THAILAND
Ending AIDS

THAILAND AIDS RESPONSE PROGRESS REPORT

2018

คณะกรรมการแห่งชาติ
ว่าด้วยการป้องกันและแก้ไขปัญหาเอดส์
NATIONAL AIDS COMMITTEE

Progress Report for Thailand
Ending AIDS

2018

(For the implementation period of
1 October 2016 - 30 September 2017)

TITLE	2018 Thailand Progress Report
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FIRST EDITION	700 copies, September 2018
PRINTING COMPANY	NC Concept Co., Ltd.
PUBLISHER	National Monitoring and Evaluation Unit Bureau of AIDS, TB and STIs

Introduction

Thailand has implemented the national policy and strategic AIDS plan for the period of 2014-2016 which has the goal of ending AIDS by 2030. The indicator targets of achieving that goal have been set at reduction of new cases of HIV to no more than 1,000 per year, reduction of AIDS mortality to no more than 4,000 cases per year, and elimination of negative stigma and discrimination (S&D) toward persons living with HIV (PLHIV) and key populations (KPs). Indeed, the 'Ending AIDS' goal has been endorsed by all countries around the world as part of the global political declaration on June 2016 at the Global AIDS Summit in New York.

The response to AIDS in Thailand is built around the framework and operational guidelines outlined in the Accelerated National AIDS Plan for Ending AIDS (2015-19). The plan calls for a cost-effective integrated prevention-to-care continuum, with full coverage of KPs. The process involves education of services and options, distribution of prevention supplies, motivation to enter the service system, HIV testing, and treatment for HIV infection with ART (Reach-Recruit-Test-Treat-Retain).

This 11th Progress Report on Ending AIDS covers program implementation during the period of 1 October 2016 – 30 September 2017 in accordance with the UNGASS agreement. The preparation of this report involved the collaboration of many organizations and development partners across all relevant sectors, government, Civil Society (CS), NGOs, academia, international organizations, and representatives from the national network of PLHIV (TNP+). These partners assisted in the compilation and analysis of the relevant data and information to measure progress against the indicator targets, and form the basis of this narrative report.

Table of Contents

List of Figures

List of Tables

ABBREVIATION

AEM:	AIDS Epidemic Model
AIDS:	Acquired immunodeficiency syndrome
ANC:	Ante-natal Clinic
ART:	Anti-retroviral therapy
ARV:	Anti–retroviral drugs (ARV drugs)
BSS:	Behavioral surveillance survey
FSW:	Female sex workers
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Imuno-deficiency Virus
HSS	HIV sero-surveillance
IBBS:	Integrated behavior-biological surveillance
MSM	Men who have sex with men
MSW	Male sex workers
PLHIV	People who living with HIV/AIDS
PWID	People who inject drugs
TB	Tuberculosis
TG	Transgender person

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Summary of Highlights of AIDS Prevention and Response in 2017

Target	Status and possibility of reaching the target	Key Issues
Access to treatment 15 MILLION ACCESSING TREATMENT		Coverage of ART continuously increased over previous years. A large gap in achieving the 90-90-90 targets is for the 2nd 90: (Diagnosed PLHIV enroll in treatment) . Another issue is the quality of data and advocacy for cross-licensing to expand access, speed, and coverage of ART
Elimination of new HIV infection among children ELIMINATE NEW HIV INFECTIONS AMONG CHILDREN		In 2015, Thailand was certified by the WHO as having achieved the goal of eliminating MTCT of HIV and syphilis at which time the rates were 1.79 in 2016 and 1.68 in 2017
Prevention in KPs REDUCE SEXUAL TRANSMISSION		Coverage of prevention in this group is still too low. Some have observed that there is an urgent need to employ new innovative methods to reach the higher-risk KPs, especially PWID. Community-led health services (CLHS) is one approach that could rapidly address this need. However, there are challenges in obtaining a sustainable budget for CLHS and establishing a linked data system at the national level
Eliminate gender inequality, violence and discrimination ELIMINATE GENDER INEQUALITIES		Thailand has made progress in developing the system of monitoring S&D, and determining the current situation. There are guidelines on how to reduce S&D, especially in the health service sector. However, implementation of these guidelines is in the early stage; there needs to be expanded coverage for the general population and, especially, the PLHIV and KPs
Prevention in youth REDUCE SEXUAL TRANSMISSION		Nearly half of new HIV cases are among the population age 15-24 years. That points to the need for youth-tailored strategies that are intensively implemented. These services need to be youth-friendly and meet the genuine needs of today's youth. These services need to be integrated into the mainstream system of relevant agencies
Community-led HIV services STRENGTHEN HIV INTEGRATION		CLHS is at an early phase and is still being implemented under a special project status. Thus, coverage is limited to a few sites. This leaves a large gap since the government policy on CLHS is not yet clear. There is a clear need for more task-sharing to reach KPs, involving both the government and CS. The outreach needs to be

Target	Status and possibility of reaching the target	Key Issues
		part of the regular health system, with links to the community to engage them in sustainable outreach and services
Closing resource gaps 		Thailand has allocated increased budget for implementation of prevention among KPs and reduction of S&D. However, obstacles remain in procedures and methods of disbursing budget for this area. There needs to be more flexibility and efficiency in budget allocation. There also needs to be a sustainable system of collaboration between the government, CS and the host community
Protecting rights and building capacity of PLHIV 		Thailand does not have any law to protect the social rights of PLHIV directly. However, there has been progress in implementing mechanism for AIDS rights protections at the provincial level in some locations and on a pilot basis
Integrated management of HIV and co-infections 		There has been progress in implementing integrated TB/ HIV case management through improvement in the efficiency of TB case detection among PLHIV using innovative screening methods (e. g. , Gene X- pert) . However, challenges remain in dispensing TB prevention (isoniazid prevention therapy - IPT), and in screening and treatment for hepatitis C (HCV) . There is a need for strengthening the screening and treatment for STIs, especially for syphilis in pregnant women and neonates

Situation of AIDS in Thailand

Thailand has endorsed the goal of ending AIDS by 2030 and has announced its Ending AIDS plan for 2015-19. That plan provides guidance for all related sectors to work together during the five-year period to help Thailand make progress toward the goal. The over-arching Ending AIDS National Strategic Plan for 2017-30 has set the targets of reducing new cases of HIV to no more than 1,000 cases per year, reducing AIDS mortality to no more than 4,000 cases per year, and reducing AIDS S&D by 90%.

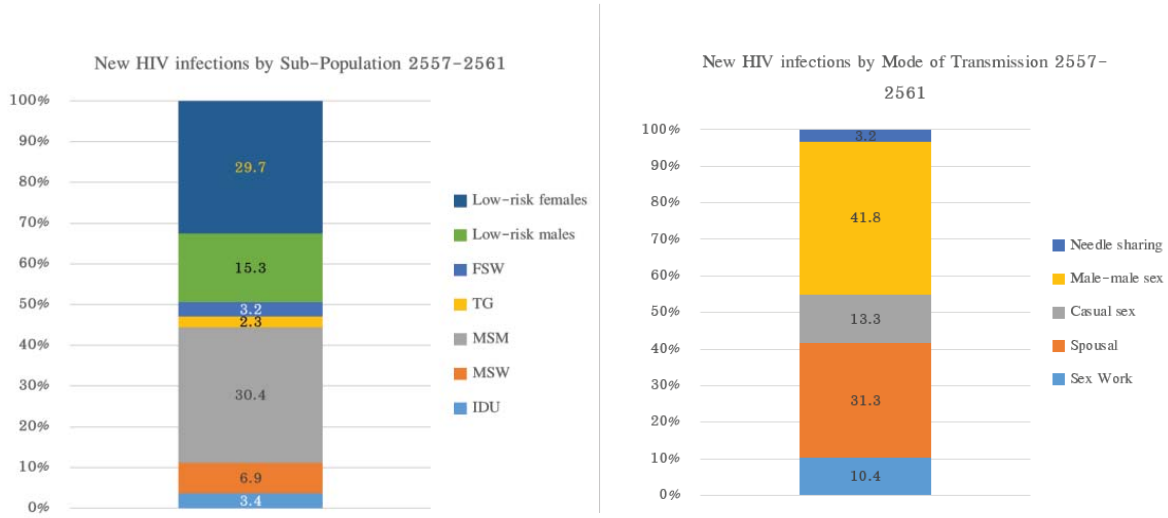
Table 1 Estimates of the number of new cases of HIV and AIDS deaths by year

Estimate for the year	2000	2005	2010	2015	2016	2017
N PLHIV new cases	**29,619**	**16,014**	**10,215**	**6,900**	**6,471**	**5,529**
- female	16,385	7,600	3,393	2,050	2,139	1,822
N PLHIV new adult cases	**28,241**	**15,266**	**10,011**	**6,800**	**6,396**	**5,461**
- female	15,716	7,237	2,294	2,000	2,103	1,789
N PLHIV new pediatric cases	**1,378**	**748**	**204**	**<100**	**75**	**68**
- female	669	363	99	<50	36	33
N AIDS deaths	**55,531**	**31,211**	**20,670**	**16,100**	**12,862**	**14,731**
- female	12,257	7,352	6,212	4,630	4,564	5,561
N adult AIDS deaths	**55,079**	**30,805**	**20,422**	**16,040**	**12,771**	**14,648**
- female	12,036	7,153	6,079	4,600	4,520	5,521
N pediatric AIDS deaths	**452**	**406**	**248**	**<60**	**92**	**83**
- female	221	199	133	<30	44	40
N PLHIV still living	**683,841**	**555,808**	**493,932**	**437,700**	**449,309**	**439,610**
- female	221,703	217,779	203,976	181,600	198,483	196,051
N PLHIV adult cases still living	**676,005**	**544,743**	**485,646**	**433,600**	**445,289**	**436,222**
- female	217,860	212,351	199,978	179,600	196,503	194,383
N PLHIV pediatric cases living	**7,836**	**11,065**	**8,286**	**4,100**	**4,019**	**3,388**
- female	3,843	5,428	3,998	2,000	1,980	1,668

Source of data: *The estimates for 2000-2015 are derived from the AEM; for 2016; the source of estimates is Thailand Spectrum-AEM July 11, 2017; the source of estimates for 2017 are from Thailand Spectrum-AEM 26 March 2018*

The Spectrum-AEM (26 March 2018) projections found that, at the end of 2017, Thailand had 439,610 PLHIV (196,051 females; 3,388 children); 5,529 new cases (1,822 females and 68 children). The AEM projections on 24 January 2018 found that over half of new infections occurred in population groups with higher risk for contracting HIV. Of these, 40% were MSM (including TG and MSW), 3.4% were PWID, and 3.2% were FSW. The estimates also found that the most common route of HIV transmission was MSM sex (41.8%) followed by sex with spouse (31.3%), and sex with a non-regular partner (13.3%), see Figure 1. About 45% of new HIV cases occurred among population groups with low risk for infection.

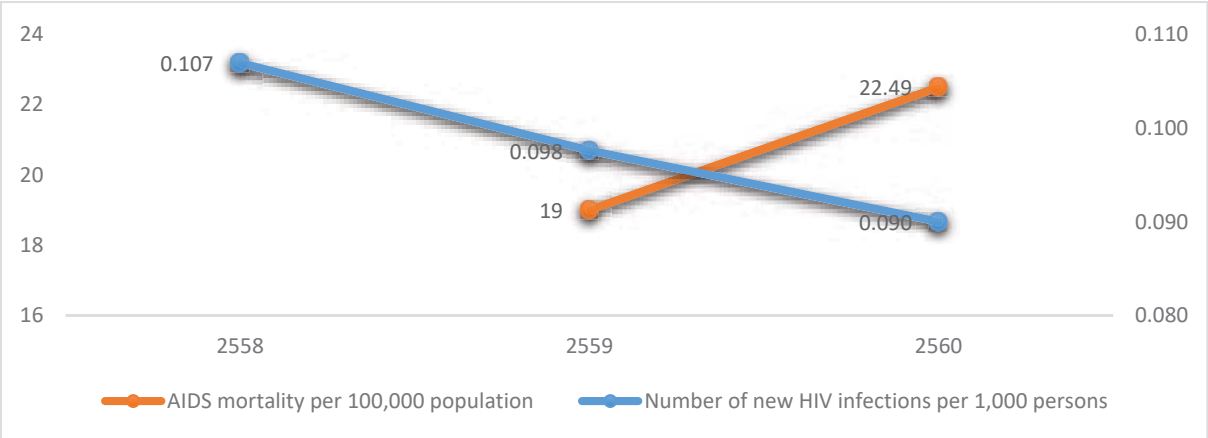
Figure 1 Estimates of new cases of HIV by population group and route of transmission



Source of data: *AEM (24 January 2018)*

Data from the National AIDS Program (NAP) indicate that, of the 432,084 PLHIV who know their serostatus (or 98.3% of the total estimated PLHIV in the country), 232,784 (74.9%) are enrolled in ART. Of these, 273,045 (84.3%) have suppressed viral loads (≤1,000/mL).[1] The proportion of new infections per 1,000 population was 0.090 in 2017, which represents a decline from the level in 2016 and 2015 of 0.098 and 0.107, respectively. At the same time, AIDS mortality per 100,000 population showed an increasing trend, to 22.5 in 2017 from 19.0 in 2016 (Figure 2). Expressed in absolute terms, there was an increase in AIDS-related deaths from 12,863 in 2016 to 14,731 in 2017. The national AIDS database recorded 11,063 PLHIV deaths in 2016 and 10,787 PLHIV deaths in 2017.

Figure 2 Number of new HIV infections per 1,000 persons and AIDS mortality per 100,000 population



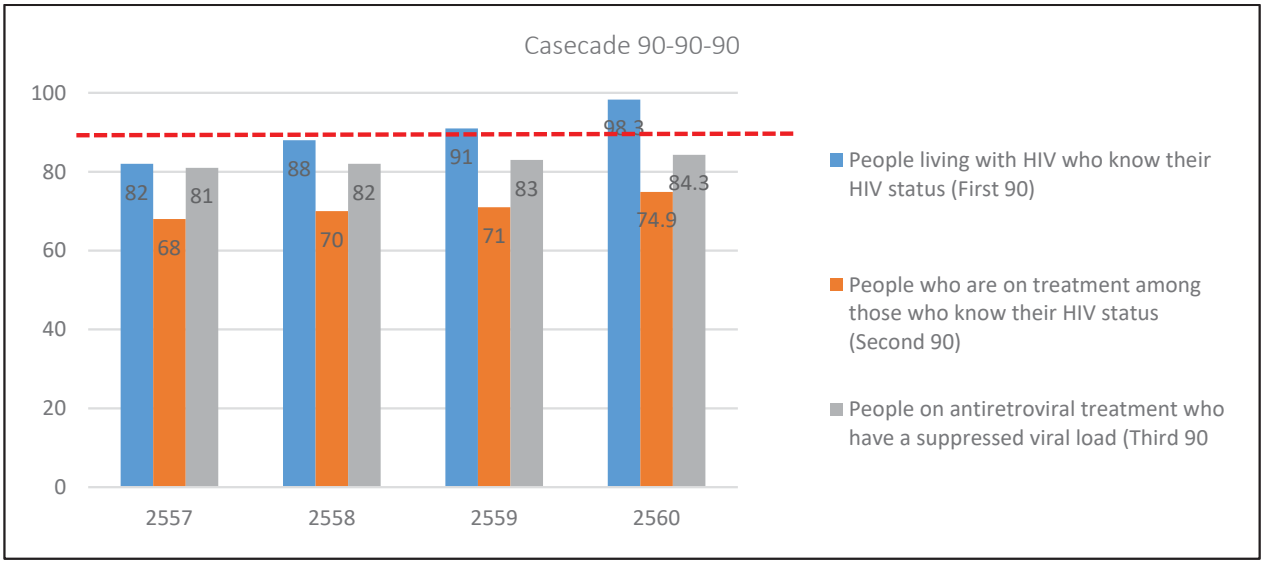
Source of data: *Estimates of HIV in 2016 from Thailand Spectrum-AEM on 11 July 2017 and estimates from 2017 from Thailand Spectrum-AEM on 26 March 2018*

[1] These data are a blow up of viral testing

The latest rounds of the Integrated Biological Behavioral Surveillance (IBBS) found that the prevalence of HIV among KPs remains unacceptably high (except for venue-based FSW who had declining HIV prevalence). In particular, young KPs (i.e., under age 25 years) had higher HIV prevalence than those age 25 years or older. For MSM in 2016, the IBBS found that about one in five (21.6%) were HIV+. The comparable figure for TG was 10.2%, and 14.1% for MSW. Non-venue-based FSW had higher HIV prevalence than their venue-based counterparts. The 2017 round of the IBBS found that HIV prevalence was 2.3% for non-venue-based FSW and 1.0% for venue-based FSW. There are also geographic differentials in HIV prevalence. MSM HIV was highest in Bangkok (30.2%) as was TG HIV (16.7%). MSW HIV was highest in Chonburi (13.4%). In terms of access to HIV testing, non-venue-based FSW and MSM had the lowest proportions of ever-testing for HIV (58.3% in 2017 and 58.8% in 2016, respectively). MSW and TG had highest prevalence of ever being tested for HIV at 77.6% and 72.3%, respectively (IBBS 2016).

The 2017 data from the NAP indicate that Thailand has achieved the first of the 90-90-90 targets in that 98.3% of PLHIV have been diagnosed and know their HIV+ status. Reaching the second 90 will require more work as only about three-fourths (74.9%) of those who know their HIV+ status were enrolled in an ART program in that year. For the third 90, Thailand is closer to the target in that 84.3% of those on ART have suppressed viral loads. Though targets # 2 and #3 have not yet been achieved, the trend toward those levels is increasing.

Figure 3 Progress toward achieving access to treatment according to the 90-90-90 cascade



Source of data: *NAP Report, Government Pharmaceutical Organization, and estimates for 2016 from the Thailand Spectrum-AEM on 11 July 2017, and estimates for 2017 from the Thailand Spectrum-AEM on 26 March 2018*

Data on the situation of STIs come from the disease surveillance Form 506 from the Bureau of Epidemiology. For the period from 2012-17, the prevalence of STIs per 100,000 populations increased from 18.9 to 28.8 for the five principal STIs in Thailand. The STI prevalence for persons age 15-24 years during 2013-17 increased from 52.4 per 100,000 population to 99.6. The most common STI was gonorrhea, followed by syphilis, both of which showed increasing trends over time.

Thailand conducts a survey of the general population on the situation of HIV/AIDS S&D. The latest round of the survey was conducted in 2014 and found that 58.6% of Thais have an unfavorable attitude about living in the same household as a PLHIV. Another survey was conducted by BATS in 2015 and 2017 concerning S&D in the health service system. The two rounds of that survey found that about one-fourth of hospital staff showed behavior indicating aversion and discrimination against PLHIV (23.7% and 27.0%, respectively). The survey also found that about one in ten PLHIV had experienced negative discrimination during a visit to the hospital (12.1% and 11.1%, respectively). A 2016 survey of KPs found that MSM and TG found that there was negative stigmatization at their place of work (12.8% and 18.9%, respectively). In addition, 1.4%-2.3% of MSM, TG, MSW, and FSW said they still experience negative stigma from family members; 6.2%-9.9% said they were stigmatized at service outlets. From 1.7%-8.4% of KPs said they avoided or delayed a trip to the hospital due to fear of stigma, and 22.1%-52.2% admitted to feeling self-stigma. From 6.6% to 13.2% said they had ever been violated sexually.

In sum. Incidence of HIV infection in Thailand has declined, though HIV prevalence remains high in some KPs. Though nearly all Thai PLHIV know their serostatus, there remain gaps in the proportion who are enrolled in ART programs. It is especially important for PLHIV to be aware of their infection at the earliest time possible in order to initiate treatment when their immune system is still strong. It is also important to monitor PLHIV on treatment to ensure that they do not transmit the virus to others. This is especially important for KPs, who generally have lower rates of awareness of their HIV infection compared to other populations of PLHIV. Thus, intensive outreach and innovative methods are needed to recruit these individuals into the HIV testing and treatment system as soon as possible. In order to achieve this, services must be made as client-friendly as possible.

