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.
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<td>AEM</td>
<td>Asian Epidemic Model</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal clinic</td>
</tr>
<tr>
<td>ART</td>
<td>Anti-retroviral Therapy</td>
</tr>
<tr>
<td>ARV</td>
<td>Anti-retroviral</td>
</tr>
<tr>
<td>BBS</td>
<td>Biobehavioral Survey</td>
</tr>
<tr>
<td>BSS</td>
<td>Behavioral Surveillance Survey</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-based organization</td>
</tr>
<tr>
<td>CRS</td>
<td>Crisis Response System</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organization</td>
</tr>
<tr>
<td>DAS</td>
<td>Division of AIDS and STIs</td>
</tr>
<tr>
<td>DDC</td>
<td>Department of Disease Control</td>
</tr>
<tr>
<td>DOC</td>
<td>Department of Corrections</td>
</tr>
<tr>
<td>DOE</td>
<td>Division of Epidemiology</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DOMS</td>
<td>Department of Medical Sciences</td>
</tr>
<tr>
<td>DTB</td>
<td>Division of Tuberculosis</td>
</tr>
<tr>
<td>EIIS</td>
<td>Epidemic Intelligence Information System</td>
</tr>
<tr>
<td>FAR</td>
<td>Foundation for AIDS Rights</td>
</tr>
<tr>
<td>FSW</td>
<td>Female sex workers</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund to fight AIDS, TB and Malaria</td>
</tr>
<tr>
<td>GAM</td>
<td>Global AIDS Monitoring</td>
</tr>
<tr>
<td>HAD</td>
<td>Health Administration Division</td>
</tr>
<tr>
<td>HCV</td>
<td>The hepatitis C virus</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HSS</td>
<td>HIV Sentinel Surveillance</td>
</tr>
<tr>
<td>IHRI</td>
<td>Institute of HIV Research and Innovation</td>
</tr>
<tr>
<td>KPLHIV</td>
<td>Key Population Living with HIV</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MICS</td>
<td>Multiple Indicator Cluster Surveys</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------------------------------------------------------</td>
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<tr>
<td>MMT</td>
<td>Methadone Maintenance Therapy</td>
</tr>
<tr>
<td>MOE</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>MOI</td>
<td>Ministry of Interior</td>
</tr>
<tr>
<td>MOL</td>
<td>Ministry of Labor</td>
</tr>
<tr>
<td>MOPH</td>
<td>Ministry of Public Health</td>
</tr>
<tr>
<td>MSDHS</td>
<td>Ministry of Social Development and Human Security</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
</tr>
<tr>
<td>MSW</td>
<td>Male sex workers</td>
</tr>
<tr>
<td>MTCT</td>
<td>Mother-to-Child-Transmission</td>
</tr>
<tr>
<td>MW</td>
<td>Migrant worker</td>
</tr>
<tr>
<td>NA</td>
<td>Not available</td>
</tr>
<tr>
<td>NAC</td>
<td>National AIDS Committee</td>
</tr>
<tr>
<td>NAP</td>
<td>National AIDS Program System</td>
</tr>
<tr>
<td>NASA</td>
<td>National AIDS Spending Assessment</td>
</tr>
<tr>
<td>NCMC</td>
<td>Narcotics Control Management Center</td>
</tr>
<tr>
<td>NCPI</td>
<td>National Commitments and Policy Instruments</td>
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<tr>
<td>NHES</td>
<td>National Health Examination Survey Office</td>
</tr>
<tr>
<td>NHSO</td>
<td>National Health Security Office</td>
</tr>
<tr>
<td>NRCT</td>
<td>National Research Council of Thailand</td>
</tr>
<tr>
<td>NSO</td>
<td>National Statistical Office of Thailand</td>
</tr>
<tr>
<td>NTIP</td>
<td>National Tuberculosis Information Program</td>
</tr>
<tr>
<td>ODPC</td>
<td>Office of Disease Prevention and Control</td>
</tr>
<tr>
<td>PCM</td>
<td>Provincial Coordinating Mechanism</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>United States President’s Emergency Plan for AIDS Relief</td>
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<tr>
<td>PHIMS</td>
<td>Perinatal HIV Intervention Monitoring Surveillance System</td>
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<tr>
<td>PHO</td>
<td>Provincial Health Office</td>
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<tr>
<td>PLHIV</td>
<td>People living with HIV</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission</td>
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<tr>
<td>PrEP</td>
<td>Pre-Exposure Prophylaxis</td>
</tr>
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<td>PWID</td>
<td>People who Inject Drugs</td>
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<tr>
<td>RTCM</td>
<td>Real Time Cohort Monitoring System</td>
</tr>
<tr>
<td>RTF</td>
<td>Raks Thai Foundation</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<td>--------------</td>
<td>-----------</td>
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<tr>
<td>S&amp;D</td>
<td>Stigma and discrimination</td>
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<tr>
<td>SI</td>
<td>Strategic information</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infections</td>
</tr>
<tr>
<td>SW</td>
<td>Sex Workers</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TBD</td>
<td>To be determined</td>
</tr>
<tr>
<td>TGW</td>
<td>Transgender Women</td>
</tr>
<tr>
<td>TNP+</td>
<td>Thai Network of People Living with HIV/AIDS</td>
</tr>
<tr>
<td>TPT</td>
<td>TB preventive therapy</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>The Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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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

<table>
<thead>
<tr>
<th>Components</th>
<th>Result areas</th>
</tr>
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<tr>
<td>A. HIV services</td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>2. Young people access sustained combination HIV prevention</td>
</tr>
<tr>
<td></td>
<td>3. Tailored and scaled HIV combination prevention and related HIV and health services accessible to and utilized by key populations</td>
</tr>
<tr>
<td>B. Integration</td>
<td>4. Eliminate vertical transmission of HIV, syphilis and hepatitis</td>
</tr>
<tr>
<td></td>
<td>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</td>
</tr>
<tr>
<td>C. Societal enablers</td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>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</td>
</tr>
<tr>
<td>D. Resources</td>
<td>8. Community-led responses are fully recognized, empowered, resourced, and integrated for a transformative and sustainable HIV response</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Goals/Result Areas /Strategies/Programs</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals</td>
<td>Impact indicators</td>
</tr>
</tbody>
</table>
| 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                       | 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 |
| 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 | 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. |
| 2 Young people access sustained combination HIV prevention | 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 |
<table>
<thead>
<tr>
<th>Goals/Result Areas /Strategies/Programs</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>B. Integration</strong></td>
<td></td>
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</tbody>
</table>
| 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 |
<p>| <strong>D. Resources</strong>                     |            |
| 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 |</p>
<table>
<thead>
<tr>
<th>Goals/Result Areas /Strategies/Programs</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicators</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Output/Coverage indicators</strong></td>
<td></td>
</tr>
</tbody>
</table>

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

**Strategies**

| 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**

**Strategies**

| 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**

**Strategies**

| 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/mm³) |
| 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 |
<p>| D | Social and economic support program | S3D.1 Proportion of eligible households receiving economic support in the reporting period |</p>
<table>
<thead>
<tr>
<th>Goals/Result Areas /Strategies/Programs</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy 4: Adjust HIV perceptions and empower of individuals, families and communities along with strengthening a rights protection mechanism</strong></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>HIV and gender-related human rights, stigma and discrimination program</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td><strong>Strategy 5: Enhance joint accountability, investment, and efficiency of administrative efforts in all sectors at the international, national, provincial and local levels</strong></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>Resource investment</td>
</tr>
<tr>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Quality assurance</td>
</tr>
<tr>
<td><strong>Strategy 6: Support and improve accessibility and utilization of strategic information and research that are inclusive and efficient</strong></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>Health Management Information System</td>
</tr>
<tr>
<td>B</td>
<td>Community based monitoring</td>
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<tr>
<td>C</td>
<td>Research and evaluation</td>
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</table>
## B. Impact Indicators with targets

