National Monitoring and Evaluation Plan for Ending HIV/AIDS 2021 – 2025

Department of Disease Control

TITLE

Thailand National Monitoring and Evaluation Plan

for Ending HIV/AIDS 2021 – 2025

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Preface

This National Monitoring and Evaluation Plan for 2021-25 is the result of collaboration from various sectors at all levels, which produced valuable opinions and raised important issues from representatives of government agencies, civil society organizations, as well as a wide range of international organizations through the approval of the National Subcommittee for Strategic Information Development and Monitoring and Evaluation.

This monitoring and evaluation (M&E) plan was developed from a review of the objectives and implementation of the National Strategic Plan on Ending AIDS 2017-30, and is a continuation of the Thai M&E plan for 2012-16.

The current national plan has set the target to limit the number of new cases of HIV to less than 1,000 per year, limit AIDS deaths to less than 4,000 per year, and reduce stigma and discrimination by 90 percent by 2030. These are very challenging targets to monitor and achieve. Strategic information from the M&E activity as detailed in this M&E Plan will help track progress and inform decisions to improve the cost-effectiveness of implementation.

The current National Strategy on Ending AIDS now has a period of less than ten years to achieve its goal. Thus, the interim period of 2021-25 is an important timeframe during which performance needs to be accelerated. This M&E plan has been amended to include the framework of key indicators and targets for intensive follow-up and generate key, strategic information in a timely manner.

The successful preparation of this edition of the M&E Plan would not have been possible without the collaborative spirit of the participating individuals and organizations. Therefore, I would like to thank all those who contributed to the process of preparing this M&E plan and, in particular, the United Nations AIDS Program (UNAIDS), the Thai-US Collaboration (TUC) for technical support, and the Principal Recipient, Department of Disease Control (PR-DDC) which provides budget support for document translation and printing.

It is hoped that this Monitoring and Evaluation Plan will be used as a reference and framework for Thailand's ongoing work towards ending the AIDS challenge.

Dr. Opart Kornkowinpong
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List of content

List of tables

List of figures

Abbreviations

AEM	Asian Epidemic Model
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal clinic
ART	Anti-retroviral Therapy
ARV	Anti-retroviral
BBS	Biobehavioral Survey
BSS	Behavioral Surveillance Survey
CBO	Community-based organization
CRS	Crisis Response System
CSO	Civil Society Organization
DAS	Division of AIDS and STIs
DDC	Department of Disease Control
DOC	Department of Corrections
DOE	Division of Epidemiology
DOH	Department of Health
DOMS	Department of Medical Sciences
DTB	Division of Tuberculosis
EIIS	Epidemic Intelligence Information System
FAR	Foundation for AIDS Rights
FSW	Female sex workers
GFATM	Global Fund to fight AIDS, TB and Malaria
GAM	Global AIDS Monitoring
HAD	Health Administration Division
HCV	The hepatitis C virus
HIV	Human Immunodeficiency Virus
HSS	HIV Sentinel Surveillance
IHRI	Institute of HIV Research and Innovation
KPLHIV	Key Population Living with HIV
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Surveys

MMT	Methadone Maintenance Therapy
MOE	Ministry of Education
MOI	Ministry of Interior
MOL	Ministry of Labor
MOPH	Ministry of Public Health
MSDHS	Ministry of Social Development and Human Security
MSM	Men who have sex with men
MSW	Male sex workers
MTCT	Mother-to-Child-Transmission
MW	Migrant worker
NA	Not available
NAC	National AIDS Committee
NAP	National AIDS Program System
NASA	National AIDS Spending Assessment
NCMC	Narcotics Control Management Center
NCPI	National Commitments and Policy Instruments
NHES	National Health Examination Survey Office
NHSO	National Health Security Office
NRCT	National Research Council of Thailand
NSO	National Statistical Office of Thailand
NTIP	National Tuberculosis Information Program
ODPC	Office of Disease Prevention and Control
PCM	Provincial Coordinating Mechanism
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHIMS	Perinatal HIV Intervention Monitoring Surveillance System
PHO	Provincial Health Office
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PrEP	Pre-Exposure Prophylaxis
PWID	People who Inject Drugs
RTCM	Real Time Cohort Monitoring System
RTF	Raks Thai Foundation

S&D	Stigma and discrimination
SI	Strategic information
STI	Sexually transmitted infections
SW	Sex Workers
TB	Tuberculosis
TBD	To be determined
TGW	Transgender Women
TNP+	Thai Network of People Living with HIV/AIDS
TPT	TB preventive therapy
UNAIDS	The Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

Introduction

This National Monitoring & Evaluation Plan provides the M&E framework for all HIV programs to measure progress on the national HIV response towards the national ending AIDS targets during 2021-2025.

The purpose of the plan is to increase the availability and accessibility of high-quality essential data to guide program planning and investment for an effective HIV/AIDS response. A major part of the plan is to measure progress towards achieving national goals and objectives in an effective, efficient and timely manner.

The plan is laid out in 6 topics. After this introductory note, the National Ending AIDS Strategy is briefly summarized. Then the M&E framework is presented as core indicators with targets at the impact, outcome and output/coverage levels. Sources of data and responsible organizations are also laid out in this section. To be more focused, the monitoring for accelerated strategic approaches towards the 2025 Global AIDS Targets is described for more frequently monitored in topic 3. Due to the COVID-19 pandemics, topic 4 will describe what to be frequently monitored for its impact to HIV services and programs to ensure that the adaptation of services will be in time. Topic 5 will describe organizational structure of M&E at national, regional and provincial levels. The M&E activities plan in 2021-2025 including monitoring the HIV epidemics, HIV responses, evaluation, strengthening the monitoring system and products of strategic information will be presented in topic 6.

There are 3 annexes including indicator definitions, operational definition of key populations and vulnerable populations and the 2025 Global AIDS Strategy, announced in the UNAIDS' document: PREVAILING AGAINST PANDEMICS BY PUTTING PEOPLE AT THE CENTRE.

It is expected that this national M&E plan will provide a comprehensive reference for HIV/AIDS stakeholders for the next 5 years, clarifying goals and providing a foundation for the effective use of empirical data for decision making.

1. Thailand National Strategy to End AIDS, 2017-2030

The 2017–2030 National Strategic Plan to End AIDS Epidemic was launched on 13th September, 2017 by the National AIDS Committee. The 13-year national strategic plan provides a road map for ending the AIDS epidemic as a public health threat in Thailand by 2030. The plan adapts the latest global commitments to Thailand, ensuring an effective, cost-efficient and high-impact HIV response.

The strategy's goal is to further reduce new HIV infections from 6,500 to less than 1,000, cut AIDS-related deaths from almost 13,000 to under 4,000 and reduced HIV-related discrimination in health-care settings by 90% by 2030.

Three key principles for implementation of the Strategy include:

- promoting fairness, reduce inequality, and address all sectors of the population;
- respect, prevent and protect human rights and gender equality; and
- promote ownership and accountability of networks and related partners of government agencies, civil societies and private sectors.

The 13-year National Strategic Plan to End AIDS Epidemic lays out six strategies for its implementation as to ensure the achievement of the goal to end AIDS by the year 2030, as follows:

Strategy 1: Focus and expedite effective and inclusive package of services to locations and populations with high HIV transmission.

Strategy 2: Strengthen and integrate currently effective prevention efforts into existing system ensuring quality and sustainability.

Strategy 3: Develop and enhance differentiated treatment, care and social support, ensuring quality, comprehensiveness and sustainability.

Strategy 4: Adjust HIV perceptions and build capacity of individuals, families and communities along with strengthening a rights protection mechanism.

Strategy 5: Enhance joint accountability, investment and efficiency of administrative efforts in all sectors at the international, national, provincial and local levels.

Strategy 6: Support and improve accessibility and utilization of strategic information and research that are inclusive and efficient.

The plan and its strategy and measures will be reviewed every five years, i.e., 2023 and 2028. It will translate and transform the strategy into a common action plan for the concerning organizations. The national monitoring and evaluation plan is to be in line with this national strategic plan.

2. National M&E Framework

The National M&E framework is designed to closely parallel the organizing principle and strategies of the 13-year National Strategic Plan to End AIDS Epidemic, which provides a road map for ending the AIDS epidemic as a public health threat in Thailand by 2030.

The current national strategy commits to a fast-track phase, where an all-out effort is made to reach the global "90-90-90" treatment targets by 2020. The global AIDS targets by 2025 have just been announced to reach "95-95-95" by 2025. This national M&E framework is planned to cover the period of 2021-2025 and modified to be aligned with the 2025 Global AIDS Targets, of which the summary is described in the annex 1.

To align with the 2025 global AIDS targets, outcome indicators are selected for 4 key components including HIV services, integration, societal enablers and resources, with 8 result areas to be monitored. (See Table 1)

Table 1: Result areas in each key components of the outcomes toward the vision of the strategy

Components	Result areas
A.HIV services	1. PLHIV, especially key populations and other vulnerable populations, know their status and are immediately offered and sustained on quality and affordable HIV treatment and care
	2. Young people access sustained combination HIV prevention
	3. Tailored and scaled HIV combination prevention and related HIV and health services accessible to and utilized by key populations
B. Integration	4. Eliminate vertical transmission of HIV, syphilis and hepatitis
	5. Equitable, people-centered sustainable and context-specific integrated HIV and health services support the achievement of AIDS targets within the strengthened, resilient systems for health
C. Societal enablers	6. PLHIV, key populations and other people who are at high risk of HIV enjoy their human rights and live with dignity, free of stigma, discrimination, with meaningful access to justice and in enabling legal environments
	7. Women and girls, men and boys, in all their diversity, practice and promote gender-equitable social norms and gender equality, and work together to end gender-based violence and to mitigate the risk and impact of HIV
D.Resources	8. Community-led responses are fully recognized, empowered, resourced, and integrated for a transformative and sustainable HIV response

The monitoring framework consists of 3 levels, including (1) progress monitoring of 3 goals with impact indicators, (2) progress monitoring of 8 result areas with outcome indicators, and (3) progress monitoring of 6 strategies with output/coverage indicators.

A list of all indicators at impact, outcome and output/coverage levels are shown in Table 2. The baseline data and targets for the year 2021-2025 of impact, outcome and output/coverage indicators as well as sources of data and responsible units are presented in Tables 3, 4 and 5 respectively.

Definitions of each indicator and operational definition of key populations are described in the annex 1 and 2 respectively.

A. List of all indicators

Table 2: List of all indicators by goals, results and strategies

Goals/Result Areas /Strategies/Programs		Indicators
Goals		Impact indicators
1	To reduce new HIV infections less than 1,000 cases/year by 2030	G1.1 Number of new HIV infections per 1 000 uninfected population G1.2 Estimated number of new HIV infection G1.3 % of KP who are living with HIV
2	To reduce AIDS-related deaths less than 4,000 cases per year by 2030	G2.1 Number of AIDS-related deaths per 100 000 population G2.2 Estimated number of AIDS-related deaths G2.3 TB/HIV mortality rate per 100 000 population
3	To reduce HIV and gender related discrimination 90% from baseline in 2016 by 2030	G3.1 % of women and men 15-49 years old who report discriminatory attitudes towards PLHIV G3.2 % of PLHIV experienced HIV related discrimination in the past 12 months
Result Areas		Outcome indicators
A. HIV services		
1	PLHIV, especially KP and other vulnerable populations, know their status and are immediately offered and sustained on quality and affordable HIV treatment and care	R1.1 % of PLHIV who know their HIV status at the end of the reporting period R1.2 % of PLHIV who are on ART at the end of the reporting period R1.3 % of PLHIV on ART who have suppressed viral loads at the end of the reporting period
2	Young people access sustained combination HIV prevention	R2.1 % of women and men (aged 15–24 years) who say they used a condom the last time they had sex with a non-marital, non-cohabitating partner, of those who had sex with such a partner in the last 12 months R2.2 % of women and men (aged 15–24 years) who correctly identify both ways of preventing sexual transmission of HIV; and reject major misconceptions about HIV transmission.
3	Tailored and scaled combination HIV prevention and related HIV and health services accessible to and utilized by KP	R3.1 % of KP reached with combination HIV prevention programs R3.2 % KP receiving PrEP R3.3 % of KP received an HIV test and know their results during the reporting period or already knew that they had positive results R3.4 % of MSM reporting the use of a condom the last time they had anal sex with a non-regular partner R3.5 % of TGW reporting using a condom in their last anal sex with a non-regular male partner R3.6 % of venue/non venue based FSW/MSW reporting the use of a condom with their most recent client R3.7 % of PWID reporting the use of sterile injecting equipment the last time they injected R3.8 % of PWID reporting condom use at last sex R3.9 % of migrants who report the use of a condom at last sexual intercourse

	Goals/Result Areas /Strategies/Programs	Indicators
	B. Integration	
4	Eliminate vertical transmission of HIV, syphilis and hepatitis	R4.1 % of children newly infected with HIV from mother-to-child transmission among women living with HIV delivering in the past 12 months R4.2 Reported congenital syphilis cases (live births and stillbirths) per 100 000 livebirths R4.3 HBsAg prevalence among children aged 5 years
5	Equitable, people-centered sustainable and context-specific integrated HIV and health services support the achievement of AIDS targets within the strengthened, resilient systems for health	R5.1 % of hepatitis and coinfection with HIV among key populations (PWID) R5.2 % of PLHIV who are newly enrolled in HIV treatment with active TB R5.3 % of MSM with active syphilis R5.4 % of sex workers with active syphilis
	C. Social enablers	
6	PLHIV, KP and other people who are at high risk of HIV enjoy their human rights and live with dignity, free of stigma, discrimination, with meaningful access to justice and in enabling legal environments	R6.1 % of PLHIV/KP who report experiences of HIV-related discrimination in health-care settings R6.2 % of PLHIV and key populations avoiding of health care because of stigma and discrimination R6.3 % of PLHIV/KP who report experiences of HIV-related discrimination at workplaces R6.4 % of PLHIV/KP who report internalized stigma R6.5 % of healthcare staff reporting observed stigma toward PLHIV in the past 12 months R6.6 % of healthcare staff reported negative attitude toward PLHIV R6.7 % of healthcare staff worried of contracting HIV while caring for PLHIV
7	Women and girls, men and boys, in all their diversity, practice and promote gender-equitable social norms and gender equality, and work together to end gender-based violence and to mitigate the risk and impact of HIV	R7.1 % of ever-married or partnered women 15-49 years old who experienced physical or sexual violence from a male intimate partner in the past 12 months R7.2 % of women living with HIV experienced gender-based violence
	D. Resources	
8	Community-led responses are fully recognized, empowered, resourced, and integrated for a transformative and sustainable HIV response	R8.1 % of domestic HIV prevention programs supporting community organizations to provide services

Goals/Result Areas /Strategies/Programs		Indicators
Strategies		Output/Coverage indicators
Strategy 1: Focus and expedite effective and inclusive package of services to locations and populations with high HIV transmission		
A	HIV KP program (MSM, TGW, MSW, FSW, PWID, prisoners, migrants)	S1A.1 % of KP reached with HIV prevention programs - defined package of services S1A.2 Number of needles and syringes distributed per PWID per year by needle- syringe programs S1A.3 % of individuals receiving Opioid Substitution Therapy who received treatment for at least 6 months S1A.4 % of KP that have received an HIV test during the reporting period and know their results S1A.5 % of HIV-positive results returned to key population in the reporting year S1A.6 % of KP newly diagnosed with HIV initiated on ART S1A.7 % of eligible KP who initiated oral antiretroviral PrEP during the reporting period
B	HIV key population program integrated with other health services	S1B.1 Proportion of KP who were tested for HCV S1B.2 Proportion of people coinfected with HIV and HCV starting HCV treatment S1B.3 % of KP screened for STI
Strategy 2: Strengthen and integrate currently effective prevention efforts into existing system ensuring quality and sustainability		
A	PMTCT program	S2A.1 % of pregnant women who know their HIV status S2A.2 % of pregnant women attending ANC whose male partner was tested for HIV S2A.3 % of HIV-positive women who received ART during pregnancy and/or labor and delivery S2A.4 % of HIV-exposed infants receiving a virological test for HIV within 2 months of birth S2A.5 % of women accessing antenatal care services who were tested for syphilis, tested positive and treated S2A.6 Number of provinces achieving the goal to eliminate MTCT for HIV and Syphilis
B	HIV education program	S2B.1 % of schools having at least 20% of teachers receiving certification of the attendance of e-learning to manage the sexuality education for students in schools
Strategy 3: Develop and enhance differentiated treatment, care and social support, ensuring quality, comprehensiveness and sustainability		
A	Differentiated HIV testing program	S3A.1 % of HIV-positive results among the total HIV tests performed S3A.2 % of PLHIV newly diagnosed with low initial CD4 cell count (<200 /<350 cells/mm^3)
B	Antiretroviral treatment program	S3B.1 ART cascade of PLHIV newly diagnosed during the reporting period S3B.2 % of people newly diagnosed who initiated ART by 7 days after diagnosis
C	TB/HIV program	S3C.1 % of registered new and relapsed TB patients with documented HIV status S3C.2 % of PLHIV in care (including PMTCT) who are screened for TB in HIV care or treatment settings S3C.3 % of estimated HIV-positive incident tuberculosis (TB) cases that received treatment for both TB and HIV S3C.4 % of PLHIV on ART who initiated TB preventive therapy (TPT) among those eligible for TPT
D	Social and economic support program	S3D.1 Proportion of eligible households receiving economic support in the reporting period

Goals/Result Areas /Strategies/Programs		Indicators
Strategy 4: Adjust HIV perceptions and empower of individuals, families and communities along with strengthening a rights protection mechanism		
A	HIV and gender-related human rights, stigma and discrimination program	S4A.1 Number of provinces implementing mechanism to protect human rights on HIV S4A.2 Number of hospitals implementing reduction of HIV and gender-related stigma and discrimination S4A.3 Number of organizations/agencies complying with in the HIV policy in workplaces S4A.4 % of general population exposed to legal literacy, stigma and discrimination reduction, gender equality and human rights protection mechanism S4A.5 % of PLHIV and Key Populations exposed information on Know Your Rights, gender equality and human rights protection mechanism S4A.6 Issues of laws/rules/regulations leading to obstacles to access to services of PLHIV and key populations
Strategy 5: Enhance joint accountability, investment, and efficiency of administrative efforts in all sectors at the international, national, provincial and local levels		
A	Resource investment	S5A.1 % of national AIDS spending from domestic public resources S5A.2 % of national AIDS spending was for HIV prevention program S5A.3 % of national AIDS spending for HIV prevention program among key populations from domestic resources S5A.4 % of national AIDS spending for reduction of stigma and discrimination S5A.5 % of community health security funds supporting HIV program S5A.6 Number of provinces with provincial ending AIDS plan
B	Quality assurance	S5B.1 Percentage of civil society organizations funded to provide HIV services complying with the standard quality accreditation system.
Strategy 6: Support and improve accessibility and utilization of strategic information and research that are inclusive and efficient		
A	Health Management Information System	S6A.1 Number of provinces that produce periodic analytical reports as per nationally agreed plan and reporting format during the reporting period
B	Community based monitoring	S6B.1 % of community-based monitoring reports presented to relevant oversight mechanisms
C	Research and evaluation	S6C.1 Number of reports of conducted researches and evaluation (specify issues)

B. Impact Indicators with targets

Table 3: Goals and impact indicators with annual targets, 2021-2025

Goals and Impact Indicators									
Indicators	Baseline value		Targets					Data sources	Responsible units
	value	year	2021	2022	2023	2024	2025		
Goal 1: To reduce new HIV infections less than 1,000 cases per year by the year 2030									
G1.1 Number of new HIV infections per 1 000 uninfected population	0.10	2020	0.07	0.06	0.05	0.04	0.04	Spectrum-AEM	DOE
G1.2 Estimated number of new HIV infections	6,600	2020	5,000	4,200	3,600	3,300	3,000	Spectrum-AEM	DOE
G1.3 Percentage of KP living with HIV									
MSM	7.3	2020		6.8		6.0		BBS	DOE
TGW	4.2	2020		3.9		3.5		BBS	DOE
MSW	3.8	2018		3.0		2.5		BBS	DOE
Venue-based FSW	0.7	2018	<1		<1		<1	BBS	DOE
Non-venue FSW	2.8	2019		2.0		1.5		BBS	DOE
PWID	7.8	2019		7.2		6.7		BBS	DOE
Prisoners	0.9	2020	<1	<1	<1	<1	<1	Program	DOC
Migrants	0.2	2020			<1			BBS	DOE
Goal 2: To reduce AIDS-related deaths less than 4,000 cases per year by 2030									
G2.1 Number of AIDS-related deaths per 100 000 population	17.4	2020	14.3	11.5	10.0	9.1	8.2	Spectrum-AEM	DOE
G2.2 Estimated number of AIDS-related deaths	12,115	2020	8,600	8,200	7,800	7,400	7,000	Spectrum-AEM	DOE
G2.3 TB/HIV mortality rate per 100 000 population	20.1	2019	18	16	15	12	10	EIIS	DOE
Goal 3: To reduce HIV and gender related discrimination 90% from baseline in 2016 by 2030									
G3.1 Percentage of women and men 15-49 years old who report discriminatory attitudes towards PLHIV	26.7	2019		20			10	MICS survey	NSO
G3.2 Percentage of PLHIV experience HIV related discrimination in the past 12 months	NA			TBD			<10	Stigma Index Survey	PLHIV Task Force

C. Outcome Indicators with targets

Table 4 : Results and outcome indicators with annual targets, 2021-2025

Results and Outcome Indicators									
Indicators	Baseline		Targets					Data sources	Responsible units
	value	Year	2021	2022	2023	2024	2025		
A. HIV SERVICES									
RESULT AREA 1: PLHIV, especially key populations and other vulnerable populations, know their status and are immediately offered and sustained on quality and affordable HIV treatment and care									
R1.1 Percentage of PLHIV who know their HIV status at the end of the reporting period	94.3	2020	95	95	95	97	97	NAP plus Estimation for all PLHIV	DAS/NHSO
R1.2 Percentage of PLHIV who are on ART at the end of the reporting period	83.5	2020	90	90	91	92	93	NAP plus Estimation for all PLHIV	DAS/NHSO
R1.3 Percentage of PLHIV on ART who have suppressed viral loads at the end of the reporting period	97.2	2020	99	99	99	99	99	NAP plus Estimation for all PLHIV	DAS/NHSO
RESULT AREA 2: Young people access sustained combination HIV prevention									
R2.1 Percentage of women and men (aged 15–24 years) who say they used a condom the last time they had sex with a non-marital, non-cohabitating partner, of those who had sex with such a partner in the last 12 months	80.3	2019	83	86	90	90	90	BSS	DOE
R2.2 Percentage of women and men (aged 15–24 years) who correctly identify both ways of preventing sexual transmission of HIV; and reject major misconceptions about HIV transmission.	52.3	2020	60			70		MICS survey	NSO
RESULT AREA 3: Tailored and scaled HIV combination prevention and related HIV and health services accessible to and utilized by key populations									
R3.1 Percentage of key populations reached with HIV combination prevention programs									