Implementation of HIV prevention and the AIDS response

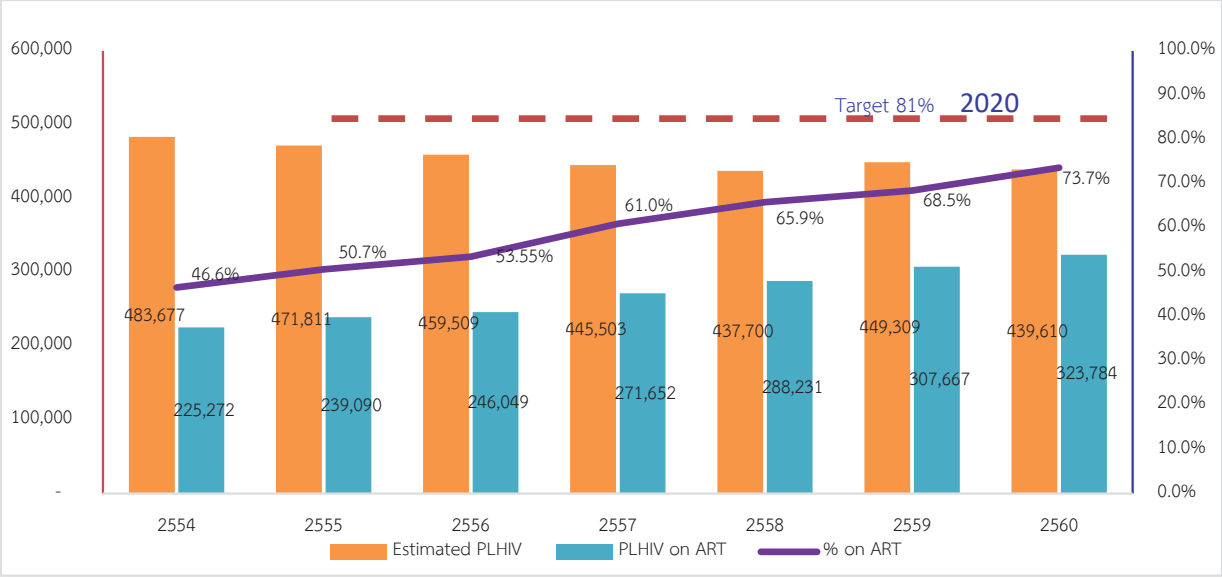
Commitment 1: Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020

Thailand has continually expanded ART for PLHIV since 2002. In October, 2014, Thailand launched the policy to provide ART for PLHIV regardless of the person's CD4 level. This is a form of 'treatment-as-prevention' strategy. Thailand also has expanded same-day results HIV testing to increase the number of PLHIV who are enrolled in ART as soon as infection is detected and to avoid loss to follow-up.

1.1 Current situation

The estimates from Spectrum-AEM (26 March 2018) suggest that, at the end of 2017, Thailand had 439,610 PLHIV, and 432,084 (98.3%) knew their serostatus. In 2017, there were 5,529 new cases of HIV infection (1,822 female and 68 pediatric). A total of 323,784 PLHIV were already on ART. Of these, 309,245 were receiving subsidized treatment as part of the national health security system, Social Security, or the government Civil Servants health insurance system (Figure 4). At the time of this report, Thailand had an estimated AIDS mortality rate of 22.5 per 100,000 population (or 14,731 AIDS deaths as per the Spectrum AEM 2017 results). The actual number of reported AIDS-related deaths was 10,787 persons.

Figure 4 Number of persons on ART compared with total estimated PLHIV



Source of data: *Thailand Spectrum-AEM and ART caseload figures of the NHSO, NAPHA-EX – from BATS, the GPO, and BOE*

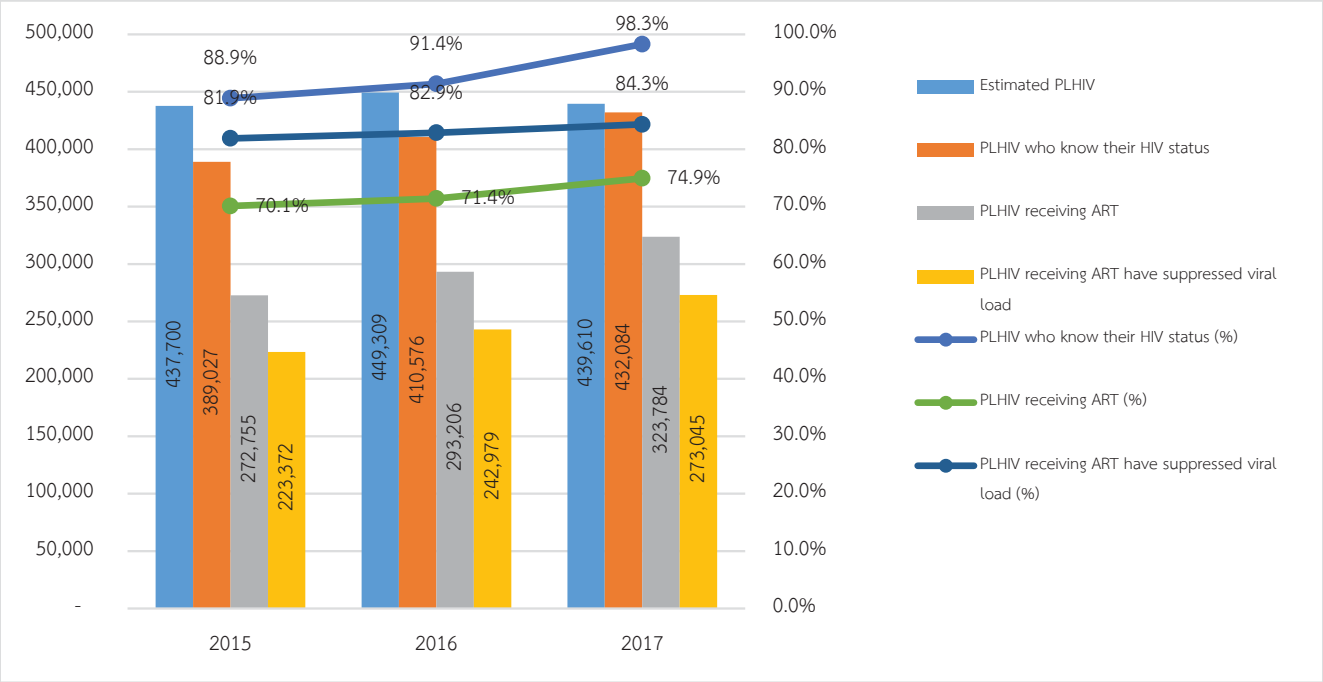
1.2 Important areas of progress

During 2017 Thailand made progress in expanding coverage of care and treatment for PLHIV, and moved the country closer to achieving all three 90-90-90 targets by 2020. However, the progress was not even across all groups and targets. As of the end of 2017, Thailand had 98%-75%-83% performance against the three targets; i.e., only the 1st 90 has been achieved. The 1st 90 increased from 91.4% in 2016 to 98.3% in 2017 (432,084 out of 439,610). The largest gap to be filled is for the 2nd 90: Proportion of PLHIV who know their serostatus who are on ART. Compared to the previous year, there has been an increase in recruitment and retention in ART (from 71.0% to 74.9%). This includes 14,461 who pay out of pocket for ART, while the vast majority receive subsidized ART through the NHSO system, Social Security, or the government Civil Servants' insurance scheme. Finally, 3,350 non-Thais living in Thailand receive ART through the NAPHA-Extension project or through personally-bought health insurance (though these are not included in the treatment coverage data).

Service statistics indicate that, among KPs, there were 3,311 MSM, 80 SW, and 69 PWID on ART at the end of 2017.

The proportion of PLHIV on ART with suppressed viral loads (<1,000 copies/mL) was approximately the same compared with the previous year (83/0% vs 84.3%). (See Figure 5.)

Figure 5 Number of PLHIV who knew their HIV+ status, had already accessed diagnosis, treatment, and had viral suppression in 2017



Source of data: *Thailand Spectrum-AEM, NHSO, NAP – May 2018) NAPHA-EX, BATS, GPO, BOE*

The preceding data show that 166,565 PLHIV (or 37.9%) still have the potential to spread their virus to others, including both those in and outside the treatment system. This is a challenge that rapidly needs to be addressed.

It can be asserted that, in terms of ART, Thailand has a quality service system, and the quality is continually improving. Still, gaps remain. NAP data indicate that in 2017, the proportion of PLHIV retained in ART at 12, 24 and 60 months was 89.8%, 88.6%, and 83.0%, respectively. This represents only a slight increase over 2016 (89.5%, 88.6%, and 82.7%). Over half of PLHIV (53.7%) had CD4 counts under 200 cells/μL when they initiated ART, and that reflects late detection and/or enrollment. The consequence is that these PLHIV had more time to pass the virus to others and may have a harder time responding to ART when their immune system has already been compromised. In addition, coverage of the viral test was only 83%, and that needs to be increased to the highest level possible.

In 2017, Thailand developed and disseminated guidelines for HIV prevention, diagnosis and treatment. The guidelines are a further attempt to standardize procedures by personnel and organizations in the network across all sectors. The guidelines call for more integrated and comprehensive services. Thailand has introduced PrEP as part of the array of options for individuals at higher risk of infection. There are guidelines for treating complicated cases by different conditions and co-infections. The NAP has defined the fundamental treatment protocol of TDF/FDC. There has been progress in decentralizing treatment and care of PLHIV through task-sharing at the community level in accordance with WHO guidelines. This is intended to reduce the caseload burden on district and sub-district hospitals. There are guidelines for being mindful of client rights and S&D prevention, as well as standard outreach services.

1.3 Challenges and guidelines for continuing implementation

As noted, Thailand has made progress, in particular by its policy to initiate ART for PLHIV at any level of CD4 to speed enrollment in treatment. However, data from 2017 show that this policy has not yet had the intended impact in that many PLHIV are appearing for diagnosis and treatment too late in their infection. Thus, it is estimated that over one-third (37.9%) of PLHIV still have potential to infect others. That means that Thailand's progress toward reducing new infections and ending AIDS is slowed down. The following summarizes these and other related challenges for the NAP:

- The data system and quality of data needs to accurately reflect actual implementation against the 90-90-90 targets. This has implications for the service statistics system and estimates and projections data.

Data from the service system

- The service statistics system for tracking care of PLHIV does not completely cover all outlets. Thus, the NAP has to find a way to incorporate the data from the Social Security system and Civil Servants insurance scheme, as well as private outlets and community-based NGOs.

- There is a problem of double-counting of ART clients because of the quasi-linked systems of the NAPHA-extension project and the NHSO database of the NAP. That overcount needs to be corrected.
- Compilation of achievement against 90-90-90 targets by KP was launched in 2016 but does not yet completely cover the total KP population. Also, there are no time series data extending from before 2016 for TPs.
- The data system which records outreach prevention services is under the RTCM database. Data on blood screening and ART enrollment is under the NAP. Thus far, it has not been possible to link these two databases in order to see the full picture of the RRTTR strategy and coverage.

Estimates and projections

- The current estimates of the number of PLHIV in Thailand seem to be an underestimate of the real total (as indicated by the nearly 100% of PLHIV who know their serostatus as calculated by a mixture of registered cases and estimated total PLHIV). Thus, there is a need to review and adjust the estimates so they are more accurate, both in total and by sex and age group.
- As noted, some PLHIV drop out of the ART system or are late to enroll. Part of the cause is the persistence of S&D against PLHIV in the health service system.
- There are some limitations in the benefits package under the universal health insurance system. For example, if a PLHIV goes for treatment outside their area of registration, they may have to cover some costs out of pocket. Also, PLHIV under the Social Security system can only receive ART from their main contractor hospital; they cannot go for treatment outside their system if they are to be covered by the insurance.
- The rather large population of non-Thai labor migrants does not have equal access to ART as do Thais. The MOPH has a program whereby migrants can buy an annual health insurance premium which includes ART, but the cost may be prohibitive for man migrants.
- Even though the government has a policy to provide ART regardless of CD4, some clinicians are not following the national guidelines and do not initiate ART until below a certain CD4 level.

Challenges which need immediate attention

- There is a need to review the data in the NAP service statistics system and increase coverage to include all PLHIV under the various insurance schemes and all sectors. There need to be guidelines for developing a more timely system to track progress toward the 90-90-90 targets which disaggregates data by KPs. The data need to be organized as a time series. There needs to be a link between the NAP and RTCM databases in order to track RRTTR progress among PLHIV and KPs.

- There should be a review and refined estimates of the number of PLHIV and KPs. In 2019, there is a scheduled review of the design and organization of data used for estimating the number of PLHIV and KPs to increase precision.
- There is a need to improve the strategic information at the sub-national level which more accurately reflects the local context of the area and resident population. There should be information on access to services by type of service and client population, by age, sex, etc. There should be improved links among the data sets on related services under the RRTTR cascade. This should also be reflected in improved reporting and more complete coverage of services provided by the government, private sector, and Civil Society.
- There should be greater advocacy of a policy to allow PLHIV to access treatment across benefits programs so that they can receive on-going treatment outside their primary service outlet without surcharge.
- There is a need to improve the service system and policy for non-Thai migrant workers (MW) to improve access to ART on a continuous basis.
- The NAP needs to improve understanding of the guidelines for care and treatment of PLHIV. There needs to be an alignment of the understanding of clinicians, and ensuring a coordinated effort to achieve the 90-90-90 targets as soon as possible.
- The quality of services needs improvement, first by reducing S&D in the formal health service system. This requires adjustment of the attitudes of service providers to make services client-friendly for all in need. That will help remove one of the main barriers to prompt diagnosis and treatment-seeking behavior by PLHIV.

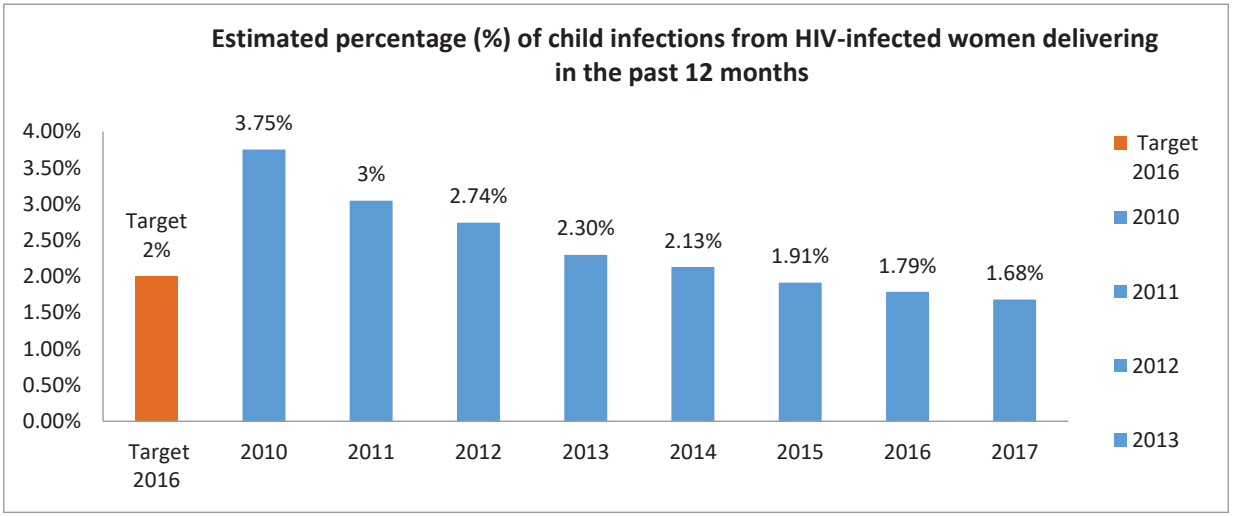
Commitment 2: Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018

During the high-level UN meeting on HIV in June 2016, the WHO certified that Thailand had succeeded in eliminating mother-to-child transmission (MTCT) of HIV and syphilis, making Thailand the first country in Asia to receive that recognition, and the second in the world (after Cuba). That success is the result of the combined effort of the government, Civil Society and all the other development partners working toward the goal of Ending AIDS by 2030.

2.1 Current situation

During 2015-17, the rate of MTCT of HIV -- as estimated by Spectrum -- declined from 1.9% in 2015 to 1.8% in 2016 and 1.7% in 2017 (Figure 6). Data from the 2017 service statistics indicate that proportion of infants born to HIV+ mothers who tested positive for HIV in the prior 12 months was 1.4%. That also represents a decline from 1.6% in 2015 and 1.4% in 2016. In absolute terms, that represents a decline from 12 HIV+ infants per 100,000 live births in 2015 to 11 in 2016 and 10 in 2017.

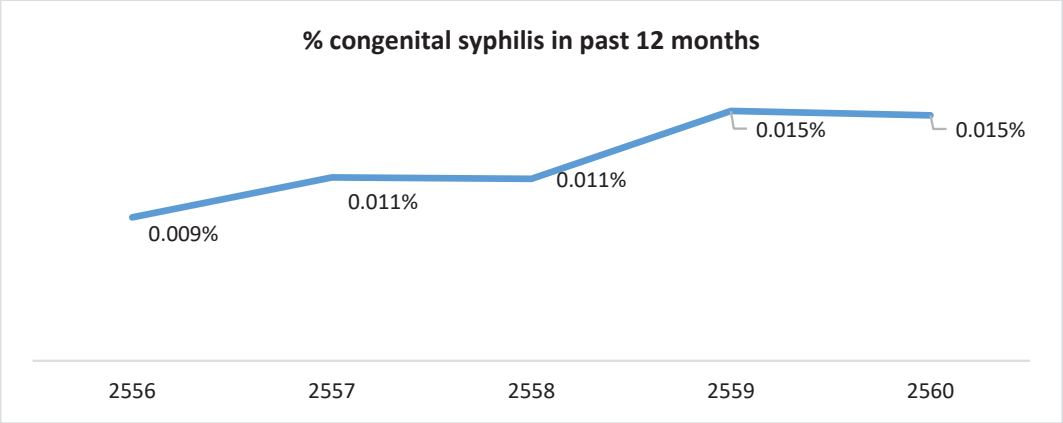
Figure 6: Estimated percent of infants born to HIV+ mothers who tested HIV+ during the past 12 months



Source of data: *Thailand Spectrum-AEM on 26 March 2018*

In 2017, congenital syphilis was under 15 cases per 100,000 live births, a slight increase from 2015 (11 cases). Data from Form 506 indicate that the rate of still births to mothers who are VDRL/ TPHA positive was 6.1 and 3.3 per 100,000 persons in 2016 and 2017, respectively. These rates, even if underestimated are well below the target.

Figure 7 Percent congenital syphilis (of live and still births) in the past 12 months

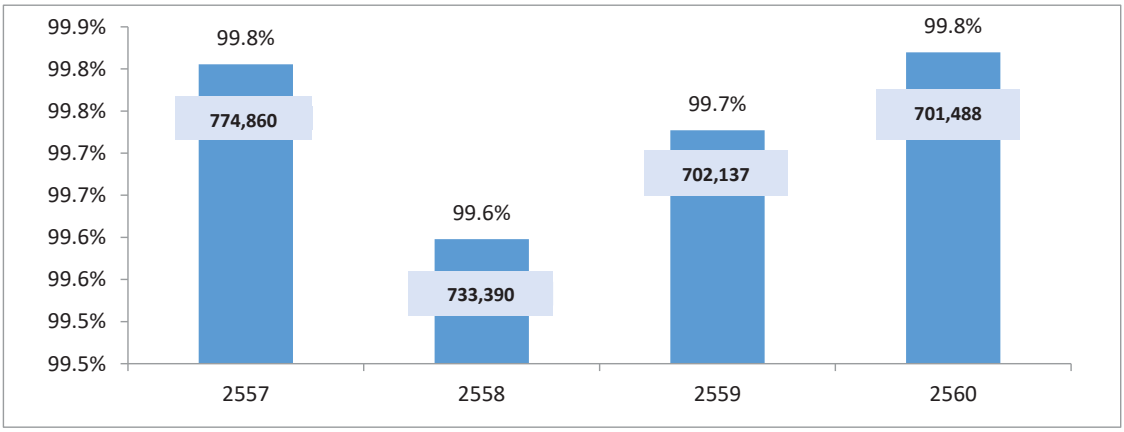


Source of data: *Report Form # 506*

2.2 Important signs of progress

Data from the Perinatal HIV Intervention Monitoring System (PHIMS) show that 701,488 pregnant women were tested for HIV in 2017, or virtually all women attending a public ANC clinic (Figure 8). Of these, 42.3% of partners were also screened for HIV in that year. That represents a slight increase from 41.5% in 2016. HIV+ pregnant women are provided with highly-active ART (HAART) before and after delivery to prevent MTCT of HIV. In addition, infants born to HIV+ mothers also receive ARV drugs, and mothers are counseled not to breastfeed. Nearly all (98.5%) these infants were also screened for HIV at age two months using PCR testing.

