FINAL REPORT

ASSESSMENT ON THE **contribution of the Global Fund** to the **Health System Strengthening**

2002-2024, Thailand

EXPERTISE FRANCE
GROUPE AFD

L'INITIATIVE
sida, tuberculose, paludisme

Abbreviation

ART	Antiretroviral treatment
CBO	Community-based organization
CSO	Civil society organization
CUP	Condom Use Program
DAS	Department of Aids and STIs
DDC	Department of Disease Control
DOT	Directly oriented treatment
FSW	Female sex worker
HCV	Hepatitis C Virus
HIV PEP	HIV Post-Exposure Prophylaxis
HPB	Hepatitis B
HSS	Health system strengthening
IDU	Injecting drug user
MOPH	Ministry of public health
MHV	Migrant health volunteer
MHW	Migrant health workers
MSM	Men who have sex with men
MSW	Male sex worker
NAPHA	National Access to ARV for People with HIV/AIDS
NHSO	National Health Security Office
NTP	National TB program
OST	Opioid substitution therapy
PCM	Provincial Coordinating Mechanism
PWID	People Who Inject Drugs
PrEP	Pre-Exposure Prophylaxis
RRTTPR	Reach, Recruit, Test, Treatment, Prevention, Retain
RTF	Raks Thai Foundation
SW	Sex worker
TBCA	Thailand Business Coalition against AIDS
TGW	Transgender women
TNP+	Thai Network of People Living with AIDS
TPT	Treatment for TB prevention
TRCARC	Thai Red Cross AIDS Research Centre
UHC	Universal health coverage
VHV	Village health volunteer
VL	Viral load

Authors:
Christelle Boulanger & Dr Jaruwaree (Fah) Snidwongse na Ayutthaya

Photo credits: Cover: Zarni PHYO — P. 2-25-31-33-38 : Zarni PHYO
P. 5 : Christelle BOULANGER — P.16-23-35 : Anna SURINYACH
May 2025

TABLE OF CONTENTS

This study was conducted as part of a technical assistance mission funded by L'Initiative, a French facility that complements the Global Fund against AIDS, Tuberculosis and Malaria. L'Initiative is implemented by Expertise France (EF) and funded by the French Ministry for Europe and Foreign Affairs (MEAE).

EDITO: INVESTING IN HEALTH SYSTEMS: a legacy of impact, a future to sustain

By Adeline Lautissier and Jean-Luc El Kaim, L'Initiative, Expertise France

This external report, prepared by Ms. Christelle Boulanger and Dr Jaruwaree Snidwongse na Ayutthaya, offers a retrospective analysis of the Global Fund's engagement in Thailand since 2003. It seeks to document the Global Fund's strategic orientations, assess the depth and evolution of its investments in health systems strengthening (HSS), highlight key innovations now integrated into national frameworks, and provide forward-looking recommendations.

Over the past two decades, the Global Fund has played both a catalytic and transformative role—not only in advancing the response to HIV, tuberculosis and malaria, but in shaping a more resilient, inclusive and resilient health system.

In Thailand, the Global Fund arrived at a pivotal juncture, when scaling up HIV treatment was financially out of reach without strong international partnerships. Its early contributions demonstrated that it was possible to sustain large cohorts on treatment, reach marginalized populations, and implement innovative screening and care models. From national strategy to last-mile delivery, including robust civil society engagement, the Global Fund has been active across all levels of the health system.

Its investments have driven decentralization, strengthened surveillance, enhanced laboratory capacity, and supported the integration of community-based care models by linking community services to the health system. One of the most significant legacies has been the empowerment of civil society. Organizations long supported by the Global Fund, have become key partners in reaching the most marginalized and underserved populations—sex workers, people with diverse sexualities and gender, and other key groups. Perhaps one of the most strategic legacies is the empowerment of civil society. Through consistent funding and technical support, civil society organizations (CSOs) in Thailand have evolved into credible service providers, now integrated into national reimbursement schemes through social contracting mechanisms.

Nonetheless, while the Global Fund's support has been instrumental in enhancing the capacity of CSO's to serve unregistered migrants and people who inject drugs, major challenges persist. Basic health needs among these populations remain unmet. Needles and syringes exchange programs are still constrained; safe consumption spaces lack institutional support; harm reduction interventions for non-injecting drug use is still underdeveloped; and undocumented migrants continue to face stigma, discrimination and severely limited access to essential health services.

Thailand's experience stands as a compelling example of how vertical investments, when designed and implemented with vision and alignment, can act as a powerful lever for systemic change. The Global Fund's role has not been peripheral—it has been foundational. Looking forward, sustaining these gains and addressing persistent gaps will require renewed partnerships, strong domestic leadership, and enduring global solidarity.

Additional Perspective from L'Initiative:

While the contributions of L'Initiative and other key partners were deliberately kept outside the scope of this analysis—to isolate the specific role of the Global Fund— it seemed relevant to briefly recall the complementary role played as well by L'Initiative in addressing unmet needs, particularly among migrants and people who use drugs. Today, this includes efforts for example to help expand health coverage for migrant populations and broaden the range of services available to people who use drugs.

In line with a shared objective of equity in access to care, these complementary contributions aim to strengthen the overall health system and support Thailand's progress toward universal health coverage.

EXECUTIVE summary

The Global Fund has been investing in Thailand since 2003, and to date has supported the health system and the response to HIV and TB to the tune of 527 million dollars. Over the 20 years of collaboration, these investments have proved key in certain areas, often innovative, and almost always key in the progressive integration of the system and domestic financing. At the end of this study, the analysis shows that:

— **The Global Fund proved to be an essential partner in the early 2000s, when putting people living with HIV on treatment could not be scaled up** without a financial partner of this stature. Early funding from the Global Fund showed that it was possible to maintain a large cohort on treatment, and to integrate innovations in screening, treatment and service delivery down to the last mile.

— **The investments made over the past 20 years have been essential in strengthening the HIV and TB monitoring and surveillance system**, and in gaining a better understanding of the situation of people at risk through studies, surveys and size estimates.

— **The Global Fund has supported the decentralization of the healthcare system**, by financing HIV and TB coordination committees at the provincial level, by training providers based on guidelines and revised protocols, and strengthening the information and laboratory system. The Global Fund is an important partner of the health system and its programs at a central level and is responsible for the prevention and management of TB and HIV.

— **The history of the Global Fund in Thailand goes hand in hand with the same period of the development of social insurance in 2001 to establish Thailand's universal health coverage.** The organization has consistently supported the process of testing models of care, co-sponsoring them, and supporting their integration into the NHSO-reimbursed care package. Nowadays, the vast majority of screening and treatment initiatives are supported by national funding, which guarantees access to care for millions of patients.

— **Support for civil society organizations has been constant since 2002,** when the first grant was awarded to the Department of Disease Control and more so during the awards to Raks Thai Foundation. Today, 2/3 of all funding goes to CSOs, which have structured themselves and, thanks to this support, CSOs have been able to craft models of care adapted to the groups furthest from the healthcare system. Through social contracting, CSOs can now be certified by NHSO and have their services reimbursed. They are seen as indispensable allies of MOPH, without whom it would be difficult, if not impossible, to gain access to the most vulnerable populations, especially unregistered migrants who represent more than 2 million people, and PWID. Their contribution and added value are constantly emphasized by health authorities at the central level, and by care providers in hospitals and clinics at the provincial and community levels.

— The integration of community into the health system at all levels from national, regional, provincial and primary health in community has strengthened access to health services for key populations (KPs) and vulnerable groups. The Global Fund has supported extended health services to the community, offering low threshold of health service in the community. CSOs and Community mobilization have lessened stigma discrimination to KPs in accessing health and social services.

— Several categories of community health workers have emerged, linking migrants and key populations to care, and providing a key feedback loop on the specific needs and the adapted response to the communities. This cooperation model between CSOs and hospitals also worked during COVID-19, where the network of volunteer workers enabled prevention and screening operations to be carried out in contaminated areas, notably factories and smokehouses due to their experiences in disease control and familiarity with the communities. **This community-based surveillance is a reality, making epidemic response strategies even more robust and sustainable.**

— Last but not least, thanks to a major effort by the Thai government, which covers the bulk of needs in terms of simple HIV and TB testing and care, **Global Fund financing has been able to focus on innovation in technology and operations**. Important operational research has been carried out in recent years, improving the cost-effectiveness of TB, HIV and hepatitis prevention and management approaches. Not only do they serve national purpose but they are sources of inspiration for other sub regional countries (C-FREE study will be exported to Cambodia and Lao PDR).

Thailand is now a higher middle-income country, embarking on a transitional process. Plans for this have begun, but there are still gaps where the question of financial and operational sustainability arises, particularly in the financing of care for unregistered migrants and PWIDs. A constant effort of dialogue and advocacy is made by civil society organizations to find ways of financing these interventions through national funding, but the stakes seem more political and legal rather than financial. Social contractualization is excellent news, but we cannot ignore the fact that it is very demanding in terms of certification conditions and that the amounts reimbursed to CSOs are far from covering their costs and guaranteeing their survival.

Financial sustainability is also critical to maintaining investments in the laboratory and molecular biology screening capabilities. The costs of these technologies are high and do not appear to be sustainable without external support for the time being, all the more as the government has yet to certify GeneXpert and Truenat and continues to purchase the supplies locally at a much higher price

Finally, a few low-key health crises are currently visible, such as the abnormally high incidence of STIs or the transition from injecting drugs such as heroin to other substances such Amphetamine Type Stimulant (ATS) like Yaba (which includes KP's risk behaviour changes to multiple risks). The required responses are urgent and still rely, in part, on financing from the Global Fund.

Building block	Level of maturity	Degree of integration into the system	Institutional sustainability	Financial sustainability
GOVERNANCE				
HMIS				
SERVICE DELIVERY				
HUMAN RESOURCES				
MEDICINE AND TECHNOLOGY				
HEALTH FINANCING				

In the process of integration into the system, but not fully integrated nor sustainable without the external donors' support

Highest level of maturity, integration into the system and sustainable beyond the donors' funds

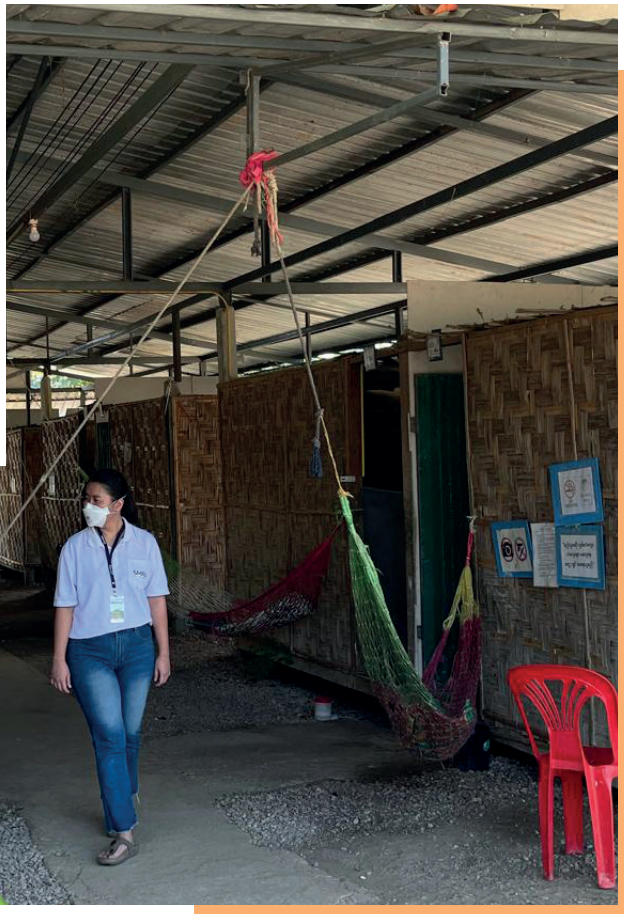
Introduction

Thailand Context

Thailand is located in the Southeast Asia region and has a population of approximately 70 million people[1]. It shares borders with Myanmar, Laos, Cambodia, and Malaysia. Since 2005, Thailand's population structure has transitioned into an aging society. This transformation is primarily driven by significant declines in fertility rates, decreases in mortality rates, and an increase in the average life expectancy of the population. In 2020, the estimated average life expectancy at birth for Thai males was 74 years, while for Thai females, 81 years. The proportion of the older population, defined as individuals aged 60 years and above, reaches 15.5% of the total population, and the trend of an increasing older population has been continuous. Furthermore, in 2020, approximately 51% of the population resided in urban areas, accounting for about 10 million people living in the Bangkok Metropolitan Region and its surrounding areas, roughly 14% of the total population.