Results and Outcome Indicators									
Indicators	Baseline		Targets					Data sources	Responsible units
	value	Year	2021	2022	2023	2024	2025		
MSM	49.5	2020		91		92		BBS	DOE
TGW	62.0	2020		91		92		BBS	DOE
MSW	74.3	2018		91		92		BBS	DOE
FSW	68.6	2018	91		92		93	BBS	DOE
PWID	31.7	2019		70		78		BBS	DOE
R3.2 Percentage of key populations receiving PrEP									
MSM	NA					TBD		BBS	DOE
TGW	NA					TBD		BBS	DOE
MSW	NA					TBD		BBS	DOE
FSW	NA						TBD	BBS	DOE
PWID	NA					TBD		BBS	DOE
R3.3 Percentage of key populations received an HIV test and know their results during the reporting period									
MSM	52.8	2020		77		80		BBS	DOE
TGW	63.4	2020		77		80		BBS	DOE
MSW	69.0	2018		80		85		BBS	DOE
FSW	45.5	2018	60		70		80	BBS	DOE
PWID	38.1	2019		55		70		BBS	DOE
R3.4 Percentage of MSM reporting the use of a condom the last time they had anal sex with a non-regular partner	77.8	2020		90		91		BBS	DOE
R3.5 Percentage of TGW reporting using a condom in their last anal sex with a non-regular male partner	78.8	2020		90		91		BBS	DOE
R3.6 Percentage of SW reporting the use of a condom with their most recent client									
Venue-based FSW	80.6	2018	90		90		90	BBS	DOE
Non-venue-based FSW	85.1	2019		90		90		BBS	DOE
MSW	90.3	2018		95		95		BBS	DOE
R3.7 Percentage of PWID reporting the use of sterile injecting equipment the last time they injected	95.0	2019		>95			>95	BBS	DOE

Results and Outcome Indicators									
Indicators	Baseline		Targets					Data sources	Responsible units
	value	Year	2021	2022	2023	2024	2025		
R3.8 Percentage of PWID reporting condom use at last sex	39.6	2019		50			70	BBS	DOE
R3.9 Percentage of migrants who report the use of a condom at last sexual intercourse	29.0	2020			50			BBS	DOE
B. INTEGRATION									
RESULT AREA 4: Eliminate vertical transmission of HIV, syphilis and hepatitis									
R4.1 Percentage of children newly infected with HIV from mother-to-child transmission among women living with HIV delivering in the past 12 months	1.65	2020	<2	<2	<2	<2	<2	Pregnant women living with HIV estimated by Spectrum	DOH/DOE
R4.2 Reported congenital syphilis cases (live births and stillbirths) per 100 000 livebirths	46	2019	<50	<50	<50	<50	<50	Surveillance report 506	DOE
R4.3 HBsAg prevalence among children aged 5 years	NA						<1	National Surveillance Survey	DAS
RESULT AREA 5: Equitable, people-centered sustainable and context-specific integrated HIV and health services support the achievement of AIDS targets within the strengthened, resilient systems for health									
R5.1 Prevalence of hepatitis and coinfection with HIV among key populations									
MSM	NA					TBD		BBS	DOE
TGW	NA					TBD		BBS	DOE
MSW	NA					TBD		BBS	DOE
FSW	NA						TBD	BBS	DOE
PWID	42.2	2019		30		20		BBS	DOE
R5.2 Percentage of PLHIV who are newly enrolled in HIV treatment with active TB	NA			TBD	TBD	TBD	TBD	Program data	DAS
R5.3 Percentage of MSM with active syphilis	6.0	2018		4.5		3.9		BBS	DOE
R5.4 Percentage of sex workers with active syphilis	1.8	2019	1.6		<1.5		<1.5	BBS	DOE

Results and Outcome Indicators									
Indicators	Baseline		Targets					Data sources	Responsible units
	value	Year	2021	2022	2023	2024	2025		
C. SOCIAL ENABLER									
RESULT AREA 6: PLHIV, KP and other people who are at high risk of HIV enjoy their human rights and live with dignity, free of stigma, discrimination, with meaningful access to justice and in enabling legal environments									
R6.1 Percentage of PLHIV and key populations who report experiences of HIV-related discrimination in health-care settings	11.1	2019	10		8		5	Hospital Surveillance survey	DAS
R6.2 Percentage of PLHIV and key populations avoiding of health care because of stigma and discrimination[1]									
PLHIV	5.2	2019	5		4.5		≤4	S&D survey	DAS
MSM	3.3	2018		2.5		≤2		BBS	DOE
TGW	4.4	2018		3		≤3		BBS	DOE
MSW	4.7	2018		4		≤3.5		BBS	DOE
Venue-based FSW	1.8	2016			1.4		≤1	BBS	DOE
PWID	8.0	2020		6		≤5		BBS	DOE
R6.3 Percentage of PLHIV and key populations who report experiences of HIV-related discrimination at workplaces									
PLHIV	3.7	2019	2.5		≤2		≤2	S&D survey	DAS
MSM	5.0	2018		4		≤3		BBS	DOE
TGW	12.1	2018		8		≤6		BBS	DOE
MSW	6.6	2016		5		≤4		BBS	DOE
FSW	NA				TBD		TBD	BBS	DOE
PWID	2.1	2020		1.8		≤1		BBS	DOE
R6.4 Percentage of PLHIV and key populations reporting internalized stigma									
PLHIV	36.1	2019	30		28		25	S&D survey	DAS
MSM	19.4	2017		18		16		BBS	DOE
TGW	22.1	2017		20		18		BBS	DOE
MSW	19.9	2017		18		16		BBS	DOE

[1] Baseline value is lower than 10%. Measurement will be revised for the future round of data collection. Standardize composite index will be used according the measurement recommended by GAM guidance

Results and Outcome Indicators									
Indicators	Baseline		Targets					Data sources	Responsible units
	value	Year	2021	2022	2023	2024	2025		
FSW	52.2	2017	40		30		20	BBS	DOE
PWID	61.1	2019			58			BBS	DOE
R6.5 Percentage of healthcare staff reporting observed stigma toward PLHIV in the past 12 months	27	2017		20		10		Hospital surveillance survey	DAS
R6.6 Percentage of healthcare staff reported negative attitude toward PLHIV	83.5	2017		60		30		Hospital surveillance survey	DAS
R6.7 Percentage of healthcare staff worried of contracting HIV while caring for PLHIV	49.7	2017		30		10		Hospital surveillance survey	DAS
RESULT AREA 7: Women and girls, men and boys, in all their diversity, practice and promote gender-equitable social norms and gender equality, and work together to end gender-based violence and to mitigate the risk and impact of HIV									
R7.1 Percentage of ever-married or partnered women 15-49 years old who experienced physical or sexual violence from a male intimate partner in the past 12 months	15	2018		TBD			10	MICS	NSO
R7.2 Percentage of women living with HIV experienced gender-based violence	NA			TBD			10	Stigma Index survey	PLHIV Task Force
D. RESOURCES									
RESULT AREA 8: Community-led responses are fully recognized, empowered, resourced, and integrated for a transformative and sustainable HIV response									
R8.1 Percentage of domestic HIV prevention programs supporting community organizations to provide services	64.0	2020	70	75	80	85	90	NHSO	NHSO

D. Output Indicators with targets

Table 5: Strategy and output/coverage indicators with annual targets, 2021-2025

Strategy and Output/Coverage Indicators									
Indicators	Baseline		Targets					Data sources	Responsible units
	Value	Year	2021	2022	2023	2024	2025		
Strategy 1: Focus and expedite effective and inclusive package of services to locations and populations with high HIV transmission									
A. HIV Key Population Program									
S1A.1 Percentage of key populations reached with HIV prevention programs - defined package of services								RTCM, E-cascade, NAP plus	DAS
MSM	64.8	2020	91	91	92	92	93		
TGW	44.8	2020	91	91	92	92	93		
MSW	28.0	2020	70	75	75	80	80		
FSW	23.0	2020	91	92	92	93	93		
PWID	23.5	2019	50	52	58	70	75		
Prisoners	97.3	2020	>95	>95	>95	>95	>95	Program data	DOC
Migrants	87.5	2020	96	97	97	97	98	RTCM	DAS/RTF
S1A.2 Number of needles and syringes distributed per person who injects drugs per year by needle and syringe programs	12.2	2020	30	31	35	40	48	RTCM	DAS
S1A.3 Percentage of individuals receiving Opioid Substitution Therapy who received treatment for at least 6 months	64.0	2019	30	50	60	70	75	Program data	NCMC
S1A.4 Percentage of key populations that have received an HIV test during the reporting period and know their results								RTCM, E-cascade, NAP plus	DAS
MSM	77.4	2020	73	77	78	85	92		
TGW	54.4	2020	73	77	78	85	85		
MSW	49.9	2020	56	64	64	89	90		
FSW	28.8	2020	91	91	92	92	93		
PWID	15.0	2020	34	42	55	78	80		
Prisoners	35.4	2020	80	84	88	90	92	Program data	DOC
Migrants	28.3	2020	50	55	60	62	65	RTCM	DAS/RTF

Strategy and Output/Coverage Indicators									
Indicators	Baseline		Targets					Data sources	Responsible units
	Value	Year	2021	2022	2023	2024	2025		
S1A.5 Percentage of HIV-positive results returned to key population in the reporting year (positivity)								E-cascade, NAP plus	DAS
MSM	6.7	2020	8.5	8	7.5	7	6.5		
TGW	4.1	2020	5	5	5	4	3.5		
MSW	4.9	2020	2	3	3	2	<2		
FSW	0.9	2020	>1	>1	>1	1	1		
PWID	3.0	2020	>5	>6	>6	6	6		
Prisoners	1.2	2020	1.2	1.2	1.2	1.2	1	Program record	DOC
Migrants	0.8	2020	0.8	0.8	0.8	0.8	0.8	Program record	DAS
S1A.6 Percentage of key populations newly diagnosed with HIV initiated on ART								NAP plus	DAS/NHSO
MSM	NA		90	92	95	95	96		
TGW	NA		90	92	95	95	96		
MSW	NA		90	92	95	95	96		
FSW	NA		90	92	95	95	96		
PWID	NA		90	92	95	95	96		
Prisoners	NA		90	92	95	95	96	Program record	DOC
Migrants	NA		90	92	95	95	96	Program record	DAS
S1A.7 Percentage of eligible key population who initiated oral antiretroviral PrEP during the reporting period								NAP plus	DAS/NHSO
Total	9.3	2020	20	30	40	50	60		
Sero-discordant couples	40.2	2020	50	70	80	90	98		
MSM	10.3	2020	20	30	40	50	60		
TGW	11.4	2020	20	30	40	50	60		
PWID	0.04	2020	8	15	20	25	25		
B. HIV Key Population Program Integration with Other Health Services									
S1B.1 Proportion of key population who were tested for HCV	New intervention				TBD	TBD	TBD	Program data	NHSO
S1B.2 Proportion of people coinfected with HIV and HCV starting HCV treatment	New intervention				TBD	TBD	TBD	Program data	NHSO

Strategy and Output/Coverage Indicators									
Indicators	Baseline		Targets					Data sources	Responsible units
	Value	Year	2021	2022	2023	2024	2025		
S1B.3 Percentage of key populations screened for STI								NAP plus	DAS
All KP	19.2	2020	28	34	41	45	52		
MSM	30.1	2020	35	40	45	45	50		
TGW	16.7	2020	30	30	35	35	40		
MSW	10.4	2020	15	20	25	30	35		
FSW	13.1	2020	20	30	40	50	60		
TGSW	NA	2020	15	20	30	40	50		
Strategy 2: Strengthen and integrate currently effective prevention efforts into existing system ensuring quality and sustainability									
A. PMTCT program									
S2A.1 Percentage of pregnant women who know their HIV status								PHIMS	DOH
Thai	99.7	2020	>99	>99	>99	>99	>99		
Non-Thai	99.5	2020	>99	>99	>99	>99	>99		
S2A.2 Percentage of pregnant women attending ANC whose male partner was tested for HIV								PHIMS	DOH
Thai	49.6	2020	60	65	70	80	90		
Non-Thai	48.0	2020	60	65	70	80	90		
S2A.3 Percentage of HIV-positive women who received ART during pregnancy and/or labor and delivery								PHIMS	DOH
Thai	98.0	2020	>99	>99	>99	>99	>99		
Non-Thai	96.1	2020	>99	>99	>99	>99	>99		
S2A.4 Percentage of HIV-exposed infants receiving a virological test for HIV within 2 months of birth								PHIMS	DOH
Thai	51.6	2020	60	70	75	80	90		
Non-Thai	50.4	2020	60	70	75	80	90		
S2A.5 Percentage of women delivered babies in the reporting period who were tested for syphilis, tested positive and treated									
(1) Percentage of women delivered babies in the reporting period who were tested for syphilis								PHIMS	DOH

Strategy and Output/Coverage Indicators									
Indicators	Baseline		Targets					Data sources	Responsible units
	Value	Year	2021	2022	2023	2024	2025		
Thai	99.5	2020	>99.5	>99.5	>99.5	>99.5	>99.5		
Non-Thai	99.4	2020	>99.5	>99.5	>99.5	>99.5	>99.5		
(2) Percentage of women delivered babies in the reporting period who were tested positive for syphilis								PHIMS	DOH
Thai	0.6	2020	<0.5	<0.5	<0.5	<0.5	<0.5		
Non-Thai	0.2	2020	<0.2	<0.2	<0.2	<0.2	<0.2		
(3) Percentage of women delivered babies in the reporting period who were tested positive for syphilis received treatment								PHIMS	DOH
Thai	98.0	2020	99	>99	>99	>99	>99		
Non-Thai	99.0	2020	99	>99	>99	>99	>99		
S2A.6 Number of provinces achieving the goal to eliminate MTCT for HIV and syphilis (total: 77 provinces)	63	2020	70	77	77	77	77	PHIMS	DOH
B. HIV education program									
S2B.1 Percentage of schools having at least 20% of teachers receiving certification of the attendance of e-learning to manage the sexuality education for students in schools	NA				TBD	TBD	TBD	Program record	MOE/MOI
Strategy 3: Develop and enhance differentiated treatment, care and social support, ensuring quality, comprehensiveness and sustainability									
A. Differentiated HIV testing program									
S3A.1 Percentage of HIV-positive results among the total HIV tests performed	2.2	2020	2	1.8	1.5	1.2	1	NAP	NHSO/DAS
S3A.2 Percentage and PLHIV newly diagnosed with low initial CD4 cell count								NAP plus	NHSO/DAS
CD4 <200 cell/mm^3	52.7	2020	45	40	35	30	25		
CD4<350 cell/mm^3	72.7	2020	65	60	55	50	45		
B. Antiretroviral treatment program									
S3B.1 ART cascade of PLHIV newly diagnosed during the reporting period								NAP plus	NHSO/DAS

Strategy and Output/Coverage Indicators									
Indicators	Baseline		Targets					Data sources	Responsible units
	Value	Year	2021	2022	2023	2024	2025		
(1) Percentage of people newly diagnosed with HIV initiated on ART	NA		90	92	95	95	96		
(2) Percentage of people newly diagnosed and on ART who had lost to follow up	NA		12	10	8	6	4		
(3) Percentage of people newly diagnosed and on ART who had viral load tests	NA		80	85	90	92	95		
(4) Percentage of people newly diagnosed and on ART who had virally suppressed	NA		95	>95	>95	>95	>95		
S3B.2 Percentage of people newly diagnosed and on ART who initiated ART by 7 days after diagnosed	NA		40	50	60	70	80	NAP plus	NHSO/DAS
C. TB/HIV program									
S3C.1 Percentage of registered new and relapsed TB patients with documented HIV status	78.2	2020	95	95	95	95	95	NTIP	DTB
S3C.2 Percentage of PLHIV in care (including PMTCT) who are screened for TB in HIV care or treatment settings	NA		70	80	90	95	95	DAS-TBHIV	DAS
S3C.3 Percentage of estimated HIV-positive incident tuberculosis (TB) cases that received treatment for both TB and HIV	50.5	2020	55	60	65	70	75	NTIP, NAP plus	DTB/DAS
S3C.4 Percentage of PLHIV on ART who initiated TB preventive therapy (TPT) among those eligible for TPT	6.6	2020	30	35	40	50	60	DAS-TBHIV	DAS
D. Social and economic support program									
S3D.1 Proportion of eligible households receiving economic support in the reporting period	NA				TBD	TBD	TBD	Program record	MOI/MSDHS
Strategy 4: Adjust HIV perceptions and empower of individuals, families and communities along with strengthening a rights protection mechanism									
A. HIV and gender-related human rights, stigma and discrimination program									
S4A.1 Number of provinces implementing mechanism to protect human right on HIV	4	2020	14	24	36	45	50	CRS	DAS
S4A.2 Number of hospitals implementing reduction of HIV and gender-related stigma and discrimination	100	2020	214	396	173	175	177	Program record	DAS

Strategy and Output/Coverage Indicators									
Indicators	Baseline		Targets					Data sources	Responsible units
	Value	Year	2021	2022	2023	2024	2025		
S4A.3 Number of organizations/agencies complying with in the HIV policy in workplaces	308	2020	1192	5936	5731	9264	5807	Program record	DAS
S4A.4 Percentage of general population exposed to legal literacy, stigma and discrimination reduction, gender equality and human rights protection mechanism	NA		TBD				20	MICS	NSO
S4A.5 Percentage of PLHIV and Key Populations exposed information on Know Your Rights, gender equality and human rights protection mechanism									
PLHIV	NA			TBD			90	Stigma Index survey	The PLHIV Task Force
Key populations	NA			TBD		80		BBS	DOE
S4A.6 Issues of laws/rules/regulations leading to obstacles to access to services by PLHIV and key populations (specify)	1. Harm reduction 2. Sex work 3. Migrant health insurance 4. LGBTQI 5. HIV disclosure	2020	5	4	3	2	1	NCPI	DAS
Strategy 5: Enhance joint accountability, investment and efficiency of administrative efforts in all sectors at the international, national, provincial and local levels									
A. Resource investment									
S5A.1 Percentage of national AIDS spending from domestic public resources	90.0	2019	91	91	92	92	93	NASA	DAS
S5A.2 Percentage of national AIDS spending was for HIV prevention program	14.0	2019			18		20	NASA	DAS
S5A.3 Percentage of national AIDS spending for HIV prevention program among key populations from domestic resources	22.0	2019			35		40	NASA	DAS
S5A.4 Percentage of national AIDS spending for reduction of stigma and discrimination	0.6	2019			3		6	NASA	DAS

Strategy and Output/Coverage Indicators									
Indicators	Baseline		Targets					Data sources	Responsible units
	Value	Year	2021	2022	2023	2024	2025		
S5A.5 Percentage of community health security funds supporting HIV program	NA			TBD	TBD	TBD	TBD	Program record	NHSO
S5A.6 Number of provinces with provincial ending AIDS plan	3	2020	14	24	36	>36	>36	Program record	DAS
B. Quality assurance									
S5B.1 Percentage of civil society organizations funded to provide HIV services complying with the standard quality accreditation system.	0.0	2020	40	50	70	80	90	Program record	DAS
Strategy 6: Support and improve accessibility and utilization of strategic information and research that are inclusive and efficient									
A. Health Management Information System									
S6A.1 Number of provinces that produce periodic analytical reports as per nationally agreed plan and reporting format during the reporting period	New intervention in 2022			18	35	60	77	Program record	DAS
B. Community based monitoring									
S6B.1 Percentage of community-based monitoring reports presented to relevant oversight mechanisms	NA			TBD	TBD	TBD	TBD	Program record	DAS
C. Research and evaluation									
S6C.1 Number of reports of conducted researches and evaluation (specify issues)	NA							NASA	DAS

3. Accelerated Strategic Approaches and Key Indicators towards the 2025 Global AIDS Targets

Based on gaps identification, Thailand has defined the strategic approaches towards the 2025 Global AIDS Targets and selected key indicators to be monitored for ensuring the progress towards the targets. The global ambitious targets and commitments for 2025 are to reduce inequalities, including[2]:

LESS THAN 10%:

- Less than 10% of PLHIV and key populations experience stigma and discrimination
- Less than 10% of women and girls and key populations experience gender-based inequalities and gender-based violence
- Less than 10% of countries have punitive laws and policies

MORE THAN 95%

- 95% of people at risk of HIV use combination prevention
- 95-95-95% HIV testing, treatment & viral suppression among adults and children
- 95% of women access sexual and reproductive health services
- 95% coverage of services for eliminating vertical transmission
- 90% of PLHIV receive preventive treatment for TB
- 90% of PLHIV and people at risk are linked to other integrated health services

To fill the gaps and accelerate the progress towards the 2025 Global AIDS Targets, Thailand defines the priority approaches in 4 areas as follow:

I. HIV services

Maximize the impact of people-centered combination prevention and Test & Treat interventions by:

(1) Rapidly scaling up PrEP in conjunction of Test & Treat with universal condom and STI management among key populations, particularly young key populations;

(2) Expanding essential services and increasing access to a youth-centered comprehensive combination prevention for and with young population including sexual and reproductive health, comprehensive sexual education, HIV prevention, harm reduction, STI management by innovative strategies and virtual interventions; and

(3) Increasing access to differentiated HIV service delivery; innovative approaches for HIV testing including HIV self-testing, index/network testing, same day ART, MMD, telemedicine and treatment retention.

II. Integrated services

[2] End Equalities. End AIDS. Global AIDS strategy 2021-2026, UNAIDS 2021

Scale up the people-centered integrated HIV, TB, STI and Hepatitis services by:
(1) Promoting the EMTCT of HIV, STI and HBV at the provincial level;
(2) Scaling up the screening and provision of preventive treatment for TB; and
(3) Scaling up the community-based diagnosis and treatment of HCV infection.

III. Societal enablers
Break down barriers to achieving HIV outcomes by:
(1) Scaling up actions to eliminate all forms of HIV-related stigma and discrimination and human rights and gender inequality.

IV. System development.
IV.1 Strengthen community-led responses by:
(1) Institutionalizing and expanding community health workers and CBO into system for health; and
(2) Establishing community-led monitoring to generate evidence and make use for service improvement as well as policy advocacy.

IV.2 Fully resource support and sustain efficient HIV response and integrate into systems for health, social protection, crises and pandemic responses by:
(1) Fully funded HIV prevention response;
(2) Sustainable financing of community -led response in UHC;
(3) Increased capacity of human resources for health; and
(4) Humanitarian settings and pandemics.

The priority approaches aim for impact and outcome targets in 2025, including

- Less than 3,000 estimated new HIV infections
- Less than 7,000 estimated AIDS related deaths
- Less than 15% of adults had discriminatory attitudes towards PLHIV

Key indicators are selected to monitor the accelerated strategic approaches more frequently, i.e., quarterly monitored at program level, and semiannually monitored at national level to ensure the corrective actions in time.