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

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline value</th>
<th>Targets</th>
<th>Data sources</th>
<th>Responsible units</th>
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<tbody>
<tr>
<td></td>
<td>value</td>
<td>year 2021</td>
<td>2022</td>
<td>2023</td>
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<tr>
<td><strong>Goal 1: To reduce new HIV infections less than 1,000 cases per year by the year 2030</strong></td>
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<tr>
<td>G1.1 Number of new HIV infections per 1,000 uninfected population</td>
<td>0.10</td>
<td>2020</td>
<td>0.07</td>
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<td></td>
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<tr>
<td>G1.2 Estimated number of new HIV infections</td>
<td>6,600</td>
<td>2020</td>
<td>5,000</td>
<td>4,200</td>
</tr>
<tr>
<td></td>
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<tr>
<td>G1.3 Percentage of KP living with HIV</td>
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<td></td>
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<td></td>
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<tr>
<td>MSM</td>
<td>7.3</td>
<td>2020</td>
<td>6.8</td>
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</tr>
<tr>
<td>TGW</td>
<td>4.2</td>
<td>2020</td>
<td>3.9</td>
<td>3.5</td>
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<tr>
<td>MSW</td>
<td>3.8</td>
<td>2018</td>
<td>3.0</td>
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<tr>
<td>Venue-based FSW</td>
<td>0.7</td>
<td>2018</td>
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<tr>
<td>Non-venue FSW</td>
<td>2.8</td>
<td>2019</td>
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<td>PWID</td>
<td>7.8</td>
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<td>7.2</td>
<td>6.7</td>
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<tr>
<td>Prisoners</td>
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<td>&lt;1</td>
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<tr>
<td>Migrants</td>
<td>0.2</td>
<td>2020</td>
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<td></td>
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<tr>
<td><strong>Goal 2: To reduce AIDS-related deaths less than 4,000 cases per year by 2030</strong></td>
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<tr>
<td>G2.1 Number of AIDS-related deaths per 100,000 population</td>
<td>17.4</td>
<td>2020</td>
<td>14.3</td>
<td>11.5</td>
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<tr>
<td>G2.2 Estimated number of AIDS-related deaths</td>
<td>12,115</td>
<td>2020</td>
<td>8,600</td>
<td>8,200</td>
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<td></td>
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<tr>
<td>G2.3 TB/HIV mortality rate per 100,000 population</td>
<td>20.1</td>
<td>2019</td>
<td>18</td>
<td>16</td>
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<tr>
<td></td>
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</tr>
<tr>
<td><strong>Goal 3: To reduce HIV and gender related discrimination 90% from baseline in 2016 by 2030</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>G3.1 Percentage of women and men 15-49 years old who report discriminatory attitudes towards PLHIV</td>
<td>26.7</td>
<td>2019</td>
<td>20</td>
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</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>G3.2 Percentage of PLHIV experience HIV related discrimination in the past 12 months</td>
<td>NA</td>
<td></td>
<td>TBD</td>
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<td></td>
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</tr>
</tbody>
</table>
### C. Outcome Indicators with targets

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

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline</th>
<th>Targets</th>
<th>Data sources</th>
<th>Responsible units</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. HIV SERVICES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>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</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>R1.1 Percentage of PLHIV who know their HIV status at the end of the reporting period</td>
<td>94.3</td>
<td>2020</td>
<td>95</td>
<td>95</td>
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<tr>
<td>R1.2 Percentage of PLHIV who are on ART at the end of the reporting period</td>
<td>83.5</td>
<td>2020</td>
<td>90</td>
<td>90</td>
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<tr>
<td>R1.3 Percentage of PLHIV on ART who have suppressed viral loads at the end of the reporting period</td>
<td>97.2</td>
<td>2020</td>
<td>99</td>
<td>99</td>
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<tr>
<td><strong>RESULT AREA 2: Young people access sustained combination HIV prevention</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>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</td>
<td>80.3</td>
<td>2019</td>
<td>83</td>
<td>86</td>
</tr>
<tr>
<td>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.</td>
<td>52.3</td>
<td>2020</td>
<td>60</td>
<td>70</td>
</tr>
<tr>
<td><strong>RESULT AREA 3: Tailored and scaled HIV combination prevention and related HIV and health services accessible to and utilized by key populations</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>R3.1 Percentage of key populations reached with HIV combination prevention programs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicators</td>
<td>Baseline value</td>
<td>Year</td>
<td>Targets</td>
<td>Data sources</td>
</tr>
<tr>
<td>------------</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>2021</td>
<td>2022</td>
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<tr>
<td>MSM</td>
<td>49.5</td>
<td>2020</td>
<td>91</td>
<td>92</td>
</tr>
<tr>
<td>TGW</td>
<td>62.0</td>
<td>2020</td>
<td>91</td>
<td>92</td>
</tr>
<tr>
<td>MSW</td>
<td>74.3</td>
<td>2018</td>
<td>91</td>
<td>92</td>
</tr>
<tr>
<td>FSW</td>
<td>68.6</td>
<td>2018</td>
<td>91</td>
<td>92</td>
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<tr>
<td>PWID</td>
<td>31.7</td>
<td>2019</td>
<td>70</td>
<td>78</td>
</tr>
<tr>
<td>R3.2</td>
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</tr>
<tr>
<td>MSM</td>
<td>NA</td>
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<td></td>
</tr>
<tr>
<td>TGW</td>
<td>NA</td>
<td></td>
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</tr>
<tr>
<td>MSW</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FSW</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PWID</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R3.3</td>
<td></td>
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<tr>
<td>MSM</td>
<td>52.8</td>
<td>2020</td>
<td>77</td>
<td>80</td>
</tr>
<tr>
<td>TGW</td>
<td>63.4</td>
<td>2020</td>
<td>77</td>
<td>80</td>
</tr>
<tr>
<td>MSW</td>
<td>69.0</td>
<td>2018</td>
<td>80</td>
<td>85</td>
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<td>FSW</td>
<td>45.5</td>
<td>2018</td>
<td>60</td>
<td>70</td>
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<tr>
<td>PWID</td>
<td>38.1</td>
<td>2019</td>
<td>55</td>
<td>70</td>
</tr>
<tr>
<td>R3.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSM</td>
<td>77.8</td>
<td>2020</td>
<td>90</td>
<td>91</td>
</tr>
<tr>
<td>R3.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSM</td>
<td>78.8</td>
<td>2020</td>
<td>90</td>
<td>91</td>
</tr>
<tr>
<td>R3.6</td>
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<tr>
<td>MSM</td>
<td>90.3</td>
<td>2018</td>
<td>95</td>
<td>95</td>
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<td>R3.7</td>
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<tr>
<td>MSM</td>
<td>95.0</td>
<td>2019</td>
<td>&gt;95</td>
<td></td>
</tr>
</tbody>
</table>

**Indicators**

- **R3.2** Percentage of key populations receiving PrEP
- **R3.3** Percentage of key populations received an HIV test and know their results during the reporting period
- **R3.4** Percentage of MSM reporting the use of a condom the last time they had anal sex with a non-regular partner
- **R3.5** Percentage of TGW reporting using a condom in their last anal sex with a non-regular male partner
- **R3.6** Percentage of SW reporting the use of a condom with their most recent client
- **R3.7** Percentage of PWID reporting the use of sterile injecting equipment the last time they injected

**Data sources**

- BBS
- DOE
## Results and Outcome Indicators

### Indicators

<table>
<thead>
<tr>
<th>Baseline</th>
<th>Targets</th>
<th>Data sources</th>
<th>Responsible units</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year</td>
<td>2021</td>
<td>2022</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R3.8 Percentage of PWID reporting condom use at last sex</td>
<td>39.6</td>
<td>2019</td>
<td>50</td>
</tr>
<tr>
<td>R3.9 Percentage of migrants who report the use of a condom at last sexual intercourse</td>
<td>29.0</td>
<td>2020</td>
<td>50</td>
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</table>