The economic growth and below-replacement fertility rates in Thailand have resulted in a demand for labour from neighbouring countries. According to the International Organization for Migration (IOM) report on Thailand's migration, it is estimated that in 2020, there were approximately 4.9 million international migrant workers residing in Thailand, out of these, 2.5 million were registered with the Ministry of Labour. However, a significant portion of undocumented migrant workers face challenges in their illegal status, hence difficulty in accessing healthcare services. Moreover, there are approximately 95,000 displaced persons living in Thai-Myanmar border camps, and around 1,000,000 stateless individuals, primarily residing in the northern and north-eastern regions of the country.

Thailand has set its national development goals: "The country with national security, public contentment, sustained economic growth, a just society, and a foundation of sustainable natural resources". It has formulated a 20-year development framework for creating balanced development, a strong economy, and a high-quality society that fosters the development of individuals in all dimensions and stages of life, ensuring well-rounded care to have skilled and high-quality people as the important workforce for the country. It aims to create opportunities and social equality and promote growth based on a quality of life that is friendly to the environment. The key driving force is to develop Thailand into "Thailand 4.0," which involves transforming the country from being driven by heavy industries to being driven by innovation, adhering to the principle of doing more with less to enhance the country's potential in various dimensions and move away from the middle-income trap towards high-income status.



1. (https://www.worldometers.info/world-population/thailand-population, data as of March 7, 2023, based on Worldometer elaboration of the latest United Nations data

The health sector

The 13th National Economic and Social Development Plan (2023-2027) is the first plan that initiates the process of formulating the framework plan under the national strategy. It sets the direction for national development during the period. Objective 4 relates to healthcare operations and disease control, through 2 main goals:

- **Goal 3:** Thai people receive equitable access to healthcare services
- **Goal 4:** The health emergency management system is prepared to respond to health risks and emergencies.

The Department of Disease Control, the main agency responsible for the prevention and control of diseases and health risks in the country, has developed a 20-year National Strategic Plan for the Prevention and Control of Diseases and Health Risks (2017-2036). The Strategic Plan serves as a framework for guiding the country's disease prevention and control efforts, with a focus on developing a disease prevention and control system centred on the population, utilizing knowledge, technology, and innovation as driving forces, while adhering to the principles of sufficiency economy, good governance, and value for money. The plan was revised in 2021 and encompasses five strategic objectives, which are:

- **Strategy 1:** Development of policies, measures, and services for the prevention and control of diseases and health risks.
- **Strategy 2:** Strengthening public health emergency operation systems.
- **Strategy 3:** Upgrading the basic infrastructure of the system for the prevention and control of diseases and health risks.
- **Strategy 4:** Improvement of management systems and the development of collaborations.
- **Strategy 5:** Development of human resources for the prevention and control of diseases and health risks.

Thailand's disease control system contains a network of operations at all levels, from regions, provinces, districts, sub-districts, to villages. The regional-level Office of Disease Prevention and Control serves as the central administrative unit, responsible for 5-7 provinces in each region. Currently, the regional level is managed by 13 offices of regional health inspectors, providing technical backstopping to the provincial level. At the provincial level, the provincial health office oversees the health service providers in the area, except in Bangkok since it is a special administrative area with its self-governing system. Hospitals are distributed in every district, with general hospitals or regional hospitals providing more than 120 beds in main cities or larger districts. Community hospitals offering 10 to 120 beds for in-patient departments are at the district level. At the sub-district level, there are sub-district health promoting hospitals, most of which do not admit patients or have resident physicians. They collaborate with physicians from community hospitals, and there are village health volunteers who coordinate with medical staff to provide community healthcare and prevention in the communities. Moreover, many cities also have medical schools, military hospitals, specialized hospitals, and private hospitals providing services to the public. Hence, these hospitals do not fall under the direct management of the MoPH system and require additional collaborative efforts for the disease control program.

The free healthcare insurance system in Thailand consists of three main systems, covering 99.8 % of the population:

1. The system that covers the largest population is the universal coverage scheme, covering 75.8%. All Thai nationals who do not fall under the health insurance schemes 2 and 3 below will automatically be covered by the National Health Security Office.
2. The social security scheme for state enterprise and private sector employees, covering 17%.
3. The civil servant medical benefits scheme for government officials, covering 7% of the population.

These three systems differ in terms of the characteristics of the population they cover, basic benefit entitlements, and healthcare benefits, initially leading to inequalities in access to healthcare. CSOs constantly advocate the 3 health schemes to create equal benefit packages for their clients.

As for migrant workers with work permits in Thailand, they can either utilize social security benefits or purchase hospital-based health insurance cards while awaiting social security entitlements. Migrants' dependents without work permits can also purchase health insurance from the hospitals. However, work permits are only renewed annually and there is a time gap during the renewal process where health insurance under the Social Security Scheme is expired and access to health is limited. Moreover, hospital-based insurance card sales is dependent upon the hospital policy and may not be available in all hospitals where the migrants reside. Fear of the illegal status of migrant dependents also prevents them from traveling to obtain hospital health insurance cards or to receive continuous healthcare.

For PWID populations despite having a Thai citizenship, many do not have identification cards or may have misplaced them, creating difficulties in accessing UHC as the hospitals require ID cards. Furthermore, police checkpoints en-route to the hospitals also prevent drug users from traveling to receive care.

HIV and TB situation in the country

In the early 2000s, Thailand was the most affected by the HIV epidemic on the Asian continent. Reports from the time indicated that 984,000 persons had been infected between 1984 and 1997 with HIV and that approximately 289,000 people had died of AIDS while over 695,000 people were living with HIV. At the end of 1999, national HIV sentinel surveillance showed that prevalence had declined among Army conscripts, female direct/indirect sex workers, and pregnant women. However, the prevalence among People Who Inject Drugs (PWID) increased from 39% in 1989 to 54.1% by June 1999, where approximately half of the living PWID, were infected with HIV.

Within 20 years, the country succeeded in curbing the epidemic by funding large-scale programs to prevent new infections, eliminate mother-to-child transmission, and make screening and immediate treatment available to as many people as possible. From 2000 to 2014, the annual number of Thai women newly infected with the disease fell from 15,000 to 1900 - an 87% reduction. That is a degree of prevention success that exceeds what has been recorded even in most high-income countries. Thailand has also introduced universal health coverage, which covers the full cost of treatment for the Thai population and foreigners registered in the country.

Thailand has not only benefited from partnerships with technical and financial partners such as PEPFAR, USAID, the Global Fund against AIDS, TB and Malaria (GFATM), and academia but has also, in turn, served as a critical source of knowledge, learning, and best practices on AIDS to the world. Thailand has been home to some of the most important HIV clinical trials and implementation studies, including to prevention of mother-to-child transmission. Thailand's early pioneering of condom promotion for sex workers has inspired effective HIV prevention measures all across the world – in both financially rich and not-so-rich countries. As Thailand's investments in health have placed it on track to achieve HIV treatment for all within the next several years, it has shown the entire world what it takes to fully leverage antiretroviral therapy to reduce new HIV infections and AIDS-related deaths.

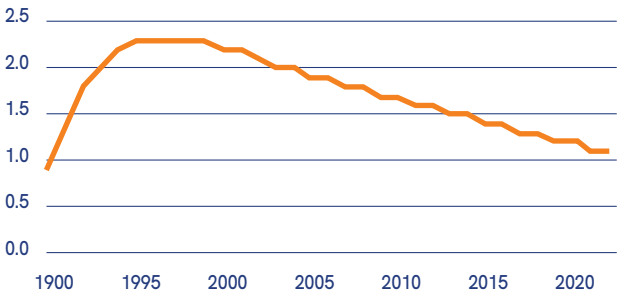


Fig 1. HIV prevalence, 1990-2022, Source: World Bank

As for TB, the estimated TB incidence in Thailand has gradually decreased over the past decade (2012-2021). The incidence of TB has reduced by an average of 2.0 cases per 100,000 population per year during this period. In 2023, the TB incidence in Thailand was estimated at 157 cases per 100,000 population, which is 113,000 estimated cases per year[2].

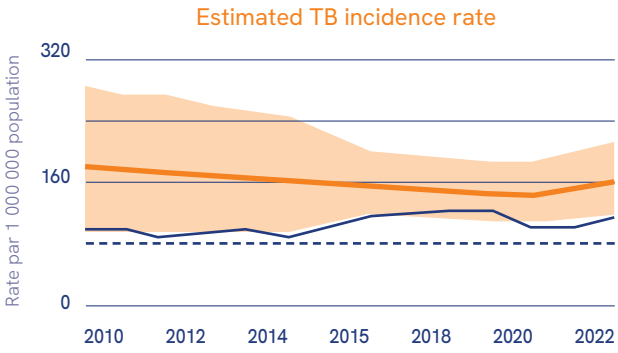


Fig 2. TB incidence according to WHO, 2000-2021

Due to limitations in Thailand's death certificate system which does not always state causes of death as directly caused by TB, the mortality rate of TB patients in Thailand is then referenced from the estimated data provided by the WHO. In 2023, the TB mortality rate (including both TB-HIV co-infected and TB patients without HIV infection) was estimated to be 19 (15-25) per 100,000 population, which corresponds to approximately 11,000 individuals (8,000-16,000). According to the estimated TB mortality rate since 2000, the mortality rate of TB-HIV co-infected patients has significantly decreased after recovering from an increase due to COVID-19 in 2022. However, the mortality rate of TB patients without HIV infection has been decreasing more slowly, remaining relatively stable at around 16 per 100,000 population between 2007 and 2023.