Table 6: Key indicators for accelerated strategic approaches towards the 2025 Global AIDS Targets

Key Indicators for Accelerated Strategic Approaches towards the 2025 Global AIDS Targets									
Indicators	Baseline		Targets					Data sources	Responsible units
	value	Year	2021	2022	2023	2024	2025		
I. HIV Services: Maximize the impact of people-centered combination prevention and Test & Treat interventions									
1. Percentage of key populations that have received an HIV test during the reporting period and know their results (S1A.4)								NAP plus RTCM, E-cascade	DAS
MSM	77.4	2020	82	85	88	90	92		
TGW	54.4	2020	68	75	80	82	85		
MSW	49.9	2020	60	65	70	75	80		
FSW	28.8	2020	40	50	60	70	75		
PWID	15.0	2020	30	40	50	55	60		
Prisoners	35.4	2020	80	84	88	90	92		
Migrants	28.3	2020	50	55	60	62	65		
2. Percentage of young populations at risk that have received an HIV test during the reporting period and know their results (S1A.4)								NAP plus	DAS
Youth (15-24 years old)	NA			TBD	TBD	TBD	TBD		
MSM < 25 years old	NA			TBD	TBD	TBD	TBD		
MSW <25 years old	NA			TBD	TBD	TBD	TBD		
TGW <25 years old	NA			TBD	TBD	TBD	TBD		
PWID < 25 years old	NA			TBD	TBD	TBD	TBD		
3. Percentage of HIV-positive results returned to key population in the reporting year (positivity) (S1A.5)								NAP plus E-cascade RTCM	DAS
MSM	6.7	2020	8.5	8	7.5	7	6.5		
TGW	4.1	2020	5	5	5	4	3.5		
MSW	4.9	2020	2	3	3	2	<2		
FSW	0.9	2020	>1	>1	>1	1	1		
PWID	3.0	2020	>5	>6	>6	6	6		
Prisoners	1.2	2020	1.2	1.2	1.2	1.2	1		

Key Indicators for Accelerated Strategic Approaches towards the 2025 Global AIDS Targets									
Indicators	Baseline		Targets					Data sources	Responsible units
	value	Year	2021	2022	2023	2024	2025		
Migrants	0.8	2020	0.8	0.8	0.8	0.8	0.8		
Youth	2.7	2020	3	3.2	3.4	3.5	3.5		
4. Percentage and number of adults and children newly diagnosed with HIV with the low initial CD4 cell count (S3A.2)								NAP plus	NHSO
CD4 <200	52.7	2020	45	40	35	30	25		
CD4<350	72.7	2020	65	60	55	50	45		
5. Percentage of people newly diagnosed who initiated ART by 7 days after diagnosis (S3B.2)	NA		40	50	60	70	80	NAP plus	NHSO
6. Number of eligible key population who initiated oral antiretroviral PrEP during the reporting period (S1A.7)	13,769	2020	28,000	42,000	57,000	71,000	84,000	NAP plus	NHSO
II. Integration: Scale up the people-centered integrated HIV, TB, STI and Hepatitis services									
1. Number of provinces reporting infants with HIV and/or congenital syphilis (total: 77 provinces) (S2A.6)	63	2020	70	77	77	77	77	PHIMS 506	DOH
2. Number of PLHIV on ART who initiated TB preventive therapy (TPT) among those eligible for TPT (S3C.4)	290 (New PLHIV)	2020	26,000	45,000	63,000	70,000	72,000	DAS-TBHIV	DAS
3. Percentage of people who were tested for HCV (S1B.1)								Program data	NHSO
Key populations	NA			TBD	TBD	TBD	TBD		
Newly registered PLHIV	NA			TBD	TBD	TBD	TBD		
4. Percentage of key populations screened for STI (S1B.3)	19.2	2020	28	34	41	45	52	NAP plus	DAS
III. Societal enablers: Break down barriers to achieving HIV outcomes									
1. Number of hospitals implementing reduction of HIV and gender-related stigma and discrimination (S4A.2)	52	2020	214	396	173	175	177	Program record	DAS

Key Indicators for Accelerated Strategic Approaches towards the 2025 Global AIDS Targets									
Indicators	Baseline		Targets					Data sources	Responsible units
	value	Year	2021	2022	2023	2024	2025		
2. Number of organizations/agencies (government, private, non-government) complying with in the HIV policy in workplaces (S4A.3)	308	2020	1192	5936	5731	9264	5807	Program record	DAS
IV. System development:									
IV.1 Strengthen community-led responses									
1. Percentage of civil society organizations complying with the standard quality accreditation system (S5B.1)	0.0	2020	40	50	70	80	90	Program record	DAS
2. Percentage of domestic HIV prevention programs supporting community organizations to provide services (R8.1)	64.0	2020	70	75	80	85	90	NHSO	NHSO
3. Number of community-based monitoring reports (S6B.1)	NA			TBD	TBD	TBD	TBD	Program record	DAS
IV.2 Fully resource support and sustain efficient HIV response and integrate into systems for health, social protection, crises and pandemic responses									
1. Amount of budget for condoms (mil. THB)	127	2020	238	255	270	285	300	DAS, NHSO	DAS
2. Percentage of national AIDS spending was for HIV prevention program (S5A.2)	14.0	2019			18		20	NASA	DAS
3. Percentage of national AIDS spending for reduction of stigma and discrimination (S5A.4)	0.6	2019			3		6	NASA	DAS

4. Monitoring the impact of COVID-19 on HIV services and programs

Along with most countries globally, Thailand has been experiencing significant impacts of the COVID-19 pandemic for a prolonged period of time. Since January 2020, the country has experienced three waves of COVID-19 outbreaks. To cope with the COVID-19 situation, the health system is certainly affected. One of the primary measures has been the impetus to decrease the number of non-urgent patient visits, to reduce congestion, minimize disease transmission in hospitals and prepare for the sudden deployment of required resources should severe situations arise. As such, there were suggestions for public health facilities to adjust their service deliveries and resources. The adjustment includes a postponement of cancer screening for high-risk patients until the COVID-19 situation can be controlled, delaying the visits of non-urgent cases, telemedicine, and sending medicines by mail to the patient with stable conditions. In addition, social distancing measures as well as restricted traveling have negative impacts to HIV services and programs.

Number of people receiving HIV testing, PLHIV on ART receiving viral load testing and key population receiving STI screening significantly declined. More PLHIV on ART lost to follow up at 90 days of appointment. (Figure 1.1 and 1.2)

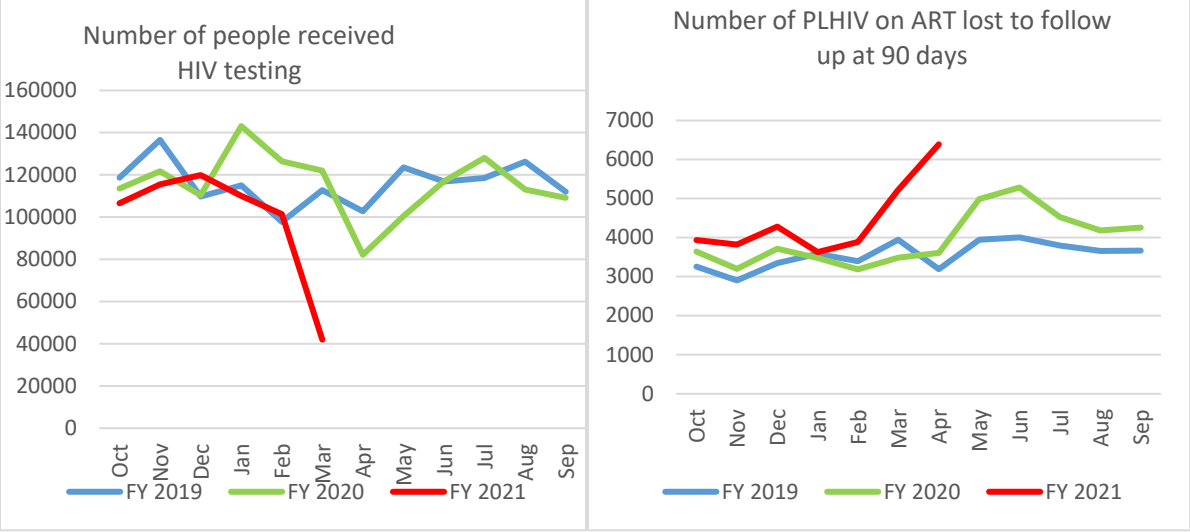

Figure 1.1: Impact of Covid-19 to HIV services in Thailand

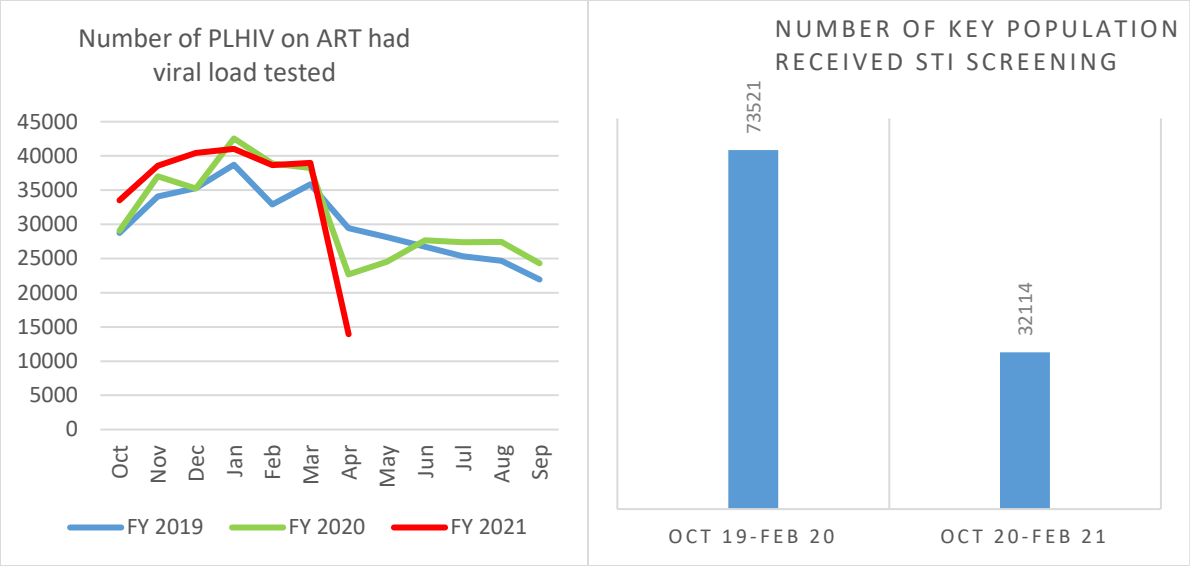

Figure 1.2: Impact of Covid-19 to HIV services in Thailand

The online hospital surveys by the DAS during the 2nd wave and by the DAS together with the U.S. Centers for Disease Control and Prevention (CDC) Thailand office during the 3rd wave of COVID-19, the condom stock out was found around 19 percent (30 out of 156 hospitals) and 17 percent (47 out of 276 hospitals during the 2nd and 3rd wave respectively. The stockout happened to the ARV medication as well, which was because of scaling up MMD approach. Some HIV clinic staff, particularly in tertiary care hospitals were repurposed to take care of COVID-19 patients, which reduced the number of doctors providing care to PLHIV.

To monitor the impact of COVID-19 outbreaks to HIV programs, selected services as well as logistics of commodities and medication will be monitored regularly and more frequently, i.e., monthly, particularly during the COVID-19 outbreak. Disaggregated data is needed for the purpose to identify priority services and geographical areas as well as hospitals for further qualitative assessment and support specific interventions accordingly.

Table 7: Selected indicators for COVID-19 impact to HIV programs

Services	Indicators	Source of data	Disaggregation
HIV testing	• Number of people received HIV testing	NAP plus, RTCM plus, E-cascade	Key population groups, provinces, service providers
HIV prevention	• Number of people received STI screening • Condom stockout	NAP plus NAP plus, DAS-report 100	Key population groups, provinces, service providers
HIV treatment	• Number of PLHIV on ART lost to follow up at 28 days of appointment • Number of PLHIV on ART receiving viral load testing • ARV stockout	NAP plus NAP plus	Provinces, service providers

5. Organization Structures with HIV M&E Functions

The organizations with HIV monitoring and evaluation functions are classified by 3 levels, i.e., national, subnational (health region) and provincial levels. In order to maximize the benefits of the monitoring and evaluation tasks, all service delivery units of public, private and civil society have an important function, apart from program recording, to analyse and make use of data and information to improve their services.

National Level

There are two pillars at the national level with the lead M&E organizational structure as follows:

1. *Monitoring the HIV epidemic (know your epidemic)*: The Division of Epidemiology (DOE) is the lead organization to develop and conduct the HIV sentinel surveillance, the second-generation surveillance system and other related activities. for understanding current and future directions of the epidemic and its consequences. The new approaches to conduct online BBS using online survey to offline biomarkers testing will be piloted and new HIV recent infection case surveillance is being developed.
2. *Monitoring the national response (know your response)*: The Division of AIDS and STIs (DAS) coupled with the Bureau of Secondary and Tertiary Service Management of the NHSO play the leading role in the national system.

These three lead organizations (DOE, DAS and NHSO) will work under the guidance and technical direction provided by the National Strategic Information/M&E Sub-Committee. The half-year meeting of the Sub-Committee will identify key issues for communicating to the National Ending AIDS Subcommittee and reporting to the National AIDS Committee accordingly. The MOPH has collaborated and received technical assistant from development partners e.g., GFATM, PEPFAR, UNAIDS to develop, maintain and monitor program these program indicators for continuous quality improvement.

Regional level

There are twelve regional Offices of Disease Prevention and Control (Regional ODPC) throughout Thailand. Each regional office provides technical support to about 5-8 provinces. The urban Office of Disease Prevention and Control is responsible to work with BMA in Bangkok. Meanwhile, the thirteen NHSO regional offices provide financial support to provinces within its responsibility, which is the same provinces under technical support of the Regional ODPC.

The regional/urban ODPC, as part of the DOE's function, monitor the HIV epidemic of the provinces in its responsibility, and coupled with the NHSO regional offices monitor the responses to HIV of the provinces in its responsibility.

Provincial level

The Provincial Health Office (PHO) serves as the secretariat office to the Provincial AIDS Committee (PAC) and/or the Provincial Coordinating Mechanism (PCM). Each PHO has an HIV unit and a planning and policy unit that collects and analyzes provincial HIV epidemiologic research and reports from within the MOPH system and from implementing partners. Alike, Division of AIDS, TB and STI of the BMA is responsible to monitor both the epidemic and responses in the area of Bangkok.

ROUTINE HIV PROGRAM MONITORING

Program implementers who received HIV funding from the government, national and international donors (e.g., local/ international NGOs, CBOs) will participate in regular (quarterly) program performance reviews to determine program achievements, gaps and identify program improvement plans.

As key HIV services are recorded in the centralized database, NAP plus - operated by the NHSO, this will enable the real time monitoring by different stakeholders. In addition to the self-monitoring by service providers, including public, civil society and private facilities, the provincial health offices / Division of AIDS, TB and STI of BMA at the provincial level will be able to access aggregated data and can provide the developed dashboard for the provincial/BMA AIDS committee or PCM to monitor the services in the province. At the regional level, the regional/urban ODPC and the NHSO regional office can access aggregated data and monitor the services in the region and Bangkok. Meanwhile, the DAS and the Bureau of Secondary and Tertiary Care Management of the NHSO will access aggregated data and monitor at national level and provide key data and information to the NHSO Board and the National AIDS Committee. The feedback and response loop will be strengthened as shown in the Figure 2.

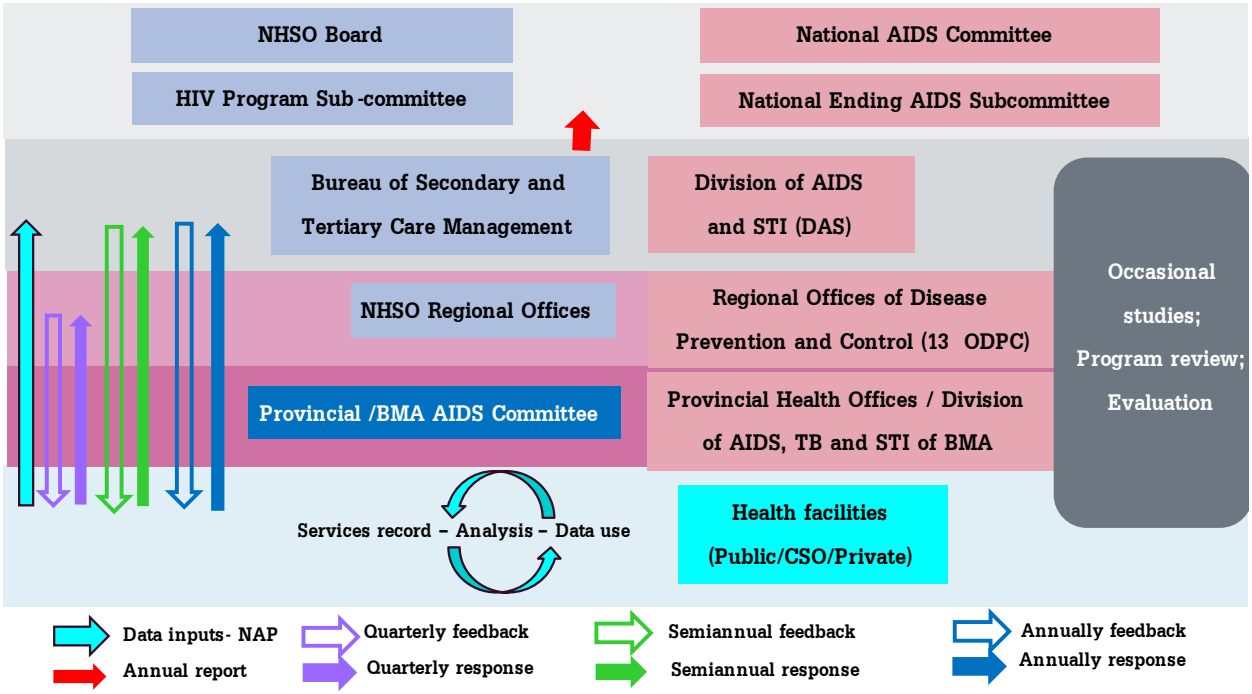

Figure 2: Organizational structure for routine HIV program monitoring

6. M&E Activity Plan, 2021-2025

The national M&E activity plan in 2021-2025 is framed into four categories, i.e., (1) monitoring the HIV epidemic, (2) monitoring the response, (3) evaluation and (4) strengthening the M&E system. The action plan to monitor the responses covers four components including HIV services, integration, societal enablers and resources. Details are in the following tables.

A. Monitoring the HIV Epidemic

The HIV prevalence trends among different population groups have been monitored continuously for low risk and high-risk population groups. Meanwhile, the biobehavioral surveillance (BBS) has been introduced for better understanding of the HIV epidemic among key populations. In 2021, the Division of Epidemiology (DOE) together with the Thai MOPH-US CDC Collaboration (TUC) will be developing web-based respondent driven sampling for BBS in Bangkok and will determine the expansion to other sites. Moreover, HIV recent infection rates among key populations will also be initiated and considered implemented in 13 sentinel sites.

The program data for HIV, TB and hepatitis testing will be used to monitor the HIV, TB and hepatitis C prevalence among prisoners.

The spectrum AEM model will be used to estimate HIV new infections, AIDS related deaths as well as pattern of HIV transmission in the country.

The activity plan with timeline, responsible agencies as well as sources of funding is shown in the following table.

Table 8: Activity plan to monitor the HIV epidemic in 2021-2025

Activities		Responsible agencies	Funding sources	Timeline				
				2021	2022	2023	2024	2025
1	Survey/Surveillance							
1.1	HIV sero-prevalence surveillance (HSS) among 6 sentinel population groups (pregnant women at ANC clinics, male military conscripts, male clients at STI clinics, male and female sex workers in venues, blood donor, migrants)	DOE, Royal Thai Army Medical Department	DDC Royal Thai Army Medical Department	X	X	X	X	X
1.2	Behavioral sentinel surveillance (BSS) among 4 sentinel population groups ▪ Students in secondary school grades 8 and 11 ▪ Students in vocational school ▪ Male and female factory workers ▪ Male conscripts	DOE	DDC	 X X 	 X X	 X X 	 X X	

Activities		Responsible agencies	Funding sources	Timeline				
				2021	2022	2023	2024	2025
1.3	Biobehavioral survey (BBS) ▪ MSM, TGW, MSW ▪ Venue and non-venue based FSW ▪ PWID ▪ Migrant workers	DOE	DDC GFATM support BBS in 2021-23	 X	X X	 X X	X X	 X
1.4	Web-based response driven biobehavioral survey (BBS) • MSM, TGW online HIV related behavioral survey and link to offline biomarkers testing (Syphilis, Hepatitis B & C) for MSM in Bangkok • Will determine expansion feasibility for biomarker testing in other provinces	DOE	PEPFAR TBD		X		TBD	
1.5	HIV recent infection surveillance • All PLHIV and sub-group analysis by key population to determine rate of recently HIV-infected clients • 13 sentinel surveillance provinces	DOE DOE	PEPFAR TBD		X	TBD TBD	TBD	TBD TBD
2	Program data							
2.1	HIV, TB, Hepatitis C prevalence among prisoners	DOC	NHSO and DOC	X	X	X	X	X
2.2	Causes of deaths	DAS	NHSO and DAS	X	X	X	X	X
3	Modeling							
3.1	Size estimation of Key Populations ▪ National level ▪ Provincial level	DAS and DOE	DDC, PEPFAR and GFATM in 2021-23	 X	 X			
3.2	HIV estimation and projection ▪ National level ▪ Provincial level	DOE	DDC and PEPFAR support	X	X	X	X	X
3.3	Mother-to Child Transmission of HIV, Syphilis	NHSO, DOH and DAS	DDC	X	X	X	X	X

B. Monitoring the Responses

The responses to be monitored comprise of HIV services, integrated services, societal enabler and resources. The activity plans for each category are defined as follows:

B.1 HIV services

The HIV services are monitored mainly by program record. In addition, the coverage of key populations accessing the HIV services will be monitored by BBS. The activity plan emphasizes on the analysis and use of data to improve the services. As young people are identified to be key target populations for the

national strategic approach to accelerate the achievements towards the 2025 Global AIDS Targets, the activity plan on how and by whom to monitor the responses should be consulted among stakeholders.

The activity plan with timeline, responsible agencies as well as sources of funding is shown in the following table.

Table 9: Activity plan to monitor the HIV services in 2021-2025

	Activities	Responsible agencies	Funding sources	Timeline				
				2021	2022	2023	2024	2025
1	HIV services targeting key population: MSM/TGW/MSW/FSW/PWID/Migrant							
1.1	BBS every 2 years to monitor coverage of KP reached with HIV prevention package of services and tested for HIV ▪ MSM, TGW, MSW ▪ Venue and non-venue-based FSW ▪ PWID ▪ Migrant workers	DOE	DDC	 X	 X X	 X X	 X X	 X
1.2	Quarterly analysis, data visualization and consultation of program data records for RRTTPR ▪ NAP plus ▪ RTCM plus ▪ E-cascade	NHSO DAS FHI360	NHSO, DDC PEPFAR	X	X	X	X	X
2	Treatment and case							
2.1	Annual analysis and consultation of program data and modeling of estimated numbers of PLHIV/KPLHIV for 95 -95 -95 cascade PLHIV	NHSO DAS TUC	NHSO DAS PEPFAR	X	X	X	X	X
3	Prevention of Mother-to-Child Transmission of HIV							
3.1	Quarterly analysis and consultation of program data (PHIMS)	DOH DOMS	DOH	X	X	X	X	X
4	HIV prevention for youth, uniform workers and the workplace							
4.1	TBD							

B.2 Integrated services

Although the integrated services of HIV with TB, STI are identified as needed interventions for years, program records have not been satisfactorily established. During the first 3 years, the establishment of the integrated services will be developed. Meanwhile, the program record system will be developed along with the initiation of integrated HIV and hepatitis C services.

