NATIONAL MONITORING AND EVALUATION PLAN FOR HIV PREVENTION targeting most-at-risk populations and migrant workers 2010-2011 THAILAND
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2010-2011

THAILAND

16 February 2010
ACKNOWLEDGMENT

On 25 April 2004, UNAIDS co-hosted a high-level meeting at which key donors reaffirmed their commitment to strengthening national AIDS responses led by the affected countries themselves. They endorsed the “Three Ones” principle, to achieve the most effective and efficient use of resources and to ensure rapid action and results-based management:

- **One** agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.
- **One** National AIDS Coordinating Authority, with a broad-based multisectoral mandate.
- **One** agreed country-level Monitoring and Evaluation System.

Thailand’s National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation, 2007-2011 lays out the action framework for HIV prevention for MARPs and migrant workers. The plan was developed through multisectoral collaboration between government and civil sectors, including affected populations, and was approved by the National AIDS Prevention and Alleviation Committee. The Round 8 grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria expands and builds upon this framework. The National AIDS Prevention and Alleviation Committee (NAPAC) sets the HIV/AIDS policies for the country, with the National AIDS Management Center (NAMC) serving as coordinating body.

Thailand’s National Monitoring and Evaluation Plan for HIV Prevention Targeting Most-At-Risk Populations and Migrant Workers was developed in a collaborative effort, involving all Implementers across sectors. A series of separate meetings were held with those implementing programs for each population (female sex workers, men who have sex with men, injecting drug users and migrant workers) to develop a consensus on the implementation framework and core indicators for each group. A Joint meeting was then held to present and discuss the overarching framework for Thailand. A smaller group of key implementers met at the Rose Garden, Nakhon Pathom from December 16th-20th, 2009 to develop the plan in detail.

The plan would not have been possible without the collaborative spirit of these colleagues who have dedicated so much of their lives to HIV prevention. Now that the plan for an integrated M&E system across levels and sectors is in place, this same spirit is needed to carry it through and make it effective. The Department of Disease Control is grateful for the time and effort that the following individuals have contributed to this plan:

- National AIDS Management Center (NAMCX)
- Department of Disease Control (PR-DDC)
- Raks Thai Foundation (RTF)
- PSI Thailand (PSI)
- The Planned Parenthood Association of Thailand (PPAT)
- Rainbow Sky Association (RSAT)
- Thanyarak Institute on Drug Abuse, Department of Medical Service
- A-Square Regional Technical Support Team, Policy Research and Development Institute
  UNAIDS Thailand
- Institute for Population and Social Research, Mahidol University

Dr. Manit Teeratantlkanont
Director-General of the Department of Disease Control
Secretariat of the National AIDS Prevention and Alleviation Committee
FORWARD

The National Monitoring and Evaluation Plan for HIV Prevention Targeting Most-At-Risk Populations and Migrant Workers provides a unified and harmonized monitoring and evaluation system for Thailand. It follows the principle of the Three Ones: one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority, with a broad based multi-sector mandate; and one agreed HIV country-level monitoring and evaluation system.

The Plan sets out a system to monitor the Royal Thai Government’s national strategy for HIV prevention for most-at-risk populations, including the activities of the principal recipients and sub-recipients of the Round 8 Global Fund project. While considerable progress has been made in establishing strong monitoring and evaluation systems for these efforts, there is also a need to link systems from various implementers to bring together important information from various sources in one integrated and comprehensive national M&E system. This unified system is particularly important as prevention efforts, and the authority to plan for these efforts, are increasingly centered at the subnational and community level.

The plan defines the core indicators that the Thai government has a long-term commitment to measure in order to monitor change in the epidemic and progress of the national prevention response. Besides setting out best practice for data collection and data quality assurance, the plan specifies how data flows from the program level to the sub-national and national level. Capacity building on international standards for data collection as well as on the use of strategic information for policy development and planning is an integral part of the system. MARP and migrant worker groups participate in capacity building for M&E as well, as they have a vital role in effective HIV prevention.

The Plan will provide a road map for all those implementing HIV prevention programs for MARPs and migrant workers in Thailand. Thailand’s most-at-risk populations and migrant workers have complex needs for HIV prevention, and a fully collaborative effort is necessary to meet the challenge of program design and implementation. Thailand’s National Monitoring and Evaluation Plan lays out a system that assures strategic information is available to improve and maintain the program’s effectiveness.

Dr. Somsak Akksilp
Deputy Director-General of the Department of Disease Control
Chair of the National M&E for HIV AIDS Response Subcommittee
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ABBREVIATIONS

AEM Asian Epidemic Model
AHRN Asian Harm Reduction Network
AIDS Acquired Immune Deficiency Syndrome
AIDSNet AIDS Network Development Foundation
BATS Bureau of AIDS TB and STI
BCC Behavior Change Communication
BoE Bureau of Epidemiology
BSS Behavioral Surveillance Survey
CBO Community Based Organization
CHAMPION Comprehensive HIV Prevention Among MARPs by Promoting Integrated Outreach and Networking
CPAT Community Pharmacy Organization of Thailand
CRIS Country Response Information System
DDC Department of Disease Control
DHSS Department of Health Service Support
DiC Drop in Center
DOC Department of Corrections
DQA Data Quality Audit
FAR Foundation for AIDS Rights
FSW Female Sex Workers
GAP Global AIDS Program
GFATM Global Fund to Fight AIDS, Tuberculosis and Malaria
HIS National Health Information System
HIV Human Immunodeficiency Virus
HSS HIV Sentinel Surveillance
IA Implementing Agency
IBBS Integrated Biological Behavioral Survey
ICD-10 International Classification of Diseases 10th revision
IDU Injecting Drug Users
IEC Information Education and Communication
IPSR Institution of Population and Social Research
KAP Knowledge, Attitude and Practice
M&E Monitoring and Evaluation
MAP Measuring Access and Performance
MARP Most at Risk Population
MOPH Ministry of Public Health
MSM Men who have Sex with Men
MSW Male Sex Worker
MW Migrant Worker
NAMC National AIDS Management Center
NAP National AIDS Program
NAPAC National HIV Prevention and Alleviation Committee
NASA National AIDS Spending Assessment
NCPI National Composite Policy Index
NGO Non-governmental Organization
NSP Needle and Syringe Program
ONCB Office of Narcotics Control Board
OST Opioid Substitution Therapy
PAC Provincial AIDS Committee
PCM Provincial Coordinating Mechanism
PHO Provincial Health Office
PLHA People Living with HIV/AIDS
PPAT Planned Parenthood Association of Thailand
PR Principal Recipient
PRISM Performance of Routine Information Systems Management
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>PSI</td>
<td>Population Services International</td>
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<tr>
<td>RAR</td>
<td>Rapid Assessment and Response</td>
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<td>RDQA</td>
<td>Routine Data Quality Audit</td>
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<tr>
<td>RDS</td>
<td>Respondent Driven Sampling</td>
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<td>RHIS</td>
<td>Routine Health Information System</td>
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<td>RSAT</td>
<td>Rainbow Sky Association of Thailand</td>
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<td>Raks Thai</td>
<td>Raks Thai Foundation</td>
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<td>RTG</td>
<td>Royal Thai Government</td>
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<tr>
<td>SOP</td>
<td>Standard Operating Procedures</td>
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<tr>
<td>SOTA</td>
<td>State-of-the-art</td>
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<tr>
<td>SR</td>
<td>Sub-recipient</td>
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<tr>
<td>SSR</td>
<td>Sub-sub Recipient</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<tr>
<td>TAO</td>
<td>Tambol Administrative Organizations</td>
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<tr>
<td>TDN</td>
<td>Thai Drug Users's Network</td>
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<tr>
<td>TG</td>
<td>Transgender</td>
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<tr>
<td>TIDA</td>
<td>Thanyarak Institute for Drug Abuse</td>
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<tr>
<td>TNP+</td>
<td>Thai Network of People Living with HIV/AIDS</td>
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<tr>
<td>TOT</td>
<td>Training of trainers</td>
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<tr>
<td>TRaC</td>
<td>Tracking Results Continuously (PSI Tracking Survey)</td>
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<tr>
<td>TUC</td>
<td>Thailand MOPH-U.S. CDC Collaboration</td>
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<tr>
<td>TWG</td>
<td>Technical Working Group</td>
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<tr>
<td>UA</td>
<td>Universal Access</td>
</tr>
<tr>
<td>UIC</td>
<td>Unique Identifier Code</td>
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<tr>
<td>UNAIDS</td>
<td>United Nations Joint Programme on AIDS</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Program</td>
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<tr>
<td>UNGASS</td>
<td>United Nations General Assembly</td>
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<tr>
<td>USG</td>
<td>United States Government</td>
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<tr>
<td>VDT</td>
<td>Venue-Day-Time-Sampling</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>WVFT</td>
<td>World Vision Foundation of Thailand</td>
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To place the plan in context, a brief overview of the current status of the HIV epidemic in Thailand is needed. HIV is still mostly concentrated among MARPs in Thailand: female sex workers (FSW); men who have sex with men (MSM), including transgender (TG) and male sex workers (MSW); and injecting drug users (IDU). The Ministry of Public Health (MOPH) has conducted HIV surveillance among those populations with presumed high risk behavior since 1989 including female sex workers (FSW), injecting drug users (IDU), and male clients of sexually transmitted infection (STI) clinics. As seen in Figure 1.1, IDUs had the highest levels of infection, ranging from 30% to 50%. After the year 1991, the prevalence gradually declined to a low of 30.0% in 1994, but then reversed upwards reaching a peak of 50.8% in 1999. In the past five years, the prevalence among IDUs has declined to a level of 36.3% in 2006. For direct female sex workers, prevalence rose to a high of 33.2% in 1994, then declined steadily until 2007 when there was a slight upturn to 5.3%. Prevalence levels for indirect sex workers and male clients of STI clinics have stayed below 10% with steady declines since the mid-1990s.

Thailand is a global leader both in HIV prevention and in the collection of high quality data on public health. The plan builds on this foundation by defining the M&E framework, identifying the paths for data flow at all levels, setting the standard for data quality, and emphasizing the use of strategic information for effective HIV prevention.

Source: HIV sero surveillance, Bureau of Epidemiology

Figure 1.1: HIV prevalence among FSWs, male STI clients and IDUs, 1989-2008

1 For the purpose of this plan, FSWs are defined as all women who sell sex, regardless of the venue. MSM, MSW and transgender refers primarily to those often buying and/or selling sex, having multiple sex partners of different types, and who frequent specific entertainment venues, establishments, and public places where MSM meet sexual partners. IDUs are defined as all drug users who inject. MSM and IDUs will also be reached in closed settings. MWs include both documented and undocumented workers from Myanmar (80%), Lao PDR (10%) and Cambodia (10%).

Findings on new infections by routes of transmission for MARPs are produced in Thailand by using the Asian Epidemic Model (AEM), drawing on baseline data since 2000 and updated in 2005 (Figure 1.2).

The model allows projections backward in time as well as forward. The initial epidemic among IDU was first detected in 1985 and increased rapidly in 1988. Following that time, while HIV spread continuously among IDUS the increase was not as rapid. Soon after detection among IDUs, epidemics were detected among female sex workers and their clients. Male clients of FSWs represented a large segment of the population and were distributed widely throughout the country, both in rural and urban areas. The number of new infections in these populations increased rapidly and reached a peak during 1990 – 1995. Infection from sex with female sex workers was the most common route of transmission and led to the spread of HIV through male clients of sex workers to wives of these men and to MSM (Figure 1.2).

The key factor leading to the decline in HIV transmission after 1995 was the 100% condom use campaign in commercial sex establishments, which began in 1992 and contributed to a national change in behavioral norms regarding commercial sex. However, efforts to promote safe behavior in other population groups was less thorough and, thus, infections have continued to occur in these other population groups. The Model shows that the proportion of new infections among MARPs is close to 60% currently, and if current trends continue will be 70% by 2020. Using the same model, if Thailand conducts aggressive prevention programs for MARPs, by 2025 fully 78,000 cases will be averted, saving 900 million baht per year.
In recent years prevention efforts for MARPs have stalled for several reasons. MARPs are hard to reach and disconnected from existing health care systems in Thailand. On the public health side, previous strategies focused primarily on sex work (where Thailand had some success in the past), but have not fully included all groups most at risk. While MSM, IDU and MW are groups that have previously received less or little attention, they are now a major focus of the National Strategic Plan for HIV. This five-year plan, issued in November 2007, fills many of the previously existing gaps in Thailand’s HIV strategy.

Decentralization of public health funding and of the planning process has further complicated the picture for MARPs. Implemented since 2005, the decentralization policy means that central authorities now have little say on health budgets, which go directly to provinces. While new budgetary authority the provincial level has increased responsibility for HIV prevention, in many if not most cases there is limited awareness and capacity to address complex prevention issues, especially regarding MARPs. Budgetary decisions have thus usually favored clinical care for other diseases over prevention for HIV.

The HIV prevention situation for MARPs is further compounded by a lack of strategic information. A key element of Thailand’s previous successes in addressing HIV/AIDS, strategic information was collected in a standardized fashion in all provinces and analyzed at the central level to set direction for action. With decentralization, most of these data collection mechanisms have been dismantled. The policy has also adversely affected funding for nongovernmental organizations (NGOs), which now have less access through provincial levels to funds that were previously available at the central level. The 2007 National Plan concludes “this system and epidemiological monitoring framework are no longer as applicable for monitoring the current HIV situation.”

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Organization of the M&E plan

This plan addresses these issues by seeing the way forward through the development of a framework for monitoring and evaluation for MARPs and MWs. The plan is organized as follows. First, Thailand’s HIV prevention strategy for MARPs and MWs is described (Section 2). Second, an overview of the monitoring and evaluation strategy is outlined, including the core indicators (Section 3). A more detailed overview of the comprehensive national monitoring and evaluation system is given in Section 4. This includes an outline of how the system is coordinated and the roles of key implementers; an explanation of the major data collection efforts, including an overview of data flow; an outline of how data quality is assured; and finally a description of the major information products that result from the system. In Section 5 the action plan for the M&E system is presented, and Section 6 details the budget.
Thailand’s strategy for HIV prevention for MARPs and migrant workers is described in the National Plan for Strategic and Integrated HIV and HIV prevention and Alleviation, 2007-2011. The plan was developed through multisectoral collaboration between government and civil sectors, including affected populations, and was approved by the National HIV Prevention and Alleviation Committee (NAPAC). The National Plan builds on the Thai government’s success in curbing HIV transmission over the last two decades. The objectives of the Plan are to integrate HIV prevention and alleviation strategies at all levels, to promote multi-sector collaboration, and to provide integrated services for all population groups.

This is accomplished through four key strategies: 1) improved management to integrate HIV/AIDS responses in all sectors; 2) integration of prevention, care, treatment and impact mitigation for each population; 3) HIV/AIDS-related rights protection; and 4) monitoring and evaluation, coupled with research on HIV prevention and alleviation.

While Thailand’s HIV prevention strategies have served as a successful model for the world in the past, several factors have adversely affected these efforts in recent years. As mentioned above, these factors include decentralization, adverse policy changes, and a shift of emphasis to AIDS treatment. The new national program has recognized the need to focus on MARPs with enhanced HIV prevention programs.

The Round 8 Global Fund project facilitates that emphasis, by extending the health system and its capabilities to the hard-to-reach MARPs and MWs who have the greatest need for HIV prevention. While the Thai health care system includes services that are among the best in the region, barriers exist to their availability to MARPs and migrant workers. The infusion of funding to mobilize civil society organizations (in many cases operated by MARPs themselves) provides HIV prevention activities in the field and actively links MARPs to the existing health care system. Tailored Behavior Change Communication (BCC), Voluntary Counseling and Testing (VCT), condom distribution, sterile needle/syringe distribution, and referral for early STI diagnosis and treatment are the major components of the HIV prevention strategy for MARPs and MWs.

The National Plan emphasizes the importance of supportive public policy and the empowerment of people to protect themselves from HIV in socially and culturally appropriate ways. This includes specific recognition for most-at-risk populations (MARPs) and migrant workers; specifically, the plan ensures that “the rights of hard-to-reach groups such as IDU, labor migrants, ethnic groups, MSM, sex workers, prisoners etc., are protected and they have access to prevention services with proper coverage and quality assurance.”

Thailand’s National HIV/AIDS Plan also recognizes the need to address the policy framework to better enable prevention efforts for MARPs and MWs, engaging key stakeholders at the highest level to support these efforts and their sustainability. Reducing stigma among the general public through the persuasive use of media is planned. Finally, in conjunction with the Global Fund project, the plan outlines ways to strengthen strategic information systems and to improve monitoring and tracking of changes in behavior and HIV infections. It also plans to build capacity of stakeholders at the national and subnational level to better use strategic information for policy and planning.

In developing its National Plan, the Thai government is committed to supporting the “Three Ones” principle endorsed by UNAIDS since 2004:

- One agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners.
- One national AIDS coordinating authority, with a broad based multi-sector mandate.
- One agreed HIV country-level monitoring and evaluation system.

The National HIV prevention and Alleviation Committee (NAPAC) sets the HIV/AIDS policies for Thailand. Evidence-based decision making by the committee relies on the high-quality data produced by the M&E system. The National AIDS Management Center (NAMC) serves as the coordinating body for HIV prevention efforts. Seventeen government ministries and departments, as well as international organizations, civil society and the private sector, share responsibility.
for implementation of the prevention efforts outlined in the National Plan. These include the three Principal Recipients (PRs) of the Round 8 Global Fund project and a number of sub-recipients (SRs).

The Round 8 Global Fund grant to Thailand is titled Comprehensive HIV Prevention among MARPs by Promoting Integrated Outreach and Networking (CHAMPION-I). The Department of Disease Control (DDC), under the Ministry of Public Health, is the PR for MSM, SW, and HIV Sentinel Surveillance (HSS), working with three NGO SRs (Rainbow Sky Association of Thailand (RSAT), the Planned Parenthood Association of Thailand (PPAT), and Thanyarak Institute for Drug Abuse (TIDA); and three governmental SRs (Bureau of AIDS, TB and STI (BATS), Department of Corrections (DOC) and the Office of Narcotics Control Board (ONCB). Raks Thai Foundation serves as PR for the migrant worker programs, in collaboration with Sub-Recipients (SRs) the Bureau of Epidemiology (BoE), the World Vision Foundation of Thailand (WVFT), the AIDS Network Development Foundation (AIDSNet), the Pattanarak Foundation, Foundation for AIDS Rights (FAR), and the Department of Health Service Support (DHSS). Finally, Population Services International (PSI) serves as PR for IDU programs, working with three SRs: the Raks Thai Foundation (Raks Thai), the Community Pharmacy Organization of Thailand (CPAT), and the Asian Harm Reduction Network (AHRN).

Figure 2.1 shows the overarching implementation strategy for HIV prevention for MARPs and MWs. In its National Plan, Thailand has committed to reducing new HIV infections by at least half (50%) by 2011. In addition, Thailand has endorsed universal access, which includes targets of 80% coverage for MARPs by prevention programs and 60% reduction in key risk behaviors. In conjunction with universal access to ART, the Thai efforts in HIV/AIDS are ambitious and increasingly focus on the special needs of MARPs in order to reach these goals.
Figure 2.1: Overarching Implementation Strategy, Thailand

**Impact**
Reduced HIV prevalence among MARPs and MWs

**Outcomes**
- Increased preventive behavior (condom use and safe injection)
- Reduced STI burden

**Intermediate outcomes:**
- Increased HIV prevention coverage and intensity of exposure
- Increased STI, VCT and OST coverage and intensity of access
- Increased HIV/AIDS knowledge
- Increased accessibility to condoms/lubricant and needles

**Outputs**

- Increased informed demand
- Improved accessibility and availability of STI and VCT services
- Improved accessibility to condoms and lubricant
- Increased accessibility to comprehensive harm reduction

**Sub-outputs**
- Increase the number of well-trained outreach and peer educators
- Establish drop-in centers for MSM & FSW
- Improve BCC contents and approaches tailored to MARPs
- Develop/distribute targeted media
- Increase demand for condoms through condom

- Increase availability of STI and VCT services (including mobile and community-based services)
- Undertake sensitized training among care providers and VCT improve their capacity in STI and services
- Develop national standard guidelines and SOP and improve quality of care

**Enabling environment for prevention activities**

- Build a safer/reinforcing environment for MARPs
- Increase capacity of MARPs for meaningful involvement and leadership in prevention activities
- Advocacy for MARP-specific policies
- Sensitized training of key stakeholders
- Community mobilization

**Effective management and sustainable financing of national and sub-national responses**

- Make available size estimation for MARPs and MWs
- Mapping of key sites for MARPs and MWs
- Undertake, improve IBBS, BSS, HSS, monitoring surveys
- Strengthen program monitoring for MARPs
- Strengthen capacity of CBO, NGO, sub-national and national government on M&E and use of data program improvement and planning
- Conduct and disseminate high-quality operations and policy research
- Improve data analysis, interpretation and use

**Improved health status and well-being among MARPs and MWs**

- Improve coordination and integration of services
- Establish/strengthen sub-national coordinating mechanisms
- Build capacity of national and sub-national mechanisms to appropriately address MARP & MW programs in the operational plan
- Mobilize and increase local authority ownership to epidemic response toward MARPs & MWs
- Mobilize financial support to national and subnational governments, CBOs and NGOs
As shown in the diagram, the two outcomes expected from the implementation strategy are increased preventative behavior among MARPs and MWs and a reduced burden of sexually-transmitted diseases. To achieve these outcomes, the implementation strategy includes four intermediate outcomes:

- Increased HIV prevention coverage and intensity of exposure
- Increased STI, VCT and OST coverage and intensity of access
- Increased HIV/AIDS knowledge
- Increased accessibility to condoms/lubricant and needles

As discussed above, the needs of most-at-risk populations and migrant workers are complex. Learning from past success in HIV prevention, the implementation strategy is designed to include an integrated package of services that is tailored to their individual needs. The key strategy for achieving the HIV prevention goal is to target those most at risk of HIV infection, reach them in sufficient numbers, and provide them with broad and effective HIV prevention services.

Though the Thai health system is relatively well-developed, it has been less effective in reaching MARPs. Sex workers (SWs), men who have sex with men (MSM), injecting drug users (IDUs) and migrant workers (MWs) are largely disconnected from the existing public health system. Thus, a key strategy is to work primarily through civil society and nongovernmental organizations (NGOs) to mobilize MARP and MW peers to reach out to these groups, provide them with HIV prevention products and services and link them with Thai health services that they currently face difficulty accessing. Thus the overall objectives are to integrate HIV prevention and alleviation strategies into organizations at all levels, to promote cross-sectoral collaboration, and to integrate prevention, care, treatment and impact reduction strategies into service provision for all target population groups. Implementation frameworks for each individual population group are found in Annex 1.

The package of services is shown graphically in Figure 2.2 and described below.
The HIV prevention strategy is linked to other needed health services for these populations through referral and other linkages; these are depicted in the box in the upper right in the two figures. These services include care and treatment for those living with HIV, reproductive health services and others specifically tailored to the populations.

The strategy includes three main outputs, as described below:

### Output 1: Increased informed demand, availability and accessibility to integrated package of services

Thailand's national strategy calls for greater accessibility of prevention services for MARPs and MWs. It provides for strengthening NGOs and community-based organizations (CBOs), especially those able to reach vulnerable population groups (including IDUs, MSM and undocumented migrants), so these population groups can receive the same prevention and treatment services as other groups. It also calls for ensuring coverage of condoms for these populations, and to develop means to ensure accessibility to other services such as voluntary counseling and testing (VCT). Finally, it emphasizes the treatment, prevention and control of STIs through greater accessibility of these services.

**O1.1: Increased informed demand** means that the MARPs' and MWs' motivation to prevent HIV is addressed through increasing knowledge and awareness of their HIV risks and of prevention methods. The integration of services means greater holistic care in terms of physical, psychological, social, spiritual and economical aspects of HIV prevention for these populations. Specific activities contributing to this component include:

- **Recruit and train outreach workers and peer educators:** Outreach workers and peer educators are key components of the services provided as part of the Global Fund project. To the extent possible across the highly varied MARP groups, standardized training and capacity-building on outreach for nongovernmental outreach volunteers and peer educators for all MARPS will ensure that all are providing an adequate level and quality of HIV prevention information and education. Peers and outreach workers working with each of the MARP groups will have specific trainings to ensure effective and sensitive outreach methodologies appropriate for each group. The outreach workers and peer educators will also function as community contact points for MARPS. To increase chances of MARPs receiving effective service from health providers, selected outreach workers and peer educators will also conduct outreach activities, designed to sensitize the government health workers and officials and staff of NGO health services to the special prevention service needs of and significant barriers faced by MARPs in accessing those services.

- **Establish and/or strengthen outreach channels for MARPs, including Drop-In Centers (DiCs):** One hundred and thirty DiCs are being established through 42 provinces with support from the Round 8 Global Fund project to reinforce the outreach activities and to offer venues where interventions with MARPs can be intensified, in order to ensure significant and sustained changes in HIV risk behaviors. Primarily, these DiCs are community-based and largely run by outreach staff and affected populations. While outreach workers and peer educators reach the MARPs at their community settings, the DiCs will serve as a meeting and information centers as well as a “safe space” for the normally marginalized populations to socialize, network, and have more extensive contact with staff and volunteers of the program. To ensure significant and sustained changes in risk behaviors – particularly increased condom use and reduced needle sharing – the program will provide intensive and repeated contacts with MARPs through multiple channels, including outreach, DiCs and, in the case of IDUs, pharmacies and closed settings. While acknowledging that efficiency could be gained by serving multiple groups through DiCs, each DiC will primarily serve a single MARP. Distinct sub-cultures and locations of MARP populations necessitate that each DiC is dedicated to a single MARP.