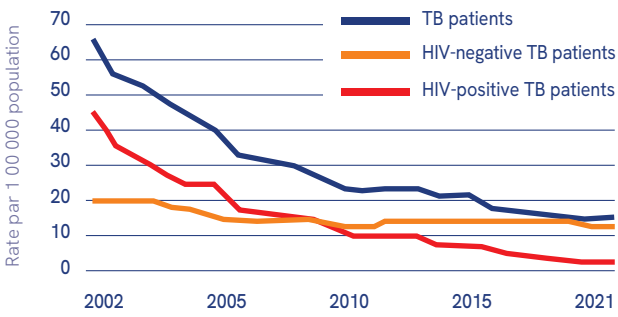
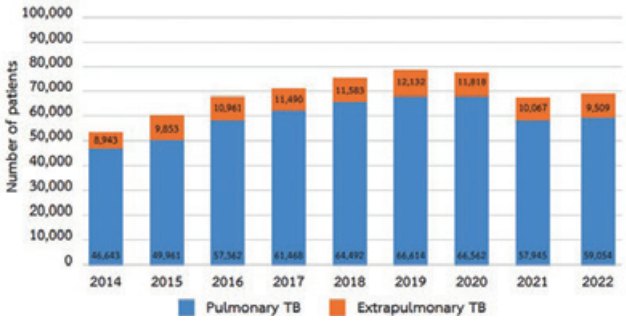


Fig 3. Estimated mortality rate of TB Patients in Thailand, Source: Global TB database, WHO

2. WHO, Global Tuberculosis Report 2024

According to the Global TB Report 2024 by the WHO, Thailand had a total of 80,200 new and relapse TB patients registered for treatment in the year 2023. This represented a treatment coverage rate of 71% Thailand reached 71% treatment coverage in 2023 (80.2k new and relapse notified over an estimated 113k). The proportion of male to female tuberculosis patients is 2:1, with 48,612 male and 22,876 female patients.



OBJECTIVES and METHODOLOGY of the study

This study was conceived as a retrospective analysis of the investments made by the Global Fund in Thailand since its inception in 2003. It was requested by the MoH Principal Recipient DDC and the community PR Raks Thai Foundation and has 4 main objectives:

1. To retrace the level of the Global Fund's involvement in Thailand, and to draw from the analysis the strategic orientations adopted
2. Analyse the volume and maturity of investments made to strengthen Thailand's healthcare system
3. Highlight innovations and approaches that are now fully integrated into the system
4. Formulate recommendations to guide future investment in HSS.

To conduct this study, the consultants carried out several exercises aimed, on the one hand at tracing funding since 2003, and on the other at analysing its impact, maturity, and long-term effects on the system. The following exercises were conducted:

- A review of all available documents relating to Global Fund grants (funding applications, progress reports, evaluations, budgets, performance frameworks, Office of the Inspector General audits)
- Reading of documents relating to the evolution of the HIV and TB epidemics in Thailand, and the country's response to them
- Analysis of documents on the Thai healthcare system and social security coverage
- Interviews with key informants from the government healthcare system and civil society organizations
- Visits to facilities receiving (or ever received) Global Fund financing.

A field mission was organized from 9-19 December 2024, to meet with players in the fight against HIV and TB in Bangkok and the provinces with high migrant populations: Tak, on the border with Myanmar, and Samut Sakhon. While Tak province receives the most migrants and refugees from Myanmar, of which a considerable amount is unregistered, Samut Sakhon is the province that employs the most workers from neighbouring countries. Observations of the programs established to ensure access to healthcare for these workers, some of whom do not have the right to universal health coverage due to lack of documentation, have enabled us to assess the extent of the Global Fund's current contribution to the country. The table below summarizes all sources of information.

	Remotely	On-site	Total
Number of interviews	11	26	37
Number of Focal Groups	0	4	4
Total number of participants in the study	36	82	**118**

The information gathered was then analyzed and triangulated to ensure its veracity, this process was important, as it proved difficult to interview the players who continue to be present and active over twenty years ago in Thailand and Geneva.

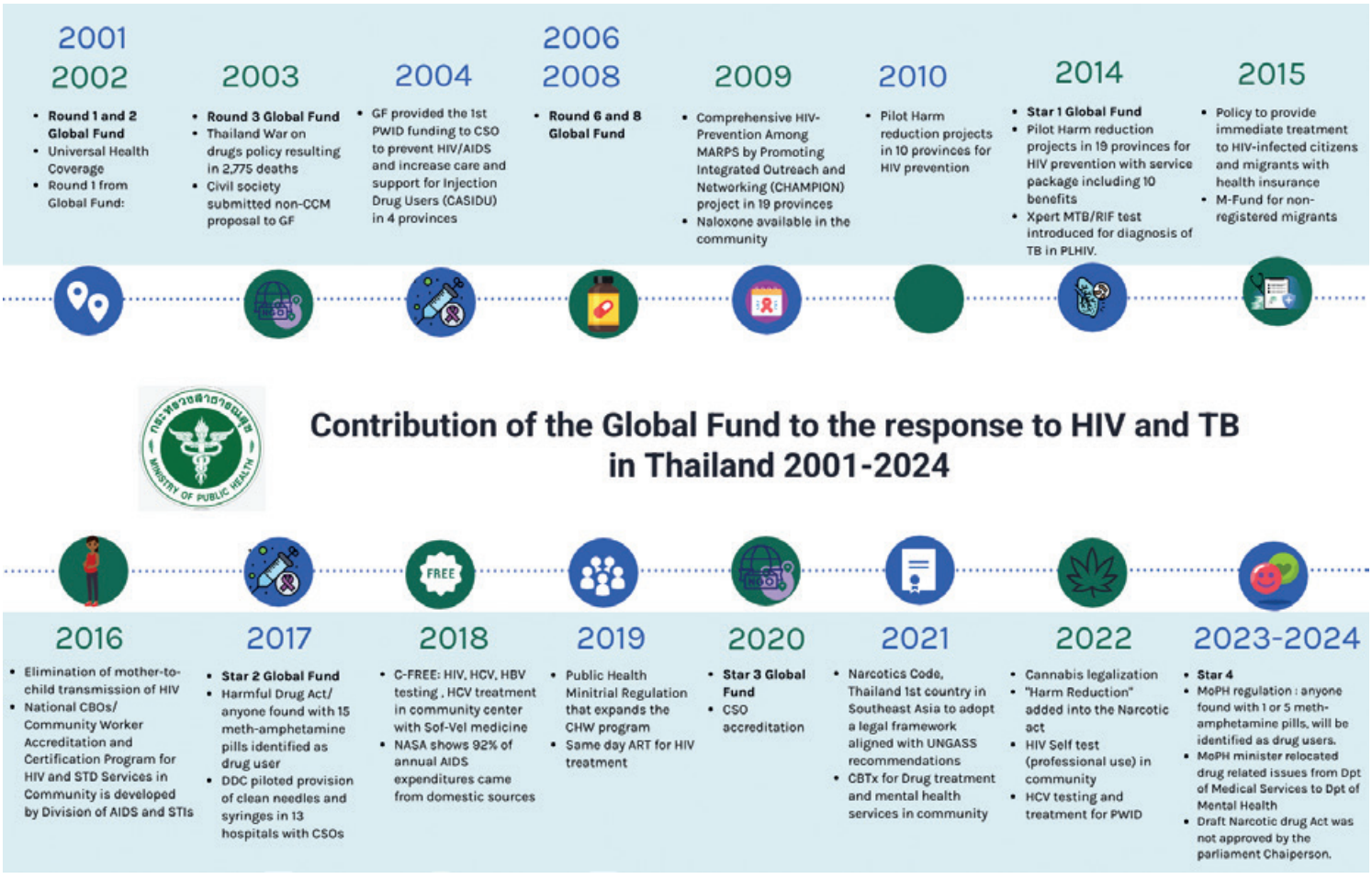
The consultants would like to warmly thank all those who shared their information, knowledge, and experience for the benefit of this study. Special thanks to Raks Thai Foundation for organizing the mission, and World Vision Foundation of Thailand for ensuring the smooth running of the visit to Mae Sot, Tak.

Record of the Global Fund's INVESTMENTS IN THAILAND

Over the past 22 years, the Global Fund has invested some 610 million US dollars in 22 grants related to HIV, TB and malaria. As for TB and HIV, the table below shows the total amount of money invested since 2003.

2003-2025

	ROUND 1	ROUND 2	ROUND 3	ROUND 8	RCC	GC5	GC6	GC7
	154 969 268	1 236 108		29 696 867	89 281 171	24 369 150	40 576 017	48 079 625
	10 266 851		15 417 365	9 022 671	24 255 588	13 096 509	20 075 452	20 116 930
TOTAL	**165 236 119**	**1 236 108**	**15 417 365**	**38 719 538**	**113 536 759**	**37 665 659**	**60 648 496**	**68 196 555**



The Global Fund's support for the fight against HIV and TB can be divided into 3 phases, which follow the epidemic dynamics in the country, adapting to the strategies implemented by the Ministry to prevent transmission and provide care for patients, and potentiating innovation and the scaling-up of cost-effective approaches:

The 1st phase started in 2003 with Round 1 investment for a total amount of 165 million dollars. This is the time of the HIV epidemic peak, during which the country was testing prevention and care models for people living with HIV. Support from the Global Fund turned out to be crucial to guarantee access to ARVs for over 500,000 infected people and to help structure the Division, train its staff, and disseminate protocols and best practices. Due to this formal response and advocacy work, the treatment package was integrated into the health insurance scheme in 2006, making treatment free of charge for hundreds of thousands of patients. Efforts were made to pilot HIV prevention and community-TB services for workplace, and migrant populations and provide clean needles and syringes to PWID (then IDUs) by CSOs.

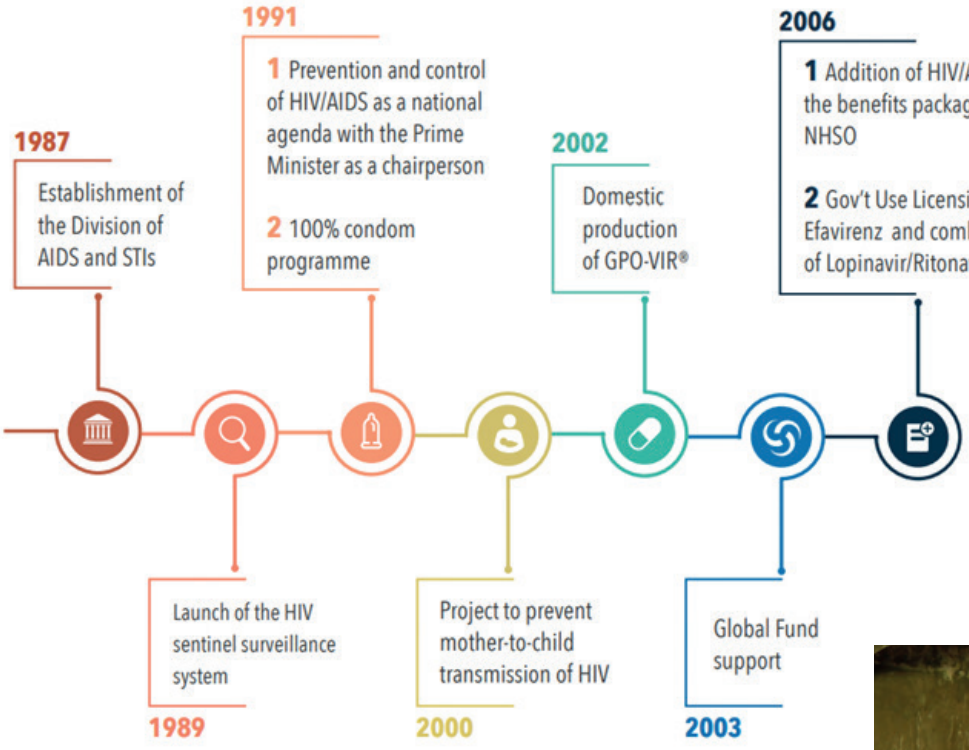


Fig 4. A short history of HIV response in Thailand, HIV Fund Management Book, NHSO, 2023.

