

# Thailand Report NCPI

---

## NCPI Header

**is indicator/topic relevant?:** Yes

**is data available?:** Yes

**Data measurement tool / source:** NCPI

**Other measurement tool / source:**

**From date:** 01/01/2014

**To date:** 03/31/2014

**Additional information related to entered data. e.g. reference to primary data source, methodological concerns::**

**Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source::**

**Data measurement tool / source:** GARPR

**Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:** Dr.Taweessap Siraprapasiri

**Postal address:** National AIDS Management Center (NAMC) Department of Disease Control, Ministry of Public Health  
Tiwanond Road, Nonthaburi, 11000, Thailand

**Telephone:** (+66)2-5903829

**Fax:** (+66)2-5903829, (+66)2-9659095

**E-mail:** taweessap@rocketmail.com

**Describe the process used for NCPI data gathering and validation:** Part A: The coordinator reviewed related documents including the NCPI collected for the 2012 Thailand AIDS response progress report and the mid-term review at country level for 2011 United Nations General Assembly Political Declaration on HIV/AIDS in May 2013. The instrument was reviewed and certain questions were selected for each group of governmental organizations. Questionnaires were disseminated among various government institutions that maintain a responsible and integral role in the National AIDS Strategy. The additional information together with the agreement on scaling the progress was conducted in the meeting on 25 March 2014. Part B: Individual interview was done with 13 respondents from 11 organizations which were selected from those working on treatment, care and support for PLHIV; key populations programs including sex workers, MSM, PWID; youth, vulnerable children including children affected by HIV/AIDS and Thai NGO Coalition on AIDS. The respondents were from organizations at both national and local levels. The additional focus group interview on working with PWID was done with 3 participants from the network working on drug users (12 D). One respondent sent the answered questionnaire back via email. The collected data was validated by group email to both respondents and non respondents.

**Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:** The National AIDS Management Center organized the meeting, where a small group discussion meeting was done for Part A. The participants from civil society organizations also joined the small group discussion. Answers to all questions in Part A were reviewed and made more explanation with the agreement among participants from both government and civil society organizations. The disagreements for Part B were reviewed between coordinators of Part A and Part B, using the evidence from related documents as well as the results of the NCPI-Part B report in the previous GARP report (2012).

**Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):** • The scale effort should be interpreted by comparing from the previous report, not by answered scale. There was no clear definition for each scale. • The scale of answers on coverage of prevention and treatment services were quite subjective. • Since the review has just been done during the mid-term review at country level for 2011 United Nations General Assembly Political Declaration on HIV/AIDS in May 2013, the data was not collected from many people as the 2012 GARP report.

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

Organization	Names/Positions	Respondents to Part A
Department of Disease Control (National AIDS Management Center)	Dr.Petchsri Sirinirund / Former Director, Advisor	A1,A2,A3,A4,A5,A6
Department of Disease Control (National AIDS Management Center)	Ms. Porntip Kemngern / Public health technical officer	A1,A4,A5,A6
Department of Disease Control (Bureau of AIDS)	Ms. Porntip Yuktanon / Public health technical officer	A2
Department of Disease Control (Bureau of AIDS)	Ms. Pensri Sawatcharoenyng / Public health technical officer	A2,A6
Department of Disease Control (Bureau of epidemiology)	Mr.Sahapab Poolkasorn / Public health technical officer	A6
National Human Rights Committee	Ms. Piroim Sriprasert / Deputy Director General	A1,A2,A3,A4,A5,A6
Department of Local Administration	Ms. Punwipa Poolsawat / Technical officer	A3,A4,A5,A6
Department of Religion	Ms. Sunee Wangsantitrakool / Technical officer	A3,A4,A5,A6
Bureau of Social Security for Children, Youth and Disadvantaged People	Ms. Archaree Pengchun / Technical officer	A1,A2,A3,A4,A5,A6
Ministry of Commerce	Ms.Urawee Ngawwaree / Deputy Permanent Secretary	A1,A2,A3,A4,A5,A6
Office of Prime Minister	NA	A1,A2,A4,A5,A6
Ministry of Labour	NA	A1,A2,A4,A5,A6
Royal Thai Army	NA	A1,A2,A4,A5,A6
Police Hospital	NA	A1,A2,A4,A5,A6
Bangkok Metropolitan Administration	Ms. Kanokrat Lertraipob / Technical officer	A3,A4,A5,A6
Lamphun Provincial Health Office (PHO)	Ms. Boontin Chitsabai / Technical officer	A3,A4,A5,A6
Pichit PHO	Ms. Passara Chanthanakorn	A3,A4,A5,A6
Nan PHO	Mr. Jeerawat Kamsongsri / Program coordinator	A3,A4,A5,A6

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

Organization	Names/Positions	Respondents to Part B
Thai NGO Coalition on AIDS	Ms. Supatra Nacapew / Chair	B1,B2,B3,B4,B5
AIDS ACCESS Foundation	Mr. Chalerm Sak Kittittrakul / Program manager	B1,B2,B4,B5
AIDS ACCESS Foundation	Ms. Aree Khumpitak / Staff	B1,B2,B3,B5
Thai National AIDS Foundation	Ms. Yenjit Sompoh / Director	B1,B2,B3,B4,B5
World Vision Thailand Foundation	Mr. Chuwongse Sangkong / Program manager	B1,B2,B3,B4
Rainbow Sky Association	Mr. Danai Linjongrat / Program manager	B1,B2,B3,B4,B5
PPAT	Mr. Montree Pekan / Secretariat	B1,B2,B4
Thai Network of PLHIV/AIDS Foundation	Mr. Apiwat kwangkaew / Director	B1,B2,B3,B4,B5
Thai Network of PLHIV/AIDS Foundation	Ms. Soontraporn Katekaew / Staff	B1,B2,B3,B5
AIDSNet Foundation (North-East Office)	Mr. Sarawut Laosai / Staff	B1,B2,B4
AIDSNet Foundation (North Office)	Ms. Lamduan Mahawan / Director	B1,B2,B4,B5
SWING	Ms. Surang Janyam / Director	B1,B2,B3,B4
PSI Thailand Foundation	Mr. Veraphan Ngam-mee / Program manager	B1,B2,B3,B4
PSI Thailand Foundation	Mr. Supot Tangserisap / Staff	B1,B2,B3,B4
Ozone	Mr. Piyabutr Nacapew / Staff	B1,B2,B3,B4
Raks Thai Foundation	Ms. Thongphit Pinyosinwat / Program manager	B1,B2,B3,B4,B5
Raks Thai Foundation	Ms. Nipa Chompupa / Staff	B1,B2,B3,B4,B5
Thai NGO Coalitions on AIDS	Ms. Kanjana Thalaengkij / Secretary	B1,B2,B3

### A.I Strategic plan

**1. Has the country developed a national multisectoral strategy to respond to HIV?:** Yes

**IF YES, what is the period covered:** 2012-2016

**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 key new developments include 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; and 4. There is a clear framework for monitoring and evaluation (M&E). Remarks: The 2012-2016 National AIDS Strategy was approved by the NAC on April 27, 2012. However, the 2012-2016 NAS was not submitted to the Cabinet for approval in time for the fiscal year budget cycle. Accordingly, the NAC agreed to a revised NAS for the period of 2014-16, which conforms to the conclusion of the concurrent five-year NESDP period.