- **Develop and deliver tailored behavior change communications for MARPs and MWs:** HIV risk behaviors and determinants of risk behaviors in Thailand are better studied and understood for the general population than they are for MARPs. When necessary, assessments of key determinants of risk behaviors will be undertaken by the PR responsible for each MARP group. Focus groups and other rapid
assessment techniques will be used to explore what is not known or not current in the information known about the variety of risk groups targeted and the different sites covered. The results will be used to inform all Information, Education and Communication (IEC) and Behavior Change Communication (BCC) materials and training and to pre-test materials for readability and acceptability to the target groups before distribution.

O1.2: Improved accessibility and quality of STI and VCT services is addressed through expansion of services specifically tailored to MARPs and MWs and improving their quality. Specific activities under this component include:

**Increase availability of friendly STI and VCT services (including mobile and community-based services):** Testing and counselling serves two roles: as an entry point to additional HIV services and, through the knowledge of one's serostatus and the counselling provided, as a motivator and facilitator of behavior change among MARPs. Currently, VCT services in Thailand are largely hospital and clinic based. VCT service providers in these settings do not routinely provide supportive services, counseling, or comprehensive referral information to all MARPs. Training and sensitization of VCT service providers conducted by the DDC help increase the uptake of VCT by MARPs, and regular mobile VCT services will be provided by hospital or health-center staff at the project DiCs. To increase access to VCT for MARPs, additional VCT sites are being created through the participating NGOs, including those in closed settings. The hospitals offer free VCT yearly to all Thai MARPs and documented MWs at the time of the regular STI check. PR-DDC also supports provincial and district hospitals in the program areas to provide MW-friendly VCT (in their own language and tailored to socio-cultural status). Community-based VCT conducted by trained health professionals targeting MSM, using rapid test for same day return results will be piloted in 6 provinces, supported by the United States Government (USG). Outreach workers and peers will refer MARPs to VCT services in DiCs or hospital-based settings. In addition, training for health providers in methadone clinics and prisons will include mechanisms for VCT referral.

Through the Round 8 Global Fund project, program activities will increase the uptake of STI services for MARPs through the outreach and referral program conducted by CBO/NGOs linked to hospitals and health centers. DIC staff, outreach volunteers, methadone clinic providers and ART treatment centers are trained to refer clients to STI services. Only documented MWs are tested for STI annually and treated if necessary by the Ministry of Public Health. To address this problem among undocumented migrant workers, Raks Thai and the Sub-Recipients (SR)/ Sub-Sub-Recipients (SSRs) for MWs provide migrant-friendly referrals, addressing language and cultural barriers, through a combination of community networks and DICs.

**Undertake sensitized training among care providers and improve their capacity in STI and VCT services:** The need for training and sensitization of service providers is addressed through a module-based curriculum, developed under the coordination of the Department of Disease Control, the Department of Health Service Support (DHSS) and the Department of Medical Service, MoPH. Training modules focus on building understanding of the unique situation, context and health needs of MARPs, and are designed to increase capacity to provide MARP-friendly services. Comprehensive harm reduction guidelines are being developed by the Thanyarak Institute on behalf of the Ministry of Public Health in collaboration with PR-PSI, the Asian Harm Reduction Network (AHRN), and participation of external technical and community members and will include optimal dosing for methadone, client staff interaction, and needle and syringe programs (NSP).

**Develop national standard guidelines and standard operating procedures (SOP) and improve quality of care:** Thailand is committed to raising the current standards for VCT and STI services. During this period, Bureau of AIDS, TB and STI (BATS) is working with stakeholders including the service implementers to develop a Standard Operation Procedure (SOP) for these services and to put these standards into practice.

**Distribute free condoms, and where necessary lubricants to MARPs in accessible venues, including closed settings:** Effective HIV prevention requires an uninterrupted supply of affordable prevention commodities. Thailand has long been a world leader in the use of condoms. However, since 1997, relatively little public sector condom distribution has taken place and some key groups most at risk of HIV in Thailand currently have only limited access to quality condoms. In 2006, only 8.5 million pieces were distributed for free. To stimulate the demand for and practice of condom use among MARPs, the number of condoms purchased for free distribution will be greatly increased to 39 million pieces for distribution to MARPs. Condoms will also be provided free of charge in targeted prisons and detention centers.
Output 2: Enabling environment for prevention activities

Tailoring the package of services for HIV prevention for MARPs and MWs and sensitizing service providers to their needs will directly address the barriers to accessibility that these populations face. However, a broader approach to address stigma and discrimination by creating a more supportive and enabling environment is necessary for effectively addressing the HIV epidemic for these groups. Advocacy activities to encourage a public health approach to MARPs will be implemented in order to support and encourage the changes already taking place in Thailand regarding attitudes towards providing MARPs with HIV prevention services. Specific activities are listed below.

02.1 Strengthened policy and rights protection, reduced stigma and discrimination, and empowerment:

The National Plan states that “human rights based on the Constitution should also be recognized.” This will be accomplished by coordinating cooperation at the community level, giving more recognition to the role of Provincial Committee for HIV prevention and Alleviation, providing support to networks of Non-governmental Organizations (NGOs) and Community-based Organizations (CBOs) and developing capacities for coordination of cooperation and service provision. Specific activities under this sub-objective are:

- Increase capacity of MARPs for meaningful involvement and leadership in prevention activities: Implementing effective HIV prevention services for MARPs requires the greater empowerment and involvement of those groups in the provincial and national response. The Round 8 Global Fund PRs organize trainings for MARP groups and networks to advocate for their specific needs and to sensitize the stakeholders they interact with on a day to day basis, with the support of People Living with HIV/AIDS (PLHA) networks such as the Thai Network of People Living with HIV/AIDS (TNP+). Capacity-building for IDU groups and networks (like the Thai Drug Users’ Network (TDN)) to engage in policy debate and advocate for supportive policy and action will be organized. Similar actions will be taken for other MRP groups as well, taking into account the context and specific needs of each. Linking of these groups for collective action will also take place.

- Advocacy for MRP-specific policies: In recent years, changes to the policy and legal environment have become more supportive to important aspects of harm reduction, in particular the establishment and scaling up of methadone treatment, under the National Security Health Office. While no national policy currently exists to guide the implementation of NSP, the Ministry of Public Health, working with the Office of Narcotics Control Board (ONCB), has begun developing national policy on comprehensive harm reduction. This activity is being expanded to include a wide range of stakeholders, including public security (ONCB, police, DOC) and civil society representation. MWs will also be an important focus, with two key priorities: health care financing (migrant health insurance that includes health promotion and disease prevention) and formalizing the role of migrant health assistants.

- Sensitized training of key stakeholders: Training and sensitization of, local officials will include information on the specific needs of all MARPs and on rights abuses against women and sexual minorities who are in marginalized settings. Sensitization and active involvement of the media to address human rights of all MARPs will be organized as part of the Round 8 Global Fund project, through workshops for journalists and editors to create a widespread awareness of stigma and human rights violations. The access of the media to field sites, target groups, and key informants will be facilitated with the goal of increasing news stories,
editorials, and short films on MARP relevant issues. The National Human Rights Committee has working groups on many MARP issues, and six regional rights protection centers will be established. Training of law enforcement (police, prison officers, etc.) to support services for MARPs is also included. This activity extends beyond general sensitization to establishing direct support from lawyers, law enforcement and other authorities for the interventions or MARPs in the implementation areas. NGOs alongside the Department of Corrections, will train prison guards from thirty closed settings to sensitize them to the needs of MARPs.

Build a safer /reinforcing environment for MARPs; community mobilization: National public events, ensuring wide media coverage and involving representatives from program stakeholders, to raise awareness of HIV prevention and increase understanding/acceptance of MARPs will be implemented. Where possible such events will be tagged onto special occasions like World AIDS Day, Day of Human Rights and Genders, Human Rights Day and International Migrants Day. Good practice and lessons learned publications, case studies and other information materials will be prepared and disseminated at these events. An entertainment establishment accreditation process will be developed to set a standard for positive workplace environment support for FSW who work in venue-based settings.

Output 3: Effective management and sustainable financing of national and sub-national responses

In the national strategy, key components that lead to the success of HIV prevention and alleviation are set forth, including national leadership, local ownership, sectoral accountability, resource mobilization from all sectors, strategic collaboration on policy formulation and implementation, monitoring, evaluation and strategic supervision leading to continuation and sustainability. This strategy will be achieved through two components, one addressing the increased availability and use of strategic information and one addressing governance and sustainability.

O3.1 Increased availability of key strategic information and increased use of data for program improvement and planning

While Thailand has been a leader in surveillance and other methods of monitoring and evaluation for some time, these efforts have not been synthesized into a single national system. The national strategy calls for one national M&E system to be developed and one joint M&E plan. In addition, a central mechanism will coordinate similar and duplicative efforts with guidelines for all concerned organizations to use the same database. Continual efforts are needed to address the challenge of using strategic information to shape programs and policies, and to incorporate lessons learned into planning. Finally, monitoring and evaluation of hard-to-reach groups involves special challenges that need advanced training and methods to be effective. Specific activities to address this component include:

Make available size estimation for MARPs and MWs; mapping of key sites for MARPs and MWs: Size estimation and site mapping of these hard-to-reach groups is especially challenging. Migrant workers, IDUs and sex workers are a “moving target” due to their marginality. The Round 8 Global Fund project and national strategy call for increased attention to this area as the foundation for monitoring and evaluation efforts.

Undertake and improve surveillance and monitoring surveys: The Department of Epidemiology (BoE) conducts three surveillance surveys: the HIV Sentinel Surveillance (HSS), for sentinel sero-surveillance; the Behavioral Surveillance Survey (BSS); and finally the Integrated Biological and Behavioral Survey (IBBS). The national strategy calls for the surveillance system to be further developed to follow up on the existing epidemic models in specific populations, including IDUs, MSM, independent sex workers, prisons, and other risk populations. A new area for surveillance includes non-venue based sex workers, who are more difficult to reach with prevention programs as well as by surveillance. The establishment of an STI surveillance system is also supported.

Strengthen program monitoring for MARPs The national strategy calls for knowledge management and research plans linked to the activities of each concerned organization. As part of the Round 8 Global Fund project, a Routine Health Information System (RHIS) that integrates information from health facilities and community based organizations providing HIV/AIDS services is being established. The focus is on area based management and monitoring of program targets. Additionally, PRs build capacity to gather the information needed to monitor and improve interventions and services at points of service delivery such as clinics and communities. They also strengthen data collection project management and monitoring of program targets.
tools at the SR and SSR levels, including data collection forms/tools to monitor quality assurance and quality control at facility-based and community-based activity sites.

**Strengthen capacity of CBO, NGO, sub-national and national government on M&E and use of data for program improvement and planning.** Strategies are being developed for disseminating and exchanging data that are obtained from HIV surveillance so that concerned organizations can share in and respond to changing situations. The capacity of human resources at provincial and community hospital levels is also being developed to provide support to this surveillance system. Under decentralization, local government organizations have more responsibilities and duties for M&E, and thus it is critical to build the capacity of these organizations to use data and information more effectively in decision-making processes. Under the Round 8 Global Fund project PRs will provide formal training for local implementing organizations on how to collect, use and analyze different types of information and how to use these data to improve their program activities. In addition, formal trainings will be provided and mentoring systems developed to improve SRs, CBOs, NGOs, and local government agencies' capacity on M&E, targeting hard-to-reach populations, and program support areas such as HR and finance.

**Conduct and disseminate high-quality operations and policy research; improve data analysis, interpretation and use.** Better use of surveillance and RHIS data, as well as efforts to conduct more in-depth evaluation studies and operations research, are a key element of the national strategy. The opportunity to exchange experiences between key stakeholder organizations to promote better learning, together with increased inter-organizational follow-up, transparency and reliability, are part of these efforts. Government agencies concerned with HIV prevention and alleviation also collaborate with universities and academic institutions to develop and implement action research. The NAMC organizes annual workshops to share lessons learned for all project partners, as cross-evaluations and sharing of experiences among key stakeholders and integrates these lessons into program implementation.

**03.2 Strengthened mechanisms for strategic planning and coordination to promote sustainability of HIV/AIDS responses.** As part of the Three Ones principle, strategic planning and coordination are a critical part of the national HIV strategy. Decentralization has posed challenges for HIV prevention programming for MARPs and MWs, as the populations are concentrated in certain areas. This component includes the following activities:

**Improve coordination and linkage of services:** The National HIV and HIV/AIDS plan calls for coordination between ministries and organizations to be improved so their work is based on the same policy and direction. Partners at all levels will jointly create goals, strategies and methods for HIV prevention and alleviation and models for implementation for the period 2007-2011. This coordination is especially important to improve prevention efforts, for example to increase access to condoms. Integration of HIV prevention and alleviation into government policy and strategy formulation processes will include collaboration with the private sector, regional and local administrative organizations. For the Round 8 Global Fund project, cross-cutting issues such as gender, stigma and discrimination reduction, and policy and legal framework development are addressed for all MARPs as a single entity.

**Establish/strengthen sub-national coordinating mechanisms** The Provincial Coordinating Mechanism (PCM) will develop a multi-sector provincial plan for MARPs. This plan will be submitted to the provincial AIDS committee for approval. It will be used by the provincial and local organizations for planning, financing and implementation of MRP activities.

**Build capacity of national and sub-national mechanisms to appropriately address MARP & MW programs in the operational plan** The Round 8 Global Fund project includes technical assistance to provincial and local organizations, including employers and authorities, for HIV policy development and resource mobilization.

**Mobilize and increase local authority ownership of the epidemic response toward MARPs & MWS.** Such efforts will include adjustment of AIDS plans in association with each sector’s policy. Authorities covered would include government departments and ministries, provincial-regional level organizations that have autonomous policies, and local administrative organizations, such as municipalities, Tambol Administrative Organizations (TAO), Pattaya city and the Bangkok Metropolitan Administration.

**Mobilize financial support to national and sub-national governments, CBOs and NGOs.** At the national level, ministries will establish budgets for HIV and HIV prevention and alleviation under activities consistent with their ministerial strategies and work plans, with less reliance on sole funding from the Ministry of Public Health. At the same time, government and private sectors will provide funding to support the work of civil society and the community. This includes developing the capacity of the CBOs involved in HIV and HIV prevention and alleviation.
The Round 8 Global Fund proposal was developed with sustainability in mind, by developing closer working relationships between the PCMs and the CBOs to facilitate a better understanding of problems and responsibilities related to sustainability of MARP programs. Additionally, the National Health Security Office funds some specific programs for MARPs through civil society and government organizations. The partial implementation of the IDU strategy through pharmacies provides a cost-efficient and ultimately more sustainable method of delivering HIV prevention commodities to IDUs compared to relying solely on fixed site NSPs.
The shared vision for HIV prevention for these populations, depicted above, was developed through a participatory process with the multi-sectoral organizations involved in implementing these programs. While the complexity of the prevention network in Thailand made the development of this unified vision particularly challenging, the effort to envision and establish one M&E system in support of the program is perhaps even more so. Coordination, systemization, quality assessment, and data utilization are all vitally necessary components of the M&E system. With the leadership of NAMC, this system will be put into place in the next two years and be institutionalized at all levels. A key aspect of the system is strengthening of the quality of data and the capacity to measure the core indicators. Specifically, the goals and objectives of this plan are as follows:

**Goal:**
Develop an effective national M&E system for obtaining and utilizing high-quality strategic information for the HIV prevention response for most-at-risk populations and migrant workers in Thailand.

**Objectives:**

*Harmonization and system strengthening:*

- Develop and strengthen a unified national M&E system, integrating efforts from all sectors and from both sub-national and national levels, to monitor the HIV epidemic and national prevention response for MARPs and MW in Thailand.

*National HIV Monitoring:*

- Develop and strengthen the routine health information system, integrating the community-based data system with the national system, to monitor progress of national prevention responses.

- Improve the availability and quality of the surveillance system (including the IBBS, HSS and BSS) to provide valid evidence for impact and outcome monitoring of HIV prevention programs for MARPs and MW.

*Evaluation and research:*

- Improve systems to estimate the size of MARPs and MW in Thailand.

- Increase the availability, quality and use of evaluation data to measure the impact, improve the effectiveness and increase the cost effectiveness of the national response.

*Capacity building*

- Develop capacity for conducting and using high-quality M&E at the national, sub-national and civil society level.

*Data use, evidence-based planning and policy development*

- Increase the use of program evidence and research findings for effective national policy development to the achievement of the desired outcomes. The outcome indicators in turn measure the ability of the entire implementation program to reach the desired impact on the HIV epidemic.
Figure 3.1 National M&E Framework with Core Indicators

**Goal**
Reduce new infections by 50% by 2011

**Outcomes**
1. % of MARPs and MWs who are HIV infected
2. % MARPs, MW reporting the use of a condom with most recent partner
3. % MARPs, MW reporting consistent condom use in the recent time period with non-regular partners and clients
4a % IDU reporting use of sterile injecting equipment at last injection in the last month
4b % IDU reporting they have not shared injecting equipment at last injection in the last month
5. % MARPs, MW with gonorrhea and/or chlamydia

**Intermediate outcomes**
6a. % MARPs, MW reached with prevention program in last 12 months
6b. % MARPs, MW received by package of services in last 12 months
6c. % MARPs, MW receiving a minimum standard of exposure to prevention programs in last 12 months
7a. % MARPs, MW receiving an HIV test and receiving test results in the last 12 months
7b. % FSW, MSW, IDU receiving an HIV test and receiving test results the minimum number of times in the last 12 months
8. % MARPs, MW receiving appropriate number of STI screenings in last 12 months
9. % Opioid-dependent IDU receiving opioid substitution therapy (OST) in last 12 months
10. % MARPs, MW who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions
11. % IDU reached by needle-syringe programs in last month
12a. % MARP, MW who report that condoms, lubricant and needles are accessible when needed
12b. % MARP, MW who report that condoms and lubricant are affordable

**Outputs**
13. % MARPs, MW reached by prevention programs
14. % MARPs, MW receiving STI screening and/or treatment
15a. % MARPs, MW receiving an HIV test and receiving test results
15b. % MARPs, MW tested for HIV who receive test results
16. % MARPs, MW receiving free condom or purchasing subsidized condom in last month
17. Score of National Policy Index related to enabling environment and stigma/discrimination
18. % MARPs, MW who are HIV+ receiving ART
19. % MARPs, MW who are HIV+ receiving ART
20. % MARPs, MW who are HIV+ receiving ART

**Impact**
Improved health status and well being among FSW
- % MARPs, MW who are HIV+ receiving ART
- % MARPs, MW who are HIV+ receiving ART
- MARP-specific indicators

- % MARPs, MW who are HIV+ receiving ART
- % MARPs, MW who are HIV+ receiving ART
- MARP-specific indicators
Core indicators were kept to a minimum in the National M&E Framework. Core indicators are those that are used to measure the national response to the epidemic over the long term; they are not tied to particular projects or implementers. They are seen as the minimum set of indicators necessary to measure the prevention response. The M&E frameworks for each of the individual population groups, showing the core indicators for each group, are found in Annex 2.

The core indicators are listed in Table 3.1. While nearly all of the core indicators are already national indicators, some indicators (marked in italics) have been added which measure the effectiveness of the response in greater depth. Because these indicators are new, there is little empirical evidence to provide guidance in defining them concretely or setting targets. Analysis of these core indicators will be conducted with the results of the IBBS, with the goal of finalizing these core indicators and setting targets by 2012.

These are:

(3) Consistent condom use: Measures of consistent condom use for FSW, MSM and MWs, along with the indicator on condom use with last partner, provides additional information on the effectiveness of the BCC programs in affecting prevention behavior among these groups.

(4B) Sharing injecting equipment among IDUs: Behavior change communication programs will promote not sharing needles, supported by the NSP program increasing the availability of needles. This indicator measures the success of the program in reducing needle and syringe sharing.

(6B) Exposure to package of services: The objective of the HIV prevention program for MARPs and MWs is to reach them with a combination of services and education programs. This indicator will measure the percent of respondents who have exposure to more than one outreach/education and service/commodity.

(6C) Intensity of exposure to prevention program: Measures of exposure to prevention programs is usually measured at a very minimal level, with programs monitoring any type of contact with the program (and often counting contacts rather than individuals, as discussed further below). Yet evaluation research has shown that interventions must reach a certain level of intensity to achieve the ultimate goal of changing risky behavior. The National M&E System will set a minimum standard of exposure for each population and will measure whether the program has reached that standard for each individual.

(7B) Frequency of HIV testing for male and female sex workers and IDU: an indicator measuring the frequency of testing will be added, to reflect their higher risk behavior and the need to detect HIV infection at an early stage for these individuals. The definition of the minimum target frequency will be set after analysis of the 2010 IBBS.

(12A, 12B) Accessibility to condoms, lubricant and needles; affordability of condoms and lubricant: There is a recognized need to increase access to prevention methods for MARPs and MWs. These two indicators examine perceptions of accessibility and affordability reported by respondents.

(01/15B) Of most-at-risk populations who are tested for HIV, the percent who receive test results: Most VCT services in Thailand do not use rapid tests. This means that some clients tested do not return to receive their results. This indicator measures the success of the VCT programs in motivating clients to return.

(01/16) Subsidized/free condoms: This indicator will monitor whether the free and subsidized condoms being provided as part of the HIV response are being received by the populations being targeted.

(02/17) As described in greater detail below, a sub-index of the National Composite Policy Index (NCPI) will be used to track progress in reducing stigma and discrimination and improving the enabling environment for MARPs and MWs. Because the NCPI does not include enough specific information to fully track progress in this area, a Policy Evaluation Study will be conducted to develop an in-depth module for the Index.

(03/18-20) Indicators are included which measure the strength of the HIV prevention response for MARPs and MWs at the local level. These include the collection and use of strategic information, commitment of financial resources and inclusion of MARP and MW representatives on coordinating committees.

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Table 3.1: Thailand National Plan Core Indicators: HIV Prevention for Most-at-Risk Populations and Migrant Workers

<table>
<thead>
<tr>
<th>No</th>
<th>Target population</th>
<th>Indicator Name</th>
<th>Data source</th>
<th>Frequency</th>
<th>Responsible unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>IMPACT: Reduced HIV/AIDS prevalence among MARPs and MWs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>FSW</td>
<td>% FSW who are HIV infected</td>
<td>IBBS</td>
<td>Every 2 years</td>
<td>BoE</td>
</tr>
<tr>
<td>1.2</td>
<td>MSM</td>
<td>% MSM, TG and MSW who are HIV infected</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3</td>
<td>IDU</td>
<td>% IDU who are HIV infected</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>OUTCOMES OUTCOME 1: Increased preventive behavior (condom use and safe injection)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>FSW</td>
<td>% FSW reporting the use of a condom with most recent sexual partner</td>
<td>IBBS</td>
<td>Every 2 years</td>
<td>BoE</td>
</tr>
<tr>
<td>2.2</td>
<td>MSM</td>
<td>% MSM, TGs and MSWs reporting the use of a condom at last anal sex with male sex partner</td>
<td>IBBS</td>
<td>Every 2 years</td>
<td>BoE</td>
</tr>
<tr>
<td>2.3</td>
<td>IDU</td>
<td>% IDU reporting the use of a condom with most recent sexual partner</td>
<td>IBBS</td>
<td>Every 2 years</td>
<td>BoE</td>
</tr>
<tr>
<td>2.4</td>
<td>MW</td>
<td>% MW reporting the use of a condom with most recent non-regular sexual partner</td>
<td>IBBS</td>
<td>Every 2 years</td>
<td>BoE</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>OUTCOME 2: Reduced STI burden</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4A</td>
<td>IDU</td>
<td>% of IDU reporting the use of sterile injecting equipment the last time they injected in the last month</td>
<td>IBBS</td>
<td>Every 2 years</td>
<td>BoE</td>
</tr>
<tr>
<td>4B</td>
<td>IDU</td>
<td>% of IDU reporting they have not shared injecting equipment the last time they injected in the last month</td>
<td>IBBS</td>
<td>Every 2 years</td>
<td>BoE</td>
</tr>
<tr>
<td>No</td>
<td>Target population</td>
<td>Indicator Name</td>
<td>Data source</td>
<td>Frequency</td>
<td>Responsible unit</td>
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</tr>
<tr>
<td>6A</td>
<td>% of most-at-risk populations and migrant workers reached with prevention programs in last 12 months</td>
<td>IBBS</td>
<td>Every 2 years</td>
<td>BoE</td>
<td></td>
</tr>
<tr>
<td>6A.1</td>
<td>FSW</td>
<td>% FSW reached with prevention programs in last 12 months</td>
<td>IBBS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6A.2</td>
<td>MSM</td>
<td>% MSM, TG and MSW reached with prevention programs in last 12 months</td>
<td>IBBS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6A.3</td>
<td>IDU</td>
<td>% IDU reached with prevention programs in last 12 months</td>
<td>IBBS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6A.4</td>
<td>MW</td>
<td>% MW reached with prevention programs in last 12 months</td>
<td>IBBS</td>
<td>Every 2 years</td>
<td></td>
</tr>
<tr>
<td>6B</td>
<td>% most-at-risk populations and migrant workers reached by package of services in last 12 months</td>
<td>IBBS</td>
<td>Every 2 years</td>
<td>BoE</td>
<td></td>
</tr>
<tr>
<td>6C</td>
<td>% most-at-risk populations and migrant workers receiving a minimum standard of exposure to prevention programs in last 12 months</td>
<td>IBBS</td>
<td>Every 2 years</td>
<td>BoE</td>
<td></td>
</tr>
<tr>
<td>7A</td>
<td>% of most-at-risk populations and migrant workers receiving an HIV test and receiving test results in the last 12 months</td>
<td>IBBS</td>
<td></td>
<td>BoE</td>
<td></td>
</tr>
<tr>
<td>7A.1</td>
<td>FSW</td>
<td>% FSW receiving an HIV test and receiving test results in the last 12 months</td>
<td>IBBS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7A.2</td>
<td>MSM</td>
<td>% MSM, TG and MSW receiving an HIV test and receiving test results in the last 12 months</td>
<td>IBBS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7A.3</td>
<td>IDU</td>
<td>% IDU receiving an HIV test and receiving test results in the last 12 months</td>
<td>IBBS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7A.4</td>
<td>MW</td>
<td>% MW receiving an HIV test and receiving test results in the last 12 months</td>
<td>IBBS</td>
<td>Every 2 years</td>
<td></td>
</tr>
<tr>
<td>7B</td>
<td>% of male and female sex workers and IDU receiving an HIV test and receiving test results the minimum number of times in the last 12 months</td>
<td>IBBS</td>
<td></td>
<td>BoE</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>% of most-at-risk populations and migrant workers receiving the appropriate number of STI screenings in the last 12 months</td>
<td>IBBS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>IDU</td>
<td>% Opioid-dependent IDU receiving opioid substitution therapy (OST) in the last 12 months</td>
<td>IBBS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>% of most-at-risk populations and migrant workers who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission</td>
<td>IBBS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.1</td>
<td>FSW</td>
<td>% FSW who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission</td>
<td>IBBS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Target population</td>
<td>Indicator Name</td>
<td>Data source</td>
<td>Frequency</td>
<td>Responsible unit</td>
</tr>
<tr>
<td>------</td>
<td>-------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>-------------</td>
<td>----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>10.2</td>
<td>MSM</td>
<td>% MSM, TG and MSW who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission</td>
<td>IBBS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.3</td>
<td>IDU</td>
<td>% IDU who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission</td>
<td>IBBS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.4</td>
<td>MW</td>
<td>% MW who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission</td>
<td>IBBS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td>% of IDU reached by needle-syringe programs in the last month</td>
<td>IBBS</td>
<td>Every 2 years</td>
<td>BoE</td>
</tr>
<tr>
<td>12A</td>
<td></td>
<td>% of most-at-risk populations and migrant workers who report that condoms, lubricant and needles are accessible when needed</td>
<td>IBBS</td>
<td>Every 2 years</td>
<td>BoE</td>
</tr>
<tr>
<td>12B</td>
<td></td>
<td>% of most-at-risk populations and migrant workers who report that condoms and lubricant are affordable</td>
<td>IBBS</td>
<td>Every 2 years</td>
<td>BoE</td>
</tr>
</tbody>
</table>