History of HIV response in Thailand

The Division of AIDS and STIs (DAS) was established in 1987 under the Department of Disease Control (DDC) to oversee the implementation of the response to HIV at the national level. In 1989, the MOPH launched the HIV sentinel surveillance system to track the emergence and trends in HIV by screening for HIV among high-risk populations. In 1992, during the administration of Prime Minister Anand Panyarachun, the prevention and alleviation of HIV/AIDS was set as the top national priority agenda. The Prime Minister also acted as the chair of the national HIV/AIDS Prevention and Alleviation Committee. A key strategy was to focus on the sexual transmission of HIV and promote safe sex in all encounters with the potential for transmission. This strategy was embraced by the public and private sector, and Civil Society organizations (CSOs) in a united front. The 100% Condom Use Program (CUP), spearheaded by Dr. Wiwat Rojanapitayakorn and focused on commercial sex establishments, was developed in 1989. The program was initially pilot-tested in Ratchaburi Province and subsequently scaled up across the country. The program had a significant effect on slowing the spread of HIV among high-risk populations and lowering the number of sexually transmitted infections (STI) among the general population.

The HIV/AIDS prevention and alleviation budget increased steadily from 5 million baht in 1988 to a peak of two billion baht in 1996. This enormous investment of the domestic budget for HIV prevention and alleviation was concrete evidence of the government's commitment to HIV/AIDS prevention and alleviation. Then, in 2003, the Global Fund (GF) joined the effort by providing grants to Thailand for the HIV prevention effort. One of the key projects supported by the GF was National Access to ARV for People with HIV/AIDS (NAPHA) to expand access to ART for underserved populations around the country.

Source. HIV Fund Management Book, NHSO, 2023.

The 2nd phase runs from 2008 to 2014, with a total investment of $152 million. During this phase, the Global Fund supported several key trends in the healthcare system:

- Efforts have been made to decentralize promotional, preventive, and curative interventions for HIV and TB in the country. Multisectoral committees were replicated at the provincial level to coordinate the response to HIV and TB, healthcare staff were trained, and the laboratory system was strengthened to such an extent that there are now over 800 TB and HIV screening laboratories in the country. These efforts have not totally succeeded as many bottlenecks are still limiting a full access to tests and treatments for key populations.
- This decentralization has been accompanied by the introduction of innovations, notably in the field of TB screening, thanks to molecular tests carried out on GeneXpert machines, which facilitate immediate results and a simple technique requiring less technical skill than culture or X-ray reading. Thanks to this widespread use of molecular testing, the detection of new cases is increasing significantly, and interventions, particularly in prisons and factories, are being implemented.
- On the other hand, the support for the development of community intervention models with the help of NGOs, which had already been active for a decade in prevention and linkage to care.
- The transition of support for people living with HIV, who receive satisfactory care free of charge, to those most at risk, from key and vulnerable population groups, or the poorest and most discriminated against (unregistered migrant populations) whose access to services is compromised by stigmatization and lack of adaptation to needs. In particular, People Who Inject Drugs (PWID), Sex Workers, youths and undocumented migrants.

The 3rd phase, which runs from 2015 to 2024, sees Global Fund financing reduced and refocused on innovation and service provision to the most vulnerable populations. 193 million dollars were invested during this phase, including $13.8 million for laboratory systems, health information systems, health governance and financing, human resources and community systems strengthening. During this phase, the Global Fund financed major operational research projects and innovations such as:

- C-FREE, to test syphilis, HPB, HIV and treat HCV in PWID, which has changed its protocol to C-FREE-CSEA (Community HCV testing and treatment for PUD (inject and non-injection), including MSM, TGW, SW with Sof-Ravidasvir with integrated diagnose and test for HIV-HBV-TB-TPT-Syphilis, Chlamydia, Gonorrhoea, and mental health screening
- The M-Fund, private insurance for unregistered migrants
- HIV screening: HIV self-test piloted and introduced into UHC
- STI screening: new rapid tests for syphilis/other STIs
- Health information management with Business Intelligence to set up a single database for tracking TB patients in Thailand or malaria cases in the sub-region
- TB Village, where TB patients are provided with care and support to guarantee their observance of the treatment, especially for MDR-TB patients.

This is also the time to start measuring the cost-effectiveness of interventions, and to work on scenarios for the gradual withdrawal of Global Fund financing. Cost studies have been carried out on the C-FREE care model concerning the cost of care models developed by CSOs with a view to integrating them into the NHSO reimbursement scheme. The certification system began in 2016, and 42 CSOs have since been certified.

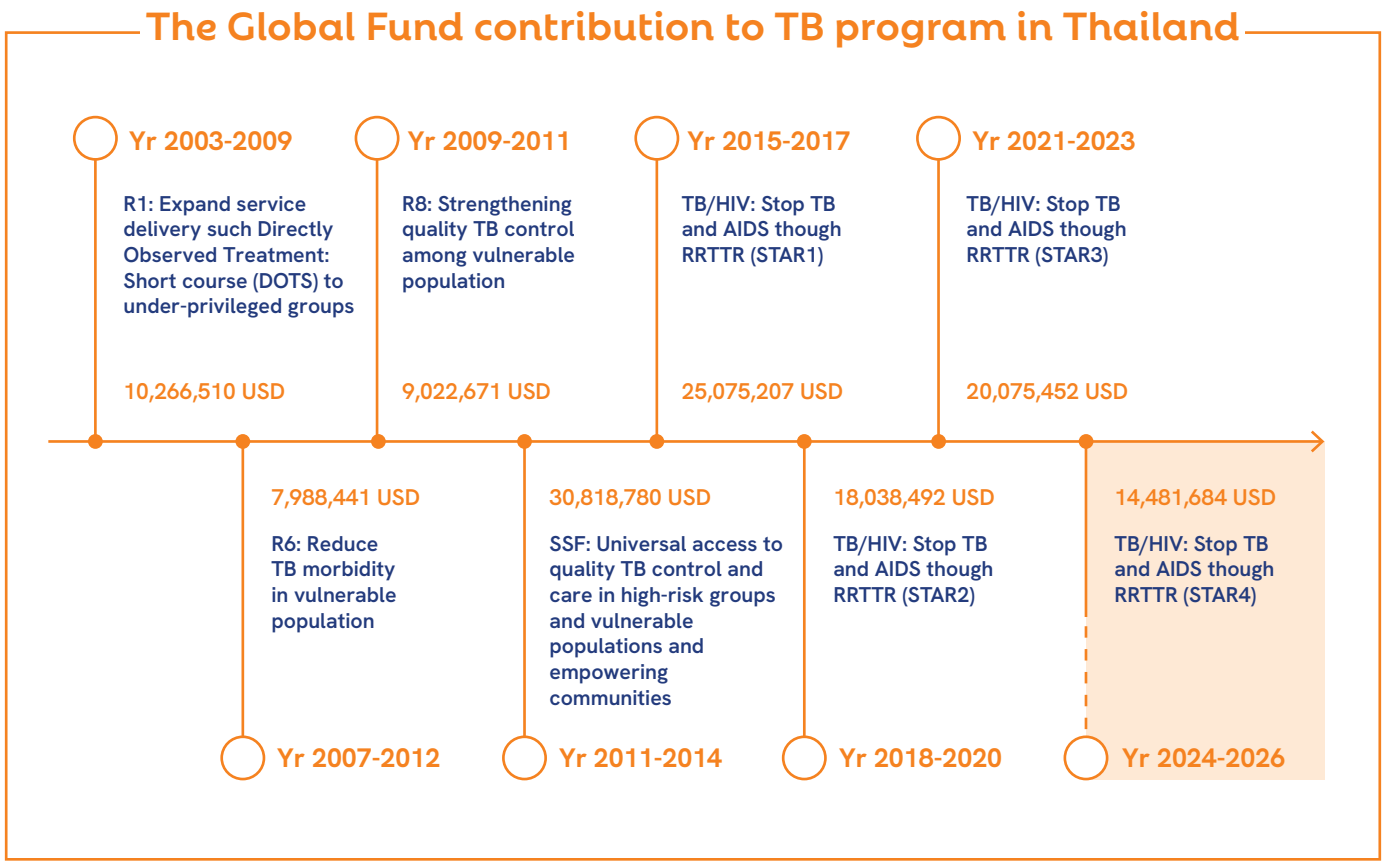


Fig.5, Source: PR-DDC, 2025

Global Fund's Engagement in Thailand

THE GLOBAL FUND

Early 2000s : scaling up of test and treatment

Support access to ART and DOT services to the Division of AIDS, TB and STIs in NAPHA project, training to Human Resources for Health (HRH) and health volunteers, production of protocols and guidelines, laboratory support, interventions in schools, workplace, detention centres and IDUs and migrants.

Round 1 : HIV, TB
Round 2 : HIV
Round 3: HIV
Round 6 : TB

HIV : 156M$
TB : 25,7M$

Round 8: HIV, TB
SSF : HIV/TB
Star 1: TB/HIV

HIV : 119M$
TB : 33,2M$

2008-2015 : decentralization and molecular test

Support to the private sector and factories to certify workplaces and regularly screen workers

Support to the laboratory sector, introduction of molecular tests and decentralisation of laboratory capacity at regional and provincial level

Support to MDR-patients (test and treat)

Development of community-based models of care

Continuation of support for services provided to migrant populations (translation of protocols and standards into many migrant languages (Burmese, Laotian and Cambodian), funding for migrant health workers), support to NGOs (in liaising with migrant communities, referrals to health services, funding for treatments TB and HIV)

2016-2024 : supporting innovations and vulnerable groups

- Tailorisation of CSO-based packages for IDUs, advocacy for an harm reduction policy
- Community-based models of care for HIV and TB with key population and migrants and linkage to hospitals
- Social contracting with CSOs, supported by the insurance scheme
- C-Free trial to test syphillis, HPB, HPB, HIV and treat HCV in IDUs
- M-Fund : private insurance for unregistered migrants
- STI screening: work on rapid tests for syphilis/other STIs
- Health information management with Business Intelligence

Star 2, 3 and 4

HIV : 133,6M$
TB : 60M$
of which :
RSSH : 13,8M$

Main contribution to the RESPONSE TO TB AND HIV according to the Health System's parties

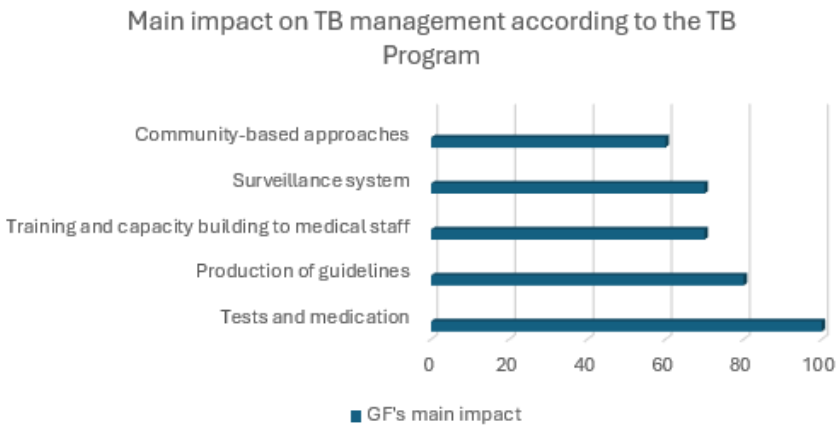


Fig 7. Perceived impact of GF's grants on TB. Source: interviews of key informants, 2025

Interviews with key informants of the TB Division show the impact they identified as the main significant changes obtained thanks to the grants. For our study, this impact can be translated as follows:

1. Medicine and technology

2. Service delivery/quality of care

3. Health workforce

4. Health Information Systems

As for the Aids Division, the perceived impact is different:

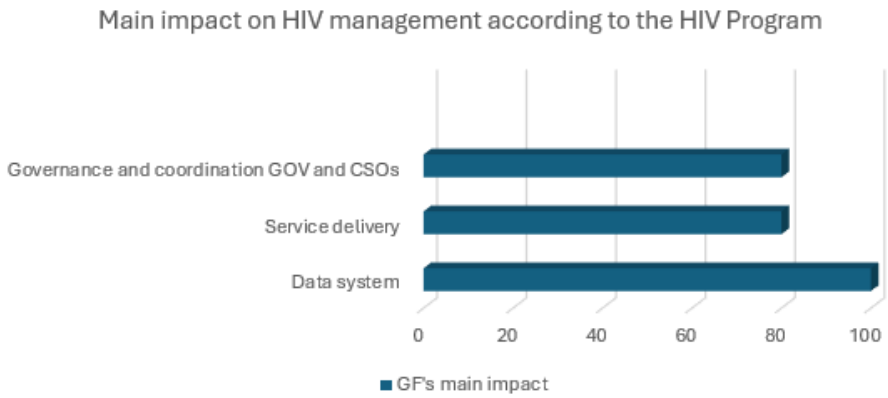


Fig 8. Perceived impact of GF's grants on HIV. Source: interviews of key informants, 2025

Main contribution to the HEALTH SYSTEM

Fig 10. WHO Building Blocks

The Global Fund has invested in the system across all pillars, as shown in the diagram above. Prior to STAR 1, funding for the system's pillars was integrated into disease component activities. However from 2014 onwards, the country presented a standalone funding request, and it is possible to trace system investments.