**IF YES, complete questions 1.1 through 1.10; IF NO, go to question 2.**

**1.1. Which government ministries or agencies have overall responsibility for the development and implementation of the national multi-sectoral strategy to respond to HIV?:** Department of Disease Control of Ministry of Public Health

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

**Education:**

**Included in Strategy:** Yes

**Earmarked Budget:** Yes

**Health:**

**Included in Strategy:** Yes

**Earmarked Budget:** Yes

**Labour:**

**Included in Strategy:** Yes

**Earmarked Budget:** Yes

**Military/Police:**

**Included in Strategy:** Yes

**Earmarked Budget:** Yes

**Social Welfare:**

**Included in Strategy:** Yes

**Earmarked Budget:** Yes

**Transportation:**

**Included in Strategy:** No

**Earmarked Budget:** No

**Women:**

**Included in Strategy:** No

**Earmarked Budget:** No

**Young People:**

**Included in Strategy:** No

**Earmarked Budget:** No

**Other:** Local Administration, Justice

**Included in Strategy:** Yes

**Earmarked Budget:** Yes

**IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?:** The National Health Security Office (NHSO) has allocated budget for HIV prevention and control, including budget for sub-district health funds with counterpart contributions from local administrative organizations. The concerned organizations in the province are able to mobilize resources from the sub-district health funds through the committee of the fund.

### **1.3. Does the multisectoral strategy address the following key populations/other vulnerable populations, settings and cross-cutting issues?**

#### **KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS:**

**Discordant couples:** Yes

**Elderly persons:** No

**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

**Transgender people:** Yes

**Women and girls:** Yes

**Young women/young men:** Yes

**Other specific vulnerable subpopulations:** No

#### **SETTINGS:**

**Prisons:** Yes

**Schools:** Yes

**Workplace:** Yes

**CROSS-CUTTING ISSUES:**

**Addressing stigma and discrimination:** Yes

**Gender empowerment and/or gender equality:** Yes

**HIV and poverty:** No

**Human rights protection:** Yes

**Involvement of people living with HIV:** Yes

**IF NO, explain how key populations were identified?:** Key populations were identified by using evidence from surveillance. Even elderly persons and disabled population were not addressed in the current national AIDS strategy; the interventions for general population will cover these 2 groups.

**1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country?**

**People living with HIV:** Yes

**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

**Prison inmates:** Yes

**Sex workers:** Yes

**Transgender people:** Yes

**Women and girls:** Yes

**Young women/young men:** Yes

**Other specific key populations/vulnerable subpopulations [write in]::**

: No

**1.5 Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?:** Yes

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

**1.7. 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

**1.8. Has the country ensured “full involvement and participation” of civil society in the development of the multisectoral strategy?:** Active involvement

**IF ACTIVE INVOLVEMENT, briefly explain how this was organised.:** Civil society participated since the beginning of development of the current National AIDS Strategy (NAS). The Thai NGO coalition on AIDS and the Thai network of PLHIV foundation are focal points to coordinate with civil society network. Apart from series of planning workshops among stakeholders, a multi-sector core group was set up to work on details of the NAS. In addition, the NAS was presented and approved by the NAC, of which representatives from civil society were members.

**IF NO or MODERATE INVOLVEMENT, briefly explain why this was the case.:**

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

**1.10. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?:** Yes, all partners

**IF SOME PARTNERS or NO, briefly explain for which areas there is no alignment/harmonization and why:**

**2.1. Has the country integrated HIV in the following specific development plans?**

**SPECIFIC DEVELOPMENT PLANS:**

**Common Country Assessment/UN Development Assistance Framework:** Yes

**National Development Plan:** Yes

**Poverty Reduction Strategy:** N/A

**National Social Protection Strategic Plan:** Yes

**Sector-wide approach:** N/A

**Other [write in]:**

:

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

**HIV-RELATED AREA INCLUDED IN PLAN(S):**

**Elimination of punitive laws:** Yes

**HIV impact alleviation (including palliative care for adults and children):** 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 protection or other schemes):** Yes

**Women's economic empowerment (e.g. access to credit, access to land, training):** Yes

**Other [write in]:**

:

**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?:** 4

**4. Does the country have 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 and children:** In Thailand, HIV services are integrated in the general health service system. However, it has been planned to decentralize the services to community in order to increase the access to services as well as to reduce the workload of ART services in hospitals.

**5. Are health facilities providing HIV services integrated with other health services?**

**a) HIV Counselling & Testing with Sexual & Reproductive Health:** Many

**b) HIV Counselling & Testing and Tuberculosis:** Many

**c) HIV Counselling & Testing and general outpatient care:** Few

**d) HIV Counselling & Testing and chronic Non-Communicable Diseases:** None

**e) ART and Tuberculosis:** Many

**f) ART and general outpatient care:** Few

**g) ART and chronic Non-Communicable Diseases:** None

**h) PMTCT with Antenatal Care/Maternal & Child Health:** Many

**i) Other comments on HIV integration:** :

**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 your country's HIV programmes in 2013?: 8**

**Since 2011, what have been key achievements in this area:** The National AIDS Committee (NAC) passed a resolution to approve the NAS 2012-2016 and the National Strategic Information and M&E Plan for the same period. Meanwhile the cabinet approved the adjusted NAS with the addition of the ending AIDS strategy to cover the period of 2014-2016. The NAC also approved the estimation of budget to end AIDS as well as the proposition of potential sources of budget.

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

## **A.II Political support and leadership**

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

**A. Government ministers:** Yes

**B. Other high officials at sub-national level:** Yes

**1.1. In the last 12 months, have the head of government or other high officials taken action that demonstrated leadership in the response to HIV?:** Yes

**Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:** The Prime Minister assigned the Deputy Prime Minister to chair the NAC. During these 2 years there were 4 Deputy Prime Ministers chaired the NAC. However, the opening speech of the Minister of Health, vice chair of the NAC, for the ICAAP 11 held in Bangkok in November 2013 expressed the strong intention to support the country to end AIDS. He also mentioned the health insurance for migrant workers and positively responded to the issue of harm reduction raised by the civil society at the opening ceremony.

