Thailand Report NCPI

NCPI Header

COUNTRY

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:
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Describe the process used for NCPI data gathering and validation:
A. Process administered to government officials: •A questionnaire was disseminated among various government institutions that maintain a responsible and integral role in the National AIDS Strategy. •Coordinators conducted a rigorous literature review of all relevant documents and reports, particularly those that related to the National AIDS Strategy 2007-2011 and its implementation. •Collected data was analyzed according to the key issues highlighted in the questionnaire. Thereafter, coordinators presented the preliminary results into a consultative meeting during 19-20 March 2012. The participatory process sought to engage all relevant stakeholders, particularly those operating in decentralized settings, and encourage their careful review, triangulation, discussion, and addressing of pending questions. The end result was the drafted conclusion. •Coordinators presented the draft conclusion at a public seminar which convened stakeholders from both government and civil society institutions. •Upon the establishment of consensus at this meeting on the draft conclusion, coordinators took steps in producing the final report. B.Process administered to civil society organizations, bilateral agencies, and UN organizations: •Discussions were held with the Thai NGO Coalition on AIDS (TNCA) to identify the key individuals involved on each issue. These individuals would then be able to offer further insight on the details of each question to ensure that information is both accurate and comprehensive. •Once key individuals within civil society institutions were identified, questions were sent to them for their careful review and response. •Interviews with several key individuals within civil society institutions were also conducted. •Data was compiled and collated. Answers were drafted in detail at the meeting on “Preparation for Global AIDS Response Progress Report” organized by the National AIDS Management Center (NAMC) on 19-20 March 2012. The meeting convened representatives of various local NGOs, international NGOs, UN agencies, and organizations of PLHA. The meeting generated constructive feedback that was integrated into question responses. The ratings on several questions were thereby clarified. •Corrections to the final report were made based on comments/questions/criticisms made at consultative meetings on 19-20 March 2012. •Updated data was presented again at a final consultative meeting held on 26 March 2012. This meeting convened representatives from various civil society institutions. Small group discussions with representatives from various CSOs were conducted to ensure that feedback from this critical sector was also integrated. •Final revisions were made to the initial draft and submission on 31 March 2012.

Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:
A. Process administered to government officials: During consultative discussions, a key source of disagreement was on how to rate the scale of success and satisfaction among respondents. To resolve any disagreements, facilitators sought input from all sides and weighed on each suggestion equally and fairly. After a rigorous series of discussions, key points of contention were eventually addressed and resolved. B. Process administered to civil society organizations, bilateral agencies, and UN organizations: The process that was used for government officials was also used for civil society institutions. A key factor in this process was the critical role that civil society institutions play in the sustaining of efforts to halt and reverse the spread of HIV. Civil society institutions offer key insight in particular areas and can offer open and constructive inputs on how well Thailand is performing. Disagreements were addressed with rigorous and well-facilitated discussions. A critical tool that was helpful in this process was the availability of background data on particular issues. Again, the rating of the scales of success and satisfaction required time and carefully-facilitated discussions. It is hoped that these discussions will continue throughout the coming years so that common goals for AIDS programming and civil society engagement can be achieved.

Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):
A.Process administered to government officials: Coordinators were very keen on ensuring that data was of high quality. They engaged in a rigorous process of collection, synthesis, analysis, and dissemination to ensure that the process was thorough and valid. A key point of concern throughout this process is the rationale/definition of several questions. There was some

confusion on what the rationale and actual definition was for specific questions, which allowed for misinterpretation. B.Process administered to civil society organizations, bilateral agencies, and UN organizations: The process of engaging civil society institutions in the NCPI process was as rigorous as with those in the government sector. One key factor that emerged with civil society institutions, however, was the challenge of soliciting the input of key frontline stakeholders. Often, civil society organizations are based at community levels and so, their input was critical to attaining input from people in the field. Given the time and resource constraints during the process, it was difficult to capture input from all stakeholders. A suggestion that was made was to organize a series of small forums at community levels so that input could be solicited and documented. This process, albeit resource-intensive, is critical in grasping knowledge and insight of civil society and local health representatives.

NCPI - PART A [to be administered to government officials]

Organization	Names/Positions	A.I	A.II	A.III	A.IV	A.V	A.VI
National Aids Management Center (NAMc)	Dr.Pairoj Saonuam	Yes	Yes	Yes	Yes	Yes	Yes
Bureau of Epidemiology, DDC	Mr.Sahaphap Pulkasem	Yes	No	Yes	Yes	No	Yes
National Health Security Office	Dr. Sornkij Pakhichip	No	No	No	No	Yes	No
Bureau of Reproductive Health, Department of Health (DOH)	Ms. Renu Chunil	Yes	No	No	Yes	No	No
Bureau of Public Health Management, Office of the Permanent Secretary, MOPH	Ms.Bunploi Tulapan	Yes	Yes	Yes	Yes	Yes	Yes
Bureau of Mental Health, Department of Mental Health	Ms.Orawan doungchan	Yes	No	No	No	No	No
Bureau of AIDS, TB and STI (BATS), DDC	Mr.Natanong Ponopadon	Yes	No	Yes	Yes	No	No
Bamrasnaradun Institute, Department for Disease Control (DDC)	Dr. Rujani Suthornkajit	Yes	No	No	No	No	No
Bureau of Policy and Strategy, Office of the Permanent Secretary, MOPH	Ms. Punsin Sriprayoon	Yes	No	No	Yes	No	No
Medical Services Division, Department of Corrections (DOC)	Ms. Nipa Ngarmtrirai	Yes	No	Yes	No	Yes	Yes
Department of Juvenile Observation and Protection	Ms. Namfon Phanpope	Yes	No	No	No	No	Yes
Division of Welfare, Department of Labor Protection and Welfare	Ms.Angkana Techakomain	Yes	Yes	Yes	Yes	No	Yes
Bureau of Policy and Strategy, Office of the Permanent Secretary,Ministry of Labor	Ms.Atchara Ngarmsomchit	Yes	Yes	Yes	Yes	No	Yes
Bureau of Special Affairs, Office of the Permanent Secretary,Ministry of Education (MOE)	Mr. Chanchai Chuaypoklang	No	Yes	Yes	Yes	No	Yes
Bureau for the Rights Protection and Legal Assistance, Office of the Attorney General	Ms. Nitha Sujaritworakul	Yes	No	Yes	Yes	No	Yes
Preventive Medicine Division, Air Force Department of Medical Services	FS2.Thitirat Pathumwiang	Yes	Yes	Yes	Yes	No	Yes
AIDS Control Division, Department of Health, Bangkok Metropolitan	Ms. Kanokrat Lert Traipope	Yes	Yes	Yes	Yes	Yes	Yes
Department of Religious Affairs	Mr. Wichian Anansirirat	No	Yes	Yes	No	No	Yes
Navy Department of Medical Services	Cdr.Puangnak Ngern	Yes	Yes	Yes	Yes	Yes	Yes
Bureau of the Budget	Mr.Vichai Teerachart	Yes	No	No	No	No	No
Office of the Public Sector Development Commission	Ms. Chawalit Chuanthong	Yes	No	No	No	No	Yes
Bureau of Strategy and Social Development Planning (Development Council)	Ms. Worawan Phlikamin	Yes	No	No	No	No	No
Office of Welfare Promotion, Protection and Empowerment of Vulnerable Groups	-	Yes	Yes	No	No	Yes	Yes

Office of the Permanent Secretary, Ministry of Social Development and Human Security (MSDHS)	Ms. Siriporn Thavarorit	Yes	Yes	Yes	Yes	Yes	Yes
-	-	No	No	No	No	No	No

NCPI - PART B [to be administered to civil society organizations, bilateral agencies, and UN organizations]

Organization	Names/Positions	B.I	B.II	B.III	B.IV	B.V
TNCA	Ms.Kanjana Thalaengkij/Coordinator	Yes	Yes	Yes	Yes	Yes
TNP+	Mr.Apiwat Kwangkaew/	Yes	Yes	Yes	Yes	Yes
AIDS Access Foundation	Mr.Nimit Thienudom, Director	Yes	Yes	Yes	Yes	Yes
AIDS Access Foundation	Mr.Niwat Suwanpatta/ project officer	Yes	Yes	Yes	Yes	Yes
AIDS Access Foundation	Ms.Sansiri Teemanka/ Project Officer	Yes	Yes	Yes	Yes	Yes
AIDS Access Foundation	Mr.Chalermsak Kittitrakul/Project Officer	Yes	Yes	Yes	Yes	Yes
Foundation for AIDS Rights (FAR)	Ms.Supatra Nacapew, Director and Chair of TNCA	Yes	Yes	Yes	Yes	Yes
Foundation for AIDS Rights (FAR)	Ms.Puttinee Kotapat/ Project Officer	Yes	Yes	Yes	Yes	Yes
PATH	Ms.Usasinee Rewthong/Project Officer	Yes	Yes	Yes	Yes	Yes
Raks Thai Foundation	Mr.Brahm Press/ Project Officer	Yes	Yes	Yes	Yes	Yes
Raks Thai Foundation	Ms.Sunee Talawat	Yes	Yes	Yes	Yes	Yes
PSI Foundatio	Ms.Lawan Sarowat/ Coordinator/ Manager	Yes	Yes	Yes	Yes	Yes
HIV+ Women Network	Ms.Pairuch Auam-aim	Yes	Yes	Yes	Yes	Yes
Thai Business Coalition on AIDS (TBCA)	Dr.Anthony Pramualratana/Executive Director	Yes	Yes	Yes	Yes	Yes
Thai Business Coalition on AIDS (TBCA)	Ms.Nunlada Punyaratana Officer	Yes	Yes	Yes	Yes	Yes
Purple Sky Network	Mr.Rapeepan Jommaroeng/Coordinator	Yes	Yes	Yes	Yes	Yes
SWING	Ms.Surang Chanyam/Director	Yes	Yes	Yes	Yes	Yes
We Understand Group	Ms.Chutima Saisaengchan/Coordinator	Yes	Yes	Yes	Yes	Yes
Positive Women Network	Ms.Sulaiporn Chonvilai/researcher	Yes	Yes	Yes	Yes	Yes
UNAIDS	Mr.Sompong Charoensuk	Yes	Yes	Yes	Yes	Yes
UNICEF	Ms.Nonglak Boonyabhudhi	Yes	Yes	Yes	Yes	Yes
-	-	No	No	No	No	No
UNHCR	Ms.Baranee Thongboonrawd	Yes	Yes	Yes	Yes	Yes
UNFPA	Ms.Suwatana Decha-umpai	Yes	Yes	Yes	Yes	Yes
UNFPA	Ms.Sri sumal Sartsara	Yes	Yes	Yes	Yes	Yes
USAID	Ms.Rawipa Vannakit	Yes	Yes	Yes	Yes	Yes
PACT Thailand	Ms.Worachanok Yuttananukorn	Yes	Yes	Yes	Yes	Yes

