the greater Bangkok area) and utilizes the preventive effects of ART in reducing HIV infections with the focus on effective package of service to key populations. Thailand adopts a new approach, the Reach-Recruit-Test-Treat-Retain (RRTR), as the framework addressing gaps in linkage between prevention and life-long treatment system by connecting five critical components. The plan also defines a tailored service package for each key population, and lays out criteria for the intensity in which services should be delivered at the provincial level. The Plan has been costed, with a total THB 9,214,862,566 for 5 years allocated to key action areas: providing RTTR services (77%), strengthening health and community system (4%), enabling environment (6%), and programme management (13%).

Figure 3 Framework of the National AIDS Strategic Plan (2014-16) and Operational Plan to End AIDS (2015-19)



3. Country Progress towards 10 targets of UN HLM and Thailand's NASP

Target 1

HLM: Reduce sexual transmission of HIV by half by 2015

Thai NASP: Reduce sexual transmission of HIV by two-third by 2016

Key Affected Populations (FSW, MSW, MSM, TG)

Female sex workers (FSW)

National milestone for 2014

- 70% of FSW reached with prevention services in the last 12 month
- 70% of FSW received HTC and know their results in the last 12 month
- 95% of FSW reported condom use at last sex

Achievement by the end of 2014

The national estimated number of FSW was 123,530 in 2010, with possibly one-fourth working as non-venue-based FSW (NVB-FSW). Based on program data, a significant proportion is non-Thai FSW (about 21% based on program reports from the Global Fund sites in 2014). HIV prevalence among venue-based FSW has declined steadily from 2.7% in 2010 to 2.2% in 2012 and 1.1% in 2014. The most recent survey among NVB-FSW in Chiang Mai, Phuket and Chonburi in 2010 found HIV prevalence about 5, 1.4, and 1.2% respectively. The next round of IBBS among NVB-FSW will take place in 2015.

Targeted peer-led outreach services are conducted in 41 provinces with mainly financial support by the Global Fund and National Health Security Office (NHSO). Outreach activities are focused on hotspots and conducted by 445 peer educators, staff and volunteers of NGOs. This is complemented with behavioral change activities at drop-in centers, disseminated information materials and targeted condom promotion. Based on the IBBS in 11 provinces, there was increased prevention coverage from 51% in 2010, to 54% in 2012 and 58% in 2014. However the increase is still insufficient to achieve the national target of 70%. The number of FSW reached with prevention interventions (based on reports from GF grantees) increased from 43,504 in 2010 to 49,756 at the end of Fiscal Year 2014. A total of 8,253 non-Thai FSW were reached with prevention interventions. Based on IBBS 2014, there has been significant achievement in selected provinces where prevention uptake has met the national targets, including Lopburi (83%), Srisaket (98%), Udon Thani (69%) and Phuket (75%).

Uptake of HTC services from IBBS data has improved somewhat but is still below the national target coverage for 2014 of 70%. According to the IBBS 2010, 48% of venue-based FSW reported having had HTC in the past 12 months and received HIV test results. This indicator improved to 57% in 2012 and 54% in 2014. There were 3 out of 11 sentinel sites reported significant increases of HTC coverage from 2010 to 2014, namely Srisaket (31% to 94%), Phuket (66% to 82%) and Songkla (56% to 88%). Data from the national evaluation of services for HTC and treatment with the survey among FSW in 7 provinces in 2013 found that 85.6% of FSW had been ever tested for HIV and 68.3% had tested within 12 months. Even though mobile HTC clinics have been deployed in selected sites, the inconvenience and the time required for knowing test results has been identified as major obstacles in addition to the fear of knowing the

results (IPSR, 2013). There was a high proportion of FSWs (30%) who did not return for their HIV test results (PPAT, 2015).

Condom use at last sex with a client is high and stable at over 95%, and this meets the national target.

The accomplishments are only known among VB-FSW. Limited data exist to demonstrate change of access to key services overtime for NVB-FSW. Based on the previous survey in 2010 and 2007, the data indicate that access to outreach activities, condoms and behavior change communication materials among NVB-FSW was lower than for the VB-FSW. A similar pattern is found on accessing STI and HTC services indicating that NVB-FSW had lower access to STI and HTC services.

Male sex workers (MSW)

National milestone for 2014

- 70% of MSW reached with prevention services in the last 12 month
- 70% of MSW received HTC and know their results in the last 12 month
- 99% of MSW reported condom use at last sex

Achievement by the end of 2014

It was estimated there were 18,239 MSW in Thailand in 2010. MSW are largely concentrated in large and tourist provinces such as Bangkok, Chonburi, Chiang Mai and Phuket. HIV prevalence among MSW has been declining but remains very high: 16.0% in 2010, 12.2% in 2012 and 11.7% in 2014.

Peer-led outreach interventions for MSW in 5 provinces were mainly funded by the US government, and the Global Fund. In 2014, USAID established incentivized case-finding activities for MSW in Bangkok, Chonburi and Chiang Mai, while the US CDC provided technical assistance for the MSW programme in Phuket and Ratchaburi. The proportion of MSW who have been given condoms (by peer/outreach workers) increased sharply from 73% in 2010 to 90% in 2012 and 94% in 2014. This trend is similar across the 5 provinces. However, the programme did not achieve such improvements when using the composite indicator of “have been given received condoms and know where to go for HTC.” The prevention coverage among MSW decreased to 64% in 2014 compare to 74% in 2012)

Uptake of HTC in MSW has improved a little from 49% in 2010, to 52% in 2012 and 54% in 2014 but still has not reached the national target for 2014 of 70%. The strategies of rapid test results and user friendly services will become the standard at MSW drop-in centers in the priority sites with an expectation to fill this gap in 2015.

Condom use at last sex with a client was high and increasing over time from 88% in 2010, to 98% in 2012 and 96% in 2014.

Men who have sex with men (MSM) and Transgender (TG) populations

National milestone for 2014

- 50% of MSM and TG populations reached with prevention services
- 60% of MSM and TG received HTC and know their results in the last 12 month
- 90% of MSM and TG reported condom use at last sex

Achievement by the end of 2014

Men who have sex with men (MSM)

There were an estimated 550,000 MSM in Thailand (excluding MSW) in 2010. The median estimates of HIV prevalence among MSM have been high and not declining, 8.0% in 2010 to 7.1% in 2012 and 9.2% in 2014 (BoE, 2015). The 2014 round of the IBBS was carried out only in five sites, with a reduction from 12 sites in 2010 and 2012. Therefore the results should be cautiously interpreted. For the purpose of comparing data during 2010 to 2014, only five sites are included for this report. The studies of HIV in Bangkok among MSM do not show any sign of decline or reversal in prevalence and incidence either. HIV prevalence among MSM in the HIV surveillance and cross-sectional studies has consistently been around 20-30% for the past 10 years. This high HIV prevalence is supported by similarly high HIV incidence of 5 to 6 per 100 person years (PY) among men enrolled in observational and synthetic cohort studies conducted in Bangkok during the same period.

Targeted HIV interventions for MSM were implemented in 29 provinces with funding support by the Global Fund, the US government, the NHSO and the Thai Health Promotion Fund. Peer-led interventions, targeted IEC/media, condom promotion and distribution, HTC and referral to HIV and STI treatment have been implemented as part of the core service package. In 2014, incentivized case-finding has been implemented in selected sites to improve recruitment of MSM and TG into prevention services. Public information campaigns via the Internet and social media have been developed and launched systematically. However, the overall coverage of prevention interventions has not increased during the report period. According to the IBBS in five sites (Bangkok, Chonburi, Chiang Mai, Ratchaburi and Phuket) uptake of MSM for prevention services rose from 44% in 2010 to 53% in 2012 but dropped to 46% in 2014. These levels are insufficient to meet the national target. Through consultation with the MSM community, the lack of improvement may be partly due to funding reduction and the trade-off of applying different approaches to reach MSM: peer-outreach through venue-based and via social networks or peer to peer networking. In addition, the IBBS was carried out using venue day time sampling frame, so it is not known what the status is for the NVB MSM for these indicators.

The percentage of MSM who had HTC and received the results in the past 12 months increased from 15% in 2010 to 26% in 2012 and to 31% in 2014. The survey among MSM in 7 provinces from the National Evaluation of HTC and treatment in 2013 found 61.8% ever been tested for HIV and 41.6% been tested in the last year. However, these levels are still low and far below the national target of 60%. Sub-national analysis shows that better progress has been made in selected sites: HTC coverage among MSM in Chonburi doubled from 2010 compared with 2014 (14% vs 27%), increased distinctly in Chiang Mai (30% vs 46%), increased nearly four-fold in Ratchaburi (8% vs 31%) and doubled in Phuket (15% vs 32%). These increases may be the result of the introduction of rapid tests with same-day results, offered at community-led HTC

clinics in six drop-in centers targeting MSM, TG and MSW. In addition, mobile HTC clinics were deployed in hot spots in partnership with provincial health offices and general hospitals. There were still a gap between coverage and the national target suggesting that the services are still limited in scale and are not yet enough to generate national level impact.

Condom use at last sex with a male partner was high and stable at 80% - 82% between 2010 and 2014.

Urban and young men who have sex with men (YMSM)

Data from observational and synthetic cohort studies found that HIV prevalence among (older) MSM of ≥ 25 years of age in Bangkok now exceeds 40%, and the HIV incidence among (younger) MSM of ≤ 21 years of age ranges from 8.8 to 12.2 per 100 PY (Van Griensven, 2015).

Urban YMSM (aged 15-22 years old) have been considered at highest risk for HIV infection. The in-depth analysis revealed that estimated HIV incidence increased from 4.1 to 7.6 per 100 PY during 2003-2014. Practice of anal sex declined from 99% in 2003 to 82% in 2014, and playing the receptive anal sex role increased from 55% to 74%. Always-condom-use has remained stable at 50%. Increases were seen in reports of drug use. History of HIV testing (ever) increased from 29% in 2003 to 47% in 2014, but testing during the past 12 months did not, and remains at 27% in 2014.

Based on this analysis, more determined and rigorous HIV prevention efforts are needed to stop the HIV epidemic among urban and YMSM.

Transgender people (TG)

A rough estimate of 75,626 TG in Thailand was used for programme planning. The rigorous estimation is planned and will be updated in the near future. A significant proportion of TG is concentrated in the major cities. Median HIV prevalence among TG in 2014 in Bangkok, Chonburi, Chiang Mai, Chonburi and Phuket was high at 12.7%

Based on available data from five sites in 2014, the reported condom use among TG was 84%, uptake of prevention services was 59% and HTC services was 34%

Trend data are available for only four sentinel surveillance sites: Bangkok, Chiang Mai and Phuket from 2005 to 2014 and Chonburi from 2012 to 2014. The data indicate that HIV prevention coverage has not increased in Bangkok, Chiang Mai and Phuket between 2010 and 2014, or in Chonburi from 2012 to 2014. Chiang Mai is the only city where HTC coverage has increased over time, from 22% in 2005 to 43% in 2014. These results reflect the nature of prevention programming for TG in Thailand, in that targeted prevention interventions and HTC designed to meet TG needs are few and limited.

Developments/factors facilitating the achievement of the target

Political commitment and national financing

- Reducing sexual transmission among MSM, TG, MSW, and FSW remains a top priority for Thailand, and is addressed in the "Ending AIDS" Operational Plan.