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

**IF NO, briefly explain why not and how HIV programmes are being managed::**

**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.Pongthep Thepkanchana

**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 coordination between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?:** Yes

**IF YES, briefly describe the main achievements::** [1] The National AIDS Management Center (NAMc) coordinates the development and implementation of the NAS, national operational plan, national SI and M&E plan. ; [2] The secretariat of the CCM coordinates and sets up technical task forces on AIDS, monitors overall implementation of the programs receiving GF support. [3] The NAC assigns the provincial AIDS committee to coordinate AIDS responses in the province. Meanwhile the establishment of Provincial Coordinating Mechanism for specific key programs coordinated by the provincial health offices under the Global Fund support has facilitated the coordination among sectors under the provincial AIDS committee.

**What challenges remain in this area:** • The private sector has not been much involved. • Capacity building for provincial health offices on using evidence to advocate and planning is needed for effective and efficient coordination at the implementation level.

**4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?:** 3

**5. What kind of support does the National HIV Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?**

**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]:**

: No

**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:** [1] The government has announced the policy to align the three funds which support the cost of ART (NHSO, Social Security, Government Civil Service) so that they all cover the same standard of treatment. There has been a review, improvement and consolidation of data into a single system, beginning on October 1, 2012. [2] The health insurance for migrants by the MOPH was amended to include ART in the benefit package and also cover both non documented migrants and migrants' dependents.

**Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:** [1] Harm reduction: In 2010, the NAC approved the policy for harm reduction from injection drug use, with a comprehensive package for 10 items of services. The Office of the Narcotics Control Board (ONCB) has also endorsed harm reduction as one intervention option. However, converting these policies into action has been difficult. The Council of State views needle/syringe program as abetting drug use. [2] Young people under 18: The Thai Medical council had the guideline that those under 18 require parental consent for HIV testing. This impedes the access to HIV testing of young people under 18.

**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 2013?:** 7

**Since 2011, what have been key achievements in this area:** [1] The ending AIDS strategy was approved. [2] The ART services and database under the three funds (NHSO, Social Security, and Government Civil Service) have been aligned so that they all cover the same standard of treatment. [3] The MOPH has provided health insurance including ART to both documented and non-documented migrants and independents.

**What challenges remain in this area:** [1] Advocating for a harm reduction policy and implementation for PWID in Thailand; [2] Advocating for the adjusted guideline that those under 18 require parental consent for HIV testing; and [3] Scaling up the implementation of health insurance for migrants.

### **A.III Human rights**

**1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups? Select yes if the policy specifies any of the following key populations and vulnerable groups:**

**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

**Transgender people:** No

**Women and girls:** Yes

**Young women/young men:** Yes

**Other specific vulnerable subpopulations [write in]:**

: No

**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 vulnerable groups?:** Yes

**IF YES, for which key populations and vulnerable groups?:**

**People living with HIV:** No

**Elderly persons:** 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

**Transgender people:** No

**Women and girls:** No

**Young women/young men:** Yes

**Other specific vulnerable populations [write in]:**

: No

**Briefly describe the content of these laws, regulations or policies::** [1] Migrant health workers are not eligible to be employed. [2] The Narcotics Criminal law of 1979 prohibits use of an addictive substance and priority drug policy to recruit more drug users to be treated. [3] Condoms are not openly allowed to be distributed in prisons. [4] The Anti-Prostitution law of 2006 authorizes the police to arrest sex workers and close commercial sex access establishments [5] 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] Migrant health workers are key to increase the access to services of migrants. [2] The criminalization of addictive drug use impedes prevention since distribution of clean needles and syringes to PWID can be construed as promoted illegal drug use and can be prosecuted under Article 863. [3] The existence of having sex between men without condom use increase HIV transmission. [4] 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. [5] 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?:**

**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]:**

: No

**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**

**a) age-appropriate sexual and reproductive health elements?:** Yes

**b) 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:** The current NAS Strategy 1: Expand rights-based and gender-sensitive comprehensive prevention services for populations with the highest numbers of HIV transmission. Targets include comprehensive, integrated prevention covering at least 80% of the Thai and non-Thai sex workers, MSM, PWID in the priority provinces. There are 3 measures comprising of (1) specify target areas by considering the context and characteristics of the target population, especially key affected populations with high numbers of new infections; (2) Increase efficiency and coverage with intensity of implementation by outreach services through CSO, and branding HIV services; and (3) Apply new technology for prevention e.g. Pre-exposure prophylaxis.

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

**People who inject drugs:** Condom promotion, Drug substitution therapy, HIV testing and counseling, Needle & syringe exchange, Reproductive health, including sexually transmitted infections prevention and treatment, Stigma and discrimination reduction, Targeted information on risk reduction and HIV education

**Men who have sex with men:** Condom promotion, HIV testing and counseling, Reproductive health, including sexually transmitted infections prevention and treatment, Stigma and discrimination reduction, Targeted information on risk reduction and HIV education

**Sex workers:** Condom promotion, HIV testing and counseling, Reproductive health, including sexually transmitted infections prevention and treatment, Stigma and discrimination reduction, Targeted information on risk reduction and HIV education

**Customers of sex workers:** Condom promotion, HIV testing and counseling, Reproductive health, including sexually transmitted infections prevention and treatment, Stigma and discrimination reduction, Targeted information on risk reduction and HIV education

**Prison inmates:** Condom promotion, HIV testing and counseling, Reproductive health, including sexually transmitted infections prevention and treatment, Stigma and discrimination reduction, Targeted information on risk reduction and HIV education

**Other populations [write in]:**

:

**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 2013?: 8**

**Since 2011, what have been key achievements in this area?:** In August of 2012, a national consultative meeting was convened on the topic of strategic use of ARV. It was concluded that, in order for Thailand to reduce new cases of HIV by two-thirds below the projected total for 2016, it will be necessary to consider use of ART for prevention. The key strategy for this is earlier detection and enrolment in treatment of PLHIV, especially for MSM, sex workers, and PWID. This will involve improvements and expansion of HIV testing, continuous care, development of the role of Civil Society, and increasing the capacity of key target populations to access services. The proposal for policy on the strategic use of ARV has been planned to proceed in 2013.

**What challenges remain in this area?:** Most of HIV prevention among key populations has been being supported by the Global Fund. Although the NAC has approved the national ending AIDS plan with estimated budget, the domestic sources of funding including the NHSO and the Thai Health Promoting Fund are to be consulted. Since quite a big proportion of implementation to reach key populations is provided by NGOs and CSO, the effective and efficient procedures to support CSO by national budget has to be developed.

**4. Has the country identified specific needs for HIV prevention programmes?: Yes**

**IF YES, how were these specific needs determined?:** The specific needs for HIV prevention programmes were determined in the process of developing the NAS aiming at the goals of 3 zeros. The evidence has shown that the HIV epidemic in Thailand is concentrated in nature, and 89% of new infections projected in 2012-2016 are among key populations. Thus the specific needs are categorized for key populations and for general population.