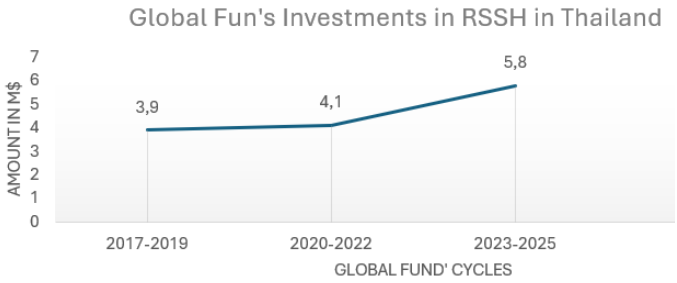


Fig 11. Global Fund's investments in HSS. Source: The Global Fund, 2024

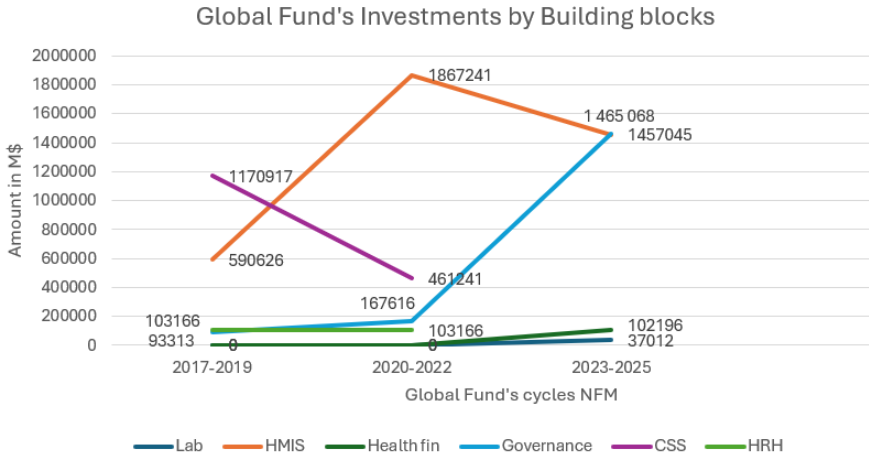


Fig 12. GF's investments by health building block. Source: The Global Fund, 2024

Most of Global Fund's investments in the health system building blocks have been either institutionalized through the system parties or linked to it. The methodology of this study questions the degree to which investments contribute to the system as a whole and attempts to provide clues as to the degree of integration into the system to ensure its sustainability. To this end, investments have been assessed from two angles:

The degree of contribution to the system, and not just to a disease component, according to 3 categories:

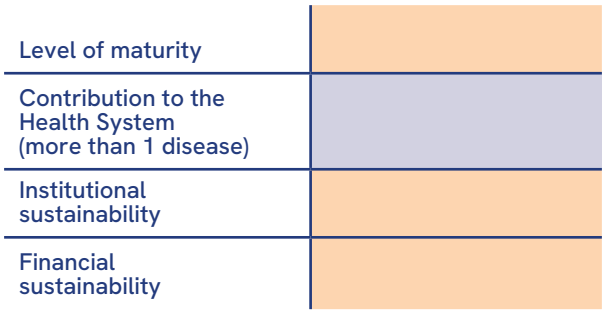
- Contribution to multi-disease outcomes beyond HTM
- Contribution to strengthen service delivery platform, including at the PHC level
- Contribution to strengthening RSSH thematic areas

The degree of integration into the system and sustainability beyond the Global Fund's intervention, measured by several criteria that form the 4S theoretical framework proposed by the Global Fund:

	System start-up	System support	System strengthening	System sustainability
SCOPE	Emergency: early development of systems	May be focused on a single disease or intervention	Activities have impact across health services and outcomes	Systems are integrated, resourced, and incorporated into health sector
LONGEVITY	Short term	Effect limited to period of funding	Effects will continue after activities end	Effects are continuing without external/extra support
APPROACH	Input all system	Provide inputs to address identified system gaps	Revise policies & institutional relationships to change behaviors & resource use to address constraints in a more sustainable manner	Systems are adjusted to adapt to changes and resources are continuous, relevant, and available domestically

Fig 13. 4S Framework to measure sustainability of RSSH Investments. Source: The GF

Governance



In the process of integration into the system, but not fully integrated nor sustainable without the external donors' support

Highest level of maturity, integration into the system and sustainable beyond the donors' funds

Governance can be defined as the design, conduct, and evaluation of collective actions from a position of authority. The aim of governance is to continuously improve the performance of the healthcare system and its component organizations and to be accountable for its success. It is based on:

- A management system (set of rules defining the distribution of power and responsibilities)
- An information system (the set of data and operating systems required to ensure that the organized system is always intelligible and transparent to professionals, managers, planners, patients, and the general public)
- A financing system (all the incentives conveyed by the system's financing arrangements, budget allocation mechanisms and payment mechanisms).

Global Fund grants have supported good governance practices in several areas:

- In paediatric HIV, grants have been structured and helped to establish coordination between the various sectors involved
- In the fight against HIV and TB, grants have helped to structure the HIV and the TB program, both at central level and at provincial level through provincial HIV-TB coordination committees
- In setting up a workplace accreditation system to prevent the transmission of TB and HIV
- In structuring relations between the public and private sectors, notably for case finding and the link to TB treatment
- For the establishment of consultation frameworks bringing together all players involved in disease control (private sector, CSOs, public health sector and other ministries) and a National-level Steering Committee with representation from the government, civil society (CSOs), the private sector and the communities of non-Thai migrants

Workplace accreditation process

Thai employees have faced HIV discrimination by compulsory HIV testing during the recruitment process by businesses and government agencies. Many PLHIV had their HIV status disclosed by healthcare providers to their potential employers, which made them lose their jobs or been denied employment. Stigma and discrimination against PLHIV prompted Thailand Business Coalition against AIDS (TBCA) as a Sub-Recipient under GF Round 1 to start establishing an accreditation process for business sectors in HIV/AIDS and, later, TB among employers and employees. TBCA worked closely with the Ministry of Labour, to identify incentives for business sectors in integrating HIV/AIDS and TB education and awareness. In 2008, Ministry of Labour, Social Security Office, Department of Disease Control, MoPH, and TBCA signed a Memorandum of Understanding on "Prevention and Management of HIV/AIDS and STI in Workplace". The objective of this MoU is to apply ASO-T (AIDS Standards Operation – TB) Thailand standards to private sectors that have undergone different levels of training for employees and employers, including anti-stigma and discrimination policies against PLHIV and those with STI and TB in the workplace. The HIV-friendly workplace policy would help to prevent and ensure treatment and care for employees with HIV, TB and STIs. The MoU signing ceremony was witnessed by representatives from ILO, UNAIDS, WHO, PR-DDC, including employer and employee councils.

Roles and responsibilities of different stakeholders for HIV & TB in the workplace.

Organisations	Roles & Responsibilities
Department of Labour Protection and Welfare, Ministry of Labour	Promote workplace to apply ASO-T Thailand standards to adopt policy on the prevention and management of HIV and TB in the workplace, support correct HIV and TB health education, and protect employees with diseases.
Social Security Office	Assure national policy on HIV and TB in the workplace according to ASO-T Thailand standards and support hospitals to treat HIV and TB according to the national programs.
Department of Disease Control, MoPH	Coordinate the national HIV strategy to collaborate and promote HIV education to employees in the workplace, build the capacity of trainers, and ensure treatment accessibility.
Thailand Business Coalition against AIDS (TBCA)	Manage and coordinate among different stakeholders on HIV and TB awareness in the workplace, provide training, review, and evaluate workplaces eligible for ASO-T Thailand.
Even though TBCA is no longer receiving funds from GFATM, the project continues by the Ministry of Labour and TBCA to provide training on HIV & TB and ASO-T Thailand has become a standard that business sectors are proud to present in their portfolio.	

Global Fund investments have also played a key role in financing national consultations and the development of HIV and TB guidelines (ART, PrEP, TPT, DQA), and have financed their dissemination via staff training. This support for programs to position them as the reference bodies for standards and benchmarks for initial and ongoing training continues to this day and is an important element in the quality of services.

Health Management Information System

The Global Fund has made the largest investments over the past 15 years in this sector. Health information management in Thailand is complex and fragmented, due to the considerable number of stakeholders involved in prevention and patient care, and the extreme decentralization of the system, which gives health facilities autonomous management of their budgets and data. 43 agencies are reporting under DDC, which runs the data issue through 2 departments: the Database Division and the Academic Division which is in charge of the analysis of epidemiological trends. Each Division (such as Aids, TB) can develop its own information system, which will be fuelled by several sources:

- Patients' information provided by hospitals and health facilities in general
- Private health facilities that manage their data system and have an obligation to report on communicable diseases
- NHSO, which uses its data for reimbursement of treatment
- Other data are collected from the hospitals and fall under the Office of the MOPH (43 files).

DDC consolidates data from 57 diseases, including the ones that are mandatory reporting. Data is analysed and reports are published but are not provided in real-time nor on a regular basis.

Over the years, GF's investments have focused on 5 priorities:

- **Development of National HIV M&E system:**
  - Support for the creation of a consolidated HIV database
  - Support for the creation of a single TB database
  - Elaboration of national M&E Plans
  - Support to national M&E system including KP size estimation, indicator description and reporting
- **Reliable data acceptable and usable among all stakeholders:** thanks to studies such as IBBS, Stigma Index, size estimation of key populations collaborating between the government, CSOs, academia with working groups and national consultations.
- **Support to data Quality Assurance** linked with Same-Day ART using national ID numbers to reduce duplication among national programs and PRs at the sub-national level. For HIV, a portal (HIV Info Hub) has been created, which provides regularly updated information in all areas: epidemiology, patient management, and health financing based on the information provided by 18 different sources.
- **Create a culture of governance, accountability, accessibility, and capacity building** among GO and CSO staff in data usage and analysis.
- **Support the data transition and ownership by DDC (from NHSO)** for better analysis and strategic planning by identifying intervention gaps from data.