**OUTPUT**

<table>
<thead>
<tr>
<th>O1/13</th>
<th>All</th>
<th>Number of most-at-risk populations and migrant workers reached by prevention programs</th>
<th>Routine HIS</th>
<th>Annually</th>
<th>NAMC</th>
</tr>
</thead>
<tbody>
<tr>
<td>O1/14</td>
<td>All</td>
<td>Number of most-at-risk populations and migrant workers receiving STI screening and/or treatment</td>
<td>Routine HIS</td>
<td>Annually</td>
<td>NAMC</td>
</tr>
<tr>
<td>O1/15A</td>
<td>All</td>
<td>Number of most-at-risk populations and migrant workers receiving an HIV test and receiving test results</td>
<td>Routine HIS</td>
<td>Annually</td>
<td>NAMC</td>
</tr>
<tr>
<td>O1/15B</td>
<td>All</td>
<td>% of most-at-risk populations tested for HIV who receive test results</td>
<td>Routine HIS</td>
<td>Annually</td>
<td>NAMC</td>
</tr>
<tr>
<td>O1/16</td>
<td>All</td>
<td>% of most-at-risk populations and migrant workers receiving free condoms or purchasing subsidized condoms in the last month</td>
<td>IBBS</td>
<td>Every 2 years</td>
<td>BoE</td>
</tr>
<tr>
<td>O2/17</td>
<td></td>
<td>Score of National Policy Index related to enabling environment and stigma/discrimination</td>
<td>National Policy assessment</td>
<td>Every 2 years</td>
<td>NAMC</td>
</tr>
<tr>
<td>O3/18</td>
<td></td>
<td>Number of provinces that have key strategic information and use it for provincial operation plan</td>
<td>Provincial survey</td>
<td>Annually</td>
<td>NAMC</td>
</tr>
<tr>
<td>O3/19</td>
<td></td>
<td>Number of local authorities that contributed financial resources to HIV/AIDS responses for most-at-risk populations and migrant workers</td>
<td>NASA</td>
<td>Every 2 years</td>
<td>NAMC</td>
</tr>
<tr>
<td>O3/20</td>
<td></td>
<td>Number of Provincial Coordinating Mechanisms and Provincial Coordinating Committees with most-at-risk population and migrant worker representatives</td>
<td>Provincial survey</td>
<td>Annually</td>
<td>NAMC</td>
</tr>
</tbody>
</table>

12 Indicator will be evaluated by analyzing the usefulness of collecting this information for measuring accessibility and affordability.
In addition to these indicators, a number of indicators are suggested at the project level. These are listed in Annex 3. Technical assistance and capacity building for measuring these indicators are included as part of the National M&E System.

Annex 4 gives a detailed description of the core and additional indicators and how they will be measured. This description references the plan for the comprehensive national M&E system described in the next section.

Limitations of the M&E framework

It should be noted that most of the core indicators for the national M&E system are being measured by second generation surveillance (the IBBS), which combines testing for HIV and STIs with a behavioral survey.

One limitation of depending on this survey for the measurement of core indicators is that the IBBS has a higher proportion of respondents with program exposure, since the initial contacts for respondent-driven sampling are made through the programs. Estimates of program exposure thus may be biased upwards. The advantage of using the IBBS is the standardization of methods across population groups and centralized survey management at the BoE, but this potential source of bias is noted. NAMC plans to analyze potential bias in the core indicators through triangulation with other surveys such as the BSS and project KAP surveys.

Secondly, the plan is ambitious in developing new M&E systems and unifying existing systems at a number of levels. It is an interim two-year plan that is designed to lay the way forward in creating a unified M&E system, while much of the needed information to fully develop the plan is not yet available. The methodology for obtaining better estimates of the size of the population groups is being developed during this period, so that estimates of coverage must be made without knowing the true denominator for the indicator.

Finally, there is not enough information available at this time to set meaningful targets for these national core indicators. Thailand is currently in the process of completing the 2010 UNGASS report, and this year the IBBS will be conducted for all groups. At the end of 2010 NAMC in collaboration with all stakeholders will set targets for the core indicators using these results.
a. Overview and coordination

The National M&E system, following the “Three Ones” principle, is an important tool for Thailand’s National HIV/AIDS Program to promote effective management and accountability for the HIV prevention response. The national M&E structure has been built by taking into account the development of the decentralization strategy in Thailand. In this way NAPAC aims to establish the M&E infrastructure in a way that includes the strengthening of human capacity at all levels. Besides the national level, this emphasis at the sub-national level includes regional, provincial and service delivery components as well. These four levels also represent the main public health structure and system in Thailand.

This national M&E plan for HIV prevention targeting MARPs and MWs is focused on developing and harmonizing a core set of data that is collected through one M&E system. In particular, the aim is for implementers to view the collection and use of M&E data as integral part of program implementation at all levels. Thus the plan is a critical step for Thailand in the ultimate goal of establishing an M&E system that improves program implementation, policy development and planning. An overview of the structure is depicted in Figure 4.1.
National Level

In early 2007, the National AIDS Committee endorsed the development of the national HIV/AIDS M&E system as part of the National HIV/AIDS Strategic Plan (2007-2011). Good progress has been made during 2008-2009, with three key functions identified and organizational responsibility clearly assigned.

1. Monitoring the national HIV epidemic, including impact and outcome monitoring: The Bureau of Epidemiology (BoE) is the lead organization to develop and conduct HIV sentinel surveillance and the second generation surveillance system. Key tasks include data analysis and synthesis to better understand current and future directions of the epidemic and its consequences.

2. Monitoring the national response: the National AIDS Management Center (NAMC) has played the role of the national HIV/AIDS M&E unit since its establishment in 2009. Specific functions of NAMC are:
   - Development, implementation, coordination and maintenance of the national M&E plan and system in collaboration with other organizations within MOPH such as the Bureau of AIDS, TB and STI (BATS), Department of Health and other ministries such as the Ministry of Interior, Ministry of Education, civil society, bilateral donors and multilateral organizations;
   - Development, implementation and maintenance of the routine program monitoring system, in particular the community-based monitoring system and its integration into the national system;
   - Serving as secretariat of the National M&E steering committee;
   - Management and coordination of M&E Technical Working Groups;
   - Management and coordination of the consortium for development, management and appropriate use of research and evaluation for effectively managing the national response;
   - Mobilization of meaningful involvement for all key stakeholders including civil society at the national level;
   - Collection, compilation, analysis and management of relevant data; and
   - Reporting, dissemination and documentation.

3. Developing the national evaluation and research agenda and plan for use of data: The Consortium for Technical Assistance on Research and Evaluation plays the role of the “think tank” to the national M&E unit and is managed and coordinated by NAMC. The Consortium consists of technical experts from multi-disciplinary areas from academia (local and international), implementers, epidemiologists, etc. The Consortium will provide state-of-the-art (SOTA) methodologies on technical aspects for program implementation, policy development, key strategic information and M&E.

These three key organizations and mechanisms have worked under the technical direction provided by the National M&E Steering Committee and M&E Technical Working Groups (TWG). TWGs are organized for each MARP and for M&E areas such as situation analysis and the health information system (see Figure 4.1). The TWGs consist of representatives from multi-sectoral agencies including government, CBOs, NGOs, academia, PLHA, MARP representatives, donors and UN organizations.

Regional Level

There are twelve regional Offices of Disease Prevention and Control (Regional DDC) throughout Thailand. Each regional office will provide technical support to about 5-8 provinces. Specific functions include:

- Assisting the BoE, NAMC, BATS and other national organization to develop and implement the national M&E system;
- Collating, analyzing and synthesizing key epidemiologic and program data in order to get a clear understanding of regional epidemics, make comparisons among provinces and provide appropriate direction to provinces within the region;
- Undertaking data quality assessment and providing technical support to provinces;
- Mobilizing meaningful involvement for all key stakeholders including civil society at the regional level; and
- Reporting, dissemination and documentation.
**Provincial level**

Provincial HIV and AIDS M&E units will be established, located at the Provincial Health Office (PHO). The PHO serves as the secretariat office to the Provincial HIV/AIDS Committee (PAC) and/or the Provincial Coordinating Mechanism (PCM).

The PHO has an HIV/AIDS unit and a planning and policy unit that collects and analyzes provincial HIV and AIDS epidemiologic research and reports from within the MOPH system and from implementing partners. As part of the national M&E system, NAMC has a clear objective to establish provincial M&E units and to strengthen the provincial M&E system. This will ensure that the PHO has needed strategic information available about the epidemic and their response. In addition, it is critical for the PHO M&E units to have the capacity to use data for developing appropriate provincial strategic and operational plans. Specific functions of the PHO are as follows:

- Assist the BoE, NAMC, BATS, regional DDC and other national organizations to develop and implement the national M&E system;
- Collate, analyze and synthesize key epidemiologic and response data in order to get a clear understanding of the provincial epidemic and the HIV response at provincial level as well as comparison among districts;
- Use key strategic information appropriately for developing the provincial strategic and operational plan;
- Build the capacity of the Provincial, District and Tambol (sub-district) Administration Office on how to use data to develop an appropriate and costed work plan for HIV prevention;
- Assist the regional office in data quality assessment and provide technical support to implementing agencies within the province;
- Mobilize meaningful involvement for all key stakeholders including civil society at the provincial level; and
- Reporting, dissemination and documentation

**Service delivery level**

“Point-of-service delivery” in the context of HIV prevention targeting MARPs refers to the implementing partners providing clinical, community outreach, enabling environment and policy activities. The M&E system for service delivery points can be divided into two systems:

1) Facility-based monitoring system, including STI and HIV counseling, reported by government hospitals, clinics, DiC with STI and VCT services and specialized/friendly STI/VCT clinics for MARPs.

2) Community-based monitoring system, including prevention programs that do BCC, distribute commodities etc. For the most part this information is reported by NGOs, CBOs, MARP groups and networks.

In general, implementing agencies (IAs) have been mandated to develop their own program monitoring system according to donor requirements. As part of the national M&E system however implementing agencies have a critical role to contribute to a functioning unified M&E system. While IAs routinely report their progress to the next level or central organization office, for the consolidated national M&E system NAMC will set forth that each IA does the following:

- Ensure that core output indicators are measured by the program monitoring data collection tool;
- Use standardized national forms for STI and VCT monitoring and submit data to the provincial level and to the national system;
- Develop the program monitoring system and share aggregated community-based data to the PHO;
- Ensure that high quality data is collected at the point-of-service and conduct routine data quality assessments (RDQA) as an integral part of implementation; and
- Analyze and use data regularly to improve program performance.
Civil Society

Civil society is not a separate level of the M&E infrastructure, but a partner at all levels in both implementation and M&E. Civil society includes the MARPs and MWs themselves who have a critical role in the prevention program. As outlined in each level description above, capacity building for NGOs, CBOs and other civil society implementers is built into the M&E system. Thailand’s National HIV strategy calls for the public and private sectors to provide funding to support the work of civil society and the community, and for local authorities to be part of this process. Civil society strengthening activities thus include building MARP capacity to represent their interests at all levels of the national response to HIV and strengthening the capacity of the CBOs involved in HIV prevention to monitor programs.

Implementing effective HIV prevention services for MARPs requires the greater empowerment and involvement of those groups in the provincial and national response. The Round 8 Global Fund activities include organizing trainings for MARP groups and networks to advocate for their specific needs and to sensitize the stakeholders they interact with on a day to day basis. Capacity-building of IDU groups and networks to engage in policy debate and advocate for supportive policy and action are also organized. Similar actions will be taken for other MARP groups as well, taking into account the context and specific needs of each, as well as linking of these groups for collective action.

Thailand’s national plan for M&E includes major efforts to harmonize the program monitoring systems of CBOs and NGOs with the national framework. During this two-year period these efforts include assessing the recording and reporting system of civil society programs and linking their monitoring and evaluation systems with the facility-based system. As mentioned above, the Routine Health Management Information System (RHIS) that is being developed includes community based programs, such as VCT, STI, and community based outreach education.

Capacity building for civil society organizations in monitoring and evaluation is also a major effort of the national M&E plan. Workshops will be held to facilitate the harmonization of the program monitoring systems. Activities are being conducted for strengthening the capacity of CBOs and NGOs to gather the information needed to monitor and improve interventions and services at points of service delivery such as clinics and communities. These include strengthening data collection project management and monitoring tools for civil society organizations, including data collection forms/tools to monitor quality assurance and quality control at facility-based and community-based activity sites. Methods include mapping to identify venues/places where MARP congregate, collecting and updating the size of hard-to-reach populations over time and data collection forms/tools to monitor quality assurance and quality control at facility-based and community-based activity sites. The project will draw upon technical assistance to develop simple data collection forms and tools to monitor quality assurance and quality control. In addition, formal trainings will be provided and mentoring systems developed to improve SRs, CBOs, NGOs, and local government agencies’ capacity on M&E, targeting hard-to-reach populations, as well as program support areas such as HR and finance. Training and workshops cover the following:

- Knowledge of the national M&E plan and M&E framework;
- Participation of MARPs and MWs in M&E activities;
- Monitoring coverage of activities;
- Measuring the effectiveness of activities according to the program performance framework, including communication activities;
- Condom/NSP distribution management and monitoring;
- Programmatic and financial performance management and reporting;
- Utilization of qualitative data; and,
- Reporting and documentation.

Strengthening in evaluation will include training community based organizations and local health facilities on measuring effectiveness as well as utilizing data for program improvement. These activities will promote and strengthen the use of empirical information for program improvement and decision making, and organize annual workshops to share lessons learned for all project partners, as cross-evaluations and sharing of experiences among PRs. This activity will be integrated into program implementation.
b. Data collection

Five key data sources are used to measure the core indicators identified above. These are the Integrated Biomarker and Behavioral Surveillance (IBBS), the Facility based and Community based Routine Health Management Information System (RHIS), the National Composite Policy Index (NCPI), the Provincial Survey, and the National AIDS Spending Assessment (NASA). Figure 4.2 presents an overview of these data sources and the data collection timeline for 2006-2014.

Data sources and timeline of national indicators for prevention targeted MARPs in Thailand

1. Second generation sentinel surveillance: Integrated Biological and Behavioral Surveillance among most-at-risk populations and migrants (IBBS)

In response to the challenges of monitoring an evolving HIV epidemic, the Bureau of Epidemiology (BoE), MOPH is the lead organization developing and conducting the IBBS for most-at-risk populations, with technical assistance from TUC/GAP. From 2003-2005 the BoE successfully conducted the IBBS among FSW and MSM in pilot provinces. Financial support from the Global Fund Round 8 proposal has facilitated rapid scale-up of IBBS implementation for these target populations, while the IBBS for IDU and migrant workers will be initiated starting from 2010 onwards. Details of the IBBS implementation plan by province and population group are presented in Annex 5.

IBBS is the main data source to monitor core national indicators (Indicator no. 1-12 in Table 3.1) and will be conducted every two years. The National AIDS Management Center (NAMC) and BoE have worked with prevention program implementers to harmonize and standardize key questions used in the IBBS across MARPs and MWS covering behavior change, coverage and intensity of exposure for community outreach.
activities, and use of HIV testing and counseling and STI screening services (see the detailed description of indicators in Annex 4).

The IBBS in Thailand for FSW, MSM and IDU uses self-reported hand-held computer-assisted structured interviews (CASI) to increase confidentiality and improve the reliability of data related to sensitive issues including sexual and other risky behaviors.

**IBBS among FSW.** The first round of IBBS for FSW was conducted in 2003 among venue-based sex workers in selected provinces. Because of the shift in prominence from direct to indirect sex establishments, it was recognized that institutionally-based sampling is not sufficient to fully measure the HIV epidemic among FSW in Thailand. Recently BoE undertook a pilot of an integrated biomarker and behavioral risk surveillance system using respondent-driven sampling (RDS) in three tourist provinces. This sampling methodology allows Thailand to accurately capture trends in the HIV epidemic for both venue and non-venue based FSW. BoE plans implement RDS in all sites starting from 2012.

**IBBS among MSM (MSM, MSW and Transgender).** Thailand has conducted HIV sero-surveillance among male sex workers since 1997. A combined HIV prevalence and behavioral study initiated among MSM in Bangkok in 2003 revealed very high prevalence of HIV among MSM (17%). Since then BoE has incorporated similar methods in the national surveillance system and expanded data collection to include Chiang Mai and Phuket province in 2005 and 2007 and Udon Thani and Pattalung provinces in 2008. The IBBS among MSM will be expanded to 13 provinces in 2009 onwards, using venue-day-time sampling for all rounds of data collection.

**IBBS among IDU.** In 2007-2008, BoE conducted Behavioral Sentinel Surveillance (BSS) of IDUs in Bangkok, Chiang Mai and Samut Prakan. With support from the Global Fund round 8, BoE and PSI plans to undertake the IBBS among IDU in 8 provinces in 2010, 2012 and 2014. With close collaboration between BoE and PSI, the IBBS of IDUs has collected broad information on the process of behavior change including attitudes, beliefs, and the accessibility and availability of condoms and needles/syringes.

**IBBS among migrant workers.** The BoE has conducted annual HIV sero surveillance among fishermen and migrant workers in seven provinces since 1989. The IBBS among migrant workers will be first introduced in 2010 and implemented in 10 provinces. Subsequent rounds will be undertaken in 2012 and 2014 to monitor change in the epidemic and HIV responses among MWs. The primary criteria for selection of these 10 provinces is the high density of migrant workers, most from Myanmar, Cambodia and Laos PDR, and the high capacity of the provincial health office to undertake the initiative.

2. Facility-based and Community-based Routine Health Information System (RHIS)

A unified routine program monitoring system will be developed by the National AIDS Management Center (NAMC). This system will be used for all implementers that provide prevention interventions for MARPs, including the Global Fund programs.

Two types of RHIS for prevention activities targeting MARPs and MWs will be developed, as follows:

**Facility-based program monitoring system for MARPs:**

**STI program data system:** STI cluster, Bureau of AIDS TB and STI (BATS), MOPH is the main organization responsible for developing and implementing the system for reporting core output indicators on STI services including STI screening, STI reported cases and STI treatment. A routine program reporting system on STI screening and treatment has been established in Thailand since the 1960s. During the earlier phase of the HIV epidemic, STI case reports have been used as a proxy indicator to demonstrate the success of the 100% condom use program. To effectively monitor prevention efforts for targeted MARPs, NAMC and BATS are working closely to implement a number of activities to strengthen the STI reporting system:

- Developing a unified STI data collection form, the 506 Form, that will be used nationwide. In addition to reporting on STI diagnosis and treatment, the 506 Form also obtains information on demographic characteristics, behavior, laboratory results, educational programs, counseling and condom distribution.

- Disaggregation by type of population, sex and age group.

- Ability to report information by individual and by number of visits through the Unique Identifier Code, so that individuals are not double-counted (as described below).

- A computerized system to be launched in 2010.
**HIV counseling and testing program data system:** Routine reporting for HIV counseling and testing in Thailand has been collected at the clinic level without any standardized system. BATS and NAMC will introduce a unified form starting from 2010. Key steps to be taken are as follows:

- Ensure that key information on the HIV counseling and testing cascade (pretest counseling, HIV test, post-test counseling and testing result) is included, in addition to information on demographic data, risk behavior, counseling/education and whether condoms are provided.

- Disaggregation by type of population, sex and age group.

- Ability to report information by individual and by number of visits through the Unique Identifier Code, so that individuals are not double-counted (as described below).

- A computerized system to be launched in 2010.

- Information to monitor the performance of HIV counseling and testing services, such as the percent of MARPs and migrants tested for HIV who receive their test result.

- Inclusion of all those who provide VCT, including CBOs.

Though the national health insurance scheme has a different system to monitor utilization of health services among insured clients (the National AIDS Program (NAP) database), NAMC will work closely with the national health security office to harmonize information on national STI and VCT efforts and responses, without jeopardizing confidentiality.

**Community based program monitoring system for MARPs**

The National AIDS Management Center (NAMC) is responsible for developing and implementing the community-based program monitoring system. This system will report on the number of individuals served by prevention programs, commodities (condom, lubricant, needle and syringe) distributed and the number of individuals trained to provide programs. Since the community based system is just being introduced, NAMC has planned to start with a paper-based reporting system in 2010, with the computerized system implemented in 2011.

- Each organization (CBO, NGO, Government etc.) implementing behavior change communication (BCC) activities targeting MARPs shall develop program monitoring forms. While the format is flexible depending on its suitability for the individual program, all national core output indicators will be included.

- NAMC will coordinate the development and standardization of an aggregation form to feed into the community based system. This is a national form used across agencies throughout the country. Each implementer will submit a report to the system including province, region and national level.

- Disaggregation by type of population will be built in.

- The program monitoring form produced by each organization should have the ability to report information by individual and by number of visits, so that individuals are not double-counted.

**Unique Identifier Code.** As part of the effort to improve data quality in the M&E system, NAMC will coordinate the development and institute the Unique Identifier Code (UIC) as part of the RHIS. Coverage—meaning the percentage of MARPs and MWS reached by prevention programs—is an essential national indicator to monitor the progress of the national response. In the past, the accuracy of coverage data is often questionable, even when a monitoring system is in place. This is because routine monitoring systems often report the number of contacts and visits rather than the number of individuals served. The result is that individuals are “double counted” and the number or percentage of individuals reached cannot be measured.

- For prevention programs serving MARPs it is particularly critical to measure the intensity of exposure, as previous research has shown that interventions must reach a certain level of intensity to achieve the ultimate goal of changing risky behavior. Therefore, during Phase 1 of the national M&E system (2009-2011), MSM and IDU programs under the Global Fund Round 8 will implement a Unique Identifier Code (UIC) for all clients of implementing agencies providing prevention services. These would include drop-in centers, community outreach activities, STI services and HIV counselling and testing clinics. The UIC is a separate code from the 13-digit identification number used by the national health system. The main advantage of implementing the UIC system is the decreased possibility
of double-counting clients across projects and within one project, and the ability to count the number of times a particular client receives services. It also assures MARPs have greater confidentiality and anonymity of their medical records, thus removing one of the barriers to access of services.

- The UIC implementation plan will be developed based on successful experiences of the USG’s MSM program monitoring system in Thailand and the monitoring system used in the drug demand reduction program implemented by PSI in central Asia. Technical assistance on the initiative will be provided by USG and PSI/global. During the first two years, the benefits and risks of implementing UIC at the national scale will be assessed and documented. Once the pilot results are available and analyzed, it will be possible to make an informed decision regarding UIC implementation throughout the country and among other MARPs.

3. National Composite Policy Index (NCPI)

HIV prevention programs for MARPs and MWs cannot be effective if these groups continue to face stigma and discrimination regarding access to services. Examples of how the detrimental impact of stigma and discrimination affects access include the failure to provide tailored services that address the needs of MARPs; negative attitudes of care providers; and barriers to promote harm reduction as an HIV prevention strategy. Thailand’s National HIV strategy plans to address stigma and discrimination by providing specialized services for MARPs and MWs that are staffed by providers who receive sensitization training, by advocating for policy changes at the national and subnational level, and by empowering MARPs to participate in HIV prevention. While indicators are needed that monitor the success of these efforts, such indicators must be sensitive enough to measure change in the specific policies affecting MARPs and other aspects of the enabling environment surrounding prevention.