**IF YES, what are these specific needs? :** Key populations: Outreach services are needed to reach target key populations. Apart from IEC, prevention commodities (i.e. condoms, lubricants, needles and syringes), demand creation for HIV early testing and counseling (HTC), STI and OST are emphasized. Meanwhile HTC, STI and OST have to be friendly and decentralized to increase availability for key populations. Enabling environment including reduction of stigma and discrimination is also needs for key populations. General populations: The eight service areas of focused attention defined in the NAS for 2012-2016 include (1) Prevention of mother to child HIV transmission; (2) Prevention among youth; (3) Comprehensive condom programming; (4) Blood safety; (5) Treatment and care for PLHIV; (6) Care and support for children affected by AIDS; (7) Reduction of stigma and discrimination; and (8) Public communication.

**4.1. To what extent has HIV prevention been implemented?**

**The majority of people in need have access to...:**

**Blood safety:** Strongly agree

**Condom promotion:** Strongly agree

**Economic support e.g. cash transfers:** Disagree

**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:** 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

**Reduction of gender based violence:** Disagree

**School-based HIV education for young people:** Strongly agree

**Treatment as prevention:** Strongly disagree

**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 2013?: 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: HTC, assessment before ART (e.g. CD4, Blood examination), ART, monitoring treatment effects (laboratory test for CD4, viral load, drug resistance), prevention and treatment of opportunistic infections, monitoring and support for adherence, and 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.

**Briefly identify how HIV treatment, care and support services are being scaled-up?:** HIV treatment, care and support services are scaled up by including HTC, ART in the benefit package under the Universal Coverage, Social Security Scheme and Civil Servant Medical Benefits. Meanwhile capacity building has been arranged for district hospitals which cover all district in the country, the financial support provided to the CSO including PLHIV networks enhance the adherence to treatment as well as psychosocial support to PLHIV on ART.

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

**The majority of people in need have access to...:**

**Antiretroviral therapy:** Strongly agree

**ART for TB patients:** Strongly agree

**Cotrimoxazole prophylaxis in people living with HIV:** Strongly agree

**Early infant diagnosis:** Strongly agree

**Economic support:** Disagree

**Family based care and support:** 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:** N/A

**Paediatric AIDS treatment:** Strongly agree

**Palliative care for children and adults Palliative care for children and adults:** 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:** Agree

**Sexually transmitted infection management:** Agree

**TB infection control in HIV treatment and care facilities:** Agree

**TB preventive therapy for people living with HIV:** Disagree

**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 include (1) care for children, (2) welfare for families of PLHIV, welfare subsidy for PLHIV, (3) infant formula, (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?:** Anti-retroviral drugs

**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 2013?:** 8

**Since 2011, what have been key achievements in this area?:** The NHSO has altered the criterion for initiating ART from a CD4 count of 250 to 350 cells/cu.mm. for insured members. The government has announced the policy to align the three funds which support the cost of ART (NHSO, Social Security, Government Civil Service) so that they all cover the same standard of treatment. There has been a review, improvement and consolidation of data into a single system, beginning on October 1, 2012. The MOPH has set up the provision of comprehensive health insurance for cross-border migrant workers and their dependents, so that both registered and non-registered workers are covered, including ART.

**What challenges remain in this area?:** Late entry to diagnosis and treatment of PLHIV is still the challenge. The stigmatization of PLHIV as well as inconvenient HTC services are barriers for access to early HTC. The coverage of HTC for key populations is still low. The MOPH-health insurance for cross-border migrants and their dependents is not well functioning yet.

**6. Does the country have a policy or strategy to address the needs of orphans and other vulnerable children?:**  
Yes

**6.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?:** Yes

**6.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?:** Yes

**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 2013?:** 7

**Since 2011, what have been key achievements in this area?:** The first 2 years of the Global Fund supported program (CHILDLIFE) has made much progress on developing Child Action Group in the community to assess the needs of vulnerable children including children affected by HIV and AIDS (CABA) and linked to the services.

**What challenges remain in this area?:** The lessons learned from the CHILDLIFE program reflect the needs to better link the health, social protection and community system. The programme monitoring needs to be developed at all levels.

## **A.VI Monitoring and evaluation**

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

**Briefly describe any challenges in development or implementation::** It took nearly a year to complete the one National M&E plan (Plan) for HIV because we put the emphasis on stakeholders' participation as well as stepwise development. The time consuming was for costing. The technical and financial support from development partners is key to the success of the development of the Plan. Due to its comprehensiveness, a number of high capacity human resources are needed to move the Plan. We also need to ensure the continuous funding for the Plan in order to track the changes; meanwhile the annual governmental budget system does not allow the certainty of the approval of the budget.

**1.1. IF YES, years covered:** 2012-2016

**1.2. IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?:** Yes, all partners

**Briefly describe what the issues are::** The Global Fund supported programs also use the indicators and national targets for the performance to be monitored.

## **2. Does the national Monitoring and Evaluation plan include?**

**A data collection strategy:** Yes

**IF YES, does it address::**

**Behavioural surveys:** Yes

**Evaluation / research studies:** Yes

**HIV Drug resistance surveillance:** Yes

**HIV surveillance:** Yes

**Routine programme monitoring:** Yes

**A data analysis strategy:** Yes

**A data dissemination and use strategy:** Yes

**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?:** 5.3

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

**Briefly describe any obstacles::** Capacity of the M&E unit in terms of number of personnel and technical skills and management, and coordination with other related units

### **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?:** No

**If elsewhere, please specify:**

**4.2. How many and what type of professional staff are working in the national M&E Unit?**

POSITION [write in position titles]	Fulltime or Part-time?	Since when?
Director, MD, MPH	Full-time	2009
Plan and Policy Analyst, Senior professional level	Full-time	2009
Public Health Technical officer, Professional level	Full-time	2009
Public Health Technical officer, Professional level	Full-time	2009
Plan and Policy Analyst, Practitioner level	Full-time	2009
Plan and Policy Analyst, Practitioner level	Full-time	2013
Computer Technical Officer	Full-time	2011
Administrative	Full-time	2009
Administrative	Full-time	2009
Financial staff		2009
Financial staff	Full-time	2009
Public Health Technical Officer, Professional level	Full-time	2008
Public Health Technical Officer, Professional level	Full-time	2008
Public Health Technical Officer, Professional level		2009
Public Health Technical Officer, Professional level	Full-time	2011
Public Health Technical Officer, Senior Professional level	Full-time	2011
Public Health Technical Officer, Professional level	Full-time	2011
Public Health Technical Officer, Practitioner level	Full-time	2011
Public Health Technical Officer, Practitioner level	Full-time	2011

POSITION [write in position titles]	Fulltime or Part-time?	Since when?
Project coordinators	Full-time	2011
Project coordinators	Full-time	2013
Project coordinators	Full-time	2013
Project coordinators	Full-time	2013
Project coordinators	Full-time	2013
Database coordinator	Full-time	2011
Financial staff		2012
Administrative	Full-time	2009
Project coordinators	Full-time	2011
Project coordinators	Full-time	2011
Computer Technical Officer	Full-time	2011
Database coordinator	Full-time	2011

**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::** 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. The PMTCT data from PHIM database is shared as the annual report. The report forms from the NAP database, of which individually HTC and ART services are electronically recorded by hospitals, was developed for the hospitals, provincial health offices to see the processed data. During these 2 years, the web-based data sharing for use tools, called the "AIDS ZERO PORTAL," has been being developed. The AIDS Zero Portal is a platform that facilitates easy and real time access to: 1) Priority key and strategic information; 2) Key program gaps for improvement; and 3) Geographical prioritization that will accelerate progress towards the HLM and national targets. The data will be automatically transferred from existing databases to the AIDS ZERO PORTAL.