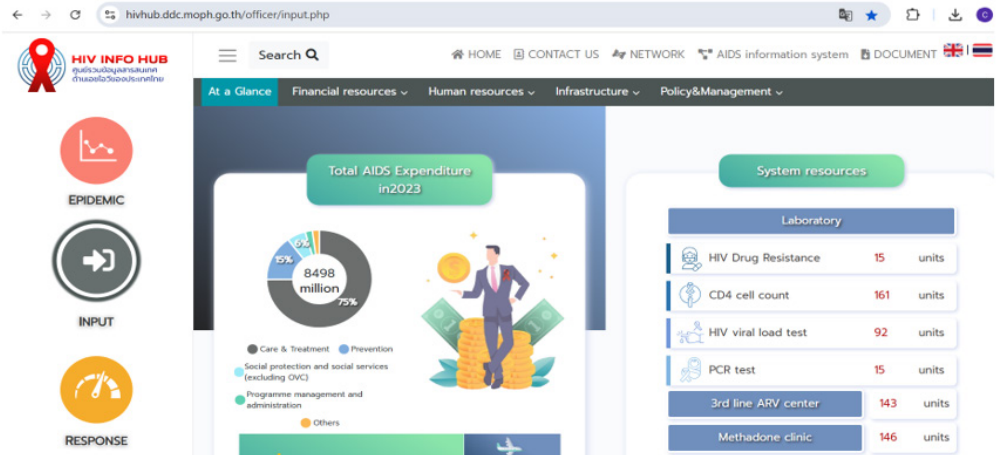
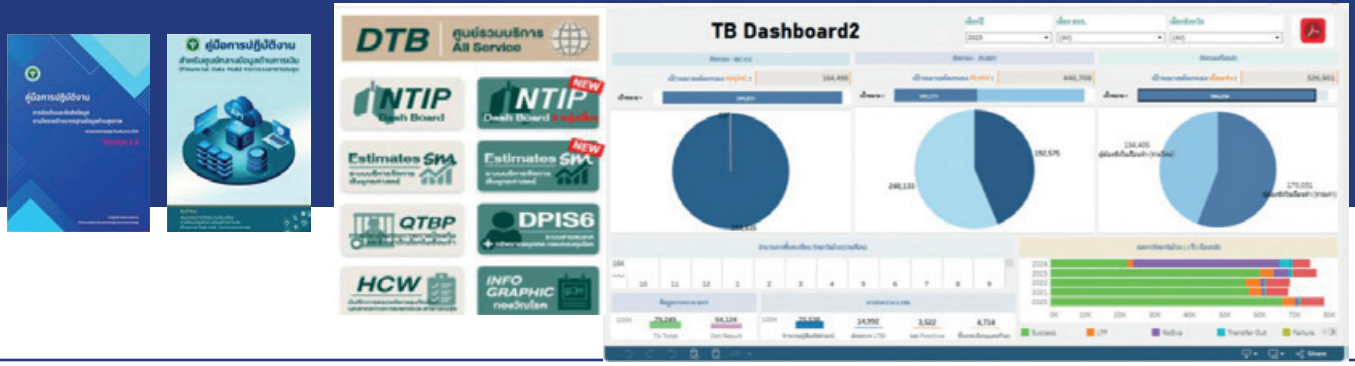


Fig 14. HIV Info Hub. Source: https://hivhub.ddc.moph.go.th/officer/input.php

Creation of NTIP, TB integrated surveillance system

Biophics, the Centre of Excellence for Biomedical and Public Health Informatics, was created in 1999 within Mahidol University. In 2008, the Unit started to work with DDC, using mobile technology to improve the surveillance system. In 2012 during Round 10, the Global Fund's investments were used to scale up the Malaria Resistance Information System that had started in 7 provinces to the national coverage. It took 2 years for Biophics to set up the electronic surveillance system, improve it (from online to offline due to connection issues), and consolidate the different data sources (coming from the malaria program and the hospitals).

In 2015, DDC asked Biophics to consolidate the TB surveillance system, whose databases were fragmented among several sources (information provided by laboratories, patient records, NHSO tracking system). It took 2 years to consolidate information from 800 TB management sites, which represented half of the clinics involved in receiving patients, who transfer out and need to continue their treatment.



Health Financing

In 2001, Thailand introduced universal health insurance, extending state-funded coverage to 18 million previously uninsured citizens - almost a quarter of the population. At the time, the country was a lower-middle-income nation, spending less than $200 per capita on healthcare. Recognition of the difficulty of delivering on the promise of universal coverage on a tight budget motivated the adoption of supply-side measures to contain costs and deliver cost-effective care. A tax-financed single-payer system with a fixed budget had been, in principle, both the incentive to contain costs and the monopsony power to limit payments to healthcare providers and pharmaceutical suppliers. The payment of mainly public providers by capitation for ambulatory care and, prospectively, at a fixed price per pathology within a global budget for hospital care, provided little incentive for healthcare providers to inflate demand or provide treatments of dubious medical efficacy. Total healthcare expenditure per capita almost doubled in real terms between 2001 and 2010, but strong economic growth kept the healthcare budget below 4% of GDP.

Indicators	Unit	Latest data	Value	Annual change	5 years ago
Gross domestic product (GDP) per capita	USD	2564	7,056.53	+1.5 %	7,091.48
Current health expenditure, % of GDP	%	2562	3.79	-0.77 %	3.78
Current health expenditure per capita	USD	2562	296.17	+6.29 %	253.48
Domestic general government health expenditure, % of current health expenditure	%	2562	71.66	+1.69 %	73
Domestic private health expenditure, % of current health expenditure	%	2562	28.23	-3.92 %	26.85
Out-of-pocket, % of current health expenditure	%	2562	8.67	-15.41 %	10.93

Fig 15. Basic Economic and Health Indicators, Source: World Development Indicators Database

Since 2006, the NHSO has continuously developed benefit packages in collaboration with MoPH, GF's PRs, the AIDS Access Foundation, Thai Network of People Living with AIDS (TNP+), and Thai Red Cross AIDS Research Centre (TRCARC), etc., to provide care for HIV/AIDS under UHC which cover all dimensions such as HIV screening test, treatment, equality in access to services, and including antiretroviral for those with drug-resistant in the benefit package.

The declaration of Compulsory Licensing (CL) by the MoPH made it possible for Thailand to manage HIV-positive and at-risk groups better through expanding antiretroviral therapy without limitations as to the immunity (CD4), antiretroviral therapy for pregnant women to prevent vertical transmission from mother to child, Voluntary Counselling and Testing (VCT) for all Thais at 2 times per year, Pre-Exposure Prophylaxis (PrEP), HIV Post-Exposure Prophylaxis (HIV PEP), screening and investigation for Hepatitis C for HIV positive individuals to receive treatment, lungs X-Ray to screen for Tuberculosis in all new patients, Reach, Recruit, Test, Treatment, Prevention, Retain (RRTTPR) service, distribution of condoms to prevent the transmission of HIV, including coordinating with organizations in hospitals to HIV positive individuals and those at high-risk, and had included HIV-Self-Test for the new benefit. Finally, UHC included tests and medications for prisoners (HepC, Syphilis, HIV), provided by Department of Correction, Ministry of Justice but medications are supported by GF.

	2022	2023	2024	2025
Treatment HIV/Aids	100 749 189 M€	97 295 499 M€	97 619 991 M€	100 651 845 M€
Prevention HIV/Aids	7 034 739 M€	16 448 105 M€	17 247 247 M€	19 705 055 M€
Budget allocated	**107 785 147 M€**	**113 792 281 M€**	**114 879 747 M€**	**120 387 501 M€**
N° of PLHIV	279 332	299 420	301 664	307 800
Target N° of HIV prevention	154 659	3 135 165	3 005 580	2 832 893
Budget utilized	**112 062 636 M€**	**108 007 469 M€**	**109 105 566 M€**	

Fig 16. UHC HIV budget, Source: NHSO, 2025

As for TB, NTP successfully introduced innovations into UHC schemes such as shorter drug regimen, GeneXpert cartridges and XDR-TB medicines, TPT – INH (9-month) regimen and TB screening for prisoners at the receiving stage.

	2017	2018	2019	2020	2021	2022	2023	2024
Treatment TB	12 425 550 M€	17 579 004 M€	17 494 946 M€	18 749 244 M€	18 749 244 M€	22 474 785 M€	12 831 481 M€	12 831 481 M€
Prevention TB							2 820 084 M€	2 863 030 M€
Budget allocated	**12 425 550 M€**	**15 579 004 M€**	**17 494 946 M€**	**18 749 244 M€**	**18 749 244 M€**	**22 474 785 M€**	**15 662 415 M€**	**15 721 M€**
N° of TB patients	83 453	115 160	114 640	78 043	350 000	1 394 000	616 000	628 300
Budget utilized for TB treatment	7 842 510 M€	5 324 770 M€	8 217 010 M€	10 306 008 M€	11 561 187 M€	7 986 430 M€	4 866 794 M€	7 011 826 M€
Budget utilized for TB prevention							5 240 497 M€	4 981 306 M€

Fig 17. UHC TB budget, Source: NHSO, 2025

The budget allocated annually for the care of TB patients is never spent, as this table shows. For 2025, the country has projected a significant increase in the number of patients put on preventive treatment, with an annual budget of 16 million euros to treat over 5 million people.

Funding of CSOs' interventions in HIV and TB

Establishment of committees at national and regional level to provide lines to remunerate the work of NGOs, which since 2017 has converted into contractualization of their services by the state through an accreditation system. This system is based on:

- long term sustainability of financing for funding HIV and TB;
- institutionalization of planning and capacity building platforms to maximize the benefits of public-sector and civil society collaboration;
- information systems enhancements to support collaborative monitoring and improvement of client-centred outcomes across service delivery points;
- and policy advocacy to remove regulatory and other barriers to more effective and efficient service delivery.

The desired outcome of these efforts will be that CSOs can become a vital part of the health system and be able to close the gap in access between health facilities and people in their communities, while allowing health insurance agencies to purchase high-quality services from them, in line with a pay for performance paradigm which is currently used by the National Health Security Office. As a result of these efforts, Thailand aims to be able to sustain all the Fast-Track services proposed in this grant application with domestic systems and financing by 2020 (NFM2).

CSO social contracting

GFATM has been providing funding to end AIDS, TB, and Malaria since 2002. Like in most countries, the key implementation partners for GFATM in Thailand have been different levels of CBOs, CSOs, and NGOs. Since GFATM funding has been supporting Thailand continuously, CSOs full implementation and administrative costs were reliant on GFATM as the main funding source. In 2014, discussions started in Thailand regarding the transition out of GFATM to ensure the country's fiscal feasibility to absorb all the costs borne by the key international donors for HIV, TB, and malaria. In 2015, the Thailand Transition plan was developed with the objectives of ensuring enough and a continuous budget for ending AIDS, TB, and elimination of malaria, not only to replace GF support and to to accelerate the continuous implementation for all people living in Thailand to end 3 diseases. GFATM provided funding for Thailand to prepare for the transition process e.g. domestic funding mobilization, identify and provide capacity building for CSOs to access funds and the introduction of innovative financing models.

