THAILAND

Ending AIDS

THAILAND AIDS RESPONSE PROGRESS REPORT

2017

คณะกรรมการแห่งชาติ
ว่าด้วยการป้องกันและแก้ไขปัญหาเอดส์
NATIONAL AIDS COMMITTEE

THAILAND PROGRESS REPORT

PREVENTION AND CONTROL OF AIDS

2017

(PERIOD OF IMPLEMENTATION: OCTOBER 1, 2015 TO SEPTEMBER 30, 2016)

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Introduction

Thailand has implemented its national AIDS Prevention and Control Plan for the period of 2014-16.That plan referenced the national goal of ending AIDS by 2030 through the targets of zero neo-natal HIV infections, reduction of HIV incidence to below 1,000 cases per year, enrolling all PLHIV in ART, reducing AIDS-related mortality to below 4,000 cases per year, and elimination of stigma and discrimination (S&D) against PLHIV and key populations.The ending AIDS goal in Thailand is part of a global commitment in accordance with the most recent Political Declaration issued at a high-level conference on AIDS in New York City in June, 2016.

The 2015-19 Accelerated Plan for Ending AIDS outlines Thailand's guidelines for achieving the 2030 goal.The principal strategy is to expand coverage of effective, integrated services, and create a prevention-to-care continuum, with a special focus on key populations (KPs).At the most basic level, this involves access to information and tools for HIV prevention. Next, is recruiting those at risk of infection in the service system for screening, diagnosis and treatment. Once PLHIV are enrolled in an ART program they must be retained to ensure full treatment compliance and viral suppression.This strategy is summarized as "Reach-Recruit-Test-Treat-Retain" or RRTTR.

This 2017 progress report on the response to AIDS in Thailand focuses on the period from October 1, 2015 to September 30, 2016.This is the 10th AIDS progress report for Thailand since its first such report in 2002, as part of the UNGASS Declaration of Political Commitment.This report represents the contribution of key agencies and partners from all the relevant sectors, including government, Civil Society, NGOs, academia, international organizations, and representatives from the PLHIV network in Thailand (TNP+). The contributors helped with the review and interpretation of the available data to assess progress against the indicator targets.The authors express their extreme gratitude to all those who made this report possible.

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Abbreviations

AEM:	Asian Epidemic Model
AIDS:	Acquired immunodeficiency syndrome
ANC:	Ante-natal care
ART:	Anti-retroviral therapy
ARV	Anti–retroviral drugs
BoE	Bureau of Epidemiology, MOPH
BSS	Behavioral surveillance survey
CLHS	Community-led HIV services
FSW	Female sex worker
GFATM	Global Fund to Fight AIDS, TB and Malaria
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Imuno-deficiency Virus
HSS	HIV sero-surveillance
IBBS:	Integrated behavior-biological surveillance
KP	Key population (i.e., MSM, TG, MSW, FSW, PWID, prisoners)
MOPH	Ministry of Public Health
MSM	Men who have sex with men
MSW	Male sex workers
MTCT	Mother-to-child transmission
NAC	National AIDS Committee
NAP	National AIDS Plan, National AIDS Program
PLHIV	People who are living with HIV/AIDS
PWID	People who inject drugs
RRTTR	Reach, Recruit, Test, Treat, Retain
TB	Tuberculosis
TG	Transgender person

Summary of Key Issues in the Implementation of the Prevention and Control of AIDS in 2016

Goal	Status and Chance of Success	Key Issues
Total coverage of treatment  		Thailand has a policy of providing ART to PLHIV regardless of their CD4 level.This has had the effect of steadily increasing coverage of ART.However, there remain important gaps in coverage, especially for KPs and for those PLHIV who seek treatment only once they have overt symptoms.Thus, the country is encouraging everyone who has or has had risk for HIV to be tested for HIV and know their serostatus.
Elimination of pediatric cases of HIV  		WHO has certified that Thailandachieved the goal of virtually eradicating mother-to-child transmission (MTCT) of HIV and syphilis in 2015 when the rate of MTCT of HIV declined to 1.9% and then to 1.8% in 2016.
Prevention among KPs  		During the report period there has been progress in extending prevention services to KPs.The locations where they congregate have been mapped and there is an increasing variety of interventions that are tailored to the context and needs of the target population. Nevertheless, prevailing stigma of some of the KPs makes them wary of formal health services and, therefore, expansion of coverage is increasingly difficult as only the hardest-to-reach remain unrecruited.Thus, it is imperative to mobilize resources to reach these hold-outs in order to achieve the ending AIDS goal and targets.Of special concern are the younger KPs and youth with higher risk behavior. In addition, the Internet and evolving social media are replacing traditional commercial sex access points and, thus, making it harder to reach non-venue-based sex workers.
Eliminating gender inequality, violence, and discrimination  		Thailand has made progress in establishing a monitoring systems for S&D and to determine the status of the situation at a given point in time. Thailand has developed guidelines for interventions to reduce S&D, especially in the health care setting. Nevertheless, this system is still in the early stages of development and there needs to an intensification of interventions to reduce S&D in the general population and reduce self-stigma among PLHIV and KPs.

Goal	Status and Chance of Success	Key Issues
Prevention in youth  		HIV prevalence among Thai youth is declining, but only slowly.Thus, there is the risk of a reversal in the trend toward higher prevalence, as forewarned by the increasing adolescent prevalence of STIs. Condom use at last sex among teenagers is increasing, but there needs to be an intensification of HIV prevention interventions for this vulnerable group of the populations. In particular, health services need to be youth-friendly and tailored to the needs of youth.These services need to be made sustainable by integrating them into the routine health care system.
Social protections for persons adversely affected by HIV		Thailand still does not have a clear system for monitoring and planning strategy that is appropriate for persons adversely impacted by HIV/AIDS.The only concrete form of assistance is government welfare.Thus, there is a need to improve and design specific services that address this need and can be sustained by integration into the routine health care system and are community-based.This will need to be a collaborative effort of the government, Civil Society and the private sector.
Community-led HIV services  		CLHS are at an early stage of development, and most are implemented through special projects.Coverage of KPs via this mechanism is still very limited.The government still does not have a clear policy on this approach and there need to be guidelines for task sharing between the government and Civil Society organizations which are best suited to implementing these services.To be effective, CLHS need to be integrated into the routine health system.
Closing gaps in resources  		Thailand has allocated more of its own budget for implementing HIV prevention among KPs and to reduce S&D. However, there remain obstacles to appropriately allocate this budget.There need to be improved management mechanisms so that there are no interruptions or gaps in essential resources.The ultimate goal is for sustainable self-reliance through collaboration of the government, Civil Society and the community.

Goal	Status and Chance of Success	Key Issues
AIDS rights protections and building capacity of PLHIV 		Thailand has no specific law for social protections for PLHIV, but there has been progress in AIDS rights at the provincial level in some locations and on a pilot basis.
Integrated service system for HIV and related conditions 		During the report period, there has been progress on integrating TB/HIV care.There is a more efficient system for detecting TB in PLHIV by using the Gene X-pert technology. However, challenges remain in administering TB treatment during the latent phase (IPT), and screening and treating HCV.The system for screening and treating STIs needs strengthening, including detection of syphilis in pregnant women and neonates.

Status of AIDS in Thailand

Thailand has endorsed the goal of ending AIDS by 2030, and has formalized this vision in the Accelerated Plan to End AIDS for the five-year period from 2015-19.The plan provides guidelines for all related sectors on the strategies to be employed.Key targets include the reduction of HIV incidence to below 1,000 cases per year by 2030; universal access to HIV VCT and ART, reduction of AIDS-related mortality to no greater than 4,000 cases per year; and elimination of stigma and discrimination (S&D) against PLHIV and key populations (KPs).Thailand also has the more immediate targets (to be achieved by 2020) of 90% of PLHIV know their HIV+ serostatus, 90% of PLHIV who know their serostatus are enrolled in ART, and 90% of PLHIV on ART have suppressed viral loads.These three "90% targets" are a formidable challenge for Thailand.

HIV prevalence has declined among the general population of Thais, as indicated by the prevalence rate of 0.6% (from a peak of over 2%) among pregnant women, and 0.6% (from a peak of over 4%) among Thai military recruits. However, HIV prevalence has remained unacceptably high in KPs such as MSM, TG, PWID, FSW and MSW.A large sub-group of the population with unknown HIV prevalence are the estimated three to four million cross-border migrants living and working in Thailand.The Spectrum-AEM Model has produced estimates of the HIV burden for Thailand as of July 2017, and these data are shown in Table 1.It is estimated that, in 2016, Thailand had 6,471 new infections of HIV (2,139 females; 75 children). By risk group, 44% of the new adult infections were among MSM (including TG), 11% among PWID, and 10% among sex workers and their clients. It is projected that, in the subsequent five years, more than half of all new infections will be among MSM (including TG).These data are consistent with the findings of the IBBS which found that HIV prevalence among the KPs is still high (with the exception of venue-based FSW who had declining HIV prevalence).The median HIV prevalence in 2014 was 9%, 13%, and 12% for MSM, TG, and MSW, respectively.HIV prevalence among PWID was 20% in that year, and 1% for venue-based FSW.

The HIV prevalence data for 2014 show differentials by geographic location and access to health services by KPs. HIV prevalence among MSM was highest in Bangkok (20%); conversely, MSM also had the lowest rate of VCT coverage among KPs (17%).By contrast, MSM HIV prevalence was only 2-3% in Chonburi and Ratchaburi Provinces. In general, it is still a challenge for Thailand to recruit MSM into the RRTTR system of services, especially in Bangkok which has the largest number of MSM for any city in the country.At the same time, communication technology is changing the way people meet up for sexual contact. In the past, risk populations met at known hot spots which were also a way for health workers to conduct outreach to vulnerable populations. Now, however, on-line communication is rapidly becoming the preferred mode of access for people seeking risk encounters.

In the area of HIV treatment, Thailand is the first country to have adopted a policy of free ART for all Thai PLHIV and, accordingly, coverage of ART is high. At the time of this report, it was estimated that there were 449,309 Thai PLHIV still alive in Thailand as of 2016 (198,483 women; 4,019 children).Also, it is estimated that 91% of that total know their serostatus (N= 410,576). Of this number, three-fourths (307,667) are enrolled in an ART program.Of these, 79% have viral load counts of under 1,000/ml (242,979).This has contributed to steady declines in AIDS-related mortality.In 2016, it is estimated that there were 12,863 AIDS deaths, or a 77% reduction from the level in 2000 (55,500).

In any event, for Thailand to achieve all three 90% targets by 2020, there will need to be an intensified effort to reach those PLHIV who still do not know their serostatus, especially the KPs, and enroll them into treatment.The country will need to continue to reduce barriers to access services and redouble efforts to eliminate S&D against PLHIV and KPs.

Table1: **Projected Number of New Cases of HIV, AIDS mortality and Number of Living PLHIV by Year**

Projection	2000	2005	2010	2015	2016
New HIV Cases	**29,619**	**16,014**	**10,215**	**6,900**	**6,471**
- Female	16,385	7,600	3,393	2,050	2,139
Adult New HIV Cases	**28,241**	**15,266**	**10,011**	**6,800**	**6,396**
- Female	15,716	7,237	2,294	2,000	2,103
Pediatric New HIV Cases	**1,378**	**748**	**204**	**<100**	**75**
- Female	669	363	99	<50	36
AIDS Mortality	**55,531**	**31,211**	**20,670**	**16,100**	**12,862**
- Female	12,257	7,352	6,212	4,630	4,564
Adult AIDS Deaths	**55,0791**	**30,805**	**20,422**	**16,040**	**12,771**
- Female	2,036	7,153	6,079	46,00	4,520
Pediatric AIDS Deaths	**452**	**406**	**248**	**<60**	**92**
- Female	221	199	133	<30	44
Living PLHIV	**683,841**	**555,808**	**493,932**	**437,700**	**449,309**
- Female	221,703	217,779	203,976	181,600	198,483
Living Adult PLHIV	**676,005**	**544,743**	**485,646**	**433,600**	**445,289**
- Female	217,860	212,351	199,978	179,600	196,503
Living Pediatric PLHIV	**7,836**	**11,065**	**8,286**	**4,100**	**4,019**
- Female	3,843	5,428	3,998	2,000	1,980

Remarks: Projections for 2000-2015 used AEM, while projections for2016 used Spectrum-AEM