The National Composite Policy Index is a comprehensive and standardized tool which is measured nationally for the UNGASS report every 2 years. This tool aims to assess the policy, strategy, legal and program implementation environment for HIV responses. While the NCPI covers the overall response to the epidemic, a number of sections in the questionnaire are available to assess policy, strategy law and environment so that a sub-index including policy, human rights and stigma and discrimination targeting MARPs and MWs may be scored and described. Because the NCPI is well-established and currently used to report for UNGASS, sub-sections of the Index will be used to monitor the core indicator measuring change in the enabling environment and effective management responses targeting MARPs and MWs. (For details of this scoring, see the detailed indicator description in Annex 4). The National AIDS Management Center and Bureau of AIDS and STI are responsible for collecting this information.

However, the NCPI questions are not specific or sensitive enough to measure the policy changes and other measures of advocacy effectiveness that are part of Thailand’s National HIV strategy. An expanded module is required for the questionnaire to accurately monitor progress in this area, with newly designed questions covering specific strategies and policy changes. Current NCPI questions such as, “Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations?” will be expanded to address specific laws and policies as targets for change. The module will be developed through the participation of key stakeholders including MARPs and MWs under the leadership of the National AIDS Management Center and Bureau of AIDS and STI. The new tool will be pre-tested in 2010 with data collection beginning in 2010, and will be incorporated into the NCPI reporting process for the next UNGASS report (2012).

4. Provincial survey

The National AIDS Management Center has initiated a provincial survey tool to monitor progress made on availability and use of key strategic information for MARPs at the provincial level and representation of MARPs in the provincial AIDS committee or provincial coordinating mechanism. In addition, the provincial survey will contribute to capacity building on M&E at the province level. It will provide an opportunity for the provincial health officers to undertake self-assessment and to prioritize their actions based on empirical data. Therefore they can immediately address issues appropriately in the provincial operation for MARPs.

The survey will be piloted in 2010 at the same time that data is collected for the 2010 UNGASS. Lessons learned will be continually reviewed and the survey tool will be improved over time to ensure accuracy and reliability.
5. National AIDS Spending Assessment (NASA)

As national response to HIV/AIDS continues to scale up, it is important to have accurate tracking of how funds are spent at the national level. Decentralization is a vital factor affecting the sustainability of HIV responses in Thailand, as local authorities such as the sub-district and district administration have increased ownership to contribute financial resources to HIV prevention responses.

The National AIDS Management Center and Institute of International Health Policy and Planning, MOPH will undertake NASA every two years, following the methodology in the UNGASS guidelines. Unlike the UNGASS guidelines covering national-level data however, Thailand will collect financial data from local authorities throughout the country. UNDP is currently supporting the Institute of International Health Policy and Planning to conduct a pilot in two provinces (Nakorn Phanom and Lampang) for collecting health expenditure data at the local authority. Lessons learned from this study will provide a guide to use for NASA.

c. Data management

The flow of data from the five key data sources discussed above to the National AIDS Management Center is presented below.

1. Second generation sentinel surveillance: Integrated Biological and Behavioral Surveillance among most-at-risk populations and migrant workers (IBBS)

The Bureau of Epidemiology (BoE) is responsible for overall management of IBBS including the design protocol, data collection, analysis, report writing and data use. The BoE works with the technical guidance provided by TWG- Situation Analysis and M&E-TWG for each MARP. After each round of IBBS, the report will be prepared by BoE and disseminated to all stakeholders and interested parties. BoE will also provide sub-analysis following requirements from the national M&E plan and the UNGASS and Universal Access (UA) report. NAMC will store key results of the IBBS in the Country Response Information System (CRIS) or another appropriate database, allowing the country to gain an overview of the epidemic and to compare the progress of impact and outcome indicators over time. NAMC and the National M&E Steering Committee, with NAMC as the secretariat, are responsible for synthesizing IBBS results and reporting to NAPAC annually or as needed. Every two years, BoE, TWG situation Analysis and M&E TWG for MARPs will use this data for preparing the UNGASS and UA report (see Figure 4.3).
2. Data flow for the National Composite Policy Index (NCPI), Provincial Survey and National AIDS Spending Assessment (NASA)

The National AIDS Management Center is responsible for compiling the National Composite Policy Index (NCPI) and for management of the Provincial survey and National AIDS Spending Assessment (NASA). This includes methodology, data collection, analysis, report writing and data use, with technical guidance provided by TWG. These surveys will be undertaken once every 2 years. Reports will be prepared by NAMC and disseminated to all stakeholders and interested parties. NAMC will also provide sub-analysis following the framework set forth in the national M&E plan and required by the UNGASS and UA report.

NAMC will store key results in the central database and/or the Country Response Information System (CRIS). NAMC and the National M&E Steering Committee are responsible for synthesizing results and reporting to NAPAC annually or as needed, and for preparing the UNGASS and UA reports every two years (see Figure 4.4).

![Diagram showing the data flow process](image)

Figure 4.4: Data Flow for the National Composite Policy Index (NCPI), Provincial Survey and National AIDS Spending Assessment (NASA)

3. Integrated Facility and Community-based Routine Health Information System (RHIS)

The program plans to build an integrated facility and community-based RHIS as one monitoring and evaluation system for the country. Thailand promotes area-based management of program activities, as local public and private health organizations know their target MARPs best and can work together to jointly plan and manage their activities. This will also assist in avoiding duplication of efforts and serving a broad geographical area. A recent review of the existing information systems for HIV/AIDS services showed several challenges in building the RHIS.13 Coordination needs to be facilitated between stakeholders and sharing of information, particularly across

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13 Aqil, A. Thailand RHIS for HIV/AIDS Prevention Services for MARPs: Some Issues and considerations; Presentation made at a meeting organized by NMAC and UNAIDS, February 5, 2010.
platforms such as CBOs and health facilities. Use of information is limited, as information tends to be reported upwards but not used for planning, managing and monitoring and evaluation. Data quality assurance systems need to be built and maintained.

To implement the area-based management approach and address the challenges of the existing information system for MARPs, an integrated RHIS is envisioned, where NGOs will report to their respective PR directly on assigned performance indicators, but will also share that information at the sub-national level. Thus, a comprehensive picture of program activities emerges at the sub-national level for better monitoring and evaluation. The Integrated RHIS will have two components, facility-based and community-based. The details on each are as follows:

**Facility based information system:** The facility-based program monitoring system for STI screening/treatment and HIV counseling and testing has been managed by the Bureau of HIV/AIDS, TB and STI (BATS). There are three standardized data collection forms used for the national RHIS system: the 506-STI form, the HIV counseling and testing form (VCT form) and the Referral form. These standard forms will be used by all specialized STI and VCT clinics throughout the country. The forms will be set up so that information may be disaggregated by MARP.

A computerized system will be implemented starting from 2010, which will allow STI and VCT data to be transmitted to provincial and regional authorities and to BATS at the national level. At the provincial level, all facilities within the province will be able to view and perform analysis of all STI and VCT data. The regional office will be able to do the same with data from all facilities of the 5-8 provinces in the region. Finally, BATS and NAMC will receive data from all facilities in the country. For facilities that are part of the Round 8 Global Fund project, data will be compiled, verified, analyzed and reported to the affiliated SSR and/or SR. Quarterly reports can then be generated and submitted to the PR. Semi-annual reports will be generated by the PHO at the provincial level and by regional DDC at the regional level using the same database for reporting to other donors. The annual report will be compiled at the national level and reported to NAPAC.

**Community based information system:** A program monitoring system will be established to collect data for monitoring the progress of community outreach and behavioral change communication activities. The indicators to be monitored include the number of individuals reached by the prevention program, number of commodities distributed, number of individuals trained, and others. While most implementing partners are CBOs, NGOs, MARP groups and networks, the system also includes government organizations that provide outreach and education activities. Currently, IAs have developed their own outreach and education data collection forms that are used for their programs; these can continue to be used as long as they include the core indicators.

Previously, community-based data is used only to generate either monthly or quarterly reports to the Global Fund or other donors. Therefore this community-based program data did not get captured by the national system. As part of the unified system developed by the national M&E plan for MARPs, a new data flow channel will be introduced to integrate the community-based data into the national routine program monitoring system. All IAs at the service delivery level are requested by NAMC to submit aggregated community outreach/education and service program data to the provincial health office (PHO) and/or sub-provincial level once every six months. An aggregation form for community-based data will be standardized for use across MARPs and across IAs. Aggregated data at the provincial level will be reported to the regional and national level. This reporting system will allow PHO/PCM, regional DDC and NAMC to analyze the data to get the “big picture” of the HIV prevention response at each level. IAs will continue to prepare reports according to the Global Fund’s requirement that reports will be submitted to SSR, SR and PR respectively.
There is a need to create consensus on the design of integrated RHIS and its information flow. Under NAMC leadership, system structure design will focus on area-based management (the denominator), illustrating information flow levels and linkages between facility and community organizations. A data warehouse will be designed integrating existing databases on HIV/AIDS services in general and MARPs in particular. A procedure manual will also be designed to document how the RHIS functions.

Since this reporting system is relatively new, it will initially be paper-based in 2010. At the same time, a computerized system will be piloted in selected provinces. A scaling-up plan of the computerized system will be implemented in subsequent years at the provincial, regional and national level.

**Program management.** Principal recipients (PRs) also report financial information, procurement information, and data on stocks and flows of commodities to NAMC. This routine reporting contributes to overall data management.

There is a need to create a data warehouse to integrate facility, community, NAP and other information systems and surveillance data to monitor and manage HIV/AIDS services for MARPs.

**RHIS performance.**\(^{14}\) Integrated RHIS performance is defined as high quality data and continuous use of information. The PRISM (Performance of Routine Information Systems Management) framework\(^ {15}\) states that data quality and use of information are a function of the RHIS processes and their technical, behavioral

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and organizational inputs. Unless the inputs and processes are aligned, it is unlikely that RHIS will produce better quality data or use of information for decision-making to improve HIV/AIDS services. Thus, RHIS design will have an inbuilt system to assure data quality and continuous use of information. The RHIS procedure manual will adapt the PRISM diagnostic tool to assess quality data and use of information at the facility and at community organizations. A separate manual on use of information will be developed to improve knowledge and skills to analyze, interpret and use data for program management focusing on MARPs and MWs.

**d. Data quality assurance**

Emphasizing data quality is one objective of the national M&E plan for HIV prevention targeting MARPs and MWs. With the recognition that national programs are working towards achieving ambitious goals, measuring the success and improving the management of national efforts requires a strong M&E system that produces high-quality data related to program implementation.

The Data Quality Audit (DQA) is a data quality assessment tool providing guidelines for an external audit team to assess a program or project’s ability to report high-quality and accurate data. This tool was developed by the Global Fund for use in assessing a sample of its funded programs globally. Thailand is developing the Routine Data Quality Assessment tool (RDQA), a simplified version of the DQA, that allows programs and projects to periodically self-assess the quality of their own data and strengthen their data management and reporting systems. This tool is being developed by NAMC.

The Global Fund and other donors mandate the use of the DQA and established the process for an external team to undertake this assessment. Thailand’s national M&E system provides an extra layer of quality control by incorporating the RDQA for periodic self-assessment.

There are two pathways for implementing RDQA in the prevention program. At the project level, PRs, SRs and other collaborating agencies will establish an internal process to assess data quality. The RDQA examines the monitoring system at the point of service delivery, which provides the foundation for the M&E system as a whole. The RDQA will not be a stand-alone process as the findings on data quality will be discussed and linked with the data analysis and feedback processes.

Data verification, analysis and the feedback mechanism will be conducted quarterly at service delivery points by the implementing agencies. For the Round 8 Global Fund grant, the PRs will conduct RDQA once a year, following the data flow from point of service delivery through all aggregated levels.

At the national level, the RDQA will help ensure that different components of the routine health information system are working together harmoniously. Lessons learned from other countries have clearly shown that staff should have a high level of confidence in conducting data accuracy checks, should have knowledge of different methods to check data accuracy, and have support from an organizational culture that emphasizes high quality data. A gap in any of these components causes data quality to suffer. To respond to these needs and opportunities, the National AIDS Management Center in collaboration with the twelve regional DDC offices will work closely to undertake and manage the routine data quality assessment process. The management mechanism of the RDQA is illustrated in Figure 4.6.

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RDQA activities to be implemented in 2009-2011 are as follows:

- Develop the RDQA tool in Thai, designed to measure M&E activities and data outputs that are appropriate for routine data quality assessment and are linked to improving program performance. Experiences can be drawn from existing tools such as the GFATM’s DQA tool and PRISM (Performance of Routine Information Systems Management).

- Establish a core RDQA team consisting of NAMC and regional DDC staff.

- Develop the training of trainer (TOT) curriculum and undertake training for NAMC and regional DDC staff in charge of the RDQA activity.

- Conduct assessments in selected provinces, aggregation levels and service points (Core RDQA team).

- Design and implement subsequent training or other interventions for provincial staff in each region to improve quality gaps (Core RDQA team).

- Document lessons learned from this development and piloting process in order to develop a RDQA strategy for the national M&E plan for 2012-2016.
**e. Evaluation and research**

The allocation of resources for HIV prevention programs is an increasingly critical issue for national program managers and planners. Competition for limited resources at the country level means that funds must be split between prevention and treatment programs, which always require a major share. At the global level there is a general perception that HIV prevention is not working, resulting from a handful of community randomized trials that have failed to show an intervention effect on HIV incidence.

Thus there is a clear need to accumulate credible evidence about what intervention programs do and do not work. As Thailand pursues the combination or “package of services” approach targeting most-at-risk populations, we must face the risk of rolling out a large scale-up of programs with uncertain effectiveness.

With these challenges, Thailand takes seriously the need for the evaluation of these innovative approaches for HIV prevention. This strategic plan for evaluation and research will provide guidance for program managers to make informed decisions on the priorities of the prevention agenda. The country’s commitment towards mobilizing the necessary resources to conduct key evaluations will provide evidence to demonstrate what difference the national response has made in reducing the HIV epidemic for MARPs and MWs.

**National evaluation agenda**

Thailand will hold a national workshop for developing the national evaluation agenda by mid-2010. Key objectives for the workshop are to:

- Promote evaluation with actionable results addressing the needs of the national HIV prevention program.
- Improve coordination, reducing duplication of effort and resources.
- Build on existing evaluation studies and promote synergies between evaluation studies.
- Leverage funds within and outside the country.
- Increase the visibility of local researchers and research institutes.

During the preparation phase, the Institute for Population Studies (IPS) at Chulalongkorn University will work closely with the National AIDS Management Center to undertake a literature review and mapping of existing, current and future evaluation activities. Results will be used to brainstorm at the workshop.

Prior to the national workshop to develop the evaluation agenda, a number of special studies and surveys, assessments/reviews and evaluation efforts have been identified as described below

**1. Surveys and special studies**

**1.1 MARP and MW size estimation.** NAMC currently works with local institutions to conduct a size estimation study, supported by the Global Fund Round 8 with technical assistance provided by UNAIDS and the World Bank. Thailand will use the network scale-up method for this study. A pilot test will be conducted in Chiang Mai in early 2010, followed by the estimation for and the method will be implemented a national scale throughout the country if the pilot is successful.

**1.2 Special studies for IDUs.** A number of studies are planned that focus on IDUs, including:

- Participatory Rapid Assessment and Response (RAR) on Drug use and HIV: The Asian Harm Reduction Network (AHRN) with support from the Global Fund will undertake RAR in 8 sites in Thailand to identify major issues related to IDUs and HIV transmission. The findings will be used to design interventions and policies. A mix of quantitative and qualitative methods will be applied for the study, which will be completed by mid-2010.
- Tracking survey (TraC Survey): In the seven provinces covered by the Round 8 Global Fund project where the IBBS for IDUs is not being conducted, PSI will undertake a tracking survey annually starting from 2010. The TraC Survey is a tool to monitor change over time of the key determinants of behavior change such as knowledge, attitudes, and beliefs; the availability of condoms and needle and syringes; the exposure and intensity of interventions; and key behaviors.
• Measuring Access and Performance (MAP): This study will be used to monitor condom and NSP coverage in catchment areas. MAP will be undertaken in the 15 provinces where IDU interventions are being implemented with support by the Global Fund Round 8.

• Qualitative study on sterile injecting equipment and condom use behavior and perspectives on access to HIV prevention services in 5 provinces.

• Study of Quality of Life among IDUs.

• Research on the relationship between NSP and new initiates to injecting drug use (to be conducted in 2012).

1.3 Studies and surveys for migrant workers. A number of studies are also planned to increase the body of knowledge on migrant workers in Thailand, as follows.

• Migrant Worker Knowledge, Attitudes and Practice (KAP) Survey: The study will be conducted by the Institute for Population and Social Research (IPSR), Mahidol University as an external organization and managed and financed by PR - Raks Thai. It will measure behavioral outcomes and their determinants among migrant workers, using sampling techniques to ensure the sample is representative of the entire migrant worker population in all 36 provinces where prevention programs are being implemented under the Round 8 Global Fund project. In addition to measuring behavioral outcomes, the KAP Survey will focus on process evaluation and assessing the quality of interventions. This information will be used to design, improve and tailor project interventions for migrant workers. The KAP Survey will be conducted in 2009, 2011 and 2013.

• Review of policies at national and provincial levels relating to migrant workers: Raks Thai Foundation will identify an external consultant(s) to review the existing Thai government policies on migrant workers related to health services, focusing on reproductive health and HIV/AIDS services, as well as proposed changes in these policies. Official statements, strategy papers, press releases and budget allocations will be documented and reviewed by Raks Thai Foundation (RTF) and its partners at the provincial level. The study will examine how national and local policies and policy implementation support or hinder the health and well being of migrant workers.

• Qualitative study on domestic violence in migrant workers.

• Study on best practices in health insurance for migrant workers who have no ID card.

2. Program review and assessment

2.1 Joint stakeholder prevention program review: NAMC will organize a joint stakeholder review for the HIV prevention program in 2011. The purpose of this joint review is to review progress made in the implementation of the national prevention response, including the Round 8 Global Fund programs, the acceleration plan, bilateral support programs and others. External experts will be invited to join the team in order to provide external views and international perspectives to improve the national responses and develop the next national strategic plan (2012-2016).

2.2 Mid-term assessment for migrant workers: Raks Thai Foundation will contract an external consultant team/institution to conduct the program’s mid-term assessment through a bidding process. The mid-term assessment will review the quality of project interventions and coordination processes among the PR, SRs and SSRs and the enabling environment. This assessment will identify what is working and is not working in program interventions after two years of implementation. The assessment will be conducted through the group and individual interviews for program staff, related agencies and migrant workers. Findings will be used to develop an operational plan for the Global Fund Phase II.
3. Evaluation studies

3.1 Process evaluation and operational research:
NAMC will manage a process evaluation and/or operations research for evaluating the prevention program supported by the Global Fund in 2010-2011. The process evaluation focuses on fidelity to program design, recruitment, reach, dose responses of prevention programs, client satisfaction/reaction and relevant context that might impact program implementation. Results of the evaluation will be used to identify problems and take corrective action and plan for the Global Fund Phase II implementation.

The USG also supports operational research in six provinces on implementation of HIV rapid tests with same day return HIV result. Results will be used to inform policy decisions on national VCT targeting MARPs. TUC/GAP supports an evaluation study among prisoners in Khon Kaen, Chiang Rai and Udon Thani. TUC/GAP is also analyzing monitoring data for three provinces that are implementing outreach prevention for MSM; the analysis will link the data to behavioral outcomes.

3.2 Impact evaluation and cost effectiveness study:
Impact evaluation and cost-effectiveness analysis will be undertaken as an integral element of the prevention program, particularly for the Global Fund Round 8 programs. The World Bank and UNAIDS will provide technical assistance as follows:

- Provide an evaluation design expert to work with MOPH to develop an optimal evaluation design.
- Ensure that IBBS rounds incorporate sampling methods and questionnaire items required for impact evaluation.
- Provide statistical and modeling support (by the World Bank) to a Thai team to analyze the results of the impact evaluation, which will be based on programmatic, coverage, behavioral and HIV prevalence data from program records and multiple rounds of IBBS.
- Undertake a costing study subject to the results of the impact evaluation and conduct a cost-effectiveness analysis. Using World Bank tools developed for China and subsequently used in Indonesia, the World Bank will provide NAMC and a local research institute to set up cost tables to track intervention costs and will work with Thai statisticians and modelers to estimate cost-effectiveness.

3.3 Policy Evaluation Study:
As discussed above, Thailand’s HIV strategy directly addresses the need to effect changes in the enabling environment surrounding HIV prevention programs for MARPs and MWs, including the development of new strategies and policies regarding these groups. A sensitive and specific measure is needed to track these changes at the national and subnational level. To that end a module will be developed to expand the Strategic Plan and Political Support and the Human Rights sections of the NCPI to include advocacy for specific policies, expressions of political support for MARPs and MWs and progress on human rights. Participation of civil society and other key stakeholders including MARPs themselves will be sought to develop the module. A policy evaluation study will be conducted to help design the module and to field test it; the study will begin in late 2010 with the goal of finalizing the module in time for the 2012 UNGASS report.

f. Capacity building

Capacity building at every level of implementation is a crucial component of this national M&E system. The introduction of surveillance for new population groups and of a new standardized monitoring system will require re-training for data collection. Under decentralization, local government organizations have a greater responsibility in monitoring and evaluation; therefore the capacity of these organizations should be developed to use data and information more effectively in decision-making processes. The need for participation in monitoring and evaluation efforts at the provincial and community level, and particularly for the use of strategic information in planning, will be a key focus. The national plan for HIV/AIDS emphasizes the need to build capacity among NGOs and CBOs to encourage high-quality data collection for these sectors, which have a critical role in the HIV prevention program. The use of surveillance and M&E systems as an early warning system for the epidemic is also a priority.

Capacity building in monitoring and evaluation is also a key component of the Global Fund project. As a means of strengthening community systems and local capacity building, the PRs will train and empower SRs and SSRs to monitor and evaluate their own project activities. PRs will work closely with the SRs to ensure that the data collected is of high quality and is appropriately analyzed so that the results can be effectively used to improve project implementation.
This close interaction between the PR and SRs will ensure the timely collection of data of SR activities by the PR.

Common guidelines and tools will be developed for this work. Sub-national core teams, coordinated by Regional DDC, will be trained as trainers to train SSRs in their responsible areas. Capacity building will use the on-the-job training approach. NAMC and PRs will introduce the standardized M&E framework to the implementing partners through training and workshops, as well as information management techniques. These techniques will be aimed at:

- Monitoring coverage of activities;
- Stakeholder reviews and participation of MARPs and MWs in M&E activities;
- Measuring the effectiveness of communication activities;
- Commodities distribution management and monitoring;
- Utilization of qualitative data; and,
- Reporting and documentation.

During 2010-2011, key activities will be implemented as follows:

- Introduce the unified M&E system and build understanding for its acceptance: NAMC will undertake a series of meetings to provide basic information and introduction of the unified system in order to gain full collaboration among key stakeholders. NAMC will work in close collaboration with M&E-TWGs at the national level and with PCM and PHC at the sub-national level.
- Build basic M&E capacity on prevention targeting MARPs at all levels: NAMC will develop an M&E manual for the national data system. These efforts would include a Training of Trainer (TOT) curriculum developed to train key staff from the regional DDC. Subsequent training at provincial and district levels will be carried out by each regional DDC to their responsible provinces.

- Strengthening data use: Improved analysis, interpretation, skill and use of data for program improvement and planning will be carried out. Each PR under the Global Fund will focus their efforts among their implementing partners to improve program implementation. NAMC through PCM will develop a training curriculum to strengthen data use capacity for PHO, TOA et al. to ensure they have the skills needed to use data effectively for developing the provincial strategic plan and work plan.
- On-the-job training and mentorship will be provided to provincial M&E units, district and sub-district offices to monitor progress of the provincial and sub-provincial M&E system and facilitate use of information with key stakeholders.
- The functional community-level M&E framework is still underdeveloped even through it is recognized as a critical part of the success of the national M&E system. In collaboration with technical provider agencies, NAMC will conduct an assessment to gain a better understanding in 2010-2011 of the local frameworks, and will use these findings to determine the future action plan.
- M&E systems strengthening and capacity assessment will be undertaken at the end of 2011. Findings will be used to inform the M&E and capacity building strategy for the next national M&E plan, 2012-2017.

### g. Data use strategy

Data and information are of most value when they are used to inform decisions, and Thailand has aimed to facilitate data use to enhance evidence-based decision making. The data use framework is a cycle, connecting data collection, data analysis/synthesis, and data utilization. When this point of the cycle is reached, data is used to improve program implementation, policy and planning. The cycle is supported by M&E capacity, coordination and collaboration. There is also a clear link between data utilization and improving the quality and availability of data.
This data use cycle can be applied across different levels of the M&E system in Thailand, as presented in Figure 4.7. At point of service delivery, STIQual will be implemented at health facilities that provide STI and VCT services. STIQual is a quality improvement model for STI and VCT services at the facility level. The main concept of the model is the measurement of service performance for the improvement of quality of care by integration of client data with the hospital quality management program. Health facilities will set targets according to the national standard.

The measurement tool was developed since 2009 under the collaboration of the STI cluster and TUC/GAP. There are two data systems with separate software, the STI Record and the STIQual software.

The STI Record is used to store individual data of clients. There are six components of the information record: demographic, risk behavior assessment, past history, present signs and symptoms, physical examination, STI management, and laboratory testing. HIV counseling and testing information is included in the risk assessment, STI management, and laboratory components of the record. Outputs from the STI Record are the STI case report and the STI clinic performance report for each population group.

The STIQual software is a tool for measurement of coverage of STI and VCT services for quality improvement. The input is an abstract from existing medical record forms and/or import from the STI Record database. The measurement can be done periodically but at least once a year. Outputs from the software are coverage of STI screening among risk groups, STI case management, and HIV counseling and testing.
The infrastructure supports for effective measurement are computers, hospital medical records, WHO’s International Classification of Diseases (ICD-10) system, STI clinic logbook and trained data management staff. The supervision from central or regional level to implementation units is important.