Figure 8 Percent of pregnant women who know their HIV serostatus



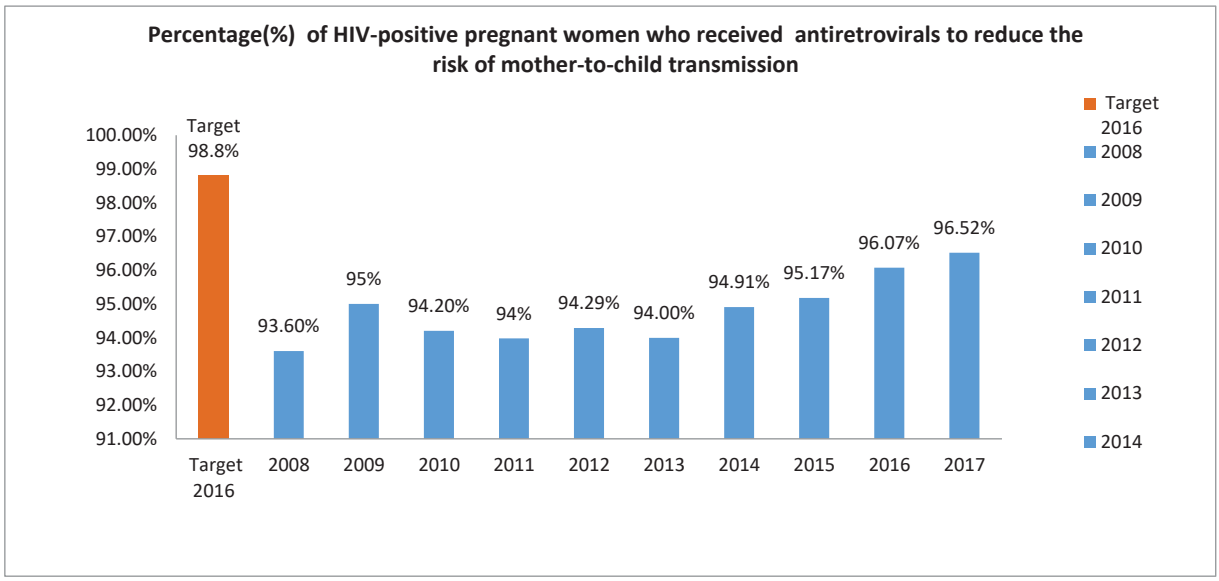
Source of data: PHIMS

In 2017, data from Spectrum-AEM indicate that 96.5% of HIV+ pregnant women received ART for MTCT prevention, which is an increase from 96.1% in 2016 (Figure 9). It is considered that all women in Thailand can access free ANC from any government hospital or clinical outlet. Thus, at least one ANC visit is virtually universal in Thailand. Two out of three women in Thailand go for their first ANC check-up before the 12th week of pregnancy. About half (53.5%) had over five ANC visits during the last pregnancy, and nearly all (98.0%) delivered in a clinical facility by a trained practitioner. In private outlets, provision of MTCT prevention was 91.6% of clients in 2016 and 86.1% in 2017. This decline

and the lower coverage is due to the fact that most private outlets refer HIV+ pregnant women to public facilities for prevention of MTCT and delivery.

The Department of Health (DOH) of the MOPH issued guidelines for prevention of MTCT, including strong recommendations for couple counseling, both during ANC and post-partum. The DOH also set targets for couple counseling in order to increase the coverage of HIV screening for male partners of HIV+ pregnant women as a possible source of the woman's infection.

Figure 9 Percent of HIV+ pregnant women receiving ART to reduce MTCT of HIV



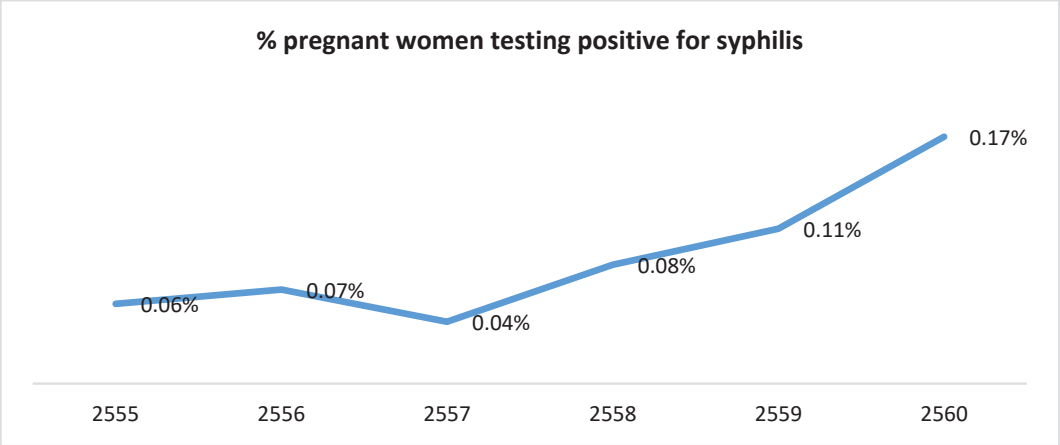
Source of data: *PHIMS*

The Bureau for Health Promotion of the DOH has implemented an intensified program for eliminating MTCT of HIV and syphilis in 55 of Thailand's 76 provinces. The program included collaboration with the Department of Disease Control (DDC) for early infant diagnosis using HIV-PCR (DBS) and to determine the source of the infection (with funding from the Department of Medical Sciences, MOPH). The Thai Red Cross also provided financial support for infant diagnosis of HIV for births to non-Thai mothers.

Thailand has set the target to reduce MTCT of syphilis to under 0.5 per 1,000 live births. For 2017, the PHIMS found that nearly all pregnant women infected with syphilis were successfully treated. Even though the level of maternal syphilis was below the WHO target, Thailand experienced a slightly increasing trend in prevalence from 0.08% in 2015 to 0.11 in 2016, and 0.17 in 2017. The number of cases of congenital syphilis increased from 80 in 2015, to 105 in 2016, and 103 in 2017.

BATS conducted a refresher training program for health personnel in all four geographic regions to review the protocols for syphilis case management in pregnant women and infants. The DDC and DOH also conducted an ad hoc survey in nine provinces to assess the data on congenital syphilis. That survey found problems of over- and under-reporting of cases in the ICD10 form and passive case passive case surveillance report.

Figure 10 Percent of pregnant women testing positive for syphilis



Source of data: *PHIMS*

HIV prevention in pregnant women who are non-Thai migrants living in Thailand is the responsibility of the DOH, with financial support from the Thai Red Cross under the Raltegravir program for high-risk HIV+ pregnant women (under Royal Patronage of HRH Princess Soamsawali). These women also received health insurance so they could access care equal to any Thai pregnant woman. In 2017, a total of 15 non-Thai women received this subsidized care in eight hospitals in Thailand. However, because many non-Thai migrants are outside the formal health system, it is not known how many are infected with HIV or have the need for MTCT prevention.

2.3 Challenges and guidelines for future implementation

There remain challenges in achieving the ultimate goal of eliminating HIV infection in newborns in the maternal and child health (MCH) system, as follows:

- The Thai policy of universal free ANC still does not cover all outlets. For example, if a woman goes to an outlet not covered by her insurance plan then she has to pay out of pocket.
- There is a need to further reduce prevalence of MTCT of syphilis and to prevent spousal transmission of HIV to their pregnant wife.
- Some HIV+ pregnant women who have taken ARV drugs over a long period of time – but not regularly – might not have suppressed viral loads; yet this may not be known to the ANC providers and delivery staff.
- Many (most) of the non-Thai female MW in Thailand do not have health insurance coverage under Social Security or the MOPH health card system. Thus, these women cannot easily access affordable prevention of MTCT of HIV and syphilis.
- The PHIMS, NAP database and passive case reports of syphilis are the source of data to measure progress to the MTCT prevention goal. However, spot surveys have detected some variability in the data systems. There is a need for a single, uniform report form for this indicator and investigation of the causes of MTCT. The DOH is planning to add stillbirths to the database in order to detect cases of congenital syphilis that might be missed by the live birth data.

Guidelines for future implementation

- There should be a campaign to promote early ANC (before 12 weeks gestation), increase access to reproductive health, and integration of funds at all levels in the system. Pregnant women should not have to switch facilities as a condition of their insurance coverage.
- There should be more premarital and pre-pregnancy screening for HIV and syphilis. In other words, there needs to be more screening of the male partner for HIV and syphilis as part of the benefits package.
- There should be advocacy for procurement of Raltegravir for pregnant women as part of the routine system since the research project which made this drug available will end. Raltegravir is important for treating HIV in pregnant women who appear late (after 32 weeks gestation) for their first ANC. Past irregular use of the drugs in the HAART regimen may have resulted in insufficient suppression of viral load. Thus, a second line of treatment is needed.
- There should be support for screening viral load in all pregnant women as they near the time of delivery. That screening should be included in the benefits package. That will help address the problem of late ANC and skipped ANC appointments. There should be evaluation and training to reduce stigma against HIV+ pregnant women in the MCH service setting.
- Congenital syphilis is usually detected in cases in which the parents are rather young or during adolescence when the rate of unplanned pregnancy is higher. Adolescence is an age of higher risk for STIs in general. Thus, a more sustainable approach to reducing congenital syphilis is to reduce unplanned pregnancy, and prevent HIV and syphilis infection in females of reproductive age. Couples need more information and awareness before deciding to have a pregnancy. Thus, sex education and reproductive health information needs to be available before youth become sexually active. Similarly, hospital staff in the reproductive health and family planning units need to be trained to deal with cases of unplanned teen pregnancy and how to provide adolescent-friendly services. There should be online sources of education and discussion forums. The hospital staff need to be role models for guiding today's youth and encouraging parents to have open communication with their adolescent child about sex.
- More of the non-Thai MW in Thailand need to be enrolled in the health insurance system. The DDC is negotiating for allocation of budget for ARV drugs for MW, including pregnant women. This would be a continuation of the NAPHA extension project. Migrants also need information and services for family planning.
- There should be more communication in all relevant organizations to adopt standard indicators for eliminating MTCT of HIV and syphilis. Each province has to play a role in tracking progress toward the indicator targets.

Commitment 3: Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations—gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners

At least 90% of the population should have access to integrated prevention, especially KPs such as MSM, TG, and SW, clients of SW, PWID and prisoners.

3.1 Current situation

Data from the latest projections for the population of KPs in Thailand (Table 2). The total number of MSM and TG is estimated to be 527,900 in 2017 (527,900 and 62,800, respectively). The MSM can be further divided into 'high-risk' (159,600) as defined by having had unprotected anal intercourse in the past six months. The projections estimate that there were 144,000 SW in Thailand in 2017. Of these, 129,000 are FSW and 15,000 are MSW. The estimate for PWID is 42,650 nationwide, in 2017. The Department of Corrections reported that there were 311,587 prisoners in 2017, and 80% are male.

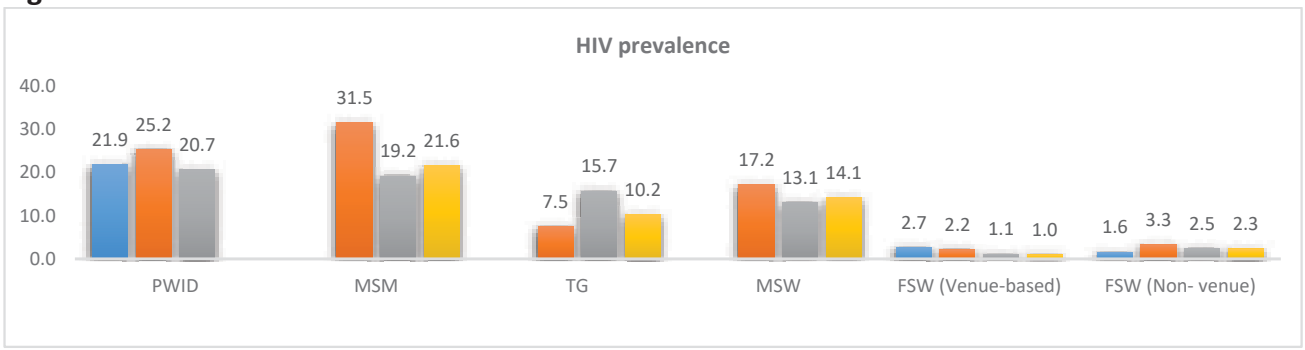
Table 2 Estimates of the number of KPs in 2017

KPs	Number
SW	144,000
FSW	129,000
MSW	15,000
MSM	527,900
High risk MSM	159,600
MSM-TG	590,700
TG (Had active sex)	62,800
PWID	42,650
Inmates+detainees	311,587

Source of data: *Spectrum AEM; BOE, Department of Disease Control*

Prevalence of HIV infection in KPs: The IBBS is conducted every two years, though not every KP is included in each round.

Figure 11 Prevalence of HIV in KPs



Source of data: *IBBS; BOE; DDC*

Remarks: Survey year by KP:

- PWID: 2010, 2012 and 2014
- MSM, TG and MSW: 2012 2014 and 2016
- FSW (Venue-based): 2010, 2012, 2014 and 2016
- FSW (Non-venue-based): 2011, 2013, 2015, and 2017

The latest round to include PWID was in 2014 and, thus, there is no update on HIV prevalence for this group than cited in the previous edition of this report. The IBBS for PWID is conducted in three provinces using RDS. During 2010-14, the trend in HIV prevalence was a slight – but uneven -- decline, from 21.9% to 25.2% to 20.5% in 2010, 2012, and 2014, respectively.

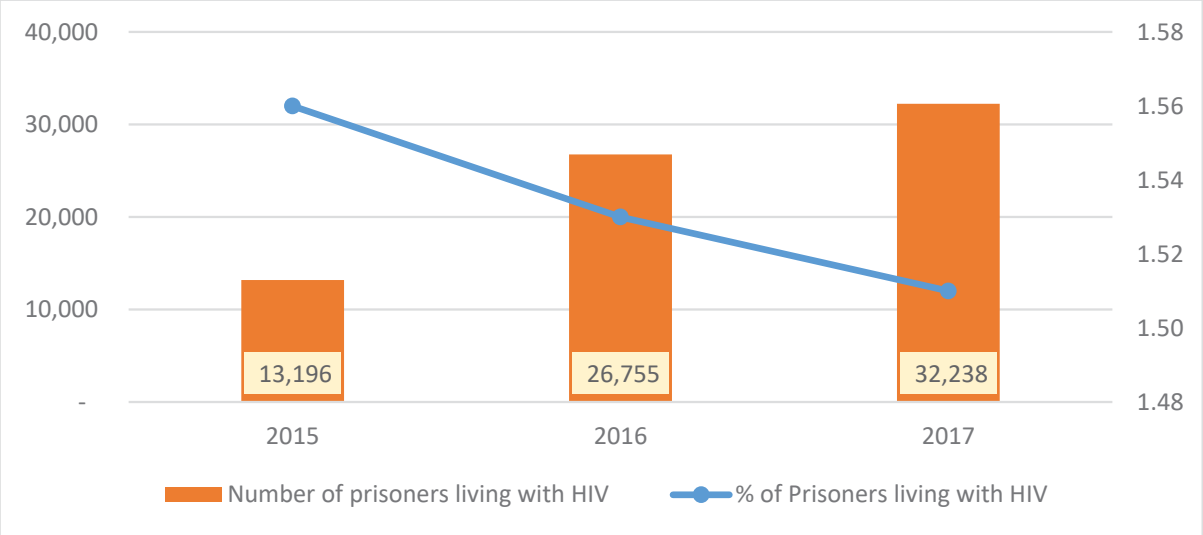
HIV prevalence among the three groups of MSM (MSM, TG, and MSW) was still unacceptably high, especially for MSM and MSW who showed an increasing trend in infection after a period of decline. HIV prevalence for TG finally declined over rounds after an extended period of increasing infection. The IBBS for MSM is conducted in five provinces and found that, for MSM, HIV prevalence increased from 19.2% in 2014 to 21.6% in 2016. For MSW the corresponding figures are 11.9% and 14.1%, respectively. By contrast, the corresponding figures for TG are 15.7% and 10.2%, respectively. Larger urban areas (e.g., Bangkok) had higher HIV prevalence for MSM and TG (19.5% and 12.0%, respectively). The next highest prevalence for these two groups was found in the second most populous Thai city (Chiang Mai) with 6.9% and 4.7%, respectively. In Chonburi, the HIV prevalence for MSM was lowest at 1.7%, while the lowest HIV prevalence for TG was in Phuket, at 1.4%. For MSW, the highest HIV prevalence was detected in Chonburi (18.1%), followed by Bangkok (13.3%), Phuket (9.0%), and Chiang Mai (6.0%).

The trend in HIV prevalence among FSW is downward, both for venue-based and non-venue-based FSW. However, the non-venue-based FSW had higher HIV prevalence than their counterparts. The IBBS found that the venue-based FSW had an HIV prevalence of 1.0% in 2016 while their non-venue-based counterparts had HIV prevalence of 2.3% in 2017. Bangkok has the highest HIV prevalence for the non-venue-based FSW (3.0%).

As of October 1, 2017, data from www.correct.go.th indicate there were 311,587 inmates in Thai prisons and, of these, 4.939 were HIV+ (1.6%). These numbers include both Thais and non-Thais.

By contrast, the NAP reported that, in 2017, the HIV prevalence among prisoners was 1.5%, based on screening of 32,238 inmates. Either way, these figures represent a decline in HIV prevalence from 2015 (Figure 12). The NAP also reported that, in 2017, 2.9% and 5.2% of inmates tested positive for HBV and HCV, respectively. Just under 1.0% of inmates had TB or TB-HIV co-infection.

Figure 12 Number of HIV+ prisoners/detainees



Source of data: *Department of Corrections; NAP database*

Data from RIHIS-VCT show that 22,007 prisoners (Thai and foreign) received HIV testing for the first time and, of these, 264 tested HIV+ (1.2%).

It is estimated that, in 2017, there were over three million non-Thai MW living in Thailand. The IBBS included a sample of MW from Cambodia, Myanmar and Lao PDR in 2014 and found HIV prevalence rates of 1.0%, 0.7% and 0.2%, respectively. The 2016 round of the IBBS found that risk behavior for HIV was still evident, especially for male MW, one-third of whom admitted to having more than one sex partner. Condom use was only 40% for males and 29% for females.

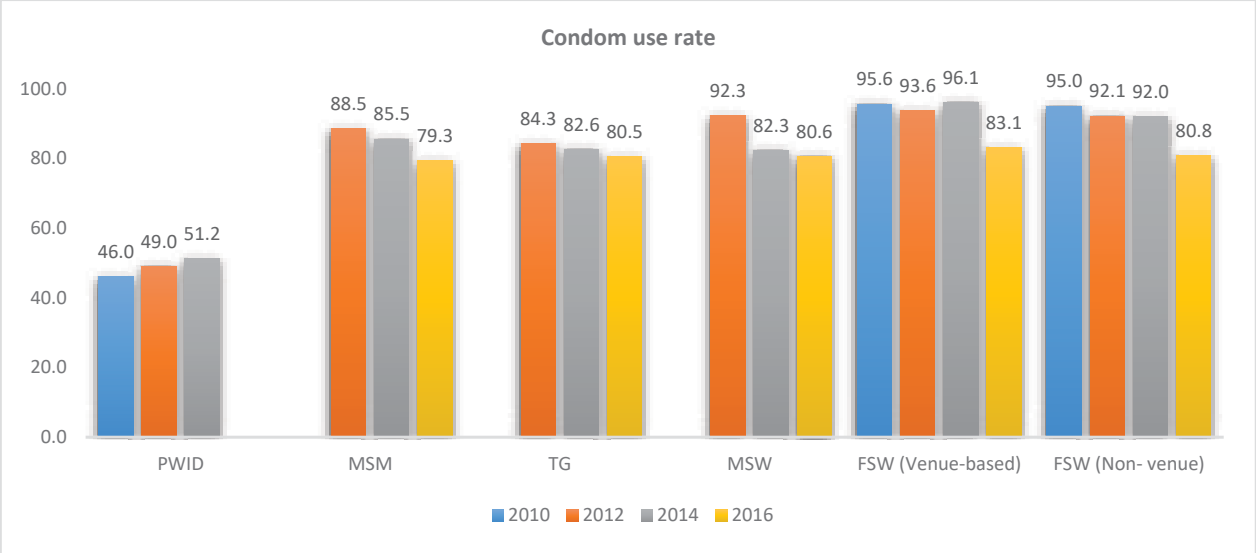
The situation of condom use during the last episode of sex:

There was only a slight increase in condom use for PWID between survey rounds (46%, 49%, and 51.2% in 2010, 2012, and 2014, respectively). PWID also reported increased use of clean needles and syringes over rounds (78%, 80%, and 95% in 2010, 2012 and 2014, respectively).

Condom use at last sex for MSM, TG and MSW declined somewhat. The greatest decline was detected for MSW (92.3%, 81.9%, and 80.6% in 2012, 2014, and 2016, respectively. Lesser declines were recorded for MSM (88.5%, 85.5%, and 79.3%, respectively). TG also had declining condom use but not at the levels of the MSW and MSM.