### B. INTEGRATION

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

<table>
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<th>&lt;2</th>
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<th>Responsible units</th>
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<tbody>
<tr>
<td>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</td>
<td>1.65</td>
<td>2020</td>
<td>&lt;2</td>
<td>&lt;2</td>
<td>&lt;2</td>
<td>&lt;2</td>
<td>&lt;2</td>
<td>Pregnant women living with HIV estimated by Spectrum</td>
<td>DOH/DOE</td>
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<tr>
<td>R4.2 Reported congenital syphilis cases (live births and stillbirths) per 100 000 livebirths</td>
<td>46</td>
<td>2019</td>
<td>&lt;50</td>
<td>&lt;50</td>
<td>&lt;50</td>
<td>&lt;50</td>
<td>&lt;50</td>
<td>Surveillance report 506</td>
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<td>R4.3 HBsAg prevalence among children aged 5 years</td>
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</table>

#### 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

<table>
<thead>
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<th>Data sources</th>
<th>Responsible units</th>
</tr>
</thead>
<tbody>
<tr>
<td>R5.1 Prevalence of hepatitis and coinfection with HIV among key populations</td>
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<td></td>
<td></td>
<td>Program data</td>
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<td></td>
<td></td>
<td>DOE</td>
</tr>
<tr>
<td>TGW</td>
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<td></td>
<td></td>
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<tr>
<td>FSW</td>
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<td>DOE</td>
</tr>
<tr>
<td>PWID</td>
<td>42.2</td>
<td>2019</td>
<td>30</td>
<td>20</td>
<td>1.2</td>
<td>1.5</td>
<td>1.5</td>
<td></td>
<td></td>
<td>DOE</td>
</tr>
<tr>
<td>R5.2 Percentage of PLHIV who are newly enrolled in HIV treatment with active TB</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>DOE</td>
</tr>
<tr>
<td>R5.3 Percentage of MSM with active syphilis</td>
<td>6.0</td>
<td>2018</td>
<td>4.5</td>
<td>3.9</td>
<td></td>
<td>1.5</td>
<td></td>
<td></td>
<td>BBS</td>
<td>DOE</td>
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<tr>
<td>R5.4 Percentage of sex workers with active syphilis</td>
<td>1.8</td>
<td>2019</td>
<td>1.6</td>
<td>&lt;1.5</td>
<td>&lt;1.5</td>
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</table>
### Results and Outcome Indicators

<table>
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<th>Baseline</th>
<th>Year</th>
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<td><strong>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</strong></td>
<td></td>
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<td>R6.1 Percentage of PLHIV and key populations who report experiences of HIV-related discrimination in health-care settings</td>
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<td>R6.2 Percentage of PLHIV and key populations avoiding of health care because of stigma and discrimination¹</td>
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<tr>
<td>TGW</td>
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<td>2018</td>
<td>3</td>
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<td></td>
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<tr>
<td>PWID</td>
<td>8.0</td>
<td>2020</td>
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<tr>
<td>R6.3 Percentage of PLHIV and key populations who report experiences of HIV-related discrimination at workplaces</td>
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<tr>
<td>PLHIV</td>
<td>3.7</td>
<td>2019</td>
<td></td>
<td>2.5</td>
<td>≤2</td>
<td>≤2</td>
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<td>S&amp;D survey</td>
<td>DAS</td>
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<tr>
<td>MSM</td>
<td>5.0</td>
<td>2018</td>
<td></td>
<td>4</td>
<td>≤3</td>
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<td></td>
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<td>MSW</td>
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<td></td>
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<td>DOE</td>
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<td>PWID</td>
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<td>2020</td>
<td></td>
<td>1.8</td>
<td>≤1</td>
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</tr>
<tr>
<td>R6.4 Percentage of PLHIV and key populations reporting internalized stigma</td>
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<td>PLHIV</td>
<td>36.1</td>
<td>2019</td>
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<tr>
<td>MSM</td>
<td>19.4</td>
<td>2017</td>
<td></td>
<td>18</td>
<td>16</td>
<td>18</td>
<td></td>
<td>BBS</td>
<td>DOE</td>
</tr>
<tr>
<td>TGW</td>
<td>22.1</td>
<td>2017</td>
<td></td>
<td>20</td>
<td>18</td>
<td></td>
<td></td>
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<td>MSW</td>
<td>19.9</td>
<td>2017</td>
<td></td>
<td>18</td>
<td>16</td>
<td></td>
<td></td>
<td>BBS</td>
<td>DOE</td>
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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

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline value</th>
<th>Year</th>
<th>2021 Target</th>
<th>2022 Target</th>
<th>2023 Target</th>
<th>2024 Target</th>
<th>2025 Target</th>
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<th>Responsible units</th>
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<td>FSW</td>
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<td>DOE</td>
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<tr>
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<td>58</td>
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<td>DOE</td>
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<tr>
<td>R6.5 Percentage of healthcare staff reporting observed stigma toward PLHIV in the past 12 months</td>
<td>27</td>
<td>2017</td>
<td>20</td>
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<tr>
<td>R6.6 Percentage of healthcare staff reported negative attitude toward PLHIV</td>
<td>83.5</td>
<td>2017</td>
<td>60</td>
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<tr>
<td>R6.7 Percentage of healthcare staff worried of contracting HIV while caring for PLHIV</td>
<td>49.7</td>
<td>2017</td>
<td>30</td>
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<td></td>
<td>Hospital surveillance survey</td>
<td>DAS</td>
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</tbody>
</table>

### 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 |

### 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

<table>
<thead>
<tr>
<th>Strategy and Output/Coverage Indicators</th>
<th>Baseline</th>
<th>Targets</th>
<th>Data sources</th>
<th>Responsible units</th>
</tr>
</thead>
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<tr>
<td>Indicators</td>
<td>Value</td>
<td>Year</td>
<td>2021</td>
<td>2022</td>
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<tr>
<td>Strategy 1: Focus and expedite effective and inclusive package of services to locations and populations with high HIV transmission</td>
<td></td>
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<tr>
<td>A. HIV Key Population Program</td>
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<td></td>
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<tr>
<td>S1A.1 Percentage of key populations reached with HIV prevention programs - defined package of services</td>
<td>MSM</td>
<td>64.8</td>
<td>2020</td>
<td>91</td>
</tr>
<tr>
<td></td>
<td>TGW</td>
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<td>2020</td>
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<td>2020</td>
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<td></td>
<td>FSW</td>
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<td>2020</td>
<td>91</td>
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<td>23.5</td>
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<td></td>
<td>Prisoners</td>
<td>97.3</td>
<td>2020</td>
<td>&gt;95</td>
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<td>Migrants</td>
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<td>2020</td>
<td>96</td>
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<tr>
<td>S1A.2 Number of needles and syringes distributed per person who injects drugs per year by needle and syringe programs</td>
<td>12.2</td>
<td>2020</td>
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<td>31</td>
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<tr>
<td>S1A.3 Percentage of individuals receiving Opioid Substitution Therapy who received treatment for at least 6 months</td>
<td>64.0</td>
<td>2019</td>
<td>30</td>
<td>50</td>
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<tr>
<td>S1A.4 Percentage of key populations that have received an HIV test during the reporting period and know their results</td>
<td>MSM</td>
<td>77.4</td>
<td>2020</td>
<td>73</td>
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<td>TGW</td>
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<td>73</td>
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<td>56</td>
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<td>28.8</td>
<td>2020</td>
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<td>PWID</td>
<td>15.0</td>
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<td></td>
<td>Prisoners</td>
<td>35.4</td>
<td>2020</td>
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<td></td>
<td>Migrants</td>
<td>28.3</td>
<td>2020</td>
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### Strategy and Output/Coverage Indicators