At the community level, the program monitoring system will be used to monitor the progress of coverage by prevention programs as well as the performance of peer and outreach educators. At decentralized units such as the Tambol Administrative Organizations (TAO), capacity will be strengthened to facilitate PHO and PCM use of core monitoring data (program, outcome and impact monitoring) to guide development of annual operational plans.

For the Provincial AIDS Committee (PAC) and PCM, capacity will be strengthened for the PAC and PCM to conduct analysis and synthesis of provincial data and disseminate reports on the HIV situation and provincial response every six months to key stakeholders within the province. Selected provinces will be identified to undertake integrated and in-depth analysis of this data. Information will be used to inform the next national strategic plan.

At the regional level, regional analysis will be encouraged to identify common characteristics of the region while recognizing variation in the provinces. A regional annual report will also be developed.

At the national level, NAMC will conduct analysis of the core indicators, develop the annual report and disseminate it to key stakeholders. In particular these analysis and results will be used to inform the development and adjustment of national targets. Other national-level outputs include:

- UNGASS and UA report: Data from various sources will be used to develop the biannual UNGASS and UA reports. Analysis and synthesis will be undertaken by M&E MARP-TWGs. Besides meeting the minimum requirements for reporting, TWG will try to collect and analyze other relevant information to further investigate the current situation and trends. The key results from the UNGASS and UA reports will be presented to NAPAC and disseminated to key stakeholders.
- Triangulation analysis of MARPs, using multiple sources of data: More in-depth information on program impact and behavior change is useful to develop next national strategic plan and the Global Fund operation plan for Phase II.
- In-depth analysis and active advocacy: The Asian Epidemic Model (AEM) will be used to estimate the number of infections averted based on the current response, as well as projections of incidence for the future. Key findings will be packaged and advocated to policy-makers in order to improve the national response and leverage financial support for HIV prevention.
- Emphasis on evidence-based planning: At the national level, active advocacy will be integrated in all processes to ensure decisions will be made informed by evidence-based data.

**h. Information products**

The M&E system will produce strategic information that goes beyond basic dissemination of study reports and estimation of project indicators. Findings from the monitoring and evaluation studies will be used to develop needed policies to create a healthier environment for MARPs and MWs. These policies include a firm commitment to harm reduction, increased accessibility to HIV prevention and other health services for migrants, and policies to improve accessibility to condoms. As discussed above, the results of the evaluation studies and operations research will provide needed evidence of global significance on the effectiveness of Thailand’s HIV strategies targeting MARPs and MWs outlined here.

- Routine reports:
  - Biannual UNGASS and UA report
  - Annual report at national and regional level

- Semi-annual report at provincial level
- Quarterly report for implementing partners to report to the GFATM
- Biannual reports from the second generation surveillance
- Biannual reports for NASA, provincial survey report and National Policy index
- Report from special studies and evaluation
  - Reports from special surveys and research
  - Mid-term evaluation and program review
- M&E plan or operation plan
  - Consolidated M&E plan
  - RHIS operation plan
  - National evaluation agenda
- Curriculum
  - Manual of M&E system
  - ToT: M&E curriculum
  - Data quality assessment curriculum.
The consolidated action plan shown in Table 5.1 provides a timeline for the major activities outlined in this plan.

### Table 5.1: Consolidated Action Plan for 2010-2011

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<thead>
<tr>
<th>A: National HIV Monitoring</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>Responsible Organization with TA support</th>
<th>Product</th>
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<tbody>
<tr>
<td>1. IBBS</td>
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<td>FSW</td>
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<td>BOE with TA from TUC/GAP</td>
<td>Report</td>
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<td>MSM</td>
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<td>Report</td>
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<td>IDU</td>
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<td>Report</td>
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<td>MW</td>
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<tr>
<td>2. Routine Health Information System (RHIS) and Project-level monitoring</td>
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<td>NAMC with TA from UN Joint Team</td>
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<tr>
<td>Develop Area based RHIS framework and operational plan</td>
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<td></td>
<td>RHIS framework developed</td>
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<td>Develop data collection form</td>
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<td>Forms developed</td>
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<td>Develop reporting form and manual</td>
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<td>Manual developed</td>
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<td>Develop integrated RHIS system</td>
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<td>System has been set up</td>
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<td>Implement paper system</td>
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<td>Progress Report</td>
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<td>Implement computerized system</td>
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<td>Progress Report</td>
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<td>Community based program monitoring for each MARP/MW</td>
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<td>PR and NAMC Outreach forms and manual developed</td>
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<td>STI and VCT monitoring system development and scale up</td>
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<td>STI cluster with TA from TUC/GAP</td>
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<td>MMT monitoring system</td>
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<td></td>
<td>NAMC On-going</td>
<td></td>
</tr>
</tbody>
</table>

The consolidated action plan shown in Table 5.1 provides a timeline for the major activities outlined in this plan.
<table>
<thead>
<tr>
<th>Year</th>
<th>Responsible Organization with TA support</th>
<th>Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>Q1-2010, Q1-2011, Q2-2011, Q3-2011</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>Q1-2010, Q1-2011, Q2-2011, Q3-2011</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>Q1-2010, Q1-2011, Q2-2011, Q3-2011</td>
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</tr>
</tbody>
</table>

3. NCIS

- National Policy Assessment (NAMC Report)
- Tool development to monitor stigma and discrimination and policy change (NAMC with TA from UN Joint Team, Tool developed)

4. Provincial Survey

- Provincial survey data collection and report (NAMC Report)

5. NASA

- NASA data collection and report (NAMC Report)
- Pilot test of NASA at decentralized unit in two provinces (NAMC and IHPP with TA from UNDP Report)

6. Evaluation and Research

- Develop national evaluation agenda including workshop (NAMC with TA from UN Joint Team Report)
- MARPs and MW Pop Size Estimation (NAMC Report)
- Tracking Survey (IDUs) (PSI Report)
- MAP - NSP coverage measurement (IDUs) (PSI Report)
- Qualitative study (IDUs) (PSI Report)
- Annual condom survey (MSM) (PSI Report)
- Rapid Assessment & Response (IDUs) (AHRN Report)
- Quality of Life of IDUs (PSI Report)
- Effect of NSP on Drug use behaviors (IDUs) (NAMC Report)
- KAP Survey (MW) (IPSR Report)
<table>
<thead>
<tr>
<th>Responsible Organization with TA support</th>
<th>Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAMC with TA from World Bank Report</td>
<td>Report</td>
</tr>
<tr>
<td>NAMC with TA from UN Joint Team</td>
<td>Report</td>
</tr>
<tr>
<td>NAMC with TA from UN Joint Team</td>
<td>Report</td>
</tr>
<tr>
<td>TUC/GAP Report</td>
<td>Report</td>
</tr>
<tr>
<td>USAID Report</td>
<td>Report</td>
</tr>
<tr>
<td>NAMC established</td>
<td></td>
</tr>
<tr>
<td>TWG established</td>
<td></td>
</tr>
<tr>
<td>M&amp;E plan developed</td>
<td></td>
</tr>
<tr>
<td>Minutes</td>
<td></td>
</tr>
<tr>
<td>Report</td>
<td></td>
</tr>
</tbody>
</table>

**C. Harmonization and System Strengthening**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Organization</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>National M&amp;E unit set up</td>
<td>NAMC</td>
<td>NAMC established</td>
</tr>
<tr>
<td>Appoint National M&amp;E Committee</td>
<td>NAMC</td>
<td>TWG established</td>
</tr>
<tr>
<td>Consolidated National M&amp;E Plan for MARPs and MWs including GF, UNGASS and Accelerated plan</td>
<td>NAMC</td>
<td>M&amp;E plan developed</td>
</tr>
<tr>
<td>Facilitate joint strategic, management and M&amp;E coordinating committee</td>
<td>NAMC and other PRs</td>
<td>Minutes</td>
</tr>
<tr>
<td>National M&amp;E system Assessment</td>
<td>NAMC</td>
<td>Report</td>
</tr>
</tbody>
</table>
### D. Capacity Building

<table>
<thead>
<tr>
<th>Activity</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>Responsible Organization with TA support</th>
<th>Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientation to the M&amp;E system for all stakeholders at all levels</td>
<td></td>
<td></td>
<td></td>
<td>NAMC and other PRs</td>
<td>Progress Report</td>
</tr>
<tr>
<td>Develop Technical M&amp;E, data quality and data use manual/curriculum for MARPs</td>
<td></td>
<td></td>
<td></td>
<td>NAMC and other PRs, TA from UN Joint Team and USG</td>
<td>Training manual developed</td>
</tr>
<tr>
<td>TOT for GF PRs, SRs and Government</td>
<td></td>
<td></td>
<td></td>
<td>NAMC and other PRs, TA from UN Joint Team and USG</td>
<td>Training done</td>
</tr>
<tr>
<td>Mentorship for each MARPs</td>
<td></td>
<td></td>
<td></td>
<td>NAMC and other PRs and USG</td>
<td>Monitoring visit report</td>
</tr>
<tr>
<td>PCM/Provincial AIDS Committee on-the-job training to compile/analyze M&amp;E to manage HIV report</td>
<td></td>
<td></td>
<td></td>
<td>NAMC and other PRs</td>
<td>Monitoring visit report</td>
</tr>
<tr>
<td>Strengthen M&amp;E at point of service delivery/CBOs</td>
<td></td>
<td></td>
<td></td>
<td>NAMC and other PRs</td>
<td>Monitoring visit report</td>
</tr>
<tr>
<td>Strengthen M&amp;E at Local authority level</td>
<td></td>
<td></td>
<td></td>
<td>NAMC</td>
<td>Monitoring visit report</td>
</tr>
<tr>
<td>Follow-up M&amp;E capacity assessment</td>
<td></td>
<td></td>
<td></td>
<td>NAMC</td>
<td>Report</td>
</tr>
</tbody>
</table>

### E. Data Use, Synthesis and Dissemination

<table>
<thead>
<tr>
<th>Activity</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>Responsible Organization with TA support</th>
<th>Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>National plan: Facilitate joint strategic, management and M&amp;E coordinating committee</td>
<td></td>
<td></td>
<td></td>
<td>NAMC with TA from UN Joint Team</td>
<td>UNGASS and UA report</td>
</tr>
<tr>
<td>IDU: Share information with National M&amp;E committee to assist in the development of national standards for IDU.</td>
<td></td>
<td></td>
<td></td>
<td>PSI</td>
<td>Report</td>
</tr>
<tr>
<td>Year</td>
<td>Q1</td>
<td>Q2-2010</td>
<td>Q3-2010</td>
<td>Q4-2010</td>
<td>Q1-2010</td>
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<table>
<thead>
<tr>
<th>Use M&amp;E data to develop harm reduction policy</th>
<th>Responsible Organization with TA support</th>
<th>Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use M&amp;E data to develop policy to increase and sustain access to HIV prevention and care for MW</td>
<td>PSI and NAMC and World Bank</td>
<td>National Policy document</td>
</tr>
<tr>
<td>Use M&amp;E data to develop condom policy</td>
<td>NAMC</td>
<td>Report</td>
</tr>
<tr>
<td>STIQual for STI and VCT facilities</td>
<td>STI Cluster with TA from TUC/GAP</td>
<td>Report</td>
</tr>
<tr>
<td>Data use and interpretation workshop at sub-district, district provincial and regional level</td>
<td>NAMC, TA from UN Joint Team and TUC/GAP</td>
<td>Report</td>
</tr>
<tr>
<td>Annual National report and dissemination workshop</td>
<td>NAMC</td>
<td>Report</td>
</tr>
<tr>
<td>Triangulation exercises among MARPs and In-depth analysis</td>
<td>NAMC and UN Joint Team and TUC/GAP</td>
<td>Report</td>
</tr>
<tr>
<td>Joint-stakeholder Review, Advocacy</td>
<td>NAMC and UN Joint Team</td>
<td>Review trip and Report</td>
</tr>
</tbody>
</table>
The budget in Table 6.1 shows contributions to the M&E plan from the Global Fund Round 8 funding, Thai government support, and additional contributions from the U.S. government, UN agencies and others. Figures are in some cases estimated as the goal is to give a broad picture of the support currently committed to the unified monitoring and evaluation system for the next two years.

The table therefore shows primarily the available (known) resources to the different components of the national M&E framework for MARPs. Values for technical assistance contributions are estimated as is the Royal Thai Government (RTG) contribution for 2011. The table will be updated at regular intervals when more information is available to reflect the overall resource needs vis-à-vis RTG and donor contributions.

At this stage it is very difficult to do a full gap analysis of the funds needed to build an effective M&E system for MARPs and MWs, as a) the M&E framework has to be fully operationalized to estimate overall resource needs, and b) budget allocations to M&E by the RTG and by donors are not yet decided (especially for 2011).

By rough estimate, Thailand will need an estimated US$8.69 million in next two years to fully build the M&E system, meaning an estimated shortfall of US$1.14 million. While the planned budget of the Round 8 Global Fund project covers most of the priority activities, both government and multi/bilateral donors are contributing financially and with technical assistance. It is hoped that the US$7.55 already committed to the effort-two-thirds of which comes from GFATM-will help to leverage funds to strengthen the sub-national system and conduct strategic evaluation studies.
Table 6.1: Consolidated Budget for National M&E Plan for HIV Prevention among MARPs and MWs

<table>
<thead>
<tr>
<th>Activity</th>
<th>The GF R8 Total (US$)</th>
<th>Government (US$)</th>
<th>TA from bilateral and UN (US$)</th>
<th>Total (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: National HIV monitoring:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data collection of core national indicators including system development and maintenance</td>
<td>749,479</td>
<td>1,933,649</td>
<td>869,831</td>
<td>75,025</td>
</tr>
<tr>
<td>B: Evaluation and Research:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any special studies, operational research, process, outcome and impact evaluation and research activities funded for the HIV prevention effort for MARPs and MWs; development of tools for new indicators</td>
<td>81,174</td>
<td>950,269</td>
<td>116,030</td>
<td>-</td>
</tr>
<tr>
<td>C: Harmonization and System Strengthening Activities contributing to harmonization and system strengthening such as developing M&amp;E plan and framework, pilot test of the system (RHIS) and funding of joint strategic M&amp;E efforts and coordination</td>
<td>71,291</td>
<td>222,128</td>
<td>64,830</td>
<td>-</td>
</tr>
<tr>
<td>Activity</td>
<td>The GF R8 Total (US$)</td>
<td>Government (US$)</td>
<td>TA from bilateral and UN (US$)</td>
<td>Total (US$)</td>
</tr>
<tr>
<td>----------</td>
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</tr>
<tr>
<td></td>
<td>Fiscal Year</td>
<td>Fiscal Year</td>
<td>Fiscal Year</td>
<td>Fiscal Year</td>
</tr>
<tr>
<td>D: Capacity Building: Any activities to build capacity for M&amp;E among MARPs &amp; MWs, CBOs, NGOs, national &amp; sub-national governments working in HIV prevention</td>
<td>83,807 195,151</td>
<td>28,735 -</td>
<td>200,000 200,000</td>
<td>50,000 70,000 50,000</td>
</tr>
<tr>
<td>E: Data Use, Synthesis, and Dissemination and Advocacy: Any activities contributing to the use of strategic information for planning and budgeting; dissemination of research efforts; documentation, policy advocacy, national and sub national data use.</td>
<td>93,115 266,087</td>
<td>112,795 -</td>
<td>42,188 39,063 -</td>
<td>85,900 100,000</td>
</tr>
<tr>
<td>Total by year (US$)</td>
<td>1,078,866 3,567,284</td>
<td>1,192,221 75,025</td>
<td>348,873 359,795</td>
<td>100,000 697,300</td>
</tr>
<tr>
<td>Total 2009-2011 (US$)</td>
<td>5,838,370</td>
<td>783,693</td>
<td>1,051,600</td>
<td>7,547,362</td>
</tr>
</tbody>
</table>
# 1.1 HIV PREVENTION FRAMEWORKS FOR FSW

## Impact
- Reduced HIV prevalence among FSW (venue- and non-venue-based)

## Outcomes
- Increased condom use (venue- and non-venue-based)
- Reduced STI burden (venue- and non-venue-based)

## Intermediate outcomes:
- Increased prevention coverage and intensity of exposure (venue and non-venue-based)
- Increased STI and VCT coverage and intensity of access to services (venue and non-venue-based)
- Increased HIV/AIDS knowledge

## Enabling environment for FSW prevention activities
- Build a safer reinforcing environment for FSW
- Train, improve cooperation with establishment owners
- Establish standardized positive working environment
- Strengthen peer network
- Increase capacity of FSW for meaningful involvement and leadership in prevention activities
- Improve public attitudes and perception

## Effective management and sustainable financing of national and subnational responses
- Make available size estimation for FSW
- Mapping of sex establishments
- Undertake IBBS (venue and non-venue based)
- Improve quality of HSS
- Strengthen program monitoring for FSW
- Strengthen capacity of CBOs, NGOs, sub-national and national on M&E and use of data for program improvement and planning

## Improved health status and well-being among FSW
- Linkage HIV/AIDS care and treatment for PLHA
- Linkage to FP/RH

## Increased availability and accessibility to integrated package of services
- Increase availability of targeted condom outlets
- Establish condom and lubricant fund
- Increase condom and lubricant availability for commercial market

## Improved accessibility and quality of STI and VCT services
- Develop national standard guidelines and SOP
- Increase availability of friendly STI and VCT services (including mobilization and community-based services)
- Improve quality of care
- Undertake sensitized training among care providers
- Improve care providers’ capacity of STI and VCT services

## Improved accessibility to condoms
- Develop national standard guidelines and SOP
- Increase availability of STI and VCT services

## Improved health status and well-being among FSW
- Linkage HIV/AIDS care and treatment for PLHA
- Linkage to FP/RH

## Sub-outputs

### Increased informed demand, availability and accessibility to integrated package of services
- Raise awareness of HIV and STI
- Increase demand for condoms through condom campaign
- Increase well-trained outreach and peer educators
- Establish drop-in centers
- Improve BCC contents and approaches tailored to FSW

### Improved accessibility and quality of STI and VCT services
- Develop national standard guidelines and SOP
- Increase availability of STI and VCT services (including mobilization and community-based services)
- Improve quality of care
- Undertake sensitized training among care providers
- Improve care providers’ capacity of STI and VCT services

### Improved accessibility to condoms
- Develop national standard guidelines and SOP
- Increase availability of STI and VCT services

### Increased availability of key strategic information and increased use of data for program improvement and planning
- Make available size estimation for FSW
- Mapping of sex establishments
- Undertake IBBS (venue and non-venue based)
- Improve quality of HSS
- Strengthen program monitoring for FSW
- Strengthen capacity of CBOs, NGOs, sub-national and national on M&E and use of data for program improvement and planning

### Strengthened mechanisms for strategic planning and coordination to promote sustainability of HIV/AIDS responses
- Improve coordination and linkage of services
- Establish strengthening sub-national coordinating mechanisms
- Build capacity of national and sub-national mechanisms to appropriately address FSW program in the operational plan
- Mobilize and increase local authority ownership to respond to epidemic trend FSW
- Mobilize financial support to national and sub-national governments, CBOs and NGOs
**Impact**
Reduced HIV prevalence among MSM, TG and MSW

**Outcomes**
- Increased condom and lubricant use
- Reduced STI burden

**Intermediate outcomes:**
- Increased prevention coverage and intensity of exposure
- Increased STI and VCT coverage and intensity of access to service
- Increased HIV/AIDS knowledge

**Enabling environment for MSM prevention activities**

**Effective management of national responses and sustainable financing**

**Strengthened mechanisms for strategic planning and coordination to promote sustainability of HIV/AIDS responses**

**Improved health status and well being among PLHA-MSM**
- linkage to HIV/AIDS care and treatment
**Impact**
Reduced HIV/AIDS prevalence among IDU

**Outcomes**
- Increased safe injection behavior
- Increased condom use

**Intermediate outcomes:**
- Increased HIV prevention coverage and intensity of exposure
- Increased STI, VCT, and OST coverage
- Increased HIV/AIDS knowledge

**Enabling environment for IDU prevention activities**
- Increased informed demand, availability and accessibility to integrated package of services for comprehensive harm reduction

**Output**
- Improved accessibility and quality of STI and VCT services
- Improved accessibility to sterile needle/syringe and injecting equipment
- Strengthen policy and rights protection, reduce stigma and discrimination, empower IDUs
- Increased availability of key strategic information and use of data for program improvement and planning

**Sub-outputs**
- Increased informed demand
- Improved accessibility of STI and VCT services
- Improved accessibility to condom
- Improved accessibility of sterile needle/syringe and injecting equipment

**Intermediate outcomes:**
- Increased HIV prevention coverage and intensity of exposure
- Increased STI, VCT, and OST coverage
- Increased HIV/AIDS knowledge

**Improved accessibility to condom**
- Increase availability of targeted NSP
- Increase availability of OST services
- Promote harm reduction approach
- Build a safer/reinforcement environment for IDUs
- Increase capacity of IDUs for meaningful involvement and leadership in prevention activities
- Strengthen peer networks
- Harm reduction advocacy and policy
- Undertake sensitized training among care providers, correction officers, police

**Increased availability of key strategic information and use of data for program improvement and planning**
- Make available size estimations for IDUs
- Map IDU sites
- Improve IBS, HSS, BSS
- Create systems for enhanced outcome monitoring
- Strengthen program monitoring for IDUs
- Strengthen capacity of CBO, NGO sub-national and national on M&E and use of data program improvement and planning
- Conduct and disseminate high-quality operations and policy research

**Effective management of national responses and sustainable financing**
- Improve coordination and linkage of services
- Establish/strengthen sub-national coordinating mechanisms
- Build capacity of national and sub-national mechanisms to appropriately address IDUs programs in the operational plan
- Mobilize and increase local authority ownership to respond to epidemic toward IDUs
- Mobilize financial support to national and subnational governments, CBOs and NGOs

**Increased health status and well being among PLHA-IDU**
- Linkage to HIV/AIDS care and treatment

**Strengthened mechanism for strategic planning, coordination for national and sub-national level to promote sustainability to HIV/AIDS responses**

---

*ANNEX 1: HIV PREVENTION FRAMEWORKS FOR MARPs AND MWs*

*1.3: HIV PREVENTION FRAMEWORKS FOR IDU*
1.4: HIV PREVENTION FRAMEWORKS FOR MWs

**Impact**
- Reduced HIV/AIDS prevalence/incidence among migrant workers

**Outcomes**
- Increased informed demand, availability and accessibility to integrated package of services
  - Improved accessibility to condom
  - Improved quality of STI and VCT services

**Intermediate outcomes:**
- Increased HIV prevention coverage and intensity of exposure
- Increased STI, VCT, and OST coverage and intensity of access
- Increased HIV/AIDS knowledge

**Outcomes**
- Increased condom use
- Reduced STI burden

**Improved accessibility to condom**
- Increase availability of condom outlets in migrant communities and workplaces
- Promote the support to local authorities (incl. employees) for free condoms

**Enabling environment for MARP prevention activities**
- Build a safe reinforcing environment for MWs
- Increase capacity of MWs for meaningful involvement and leadership in prevention activities
- Advocacy for MW rights and policies
- Sensitized training of key stakeholders
- Sensitize media to present positive message on MWs; develop MW messages and news presented to international and national public
- Community mobilization (Improve attitude of law enforcement and law implementers; Improve attitude of communities toward MWs)

**Effective management and sustainable financing of national and sub-national responses**
- Make available size estimation for MWs
- Mapping of key provincial sites for planning and implementation
- Undertake, improve IBBS on MWs
- Strengthen capacity of CBO, NGO, sub-national and national government on M&E and use of data program improvement and planning
- Conduct and disseminate high-quality operations and policy research
- Improve data analysis, interpretation and use

**Reduced health status and well being among MWs**
- linkage HIV/AIDS care and treatment for PLHA

**Sub-outputs**
- Improved health status and well being among MWs
  - linkage HIV/AIDS care and treatment for PLHA

**Intermediate outcomes:**
- Increased HIV prevention coverage and intensity of exposure
- Increased STI, VCT, and OST coverage and intensity of access
- Increased HIV/AIDS knowledge

**Outputs**
- Increased condom use
- Reduced STI burden

**Sub-outputs**
- Improved accessibility to condom
- Improved quality of STI and VCT services

**Sub-outputs**
- Improved accessibility to condom
- Improved quality of STI and VCT services

**Sub-outputs**
- Improved accessibility to condom
- Improved quality of STI and VCT services

**Enabled environment for MARP prevention activities**
- Build a safe reinforcing environment for MWs
- Increase capacity of MWs for meaningful involvement and leadership in prevention activities
- Advocacy for MW rights and policies
- Sensitized training of key stakeholders
- Sensitize media to present positive message on MWs; develop MW messages and news presented to international and national public
- Community mobilization (Improve attitude of law enforcement and law implementers; Improve attitude of communities toward MWs)

**Effective management and sustainable financing of national and sub-national responses**
- Make available size estimation for MWs
- Mapping of key provincial sites for planning and implementation
- Undertake, improve IBBS on MWs
- Strengthen capacity of CBO, NGO, sub-national and national government on M&E and use of data program improvement and planning
- Conduct and disseminate high-quality operations and policy research
- Improve data analysis, interpretation and use

**Strengthened mechanism for strategic planning, coordination to promote sustainability to HIV/AIDS responses**
- Improve coordination and linkage of services
- Establish/strengthen sub-national coordinating mechanisms
- Build capacity of national and sub-national mechanisms to appropriately address MWs programs in the operational plan
- Mobilize and increase local authority ownership to epidemic response toward MWs
- Mobilize financial support to national and subnational governments, CBOs and NGOs
ANNEX 2: Monitoring and Evaluation Frameworks for MARPs and MWs