**What are the major challenges in this area::** The epidemiological reports were published and distributed quite late. The use of data from NAP database as processed in the report forms are limited.

**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. The AIDS ZERO PORTAL is being developed for this purpose.

**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. HTC 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)?:**

**7.1. 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

**7.2. Is HIV programme coverage being monitored?:** Yes

**(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?:** MSM, MSW, FSW, PWID, migrants, HIV infected mothers, adult and children on ART, TB-HIV patients

**Briefly explain how this information is used:** This information is used in the process of writing national GARP report. The working groups for each programme use these data together with other relating data identify gaps and recommended the actions to be taken.

**(c) Is coverage monitored by geographical area?:** Yes

**IF YES, at which geographical levels (provincial, district, other)?:** Provincial and hospital levels

**Briefly explain how this information is used:** Coverage data being monitored at provincial and hospital level is PMTCT data. The province and hospitals can use their own data from PHIM database. The AIDS ZERO PORTAL is being developed to share these data by provinces and hospitals.

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

## **9. 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]::**

: No

**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 key populations, and for specifying the target groups and aligning implementation.

## **10. In the last year, was training in M&E conducted**

**At national level?:** Yes

**IF YES, what was the number trained?:** 439

**At subnational level?:** Yes

**IF YES, what was the number trained:** 6419

**At service delivery level including civil society?:** Yes

**IF YES, how many?:** 5,394 (1,605 from CSO; 3,729 from government organizations)

**10.1. Were other M&E capacity-building activities conducted other than training?:** Yes

**IF YES, describe what types of activities:** On the job training for program monitoring at the national level by reviewing the submitted report from the implementation areas and use data to plan site visits.

**11. 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 2013?:** 9

**Since 2011, what have been key achievements in this area:** The first costed national strategic information (SI) and M&E plan for the period of 2012-2016 was endorsed by the NAC. The innovation of data use tools, called the "AIDS ZERO PORTAL," was developed. This tool targets policy makers and program managers which go beyond traditional approaches on systems strengthening on strategic information and M&E. The AIDS Zero Portal is a platform that facilitates easy and real time access to: 1) Priority key and strategic information; 2) Key program gaps for improvement; and 3) Geographical prioritization that will accelerate progress towards the HLM and national targets. The automatic transfer of data from existing database The innovation of setting up the system to monitor stigma and discrimination in health service system, toward key populations as well as among general population toward HIV was designed and being implemented in the year 2012. The national evaluation mechanism has been established. Seven studies were completed and findings were used as the input to develop the NAS for the period 2012-2016 and for improving the programs. Another one study has been started in late 2012 and expected to be complete in 2013.

**What challenges remain in this area:** [1] Budget for the costed national SI and M&E plan has to be ensured. More staff with higher capacity on M&E is needed to coordinate the implementation of the national SI and M&E plan. [2] The innovation of establishing national evaluation mechanism as well as the national agenda for evaluation (developed in June 2010) has to be reviewed for further improvement. The preparation for evaluation of the national AIDS responses toward ending AIDS needs technical assistance from experts.

## **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:** Overall, Civil Society is an important influence in the AIDS policy and strategy formulation. Civil Society has advocated for many aspects of the NAP plan for 2012-16 such as equal access to standard HIV treatment and care for all Thais. In 2013, the MOPH launched a program to provide health insurance to cross-border migrants not covered by social security, which includes ART. In its capacity as a member of the NAC, Civil Society has advocated for the policy to end the threat of AIDS and earliest access to ART for the infected (i.e., regardless of CD4 level). Civil Society has also promoted campaigns to encourage society to view HIV/AIDS as a manageable, chronic condition as a way to reduce stigma and encourage all those at risk to seek VCT. During the opening ceremony of the 11th ICAAP international AIDS meeting in

Bangkok, representatives of Civil Society presented issues related to program implementation for PWID to the Minister of Health.

**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)?:** 4

**Comments and examples:** Civil Society has participated in the preparation of the national AIDS strategy for 2012-16 from the stage of defining the objectives, developing the strategic and budget framework, and advocating for human rights, sex rights, and combatting stigma and discrimination. Civil Society participated in the drafting of components of the AIDS strategy budget, and provided inputs to government agencies. However, Civil Society is not aware whether their inputs were accepted or rejected.

**3. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:**

**a. The national HIV strategy?:** 4

**b. The national HIV budget?:** 2

**c. The national HIV reports?:** 4

**Comments and examples:** The national AIDS strategy for 2012-16 calls for the expansion of prevention interventions to more fully cover the key affected populations (KAP), and Civil Society is an important sector in accessing these KAP and in supporting the role of the community in promoting adherence to the ART regimen. During 2012-13, the budget for Civil Society implementation contains 50 million baht from the Bureau of AIDS TB and STIs, Department of Disease Control and the National Health Security Office (NHSO) for support for the holistic centers which work with the Thailand Network of Positive People (TNP+). Most of the direct budget for Civil Society has come from the Global Fund. The 2013 country progress report referenced the conditions by which Thailand could achieve an end to the AIDS threat, and includes mention of the important role which Civil Society can play to improve access to/for the KAP, and increase demand for VCT, and care for PLHIV to ensure that adhere to the ART regimen.

**4. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) is civil society included in the monitoring and evaluation (M&E) of the HIV response?**

**a. Developing the national M&E plan?:** 3

**b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?:** 3

**c. Participate in using data for decision-making?:** 3

**Comments and examples:** Civil Society is heavily involved in planning and development of strategic information and monitoring implementation for the 2012-16 NAP. Civil Society is represented on the M&E Task Force and participates in the review and selection of indicators. In 2013, Civil Society participated in the development of a system for disseminating data for decision-making by policy makers and managers (“AIDS ZERO PORTAL”). In the past, Civil Society has used M&E data from the Bureau of Epidemiology, IBBS, BSS, evaluation data from the domestic implementing partners and external evaluations of the Global Fund, to inform improvements to its interventions. In 2013, Civil Society participated in the development of a survey tool on stigma and discrimination in health service outlets (on-going).