A - I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?
(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2):
Yes
IF YES, what was the period covered:
2007-2011
IF YES, briefly describe key developments/modifications between the current national strategy and the prior one. IF NO or NOT APPLICABLE, briefly explain why.:
The process of developing the National Strategy for 2007-11 built upon previous plans. The process and steps were clear. Importance was given to the role and participation of all sectors, including analysis of outcomes and implementation for use in

developing the draft. There were public hearings to solicit opinions of stakeholders, and to reflect the different contexts of the field. Public relations was conducted on a broad scale covering all relevant agencies in the country and international organizations. There was a technical team to define the strategic direction of implementation including task forces for efficient management. The use of resources --- personnel, time, and budget --- was maximized, in part through the support of UNDP. In 2011, Thailand developed the National AIDS Prevention and Control Plan (NAP) for 2012-16 with the following new developments: 1. Clear strategic direction: (1) Innovation and change; and (2) Integration quality, intensification and sustainability 2. The strategic plan and implementation plan are clearly differentiated 3. There are clear implementation targets 4. There is a clear framework for monitoring and evaluation (M&E)

1.1 Which government ministries or agencies

Name of government ministries or agencies [write in]:
Ministry of Public Health

1.2. Which sectors are included in the multisectoral strategy with a specifc HIV budget for their activities?

SECTORS

Included in Strategy	Earmarked Budget
Yes	Yes
Yes	Yes
Yes	Yes
Yes	Yes
Yes	-
Yes	Yes
Yes	Yes

Other [write in]:
The following sectors are included in the multisectoral strategy with a specifc HIV budget for their activities; Local Administration, Laws, Foreign Affair,Right Protection,and Tourism and Sports. However, Sectors on Local Administration and Laws only have the earmarked budget.

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specifc activities?:
1) Over half of the domestic budget for AIDS in the past two years was allocated for care and treatment. For interventions with most-at-risk populations (MARP), youth and affected children, most of the support budget came from international donors, principally the Global Fund (GF), through a system of Principal Recipients from the public and private sectors. NGOs and allies in the network of field were the primary implementing partners. The donors include the GF, UNAIDS, UNFPA, UNICEF, the TUC and WHO, each with separate areas of support. 2) Additional support was mobilized for management, medical supplies, medicines, surveillance, etc. The donors for this include the TUC, GF and UNICEF. Funds were also provided for the Assessment of Thailand Early HIV Diagnosis Program 3) The National Health Security Office (NHSO) has allocated budget for HIV prevention and control, including budget for Tambon health funds without counterpart contributions from local administrative organizations. 3) The government has allocated budget to the provinces, and agencies can make requests under the social development strategy.

1.3. Does the multisectoral strategy address the following key populations, settings and cross-cutting issues?

Men who have sex with men:
Yes
Migrants/mobile populations:
Yes
Orphans and other vulnerable children:
Yes
People with disabilities:
No
People who inject drugs:
Yes
Sex workers:
Yes
Transgendered people:
Yes
Women and girls:
Yes
Young women/young men:
Yes
Other specific vulnerable subpopulations:
Yes

Prisons:
Yes
Schools:
Yes
Workplace:
Yes
Addressing stigma and discrimination:
Yes
Gender empowerment and/or gender equality:
Yes
HIV and poverty:
Yes
Human rights protection:
Yes
Involvement of people living with HIV:
Yes

IF NO, explain how key populations were identifed?:
The disabled population is addressed under Strategy 3 through AIDS rights protection with the following success: 1. Persons living with HIV/AIDS (PLA) and AIDS-affected persons have their rights protected and are treated equally as others in society; 2. Hard-to-reach populations (e.g., IDU, migrant laborers, ethnic minorities, MSM, sex workers, prison inmates, etc.) have their rights protected and can access quality prevention across a range of dimensions.

1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country [write in]?:
1) The core populations are discordant married couples or pairs of lovers, MSM, sex workers, clients of sex workers, IDU, children and youth; 2) Other populations include prison inmates, persons in detention centers, foreign migrants, Thai migrant laborers, factory workers, ethnic minorities, displaced persons and refugees.

1.5. Does the multisectoral strategy include an operational plan?: Yes

1.6. Does the multisectoral strategy or operational plan include

a) Formal programme goals?:
Yes
b) Clear targets or milestones?:
Yes
c) Detailed costs for each programmatic area?:
Yes
d) An indication of funding sources to support programme implementation?:
No
e) A monitoring and evaluation framework?:
Yes

1.7

1.7. Has the country ensured "full involvement and participation" of civil society in the development of the multisectoral strategy?:
Moderate involvement
IF NO or MODERATE INVOLVEMENT, briefly explain why this was the case:
Civil Society participated in development of the strategy for the NAP from the early process of synthesizing data for the analytical direction of the NAP, and review and approval of components. If there were parts that were mostly in the sphere of the government, then Civil Society did not participate as much. Civil society proposed projects for budget support by the government, and implemented interventions for various target populations such as IDU and youth.

1.8. Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?:
Yes

1.9

1.9. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?:
Yes, some partners
IF SOME PARTNERS or NO, briefly explain for which areas there is no alignment/harmonization and why:
In implementing the NAP (specified in the NAP for 2007-11) 18 agencies had responsibility for applying the strategy. Overall, after reviewing the strategy, it can be seen that there was a clear strategy and target populations specified. However, there was no indication of the budget required for interventions and the source of that budget. Thus, in that sense, the NAP was merely a conceptual framework which gave flexibility for degree of implementation since the funding would rely most heavily on government resources. From another viewpoint, the lack of specification of budget or source of budget may have been the result of uncertainty of the degree of support from the government finance offices. Thus, instead of motivating the various agencies for joint action, the various sectors operated somewhat independently, funding what they deemed suitable and most consistent with their routine operations – whether or not this activity addressed the core

indicators. Sources: 1) Mid-Term Program Review Report 2) Review of policy and planning for AIDS in Thailand: 2010 (IHPP)

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?:
Yes

2.1. IF YES, is support for HIV integrated in the following specifc development plans?

Common Country Assessment/UN Development Assistance Framework:
Yes
National Development Plan:
Yes
Poverty Reduction Strategy:
-
Sector-wide approach:
N/A
Other [write in]:
Thailand has integrated HIV into Guidelines for development in achieving MDGs.

2.2. IF YES, are the following specifc HIV-related areas included in one or more of the development plans?

HIV impact alleviation:
Yes
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support:
Yes
Reduction of income inequalities as they relate to HIV prevention/treatment, care and/or support:
No
Reduction of stigma and discrimination:
Yes
Treatment, care, and support (including social security or other schemes):
Yes
Women's economic empowerment (e.g. access to credit, access to land, training):
Yes
Other[write in below]:
-

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?:
Yes
3.1. IF YES, on a scale of 0 to 5 (where 0 is "Low" and 5 is "High"), to what extent has the evaluation informed resource allocation decisions?:
3
4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?:
Yes
5. Has the country followed up on commitments made in the 2011 Political Declaration on HIV/AIDS?:
Yes
5.1. Have the national strategy and national HIV budget been revised accordingly?:
Yes
5.2. Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?:
Estimates of Current and Future Needs
5.3. Is HIV programme coverage being monitored?:
Yes

5.3

(a) IF YES, is coverage monitored by sex (male, female)?:
Yes
(b) IF YES, is coverage monitored by population groups?:
Yes
IF YES, for which population groups?:
There was a unique M&E plan for MARP at the national level and which was formally applied in Fiscal Year 2010 under the integration implementation plan of the GF and national M&E plan, and implemented by the Bureau of Epidemiology and the NAMC.
Briefly explain how this information is used:
1)Improved the structure and strategy of the national M&E committee and in the field; 2)Developed a data system for monitoring the status and implementation for quality and efficiency 3)Improved the annual implementation plan to make it consistent with the current status of the challenge and context, challenges, and gaps. 4)This information was used to inform

guidelines for developing the NAP for 2012-2016 5)This information was used to develop the integrated implementation plan framework for accelerated prevention of new infections by half as of 2012.

(c) Is coverage monitored by geographical area:

Yes

IF YES, at which geographical levels (provincial, district, other)?:

In Fiscal Years 2010-11 the NAMC expanded the areas for status monitoring and comprehensive monitoring sites in 13 provinces including Lopburi, Buriram, Trad, Tak, Payao, Songkla, Mae Hong Son, Chiang Rai, Chiang Mai, Lampang, Lamphun, Phrae and Nan.

Briefly explain how this information is used:

1) To establish a system of data collection and compilation for NAP M&E 2) Establish comprehensive monitoring sites 3) Develop a draft strategy for prevention and control of AIDS for 2012-16 4) Framework for the NAP plan for 2012 5) Implementation plan for 2012 for integrated, accelerated prevention of new HIV infections by half

5.4. Has the country developed a plan to strengthen health systems?:

Yes

Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications:

The plan for health development impacted on the structure of services related to HIV in two ways as follows: 1) Expansion of clinical outlets and health personnel to cover the entire country, as witnessed by the 3rd national strategy for health development, and the creation of a health service and medical system which is client-friendly, and produces client satisfaction, with the following goals: - To build a health and medical service system which is client friendly and yields client satisfaction - To accelerate the production and development of health personnel to meet quantity and quality needs which is appropriate with the changing situation, with fair distribution with full coverage - Expand and raise the level of quality of the primary care system to increase capacity and access 2) Expanded the health financial risk protection as witnessed by the target of health development in the 10th national health development plan (Item 6) Equitable health insurance with total coverage and quality These components are key elements in planting a foundation for full health development of the population.

6. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy planning efforts in the HIV programmes in 2011?:

7

Since 2009, what have been key achievements in this area:

From 2009, the key areas of success include the following: 1. Guidelines for integrated implementation across ministries using joint KPIs during the FY 2011 period. The AIDS strategy was one out of nine national strategies with joint indicators to reflect success based on weighted percentages and averages. A weight of 10% was assigned to the AIDS sector and this was a key tool in advancing the national AIDS strategy toward success. A total of four new measures and 35 indicators were developed to propel the work toward the goal of reducing new infections. 2. Implementation of the plan involved participation from many domestic and international organizations through a process of coordination in order to align the direction of implementation and provide mutual support. There was not that much dispersal of implementation; instead most of the work was conducted through teamwork and this will help the country succeed in its goals.

What challenges remain in this area:

Translating the strategy into practice required each agency to dedicate itself to the activity on a continuous basis, especially at the provincial level: 1) Central level agencies: Integrate the work among agencies so that they see their role as part of a national AIDS control effort; 2) Provincial level agencies: Increase their responsibility for managing AIDS work and develop a structure for AIDS control and prevention which can be adapted to changing circumstances.

A - II. POLITICAL SUPPORT AND LEADERSHIP

1. Do the following high offcials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year

A. Government ministers:

Yes

B. Other high offcials at sub-national level:

Yes

1.1

(For example, promised more resources to rectify identified weaknesses in the HIV response, spoke of HIV as a human rights issue in a major domestic/international forum, and such activities as visiting an HIV clinic, etc.):

Yes

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:

1. The Prime Minister gave priority to AIDS as seen from his attendance at all NAC meetings, serving as Chairperson. He too under consideration the recommendation to set an AIDS fund and presented a poster during the campaign "One Heart One Love;" 2. The signing of the Memorandum of Understanding between Bangkok and the New South Wales Health Management Organization, along with the Thai Red Cross in order to build technical capacity for implementing harm reduction for IDU; 3. Giving mass media presentations to inform HIV+ workers who are laid off due to their infection that they can file a grievance

against their employer with the labor court; 4. Responding to the call for action from UNAIDS by setting up a pilot province to implement the “Getting to Zero” strategy, and signing onto the 5th NAP for 2012-16. 5. Participating in the national AIDS seminar and supporting World AIDS Day campaigns

2. Does the country have an offcially recognized national multisectoral HIV coordination body (i.e., a National HIV Council or equivalent)?:

Yes

2.1. IF YES, does the national multisectoral HIV coordination body

Have terms of reference?:

Yes

Have active government leadership and participation?:

Yes

Have an official chair person?:

Yes

IF YES, what is his/her name and position title?:

Mr. Abhisit Vejajiva, Prime Minister

Have a defined membership?:

Yes

IF YES, how many members?:

36 members

Include civil society representatives?:

Yes

IF YES, how many?:

4 members

Include people living with HIV?:

Yes

IF YES, how many?:

1 member

Include the private sector?:

No

Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?:

No

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?:

Yes

IF YES, briefly describe the main achievements:

1)The NAMC coordinates the development of the NAP plan, development of guidelines for implementation, development of the integrated plan for accelerated decline of new HIV infection by half by 2011; 2)The secretariat of the CCM coordinates and sets up technical task forces on AIDS, monitors overall implementation of the programs receiving GF support, and develops project proposals for new funding, establishes a strategic management committee comprised of the three PRs; 3)The Department for Disease Control, as the PR, coordinates implementation of GF assistance with the government, NGOs and networks of PLA for Round 8 implementation with a focus on support for small organizations which have difficulty accessing major sources of funding; 4)There is a structure for M&E of national AIDS prevention and control that is clear and informs the UNGASS report, including on-going development and improvement of the M&E system. Regarding the strategy for inter-ministerial advancement, the Office of the Public Sector Development Commission issued a guarantee for Fiscal Year 2011 that implementation would be integrated across ministries under a common goal.

What challenges remain in this area:

1) There is a shortage of experts, and the relevant implementation units are understaffed.

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?:

-

5.

Capacity-building:

Yes

Coordination with other implementing partners:

Yes

Information on priority needs:

Yes

Procurement and distribution of medications or other supplies:

Yes

Technical guidance:

Yes

Other [write in below]:

-

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National HIV Control policies?:
Yes
6.1. IF YES, were policies and laws amended to be consistent with the National HIV Control policies?:
Yes
IF YES, name and describe how the policies / laws were amended:
The anti-discrimination law protecting the rights of PLA to continue employment after disclosure of sero-status, receiving equal medical care, and protection from other forms of discrimination;
Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:
1) The anti-prostitution law still makes selling sex illegal, leading to the suppression and arrest of sex workers, and closure of establishments where commercial sex can occur. The national security policy and immigration laws make it illegal for foreign migrants to enter Thailand for work without authorization.
7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the political support for the HIV programme in 2011?:
7
Since 2009, what have been key achievements in this area:
1)The national leaders show importance for the NAP by serving as chair of the NAC and support the implementation plan and budget. 2)In 2010, the Cabinet passed a resolution for inter-ministerial integration of strategic implementation under the joint KPIs for FY 2011. 3)There was budget support for access to free VCT twice a year, and ART, which greatly expanded access to standard treatment throughout the country.
What challenges remain in this area:
1)Advocating for a harm reduction policy for IDU in Thailand 2)Advocating for benefits to covering everyone residing in Thailand 3)Rectifying laws or regulations which impede implementation such as the guideline that those under 18 require parental consent for HIV testing 4)Policy of the government and MOPH listing AIDS as a national agenda item with the Dept. of Disease Control developing the budget for all ministries 5)Support for production of condoms appropriate for adolescents including information about sage and appropriate sex 6)Advocate for the political sector at the local level to recognize AIDS as an election campaign policy, and provide budget to improve knowledge and prevention campaigns, and improve participation at the local level

A - III. HUMAN RIGHTS

1.1

People living with HIV:
Yes
Men who have sex with men:
No
Migrants/mobile populations:
No
Orphans and other vulnerable children:
Yes
People with disabilities:
Yes
People who inject drugs:
No
Prison inmates:
No
Sex workers:
No
Transgendered people:
No
Women and girls:
Yes
Young women/young men:
Yes
Other specific vulnerable subpopulations [write in]:
-

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?:
Yes
IF YES to Question 1.1. or 1.2., briefly describe the content of the/laws:
1) Article 30 of the 2007 Thai Constitution specifies that all persons are equal under the law and are equally protected by the law, including equality of men and women. Any discrimination based on differences of place of origin, ethnicity, language, gender, age, disability, health or physical condition, individual status, socio-economic status, religion, education, or political view that does not conflict with the constitution is prohibited. 2) The child protection law of 2003 describes rights and freedoms of children and youth, and that they are to receive protection by the state without discrimination with the child's welfare at the

forefront of concern. 3) The law which supports the disabled specifies that the disabled have rights to access and benefit from public conveniences, welfare and assistance by the government, acceptance and full participation in social, economic and political activities, and have equality with others in society, and access to special services for the disabled. 4) The labor law of 1998 (Article 15) requires employers to treat their male and female employees equally except for work that is appropriately performed by one gender or the other; 5) The laws for protection of reproductive health, national health, domestic violence of 2007

Briefly explain what mechanisms are in place to ensure these laws are implemented:

1) The constitution is the supreme law and any law that conflicts with the constitution is subordinate to the dictates of the constitution. 2) The child protection law of 2003 specifies that there be a national child protection committee, with provincial branches. The law specifies that any dealings with children put the welfare of the child first, that there be no discrimination or inequality of care and assistance. Article 29 paragraph 2 specifies that doctors, nurses, psychiatrists, and social workers who encounter a child they suspect is a victim of abuse have the authority to inform the relevant officials to ensure protection of the child's welfare until the child is safe from abuse or is returned to a safe family environment. 3) The labor protection law includes the formation of a labor protection center under the Department for Labor Welfare and Protection of the Ministry of Labor with the responsibility to oversee employers to ensure that employee rights are protected with corresponding units at the provincial level and sectors of Bangkok.

Briefly comment on the degree to which they are currently implemented:

The 2003 child protection law has been applied more broadly than the 2007 domestic violence law because of the complexity in pursuing cases of the latter. For domestic violence, there has to be a formal complaint filed before action can be taken. In most cases, the victim is the wife of the household head, and is reluctant to file a grievance, and police don't want to get involved in mediating these cases.

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?:

Yes

IF YES, for which subpopulations?

People living with HIV:
No
Men who have sex with men:
No
Migrants/mobile populations:
Yes
Orphans and other vulnerable children:
No
People with disabilities:
No
People who inject drugs :
Yes
Prison inmates:
Yes
Sex workers:
Yes
Transgendered people:
No
Women and girls:
No
Young women/young men:
Yes
Other specific vulnerable subpopulations [write in below]:
-

Briefly describe the content of these laws, regulations or policies:

1) National Health Security law specifies coverage only for Thai nationals 2) The Narcotics Criminal law of 1979 prohibits use of an addictive substance 3) The Anti-Prostitution law of 2006 authorizes the police to arrest sex workers and close commercial sex access establishments 4) The Thai Medical Council guidance on AIDS requiring parental consent for HIV testing for those under age 18 years unless married

Briefly comment on how they pose barriers:

1) The restriction of services only to Thai nationals with ID cards harms foreign migrants, laborers and detainees, and other vulnerable persons who are undocumented. They cannot receive full coverage, especially access to ART which is costly if procured independently. 2) The criminalization of addictive drug use impedes prevention since distribution of clean needles and syringes to IDU can be construed as promoted illegal drug use and can be prosecuted under Article 863. 3) The criminalization of prostitution forces sex workers to conceal their activity from officials and to move frequently to avoid arrest. There is lack of trust of government officials and this impedes prevention efforts such as condom distribution and health education. 4) Youth are high risk. Requiring parental consent for VCT for those under age 18 reduces access to this service and makes it more difficult to help them.