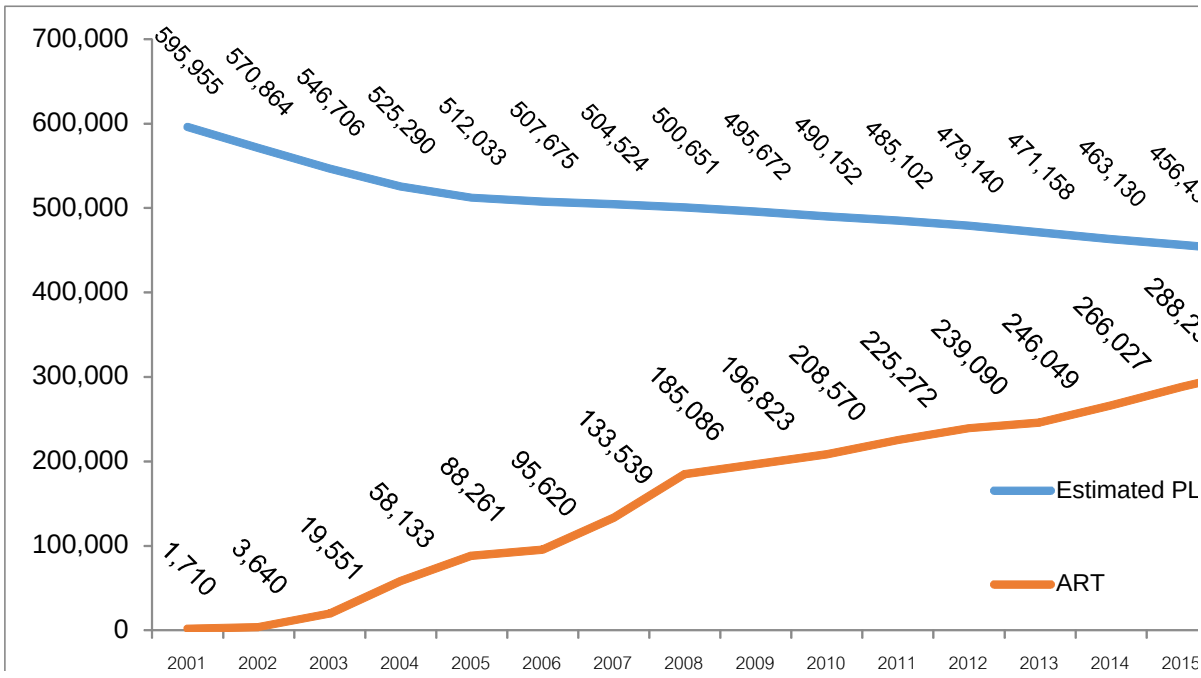
Implementation of AIDS Prevention and Control

1. Care and Treatment of PLHIV

In 2002, Thailand significantly expanded its HIV treatment program when the Thai Government Pharmaceutical Organization began producing its own version of triple therapy (GPO-vir) and procure certain ARVs at low cost using compulsory licensing authority.This enabled the country to include ART as one of the benefits of universal health insurance for Thais, starting in 2006. Prior to 2000, only 3,000 PLHIV newly enrolled in ART each year. But as ART became more affordable, the coverage of ART is now 75% of the estimated number of PLHIV.

Ever since October 2014, Thailand adopted the policy of providing ART regardless of the PLHIV's CD4 level.This policy is in line with the "treatment as prevention"strategy, and was the first of its kind for a country globally. At the same time, Thailand proclaimed the standard of same-day test results for all VCT clients.These factors have contributed to the high proportion of PLHIV enrolled in ART (Figure 1).The vast majority of PLHIV receiving ART are covered either by the national health insurance plan, social insurance or the government civil servant's health insurance scheme.

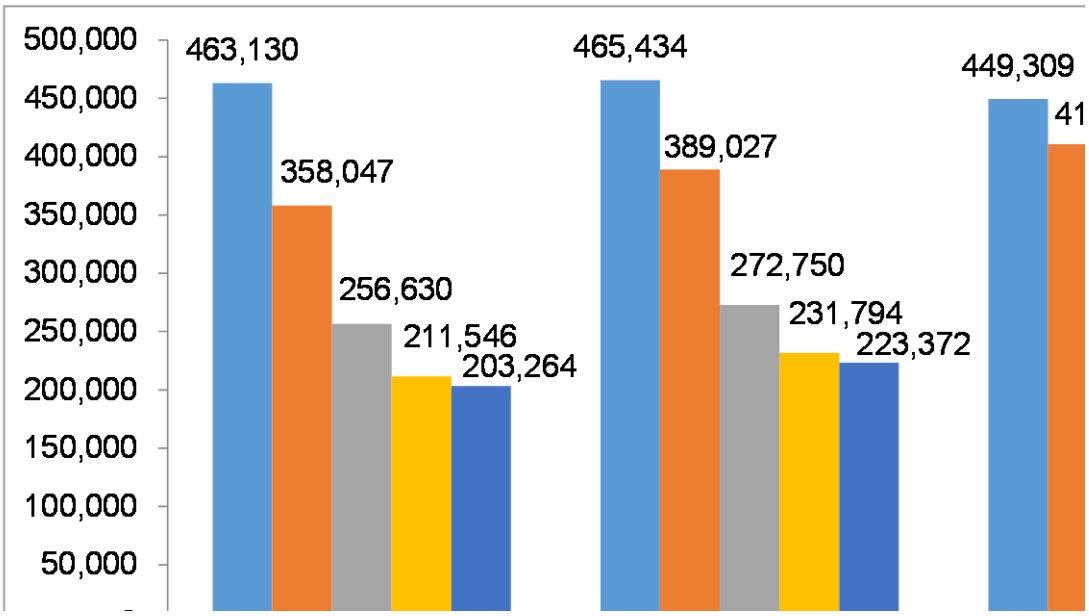
Figure1: **Number of Thai PLHIV Enrolled in ART Programs**



Source of data: Thailand Spectrum-AEM and National Health Insurance Programs

Figure 2 shows access to services by PHWA, compared with the projected total number of PLHIV during 2014-16.The data show that an increasing proportion of PLHIV who know their serostatus are receiving ART. As of 2016, of the estimated living caseload of 449,309 PLHIV, 410,576 (91.4%) knew their serostatus; 307,667 (68.5%) were on ART (including 14,461 who bought their own ARV drugs); and of the 251,065 of PLHIV who had viral load tests, 242,796 (96.7%) had suppressed (undetectable) viral loads. Retention in ART over a 12-month period was 89.5% in 2016. Nevertheless, it is clear that too many PLHIV are entering treatment too late in the course of their infection.In 2016, over half (54%) of new enrollees in ART had CD4 counts under 200 cells/mm.[3]This implies that these persons were either unaware of their serostatus or chose to wait until they had symptoms of disease before seeking treatment. Delayed initiation of ART implies a risk for transmission of HIV as well as the prospect of reduced efficacy of ART.

Figure2: Number of PLHIV Accessing Diagnosis, Treatment and Viral Suppression during 2014-16



Source of data: NAP, NHSO

The 2014 IBBS found that access to HIV diagnosis and treatment among KPs was low.Only 61% of PWID, 31% of MSM, and 54% of sex workers had gone for HIV VCT and knew the results in the prior year.Data from the National Health Security Office for 2008-13 show that only 59% of PWID, 44% of MSM, and 51% of FSW who were HIV+ had enrolled in an ART program.

In sum, Thailand's aggressive policy and program to detect HIV infection early and enroll all PLHIV in ART has increased coverage of treatment from 53.5%, 60.9%, 65.8%, and 68.5% during 2012-16, respectively.In any case, when compared with the three 90% targets, Thailand had achieved only the first by 2016 (i.e., the percent of PLHIV knowing their serostatus).Thus, a top priority for the Thai NAP is to reach and recruit as many of the HIV+ KPs as possible so that they are enrolled and maintained on ART.

Despite Thailand's policy to allow any PLHIV to enroll in ART regardless of CD4 level, this does not always happen in practice, as some outlets have not adopted the national policy as their own, or some health providers still practice S&D against PLHIV and KPs.Insurance plans do not necessarily cover all the costs of diagnosis and treatment, and that can be a further deterrent to enrollment.Thus, there needs to be uniform implementation of the NAP policies and guidelines in all health outlets.Another gap is lack of enough health services for the millions of lower-income cross-border migrants who have come to Thailand to work.These non-Thais cannot access the universal health insurance; they can buy annual insurance but at a significant cost.Finally, there needs to be more systematic collection and use of strategic data, disaggregated by target population and type of service, so that managers can fine-tune the RRTTR strategy.All service outlets – government, private and Civil Society – need to report to a central database so that the national situation can be accurately assessed.

2. Eliminating MTCT of HIV and Syphilis

A high-level meeting on HIV/AIDS was convened at WHO in June 2016, and Thailand was recognized as having effectively controlled MTCT of HIV and syphilis.This is an important milestone toward the country's goal of ending AIDS by 2030.Thailand offers HIV VCT to all pregnant women and their partners, and those found HIV+ are put on highly-active ART up to delivery and including the newborn. Mothers are instructed not to breastfeed, and the status of the infant is tracked through the Perinatal HIV Intervention Monitoring System (PHIMS).While coverage of pregnant women is high because of the ubiquitous ANC system, only 41.5% of male partners appeared for testing at the attending clinic in 2016. HIV infection among pregnant women was 0.6%, and ART coverage of infected pregnant women was 95% in 2015 and 96% in 2016. MTCT of HIV declined from 1.9% in 2015 to 1.8% in 2016.Thailand started its more aggressive preventive treatment for infants born to HIV+ mothers in 2014, and the infected are put on ART as soon as possible.

Thailand has set the target of reducing MTCT of HIV to below 1% by 2020, and zero by 2030.It is estimated that one-third of MTCT of HIV is due to late initiation of ANC care of the HIV+ pregnant woman.Another third is attributed to irregular use of ARV drugs during pregnancy.In addition, infection of approximately one out of seven HIV+ infants is attributed to the mother becoming infected with HIV after her first ANC check-up and delivery, or during the post-partum period while still breastfeeding her infant.

Data from the PHIMS for 2016 show that nearly all women in the ANC system were screened for syphilis and, if infected, were treated.Even though Thailand's level of congenital syphilis exceeds the WHO recommendation, the trend in syphilis among pregnant women has been edging up slightly, from 0.08% in

2015 to 0.11% in 2016.In addition, the number cases of congenital syphilis increased from 80 in 2015 to 105 in 2016.These trends mirror the increase in prevalence of syphilis among the general, reproductive-age population.Thailand has set the target of reducing MTCT of syphilis to under 0.5 per 1,000 live births.The Bureau for AIDS, TB and STIs (BATS) of the Ministry of Public Health (MOPH) has implemented a refresher training program throughout the country on management of syphilis in pregnancy and delivery.There also needs to be improvements in the passive case surveillance reporting system to eliminate over- and under-reporting of cases of congenital syphilis.

Challenges and recommendations

In theory every Thai woman should have access to free ANC but, in practice, this is not the case.Some pregnant women have to pay for ANC if they do not have the requisite health insurance.There needs to be a campaign to motivate women to go for ANC at the first sign of pregnancy.There should also be one-stop prevention of MTCT for HIV and syphilis by integration with the pregnancy and delivery services.The MOPH is also promoting ANC couple counseling to get male partners more involved with caring for the pregnancy by recruiting them into VCT for HIV and syphilis, even during the pre-marital period.However, most health insurance plans do not cover the cost of male partner VCT.The government should consider making couple VCT part of the package of essential ANC care.The 2017 MOPH guidelines for prevention of MTCT of HIV will emphasize couple VCT, both during the pregnancy and post-partum.The MOPH is adding Raltegravir to the highly-active ART regimen for HIV+ pregnant women who first appear for ANC after the 32nd week of gestation. HRH Princess Soamsawali, through her fund at the Thai Red Cross, contributed a supply of Raltegravir for research on the efficacy of this drug and determination of any side effects of the drug among Thai women. Preliminary findings indicate that the addition of this drug to the ART regimen for higher-risk pregnant women increases the effectiveness of prevention of MTCT of HIV.The next step is to formally include Raltegravir in the list of essential drugs. Because some HIV+ pregnant women may have been taking ARV drugs for some period of time, but had interruptions of treatment, it is important for ANC clinics to also conduct viral load tests of the woman to see if she poses a special risk for MTCT of HIV to her infant.This should be part of the standard package of ANC services for women who meet the criteria.There should be more training for ANC clinic staff to reduce S&D toward clients which may discourage some marginalized pregnant women from seeking ANC or completing the full schedule of check-ups.

When examining the data on congenital syphilis, most of the cases are infants born to relatively young parents.Thai adolescents are currently having unacceptable levels of unplanned pregnancy, and STIs are

increasing among younger cohorts.Thus, there should be more programs and campaigns to combat unplanned teen pregnancy.This should be part of a standard sex education and reproductive health curriculum which all Thai youth receive.With the popularity of the Internet and social media among the younger generation of Thais, on-line training should be an effective channel to reach vulnerable teens with information on preventing pregnancy.In addition, popular role models should be publicized to improve norms among young, sexually-active persons.Adults, in particular, need to play a more active role in sex education of the youth in their care.