- Thailand has reinforced implementation of same-day HIV results at public health facilities throughout the country while introducing national guidelines for using rapid HIV testing. These efforts are making community-based HTC services possible and popular.
- The NHSO and the Thai Health Promotion Fund (THPF) allocated a significant amount of budget to scale-up MSM prevention interventions (25 million baht from NHSO) in 11 sites, and support for media and social media targeting MSM (30 million baht from THPF).
- The US government has approved additional budget to revitalize MSM/TG and MSW programs, starting in 2014 and expected to continue.

Strong civil society

- With funding support from the Global Fund and USAID, civil society continues to be the backbone for delivering community services, safeguarding treatment access, providing case management for retaining MSM, TG and MSW in key services, providing substantive involvement in program design and planning and improving the policy and legal context for these groups.
- Key implementing organizations for these interventions include Rainbow Sky, SWING, M-plus, the Poz, Home Center, Care-Mat, Sisters and Thailand Red Cross.

Challenges/ factors hindering the achievement of the target

- Capacity of community service organizations (CSO) for delivering high-quality key services (reaching and recruiting the target population to key services) is still inconsistent across sites. High staff turnover is still a problem among most of CSO.
- Task-shifting to CSO and communities in carrying out HTC is a prerequisite for fast, massive scale-up of HTC and early treatment. However, implementing task-shifting is a challenge, because Thai government regulations do not usually allow HTC outside authorized health outlets, and most of the CSO/communities have limited technical capacity to do HTC. The health-community interface is not yet sufficiently strong.
- HIV prevention interventions should be extended to cover NVB FSW, MSW, MSM and TG, including non-Thais.
- Tailored programs and key services are needed to address the needs of young MSM, TG and Sex workers.
- There is a need to ensure sustainable domestic budget support for CSO and community involvement in delivery of interventions for MSM, TG and SW.

Conclusion

Reported condom use at last sex among FSW, MSW and MSM, TG remains at a high level. While uptake of prevention and HTC services has increased slowly, service coverage has not reached optimal levels and not be able to meet national targets. Progress has been made in reaching venue-based FSW but still limited among NVB-FSW. HIV prevalence and incidence remain high or increasing among MSM, TG including YMSM. Services need to be adapted to the local context and address specific needs across the spectrum of MSM groups and sub-groups to increase service utilization.

The Way Forward: Priority Actions

1. Urgently mobilize efforts and resources to rapidly expand the tailored package of services for MSM, TG, MSW, and FSW to meet the targets by 2016 in priority provinces.

2. Adjust and apply innovative approaches to reach and recruit diverse group and more number of SW, MSM, and TG including incentivized case finding and expand options including community based HTC and self-test of HIV to increase percentage of knowing HIV status.
3. Develop and implement the innovative program monitoring system including real-time monitoring among the key populations using national, single, unique identifiers; and integrating database of the Routine Health Information System (RHIS) and NAP database.

Youths and General Population

National milestone for 2014

- 60% of youth aged 15-24 year reported condom use at last sex
- 55% of adult population (aged 15-49) who had more than one partner reported condom use at last sex

Achievement by the end of 2014

In 2014, prevalence of HIV among pregnant women age 15-24 years and male military recruits is stable about 0.5%.

Risk of HIV for persons who are in the reproductive age groups has not changed significantly in recent years. The 2014 round of the behavioral surveillance (BSS) found that Male factory workers had more than one concurrent sex partner ranged from 16% to 22% and female factory workers ranged from 4% - 5%. Further, condom use in these relationships ranged from 48% to 54% for males and from 27% to 31% for females. The proportion of factory workers who had been tested for HIV in the last 12 months remained at 18% to 19%.

HIV prevention interventions for youth have been funded by the Global Fund against AIDS, TB and Malaria (GF) through the ACHIEVED Project. An external evaluation of the Project sampled youth age 12 to 24 years in school, factories, and the community in Bangkok, Udon Thani, Petchburi, Nakornsawan, Nakhon Pratom Pattalung and Phuket Provinces. The evaluation found that, overall, youth had a good knowledge of condoms, but did not have improved HIV knowledge levels. Youth in school had knowledge/understanding and positive attitudes toward PLHIV less than the factory and community youth. About 32% of school youth used a condom for all episodes of sex in the past year with a non-regular partners. The comparable rates of condom use for youth in the community and factory workers were 41.7% and 25%, respectively.

Developments/ factors facilitating the achievement of the target

Policy Improvements

- The clinical guidelines for HTC in young people have been successfully changed so that persons aged under age 18 are no longer required parental consent for HIV testing. The NAP also produced operational guidelines on disclosure of test results and referral for, or receipt of, ART. These measures are intended to help youth with HIV risk to enter the diagnosis and treatment system sooner, and help providers create a youth-friendly service;
- The National AIDS Programme produced a National Condom Strategy for the period of 2015-19 as a framework and guide for implementation to promote use of the male and female condoms, and lubricant. This strategy addresses issues of demand, supply and creation of an

enabling environment. There are five sub-strategies as follows: (1) Promotion of the acceptance and reduction of negative stigma of condoms and lubricant; (2) Promotion of access to and use of condoms and lubricant; (3) Development of a system of management and control of condom quality; (4) Creation of an enabling environment for condom use; and (5) Implementation of monitoring and evaluation of the condom promotion activities.

AIDS and sex education

- School-based AIDS and sex education for youth has continued to implement and expand in the 43 priority provinces receiving GF support. An additional 34 provinces are implemented with support from the Thai Health Promotion Foundation (THPF). In 2014, a total of 1,380 schools delivered the GF-supported sex education curriculum through 6 to 16 sessions (or 28% of the 5,001 schools in the 43 provinces). A total of 372,599 school youth were exposed to the curriculum.
- Sex education was designated as one component of health promotion in the school setting. Participating schools were evaluated to assess the degree to which they were prepared to deliver the curriculum as intended. The evaluation found that the sex education curriculum was well-accepted by the participating schools and is consistent with the quality assurance system of schools, and linked with the policy and principles of health promotion, care and assistance for students. There has been a clear hand-over of responsibility for maintaining and expanding the sex education curriculum;
- In 2014, an evaluation was conducted among students to measure their knowledge, attitudes, and accuracy of self-risk perception, and life skills. The evaluation was conducted in schools which delivered 16 sessions of the GF-supported sex education curriculum in the previous academic year. The evaluation documented significant improvements in these schools in comparison with a control group which had not yet implemented the curriculum. In addition, an external evaluation of ACHIEVED found that the comprehensive sexuality education curriculum was well-accepted by participating schools, and capacity of teachers was strengthened in delivering the curriculum. Attitudes toward sex are becoming more positive, and this is helping spur a trend among implementers to work more constructively with youth. Expansion these success at larger scale with domestic funds is needed.

Prevention of HIV and STI in youth

- The Bureau of AIDS, TB and STI (BATS) of the Department of Disease Control (DDC) of the Ministry of Public Health (MOPH) collaborated with schools at all levels in Bangkok and the provinces to implement the youth-focused project called the Anti-AIDS Academy (AAA). The purpose of AAA is to build awareness, understanding and motivation for youth to practice prevention of HIV/STI. The project uses a variety of strategies including expanding the network of youth-friendly services to increase youth access and utilization of sexual health services;
- The NAP has promoted public information dissemination to improve the image of the condom so that it is seen as a health product for safe living and healthy sex lives for all members of the reproductive age group. In the report period, the NAP requested cooperation of all the provincial health offices and regional disease control centers throughout the country to conduct campaigns on prevention of HIV/STI in conjunction with Valentine's Day using the slogan '**Sex Roawp Koawp Toawp OK**' (Say Yes to caring sex)

Integrated activities for youth

The DDC, Department of Mental Health, and the Department of Health collaborated in the development and implementation of an integrated health promotion program for youth to address problems of alcohol and cigarette consumption, unsafe sex, reproductive health problems, and mental health disorders. The programme used a variety of strategies such as creation of an enabling environment in the workplace, stricter enforcement of laws, training in life skills and sex education, and screening to identify and assist school-based youth in need. Hospitals set up youth-friendly clinics, including contraception for sexually-active single teens. The program supported communities to create spaces for youth, host outreach services, and implement a 'parents school' to help improve communication between the generations about sex and other challenges which today's youth face.

Challenges/factors hindering achievement of the target/

- Proven comprehensive sexual and life skill curriculum existed. Institutionalized these models in the educational system is still challenge. There is a lack of integration of implementation at national scale, and there is a lack of a formal host to champion the response.
- Motivation for HIV prevention and availability of youth-friendly services need to be refined and expanded given the diversity of lifestyles and behavior of today's youth. There need to be more effective methods to identify at-risk youth in need of services.
- It remains a challenge to formally integrate AIDS into the routine health and reproductive health plans for youth at all levels of the system.

Conclusion

Progress of activities for young people has continued but has limited positive change in the trends of awareness, risk behavior and incidence. The population has not been sufficiently motivated to know HIV status and stay in healthy behaviors.

The Way Forward: Priority Actions

1. Improve policy, coordination and strategies/measures of HIV prevention for young people with integration of sexual and reproductive health, drugs, and other development issues.
2. Conduct public campaigns with wide reach to increase awareness and motivation for prevention behaviors particularly the right to free HTC twice a year.
3. Support and coordinate with relating agencies, organizations to take joint responsibility of programmes and progress for the target populations of youths and other general population using a set of joint key performance indicators.
4. Support government agencies to serve as models of good practice, to be emulated by business and the private sector in creating an environment for prevention and response to HIV/AIDS in the workplace.

Migrant Workers (MW)

The actual number of non-Thai living in the country is unknown. The latest attempt to estimate was 3.7 million in 2013 (2014 Migration report). The estimated number of workers from Cambodia, Lao and Myanmar was 2.7 million with work permits 1.1 million and irregular status 1.6 million. Registered migrants have access to the Thai health-care insurance system through either the social security scheme (SSS) for those employed in the formal sector or the migrant health insurance scheme for the rest. In August 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, including both registered and unregistered migrants. As of September 30, 2014, the number of migrants who registered with the migrant health insurance increased 1,423,831.

Developments

Significant improvement has been made on migrant health policies. In August 2013, the Cabinet revised its policy on health check-ups, and included ARV treatment in the health insurance package. A subsidy of 500 THB was approved at first enrollment for documented and undocumented migrants from Myanmar, Lao PDR and Cambodia.

In June 2014, the Government has established one-stop service center for migrant's registration and the MOPH has reduced the health insurance fees. The "Samutsakorn Model" where migrants can be registered and enrolled on health insurance via a one-stop service has been expanded and implemented to other provinces.

Challenges

Migrants still have limited access to HIV diagnosis treatment and care due to legal, financial and language constraints. Fears of job loss and interactions with the Ministry of Labour, police and immigration authorities are not supportive to positive health seeking behavior among undocumented migrants.

The implementation of the MHI scheme is ongoing, but the system is not fully rolled out due to management and financial challenges. There are also gaps in coverage. Hospitals are still reluctant to sell MHI for fear of incurring net losses or administrative procedures. Therefore, access for migrants to prevention and care services for HIV and TB, while improving, is still limited.