A - IV. PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?:
Yes

IF YES, what key messages are explicitly promoted?

Abstain from injecting drugs:
No
Avoid commercial sex:
No
Avoid inter-generational sex:
No
Be faithful:
Yes
Be sexually abstinent:
No
Delay sexual debut:
Yes
Engage in safe(r) sex:
Yes
Fight against violence against women:
Yes
Greater acceptance and involvement of people living with HIV:
Yes
Greater involvement of men in reproductive health programmes:
Yes
Know your HIV status:
Yes
Males to get circumcised under medical supervision:
No
Prevent mother-to-child transmission of HIV:
Yes
Promote greater equality between men and women:
Yes
Reduce the number of sexual partners:
Yes
Use clean needles and syringes:
Yes
Use condoms consistently:
Yes
Other [write in below]:
-

1.2. In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?:
Yes
2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?:
Yes

2.1. Is HIV education part of the curriculum in

Primary schools?:
Yes
Secondary schools?:
Yes
Teacher training?:
Yes

2.2. Does the strategy include age-appropriate, gender-sensitive sexual and reproductive health elements?:
Yes
2.3. Does the country have an HIV education strategy for out-of-school young people?:
Yes
3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for key or other vulnerable sub-populations?:
Yes
Briefly describe the content of this policy or strategy:
-Educating employers and workers in the worksite through training in HIV and primary health care for HIV+ workers or those with AIDS; -Disseminating knowledge about AIDS rights protection under the law through activities in 30 villages/communities/schools/worksites per province as appropriate -There is a policy and strategy with indicators set by the

Department of Navy which focuses on the officers, navy recruits, contractors and families of navy staff -Implementation of PICT for all clients -Protection of rights of children, youth, adults, service sites, partner -In the area of treatment and care for PLA -In the area of care and assistance for affected children -In the area of humanity, children and women -Regarding the NAP for 2012-16, there is integration of measures and plans to improve quality and intensity of activities for affected and vulnerable children. There are service sites which are sensitive to the issue of HIV/AIDS and social protections for vulnerable children

3.1. IF YES, which populations and what elements of HIV prevention does the policy/strategy address?

IDU	MSM	Sex workers	Customers of Sex Workers	Prison inmates	Other populations
Yes	Yes	Yes	Yes	Yes	Youth, Male Conscripts, Employee/Employer, Pregnant Women and Their Husband
Yes	No	No	No	No	-
Yes	Yes	Yes	Yes	Yes	Youth, Male Conscripts, Employee/Employer, Pregnant Women and Their Husband
Yes	No	No	No	No	-
Yes	Yes	Yes	Yes	Yes	Youth, Male Conscripts, Pregnant Women and Their Husband
Yes	Yes	Yes	Yes	Yes	Youth
Yes	Yes	Yes	Yes	Yes	Youth, and Male Conscripts
No	No	No	No	Yes	-

3.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate policy efforts in support of HIV prevention in 2011?:

8

Since 2009, what have been key achievements in this area:

-Teaching and learning school-based sex education -Campaigns to promote HIV-prevention behavior -The White Classroom Project -Training for counselors on AIDS -Training of parents of adolescents to help change risk behavior -Accessing the target population of hard-to-reach more effectively by using GF budget and working more with Civil Society through the PCM -Policy to promote condom use for youth such as the 100% Condom Confidence & Carry campaign -Expansion of VCT as a part of the national health insurance benefits -Criteria for post-exposure prophylaxis in the implementation handbook for assisting children and women who are victims of abuse for use by staff of safe-house shelters in the case of rape or molestation. ART must be provided within 72 hours of the potential exposure incident.

What challenges remain in this area:

-Educating and motivating population groups and the general population, and reducing risk behavior -Improving client-friendly services in government medical outlets -Referral to/from Civil Society with government medical outlets -Providing family counseling for discordant couples to promote harmonious living -Developing the AIDS database for M&E of implementation and use of data to improve implementation for greater efficiency -Sustainability of project implementation after GF assistances ends -Support for local areas so that they feel a sense of ownership of the AIDS work, and be a source of budget to support health development in the locality

4. Has the country identified specifc needs for HIV prevention programmes?:

Yes

IF YES, how were these specific needs determined?:

1)Accelerate implementation of comprehensive prevention using a package of standard services and protection of human rights in a way that is gender-sensitive and covers the important populations who have the greatest risk for HIV spread; 2)Accelerate expansions of social protections, and improve the legal environment so that it facilitates prevention, care and treatment; 3)Increase collaborative responsibility and sense of ownership at the national and local levels in expanding prevention and control of AIDS 4)Apply the new generation of strategic information to inform guidelines for prevention and control of AIDS at all levels; 5)Raise the quality of measures and plans so that they are more intensive and integrated

4.1. To what extent has HIV prevention been implemented?

Blood safety:
Strongly Agree
Condom promotion:
Strongly Agree
Harm reduction for people who inject drugs:
Agree
HIV prevention for out-of-school young people:
Disagree
HIV prevention in the workplace:
Agree
HIV testing and counseling:
Strongly Agree
IEC on risk reduction:
Strongly Agree

IEC on stigma and discrimination reduction:
Agree
Prevention of mother-to-child transmission of HIV:
Strongly Agree
Prevention for people living with HIV:
Strongly Agree
Reproductive health services including sexually transmitted infections prevention and treatment:
Agree
Risk reduction for intimate partners of key populations:
Disagree
Risk reduction for men who have sex with men:
Agree
Risk reduction for sex workers:
Strongly Agree
School-based HIV education for young people:
Strongly Agree
Universal precautions in health care settings:
Strongly Agree
Other[write in]:
-

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in implementation of HIV prevention programmes in 2011?:
7

A - V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?:
Yes
If YES, Briefly identify the elements and what has been prioritized:
The package of treatment, care and assistance consists of the following: 1.HIV VCT 2. Self-management of care and treatment through comprehensive education about all the components, knowledge about disease and care and treatment, care and treatment with ART, health maintenance, positive prevention, building motivation and including treatment in the benefits package 3. Monitoring of health status (CD4) 4. ART (1st line and 2nd line regimens) 5. Monitoring treatment effects (CD4, VL, DR) 6. Prevention and treatment of opportunistic infections 7. Monitoring and support for adherence
Briefly identify how HIV treatment, care and support services are being scaled-up?:
-

1.1. To what extent have the following HIV treatment, care and support services been implemented?

Antiretroviral therapy:
Strongly Agree
ART for TB patients:
Strongly Agree
Cotrimoxazole prophylaxis in people living with HIV:
Strongly Agree
Early infant diagnosis:
Strongly Agree
HIV care and support in the workplace (including alternative working arrangements):
Disagree
HIV testing and counselling for people with TB:
Strongly Agree
HIV treatment services in the workplace or treatment referral systems through the workplace:
Disagree
Nutritional care:
Disagree
Paediatric AIDS treatment:
Strongly Agree
Post-delivery ART provision to women:
Strongly Agree
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault):
Strongly Agree
Post-exposure prophylaxis for occupational exposures to HIV:
Strongly Agree
Psychosocial support for people living with HIV and their families:
Strongly Agree
Sexually transmitted infection management:

Disagree
TB infection control in HIV treatment and care facilities:
Strongly Agree
TB preventive therapy for people living with HIV:
Agree
TB screening for people living with HIV:
Agree
Treatment of common HIV-related infections:
Strongly Agree
Other [write in]:
-

2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?:
Yes
Please clarify which social and economic support is provided:
Benefits related to HIV/AIDS 1.Care for children 2.Welfare for families of PLA, welfare subsidy for PLA, infant formula and disposable diapers, reimbursement for medical costs 3.Occupational support for positive women an affected persons 4.Welfare fund, educational scholarships for children in affected families 5.Support for capacity building and rights protection for children, youth, women, the elderly, and disadvantaged populations through government strategies for supporting the public and private sectors to implement the specified measures to support good quality of life and stability such as through vocational capacity building 6.In addition, national policy supports the social foundation for the disadvantaged, for example, through orphanages, support for families, safe homes and shelters, and education
3. Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV?:
Yes
4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy medications, condoms, and substitution medications?:
Yes
IF YES, for which commodities?:
-
5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2011?:
7
Since 2009, what have been key achievements in this area:
Achievement has not improved. Despite expansion of coverage and access to treatment, the mortality rate and treatment retention remain constant. The country is working on ways to increase coverage and quality in the following areas: 1. Development and expansion pediatric treatment, positive prevention, strengthening self-management; 2. Improve the monitoring system to track implementation at all levels, and set up an information system to promoted use of data for planning and adjustment to implementation. This system is called NAP database, HIVQual , STI-Qual, and EWI and there is training for staff in utilization of the system. 3. Plan for improvement and expansion of the system of counseling to cover the hard-to-reach group, the vulnerable groups, and general population so that people know their sero-status and the PLA can be referred to treatment in a timely way. The National Health Security Scheme help increase access for PLA to care and treatment, and social assistance through coordination with Civil Society.
What challenges remain in this area:
No change in challenges except that efforts will continue to improve services and AIDS implementation. 1.Access to HIV testing 2.Most PLA enter treatment late (when they start to have symptoms) and this contributes to high mortality in the first year of treatment 3.Maintaining the efficiency of the 1st-line regimen and prevention of drug resistance. 4.Problems of access to ART for foreign migrant laborers and undocumented residents (without a national ID card). They lack coverage under the national health insurance scheme and, thus, cannot access treatment. They are relying on support from the GF as an interim solution. 5. Support for families and children for care and assistance, and for affected persons/PLA
6. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?:
Yes
IF YES, is there an operational definition for orphans and vulnerable children in the country?:
Yes
IF YES, does the country have a national action plan specifically for orphans and vulnerable children?:
Yes
IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?:
No
IF YES, what percentage of orphans and vulnerable children is being reached? :
90%
7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?:
6
Since 2009, what have been key achievements in this area:

Since 2009, an important area of success has been the number of agencies providing care and welfare assistance and welfare payments/occupational scholarships.