2.1 National M&E Framework for FSW with FSW-specific Indicators

**Goal**
- Reduce new infections by 50% by 2011

**Outcomes**
1. % FSW who are HIV-infected
2. % FSW reporting the use of a condom with most recent client
3. % FSW reporting consistent condom use in recent time period with clients, non-regular partners
4. % FSW with gonorrhea and/or chlamydia
5. % of FSW with HIV who receive ART

**Intermediate outcomes**
6a. % FSW reached with prevention program in last 12 months
6b. % FSW receiving package of services in last 12 months
6c. % FSW receiving minimum standard of exposure to prevention programs in last 12 months
7a. % FSW receiving an HIV test and receiving test results in the last 12 months
7b. % FSW receiving an HIV test and receiving test results the minimum number of times in the last 12 months
8b. % FSW receiving testing and counseling appropriate number of times in last 12 months
10. % FSW who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions
12a. % FSW who report condoms are accessible when needed.
12b. % FSW who report condoms are affordable

**Output**
- % FSW who are HIV+ receiving ART
- % FSW who are HIV+ receiving HIV care
- % FSW using FP

**Sub-Outputs**

O1. Increased informed demand, availability and accessibility to integrated package of services
13. % FSW reached by prevention program
14. % FSW receiving STI screening and/or treatment
15a. % FSW receiving an HIV test and receiving test results
15b. % FSW tested for HIV who receive test results
16. % FSW receiving free condom or purchasing subsidized condom

O1.1 Increased informed demand
21. % of outreach and peer educators trained
22a. % of DIC established and operating
22b. % of DIC meeting national standard

O1.2 Improved accessibility and quality of STI and HCT services
21. % of individuals trained on STI and VCT
23a. % of STI sites and VCT clinics where quality of services met national standard
24. % referral cases to STI and VCT

O1.3 Improved accessibility to condoms
25. % of condoms distributed/sold
27. % of targeted condom outlets

O2. Enabling environment for prevention activities

O2.1 Strengthened policy and rights protection, reduced stigma and discrimination, and empowerment of FSW
21. % of individuals trained on policy and participating in community mobilization activities
21. % of individuals trained in sensitization

O2.2 Enabling environment for HIV/AIDS responses
19. % of local authorities contributing financial resources to HIV/AIDS responses for FSWs
20. % of Provincial Coordinating Mechanisms and Provincial Coordinating Committees with FSW representatives

O3. Effective management and sustainable financing of national and sub-national responses

O3.1 Increased availability of key strategic information and increased use of data for program improvement and planning
21. % of individuals trained on SI and M&E

O3.2 Strengthened mechanisms for strategic planning and coordination to promote sustainability of HIV/AIDS responses
21. % of local authorities trained on developing operational plan
29. Number of organizations implementing HIV/AIDS prevention activities targeting FSWs
## ANNEX 2: Monitoring and Evaluation Frameworks for MARPs and MWs

### 2.2 National M&E Framework for MSM with MSM-specific Indicators

<table>
<thead>
<tr>
<th>Output Sub-Output</th>
<th>Goal</th>
<th>Impact</th>
<th>Outcome</th>
<th>Intermediate outcomes</th>
<th>Outcomes</th>
<th>% MSM, TG &amp; MSW reporting the use of a condom during last anal sex with male sex partner</th>
<th>% MSM, TG &amp; MSW reporting consistent condom use in recent period during anal sex male partners</th>
<th>% of MSM, TG &amp; MSW with gonorrhea and/or chlamydia</th>
</tr>
</thead>
<tbody>
<tr>
<td>O1. Increased informed demand, availability and accessibility to integrated package of services</td>
<td>Reduce new infections by 50% by 2011</td>
<td># of new infections</td>
<td>Reduced HIV prevalence among MSM, TG &amp; MSW</td>
<td>% MSM, TG &amp; MSW reporting the use of a condom during last anal sex with male sex partner</td>
<td>1. % MSM, TG &amp; MSW reporting the use of a condom during last anal sex with male sex partner</td>
<td>3. % MSM, TG &amp; MSW reporting consistent condom use in recent period during anal sex male partners</td>
<td>5. % of MSM, TG &amp; MSW with gonorrhea and/or chlamydia</td>
<td></td>
</tr>
<tr>
<td>O1.1 Increased informed demand</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O1.2 Improved accessibility and quality of STI and HCT services</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O1.3 Improved accessibility to condom</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### 2.1 Strengthened policy and rights protection, reduced stigma and discrimination, and empowerment of MSM

- % MSM, TG & MSW who report that condoms and lubricant are accessible when needed
- % MSM, TG & MSW who report that condoms and lubricant are affordable

### 2.2 National M&E Framework for MSM with MSM-specific Indicators

<table>
<thead>
<tr>
<th>Output Sub-Output</th>
<th>Goal</th>
<th>Impact</th>
<th>Outcome</th>
<th>Intermediate outcomes</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>O2. Enabling environment for prevention activities</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>O2.1 Strengthened policy and rights protection, reduced stigma and discrimination, and empowerment of MSM</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O2.1 Strengthened policy and rights protection, reduced stigma and discrimination, and empowerment of MSM</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### 2.3 Effective management and sustainable financing of national and sub-national responses

- % of local authorities contributing financial resources to HIV/AIDS responses for MSM, TG & MSWs
- % of Provincial Coordinating Mechanisms and Provincial Coordinating Committees with MSM, TG & MSW representatives

### Annex 2: Monitoring and Evaluation Frameworks for MARPs and MWs

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Impact</th>
<th>Goal</th>
<th>Intermediate outcomes</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>O3. Effective management and sustainable financing of national and sub-national responses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O3.1 Increased availability of key strategic information and increased use of data for program improvement and planning</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>O3.2 Strengthened mechanisms for strategic planning and coordination to promote sustainability of HIV/AIDS responses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O3.3 Effective management and sustainable financing of national and sub-national responses</td>
<td></td>
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</tr>
</tbody>
</table>

### Improved health status and well being among MSM, TG, MSW

- % MSM, TG, MSW who are HIV+ receiving HIV care
- % MSM, TG, MSW who are HIV+ receiving ART

### Number of organizations implementing HIV/AIDS prevention activities targeting MSM, TG, MSW

- % MSM, TG & MSW reporting the use of a condom during last anal sex with male sex partner
- % MSM, TG & MSW reporting consistent condom use in recent period during anal sex male partners
- % of MSM, TG & MSW with gonorrhea and/or chlamydia
### 2.3 National M&E Framework for IDU with IDU-specific Indicators

#### Impact Goal

- **Output Sub-Output**
  - **Increased informed demand, availability and accessibility to integrated package of services**
    - 13. IDU reached by prevention program
    - 14. IDU receiving package of services in last 12 months
    - 15a. IDU receiving an HIV test and receiving test results in the last 12 months
    - 15b. IDU receiving OST
    - 21a. Condoms distributed sold
    - 21b. Condoms distributed sold
    - 22. DIC established and operating
    - 28. Needles and syringes distributed to IDU
    - 28b. NSP sites

- **Intermediate outcomes**
  - 6a. IDU reached with prevention program in last 12 months
  - 6b. IDU receiving OST in last 12 months
  - 6c. IDU receiving minimum standard of exposure in last 12 months
  - 7a. IDU receiving an HIV test and receiving test results in the last 12 months
  - 7b. IDU receiving OST in last 12 months
  - 9. IDU receiving OST in last 12 months

#### Outcomes

- 2. % IDU reporting the use of a condom with most recent partner
- 4A. % IDU reporting use of sterile injecting equipment at last injected in the last month
- 12. % IDU who report that condoms and needles are accessible when needed

#### Evaluation Frameworks for MARPs and MWs

**ANNEX 2: Monitoring and Evaluation Frameworks for MARPs and MWs**

- **Outcome Impact Goal**
  - Reduce new infections by 50% by 2011
  - Reduced HIV prevalence among IDU
  - % IDU who are HIV+ receiving HIV care
  - % IDU who are HIV+ receiving ART
  - % IDU who are HIV infected

---

**Reduced HIV prevalence among IDU**

- % IDU who are HIV infected

**Improved health status and well being among IDU**

- % IDU who are HIV receiving ART
- % IDU who are HIV infected

---

**Number of organizations implementing HIV/AIDS prevention activities targeting IDU**

- Number of organizations implementing HIV/AIDS prevention activities targeting IDU

---

**Intermediate outcomes**

- 6a. % IDU reached with prevention program in last 12 months
- 6b. % IDU receiving OST in last 12 months
- 6c. % IDU receiving minimum standard of exposure in last 12 months
- 7a. % IDU receiving an HIV test and receiving test results in the last 12 months
- 7b. % IDU receiving OST in last 12 months
- 9. % IDU receiving OST in last 12 months

---

**Outcomes**

- 2. % IDU reporting the use of a condom with most recent partner
- 4A. % IDU reporting use of sterile injecting equipment at last injected in the last month
- 6a. % IDU reached prevention program in last 12 months
- 6b. % IDU receiving OST in last 12 months
- 6c. % IDU receiving minimum standard of exposure in last 12 months
- 7a. % IDU receiving an HIV test and receiving test results in the last 12 months
- 7b. % IDU receiving POS in last 12 months
- 9. % IDU receiving OST in last 12 months

---

**Intermediate outcomes**

- 6a. % IDU reached with prevention program in last 12 months
- 6b. % IDU receiving package of services in last 12 months
- 6c. % IDU receiving minimum standard of exposure in last 12 months
- 7a. % IDU receiving an HIV test and receiving test results in the last 12 months
- 7b. % IDU receiving OST in last 12 months
- 9. % IDU receiving OST in last 12 months

---

**Outcomes**

- 2. % IDU reporting the use of a condom with most recent partner
- 4A. % IDU reporting use of sterile injecting equipment at last injected in the last month
- 6a. % IDU reached prevention program in last 12 months
- 6b. % IDU receiving OST in last 12 months
- 6c. % IDU receiving minimum standard of exposure in last 12 months
- 7a. % IDU receiving an HIV test and receiving test results in the last 12 months
- 7b. % IDU receiving OST in last 12 months
- 9. % IDU receiving OST in last 12 months

---

**Intermediate outcomes**

- 6a. % IDU reached prevention program in last 12 months
- 6b. % IDU receiving package of services in last 12 months
- 6c. % IDU receiving minimum standard of exposure in last 12 months
- 7a. % IDU receiving an HIV test and receiving test results in the last 12 months
- 7b. % IDU receiving OST in last 12 months
- 9. % IDU receiving OST in last 12 months
ANNEX 2: Monitoring and Evaluation Frameworks for MARPs and MWs

2.4 National M&E Framework for Migrant Workers with MW-specific Indicators

### Improved health status and well being among MW
- % MW who are HIV+ receiving ART
- % MW receiving FP

### Reduced HIV prevalence among MW
1. % of MW who are HIV infected

### Outcomes
2. % MW reporting the use of a condom with most recent partner
3. % MW reporting consistent condom use in recent time period with non-regular partners
4. % MW with gonorrhea and chlamydia

### Intermediate outcomes
5. % MW reached with prevention program in last 12 months
6. % MW receiving package of services in last 12 months
7. % MW receiving minimum exposure to prevention program in last 12 months
8. % MW receiving an HIV test and receiving test results in the last 12 months
9. % MW receiving appropriate number of STI screening in last 12 months
10. % MW who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions
11. % MW who report that condoms are accessible when needed
12. % MW who report that condoms are affordable

### Outputs

#### O1. Increased informed demand, availability and accessibility to integrated package of services

13. # MW reached by prevention program
14. # MW receiving STI screening and/or treatment
15a. # MW receiving an HIV test and receiving test results
15b. % MW tested for HIV who receive test results
16. % MW receiving free condom or purchasing subsidized condom

#### O2. Enabling environment for prevention activities

O2.1 Strengthened policy and rights protection, reduced stigma and discrimination, and empowerment of FSW

21. % of individuals trained on policy and participating in community mobilization activities
22a. # of individuals trained on STI and VCT
22b. # of DIC meeting national standard

#### O3. Effective management and sustainable financing of national and sub-national responses

21. # of local authorities contributing financial resources to HIV/AIDS responses for MWs
20. # of Provincial Coordinating Mechanisms and Provincial Coordinating Committees with MW representatives

### Sub-Outputs

#### O1.1 Increased informed demand

21a. # of outreach and peer educators trained
22a. # of DIC established and operating

#### O1.2 Improved accessibility and quality of STI and HCT services

21. % of individuals trained on STI and VCT
23b. % of STI sites and VCT clinics where quality of services met national standard
24. % of referral cases to STI and VCT

#### O1.3 Improved accessibility to condoms

25. # of condoms distributed/sold
27. # of targeted condom outlets

#### O2.1 Strengthened policy and rights protection, reduced stigma and discrimination, and empowerment of FSW

21. % of individuals trained on policy and participating in community mobilization activities
21. % of individuals trained on sensitization

#### O3.1 Increased availability of key strategic information and increased use of data for program improvement and planning

21. % of individuals trained on SI and M&E

#### O3.2 Strengthened mechanisms for strategic planning and coordination to promote sustainability of HIV/AIDS responses

21. % of local authorities trained on developing operational plan
29. Number of organizations implementing HIV/AIDS prevention activities targeting MW
## ANNEX 3: PROJECT-LEVEL INDICATORS

<table>
<thead>
<tr>
<th>#</th>
<th>Target population</th>
<th>Indicator Name</th>
<th>Data source</th>
<th>Frequency</th>
<th>Responsible unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>All</td>
<td>Number of individuals trained by type of trainee by MARPs by topic by province</td>
<td>Project monitoring</td>
<td>Annually</td>
<td>All implementers</td>
</tr>
<tr>
<td></td>
<td>O1.1/21</td>
<td>- to implement HIV prevention activities</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>O1.2/21</td>
<td>- to provide MARP -VCT and STI friendly health services</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>O1.4/21</td>
<td>- to implement Harm Reduction approach</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>O2/21</td>
<td>- on HIV-related policy development</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>O2/21</td>
<td>- on sensitization for MARPs and/or gender sensitivity</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>O3.1/21</td>
<td>- on strategic information and M&amp;E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>O3.2/21</td>
<td>- on strategic/operation planning and costing</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>O1.1/22A</td>
<td>All Number of drop in centers providing services for MARPs and MWs</td>
<td>Project monitoring</td>
<td>Annually</td>
<td>All implementers</td>
</tr>
<tr>
<td></td>
<td>O1.1/22B</td>
<td>% of drop-in centers adhering to national standard for MARPs</td>
<td>Project monitoring</td>
<td>Annually</td>
<td>All implementers</td>
</tr>
<tr>
<td></td>
<td>O1.2/23A</td>
<td>All Number of STI and or VCT centers</td>
<td>Project monitoring</td>
<td>Annually</td>
<td>STI cluster</td>
</tr>
<tr>
<td></td>
<td>O1.2/23B</td>
<td>% of STI, VCT, OST clinics adhering to national standard for MARPs and MWs</td>
<td>Project monitoring</td>
<td>Annually</td>
<td>STI cluster</td>
</tr>
<tr>
<td></td>
<td>O1.2/24</td>
<td>All Number of referrals to VCT and/or STI screening made for MARPs and MWs</td>
<td>Project monitoring</td>
<td>Annually</td>
<td>All implementers</td>
</tr>
<tr>
<td></td>
<td>O1.3/25</td>
<td>All Number of condoms distributed to MARPs and MWs</td>
<td>Project monitoring</td>
<td>Annually</td>
<td>All implementers</td>
</tr>
<tr>
<td></td>
<td>O1.3/26</td>
<td>MSM Number of lubricants distributed to MSMs (free of charge)</td>
<td>Project monitoring</td>
<td>Annually</td>
<td>All implementers</td>
</tr>
<tr>
<td></td>
<td>O1.3/27</td>
<td>All Number of targeted condom outlets</td>
<td>Project monitoring</td>
<td>Annually</td>
<td>All implementers</td>
</tr>
<tr>
<td></td>
<td>O1.4/28a</td>
<td>IDU Number of needles and syringes distributed to IDUs</td>
<td>Project monitoring</td>
<td>Annually</td>
<td>All implementers</td>
</tr>
<tr>
<td></td>
<td>O1.4/28b</td>
<td>IDU Number of NSP sites</td>
<td>Project monitoring</td>
<td>Annually</td>
<td>All implementers</td>
</tr>
<tr>
<td></td>
<td>O3.2/29</td>
<td>All Number of organizations implementing HIV prevention activities targeting MARPs</td>
<td>Project monitoring</td>
<td>Annually</td>
<td>All implementers</td>
</tr>
</tbody>
</table>
Outcome Indicators

Indicator 1: Percentage of MARPs, MWs who are HIV infected

PURPOSE
HIV prevalence is used to monitor the impact of the HIV prevention program among MARPs and MWs, utilizing the national sero surveillance system.

DATA COLLECTION FREQUNCY
Every two years (2010, 2012)

MEASUREMENT TOOL
Integrated Biomarker and Behavioral Surveillance (IBBS) Survey

METHOD OF MEASUREMENT

FSWs: Data from HIV tests conducted among FSWs at 13 sentinel sites (10 venue-based only and 3 both venue-based and non-venue based) in 2010 and 15 sentinel sites (3 venue-based only and 12 venue-based and non-venue based) in 2012 (see Annex 5 for site list)

MSMs: Data from HIV tests conducted among MSMs at VDT sites, MSW and TG in the sentinel sites. Surveillance is conducted in 12 sentinel sites classified into 2 categories of the provincial context, including 1) Highly urbanized tourist provinces where are the main port and economic center with large density sexual industries; (Bangkok, Chiang Mai, Phuket, Chonburi and Songkhla), and 2) Less urbanized non-tourist provinces where do not meet classification criteria for highly urbanized provinces. Sampling methods differ by group (MSM, TG, MSW) (see Annex 5 for site list)

IDUs: Data from HIV tests conducted among IDUs at 8 sentinel sites beginning in 2010 (see Annex 5 for site list)

MWs: Data from HIV tests conducted among MWs at 10 sentinel sites in 2010 and 9 sites in 2012 (see Annex 5 for site list)

Numerators:
Number of MARPs, MWs tested whose HIV test results are positive

Denominators:
Number of MARPs, MWs tested for HIV

DISAGGREGATION

FSWs: Data for this indicator will be disaggregated by age (<25; 25+) and calculated separately by type of sex work (venue-based, non-venue-based)

MSMs: Data for this indicator will be disaggregated by age (<25; 25+) and calculated separately by group (MSM, TG, MSW)

IDUs: Data for this indicator will be disaggregated by age (<25; 25+), gender, and employment status.

MWs: Data for this indicator will be disaggregated by age (<25; 25+), gender, type of job (fisheries, construction, factories) and country of origin
Impact Indicators

Outcome 1: Increased preventive behavior (condom use and safe injection)

Indicator 2: Percentage of MARPs, MWs reporting the use of a condom with most recent sexual partner

**PURPOSE**
This indicator is used to measure the effectiveness of HIV prevention programs in increasing HIV preventive behavior through condom use.

**DATA COLLECTION FREQUENCY**
Every two years (2010, 2012)

**MEASUREMENT TOOL**
Integrated Biomarker and Behavioral Surveillance (IBBS) Survey

**METHOD OF MEASUREMENT**

- **FSWs**: Respondents are asked the following question:
  Did you use a condom with your most recent client?

- **MSMs**: Respondents are asked the following question:
  Did you use a condom the last time you had anal sex with a male partner?

- **IDUs**: Respondents are asked the following question:
  Did you use a condom the last time you had sex with a partner?

- **MWs**: Respondents are asked the following question:
  Did you use a condom the last time you had sex with a non-regular partner?

**Numerator:**
- **FSWs**: Number of FSWs who reported using a condom with most recent client
- **MSMs**: Number of MSMs who reported using a condom at most recent anal sex with a male partner
- **IDUs**: Number of IDUs who are injecting drugs in the last three months and who reported using a condom with their most recent partner
- **MWs**: Number of MWs who are aged >18 and who reported using a condom with the most recent non-regular partner(s) in the last month

**Denominator:**
- **FSWs**: Number of FSWs interviewed for IBBS who report having commercial sex in the past 12 months
- **MSMs**: Number of (MSM, TG, MSW) and MSW interviewed for the IBBS who report having anal sex with a male partner in the last three months
- **IDUs**: Number of IDUs interviewed for the IBBS who report injecting drugs in the last three months and having had sexual intercourse with a regular partner
- **MWs**: Number of MWs interviewed for the IBBS who are aged >18 and who report having sexual intercourse with a non-regular partner(s) in the last month

**DISAGGREGATION**

- **FSWs**: Data for this indicator will be disaggregated by age (<25; ≥25) and calculated separately by type of sex work (venue-based, non-venue-based)
- **MSMs**: Data for this indicator will be disaggregated by age (<25; ≥25) and calculated separately by group (MSM, TG, MSW)
- **IDUs**: Data for this indicator will be disaggregated by age (<25; ≥25), gender, and employment status.
- **MWs**: Data for this indicator will be disaggregated by age (<25; ≥25), gender, type of job (fisheries, construction, factories) and country of origin.
**Indicator 3: Percentage of MARPs, MWS reporting consistent condom use in the recent time period with non-regular partners and clients (Additional National Indicator)**

**PURPOSE**

While condom use at last sex is usually used as a proxy measure for consistent condom use, adding a direct measure on the consistency of use adds additional evidence of whether programs are effectively promoting HIV preventive behavior.

**DATA COLLECTION FREQUENCY**

Every two years (2010, 2012)

**MEASUREMENT TOOL**

Integrated Biomarker and Behavioral Surveillance (IBBS) Survey

**METHOD OF MEASUREMENT**

**FSWs:** Respondents are asked the following question:

How often did you use a condom with your husband/boyfriend/lover in the last week? (always/sometimes/never)

How often did you use a condom with your regular clients in the last week? (always/sometimes/never)

How often did you use a condom with your non-regular clients in the last week? (always/sometimes/never)

**MSMs:** Respondents are asked the following question:

How often did you use a condom when having anal sex with your male partners in the last three months? (always/sometimes/never)

**MWS:** Respondents are asked the following question:

How often did you use a condom with your non-regular partners in the last three months? (always/sometimes/never)

**Numerator:**

**FSWs:** Number of FSWs who reported using a condom “always” with all partners in the last week

**MSMs:** Number of MSMs, TG and MSWs who reported using a condom “always” during anal sex with all male partners in the last three months

**MWS:** Number of MWS interviewed who are aged >18 and who report using a condom “always” with non-regular partner(s) in the last three months

**Denominator:**

**FSWs:** Number of FSWs interviewed for IBBS who report having commercial sex in the past 12 months

**MSMs:** Number of (MSM, TG, MSW) interviewed for the IBBS who report having sex with a male partner in the last three months

**MWS:** Number of MWS interviewed for the IBBS who are aged >18 and who report having sexual intercourse with a non-regular partner(s) in the last three months

**DISAGGREGATION**

**FSWs:** Data for this indicator will be disaggregated by age (<25; 25+) and calculated separately by type of sex work (venue-based, non-venue-based)

**MSMs:** Data for this indicator will be disaggregated by age (<25; 25+) and calculated separately by group (MSM, TG, MSW)

**MWS:** Data for this indicator will be disaggregated by age (<25; 25+), gender, type of job (fisheries, construction, factories) and country of origin
Indicator 4A: Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected in the last month

PURPOSE
This indicator is used to measure the effectiveness of HIV prevention programs in increasing HIV preventive behavior among IDUs through use of sterile injecting equipment.

DATA COLLECTION FREQUENCY
Every two years (2010, 2012)

MEASUREMENT TOOL
Integrated Biomarker and Behavioral Surveillance (IBBS) Survey

METHOD OF MEASUREMENT
Respondents are asked the following questions:
1. Have you injected drugs at any time in the last month?
2. If yes: The last time you injected drugs, did you use a sterile needle and syringe?

Numerator:
Number of IDUs who reported using sterile injecting equipment the last time they injected drugs.

Denominator:
Number of IDUs who reported injecting drugs in the last three months.

DISAGGREGATION
Data for this indicator will be disaggregated by age (<25; 25+), gender, and employment status.
Indicator 4B: Percentage of injecting drug users reporting they did not share injecting equipment the last time they injected in the last month

**PURPOSE**
This indicator is used to measure the effectiveness of HIV prevention programs in increasing HIV preventive behavior among IDUs through not sharing needles and / or syringes

**DATA COLLECTION**
Every two years (2010, 2012)

**FREQUENCY**

**MEASUREMENT TOOL**
Integrated Biomarker and Behavioral Surveillance (IBBS) Survey

**METHOD OF MEASUREMENT**
Respondents are asked the following questions:
1. Have you injected drugs at any time in the last month?
2. If yes: The last time you injected drugs, did you share a needle / or syringe?

**Numerator:**
Number of IDUs who reported not sharing a needle and / or syringe the last time they injected drugs

**Denominator:**
Number of IDUs who reported injecting drugs in the last month

**DISAGGREGATION**
Data for this indicator will be disaggregated by age (<25; 25+), gender, and employment status.
### Outcome 2: Reduced burden of STIs

**Indicator 5: Percentage of MARPs, MWs with gonorrhea and/or chlamydia**

**PURPOSE**
Sexually transmitted diseases such as gonorrhea and chlamydia increase the risk of HIV transmission. The presence of STIs is also a reliable indicator that condoms are not being used.