**5. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) is civil society representation in HIV efforts inclusive of diverse organizations (e.g. organisations and networks of people living with HIV, of sex workers, community based organisations , and faith-based organizations)?:** 3

**Comments and examples:** Over the past two years, Civil Society agencies involved in national AIDS policy and programs include a wide array of national and regional organizations. However, there has been less involvement of community-based Civil Society groups (e.g., those working with cross-border migrants and those working on human rights and sex rights). There

is also limited representation from peer leaders of the KAP groups in some locations, and from foreign migrant workers due to the language barrier and restriction of travel of migrants. It has been observed that some of the peer leaders from various communities do not always represent the views of the communities they are supposed to represent.

**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:** Overall, Civil Society received adequate financing for prevention interventions, though most came from the Global Fund. Government and Civil Society have been conferring on setting up a prevention fund, and the NAC has set up a sub-committee for prevention to identify sources of domestic funding for this initiative. Government funding for Civil Society comes through BATS and the State Enterprise Policy Office, but this funding is limited and is allocated on a year-to-year basis. In addition, funding is restricted to those agencies with a track record of performance and quality budget management, and this limits eligibility of the smaller, community-based organizations without a reputation. The NHSO is the principle agency which supports Civil Society in the area of care and treatment, through support for the TNP+ to provide services through the holistic centers. Representatives of Civil Society participate on the Treatment Sub-committee for PLHIV of the NHSO, and play a role in budget allocation decisions. In the past two years, Civil Society has compared and shared its knowledge and experience among agencies at international meetings, and shared research findings.

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

**Prevention for key-populations:**

**People living with HIV:** 51-75%

**Men who have sex with men:** 51-75%

**People who inject drugs:** 51-75%

**Sex workers:** 51-75%

**Transgender people:** 51-75%

**Palliative care :** <25%

**Testing and Counselling:** >75%

**Know your Rights/ Legal services:** 51-75%

**Reduction of Stigma and Discrimination:** 51-75%

**Clinical services (ART/OI):** <25%

**Home-based care:** >75%

**Programmes for OVC:** >75%

**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 2013?:** 6

**Since 2011, what have been key achievements in this area:** In 2013, Civil Society sent representatives to participate in tri-sector task forces with government and private sector groups to assess adverse impacts of drug prices, develop talking points on free trade agreement negotiations, and advocate for compulsory licensing of Lopinavir and Ritonavir ARVs to reduce cost and improve access. Civil Society has advocated for migrant health and, in 2013, the MOPH launched a health insurance program for registered and unregistered foreign migrants, which includes access to ART. At the field level, Civil Society helped members of the holistic centers to serve on the Tambon health fund board. Civil Society advocated for the implementation of harm reduction for PWID in 19 pilot program provinces. Accordingly, the National Command Center for Combating Drugs Elimination (NCCCDE) has announced clear policy and guidelines, and is collaborating with the NHSO to develop a standard quality system for MMT that can be extended for maximum coverage and access for those in need. Civil Society has submitted an appeal to the Social Insurance Fund Division to include MMT as a benefit. The Division is currently reviewing the financial feasibility of including MMT.

**What challenges remain in this area:** The government has the policy to enter into free trade agreements, and there are attempts to change Article 190 of the Constitution which guarantees public participation as part of oversight of the process of decision-making before signing agreements/accords, and convening public hearings prior to final decisions. Countries of the EU and the US have appealed for increased patent protection and this could affect population access to essential drugs. There is a need for more involvement of local NGOs which work with migrants and those working on gender issues. There is a need to build capacity of Civil Society organizations, peer leaders, and communities so that they can assert their opinions and be more active in decision-making on the national AIDS response at all levels. In the past, much of the funding for Civil Society has been from the Global Fund, and it is not yet known how well this will be substituted for from domestic sources. The distribution of clean needles and syringes to PWID is still problematic and not fully accepted because the interpretation of the Council of State is that needle exchange contravenes anti-narcotics laws, and is a form of promoting drug addiction. There is a need for more advocacy to review this standpoint. There is a need for on-going and adequate financial support for Civil Society as part of the AIDS response team to increase access to and use of health services.

## **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:** During 2012-13, Civil Society did not observe that much support from political powers and national leaders, in part because the Prime Minister delegated the chair the NAC to three deputy PMs. Political leaders rarely mentioned HIV/AIDS. Representatives of the KAP and Civil Society agencies did serve as members of the NAC and its various sub-committees, and the Treatment Sub-committee of the NHSO, and the Collaborative Budget Mechanism Committee, which was supported by the Global Fund, with linkages to the PCM at the provincial level.

## **B.III Human rights**

**1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations? Circle yes if the policy specifies any of the following key populations:**

**KEY POPULATIONS and VULNERABLE SUBPOPULATIONS:**

**People living with HIV:** No

**Men who have sex with men:** No

**Migrants/mobile populations:** Yes

**Orphans and other vulnerable children:** Yes

**People with disabilities:** Yes

**People who inject drugs:** No

**Prison inmates:** No

**Sex workers:** No

**Transgender people:** No

**Women and girls:** Yes

**Young women/young men:** Yes

**Other specific vulnerable subpopulations [write in]:**

: No

**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:** The Thai constitution (2007), Article 4 states: "Human dignity, rights, freedom and equality shall be protected," and Article 30 states that "All persons are equal under the law and are equally protected by the law; men and women have equal rights and discrimination based on place of birth, ethnicity, language, gender, age, and disability or physical or health condition is wrong. There shall be no discrimination based on individual status, socio-economic status, religion, education, or political beliefs." In addition, the intention of the constitution implies protection of sexually-diverse persons. Some of the vulnerable populations in the above table (e.g., disabled) have legal protections for work. Women and girls are protected under CEDAW provisions, and youth (under age 18 years) are protected by the CRC convention. Orphans and other vulnerable children are protected by the child protection law (2003), and the elderly are protected from age discrimination by law.

**Briefly explain what mechanisms are in place to ensure that these laws are implemented::** - National Human Rights Commission - National Ombudsman - Department for the Protection of Rights and Freedoms, Ministry of Justice - Office of the Attorney General - Police - Ministry of Social Development and Human Security - Ministry of Public Health - NHSO and provincial health offices

**Briefly comment on the degree to which they are currently implemented:** The personnel who implement the mechanisms to support and protect human rights still lack adequate knowledge about HIV/AIDS. Implementation depends on the due diligence of the relevant authorities, and the confidence and ability of victims to file grievances. Some victims are reluctant to come forward out of concern of confidentiality. The process of implementation involves too many steps and is time-consuming.