What challenges remain in this area:

1.Data on the number of affected children 2.System of protection for children lacks coordination and linkages among services provided by the government, community and Civil Society 3.Stigma and prejudice against affected children 4.Personnel working in this area need capacity development and skills in working with affected children and vulnerable children or care providers, and who are in need of referral for other care and assistance.

A - VI. MONITORING AND EVALUATION

1. Does the country have one national Monitoring and Evaluation (M&E) plan for HIV?:

No

Briefly describe any challenges in development or implementation:

As yet, there is no unified M&E plan for the country. In the various sub-plans, projects have M&E for that specific project. In any event, there remain the following challenges: 1. Development of the M&E framework of the country so that it is unified through a systematic process 2. How can the task forces that exist to perform the assigned tasks on a regular basis 3. How can the agencies and allies acquire a sense of ownership, and participate in data collection, reporting and use the data systematically. In 2010, Thailand started to prepare a national M&E plan for prevention of HIV in populations who are significant in the HIV epidemic (KAPs) with participation from the target populations and implementers being supported by the GF, and which can be used as a handbook for implementation monitoring by staff at all levels. In 2011, Thailand implemented a process of strategic planning which included an M&E plan as one of three components of the NAP strategy, including an M&E assessment and development of the M&E plan based on experience and lessons learned.

Briefly describe what the issues are:

-

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy:
Yes
Behavioural surveys:
Yes
Evaluation / research studies:
Yes
HIV Drug resistance surveillance:
Yes
HIV surveillance:
Yes
Routine programme monitoring:
Yes
A data analysis strategy:
No
A data dissemination and use strategy:
No
A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate):
Yes
Guidelines on tools for data collection:
Yes

3. Is there a budget for implementation of the M&E plan?:

Yes

3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities? :

0.72%

4. Is there a functional national M&E Unit?:

Yes

Briefly describe any obstacles:

1. Capacity of the M&E unit in terms of number of personnel and technical skills and management, and coordination with other related units 2. Support for budget for unit management In the past two years, there has been technical and budgetary support from the UN such as UNAIDS, and the TUC, more so than in the previous round.

4.1. Where is the national M&E Unit based?

In the Ministry of Health?:
Yes
In the National HIV Commission (or equivalent)?:
Yes
Elsewhere [write in]?:
-

Permanent Staff [Add as many as needed]

POSITION [write in position titles in spaces below]	Fulltime	Part time	Since when?
Director	1	-	-
Medical Physician, Senior Professional Level	1	-	-
Plan and Policy Analyst, Senior Professional Level	1	-	-
Public Health Technical Officer, Professional Level	2	-	-
Plan and Policy Analyst,Practitioner Level	2	-	-
Financial Staff	1	-	-
Permanent Staff	1	-	-

Temporary Staff [Add as many as needed]

POSITION [write in position titles in spaces below]	Fulltime	Part time	Since when?
Temporary Staff	1	-	-
Project Coordinator	6	-	-

4.3. Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?:
Yes
Briefly describe the data-sharing mechanisms:
There is a limitation in application of data due to the complex data collection methods which require complex procedures for analysis and precautions in extracting findings for use.
What are the major challenges in this area:
The Bureau of Epidemiology (BOE) is the principal agency for compilation of epidemiological data, and relies on the surveillance network in the field and at the provincial level. The BOE has prepared an annual report to present these data. For ad hoc needs, the BOE coordinates with agencies to assemble data as requested.
5. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?:
Yes
6. Is there a central national database with HIV- related data?:
Yes
IF YES, briefly describe the national database and who manages it.:
Yes, but this is still not unified. The various agencies maintain their own databases without central consolidation at the national level in one place for use as a reference.
6.1. IF YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?:
Yes, but only some of the above
IF YES, but only some of the above, which aspects does it include?:
National level: 1. Surveillance among sentinel populations 2. PMTCT Program 3. HIV TB & STI treatment monitoring 4. VCT monitoring 5. KAPs Prevention Program monitoring (RIHIS)

6.2. Is there a functional Health Information System?

At national level:
Yes
At subnational level:
Yes
IF YES, at what level(s)?:
-

7. Does the country publish an M&E report on HIV , including HIV surveillance data at least once a year?:
Yes

8. How are M&E data used?

For programme improvement?:
Yes
In developing / revising the national HIV response?:
Yes
For resource allocation?:
Yes
Other [write in]:
-

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:
1) Data were used to inform the NAP plan with contributions from all sectors. This involvement helped to increase the

credibility of the data for decision-making. 2) Data were used in the re-allocation of resources for implementation in the various risk groups, and for specifying the target groups and aligning implementation.

9. In the last year, was training in M&E conducted

At national level?:
Yes
IF YES, what was the number trained:
340 persons
At subnational level?:
Yes
IF YES, what was the number trained:
1210 persons
At service delivery level including civil society?:
Yes
IF YES, how many?:
160 persons

9.1. Were other M&E capacity-building activities conducted` other than training?:
Yes
IF YES, describe what types of activities:
- Monitoring and supervision of all agencies related to M&E - Reporting by agencies in the field - Convening meetings of the Committee for Inspections to monitor and evaluation implementation to align understanding and review the objectives of the inspection and M&E, including assignment of responsibility - Convening experience-exchange meetings - Produce SOP for monitoring implementation and AIDS surveillance among the various populations - Have tools for monitoring implementation and AIDS surveillance in the populations - Strengthen capacity and networking in M&E at the provincial level with support from staff of the regional disease control office.

10. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluation (M&E) in 2011?:
8
Since 2009, what have been key achievements in this area:
The M&E plan for AIDS is one component of the NAP strategy, with indicators, responsible agencies, and procedures for data reporting, compilation and application. The AIDS Division of the BMA: - Has set up an M&E unit and an M&E committee for the province - Has specified the direction and flow of AIDS data in the province - Has developed forms for recording data on AIDS, and referral of services from the Civil Society to the government Bureau of Epidemiology, Dept. of Disease Control The BOE has implemented the AIDS surveillance system as part of the NAP on a regular basis each year. The BOE assures quality of the data and efficient collection and reporting. The BOE has made improvements to the AIDS surveillance system so that it adapts to the changing nature of the AIDS epidemic. There has been success in expanding the surveillance to include non-venue-based FSW, and this has provided valuable data for the country and related agencies for use in planning interventions and improving coverage. The Office of Welfare Protection, Promotion and Empowerment of Vulnerable Groups: - NGOs who received budget support are able to extend the protection of rights and build capacity of the target population in accordance with the implementation plan and project targets; - NGOs have received capacity building to help them implement interventions that are consistent with the strategy of the Office and the strategy of the Ministry for Social Development and Human Security - A working meeting was convened to evaluate implementation of NGOs (including lessons learned) so that the NGOs have an opportunity to compare experience and knowledge in working with vulnerable populations in ways that are efficient and of good quality.
What challenges remain in this area:
Decision-making about the details of indicators is dependent upon a consensus understanding and methods of data collection and the process of implementation of the following relevant agencies: Office of Special Affairs, Office of the Permanent Secretary, Ministry of Education There is a policy for monitoring, and tools that are systematic and consistent for the target groups The Preventive Medicine Department of the Air Force Department of Medical Services - There is a new group of evaluators or researchers - There are plans for a seminar/training and an M&E committee to increase the efficiency of work Office of the Public Sector Development Commission - This office has defined indicators for relevant persons to apply in M&E of implementation in the various sections in order to improve progress to achieving the targets in the NAP AIDS Division, Dept. of Health, BMA - This office is not yet able to cover the entire BMA area since there are many overlapping areas of jurisdiction. Thus, it is difficult to implement when having to seek authorization from a wide variety of agencies. The BMA is working on a pilot basis with the units directly under its authority. Office of the Permanent Secretary of the Ministry of Social Development and Human Security - This office established an M&E committee to assess implementation during each Fiscal Year Bureau of Epidemiology, Dept. of Disease Control The plan for the coming 5 years: GOAL : Strengthening HMIS and information utilization to enhance effective HIV/AIDS program management 1.Strengthening surveillance system : 1.1 Surveillance methodology 1.2 Integration of referral system to HIV/AIDS care prevention among MARPs in Surveillance system 2. Strengthening utilization of information for program planning and improvement 2.1 Development of an information bank & dissemination system (1yr) 2.2 Develop the mathematical components of the AEM Model to assess the AIDS situation and achievement at the national and provincial levels (4yr) through proxies of HIV incidence 3. HMIS to support nation prevention and care & treatment program, Social media 3.1 HMIS to support national prevention among IDU: Develop a system of data collection among IDU and among drug centers: Apply the data to improve implementation through integration with sero-surveillance among IDU 3.2 HMIS to support national care and treatment program

B - I. CIVIL SOCIETY INVOLVEMENT

1. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?:
4
Comments and examples:
Civil Society participated in the development of the national AIDS strategy at all levels. Many of the issues in the policy for AIDS prevention and control resulted from the advocacy and recommendations of Civil Society. In addition, Civil Society played an important role as a change agent and imposed conditions on policy such as the following: - Resolution of the National AIDS Committee (NAC) to appoint a sub-committee for the support and protection of AIDS rights on November 1, 2010; - Harm reduction policy as a strategy for HIV prevention, as one measure under the National Drug Control Policy submitted to the Prime Minister as 306/2553; - Social welfare approval to include the second-line drug Atazanavir as part of the benefits package of the insured for ART; - Modifications of the criteria for initiating ART at a CD4 count 350 cell/ul from the previous level of 200 cell/ul (still under development of guidelines). - Establishment of a fund for treating PLHIV under the National Health Security Office (NHSO), including an enhance benefits package with participation of PLHIV in provision of health services as one part of the package, and with budget allocated for this participation. - Advocacy for policy on free VCCT every six months; - Acceptance, by the NHSO to include ART coverage for foreign migrant laborers – equivalent to that for Thai nationals -- (under development of implementation guidelines); - The decision, by the Office of the Public Sector Development Commission, to include, as an indicator of success, the implementation of the inter-ministerial AIDS target for Fiscal Year 2011 of the percent of children and youth age 15-24 who practice safe sex using condoms. This indicator will serve as a joint key performance indicator for evaluating the performance of the Ministry of Public Health (MOPH), the Ministry of Education (MOE), the Ministry of Defense (MOD), the Ministry of Culture (MOC), the Ministry of Tourism and Sports (MOTS), and the Ministry of Labor (MOL).
2. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?:
3
Comments and examples:
(1) Civil Society played an important role in providing recommendations and opinions concerning the National AIDS Strategy (NAS) for 2007-11 and in conceptual development for the 2012-16 NAS through periodic forums throughout 2011. In addition, Civil Society advocated for the comprehensive coverage of the population. However, Civil Society did not play much of a role in the national budget authorization process; (2) Civil Society participated in producing the proposal to seek support from the Round 10 Global Fund against AIDS, TB and Malaria (GFATM) allocation in the topic area of children affected by AIDS. This received approval in October, 2011.