In order to encourage migrants to subscribe to health insurance, they must feel that it is to their benefit. The development of "Migrant Friendly" services, which primarily incorporates Migrant Health Workers and community-based services, has been in process some time, but needs for institutionalization.

Conclusion

The management of the Migrant Health Insurance scheme needs to be further developed to increase willingness of the hospitals to cover additional migrant workers and their dependents. Risk mitigation in this respect should be advocating for policy change to ensure that hospitals have finance mechanisms in place that will support the provision of health services for migrants, especially for HIV prevention and treatment services.

The Way Forward: Priority Actions

1. Improve coordination mechanism and management of migrant health insurance scheme, social security scheme at central level in order to effectively translated policy into implementation.
2. Reorganize fund management of MHI to assure that hospital will be able to recover their costs.
3. Institutionalize Migrant Assistant Health Workers and Migrant Health Volunteers in the government's health services for migrants.

Refugees

Key accomplishments in 2014

As of 31 December 2014, Thailand was hosting more than 118,000 refugees including approximately 110,000 refugees from Myanmar residing in 9 temporary shelters along the Thai-Myanmar border, and approximately 8,560 refugees and asylum seekers of various origins living in urban areas across Thailand. The HIV prevalence among refugees is low, both in camps and in urban settings.

Refugees are provided access to HIV prevention, care and treatment through activities supported by UNHCR and its partners, under the umbrella of the Royal Thai Government. Refugees and asylum seekers have access to male condoms. Information, education and communication (IEC) materials were disseminated to reinforce the messages of HIV/AIDS prevention and stigma reduction as well as to promote gender equality and non-violence, ensuring that women and children were also targeted to receive the messages.

HTC services was available free of charge and focused on but not limited to key affected populations, new arrivals and pregnant women. Comprehensive HIV/AIDS care and treatments have also been offered to the refugees, partly under the specific national ART scheme for migrants and Non-Thai population (NAPHA extension programme), partly under the financial contribution of international donors. As a result, almost 100 people living in temporary shelters and 11 people living in Bangkok have received ART as per Thailand's National Guidelines on HIV/AIDS Diagnosis and Treatment.

Anticipating a possible future voluntary repatriation of refugees living in the temporary shelters, in 2014 UNHCR has developed contacts and facilitated exchange of information between the Myanmar national AIDS program and the NGO's working in Thailand. A referral protocol has been established.

The Way Forward: Priority Actions:

Continue to prioritize and include HIV in the agenda of health and all preparation for the repatriation process.

Target 2

HLM: Reducing HIV transmission among PWID by 50% by 2015

Thai NASP: Reduce HIV transmission among PWID by two-third by 2016

HIV prevalence among people who injection drug (PWID) has been on the decline but remains high (21.9%, 25.2% and 19.0% in 2010, 2012 and 2014 respectively). Substance use patterns have been changing and diverse by local context, with non-injecting substance use replacing the injections in some settings.

National milestone for 2014

- 65 % of PWID reached with prevention services
- 60% of PWID received HTC and know their results in the last 12 month
- 65 % of PWID reported condom use at last sex
- 81% of PWID reporting the use of sterile injecting equipment the last time they injected

Achievement by the end of 2014

Thailand has an estimated 40,300 people who inject drugs in 2010. According to IBBS data collected from three provinces (Bangkok, Chiang Mai and Songhkla), the proportion of PWID who reported the use of a condom at last sexual intercourse were still less than 50%. There has been an increase in the percentage of people who reported using sterile injecting equipment the last time they injected (from 42% in 2009 to 85% in 2014 in Figure 3). Other achievements include the number of people testing for HIV and knowing their status has increased from 40% in 2009 to 61.2% in 2014 (Figure 4). The median HIV prevalence declined from 25.2% in 2012 to 19.02% in 2014. However, IBBS data for PWID is limited to 3 sites only and should be interpreted with caution.

Figure 4 Percentage (%) of people who inject drugs who reported using sterile injecting equipment the last time they injected, IBBS data

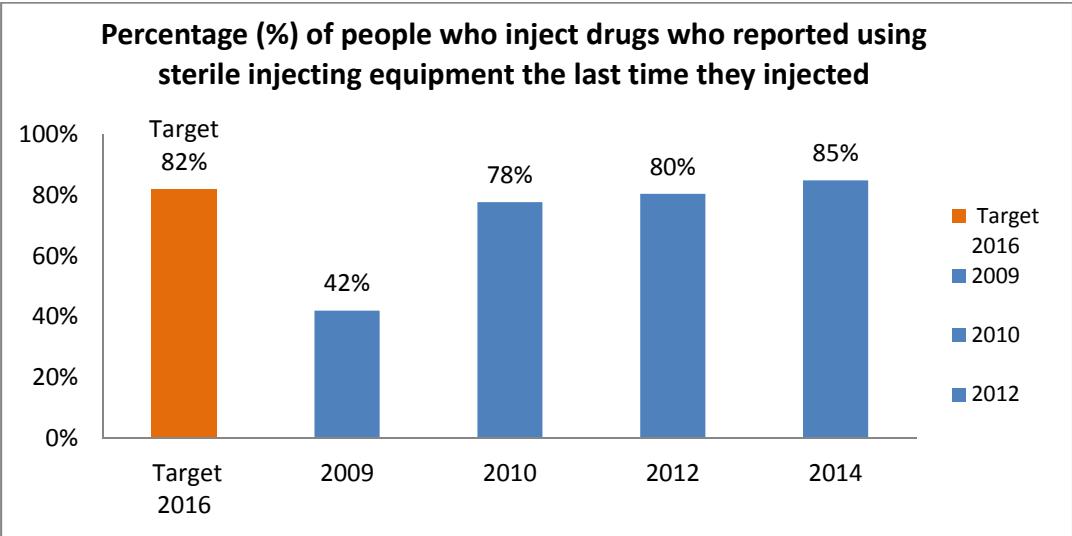
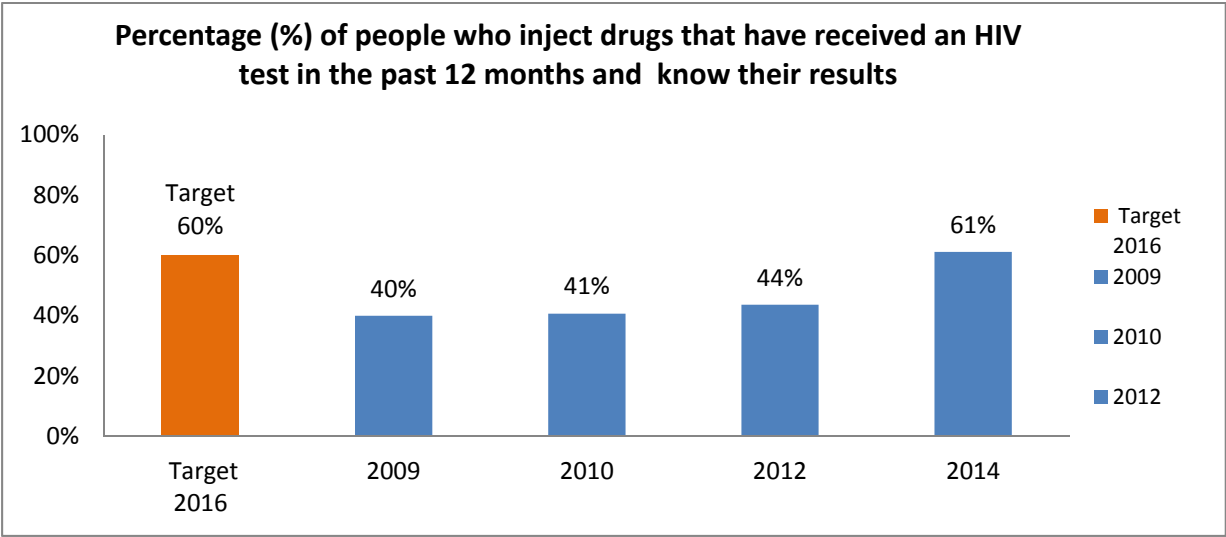


Figure 5 Percentage (%) of people who inject drugs that have received an HIV test in the past 12 months and know their results



In 2014 there were 42 sites which distributed needles and syringes at no cost, this includes some pharmacies. The average number of needles and syringes distributed to the estimated total PWID in 2014 was 14, improved from the previous year but far from reaching the country target of 88.

The number of opioid substitution therapy (OST) sites in 2014 was 140, decreased from 147 in 2013, and the number of people on OST through those sites was 3,646 individuals, decreased from 4068 individuals on OST in 2013).

It is noted that OST is appropriate in the treatment of the dependence on Opiate (Heroin and Opium) whereas no specific treatment has been developed for treatment of the dependence of ATS and MA with injection.

Developments/ factors facilitating the achievement of the target

Political commitment

Thailand has been demonstrating sustained political commitment to curb the HIV epidemic. The country has been one of the first to take on board the goal of ending the AIDS epidemic by 2030. In February 2014 the Thai Office Narcotics Control Board (ONCB) launched a new harm reduction strategy. The strategy was the first multi-sectoral coordinated harm reduction project involving key government agencies and civil society.

In November 2014, the NAC endorsed the policy and strategies on harm reduction for drug use to support the Ending AIDS measures. It is first time that harm reduction is formally approved in the HIV programme after a long struggle with the negative law interpretation from the State Council. NAC further authorized the Department of Disease Control to use government budget to procure needle and syringe to support harm reduction programme.

National financing

Much of the funding for harm reduction services on outreach and NSP comes from the Global Fund grant through the PSI Champion IDU project which was based in 19 provinces over the year. But, that grant came to an end in 2014. The prioritization process was undertaken to reach

larger number of PWID despite fewer number of provinces. In 2015, the GF provided support for community outreach in 12 provinces, whilst the domestic budget is supporting the MMT service. The effort has been made to request funding to support from government and National Health Security Office for the 7 demonstration sites.

Strong civil society

Civil Society groups have played a key role in accessing the target group of drug users, especially with harm reduction interventions, including community outreach and peer educators. The outreach workers provide prevention information and services, and motivation for other PWID to go for HIV VCT and harm reduction services. Civil Society has been also a key player in the needle/syringe exchange programme and community-based MMT.

Challenges/factors hindering the achievement of the target

- The closing down of the Champion IDU project in 7 of the 19 provinces has resulted in fewer outreach and NSP sites nationally to offer the required Harm Reduction services, although the targeted numbers from the previous grants have been maintained.
- The laws and policies on drug often conflict with each other, and this causes confusion and different practice of intervention programmes. The guidelines for harm reduction view drug dependence as a health problem which requires therapy and care. However, the 1979 Narcotics Control Act views drug use as a crime, subject to arrest and imprisonment.
- While Thailand now has a policy to support harm reduction, the implementation of this policy is incomplete, and the responsible authorities and staff at the provincial level do not have a good understanding of the policy and implementation guidelines. The provincial task forces on drugs have not been established yet, and this could be a result of the political upheaval in recent years. Many people still have inadequate knowledge, understanding and negative prejudice against harm reduction.
- The current status of harm reduction is not consistent with the needs and context of the local community where PWID live. There are gaps in outreach by the Civil Society groups, and gaps in static services in the public sector. There is a need for more integrated effort among the government and Civil Society groups to link outreach with government clinics, ensure better coverage of clean needle/syringe distribution, and spur greater uptake of MMT services in the community and clinic settings.