**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?**

**KEY POPULATIONS and VULNERABLE SUBPOPULATIONS:**

**People living with HIV:** Yes

**Men who have sex with men:** Yes

**Migrants/mobile populations:** Yes

**Orphans and other vulnerable children:** Yes

**People with disabilities:** Yes

**People who inject drugs:** Yes

**Prison inmates:** Yes

**Sex workers:** Yes

**Transgender people:** Yes

**Women and girls:** Yes

**Young women/young men:** Yes

**Other specific vulnerable populations [write in]:**

: No

**Briefly describe the content of these laws, regulations or policies::** PLHIV: Some government agencies have procedures screening for HIV as pre-employment. PLHIV are not allowed membership in the village cremation fund. Some hospitals will not provide kidney dialysis for PLHIV. Women: There are restrictions to legal abortion as per Thai Medical Council guidelines and Article 305 of Criminal Code (2005). MW and mobile populations: The 2008 Alien Labor Law specifies only certain occupations which migrants can engage in, and those who covered under the MOU are compelled to enroll in the social security scheme which does not include coverage for health promotion. PWID: The 1979 drug abuse law states that illegal drug use is a crime; the 2002 Drug Addict Rehabilitation Law coerces drug addicts to enter rehabilitation facilities. In-mates do not have access to condom supply or MMT while imprisoned. The government policy 2012 enrolling 400,000 drug addicts in rehabilitation programs each year, violated basic rights of drug users. Sex workers: The 1996 Prostitution Law (Articles 5, 6, and 7) specifying prostitution is illegal. The 2004 Law on Entertainment Establishments includes no protections for sex workers. Male and female youth: The Thai Medical Council guidelines stipulate that persons under age 18 years who seek HIV VCT require parental consent.

**Briefly comment on how they pose barriers::** • The restrictions against PLHIV by the cremation fund committees leads persons with risk for HIV to avoid HIV testing; • MW who are allowed to work under the MOU can access social security but there is no benefit for HIV prevention in this group; • Because PWID are viewed as criminals, it is harder for outreach programs to deliver services, and peer educators cannot operate on a regular basis; • Not specifying who are sex workers in an entertainment establishment means that persons working in these establishments are not protected by labor law; • Requiring parental consent for VCT for persons under 18 years inhibits youth with HIV risk factors from seeking VCT.

**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 2007 law for Protection of Victims of Domestic Abuse should be having an impact on protecting household members from violence, especially women. Criminal law protects victims of violence outside the family, Article 276 protects wives from spousal abuse, and Article 277 protects victims of child (under age 15 years) abuse. The NHSO allows provision of post-exposure prophylaxis with ART for persons whose sexual rights have been violated.

**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 2012-16 national AIDS strategy specifies a clear vision and goal to eliminate HIV/AIDS stigma and discrimination by: (1) Accelerating comprehensive prevention with a standard package including protection of human rights and sensitivity to gender and sexuality, and covering persons with risk behavior and who are most likely to contract HIV; and (2) Accelerating the provision of social protections and promoting a favorable legal environment for prevention, care and treatment, with documentation of the reduction of stigma and discrimination as a key element of the NAP plan. The NAC has appointed a sub-committee for promotion and protection of AIDS rights as a mechanism to advocate this strategy.

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

**IF YES, briefly describe this mechanism::**

**6. Does the country have a policy or strategy of free services for the following? Indicate if these services are provided free-of-charge to all people, to some people or not at all (circle "yes" or "no" as applicable).**

**Antiretroviral treatment:**

**Provided free-of-charge to all people in the country:** No

**Provided free-of-charge to some people in the country:** Yes

**Provided, but only at a cost:** Yes

**HIV prevention services:**

**Provided free-of-charge to all people in the country:** No

**Provided free-of-charge to some people in the country:** Yes

**Provided, but only at a cost:** No

**HIV-related care and support interventions:**

**Provided free-of-charge to all people in the country:** No

**Provided free-of-charge to some people in the country:** Yes

**Provided, but only at a cost:** No

**If applicable, which populations have been identified as priority, and for which services?:** • ART: Free for all Thai citizens. Foreign MW who are enrolled in social security or the MOPH health insurance system can access ART. • Prevention: Condoms are free for KAP such as sex workers, MSM, and PLHIV. • HIV/AIDS care: Welfare stipend is only for Thai nationals and for a limited number.

**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::** Strategy 1: Accelerating comprehensive prevention with a standard package including protection of human rights and sensitivity to gender and sexuality, and covering persons with risk behavior and those most likely to contract HIV. It is projected that there will be 43,040 new HIV infections, 62% of which are among MSM, sex workers, their clients, and PWID, and 32% among discordant couples.

**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:** There is involvement of KAPs in providing peer-to-peer services that are consistent with the lifestyle of the intended beneficiary. This includes, for example, opening after-hours or evening clinics for sex workers. There are translators to facilitate communication between cross-border migrants and Thai hospital staff.

**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 are national guidelines for AIDS management in the workplace endorsed by the NAC in 2009. These guidelines are for government and private sector worksites, and for the development of AIDS in the workplace plans and programs with protection of rights, for prevention, care and treatment of HIV. The guidelines specify that HIV status cannot be the basis for termination of a worker. However, there is no legal provision to enforce these guidelines. There are merely for motivational purposes.

**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:** The Institute for the Promotion and Protection of Human Rights is an independent entity under the Constitution and comprises the following: - National Human Rights Commission - Legal Reform Committee - National Ombudsman The Thai Human Rights Commission is an independent organization comprising the Human Rights Committee, the Legal Reform Committee, watchdogs, and the National Ombudsman. However there is no specific reference to HIV/AIDS in their mandate. The national AIDS strategy has indicators of achievement in the area of human rights standards in the context of AIDS work as follows: • The number of laws, policies and regulations that are improved; • The percent of service providers who are cognizant of stigma and discrimination issues as they relate to the KAP, and the impact of that. • The number of provinces with mechanisms to protect the rights of the KAPs.

**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<sup>46</sup> 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:** Yes

**Programmes for the media:** Yes

**Programmes in the work place:** No

**Other [write in]:**

: No

**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 2013?:** 5

**Since 2011, what have been key achievements in this area:** The Rights Promotion and Protection Sub-committee of the NAC, has been active in preparing policy recommendations for the NAC on the topic of compulsory HIV screening, harm reduction of drug use, and persuading employers to remove HIV testing before hiring and annual health exams for its employees (as a basis for employment) and denying or terminating employment if found to be infected.

**What challenges remain in this area:** There need to be genuine measures and action to reduce these disincentives and eliminate discrimination based on HIV infection in the schools and workplace. There is a need to change laws which criminalize drug addicts, and shift the view toward drug addicts as persons with an illness, not criminals. There is a need for more improvement in policy, laws and regulations that are obstacles to implementation of prevention, care and treatment of HIV, especially those related to drug use and harm reduction. There is a need for better understanding of human rights in the population, among the work force and the society at-large.

**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 2013?:** 3

**Since 2011, what have been key achievements in this area:** Civil Society has conducted training on rights with the vulnerable populations such as MW, HIV children and other vulnerable children, sex workers, PWID, PLHIV, and sexually diverse groups, so that they understand what their rights are. The Foundation for AIDS Rights is working with Office of Education of the National Police Headquarters, with support from UNDP, to develop a police training curriculum on AIDS rights. The Foundation for AIDS Rights has collaborated with TNP+ to develop mechanisms to support and protect AIDS rights in 7 pilot program provinces. The TNP+ network and AIDS ACCESS Foundation have produced 29 short films, and have conducted awareness-raising campaigns at the community level and through mass media to promote harmonious living with PLHIV and respecting the rights of PLHIV.