3.

a. The national HIV strategy?:
3
b. The national HIV budget?:
1
c. The national HIV reports?:
2
Comments and examples:
Civil Society gave opinions to inform the NAS and made quite a number of significant inputs to issues related to prevention and control of AIDS. Thus, the service experience of Civil Society is well-reflected in the plan content. However, Civil Society only received a relatively small proportion of the government budget for implementation. The annual support included 50 million baht for both prevention and care through Bureau of AIDS and around 35 million baht to TNP+ for holistic care centers for PLHIV through the NHSO. The bulk of the support needs of Civil Society are met by funds from external sources. As far as NAS reporting is concerned, Civil Society submits a report of progress which is amended to the full country report. However, it is not apparent that this reporting yields much benefit.

4.

a. Developing the national M&E plan?:
2
b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?:
2
c. Participate in using data for decision-making?:
2
Comments and examples:
The structure and involvement of Civil Society in M&E policy formulation is there on paper, but this is limited, and the majority of involvement occurs among the Principal Recipients (PR) of GFATM grants, which mandates the use of the GFATM standards for M&E. The M&E system of the country still has a strong emphasis on epidemiological data. There is lack of clarity in database development in areas such as socio-cultural-economic impacts. There is no evaluation of the degree of acceptance of PLHIV in the general community, respect for sexual diversity, etc. There is no system for monitoring the socio-cultural impacts or participation of Civil Society in this endeavor. In addition, there is no system of support for Civil Society to fully participate at an appropriate level. For example, there is a large volume of documentation that needs to be absorbed, but most of that is in English, thus depriving Civil Society from fully accessing the content. In

addition, there is too little time to read the documentation under consideration before the deadline to submit recommendations, thus reducing input of Civil Society.

5. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. organisations and networks of people living with HIV, of sex workers, and faith-based organizations)?:
4
Comments and examples:
Civil Society organizations which send representatives to participate in the NAP are diverse and include 214 members of the NGO coalition on AIDS (TNCA). They are conscientious in representing their constituencies, and help fill the gaps in coverage for some populations which the government programs may overlook or underestimate. The Civil Society sector encompasses about 15 networks such as TNP+, SWING, the Sexual Diversity Network, the IDU Network, youth networks, networks of foreign migrant laborers, networks of ethnic minorities and indigenous groups. Civil Society also address the needs of some groups that have not formed networks such as the transgender (TG), men-who-have-sex-with men (MSM) populations, male sex workers, and women living with HIV. Civil Society is an important factor in ensuring representation of these groups so that their needs are clearly addressed by the NAP. Yet problems remain in the system of support and encouragement of Civil Society participation because of factors related to the above points.

6. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society able to access

a. Adequate financial support to implement its HIV activities?:
3
b. Adequate technical support to implement its HIV activities?:
2
Comments and examples:
As stated, the budget for prevention among KAPs is largely dependent on the GFATM. In the absence of this external support, the Thai government would only be able to provide 50 million baht to Civil Society which, when distributed to the various agencies throughout the country would result in too little funding to have meaningful results. The management of budget in this area is overly dependent on government authority, and lacks a comprehensive budget support strategy. There is still too little technical assistance for implementation. Mostly, this assistance is provided by Civil Society itself. For example, in working with PWID, Civil Society provides technical assistance to the government more than the reverse. There is no data management system to improve the knowledge base for either the government or Civil Society. There is no focal point for improving knowledge management. The approach of the government is mostly to conduct training for large numbers of trainees, emphasizing the quantitative outputs and focusing on epidemiology. Instead, the government needs to provide more qualitative, in-depth, comprehensive training.

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

People living with HIV:
>75%
Men who have sex with men:
>75%
People who inject drugs:
>75%
Sex workers:
>75%
Transgendered people:
>75%
Testing and Counselling:
<25%
Reduction of Stigma and Discrimination:
>75%
Clinical services (ART/OI)*:
51-75%
Home-based care:
51-75%
Programmes for OVC:**
25-50%

8. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to increase civil society participation in 2011?:
7
Since 2009, what have been key achievements in this area:
There have been efforts to specify the participation of Civil Society in the membership of committees and task forces related to strategy, policy, M&E at the national level, and in the Country Coordination Mechanism (CCM). The number of representatives of Civil Society who represent a diverse range of beneficiary populations is increasing, and there is participation with the government in various forums. In the past, mostly only representatives of the TNCA and Positive People's Network participated. Now other groups are eager and motivated to participate, and they do.
What challenges remain in this area:

For sure, Civil Society has participated in the development of policy at all levels, and is an internationally-recognized partner. The reason for including Civil Society is to help inform the directions of implementation and how to provide comprehensive services from a variety of perspectives. However, there are different interpretations of what this involvement is, what "participation of the community sector" consists of, and the intensity and dedication needed to make this happen is uneven. In addition, there are limitations to the ability of some Civil Society organizations to send representatives when requested due to competing demands for time when faced with ad hoc challenges, or unwillingness of supervisors to release staff to attend meetings on a regular basis. In addition, there are areas of conflict of interest in the case where an NGO which is seeking a grant cannot offer frank criticism in a form including the potential donor. This reduces the significance of their participation. Some NGOs lack data or understanding of some issues so that, even though they have a place at the table, they cannot usefully participate. More flexible methods are needed to help facilitate more complete and regular involvement of Civil Society, including budget support to create a technical database specific to the Civil Society sector.

B - II. POLITICAL SUPPORT AND LEADERSHIP

1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?:
Yes
IF YES, describe some examples of when and how this has happened:
Representatives of PLHIV are given the opportunity to serve as committee members at the national level (NAC), subcommittee on care and treatment through the NHSO system, subcommittee for support and protection of AIDS rights, and the CCM and PCM at the provincial level. Representatives of various population groups are members of task forces and committees in fairly complete proportion to their distribution in the population. And in developing the NAP, Civil Society is routinely involved. In any event, in terms of resource persons in the NAC, the representation of Civil Society is not meaningful if decisions are made by a plurality of votes. Also, in some areas of implementation there is negative stigma which hinders full Civil Society involvement. 1.In 2010-11, Prime Minister Abhisit Vejajiva, as chair of the NAC, raised the importance given to prevention and control of AIDS by participating in person at NAC meetings. The Prime Minister actively participated in these meetings and tracked progress of NAP implementation. At the same time, many aspects of the program did not progress that well, such as the lack of any indication that the NAP is progressing toward the "Getting to Zero" targets. There is a lack of policy or implementation that clearly advances the prevention, care and treatment agenda in order to achieve the "Getting to Zero" target. In particular, the Free Trade Agreement with the European Community and the USA must not have conditions attached regarding the price of drugs or the expanded TRIPS agreement. From the past government to the present, it is still not clear who is going to provide the national level leadership to advance the NAP. In addition, there was little progress on budget mobilization for prevention and harm reduction. Much of the existing prevention budget had come from the GFATM, while the Thai government has not increased support for social services of the NGO sector (which remains at 50 million baht per year). Thus, at a minimum, the government has to allocate budget to cover the amount of GFATM assistance in the past.

B - III. HUMAN RIGHTS

1.1.

People living with HIV:
No
Men who have sex with men:
No
Migrants/mobile populations:
No
Orphans and other vulnerable children:
No
People with disabilities:
Yes
People who inject drugs:
No
Prison inmates:
No
Sex workers:
No
Transgendered people:
No
Women and girls:
Yes
Young women/young men:
Yes
Other specific vulnerable subpopulations [write in]:
Elderly population is included.

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?:
Yes

If YES to Question 1.1 or 1.2, briefly describe the contents of these laws:
Item 1.1 There are some groups, such as the disabled, for whom there are laws defending their right to employment. There are laws to protect women and girls from all forms of discrimination (CEDAW) and the Convention on the Rights of the Child (CRC). Adolescents (under 18 years) are protected by CRC, while the elderly are protected by laws related to their demographic group. Thus, Civil Society does not agree that there should be a law specific to HIV. Item 1.2 The 2007 Constitution, Resolution 4 states: "The dignity of one's humanity, rights, freedom, and equality will be protected." Resolution 30 states that "People are equal under the law and receive equal protection of the law, male or female. Any unfair discrimination based on place of origin, ethnicity, language, gender, age, disability, individual socio-economic status, religion, education or political views which do not conflict with this Constitution is prohibited." In addition, the spirit of the Constitutional laws also provides protection for the sexually diverse populations. The 2007 laws to protect victims of domestic violence emphasize family reconciliation and protection of victims of abuse – both males and females – but still suffer from some shortcomings (see below).

Briefly explain what mechanisms are in place to ensure that these laws are implemented:
The National Human Rights Commission of Thailand, the National Ombudsman, and the Rights and Liberties Protection Department are mechanisms for the protection of rights, hearing of grievances, cases of violation of rights, or discrimination in various situations. In the area of health and treatment, the NHSO, PCMO and PCM are mechanisms of appeal and resolution. In the education sector, the Educational Service Area and PCM are sources of protection. In the area of labor, the Provincial Labor Office and the PCM are the focal points in this area.