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<th>Targets</th>
<th>Data sources</th>
<th>Responsible units</th>
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<td></td>
<td>Value</td>
<td>Year</td>
<td>2021</td>
<td>2022</td>
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<tr>
<td>S1A.5 Percentage of HIV-positive results returned to key population in the reporting year (positivity)</td>
<td>MSM 6.7</td>
<td>2020</td>
<td>8.5</td>
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<tr>
<td></td>
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<td></td>
<td>MSW 4.9</td>
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<td>Migrants 0.8</td>
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<td>S1A.6 Percentage of key populations newly diagnosed with HIV initiated on ART</td>
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<td>92</td>
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<tr>
<td></td>
<td>TGW NA</td>
<td></td>
<td>90</td>
<td>92</td>
</tr>
<tr>
<td></td>
<td>MSW NA</td>
<td></td>
<td>90</td>
<td>92</td>
</tr>
<tr>
<td></td>
<td>FSW NA</td>
<td></td>
<td>90</td>
<td>92</td>
</tr>
<tr>
<td></td>
<td>PWID NA</td>
<td></td>
<td>90</td>
<td>92</td>
</tr>
<tr>
<td></td>
<td>Prisoners NA</td>
<td></td>
<td>90</td>
<td>92</td>
</tr>
<tr>
<td></td>
<td>Migrants NA</td>
<td></td>
<td>90</td>
<td>92</td>
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<td>S1A.7 Percentage of eligible key population who initiated oral antiretroviral PrEP during the reporting period</td>
<td>Total 9.3</td>
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<td></td>
<td>Sero-discordant couples 40.2</td>
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<td>70</td>
</tr>
<tr>
<td></td>
<td>MSM 10.3</td>
<td>2020</td>
<td>20</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>TGW 11.4</td>
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### B. HIV Key Population Program Integration with Other Health Services

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<td>S1B.1 Proportion of key population who were tested for HCV</td>
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<td>TBD</td>
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<tr>
<td>S1B.2 Proportion of people coinfected with HIV and HCV starting HCV treatment</td>
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<td>TBD</td>
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<td>Strategy and Output/Coverage Indicators</td>
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<td><strong>Indicators</strong></td>
<td><strong>Baseline</strong></td>
<td><strong>Targets</strong></td>
<td><strong>Data sources</strong></td>
<td><strong>Responsible units</strong></td>
</tr>
<tr>
<td></td>
<td>Value</td>
<td>Year</td>
<td>2021</td>
<td>2022</td>
</tr>
<tr>
<td>S1B.3 Percentage of key populations screened for STI</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>All KP</td>
<td>19.2</td>
<td>2020</td>
<td>28</td>
<td>34</td>
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<td>MSM</td>
<td>30.1</td>
<td>2020</td>
<td>35</td>
<td>40</td>
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<tr>
<td>TGW</td>
<td>16.7</td>
<td>2020</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>MSW</td>
<td>10.4</td>
<td>2020</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>FSW</td>
<td>13.1</td>
<td>2020</td>
<td>20</td>
<td>30</td>
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<tr>
<td>TGSW</td>
<td>NA</td>
<td>2020</td>
<td>15</td>
<td>20</td>
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</tbody>
</table>

*S1B.3* Percentage of key populations screened for STI

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

**A. PMTCT program**

<table>
<thead>
<tr>
<th>S2A.1 Percentage of pregnant women who know their HIV status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thai</td>
</tr>
<tr>
<td>Non-Thai</td>
</tr>
</tbody>
</table>

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

| 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**

| 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**

| 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**

**Data sources:** PHIMS, DOH

**Responsible units:** NAP plus, DAS
## Strategy and Output/Coverage Indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline</th>
<th>Targets</th>
<th>Data sources</th>
<th>Responsible units</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Value</td>
<td>Year</td>
<td>2021</td>
<td>2022</td>
</tr>
<tr>
<td>Thai</td>
<td>99.5</td>
<td>2020</td>
<td>&gt;99.5</td>
<td>&gt;99.5</td>
</tr>
<tr>
<td>Non-Thai</td>
<td>99.4</td>
<td>2020</td>
<td>&gt;99.5</td>
<td>&gt;99.5</td>
</tr>
<tr>
<td>(2) Percentage of women delivered babies in the reporting period who were tested positive for syphilis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thai</td>
<td>0.6</td>
<td>2020</td>
<td>&lt;0.5</td>
<td>&lt;0.5</td>
</tr>
<tr>
<td>Non-Thai</td>
<td>0.2</td>
<td>2020</td>
<td>&lt;0.2</td>
<td>&lt;0.2</td>
</tr>
<tr>
<td>(3) Percentage of women delivered babies in the reporting period who were tested positive for syphilis received treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thai</td>
<td>98.0</td>
<td>2020</td>
<td>99</td>
<td>&gt;99</td>
</tr>
<tr>
<td>Non-Thai</td>
<td>99.0</td>
<td>2020</td>
<td>99</td>
<td>&gt;99</td>
</tr>
<tr>
<td>S2A.6 Number of provinces achieving the goal to eliminate MTCT for HIV and syphilis (total: 77 provinces)</td>
<td>63</td>
<td>2020</td>
<td>70</td>
<td>77</td>
</tr>
</tbody>
</table>

### 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/mm³ | 52.7 | 2020 | 45 | 40 | 35 | 30 | 25 |
| CD4 <350 cell/mm³ | 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

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline</th>
<th>Targets</th>
<th>Data sources</th>
<th>Responsible units</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Value</td>
<td>2021</td>
<td>2022</td>
<td>2023</td>
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<tr>
<td>(1) Percentage of people newly diagnosed with HIV initiated on ART</td>
<td>NA</td>
<td>90</td>
<td>92</td>
<td>95</td>
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<tr>
<td>(2) Percentage of people newly diagnosed and on ART who had lost to follow up</td>
<td>NA</td>
<td>12</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>(3) Percentage of people newly diagnosed and on ART who had viral load tests</td>
<td>NA</td>
<td>80</td>
<td>85</td>
<td>90</td>
</tr>
<tr>
<td>(4) Percentage of people newly diagnosed and on ART who had virally suppressed</td>
<td>NA</td>
<td>95</td>
<td>&gt;95</td>
<td>&gt;95</td>
</tr>
<tr>
<td>S3B.2 Percentage of people newly diagnosed and on ART who initiated ART by 7 days after diagnosed</td>
<td>NA</td>
<td>40</td>
<td>50</td>
<td>60</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>C. TB/HIV program</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>S3C.1 Percentage of registered new and relapsed TB patients with documented HIV status</td>
<td>78.2</td>
<td>2020</td>
<td>95</td>
<td>95</td>
</tr>
<tr>
<td>S3C.2 Percentage of PLHIV in care (including PMTCT) who are screened for TB in HIV care or treatment settings</td>
<td>NA</td>
<td>70</td>
<td>80</td>
<td>90</td>
</tr>
<tr>
<td>S3C.3 Percentage of estimated HIV-positive incident tuberculosis (TB) cases that received treatment for both TB and HIV</td>
<td>50.5</td>
<td>2020</td>
<td>55</td>
<td>60</td>
</tr>
<tr>
<td>S3C.4 Percentage of PLHIV on ART who initiated TB preventive therapy (TPT) among those eligible for TPT</td>
<td>6.6</td>
<td>2020</td>
<td>30</td>
<td>35</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D. Social and economic support program</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>S3D.1 Proportion of eligible households receiving economic support in the reporting period</td>
<td>NA</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>A. HIV and gender-related human rights, stigma and discrimination program</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>S4A.1 Number of provinces implementing mechanism to protect human right on HIV</td>
<td>4</td>
<td>2020</td>
<td>14</td>
<td>24</td>
</tr>
<tr>
<td>S4A.2 Number of hospitals implementing reduction of HIV and gender-related stigma and discrimination</td>
<td>100</td>
<td>2020</td>
<td>214</td>
<td>396</td>
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</tbody>
</table>
### Strategy and Output/Coverage Indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline</th>
<th>Targets</th>
<th>Data sources</th>
<th>Responsible units</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>S4A.3 Number of organizations/agencies complying with in the HIV policy in workplaces</strong></td>
<td></td>
<td>2021</td>
<td>2022</td>
<td>2023</td>
</tr>
<tr>
<td>Value</td>
<td>Year</td>
<td>2020</td>
<td>1192</td>
<td>5936</td>
</tr>
<tr>
<td><strong>S4A.4 Percentage of general population exposed to legal literacy, stigma and discrimination reduction, gender equality and human rights protection mechanism</strong></td>
<td>NA</td>
<td>TBD</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>S4A.5 Percentage of PLHIV and Key Populations exposed information on Know Your Rights, gender equality and human rights protection mechanism</strong></td>
<td>PLA</td>
<td>NA</td>
<td>TBD</td>
<td>90</td>
</tr>
<tr>
<td><strong>S4A.6 Issues of laws/rules/regulations leading to obstacles to access to services by PLHIV and key populations (specify)</strong></td>
<td>1. Harm reduction</td>
<td>2. Sex work</td>
<td>3. Migrant health insurance</td>
<td>4. LGBTQI</td>
</tr>
</tbody>
</table>