FSW were asked about condom use at last sex with a paying customer. The levels of condom use were similar for venue-based and non-venue-based FSW. However the trend in use was slightly downward for both, especially the non-venue-based FSW (who reported condom use with last customer at 80% in 2017, down from 92% in the previous round). Interestingly, condom use was higher among FSW in Bangkok compared with the national average in 2017.

Figure 13 Condom use by KPs



Source of data: *IBBS, BOE*

Remarks: Survey year by KP:

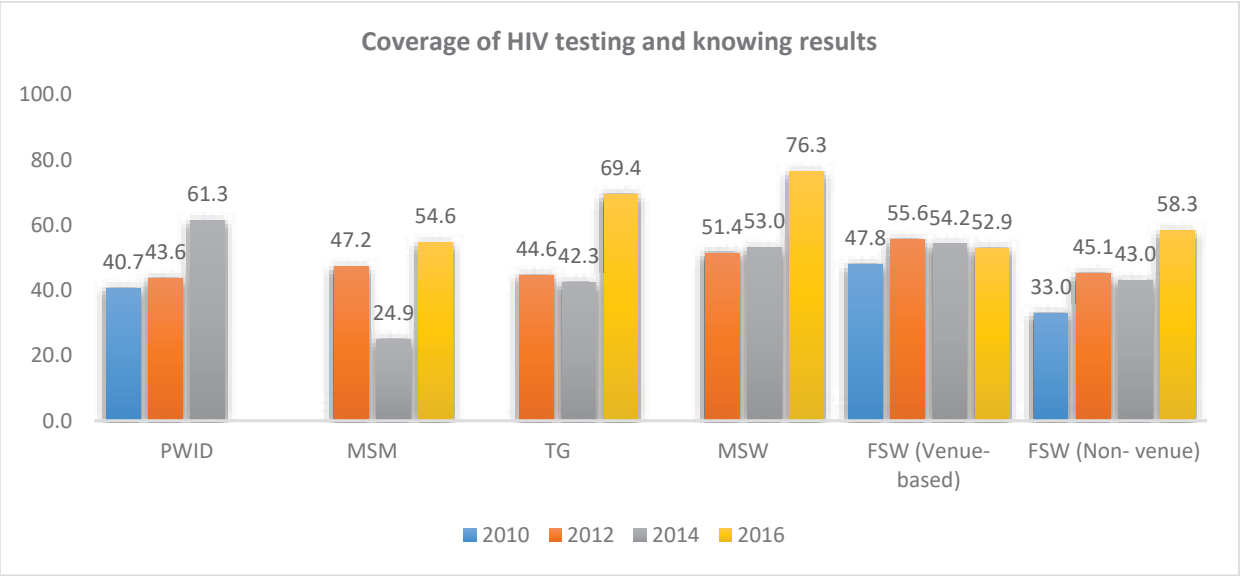
- PWID: 2010, 2012, and 2014
- MSM TG and MSW: 2012, 2014, and 2016
- FSW (Venue-based): 2010, 2012, 2014 and 2016
- FSW (Non-venue-based): 2011, 2013, 2015 and 2017

3.2 Important signs of progress

Coverage of HIV testing and knowing the results: In 2017, MSM had the lowest level of having HIV testing and knowing the result (54.6%). By contrast, TG and MSW tested at the rated of 69.4% and 76.3%. Both types of FSW had testing rates below the target: 52.9% and 58.3% for venue-based and non-venue-based FSW, respectively. Testing and knowledge of results is highest in Bangkok for non-venue-based FSW (76.6%). Still, the non-venue-based FSW are the bigger challenge given their mobility and lack of a support infrastructure.

PWID showed an increase in HIV testing with results from 41%, 44%, and 61% in 2010, 2012, and 2014, respectively.

Figure 14 Coverage of HIV testing and knowledge of results



Source of data: *BOE*

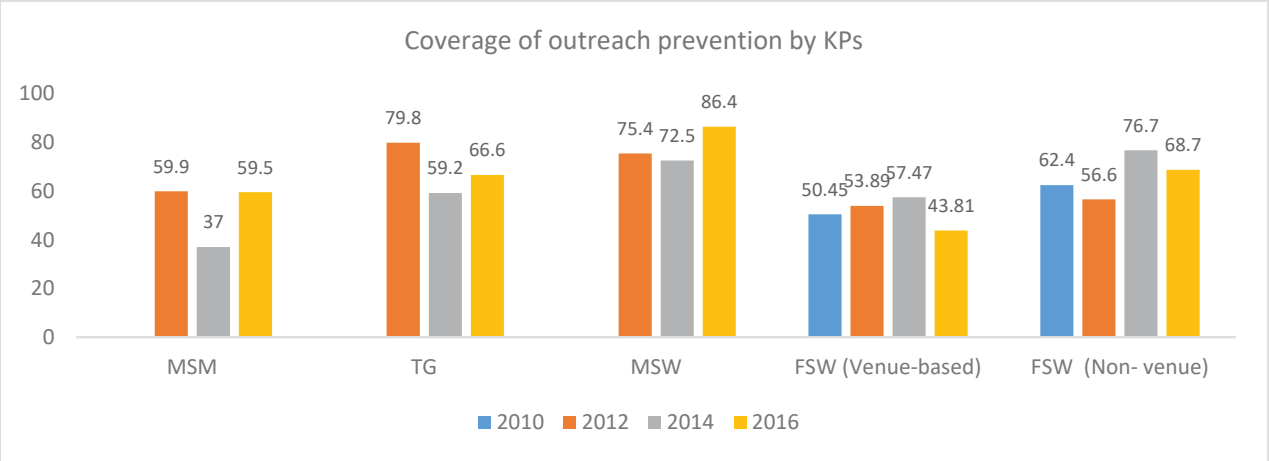
Remarks: Survey year by KP:

- PWID: 2010, 2012 and 2014
- MSM TG and MSW: 2012, 2014 and 2016
- FSW (Venue-based): 2010, 2012, 2014 and 2016
- FSW (Non-venue-based): 2011, 2013, 2015 and 2017

Coverage of outreach HIV prevention for KPs: MSM had lower levels of receiving prevention outreach in 2017 compared to TG and MSW: 59.6%, 66.5%, and 86.4%, respectively. Also surprising is that the venue-based FSW had a low rate of receiving prevention outreach (43.8% in 2016). About two-thirds of venue-based FSW received HIV prevention outreach in 2017. But both those levels of outreach coverage are 10 percentage points below what they were in the previous survey round.

Access to prevention outreach was highest in Bangkok (91.6%). However the overall low and declining levels of outreach coverage reflect a decline in intensity of the HIV prevention program for FSW.

Figure 15 Coverage of outreach prevention by KPs



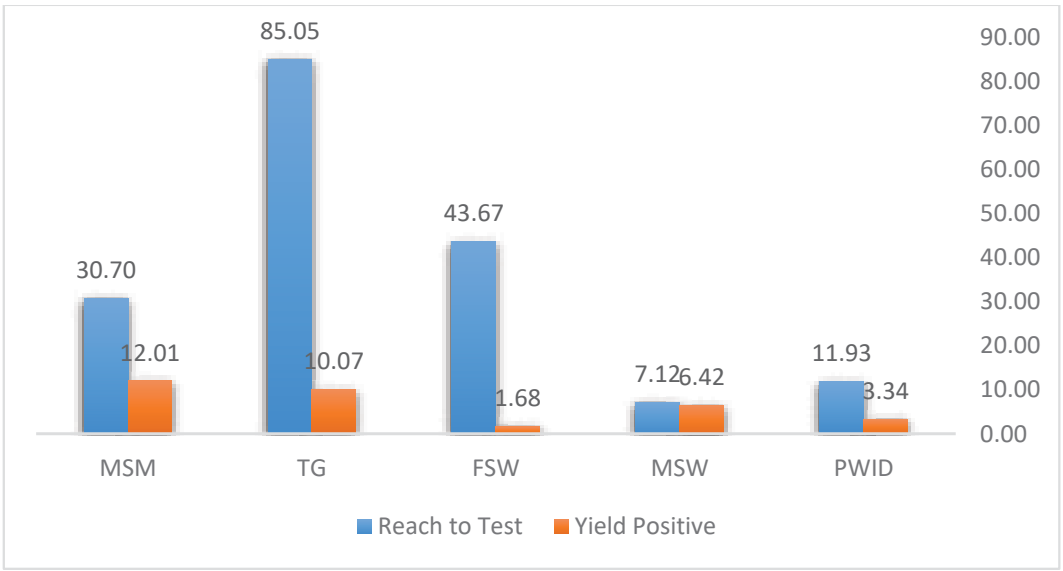
Source of data: *BOE*

Remarks: Survey year by KP:

- MSM TG and MSW: 2012, 2014 and 2016
- FSW (Venue-based): 2010, 2012, 2014 and 2016
- FSW (Non-venue-based): 2011, 2013, 2015 and 2017

All of the reporting systems that feed into the national database indicate the KPs accessed outreach prevention in 2017, including 120,376 MSM, 4,215 TG, 18,134 MSW, 9,535 PWID, and 27,333 FSW. Of these, the following number had been tested for HIV and know the results; 36,951 MSM, 3,585 TG, 1,292 MSW, 1,138 PWID, and 11,935 FSW. These data indicate a reach-to-test ratio of 30% in MSM, 85% in TG, 44% in FSW, 7% in MSW, and 12% in PWID. From this number, the proportion of detecting HIV infection (HIV yield) is 12.0% in MSM, followed by 10.1% in TG. Funding from the Global Fund enabled Thailand to deliver HIV prevention and screening to 104,221 non-Thai MW in 2017. A total of 49,870 were found to be HIV+ and 3,279 were enrolled in ART.

Figure 16 Reach-to-test ratio and HIV Yield



Source of data: *RTCM, RIHIS-Outreach, RTF*

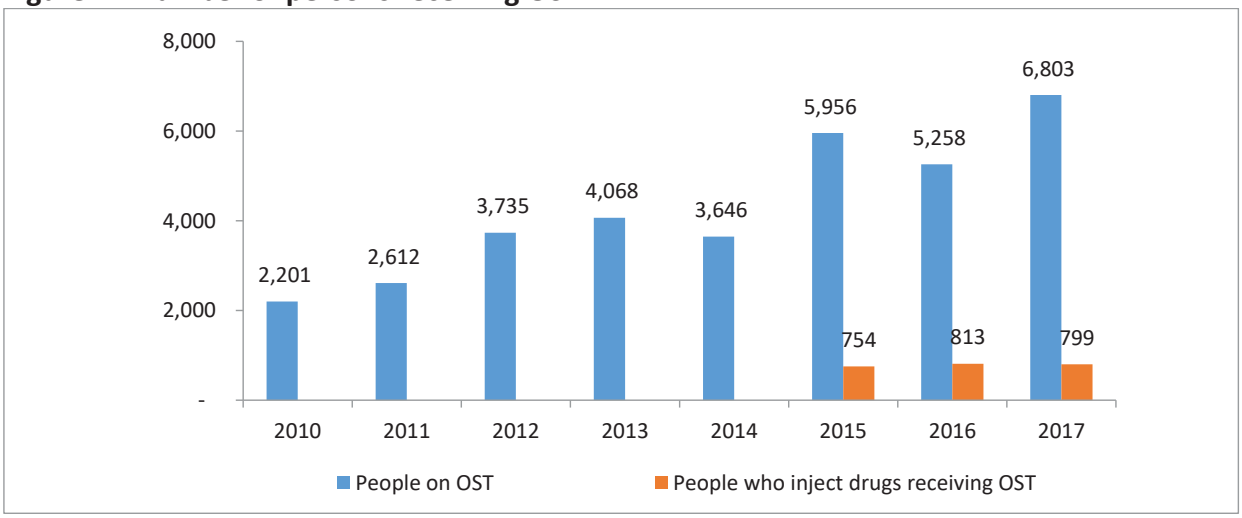
USAID is collaborating with the Center for AIDS Research of the Thai Red Cross to implement the 3-year USAID Community Partnership Project. The objective of the Project (which began in November 2017) is to build capacity of community health care outlets to deliver HIV prevention and care to KPs such as MSM, TG, and SW in 13 provinces. If it is incorporated into the national health service delivery system, this model of community-led health services could significantly expand access and coverage for the hard-to-reach groups that are vulnerable to HIV.

During Fiscal Year 2017, the NHSO provided funding for RRTTR to help achieve the Ending AIDS goals, with a focus on KPs (200 million baht fund). The following numbers are the total reported persons receiving outreach prevention: 50,380 MSM and TG, 26,930 FSW, 4,472 MSW, and 4,870 PWID.

Services for PWID: In 2017, 11.7% of PWID received opioid substitution therapy (OST) through one of 131 outlets (a slight decline from 147 outlets in 2016). However, there was a significant decline in the number of provinces which have OST outlets, from nearly all in 2016, to only 32 in 2017. At the same time, there was expansion of the needle/syringe distribution program to 30 outlets in 2017, from only 17 in 2016. Those 30 outlets include 13 governments and 17 Civil Society organizations. Provincial-level task forces have been appointed to track progress in coverage of services for PWID. Services are also being decentralized to the sub-district health promotion hospitals, with referral connections to the extension facilities of the Department of Medical Services (DMS) of the MOPH.

In 2017, Thailand's harm reduction program provided OST to 6,803 persons, or an increase from the number in 2015 and 2016 (5,956 and 5,258 persons, respectively). Of those persons receiving OST in 2017, 799 were PWID, compared to 754 in 2015, and 813 in 2016 (Figure 23). For 2017, it was estimated that 19,256 were in need of OST (based on a national household survey of opioid dependency in 2016; Manop Kanato et al).

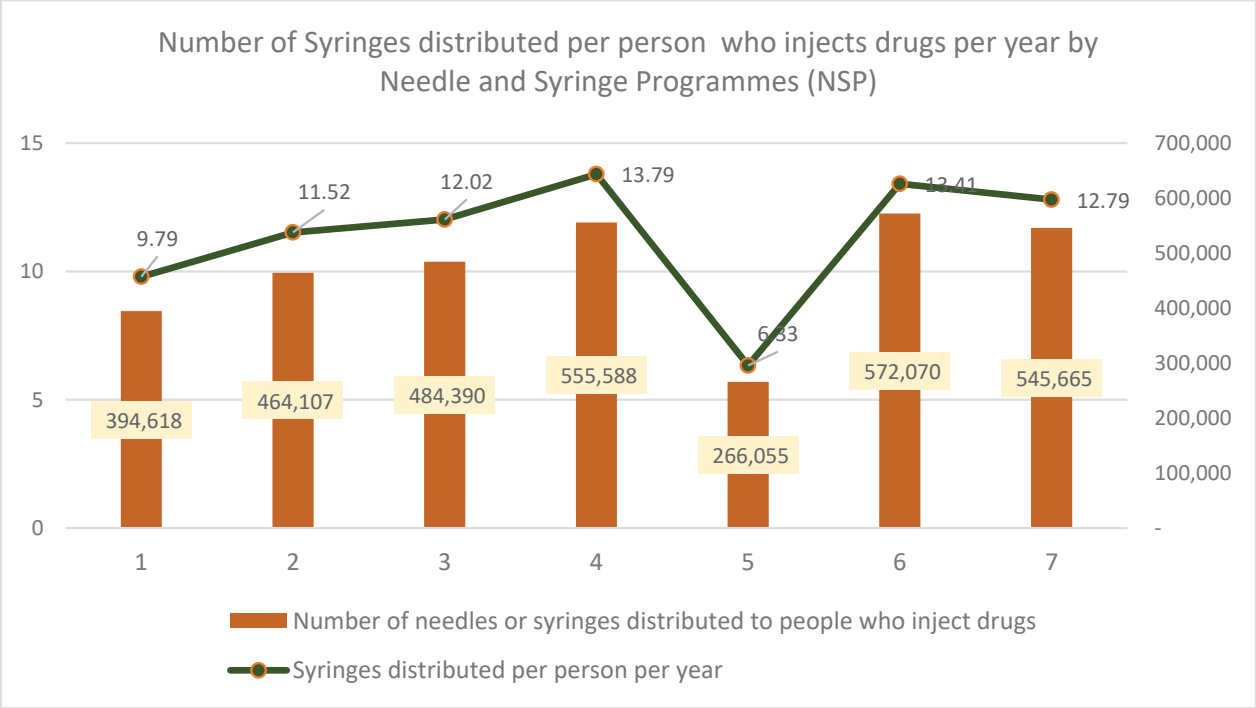
Figure 17 Number of persons receiving OST



Source of data: *National OST monitoring report from the Department of Health Service Support, MOPH*

In 2017, a total of 545,665 clean needle/syringe packets were distributed to PWID, or about 13 packets per person per year. This service is primarily provided by Civil Society organizations since there is controversy within the public sector about needle exchange. There are advocacy efforts to expand this service to 37 provinces through a pilot project approach.

Figure 18 Distribution of clean needles and syringes to PWID in 2017



Source of data: *Raks Thai Foundation and BATS*

Pre-exposure prophylaxis (PrEP) for prevention of HIV infection: Thailand is the first country in Asia to adopt a policy for free PrEP for all clients who qualify. This is part of a community-based rapid diagnosis and ART treatment program, and part of a 7-province pilot project to evaluate efficacy of PrEP in MSM and TG. Funding for the project comes from USAID and the US CDC. In 2017, a total of 1,865 persons received PrEP at least once, including 1,706 KP (1,549 MSM, 13 FSW, and 144 TG). Of these 1,865 recipients, 198 were first-time recipients of PrEP. Civil Society played a key role in advocating for PrEP to be provided by community-led health services. Fully 1,642 persons who received PrEP in 2017 did so through these grassroots outlets. WHO policy is to provide PrEP for individuals with a 3% annual risk of infection per year, and MSM and TG meet this criterion. However, PrEP is still not part of the health insurance benefits package. In June, 2016, the MOPH issue a guidance paper on PrEP to encourage hospitals under the MOPH to provide PrEP to those in need, such as sero-discordant couples, MSM, TG, sex workers and PWID. However, the client would have to pay out-of-pocket for PrEP. The estimated cost of PrEP for a repeat user would range from 600 to 2,000 baht per month. In addition, BATS launched a program to strengthen the health care system to increase access to PrEP for FY 2017-19. That pilot project is being implemented in seven provinces (Nonthaburi, Pathum Thani,

Phuket, Songkhla, Udorn Thani, Khon Kaen, and Nakorn Ratchsima). The objective is to standardize the service while increasing access to PrEP for KPs with high risk of HIV. Eventually, the goal is to have national access to affordable PrEP. Other pilot projects which provide PrEP include the Princess PrEP Project, which is implemented by the Center for AIDS Research of the Thai Red Cross in collaboration with SWING, SISTER, and RSAT organizations. There is the PrEP@PIMAN Project which is another pilot effort to provide PrEP for MSM at no cost. There are research projects for provision of PrEP to MSM in Lertsin and Thammasat Hospitals. Some private clinics are also offering PrEP, but at cost. KP-led health services were implemented in 2017 as part of a pilot project to reach vulnerable KPs. Initially, PWID were trained to distribute PrEP, and this was expanded to include TG, and other services such as screening and treatment for HCV.

3.3 Challenges and guidelines for future implementation

HIV prevention and access to HIV testing: One challenge that needs urgent attention is the low up-take in HIV screening for KPs. This has a ripple effect on other areas such as lack of use of PrEP, late enrollment in ART, etc. Thus, there need to be better guidelines for accessing KPs with higher risk and motivating them to enter the screening and referral system. There needs to be a special understanding of the complex situations which confer risk for HIV. For example, some Civil Society groups report that a significant proportion of MSM also use addictive drugs, sometimes injecting these drugs and sharing used needles with other users. Thus, different models of outreach are needed which are tailored to the different risk profiles of the KPs. In addition, the types of risk behavior evolve over time. Another challenge is to find a balance between law enforcement and recruitment into the health system. For example, a number of the KPs are practicing illegal behaviors (e.g., injecting illegal drugs, selling sex). It is important that law enforcement crackdowns do not drive these KPs further underground, as that would make it even harder for outreach programs and health staff to reach them. What is more, the Internet provides new channels for individuals to arrange commercial sex transactions at random locations. That makes it exceedingly difficult to reach out to those individuals with prevention interventions. Thirdly, Thailand does not have a clear direction on dealing with the population of PWID. For example, there are groups who feel that injection drug use should be considered a criminal offense while others feel it should be treated as a public health problem. This has implications for the potential for harm reduction programs. Finally, the lack of budget for prevention is another obstacle to Ending AIDS. Civil Society groups are key players in reaching KPs. However, with the end of Global Fund assistance to Thailand, many of these groups are being defunded or having to shift to other development pursuits.