Briefly comment on the degree to which they are currently implemented:
There is a policy but, in practice, proper action depends on the personality of the official in question. The victims of rights violation are often reluctant to file a grievance because they do not trust the confidentiality of the staff they have to deal with. While the law to protect victims of domestic violence strives for equality and balance, the law is weak in many areas. First, in promoting domestic reconciliation often lets the abuser off without any punishment. The law is not gender sensitive either in its attempt to treat males and females in the household equally, despite gender disparities in the society and culture and the fact that women and girls are overwhelming more often the victim of domestic abuse than males. The law doesn't recognize sexual diversity. Also, the law does not provide for social and medical support services that are sensitive to female-male dimension and the repercussions of abuse based on that. In terms of applying the law, the strategies of implementation requires the collaboration of the police, the Ministry of Social Development and Human Security (MSDHS), the MOPH, the Ministry of Justice (MOJ) and Civil Society. However, a current limitation of this strategy is that some staff of these agencies still don't understand the dimensions of the problems, and enforcement depends on the attitudes of the official. And, in the end, the victim of the abuse may receive no protection at all.

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?:
Yes

2.1. IF YES, for which sub-populations?

People living with HIV:
Yes
Men who have sex with men:
Yes
Migrants/mobile populations:
Yes
Orphans and other vulnerable children:
No
People with disabilities:
No
People who inject drugs:
Yes
Prison inmates:
Yes
Sex workers:
Yes
Transgendered people:
Yes
Women and girls:
Yes
Young women/young men:
Yes
Other specific vulnerable subpopulations [write in]:
Displaced person, ethnic minorities and indigenous peoples.

Briefly describe the content of these laws, regulations or policies:
Women still face challenges of accessing legal abortion services, the regulations of the NHSO for the NHSS specify that coverage is only for Thai nationals --- foreign migrant laborers and undocumented Thais, and displaced persons cannot access health insurance coverage, including ART. The multi-lateral MoU between Thailand, Lao P.D.R., Myanmar and Cambodia concerning labor migration through nationality verification places these individuals under the aegis of the social welfare program and for whom there is no budget for HIV prevention. The Thai Medical Council has specified that youth under 18 require parental consent for HIV testing. As stated above, the ruling that distribution of needles and syringes to IDU

represents promotion of criminal activity denies the ability of programs to conduct harm reduction. Condoms and VCCT are not included in the package of health services for prison inmates despite the fact that it is well-known that sex takes place in prisons. The 1996 Prostitution Law, Resolutions 5, 6, and 7 classifies selling sex as a criminal act and the Workplace law of 2004 does not recognize the rights of workers in sex establishments. These laws increase the power of the establishment owner over the workers, often including abusive or unethical practices such as compulsory HIV testing, with outside agencies powerless to intervene on behalf of the sex workers.

Briefly comment on how they pose barriers:

Many antiquated Thai laws and regulations continue to be an obstacle which restricts the social opportunities of individuals to practice occupations, study sexual development, or access medical care. These laws and attitudes of social service providers toward issues related to sex are also an obstacle to access to services when they refuse to acknowledge and accept adolescent sexual activity. Female students who are pregnant are not allowed to continue their studies. PLHIV are screened out of employment by clandestine testing of sero-status, including applicants for positions in the army, police, judiciary, medical and nursing professions. The Anti-Prostitution law limits sex worker access to information about prevention and ART because they are afraid of violating the law, while the Workplace Law does not facilitate access of sex workers to VCCT by outreach programs.

3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?:

Yes

Briefly describe the content of the policy, law or regulation and the populations included:

The laws are not for the protection of women only, such as the domestic violence law described above. Thailand has laws to reduce violence against women, but these do not protect women in all situations. For example, the law on domestic violence protection focuses on abuse between close relatives. The law also tries to promote domestic harmony as the goal. This is still a conservative approach and does not address the power imbalance between a man and a woman in the household – regardless of relationship. The law encourages disputing domestic factions to negotiate for a peaceful solution without regard to fairness or equality of the result. Gender imbalances, with regard to the HIV-infected, pose the risk of transmission of HIV as a result of sexual violence or can adversely affect access to treatment. The law tries to protect victims of domestic violence, most of whom are women and children. But the law does not specify special protections for HIV+ women, nor does it protect women from abuse by non-family members living in the household. The law may protect women from violence to some degree, but it does not protect HIV+ women in particular from abuse, nor from abuse by someone outside the family. The original abuse protection law protected victims of rape only for women and children. The Resolution 276 now covers both sexes and includes spousal rape as an offense. Regulation 277 refers to child molestation for someone 15 years old or younger and includes acts performed for sexual gratification of the perpetrator involving the genitals or anus, or mouth, or use of an object to penetrate the victim.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?:

Yes

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

The NAS for 2007-11 has strategy # 3 as protection of AIDS rights. The key measure in this is the promotion of knowledge about rights and improvements in the laws and regulations to speed response to incidents of rights violation, consistent with the societal environment. In addition, the measures provides for dissemination of awareness about rights for individuals and target populations, promotion of the role of women and men, role parity, development of strategies to support and protect rights, support for positive attitudes, and provision of reports on the status of AIDS rights. The goals include (1) The rights of PLHIV and affected persons are protected with equality as are others in society; (2) The rights of hard-to-reach populations (e.g., PWID, migrant laborers, ethnic minorities, MSM, sex workers, prisoners, etc.) are protected and they can access quality, comprehensive prevention services. In addition, there is a harm reduction policy for drug users, and a policy that prohibits entertainment establishments from forcing HIV tests of its workers. The Constitution prohibits using AIDS as a reason for obstructing someone. In the past two years, a mid-term review of the 2007-11 NAS with regard to AIDS rights protection found that there has been no implementation of this strategy in the review period. Even though ART is part of the benefits package for all Thais, over 200,000 PLA who are receiving ART and have no overt symptoms cannot resume a normal life in society. This was the basis for Civil Society's recommendation for a subcommittee on rights protection and monitoring incidents of stigma and discrimination at the national level.

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and/or other vulnerable sub-populations?:

Yes

IF YES, briefly describe this mechanism:

There is no clear strategy for formal documentation of cases discrimination against members of the core populations or vulnerable groups. Some projects and organizations do this such as the project to develop indicators of stigmatization. As yet, there is no national strategy to implement this. Some Civil Society groups receive reports of grievances such as the Foundation for AIDS Rights, TNP+ and the Positive Women's Network in collaboration with the Raks Thai Foundation which is assembling a database of HIV+ women who have had their rights violated during the course of seeking ante-natal care.

6. Does the country have a policy or strategy of free services for the following?

Provided free-of-charge to all people in the country	Provided free-of-charge to some people in the country	Provided, but only at a cost
-	Yes	-
-	Yes	-
-	Yes	-

If applicable, which populations have been identified as priority, and for which services?:
ART: Only for Thai nationals; excludes foreign migrant laborers, ethnic minorities waiting for citizenship documentation, and those without national ID numbers. Prevention: The government provides condoms for sex workers and only PLHIV who come to the hospital. Free distribution of condoms for the general population is rarely conducted. The government motivates people to practice safe and to purchase condoms on their own through condom vending machines. The remainder is supported by funds from the GFATM.) Care and assistance for HIV/AIDS: A monthly welfare subsidy is given to only to those Thai PLA who appear in person at the appropriate government office. There have been problems with this in many places including lack of transparency of management. Some eligible PLA did not receive their subsidy or received less than allowed. Assistance for AIDS-affected families is not widespread. The MSDHS conducts this passively and with limited budget. Occupational income supplements are available for PLA, but some PLA may be reluctant to apply for this in person and thus, forego the benefit. Civil Society recommends that there should be a choice of benefits, including placement in an occupation that one is qualified for and needs workers.

7. Does the country have a policy or strategy to ensure equal access for women and men to HIV prevention, treatment, care and support?:
No

7.1. In particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?:
No

8. Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?:
Yes

IF YES, Briefly describe the content of this policy/strategy and the populations included:
Yes, but not clear. The country has specified the provision of HIV prevention, care and treatment in the NAS plan for 2007-11, with the target to reduce HIV transmission in the general population and MARP. However, there has not been much effort to ensure equal access for the population of vulnerable women (adolescent and married women) adolescents and general men (who are not gay). They are not sensitive to issues of the female-male cultural dynamics. The PWID have not been able to receive essential prevention supplies. Foreign migrant workers cannot access ART.

8.1

8.1. IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?:
Yes

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:
Under the NAS, there are sub-plans for implementation of M&E in this area. However, in the past, there has not been clear implementation to help answer the question. There is just a broad statement.

9. Does the country have a policy or law prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?:
Yes

IF YES, briefly describe the content of the policy or law:
There is a policy and implementation guidelines for this (2009). But it is not a law that requires voluntary informed consent. In the past, there have been strategies with guidelines which can be enforced, including a subcommittee for this issue in particular.

10. Does the country have the following human rights monitoring and enforcement mechanisms?

a. Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work:
Yes

b. Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts:
Yes

IF YES on any of the above questions, describe some examples:
There is no indicator for this, but there are sections of implementation guidelines that specify that there should be no compulsory pre-employment HIV testing, or denial of treatment based on sero-status. The master plan on human rights under the Rights and Liberties Protection Department of the Ministry of Justice calls for monitor of the status and evaluation every 2 to 3 years.

11. In the last 2 years, have there been the following training and/or capacity-building activities

a. Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)?:
Yes

b. Programmes for members of the judiciary and law enforcement on HIV and human rights issues that may come up in the context of their work?:
Yes

12. Are the following legal support services available in the country?

a. Legal aid systems for HIV casework:
Yes
b. Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV:
Yes

13. Are there programmes in place to reduce HIV-related stigma and discrimination?:
Yes

IF YES, what types of programmes?

Programmes for health care workers:
No
Programmes for the media:
No
Programmes in the work place:
No
Other [write in]:
Programmes on Stigma and Discrimination Reduction, were operated by FAR, TNP+, Positve Women Network and Rak Thai Foundation.

14. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2011?:
5
Since 2009, what have been key achievements in this area:
-Appointment of the subcommittee on support and protection of rights under the NAC -The network of sexually diverse populations appealed for changes in the blood screening recording form for army reserves of Saw Daw 43 and Saw Daw 9 which classified the sexually diverse as have a "Chronic mental illness." The requested change was to "Sexual preference does not match birth gender" and this change was approved by the court.
What challenges remain in this area:
There remain challenges in many areas of human rights, care, treatment and prevention. In the area of prevention, the policy of harm reduction still can't be fully implemented, and most of the budget for prevention comes from external sources such as the GFATM. Once this funding ends, prevention will suffer a set-back unless there is budget or a fund set up to cover this. There will need to be supplemental budget for human and AIDS rights protection, including the expansion of strategies to make this more effective and accessible for those in need. In the area of treatment, there are still limitations of access to ART for migrants and undocumented persons. In addition, there are gaps in protection of sex rights, reproductive health rights, compulsory testing, and undisclosed screening in many settings, for example, in entertainment establishments, as part of the academic application process, when having dental work, lasik surgery, and applying for life insurance. Even the Dhammakaya monastery requires pre-ordination HIV screening to allow initiation. Even though government policy is for universal access to education, there are still cases of HIV+ children who are denied admittance to the home community school. In the past, Civil Society has tried to advocate for and create an environment and tools to facilitate sex rights protection, reproductive health rights and gender parity in order to reduce stigma and discrimination against persons seeking HIV prevention, care and treatment services, and harmonious co-existence in the community. This is an important factor which impacts on the individual's ability to manage and negotiate safe sex, and freedom from sexual violence which occurs too often for women and girls. There have been campaigns to improve understanding in society, changing attitudes first with the implementation and implementers in Civil Society and the government. Then advocating for legal changes to improve sex rights protection, reproductive health rights, legal rights and gender parity. A draft law reflects this so clearly in the context of sexual rights. The draft reflects better understanding of sex and reproductive health rights in many dimensions. It specifies the requirement of providing protection The outcome of this effort is the draft reproductive health law of 20XX, which has shown advanced understanding of sex rights protection and reproductive health rights, definition of terms to improve understanding about sex rights and reproductive health rights, and improved sensitivity in using language and being positive, more so than in other legislation. For example, the draft law uses terms such as pregnancy termination, defined as ending the pregnancy. This is non-judgmental. Also, the definition of counselor is someone who is knowledgeable and capable of providing counsel on reproductive health with an emphasis on human rights. This allusion to human rights is key and may be the first time that for victims of sexual violence. It is regrettable that this draft law has still not passed parliament. At the very least, the drafting of this law increased awareness of unplanned pregnancy issues, and inspired greater efforts to address this problem for students with unwanted pregnancy. Nevertheless, there is a need to advocate for the passage of this law. In the meantime, incidents which are social issues, such as allowing pregnant students to return to the classroom, requires that there be consideration that this does not become a motivation or a role model for others to follow. Society needs to see that it is not only adolescents who have unwanted pregnancies. There are many groups and many different contexts in which this problem occurs, requiring a more comprehensive understanding. In addition, there were campaigns for gender equality for protection of both males and females, and those with diverse sexual lifestyles. The concept of sexual diversity has received greater attention, understanding and acceptance as evidenced by the Yogyakarta Principles that are being applied to programs. In the middle of 2011, the Sexual Diversity Network, technical experts in gender studies, and human rights came together to create the Foundation for SOGI Rights and Justice.

15. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the effort to implement human rights related policies, laws and regulations in 2011?:

2
Since 2009, what have been key achievements in this area:
Master plan for human rights at the national level Subcommittee to support and protect AIDS rights
What challenges remain in this area:
There is a need to apply the existing policy so that it produces genuine results. The government needs to abolish laws, regulations and policies which impede access to prevention, care and treatment, and apply the master plan to actual implementation. For the strategy for rights protection, there needs to be more assistance and facilitation for victims of rights violation. These are not yet moving in the right direction. The government issues laws and policies that continue to violate the rights of the citizens, such as those related to drug use and prostitution. 1.Building the structure for rights protection – even ten years after the creation of the Department for Rights Protections and Freedoms --- still requires effort by Civil Society and the government to advance this cause. Without that, the few Civil Society agencies focusing on this cannot alone achieve the goal in the near term.

B - IV. PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?:
Yes
IF YES, how were these specific needs determined?:
1. Application of the computerized Asian Epidemic Model has resulted in the specification of high-risk population and the need for targeted interventions for these groups. Civil Society feels that the identification of high-risk groups cannot effectively address the AIDS challenge in the country, since the root causes of HIV spread have socio-cultural origins. In addition, specifying high-risk groups as a policy is a form of stigmatization and discrimination, and this brands the populations in ways that infringes on their rights and freedoms. For example, the Thai Red Cross denies blood donations from gay men since they are classified as a high-risk population. Using the AEM to identify priority groups can lead programs to ignore other vulnerable populations such as women. Women are constantly slipping through the prevention safety net. Women are not listed as a high risk group and are thus overlooked in the accelerated prevention effort. This makes them less concerned about their own vulnerability to HIV as well. Thus, defining high risk groups doesn't necessarily lead to a successful prevention outcomes. Just as the passing of a harm reduction policy doesn't lead to harm reduction interventions initially. What is more, even though identifying high-risk groups such as PWID can steer helpful services to them, without an effective harm reduction policy, the targeting for prevention is not feasible in practice.

1.1 To what extent has HIV prevention been implemented?

Blood safety:
Strongly Agree
Condom promotion:
Disagree
Harm reduction for people who inject drugs:
Strongly Disagree
HIV prevention for out-of-school young people:
Strongly Disagree
HIV prevention in the workplace:
Disagree
HIV testing and counseling:
Disagree
IEC on risk reduction:
Disagree
IEC on stigma and discrimination reduction:
Strongly Disagree
Prevention of mother-to-child transmission of HIV:
Agree
Prevention for people living with HIV:
Strongly Disagree
Reproductive health services including sexually transmitted infections prevention and treatment:
Strongly Disagree
Risk reduction for intimate partners of key populations:
Strongly Disagree
Risk reduction for men who have sex with men:
Agree
Risk reduction for sex workers:
Agree
School-based HIV education for young people:
Strongly Disagree
Universal precautions in health care settings:
Disagree
Other [write in]:
-

2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV prevention programmes in 2011?:
4
Since 2009, what have been key achievements in this area:
-Harm reduction policy approved as a resolution of the NAC -There are national media campaigns which have helped the general population become familiar with prevention through promotion of condom use
What challenges remain in this area:
At present, most of the prevention budget comes from the GFATM and is focused on certain populations groups. There is lack of government budget for continuation of the interventions in the absence of external assistance. While the GFATM support has enabled expansion of interventions widely under the management of government personnel, there is still a question of standards of quality of the various projects, and this aspect should be looked into further.

B - V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV and AIDS treatment, care and support services?:
Yes
IF YES, Briefly identify the elements and what has been prioritized:
The package of care and treatment services for HIV under the NHSS has been used as a standard for diagnosis, care and treatment of PLA nationally since 2010 (including treatment by HAART which is administered only to HIV+ pregnant women).
Briefly identify how HIV treatment, care and support services are being scaled-up?:
- Expand care through the community hospital based on the policy of universal health insurance. Expand more ante-natal care (ANC) to the Tambon health promotion level

1.1. To what extent have the following HIV treatment, care and support services been implemented?

Antiretroviral therapy:
Agree
ART for TB patients:
Strongly Agree
Cotrimoxazole prophylaxis in people living with HIV:
Disagree
Early infant diagnosis:
Agree
HIV care and support in the workplace (including alternative working arrangements):
Strongly Disagree
HIV testing and counselling for people with TB:
Disagree
HIV treatment services in the workplace or treatment referral systems through the workplace:
Strongly Disagree
Nutritional care:
Disagree
Paediatric AIDS treatment:
Agree
Post-delivery ART provision to women:
Agree
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault):
Agree
Post-exposure prophylaxis for occupational exposures to HIV:
Strongly Agree
Psychosocial support for people living with HIV and their families:
Disagree
Sexually transmitted infection management:
Strongly Disagree
TB infection control in HIV treatment and care facilities:
Agree
TB preventive therapy for people living with HIV:
Agree
TB screening for people living with HIV:
Agree
Treatment of common HIV-related infections:
Strongly Agree
Other [write in]:
-

1.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011?:
8

Since 2009, what have been key achievements in this area:
Thailand has a policy to provide care and treatment which can be said to have achieved impressive coverage of all the dimensions of service for most of the eligible PLHIV. Coverage of ART has expanded steadily over time. Access to condoms has increased and the rate of AIDS-related mortality has declined. There are still problems of implementation, notably integration of the various clinic activities such as ANC with ART and TB, among others.
What challenges remain in this area:
-Guidelines for support in increasing the proportion of eligible PLHIV receiving ART -Support and improving the reduction of drug resistance or developing 2nd line regimens -Expanding care and ART to cover every eligible person in Thailand, including non-Thais, migrant laborers, undocumented persons, and displaced persons -Finding ways to ensure that PLHIV access treatment as soon as appropriate, and establish linkages with drug addiction therapy with ART services -The TB-infected PLHIV mortality rate is still high -Better monitoring of post-partum women and infants that need follow-up -Improving the quality of services which do not meet the standard in order to reach the standard -Treatment, care and assistance in the workplace is still a challenge -The HIV rapid test has been implemented as a pilot project among MSM in many provinces with funding from USAID. The good outcomes led to recommendations for institutionalizing this strategy. But no policies have been forthcoming from the government sector in this area.
2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?:
No
3. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?":
3
Since 2009, what have been key achievements in this area:
This aspect of implementation has not shown significant achievement.
What challenges remain in this area:
There is a need to improve the system and national policy for care and protection of orphans and other vulnerable children to provide continuous coverage, and services need to be more youth-friendly, which do not blame the children, or show aversion, or rejection.