In 2015 onwards, the Department of AIDS and STI (DAS), in conjunction with CCM Thailand proposed funding for CSOs to use a social contracting model between the National Health Security Office and CSOs with an initial budget of 200 million Baht to support Public Health Offices and government hospitals in the provinces without GFATM to pilot the model. The HIV cascade of RRTTPR (Reach-Recruit-Test-Treat-Prevention-Retain) was used for HIV budget request to focus on Reach and Recruit cascades implemented by Public Health Offices and the hospitals to cover GFATM key activities implemented by CSOs. After a few years of implementation, DAS recognized the challenges of hospitals and PHOs staff in conducting outreach activities, which were the strengths of CSOs. NHSO, then, faced the fiscal limitation barring them from providing direct funding to CSOs due to their lack of medical expertise as part of healthcare service nodes. CSOs, meanwhile collaborated with PRs and International HIV Research and Innovation (IHRI) and DAS to develop capacity-building modules for CSOs to become accredited healthcare service providers. DAS took over the capacity-building role of CSOs and also provided accreditation to CSOs to enable them to be registered under NHSO as one of the healthcare service providers.

Roles of CSOs under NHSO social contract were:

- **Provide** HIV outreach activities to 5 key populations: MSM, TGW, MSW, FSW and PWID, HIV education, screening and referral to government facilities for HIV test and treat
- **Recruit key populations** for HIV testing
- **Follow up key populations** for repeat testing for positive retention and negative prevention

The CSO social contracting model with NHSO is for NHSO to reimburse CSOs upon delivery of targets set out annually. This model may not have been perfected to cover all CSO implementation costs but have propelled Thailand to sustainability mode before the full transition process from GFATM. Meanwhile, human resource, operation cost commodity and capacity building for staff have been supported by international funds, the Global Fund and PEPFAR.

Service Delivery

Level of maturity		
Contribution to the Health System (more than 1 disease)		
Institutional sustainability		
Financial sustainability		

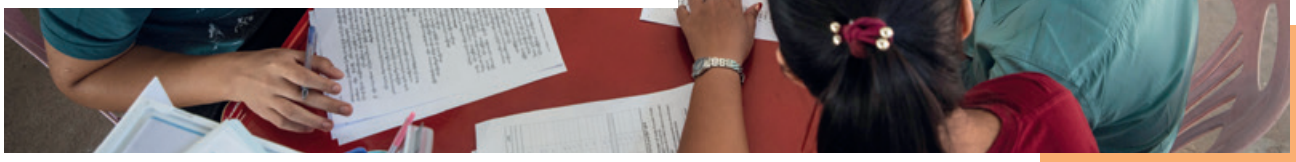
In the process of integration into the system, but not fully integrated nor sustainable without the external donors' support

Highest level of maturity, integration into the system and sustainable beyond the donors' funds

Strengthening service delivery is crucial to the achievement of the health-related Millennium Development Goals (MDGs), which include the delivery of interventions to reduce child mortality, maternal mortality and the burden of HIV/AIDS, tuberculosis and malaria. Service provision or delivery is an immediate output of the inputs into the health system, such as the health workforce, procurement and supplies, and financing. Increased input should lead to improved service delivery and enhanced access to services. Ensuring the availability of health services that meet a minimum quality standard and securing access to them are the key functions of a health system. WHO defines 8 criteria that impact delivery service and its quality:

1. **Comprehensiveness:** a comprehensive range of health services is provided, appropriate to the needs of the target population, including preventative, curative, palliative, and rehabilitative services and health promotion activities.
2. **Accessibility:** services are directly and permanently accessible with no undue barriers of cost, language, culture, or geography. Health services are close to the people, with a routine point of entry to the service network at the primary care level (not at the specialist or hospital level). Services may be provided in the home, the community, the workplace, or health facilities as appropriate.
3. **Coverage:** Service delivery is designed so that all people in a defined target population are covered, i.e. the sick and the healthy, all income groups, and all social groups.
4. **Continuity:** Service delivery is organized to provide an individual with continuity of care across the network of services, health conditions, levels of care, and over the life cycle.
5. **Quality:** Health services are of high quality, i.e. they are effective, safe, centred on the patient's needs, and given in a timely fashion.
6. **Person-centeredness:** Services are organized around the person, not the disease or the financing. Users perceive health services to be responsive and acceptable to them. There is participation from the target population in service delivery design and assessment. People are partners in their own health care.
7. **Coordination:** local area health service networks are actively coordinated, across types of providers, types of care, levels of service delivery, and for both routine and emergency preparedness. The patient's primary care provider facilitates the route through the needed services and works in collaboration with other levels and types of providers. Coordination also takes place with other sectors (e.g. social services) and partners (e.g. community organizations).
8. **Accountability and efficiency:** Health services are well managed to achieve the core elements described above with minimum wastage of resources. Managers are allocated the necessary authority to achieve planned objectives and held accountable for overall performance and results. Assessment includes appropriate mechanisms for the participation of the target population and civil society.

Global Fund's investments in service delivery are therefore analysed in the light of these 8 criteria.



Evaluation criteria	TB and HIV services	Contribution of the Grants
Comprehensiveness	TB and HIV services are still separate from the rest of the services, and don't cover certain key needs such as mental health, outreach session to KPs especially PWID and migrants, harm reduction service in community including HCV, NSP, and MMT, transportation, and nutrition. GF's grants contribute to complementing the package and making it more comprehensive.	
Accessibility	TB and HIV services are mainly hospital-based with a wide range of outreach activities led by CSOs to improve accessibility for the most vulnerable population. Services are financially and geographically accessible (community health service, KPLHS, referral and linkage KPs to health service, especially in the rural and remoted areas supported by the GF) for Thai patients and supported by GF for non-Thai patients and KP.	
Coverage	TB and HIV services cover all the regions but stay in the cities and at the health facility level (163 labs for HIV CD4 and VL, 134 hospitals, 143 methadone clinics in 13 regions). GF contributes to a wider coverage (covers 77 provinces for TB testing, covers, the IGRA centres, and TPT and MDR treatment for migrants).	
Continuity	Continuity of care is an issue in the Thai system as the health care system is mainly hospital centred. GF improves continuity in the community and over the borders thanks to CSOs' actions.	
Quality	Norms and protocols are issued, and satisfaction surveys are conducted with patients and health practitioners to evaluate the quality of services. GF's grants have contributed to the quality of TB and HIV care through the development of guidelines on innovative tests and medications and capacity building of laboratory and healthcare staff from the national level to the regional and local service centres.	
Person-centeredness	TB and HIV services are well funded and designed for urban Thai-literate patients but are not fully capable of serving other specific needs. GF's grants fund patients-centred approaches, tailor-made by CSOs' interventions (such as harm reduction for PWID and PUD), and respond directly to the needs of the most vulnerable groups such as key populations and migrants.	
Coordination	Coordination between different parties in the delivery of HIV and TB services is well settled at the hospital level. GF's grants contribute to the coordination at the provincial and regional level, and in the linkage between CSOs and hospitals (coordination with MoPH, Ministry of Interior (MOI), Ministry of Justice (MOJ) Ministry of Labour (MOL), Ministry of Social Welfare (MOSW) for policy advocacy at national level especially for PWID harm reduction and migrant (MHI Regional and local level coordination and advocate for policy implementation).	
Accountability and efficiency	The health system has its mechanisms to overview the services. GF's grants have supported surveys, program reviews, and cost-effectiveness studies may have contributed.	

GF's contribution significant for HIV and TB service delivery

GF's contribution not as significant for HIV and TB service delivery

TB service delivery at the facility level

In 2023, The Global Fund provided 76% of all international financing for TB, out of which $9.9 billion dollars were invested in programs to prevent and treat TB between 2002 to June 2024, and an additional US$1.9 billion in TB/HIV programs from 2022 to June 2024.

7.1 million people treated for TB between 2002 and 2023

121,000 people on treatment for drug-resistant TB between 2002 and 2023

353,000 TB patients living with HIV on antiretroviral therapy during TB treatment between 2002 and 2023

2 million people exposed to TB received preventive therapy between 2002 and 2023

HIV service delivery at the facility level

In 2023, expenses for HIV prevention and care rose to 7,710 billion dollars for domestic resources (84% of the total amount disbursed) and to 788 million dollars from external sources, out of which almost 50 million dollars from the Global Fund.

474,675 PLHIV currently on ART

26.619 patients receive PrEP

54.9% of patients receiving both TB treatment and ARTs

Service delivery from civil society organizations

The Global Fund was quick to support civil society organizations in their efforts to reach out to the populations furthest from healthcare. As early as 2003, NGOs submitted a funding request to the Global Fund, which was not endorsed by the CCM, as most of the activities targeted stigmatized or criminalized groups (drug users, sex workers). In 2004, the first HIV and TB prevention and care linkage project was launched by organizations such as the Raks Thai Foundation. Designed to help injecting drug users, the project was developed in 4 pilot provinces, then extended to 19 provinces in 2014. Over the years and as legislation evolved, CSOs developed tailor-made service packages for injecting drug users and key populations, as well as for undocumented migrants. Parallel advocacy was conducted with the Ministry of Health to gain recognition for the undeniable contribution of NGOs, particularly in HIV and TB case finding and in linking care with hospitals.

In 2016, the NHSO took the decision to allow contractualization with CSOs for payment of their services. Between 2017 and 2024, 42 CSOs obtained their accreditation, enabling them to obtain reimbursement for their services from the NHSO. To facilitate this operation, a special fund was set up, whose endowment has been steadily increasing since 2019, increasing from 200 million Baht in 2019 to 226 million in 2020 and 235 million Baht in 2021.

Global Fund's support to CSOs represents half of the investments since 2003 and has kept on increasing over the years, as graph 4 below shows. As a result, models of prevention, screening and treatment have been developed and adopted by the health system and NHSO. At the same time, thanks to the funding of CSO advocacy strategies, the latter have succeeded in positioning themselves as major complementary players in Thailand's highly hospital-centric system.

NHSO Special fund to support civil society and PLHIV

The CSO and network of PLHIV know where these groups congregate and understand the challenges these individuals face in seeking services related to HIV/AIDS. Accordingly, the NHSO set up a special fund to support those groups as part of the UHC benefits package and, in 2019, 200 million baht was allocated. Of this, 172 million baht was earmarked for RRTTR activities. The balance of 28 million baht was earmarked for operations of the CCCs.17 This fund of the NHSO has increased each year and, as of Fiscal Years 2020 and 2021, the amount increased to 226 million baht and 235 million baht, respectively.