**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**

<p>| SSA.1 Percentage of national AIDS spending from domestic public resources | 90.0 | 2019 | 91 | 91 | 92 | 92 | 93 | NASA | DAS |
| SSA.2 Percentage of national AIDS spending was for HIV prevention program | 14.0 | 2019 |       | 18 | 20 | | | NASA | DAS |
| SSA.3 Percentage of national AIDS spending for HIV prevention program among key populations from domestic resources | 22.0 | 2019 |       | 35 | 40 | | | NASA | DAS |
| SSA.4 Percentage of national AIDS spending for reduction of stigma and discrimination | 0.6 | 2019 |       | 3 | 6 | | | NASA | DAS |</p>
<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline Value</th>
<th>Baseline Year</th>
<th>Targets 2021</th>
<th>Targets 2022</th>
<th>Targets 2023</th>
<th>Targets 2024</th>
<th>Targets 2025</th>
<th>Data sources</th>
<th>Responsible units</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSA.5 Percentage of community health security funds supporting HIV program</td>
<td>NA</td>
<td></td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>Program record</td>
<td>NHSO</td>
</tr>
<tr>
<td>SSA.6 Number of provinces with provincial ending AIDS plan</td>
<td>3</td>
<td>2020</td>
<td>14</td>
<td>24</td>
<td>36</td>
<td>&gt;36</td>
<td>&gt;36</td>
<td>Program record</td>
<td>DAS</td>
</tr>
<tr>
<td><strong>B. Quality assurance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSA.1 Percentage of civil society organizations funded to provide HIV services complying with the standard quality accreditation system.</td>
<td>0.0</td>
<td>2020</td>
<td>40</td>
<td>50</td>
<td>70</td>
<td>80</td>
<td>90</td>
<td>Program record</td>
<td>DAS</td>
</tr>
</tbody>
</table>

**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 | TBD | TBD | TBD | TBD | 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:

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

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline value</th>
<th>Year</th>
<th>Targets 2021</th>
<th>2022</th>
<th>2023</th>
<th>2024</th>
<th>2025</th>
<th>Data sources</th>
<th>Responsible units</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. HIV Services: Maximize the impact of people-centered combination prevention and Test &amp; Treat interventions</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1. Percentage of key populations that have received an HIV test during the reporting period and know their results (S1A.4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSM</td>
<td>77.4</td>
<td>2020</td>
<td>82</td>
<td>85</td>
<td>88</td>
<td>90</td>
<td>92</td>
<td>NAP plus RTCM, E-cascade</td>
<td>DAS</td>
</tr>
<tr>
<td>TGW</td>
<td>54.4</td>
<td>2020</td>
<td>68</td>
<td>75</td>
<td>80</td>
<td>82</td>
<td>85</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSW</td>
<td>49.9</td>
<td>2020</td>
<td>60</td>
<td>65</td>
<td>70</td>
<td>75</td>
<td>80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FSW</td>
<td>28.8</td>
<td>2020</td>
<td>40</td>
<td>50</td>
<td>60</td>
<td>70</td>
<td>75</td>
<td></td>
<td></td>
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<tr>
<td>PWID</td>
<td>15.0</td>
<td>2020</td>
<td>30</td>
<td>40</td>
<td>50</td>
<td>55</td>
<td>60</td>
<td></td>
<td></td>
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<tr>
<td>Prisoners</td>
<td>35.4</td>
<td>2020</td>
<td>80</td>
<td>84</td>
<td>88</td>
<td>90</td>
<td>92</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migrants</td>
<td>28.3</td>
<td>2020</td>
<td>50</td>
<td>55</td>
<td>60</td>
<td>62</td>
<td>65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Percentage of young populations at risk that have received an HIV test during the reporting period and know their results (S1A.4)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Youth (15-24 years old)</td>
<td>NA</td>
<td></td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>NAP plus</td>
<td>DAS</td>
</tr>
<tr>
<td>MSM &lt; 25 years old</td>
<td>NA</td>
<td></td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSW &lt; 25 years old</td>
<td>NA</td>
<td></td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TGW &lt;25 years old</td>
<td>NA</td>
<td></td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
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</tr>
<tr>
<td>PWID &lt; 25 years old</td>
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<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
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<tr>
<td>3. Percentage of HIV-positive results returned to key population in the reporting year (positivity) (S1A.5)</td>
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<tr>
<td>MSM</td>
<td>6.7</td>
<td>2020</td>
<td>8.5</td>
<td>8</td>
<td>7.5</td>
<td>7</td>
<td>6.5</td>
<td>NAP plus E-cascade RTCM</td>
<td>DAS</td>
</tr>
<tr>
<td>TGW</td>
<td>4.1</td>
<td>2020</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>3.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSW</td>
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<td>2020</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>&lt;2</td>
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<td></td>
</tr>
<tr>
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<td>&gt;1</td>
<td>&gt;1</td>
<td>&gt;1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PWID</td>
<td>3.0</td>
<td>2020</td>
<td>&gt;5</td>
<td>&gt;6</td>
<td>&gt;6</td>
<td>6</td>
<td>6</td>
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<td></td>
</tr>
<tr>
<td>Prisoners</td>
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<td>2020</td>
<td>1.2</td>
<td>1.2</td>
<td>1.2</td>
<td>1.2</td>
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<td>Indicators</td>
<td>Baseline</td>
<td>Targets</td>
<td>Data sources</td>
<td>Responsible units</td>
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<td></td>
</tr>
<tr>
<td></td>
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<td>Year 2021 2022 2023 2024 2025</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migrants</td>
<td>0.8</td>
<td>0.8 0.8 0.8 0.8 0.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth</td>
<td>2.7</td>
<td>3 3.2 3.4 3.5 3.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Percentage and number of adults and children newly diagnosed with HIV with the low initial CD4 cell count (S3A.2)</td>
<td></td>
<td></td>
<td>NAP plus</td>
<td>NHSO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CD4 &lt;200</td>
<td>52.7</td>
<td>45 40 35 30 25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CD4 &lt;350</td>
<td>72.7</td>
<td>65 60 55 50 45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Percentage of people newly diagnosed who initiated ART by 7 days after diagnosis (S3B.2)</td>
<td>NA</td>
<td>40 50 60 70 80</td>
<td>NAP plus</td>
<td>NHSO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Number of eligible key population who initiated oral antiretroviral PrEP during the reporting period (S1A.7)</td>
<td>13,769</td>
<td>28,000 42,000 57,000 71,000 84,000</td>
<td>NAP plus</td>
<td>NHSO</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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       | 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) | 26,000 45,000 63,000 70,000 72,000 | DAS-TBHIV    | DAS               |
| 3. Percentage of people who were tested for HCV (S1B.1) | Key populations | NA | TBD | TBD | TBD | Program data | NHSO |
|                                                          | Newly registered PLHIV | NA | TBD | TBD | TBD |             |       |
| 4. Percentage of key populations screened for STI (S1B.3) | 19.2     | 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       | 214 396 173 175 177     | Program record | DAS              |
### Key Indicators for Accelerated Strategic Approaches towards the 2025 Global AIDS Targets