Monitoring and evaluation: Currently, the national data system is not comprehensive enough to present the full and accurate picture of the HIV situation and coverage of services. The data are not timely enough either (e.g., the updated estimates and projections of the numbers of KPs are delayed). In addition, the different data systems are not well linked, and that makes it hard to assess the progress of the RRTTR cascade. Data need to be aggregated across agencies, and duplicate counting needs to be eliminated. Many KPs might be going to private clinics for HIV screening or related services, and those service statistics are not entered into the NAP database. Thus, much of the service data is probably a serious undercount.

PrEP: At present, PrEP is primarily targeted for MSM and TG through research projects with limited geographic coverage. In any event, the MOPH is advocating for a policy to include PrEP in the benefits package of the NHSO to reduce the cost burden for those in need. The MOPH is developing guidelines for delivering PrEP and preparing implementation plans for building capacity of service outlets to provide it. Civil Society is playing an important role in helping to expand coverage of PrEP and steering it to the most vulnerable KPs. That said, any provision of PrEP must be closely linked with or part of the public health service system.

HIV non-occupational Post-Exposure Prophylaxis (HIV nPEP): nPEP has not yet been included as part of a comprehensive prevention package. In the public hospital setting, subsidized nPEP is only administered in cases of rape. Persons who experienced HIV prevention failure (e.g., broken condom) may seek nPEP from a hospital but they have to pay out-of-pocket.

Harm reduction for PWID and treatment for addiction: The guidelines for harm reduction of the ONCB and the MOPH are not the same. Most practitioners apply the MOPH guidelines, which do not include needle/syringe exchange. Thus, at the time of this report, only certain Civil Society groups were providing needle exchange, and that is outside the formal government health system. Accordingly, those groups cannot receive government reimbursement, and their services are not recorded in the Folder 43 service statistics. Also, the principle treatment for PWID is methadone maintenance therapy (MMT), but that is only effective for those who inject opioids. Also, there is no firm evidence that MMT is effective in helping PWID to quit injecting drugs. New drugs are becoming available all the time and, thus, more methods are needed to discourage injection and needle sharing. Home-based treatment for drug addiction has not been found to be effective in the Thai setting.

Prisoners/detainees: As of 2017, there were no guidelines or standards for care for incarcerated PLHIV not covered by an insurance program, including non-Thais. Thus, there are gaps in ART in the prison setting, and this poses significant risk of inmate transmission by multiple routes of transmission. What is more, the unacceptable crowding of Thai prisons and detention centers means that risk of TB and HIV transmission is intensified. In other words, people in Thai prisons are not covered by the routine health care system of Thailand that the non-incarcerated enjoy. There also need to be guidelines for on-going ART for HIV+ prisoners who are released back into the home community.

Budget and sustainability of implementation: Thailand has invested large amounts of domestic budget for the AIDS ever since the HIV epidemic hit. However, those agencies which work to implement the RRTTR cascade with KPs have received relatively little government budget. Part of the reason was that external donors (principally the Global Fund and PEPFAR) filled the gap in funding prevention for KPs through Civil Society groups. Thus, over the coming two to five years, Thailand needs to urgently find ways to

make up for the discontinuation of external funding for the prevention program among KPs. While the NHSO has ostensibly created a 200 million baht fund for prevention, which would include grants to Civil Society, in practice it has been difficult for NGOs to access these funds since they are channeled through provincial hospitals with varying criteria for NGO eligibility.

Non-Thai MW: This is the only group of KPs living in Thailand who are not eligible for government budget support in HIV prevention and care. Thailand also has policy to allow only temporary stay for MW, who must then return to their home country. Although the MOPH does have a health card (i.e., insurance) program which MW can buy annually, the cost may be a barrier for most. Thus, MW either pay out-of-pocket or use the non-formal system for health care. This also means that any services they receive are not reported into the service statistics database. So it is difficult to gain an accurate estimates of their total population and coverage with services. Besides, MW by definition are mobile populations and may transfer among worksites and provinces as opportunities arise. This makes it even more difficult to track and serve the MW population who are vulnerable to HIV and related conditions.

In order to maximize coverage of KPs in Thailand with services, there needs to be a "New Fast-Track Strategy" to boost access to the RRTTR cascade. This must involve host communities to join the service and referral network. There should be an equitable partnership between government and Civil Society groups with links to the KP. This will require some capacity building of local groups and NGOs in the area of HIV counseling and testing, as well as community-led health services. There would need to be an accreditation system to ensure that grassroots providers deliver standard quality services. There must also be some local budget support to enable sustainability of community-based services. At the same time, the formal health outlets need improvement, first to eliminate S&D against PLHIV or KPs, and to make services client-friendly for all. Service hours and methods need to be tailored to the special needs of the some of the KPs to increase access. Above all, the confidentiality of the KP client must be strictly maintained. Government health staff need refresher training on serving the diverse populations that comprise the KPs and understanding the difficult circumstances they live in. The referral system needs to be efficient, easy, convenient and fast in order to ensure that once a KP or PLHIV enters the system, they are not lost to follow-up. Private (for-profit) clinics and outlets also need to be brought into the larger health service system. This will help for cross-referral and compiling data on coverage of services by type of population. There should be an accelerated expansion of PrEP and nPEP, and include these as part of the health insurance benefits package. Any policies which work against the RRTTR cascade need to be scrapped, modified and improved. That way, all related sectors of the government will move in the same direction toward Ending AIDS and be mutually reinforcing. Prisoners and detainees are a special group that are out of reach of mainstream prevention and treatment. Ways must be found to care for these individuals and link them with sustainable services after release.

Commitment 4: Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020

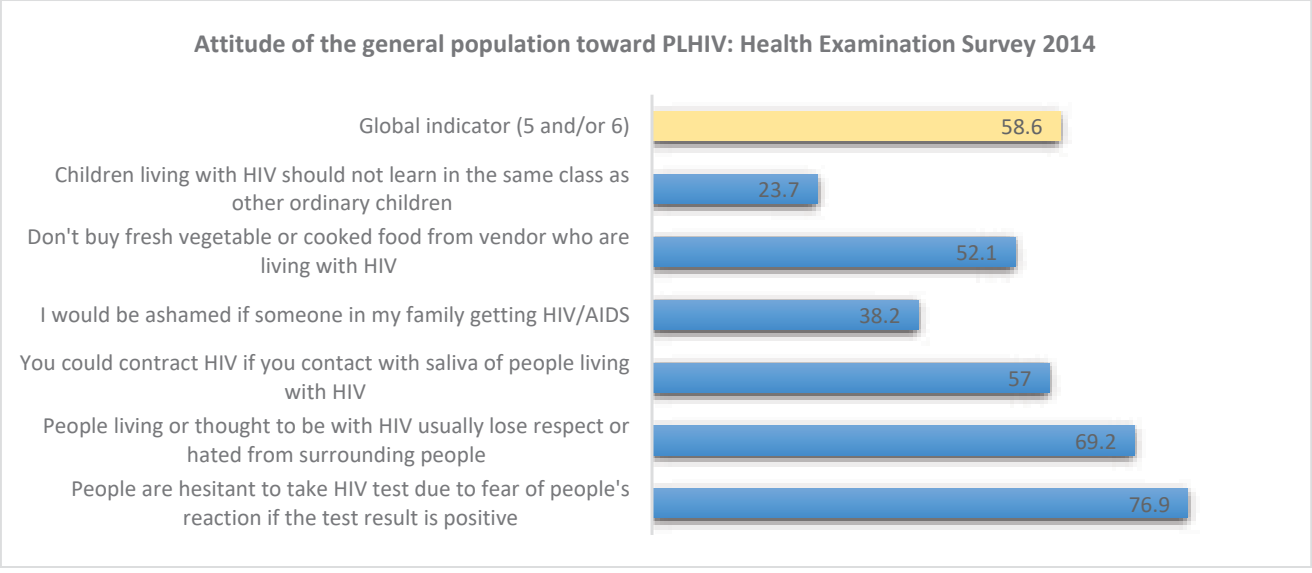
AIDS S&D is still a powerful deterrent to KPs and others who might be at risk to seek HIV testing and diagnosis. Thailand recognizes the importance of combatting S&D and has adopted the reduction (by 90%) of S&D as one of the three principal targets of Ending AIDS by 2030. Over the years, Thailand has implemented a number of campaigns to reduce AIDS S&D, but there remain incidents of mistreatment of PLHIV and KPs and their family members due to the persistence of negative prejudice. These incidents may occur in the community, workplace, service site, school, daycare center, and health outlets. In addition, many government agencies have regulations and methods – both direct and indirect – which deny equal opportunity for PLHIV to be employed and stay employed.

4.1 Current situation

In 2017, it is still too early to assess the latest interventions to combat negative S&D. The Health Examination Survey (HES) in 2015 found that there continues to be irrational fear of PLHIV in one form or another (e.g., refusing to buy fresh vegetables or food from an HIV+ vendor; HIV+ children should not be allowed in classrooms with uninfected children; etc.). Some S&D was detected in over half of general population respondents in the HES. The MICS Survey in 2015-2016 found that about one-fourth of people age 15-49 had discriminatory attitudes toward PLHIV.

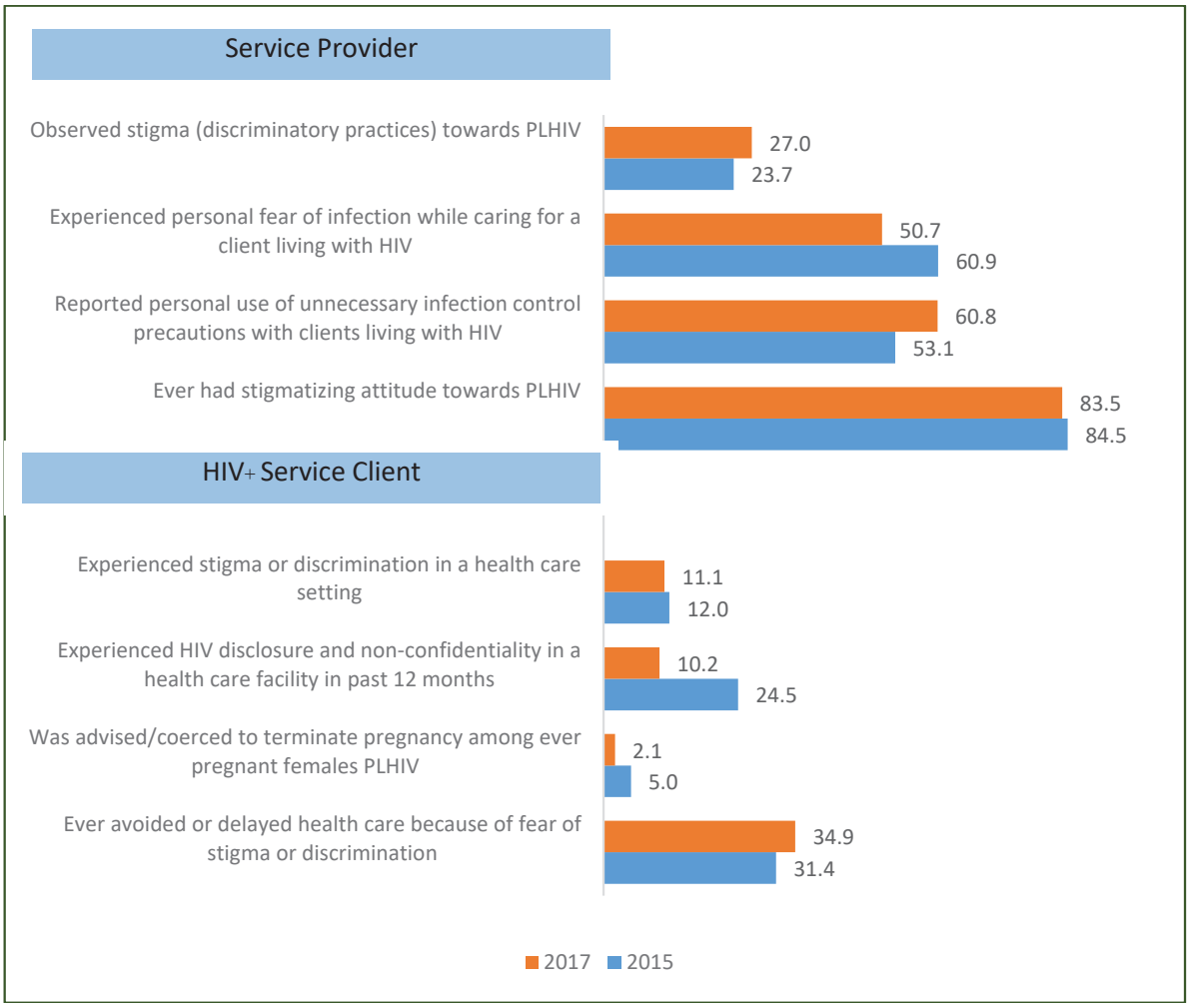
The 2016 round of a survey in 13 provinces found that about one in ten (11.1%) PLHIV had experienced S&D related to their infection in a health facility in the prior 12 months. That represented a slight decline from 12.0% in the 2015 round of the survey.

Figure 19 Results of the study of discriminatory attitudes toward PLHIV in the general population



Source of data: HES Survey, Bureau of Health Surveys

Figure 20 Results of the survey of S&D in health service outlets among service providers and clients



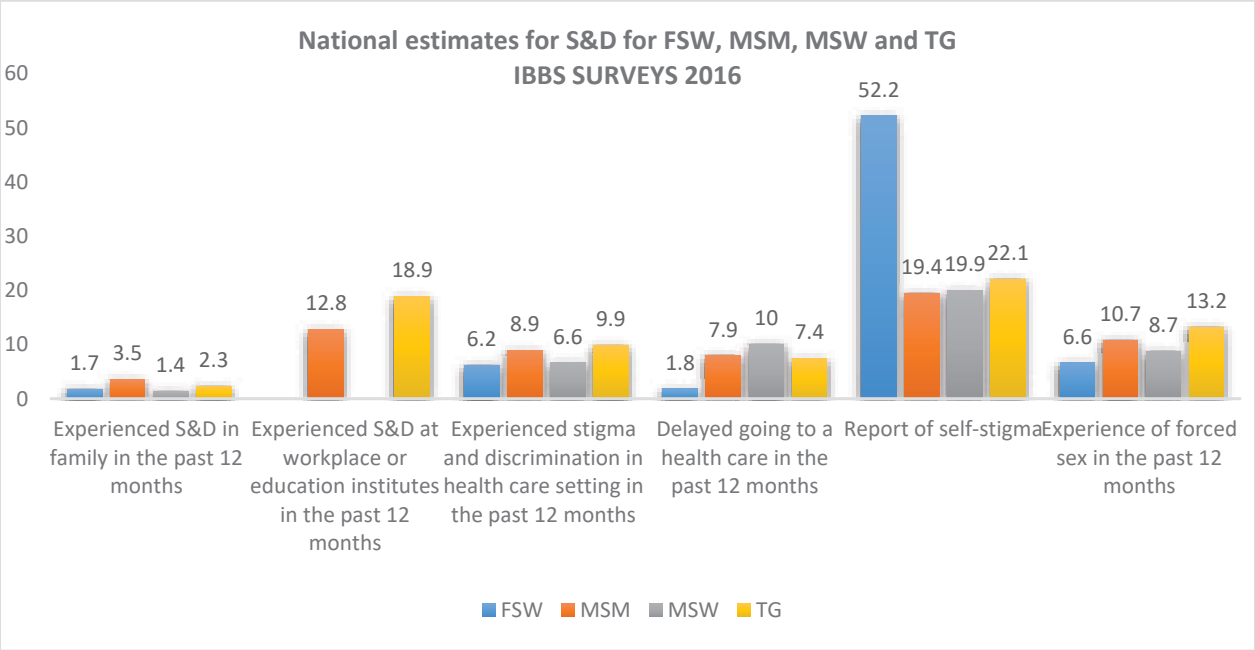
Source of data: *BATS, DDC*

Thus, S&D in Thailand is still a challenge. The survey found that the proportion of persons who were reluctant to go to the government health service outlet in the past year because of potential for S&D increased from 31.4% in 2015 to 34.9% in the latest round. Of PLHIV clients, 10.2% had their HIV+ status shared with others without their permission. Among HIV+ pregnant women, 2.1% had been pressured to abort the pregnancy.

The survey of health providers also confirms that the S&D situation has not improved significantly as of this report. The proportion of health providers who display negative discrimination against KPs was 27.0% in 2017, or an increase from 23.7% in 2015. This is most evident when the health practitioner takes unnecessary precautions when touching a PLHIV client, a practice which increased to 60.0% in 2017 from 53.0% in 2015. These external sources of S&D causes PLHIV and KP clients to develop self-stigma, and start to think that they are tainted and not worthy of equal treatment.

In addition, the situation of S&D in KPs (MSM, TG, MSW, FSW) based on the latest round of the IBBS (2016) is that KPs still suffered from S&D in the family setting, workplace, schools and health service outlets in the prior 12 months. The TG group experience the most stigma in the workplace or school (18.9%), or in health service outlet (9.9%). One in ten MSW delayed going for a health service in the past 12 months (due to anticipated S&D), while 7.9% of MSM, 7.4% of TG, and 1.8% of FSW delayed health service visits out of fear of S&D. Experience of sexual violation or violence was as high as 13.2% in TG, following by 10.7% in MSM, 8.7% in MSW, and 5.6% in FSW.

Figure 21 National estimates for S&D for FSW, MSM, MSW and TG - IBBS SURVEYS 2016



Source of data: BOE, DDC

4.2 Important signs of progress

Thailand recognizes the importance of eliminating gender inequality, and that is reflected in the NAP strategic plan for AIDS for 2014-16. Every component of the plan includes a segment on rights protections, respect for a person's sexual orientation, and tolerance of diversity. In the past two years, there has been progress on this front through the application of the Gender Equality Act of 2015. The purpose of the Act is to protect individuals from discrimination on the basis of gender, and in order to be consistent with the UN Declaration of Human Rights, to which Thailand is a signatory. The Act stipulates that any arbitrary discrimination based on gender is prohibited. The ACT also includes protection of rights and protection from discrimination for those with diverse sexual orientation and identity.

The 2016 Act on Prevention and Response to Teen Pregnancy supports adolescents to take responsibility for their sex life and be able to access sex education as appropriate. Thailand has 'AIDS in the Workplace' policies which include elimination of HIV-related S&D, starting with government offices to serve as a role model for others. There is a project called "Worksites Work To Prevent AIDS" with the following policy: (1) A person's HIV status or sexual orientation cannot be a condition for not

recruitment or hiring them; (2) PLHIV should be employed if they meet the hiring criteria, and they should have equal opportunity to advance in the workplace hierarchy; (3) HIV infection alone cannot be used as a criterion for termination of employment; (4) A worker's personal information must be kept confidential; (5) The worksite is to support HIV prevention and access to HIV testing on a voluntary basis; workers should be encouraged to interact normally and professionally with each other regardless of HIV status; (6) The worksite should facilitate PLHIV and family members to access welfare services that they are eligible for, including treatment and care for HIV infection.

Thailand has pioneered a national monitoring and evaluation system for S&D affecting PLHIV and KPs. This system allows the tracking of the level and location of S&D to that measures can be taken to reduce or eliminate S&D. IBBS survey modules for KPs in 2014 and 2016 include questions on experience of stigma from family members, society in general, and health service providers in the past 12 months. This information also helps inform guidelines for combatting S&D against PLHIV and KPs. There are pilot projects underway in some provinces to develop a model for understanding and eliminating S&D in the health care setting in conjunction with mechanisms for rights protection. Thailand recognizes and participates in the international "Zero Discrimination Day" to improve public understanding of S&D that adversely affects PLHIV and how to reduce or eliminate S&D. This is implemented in conjunction with programs to eliminate gender inequality and violence. Nevertheless, there needs to be expansion of these efforts in the school setting and among local administrative organizations in their role in providing welfare for PLHIV.

4.3 Challenges and areas for future action

Aversion and discrimination toward PLHIV and suspicion of HIV infection toward KPs is still a problem in Thai society, and that alone can cause more suffering than the disease itself. S&D is an obstacle toward access to services, and current plans and programs are not yet specific enough to protect the rights of those with diverse sexual identities. Thus, success in this area has been uneven. In any case, Thailand is implementing an accelerated program to reduce negative prejudice, aversion and discrimination based on actual or suspected HIV infection. The goal is that society and the health community view HIV/AIDS as just another chronic condition which can be managed by available and affordable treatment. That alone should help improve attitudes of health staff and the general population toward PLHIV and KPs. Still, there needs to be a system for filing grievances when rights or liberties are violated based on AIDS S&D.