Coverage of HIV+ pregnant women who are non-Thai cross-border migrants is improving, but there are gaps for independently-employed migrants who do not have health insurance, or do not have enough money to buy the annual health insurance for migrants offered by the MOPH. It is in the interest of Thai public health programs to enable all non-Thai migrants to be legally registered and provided with affordable health insurance.This is needed to protect both the migrants and the Thai communities they live in.The MOPH is currently considering ways to finance expansion of insurance to cover all residents, regardless of nationality.

Data on prevention of MTCT of HIV and syphilis come from the PHIMS, NAP and passive case reports (syphilis).The MOPH has plans to review the history of cases of congenital syphilis by issuing a standard reporting form throughout the country.The MOPH has plans to add the indicator of 'stillbirth' in the PHIMS system.All relevant service outlets need to apply the standard indicators for prevention of MTCT of HIV and syphilis.

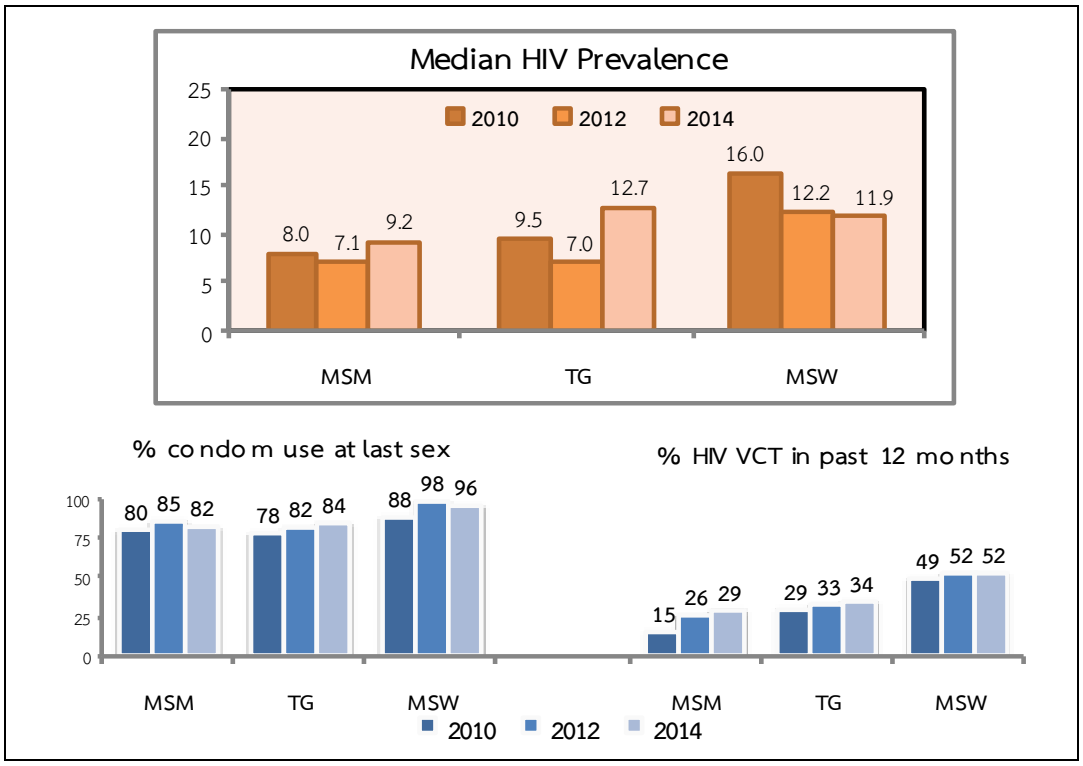
3. Prevention of HIV in KPs

In this report, KPs include MSM, TG, MSW, FSW, PWID and prisoners.

MSM, TG, MSW

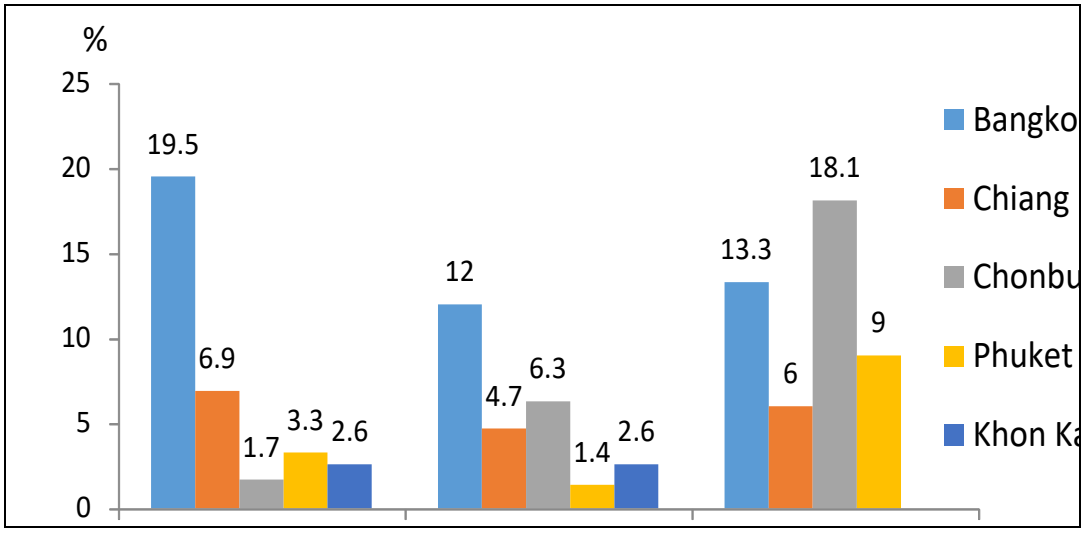
The projections for 2016 indicate that the number of MSM in Thailand totaled 590,700 persons, or 3.3% of the population age 15-59.This total includes 62,800 TG, 527,900 MSM, and 15,000 MSW (2015).The prevalence of HIV among these three groups is still unacceptably high, though HIV infection among MSW has been declining.The IBBS included a set of periodic surveys of MSM, TG and MSW in five provinces during 2010-14 (Figure 3). HIV among MSM increased from 8.1% in 2010 to 9.2% in 2014. The comparable figures for TG are 9.5% and 12.7%, respectively; and for MSW are 16.0% and 11.9%, respectively.

Figure3: IBBS among MSM, TG, and MSW



Source of data: IBBS, BoE, MOPH, 2010-2014

Figure 4: HIV Prevalence among MSM, TG, and MSW in 2016



Source of data: BoE, MOPH

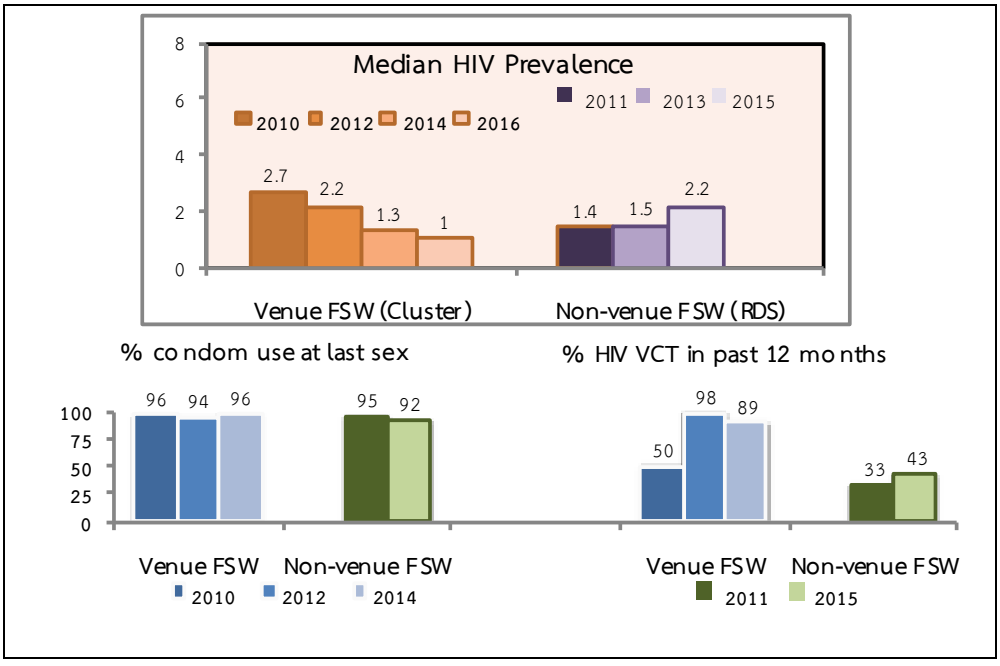
The 2016 round of the IBBS found persistently high levels of HIV prevalence for these vulnerable populations, and differentials by location (Figure 4).Bangkok had the highest HIV prevalence for MSM and TG:19.5% and 12.0%, respectively.Chiang Mai recorded HIV prevalence of 6.9% and 4.7%,

respectively.Chonburi had the lowest HIV prevalence for MSM (1.7%) and Phuket had the lowest HIV prevalence for TG (1.4%). HIV among MSW was highest in Chonburi (18.1%), followed by Bangkok (13.3%), Phuket (9.0%), and Chiang Mai (6.0%).The IBBS also asked questions about HIV prevention behavior (Figure 3). In latest three rounds, the survey found that MSW had the highest levels of condom use at last sex and VCT visits in the year prior to the survey, while MSM had the lowest prevention behavior of the three groups.

FSW

In 2015, it was estimated that there were 132,000 FSW in Thailand.The IBBS included venue-based FSW from 12 provinces in its survey rounds 2010, 2012 and 2014. Non-venue-based FSW were identified using Respondent Driven Sampling (RDS) in six provinces during 2011-2015 (see Figure5). It is noteworthy that the non-venue-based FSW had higher levels of HIV and STI than the venue-based FSW.They also reported less prevention behavior for each survey round. HIV prevalence among venue-based FSW declined steadily from 2.7% in 2010 to 1.13 in 2012, and 1.0% in 2014.The HIV prevalence rates for non-venue-based FSW were 1.4% in 2011 and 2.2% in 2015. Infection with gonorrhea was 7.3% for non-venue-based FSW and 4.2% for venue-based FSW.Condom use at last sex is very high (over 90%) for both groups of FSW.However, having had an HIV test in the year prior to the survey was significantly lower for non-venue-based FSW than their venue-based counterparts.

Figure 5: IBBS among FSW using Cluster and RDS Methods

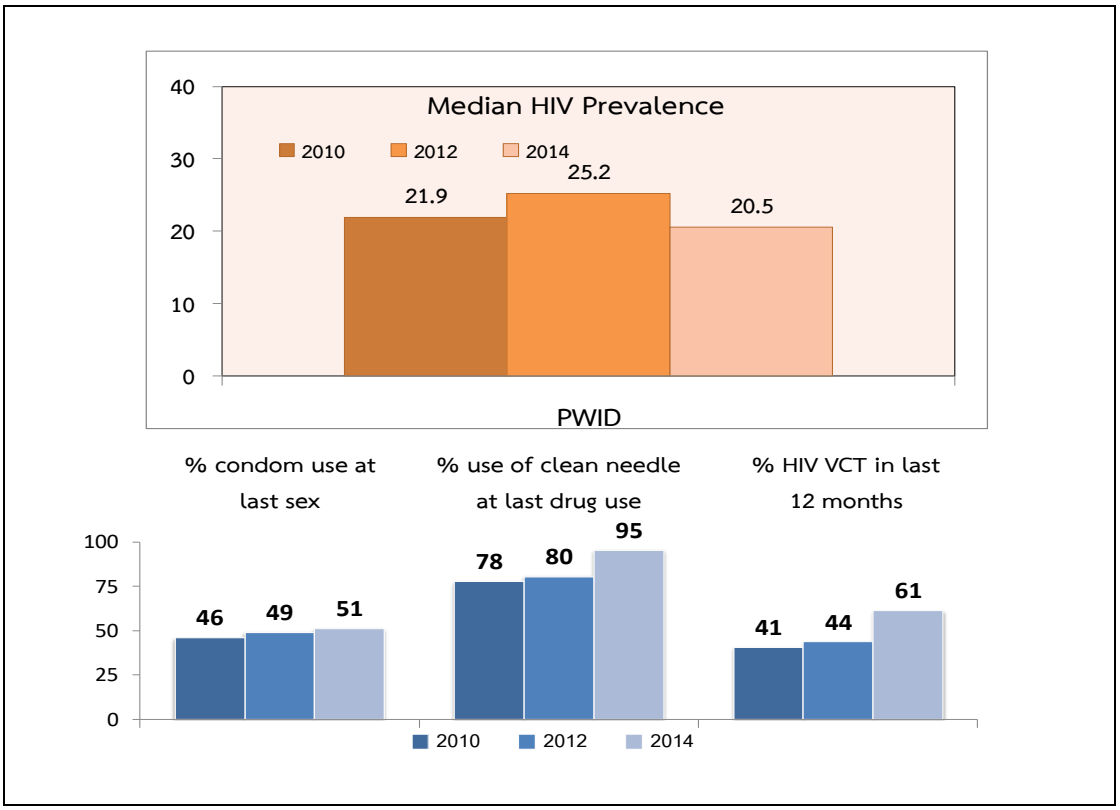


Source of data: BoE, Thailand MOPH, 2010-2016

PWID

The projections indicate that there were 71,000 PWID for the most recent year, and 60% of these inject at least once a month.The IBBS used RDS to survey PWID during 2010-14 (see Figure 6).The HIV prevalence rose somewhat and then declined over rounds from 21.9% to 25.2% and 20.5% in 2010, 2012 and 2014, respectively.Prevention behavior increased over rounds for condom use at last sex, use of clean needles/syringe at last injection, and being tested for HIV (and knowing the results) in the year prior to the survey. The numbers of drug addicts enrolled in opioid substitution therapy (OST) programs in 2015 and 2016 were 5,956 and 5,258, respectively. However, only 754 and 813 of these totals were PWID.Various harm reduction programs distributed 266,000 clean needle/syringe kits in 2015 (or 6.2 kits per PWID), and 571,937 kits in 2016 (13 kits per PWID).