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline</th>
<th>Targets</th>
<th>Data sources</th>
<th>Responsible units</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>value</td>
<td>Year 2021</td>
<td>2022</td>
<td>2023</td>
</tr>
<tr>
<td>2. Number of organizations/agencies (government, private, non-government) complying with in the HIV policy in workplaces (S4A.3)</td>
<td>308</td>
<td>2020</td>
<td>1192</td>
<td>5936</td>
</tr>
</tbody>
</table>

#### 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 | 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 |
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
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

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

<table>
<thead>
<tr>
<th>Activities</th>
<th>Responsible agencies</th>
<th>Funding sources</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>2021</td>
</tr>
<tr>
<td>1</td>
<td>Survey/Surveillance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>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)</td>
<td>DOE, Royal Thai Army Medical Department</td>
<td>DDC Royal Thai Army Medical Department</td>
</tr>
</tbody>
</table>
| 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 |
<table>
<thead>
<tr>
<th>Activities</th>
<th>Responsible agencies</th>
<th>Funding sources</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3 Biobehavioral survey (BBS)</td>
<td>DOE</td>
<td>DDC GFATM support BBS in 2021-23</td>
<td>2021 2022 2023 2024 2025</td>
</tr>
<tr>
<td>▪ MSM, TGW, MSW</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>▪ Venue and non-venue based FSW</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>▪ PWID</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Migrant workers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4 Web-based response driven biobehavioral survey (BBS)</td>
<td>DOE</td>
<td>PEPFAR</td>
<td>2021 2022 2023 2024 2025</td>
</tr>
<tr>
<td>▪ MSM, TGW online HIV related behavioral survey and link to offline biomarkers testing (Syphilis, Hepatitis B &amp; C) for MSM in Bangkok</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>▪ Will determine expansion feasibility for biomarker testing in other provinces</td>
<td></td>
<td></td>
<td>TBD</td>
</tr>
<tr>
<td>1.5 HIV recent infection surveillance</td>
<td>DOE</td>
<td>PEPFAR</td>
<td>2021 2022 2023 2024 2025</td>
</tr>
<tr>
<td>▪ All PLHIV and sub-group analysis by key population to determine rate of recently HIV-infected clients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ 13 sentinel surveillance provinces</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Program data</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 HIV, TB, Hepatitis C prevalence among prisoners</td>
<td>DOC</td>
<td>NHSO and DOC</td>
<td></td>
</tr>
<tr>
<td>2.2 Causes of deaths</td>
<td>DAS</td>
<td>NHSO and DAS</td>
<td></td>
</tr>
<tr>
<td>3 Modeling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1 Size estimation of Key Populations</td>
<td>DAS and DOE</td>
<td>DDC, PEPFAR and GFATM in 2021-23</td>
<td>2021 2022 2023 2024 2025</td>
</tr>
<tr>
<td>▪ National level</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>▪ Provincial level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2 HIV estimation and projection</td>
<td>DOE</td>
<td>DDC and PEPFAR support</td>
<td></td>
</tr>
<tr>
<td>▪ National level</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>▪ Provincial level</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>3.3 Mother-to Child Transmission of HIV, Syphilis</td>
<td>NHSO, DOH and DAS</td>
<td>DDC</td>
<td></td>
</tr>
</tbody>
</table>

**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

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

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

<table>
<thead>
<tr>
<th>Activities</th>
<th>Responsible agencies</th>
<th>Funding</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>2021</td>
</tr>
<tr>
<td>1 HIV and TB services integration</td>
<td></td>
<td>GFATM</td>
<td>X</td>
</tr>
<tr>
<td>1.1 Develop data framework of HIV and TB services integration</td>
<td>DAS and DTB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2 Establish information system for HIV and TB services integration</td>
<td>DAS and DTB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 HIV and hepatitis C services integration</td>
<td></td>
<td>GFATM</td>
<td>X</td>
</tr>
<tr>
<td>2.1 Develop data framework of HIV and hepatitis C services integration</td>
<td>DAS</td>
<td>DDC and NHSO</td>
<td>X</td>
</tr>
<tr>
<td>2.2 Establish information system for HIV and hepatitis C services integration</td>
<td>DAS</td>
<td>DDC and NHSO</td>
<td></td>
</tr>
<tr>
<td>3 HIV and STI services integration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1 Develop data framework of HIV and STI services integration</td>
<td>DAS</td>
<td>DDC</td>
<td>X</td>
</tr>
<tr>
<td>3.2 Establish information system for HIV and STI services integration</td>
<td>DAS</td>
<td>DDC</td>
<td>X</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Activities</th>
<th>Responsible agencies</th>
<th>Funding</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>2021</td>
</tr>
<tr>
<td>1 Inclusion of HIV-related S&amp;D in other surveys</td>
<td>National Health Examination Survey Office (NHES)</td>
<td>MOPH, HSRI, THPF, NRCT</td>
<td></td>
</tr>
</tbody>
</table>
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
1.4 | Survey by using National Commitments and Policy Instrument (NCPI) every 2 years | DAS | DDC | X | | | X
2 | S&D Survey | DAS | DDC | | | | X X X
2.1 | S&D sentinel surveillance in hospitals in 13 provinces very 2 years | DAS | DDC | | 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