Conclusion

There has been considerable progress in harm reduction policy and programs, resulting in improved access to related services. However, challenges remain particularly in achieving full implementation of the policy and strategies to achieve optimal coverage. Implementing staff, especially in the public sector, from the top levels down to the front-line services, need to have better knowledge and understanding of harm reduction. Thus, there needs to be a shift in strategy toward more genuine implementation, including changes to the relevant laws so that drug addiction is viewed as a public health problem and not a criminal offence. Thailand should eliminate the practice of arresting and imprisoning drug users. There should be more access to quality services for drug users and protection of their basic human rights.

The Way Forward: Priority Actions

1. Support, monitor and evaluate the implementation of harm reduction services in the 19 pilot provinces as demonstration of translating policy into effective actions.

2. Increase the role of government in expanding harm reduction services and reduce negative attitudes of government personnel toward drug users,
3. Develop and improve service model e.g. government's role in clean needle/syringe distribution, the community-based program MMT service, education on HIV and hepatitis C, prevention of drug overdosing, operational guideline for harm reduction services, and static and outreach services through collaboration among the government, private, civil society and the population of drug users.
4. Advocate for change the laws which conflict with policies in order to create a more enabling environment for prevention. There should be consideration of eliminating the policies which criminalize drug use, and there should be provision of MMT in the prison setting.

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%

National milestone for 2014

95.5% of Thai and non-Thai HIV positive pregnant women received ARV drugs to reduce the risk of MTCT

80% of infants born to HIV-infected women received virological tests for HIV within 2 months of birth.

2.5% of infants born to HIV infected mothers are infected

Achievements by the end of 2014

The rate of MTCT declined from 2.3% in 2013 to 2.1% in 2014 which suggests good progress toward the goal of under 2.0% MTCT by 2016. Data from 2014 indicate that the proportion of pregnant women not receiving any kind of ART declined from 4.9% in 2013 to 4.2% in 2014.

The proportion of newborns to HIV+ mothers who received PCR screening for HIV in the first two months of life increased from 73% in 2013 to 76% in 2014. However, to reach the 2016 target of 90%, there need to be new and intensified strategies for neonatal HIV screening for infants of HIV infected mothers.

Coverage of couple testing for HIV in the ANC increased from 38% in 2013 to 41% in 2014, though this level is still far below the 2016 target of 60% coverage.

Developments/ factors facilitating the achievement of the target

Increased coverage of PMTCT

- The MOPH announced the policy to provide free ANC to all couples who register for care within the first 12 weeks of the pregnancy in order to reduce the problem of late initiation of ANC and no ANC
- Since August 2014, the MOPH has implemented an outreach program to diagnose HIV infection of newborns and promote earlier initiation of ART among infected infants. This effort includes training of relevant staff in PMTCT and immediate blood testing of the infants (of HIV+ mothers) at birth
- In October 2014, new HIV treatment guidelines were introduced, including guidelines and regimens for PMTCT from the original protocol of AZT+3TC+LPV/r to be changed to TDF+3TC+EFV. ART is to begin at the time of diagnosis, regardless of the age of gestation or CD4 level. All cases are counseled to continue ART post-partum in accordance with the new treatment guidelines for adult cases of HIV infection. This should help increase coverage of ART for new and repeat cases of pregnancy among HIV+ women, and further reduce MTCT in the coming years.
- Implementation of a program to improve control, monitoring and evaluation of the PMTCT service. This includes a various following steps:
 1. Meeting of the national committee and regional health centers to develop the system and handbook for use of M&E data on PMTCT;
 2. Meeting of the Task Force to promote monitoring of implementation progress, planning the monitoring system, database maintenance, and applied use of the data

in the ICT system to feed into the GIS and website graphs to inform decisions and use of data from the PHMIS and NAP.

3. Workshop for national committee members, resource persons and regional health centers to improve use of M&E data.
4. Inspect and feed data back to managers and relevant others
5. Present results of implementation of PMTCT for managers and relevant other stakeholders.

Promoted HTC for pregnant women and their partners

- Develop and produce a handbook with guidelines for promoting and expanding couple ANC HTC.
- Support activities at service outlets, educational media, flip charts on ANC HIV testing, a couple counseling handbook, and videos on couple ANC HTC.
- Follow-up results of couple counseling services using the PHMIS to assess coverage, expose gaps, and identify target areas for supervision;
- Conduct monitoring at the level of the zone and service outlet by the program staff with service providers to increase knowledge, understanding and confidence in service provision.

Challenges/ factors hindering achievement of the target

- Coverage of the couple counseling program in 2014 was only in 60% of service outlets, and this prevented more complete identification of discordant couples as evidenced by the finding that only 42% of ANC couples received HTC. This low level of coverage threatens to increase partner HIV transmission, reduces confidence in the service system, and exposes the need for more training of staff in couple counseling;
- There remain a significant number of pregnant women who have not registered for ANC and, thus, the full picture of ANC infection is not known. This impedes care for pregnant and delivering women, and limits achievement of the PMTCT target goals;
- Access to PMTCT for non-Thai pregnant women in Thailand is not universal, in part because they have to pay for service;
- Fully 40% of the pregnant women diagnosed with HIV do not return to the delivering facility for on-going care post-partum;
- The progress reports on PMTCT do not include data from private hospitals and large hospitals outside the MOPH system, and these facilities could have a different level of performance than the MOPH outlets.

Conclusion

Thailand succeeded in reducing HIV transmission from mother to child. The MTCT rates fell to 2.1 % in 2014, coincided with the national target that is below 2% by 2016. The country could be among the first countries in the world to achieve the target of getting zero PMTCT related infection.

The Way Forward: Priority Actions

1. Review data on PMTCT, and reflect these data back to those locations which are below the national target for coverage so that they will implement improvements to services, improve laboratory procedures, and extend coverage of the right to receive care for the target groups, toward the goal of eliminating MTCT.

2. Increase coverage of PMTCT for migrant women in Thailand through increased coverage of the insurance for migrants so that HIV+ pregnant migrant women and their newborns receive equal and quality care.
3. Conduct evaluation on the impact of policy changes, the coverage and retention into the ART system of HIV+ pregnant women, and identify obstacles to couples counseling.

Target 4

HLM: Reach 15 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

National milestone for 2014

- 75% of eligible adults and children with HIV (CD 4 \leq 350) receiving antiretroviral therapy (NASP)
- 60% of adults and children with HIV received anti-retroviral therapy (OP target)
- 86% of adults and children with HIV still alive and to be on treatment 12 months after initiating antiretroviral therapy
- 81% of people on ART for 12 months having viral load suppression

Achievements by the end of 2014

Thailand has been one of the first countries to adopt the Test and Treat Strategy with revised HIV treatment guideline that recommend the provision of anti-retroviral treatment to all HIV positive people irrespective of CD4 count. This policy has been fully implemented nation-wide on October 1, 2014. Previously, the guidance was to initiate treatment at CD4 350 or less per mm³, at which level Thailand had ART coverage of 80.3% in 2013.

A total of 426,274 adults and children were enrolled in HIV care by 2014, of which 271,652 were receiving ART. Of these, 267,150 were adults and 4,502 were children aged below 15. Of these, 35,282 patients were newly enrolled in 2014. The coverage of ART was 61% of all HIV positive adults and children.

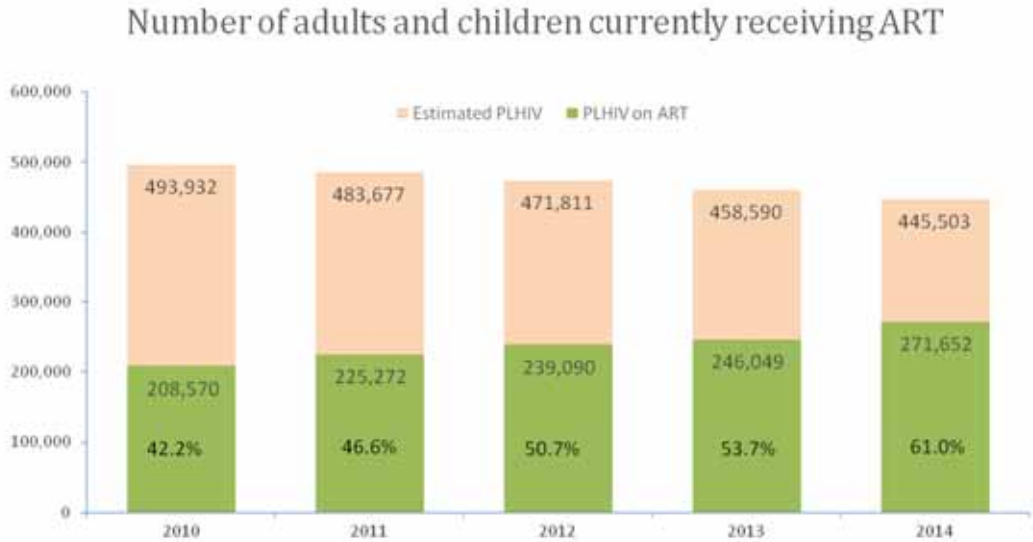
ART was delivered via 949 health facilities (that can initiate or provide follow up for PLHIV on ART). Retention in treatment at the end of 12 months was 83.0%. The rate among men and women was slightly different (82.4% among men vs. 83.8% among women), and higher among children than adults (87.3% vs. 82.9%, respectively). The 2014 retention rate, compared with the 2013 results, was very similar (83.0% in 2014 vs. 82.7% in 2013). The loss to follow-up was 8.5%, mortality was 8.3% and 0.13% people chose to stop ART. The trend of death rate, lost-to-follow and those who stopped therapy was also stable. Longer term retention at 24 and 60 months was 77.9% and 74.6% respectively. However, mortality at 24 months was 11.5% and increased to 17.4% at 60 months.

Coverage of ART

Access to ART has continued to improve in Thailand at a rapid rate, with coverage increasing from 64.6% in 2011, and increasing more than 15% only two years later in 2013 to 80.3%. It should be noted that this increase is based on a different treatment initiation criterion than what is used now. Apart from improvements in treatment access and high retention rates, Thailand has made exception progress in improving the quality of ART. This is seen through the improvements in access to viral loads testing and levels of viral load suppression – in 2014, 96.1% of ART patients who tested for viral load during the reporting period had suppressed viral loads. It is also notable that in Thailand, ART stock outs are very rare – in 2014, only 3.1% facilities reported ART stock-out.

Many HIV positive people are unaware of HIV status and seek HIV services late. It is critical that rapid diagnosis and massive scale up of HIV Counseling and Testing, strong linkages are in place to support early treatment initiation and retention. This will in turn require well-functioning referral linkages, task sharing, and consistent promotion of early diagnosis and treatment adherence.

Figure 6 Percentage of adults and children with HIV currently receiving antiretroviral therapy



Developments/ factors facilitating the achievement of the target

Political commitment

Thailand has been demonstrating sustained political commitment to curb the HIV epidemic. The country has been one of the first to take on board the goal of ending the AIDS epidemic by 2030. In doing this, Thailand has very quickly utilized new scientific knowledge, and been able to translate that into context specific policy and implementation practice. This has been reflected in the HIV/AIDS Operational Plan (2015-2019), which is focused on combination prevention approaches and early treatment (including bio-medical interventions). This has been endorsed by the National AIDS Council.