**DATA COLLECTION FREQUENCY**
Every two years (2010, 2012)

**MEASUREMENT TOOL**
Integrated Biomarker and Behavioral Surveillance (IBBS) Survey

**METHOD OF MEASUREMENT**

<table>
<thead>
<tr>
<th>Group</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FSWs</strong></td>
<td>Data from HIV tests conducted among FSWs at 13 sentinel sites (10 venue-based only and 3 both venue-based and non-venue based) in 2010 and 15 sentinel sites (3 venue-based only and 12 venue-based and non-venue based) in 2012 (see Annex 5 for site list)</td>
</tr>
<tr>
<td><strong>MSMs</strong></td>
<td>Data from HIV tests conducted among MSMs at VDT sites, MSW and TG in the sentinel sites. Surveillance is conducted in 12 sentinel sites classified into 2 categories of the provincial context, including 1) Highly urbanized tourist provinces where are the main port and economic center with large density sexual industries; (Bangkok, Chiang Mai, Phuket, Chonburi and Songkhla), and 2) Less urbanized non-tourist provinces where do not meet classification criteria for highly urbanized provinces. Sampling methods differ by group (MSM, TG, MSW) (see Annex 5 for site list)</td>
</tr>
<tr>
<td><strong>IDUs</strong></td>
<td>Data from HIV tests conducted among IDUs at 9 sentinel sites beginning in 2010 (see Annex 5 for site list)</td>
</tr>
<tr>
<td><strong>MWs</strong></td>
<td>Data from HIV tests conducted among MWs at 10 sentinel sites in 2010 and 9 sites in 2012 (see Annex 5 for site list)</td>
</tr>
</tbody>
</table>

**Numerator:** Number of MARPs, MWs tested whose gonorrhea/chlamydia test results are positive

**Denominator:** Number of MARPs, MWs tested for gonorrhea and chlamydia

**DISAGGREGATION**

<table>
<thead>
<tr>
<th>Group</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FSWs</strong></td>
<td>Data for this indicator will be disaggregated by age (&lt;25; 25+) and calculated separately by type of sex work (venue-based, non-venue-based)</td>
</tr>
<tr>
<td><strong>MSMs</strong></td>
<td>Data for this indicator will be disaggregated by age (&lt;25; 25+) and calculated separately by group (MSM, TG, MSW)</td>
</tr>
<tr>
<td><strong>IDUs</strong></td>
<td>Data for this indicator will be disaggregated by age (&lt;25; 25+), gender, and employment status.</td>
</tr>
<tr>
<td><strong>MWs</strong></td>
<td>Data for this indicator will be disaggregated by age (&lt;25; 25+), gender, type of job (fisheries, construction, factories) and country of origin</td>
</tr>
</tbody>
</table>
**Intermediate Outcomes**

**Intermediate Outcome 1: Increased HIV prevention coverage and intensity of exposure**

**6A. Percentage of MARPs, MWs reached with prevention program in last 12 months**

**PURPOSE**
This indicator measures the success of the HIV prevention program in reaching a significant proportion of MARPs and MWs.

**DATA COLLECTION FREQUENCY**
Every two years (2010, 2012)

**MEASUREMENT TOOL**
Integrated Biomarker and Behavioral Surveillance (IBBS) Survey

**Indicator 6A.1:** Percentage of female sex workers reached with HIV prevention program in last 12 months

**METHOD OF MEASUREMENT**
Respondents are asked the following questions:
1. Do you know where you can go if you wish to receive an HIV test?
2. In the last twelve months, have you been given condoms (e.g. through an outreach service, drop-in centre or sexual health clinic)?

**Numerator:** Number of FSW respondents who replied “yes” to both questions

**Denominator:** Number of FSWs interviewed for IBBS who report having commercial sex in the past 12 months

**DISAGGREGATION**
Data for this indicator will be disaggregated by age (<25; 25+) and calculated separately by type of sex work (venue-based, non-venue-based)

**Indicator 6A.2:** Percentage of MSMs, TG and MSWs reached with HIV prevention program in last 12 months

**METHOD OF MEASUREMENT**
Respondents are asked the following questions:
1. Do you know where you can go if you wish to receive an HIV test?
2. In the last twelve months, have you been given condoms (e.g. through an outreach service, drop-in centre or sexual health clinic)?

**Numerator:** Number of MSM, TG and MSW respondents who replied “yes” to both questions

**Denominator:** Number of MSMs, TGs and MSWs interviewed for IBBS

**DISAGGREGATION**
Data for this indicator will be disaggregated by age (<25; 25+) and calculated separately by group (MSM, TG, MSW)

**Indicator 6A.3:** Percentage of injecting drug users reached with HIV prevention program in last 12 months
Respondents are asked the following questions:

1. Do you know where you can go if you wish to receive an HIV test?

2. In the last twelve months, have you been given condoms (e.g. through an outreach service, drop-in centre or sexual health clinic)?

3. In the last twelve months, have you been given sterile needles and syringes (e.g. by an outreach worker, a peer educator or from a needle exchange programme)?

**Numerator:** Number of IDU respondents who replied "yes" to all three questions

**Denominator:** Number of IDUs surveyed by second generation surveillance who have injected drugs in the past 12 months

**Disaggregation**

Data for this indicator will be disaggregated by age (<25; 25+), gender, and employment status.

**Indicator 6A.4:** Percentage of migrant workers reached with HIV prevention program in last 12 months

Respondents are asked the following questions:

1. Do you know where you can go if you wish to receive an HIV test?

2. In the last twelve months, have you been given condoms (e.g., through an outreach service, drop-in centre or sexual health clinic)?

**Numerator:** Number of MW respondents who replied "yes" to both questions

**Denominator:** Number of MWs interviewed for the IBBS

**Disaggregation**

Data for this indicator will be disaggregated by age (<25; 25+), gender, type of job (fisheries, construction, factories) and country of origin.
### 6B. Percentage of MARPs, MWs reached with package of services in last 12 months
(Additional National Indicator)

<table>
<thead>
<tr>
<th>PURPOSE</th>
<th>This indicator measures the success of the HIV prevention program in reaching a significant proportion of MARPs and providing them with a broad and effective package of HIV prevention services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATA COLLECTION FREQUENCY</td>
<td>Every two years (2010, 2012)</td>
</tr>
<tr>
<td>MEASUREMENT TOOL</td>
<td>Integrated Biomarker and Behavioral Surveillance (IBBS) Survey</td>
</tr>
<tr>
<td>METHOD OF MEASUREMENT</td>
<td>Respondents are asked about all of the HIV prevention services in the implementation framework that have been received in the last 12 months: behavior change communication through Drop-in Centers or outreach; VCT; STI services; targeted media and condoms; for IDUs, also NSP and OST programs (when appropriate). Analysis will examine the combination of services received to determine how best to measure the appropriate package of services for each MARP group; the indicator will be finalized once this analysis is complete.</td>
</tr>
</tbody>
</table>
6C. Percentage of MARPs, MWs reached with a minimum standard of exposure to prevention programs in last 12 months (Additional National Indicator)

PURPOSE
Exposure to prevention programs is usually measured at a very minimal level, with programs monitoring any type of contact with the program (and often counting contacts rather than individuals). Yet evaluation research has shown that interventions must reach a certain level of intensity to achieve the ultimate goal of changing risky behavior. The National M&E System will set a minimum standard for exposure for each population and will measure whether the program has reached that standard for each individual.

DATA COLLECTION FREQUENCY
Every two years (2010, 2012)

MEASUREMENT TOOL
Integrated Biomarker and Behavioral Surveillance (IBBS) Survey

METHOD OF MEASUREMENT
Respondents are asked how many times they received the package of HIV prevention services as described in Indicator 6B. Analysis will examine the frequency of services received to determine how best to measure the appropriate minimum frequency of services for each MARP group; the indicator will be finalized once this analysis is complete.
Intermediate Outcome 2: Increased STI, HCT and OST coverage and intensity of access

7a. Percentage of MARPs, MWs receiving an HIV test and receiving test results in the last 12 months

**PURPOSE**

HIV testing and counseling serves two roles: as an entry point to additional HIV services, and, through the knowledge of one's serostatus and the counseling provided, as a motivator and facilitator of behavior change among MARPs. This indicator measures the success the HIV prevention program at motivating MARPs and MWs to receive testing and counseling services.

**DATA COLLECTION FREQUENCY**

Every two years (2010, 2012)

**MEASUREMENT TOOL**

Integrated Biomarker and Behavioral Surveillance (IBBS) Survey

**METHOD OF MEASUREMENT**

Respondents are asked:
1. I don't want to know the results, but have you been tested for HIV in the last 12 months?
2. If yes: I don't want to know the results, but did you get the results of that test?

**Numerator:** Number of respondents who have been tested for HIV in the last 12 months and who know their result

**Denominator:** Number of MARPs and MWs interviewed for the IBBS

**DISAGGREGATION**

**FSWs:** Data for this indicator will be disaggregated by age (<25; 25+) and calculated separately by type of sex work (venue-based, non-venue-based)

**MSMs:** Data for this indicator will be disaggregated by age (<25; 25+) and calculated separately by group (MSM, TG, MSW)

**IDUs:** Data for this indicator will be disaggregated by age (<25; 25+), gender, and employment status.

**MWs:** Data for this indicator will be disaggregated by age (<25; 25+), gender, type of job (fisheries, construction, factories) and country of origin
7B. Percentage of male, female sex workers and IDUs receiving an HIV test and receiving test results at the minimum number of times in the last 12 months (Additional National Indicator)

PURPOSE
For sex workers, it is particularly important to receive frequent testing and counseling for HIV. This indicator measures whether FSWs and MSWs have been tested and received their results at the minimum number of times in the past 12 months.

DATA COLLECTION FREQUENCY
Every two years (2010, 2012)

MEASUREMENT TOOL
Integrated Biomarker and Behavioral Surveillance (IBBS) Survey

METHOD OF MEASUREMENT
Respondents are asked:
1. I don't want to know the results, but have you been tested for HIV in the last 12 months?
2. If yes: I don't want to know the results, but did you get the results of that test?
3. If yes: How many times have you been tested for HIV in the past 12 months?
4. (If more than once) Did you receive the results of your test each time you were tested?

Numerator: Number of FSWs, MSWs and IDUs who have been tested for HIV at the minimum number of times and who know their result from each test in the last 12 months.

Denominator: Number of FSWs, MSWs interviewed for the IBBS.

DISAGGREGATION
FSWs: Data for this indicator will be disaggregated by age (<25; 25+) and calculated separately by type of sex work (venue-based, non-venue-based).

MSWs: Data for this indicator will be disaggregated by age (<25; 25+).

IDUs: Data for this indicator will be disaggregated by age (<25; 25+), gender, and employment status.
8. Percentage of MARPs and MWs receiving the appropriate minimum number of STI screenings in last 12 months (Additional National Indicator)

PURPOSE
Frequent screening for STIs is particularly important to prevent the spread of STIs and as an indicator of irregular condom use. This indicator measures the effectiveness of the STI program in motivating MARPs and MWs to receive the appropriate number of screenings per year.

DATA COLLECTION
Every two years (2010, 2012)

MEASUREMENT TOOL
Integrated Biomarker and Behavioral Surveillance (IBBS) Survey

METHOD OF MEASUREMENT
Respondents are asked how many times they received STI screening in the last 12 months as reported for each group. Analysis will examine the frequency of screenings received to determine how best to measure the appropriate minimum frequency of screening, the indicator will be finalized once this analysis is complete.

Respondents are asked:
1. Have you been screened for STIs in the last 12 months?
2. If yes: How many times have you been screened for STIs in the past 12 months?

Numerator: Number of MARPs and MWs who have been screened for STIs at the minimum number of times in the last 12 months

Denominator: Number of MARPs and MWs interviewed for the IBBS

DISAGGREGATION
FSWs: Data for this indicator will be disaggregated by age (<25; 25+) and calculated separately by type of sex work (venue-based, non-venue-based)

MSMs: Data for this indicator will be disaggregated by age (<25; 25+)

MWs: Data for this indicator will be disaggregated by age (<25; 25+), gender, type of job (fisheries, construction, factories) and country of origin
<table>
<thead>
<tr>
<th>Indicator 9: Percentage of opioid-dependent injecting drug users reporting receiving OST in the last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PURPOSE</strong></td>
</tr>
<tr>
<td><strong>DATA COLLECTION FREQUENCY</strong></td>
</tr>
<tr>
<td><strong>MEASUREMENT TOOL</strong></td>
</tr>
<tr>
<td><strong>METHOD OF MEASUREMENT</strong></td>
</tr>
<tr>
<td><strong>Numerator:</strong></td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
</tr>
<tr>
<td><strong>DISAGGREGATION</strong></td>
</tr>
</tbody>
</table>
Intermediate Outcome 3: Increased HIV/AIDS knowledge

Indicator 10: Percentage of MARPs, MWs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions

(Indicator is measured the same way for all groups)

10.1 Percentage of FSW who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

10.2 Percentage of MSM, TG and MSW who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

10.3 Percentage of IDU who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

10.4 Percentage of MW who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

PURPOSE
Behavior change communication efforts with MARPs strive to disseminate knowledge about HIV transmission and prevention. This indicator tracks the effectiveness of these programs in increasing the proportion of MARPs and MWs with correct knowledge of HIV prevention and no misperceptions about transmission.

DATA COLLECTION FREQUENCY
Every two years (2010, 2012)

MEASUREMENT TOOL
Integrated Biomarker and Behavioral Surveillance (IBBS) Survey

METHOD OF MEASUREMENT
Respondents are asked the following set of prompted questions:
1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?
2. Can a person reduce the risk of getting HIV by using a condom every time they have sex?
3. Can a healthy-looking person have HIV?
4. Can a person get HIV from mosquito bites?
5. Can a person get HIV by sharing food with someone who is infected?

Numerator: Number of respondents who gave the correct answer to all five questions
Denominator: Number of all respondents

DISAGGREGATION
FSWs: Data for this indicator will be disaggregated by age (<25; 25+) and calculated separately by type of sex work (venue-based, non-venue-based)

MSMs: Data for this indicator will be disaggregated by age (<25; 25+) and calculated separately by group (MSM, TG, MSW)

IDUs: Data for this indicator will be disaggregated by age (<25; 25+), gender, and employment status.

MWs: Data for this indicator will be disaggregated by age (<25; 25+), gender, type of job (fisheries, construction, factories) and country of origin
**Intermediate Outcome 4: Increased accessibility to condoms/lubricant and needles**

**Indicator 11: Percentage of injecting drug users reached by NSP in the last month**

**PURPOSE** The percentage of IDUs able to obtain sterile needles and syringes distributed will measure the success to broaden the availability of sterile injecting equipment to IDUs.

**DATA COLLECTION FREQUENCY** Every two years (2010, 2012)

**MEASUREMENT TOOL** Integrated Biomarker and Behavioral Surveillance (IBBS) Survey

**METHOD OF MEASUREMENT** Respondents are asked whether they were reached by the NSP in the last month

**Numerator:** Number of IDUs who reported being reached by the NSP in the last month

**Denominator:** Number of IDUs who reported injecting drugs in the last month

**DISAGGREGATION** Data for this indicator will be disaggregated by age (<25; 25+), gender, and employment status.
**Indicator 12A: Percentage of MARPs, MWs who report that condoms/lubricant/needles are accessible when needed (Additional National Indicator)**

**PURPOSE**
Effective HIV prevention requires an uninterrupted supply of affordable prevention commodities. This indicator measures whether MARPs and MWs perceive that these prevention commodities are accessible when needed. All MARPs and MWs will be asked about condoms; MSM will also be asked about lubricant and IDUs will be asked about needles.

**DATA COLLECTION FREQUENCY**
Every two years (2010, 2012)

**MEASUREMENT TOOL**
Integrated Biomarker and Behavioral Surveillance (IBBS) Survey

**METHOD OF MEASUREMENT**
All MARPs and MWs are asked their response to the following statement:
1. I can get a condom when I need it (strongly agree, agree, disagree, strongly disagree)

MSM, TG and MSW are also asked:
2. I can get lubricant when I need it (strongly agree, agree, disagree, strongly disagree)

IDUs are also asked:
2. I can get a needle when I need it (strongly agree, agree, disagree, strongly disagree)

**Numerator:**
Number who say they agree or strongly agree with the statement

**Denominator:**
Number of all respondents

**DISAGGREGATION**

**FSWs:** Data for this indicator will be disaggregated by age (<25; 25+) and calculated separately by type of sex work (venue-based, non-venue-based)

**MSMs:** Data for this indicator will be disaggregated by age (<25; 25+) and calculated separately by group (MSM, TG, MSW)

**IDUs:** Data for this indicator will be disaggregated by age (<25; 25+), gender, and employment status.

**MWs:** Data for this indicator will be disaggregated by age (<25; 25+), gender, type of job (fisheries, construction, factories) and country of origin
Indicator 12B: Percentage of MARPs, MWs who report that condoms/lubricant are affordable
(Additional National Indicator)

PURPOSE
Effective HIV prevention requires an uninterrupted supply of affordable prevention commodities. This indicator measures whether MARPs and MWs perceive that these prevention commodities are affordable. All MARPs and MWs will be asked about condoms; MSM will also be asked about lubricant.

DATA COLLECTION FREQUENCY
Every two years (2010, 2012)

MEASUREMENT TOOL
Integrated Biomarker and Behavioral Surveillance (IBBS) Survey

METHOD OF MEASUREMENT
All MARPs and MWs are asked their response to the following statement:
1. Condoms are affordable for me (strongly agree, agree, disagree, strongly disagree)

MSM, TG and MSW are also asked:
2. Lubricant is affordable for me (strongly agree, agree, disagree, strongly disagree)

Numerator: Number who say they agree or strongly agree with the statement
Denominator: Number of all respondents

DISAGGREGATION
FSWs: Data for this indicator will be disaggregated by age (<25; 25+) and calculated separately by type of sex work (venue-based, non-venue-based)

MSMs: Data for this indicator will be disaggregated by age (<25; 25+) and calculated separately by group (MSM, TG, MSW)

IDUs: Data for this indicator will be disaggregated by age (<25; 25+), gender, and employment status.

MWs: Data for this indicator will be disaggregated by age (<25; 25+), gender, type of job (fisheries, construction, factories) and country of origin
Output Indicators

Indicator 13: Number of MARPs, MWs reached by prevention programs

PURPOSE
This indicator measures the success of the HIV prevention program in reaching a significant number of MARPs and MWs.

DATA COLLECTION FREQUENCY
Annually

MEASUREMENT TOOL
Routine HIS

Indicator 13.1: Number of female sex workers reached with HIV prevention program in last 12 months

METHOD OF MEASUREMENT
Number of FSWs who received at least one kind HIV prevention services through outreach workers, peer educators, volunteers or DiCs.

DISAGGREGATION
Data for this indicator will be disaggregated by site, province and calculated separately by type of sex work (venue-based, non-venue-based)

Indicator 13.2: Number of MSMs, TG and MSWs reached with HIV prevention program in last 12 months

METHOD OF MEASUREMENT
This indicator counts the number of MSM who have participated in or benefited from:
• individual (casual or intensive) intervention,
• group (casual or intensive) intervention,
• health communication/public intervention during the reporting period.
It is disaggregated by HIV intervention (i.e., outreach, capacity building/training, counseling), level of intensity (intensive or casual), and whether it was an individual or small group interaction.

For each reporting period, MSM being reached should be categorized as “new” (never before participating or benefiting from an intervention during the reporting period) and “old” (they have participated in or benefited from an intervention already during the reporting period). MSM should only be counted as “new” once; they are counted the first time that they participate or benefit from the intervention during the reporting period.

DISAGGREGATION
Data for this indicator will be disaggregated by site, province separately by group (MSM, TG, MSW)

Indicator 13.3: Number of injecting drug users reached with HIV prevention program in last 12 months
METHOD OF MEASUREMENT
Number of IDUs who received HIV prevention services through outreach workers, peer educators, DICs, pharmacies and closed settings.
IDUs are defined as all people who have injected any substance during the past twelve months. This period is necessary to include IDUs who are on treatment and/or are at risk of relapse to ensure they are provided with necessary HIV prevention services.

HIV prevention services include:

Information: providing HIV prevention, risk reduction and sexual health information including explaining routes of HIV transmission, risk of blood borne transmission of HIV and avoiding risk behaviors. Information will be delivered through interpersonal communication as well as through IEC and BCC materials or/and counseling;

Services and Commodities:

• referral for STI diagnosis and treatment
• referral for VCT
• referral for substitution therapy
• sterile injection equipment
• condoms

To be counted as having been reached with HIV prevention services, the IDU must have received HIV prevention information and at least one item of either the services or commodities.

DISAGGREGATION
Data for this indicator will be disaggregated by gender, site, province

Indicator 13.4: Number of migrant workers reached with HIV prevention program in last 12 months

METHOD OF MEASUREMENT
Number of MWs who received HIV prevention services through outreach workers, peer educators, volunteers or DICs

MWs include both documented and undocumented workers from Myanmar, Lao PDR and Cambodia, working in fishery and seafood processing, factories, agricultural industry and construction.

HIV prevention services include

• providing HIV prevention information and education as well as sexual and reproductive health through IEC and BCC materials or/and counseling;

• distributing condoms

• referral for STI diagnosis and treatment

• referral for VCT

DISAGGREGATION
Data for this indicator will be disaggregated by gender, site, province, and type of job (fisheries, construction, factories) and country of origin
Indicator 14: Number of MARPs, MWs receiving STI screening and/or treatment

**PURPOSE**
Screening and treatment for STIs is particularly important to prevent the spread of STIs and as an indicator of irregular condom use. This indicator measures the effectiveness of the STI program in motivating MARPs and MWs to be screened for STIs in large numbers and if an STI is diagnosed, to be treated.

**DATA COLLECTION FREQUENCY**
Annually

**MEASUREMENT TOOL**
Routine HIS

**METHOD OF MEASUREMENT**
Program monitoring records

**DISAGGREGATION**
Indicator will be disaggregated by population group, age, gender, site, province
### Indicator 15A: Number of MARPs, MWs receiving an HIV test and receiving test results

**PURPOSE**
Voluntary HIV counseling and testing serves two roles: as an entry point to additional HIV services, and, through the knowledge of one's serostatus and the counseling provided, as a motivator and facilitator of behavior change among MARPs. This indicator measures the success the HIV prevention program at motivating MARPs and MWs to receive testing and counseling services in large numbers.

**DATA COLLECTION FREQUENCY**
Annually

**MEASUREMENT TOOL**
Routine HIS

**METHOD OF MEASUREMENT**
Program monitoring records

**DISAGGREGATION**
Indicator will be disaggregated by population group, age, gender, site, province
### Indicator 15B: Percentage of MARPs, MWs who are tested for HIV who receive test results

**PURPOSE**

Voluntary HIV counseling and testing serves two roles: as an entry point to additional HIV services, and, through the knowledge of one's serostatus and the counseling provided, as a motivator and facilitator of behavior change among MARPs.

Testing is most effective for HIV prevention when the individual receives both pre- and post-test counseling and receives their test results. If the test is negative, the motivation increases to maintain their status, and a risk reduction plan can be discussed with the counselor. If the test is positive, counseling about living with HIV and referral to HIV services can be received.

Many VCT services in Thailand still do not provide rapid tests for HIV. This means that those who are tested must return on a subsequent day to receive their results, and inevitably some do not return. Quality improvement at HCT services should include 1) increased use of rapid tests and 2) if rapid tests are not available increased success at motivating those tested to return to receive their results.

**DATA COLLECTION FREQUENCY**

Annually

**MEASUREMENT TOOL**

Routine HIS

**METHOD OF MEASUREMENT**

Program records

**Numerator:**

Number of MARPs and MWs who receive HIV test results

**Denominator:**

Number of MARPs and MWs tested

**DISAGGREGATION**

Indicator will be disaggregated by population group, age, gender, site and province
Indicator 16: Percentage of MARPs, MWs receiving free condom or purchasing subsidized condom in the last month

PURPOSE Effective HIV prevention requires an uninterrupted supply of affordable prevention commodities. This indicator measures whether MARPs and MWs are receiving the free and subsidized condoms that are targeted for them by the HIV prevention program.

DATA COLLECTION FREQUENCY Every two years (2010, 2012)

MEASUREMENT TOOL Integrated Biomarker and Behavioral Surveillance (IBBS) Survey

METHOD OF MEASUREMENT All MARPs and MWs are asked the following question:
1. In the last month have you received a free condom?
2. In the last month have you purchased a subsidized condom? (Cues for where subsidized condoms are available and their characteristics are included here.

Numerator: Number who say they have received a free condom or purchased a subsidized condom in the past month

Denominator: Number of all respondents

DISAGGREGATION Indicator will be disaggregated by population group, age gender, site and province
### Indicator 17: Score of National Policy Index related to enabling environment and stigma/discrimination

**PURPOSE**

The National Composite Policy Index is a comprehensive and standardized tool which is measured nationally for the UNGASS report every 2 years. This tool aims to assess the policy, strategy, legal and program implementation environment for HIV responses. While the NCPI covers the overall response to the epidemic, a number of sections in the questionnaire are available to assess policy, strategy, law and environment so that a sub-index including human rights and stigma and discrimination targeting MARPs and MWs may be calculated. Because the NCPI is well-established and currently used to report for UNGASS, sub-sections of the Index will be used to monitor the core indicator measuring change in the enabling environment and effective management responses targeting MARPs and MWs.

As described in the National M&E Plan for MARPs and MWs, a more targeted and specific module on the enabling environment and stigma/discrimination will be developed by 2012.

**DATA COLLECTION FREQUENCY**

Every two years in years 2010 and 2012.

**MEASUREMENT TOOL**

NAMC completes the NCPI as part of the UNGASS report.

**METHOD OF MEASUREMENT**

National score on the NCPI on the Strategic Plan and Political Support and the Human Rights sections.
### Indicator 18: Number of provinces that have key strategic information and use it for provincial operation plan

**PURPOSE**  
New budgetary authority at the provincial level has created increased responsibility for HIV programs and planning in local areas. A major effort of the HIV strategy is to increase awareness of HIV issues for MARPs and MWs among provincial officials and to increase their capacity to use strategic information for planning. This indicator measures the effectiveness of those efforts in increasing the number of provincial operating plans that use data on the HIV epidemic among MARPs and MWs for HIV prevention planning.

**DATA COLLECTION FREQUENCY**  
Annually

**MEASUREMENT TOOL**  
Provincial Survey

**METHOD OF MEASUREMENT**  
Provinces respond to two questions:

1) How often do provincial health office use epidemiological data for developing the current workplan or/provincial operational/strategic plan?