While Thailand has endorsed the goal to eliminate gender inequality and violence as part of its Ending AIDS strategic plan for 2017-30, the guidelines for achieving that are not clear. Plus, there needs to be a specific allocation of budget for implementing those guidelines; it will not happen by itself. To-date much of the activity is basic orientation meetings for staff in the health sector in order to improve attitudes and broaden viewpoints on sexuality and sexual violence, and to show respect for diverse sexual orientation and gender identity. However, these efforts need to be expanded beyond the health sector to include the schools and local administrative organizations given their role in supporting PLHIV in the community. A remaining challenge is how to link members of the network to apply the relevant policy to eliminate S&D so that it is a sustainable accomplishment.

Commitment 5: Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100 000 per year

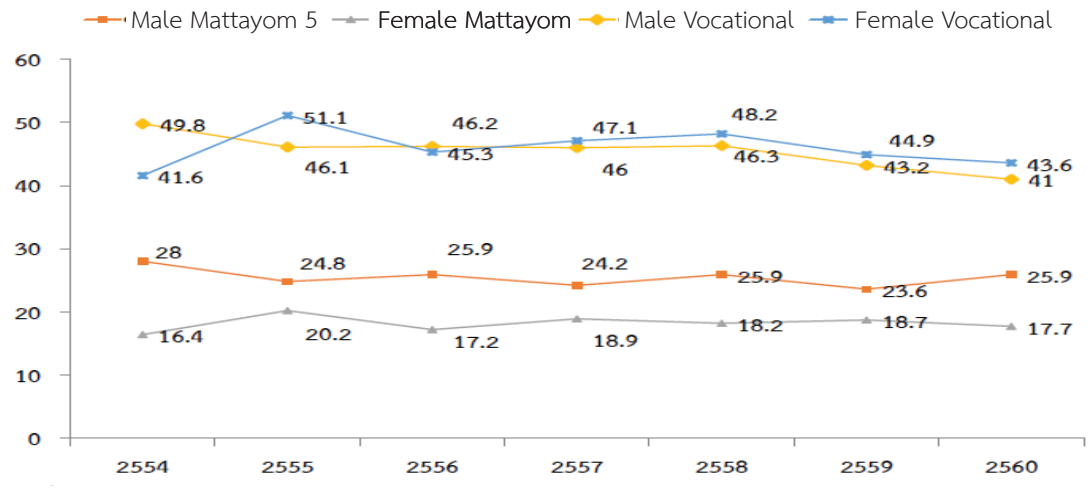
This global target has the aim to reduce new HIV infection in female youth to less than 100,000 cases per year.

5.1 Current situation

Youth are a priority target in Thailand's program for prevention of HIV and STIs. Data from the AEM projections indicate that new infections among people age 15-24 years accounted fro 47% of total new infections (1,803 males and 799 females). The number of youth PLHIV as of this report totaled 30,754 persons, and the AIDS mortality for this group is estimated to be 3.3 per 100,000 population per year.

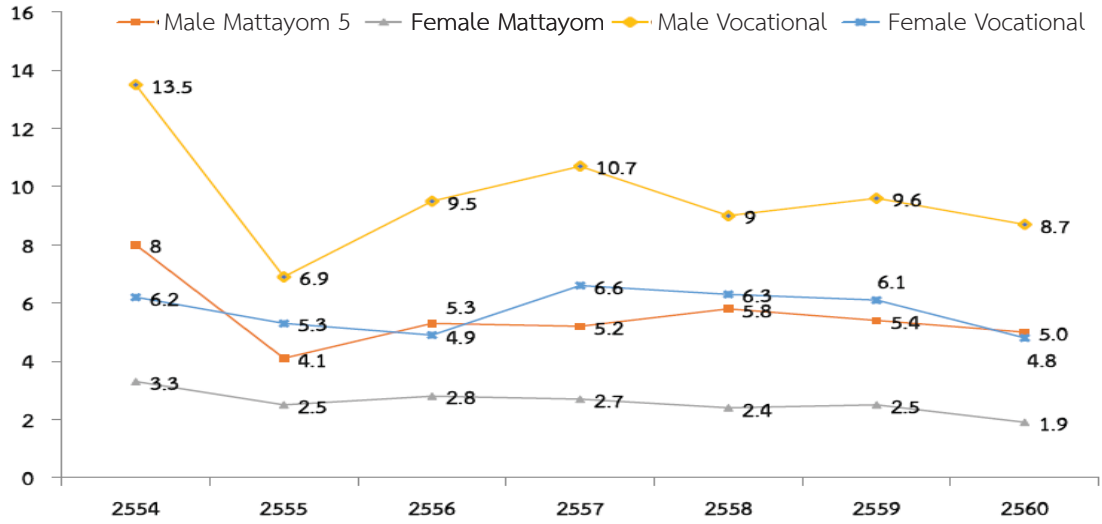
The 2017 round of the HIV risk behavioral surveillance survey among Thai students (Mattayom 2 and 5, and Year 2 vocational students) in 42 provinces did not find any increase sexual activity among M5 and VS2 students, male or female. However, it is clear that VS2 students are more sexually active than their M5 counterparts (Figure 22). For the younger cohort of M2 students, mean age at first sex was similar for males and females, or about 13 years. Prevalence of being sexually active of this group of students is still low, at 3%. However, as Figure 23 shows, the proportion having their first sex under age 15 years for M5 and VS2 students was increasing.

Figure 22 Percent of sexually active students



Source of data: *BOE, DDC*

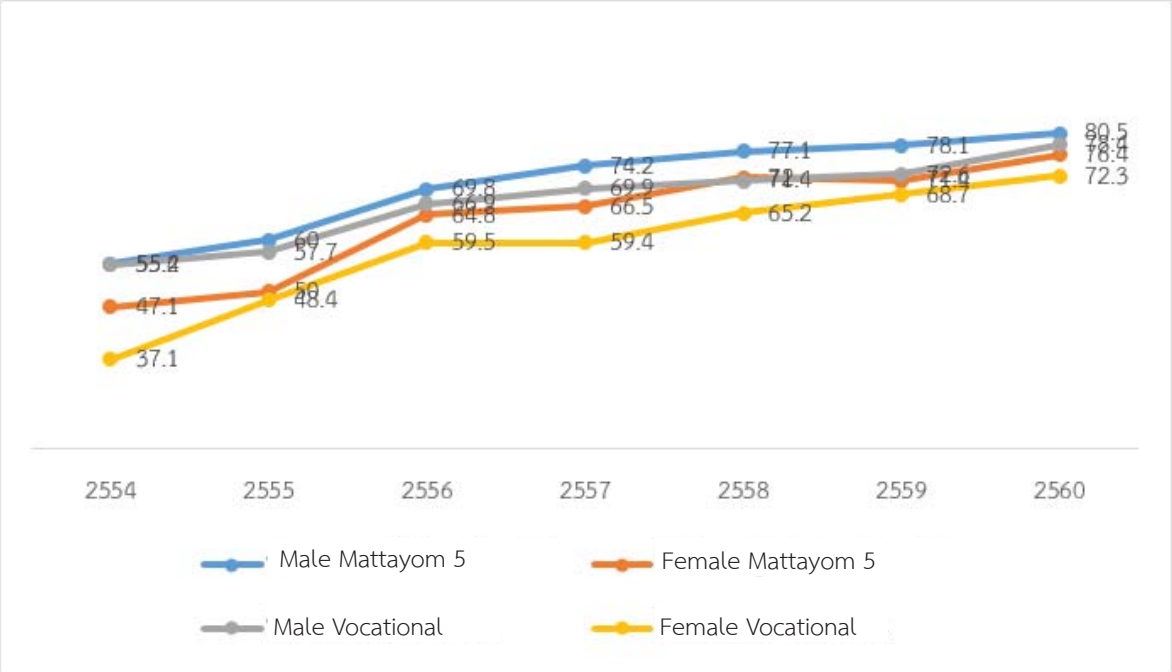
Figure 23 Percent of students who had sex before the age of 15 years



Source of data: *BOE, MOPH*

The data on condom use suggests that the students are conscientious about the need for safe sex. Use of a condom at last sex has increased over time. In 2017, 80.5% of male HS5 students, 76.4% of female HS5 students, 78.4% of VS2 students and 72.3% of female VS2 students used a condom at last sex.

Figure 24 Percent condom use at last sex



Source of data: *BOE, DDC*

5.2 Important signs of progress

The MICS survey collects data on the situation of youth and women in Thailand, with the latest round being conducted during 2015-16. That survey found that 45.6% of persons age 15-24 were knowledgeable about HIV prevention, and could correctly identify sexual routes of transmission. They could also identify false myths about HIV transmission. Nearly all females age 15-24 (married or cohabiting with a male partner) expressed a need for family planning and modern contraception.

The HIV risk behavioral surveillance survey among students in Thailand in 2017 also assessed knowledge about HIV prevention. Surprisingly, correct knowledge that HIV is not transmitted by sharing a meal with a PLHIV was only 44.8% in males and 39.7% in females. By contrast, most correctly responded that using a condom for every sex reduced risk of HIV (91.1% of males and 90.8% of females). The proportion who could correctly answer the five UNGASS HIV/AIDS knowledge questions was only 13.5% among female students and 14.1% of male students. That represents a decline in correct knowledge from previous rounds. Another area of knowledge deficiency was that emergency contraception could prevent HIV (not true) and was correctly answered by 75.7% of males and 85.0% of females.

Thailand has been trying to increase access of youth to reproductive health services, for example, through the Reproductive Health Act. The DDC, DOH, and Department of Mental Health (DMH) endorse comprehensive sex education and life skills in the school setting. The MOPH also promotes youth-friendly health services (YFHS) through its network of outlets. These efforts are having positive results, as indicated by successive rounds of surveys. During the report year, there was progress in support of prevention among groups of vulnerable youth. Thailand passed the Prevention and Response to Teen Pregnancy Act in mid-2016 and that is helping to integrate HIV prevention as a part of routine reproductive health services. This is also helping to push education on reproductive health in the classroom in both the formal and non-formal education sector. This is a multi-sectoral effort involving the MOPH, the Ministry of Education, the Ministry of Social Development and Human Security, and the Ministry of Interior. The most intensive work is being led by the DDC, DOH and DMH to prevent STIs and unplanned pregnancy in youth. This includes youth-targeted campaigns, and promotion of condoms and contraception. The DOH received funding from the NHSO to procure 20 million condoms to distribute through the public health service network in all 76 provinces. The interventions for youth are targeted to those provinces with greater need, including a formal sex education curriculum implemented with assistance from the p2h Foundation (formerly PATH) network in 2,406 schools. Other NGOs involved in youth programs include the Planned Parenthood Association of Thailand, the Population and Community Development Association, the Women's Health Association of Thailand, the Bureau of Reproductive Health, and various health centers in those locations. There are more public service outlets which provide youth-friendly counseling and sexual health, and standards for YFHS based on WHO guidelines. The results of implementation are that three-fourths of MOPH hospitals already provide youth-friendly sexual health services. However, as of this report, there is no visible impact since teen pregnancy and delivery has not yet declined significantly.

In addition, the Office of the Permanent Secretary of Education stated in 2017 that it was preparing a handbook with guidance on protecting AIDS rights in schools under the Ministry of Education. The guidelines include essential knowledge and understanding about AIDS rights and promoting non-discriminatory attitudes toward PLHIV by staff, students, and agencies in the Ministry of Education.

5.3 Challenges and next steps

Unsafe sex and unplanned pregnancy is still a problem about Thai youth. This reflects gaps in utilization of sexual health services by adolescents, due to ignorance, lack of motivation, or lack of access. Thus, there is a need to review the standards and guidelines for implementation of YFHS in the public sector to make sure that these are relevant, understood and being applied. The relevant outlets in the private sector and Civil Society must be part of the outreach and referral network to increase convenient access for youth, while providing more confidentiality than in the public sector. There will need to be more counseling services for students in the school setting. However, one constraint in this is the inability of some schools to guard student confidentiality. Thus, new guidelines are needed for student counseling and records. One approach is to locate the student counseling center off-campus, staffed by personnel who are not the students' teachers. The counseling center would have a direct referral to clinical services as needed.

Programs for HIV prevention and general reproductive health services are focusing on those under age 24 years, but who are reached in different contexts, e.g., the school, worksite, or groups of youth with certain vulnerability (i.e., young KPs). Thus, going forward, implementation should involve collaboration among partners in the health service network at the district or sub-district level. There should also be drop-in centers that are attractive to youth, in addition to community-based YFHS. The local administrative organizations need to provide infrastructure and budget support for these efforts.

Sex education in the Thai school setting is still faced with obstacles. A report by UNICEF found that many teachers still have outdated attitudes toward sex, especially in adolescence. Also, sex education teaching methods still rely on one-way communication, such as lecture. The NGO p2h is trying to help schools overcome these obstacles and has produced a set of curricula for comprehensive sex education which guides teachers through the various modules. There are different curricula for younger students and the older students so that content is age-appropriate. The p2h curricula try to build skills in Thai youth so that they will be able to manage sexual relationships when the time comes. At the time of this report, p2h was still lobbying the Ministry of Education to incorporate these sex education tools into the standard curriculum of all schools around the country.

The expansion of the Internet and social media presents new challenges to protect youth from exposure to indecent images and text, and from sexual exploitation or rights violations. There is a need for a new form of communication and education for youth that helps them navigate social media and the Internet so that it is safe and builds capacity so that they can manage unpredictable situations that arise.

Commitment 8: Ensure that HIV investments increase to US$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers

This 2017 report presents a time series on AIDS expenditures during the period of 2008-17. The financial data are presented according to UNAIDS guidelines. The funding refers to that provided by the Thai government and international development partners. Thus, the totals do not include household and private sector expenditure on AIDS. The data in Table 3 show that AIDS expenditures increased from 2016 to 2017: 7.9 billion baht to 8.4 billion baht, respectively. That amount is equivalent to 120 baht and 127 baht per capita, or 17,613 baht and 19,191 baht per PLHIV, respectively. AIDS expenditure as a percent of the GDP was less than 1% (or about 0.05 of GDP in 2016-17). Also, AIDS expenditure was about 1.4% of total health expenditure for that period. The Thai policy in 2003 to subsidize the cost of ART meant that the proportion of total AIDS expenditure for treatment has increased steadily, and stood at 68.0% in 2016 and 70.5% in 2017. By contrast, only 15% of total AIDS expenditure was on prevention, and that level has remained more or less constant over the time period. Most of the funds for treatment come from domestic Thai budget. The international donor funding is mostly for prevention and program management. The most significant change in international funding for AIDS in Thailand has been the phase out of Global Fund assistance to the NAP. This is having the greatest impact on the prevention sector, particularly for outreach to KPs and other vulnerable populations by Civil Society organizations.

Table 3 Expenditure on AIDS in Thailand 2008-2017 (Thai government and international donor sources)

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Total AIDS (million baht)	6,928	7,208	7,733	9,922	8,793	8,827	8,710	8,248	7,914	8,436
AIDS expenditure:										
· per capita (baht)	109	113	121	155	136	137	134	125	120	127
· per PLHIV (baht)	13,010	13,953	15,487	20,594	18,808	19,209	19,551	18,844	17,613	19,191
· as a % of GDP	0.07	0.07	0.07	0.09	0.07	0.07	0.07	0.06	0.05	0.05
· as a % of total health expenditure	1.9	1.9	2.0	2.3	1.9	1.9	1.7	1.5	1.4	1.4
Source of budget										
% domestic	85	93	85	86	90	89	76	89	90	89
% international	15	7	15	14	10	11	24	11	10	11
Expenditure by category										
% for prevention	21.7	13.7	13.1	13.4	16.7	17.1	17.4	17.3	15.5	14.9
% for treatment	65.8	76.1	73.4	73.2	70.2	67.5	64.6	66.9	68.0	70.5

Commitment 10: Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C

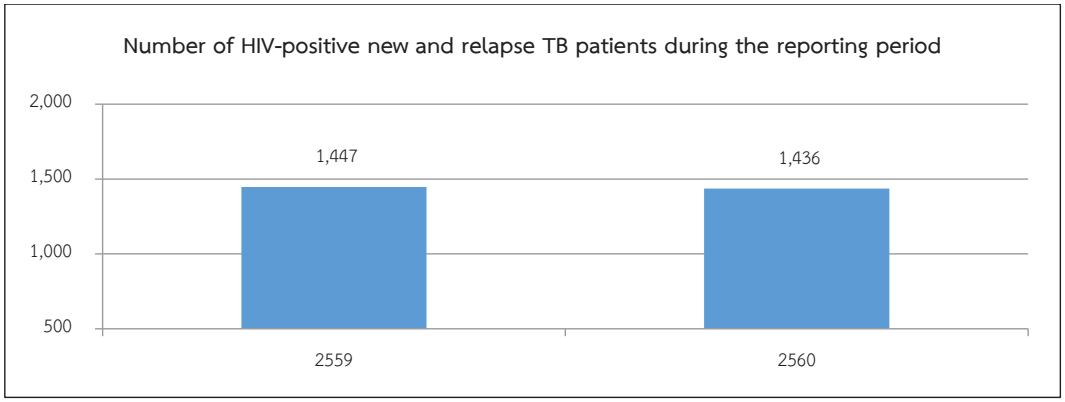
This target addresses the integrated management of services for HIV and other related diseases (e.g., TB, cervical cancer, hepatitis B and C) by using a client-centered approach to improve the universal health care system.

10.1 Situation

HIV and TB

Mortality attributed to TB-HIV co-infection has declined significantly, especially after Thailand expanded access to ART throughout the country. TB-HIV mortality declined from 20.4 per 100,000 population in 2001 to 3.3 per 100,000 in 2012. It was estimated that Thailand had 10,000 PLHIV who also had TB (using the WHO estimation method). Of this total, the number of new or repeat cases of TB who had initiated ART was 4,577 (45.8%). At the same time, data from BATS based on 459 hospital reports indicate that there were 1,436 cases of incident TB diagnosed (or 13% of the total of 11,077 in the record system).

Figure 25: Number of HIV-positive new and relapse TB patients during the Report Period

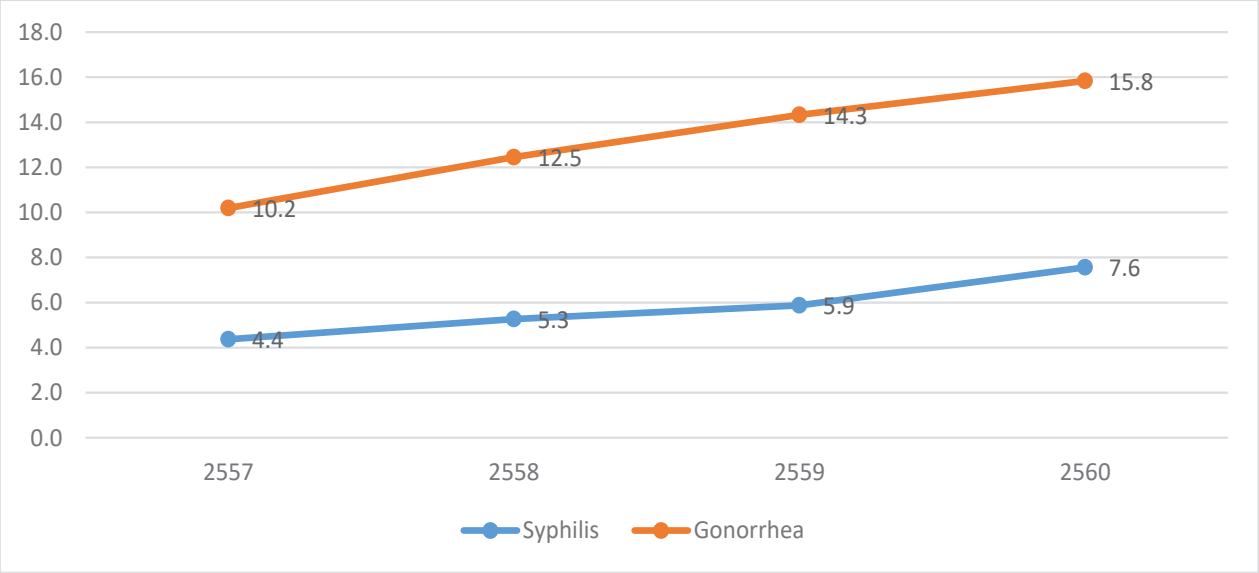


Source: BATS, Department of Disease Control

Sexually Transmitted Infections (STIs)

In 2017, the incidence of syphilis was 7.6 per 100,000 population, or an increase from 4.4 per 100,000 in 2013. Prevalence of gonorrhea increased from 10.2 to 15.8 per 100,000 population during the same time period.