The activity plan with timeline, responsible agencies as well as sources of funding is shown in the following table.

Table 10: Activity plan to monitor the integrated services in 2021-2025

Activities		Responsible agencies	Funding	Timeline				
				2021	2022	2023	2024	2025
1	HIV and TB services integration							
1.1	Develop data framework of HIV and TB services integration	DAS and DTB	GFATM	X	X			
1.2	Establish information system for HIV and TB services integration	DAS and DTB	GFATM		X	X		
2	HIV and hepatitis C services integration							
2.1	Develop data framework of HIV and hepatitis C services integration	DAS	DDC and NHSO		X	X		
2.2	Establish information system for HIV and hepatitis C services integration	DAS	DDC and NHSO			X	X	X
3	HIV and STI services integration							
3.1	Develop data framework of HIV and STI services integration	DAS	DDC	X	X			
3.2	Establish information system for HIV and STI services integration	DAS	DDC		X	X		

B.3 Societal enablers

To monitor the HIV and gender related stigma and discrimination, inclusion the issues in other surveys comprising of the nation-wide survey, i.e., MICS and national health examination survey will be done every 3 and 5 years respectively, and the BBS every 2 years for each key population group. The survey using the UNAIDS tool - National Composite Policy Index (NCPI) will be done every 2 years for more understanding on laws and policy affecting the access to HIV and other services among PLHIV and key populations.

The sentinel surveillance for S&D within health services will be monitored every 2 years. Meanwhile the PLHIV network and partners will conduct the stigma index survey in 2022.

According to the costed action plan for national S&D reduction and human rights promotion and protection, the monitoring of activities and outputs will be done by the national subcommittee on S&D reduction and human rights promotion and protection regularly.

The activity plan with timeline, responsible agencies as well as sources of funding is shown in the following table.

Table 11: Activity plan to monitor the societal enablers in 2021-2025

Activities		Responsible agencies	Funding	Timeline				
				2021	2022	2023	2024	2025
1	Inclusion of HIV-related S&D in other surveys							
1.1	National health examination survey every 5 years	National Health Examination Survey Office (NHES)	MOPH, HSRI, THPF, NRCT				X	

Activities		Responsible agencies	Funding	Timeline				
				2021	2022	2023	2024	2025
1.2	Multiple Indicator Cluster Services (MICS) every 3 years	National Statistical Office (NSO)	UNICEF and NSO	X			X	
1.3	BBS among key population every 2 years ▪ MSM, TGW, MSW ▪ Venue and non-venue-based FSW ▪ PWID ▪ Migrant workers	DOE	DDC and GFATM in 2021-23	 X	 X X X	 X X	 X X X X	 X
1.4	Survey by using National Commitments and Policy Instrument (NCPI) every 2 years	DAS	DDC		X		X	
2	S&D Survey							
2.1	S&D sentinel surveillance in hospitals in 13 provinces very 2 years	DAS	DDC	X		X		X
2.2	Stigma index survey	TNP plus	?		X			
3	Program data							
3.1	Crisis response monitoring	DAS&FAR	DDC and GFATM in 2021-23	X	X	X	X	X

B.4 Resources

The annual national AIDS spending will be assessed every 2 years to monitor the sufficiency of financial support to the responses. The NCPI survey will also provide the policy context to the resources support to the responses.

The activity plan with timeline, responsible agencies as well as sources of funding is shown in the following table.

Table 12: Activity plan to monitor the resources for HIV programs in 2021-2025

Activities		Responsible agencies	Funding	Timeline				
				2021	2022	2023	2024	2025
1	Survey for National AIDS Spending Assessment (NASA)	DAS	DDC		X		X	
2	Survey by using National Commitments and Policy Instrument (NCPI)	DAS	DDC		X		X	

C. Evaluation, special studies and research

Based on the identified gaps and accelerated strategy, the issues for program review, evaluative researches as well as study are preliminary identified. The activity plan with timeline, responsible agencies as well as sources of funding is shown in the following table.

Table 13: Activity plan for evaluation, special studies and research in 2021-2025

Activities		Responsible agencies	Funding	Timeline				
				2021	2022	2023	2024	2025
1	Program review							
1.1	Key population program	DAS	GFATM		X			
1.2	Impact achievement (95-95-95)	DAS	GFATM		X			
1.3	Condom management	DAS	DDC		X			
1.4	Condom strategy	DAS	DDC				X	
1.5	CBO certification	DAS	GFATM		X			
1.6	STI strategy	DAS	DDC					X
1.7	Hepatitis strategy	DAS	DDC					X
2	Evaluative research							
2.1	PrEP services	DAS	UNAIDS PEPFAR GFATM			X		
2.2	S&D program	DAS	UNAIDS PEPFAR					X
2.3	TPT Program	DAS	DDC GFATM			X		
3	Studies and researches							
3.1	Using rapid recency for HIV incidence surveillance	DOE	PEPFAR DDC		X		X	

D. Strengthening the monitoring system

To strengthen the monitoring system, the methodology for estimation/projection as well as BBS will be reviewed; community-based monitoring system will be established; data quality system will be regularly executed; databases will be linked as appropriate; and capacity to use data for stakeholders will be strengthened for national, regional and provincial level. The web-based data and information will be regularly updated and improved to enhance the access to the information for better use for those who need it.

The activity plan with timeline, responsible agencies as well as sources of funding is shown in the following table.

Table 14: Activity plan for strengthening the monitoring system in 2021-2025

Activities		Responsible agencies	Funding	Timeline				
				2021	2022	2023	2024	2025
1	Monitoring HIV epidemic							
1.1	Review methodology of size estimation of Key Populations	DAS	DDC and GFATM in 2021-23	X				X
1.2	Review HIV estimation and projection	DOE	DDC and GFATM	X				
1.3	Review BBS among KPs	DOE	GFATM		X			
2	Community-based monitoring system							
2.1	Develop community think tank for HIV and TB programs	IHRI	GFATM	X	X	X		

Activities		Responsible agencies	Funding	Timeline				
				2021	2022	2023	2024	2025
3	Human capacity for HIV M&E							
3.1	Train trainers at regional level	DAS	GFATM in 2021-2023 PEPFAR, DDC	X	X	X	X	X
3.2	Train provincial SIME units	DAS	GFATM in 2021-23 PEPFAR, DDC	X	X	X	X	X
4	National and sub-national databases							
4.1	Complete linkages between databases of RRTTPR services for key populations (NAP-RTCM-E-cascade)	NHSO	NHSO	X	X			
4.2	Establish integrated drug treatment for PWUD monitoring system	HAD	GFATM	X				
5	Data auditing and data quality assurance							
5.1	NAP plus database	DAS	GFATM in 2021-23 and PEPFAR	X	X	X	X	X
5.2	RTCM database	DAS	GFATM	X				
5.3	PHIMS database	DOH and DAS	DOH and PEPFAR			X	X	X
5.4	MMT database	NHSO	NHSO		X	X	X	X
6	Data visualization, dissemination and data use							
6.1	Maintain and update data warehouse and visualizations • HIV Info Hub • EIIS	 DAS DOE	 DDC, PEPFAR DDC, PS-ICT, PEPFAR	X	X	X	X	X
6.2	Regular feedback reports	DAS	DDC	X	X	X	X	X
6.3	Produce reports (details in section 5)	DAS	DDC	X	X	X	X	X
6.4	Develop guidance of regional and provincial annual report	DAS	GFATM		X	X		
6.5	Annual meeting							
	National level	DAS	GFATM in 2021-23 and DDC	X	X	X	X	X
	Regional level	DAS	GFATM in 2021-23 and DDC	X	X	X	X	X
	Provincial level	DAS and HAD	GFATM in 2021-23	X	X	X	X	X

Strategic Information Products

The National SI and M&E plan includes guidelines for core information products that will be compiled periodically by different stakeholders. Developing routine, standardized information products to be used as strategic information for planning and monitoring is a major step forward for Thailand's M&E efforts, and can be accomplished with strong commitment from key stakeholders. These core information products will be used by provincial sub-committees, the National SI AND M&E Subcommittee, the National Ending AIDS Subcommittee and lastly the National AIDS Committee for evidence-based planning and to gain a holistic picture to monitor the HIV response. The core information products are as follows:

1. Quarterly and half-year service reports
2. Community-led monitoring reports
3. Annual HIV and AIDS reports /GAM reports
4. Web-based visualization
5. Ad hoc reports

These are described in detail below.

1. Service reports

The purpose of this report is to provide a real-time overview of service coverage by key intervention programs and to identify gaps in implementation. The achievements of services will be assessed comparing to targets setting. The DAS will develop guidelines for standardized reporting that will be used throughout the country. The reporting manual will provide standardized definitions and guidelines for reporting on key indicators, methods for disaggregation and a reporting format as well as requirements for submission on a routine basis. Aggregated data from the organizations will be shared at the provincial level with the provincial M&E unit as the entry point.

At the point of service delivery, it is suggested that data should be compiled on a monthly basis. A quarterly report is requested and should be shared with the provincial M&E units. The quarterly report should provide aggregated data by month and district. Quarterly meetings should be held by the Provincial AIDS Committee, the Regional Forum and national subcommittee levels to discuss progress and its implications.

At the end of the fiscal year, the annual report will be required to report accomplishments from the period of 1st of October to 30th September each year. In addition to monitor the achievements of services versus targets, the coverage of target population receiving services will be calculated and compared with coverage indicator targets.

2. Community-led monitoring reports

With the GFATM support, the Thailand Community Think Tank will be developed for HIV and TB programs during 2021-2023. This is to contribute to the Thailand national agenda on sustaining the HIV and TB responses through developing and sustaining technical capacity of the HIV and TB communities, enabling them to monitor, track and improve the national responses. Key purposes are to establish a national technical platform for developing capacity of the HIV and TB communities; to elevate community participation at national and sub-national levels in monitoring and tracking progress of HIV and TB service delivery, ensuring access, quality, affordability and coverage of these services for key populations; and to assist the national AIDS and TB programs in developing sound and data driven strategies and policies for ending these diseases.

As the outputs of the developed Thailand Community Think Tank, community-led monitoring reports will be produced to communicate to stakeholders as well as to be used for advocacy of enabling policies.

3. Annual HIV and AIDS reports /GAM reports

The purpose of this report is to provide a comprehensive overview of the HIV response at the national and sub-national level. This report will include a synthesis of all national indicators contained in the national SI and M&E plan and other complementary information; for example, data on the HIV epidemic and recent results from assessments, program evaluations, research studies and economic studies. The annual report will also serve as the GAM report for sharing internationally. DAS is the lead organization preparing the GAM report, with full participation and collaboration of all key stakeholders

At the national level, DAS is the lead organization to prepare this report on an annual basis. It is expected that DAS will provide technical assistance to provincial M&E units to develop the same report but with a provincial focus.

The annual HIV and AIDS report will be presented to NAC at the national level and to the PAC/PCM at the provincial level. This report will be used to inform decisions on developing program implementation and M&E operational plans as well as to provide up-to-date national and provincial targets.

4. Web-based visualization:

4.1 HIV INFO HUB

The web-based has been developed with the purpose to increase access of quality HIV information for enhancing the use of evidence for better decision at both policy and operational level. It serves as database of data collected from various data sources and visualized as dashboard for convenient use. Data and dashboard shown in the web-based comprise of 3 groups, including epidemic, inputs and responses, of which details are shown in the following Figure.

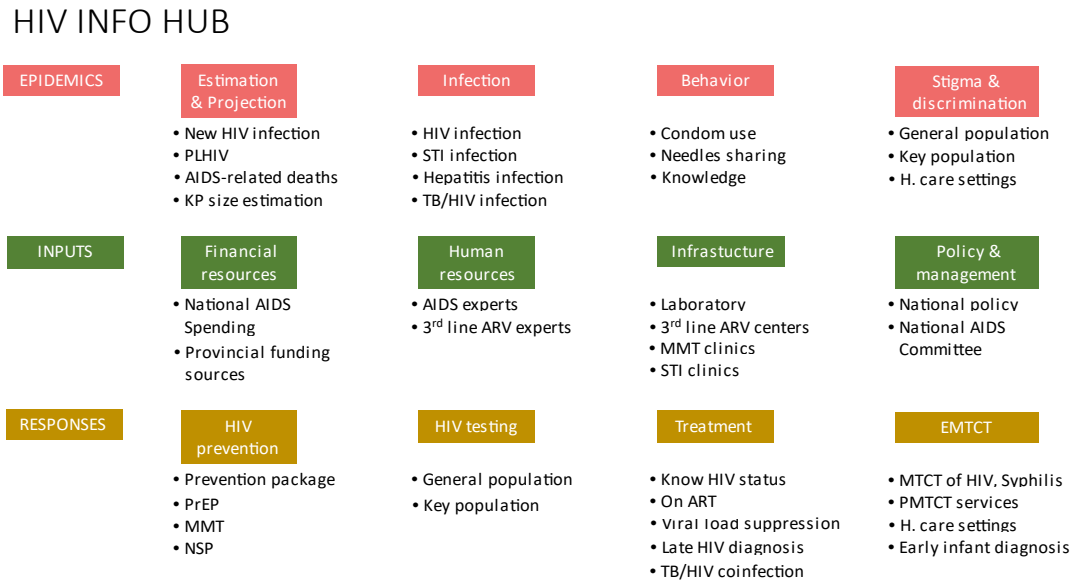

Figure 3: Data and information in the web-based HIV INFO HUB

4. 2 EIIS (Epidemic Intelligence Information System)
The electronic HIV care report and the monitoring system for HIV co-morbidity and mortality are being developed from the MOPH Health Data Center by DOE and Information and Communication Technology (ICT) of The Permanent Secretary Office. The system will provide HIV related co-morbidity and mortality reports/ dashboard. Trend overtime and by geographic areas of HIV morbidity and mortality will be able to monitor and support treatment and care programs.

5. Ad hoc reports
During the course of the National AIDS Strategy, a number of reports will be produced including survey and surveillance reports, research studies and evaluation reports, etc. The DAS will establish an inventory that contains all studies and reports both from Thailand and outside. This database can be accessed by anyone interested.

Annexes

Annex 1: Indicator definition

IMPACT INDICATORS

GOAL 1: To reduce new HIV infections less than 1 000 cases per year by the year 2030

G1.1 Number of new HIV infections per 1 000 uninfected population
G1.2 Estimated number of new HIV infections

What it measures
Progress towards ending the AIDS epidemic

Rationale
The overarching goal of the national AIDS response is to reduce the number of people newly infected to less than 1,000 cases in 2030. Monitoring the rate of people newly infected over time measures the progress towards achieving this goal.

Numerator
Number of people (adults and children) newly infected during the reporting period

Denominator
Number of uninfected populations (adults and children)

Calculation
Numerator/denominator x 1000

Method of measurement
Numerator: estimated by using spectrum-AEM 2020
Denominator: estimated by using country population (WPP: World Population Projection) minus estimated PLHIV (AEM)

Measurement frequency
Annual

Disaggregation
- Sex (male and female)
- Age (0–14, 15–24, 15–49 and 50+ years)

G1.3 Percentage of key populations who are living with HIV

What it measures
Progress on reducing HIV prevalence among key populations (MSM, TGW, MSW, FSW, PWID, prisoners, migrants)

Rationale
As Thailand's HIV epidemic is concentrated, with the higher HIV prevalence among key populations, it is needed to monitor the HIV prevalence among MSM, TGW, MSW, FSW, PWID, prisoners and migrants. Although the HIV prevalence among key population has been declining, still higher than general population. Addressing HIV among key populations is an important component of the national response.

Numerator

Number of people in a specific key population who test positive for HIV

Denominator

Number of people in a specific key population tested for HIV

Calculation

Numerator/Denominator x 100

MSM, TGW - weighted by number of different groups of samples

MSW – weighted by number of different groups of samples and by risk level of sites

Venue-based FSW – median

Non-venue-based FSW – median

PWID – weighted by number of different groups of samples

Method of measurement

This indicator is calculated using data from HIV tests conducted among respondents in the Biobehavioral Survey (BBS) with different sampling methodology at the sentinel sites as the followings:

MSM: using Venue-Date-Time (VDT) sampling in 4 sentinel provinces including Bangkok, Chiang Mai, Phuket and Chonburi

TGW: using Venue-Date-Time (VDT) sampling in 4 sentinel provinces including Bangkok, Chiang Mai, Phuket and Chonburi

MSW: using Venue-Date-Time (VDT) sampling in 4 sentinel provinces including Bangkok, Chiang Mai, Phuket and Chonburi

Venue-based FSW: using cluster sampling in 10 sentinel provinces including Bangkok, Chiangrai, Nakhonsawan, Lopburi, Rayong, Udonthani, Burirum, Srisaket, Phuket and Songkhla

Non venue-based FSW: using Respondent Driven Sampling in 6 sentinel provinces including Bangkok, Chiang Mai, Phuket, Chonburi, Nakhonratchasima and Prachuabkirikhan

PWID: using Respondent Driven Sampling in 3 sentinel provinces including Bangkok, Chiangmai and Songkhla

Migrants: using simple random sampling in 12 sentinel provinces including Bangkok, Chiangmai, Tak, Nonthaburi, Pathumthani, Samutsakhon, Samutprakarn, Chonburi, Rayong, Trat, Phuket and Songkhla

Prisoners, this indicator is calculated using program data

Measurement frequency

Every 2 years for IBBS among MSM, TGW, MSW, FSW, PWID and migrants

Annual for prisoners

Disaggregation

Age (<25 and 25+ years)

Sex (male and female)

Key population (MSM, TGW, MSW, FSW, PWID)

GOAL 2: To reduce AIDS-related deaths less than 4,000 cases per year by the year 2030

G2.1 Number of AIDS-related deaths per 100 000 population
G2.2 Estimated number of AIDS-related deaths

What it measures

Impact of HIV prevention, care and treatment programs

Rationale

Thailand has started treatment for all PLHIV, regardless of CD4 level since 2019. This should significantly reduce the number of people dying from AIDS- related causes, if these services are accessible and delivered effectively. The impact of the HIV response should be assessed by monitoring changes in AIDS-related mortality over time.

Numerator

Number of people (adults and children) dying from AIDS-related causes

Denominator

Total population (adults and children) regardless of HIV status

Calculation

Numerator/denominator x 100 000

Method of measurement

Numerator: estimated by using spectrum-AEM 2020

Denominator: using country population (WPP: World Population Projection)

Measurement frequency

Annual

Disaggregation

Sex (male and female)

Age (<5, 5–14 and 15+ years)

G2.3 TB/HIV mortality rate per 100 000 population

What it measures

Impact of TB/HIV integration program

Rationale

TB is a leading cause of mortality among PLHIV, including those receiving ART. Annual TB screening and prompt TB treatment and early ART are critical for reducing the mortality due to HIV-associated TB and must be the high-priority activity for both the AIDS program and TB program. This indicator will represent the effectiveness of TB/HIV integration program.

Numerator

Number of HIV positive people who die of HIV with TB as a contributory cause of death

Denominator

Total population in the country

Calculation

Numerator/denominator x 100 000

Method of measurement

Numerator: program record (NAP plus and individual check linked with central mortality registration of the Ministry of Interior)

Denominator: estimated by using country population (WPP: World Population Projection)

Measurement frequency

Annual

Disaggregation

ART (yes and no)

GOAL 3: To reduce HIV and gender related discrimination 90% from baseline in 2016 by 2030

G3.1 Percentage of women and men 15-49 years old who report discriminatory attitudes towards PLHIV

What it measures

Progress towards reducing discriminatory attitudes and support for discriminatory policies

Rationale

Discrimination is a human rights violation prohibited by international human rights law and most national constitutions. Discrimination in the context of HIV refers to unfair or unjust treatment (an act or an omission) of an individual based on his or her real or perceived HIV status. Discrimination exacerbates risks and deprives people of their rights and entitlements, fueling the HIV epidemic. This indicator does not directly measure discrimination but rather measures discriminatory attitudes that may result in discriminatory acts (or omission).

Numerator

Number of respondents (15–49 years old) who respond no to either of the two questions

1. Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV? (Yes, no, don't know/not sure/it depend)

2. Do you think that children living with HIV should be able to attend school with children who are HIV negative? (Yes, no, don't know/not sure/it depend)

Denominator

Number of all respondents (15–49 years old) who have heard of HIV

Calculation

Numerator/denominator x 100

Method of measurement

Population-based surveys (Multiple Indicator Cluster Survey: MICS)

Measurement frequency

Every 3 years

Disaggregation

Age (15–19, 20–24 and 25–49 years)

Sex (male and female)

G3.2 Percentage of PLHIV experienced HIV related discrimination in the past 12 months

What it measures

Progress towards reducing discriminatory attitudes and support for discriminatory policies

Rationale

Discrimination is a human rights violation prohibited by international human rights law and most national constitutions. Discrimination in the context of HIV refers to unfair or unjust treatment (an act or an omission) of an individual based on his or her real or perceived HIV status. Discrimination exacerbates risks and deprives people of their rights and entitlements, fueling the HIV epidemic. This indicator does not directly measure discrimination but rather measures discriminatory attitudes that may result in discriminatory acts (or omission).

Numerator

Number of respondents reporting “yes” to the questions on experiences HIV related discrimination in the past 12 months

Denominator

Number of respondents

Calculation

Numerator/denominator x 100

Method of measurement

Stigma index survey

Measurement frequency

Every 5 years

Disaggregation

Age (15–19, 20–24 and 25–49 years)
Sex (male and female)

OUTCOME INDICATORS

A. HIV services

RESULT AREA 1: PLHIV, especially key populations and other vulnerable populations, know their status and are immediately offered and sustained on quality and affordable HIV treatment and care

R1.1 Percentage of PLHIV/KPLHIV who know their HIV status

What it measures

Progress towards increasing the proportion of PLHIV who know their HIV status and the efficacy of HIV testing interventions

Rationale

PLHIV who know their HIV status will be able to access the HIV care and treatment services required to live healthy, productive lives and to reduce the potential of transmitting HIV to other people.

This measure is the first 95 of the UNAIDS 95–95–95 target: that 95% of the PLHIV know their HIV status by 2025. However, it is important for Thailand, as the concentrated epidemic country, to monitor the coverage of different groups among KPLHIV who know their HIV status.

Numerator

Number of PLHIV who know their HIV status at the end of the reporting period

Denominator

Estimated number of PLHIV in the country

Calculation

Numerator/denominator x 100

Method of measurement

Numerator: program record (NAP plus database); counting number of people diagnosed with HIV who are still alive.