Figure 6: IBB Samong PWID Using RDS Method



Source of data: IBBS among PWID using RDS sampling, BoE, Thailand MoPH, 2010-2014

Prisoners

In 2015, 341,760 persons were incarcerated in Thailand.Of these, 310,399 were in prisons, the vast majority were male as only 44,351 were women.A total of 31,361 were in juvenile detention, including 29,252 males and 2,109 females. HIV VCT found prevalence rates of 1.8% and 1.5% in 2015 and 2016, respectively.

Progress in implementation

Thailand has a clear policy and strategy for achieving its goal of ending AIDS by 2030.The strategy is neatly summarized by the RRTTR letters. However, coverage of KPs in 2016 was only 79% for Reach, 70% for Recruit, 64% for HIV VCT (Test), 70% for ART (Treat) and 90% for Retain.There is a system for monitoring implementation of AIDS program implementation (Routinely Integrated HIV Information System or RIHIS). RIHIS disaggregates data for KPs and this allows more specific assessment of progress toward the targets. For example, coverage of the Reach strategy in 2016 was 72% for MSW, while for MSM, TG and prisons coverage was 59%, and coverage was lowest for FSW and PWID at 22% and 36%, respectively. The NAP and implementing partners are making more use of social media and other on-line channels to improve coverage of the Reach component.

For HIV VCT in the past year, the RIHIS data indicate that coverage is low for all KPs: 20% for MSM and TG, 8% to 10% for MSW and FSW, and 5% to 6% in PWID and prisoners. However, it could be that a significant proportion of KPs have been tested before, just not in the past year.Thus, the proportion who said they know their serostatus was high:80% for FSW, 73% for MSW, 63% for MSM (including TG), 61% for PWID, and 51% for prisoners. However, if those persons who last tested HIV-negative still engage in risk behavior for HIV, then it is important that they go for re-testing until they have eliminated the risk. The NAP is also using a greater variety of approaches to VCT such as mobile outreach clinics and community-led HIV VCT.

Thailand is also making strong advances in PrEP (pre-exposure prophylaxis for HIV).In June 2016, the MOPH issued “Guidance on Use of PrEP for HIV Prevention” so that hospitals under the MOPH authority could provide standard PrEP service for serodiscordant couples, MSM, TG, sex workers, and PWID.Initially, this service is being provided for a fee since PrEP is not yet part of the essential medicines list. Requests for PrEP range from 600 to 2,000 cases per month.In addition, BATS is piloting a PrEP strengthening program during 2017-19 in seven provinces (Nonthaburi, Pathum Thani, Phuket, Songkhla, Udorn Thani, Khon Kaen, and Nakorn Ratchasima).The aim of the program is to make PrEP more accessible to KPs with high risk of infection.BATS hopes to expand the program nationwide. Initially, PrEP was only available through special projects such as the Princess PrEP Project of HRH Soamsawali in collaboration with the AIDS Research Center of the Thai Red Cross. Another project is the PrEP@PIMAN which is a pilot study of MSM which provides a free supply of PrEP.The MSM pilot study is being implemented in Lertsin Hospital and Thammasat Hospital through collaboration with SWING, SISTER, and Rainbow Sky organizations.Some private clinics are also participating in PrEP dispensing. Altogether, in 2016, a total of 3,365 persons obtained PrEP.

Challenges and Guidelines for Solutions

The data from the IBBS and RIHIS show that gaps remain in achieving the RRTTR targets, especially for MSM for whom coverage with prevention is only about half. Coverage for some services is very low for FSW and PWID. Further, access to ART is only 42%-54% for MSM and FSW.Thailand has set the targets for 2020 to achieve the three 90% indicators. To achieve the first two targets, Thailand will need to implement "new fast-track strategies."This means accelerating implementation through the indigenous networks of KPs, forming partnerships with these networks, increasing the client-friendly nature of government services, tailoring services to the lifestyle of the KPs, making services more accessible to the KPs, ensuring privacy and confidentiality of data, improving attitudes of service providers, increasing skills of counselors, encouraging the acceptance of diverse sexual orientations, increasing collaboration between government and Civil Society, streamlining the PLHIV referral system and process, and strengthening the prevention-to-care continuum.

Another challenge for the AIDS response is collecting data on the large number of MSM, TG and MSW who obtain services from private outlets which are outside the government's reporting system.This makes it difficult to get more accurate estimates of service coverage.Thus, the government needs to find a way to collaborate with these outlets and tap into their data on services and client populations.

While the government has allocated significant budget and resources to the AIDS response, the community-based organizations which provide the bulk of services to KPs do not receive an appropriate share of the funding for this work.That limits coverage and ability to expand services.For example, there are restrictions and obstacles for NGOs to access the 200 million baht HIV prevention fund of the National Health Security Office.In the past, many NGOs working on HIV prevention for KPs were funded by the GFATM. Now that the Global Fund is phasing out financial assistance to Thailand, it is imperative for the government to help find ways to sustain the essential NGO-managed programs.

Some Civil Society groups are piloting community-led HIV services (e.g., HIV VCT) in collaboration with the Thai Red Cross.While these services have been shown to be feasible, safe and effective, government regulations prevention non-clinicians from providing certain services that are part of VCT.This limits the ability to expand services closer to the communities in which the KPs feel safest.Ways must be found to provide accreditation to these NGOs so that they can legally provide certain services to increase coverage of the RRTTR strategy.

In the past, the CHAMPION and STAR projects (supported by the GFATM) had supported interventions and harm reduction for PWID. Now that these projects have ended, the government is trying to identify alternative

sources of support to continue the interventions. NGOs need to be legally empowered to provide HIV prevention and care services directly to PWID. In addition, this KP also suffers from hepatitis B and C infections at a much higher rate than other KPs or the general population.

Non-Thai migrants

The three million or more non-Thai cross-border populations are usually lower income and have come to Thailand to improve their economic status. Many migrants cross the border illegally and, thus, they may be reluctant to go for government health services. Also, many cannot communicate well in Thai and that erects another barrier to health care and prevention.While not considered KPs per se, these migrants are vulnerable for contracting and spreading HIV and other communicable diseases.The 2014 IBBS included a sample of migrants from Myanmar, Cambodia and Lao PDR in ten provinces.HIV prevalence was low for these migrants with levels of 1.0%, 0.7% and 0.2%, respectively.However, the 2016 IBBS found that a significant proportion of the migrants had HIV risk behavior:one-third of the sample of males had multiple sex partners, while condom use was reported by only 40% of men and 29% of women.

The Thai government is implementing a policy to regularize all migrants from Myanmar, Cambodia and Lao PDR so that they are registered and can purchase an annual health insurance premium offered by the MOPH. However, in practice, some hospitals refuse to sell the insurance to these migrants, especially those who only seek insurance when they are sick or injured.Also, not all outlets with a large number of migrants in their catchment area can afford to hire bi-lingual migrant health volunteers who help interpret for migrants.There is lack of a uniform standard for recording information of the migrant clients.Thus, the NAP needs to include migrants as part of their strategy since Thai public health depends on all residents to use needed prevention services.

4: Eliminating Gender Inequality, Violence and Discrimination

Thailand recognizes that there is gender inequality in society, and the NAP tries to address this in the context of HIV prevention and control.All of the strategic components of the NAP include a segment on rights and respect for clients regardless of their gender or sexual orientation.In the past two years, there has been progress in advancing policy related to gender inequality in Thai society. For example, the Ministry of Social Development and Human Security sponsored a law on Gender Equity (2015) which is broad enough to extend rights to TG populations and protect a woman's right to be treated equally as a man. In 2016, a law was enacted on 'Adolescent Pregnancy Prevention and Alleviation' which emphasizes the importance of youth to

take responsibility for their sexual behavior, and the need to provide sex education to all youth.The national Guidelines for AIDS in the Workplace emphasize the need to reduce S&D related to HIV/AIDS, with government offices taking the lead to serve as a role model.

Nevertheless, there is limited integration of these guidelines in most worksites.In addition, male-female inequality is deeply rooted in many aspects of Thai culture and society.Thus, it may take generations before there is true gender equity and elimination of gender-based violence and discrimination.More budget will be needed to fund campaigns on this issue in relation to the NAP goals and strategies.Health staff will need on-going training to adjust negative attitudes toward KPs, sexual orientation, and diverse gender identity.S&D remains an important deterrent to many KPs who need HIV prevention, diagnosis and care services. Accordingly, Thailand has adopted 'Ending AIDS S&D' as one of the three principal targets of the Ending AIDS by 2030 goal. Nevertheless, stigma remains in the workplace, school, health outlets, and other institutions. In addition, there remain many laws which directly or indirectly discriminate against PLHIV.

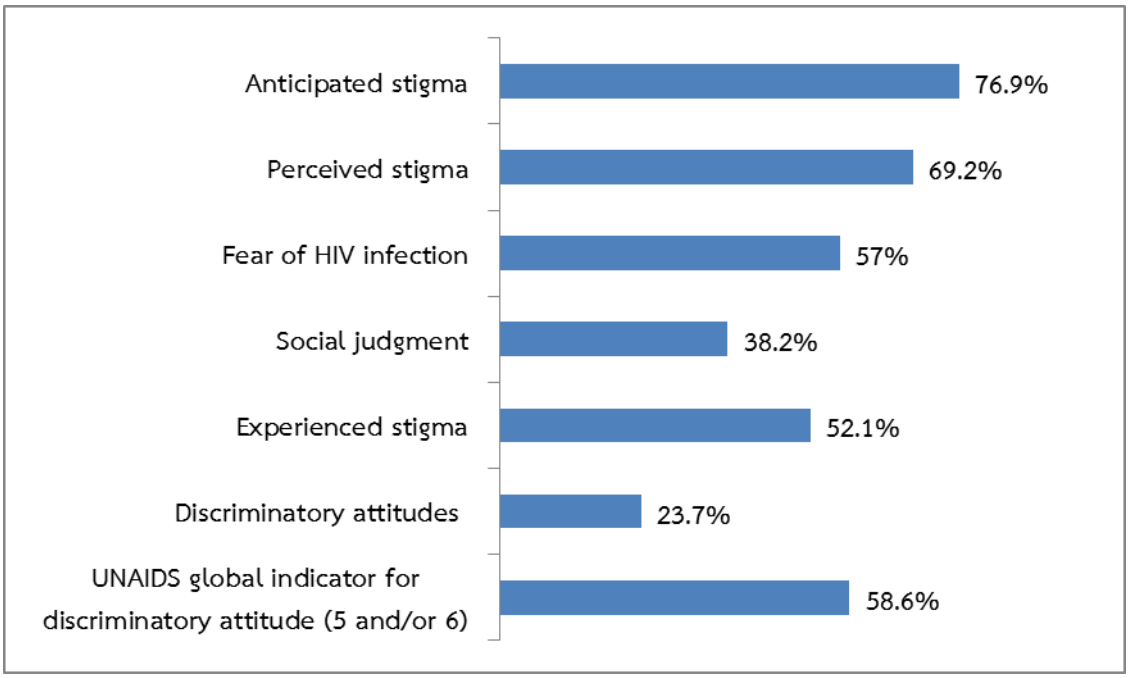
The 5th National Health Examination Survey (2014) collected information from 10,422 persons age 20-59 years to measure opinions and attitudes toward HIV.The following are questions used to assess the level of stigma in society:

1) Anticipated Stigma: "Do you think that most people are reluctant to go for HIV testing because others might see them?"
2) Perceived Stigma:"Do you think that PLHIV or persons suspected to be HIV+ are disdained or scorned by those around them?"
3) Fear of HIV infection:"Do you fear contracting HIV if you have contact with the saliva of a PLHIV?
4) Social Judgement:"Would you be ashamed if others knew that someone in your family had AIDS?"
5) Discriminatory attitudes:"Would you avoid buying fresh produce or food from an HIV+ vendor?"
6) Discriminatory attitudes: "Do you think that children living with HIV should not attend the same classroom with other children?"
7) (Global indicator of discriminatory attitudes against PWHA is to answer "yes" for both/either Question 5 and/or Question 6)

Figure 7 shows the distribution of responses to the questions. Over three-fourths (76.9%) agreed that there is anticipated stigma about going for HIV VCT.Over two-thirds (69.2%) perceive that PLHIV are negatively stigmatized.Over half (57.0%) believe they could be infected by contact with the saliva of a PLHIV.Over one-third (38.2%) feel there is negative social judgment about HIV/AIDS.Finally, about half (52.1%) would avoid

buying fresh produce or food prepared by a PLHIV. Nearly one-fourth (23.7%) agreed that children living with HIV should not attend the same classroom as other children. Conclusion of discriminatory attitudes against PWHA (answer "yes" for both/either Q.5 and/or Q. 6) was 58.6%.