<table>
<thead>
<tr>
<th>Activities</th>
<th>Responsible agencies</th>
<th>Funding</th>
<th>Timeline 2021</th>
<th>2022</th>
<th>2023</th>
<th>2024</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Survey for National AIDS Spending Assessment (NASA)</td>
<td>DAS</td>
<td>DDC</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>2</td>
<td>Survey by using National Commitments and Policy Instrument (NCPI)</td>
<td>DAS</td>
<td>DDC</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Activities</th>
<th>Responsible agencies</th>
<th>Funding</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Program review</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Key population program</td>
<td>DAS</td>
<td>GFATM</td>
<td>X</td>
</tr>
<tr>
<td>1.2 Impact achievement (95-95-95)</td>
<td>DAS</td>
<td>GFATM</td>
<td>X</td>
</tr>
<tr>
<td>1.3 Condom management</td>
<td>DAS</td>
<td>DDC</td>
<td>X</td>
</tr>
<tr>
<td>1.4 Condom strategy</td>
<td>DAS</td>
<td>DDC</td>
<td>X</td>
</tr>
<tr>
<td>1.5 CBO certification</td>
<td>DAS</td>
<td>GFATM</td>
<td>X</td>
</tr>
<tr>
<td>1.6 STI strategy</td>
<td>DAS</td>
<td>DDC</td>
<td>X</td>
</tr>
<tr>
<td>1.7 Hepatitis strategy</td>
<td>DAS</td>
<td>DDC</td>
<td>X</td>
</tr>
<tr>
<td>2. Evaluative research</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 PrEP services</td>
<td>DAS</td>
<td>UNAIDS PEPFAR GFATM</td>
<td>X</td>
</tr>
<tr>
<td>2.2 S&amp;D program</td>
<td>DAS</td>
<td>UNAIDS PEPFAR</td>
<td>X</td>
</tr>
<tr>
<td>2.3 TPT Program</td>
<td>DAS</td>
<td>DDC GFATM</td>
<td>X</td>
</tr>
<tr>
<td>3. Studies and researches</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1 Using rapid recency for HIV incidence</td>
<td>DOE</td>
<td>PEPFAR DDC</td>
<td>X</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Activities</th>
<th>Responsible agencies</th>
<th>Funding</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Monitoring HIV epidemic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Review methodology of size estimation of Key Populations</td>
<td>DAS</td>
<td>DDC and GFATM in 2021-23</td>
<td>X</td>
</tr>
<tr>
<td>1.2 Review HIV estimation and projection</td>
<td>DOE</td>
<td>DDC and GFATM</td>
<td>X</td>
</tr>
<tr>
<td>1.3 Review BBS among KPs</td>
<td>DOE</td>
<td>GFATM</td>
<td>X</td>
</tr>
<tr>
<td>2. Community-based monitoring system</td>
<td></td>
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<tr>
<td>2.1 Develop community think tank for HIV and TB programs</td>
<td>IHRI</td>
<td>GFATM</td>
<td>X</td>
</tr>
<tr>
<td>Activities</td>
<td>Responsible agencies</td>
<td>Funding</td>
<td>Timeline</td>
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<td>--------------------------------------------------------------------------</td>
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<td></td>
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<td>2021</td>
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<tr>
<td>3  Human capacity for HIV M&amp;E</td>
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<tr>
<td>3.1 Train trainers at regional level</td>
<td>DAS</td>
<td>GFATM in 2021-2023 PEPFAR, DDC</td>
<td>X</td>
</tr>
<tr>
<td></td>
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<tr>
<td>3.2 Train provincial SIME units</td>
<td>DAS</td>
<td>GFATM in 2021-23 PEPFAR, DDC</td>
<td>X</td>
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<td></td>
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<tr>
<td>4  National and sub-national databases</td>
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<tr>
<td>4.1 Complete linkages between databases of RRTTPR services for key</td>
<td>NHSO</td>
<td>NHSO</td>
<td>X</td>
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<tr>
<td>populations (NAP-RTCM-E-cascade)</td>
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<tr>
<td>4.2 Establish integrated drug treatment for PWUD monitoring system</td>
<td>HAD</td>
<td>GFATM</td>
<td>X</td>
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<tr>
<td>5  Data auditing and data quality assurance</td>
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<tr>
<td>5.1 NAP plus database</td>
<td>DAS</td>
<td>GFATM in 2021-23 and PEPFAR</td>
<td>X</td>
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<tr>
<td></td>
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<tr>
<td>5.2 RTCM database</td>
<td>DAS</td>
<td>GFATM</td>
<td>X</td>
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<tr>
<td>5.3 PHIMS database</td>
<td>DOH and DAS</td>
<td>DOH and PEPFAR</td>
<td>X</td>
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<tr>
<td>5.4 MMT database</td>
<td>NHSO</td>
<td>NHSO</td>
<td>X</td>
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<tr>
<td>6  Data visualization, dissemination and data use</td>
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<tr>
<td>6.1 Maintain and update data warehouse and visualizations</td>
<td>DAS</td>
<td>DDC, PEPFAR</td>
<td>X</td>
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<tr>
<td></td>
<td>DOE</td>
<td>DDC, PS-ICT, PEPFAR</td>
<td>X</td>
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<tr>
<td>6.2 Regular feedback reports</td>
<td>DAS</td>
<td>DDC</td>
<td>X</td>
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<tr>
<td>6.3 Produce reports (details in section 5)</td>
<td>DAS</td>
<td>DDC</td>
<td>X</td>
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<tr>
<td>6.4 Develop guidance of regional and provincial annual report</td>
<td>DAS</td>
<td>GFATM</td>
<td>X</td>
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<tr>
<td>6.5 Annual meeting</td>
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<tr>
<td>National level</td>
<td>DAS</td>
<td>GFATM in 2021-23 and DDC</td>
<td>X</td>
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<tr>
<td></td>
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</tr>
<tr>
<td>Regional level</td>
<td>DAS</td>
<td>GFATM in 2021-23 and DDC</td>
<td>X</td>
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<tr>
<td></td>
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<tr>
<td>Provincial level</td>
<td>DAS and HAD</td>
<td>GFATM in 2021-23</td>
<td>X</td>
</tr>
</tbody>
</table>
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.
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.
<table>
<thead>
<tr>
<th><strong>Numerator</strong></th>
<th>Number of people in a specific key population who test positive for HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator</strong></td>
<td>Number of people in a specific key population tested for HIV</td>
</tr>
<tr>
<td><strong>Calculation</strong></td>
<td>Numerator/Denominator x 100</td>
</tr>
<tr>
<td><strong>MSM, TGW</strong></td>
<td>weighted by number of different groups of samples</td>
</tr>
<tr>
<td><strong>MSW</strong></td>
<td>weighted by number of different groups of samples and by risk level of sites</td>
</tr>
<tr>
<td><strong>Venue-based FSW</strong></td>
<td>median</td>
</tr>
<tr>
<td><strong>Non-venue-based FSW</strong></td>
<td>median</td>
</tr>
<tr>
<td><strong>PWID</strong></td>
<td>weighted by number of different groups of samples</td>
</tr>
</tbody>
</table>

**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, Buriram, 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**

<table>
<thead>
<tr>
<th>G2.1 Number of AIDS-related deaths per 100 000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>G2.2 Estimated number of AIDS-related deaths</td>
</tr>
</tbody>
</table>

**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

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)
**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)
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)

<table>
<thead>
<tr>
<th>R3.5 Percentage of TGW reporting using a condom in their last anal sex with a non-regular male partner</th>
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<table>
<thead>
<tr>
<th>What it measures</th>
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</thead>
<tbody>
<tr>
<td>Progress in preventing exposure to HIV among TGW through unprotected sex with partners</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Rationale</th>
</tr>
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<tbody>
<tr>
<td>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</td>
</tr>
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<table>
<thead>
<tr>
<th>Numerator</th>
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<tbody>
<tr>
<td>Number of TGW who reported using a condom at last sexual intercourse or anal sex</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Denominator</th>
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<tbody>
<tr>
<td>Number of TGW surveyed who reported having sexual intercourse or anal sex in the past six months</td>
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</table>

<table>
<thead>
<tr>
<th>Calculation</th>
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<tbody>
<tr>
<td>The percentage was calculated and weighted proportionate to size of high risk and low risk.</td>
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<table>
<thead>
<tr>
<th>Method of measurement</th>
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<tbody>
<tr>
<td>The survey was conducted in 4 sites, including Bangkok, Chiangmai, Phuket and Chonburi, using methodology of VDT: Venue Date Time Location.</td>
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<table>
<thead>
<tr>
<th>Measurement frequency</th>
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<tbody>
<tr>
<td>Every 2 years</td>
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<table>
<thead>
<tr>
<th>Disaggregation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (&lt;25 years and 25+ years)</td>
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<table>
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<tr>
<th>R3.6 Percentage of Sex workers (SW) reporting the use of a condom with their most recent client</th>
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<table>
<thead>
<tr>
<th>What it measures</th>
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</thead>
<tbody>
<tr>
<td>Progress in preventing exposure to HIV among SW through unprotected sex with clients</td>
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<table>
<thead>
<tr>
<th>Rationale</th>
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</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
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<table>
<thead>
<tr>
<th>Numerator</th>
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<tbody>
<tr>
<td>Number of SW who reported using a condom with their last client</td>
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<table>
<thead>
<tr>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of SW who reported having commercial sex in the past 12 months</td>
</tr>
</tbody>
</table>
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)

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

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
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
National Surveillance Survey

Measurement frequency
Every 5 years

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

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
\[
\text{Numerator/denominator} \times 100
\]