Denominator: using the estimation model of AIDS Epidemic Model for all PLHIV, MSM, TGW, MSW, FSW, PWID

Measurement frequency

Annual

Disaggregation

- 0–14 years for children and 15 years and older by sex (male and female) for adults.
- Disaggregation by detailed age and sex: <1 year, 1-4 years, 5-9 years and 10-14 years for children and 15-19 years, 20-24 years, 25-49 years and 50+ years by sex (male and female)
- Bangkok and provinces for all PLHIV data
- Key populations (MSM, TGW, MSW, FSW, PWID)

R1.2 Percentage of PLHIV who are on ART at the end of the reporting period

What it measures

Progress towards providing antiretroviral therapy to all PLHIV

Rationale

Antiretroviral therapy has been shown to reduce HIV-related morbidity and mortality among PLHIV, and to halt onward transmission of the virus. Studies also show that early initiation, regardless of a person's CD4 cell count, can enhance treatment benefits and save lives. The national guideline on ART recommends treatment at any CD4 level.

When considered as a proportion of Indicator R1.1, this indicator monitors progress toward the second 95 of the UNAIDS 95–95–95 target: that 95% of people who know their HIV-positive status are accessing treatment by 2025. However, it is important for Thailand, as the concentrated epidemic country, to monitor the coverage of different groups among KPLHIV on ART.

Numerator

Number of PLHIV on ART at the end of the reporting period

Denominator

To determine treatment coverage: estimated number of PLHIV

To determine the second 95: number of PLHIV who know their HIV status

Calculation

Numerator/denominator x 100

Method of measurement

Numerator: program records (NAP plus database); counting the number of adults and children, MSM, TGW, MSW, FSW, PWID who are on ART at the end of the reporting period.

Denominator:

To determine treatment coverage: using the estimation model of AIDS Epidemic Model for all PLHIV, MSM, TGW, MSW, FSW, PWID.

To determine the second 95: program records (NAP plus database); counting the number of adults and children with HIV/KPLHIV who know their HIV status

Measurement frequency

Annual

Disaggregation

- 0–14 years for children, and 15 years and older by sex (male and female) for adults.
- Disaggregation by detailed age groups for children: <1 year, 1–4 years, 5–9 years and 10–14 years for children; and by detailed age sex groups for adults: 15–19 years, 20–24 years, 25–49 years and 50+ years.
- Bangkok and provinces for all PLHIV
- Key population (MSM, TGW, MSW, FSW, PWID)

R1.3 Percentage of PLHIV on ART who have suppressed viral loads at the end of the reporting period

What it measures

Progress towards increasing the proportion of PLHIV on ART who have suppressed viral load.

Rationale

Individual-level viral load is the measure of ART efficacy and indicates treatment adherence and the risk of transmitting HIV. People with viral load test results below the threshold, <1,000 copies/mL, should be considered as having suppressed viral loads.

When considered as a proportion of the number of people on treatment, this indicator monitors the third 95 of the UNAIDS 95–95–95 targets: that 95% of the people receiving antiretroviral therapy will have suppressed viral loads by 2025. However, it is important for Thailand, as the concentrated epidemic country, to monitor the coverage of different groups among KPLHIV on ART who have suppressed viral loads.

Numerator

Number of PLHIV in the reporting period with suppressed viral loads (<1,000 copies/mL)

Denominator

To determine viral load suppressed coverage: estimated number of PLHIV

To determine the third 95: number of PLHIV who are on ART

Calculation

Numerator/denominator x 100

Method of measurement

Numerator: program records (NAP plus database); counting the number of adults and children on ART living at the end of the reporting period who have latest viral load < 1000 cells/mL

Denominator:

To determine viral load suppressed coverage: using the estimation model of AIDS Epidemic Model for all PLHIV, MSM, TGW, MSW, FSW, PWID.

To determine the third 95: program records (NAP plus database); counting the number of adults and children with HIV/KPLHIV on ART who had viral load tested

Note: The coverage of PLHIV/KPLHIV had viral load tested has to be taken into consideration for determining the third 95.

Measurement frequency

Annual

Disaggregation

- 0–14 years for children and 15 years and older by sex (male and female) for adults; data reported for unknown age or sex should be allocated to the age and sex disaggregated data cells using the same distribution of the data with known age and sex.
- Disaggregation by detailed age and sex: <1 year, 1–4 years, 5–9 years and 10–14 years for children and 15–19 years, 20–24 years, 25–49 years and 50+ years by sex (men and women)
- Bangkok and provinces
- Key population (MSM, TGW, MSW, FSW, PWID)

RESULT AREA 2: Young people access sustained combination HIV prevention

R2.1 Percentage of respondents who say they used a condom the last time they had sex with a non-marital, non-cohabitating partner, of those who had sex with such a partner in the last 12 months

What it measures

Progress towards preventing exposure to HIV through unprotected sexual intercourse among people with non-marital / non-cohabiting partners.

Rationale

Condom use is an important way of protecting against HIV, especially among people with non-regular sexual partners.

Numerator

Number of respondents who report using a condom the last time they had sex with a non-marital, non-cohabiting partner

Denominator

Number of respondents who report that they had sex with a non-marital, non-cohabiting partner in the last 12 months

Calculation

Numerator/denominator x 100

Method of measurement

Behavioral Surveillance Survey (BSS) among students

Measurement frequency

every 3–5 years

Disaggregation

- Sex (male and female)
- Age (15–19, 20–24 and 25–49 years)
- Level of education (grade 8, 10, and occupational education year 1)

R2.2 Percentage of women and men (aged 15–24 years) who correctly identify both ways of preventing sexual transmission of HIV; and reject major misconceptions about HIV transmission.

What it measures

Progress towards universal knowledge of the essential facts about HIV transmission

Rationale

HIV epidemics are perpetuated primarily through the sexual transmission of infection to successive generations of young people. Sound knowledge about HIV and AIDS is necessary (although often insufficient) for adopting behavior that reduces the risk of HIV transmission.

Numerator

Number of respondents 15–24 years old who correctly answered all five questions:

1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?

2. Can a person reduce the risk of getting HIV by using a condom every time they have sex?
3. Can a healthy-looking person have HIV?
4. Can a person get HIV from mosquito bites?
5. Can a person get HIV by sharing food with someone who is infected?

Denominator
Number of all respondents 15–24 years old

Calculation
Numerator/denominator x 100

Method of measurement
Multiple Indicator Cluster Survey

Measurement frequency
Every 3 years

Disaggregation
- Age (15–19 and 20–24 years)
- Sex (male and female)

RESULT AREA 3: Tailored and scaled HIV combination prevention and related HIV and health services accessible to and utilized by key populations

R3.1 Percentage of key populations reached with HIV prevention programs

What it measures
Progress of efforts in increasing coverage of key populations (MSM, TGW, MSW, FSW, PWID) received defined package of HIV prevention services

Rationale
Successfully confronting the HIV epidemic requires combining preventive behavior and antiretroviral therapy. Coverage with evidence-informed prevention programming is a critical component of the response, the importance of which is reflected in the National Strategy

Numerator
Number of people in a key population (MSM, TGW, PWID) who report receiving defined package of HIV prevention services in the past three months:

- In the past three months, have you been given condoms and lubricant?
- In the past three months, have you received counselling on condom use and safe sex?
- Have you been tested for sexually transmitted infections in the past three months?
- Have you received new, clean needles or syringes in the past three months? (PWID)

Number of people in a key population (FSW, Migrants) who report receiving 2/3 of defined package of HIV prevention services in the past 12 months: HIV education, condoms, knew where they can receive HIV testing.

Denominator
Number of people in a key population responding to the survey

Calculation
Numerator/denominator x 100

Method of measurement
Biobehavioral Survey (BBS)
See details in Indicator G1.2

Measurement frequency
Every 2 years

Disaggregation
Age (<25 years and 25+ years)
Key populations (MSM, TGW, MSW, FSW, PWID)

R3.2 Percentage of key populations receiving PrEP

What it measures
Progress providing PrEP to key populations (MSM, TGW, MSW, FSW, PWID)

Rationale
This indicator is key to assessing the availability and uptake of PrEP, especially among people at higher risk of HIV infection (MSM, TGW, MSW, FSW, PWID). The use of antiretroviral medicine by people who are HIV-negative before they are exposed to HIV can prevent HIV infection. PrEP has been shown to be effective in a wide range of HIV-negative populations.

Numerator
Number of key populations who reported uptake of oral PrEP during the previous 12 months

Denominator
Number of people in a key population responding to the survey of respondents

Calculation
Numerator/denominator x 100

Method of measurement
Biobehavioral Survey (BBS)
See details in Indicator G1.2

Measurement frequency
Every 2 years

Disaggregation
Key populations (MSM, TGW. MSW, FSW, PWID).
<25 years and 25+ years

R3.3 Percentage of key populations that have received an HIV test during the reporting period and know their results

What it measures
Progress providing HIV testing services to members of key populations (MSM, TGW, MSW, FSW, PWID)

Rationale

Ensuring that PLHIV receive the care and treatment required to live healthy, productive lives and reducing the chance of transmitting HIV require that they know their HIV status. This indicator captures the effectiveness of HIV testing interventions targeting populations at higher risk of HIV infection.

Numerator

Number of respondents who received HIV testing during the previous 12 months

Denominator

Number of people in a key population responding to the survey of respondents

Calculation

Numerator/denominator x 100

Method of measurement

Biobehavioral Survey (BBS)
See details in Indicator G1.2

Measurement frequency

Every 2 years

Disaggregation

Key populations (MSM, TGW. MSW, FSW, PWID)
<25 years and 25+ years

R3.4 Percentage of MSM reporting the use of a condom the last time they had anal sex with a non-regular partner

What it measures

Progress in preventing exposure to HIV among men who have unprotected anal sex with a male partner

Rationale

Condoms can substantially reduce the risk of sexually transmitting HIV. Consistently and correctly using condoms is therefore important for MSM because of the high risk of HIV transmission during unprotected anal sex. In addition, men who have anal sex with other men may also have female partners, who could become infected as well. Condom use with the most recent male partner is considered a reliable indicator of longer-term behavior.

Numerator

Number of MSM who reported using a condom the last time they had anal sex

Denominator

Number of MSM who reported having had anal sex with a male partner in the past six months

Calculation

Numerator/Denominator x 100
Weighted by number of different groups of samples

Method of measurement

Biobehavioral Survey (BBS)
A sample of MSM, respondents are asked about sexual partnerships in the past six months, about anal sex within these partnerships and about condom use when they last had anal sex. Condom use applies whether the respondent is the receptive and insertive partner.

Measurement frequency
Every 2 years

Disaggregation
Age (<25 and 25+ years)

R3.5 Percentage of TGW reporting using a condom in their last anal sex with a non-regular male partner

What it measures
Progress in preventing exposure to HIV among TGW through unprotected sex with partners

Rationale
Condoms can substantially reduce the risk of sexually transmitting HIV. Consistently and correctly using condoms is therefore important for TGW because of the high risk of HIV transmission during unprotected anal sex. Condom use with the most recent penetrative sex partner is considered a reliable indicator of longer-term behavior

Numerator
Number of TGW who reported using a condom at last sexual intercourse or anal sex

Denominator
Number of TGW surveyed who reported having sexual intercourse or anal sex in the past six months

Calculation
The percentage was calculated and weighted proportionate to size of high risk and low risk.

Method of measurement
The survey was conducted in 4 sites, including Bangkok, Chiangmai, Phuket and Chonburi, using methodology of VDT: Venue Date Time Location.

Measurement frequency
Every 2 years

Disaggregation
Age (<25 years and 25+ years)

R3.6 Percentage of Sex workers (SW) reporting the use of a condom with their most recent client

What it measures
Progress in preventing exposure to HIV among SW through unprotected sex with clients

Rationale
Various factors increase the risk of exposure to HIV among SW, including multiple, non-regular partners and more frequent sexual intercourse. However, SW can substantially reduce the risk of HIV transmission, both from clients and to clients, by consistently and correctly using condoms.

Numerator
Number of SW who reported using a condom with their last client

Denominator
Number of SW who reported having commercial sex in the past 12 months

Calculation
Numerator/denominator x 100

Method of measurement
Biobehavioral Survey (BBS): The survey was conducted in 4 sites, including Bangkok, Chiangmai, Phuket and Chonburi, using methodology of VDT: Venue Date Time Location.

Measurement frequency
Every 2 years

Disaggregation
Sex (female, male and transgender)
Age (<25 years and 25+ years)

R3.7 Percentage of PWID reporting the use of sterile injecting equipment the last time they injected

What it measures
Progress in preventing transmission of HIV through injection among PWID

Rationale
Safer injecting and sexual practices among PWID are essential. The risk of HIV transmission from contaminated injecting equipment is extremely high, and PWID can spread HIV (such as through sexual transmission) to the wider population.

Numerator
Number of PWID who reported using sterile injecting equipment the last time they injected drug

Denominator
Number of PWID who report having injected drugs in the past month

Calculation
Numerator/denominator x 100

Method of measurement
Biobehavioral Survey (BBS): using Respondent Driven Sampling method to cover male, female and young PWID in 3 provinces including Bangkok (capital city), Chiangmai (province in the north) and Songkhla (province in the south).

Measurement frequency
Every 2 years

Disaggregation
Gender (female, male, MSM, TGW)
Age (<25 and 25+ years)

R3.8 Percentage of PWID reporting condom use at last sex

What it measures
Progress in preventing sexual transmission of HIV among PWID

Rationale

Safer injecting and sexual practices among PWID are essential. The HIV transmission from contaminated injecting equipment is extremely high, and PWID can spread HIV (such as through sexual transmission) to the wider population.

Numerator

Number of PWID who reported using a condom the last time they had sex

Denominator

Number of PWID who report having injected drugs and having had sexual intercourse in the past month

Calculation

Numerator/denominator x 100

Method of measurement

Biobehavioral Survey (BBS) using Respondent Driven Sampling method to cover male, female and young PWID in 3 provinces including Bangkok (capital city), Chiangmai (province in the north) and Songkhla (province in the south).

Measurement frequency

Every 2 years

Disaggregation

- Sex (female, male, MSM, TGW)
- Age (<25 years and 25+ years)

R3.9 Percentage of migrants who report the use of a condom at last sexual intercourse

What it measures

Progress in preventing sexual transmission of HIV among migrants at risk of HIV

Rationale

Migrants at risk of HIV include migrants from 5 occupations, i.e., fishermen, seafood processing, factory workers, construction workers and female sex workers from Myanmar, Cambodia and Lao PDR

Numerator

Number of male migrants reporting the use a condom at last sex with FSW

Denominator

Number of respondents

Calculation

Numerator/denominator x 100

Method of measurement

Biobehavioral Survey (BBS)

See details in indicator G1.3

Measurement frequency

Every 2 years

Disaggregation

• Gender (female, male, TGW).

• Age (<25 years and 25+ years)

B. Integration

RESULT AREA 4: Eliminate vertical transmission of HIV, syphilis and hepatitis

R4.1 Percentage of children newly infected with HIV from mother-to-child transmission among women living with HIV delivering in the past 12 months

What it measures

Progress in providing women with ARV to reduce mother-to-child transmission of HIV

Rationale

Efforts have been made to increase access to interventions that can significantly reduce mother-to-child transmission of HIV, including combining antiretroviral medicine prophylactic and treatment regimens and strengthening counselling on infant feeding. The impact of interventions for preventing mother-to-child transmission in reducing the number of children newly infected with HIV through mother-to-child transmission needs to be assessed.

Numerator

Estimated number of children newly infected with HIV in the previous 12 months from mother-to-child transmission

Denominator

Estimated number of births to women living with HIV in the previous 12 months

Method of measurement

HIV estimated by Spectrum

Measurement frequency

Annual

Disaggregation

Thai and non-Thai

R4.2 Reported congenital syphilis cases (live births and stillbirths) per 100 000 livebirths

What it measures

Progress in eliminating the mother-to-child transmission of syphilis

Rationale

Untreated syphilis infection in pregnancy can not only increase the risk of the mother and the infant transmitting and acquiring HIV but also lead to stillbirth, neonatal death and congenital disease. Given the high efficacy, simplicity and low cost of syphilis testing and treatment, global and regional initiatives to eliminate the mother-to-child transmission of syphilis have been launched. The rate of congenital syphilis is a measure of the impact of programmatic interventions to eliminate the mother-to-child transmission of syphilis.

Numerator

Number of reported congenital syphilis cases (livebirths and stillbirths) in the past 12 months

Denominator

Number of livebirths

Calculation

Numerator/denominator x 1 000

Method of measurement

Numerator: using the program record investigating for confirmed diagnosis with the following criteria:

1. Syphilis treatment of mothers- not within standard or incomplete or late treatment or do not know whether she was treated
2. VDRL/RPR titer of children – equal or 4 times more than mothers' VDRL/RPR titer
3. Clinical and investigation – compatible with congenital syphilis
4. Stillbirths and syphilis positive in mothers

Denominator: program record

Measurement frequency

Annual

Disaggregation

Thai and non-Thai

R4.3 HBsAg prevalence among children aged 5 years

What it measures

Progress in eliminating the mother-to-child transmission of hepatitis B virus

Rationale

Globally 90 % of transmission of Hepatitis B virus (HBV) is from mother-to child and occurs predominantly in resource limited countries where the prevalence of HBV is high. The WHO Regional Framework for Triple Elimination of Mother-to-Child Transmission (EMTCT) of HIV, Hepatitis B (HBV) and Syphilis was adopted in Asia and the Pacific 2018-30. The regional targets and strategies are aligned with program targets established by the WHO Global Health Sector Strategy on Viral Hepatitis 2016–2021 that aim to reduce HBsAg prevalence among children aged 5 years to ≤1% by 2020 and to ≤0.1% by 2030.

Thailand had been endorsed for EMTCT of HIV and syphilis in 2016 and 2020 for children born in 2019-2020. Meanwhile the EMTCT of Hepatitis B was endorsed in 2018 to reduce HBsAg prevalence among children aged 5 years to less than 1% by 2025.

The hepatitis B vaccination (HBV) for newborns had begun since 1992. The HBV will be given at birth, followed for 2nd and 3rd doses at 1 and 6 months of age. The coverage of the HBV vaccine at birth dose and the 3rd HBV vaccine (HB3) from the National vaccine coverage survey in 2018 are 99.6 and 96.5 percent respectively. However, the vaccine coverage data from Health Data Center (HDC) Dashboard of the Ministry of Public Health shows that the HBV vaccine coverage and HB3 in the fiscal year 2021 are 94.8 and 86.7 percent.

Numerator

Number of children aged 5 years tested positive for HBsAg

Denominator

Number of children aged 5 years tested for HBsAg

Calculation
Numerator/denominator x 100

Method of measurement
National Surveillance Survey

Measurement frequency
Every 5 years

RESULT AREA 5: Equitable, people-centered sustainable and context-specific integrated HIV and health services support the achievement of AIDS targets within the strengthened, resilient systems for health

R5.1 Prevalence of hepatitis and coinfection with HIV among key populations

What it measures
Comorbidity with HIV and potential need for appropriate treatment

Rationale
Appreciation of hepatitis and HIV coinfection has improved recently. Many people living with HIV receiving antiretroviral therapy are dying from liver disease resulting from untreated viral hepatitis. HIV treatment regimens can be adjusted to treat chronic hepatitis B infection as well. New, highly effective hepatitis C treatment is available and has a high rate of virus clearance regardless of hepatitis C virus subtype. Measuring the hepatitis burden among key populations living with HIV can help national planners determine the resources needed to address the syndemic.

Numerator
Number of people in a key population who test positive for antibody to hepatitis C virus or hepatitis B surface antigen and number of people in a key population who also test positive for HIV together with one of the above

Denominator
Number of respondents tested for both HIV and one or both of hepatitis B and C

Calculation
Numerator/denominator x 100

Method of measurement
Included in BBS: to be determined.

Measurement frequency
Every 2 years

Disaggregation
- Age (<25 years and 25+ years)
- Gender (male, female and transgender)
- Key population (MSM, TGW, MSW, FSW, PWID)

R5.2 Percentage of PLHIV who are newly enrolled in HIV treatment with active TB

What it measures

The burden of active TB among people living with HIV who are newly enrolled in HIV treatment. It also indirectly measures efforts to detect HIV-associated TB early.

Rationale

The primary aims of intensified TB case-finding in HIV care settings and provider-initiated HIV testing and counselling for TB patients are early detection of HIV-associated TB and prompt provision of antiretroviral therapy and TB treatment. Although intensified TB case-finding should be implemented among all PLHIV at each visit to HIV care and treatment facilities, it is particularly important at the time of enrolment, since the risk of undetected TB is higher among newly enrolled patients than among those already receiving ART. Furthermore, newly enrolled PLHIV may be less aware of TB symptoms and the importance of early detection and treatment, and they may not seek care for general or specific TB symptoms. Intensified TB case-finding offers an opportunity to educate PLHIV and to detect TB early.

Numerator

Number of PLHIV newly enrolled in HIV treatment who have active TB disease during the reporting period

Denominator

Number of people newly enrolled in HIV treatment

Calculation

Numerator/denominator x 100

Method of measurement

Numerator: program record (NAP plus database); counting the total number of PLHIV newly enrolled in HIV treatment who have active TB disease. Data will be counterchecked from NTIP database.

Denominator: program record; counting the total number of PLHIV who are newly enrolled in HIV treatment.

Measurement frequency

Annual

Disaggregation

Bangkok and provinces

R5.3 Percentage of MSM with active syphilis

What it measures

Progress in decreasing high-risk sexual behavior and intervention efforts to control syphilis among MSM.

Rationale

Testing of syphilis among MSM is important for their health and for second-generation surveillance purposes.

Numerator

Number of MSM testing positive for active syphilis

Denominator
Number of MSM tested for active syphilis

Calculation
Numerator/denominator x 100

Method of measurement
Included in BBS
Rapid treponemal tests are easy to use, which encourages the utility of these tests for screening, ideally paired with a non-treponemal test that detects reaginic antibody. Regardless of test, the proposed indicator requires both a positive non-treponemal test and a positive treponemal test to give a proxy for active infection.

Measurement frequency
Every 2 years

Disaggregation
Age (<19, 19-24, and 25+years)

R5.4 Percentage of sex workers with active syphilis

What it measures
Progress in decreasing high-risk sexual behavior and intervention efforts to control syphilis among sex workers

Rationale
Testing sex workers for syphilis is important for their health and for second-generation surveillance purposes

Numerator
Number of sex workers who tested positive for active syphilis

Denominator
Number of sex workers who were tested for active syphilis

Calculation
Numerator/denominator x 100

Method of measurement
- Included in BBS
- Rapid treponemal tests are easy to use, which encourages the utility of these tests for screening, ideally paired with a non-treponemal test that detects reaginic antibody. Regardless of test, the proposed indicator requires both a positive non-treponemal test and a positive treponemal test to give a proxy for active infection.

Measurement frequency
Every 2 years

Disaggregation
Gender (female, male and transgender women)
Age (<19, 19-24, and 25+years)

C. Social enablers

RESULT AREA 6: People living with HIV, key populations and other people who are at high risk of HIV enjoy their human rights and live with dignity, free of stigma, discrimination, with meaningful access to justice and in enabling legal environments

R6.1 Percentage of PLHIV/key populations who report experiences of HIV/gender/sex work/drug use-related discrimination in health-care settings

What it measures

Progress in reducing HIV/gender/sex work/drug use-related discrimination experienced by PLHIV and key populations when seeking health-care services.