Figure7: Survey of Attitudes about HIV: 2014



Source of data: Report "Stigmatizing attitudes towards people living with HIV among the general adult Thai population"

S&D against AIDS also exists in the health care setting.Surveys of PLHIV and health personnel in 18 provinces of Thailand during 2014-16 found that 12% of PLHIV reported having personally experienced S&D at a health outlet related to their infection in the 12 months prior to the survey.One-fourth (24%) of PLHIV said that health staff shared (directly or indirectly) the information that they were HIV+.Finally, 5% of HIV+ pregnant women said they were forced or pressured to abort the pregnancy.The survey of health providers found that 24% had observed colleagues who did not want to attend to PLHIV clients; 70% had a personal experience which they thought posed a risk of HIV infection from a PLHIV client; and 53% had seen colleagues use extra and unnecessary precautions when treating or examining a PLHIV client.

In addition to S&D against PLHIV themselves, KPs who (by definition) are members of groups with higher vulnerability to HIV infection, also experience AIDS-related stigma.The above surveys found that between 4% and 5% of MSM and TG reported that health personnel preferred not to treat them on occasion (because of their sexual orientation) and 8% of PWID reported reluctance among staff to treat them if they knew they were an IV drug addict.

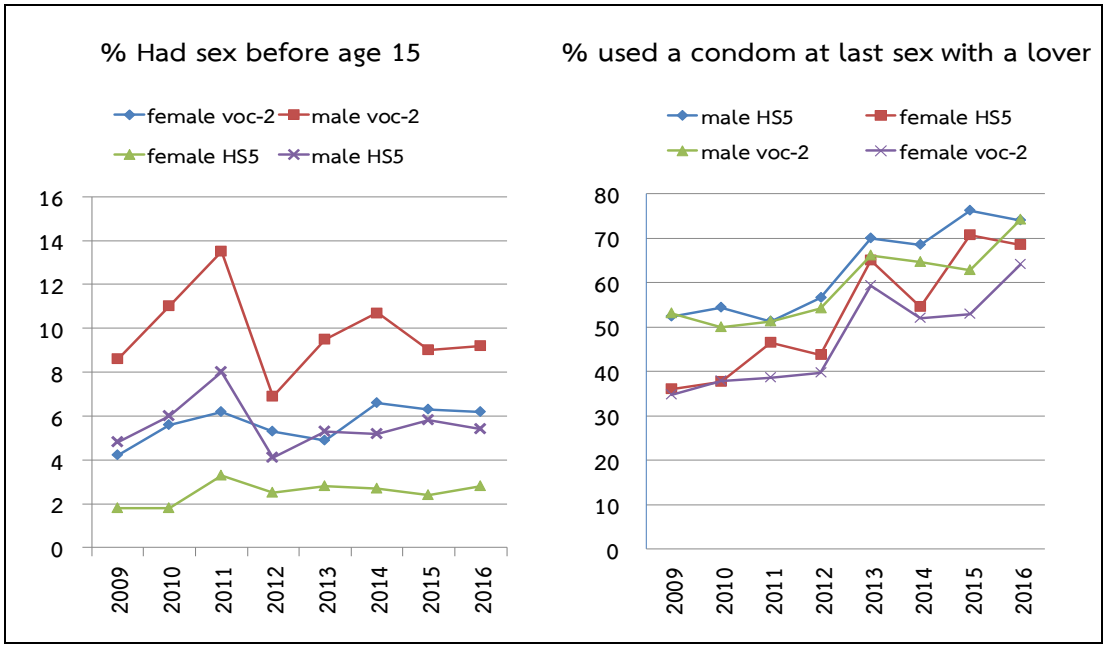
The 2016 round of the IBBS included a new question for MSM, TG, MSW, and FSW about whether they experienced an episode of S&D in their family, society, or by health personnel in the past 12 months.The IBBS found that 1.7% of FSW, 3.5% of MSM, 1.4% or MSW, and 2.3% of TG responded that they had experienced S&D in the family.The responses for S&D by a health care provider were 6.2%, 8.9%, 6.6%, and 9.9%, respectively. For S&D in the workplace or school, 12.8% of MSM said they had experienced that, while 18.9% of TG said they had. Despite these levels of S&D, only 1.8% of FSW, 7.9% of MSM, 10.0% of MSW, and 7.4% of TG said that the existence of S&D would deter them from seeking health care. A larger problem is self-stigma by the KPs, especially FSW, among whom more than half (55.3%) self-stigmatized.By contrast, only about one-fifth of MSM, MSW and TG felt self-loathing as a KP.

Thailand is one of the few countries which measures and tracks S&D toward PLHIV and KPs.These data can help identify gaps and needs for finally eradicating S&D.Currently there are pilot projects at the provincial level on improving compassion and empathy for vulnerable populations to reduce AIDS S&D, especially in the health care setting.At the same time, there are intensified efforts to protect PLHIV rights. Thailand participated actively in the World Zero Discrimination Day in an effort to raise public awareness of this issue, along with the problems of gender-based violence and gender inequality that remains today.The interventions to eliminate S&D are being expanded to the schools, and even to the local administrative organizations since they are responsible for paying monthly government welfare subsidies to PLHIV in their area of jurisdiction.

5: Prevention of HIV in Youth

Thai youth are an important target population for prevention of STIs and HIV. Data from the Spectrum-AEM projections estimate that 47% of new infections in 2016 were among the population age 15-24 years.The priority for prevention programs is those age under 24 years who are at greater risk.

Figure 8: Survey of High School Grade 5 and Vocational Year 2 Students



Source of data: BoE, MOPH

At the policy level, past efforts have focused on creating an enabling environment to deliver services youth, or to amend existing laws (e.g., the Reproductive Health Act) to include youth -- not just adults.There have been a number of projects which promote sex education in the school and community.The health service sector has made some effort to create youth-friendly services.Combined, these efforts are starting to show improvements for some indicators.A survey was conducted among male and female students in high school grade 5 and the second year of vocational school.The proportion reporting first sex under age 15 years was constant over rounds for high school students and declined for vocational students.In addition, condom use at last sex for this sample of youth increased over survey rounds (Figure 8).The MICS survey of women and children in Thailand for 2015-16 found that, among persons age 15-24 years, 45.6% (equal proportions of males and females) were sufficiently knowledgeable about HIV prevention.

As noted above, Thailand passed the Adolescent Pregnancy Prevention and Alleviation Act in 2016, with the following key provisions:

1. Schools are to deliver age-appropriate sex education. Sex education instructors should also have skills in counseling and support for students who are pregnant and wish to continue their education.

2. Health service outlets must provide information, and deliver reproductive health services for youth as appropriate, and refer cases to social services as needed.

3. Worksites must provide information and support access to reproductive health services, including referral to social services.

4. There should be social services to help prevent/alleviate unplanned teen pregnancy, and local government is authorized to enact local laws to protect the rights of adolescents.

It is clear that this law provides a framework to deliver HIV prevention knowledge and services to vulnerable youth as part of the broader reproductive health mandate.The act is also relevant for the policies and programs of the MOPH, Ministry of Education, Ministry of Social Development and Human Security, Ministry of Labor, and Ministry of Interior.In the MOPH, three departments are collaborating on this issue:Department of Disease Control, Department of Mental Health and the Department of Health.The focus is the prevention of STIs and unplanned pregnancy in youth, and budget has been allocated for prevention campaigns, condoms, contraception, etc.The National Health Security Office has made available funding to the Department of Health for procurement of 20 million pieces of condoms, which will be distributed through the network of provincial health offices, and through the network of 2,406 schools implementing comprehensive sex education (p2h Foundation), the Planned Parenthood Association of Thailand, the Population and Community Development Association, the Women's Health Advocacy Foundation, the Bureau of Reproductive Health,

and associated health service outlets.Services will include counseling and sexual health that are youth-friendly in all public outlets.To that end, standards have been developed for youth-friendly health services (YFHS) which are patterned after the WHO guidelines. The standards apply to management, accessing the target population, coverage, and meeting the needs of the target group.At the time of this report, 75% of the hospitals under the MOPH were delivering YFHS which meet the standard.

However, some time will be required to assess the effectiveness or outcomes of the new law and standards. For example, the number of teen deliveries has not yet declined -- however, those teen births were nine months in the making (i.e., before many of the YFHS were active).In any case, the law and guidelines are important first steps in reaching vulnerable youth.All channels must be involved – government, private and Civil Society – as well as social media -- to inform youth about services and safe practices.Youth must also be reassured that their confidentiality will be protected since pre-marital casual sex in Thailand is still considered taboo by mainstream society. School-based sexual health counseling, in particular, needs to protect the privacy of students who seek those services. Preferably, sexual health services should be near, but not on-site in the school to offer more confidentiality.

UNICEF sponsored a survey of teachers and students at 398 high schools and vocational colleges, including a sample of 8,000 respondents.The survey was managed by the Center for Public Health Policy, of Mahidol University and conducted during September 2015 to March 2016.The following are some of the key findings:

- There is a shortage of teachers to deliver sex education; teachers need more skills building in the area of sex education; teachers need to be more comfortable in delivering the sex education content;
- The sex educational curriculum in some schools still takes a negative view of student sexual activity and emphasizes the potential negative outcomes of sex and unsafe sex.There is gender bias in some of the content and not enough emphasis on respect for the other's preferences in making decisions about sex and taking personal responsibility for the consequences by both partners;
- The method of instruction still relies too much on didactic lectures.There is a need for more multi-media presentations of content, and active participation of students in the learning process.

The p2h Foundation (formerly PATH) is one of the most active organizations in promoting innovative teaching and learning of sex education, not only for teachers and students, but also for the parents with adolescents in their care. P2h is working with the Ministry of Education to find a way to incorporate the p2h

Comprehensive Sexuality Education modules into the national school curriculum – at both the upper primary and high school levels.This effort is increasingly important as the easy access to false information and distorted images on the Internet is where most Thai youth probably learn about sex today.Youth are also vulnerable to sexual predators via social media.Youth need to be able to discern which sources are providing factual information and when it is safe or unsafe to make contact with strangers on the Internet or through social media. Appropriate and accurate sex education of youth needs to be a national effort, and at all levels from the central authorities down to the local community, with adequate resources allocated accordingly.

6: Social Protections for Persons Adversely Impacted by HIV/AIDS

At present, Thailand has no national data collection system to record the number of children adversely affected by AIDS or their families.Thus, it is hard to assess the scope and scale of the need for assistance and services.The UNICEF-supported MICS in 2016 indicates that the prevalence of childhood disability (all causes) decreased compared to a comparable survey in 2014 (from 4.7% to 3.5% in 2016).Certainly, the universal access to ART is keeping parents alive longer, thus reducing the number of AIDS orphans. Advances in treatment also mean that pediatric PLHIV are better cared for, and can lead quality lives.

Thailand has no specific measures or plans for social protections for those adversely impacted by AIDS. Instead, it is expected that affected persons can tap into the routine, existing social services.There are child protection laws and programs to assist vulnerable families that are general and not AIDS-specific.As noted earlier, PLHIV are eligible to receive a welfare subsidy (500 baht per person per month) and this is administered locally through the local Tambon Administrative Organization (TAO) at the sub-district level.However, the budget is not adequate for the need, and some TAO redirect the funds for other purposes. Also, a person must have a medical certificate attesting to the fact that they are a PLHIV in order to be eligible.This requirement compromises the confidentiality and status of the PLHIV.

Needy AIDS orphans are usually cared for at children's protection centers in the public or private sector.UNICEF has counted 34 public and 37 private sector children's homes.As of 2015, a total of 254 residents of the public sector homes were HIV+ (out of the total number of 7,313 residents, or 3.5%).The private sector recorded 178 residents of their children's homes who were HIV+ out of a total of 2,325 residents (7.7%).While the HIV+ children might receive special treatment in the children's homes, there is a lack of data on their socio-emotional development, and constructive acceptance of and coping with their HIV+ status.