National financing

The National HIV response is largely funded by domestic resources. In particular, where treatment is concerned, a 100% of resources are domestic. All three health insurance schemes for Thai nationals offer a comprehensive benefits package addressing the entire continuum of diagnosis, treatment, and follow up (including free first and second line ARV, salvage regimens, viral load and resistance monitoring).

Conclusion

Thailand is on track to meet the HLM and National Targets for access to life saving ART. The country performed well both in terms of the coverage of ARV and the quality of ART services.

The Way Forward: Priority Actions

1. Increase the proportion of people who know their sero-status by investing in demand generation programme, HTC services, and reduction of stigma and discrimination.
2. Improve access to simplified and decentralized diagnostic technologies as well early diagnosis and completed referrals into care and treatment.
3. Improved mechanisms to support adherence and life-long treatment as part of the Test and Treat approach.
4. Ensure universal access to ART and quality treatment for unregistered migrants.

Target 5

HLM: Reduce tuberculosis deaths in PLHIV by half by 2015

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

National milestone for 2014

- 32 % of estimated HIV positive incident TB cases that received treatment for TB and HIV
All HIV positive patients are screened for TB in HIV care settings at each visit
- 95% of TB patients will be tested for HIV and have their test result recorded in the TB Register
- 8% of people with HIV and TB co-infection die after beginning of treatment

Achievements by the end of 2014

At the end of 2014, the Bureau of Tuberculosis reported 50,670 TB patients had been tested for HIV at the time of TB diagnosis or had a known HIV status. Among these, 6,831 were HIV positive. Of these, 4,691 were on ART and 4,359 were receiving co-trimoxazole preventive therapy.

Reporting for HIV -TB indicators is not complete in Thailand, and there is significant under-reporting of HIV testing and treatment among TB patients from specific sites. Data to report on GARP HIV -TB indicators 5.2, 5.3 and 5.4 are not routinely collected at a nationally representative level. However some other data sources allow some conclusions to be drawn. For example, the HIV performance measurement for hospital quality improvement, namely HIVQUAL-T, in which patient charts who visited clinics during the review period were abstracted using a sampling methodology to achieve 90% confidence interval (+/- 8% random error) are available. This database specifically provides information on the percentage of PLHIV receiving care/treatment services at HIV clinics that had TB screening at least one time during the reporting year. In 2014, coverage of at least one-screening for TB was 98.8% according to HIV -QUAL data. Data on TB screening for each visit are not routinely collected and reported at the moment.

Coverage of ART for TB patients with HIV

There are an estimated 12,000 HIV positive incident TB case in Thailand. The proportion of estimated HIV positive incident TB cases that received treatment for TB and HIV has gone up steadily in Thailand from 26.07% in 2010 to 39.1% in 2014 (4,691/12,000). However, as a proportion of those diagnosed TB patients with HIV, this is 68.6% (4,691/6,831). This number has also steadily improved compared to 2013, when it was lower at 59.6%. However, this increase in the proportion is a result of a decline in the number of TB patients who were recorded to be HIV positive. This is a reporting issue rather than a decline in actual testing rates.

Developments/ factors facilitating the achievement of the target

National financing

The National HIV-TB response is largely funded by domestic resources. In particular, where treatment is concerned, a 100% of resources are domestic. All three health insurance schemes for Thai nationals offer a comprehensive benefits package addressing the entire continuum of diagnosis, treatment, and follow up (including free first and second line ARVs, first line and

second line TB treatment, molecular diagnostics, viral load and resistance monitoring). HIV testing is also free for all Thai citizens and registered migrants.

Challenges/ factors hindering the achievement of the target

For HIV-TB, inadequate diagnosis of TB among HIV patients remains a gap, specifically due to the large proportion of smear negative cases, extra-pulmonary and asymptomatic TB noted in this group, (which is poorly diagnosed in routine verbal screening algorithms). The main intervention to address this gap in detection of TB infections is to improve the quality of diagnosis by using Gene-Xpert, even though asymptomatic patients will need ongoing evaluation and investigations. Overall HIV testing rates among TB patients are high, but still not universal and extra effort to ensure 100% testing coverage among TB patients is required. Finally, clinical practice among TB care providers which may lead to delayed initiation of ART in TB patients needs revision. While this has been addressed in the National HIV and TB treatment guidance, more consultation and capacity building to give clinicians adequate confidence to treat with ART early is still needed.

Conclusion

Thailand has made considerable progress in alignment of HIV and TB programmes over time. Overall, the proportion of estimated HIV positive incident TB cases in Thailand who are receiving ART is still low and requires ongoing focus and commitment in order to achieve the targets set for 2016. It is notable that this is not a financial resource or technical guidance issue, as adequate financing and technical tools are already available. The focus needs to be on monitoring and improving clinical practice to ensure early detection of HIV and or TB and prevention of leakage in the treatment cascade.

The Way Forward: Priority Actions

1. Improve case finding of TB among those living with HIV including adequate diagnosis of smear negative and extra-pulmonary TB patients to ensure early diagnosis, and antiretroviral treatment using new molecular diagnostic technology and initiation of ART.
2. Ensuring universal testing for HIV among TB patients and completed referral for ART for all those with a HIV positive test result.
3. Improve and harmonize information system of TB and HIV co-activities in order to monitor progress and identify gaps for improvement.

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: Increase budget proportion for prevention in priority provinces by 2016

Based on the recent NASA in 2013, total HIV expenditure was 8,827 million THB, reflecting an increase of 14% from 2010 (7,733 million THB). Thailand was financing 89% of the total HIV expenditure through domestic funds (7,889 million THB), which is an increase from 85% or 6,588 million THB in 2010.

The spending on prevention increased from 1,015 in 2010 to 1,506 million THB in 2013, or 48% increased. Domestic financial resources were still a major funding source of prevention activities accounted for 78% in 2013. However, the proportion of spending for prevention among MSM, female and male SW, and PWID was only 13% of the total prevention expenditure in 2010 (134 million THB), 18% in 2011 (247 million THB), 11% in 2012 (166 million THB) and 11% in 2013 (167 million THB).

The Global fund is the main funding source for prevention among key populations: 73% in 2010, 86% in 2011, 86% in 2012 and 78% in 2013. Even though the proportion of domestic funds for prevention among key populations increased from 6% in 2010 to 14% in 2013, there remains a large gap to achieve self-reliance of domestic financing for the HIV response among key populations.

National priorities for 2014:

Closing the AIDS resource gaps for prevention services among key populations, in particular for community-based/led service delivery in priority provinces, is a national priority. Thailand has made efforts through different mechanism of central budgeting system including AIDS Care Fund, and Thai Health Promotion Fund to support prevention services. In the meantime, Thailand is focusing on preparing for the transition to fully self-reliance to ensure sustainable domestic financing of the HIV response. Thailand is establishing, advocating and accelerating leadership at the sub-national level, including Local Administrative Organizations (LAO), for a sense of local ownership and contributing budget to fund the HIV response in local areas.

Key achievements by 2014:

Political commitment

- The costed five-year Operational Plan for ending the AIDS epidemic was finalized and endorsed by the National AIDS Committee. Informed by quality up-to-date evidence, the Ending AIDS Strategy and Operational Plan prioritized combination prevention (including treatment as prevention), early treatment, and reduction of stigma and discrimination; placed a strong emphasis on reaching with quality services the key populations of MSM, PWID, SW and migrant workers; and accentuated the shift to community-based/led service delivery.
- The Joint Key Performance Indicators for HIV response (Joint KPI) has been approved by the NAC to be used by relating Ministries for 2015-16 on measuring progress of HIV response across government organizations and line ministries.
- The National Health Security Office with the endorsement from NAC agreed to establish prevention service category in the AIDS Care Fund for 2015. The 2015 budget request was

initiated at 500 million THB to support the prevention services for key populations. Unfortunately, the budget allocation in 2015 of NHSO was not increased due to economic constraints. The 2015 HIV prevention budget has been postponed. However, the prevention budget has been requested again for fiscal year 2016. The initial approval is endorsed at 186 million THB for delivering prevention services and 14 millions for service strengthening.

National financing

The Global Fund New Funding Model (NFM) concept note was developed and viewed as a means of strategic short-term support that would cushion the transition to a full, domestically-funded HIV and TB response. This front-load investment will allow Thailand to sustain and expand the gains in the HIV response while concentrating on mobilizing diversified domestic financing. The total amounts to US\$ 39.75 million over a two-year period from 1st January 2015 to 31st of December 2016. The budget for HIV (about US\$ 24 million) is focused on service delivery for key populations in prioritized provinces, as epidemiological and cost-benefit investment analysis indicate that the highest return on investment will be obtained by that focus. To fill country gaps, over a third (38%) of the budget is allocated for prevention and HTC for KPs; with the largest share going to prevention and HTC activities for MSM and TG populations (reflecting the highest burden of infections in this group). The second largest allocation goes to PWID interventions, and the remainder of the investments addresses heterosexual transmission.

With the updated NSP reinforced additional measures, the National Health Security Office (NHSO) continued its support to prevention and STI services for key populations (22 million THB in Fiscal Year 2014). Prevention activities include peer-led interventions, community mobilization, demand-generation for HTC through social and health networks, linkage of services provided at the district, sub-district and community levels, and quality of counseling services in the community and health outlets.

Steps were taken in preparing for the transition to self-reliance and ensuring sustainable domestic financing of the HIV response. A review of funding mechanisms and alternative funding sources and management as well as a prioritization of services is underway. An alliance with CSO was established to support an analysis of existing and potential domestic funding mechanisms and sources, including examining government-NGO financial models that could be adapted to Thailand's context.

Increase involvement and local ownership

The national sub-committee on promoting provincial and local stakeholder ownership fully preformed its functions throughout 2014. A number of approaches have been developed to promote involvement and a sense of ownership in the expansion of the HIV response at local levels including;

- Established a memorandum of understanding (MOU) between the Department of Provincial Administration, Ministry of Interior and Ministry of Public Health to integrate the HIV response into the "district health system".
- Supported the "ASEAN Cities Getting to Zero" initiative, and four provinces in Thailand namely Bangkok, Phayao, Ubonratcha Thani and Lopburi were selected for pilot activities. These cities received support from BATS and UNAIDS to effectively translate the Ending AIDS strategy into actions with inclusive effort from relevant key partners and stakeholders within each city. The goal is to enhance the response to HIV and

mobilize all resources by the local team to support the Ending AIDS operations in an effective and harmonized manner.

- Promoted the use of the “AIDS ZERO PORTAL” as an innovative interactive tool for policy makers and program managers to provide quality and up-to-date strategic information to guide the HIV response at sub-national levels.
- Translated the national Ending AIDS operational plan into actions, including a “Flagship Project” to accelerate the HIV response in 13 priority provinces.
- The Health Promotion Fund provided financial support for implementation of Ending AIDS in three provinces with inclusive engagement of key stakeholders and LOA. Systematic documentation of this process will be undertaken for future replication.