Rationale

The health sector is one of the main settings where PLHIV and key populations experience discrimination. This indicator directly measures discrimination experienced by PLHIV and key populations when seeking services in health-care settings.

Numerator

Number of respondents who respond in the affirmative ("Yes") to at least one in each domain during the last 12 months

Denominator

Number of all respondents

Calculation

Numerator/denominator x 100

Method of measurement

Sentinel surveillance survey in sentinel sites including 1 province/regional health area, totaling Bangkok and 12 provinces (4 provinces in the north-east, 3 provinces in the north, 3 provinces in the central and 2 provinces in the south).

The survey populations include heath care workers and PLHIV on ART at hospitals.

Respondents of the survey are asked if they experienced any of the following forms of HIV-related discrimination when seeking HIV and non-HIV specific health services in the last 12 months:

- Denial of care due to HIV status.
- Move to be in the last que to receive services.
- Less attention comparing to other patients.
- Asked to put used clothes in separate place by him/herself.
- Advised not to have sex because of HIV status.
- Advised not to have a child.
- Provide ART only if using birth control or sterilization.
- Disclose HIV status to others without consent
- Being the subject of gossip or negative talk because of HIV status.

Measurement frequency

Every 2 years

Disaggregation

Type of health service (HIV, non-HIV).

Gender (male, female or transgender).

Key population (MSM, TGW, MSW, FSW, PWID).
Age group (15–19 years, 20–24 years or 25–49 years).
Length of time living with HIV (0–<1 years, 1-4 years, 5-9 years, 10-14 years or 15+ years)

R6.2 Percentage of PLHIV and key populations avoiding of health care because of stigma and discrimination

What it measures
Progress towards reducing avoiding of health care caused by S&D of PLHIV and key populations (MSM, TGW, MSW, FSW, PWID)

Rationale
Stigma and discrimination impede HIV services at every step, limiting access to prevention services, engagement in care and adherence to ART. Being afraid to be stigmatized and/or experiencing stigmatized and discriminated of PLHIV and key populations are critical barriers of seeking not only HIV services, but also other health services.

Numerator
Number of respondents reporting “yes” to the question on used to avoid health care because of stigma and discrimination

Denominator
Number of all respondents

Calculation
Numerator/denominator x 100

Method of measurement
PLHIV: as part of the sentinel surveillance survey of stigma and discrimination in health care settings
Key populations (MSM, TGW. MSW. FSW, PWID, migrants): included in the BBS for each key population group.

Measurement frequency
Every 2 years

Disaggregation
Age (<25 years, 25 years and more)
Gender (male, female, transgender)

R6.3 Percentage of PLHIV/KP who report experiences of HIV-related discrimination at workplaces

What it measures
Progress towards reducing discrimination to PLHIV and key populations (MSM, TGW, MSW, FSW, PWID)

Rationale
Stigma and discrimination impede not only HIV services but also at workplaces. The ART leads PLHIV to be able to live a normal life. Discrimination at workplaces including recruitment, career promotion or other treatments different from others due to HIV or because they are any group of key populations is a kind of human rights violation.

Numerator
Number of respondents who reported experiences of HIV-related discrimination at workplaces during the last 12 months

Denominator
Number of all respondents

Calculation
Numerator/denominator x 100

Method of measurement
PLHIV: stigma index survey
Key populations (MSM, TGW. MSW. FSW, PWID, migrants): the internalized stigma questions are included in the BBS for each key population group.

Measurement frequency
Every 2 years

Disaggregation
Age (<25 years, 25 years and more)
Gender (male, female, transgender)
Key population (MSM, TGW, MSW, FSW, PWID, migrants)

R6.4 Percentage of PLHIV/ key populations who report internalized stigma

What it measures
Progress towards reducing self-stigma of PLHIV and key populations (MSM, TGW, MSW, FSW, PWID)

Rationale
Stigma and discrimination impede HIV services at every step, limiting access to prevention services, engagement in care and adherence to ART. Internalized stigma for PLHIV and key populations is also a critical barrier of seeking not only HIV services, but also other health services.

Numerator
Number of respondents who respond in the affirmative (“Yes”) to at least one in each domain during the last 12 months

Denominator
Number of all respondents

Calculation
Numerator/denominator x 100

Method of measurement
PLHIV: as part of the sentinel surveillance survey of stigma and discrimination in health care settings
Key populations (MSM, TGW, MSW, FSW, PWID, migrants): the internalized stigma questions are included in the BBS for each key population group.

Measurement frequency
Every 2 years

Disaggregation
Age (<25 years, 25 years and more)
Gender (male, female, transgender)
Key populations (MSM, TGW, MSW, FSW, PWID)

R6.5 Percentage of healthcare staff reporting observed stigma toward PLHIV in the past 12 months

What it measures

Progress towards reducing human rights violation in health care services

Rationale

The health sector is one of the main settings where PLHIV and key populations experience discrimination. This indicator measures stigmatized behaviour through observation by health care workers in their own hospitals.

Numerator

Number of health care worker respondents who respond in the affirmative ("Yes") to at least one question of observed stigma bahaviour during the last 12 months

Denominator

Number of all health care worker respondents

Calculation

Numerator/denominator x 100

Method of measurement

Sentinel hospital surveillance survey in sentinel sites including 1 province/regional health area, totaling Bangkok and 12 provinces (4 provinces in the north-east, 3 provinces in the north, 3 provinces in the central and 2 provinces in the south). The survey populations include heath care workers and PLHIV on ART at hospitals.

Health care worker respondents of the survey are asked to reply whether they observed stigmatized behaviors of health care workers in the hospitals during the previous 12 months as follows:

1. unwilling to provide services to PLHIV or those suspected to have HIV
2. provide services to PLHIV or those suspected to have HIV with less quality manner.

Measurement frequency

Every 2 years

Disaggregation

Provinces

R6.6 Percentage of healthcare staff reported negative attitude toward PLHIV

What it measures

Progress towards reducing stigma and discrimination in health care services

Rationale

The health sector is one of the main settings where PLHIV and key populations experience discrimination. The negative attitude toward PLHIV of health care workers may bring about the discrimination practices to PLHIV seeking services in health-care settings.

Numerator

Number of health care worker respondents who respond in the affirmative ("Yes") to at least one question of negative attitude toward PLHIV

Denominator

Number of all health care worker respondents

Calculation
Numerator/denominator x 100

Method of measurement
Sentinel hospital surveillance survey in sentinel sites including 1 province/regional health area, totaling Bangkok and 12 provinces (4 provinces in the north-east, 3 provinces in the north, 3 provinces in the central and 2 provinces in the south). The survey populations include heath care workers and PLHIV on ART at hospitals.
Health care workers respondents of the survey are asked if they agree with the following statements:
1. Most of PLHIV are not aware that they may transmit HIV to others.
2. PLHIV should be ashamed that they are HIV infected.
3. People get HIV infection because they do not have responsibility and have inappropriate behaviour.
4. Do not agree that women living with HIV can have children if they want.

Measurement frequency
Every 2 years

Disaggregation
Provinces

R6.7 Percentage of healthcare staff worried of contracting HIV while caring for PLHIV

What it measures
Progress towards reducing stigma and discrimination in health care services

Rationale
The health sector is one of the main settings where PLHIV and key populations experience discrimination. The worriedness of contracting HIV from PLHIV may bring to the over action of healthcare staff while caring for PLHIV. This can affect PLHIV to avoid receiving services.

Numerator
Number of health care worker respondents who respond in the affirmative (“Yes”) to at least one in question of having worried to contract HIV while caring for PLHIV

Denominator
Number of all health care worker respondents

Calculation
Numerator/denominator x 100

Method of measurement
Sentinel surveillance survey in sentinel sites including 1 province/regional health area, totaling Bangkok and 12 provinces (4 provinces in the north-east, 3 provinces in the north, 3 provinces in the central and 2 provinces in the south). The survey populations include heath care workers and PLHIV on ART at hospitals.
For this indicator, health care workers are asked whether they are worried to contract HIV while caring PLHIV in the following practices:
1. touching clothes or any other personal items of PHIV
2. dressing PLHIV’s wounds
3. drawing PLHIV’s blood

Measurement frequency
Every 2 years

Disaggregation
Province

RESULT AREA 7: Women and girls, men and boys, in all their diversity, practice and promote gender-equitable social norms and gender equality, and work together to end gender-based violence and to mitigate the risk and impact of HIV

R7.1 Percentage of ever-married or partnered women 15-49 years old who experienced physical or sexual violence from a male intimate partner in the past 12 months

What it measures
Progress in reducing the prevalence of intimate partner violence against women, as an outcome itself and as a proxy for gender inequality. An intimate partner is defined as a cohabiting partner, whether or not they were married at the time. The violence could have occurred after they separated.

Rationale
Globally, high rates of HIV infection among women have brought into sharp focus the problem of violence against women. There is growing recognition that deep-rooted, pervasive gender inequalities, especially violence against women and girls, shape their risk of and vulnerability to HIV infection. Violence and HIV have been linked through direct and indirect pathways. Studies in many countries indicate that many women have experienced violence in some form or another at some point in their life. WHO estimates that one in three women globally has experienced intimate partner violence and/or non-partner sexual violence.

Numerator
Number of women 15–49 years old who have or have ever had an intimate partner and report experiencing physical or sexual violence from at least one of these partners in the past 12 months.

Denominator
Number of women 15–49 years old surveyed who currently have or have had an intimate partner

Calculation
Numerator/denominator x 100

Method of measurement
To be determined (MICS or National Health Survey)

Measurement frequency
Every 3 years

Disaggregation
- Age (15–19, 20–24 and 25–49 years)

R7.2 Percentage of women living with HIV experienced gender-based violence

What it measures

Progress in reducing the prevalence of intimate partner violence against women living with HIV. An intimate partner is defined as a cohabiting partner, whether or not they were married at the time. The violence could have occurred after they separated.

Rationale

Globally, high rates of HIV infection among women have brought into sharp focus the problem of violence against women. There is growing recognition that deep-rooted, pervasive gender inequalities, especially violence against women and girls, shape their risk of and vulnerability to HIV infection. The gender-based violence of women living with HIV should be regularly monitored.

Numerator

Number of women living with HIV 15–49 years old who have or have ever had an intimate partner and report experiencing physical or sexual violence from partners in the past 12 months.

Denominator

Number of women living with HIV 15–49 years old surveyed who currently have or have had an intimate partner

Calculation

Numerator/denominator x 100

Method of measurement

Stigma index survey

Measurement frequency

Every 3 years

Disaggregation

- Age (15–19, 20–24 and 25–49 years)

D. Resources

RESULT AREA 8: Community-led responses are fully recognized, empowered, resourced, and integrated for a transformative and sustainable HIV response

R8.1 Percentage of domestic HIV prevention programs supporting community organizations to provide services

What it measures

Progress of inclusion of community-led responses in country health system

Rationale

The National Health Security Office has supported the HIV prevention among key populations since 2016. The allocation to CSOs was limited due to the government regulation. The increasing of allocation proportion will be a measure of increasing recognition of community-led responses.

Numerator

Amount of budget support to CSOs for HIV prevention among key populations

Denominator

Total amount of budget for HIV prevention among key populations

Calculation

Numerator/denominator x 100

Method of measurement

Information from the National Health Security Office

Measurement frequency

Annual

Disaggregation

key population program (MSM, TGW, MSW, FSW, PWID)

Bangkok and provinces

OUTPUT / COVERAGE INDICATORS

Strategy 1: Focus and expedite effective and inclusive package of services to locations and populations with high HIV transmission

A. HIV key population program (MSM, TGW, MSW, FSW, PWID, prisoners, migrants)

S1A.1 Percentage of key populations reached with HIV prevention programs - defined package of services during the reporting period

What it measures

Progress of efforts in increasing coverage of key populations (MSM, TGW, MSW, FSW, PWID, prisoners, migrants) received defined package of HIV prevention services

Rationale

Successfully confronting the HIV epidemic requires combining preventive behavior and antiretroviral therapy. Coverage with evidence-informed prevention programming is a critical component of the response, the importance of which is reflected in the National Strategy

Numerator

Number of people in a key population who received defined package of HIV prevention services during the reporting period

Defined package of HIV prevention services for each group of key population includes:

- For MSM, TGW, FSW, MSW: HIV, STI knowledge, condoms and lubricants, service locations information, as well as providing UIC through outreach services, or through social media.
- For PWID: HIV, STI, harm reduction and HCV, service locations information, needles and syringes, as well as providing UIC through outreach services, or through social media (no needles and syringes through this channel)

Denominator

Estimated size of key population

Calculation

Numerator/denominator x 100

Method of measurement

Numerator: Program records (RTCM, NAP, E-cascade): counting number of key populations receiving all defined HIV prevention services during the reporting period.

Denominator: Estimation of the number of each key population group in the country.

Measurement frequency

Annual

Disaggregation

Age (<25 years and 25+ years)

Type of provider (public services, key population-led organization, NGOs, or other entities)

Bangkok / provinces

Sources of funding

S1A.2 Number of needles and syringes distributed per person who injects drugs per year by needle-syringe programs

What it measures

Progress in improving the coverage of needles and syringes provided, an essential HIV prevention service for PWID

Rationale

Injecting drug use is the main route of transmission for about 12% of people acquiring HIV globally. Preventing HIV transmission caused by injecting drug use is one of the key challenges in reducing the burden of HIV. Needle–syringe programs are one of nine interventions in the World Health Organization (WHO), United Nations Office on Drugs and Crime (UNODC) and UNAIDS comprehensive package for the prevention, treatment and care of HIV among people who inject drugs. Needle–syringe programs greatly enhance HIV prevention for people who inject drugs, and a wealth of scientific evidence supports their efficacy in preventing the spread of HIV.

Numerator

Number of needles and syringes distributed by needle–syringe programs during the reporting period

Denominator

Estimated size of PWID in the country

Calculation

Numerator/denominator

Method of measurement

Numerator: Program data (RTCM, NAP); counting number of sterile needle-syringe sets distributing by the program during the reporting period
Denominator: Estimation of the number of PWID in the country

Measurement frequency

Annual

Disaggregation

Type of provider (public services, key population-led organization, NGOs, or other entities).
Source of funding

S1A.3 Percentage of individuals receiving Opioid Substitution Therapy (OST) who received treatment for at least 6 months during the reporting period

What it measures

A program's ability to deliver OST among PWUD using opium, heroin, and opium derivatives.

Rationale

OST represents a commitment to treat opioid dependence and reduce the frequency of injecting, preferably to zero. It is the most effective, evidence-based public health tool for reducing use among the people who inject opioids. OST provides crucial support for treating other health conditions, including HIV, tuberculosis and viral hepatitis.

Numerator
Number of people from the cohort still in treatment 6 months after starting OST during the reporting period

Denominator
Number of people starting OST during the time period defined as the cohort recruitment period

Calculation
Numerator/denominator x 100

Method of measurement
Program data for both numerator and denominator

Measurement frequency
Annual

Disaggregation
Gender (male, female and transgender)
Age (<25 years and 25+ years)
Drug use methods (injection and non-injection)

S1A.4 Percentage of key populations that have received an HIV test during the reporting period and know their results

What it measures
Progress of providing HIV testing services to members of key populations (MSM, TGW, MSW, FSW, PWID, prisoners, migrants)

Rationale
Ensuring that PLHIV receive the care and treatment required to live healthy, productive lives and reducing the chance of transmitting HIV require that they know their HIV status. This indicator captures the effectiveness of HIV testing interventions targeting populations at higher risk of HIV infection.

Numerator
Number of key populations receiving HIV tests including oral fluid and finger pricked screening test, as well as providing UIC through diagnosis and testing at health facilities of government, private, community led services or at mobile testing unit and know their HIV test results

Denominator
Estimated size of key population minus estimated number of KPLHIV

Calculation
Numerator/denominator x 100

Method of measurement
Numerator: program records (RTCM, NAP, E-cascade)
Denominator: estimation of the total number of key populations in the country minus estimated number of KPLHIV

Measurement frequency
Annual

Disaggregation
Gender (female, male and transgender).
Age (<25 years and 25+ years)
Type of provider (public services, key population-led organization, NGOs, or other entities).
Source of funding

S1A.5 Percentage of HIV-positive results returned to key populations in the reporting year

What it measures
Trends in the number of HIV tests conducted and the effectiveness of HIV testing services in reaching people who are HIV-positive

Rationale
Positivity data among those tested who have received a result can help to validate the number of people reported as newly diagnosed through routine reporting systems and estimates of HIV prevalence from survey data. When disaggregated by age, sex, testing modality and HIV status, these data are useful in assessing the effectiveness of delivering HIV testing services and addressing gaps in various settings, contexts and populations.

Numerator
Number of tests conducted where an HIV-positive result was returned to key population tested

Denominator
Number of tests performed where results were received by key population tested

Calculation
Numerator/denominator x 100

Method of measurement
For numerator and denominator: program data in NAP plus database

Measurement frequency
Annual

Disaggregation
Age (15-19, 20-24, 25+ years)
Key population (MSM, TGW, MSW, FSW, prisoner, migrant)
Testing modality
- – Community-level HTS reporting:
  - o Mobile testing (e.g., through vans or temporary testing facilities).
  - o VCT centers (not within a health-facility setting).
- – Facility-level testing:
  - o Provider-initiated testing in clinics or emergency facilities.
  - o Antenatal care clinics (including labor and delivery).
  - o VCT (within a health-facility setting).
  - o TB clinic (if available)
  - o Family planning clinic.

S1A.6 Percentage of key populations newly diagnosed with HIV initiated on Antiretroviral Therapy (ART)

What it measures

Progress towards providing ART to people living with HIV in key populations (MSM, TGW, FSW, MSW, PWID, prisoners, migrants)

Rationale

ART has been shown to reduce HIV-related morbidity and mortality among PLHIV and to reduce the transmission of HIV. PLHIV in key populations should be able to access mainstream services that provide ART without fear of facing stigma or discrimination and to be able to receive care from health-care workers who have the clinical knowledge to meet their specific needs. Accordingly, ART coverage is a crucial way of assessing access to mainstream services.

Numerator

Number of key populations newly diagnosed with HIV who initiated on ART in the reporting year

Denominator

Number of key populations newly diagnosed with HIV in the reporting year

Calculation

Numerator/denominator x 100

Method of measurement

Numerator and denominator:
- MSM, TGW, FSW, MSW, PWID, prisoners: program data in NAP plus database
- Migrants: database of Division of Health Economics and Health Security, MOPH and Social Security Office, MOL

Measurement frequency

Annual

Disaggregation

Key populations (MSM, TGW, FSW, MSW, PWID, prisoners, migrants)
Age (<25 years and 25+ years)
Bangkok and provinces

S1A.7 Percentage of eligible key population who initiated oral antiretroviral Pre-Exposure Prophylaxis (PrEP) during the reporting period

What it measures

Progress towards scaling up PrEP nationally.

Rationale

This indicator is key to assessing the availability and uptake of PrEP, especially among people at higher risk of HIV infection (MSM, TGW, MSW, FSW, PWID). The use of antiretroviral medicine by people who are HIV-negative before they are exposed to HIV can prevent HIV infection. PrEP has been shown to be effective in a wide range of HIV-negative populations.

Numerator
Number of eligible key populations who initiated oral PrEP in each Fiscal Year (FY), including those used to take PrEP and counted at the first visit of PrEP in the reporting year.

Denominator
Number of key populations with substantial risk who need PrEP in the reporting year

Calculation
Numerator/denominator x 100

Method of measurement
Numerator: program record (NAP database)
Denominator: estimation of PrEP targets for key and high-risk populations in Thailand, 2020-2022

Measurement frequency
Annual

Disaggregation
People who received PrEP for the first time in their lives.
Gender (male, female or transgender).
Age (<25 years and 25+ years)
Key population (MSM, TGW, SW, PWID, prisoner)
Type of service providers (community led services, community and facility, facility)

B. Integration with other health services

S1B.1 Proportion of people starting ART who were tested for HCV

What it measures
It monitors trends in HCV testing, a critical intervention for assessing needs related to managing HCV

Rationale
Testing for HCV identifies HIV and HCV coinfection to adapt treatment. Many people living with HIV receiving antiretroviral therapy are dying from liver disease resulting from untreated viral hepatitis. New, highly effective hepatitis C treatment is available and has a high rate of virus clearance regardless of hepatitis C virus subtype.

Numerator
Number of adults and children starting ART who were tested for HCV during the reporting period

Denominator
Number of adults and children starting ART during the reporting period

Calculation
Numerator/denominator x 100

Method of measurement
Program record in NAP plus database

Measurement frequency
Annual

Disaggregation
Gender (male, female and transgender)
Age (<15 and 15+ years)
Key population (MSM, TGW, MSW, FSW, PWUD)

S1B.2 Proportion of people coinfected with HIV and HCV starting HCV treatment

What it measures
Initiation of HCV treatment for people coinfected with HIV and HCV among people enrolled in HIV care

Rationale
The prevalence of HCV coinfection is high among people living with HIV in Thailand because of injecting drug use. Treating people living with HIV for hepatitis C influences quality of life, life expectancy and mortality.

Numerator
Number of people diagnosed with HIV and HCV coinfection starting treatment for HCV during the reporting period

Denominator
Number of people diagnosed with HIV and HCV coinfection enrolled in HIV care during the reporting period

Calculation
Numerator/denominator x 100

Method of measurement
Program records for both numerator and denominator

Measurement frequency
Annual

Disaggregation
Sex (female, male and transgender).
Age (<25 years and 25+ years)
Key population (MSM, TGW, MSW, FSW, PWUD)

S1B.3 Percentage of key populations screened for STI

What it measures
Progress of coverage of key populations (MSM. TGW, MSW, TGSW, FSW) screened for STI

Rationale
Key populations including MSM, TGW, MSW, TGSW and FSW are at higher risk of STI. Thus, regular STI screening is encouraged for early detection and treatment.

Numerator
Number of key populations screened for STI according to the national guidance (see details in the Note):
MSW, FSW and TGSW: STI screening at least 4 times/year and VDRL/RPR test annually
MSM and TGW: STI screening and VDRL/RPR test annually

Denominator

Estimated size of key population

Calculation

Numerator/denominator x 100

Method of measurement

Numerator: program record (to be developed)

Denominator: estimation of the number of MSM, TGW, MSW and FSW in the country

Measurement frequency

Annual

Disaggregation

Age (<19, 19-24, and 25+ years)

Key population (MSM, TGW, MSW, FSW)

Note

National guidance of STI screening

MSM/MSW: specimen collection from

- Urethra; gram stain for identifying PMNs and GC culture
- Rectum (receptive anal intercourse); gram stain for identifying PMNs and GC culture
- Throat; GC culture

FSW/TGW: vagina examination

- Urethra, endocervix, and vagina; gram stain for identifying PMNs and GC culture
- Vaginal wet smear; checking for Trichomonas vaginalis and clue cells
- Collect specimen from the other sexual roots according to the history

Strategy 2: Strengthen and integrate currently effective prevention efforts into existing system ensuring quality and sustainability

S2A.1 Percentage of pregnant women who know their HIV status

A. Prevention of mother-to-child transmission (PMTCT) program

What it measures

Coverage of the first step in the PMTCT cascade. High coverage enables early initiation of care and treatment for HIV-positive mothers. The total number of identified HIV-positive women provides the facility-specific number of pregnant women with HIV to start a facility-based prevention of mother-to-child transmission cascade

Rationale

The risk of mother-to-child transmission can be reduced significantly by: (a) providing ARV—either as lifelong therapy or as prophylaxis—for the mother during pregnancy and delivery; (b) supplying ARV prophylaxis for the infant and ARV medicines for the mother or child during breastfeeding; (c) instigating safe delivery practices and safer infant feeding.