   - 0 = 0-5%
   - 1 = 6-20%
   - 2 = 21-50%
   - 3 = 51-70%
   - 4 = 71-100%

2) How often do provincial health office use program monitoring and evaluation data for developing the current workplan or/provincial operational/strategic plan?

   - 0 = 0-5%
   - 1 = 6-20%
   - 2 = 21-50%
   - 3 = 51-70%
   - 4 = 71-100%

The indicator will be constructed as a composite index of these two questions.
### Indicator 19: Number of local authorities that contributed financial resources to HIV/AIDS responses for MARPs

**Purpose**
New budgetary authority at the provincial level has created increased responsibility for HIV programs and planning in local areas. A major effort of the HIV strategy is to increase awareness of HIV issues for MARPs and MWs among provincial officials and to increase their capacity to use strategic information for planning. This indicator measures the effectiveness of those efforts in increasing the number of provincial budgets that include funding for HIV prevention programs for MARPs and MWs.

**Data Collection Frequency**
Annually

**Measurement Tool**
National AIDS Spending Assessment (NASA)

**Method of Measurement**
Actual expenditures classified by eight AIDS Spending Categories and by financing source, including public expenditure from its own sources (i.e. government revenues such as taxes) and from international sources:

1. Prevention
2. Care and treatment
3. Orphans and vulnerable children
4. Programme management and administration strengthening
5. Incentives for human resources
6. Social protection and social services (excluding orphans and vulnerable children)
7. Enabling environment and community development
8. Research (excluding operations research included under programme management)
Indicator 20: Number of Provincial Coordinating Mechanisms and Provincial Coordinating Committee with MARPs representatives

PURPOSE
Implementing effective HIV prevention services for MARPs requires the greater empowerment and involvement of those groups in the provincial and national response. This indicator measures the representation of MARPs at the provincial level in the Provincial Coordinating Mechanisms and Provincial Coordinating Committee.

DATA COLLECTION FREQUENCY
Annually

MEASUREMENT TOOL
Provincial Survey

METHOD OF MEASUREMENT
Provinces respond to the questions:
1. Are there any members of the PCM drawn from most-at-risk populations and/or migrant workers?
2. Are there any members of the Provincial Coordinating Committee who are from most-at-risk populations and/or migrant workers?

DISAGGREGATION
Indicator will be disaggregated by population group.
<table>
<thead>
<tr>
<th>Province/Calendar Year</th>
<th>FSW</th>
<th>MSM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Central</strong></td>
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<tr>
<td>Bangkok</td>
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<td>Venue based FSW</td>
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<td>Lopburi</td>
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<td>Ratchaburi</td>
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<td>Pathumthani</td>
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<td>Province/Calendar Year</td>
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<td>MSM</td>
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<tr>
<td><strong>Khon Kaen</strong></td>
<td></td>
<td>Venue based and non venue based FSW</td>
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<tr>
<td><strong>Northern</strong></td>
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<tr>
<td><strong>Tak</strong></td>
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<td>Venue based and non venue based FSW</td>
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<tr>
<td><strong>Phitsanulok</strong></td>
<td>Venue based FSW</td>
<td>Venue based and non venue based FSW</td>
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<tr>
<td>------------------------</td>
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</tr>
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<td><strong>Chiang Rai</strong></td>
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<td>Venue based FSW</td>
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<tr>
<td><strong>Chiang Mai</strong></td>
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<td>Venue based and non venue based FSW</td>
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<tr>
<td><strong>Mae Hong Son</strong></td>
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<tr>
<td><strong>Southern</strong></td>
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<td><strong>Phuket</strong></td>
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<td>Venue based and non venue based FSW</td>
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<td><strong>Songkra</strong></td>
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<td><strong>Phattalung</strong></td>
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<td>Pattani</td>
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<td>Prachuap Khirikhan</td>
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## Part B: IDU & MW

<table>
<thead>
<tr>
<th>Province/Calendar Year</th>
<th>IDU</th>
<th>Migrant worker</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>BSS</td>
<td>IBBS/ RDS</td>
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<tr>
<td>Central</td>
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</tr>
<tr>
<td>Bangkok</td>
<td>BSS</td>
<td>IBBS/ RDS</td>
</tr>
<tr>
<td>Lopburi</td>
<td></td>
<td>IBBS</td>
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<td>Trat</td>
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<td>IBBS</td>
</tr>
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<td>Pathumthani</td>
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<td>IBBS/ RDS</td>
</tr>
<tr>
<td>Rachaburi</td>
<td>BSS</td>
<td>IBBS/ RDS</td>
</tr>
<tr>
<td>Chachoengsao</td>
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<td>IBBS</td>
</tr>
<tr>
<td>Samutprakan</td>
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<td>IBBS/ RDS</td>
</tr>
<tr>
<td>Samut Sakhon</td>
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<td>IBBS/ RDS</td>
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<tr>
<td>North Saen</td>
<td>BSS</td>
<td>IBBS/ RDS</td>
</tr>
<tr>
<td>Sukhothai</td>
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<td>IBBS/ RDS</td>
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<tr>
<td>Nakhon Phanom</td>
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<td>IBBS</td>
</tr>
<tr>
<td>Khon Kaen</td>
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<td>IBBS</td>
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<tr>
<td>Northern</td>
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<td>IBBS</td>
</tr>
<tr>
<td>Tak</td>
<td></td>
<td>IBBS</td>
</tr>
</tbody>
</table>

**Note:** The table above shows the presence of IDU and Migrant worker activities across different provinces and years.
<table>
<thead>
<tr>
<th>IDU</th>
<th>Phitsanulok</th>
<th>Chiang Rai</th>
<th>Chiang Mai</th>
<th>Mae Hong Son</th>
<th>Phuket</th>
<th>Songkhla</th>
<th>Phatthalung</th>
<th>Trang</th>
<th>Ranong</th>
<th>Pattani</th>
<th>Phichai Kiri Khan</th>
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</thead>
<tbody>
<tr>
<td>Mae Hong Son</td>
<td>IBBS/RDS</td>
<td>IBBS/RDS</td>
<td>IBBS/RDS</td>
<td>IBBS/RDS</td>
<td>IBBS/RDS</td>
<td>IBBS/RDS</td>
<td>IBBS/RDS</td>
<td>IBBS/RDS</td>
<td>IBBS/RDS</td>
<td>IBBS/RDS</td>
<td>IBBS/RDS</td>
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</tbody>
</table>
A. Periods covered and dates

<table>
<thead>
<tr>
<th>Period</th>
<th>Period 1</th>
<th>Period 2</th>
<th>Period 3</th>
<th>Period 4</th>
<th>Period 5</th>
<th>Period 6</th>
<th>Period 7</th>
<th>Period 8</th>
<th>Period 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>From</td>
<td>1-Jun-09</td>
<td>1-Oct-09</td>
<td>1-Jan-10</td>
<td>1-Apr-10</td>
<td>1-Jul-10</td>
<td>1-Oct-10</td>
<td>1-Jan-11</td>
<td>1-Apr-11</td>
<td>1-Jun-11</td>
</tr>
<tr>
<td>To</td>
<td>30-Sep-09</td>
<td>31-Dec-09</td>
<td>31-Mar-10</td>
<td>30-Jun-10</td>
<td>30-Sep-10</td>
<td>31-Dec-10</td>
<td>31-Mar-11</td>
<td>31-May-11</td>
<td>31-Aug-11</td>
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</table>

<table>
<thead>
<tr>
<th>DDC Timeline</th>
<th>Raks Thai Timeline</th>
<th>PSI Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Report</td>
<td>Y1= 30 Sep 10, Y2=30</td>
<td>30-Nov-10</td>
</tr>
<tr>
<td>Audit Report Due</td>
<td>Y1=31 Dec 10, Y2=31</td>
<td>31-Dec-10</td>
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</table>
## B. Program Goal, Impact and Outcome Indicators

<table>
<thead>
<tr>
<th>Impact / Outcome Indicator</th>
<th>Indicator</th>
<th>Baseline</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>value</td>
<td>Year</td>
</tr>
<tr>
<td>Impact</td>
<td>1. Percentage of female sex workers who are HIV infected</td>
<td>4%</td>
<td>2007</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(76 provinces)</td>
<td></td>
</tr>
<tr>
<td>Impact</td>
<td>2. Percentage of men who have sex with men who are HIV infected</td>
<td>8%</td>
<td>2007</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(6 provinces)</td>
<td></td>
</tr>
<tr>
<td>Impact</td>
<td>3. Percentage of injecting drug users who are HIV infected</td>
<td>38.63%</td>
<td>2007</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(5 yr average results 2004-08)</td>
<td></td>
</tr>
<tr>
<td>Impact</td>
<td>4. Percentage of migrant workers who are HIV infected</td>
<td>2.49%</td>
<td>2007</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(5 provinces)</td>
<td></td>
</tr>
<tr>
<td>Outcome</td>
<td>1. Percentage of female sex workers reporting the use of a condom with their most recent client</td>
<td>89.40%</td>
<td>2007</td>
</tr>
<tr>
<td></td>
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<td></td>
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<tr>
<td>Impact / outcome Indicator</td>
<td>Indicator</td>
<td>Baseline</td>
<td>Targets</td>
</tr>
<tr>
<td>----------------------------</td>
<td>---------------------------------------------------------------------------</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>value</td>
<td>Year</td>
</tr>
<tr>
<td>Outcome</td>
<td>2. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner</td>
<td>84.45%</td>
<td>2007</td>
</tr>
<tr>
<td>Outcome</td>
<td>3. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected</td>
<td>Not available</td>
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</tr>
<tr>
<td>Outcome</td>
<td>4. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse with a regular partner</td>
<td>32.60%</td>
<td>2007</td>
</tr>
<tr>
<td>Outcome</td>
<td>5. Percentage of migrant workers reporting the use of a condom the last time they had sexual intercourse with a non-regular partner</td>
<td>Not available</td>
<td></td>
</tr>
</tbody>
</table>

1 HSS: HIV Sentinel Sero Surveillance. NAMC and BOE will review and analyze with IBBS in 2010. Results will be used to revise national targets.
2 BSS: Behavioral Surveillance Survey. NAMC and BOE will review and analyze with IBBS in 2010. Results will be used to revise national targets.
3 2009: Implementation of the IBBS has been delayed; it will be conducted in 2010.
## C. Program Objectives, Service Delivery Areas and Indicators

### Objective description

| 1  | To strengthen and scale up delivery of comprehensive HIV prevention services for MARPs |
| 2  | To build a strong enabling environment for equitable and sustainable delivery of HIV services for MARPs |
| 3  | To strengthen the strategic information system for program and policy improvement for MARPs |

<table>
<thead>
<tr>
<th>Obj.</th>
<th>Service Delivery Area</th>
<th>Indicator</th>
<th>Periodical targets for year 1 &amp; 2</th>
<th>P9 Targets (applicable if phase 1 is extended by 3 month)</th>
<th>Targets cumulative</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>FSW</td>
<td>Number of Female Sex Workers (FSWs) reached with HIV prevention programs</td>
<td>2,000 5,330 12,459 17,789 5,684 12,684 19,684 26,684</td>
<td>7,000</td>
<td>Y - cumulative annually</td>
</tr>
<tr>
<td>1.2</td>
<td>MSM</td>
<td>Number of MSM reached with HIV prevention programs</td>
<td>2,000 6,575 15,341 21,916 7,255 15,755 24,255 32,755</td>
<td>8,500</td>
<td>Y - cumulative annually</td>
</tr>
<tr>
<td>Obj.</td>
<td>Service Delivery Area</td>
<td>Indicator</td>
<td>P1</td>
<td>P2</td>
<td>P3</td>
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<tr>
<td>1.3</td>
<td>Prisoner</td>
<td>Number of prisoners reached by HIV prevention programs</td>
<td>875</td>
<td>2625</td>
<td>4375</td>
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<td>BCC-community outreach</td>
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</tr>
<tr>
<td>1.3</td>
<td>IDU</td>
<td>Number of IDUs reached with HIV prevention programs</td>
<td>1420</td>
<td>2290</td>
<td>4388</td>
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<td>BCC-community outreach</td>
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<tr>
<td>1.1</td>
<td>MW</td>
<td>Number of MW reached with HIV prevention programs</td>
<td>25665</td>
<td>50038</td>
<td>74211</td>
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<td>BC -community outreach</td>
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<td>1.4</td>
<td>DDC</td>
<td>Number of individuals trained to implement HIV prevention activities for MARPs</td>
<td>160</td>
<td>1697</td>
<td>1697</td>
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<td>BCC-community outreach</td>
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<td>1.6</td>
<td>IDU</td>
<td>Number of people trained to implement HIV prevention activities for IDUs</td>
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<td>143</td>
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<td>BCC-community outreach</td>
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<td>1.2</td>
<td>RTF</td>
<td>Number of peer educators and outreach workers trained to implement HIV prevention activities for MW</td>
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<td>154</td>
<td>243</td>
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</tbody>
</table>

**Periodical targets for year 1 & 2**

- **P9 Targets** (applicable if phase 1 is extended by 3 month)
- **Targets cumulative**
  - Y-over program term
  - Y-cumulative annually
  - N-not cumulative

**Notes**

- Y - cumulative annually
- Y - over program term
- N/A
<table>
<thead>
<tr>
<th>Service Delivery Area</th>
<th>Obj.</th>
<th>Periodical targets for year 1 &amp; 2</th>
<th>Targets cumulative</th>
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<td></td>
<td></td>
<td>Y-over program term</td>
<td>Y-cumulative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Y-over program term</td>
<td>Y-cumulative</td>
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<td>Y-cumulative</td>
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<td>Y-over program term</td>
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<td>Y-cumulative</td>
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<td>Y-over program term</td>
<td>Y-cumulative</td>
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<tr>
<td></td>
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<td>Y-over program term</td>
<td>Y-cumulative</td>
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<th>P5</th>
<th>P6</th>
<th>P7</th>
<th>P8</th>
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<td>1.5 FSW Commodities</td>
<td>639,600</td>
<td>0</td>
<td>1,455,080</td>
<td>2,134,880</td>
<td>682,080</td>
<td>1,522,080</td>
<td>2,352,080</td>
<td>3,202,080</td>
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<td>1.6 DDC Commodities</td>
<td>0</td>
<td>657,458</td>
<td>0</td>
<td>0</td>
<td>505,876</td>
<td>1,128,876</td>
<td>1,751,876</td>
<td>2,374,876</td>
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<tr>
<td>1.7 MSM Commodities</td>
<td>199,993</td>
<td>328,729</td>
<td>1,534,070</td>
<td>2,191,528</td>
<td>725,486</td>
<td>1,575,471</td>
<td>2,425,455</td>
<td>3,275,49</td>
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<td>1.8 IDU Commodities</td>
<td>99,997</td>
<td>104,024</td>
<td>767,035</td>
<td>1,095,764</td>
<td>362,743</td>
<td>787,735</td>
<td>1,637,727</td>
<td>2,429,992</td>
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<tr>
<td>1.3 IDU Number of needles and syringes distributed to IDUs (free distribution)</td>
<td>546,638</td>
<td>324,413</td>
<td>767,663</td>
<td></td>
<td></td>
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</table>

- Number of peer educators and outreach workers trained to implement HIV prevention activities for MW: 639,600
- Number of condoms distributed to Female Sex Workers (free of charge): 2,352,080
- Number of lubricants distributed to MSM (free of charge): 1,212,720
- Number of needles and syringes distributed to IDUs (free distribution): 546,638
<table>
<thead>
<tr>
<th>Obj.</th>
<th>Service Delivery Area</th>
<th>Indicator</th>
<th>Periodical targets for year 1 &amp; 2</th>
<th>P9 Targets (applicable if phase 1 is extended by 3 month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.4</td>
<td>IDU</td>
<td>Number of condoms distributed to IDUs (free distribution)</td>
<td>P1 21,300 P2 64,875 P3 109,395 P4 153,495</td>
<td>N - not cumulative</td>
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<tr>
<td>1.3</td>
<td>MW</td>
<td>Number of free condoms distributed to MW</td>
<td>312,210 397,359 354,785 408,474</td>
<td>412,022</td>
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<td>1.9</td>
<td>FSW</td>
<td>Number of FSW who received an HIV test in the last 12 months and who know their results</td>
<td>0 3,198 7,475 10,673 3,410 7,610 11,810 16,010</td>
<td>Y - cumulative annually</td>
</tr>
<tr>
<td>1.10</td>
<td>MSM</td>
<td>Number of MSM who received an HIV test in the last 12 months and who know their results</td>
<td>0 1,973 4,602 6,575 2,177 4,727 7,277 9,827</td>
<td>2,550</td>
</tr>
<tr>
<td>1.15</td>
<td>IDU</td>
<td>Number of IDUs referred for HIV testing and counseling</td>
<td>475 950 1,679 2,408</td>
<td>Y - over program term</td>
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<tr>
<td>Service Delivery Area</td>
<td>Service Delivery Area</td>
<td>Obj.</td>
<td>Indicator 1</td>
<td>Indicator 2</td>
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<td>P9</td>
<td>Targets</td>
<td>Cumulative</td>
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<td>year 1 &amp; 2</td>
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<table>
<thead>
<tr>
<th>Indicator 1</th>
<th>Y-over program term</th>
<th>Y-cumulative annually</th>
<th>N-cumulative annually</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testing and Counseling</td>
<td>Number of MW who received an HIV test in the last 6 months and who know their results</td>
<td>141</td>
<td>340</td>
</tr>
<tr>
<td>STI diagnosis and treatment</td>
<td>Number of cases of sexually transmitted infections treated among FSW</td>
<td>0</td>
<td>85</td>
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<tr>
<td>STI diagnosis and treatment</td>
<td>Number of cases of sexually transmitted infections treated among MSM</td>
<td>0</td>
<td>402</td>
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<tr>
<td>STI diagnosis and treatment</td>
<td>Number of referrals made for IDU to appropriate STI diagnosis, treatment, and counseling</td>
<td>513</td>
<td>1,026</td>
</tr>
</tbody>
</table>

P9 Targets (applicable if phase 1 is extended by 3 month)

- P1: 166 (35% of 475)
- P2: 328 (45% of 729)
- P3: 695
- P4: 1,015
- P5: 1,390
- P6: 391
- P7: 1,380
- P8: 1,935
- P9: 2,308

Targets cumulative

- P1: 166
- P2: 328
- P3: 695
- P4: 1,015
- P5: 1,390
- P6: 391
- P7: 1,380
- P8: 1,935
- P9: 2,308

- Not cumulative
- Y-over program term
<table>
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<tr>
<th>Obj.</th>
<th>Service Delivery Area</th>
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<th>P1</th>
<th>P2</th>
<th>P3</th>
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<th>P6</th>
<th>P7</th>
<th>P8</th>
<th>P9 Targets (applicable if phase 1 is extended by 3 month)</th>
<th>Targets cumulative Y-over program term Y-cumulative annually N-not cumulative</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5</td>
<td>MW</td>
<td>2. Number and percentage of cases of STI referral that are diagnosed (Result received)</td>
<td>205 (40% of 513)</td>
<td>205 (40% of 513)</td>
<td>321 (50% of 641)</td>
<td>321 (50% of 641)</td>
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<td></td>
<td>Not cumulative</td>
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<tr>
<td>1.13</td>
<td>DDC</td>
<td>Number of cases of sexually transmitted infections among migrant workers diagnosed, treated and counseled</td>
<td>336</td>
<td>790</td>
<td>1,210</td>
<td>1,680</td>
<td>515</td>
<td>1,074</td>
<td>1,568</td>
<td>2,147</td>
<td>548</td>
<td>Y-cumulative annually</td>
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<td>2.1</td>
<td>RTF</td>
<td>Number of government health service providers trained for providing MARP-friendly health services</td>
<td>270</td>
<td>1,187</td>
<td>2,290</td>
<td>2,786</td>
<td>3,644</td>
<td>4,911</td>
<td>5,744</td>
<td>5,884</td>
<td>6,195</td>
<td>Y-over program term</td>
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<td>Number of government health service providers trained for providing MW-friendly health services</td>
<td>0</td>
<td>0</td>
<td>180</td>
<td>N/A</td>
<td>N/A</td>
<td>375</td>
<td>570</td>
<td>N/A</td>
<td>N/A</td>
<td>Y-over program term</td>
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<tr>
<td>2.1</td>
<td>DDC Policy development including workplace policy</td>
<td>Number of people from local organizations and authorities trained in HIV-related policy development and resource mobilization</td>
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<tr>
<td>2.2</td>
<td>PSI Reducing stigma in all settings</td>
<td>Number of people participating in advocacy workshops held to create an enabling environment for harm reduction in targeted provinces</td>
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<tr>
<td>2.3</td>
<td>RTF Policy development including workplace policy</td>
<td>Number of people from local organizations and authorities trained on HIV-related policy development and resource mobilization workshop</td>
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**Periodical targets for year 1 & 2**

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<tr>
<th>P9 Targets</th>
<th>Targets cumulative</th>
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<tr>
<td>(applicable if phase 1 is extended by 3 month)</td>
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<td>2.2</td>
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<td>2.4</td>
<td>PSI</td>
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<td>2.4</td>
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<td>Obj.</td>
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<tr>
<td>3.1</td>
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<td>3.2</td>
<td>PSI</td>
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</table>
7. LIST OF CONTRIBUTORS

**National AIDS Management Center (NAMC)**
Dr. Petchsri Sirinirund  
Ms. Wassana Nimvorapun  
Ms. Porntip Khemngern  
Ms. Busaba Warakamin

**Principal Recipient Administrative Office, Department of Disease Control (PR-DDC)**
Dr. Anupong Chitwarakorn  
Ms. Bussaba Tantisak  
Mr. Tan Tantinoraj  
Mr. Chaitawat Teeranuson

**Bureau of AIDS, TB and STI (BATS)**
Dr. Angkana Charoenchokchai  
Ms. Ratreep Sirisreetreeluck  
Ms. Narumon Yenyasun  
Ms. Vipa Pawanaporn  
Ms. Wipada Mahattanaviroj

**Bureau of Epidemiology (BOE)**
Dr. Chawetsan Namwat  
Ms. Niramon Rattanasuporn  
Ms. Keratikarn Kludsawad  
Ms. Sarinya Pongpan  
Mr. Sahaphap Poonkesorn

**Raks Thai Foundation (Raks Thai)**
Mr. Promboon Panitchpakdi  
Ms. Thongphit Pinyosinwat  
Ms. Tassanee Surawanna  
Mr. Bruce Ravesloot  
Mr. Watcharapol Boorananet  
Ms. Sawitree Boonthawee

**Population Services International -Thailand Foundation (PSI)**
Ms. Yaowalak Jittakoat  
Mr. Donlachai Hawangchu

**The Planned Parenthood Association of Thailand (PPAT)**
Mr. Montri Pekanan  
Mr. Voravud Tomon  
Ms. Ladda Jitwatanapataya

**Rainbow Sky Association of Thailand (RSAT)**
Mr. Kosol Chuenchomsakulchai

**Thanyarak Institute on Drug Abuse, Department of Medical Services**
Dr. Angoon Patarakorn  
Ms. Chaweewan panjabutr  
Ms. Yaowaret Nakayothinsakun  
Ms. Jamreang Ruangmak
Office of Disease of Prevention and Control, Region 3
Ms. Jirapan Rattaprasert

Samutprakarn Provincial Health Office
Dr. Pittaya Piboonsiri
Mr. Anan Punngok
Ms. Rattana Jaitadkul

Samutprakarn Hospital
Dr. Sittichai Kulpormsirikul
Dr. Prapan Sapsanong
Ms. Bangorn Yamlertjang
Ms. Virawan Tantiwatsakul
Ms. Pimpan Kupmirutkul

A-Square Regional Technical Support Team, Policy Research and Development Institute
Dr. Wiwat Peerapatanapokin

The Office of the Narcotics Control Board (ONCB)
Ms. Supojjanee Chutidamrong

Drug Abuse Prevention and Treatment Division, Bangkok Metropolitan Administration (BMA)
Ms. Kanda Chautmuang

Empower
Ms. Jantavipa Apisuk

Health Information System (HIS) Consultant, John Snow Inc.
Dr. Anwer Aqil

Health Intervention and Technology Assessment Program (HITAP)
Dr. Yot Teerawattananon
Ms. Jantana Pattanapaesat

Chulalongkorn University
Dr. Bhassorn Limanonda

Family Health International (FHI)
Dr. Jittinee Kaenwijit

Pact Thailand
Ms. Chutima Chomsookprakit

Thailand MOPH - U.S. CDC Collaboration (TUC)
Dr. Dimitri Prybylski
Dr. Achara Teeraratkul
Dr. Chitlada Uthaipiboon
Ms. Chomnad Manopaiboon
Ms. Chollada Nandavisai
Ms. Puangthong Tangpratyasakul
Ms. Suvimon Tanpradech
Ms. Anchalee Varanrat
**USAID**
Dr. Cameron Wolf
Mr. Panus Na Nakorn

**UNESCO**
Mr. Rapeepun Jommaroeng

**UNFPA**
Dr. Taweesap Siraprapasiri

**WHO**
Dr. Sombat Thanprasertsuk

**The World Bank - Bangkok Office**
Dr. Sutayut Osornprasop

**UNDP**
Ms. Tongta Khiewpaisal

**UNAIDS Thailand**
Dr. Micheal Hahn
Mr. Sompong Chareonsuk
Dr. Patchara Benjarattanaporn
Ms. Ploycarat Nana

**Consultant, Institute for Population and Social Research, Mahidol University**
Dr. Kerry Richter
National AIDS Management Center

Department of Disease Control, Ministry of Public Health
Tiwanon Road, Nonthaburi 11000
Tel : 66-2-590-3829,
Fax: 66-2-965-9153