Nakhon Ratchasima Province was successful in mobilizing financial support for the HIV response from local organizations, in particular for HIV prevention for youth. In early 2015, 165 out of 232 (75%) of LAO provided financial support for HIV-related activities in the amount of 30 million THB. This represents an average LAO contribution of 182,000 THB and a significant increase over the contribution during 2006-2008 which ranged from 39,000-81,000 THB per LAO per year (UNDP, 2010). There was effective implementation of the joint KPI at the provincial level, with a clear HIV strategic framework and establishment of standard operation procedures to support HIV activities for local organizations.

Challenges/ factors hindering the achievement of the target

- There is a need to ensure sustainable allocation of domestic financing for continued engagement of CSO and communities in delivery of an appropriate response by targeting the key populations of MSM, SW, PWID and migrants.
- The capacity of local organizations to mobilize financial support is still modest. A more systematic approach is needed for this, including skills-building in sharing lessons learned between provinces.

Conclusion

Thailand achieved top-level commitment in policy endorsement towards Ending AIDS by 2030. Progress was made with additional financial support for prevention, targeting MSM and FSW, from domestic funds in 2014, but the amount is still limited. Steps were taken in establishing prevention category in AIDS Care Fund of NHSO and preparing for the transition to self-reliance. Both existing mechanism and new model are needed to ensure sustainability of financing the HIV response to continue engagement of CSO and communities in delivery of appropriate HIV interventions targeting key populations. Scale up good practices of mobilization of local ownership as well as leveraging financial support for the HIV response at the sub-national level are also important mechanism to support the ending AIDS strategy.

The Way Forward: Priority Actions

1. Develop new funding mechanisms for sustainable and flexible domestic financing support of the HIV response particularly the CSO activities.
2. Capacitating and empowering CSO and communities for effective engagement in policy work related to sustained financing of the HIV response.
3. Engaging leadership and accelerating capacity-building at the provincial level, including local organizations to strengthen ownership of the HIV response, including creating more opportunities for CSO and communities.

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

Data on Violence against Women (VAW) and Intimate Partner Violence (IPV)

- The National Statistical Office (NSO) survey of 27,000 sampled households on the status of women and children in Thailand and found that 13.1% of women aged between 15-49 think that physical violence by a husband is justifiable in cases in which the wife leaves the house without informing the husband, not being attentive in taking care of children, refusing to have sex with the husband and burning the food.
- Data from the One Stop Crisis Center (OSCC) in 829 hospitals of the MOPH for 2013 show that 12,637 women and 19,229 children received services from the OSCC. The majority of clients receiving the services were victims of either physical or sexual violence from their intimate partners or boyfriends. The VAW was highest among the population age of 24-45 years. Fifty-three percent of perpetrators were spouses. These findings are consistent with the national survey conducted in 2013 by the MSDHS. That study identified 2,976 cases of domestic violence, who were mostly women, children and elderly. Of these, 85.2% suffered from emotional violence, 69.9% from physical violence and 21.6% from sexual violence. The majority of perpetrators were spouses, siblings or intimate partners.

Achievements by the end of 2014

Empowerment of Women Living with HIV (WLHIV) Network

- ***Participation in Reproductive Health (RH) Services.*** The WLHIV network was empowered to participate in RH services for pregnant women at ANC clinics in 13 hospitals across nine provinces. The RH services include provision of knowledge on prevention and care for HIV/AIDS, rights-based information, assistance for cases of gender-based violence, as well as life planning for couples. The gender perspective was applied to solve the problems regarding STI, AIDS, RH and human rights.
- ***Strengthening the network and capacities of women living with HIV (WLHIV).*** In December 2014, 36 WLHIV attended a workshop, organized by UN Women, Mahidol University, the Raks Thai Foundation, the Network of WLHIV and government agencies. This workshop provided an opportunity for participants to brainstorm on progress, gaps, challenges, lessons learnt and strategic directions for the network of WLHIV. Three key issues were identified and addressed. Firstly, the WLHIV network needs to be reconstructed to reflect its organizational capacity. That is, the network needs to be re-formulated into either an association or a foundation, at the sub-national or national level. Secondly, the representatives of the WLHIV network identified challenges in building a new generation of WLHIV leaders. Thus, there is a need for capacity building to groom the new generation of WLHIV leaders. Thirdly, the network identified priority areas for implementation in RH and rights. Also, it is essential to advocate for other rights, such as economic, social and cultural rights. These are reflected in some of the activities of the “Strengthening Evidence and Empowerment Living with HIV/AIDS in Thailand Towards Gender-Sensitive and Rights-base HIV/AIDS Prevention and Response” Project, which was launched in 2015 by Mahidol University and the Raks Thai Foundation, supported by UNWOMEN and UNAIDS.

Legal framework for gender equality

The draft Gender Equality Law was submitted to the National Assembly in December 2014, and subsequently approved by the National Assembly in January 2015. Article 3 includes the statement that sexual expression that is different from one's sex at birth' as a basis for gender discrimination is prohibited¹. There was also policy advocacy on the laws related to who constitutes a "marital partner."

Evidence and knowledge generation

Mahidol University, supported by UNWOMEN and UNAIDS, conducted a study to document and analyze the contribution of gender in the cause and consequence of HIV and the extent to which gender issues are considered and integrated into HIV policy and programmes at the national and sub-national level, as well as provide policy recommendations in 2015.

Developments/factors facilitating the achievement of the targets

Policy commitment

Gender equality is one of the core concepts of the National AIDS Strategy (NAS) 2014-2016 related to social justice and "promoting equality in the society through respect and protection of full enjoyment one's rights and gender equality". Gender is incorporated in Strategy 1 of the NAS 2014-2016 by virtue of "expand rights-based and gender-sensitive comprehensive prevention services for population/risk behavior at highest risk of HIV transmission." In addition the Gender Equality Law was presented to the National Assembly in late 2014 and was approved by the National Assembly in January 2015.

Policy space for participation of women living with HIV

In 2014, the Network of WLHIV participated in policy advocacy for the draft Gender Equality Legislation (GEL) in consultation brokered and supported by UNWOMEN, including input by Civil Society, for submission to the National Assembly Working Group for consideration. The Network of WLHIV also participated in consultations to review the progress of the Beijing Platform for Action adopted at the Fourth World Conference on Women in Beijing, China in 1995 as well as coordination of inputs on women and health, as brokered and supported by UNWOMEN, and organized by the Foundation for Women and Social Watch, Thailand. In addition, the Network of WLHIV also participated in consultation and advocacy forums to identify key issues and to tender proposals from the women's groups to the Constitution Drafting Committee, as brokered and supported by UNWOMEN and the Women's Reform Network.

Challenges/factors hindering the achievement of the targets

The overall challenge hindering the achievement of the target lies in the lack of follow-through of policy commitment/gender equality in the policy space for implementation.

Stigma & Discrimination and Rights Violations against WLHIV

- Universal access to ARV and health services, comprehensive services for PLHIV, and options in caring for one's health are commendable policies. However, WLHIV still face discriminatory attitudes in service provision. In many cases, service providers adopt a 'superior' position in provision of counseling, and make decisions for WLHIV, including

¹ Article 3: Unjust gender discrimination refers to an action or an omission of action of distinction, exclusion or restriction of benefits, either direct or indirect that is unjust on grounds of self-identified sex or of sexual expression that is different from sex at birth.

decisions to terminate or continue pregnancy. Regarding prevention, many WLHIV are 'forced' to bring their spouse/intimate partners to receive services. Disclosure of HIV status, as recounted by the majority of WLHIV, leads to intimate partner violence, both verbal and physical, for 'infecting' the husband/spouse, regardless of the reality. WLHIV whose husband passed away face pressure to leave the household. Children of WLHIV and girls living with HIV are often stigmatized and discriminated against by the community.

- WLHIV also face discrimination and stigmatization in the workplace, receiving lower pay than others/minimum wage and being forced to work in involuntary positions.

Limited Capacities and Policy Platform for Advocacy by the Network of WLHIV

While progress has been made, the Network of WLHIV remains rather weak in their collective capacity for policy advocacy, influencing gender-sensitive services and addressing discrimination, stigmatization and VAW & IPV. The Network of WLHIV, which was formed in 1999, remains an informal and loosely formed network, with a number of committed WLHIV, with technical support mainly from the Raks Thai Foundation. Identified gaps include inadequate and uneven understanding and exposure to rights, particularly reproductive health and other rights related to gender equality, women's human rights, discriminatory issues, and limited managerial and organizational capacities. The Network is still a small, informal, and loosely formed operation. The effectiveness of the network ebbs and flows depending on project-based funding, challenges in recruiting new generations of members of the WLHIV network, as well as the need to strengthen opportunities and space for formal advocacy at the policy level, with a corresponding capacity to do so.

Intimate Partner Violence (IPV)

Many women living with HIV experience IPV, mostly physical violence, when disclosing the HIV status to their partners.

No indicators on gender and gender-based violence (GBV)

- Gender issues were incorporated in the review undertaken during the preparation and development of the National AIDS Strategy 2014-2015. Despite success of having CEDAW and gender mentioned in the strategy, there is no mechanism to follow up with regards to specific strategies and actions.
- There are *no gender-specific indicators*. Gender indicators are now under development. However, all indicators related to gender issues are quantitative and only focused on key affected populations and their spouses, including discordant couples, and PLHIV. Therefore, it is difficult to capture the situation and trend of comprehensive gender inequalities in the context of HIV. In addition, there are no indicators to capture rights violations and discrimination against WLHIV, as well as capturing the risks and vulnerabilities of women to GBV.
- There are no indicators that capture GBV amongst women and men, violence against women, violence against people with gender diversity, or violence amongst same-sex couples.

Lack of coordination for the implementation to achieve the targets

There is no institutional cross-cutting mechanism on gender and HIV among the relevant government organizations. While the National Strategy on HIV/AIDS 2014-2016 encourages using the Convention on the Elimination of All Forms of Violence against Women (CEDAW) as a direction in HIV and AIDS-related service provision, there is no clear implementation nor monitoring mechanism for the integration of gender into the rolling out of the strategy. Similarly, the National Plan on the Advancement of Women 2012-2014 refers to HIV/AIDS in its

Strategy 3 on the Promotion of Well-being, Quality and Security of Life, but primarily from the health and prevention perspectives. In addition, reference to HIV work in the plan and its implementation framework is minimal. On top of this, there is no platform nor formal mechanism to coordinate the work of gender and HIV in Thailand. Given the lack of formal coordination mechanisms on gender and HIV, there is no platform for policy discussion and recommendations towards a vision of “Getting to Zero Stigma and Discrimination” for Thailand, a goal for 2016, in which ‘human rights and gender-specific needs are addressed in all HIV responses’.

Lack of sex-disaggregated data

There is no systematic collection of sex-disaggregated data with regard to IPV beyond married women, violence against women, women’s vulnerabilities to HIV infection or vulnerabilities of women affected by HIV.

Conclusion

VAW and IPV remain a common issue in Thailand, but systemic empirical data on GBV, either at the national or sub-national levels, is still limited. The NAS still lacks mechanisms to translate strategy in to the implementation. It is not clear how gender perspective be integrated into the roll-out strategies.