Numerator

Number of pregnant women attending antenatal clinics and/or giving birth at a facility who were tested for HIV during pregnancy, at labor and/or delivery, or those who already knew they were HIV-positive at the first antenatal care visit.

Denominator

Number of pregnant women who attended an antenatal clinic or gave birth at a facility in the past 12 months

Calculation

Numerator/denominator x 100

Method of measurement

Numerator: program records (PHIM)
Denominator: program records (PHIM)

Measurement frequency

Annual

Disaggregation

HIV status/test results:
- Known (positive) HIV infection at antenatal clinic entry.
- Tested HIV-positive at first antenatal care during current pregnancy, labor and/or delivery. This excludes women who already knew their HIV-positive status prior to current pregnancy.
- Tested HIV-negative at first antenatal care during current pregnancy, labor and/or delivery. This should be based on the latest test result in the case of repeat testing.

Pregnant women who inject drugs.
Thai and non-Thai
Bangkok and provinces

S2A.2 Percentage of pregnant women attending ANC whose male partner was tested for HIV

What it measures

Progress of coverage of couple counseling in the ANC services

Rationale

Partners of HIV positive pregnant women are most likely to be positive too. Meanwhile couple counseling and testing for ANC clients will enhance the preparedness of couples for knowing the results and what to do for cases of negative couples, positive couples and sero-discordant couples.

Numerator

Number of pregnant women attending ANC whose male partner was tested for HIV or known that he is infected during the reporting period

Denominator

Number of all pregnant women attending ANC during the reporting period

Calculation

Numerator/denominator x 100

Method of measurement

Program record for both numerator and denominator (PHIM)

Measurement frequency

Annual

Disaggregation

Age (<24 and 25+ years)
Thai and non-Thai
Bangkok and provinces

S2A.3 Percentage of HIV-positive women who received ART during pregnancy and/or labor and delivery

What it measures

Progress in PMTCT of HIV during pregnancy and delivery by providing antiretroviral medicine

Rationale

Providing ARV medicines to a woman living with HIV—either before conception or during pregnancy or delivery—can significantly reduce the risk of mother-to-child transmission. This intervention is most effective if ARV medicine is provided during pregnancy, delivery and breastfeeding, and if safe delivery practices and safer infant feeding methods are used.

Numerator

Number of pregnant women living with HIV who delivered during the past 12 months and received antiretroviral medicines to reduce the risk of mother-to-child transmission of HIV.

Denominator

Number of all women living with HIV who delivered within the past 12 months

Calculation

Numerator/denominator x 100

Method of measurement

Program records for both numerator and denominator (PHIM)

Measurement frequency

Annual

Disaggregation

Thai and non-Thai

Bangkok and provinces.

The numerator should be disaggregated across the regimens.

S2A.4 Percentage of HIV-exposed infants receiving a virological test for HIV within 2 months of birth

What it measures

Progress in the extent to which infants born to women living with HIV are tested within the first two months of life to determine their HIV status and eligibility for antiretroviral therapy disaggregated by test results

Rationale

Infants acquiring HIV during pregnancy, delivery or early postpartum often die before they are recognized as having HIV infection. The World Health Organization (WHO) recommends that national program establish the capacity to provide early virological testing of infants for HIV at six weeks or as soon as possible thereafter to guide clinical decision-making at the earliest possible stage. HIV disease progresses rapidly among children; they need to start treatment as early as possible because, without early treatment, almost 50% of children would be dead by the second year.

Numerator

Number of infants who received an HIV test within two months of birth during the reporting period.
Infants tested should only be counted once.

Denominator

Number of all infants borne to pregnant women living with HIV giving birth in the past 12 months

Calculation

Numerator/denominator x 100

Method of measurement

Program records for both numerator and denominator (PHIM)

Measurement frequency

Annual

Disaggregation

The numerator should be disaggregated by the result: positive, negative or indeterminate.

S2A.5 Percentage of women accessing antenatal care services who were tested for syphilis, tested positive and treated

What it measures

A. Coverage of syphilis testing in women attending antenatal care services

B. Percentage of pregnant women attending antenatal clinics with a positive (reactive) syphilis serology

C. Percentage of antenatal care attendees during a specified period with a positive syphilis serology who were treated adequately

Rationale

A. Testing pregnant women for syphilis early in pregnancy is important for their health and that of the fetus. This contributes to monitoring the quality of antenatal care services and services to prevent HIV among pregnant women. It is also a process indicator for assessing the validation of eliminating the mother-to-child transmission of syphilis.
B. Syphilis infection in antenatal care attendees can be used to guide programs for preventing sexually transmitted infections and may provide early warning of potential changes in HIV transmission in the general population.
C. Treating antenatal care attendees who test positive for syphilis directly measures the program for eliminating the mother-to-child transmission of syphilis and efforts to strengthen primary HIV prevention. It is also a process indicator for validating the elimination of mother-to-child transmission of syphilis.

Numerator

A. Number of women attending antenatal care services who were tested for syphilis
B. Number of women attending antenatal care services who tested positive for syphilis
C. Number of antenatal care attendees with a positive syphilis test who received standard treatment

Denominator

A. Number of women attending antenatal care services
B. Number of antenatal care attendees who were tested for syphilis
C. Number of antenatal care attendees who tested positive for syphilis

Calculation

Numerator/denominator (for A, B and C, respectively)

Method of measurement

A. Program records (PHIM): Screening by VDRL or RPR or TPHA.
B. Program records (PHIM): This indicator (intended to measure seropositivity), reporting positivity based on a single test result is acceptable. If both treponemal and nontreponemal test results on an individual person are available, then syphilis positivity should be defined as having positive results in both tests.
C. Program records (PHIM):

Measurement frequency

Annual

Disaggregation

A. Tested at any visit, tested at first visit
B. Age (15–24 and 25+ years)
C. None

S2A.6 Percentage of provinces achieving the goal to eliminate MTCT for HIV and Syphilis in new born

What it measures

Sustainability of achieving goal of elimination of MTCT (EMTCT) for HIV and syphilis in new born

Rationale

Thailand has achieved the goal of EMTCT for HIV and syphilis in new born since 2016. The recent validation by WHO and UNICEF in 2019, the rate of MTCT for HIV was 1.97% In 2020, 61 provinces had no newborn infected with HIV and syphilis. In order to keep the country achieving the goal of EMTCT for HIV and syphilis, number of provinces achieving the goal of EMTCT for HIV and syphilis should be increasing.

Numerator
Number of provinces with no newborn infected with HIV and syphilis in the reporting period

Denominator
Total number of provinces including Bangkok and provinces (77)

Calculation
Numerator/denominator x 100

Method of measurement
Program records (PHIM)

Measurement frequency
Annual

Disaggregation
Health region

B. HIV education program

S2B.1 Percentage of schools having at least 20% of teachers receiving certification of the attendance of e-learning to manage the sexuality education for students in schools

What it measures
Progress of coverage of young people aged 10-24 years in and out of schools reached with sexuality education and life skills-based HIV education

Rationale
HIV epidemics are perpetuated primarily through the sexual transmission. Comprehensive sexuality education should be provided to young people. Based on the Act for Prevention and Solution of the Adolescent Pregnancy Problem, B.E.2559 (2016), the e-learning for teachers to manage the sexuality education for students in schools, developed by the Office of the Basic Education Commission, Ministry of Education and P2H Foundation, with the support from the Thai Health Promotion Fund is being expanded to the schools under local administrative organizations and private schools. The e-learning for teachers is considered as part of certification to teachers attending the e-learning.
This is a proxy indicator to reflect the coverage of young people aged 10–24 years reached by comprehensive sexuality education and/or life skills–based HIV education out of schools.

Numerator
Total number of schools having at least 20% of teachers receiving certification of the attendance of e-learning to manage the sexuality education for students in schools

Denominator
Total number of schools at basic level (Grade 1-Grade 12)

Calculation
Numerator/denominator x 100

Method of measurement
Numerator: program record of the Ministry of Education
Denominator: program record of the Ministry of Education

Measurement frequency Annual

Disaggregation
Responsible organizations (Public schools, Local Administrative Organization's schools, Private schools)

Strategy 3: Develop and enhance differentiated treatment, care and social support, ensuring quality, comprehensiveness and sustainability

A. Differentiated HIV testing program

S3A.1 Percentage of HIV-positive results among the total HIV tests performed during the reporting period

What it measures

Trends in the number of HIV tests conducted and the effectiveness of HIV testing services (HTS) in reaching people who are HIV-positive.

Rationale

Testing volume and data on positivity are useful for program monitoring. Knowing the numbers of people tested annually and the modality of testing or uptake of self-tests is critical to commodity forecasting and staff resource planning. Positivity data among those tested who have received a result also can help to validate the number of people reported as newly diagnosed through routine reporting systems and estimates of HIV prevalence from survey data.

Numerator

Number of tests conducted where an HIV-positive result was returned to a person (positivity)

Denominator

Number of tests performed where results were received by a person (testing volume)

Calculation

Numerator/denominator x 100

Method of measurement

Program records: RTCM, e-cascade, NAP plus database

Reported data will be a count of the number of tests conducted where results were returned to a person and not the number of unique persons who tested at least once during the fiscal year. If a person who is HIV-positive tests once at a mobile testing service and then again at a clinic during the same fiscal year, she should be counted twice in the numerator and twice in the denominator. In an alternative scenario, if a person tests negative at a mobile testing service and then positive through provider-initiated testing, she will be reported once in the numerator and twice in the denominator.

Self-tests will be counted separately for numbers of self-test kits procured and distributed in the fiscal year.

Disaggregation

Age (0–14 years for children and 15 years and older)

Sex (men and women) for adults.

Testing modality.

– Community-level HTS reporting:
  - o Mobile testing services
  - o Community Drop-in centers
  - o Sub-district health promoting hospitals

– Facility-level testing:
  - o Provider-initiated testing in clinics or emergency facilities.
  - o Antenatal care clinics (including labor and delivery).
  - o VCT (within a health-facility setting).
  - o TB clinic
  - o Family planning clinic.

S3A.2 Percentage and PLHIV with an the initial CD4 cell count <200 cells/mm3 and <350 cells/mm3 during the reporting period

What it measures

People who have not received a timely HIV diagnosis

Rationale

As countries scale up HIV services, it is important to monitor whether people are diagnosed at an earlier stage and what percentage of the people are still diagnosed at a late stage. Late diagnosis is detrimental to people's health, and those with low CD4 counts are more likely to transmit the virus.

Numerator

Numbers of PLHIV (adults -15 years and older) with an initial CD4 cell count less than 350 cell/mm^3 at the time of diagnosis (within one month of the diagnosis date).

Denominator

Number of PLHIV who had an initial CD4 lymphocyte count at the time of diagnosis in the reporting period.

Calculation

Numerator/denominator x 100

Method of measurement

Program records: NAP plus database

Measurement frequency

Annual

Disaggregation

0–14 years (disaggregated by ages 12–35 months, 36–59 months and 5–14 years) for children, and 15 years and older by sex (men and women) for adults.

B. Antiretroviral treatment program

S3B.1 ART cascade of PLHIV newly diagnosed during the reporting period

What it measures

A. Coverage of PLHIV newly diagnosed during the reporting period had ART initiation

B. PLHIV newly diagnosed during the reporting period lost to follow up

C. Coverage of PLHIV newly diagnosed during the reporting period and on ART had viral load test

D. Coverage of PLHIV newly diagnosed during the reporting period and had viral load test had viral suppressed

Rationale

Antiretroviral therapy has been shown to reduce HIV-related morbidity and mortality among PLHIV, and to halt onward transmission of the virus. Studies also show that early initiation, regardless of a person's CD4 cell count, can enhance treatment benefits and save lives.

Retaining on ART will ensure the good results of treatment. Individual-level viral load is the measure of ART efficacy and indicates treatment adherence and the risk of transmitting HIV. People with viral load test results below the threshold, <1 000 copies/mL, should be considered as having suppressed viral loads. The national guideline on ART recommends treatment at any CD4 level. Currently, HIV testing, ART and viral load testing are benefit packages under UHC, Social Security Scheme and Civil Servant Medical

Benefit Scheme for all Thai people. For migrants living with HIV, only documented migrants under SSS receive the same benefit package as Thai people.

The cascade starts with the PLHIV newly diagnosed during the reporting period, aiming to reflect the current service system.

Numerator

A. Number of PLHIV newly diagnosed during the reporting period had ART initiation
B. Number of PLHIV newly diagnosed during the reporting period lost to follow up (90 days after appointment)
C. Number of PLHIV newly diagnosed during the reporting period who had viral load test
D. Number of PLHIV newly diagnosed during the reporting period with viral load test results <1 000 copies/mL

Denominator

A. Number of PLHIV newly diagnosed during the reporting period
B and C Number of PLHIV newly diagnosed during the reporting period had ART initiation
D. Number of PLHIV newly diagnosed during the reporting period had viral load test

Calculation

Numerator/denominator x 100 (for A, B, C, D respectively)

Method of measurement

Program record (NAP plus database)

Measurement frequency

Annual

Disaggregation

Age (<15 and 15 years)
Sex (male and female)
Key population (MSM, TGW, MSW, FSW, PWID, prisoner, migrant)
Bangkok and provinces

S3B.2 Percentage of people newly diagnosed who initiated ART by 7 days after diagnosis

What it measures

Progress of the implementation of the same-day ART intervention

Rationale

Antiretroviral therapy has been shown to reduce HIV-related morbidity and mortality among PLHIV, and to halt onward transmission of the virus. Studies also show that early initiation, regardless of a person's CD4 cell count, can enhance treatment benefits and save lives. The national guideline on ART recommends treatment at any CD4 level.

This indicator focused on the PLHIV newly diagnosed during the reporting period, which will reflect the current service system.

Numerator

Number of newly diagnosed PLHIV during the reporting period who initiated ART within 7 days after diagnosis

Denominator

Total number of newly diagnosed PLHIV during the reporting period

Calculation
Numerator/denominator x 100

Method of measurement
Numerator: program record (NAP plus database)
Denominator: program record (NAP plus database)

Measurement frequency
Annual

Disaggregation
Days after diagnosis (1,3,7 days)
Age (<15 and 15 years)
Sex (male and female)
Key population (MSM, TGW, MSW, FSW, PWID, prisoner, migrant)

C. TB/HIV program

S3C.1 Percentage of registered new and relapsed TB patients with documented HIV status

What it measures
Coverage of TB patients screened for HIV infection

Rationale
The primary aims of intensified TB case-finding in HIV care settings and provider-initiated HIV testing and counselling for TB patients are early detection of HIV-associated TB and prompt provision of antiretroviral therapy and TB treatment.

Numerator
Number of registered new and relapsed TB patients with documented HIV status during the reporting period

Denominator
Number of registered new and relapsed TB patients during the reporting period

Calculation
Numerator/denominator x 100

Method of measurement
Numerator: program record (NTIP database of the DTB)
Denominator: program record (NTIP database of the DTB)

Measurement frequency
Annual

Disaggregation
Bangkok and provinces

S3C.2 Percentage of PLHIV in care (including PMTCT) who are screened for TB in HIV care or treatment settings

What it measures

Coverage of PLHIV screened for TB

Rationale

The primary aims of intensified TB case-finding in HIV care settings and provider-initiated HIV testing and counselling for TB patients are early detection of HIV-associated TB and prompt provision of antiretroviral therapy and TB treatment. Meanwhile, TPT will be given to PLHIV who do not have active TB disease. All newly diagnosed PLHIV will be screened by chest x-ray. PLHIV currently on ART will be verbally screened and for those with positive verbal screened will have chest x-ray for TB screening.

Numerator

Number of PLHIV screened for TB by chest x-ray during the reporting period

Denominator

Number of PLHIV registered in ART clinics during the reporting period

Calculation

Numerator/denominator x 100

Method of measurement

Numerator: program record

Denominator: program record (NAP plus database)

Measurement frequency

Annual

Disaggregation

Newly diagnosed PLHIV and currently on ART

Bangkok and provinces

S3C.3 Percentage of estimated HIV-positive incident tuberculosis (TB) cases that received treatment for both TB and HIV

What it measures

Progress in detecting and treating TB and HIV among people with HIV-associated TB

Rationale

TB is a leading cause of morbidity and mortality among PLHIV, including those receiving ART. Prompt TB treatment and early ART are critical for reducing the mortality due to HIV-associated TB and is the highest-priority activity for both the AIDS Program and National TB Program. A measure of the percentage of HIV-positive TB patients that access appropriate treatment for their TB and HIV is therefore very important.

Numerator

Number of HIV-positive new and relapsed TB patients started on TB treatment during the reporting period who are already on ART or who start on ART during TB treatment within the reporting year.

Denominator

Number of HIV-positive new and relapsed TB patients registered during the reporting period and estimated incident TB cases in PLHIV

Calculation

Numerator/denominator x 100

Method of measurement

Numerator: program records (NTIP and NAP databases); Count the total number of HIV-positive new and relapse TB patients who were started on TB treatment (as recorded in the NTIP) and antiretroviral therapy, or those already on antiretroviral therapy (as recorded in the NAP). The information will be reconciled quarterly and annually between NTIP and NAP databases.
Denominator: estimated number of PLHIV with active TB

Measurement frequency

Continuously at the facility level, reconciled with the TB registers and aggregated periodically by quarter, and reported annually.

Disaggregation

- Sex (male and female)
- Age (<15 years and 15+ years)
- Bangkok and Provinces

S3C.4 Percentage of PLHIV on ART who initiated TB preventive therapy among those eligible for TPT

What it measures

The extent to which people who are on antiretroviral therapy and eligible to take TPT do initiate TPT.

Rationale

TPT reduces the risk of developing active TB and improves survival of all PLHIV. People living with HIV should be screened for TB at every visit, using a clinical algorithm recommended by the World Health Organization (WHO). Adults and adolescents living with HIV who do not report any of the symptoms of TB —current cough, fever, weight loss or night sweats—are unlikely to have active TB and should be offered TPT. Similarly, children living with HIV who do not have poor weight gain, fever or current cough should be offered TPT regardless of whether or not they are receiving ART.

Numerator

Number of PLHIV on ART and eligible for TPT who start TPT during the reporting period.

Denominator

Number of PLHIV on ART who are eligible for TPT during the reporting period.

Calculation

Numerator/denominator x 100

Method of measurement

Numerator: Count the total number of people on ART during the reporting period who are eligible for TPT and who start TPT.
Denominator: The formula for determining the number of people on ART who are eligible for TPT during the reporting period is as follows: Number of PLHIV on ART at the end of the last reporting period [minus] number of notified HIV-positive TB patients in last reporting period [also minus, where possible] number of PLHIV who previously received TPT (actual, if available, or based on country estimate) [also minus,

where possible] number/estimate of PLHIV not eligible for TPT due to co-morbidities, including active hepatitis, chronic alcoholism and/or neuropathy

Measurement frequency

Quarterly and annual

Disaggregation

ART initiation (new on ART in the last 12 months or on ART >12 months)
Gender (male, female or transgender)
Age (<5 years, 5-14 years and 15+years)
Bangkok and provinces
Type of TPT regimen (6H, 3HP, 1HP, and Other) ["HP" refers to isoniazid and rifapentine]

D. Social and economic support program

S3D.1 Proportion of eligible households receiving economic support in the reporting period

What it measures

Coverage of eligible households receiving economic support

Rationale

Although the PLHIV receiving ART are mostly healthy, many of them cannot earn enough for themselves and their families. The economic support is still needed for some households.
There are three economic support programs in Thailand, including monthly living allowance by the Ministry of Interior, career support to PLHIV or family and career support to women living with HIV by the Ministry of Social Development and Human Security.

Numerator

Number of PLHIV or family receiving economic support (monthly living allowance or career support) in the fiscal year

Denominator

Number of PLHIV registered for monthly living allowance and family/women living with HIV requesting for career support in the fiscal year

Calculation

Numerator/denominator x 100

Method of measurement

Program record of the Ministry of Interior and Ministry of Social Development and Human Security

Measurement frequency

Annual

Disaggregation

Sex (male and female)
Age (<15, 15-24, 25-60, >60 years)

Strategy 4: Adjust HIV perceptions and build capacity of individuals, families and communities along with strengthening a rights protection mechanism

A. HIV and gender-related human rights, stigma and discrimination program

S4A.1 Number of provinces implementing mechanism to protect HIV and gender-related human

What it measures

Coverage of provinces implementing mechanism to protect HIV and gender-related human rights

Rationale

Reduction of HIV and gender-related discrimination by 90% is one goal of the National Strategy to End AIDS, 2017-2030. One of the intended results of the strategy to protect HIV and gender-related human rights and reduce stigma and discrimination is to establish a mechanism at provincial level to respond to the human rights violation as well as discrimination which PLHIV and key populations are facing.

Numerator

Number of provinces setting up and implementing mechanism to protect HIV and gender-related human rights

Method of measurement

Report from Crisis Response System (CRS)

Measurement frequency

Annual

Disaggregation

Regional Health Areas

S4A.2 Number of hospitals implementing reduction of HIV and gender-related stigma and discrimination

What it measures

Progress of scaling up the HIV and gender-related stigma and discrimination reduction program in health-care setting

Rationale

Reduction of HIV and gender-related discrimination by 90% is one goal of the National Strategy to End AIDS, 2017-2030. The health sector is one of the main settings where PLHIV/key populations experience discrimination.

Thailand's S&D reduction interventions using participatory training techniques, called the Thailand's 3 by 4 facility-based HIV related S&D reduction intervention package, is effective in reducing S&D among health care providers. The 3 levels of interventions include individual (health facility staff), system/health facility structure and health facilities-community linkage. The 4 actionable drivers of S&D reduction comprise of awareness raising, fear of HIV infection, social stigma attitudes (blame, shame) and environment in health facilities.

Numerator
Number of hospitals initiating implementation of 3 by 4 facility-based HIV related S&D reduction intervention package in the previous 12 months

Method of measurement
Report of the DAS

Measurement frequency
Annual

Disaggregation
Bangkok and regional health areas

S4A.3 Number of organizations/agencies (government, private, non-government) complying with in the HIV policy in workplaces

What it measures
Progress of utilization of national HIV policy in workplaces

Rationale
The National AIDS Committee has endorsed the HIV policy in workplaces, including public, private and CSO workplaces. One intervention to promote the use of the national guideline of the HIV policy in workplaces is to recognize the workplaces who comply with the HIV policy in workplaces.

Numerator
Number of organizations/agencies (government, private, non-government) newly complying with in the HIV policy in workplaces in the previous 12 months

Method of measurement
The assessment of compliance to the HIV policy in workplaces will be managed by the DAS.