**What challenges remain in this area:** Even if there was a national system for documenting cases of stigma and discrimination or mechanisms for monitoring and enforcing human rights protections, it is not clear how well these cases of rights violations would be pursued for PLHIV, and whether that entail public exposure of one’s serostatus or repercussions from the source of the discrimination if filing a complaint. For example, a sex worker might fear being fired if s/he files a complaint.

## **B.IV Prevention**

**1. Has the country identified the specific needs for HIV prevention programmes?:** Yes

**IF YES, how were these specific needs determined?:** Thailand has defined the KAP based on epidemiological principles of HIV risk, in order to guide the intensification of interventions and efficient use of limited resources.

**IF YES, what are these specific needs? :** Each of the KAP need access to information and understanding about HIV transmission, condom use, diagnosis and treatment of STIs, VCT, and (for PWID) information about harm reduction, use of clean injection equipment and methadone maintenance therapy.

**1.1 To what extent has HIV prevention been implemented?**

**The majority of people in need have access to...:**

**Blood safety:** Strongly agree

**Condom promotion:** Agree

**Harm reduction for people who inject drugs:** Disagree

**HIV prevention for out-of-school young people:** Agree

**HIV prevention in the workplace:** Disagree

**HIV testing and counseling:** Strongly agree

**IEC on risk reduction:** Agree

**IEC on stigma and discrimination reduction:** Disagree

**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:** Strongly agree

**Risk reduction for intimate partners of key populations:** Strongly disagree

**Risk reduction for men who have sex with men:** Strongly agree

**Risk reduction for sex workers:** Strongly agree

**School-based HIV education for young people:** Agree

**Universal precautions in health care settings:** Strongly agree

**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 2013?:** 4

**Since 2011, what have been key achievements in this area::** The Global Fund support has helped Thailand create and maintain a network of allies for Civil Society, and the NAC has appointed a sub-committee on prevention which has begun to identify alternative sources of funding for prevention.

**What challenges remain in this area::** Civil Society does not agree with the definition of "KAP" since Civil Society believes that everyone should access information about HIV/AIDS on an equal basis: "HIV is everyone's issue." The groups which are receiving too little attention are the general population males, housewives, and married couples. Focusing on KAP will make it even more difficult to achieve the "Getting to Zero" goals, and will increase the stigma and discrimination of these groups in the eyes of society, as people of high risk. Thus, it is recommended that Thailand discontinue use of "risk populations and focus on risk behavior instead." The policy to set targets for the number of PWID who enter rehabilitation makes it harder to implement harm reduction to prevent HIV among PWID. The programs working with MW have recruited and trained migrant health workers to improve coverage. However, there is still no authorization to use government budget to support the salaries and compensation for the (non-Thai) migrant health workers. During 2012-13, and well before that, there has been an absence of large public campaigns. These campaigns should be conducted on a regular basis and include more content on stigma and discrimination. The M&E which is conducted with funding from the Global Fund focuses more on management than on individual capacity building.

## **B.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 service package includes HIV VCT twice a year, standard CD4 and viral load tests for those on ART, diagnosis of drug resistance, alternate regimens in case of resistance, home visits and follow-up to assess psycho-social status of PLHIV.

**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?**

**The majority of people in need have access to...:**

**Antiretroviral therapy:** Agree

**ART for TB patients:** Agree

**Cotrimoxazole prophylaxis in people living with HIV:** 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:** Agree

**HIV treatment services in the workplace or treatment referral systems through the workplace:** Disagree

**Nutritional care:** Strongly agree

**Paediatric AIDS treatment:** Strongly agree

**Post-delivery ART provision to women:** Strongly 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:** Strongly agree

**Sexually transmitted infection management:** Disagree

**TB infection control in HIV treatment and care facilities:** Disagree

**TB preventive therapy for people living with HIV:** Disagree

**TB screening for people living with HIV:** Strongly 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 2013?: 8**

**Since 2011, what have been key achievements in this area:** During 2012-13, Lopinavir and Atazanavir were used more as a new alternative therapy for those with drug resistance, such as Darunavir. During 2012-13, there was support for use of rapid tests, same-day results testing, and self-tests for confidentiality for persons in establishments catering to MSM and female sex workers. In June, 2013, Efavirenz went off-patent, and this allowed the Thai Pharmaceutical Organization to produce this group of ARV drugs locally, reducing cost. In August, 2013, the MOPH announced the policy to offer health insurance to MW, inclusive of ART, and available for MW regardless of registration status. Nevertheless, this initiative is experiencing some difficulty in implementation. There has been more outreach to improve coverage of HIV VCT in the community, and to increase early detection of infection and rapid initiation of ART. The criteria for initiating ART has been raised to a CD4 count of  $\leq 350$  cells. The program is considering broadening this threshold to a level of  $\leq 500$  cells, or any CD4 count.

**What challenges remain in this area:** Coverage of ART still is not reaching all eligible in the country. Those who are not fully covered include MW, prisoners, persons without the 13-digit national ID card, among others. Health insurance needs to be genuinely available for MW, inclusive of ART. There is a need for more rapid initiation of ART and increased options for those with drug resistance since the number of cases is likely to increase over time. There are side effects of treatment such as acute kidney failure, lipodystrophy, diabetes, and blood pressure issues. There is a need for greater attention to these side effects. The policy to promote rapid tests and same-day-results tests is a sensitive issue, and providers need to be careful about preventing community stigma as a result of these.

**2. Does the country have a policy or strategy to address the needs of orphans and other vulnerable children?:**  
Yes

**2.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?:** Yes

**2.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?:** Yes

**3. 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 2013?: 5**

**Since 2011, what have been key achievements in this area:** During 2012-13, Child Action Groups were formed in many communities to assist HIV+ and other vulnerable children to access services. The Ministry of Social Development and Human Security is now feeling the need to set up a database of children to monitor the status of children. Currently, the ministry is working with the NHSO on setting up such a database.

**What challenges remain in this area:** Problems affecting children can be complex and require sensitive approaches. The number of affected children is increasing as well. There is no CAG handbook or guidelines for how to implement activities. The work relies on soft skills, and some of the tasks of the CAG may be beyond its capacity to implement. There is a need for more efficient collaboration between related organizations, for example, to improve referral between the hospital and the local office of the Ministry of Social Development and Human Security, and greater efficiency of the Provincial Child Protection Committees. There is a need for more planning for sustainability of the CAG as institutionalized components of the Ministry of Social Development and Human Security. Success will only come when the members of the community, the government and partner agencies recognize the importance of working with the vulnerable populations most in need.