The Way Forward: Priority Actions

1. Establish a formal platform for coordination of the work on gender and HIV. Strengthen national coordination among government agencies for the full protection of rights of WLHIV and their access to gender-sensitive, rights-based and effective services, as well as implementation of the multi-sectoral coordination mechanism at the provincial level.
2. Strengthen capacity of the national and sub-national networks of women and girls living with HIV, including individual and organizational capacity building, and government funding. Engage the network of women and girls living with HIV in national platforms to amplify their voice and reduce gender inequality. Engage the network of women and girls living with HIV in the mainstream work of PLHIV.
3. Improve attitudes of service providers so that they are non-discriminative and respectful toward WLHIV, and ensure the provision of gender-sensitive services, with participation from WLHIV. Ensure a comprehensive approach for women’s empowerment in service provision, instead of taking the social welfare approach.
4. Strengthen accountability frameworks and mechanisms, including clear targets, indicators, sex-disaggregated data collection and analysis which will enable reporting under Target 7. Support active use of strategic information relevant for gender-sensitive services and GBV protection.

Target 8

HLM: **Eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms by 2015**

Thai NASP: **Reduce stigma and discrimination by 50% in 2016**
Expand the protective social and legal environment essential for HIV prevention and care

National priorities

Thailand has identified stigma and discrimination (S&D) as key drivers of epidemic and barriers in making progress to end the AIDS epidemic. Non-discrimination and promoting human rights and gender equality remain a priority of Thailand's HIV response. The national plan focused on revising laws and policies on drug use, age of consent for HIV testing among young people (<18 years), health policy related to non-Thais accessing health services, expanding implementation of the national code of conduct to reduce S&D at workplaces, implementation of "normalizing HIV" and developing and rolling-out tools to routinely measure HIV-related S&D, and human rights violations.

Achievements by the end of 2014

Political commitment

- Progress was made in revision of certain laws and policies as well as enhanced implementation:
 1. The ONCB launched the order and operational plan for implementation of harm reduction in 19 provinces for 2014-15 and the National AIDS Committee (NAC) endorsed the policy and strategies on Harm reduction for drug user in November 2014. A Task Force was established and serves as a platform for effective coordination, enhancing collective efforts among all relevant organizations. Nineteen priority provinces have been identified to implement a comprehensive harm reduction programme, and the evaluation at the end of the first year of its implementation is to be finalized;
 2. An official declaration was made by the Medical Council of Thailand eliminating the requirement of parental consent for HIV testing by clients age below 18 years; the NAC acknowledged the statement and has disseminated it widely;
- Because S&D still exist in many worksites, the Bureau of AIDS and STI, (BATS) worked in close collaboration with 12 Regional Department of Disease Prevention Control units to reinforce the implementation of "the national code of conduct" at public workplaces throughout the country. During the report period, human rights, gender equality and reduction of S&D towards people living with HIV (PLHIV) were cornerstones of these efforts. 93 workplaces participated an initiative to create workplaces. These best-practice worksites were acknowledged and received awards at the 2014 National AIDS Seminar and serve as models for replication. The AIDS Standard Organization (ASO) certification is used as a tool for promoting good AIDS policy at companies and private workplaces with no HIV testing for job applicants, and support for HIV+ employees.
- Led by the National AIDS Management Center with strong involvement of civil society, PLHIV and key population networks, academia and international organizations (RTI/USAID and the UN Joint team on AIDS) made significant progress on developing tools to routinely measure S&D in various settings, including the following:

1. Successful introduction of six S&D questions including a new indicator that was first introduced in the 2014 Global AIDS Progress Report Guidance on measuring attitudes towards PLHIV among the general population in a population-based survey for the first time ever;
2. The tool for routinely monitoring S&D in healthcare settings and among PLHIV, along with the respective manuals, was completed. A total of 51 professionals from 10 regions and 22 provinces were trained in using the tool. Currently, the tool is being rolled out throughout the country. In particular, eight provinces have committed to participate as the national sentinel sites to systematically monitor the situation and response toward S&D in healthcare settings. PLHIV and key populations in the community are fully engaged in the tool development and roll-out, and its findings are informing stigma-reduction action at the national and sub-national levels;
3. Completed development of optimal sets of question to be integrated in the integrated biological and behavioral surveys among key populations (MSM, SW, PWID) and migrant workers.

National financing

Results from a pilot study in two provinces showed HIV-related to S&D in health care settings and among PLHIV are common and very resilient even in a country with a mature epidemic like Thailand. Health facility staff still displayed a high level of enacted and observed stigma. PLHIV reported experiencing S&D as well as avoiding health services because they anticipated stigma at the health care settings. This evidence is critical information and is used to inform design of the national operational plan. In 2014 the Ministry of Public Health took action in designing a S&D reduction curriculum and sustained in-service training of health care staff, including enhanced implementation of universal precautions, and developed communication strategies for raising awareness related to S&D and rights of PLHIV and key populations. Through the Global Fund/NFM, activities will be implemented in 2015 on expansion of protective mechanisms in response to human rights violations and S&D in four provinces. Creating an enabling environment is proposed as one of core approaches under the National Ending AIDS operational plan for 2015-2019. Securing funding support to implement comprehensive activities as planned is underway.

Civil society involvement

Stigma reduction was at the core of the National AIDS Campaign/ World AIDS Day activities in 2014. Civil society and communities carried out stigma-reduction campaigns, including media coverage. The campaign culminated at the National AIDS Seminar. In the build-up to the Seminar, civil society implemented a series of public awareness and social mobilization campaign activities, involving media representatives and companies which targeted various audiences. These campaigns produced and disseminated material in support of provincial campaigns. As a result, CSO-media partnership grew and public awareness on S&D increased. Throughout 2014, key affected population networks continued to campaign and disseminate communication materials to promote use of clean needles and syringes and reduce drug-use-related stigma. NGOs 12D, TDN led the CSO/ community effort.

Challenges/ factors hindering achievement of the target

Revision of some conflicting laws, policies and harm reduction operational guidelines regarding recreational and illegal drugs is needed. For example, the harm reduction policy considers drug users as patients while the Criminal Drug Law for 1979 defined drug users as criminals who

must be jailed. Distribution of sterile needles is not yet widely accepted, and this prohibits clean needle distribution in certain provinces;

Fragmented evidence is available related to various types of drug dependence treatment centers, and this information would facilitate effective transition towards community-based drug dependence treatment and supporting services.

Conclusion

Progress was made in removing certain legal and policy barriers that impede access to key services among PLHIV and key populations. Continued efforts are still required to maintain momentum towards eliminating remaining including ensuring effective implementation at the sub-national level.

Tools for routinely measuring S&D in the general population, health care setting (health facility staff and PLHIV) and among key populations exist. Rolling out these tools demonstrated has achieved significant progress. Evidence-informed design and implementation of S&D reduction interventions at the health care setting and public campaign are occurring.

The way forward: Priority actions

1. Remove conflicting laws and policies related to drug users and sex workers.
2. Develop a 'reduction of S&D' curriculum for health facility staff, and conduct training in selected provinces. In addition, scale up implementation of national the code of conduct at public and private workplaces.
3. Establish mechanisms that effectively response to human rights violations, and S&D in selected provinces including empowering PLHIV and key populations on AIDS rights protection, and reduce internal stigma.
4. Create the enabling environment with public communication and campaigns to "normalize HIV".

Target 9

HLM	Eliminate Travel Restriction
Thai NSP	Thailand has no travel restriction

Target 10

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

Thai NSP: **No specific target**

Overview

The Global-Fund-supported CHILDLIFE program aims to strengthen the community system by building capacity and providing support to 1,160 Child Action Groups (CAGs) in 257 districts in 29 provinces. CAGs work as the first-contact point to recruit vulnerable children and assess their needs in order to provide appropriate services, including referring them to social and protection services. CAGs also follow up the referred cases in both sectors to ensure the needs are fulfilled. Activities and services provided by CAGs are child's camp to provide psychosocial support in groups, quarterly peer-group support, and training for parents and caretakers, in addition to services given to individual cases based on special needs. Throughout the three years of the program, a total of 107,200 children affected by AIDS (CABA) and other vulnerable children (OVC) were reached by the CAGs.

Achievements by the end of 2014

From October 2012 – September 2014, 81,141 children (aged 0 – 18 years) were enrolled into the CHILDLIFE program and 83% were considered as OVC in accordance with the MSDHS's definition. Nearly 70,000 CABA and OVC in the 29 provinces received services under the CHILDLIFE program, provided by CAGs.

The MSDHS has provided support for people affected by HIV/AIDS including CABA. In 2014, a total of 15,674 children received support from the MSDHS. The support included provision of four orphanage shelters, located in Bangkok, Chiang Mai, Udonthani and Songkhla, where CABA have received special support in basic needs including education, child development and foster family placement. A total of 211 CABA were placed in foster families in 2014.

A Child Status Index (CSI) survey was conducted to measure child well-being status and external support among 902 families with CABA and OVC in five provinces. The survey found that only 29.7% of children were living in circumstances that could be rated as satisfactory, and 79.1% of families with CABA and OVC received economic support in the three months prior to the survey.

Challenges / factors hindering the achievement of the targets

The cessation of support by the Global Fund for the CHILDLIFE Project presents the biggest challenge. The linkages among community systems and government support service systems have only just been initiated. However, there is an on-going effort to maintain these mechanisms using local resources.

Conclusions

Strengthening system and collaboration across the sectors (e.g., community, health, and social protection) as well as reduction of stigma and discrimination towards CABA and OVC is essential. The end of GF support has created major challenge to promote a community-based holistic care program for CABA and OVC in the HIV-affected provinces.

The Way Forward: Priority Actions

1. Continue functions of Child Action Group through collaboration of the MOPH and MSDHS, and integrate these functions into the MSDHS structure.
2. Enhance the Provincial Child Protection Committees (PCPC), which are a legally-binding mechanism of the MSDHS, to be more proactive in addressing problems of children and youth at different levels, and translate the Child Protection Act into strategies and action plans at the provincial level with meaningful participation of the CAGs.
3. Restructure the Child Department under the MSDHS to be more effective in implementation of the Child Protection Act; the support should also cover non-Thai children.