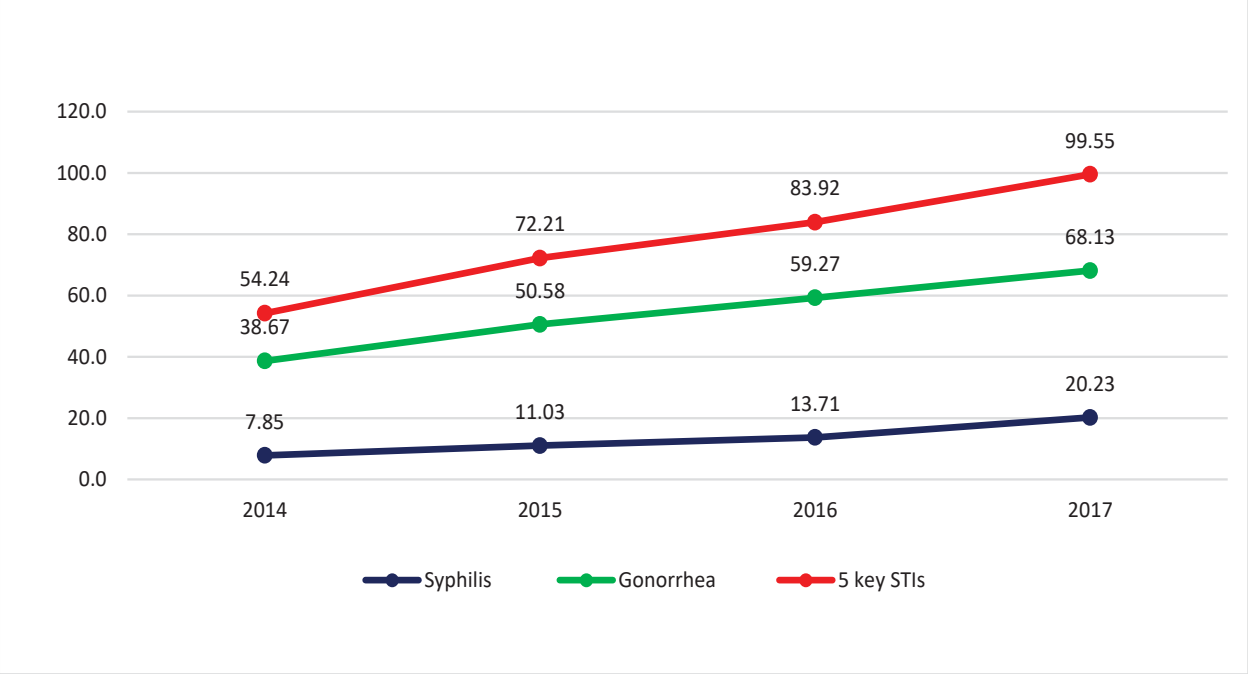
Figure 26: Prevalence of Gonorrhea and Syphilis per 100,000 Population in Fiscal Years 2013-17



Source: *Form 506 database, modified on October 4, 2018*

The data for the population age 15-24 years showing a doubling in prevalence during the three to four year period. The data from the Form 506 reports of the Bureau of Epidemiology show that syphilis increased from 7.8 per 100,000 population in 2014 to 20.2 in 2017. Gonorrhea increased from 38.7 per 100,000 population in 2014 to 68.1 in 2017. The combined figures for the five most common STIs were 54.2 and 99.6 per 100,000 for the two years. These data indicate that the younger segment of the population is practicing unsafe sex at an increasing rate and, thus, is vulnerable to HIV infection.

Figure 27: Prevalence of STIs for the Population Age 15-24 Years during Fiscal Years 2014-18



Source: *Form 506, Bureau of Epidemiology*

The IBBS for 2014 contains data on STI prevalence in the key populations. That survey found that the prevalence of gonorrhea and chlamydia in MSM was 1.3% and 5.9%, respectively. The comparable figures for TG were 0.8% and 4.2%. For MSW, the prevalence was 3.0% and 14.1%. For venue-based FSW, the prevalence was 4.2% and 18.6%. For non-venue-based FSW, the prevalence was 7.3% and 4.0%.

Hepatitis B (HBV) and C (HCV)

Prevalence of chronic HBV infection was 4.5% for the population born before 1992 (i.e., before there was HBV vaccine available). The prevalence of HBV for those born after 1992 was 0.6%. It is estimated that Thailand had two to three million cases of HBV. The prevalence for chronic HCV was 1 – 2%, with an estimated caseload of one million. Prevalence of HCV was highest in the north and northeast regions of the country. The primary risk factor for HCV was history of injection drug use.

The IBBS also found a high level of HIV-hepatitis co-infection. The prevalence of HCV and HBV among PLHIV was 3% and 8%, respectively. However, among PWID, the prevalence of HCV was as high as 90%, while the comparable figure for HBV was 12%. PLHIV with chronic hepatitis have three times the risk of liver failure as those without. About two-thirds of liver-related death among PLHIV is attributed to HCV infection.

10.2 Important signs of progress

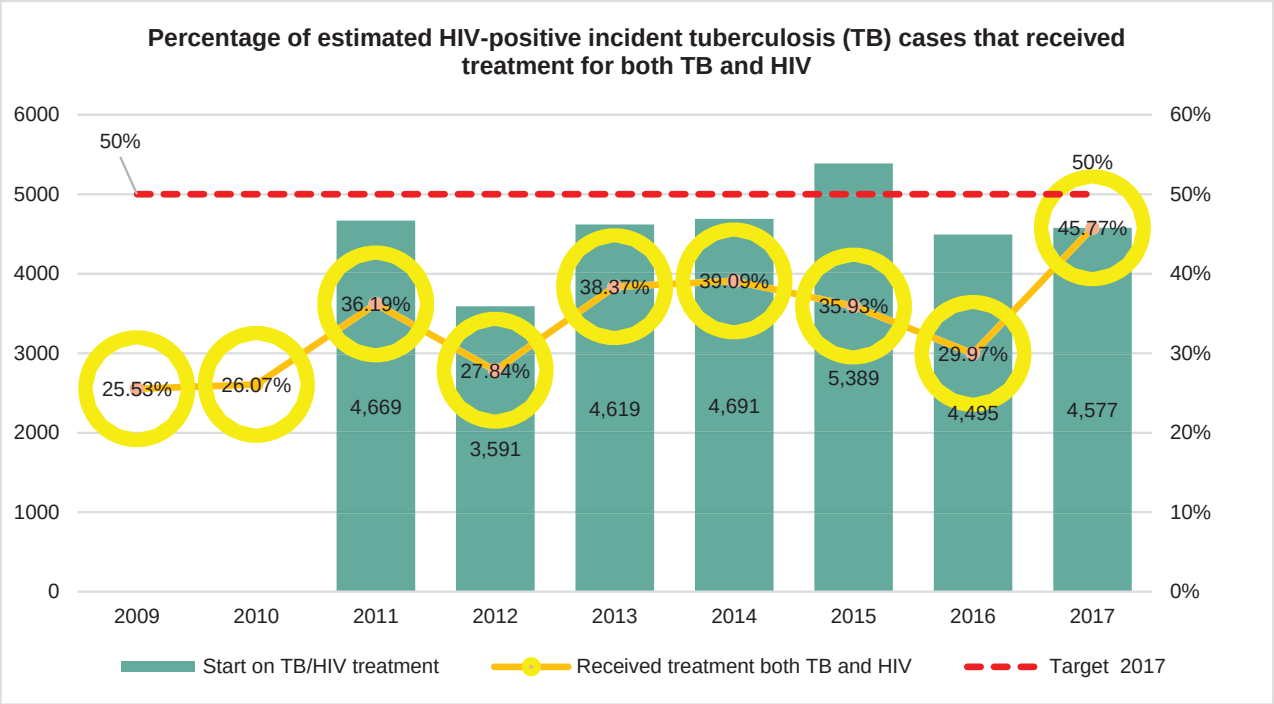
HIV and TB

Integrated management of HIV and related diseases using a client-centered approach is a strategy to improve universal health care in Thailand, and has been implemented since 2015. Thailand received funds from the Global (under the New Funding Model, or STAR) to address prevention and control of HIV and TB infection simultaneously. These funds were used for intensified prevention of HIV/TB in 38 priority provinces, and a targeted focus on TB in 27 provinces through HIV screening in TB patients and vice versa. The goal was to initiate treatment for both diseases as soon as possible in the course of the infection. In addition, Isoniazid Prevention Therapy (IPT) was provided for PLHIV to address latent cases of TB in government hospitals in Srisaket, Rayong, Pathum Thani, Nakorn Sawan and Chiang Mai Provinces. The participating six hospitals include: Khukan, Pathum Thani, Ban Khai, Chiang Rai Prachanukroh, Chiang Dao, and San Pa Tong. Fully 110 PLHIV received IPT under this pilot program.

In 2017, it was clear that senior managers at the ministerial level were giving priority to addressing TB and had assigned 'urgent' status to its control. TB incidence and prevalence were assigned as indicators for provincial performance assessment, and the control program was expanded nationwide, including in correctional institutions. Thailand has guidelines for integrated case management of HIV/TB which are supported by Thai research findings.

Results of the integrated approach to HIV/TB show that there were 4,577 HIV+ new/repeat cases of TB during the report period receiving both ART and TB treatment (or 45.8% of the estimated population of HIV/TB co-infected). That coverage of treatment represents an increase from 30.0% in 2016.

Figure 28: Percent HIV+ Incident TB Cases Receiving Treatment for both TB and HIV



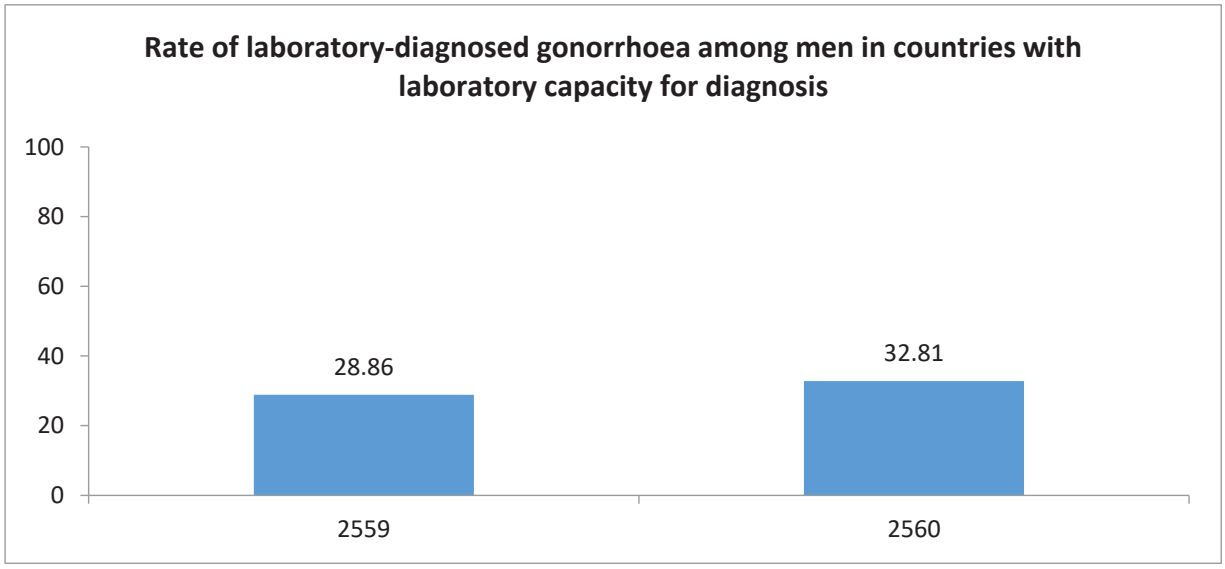
Source: TB data center

In 2017, there was an expansion of the IPT program, but it still remains as a pilot project. Referral of suspected cases of TB was 90.6%, and coverage of IPT was 1.6%.

STIs

The case-detection rate of gonorrhea in males was 32.8% of laboratory-tested cases, which is an increase from 28.9% in 2016.

Figure 29: Prevalence of Gonorrhea in Males



Source: Form 506, Bureau of Epidemiology

HBV and HCV

The MOPH has produced a strategic plan for prevention and control of hepatitis for the period of 2017-21. That plan has the following strategic components: Disease surveillance/data system, prevention/control, communication of risk, case finding/management, applied research, and resource management. The focus on HBV control is through expanded coverage of the vaccine for newborns (to at least 90%). The target for HCV control is at least 90% screening of donated blood, and at least a 50% increase in access to treatment for cases of chronic infection by 2021.

The MOPH participated in the World Hepatitis Day events in 2017 under the slogan of "Rapid screening and treatment combats liver cancer." The campaign encouraged persons to seek screening for HBV and HCV, which was offered free of charge during July 31 to August 4, 2017 in 104 hospitals under the MOPH. The campaign focused on the following target groups: (1) Persons born before 1992; (2) Persons with a history of injection drug use; (3) PLHIV; (4) Persons with a history of receiving a transfusion of blood or blood products; (5) Persons with a history of receiving an organ transplant; (6) Persons with a history of kidney dialysis; (7) Persons with a history of unsafe sex; (8) Persons who have a family member who has/had HBV or HCV; (9) Persons with a history of tattooing, wearing pierced jewelry, or acupuncture in a non-clinical setting; (10) Persons with a history of being injected by or had a minor operation performed by a traditional healer; (11) A clinical worker with a history of needle prick or sharps wound; and (12) Persons with a history of sharing certain implements such as tooth brushes, razor blades, nail clippers, syringes/needles, etc.

10.3 Challenges and Directions for Future Implementation

HIV and TB

Coverage of treatment for suspected cases HIV-TB co-infection has not increased significantly, and initiation of ART is late in the course of infection. There needs to be more coordinated planning and action among agencies working on TB and HIV control at all levels in the system. That said, Thailand is applying the latest technology for screening and diagnosis of TB among PLHIV. Thailand is also reaching out to those with limited access to services, such as the incarcerated or non-Thai migrant workers without a health card. The MOPH has produced a handbook for prevention of latent TB through IPT for PLHIV. There are training programs for physicians to improve coordination of implementation on TB and HIV/AIDS. There are planning and exchange meetings for staff at all levels. Finally, Thailand continues to improve the data system on HIV/AIDS and TB for monitoring and evaluation, and to improve planning.

STIs

The STI control program in Thailand is not as successful as it should be. That is reflected in the upturn of STI incidence and prevalence in the past four to five years, especially among the younger age groups. Thus, Thailand needs to address the following challenges:

1) There needs to be an improved system of case finding, public education, access to services, motivation to seek diagnosis and treatment, and design of client-friendly services, especially for the population age 15-24 years. These efforts should include army recruits and worksite populations, in addition to the key populations, such as MSM and sex workers.

2) Thailand still has not defined the essential service package for STI case management.

To address these gaps, Thailand needs to implement the RRTTR strategy through an HIV-STI integrated approach. There needs to be collaboration of all the related sectors so that there is unified action going in the same direction, in addition to the production and use of strategic information and data on STIs at the national level.

Thailand has produced the National Strategic Plan for Prevention and Control of STIs (2017-21), and the National Condom Strategy for 2015-19. However, there are limitations to implementation of these plans that need to be addressed.

HBV and HCV

The routes of infection for hepatitis are similar to those for HIV (i.e., blood, bodily fluid excretions, sharing contaminated needles, unsafe sex, and mother-to-child transmission). Many persons with hepatitis infection are asymptomatic and may not know they are infected at all. Many only learn of their hepatitis infection when they begin to develop symptoms of disease, or even at the stage of advanced disease such as liver failure or liver cancer. However, at that late stage of disease, it is too late to treat effectively or efficiently. Thus, it is imperative that the population has more awareness of the need for hepatitis prevention and detection at the earliest stage of infection.

The situation of HBV and HCV in Thailand has been improving over time. This is because of the improved screening for HBV in pregnant women, vaccination to protect from HBV for all newborns (and boosters at age 2, 4, and 6 months), screening of blood donations, and improved standards for safety in transfusions of blood and blood products. Thus, prevalence of HBV and HCV has declined from 4% and 2%, respectively, in 2004 to 2% and 1% as of 2014. HBV and HCV are also of concern in relation to co-infection with HIV. This is mostly a problem with PWID who have dual risk of HIV and hepatitis if they share contaminated needles and practice unsafe sex.

Since 2015, Thailand has subsidized treatment of all types of hepatitis, including PLHIV with hepatitis co-infection, through the three health insurance schemes (government civil servants, universal health care, and social security). In addition, PLHIV can receive subsidized screening for hepatitis and, if infected, they are treated with the standard formulations of Peginterferon and Ribavirin. That said, there are still some limitations to access for treatment. One restriction is that treatment for hepatitis in PLHIV is contraindicated if the viral load >= 1,000 copies/mm3 or the CD4 count < 350 cells/mm3 . In addition, some public health outlets need to be upgraded to be able to perform effective screening and treatment of HCV. Thus, there need to be improvements in both treatment and coverage of hepatitis, especially for PLHIV. There needs to be special attention to reducing side effects of hepatitis treatment and drug resistance for PLHIV with co-infection. Access to treatment needs to be continuous and universal.

Table of Indicators of Progress in the Prevention and Control of AIDS

Commitment 1: Care and Treatment of PLHIV														
Global Target: Ensure that 30 million PLHIV have access to treatment through meeting the 90-90-90 targets by 2020														
Component	**Indicator**	**GAM**	**UA**	**National Target 2017**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
	Estimated PLHIV (Adults and children)								459,509	445,503	437,700	449,309	439,610
Know HIV status	1.1 Percentage of people living with HIV who know their HIV status at the end of the reporting period										88.88%	91.38%	98.29%
	Number										389,027	410,576	432,084
On ART	1.2 Percentage and number of adults and children on antiretroviral therapy among all adults and children living with HIV at the end of the reporting period - CD4 <200 cell/ml	☐	☐	90.0%	75.76%	71.80%	77.00%						
	- (CD4 <350 cell/ml)					59.10%	64.61%	69.96%	80.25%				
	- any CD4 Level								53.55%	60.98%	65.85%	68.48%	73.65%
	Number of eligible adults and children currently receiving antiretroviral therapy						225,272	239,090	246,049	271,652	288,231	307,667	323,784
	Percentage and number of adults and children on antiretroviral therapy among all adults and children living with HIV at the end of the reporting period										70.11%	71.41%	74.94%
	Only public sector (Not includeted private sector)						206,530	220,628	227,372	256,630	272,755	293,206	323,784
	Migrant on ART										2,938	3,047	3,550
Retention	1.3 Percentage (%) of adults and children with HIV known to be on treatment 12 months after initiating antiretroviral therapy	☐	☐	95.0%	85.14%	80.70%	83.12%	82.11%	82.70%	83.03%	86.90%	89.49%	89.82%
	Percentage of adults and children with HIV still alive and known to be on treatment 24 months after initiation of antiretroviral therapy (among those who initiated antiretroviral therapy in 2011) *(not required in 2016)*		☐			79.80%	79.82%	78.89%	78.38%	77.90%	89.95%	85.86%	88.56%
	Percentage of adults and children with HIV still alive and known to be on treatment 60 months after initiation of antiretroviral therapy (among those who initiated antiretroviral therapy in 2008) *(not required in 2016)*		☐					no data	75.91%	74.59%	82.88%	82.71%	83.00%
VL suppression	1.4 Percentage of adult and children receiving antiretroviral therapy who were virally suppressed in the reporting period (not required in 2016) (amomg VL tested) (Only from NAP report)		☐						95.38%	96.09%	96.37%	96.78%	96.85%

Commitment 1: Care and Treatment of PLHIV														
Global Target: Ensure that 30 million PLHIV have access to treatment through meeting the 90-90-90 targets by 2020														
Component	**Indicator**		**GAM**	**UA**	**National Target 2017**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
		Percentage of adult and children receiving antiretroviral therapy who were virally suppressed in the reporting period (VL≤ 1,000 copies/ml) (Third 90; Denominator: all of those currently on ART in NAP										81.89%	82.87%	84.33%
		Percentage of people on ART tested for viral load with a VL level 1000 copies/ml after 12 months of therapy (not required in 2016)								92.54%	94.81%			
		Percentage of people on ART tested for viral load (VL) with undetectable viral load in the reporting period (not require in 2016) VL level 50 copies/ml									90.72%	76.27%	92.71%	92.78%
	1.4	Percentage of people living with HIV who have suppressed viral loads (VL 1000 copies/mL) at the end of the reporting period (Denominator = Estimated PLHIV) Target 73%											54.08%	62.11%
		Number										223,372	242,979	273,045
Late HIV diagnosis	1.5	Percentages of people living with HIV with the initial CD4 cell count <200 cells/mm3 and <350 cells/mm3 during the reporting period												
		initial CD4 cell count <200 cells/mm3									57.03%	57.45%	55.54%	53.72%
		initial CD4 cell count <350 cells/mm3											no data	72.87%
		Median CD4 after diagnosis (first CD4 cell) (all scheme)				95	102	98	98	109	121	no data	no data	174
		Median CD4 at ART Initiation (all scheme)				82	91	113	105	131	129	186	194	167
ART stock-outs	1.6	Percentage of treatment sites that had a stock-out of one or more required antiretroviral medicines during a defined period						3.14%	no data	3.55%	3.05%	no data	no data	no data
AIDS mortality	1.7	Total number of people who have died from AIDS-related causes per 100 000 population (from spectrum AEM)											19.27	22.49
		Numer (from spectrum AEM)										14,214	12,863	14,731