7: Community-led HIV Services

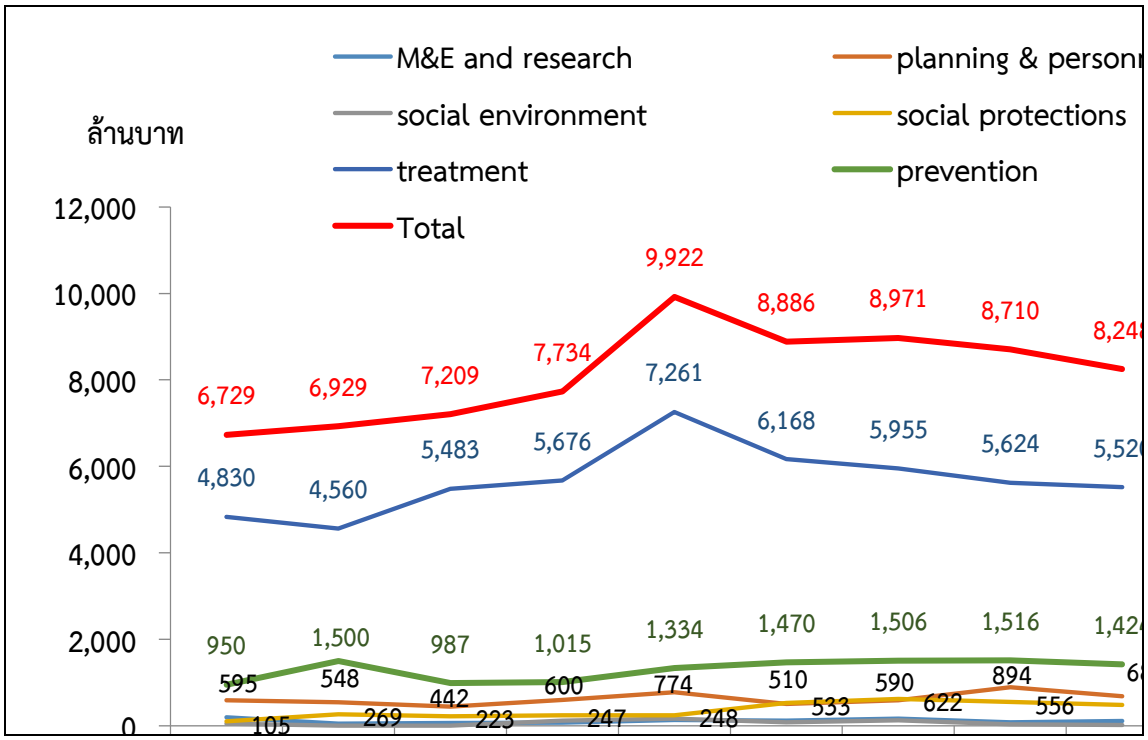
As noted earlier, many members of the KPs may be or feel marginalized or stigmatized and, for that reason, avoid seeking services at public health outlets when in need of care.This presents a particular challenge in trying to reach the Ending AIDS targets and achieving optimal coverage of the RRTTR strategy.In particular, trying to recruit KPs for VCT is crucially important in reaching the PLHIV at risk of spreading HIV and getting them into ART as soon as possible after infection.To address this challenge, Thailand is piloting an approach called community-led HIV services (CLHS).Currently, implementation of CLHS is a type of research project being managed by the AIDS Research Center of the Thai Red Cross, and implemented by several Civil Society organizations in different cities around the country.A key feature of CLHS is that the service providers are members of the target population they intend to serve.This creates a very client-friendly atmosphere for service.CLHS are also located in the most convenient access points for the target population.At the time of this report, there were seven CLHS outlets in four cities:Bangkok and Hat Yai (Rainbow Sky Association); Bangkok and Pattaya (SWING); Pattaya (SISTER); Chiang Mai (CARE MAT and MPlus).The CLHS are able to take blood for HIV testing, provide pre- and post-test counseling, and other related services.The personnel are well trained to provide a standard quality of service.It is notable that the KPs who were first diagnosed with HIV infection by the CLHS had rather high CD4 counts (over 370cells/mm^3) and 86% of newly-detected cases were enrolled in ART programs.The CLHS personnel, who are not credentialed clinicians, are allowed to provide these services because they are part of a research project.Thus, unless CLHS becomes a legal part of the general health service system, it will be difficult to expand coverage of this service.But it is important that CLHS becomes legal because it has been demonstrated to fill gaps in VCT coverage for some of the most vulnerable populations in society.To achieve this, the government will first have to issue a policy endorsing CLHS. Next there needs to be some sort of accreditation to legalize the services delivered by trained KPs to their peers.The personnel themselves will also need legal protections just as any credentialed health worker enjoys.There will need to be a system of quality controls and regular external monitoring.WHO already endorses this form of task-sharing in resource-constrained settings.CLHS also represents a close partnership between the government and Civil Society.

8: Allocation of AIDS Budget and Closing Resource Gaps

This report uses data on AIDS budget allocation for 2014 and 2015, since data for 2016 are forthcoming.Thailand allocated 8,710 million baht for the AIDS response in 2014 and 8,248 million baht in 2015.This represents a decline from the peak of 9,922 million baht in 2011.Since the Thai government was underwriting the cost of ART, 89% of the budget was domestic, while only 11% was from international

donors.Figure 9 displays the AIDS budget by component.Treatment accounted for two-thirds of the total allocation, while prevention comprised 17% of the budget.Fully 8% of the budget was for monitoring and evaluation.

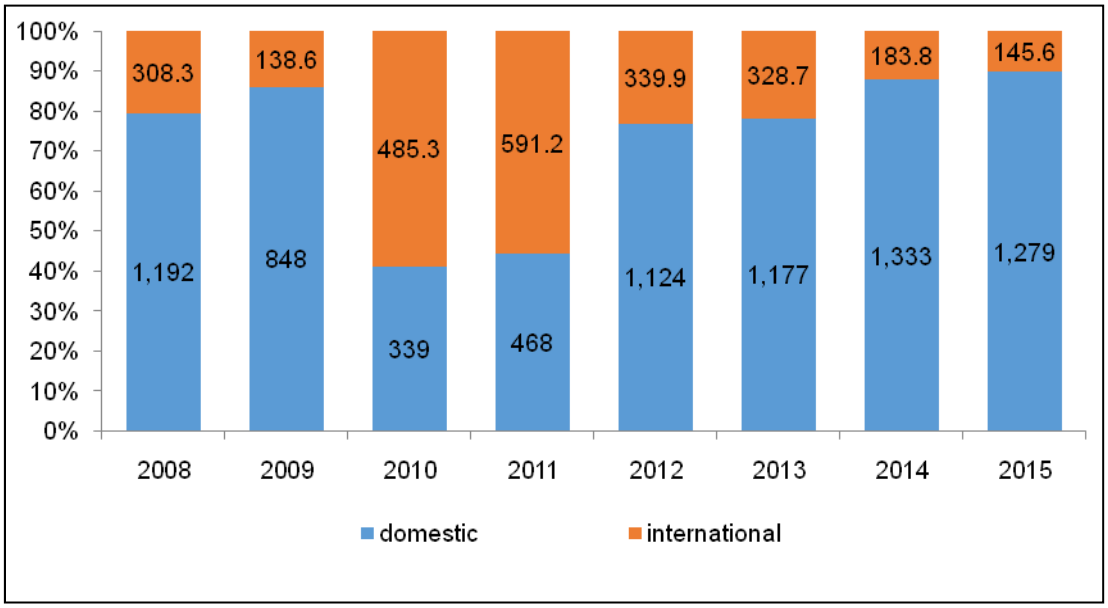
Figure9: Allocation of AIDS Response Budget by Component (million baht)



Source of data: Thailand National AIDS Spending Assessment (NASA) 2014-2015

Over time, Thailand has assumed responsibility for funding the AIDS response from domestic sources.As a result, international donor funding for the program has become less as a proportion over that period (Figure 10). At its peak in 2010-11, international donor funding for the Thai AIDS response reached 60%.However, domestic funding accounted for 77%, 88%, and 90% in 2012, 2014, and 2015, respectively.

Figure10: Funding for Prevention by Source of Budget (millon baht)



Source of data: Thailand National AIDS Spending Assessment (NASA) 2014-2015

9: Protection of Rights and Building Capacity of PLHIV

Thailand has no specific law or mechanism to ensure social protections for PLHIV.Instead, the country supports human rights protections for all persons.There is a National Human Rights Commission which reviews complaints and provides recommendations regarding cases of rights violations.The Commission cannot make charges or prosecute alleged perpetrators.The Commission does not usually hear complaints about violations related to HIV/AIDS.There is a sub-committee on AIDS rights protections of the National AIDS Committee (NAC) which was appointed in 2012, and there are branches of this committee in all provinces. Most of the advocacy on AIDS rights protections has been conducted by Civil Society through campaigns to change laws and policies which discriminate, promote harm reduction for drug users, decriminalize drug addiction, enroll PLHIV in ART regardless of CD4 level, and monitor the situation regarding HIV/AIDS rights violations. In 2016, there was advocacy to enact a policy on eliminating discrimination against PLHIV who apply for, are accepted, or enrolled in an academic institution.The NAC endorsed this proposal and issued a resolution effective January 2017. Related agencies to provide oversight of this policy include the Ministry of Education, Ministry of Interior, Royal Thai Police and the Bangkok Metropolitan Administration.These agencies are expected to develop operational guidelines to implement the policy.Actual mechanisms for protecting AIDS rights have been set up in six provinces, including Bangkok, Chiang Mai, Tak, Songkhla, Rayong, and Chonburi.While this is progress, it is considerably below the target of 33 provinces as stated in the NAP for 2014-16.

One law that needs revision is the 1996 Prostitution Prevention and Suppression Act which is discriminatory for sex workers and presents a barrier to organizing HIV prevention and care services for this vulnerable population.Yet any law to reduce rights violations is only as good as its enforcement.Too often, there is a large gap between policy and action in the field.The relevant staff need to receive orientation about rights and rights protections and be sure to adhere to these in their daily operations.

10: System of Integrated Services for HIV and Related Conditions

HIV and Tuberculosis (TB)

Increased coverage of effective ART has significantly reduced HIV-related opportunistic infections (OIs) including, of course, TB. AIDS mortality declined from 20.4 per 100,000 population in 2001 to 3.3 in 2012.The prevalence of TB in PLHIV in 2016 was 14%.Still, there are important areas for improvement of treatment of HIV-TB co-infection, including coverage, identifying TB-suspected cases, and reducing delayed enrollment in treatment.During 2015-16, Thailand received some GFATM funding for the STAR Project to supplement domestic budget for the response to AIDS and TB in 38 priority provinces, and intensify TB control in an additional 27 provinces.The focus was on improved HIV screening of TB patients, TB screening of PLHIV, and initiating combination treatment as early as possible.TB prophylaxis (Isoniazid Prevention Therapy or IPT) is provided to vulnerable PLHIV in some government hospitals in pilot sites.

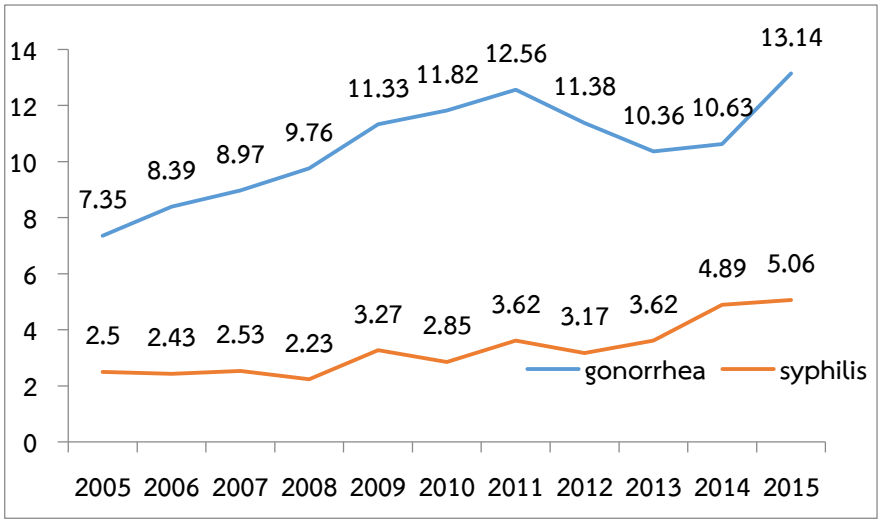
Thailand is trying to improve implementation by the following: (1) Using new technology for diagnosing TB in PLHIV to speed initiation of treatment; (2) Extending services to those with limited access, e.g., prisoners and cross-border populations without health insurance; (3) Developing a handbook for IPT in PLHIV; (4) Training physicians and the clinical team to promote greater coordination of TB and AIDS staff; (5) Convening meetings to plan and exchange data at all levels; and (6) Developing an integrated database with AIDS and TB information for monitoring and evaluation.