Summary GARP Indicators for all targets between 2009 and 2014

TARGET 1: Reduce sexual transmission of HIV

HLM Target: Reduce sexual transmission of HIV by 50% by 2015

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

Indicators		Indicator Description	GARP	UA	National target by 2016	2009	2010	2011	2012	2013	2014
General population	1.1	Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	●	●		Data not available					
	1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	●	●		Data not available					
	1.3	Percentage of adult (woman and men) aged 15 - 49 who have had sexual intercourse with more than one partner in the past 12 months	●	●		Data not available					
	1.4	Percentage of adult (woman and men) aged 15-49 who have had more than one sexual partner in the past 12 months who reported the use of a condom during their last sexual intercourse	●	●		Data not available					
	1.5	Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	●	●		Data not available					
	1.6	Percentage of young people (woman) aged 15-24 who are living with HIV	●	●	0.33%	0.58%	0.44%	0.44%	0.40%	0.43%	0.52%

Indicators		Indicator Description	GARP	UA	National target by 2016	2009	2010	2011	2012	2013	2014
Sex workers	B1	Estimated number of sex workers (man and woman)	●				141,769		141,769		141,769
Female sex workers	1.7	Percentage of sex workers reached with HIV prevention programmes	●	●	80.00%		50.45%		53.89%		57.74%
	1.8	Percentage of sex workers reporting the use of a condom with their most recent client	●	●	95.00%		95.56%		93.60%		96.09%
	1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	●	●	90.00%		47.76%		55.60%		54.19%
	1.10	Percentage of sex workers who are living with HIV	●	●	1.00%		2.69%		2.16%		1.13%
Male sex workers	1.7	Percentage of sex workers reached with HIV prevention programmes	●	●	80.00%		61.00%		73.77%		64.04%
	1.8	Percentage of sex workers reporting the use of a condom with their most recent client	●	●	99.00%		88.00%		98.18%		95.52%
	1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	●	●	90.00%		49.00%		52.38%		54.37%
	1.10	Percentage of sex workers who are living with HIV	●	●	10.20%		16.00%		12.20%		11.66%
Man who have sex with man	B2	Estimated number of men who have sex with men	●				550,000		550,000		550,000
	1.11	Percentage of men who have sex with men reached with HIV prevention programmes	●	●	80.00%		43.79%		52.65%		45.92%
	1.12	Percentage men reporting the use of a condom the last time they had anal sex with a male partner	●	●	95.00%		80.22%		85.49%		82.08%
	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	●	●	90.00%		14.93%		25.58%		30.85%
	1.14	Percentage of men who have sex with men who are living with HIV	●	●	6.00%		8.02%		7.13%		9.15%

Indicators		Indicator Description	GARP	UA	National target by 2016	2009	2010	2011	2012	2013	2014
Counseling and testing	1.15	Percentage of health facilities that provide HIV testing and counseling services		●				100%	100%		100%
		Number of Health facilities						1324	1365		1480
	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	1,357,350
		Number of HIV+						22,339	21,907	22,122	22,650
		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	609,079
		Number of HIV+						17,464	16,984	17,031	18,061
	1.16.1	Percentage of health facilities dispensing HIV rapid test kits that experienced a stock-out in the last 12 months.		●						Data not available	
Sexually transmitted infections	1.17	Sexually Transmitted Infections (STIs)									
	1.17.1	Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit		●					91.55%	95.78%	96.84%
	1.17.2	Percentage of antenatal care attendees who were positive for syphilis		●					0.06%	0.05%	0.07%
	1.17.3	Percentage of antenatal care attendees positive for syphilis who received treatment		●					93.10%	97.87%	97.79%
	1.17.4	Percentage of sex workers with active syphilis		●			Median	0.26%	0.00%	0.00%	NA
						Mean	0.62%	0.54%	0.69%	NA	

Indicators		Indicator Description	GARP	UA	National target by 2016	2009	2010	2011	2012	2013	2014
	1.17.5	Percentage men who have sex with men with active syphilis		●				Data not available		24.36%	NA
	1.17.6	Number of adults reported with syphilis (primary/secondary and latent/unknown) in the past 12 months		●						2,273	2,990
	1.17.7	Number of reported congenital syphilis cases (live births and stillbirths) in the past 12 months		●						Data not available	Data not available
	1.17.8	Number of men reported with gonorrhoea in the past 12 months		●						6,409	5,210
	1.17.9	Number of men reported with urethral discharge in the past 12 months		●						NA	NA
	1.17.10	Number of adults reported with genital ulcer disease in the past 12 months		●						NA	NA
	1.19	Diagnosis of HIV and AIDS cases (New 2014)		●							
	1.19.1	Number of HIV cases diagnosed by age and sex from 2010-2014 (New 2014)		●			40,069	38,602	37,922	54,840	37,287
	1.19.2	Number of AIDS cases diagnosed by age and sex from 2010-2014 (New 2014)		●			28,759	39,753	25,598	27,424	29,627

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

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

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

Indicator	Indicator description	GARP	UA	National target by 2016	2009*	2010	2011	2012	2013	2014
B3	Estimated number of People who inject drugs (PWID)	●			40,300	40,300		40,300		40,300
2.1	Number of Syringes distributed per person who injects drugs per year by Needle and Syringe Programmes	●	●	88.0			9.79	11.52	12.02	13.79
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%		47.16%
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%		84.88%
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%		61.15%
2.5	Percentage of people who inject drugs who are living with HIV	●	●	21.0%	17.20%	21.87%		25.20%		19.02%
2.6	Estimated number of opiate users (injectors and non-injectors) Number of people on opioid Substitution therapy (OST)									
	2.6a Estimated number of opiate users (injectors and non-injectors)		●		Data not available					
	2.6b Number of people on opioid substitution therapy (OST)		●	4,500		2,201	2,612	3,735	4,068	3,646
2.7	Number of needle and syringe programme (NSP) sites Number of substitution therapy (OST) sites (WHO)									
	2.7a Number of needle and syringe programme (NSP) sites		●		39	49	42	36	38	42
	2.7b Number of substitution therapy (OST) sites		●		49	Data not available	147	147	147	140

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

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

Thai NASP: Vertical transmission of HIV less than 2%

Indicator	Indicator Description	GARP	UA	National target by 2016	2008	2009	2010	2011	2012	2013	2014
3.1	Percentage of HIV-positive pregnant women who received antiretroviral medicine to reduce the risk of mother-to-child transmission	●	●	98.80%	93.60%	95.00%	94.20%	93.98%	93.75%	95.15%	95.78%
3.1a	Percentage of women living with HIV who are provided with antiretroviral medicines for themselves or their infants during the breastfeeding period									Indicator not relevant	
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	●	●	90.00%			75.80%	73.13%	77.23%	72.87%	76.14%
3.3	Estimated percentage of child infections from HIV-infected women delivering in the past 12 months	●	●	2.00%			3.75%	3.04%	2.74%	2.30%	2.13%
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%	99.83%
3.5	Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months		●	60.00%					32.30%	38.41%	41.08%
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%	88.30%

Indicator	Indicator Description	GARP	UA	National target by 2016	2008	2009	2010	2011	2012	2013	2014
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%	99.48%
3.8	Percentage of infants born to HIV-infected women (HIV-exposed infants) who are provided with antiretrovirals (either mother or infant) to reduce the risk of HIV transmission during the breastfeeding period.		●		Indicator not relevant						
3.9	Percentage of infants born to HIV-infected women started on cotrimoxazole (CTX) prophylaxis within two months of birth		●			35.90%		42.00%	51.99%	57.34%	52.55%
3.10	Distribution of Outcomes of HIV-Exposed Infants (WHO)		●								
3.10.1	Number of infants born to HIV positive mothers (“HIV-exposed infants”) born in 2013 (or latest data available)		●								4589
3.10.2	Number of infants, born in 2013 (or latest data available) to HIV positive mothers, classified as indeterminate (i.e.: all lost to follow up, death before definitive diagnosis, indeterminate lab results)		●								1103
3.10.3	Number of infants born in 2013 (or latest data available) to HIV positive mothers that are diagnosed as positive for HIV		●								70
3.10.4	Number of infants born to HIV positive mothers in 2013 (or latest data available) that are diagnosed as negative for HIV		●								3416
3.11	Number of pregnant women attending ANC at least once during the reporting period		●				772,772	747,967	783,305	804,484	737,150

Indicator	Indicator Description	GARP	UA	National target by 2016	2008	2009	2010	2011	2012	2013	2014
3.12	ANC and EID Facilities (WHO)										
3.12.1	Number of antenatal care facilities providing HIV testing and counseling services		●								1468
3.12.2	Number of antenatal care facilities providing HIV testing and counseling services and dispensing antiretrovirals		●								949
3.12.3	Percentage of health facilities that provide virological testing services (e.g. polymerase chain reaction) for diagnosis of HIV in infants on site or from dried blood spots		●								77%
	Number of Health facilities										700

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

Indicator	Indicator Description	GARP	UA	National target by 2016	2009	2010	2011	2012	2013	2014
4.1	Percentage (%) of eligible adults and children currently receiving antiretroviral therapy	●	●	90.0%	75.76%	71.80%	77.00%			
	- CD4 \leq 200 cell/ml					59.10%	64.61%			
	- CD4 \leq 350 cell/ml							53.55%	60.98%	
	- any CD4 Level							53.55%	60.98%	
4.2	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%	83.03%
	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%	77.90%
	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			75.91%	74.59%

Indicator	Indicator Description	GARP	UA	National target by 2016	2009	2010	2011	2012	2013	2014
4.3	Number of health facilities that offer ART(i.e. prescribe and/or provide clinical follow-up) - Adult		●		1014	943	937	949	978	949
	- Pediatric							672	675	640
4.4	Percentage of health facilities dispensing antiretroviral drugs 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%	3.05%
4.5	Percentage of HIV positive persons with first CD4 cell count < 200 cells/ μ L in 2014		●							57.03%
4.6	HIV care		●							
	4.6a Total number of adults and children enrolled in HIV care at the end of the reporting period		●						407,046	426,274
	4.6b Number of adults and children newly enrolled in HIV care during the reporting period		●						52,521	35,282
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		●						95.38%	96.09%
	4.7b Percentage of people on ART tested for viral load with VL level \leq 1000 copies/ml after 12 months of therapy		●						92.54%	94.81%

Indicator	Indicator Description	GARP	UA	National target by 2016	2009	2010	2011	2012	2013	2014
4.7c	Percentage of people on ART tested for viral load (VL) with undetectable viral load in the reporting period		●							90.72%

TARGET 5: Reduce tuberculosis deaths in people living with HIV

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

Indicator	Indicator Description	GARP	UA	National target by 2016	2009	2010	2011	2012	2013	2014
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	●	●	50.00%	25.53%	26.07%	36.19%	27.84%	38.37%	39.09%
5.2	Percentage of adults and children living with HIV newly enrolled in care who are detected having active TB disease		●						Data not available	Data not available
5.3	Percentage of adults and children newly enrolled in HIV care (starting Isoniazid Preventive Therapy (IPT))		●			Data not available	Data not available	Data not available	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	Data not available

TARGET 7: Eliminating gender inequalities

HML Target: 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

Indicator	Indicator Description	GARP	UA	National target by 2016	2012	2013	2014
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	●		NA		Data not available	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 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
Reduce stigma and discrimination by 50% in 2016

Indicator	Indicator Description	GARP	UA	National target by 2016	2006	2012	2014
8.1	Percentage of women and men aged 15-49 who report discriminatory attitude towards people living with HIV	●		TBD		Data not available	Data not available
	8.1.1. Percentage of women aged 15-49 who would buy fresh vegetable from a shopkeeper or vendor who has HIV					58.7%	
	8.1.2. Percentage of women aged 15-49 who think children living with HIV should be able to attend school					Not available	
	8.1.3. Percentage of women aged 15-49 who would not want to keep secret if a family member had HIV					53.6%	
	8.1.4. Percentage of women aged 15-49 who believe that a female teacher with HIV should be allowed to continue teaching					70.0%	
	8.1.5. Percentage of women aged 15-49 who are willing to care for a family member with HIV in own home					92.1%	

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

Indicator	Indicator Description	GARP	UA	National target by 2016	2006	2012	2014
10.1	Current school attendance among orphans and non-orphans (10–14 years old, primary school age, secondary school age)	●		NA			
	Part A: Current school attendance rate of orphans aged 10-14 primary school age, secondary school age				93.6%	91.70%	NA
	Part B: Current school attendance rate of children aged 10-14 primary school age, secondary school age both of whose parents are alive and who live with at least one parent				96.3%	97.70%	NA
10.2	Proportion of the poorest households who received external economic support in the last 3 months	●				80.19%	NA