### 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)

---

### 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
\[
\text{Numerator/denominator} \times 100
\]

### 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

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

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 health 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).
Race 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)

<table>
<thead>
<tr>
<th>R6.4 Percentage of PLHIV/ key populations who report internalized stigma</th>
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</table>

### 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 behaviour 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 health 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 health 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 health 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

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<thead>
<tr>
<th><strong>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</strong></th>
</tr>
</thead>
</table>

**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)
**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
<table>
<thead>
<tr>
<th><strong>Denominator</strong></th>
<th>Total amount of budget for HIV prevention among key populations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calculation</strong></td>
<td>Numerator/denominator $\times$ 100</td>
</tr>
<tr>
<td><strong>Method of measurement</strong></td>
<td>Information from the National Health Security Office</td>
</tr>
<tr>
<td><strong>Measurement frequency</strong></td>
<td>Annual</td>
</tr>
<tr>
<td><strong>Disaggregation</strong></td>
<td>key population program (MSM, TGW, MSW, FSW, PWID)</td>
</tr>
<tr>
<td></td>
<td>Bangkok and provinces</td>
</tr>
</tbody>
</table>
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
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

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)

---

**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.
**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)

<table>
<thead>
<tr>
<th>S1B.2 Proportion of people coinfected with HIV and HCV starting HCV treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What it measures</strong></td>
</tr>
<tr>
<td><strong>Rationale</strong></td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
</tr>
<tr>
<td><strong>Calculation</strong></td>
</tr>
<tr>
<td><strong>Method of measurement</strong></td>
</tr>
<tr>
<td><strong>Measurement frequency</strong></td>
</tr>
</tbody>
</table>
| **Disaggregation** | Sex (female, male and transgender).
Age (<25 years and 25+ years)
Key population (MSM, TGW, MSW, FSW, PWUD) |

<table>
<thead>
<tr>
<th>S1B.3 Percentage of key populations screened for STI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What it measures</strong></td>
</tr>
<tr>
<td><strong>Rationale</strong></td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
</tr>
<tr>
<td>-----------------</td>
</tr>
<tr>
<td><strong>Calculation</strong></td>
</tr>
</tbody>
</table>
| **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.

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.

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

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

<table>
<thead>
<tr>
<th>S3A.1 Percentage of HIV-positive results among the total HIV tests performed during the reporting period</th>
</tr>
</thead>
</table>

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-distict 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.
### 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/mm³ 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

\[
\text{Numerator/denominator x 100}
\]

### 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 < 1000 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

**Summary**

**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
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

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]

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**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

<table>
<thead>
<tr>
<th>S4A.1 Number of provinces implementing mechanism to protect HIV and gender-related human rights</th>
</tr>
</thead>
</table>

**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

<table>
<thead>
<tr>
<th>S4A.2 Number of hospitals implementing reduction of HIV and gender-related stigma and discrimination</th>
</tr>
</thead>
</table>

**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

<table>
<thead>
<tr>
<th><strong>Method of measurement</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Report of the DAS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Measurement frequency</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Disaggregation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangkok and regional health areas</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th><strong>Method of measurement</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The assessment of compliance to the HIV policy in workplaces will be managed by the DAS.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Measurement frequency</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Disaggregation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Grouping: public (health, non-health), private (health, non-health) and CSO</td>
</tr>
</tbody>
</table>

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

**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)

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

<table>
<thead>
<tr>
<th>SSA.3 Percentage of national AIDS spending for HIV prevention program among key populations from domestic resources</th>
</tr>
</thead>
</table>

**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)

<table>
<thead>
<tr>
<th>SSA.4 Percentage of national AIDS spending for reduction of stigma and discrimination</th>
</tr>
</thead>
</table>

**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)

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**SSA.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

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

<table>
<thead>
<tr>
<th>Population</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women of reproductive age in high HIV prevalence settings, within key populations and living with HIV</td>
<td>95% have their HIV prevention and sexual and reproductive health service needs met</td>
</tr>
<tr>
<td>Pregnant and breastfeeding women</td>
<td>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.</td>
</tr>
<tr>
<td>Pregnant and breastfeeding women living with HIV</td>
<td>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).</td>
</tr>
<tr>
<td>Children (aged 0–14 years)</td>
<td>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</td>
</tr>
</tbody>
</table>

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
Thresholds for the prioritization of HIV prevention methods

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

| 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 |
| 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 OR 0.3–<1% incidence | <0.3% incidence OR 0.3–<1% incidence |
### Detailed HIV prevention targets for key populations

<table>
<thead>
<tr>
<th>KEY POPULATIONS</th>
<th>Sex workers</th>
<th>Gay men and other men who have sex with men</th>
<th>People who inject drugs</th>
<th>Transgender people</th>
<th>Prisoners and others in closed settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>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)</td>
<td>--</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>--</td>
</tr>
<tr>
<td>Condom/lubricant use at last sex with a client or non-regular partner</td>
<td>90%</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>90%</td>
</tr>
<tr>
<td>PrEP use (by risk category)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very high</td>
<td>80%</td>
<td>50%</td>
<td>15%</td>
<td>50%</td>
<td>15%</td>
</tr>
<tr>
<td>High</td>
<td>15%</td>
<td>15%</td>
<td>5%</td>
<td>15%</td>
<td>5%</td>
</tr>
<tr>
<td>Moderate and low</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Sterile needles and syringes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>90%</td>
</tr>
<tr>
<td>Opioid substitution therapy among people who are opioid dependent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>50%</td>
</tr>
<tr>
<td>STI screening and treatment</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## KEY POPULATIONS

<table>
<thead>
<tr>
<th></th>
<th>Sex workers</th>
<th>Gay men and other men who have sex with men</th>
<th>People who inject drugs</th>
<th>Transgender people</th>
<th>Prisoners and others in closed settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular access to appropriate health system or community-led services</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Access to post-exposure prophylaxis as part of package of risk assessment and support</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
</tr>
</tbody>
</table>

Detailed HIV prevention targets for the general population

### GENERAL POPULATION

#### Risk by prioritization stratum

<table>
<thead>
<tr>
<th></th>
<th>Very high</th>
<th>Moderate</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>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)</strong></td>
<td>95%</td>
<td>70%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>PrEP use (by risk category)</strong></td>
<td>50%</td>
<td>5%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>STI screening and treatment</strong></td>
<td>80%</td>
<td>10%</td>
<td>10%</td>
</tr>
</tbody>
</table>

#### Adolescents and young people

|                               | 90%       | 90%      | 90% |
| **Comprehensive sexuality education in schools, in line with UN international technical guidance** |          |          |     |

### GENERAL POPULATION

#### Strata based on geography alone

<table>
<thead>
<tr>
<th></th>
<th>Very high (&gt;3%)</th>
<th>High (1–3%)</th>
<th>Moderate (0.3–1%)</th>
<th>Low (&lt;0.3%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access to post-exposure prophylaxis (PEP) (non-occupational exposure) as part of package of risk assessment and support</strong></td>
<td>90%</td>
<td>50%</td>
<td>5%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Access to PEP (nosocomial) as part of package of risk assessment and support</strong></td>
<td>90%</td>
<td>80%</td>
<td>70%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### GENERAL POPULATION

#### Strata based on geography alone

<table>
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<tr>
<th></th>
<th>Very high (&gt;3%)</th>
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<th>Moderate (0.3–1%)</th>
<th>Low (&lt;0.3%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Economic empowerment</strong></td>
<td>20%</td>
<td>20%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>VMMC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>People within serodiscordant partnerships</strong></td>
<td>90% in 15 priority countries</td>
<td>95%</td>
<td>30%</td>
<td>100% after high-risk exposure</td>
</tr>
</tbody>
</table>
Annex 4: List of Collaborators/Contributors

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    Private Sector Development AIDS Committee

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