STIs

As noted earlier, STI prevalence is increasing for some infections in some populations. In 2015, there were 8,560 cases of gonorrhea and 3,296 cases of syphilis reported in the disease reporting system. This represents population prevalence of 13.1 and 5.1 per 100,000 population, respectively (Figure 11).Of the cases of gonorrhea, 73% were age under 24 years, while one-third of syphilis cases were under 24 years.When looking at just the population age 15-24 years, Figure 12 shows clear increasing trends for both gonorrhea and syphilis for the period from 2012-16.Syphilis prevalence increased three-fold since the beginning of the five-year

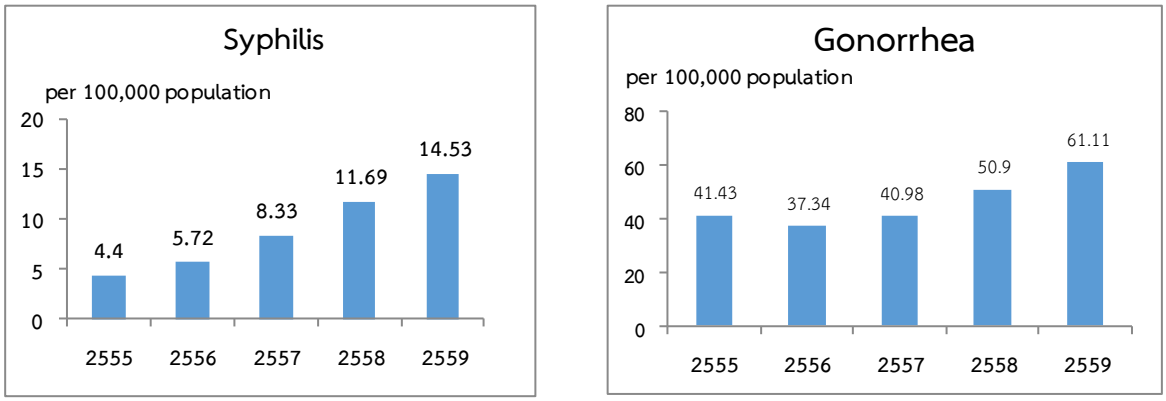
period while gonorrhea increased 50%.These trends imply increased practice of unsafe sex with risky partners.The IBBS also measured STI prevalence in KPs and, in 2014, found levels of 1.3% and 5.9% with gonorrhea and/or chlamydia, respectively, among MSM.The corresponding rates for TG were 0.8% and 4.2%.The rates for MSW were 3.0% and 14.1%, respectively.

Figure11: Number of Cases ofGonorrheaandSyphilis per 100,000 persons: 2005-2012



Source of data: BoE, MOPH

Figure12: Prevalence of STIs in the Population Age 15-24 Years: 2012-16



Source of data: BATS, MOPH

Venue-based FSW had prevalence rates for gonorrhea and chlamydia of 4.2% and 18.6%, respectively.The corresponding rates for non-venue-based FSW were 7.3% and 4.0%, respectively.

In sum, Thailand still has work to do to reverse the increasing trend in STIs, especially the younger cohorts, since STIs significantly increase risk of transmitting/contracting HIV. The following are the principal challenges for Thailand's STI prevention and control program:

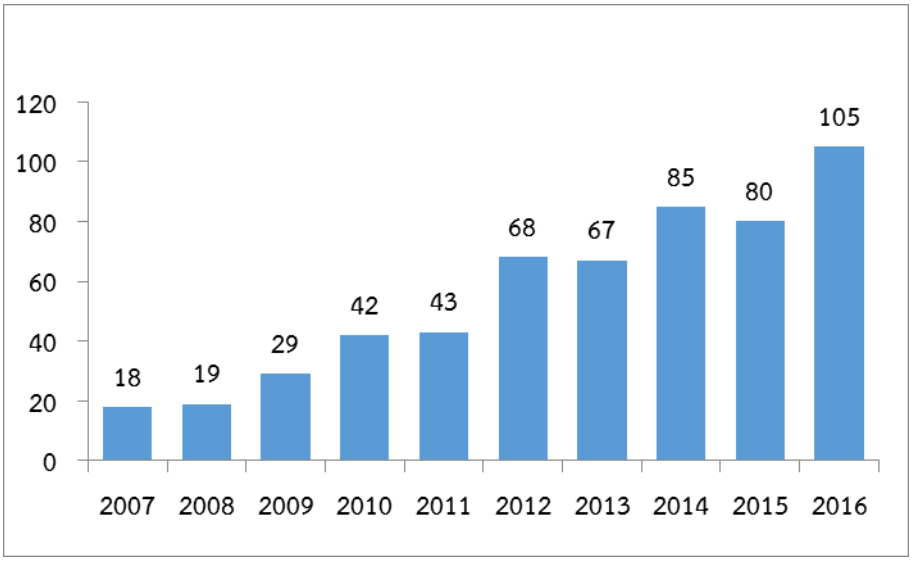
1) There is no system for active STI case detection or STI education in youth (age 15-24 years). This applies to both the general population (e.g., army recruits; factory workers) and KPs such as MSM and sex workers;
2) There is no definition of essential services for STIs;
3) There is no strategic database at the national level with information on prevention and control of STIs.

Thus, the RRTTR strategy for HIV needs to be as intensively applied to STIs if the NAP is to be successful in achieving its targets and goal. All related sectors need to collaborate in this to align mechanisms and standards, with full sharing of strategic data.

Congenital Syphilis

Thailand has implemented prevention of congenital syphilis since 1990. Pregnant women are screened for syphilis during ANC check-ups and, in 2015, nearly all (98.5%) ANC clients were screened in public ANC clinics.Of these, 96.2% were treated for their infection.Prevalence of syphilis in pregnant women was nearly zero at 0.1%.

Figure13: Number of Cases of Syphilis in Children Age 0 to 2 Years: 2007-16



Source of data: BoE, MOPH

Fully 80% of the few cases of MTCT of syphilis were attributed to late initiation of ANC or no ANC at all. Some pregnant women were screened but did not return to the clinic to learn the results and get treated.Some ANC clinics were out of stock of treatment.Finally, some pregnant women were infected after their last syphilis test and delivery.Given the increase of syphilis prevalence in the general population, it is not surprising that the number of cases of syphilis for infants age 0 to 2 years increased from 18 cases in 2007 to 105 cases in 2016 (see Figure 13).

Thailand has set the target for MTCT of syphilis at no higher than 0.05 cases per 1,000 live births by 2020.Thailand has issued national guidelines for prevention of congenital syphilis, but more budget in this area may be needed to achieve the target.

Hepatitis Virus B and C (HBV; HCV)

The situation regarding HBV and HCV is improving in Thailand as of this report.This is due to increased screening of HBV in all ANC clients, and providing the HBV vaccine (four times: at birth, and at two, four and six months of age).There is also screening of blood donors and tighter control of the blood supply.Prevalence of HBV and HCV was 4% and 2%, respectively, in 2004, and declined to 2% and 1%, respectively in 2014.Hepatitis-HIV co-infection is of some interest due to shared transmission routes (e.g., blood and sex).Among PLHIV, prevalence of HCV and HBV was 3% and 8%, respectively, at last measurement. However, among PWID, very high levels of HCV are found (90%) while 12% had HBV.nPLHIV with hepatitis co-infection have three times higher risk of chronic liver disease/failure than PLHIV without hepatitis.Two-thirds of PLHIV deaths whose primary cause of death was liver failure had a history of co-infection with hepatitis.

Since 2015, each of the national health insurance schemes cover treatment of hepatitis.PLHIV may receive one free screening for hepatitis and, if infected are eligible for treatment with Peginterferon and Ribavirin. Nevertheless, there are limitations in access to treatment due to the restriction that the PLHIV must have an HIV viral load under 1,000 copies/mm^3or CD4 count of 350 cells/mm^3or higher. This increases the importance of prevention of co-infection.There are also issues of drug resistance which must be addressed by stricter adherence to treatment regimens.

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 2016**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
PLHIV who know their serostatus	1.1	**% PLHIV who know their serostatus** (1st "90" target: only use data from the NAP system)									81.7%	88.88%	91.38%
		Number									364,060	389,027	410,576
On ART	1.2	**% PLHIV on ART** - CD4 <200 cells/ml	●	●	90.0%	75.76%	71.80%	77.00%					
		- CD4 <350 cells/ml					59.10%	64.61%	69.96%	80.25%			
		- Any CD4 Level								53.55%	60.98%	65.85%	68.48%
		Number						225,272	239,090	246,049	271,652	288,231	307,667
		% PLHIV on ART (2nd "90%" target:only use data from the NAP system)									68.3%	70.11%	71.41%
		Number						206,530	220,628	227,372	256,630	272,755	293,206
		Number of non-Thai PLHIV on ART										2,938	3,047

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 2016**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
Retain in the ART system	1.3	% PLHIV retained in the ART system for at least 12 months after initiating treatment	●	●	95.0%	85.14%	80.70%	83.12%	82.11%	82.70%	83.03%	86.90%	89.49%
		% PLHIV retained in the ART system for at least 24months after initiating treatment *(not an indicator for 2016)*		●			79.80%	79.80%	78.89%	78.38%	77.90%	89.95%	85.86%
		% PLHIV retained in the ART system for at least 60months after initiating treatment *(not an indicator for 2016)*		●					NA	75.91%	74.59%	82.88%	82.71%
Suppress viral load	1.4	% of ART clients with suppressed viral load (VL ≤1000 copies/mL)in the report period *(not an indicator for 2016)*		●						95.38%	96.09%	96.37%	96.78%
		% of ART clients with viral load suppression (VL ≤1000 copies/mL) (3rd "90%" target) (*the numerator is from the NAP data system)*									80.71%	81.89%	82.87%

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 2016**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
		%ART clients withVL < 1,000 copies/ml after12months of treatment *(not an indicator for2016)*		●						92.54%	94.81%		
		% of ART clients with VL≤50 copies/mlinthe report period *(not an indicator for2016)*		●							90.72%	76.27%	
	1.4	**% of PLHIV on ART with suppression of viral load (VL ≤1000 copies/mL)** *(Projections of number of PLHIV)* (new)											54.08%
		Number										223,372	242,979
Late diagnosis	1.5	% of PLHIV with CD4 cell count < 200 cells/µLandCD4 cell count < 350 cells/µLduring the report period											
		- Proportion of PLHIV with CD4cell count at diagnosis < 200 cells/µL									57.03%	57.45%	55.54%
		- Proportion of PLHIV with CD4 count at diagnosis < 350 cells/µL											73.86%

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 2016**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
		Median CD4 cell count at diagnosis (cells/μL) (data from all insurance schemes)				95	102	98	98	109	121	no data	
		Median CD4 cell count before initiation of ART (cells/μL) (data from all insurance schemes)				73	81	96	91	133	130	186	194
Stock-outs of ARVs	1.6	% of ART clinics experiencing temporary stock-outs of ARVs at least once in the prior 12 months		●				3.14%	NA	3.55%	3.05%	no data	no data
AIDS mortality	1.7	Number of AIDS-related deaths per 100,000 population (data from the Spectrum model) (new)	●										19.27
		Number (from the model)		●								14,214	12,863
		Number of AIDS-related deaths (data from service system)										10,513	11,063

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 2016**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
Diagnosis of pediatric PLHIV	2.1	% of infants born to HIV+ mothers tested for HIV (PCR) within 2 months post-partum	●	●	**90.00%**			75.80%	73.13%	77.23%	72.87%	76.14%	92.80%	89.97%
MTCT of HIV	2.2	Rate of MTCT of HIV (Spectrum model)	●	●	**2.00%**			3.75%	3.04%	2.74%	2.30%	2.13%	1.91%	1.79%
		Number							149	135	117	98	86	75
		% of infants infected with HIV by their mother within the past 12 months (data from the service system)	●										1.63%	1.43%
		Number											68	59
Preventionof MTCT	2.3	% of HIV+ pregnant women receiving ARVs to reduce MTCT	●	●	**98.80%**	93.60%	95.00%	94.20%	93.98%	93.75%	95.15%	95.78%		
		(used model data starting in2012)								94.29%	94.00%	94.91%	95.17%	
		(Adjusted Spectrum model for 2016)												96.07%
syphilis	2.4	% of ANC clients screened for syphilis who are found positive and treated												

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 2016**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
		A. % of pregnant women diagnosed with syphilis at first ANC check-up		●						91.55%	99.33%	98.91%	99.13%	99.22%
		B. % of screened pregnant women testing positive for syphilis		●						0.06%	0.07%	0.04%	0.08%	0.11%
		C. % of pregnant women diagnosed with syphilis and treated		●						93.10%	94.51%	98.10%	95.94%	97.84%
	2.5	% of infants diagnosed with syphilis at birth (both live and still births) in the past 12 months (congenital syphilis)	●	●							0.01%	0.01%	0.01%	0.01%
		Number									67	85	80	105