Measurement frequency
Annual

Disaggregation
Grouping: public (health, non-health), private (health, non-health) and CSO

S4A.4 Percentage of general population exposed to legal literacy, stigma and discrimination reduction, gender equality and human rights protection mechanism

What it measures
Progress of legal, stigma and discrimination and human rights literacy program

Rationale
The understanding of general population on the negative impact of stigma and discrimination to the PLHIV and key population as well as the relating legal and human rights issues will create societal enablers to increase effectiveness of implementation towards ending AIDS of the country.

Numerator
Number of respondents reported the exposure to the legal and human rights literacy program

Denominator
All respondents

Calculation
Numerator/denominator x 100

Method of measurement
Population-based survey (Multiple Indicator Cluster survey: MICS)

Measurement frequency
Every 3 years

Disaggregation
Sex (male and female)
Age (<15, 15-24, 25-49 years)

S4A.5 Percentage of PLHIV and Key Populations exposed information on Know Your Rights, gender equality and human rights protection mechanism

What it measures
Progress of legal, stigma and discrimination and human rights literacy program

Rationale
In addition to the understanding of general population on the human rights issues and do not have the negative attitudes toward PLHIV and key populations, the knowledge of PLHIV and key populations on their own rights and how to access human rights protection is essential for keeping their human rights not to be violated.

Numerator
Number of respondents reported the exposure to the legal and human rights literacy program

Denominator
All respondents

Calculation
Numerator/denominator x 100

Method of measurement
Stigma Index Survey

Measurement frequency
Every 3 years

Disaggregation
Sex (male and female)
Age (<15, 15-24, 25-49 years)
HIV status
Key populations (MSM, TGW, MSW, FSW, PWID)

S4A.6 Number of laws/rules/regulations leading to obstacles to access to services of PLHIV and key populations (specify)

What it measures

Progress in removing legal impediments to an enabling environment that limit access or utilization of HIV services

Rationale

Certain laws/rules/regulations leading to obstacles for PLHIV and key populations to access services still exist.

Referring to the 2025 Global AIDS Targets, i.e., less than 10% of countries have punitive legal and policy environments that deny or limit access to services; less than 10% of people living with HIV and key populations experience stigma and discrimination; and less than 10% of women, girls, people living with HIV and key populations experience gender inequality and violence; modelling has been undertaken to project the impact that achievement of these targets would have on the epidemic's trajectory, achieving steep reductions to about 370 000 HIV infections and 250 000 AIDS-related deaths in 2025, and putting the world firmly on track to the ultimate goal of ending the epidemic in all settings and for all populations by 2030.

Numerator

Number of laws/rules/regulations leading to obstacles to access to services of PLHIV and key populations

Method of measurement

Included in the data collection of the National Composite Policy Index (NCPI) process
Specify and identify the organizations responsible for those laws/rules/regulations

Measurement frequency

Every 2 years

Disaggregation

Specify laws/rules/regulations
Grouping (laws, rules, regulations)

Strategy 5: Enhance joint accountability, investment, and efficiency of administrative efforts in all sectors at the international, national, provincial and local levels

A. Resource investment

S5A.1 Percentage of national AIDS spending from domestic public resources

What it measures

The total domestic public resources allocated and executed for HIV from central and subnational levels.

Rationale

The monitoring of domestic public budgets and their short-term forecasts aims to foster national efforts to mobilize resources to achieve the targets to end AIDS by 2030. This will reflect sustainability of the national responses.

Numerator

Amount of AIDS spending from government sources in the Fiscal Year

Denominator

Total amount of AIDS spending in the Fiscal Year

Calculation

Numerator/denominator x 100

Method of measurement

Budget analysis: National AIDS Spending Assessment (NASA)

Measurement frequency

Every 2 fiscal years for annual data

Disaggregation

Types of programs
Sources of funding

S5A.2 Percentage of national AIDS spending was for HIV prevention program

What it measures

The increase of government support to the HIV prevention program.

Rationale

HIV testing and treatment and care services are included in the benefit packages of the UHC, SSS and CSMBC in Thailand. Proportion of national AIDS spending has been the highest for treatment and care, meanwhile only 14% was for HIV prevention. The big proportion of HIV prevention was for blood safety. A significant portion of HIV prevention among key populations was from international support.

Numerator

Amount of AIDS spending for HIV prevention program in the Fiscal Year

Denominator

Total amount of AIDS spending for HIV prevention program in the Fiscal Year

Calculation

Numerator/denominator x 100

Method of measurement
Budget analysis: National AIDS Spending Assessment (NASA)

Measurement frequency
Every 2 fiscal years for annual data

Disaggregation
Details of the prevention program
Source of funding (domestic, international)

S5A.3 Percentage of national AIDS spending for HIV prevention program among key populations from domestic resources

What it measures
The increase of government support to the HIV prevention program among key populations.

Rationale
The monitoring of domestic public budgets, particularly for HIV program among key populations, which is prioritized in the national strategy, aims to foster national efforts to mobilize resources to achieve the targets to end AIDS by 2030. This will reflect sustainability of the national responses.

Numerator
Amount of AIDS spending for HIV prevention program among key populations from government source in the Fiscal Year

Denominator
Total amount of AIDS spending for HIV prevention program among key populations in the Fiscal Year

Calculation
Numerator/denominator x 100

Method of measurement
Budget analysis: National AIDS Spending Assessment (NASA)

Measurement frequency
Every 2 fiscal years for annual data

Disaggregation
Source of funding
Key populations (MSM, TGW, FSW, MSW, PWID, prisoner, migrant)

S5A.4 Percentage of national AIDS spending for reduction of stigma and discrimination

What it measures
The increase of government support for reduction of stigma and discrimination as well as human rights promotion and protection.

Rationale
HIV testing and treatment and care services are included in the benefit packages of the UHC, SSS and CSMBC in Thailand. Proportion of national AIDS spending has been the highest for treatment and care,

meanwhile only 0.6% was for S&D reduction. Although the global commitment has set the target to ensure the HIV investment for social enablers to 6%.

Numerator
Amount of national AIDS spending for S&D reduction and human rights promotion and protection in the Fiscal Year

Denominator
Amount of all national AIDS spending for the Fiscal Year

Calculation
Numerator/denominator x 100

Method of measurement
National AIDS Spending Assessment (NASA)

Measurement frequency
Every 2 years

Disaggregation
Activities in the national costed action plan on S&D reduction and human rights promotion and protection
Sources of funding (Domestic. International)

S5A.5 Percentage of Community Health Security Funds supporting HIV program

What it measures
Progress of HIV funding through Community Health Security Funds

Rationale
The Community Health Security Funds were established by the NHSO coupled with funding from local administrative organizations. The Funds will be managed by the local committee within the scope provided by the NHSO. The support from the Funds will also reflect the awareness on HIV of the community.

Numerator
Number of the Community Health Security Funds providing financial support for HIV services/activities

Denominator
Total number of the Community Health Security Funds

Calculation
Numerator/denominator x 100

Method of measurement
Report from the Community Health Security Funds to the NHSO
Amount and amount of financial support per Fund will also be monitored

Measurement frequency
Annual

Disaggregation
Bangkok and provinces

S5A.6 Number of provinces with provincial ending AIDS plan

What it measures

Opportunities to mobilize resources by the province

Rationale

The provincial ending AIDS plan is expected to increase the ownership of the province for its common goal to end AIDS in its province. With its own ending AIDS plan, costed services and activities as well as available resources will identify resource gaps which should be mobilized from both in the province or outside the province.

The DAS has developed the guideline of using evidence for planning the provincial ending AIDS plan.

Numerator

Number of provinces which have their own provincial ending AIDS plan

Method of measurement

DAS records

Measurement frequency

Annual

Disaggregation

Bangkok and Regional health areas

B. Quality assurance

S5B.1 Percentage of civil society organizations funded to provide HIV services complying with the standard quality accreditation system

What it measures

Progress of establishing quality assurance system to the community-led HIV services

Rationale

It is well recognized that the community-led HIV services increasing access to the services. However, the quality assurance system will ensure and enable the public health system to include community-led HIV services into the national health system, which will bring about the sustainable funding to HIV services provided by civil society organizations. Currently, the NHSO has been funding CSOs/CBOs to provide HIV prevention services, using only previous performances on quantity as selection criteria.

Thailand has been working on institutionalizing capacity building for intensified community-led approaches. With the Global Fund supported grant during 2021-2023, this effort will leverage and further professionalize three cadres: i) clinical cadre; ii) community-based cadre – KP service providers, community health care workers and village health volunteers; iii) the cadre of peer workers/navigators and PLHIV. The national task force established by the National Subcommittee on Accelerating Ending AIDS will spearhead this effort. The National Guidelines on Accreditation and the Development Program for Community Health Workers on HIV/AIDS will guide the establishment of certification and accreditation for these cadres.

Numerator

Number of CSOs/CBOs funded by the NHSO for the HIV services complies with the standard quality accreditation system

Denominator
Number of CSOs/CBOs funded by the NHSO for the HIV services in the fiscal year

Calculation
Numerator/denominator x 100

Method of measurement
Quality assessment of the CSOs/CBOs will be managed by the DAS
Name list of CSOs/CBOs received funding will be provided by the NHSO

Measurement frequency
Annual

Disaggregation
Programs
- Key population programs: MSM, TGW, MSW, FSW, PWID
- Key population led health services: HIV testing, PrEP, ART

Strategy 6: Support and improve accessibility and utilization of strategic information and research that are inclusive and efficient

A. Health Management Information System

S6A.1 Number of provinces that produce periodic analytical reports as per nationally agreed plan and reporting format during the reporting period

What it measures
Data use to improve programs implementation

Rationale
The purpose of data collection is not only for reporting but also the use of data to improve the implementation. Provinces is the appropriate level to analyze collected data and use data to improve the implementation in their own provinces in time.

Numerator
Number of provinces that produce annual analytical reports

Method of measurement
Report to the Division of AIDS and STIs, Department of Disease Control, MOPH

Measurement frequency
Annual

Disaggregation
Health region

B. Community based monitoring

S6B.1 Percentage of community-based monitoring reports presented to relevant oversight mechanisms

What it measures
Utilization of community-based information

Rationale

Community-based monitoring will provide more understanding of the programs at the implementation level, which is essential for guiding the programs. With the GFATM-supported grant during 2021-2023, the "Community Think Tank" will be established to support institutionalizing a national technical platform. The Think Tank will foster a data-driven approach for community monitoring/oversight and facilitating the timely provision of technical support for the early identification of performance issues. This will involve setting up a collaborative platform engaging all technical and community stakeholders, researchers, academics and government counterparts to review and analyze data, evidence and information to support community monitoring actions. with the purpose to contribute to the Thailand national agenda on sustaining the HIV and TB responses through developing and sustaining technical capacity of the HIV and TB communities, enabling them to monitor, track and improve the national responses.

Numerator

Number of community-based monitoring reports presented to the CCM-oversight committee or the national ending AIDS subcommittee

Denominator

Number of community-based monitoring reports

Calculation

Numerator/denominator x 100

Method of measurement

Program report

Measurement frequency Annual

Disaggregation programs

C. Research and evaluation

S6C.1 Number of reports of conducted researches and evaluation (specify issues)

What it measures

Availability of strategic information to inform the policy or program improvement

Rationale

Sound surveillance and surveys to track the epidemic and routine monitoring for health facilities, non-health and community-based HIV and AIDS programs provide essential but insufficient information to guide the response. High quality evaluations and research studies will provide evidence for planning the response. For prioritization and for determining the right programs to generate high impact and the best return for investment in addressing the HIV epidemic.

Numerator

Number of reports of evaluations and researches conducting in the fiscal year (specify the issues)

Method of measurement

Include the questions in the National AIDS Spending Assessment for the spending on research studies and evaluation

Measurement frequency

Annual

Disaggregation

Type of studies (clinical, biological, evaluation)

Annex 2: Operational Definitions of Key Populations and Vulnerable Groups

A. Key populations are people who are at greatest risk of HIV. They influence epidemic dynamics and play a key role in determining the nature and effectiveness of the response to HIV. Their risks reflect both behavior and specific social and legal barriers that further increase their vulnerability.

According to the National Ending AIDS Strategy 2017-2030, identified key populations include:

1) Men who have Sex with Men (MSM) refers to men at all ages who engage in sexual and/or romantic relations with other men;
2) Transgender women (TGW) refer to those with male biological sex at birth, who currently identify gender identity and expression as female. This includes people who have or have not had sex reassignment surgery to be female;
3) Sex workers refers to female, male and transgender adults who receive money or goods in exchange for sexual services, either regularly or occasionally. Their customers may be male or female;
4) People Who Inject Drugs (PWID) refers to people who inject psychotropic (or psychoactive) substances for non-medical purposes. These drugs include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypno-sedatives and hallucinogens. Injection may be through intravenous, intramuscular, subcutaneous or other injectable routes
5) People Who Use Drugs (PWUD) includes people who use psychotropic substances through any route of administration, including injection, oral, inhalation, transmucosal (sublingual, rectal, intranasal) or transdermal. This definition does not include the use of such widely used substances as alcoholic and caffeine-containing beverages and foods; and
6) People in prisons and other closed settings include adult male and female prisoners and young detainees (male and female) aged <18 years old in juvenile detention centers.

B. Vulnerable populations are groups of people who are particularly vulnerable to HIV infection in certain situations or contexts, including:

1) Migrants refers to non-Thai people living in Thailand including documented and undocumented migrants. Their nationalities include, but not limited to Myanmar, Cambodia, Lao PDR. The HIV program focuses on fishermen, seafood processing workers, factory workers, construction laborers and sex workers; and
2) Adolescents refers to individuals between the ages of 10 and 19 years old.

Notes:

- Many individuals will relate to more than one key population. For example, some men who have sex with men and some transgender people may also engage in sex work and/or inject drugs.
- Key populations include Thai and non-Thai people.

Annex 3: 2025 Global AIDS Targets

People living with HIV and communities at risk have been placed at the center of the proposed targets for 2025

Investment framework for the development of the 2025 AIDS targets includes:

I. HIV services: Services proven to prevent HIV infections or AIDS-related mortality.

II. Enablers: A law, system or action that positively modifies the effectiveness of an HIV service.

- Societal enablers include supportive laws and policies, and societies that respect gender equality and do not discriminate against PLHIV and key populations.
- Service enablers include the linkage or integration of services, differentiated service delivery and community-led services.
- System enablers include infrastructure, strategic planning, budgeting and management systems, monitoring and evaluation systems and communications systems.

III. Development synergies: Broader efforts in different sectors that advance the results of the HIV response. Examples include efforts to end poverty and fulfil the right to health and other human rights. Development synergies HIV services

Top-line targets for 2025

I. HIV services

- 95–95–95 testing and treatment targets achieved within all subpopulations and age groups.
- 95% of women of reproductive age have their HIV and sexual and reproductive health service needs met; 95% of pregnant and breastfeeding women living with HIV have suppressed viral loads; and 95% of HIV-exposed children are tested by 2025.
- 95% of people at risk of HIV infection use appropriate, prioritized, person centered and effective combination prevention options.

II. Integration

Adoption of people centered and context specific integrated approaches that support the achievement of the 2025 HIV targets and result in at least 90% of people living with HIV and individuals at heightened risk of HIV infection linked to services for other communicable diseases, noncommunicable diseases, sexual and gender-based violence, mental health and other services they need for their overall health and well-being.

III. Societal enablers

10–10–10 targets for removing societal and legal impediments to an enabling environment that limit access or utilization of HIV services.

- Less than 10% of countries have punitive legal and policy environments that deny or limit access to services.
- Less than 10% of people living with HIV and key populations experience stigma and discrimination.
- Less than 10% of women, girls, people living with HIV and key populations experience gender inequality and violence.

Modelling has been undertaken to project the impact that achievement of these targets would have on the epidemic's trajectory, achieving steep reductions to about 370 000 HIV infections and 250 000 AIDS-related deaths in 2025, and putting the world firmly on track to the ultimate goal of ending the epidemic in all settings and for all populations by 2030.

Detailed testing and treatment targets

Children (aged 0–14 years)	*Adolescent girls and young women (aged 15–24 years)*	*Adolescent boys and young men (aged 15–24 years)*	*Adult women (aged 25 years and older)*	*Adult men (aged 25 years and older)*	*People on the move (such as migrants and refugees)*
Gay men and other men who have sex with men	*Transgender people*	*Sex workers*	*People who inject drugs*	*People in prisons and other closed settings*	
95% of people within the subpopulation who are living with HIV know their HIV status					
95% of people within the subpopulation who are living with HIV and who know their HIV status are on antiretroviral therapy					
95% of people within the subpopulation who are on antiretroviral therapy have suppressed viral loads					

Detailed targets for sexual and reproductive health services and eliminating vertical HIV transmission

Population	*Target*
Women of reproductive age in high HIV prevalence settings, within key populations and living with HIV	95% have their HIV prevention and sexual and reproductive health service needs met
Pregnant and breastfeeding women	95% of pregnant women are tested for HIV, syphilis and hepatitis B surface antigen at least once and as early as possible. In high HIV burden settings, pregnant and breastfeeding women with unknown HIV status or who previously tested HIV-negative should be re-tested during late pregnancy (third trimester) and in the post-partum period.
Pregnant and breastfeeding women living with HIV	90% of women living with HIV on antiretroviral therapy before their current pregnancy All pregnant women living with HIV are diagnosed and on antiretroviral therapy, and 95% achieve viral suppression before delivery All breastfeeding women living with HIV are diagnosed and on antiretroviral therapy, and 95% achieve viral suppression (to be measured at 6–12 months)
Children (aged 0–14 years)	95% of HIV-exposed infants receive a virologic test and parents provided the results by age 2 months 95% of HIV-exposed infants receive a virologic test and parents provided the results between ages 9 and 18 months 95–95–95 testing and treatment targets achieved among children living with HIV

Thresholds for the prioritization of HIV prevention methods

	Criterion	*Very high*	*High*	*Moderate and low*
Sex workers	National adult (15–49 years) HIV prevalence	>3%	>0.3%	<0.3%
Prisoners	National adult (15–49 years) HIV prevalence	>10%	>1%	<1%
Gay men and other men who have sex with men	UNAIDS analysis by country/region	Proportion of populations estimated to have incidence >3%	Proportion of populations estimated to have incidence 0.3–3%	Proportion of populations estimated to have incidence <0.3%
Transgender people	Mirrors gay men and other men who have sex with men in absence of data	Proportion of populations estimated to have incidence >3%	Proportion of populations estimated to have incidence 0.3–3%	Proportion of populations estimated to have incidence <0.3%
People who inject drugs	UNAIDS analysis by country/region	Low needle–syringe program and opioid substitution therapy coverage	Some needle–syringe program; some opioid substitution therapy	High needle–syringe program coverage with adequate needles and syringes per person who injects drugs; opioid substitution therapy available

	Criterion	*High and very high*		*Medium*	*Low*
Adolescent girls and young women	Combination of [national or subnational incidence in women 15–24 years] AND [reported behavior from DHS or other (>2 partners; or reported STI in previous 12 months)]	1–3% incidence AND high-risk reported behavior	>3% incidence	0.3–<1% incidence and high-risk reported behavior OR 1–3% incidence and low-risk reported behavior	<0.3% incidence OR 0.3–<1% incidence and low-risk reported behavior

	Criterion	*High and very high*		*Medium*	*Low*
Adolescent boys and young men	Combination of [national or subnational incidence in men 15–24 years] AND	1–3% incidence AND	>3% incidence	0.3–<1% incidence and high-risk reported behavior	<0.3% incidence OR 0.3–<1% incidence

	[reported behavior from DHS or other (>2 partners; or reported STI in previous 12 months)]	high-risk reported behavior		OR 1–3% incidence and low-risk reported behavior	and low-risk reported behavior
Adults (aged 25 and older)	Combination of [national or subnational incidence in adults 25–49 years] AND [reported behavior from DHS or other (>2 partners; or reported STI in previous 12 months)]	1–3% incidence AND high-risk reported behavior	>3% incidence	0.3–<1% incidence and high-risk reported behavior OR 1–3% incidence and low-risk reported behavior	<0.3% incidence OR 0.3–<1% incidence and low-risk reported behavior
Serodiscordant partnerships	Estimated number of HIV negative regular partners of someone newly starting on treatment	Risk stratification depends on choices within the partnership: choice of timing and regimen of antiretroviral therapy for the HIV-positive partner; choice of behavioral patterns (condoms, frequency of sex); choice of PrEP			

Detailed HIV prevention targets for key populations

KEY POPULATIONS	*Sex workers*	*Gay men and other men who have sex with men*	*People who inject drugs*	*Transgender people*	*Prisoners and others in closed settings*
Condoms/lubricant use at last sex by those not taking PrEP with a non-regular partner whose HIV viral load status is not known to be undetectable (includes those who are known to be HIV-negative)	--	95%	95%	95%	--
Condom/lubricant use at last sex with a client or non-regular partner	90%	--	--	--	90%
PrEP use (by risk category) • Very high • High • Moderate and low	 80% 15% 0%	 50% 15% 0%	 15% 5% 0%	 50% 15% 0%	 15% 5% 0%
Sterile needles and syringes			90%		90%
Opioid substitution therapy among people who are opioid dependent			50%		
STI screening and treatment	80%	80%		80%	

KEY POPULATIONS	*Sex workers*	*Gay men and other men who have sex with men*	*People who inject drugs*	*Transgender people*	*Prisoners and others in closed settings*
Regular access to appropriate health system or community-led services	90%	90%	90%	90%	100%
Access to post-exposure prophylaxis as part of package of risk assessment and support	90%	90%	90%	90%	90%

Detailed HIV prevention targets for the general population

GENERAL POPULATION		*Risk by prioritization stratum*		
		Very high	*Moderate*	*Low*
All ages and genders	Condoms/lubricant use at last sex by those not taking PrEP with a non-regular partner whose HIV viral load status is not known to be undetectable (includes those who are known to be HIV-negative)	95%	70%	50%
	PrEP use (by risk category)	50%	5%	0%
	STI screening and treatment	80%	10%	10%
Adolescents and young people	Comprehensive sexuality education in schools, in line with UN international technical guidance	90%	90%	90%

GENERAL POPULATION		*Strata based on geography alone*			
		Very high (>3%)	*High (1–3%)*	*Moderate (0.3–1%)*	*Low (<0.3%)*
All ages and genders	Access to post-exposure prophylaxis (PEP) (non-occupational exposure) as part of package of risk assessment and support	90%	50%	5%	0%
	Access to PEP (nosocomial) as part of package of risk assessment and support	90%	80%	70%	50%

GENERAL POPULATION		*Strata based on geography alone*			
		Very high (>3%)	*High (1–3%)*	*Moderate (0.3–1%)*	*Low (<0.3%)*
Adolescent girls and young women	Economic empowerment	20%	20%	0%	0%
Adolescent boys and men	VMMC	90% in 15 priority countries			
People within serodiscordant partnerships	Condoms/lubricant use at last sex by those not taking PrEP with a nonregular partner whose HIV viral load status is not known	95%			
	PrEP until positive partner has suppressed viral load	30%			
	PEP	100% after high-risk exposure			

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