Commitment 1: Care and Treatment of PLHIV													
Global Target: Ensure that 30 million PLHIV have access to treatment through meeting the 90-90-90 targets by 2020													
Component	**Indicator**	**GAM**	**UA**	**National Target 2017**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
	Total number who have died of AIDS related illness (from program)										10,513	11,063	10,787

Commitment 2: Elimination of Pediatric HIV Infections															
Global Target: Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children infected with HIV have access to HIV treatment by 2018															
Component	**Indicator**		**GAM**	**UA**	**National Target 2017**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**Component**
Early infant diagnosis	2.1	Percentage of infants born to women living with HIV receiving a virological test for HIV (PCR) within two months of birth			**90.00%**			75.80%	73.13%	77.23%	72.87%	76.14%	92.80%	91.81%	98.61%
MTCT	2.2	Estimated percentage of children newly infected with HIV from mother-to-child transmission among women living with HIV delivering in the past 12 months (Spectrum modeling)			**2.00%**			3.75%	3.04%	2.74%	2.30%	2.13%	1.91%	1.79%	1.68%
		Number							149	135	117	98	86	75	68
		Registered percentage of child HIV infections from HIV-positive women delivering in the past 12 months											1.63%	1.43%	1.41%
		Number											68	59	56
PMTCT	2.3	Percentage of pregnant women living with HIV who received antiretroviral medicine to reduce the risk of mother-to-child transmission of HIV			**98.80%**	93.60%	95.00%	94.20%	93.98%	93.75%	95.15%	95.78%			
		(First modelling in 2012)								94.29%	94.00%	94.91%	95.17%		
		(2017 data is based on spectrum AEM 2017)												96.07%	96.52%
syphilis	2.4	Percentage of women accessing antenatal care services who were tested for syphilis, tested positive and treated													
		a Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit								91.55%	99.33%	98.91%	99.13%	99.22%	99.14%
		b Percentage of pregnant women attending antenatal clinics with a positive (reactive) syphilis serology								0.06%	0.07%	0.04%	0.08%	0.11%	0.17%
		c Percentage of antenatal care attendees during a specified period with a positive syphilis serology who were treated adequately								93.10%	94.51%	98.10%	95.94%	97.84%	97.54%
	2.5	Percentage of reported congenital syphilis cases (live births and stillbirths)									0.009%	0.011%	0.011%	0.015%	0.015%
		Number									67	85	80	105	103
	2.6	**Percentage of pregnant women with known HIV status (New 2017)**										99.81%	99.60%	99.73%	99.82%
		Number										774,860	733,390	702,137	701,488

Commitment 3: HIV prevention among Key Population																
Global Target: At least 90% of the population can access integrated prevention services, especially the key populations (MSM, TG, sex workers and clients, PWID, and prisoners) Ensure access to combination prevention option, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of the population by 2020, especially young women and adolescent girls in high-prevalece countries and key populations-gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners.																
Component	**Indicator**			**GAM**	**UA**	**National Target 2017**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
Incidence	3.1	Number of people newly infected with HIV in the reporting period per 1000 uninfected population		☐									0.11	0.10	0.09
KPs size estimation	3.2	Estimates of the size of key populations													
		a	Sex workers (SW)	☐				141,769		141,769		141,769	147,000	155,000	144,000
			Female sex workers (FSW)									123,530	132,000	129,000	129,000
			Male sex workers (MSW)									18,239	15,000	15,000	15,000
		b	Men who have sex with men (MSM)	☐				550,000		550,000		550,000	521,000	590,700	590,700
			People who inject drugs (PWID)												159,600
		c	Transgender people (TG)	☐			40,300	40,300		40,300		40,300	42,650	42,650	42,650
		d	Prisoners Inmates/detainees (Immates+detainees)	☐									50,000	62,800	62,800
		e	Men who have sex with men (MSM)	☐									341,760	306,700	311,587
KPs living with HIV	3.3	Percentage of specific key populations living with HIV													
		a	Sex workers (SW) who are living with HIV												
			Female sex workers (FSW) who are living with HIV	☐	☐	**1.0%**		2.69%		2.16%		1.13%		1.0%	
			Female sex workers (FSW) non-venue								3.33%		2.45%		BKK 3.0% Include 5 RDS sites = 2.3%
			Male sex workers (MSW) who are living with HIV	☐	☐	**10.2%**		16.00%		17.20%		13.11%		14.11%	

Commitment 3: HIV prevention among Key Population																
Global Target: At least 90% of the population can access integrated prevention services, especially the key populations (MSM, TG, sex workers and clients, PWID, and prisoners) Ensure access to combination prevention option, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of the population by 2020, especially young women and adolescent girls in high-prevalece countries and key populations-gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners.																
Component	**Indicator**			**GAM**	**UA**	**National Target 2017**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
		b	Men who have sex with men (MSM) who are living with HIV	☐	☐	**6.0%**		8.02%		31.52%		19.23%		21.61%	
		c	People who inject drugs (PWID) who are living with HIV	☐	☐	**21.0%**	17.20%	21.87%		25.20%		20.50%		ไม่ได้สำรวจ	no data
		d	Transgender people (TG) who are living with HIV	☐						7.49%		15.68%		10.16%	
		e	Prisoners (inmates/detainees) who are living with HIV	☐									1.56%	1.53%	1.51%
Know HIV status among KPs	3.4	Knowledge of HIV status among key populations													IBBS
		a	Knowledge of HIV status among sex workers												
			Percentage (%) of sex workers (FSW) who have received an HIV test in the past 12 months and know their results	☐	☐	**90.0%**		47.76%		55.60%		54.19%		52.86%	
			Female sex workers (FSW) non-venue												Bangkok 76.6% Include 5 RDS sites = 58.3%
			Percentage (%) of sex workers (MSW) who have received an HIV test in the past 12 months and know their results							51.40%		52.93%		76.30%	
		b	Percentage (%) of men who have sex with men who received an HIV test in the past 12 months and know their results	☐	☐	**90.0%**		14.93%		47.25%		24.88%		54.62%	
		c	Percentage (%) of people who inject drugs who received an HIV test in the past 12 months and know their results	☐	☐	**90.0%**	39.99%	40.71%		43.65%		61.30%		ไม่ได้สำรวจ	no data
		d	Percentage (%) of transgender people (TG) who received an HIV test in the past 12 months and know their results							44.62%		42.30%		69.47%	

Commitment 3: HIV prevention among Key Population																
Global Target: At least 90% of the population can access integrated prevention services, especially the key populations (MSM, TG, sex workers and clients, PWID, and prisoners) Ensure access to combination prevention option, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of the population by 2020, especially young women and adolescent girls in high-prevalece countries and key populations-gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners.																
Component	**Indicator**			**GAM**	**UA**	**National Target 2017**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
ART among KPs	3.5	Antiretroviral therapy coverage among people living with HIV in key populations													
		a	Percentage (%) of sex workers living with HIV receiving antiretroviral therapy in the past 12 months											no data	no data
		b	Percentage (%) of men who have sex with men living with HIV receiving antiretroviral therapy in the past 12 months											no data	no data
		c	Percentage (%) of people who inject drugs living with HIV receiving antiretroviral therapy in the past 12 months											no data	no data
		d	Percentage (%) of transgender people living with HIV receiving antiretroviral therapy in the past 12 months											no data	no data
		e	Percentage (%) of prisoners living with HIV receiving antiretroviral therapy in the past 12 months											no data	no data
Condom use among KPs	3.6	Condom use among key populations													IBBS
		a	Percentage (%) of sex workers (SW) reporting using a condom with their most recent client												
			Percentage (%) of sex workers (FSW) reporting using a condom with their most recent client			**95.0%**		95.56%		93.60%		96.09%		83.1%	
			Female sex workers (FSW) non-venue												Bangkok 92.0% Include 5 RDS sites = 80.8%
			Percentage (%) of sex workers (MSW) reporting using a condom with their most recent client							92.31%		82.32%		80.60%	

Commitment 3: HIV prevention among Key Population																
Global Target: At least 90% of the population can access integrated prevention services, especially the key populations (MSM, TG, sex workers and clients, PWID, and prisoners) Ensure access to combination prevention option, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of the population by 2020, especially young women and adolescent girls in high-prevalece countries and key populations-gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners.																
Component	**Indicator**			**GAM**	**UA**	**National Target 2017**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
		b	Percentage (%) men reporting using a condom the last time they had anal sex with a male partner			**95.0%**		80.22%		88.48%		85.50%		79.34%	
		c	Percentage (%) of people who inject drugs reporting using a condom the last time they had sexual intercourse			**95.0%**	39.18%	46.02%		49.06%		51.20%		ไม่ได้สำรวจ	no data
		d	Percentage of transgender people reporting using a condom during their most recent sexual intercourse or anal sex							84.30%		82.56%		80.47%	
HIV prevention among KPs	3.7		Coverage of HIV prevention programmes among key populations (For 2010-2016 – the coverage refers to the past 12 months												IBBS
		a	Percentage of sex workers (SW) reporting having received a combined set of HIV prevention interventions												
			Percentage of female sex workers (FSW) reporting having received a combined set of HIV prevention interventions			**80.0%**		50.45%		53.89%		57.74%		43.81%	
			female sex workers (FSW) non-venue								56.6		76.70		Bangkok 91.6% Include 5 RDS sites = 68.7%
			Percentage of male sex workers (MSW) reporting having received a combined set of HIV prevention interventions							75.44%		72.54%		86.43%	
		b	Percentage of men who have sex with men reporting having received a combined set of HIV prevention interventions			**80.0%**		43.79%		59.96%		37.02%		59.49%	

Commitment 3: HIV prevention among Key Population																
Global Target: At least 90% of the population can access integrated prevention services, especially the key populations (MSM, TG, sex workers and clients, PWID, and prisoners) Ensure access to combination prevention option, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of the population by 2020, especially young women and adolescent girls in high-prevalece countries and key populations-gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners.																
Component	**Indicator**				**GAM**	**UA**	**National Target 2017**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
		c	Percentage of people who inject drugs reporting having received a combined set of HIV prevention interventions												no data	no data
			a.	Number of people who inject drugs reached with individual and/or small group–level HIV prevention interventions designed for the target population (programme data)											no data	no data
			b.	Number of needles or syringes distributed to people who inject drugs (programme data)						394,618	464,107	484,390	555,588	266,055	572,070	545,665
		d	Percentage of transgender people reporting having received a combined set of HIV prevention interventions								79.81%		59.24%		66.60%	
service provision sites for PWID	3.7.1	Number of service provision sites dedicated to people who inject drugs														
		a	Total number of service provision sites												164	161
			1)	Number of substitution therapy (OST) sites				49	no data	147	147	147	140		147	131
				Sites operated by the national programme (government)											147	131
				Sites operated by the community (civil society or NGO)											0	0
			2)	Number of needle and syringe programme (NSP) sites				39	49	42	36	38	42	16	17	30
				Sites operated by the national programme (government)											3	13
				Sites operated by the community (civil society or NGO)											14	17
		b	Total number of administrative areas in the country												89	45

Commitment 3: HIV prevention among Key Population																
Global Target: At least 90% of the population can access integrated prevention services, especially the key populations (MSM, TG, sex workers and clients, PWID, and prisoners) Ensure access to combination prevention option, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of the population by 2020, especially young women and adolescent girls in high-prevalece countries and key populations-gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners.																
Component	**Indicator**				**GAM**	**UA**	**National Target 2017**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
			1)	Number of substitution therapy (OST) administrative areas (Province)											77	32
			2)	Needle and syringe programme (NSP) administrative areas											12	13
People who inject drugs	3.8	Percentage of people who inject drugs reporting using sterile injecting equipment the last time they injected			☐	☐	**82.0%**	42.02%	77.68%		80.45%		95.30%	no data	no data	no data
	3.9	Number of needles and syringes distributed per person who injects drugs per year by needle and syringe programmes			☐	☐	**88.0**			9.79	11.52	12.02	13.79	6.33	13.41	12.79
	3.10	Percentage (%) of people who inject drugs receiving opioid substitution therapy (OST)			☐									12.66%	15.46%	4.15%
		Number of people who inject drugs receiving opioid substitution therapy (OST)			☐									754	813	799
People who inject drugs		Estimated number of opiate users (injectors and non-injectors) Number of people on Opioid Substitution therapy (OST) (not required in 2016)														
		a Estimated number of opiate users (injectors and non-injectors)				☐		Data not available								
		b. Number of people on opioid substitution therapy (OST)				☐	**4,500**		2,201	2,612	3,735	4,068	3,646	5,956	5,258	6,246
		Number of opioid-dependent people who inject drugs in the country			☐											19,256
Sex worker	3.11	Percentage of sex workers (SWs) with active syphilis				☐		ค่ามัธยฐาน		0.26%	0.00%	0.00%	no data		no data	no data
						☐		ค่าเฉลี่ย		0.62%	0.54%	0.69%	no data		no data	no data
MSM	3.12	Percentage men who have sex with men (MSM) with active syphilis				☐				no data	no data	24.36%	no data		no data	no data

Commitment 3: HIV prevention among Key Population																
Global Target: At least 90% of the population can access integrated prevention services, especially the key populations (MSM, TG, sex workers and clients, PWID, and prisoners) Ensure access to combination prevention option, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of the population by 2020, especially young women and adolescent girls in high-prevalece countries and key populations-gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners.																
Component	**Indicator**			**GAM**	**UA**	**National Target 2017**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
Prisoners	3.13	HIV prevention and treatment programmes offered to prisoners while detained													
		a	Number of clean needles distributed to prisoners												no data
		b	Number of prisoner receiving opioid substitution therapy												no data
		c	Number of condom distributed to prisoners												no data
		d	Number of prisoner receiving antiretroviral therapy												no data
		e	Number of prisoner tested for HIV												32238
		f	Percentage of prisoners with hepatitis C												5.22%
		g	Percentage of prisoners with hepatitis B												2.91%
		h	Percentage of people living with HIV among prisoners										1.56%	1.53%	1.51%
		i	Percentage of prisoners with hepatitis C or co-infected with HIV and hepatitis C virus											no data	no data
		j	Percentage of prisoners with TB or co-infected with HIV and TB											0.64%	0.98%
Viral hepatitis	3.14	Prevalence of hepatitis and coinfection with HIV among key populations (NEW)												no data	no data
		a	Prevalence of hepatitis B and coinfection with HIV among key populations											no data	no data
			☐ Sex workers (SW)											no data	no data
			☐ Men who have sex with men (MSM)											no data	no data
			☐ People who inject drugs (PWID)											no data	no data
			☐ Transgender people (TG)											no data	no data
			☐ Prisoners											no data	no data
		b	Prevalence of hepatitis C and coinfection with HIV among key populations											no data	no data

Commitment 3: HIV prevention among Key Population																
Global Target: At least 90% of the population can access integrated prevention services, especially the key populations (MSM, TG, sex workers and clients, PWID, and prisoners) Ensure access to combination prevention option, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of the population by 2020, especially young women and adolescent girls in high-prevalece countries and key populations-gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners.																
Component	**Indicator**				**GAM**	**UA**	**National Target 2017**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
				Sex workers (SW)											no data	no data
				Men who have sex with men (MSM)											no data	no data
				People who inject drugs (PWID)											no data	no data
				Transgender people (TG)											no data	no data
				Prisoners											no data	no data
Pre-Exposure Prophylaxis	3.15	Number of people receiving oral PrEP for the first time during the reporting period													1,224	1,865
	3.18	The percent of respondents who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months													no data	75.69%

Commitment 4: Elimination of Gender Inequality, Violence/Discrimination														
Global Target: Eliminated gender inequalities and end all forms of violence and discrimination against women and girls, PLHIV and KPs by 2020														
Component	**Indicator**		**GAM**	**UA**	**National Target 2017**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
Stigma and Discrimination	4.1	Percentage of women and men 15-49 years old who report discriminatory attitudes towards people living with HIV			**52.7%**					no data		58.60%	Not yet time for survey	Not yet time for survey
		MICS Survey 2015-2016												26.08%

Commitment 4: Elimination of Gender Inequality, Violence/Discrimination														
Global Target: Eliminated gender inequalities and end all forms of violence and discrimination against women and girls, PLHIV and KPs by 2020														
Component	**Indicator**		**GAM**	**UA**	**National Target 2017**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
	4.2	Avoidance of HIV services because of stigma and discrimination among key populations											Not applicabe	Not applicabe
		a Avoidance of HIV services because of stigma and discrimination by sex workers											Not applicabe	Not applicabe
		Delayed going to a health care in the past 12 months among female sex workers (FSW) (IBBS) venue FSW											1.8%	
		non-venue FSW												10.51%
		Delayed going to a health care in the past 12 months among male sex workers (MSW) (IBBS)											10.0%	
		b Avoidance of HIV services because of stigma and discrimination by men who have sex with men											Not applicabe	Not applicabe
		Delayed going to a health care in the past 12 months among men who have sex with men (MSM) (IBBS)											7.9%	
		c Avoidance of HIV services because of stigma and discrimination by people who inject drugs											Not applicabe	Not applicabe
		d Avoidance of HIV services because of stigma and discrimination by transgender people											Not applicabe	Not applicabe
		Delayed going to a health care in the past 12 months among transgender people (TG) (IBBS)											7.4%	
		e Avoided or delayed health care because of fear of S&D, among ever pregnant females PLHIV											12.0%	0.53%
Violence	4.3	Proportion 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								no data				
Stigma and Discrimination	4.4	Experience of HIV-related stigma and discrimination in the healthcare setting (New 2017)												11.1%

Commitment 5: HIV PreventioninYouth														
Global target: Ensure that 90% of young people have the knowledge, skills and capacity to protect themselves from HIV infection and have access to sexual health and reproductive health services by 2020 in order to reduce the number of new HIV infection amoung adolescent girls and young women to below 100,000 per year														
Component	**Indicator**		**GAM**	**UA**	**National Target 2017**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
HIV knowledge	5.1	Percentage of women and men 15-24 years old who correctly identify both ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission (MICS)				no data							45.56%	no data ใหม่
Reproductive Health	5.2	Percentage of women of reproductive age (15-49 years old) who have their demand for family planning satisfied with modern methods (MICS)											96.5%	no data ใหม่

Commitment 10: Integrated Service System for HIV and Related Conditions														
Global target: Commit to taking AIDS out of isolation through people – center system to improve universal health coverage, including treatment for Tubercolosis, Cervical cancer and Hepatitis B and C (TB, cervical cancer, HBV, HBC)														
Component	**Indicator**		**GAM**	**UA**	**National Target 2017**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
TB-HIV	10.1	Percentage of estimated HIV-positive incident tuberculosis (TB) cases that received treatment for both TB and HIV			**50.00%**	25.5%	26.1%	36.2%	27.8%	38.4%	39.1%	35.9%	30.0%	45.8%
		Number of HIV-positive new and relapse TB patients started on TB treatment during the reporting period who were already on antiretroviral therapy or started on antiretroviral therapy during TB treatment within the reporting year						4,669	3,591	4,619	4,691	5,389	4,495	4,577
	10.2	Total number of people living with HIV with active TB expressed as a percentage of those who are newly enrolled in HIV care (pre-antiretroviral therapy or antiretroviral therapy) during the reporting period								no data			1,447	1,436
		Percentage											14.0	13.0
	10.3	Number of patients started on treatment for latent TB infection, expressed as a percentage of the total number newly enrolled in HIV care during the reporting period					no data							no data
STIs	10.4	Number of men reporting urethral discharge in the past 12 months								no data				no data
	10.5	Rate of laboratory-diagnosed gonorrhoea among men in countries with laboratory capacity for diagnosis											28.9	32.8
Hepatitis B and C	10.6	Proportion of people starting antiretroviral therapy who were tested for hepatitis B										no data		no data
	10.7	Proportion of people coinfected with HIV and HBV receiving combined treatment										no data		no data
	10.8	Proportion of people starting antiretroviral therapy who were tested for hepatitis C virus (HCV)										no data		no data
	10.9	Proportion of people coinfected with HIV and HCV starting HCV treatment during a specified time frame (such as 12 months)										no data		no data
Cervical cancer	10.10	Cervical cancer screening among women living with HIV											no data	no data