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.													
Indicator			**GAM**	**UA**	**National target 2016**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
3.1	**Number of new HIV infections in the report period per 1,000 HIV-negative population**		●									0.11	0.10
3.2	**Projected number ofKPs**												
	A.	MSW and FSW	●				141,769		141,769		141,769	147,000	155,000
		FSW									123,530	132,000	129,000
		MSW									18,239	15,000	26,000
	B.	MSM-TG	●				550,000		550,000		550,000	571,000	590,700
	C.	PWID	●			40,300	40,300		40,300		40,300	42,650	42,650
	D.	TG	●									50,000	62,800
	E.	Prisoners	●									341,760	306,700
3.3	**% KPs who are PLHIV**												
	A.	MSW and FSW											
		% FSWs HIV+	●	●	**1.0%**		2.69%		2.16%		1.13%		1.0%
		% MSWs HIV+	●	●	**10.2%**		16.00%		12.20%		11.90%		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.													
Indicator			**GAM**	**UA**	**National target 2016**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
	B.	% MSM HIV+	●	●	**6.0%**		8.02%		7.13%		9.15%		no data
	C.	% PWID HIV+	●	●	**21.0%**	17.20%	21.87%		25.20%		20.50%		no data
	D.	% TG HIV+	●				9.5%		7.0%		12.7%		no data
	E.	% prisoners HIV+ (from the service system)	●									1.56%	1.53%
3.4	**KPs who know they are infected with HIV**												
	A.	Sex workers who know they are HIV+											
		% of FSW who were tested for HIV in the past year and know the results	●	●	**90.0%**		47.76%		55.60%		54.19%		52.86%
		% of MSW who were tested for HIV in the past year and know the results	●	●	**90.0%**		49.00%		52.38%		52.35%		no data
	B.	% of MSM who were tested for HIV in the past year and know the results	●	●	**90.0%**		14.93%		25.58%		28.70%		no data
	C.	% of PWID who were tested for HIV in the past year and know the results	●	●	**90.0%**	39.99%	40.71%		43.65%		61.30%		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.													
Indicator			**GAM**	**UA**	**National target 2016**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
	D.	% of TG who were tested for HIV in the past year and know the results (new)	●				29.1%		32.5%		34.4%		no data
3.5	**Coverage of ART for PLHIV KPs (new)**												
	A.	% sex workers receiving ARVs in past 12 months	●										no data
	B.	% MSM receiving ARVs in past 12 months	●										no data
	C.	% PWID receiving ARVs in past 12 months	●										no data
	D.	% TG receiving ARVs in past 12 months	●										no data
	E.	% prisoners receiving ARVs in past 12 months	●										no data
3.6	**Condom use among KPs**												
	A.	% sex workers used a condom at last sex											
		% FSW used a condom at last commercial sex	●	●	**95.0%**		95.56%		93.60%		96.09%		83.1%
		% MSW used a condom at last commercial sex	●	●	**99.0%**		88.00%		98.18%		95.52%		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.													
Indicator			**GAM**	**UA**	**National target 2016**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
	B.	% MSM used a condom at last anal sex	●	●	**95.0%**		80.22%		85.49%		82.08%		no data
	C.	% PWID used a condom at last sex	●	●	**95.0%**	39.18%	46.02%		49.06%		51.20%		no data
	D.	% TG used a condom at last sex (including anal sex)					78.0%		81.6%		84.4%		no data
3.7	**Coverage of HIV preventionservices for KPs**												
	A.	% sex workers receivingprevention services											
		% FSW receiving prevention services	●	●	**80.0%**		50.45%		53.89%		57.74%		43.81%
		% MSW receiving prevention services	●	●	**80.0%**		61.00%		73.77%		67.26%		no data
	B.	% MSM receiving prevention services	●	●	**80.0%**		43.79%		52.65%		43.60%		no data
	C.	% PWID receiving prevention services (new)	●										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.														
Indicator				**GAM**	**UA**	**National target 2016**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
		1)	PWID accessing individual or group HIV prevention services (data from the service system)											no data
		2)	Number of clean needles/syringes given out to PWID according to plan (NSP) (*data from the services system)*											572,070
	D.	% TG who receivedprevention services (new)		●								50.8		no data
3.7.1	**Number ofservice outlets for PWID**			●										
	A.	**Number of service outletsforPWID**		●										164
		1)	Number of service outlets which provide opioid substitution therapy (OST)				49	no data	147	147	147	140		147
			Provided by the government (according to the national plan)											147
			Provided by Civil Society or NGO											0

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.													
Indicator				**GAM**	**UA**	**National target 2016**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
		2)	Number of service outlets according to plan which distribute clean needles and syringes (NSP)				39	49	42	36	38	42	16	17
			Provided by the government (according to the national plan)											3
			Provided by Civil Society or NGO											14
	B.	**Number of areas of responsibility nationwide**		●										89
		1)	Number of locations providing OST (provinces)											77
		2)	Number of locations providing clean needles and syringes (NSP)											12
3.8	% PWID who used a clean needle/syringe at last injection			●	●	**82.0%**	42.02%	77.68%		80.45%		95.30%	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.													
Indicator		**GAM**	**UA**	**National target 2016**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
3.9	Number of needle/syringe kits distribute per PWID per year as per NSP	●	●	**88.0**			9.79	11.52	12.02	13.79	6.33	13.41
3.10	% PWID who received OST (as a proportion of all PWID in treatment)	●									12.66%	15.46%
	Number										754	813
	Projection of the number of opioid users (injection or non-injection); Number who received OST*(not required in 2016)*											
	A.Projection of the number of opioid users (injection or non-injection)		●		no data							
	B.Number who received OST		●	**4,500**		2,201	2,612	3,735	4,068	3,646	5,956	5,258
3.11	% sex workers with acute syphilis infection		●		median		0.26%	0.00%	0.00%	no data		no data
			●		mean		0.62%	0.54%	0.69%	no data		no data
3.12	% MSM with acute syphilis infection		●				NA	NA	24.36%	NA		no data
3.13	**Plan for HIV prevention services and treatment for HIV+ prisoners during incarceration** (new)											

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.												
Indicator			**GAM**	**UA**	**National target 2016**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
	A. % PLHIV who are prisoners												1.53%
	B. % prisoners infected with HCV or who have co-infection with HIV												no data
	C. % prisoners infected with TB or co-infection with HIV												0.64%
3.14	Prevalence of hepatitis and co-infection with HIV among KPs (new)												no data
	A.	Prevalence of HBV and co-infection with HIV among KPs											no data
		● MSW and FSW											no data
		● MSM											no data
		● PWID											no data
		● TG											no data
		● prisoners											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.													
Indicator			**GAM**	**UA**	**National target 2016**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
	B.	Prevalence of HCV and co-infection with HIV among KPs											no data
		● MSW and FSW											no data
		● MSM											no data
		● PWID											no data
		● TG											no data
		● prisoners											no data
3.15	Number receiving PrEP for the first time in the report period (new)												1,224
3.18	% using a condom for last sex with a non-regular partner or regular partner in the past 12 months (new)												no data

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**		**GARPR**	**UA**	**National target 2016**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
S&D	4.1	% of the population age 15-49 years reporting discriminatory attitudes toward PLHIV	●		**52.7%**					no data		58.60%	no data
	4.2	Avoiding HIV services due to S&D against KPs											not applicable
		A. Avoiding HIV services due to S&D against sex workers											not applicable
		FSW delayed seeking health care in the past 12 months											1.8%
		MSW delayed seeking health care in the past 12 months											10.0%
		B. Avoiding HIV services due to S&D against MSM											not applicable
		MSM delayed seeking health care in the past 12 months											7.9%
		C. Avoiding HIV services due to S&D against PWID											not applicable
		D. Avoiding HIV services due to S&D against TG											not applicable
		TG delayed seeking health care in the past 12 months											7.4%

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**			**GARPR**	**UA**	**National target 2016**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
		E.	Avoiding seeking health care or delayed seeking care because of S&D against pregnant PLHIV											12.0%
Violence	4.3	Proportion of women age 15-49 years who are married or in a relationship who have experienced physical abuse or sexual abuse by their partner in the past 12 months		●							no data			

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 x2016**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
HIV knowledge	5.1	% youth age15-24 years who correctly identify methods of preventing sexual transmission of HIV, and disagreeing with false myths about how HIV is contracted or transmitted (*data from the 2016 MICS)*	●	●		no data							43.3%

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													
Reproductive health	5.2	%women age 15-49 (married or cohabiting) who have unmet need for family planning and modern contraception (MICS)	●										91.0%
		1.6) % HIV infected women age 15-24 years (ANC) *(not an indicator for 2016)* Median	●	●	0.33%	0.58%	0.44%	0.44%	0.40%	0.43%	0.52%	0.43%	0.32%

Commitment 8: AIDS Expenditures and Closing the Resource Gap											
Global target: Ensure that HIV investments increase to $26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers											
Indicator			**GAM**	**UA**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
8.1	Domestic and international expenditures for AIDS by source (million baht)		●		7,208.49	7,733.28	9,921.65	8,793.06	8,826.93	8,710.15	8,247.93
	A.	HIV VCT	●		0.51%	0.47%	1.02%	0.96%	0.83%	1.78%	1.60%
	B.	ART	●		43.35%	39.63%	42.38%	36.01%	31.16%	50.33%	48.53%
	C.	Lab monitoring (CD4, VL, Cholesterol)	●		5.18%	8.81%	10.73%	10.70%	10.20%	10.25%	13.95%
	D.	Treatment and prevention of OIs (excluding AIDS and TB)	●		no data					0.24%	0.70%
	E.	Five integrated prevention components	●								

Commitment 8: AIDS Expenditures and Closing the Resource Gap												
Global target: Ensure that HIV investments increase to $26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers												
Indicator				**GAM**	**UA**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
		1)	Prevention among women and females age 10-24 (only for countries with high levels of HIV in the general population)									
		2)	Voluntary male circumcision (only for countries with high levels of HIV in the general population)									
		3)	PrEP for KPs			no data						
		4)	Condoms									
			• Promotion of use and access to condoms			0.32%	0.00%	0.00%	0.37%	0.36%	0.02%	0.00%
			• Female condoms			0.01%	0.01%	0.01%	0.05%	0.02%	NA	NA
			• Social marketing of condoms			0.00%	0.34%	0.45%	0.00%	0.00%	0.55%	0.37%
		5)	HIV prevention for KPs	•								
			• Sex workers and their clients			0.05%	0.79%	0.68%	0.55%	0.51%	0.69%	0.05%
			• MSM			0.11%	0.71%	1.10%	0.76%	0.94%	0.69%	0.77%
			• TG								0.02%	0.02%
			• PWID (harm reduction)			0.50%	0.24%	0.71%	0.58%	0.44%	0.24%	0.32%
			• Prisoners			no data						

Commitment 8: AIDS Expenditures and Closing the Resource Gap											
Global target: Ensure that HIV investments increase to $26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers											
Indicator			**GAM**	**UA**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
	6)	Prevention of MTCT of HIV	●		1.82%	0.98%	0.85%	0.80%	0.82%	0.50%	0.43%
	7)	Enabling social environment	●		0.12%	1.60%	1.70%	0.93%	1.48%	0.44%	0.25%
	8)	Financial assistance (cash) for girls and women	●		no data						

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 target2016**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
HIVandTB	10.1	Projected %and number of PLHIV with TB treated for both HIV and TB	●		**50.00%**	25.5%	26.1%	36.2%	27.8%	38.4%	39.1%	35.9%	30.0%
		- Number of PLHIV with new TB infection or re-infection who started treatment for TB during the report period, and who received ARVs before or who started ART while receiving TB treatment in report period						4,669	3,591	4,619	4,691	5,389	4,495

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 target2016**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
	10.2	Number of PLHIV with infectious TB enrolled in treatment during the report period	●	●						no data			14.0%
	10.3	% of patients receiving TB treatment during the asymptomatic phase during the report period	●				no data						
Other STIs	10.4	Number of males with penile discharge in the past 12 months	●							no data			
	10.5	Rate of detection of gonorrhea among males using laboratory confirmation (new)	●										23.92
HCB and HVC	10.6	% of PLHIV starting on ART screened for HVB	●									no data	
	10.7	%of PLHIV with HVB co-infection receiving treatment for both HIV and HVB	●									no data	
	10.8	% of PLHIV starting on ART screened for HVC	●									no data	
	10.9	% of PLHIV with HVC co-infection receiving treatment for HVC during the specified period (e.g., 12 months)	●									no data	
Cervical cancer	10.1	Screening for cervical cancer among female PLHIV (new)	●										no data