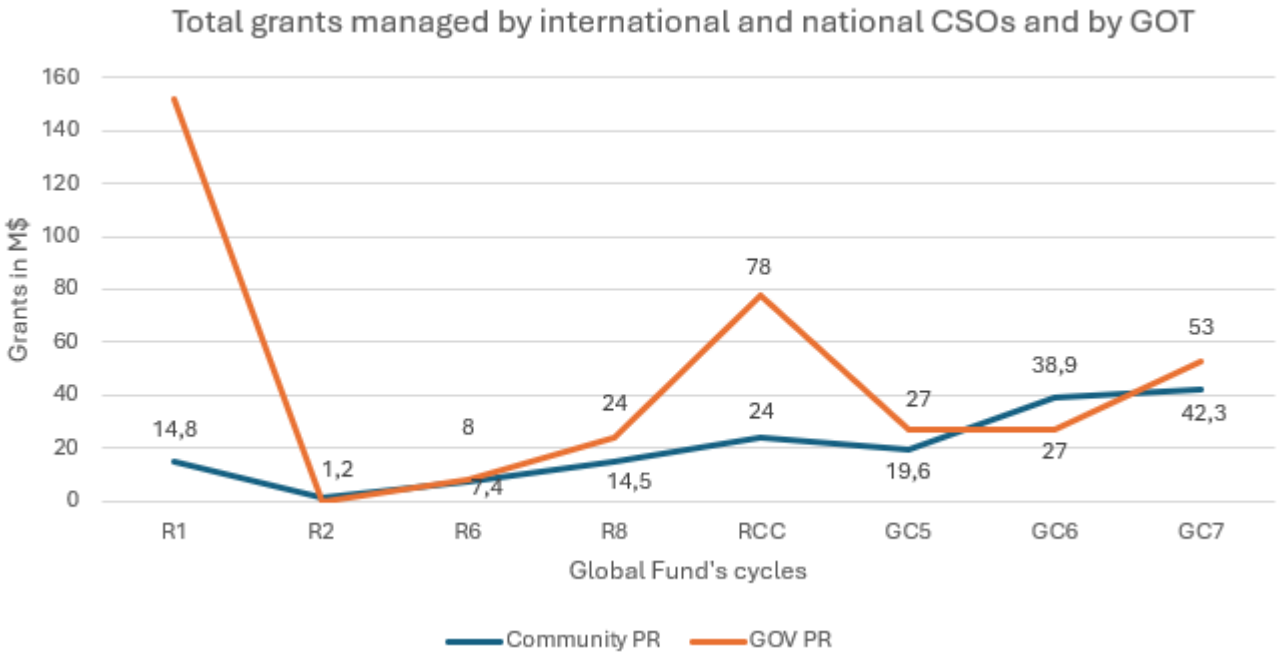


Fig 18. Source: Global Fund 2024

In the past 10 years, Raks Thai Foundation has managed a total amount of 89 million dollars, mainly dedicated to HIV services in community (prevention, testing and care), especially for PWID and migrants. They have managed an average of 50% of the grants and sub-contracted with SRs for the rest of the grant.

RTF's grant	Number of SRs and proportion managed
GC5: 19,6M$, 40% of the total budget	9 SRs from civil society, 60% of the total budget
GC6: 39M$, 46% of the total budget	20 SRs from civil society, 54% of the total budget
GC7: 30,5M$, 55% of the total budget	11 SRs from civil society, 45% of the total budget

Seven out of these SRs have received funds during the 3 cycles: Thai Drug User's Network (TDN), Dreamlopments Foundation, Sisters Foundation, Give Hope Group, People for Change Group, Rainbow Sky Association Thailand (RSAT), and MPLUS Foundation. This has enabled them to build a network of organizations capable of managing funds, planning for the long term, strengthening their human resources in quantity and quality, and becoming key partners in the health sector, recognized by HIV and TB programs and by hospital care providers.

These models of care tested by CSOs with donor funding (in particular from the Global Fund and USAID) have advanced care protocols, with the gradual inclusion of NGO actions in a package recognized by the Ministry authorized for community players:

- In 2003, CSOs started Community DOT, sputum collection, health and peer education for specific groups.
- In 2014, they participated in the development of training modules for migrant health workers and helped facilitate sessions organized by the Department of Health services.
- In 2015, they took part in the Provincial Coordinating Mechanism (PCM) between GO and CSO. The same year, Migrant Health volunteers were recognized by the Ministry of Labour as an acceptable occupation in Thailand for migrant workers.
- In 2021, they obtained the establishment of the Border Health Committee in Ranong Province.
- In 2021-2022, CSO were allowed to provide HIV supervised self-testing at KPLHS and TB testing by GeneXpert

Among the different models of care developed by CSOs, the report highlights 2 that are specific to civil society and still to be introduced into the UHC scheme:

TB management among migrants by migrants

TB management in any community requires community members' participation for successful implementation. This applied to the migrant communities in Thailand where non-Thai populations were selected and trained on TB health education, screening, and in some cases, to provide TB DOT or patient follow-ups. Initially, migrant workers or their dependents would be trained in health information. Those identified with voluntary mindsets and were able to reach different households were selected and trained by Migrant Health Workers (MHWs) employed under GF grants to provide information more suitable to the languages and contexts in the communities. For TB screening and treatment, the migrant volunteers or their family members were selected to be DOT providers to record the daily TB medication of the migrant patients. MHWs and MHVs would also conduct home visits to provide nutrition packages and psychosocial support. In many instances, they had to assist in finding new lodgings for the patients if they were asked to leave their current homes due to TB stigma. If the patients decided to return to their home countries, MHWs and MHVs would try to verify and contact patients' family members and addresses in the destination country before departure. CSO staff would contact hospitals on both sides to ensure a continuum of care and reduce patients defaulting from TB treatment.

Harm Reduction programs

Drug users have been criminalized under Thai law and programs related to drug users have focused on detoxification or institutional rehabilitation by government service providers aiming to eliminate dependency and addiction. After many years of prosecution without success and high death rates from drug control programs by the government, CSOs initiated a Harm Reduction program for PWID in Thailand during a non-CCM GF Round 3 grant. During Round 8 (2010-2014), CSOs and the PWID network advocated for policy changes to the Office of Narcotic Control Board (ONCB) to consider harm reduction programs. In 2017, the Ministry of Justice called upon all key stakeholders including ONCB, CSOs, while HRH Princess Bajrakitiyabha presided over the meeting to start the amendment of the Narcotics code. ONCB, with CSO advocacy and participation, has included harm reduction as part of the 20-year Narcotic Prevention and Control Strategic Plan but trickled down to the level of an Order of the Office Narcotic Control Board letter which was not legally binding. By 2021, the amended Narcotic Code included "harm reduction" as part of ONCB's acceptable term while the Ministry of Public Health had to define what harm reduction entailed.

With GF's support, CSOs and PWID network have focused their efforts on the following issues:

1. Active policy and legal advocacy: drug use decriminalization, PWID & PWUD health benefits package, treatment therapy, medication, community-based programs, advocating for client-centred standards and guidelines, CSOs and CHWs as health care providers under UHC.

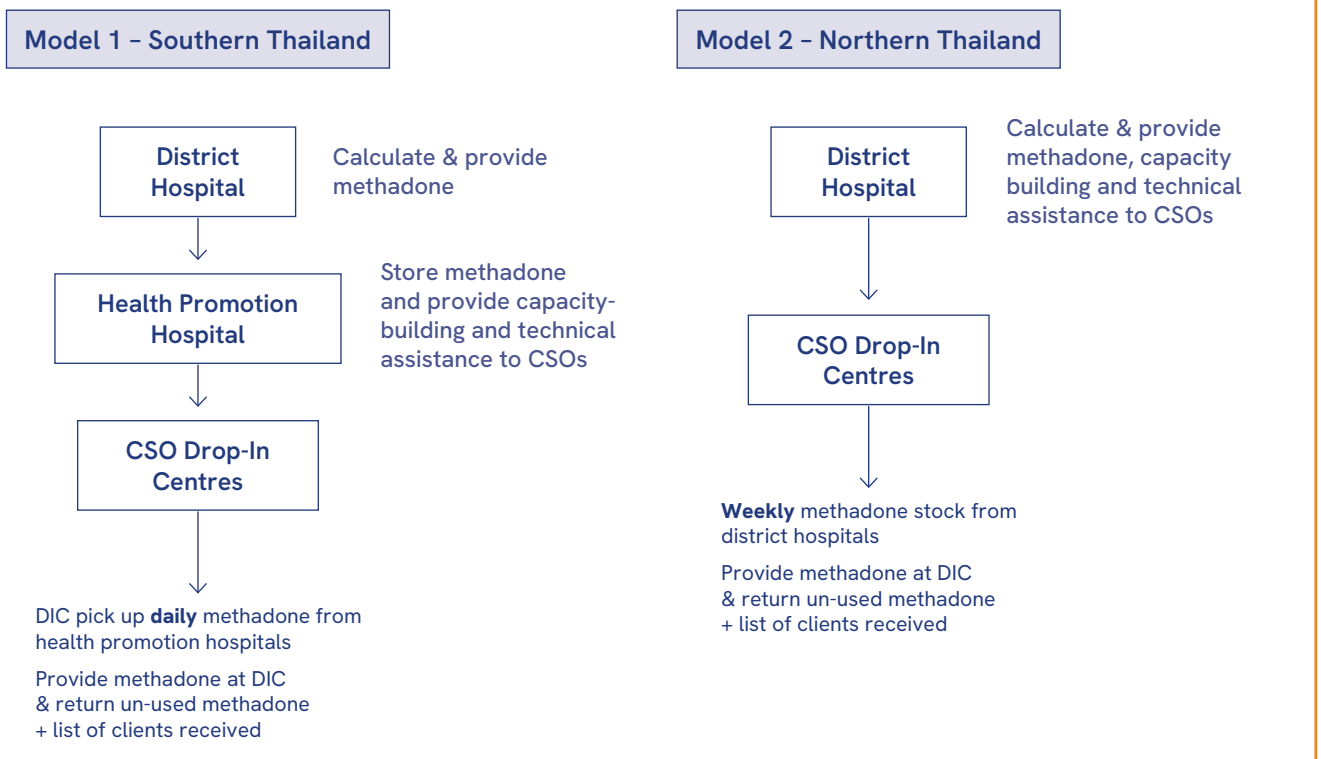
2. Initiating collaborative efforts at the local, provincial, and national levels among different stakeholders e.g. ONCB, Ministry of Interior, Ministry of Public Health, Princess Mother National Institute on Drug Abuse Treatment (PMNIDAT), hospital directors, community officers, community health volunteers, PWID, police and law enforcers, etc.

3. Piloting harm reduction programs for PWID e.g. Methadone Maintenance Therapy, Methadone take home, Drop-In Clinics, psychosocial and mental support, and C-Free clinics.

4. Identifying gaps and barriers while building staff capacity to provide measures to overcome barriers, stigma, and discrimination to ensure PWID access to health.

5. Developing guidelines for community-based harm reduction to be included in the UHC benefit package.

Roles of government and CSOs in community-based Methadone Maintenance Therapy



Roles of government and CSOs in community-based Methadone Maintenance Therapy

There are currently 21 differentiating benefit packages for PWID and PWUD who are opioid and ATS dependents consecutively:

1. Needle and Syringe program
2. Drug replacement
3. VCT
4. ARV
5. STI prevention and treatment
6. Condom distribution
7. Health education and information communication
8. Hepatitis B vaccination, screening and treatment
9. TB screening and treatment
10. Basic health care including overdosage prevention and management
11. Harm Reduction for prisoners
12. Stigma and discrimination reduction among drug users
13. Psychosocial and monetary support
14. Access to the legal and judicial system
15. Youth and Young People program
16. Education, Skills, and money management training
17. Safe consumption room
18. Services for gender-sensitive groups
19. Drug Checking
20. Distribution of smoking paraphernalia, glass pipes, mouthpieces, filters
21. Social support e.g. housing and employment

CSO client-centred Harm Reduction Service Provision is organised as follows:

Key Populations	Services provided
MSM	Chemsex, condoms, lubricants
Youth and Young People	Prevent transition from PWUD to PWID, HIV, PrEP
Women & FSW	Reproductive health, pap smear, pelvic exam, partner violence, self-esteem, female empowerment
PWID/PWUD	C-Free clinic, 21 benefit package*
All	Psychosocial support: mental health screening, reskills, employment opportunities, risk behaviour

GF impact on PWID programs has been major over the 20 years of support and has covered all the domains (advocacy service provision, legal reform):

1. Harm Reduction is embedded in the Narcotics Code
2. Methadone take-home service is included into NHSO scheme
3. Free Hepatitis C diagnosis and treatment for PWIDs
4. Gradual change of government mindset in harm reduction and collaborative efforts across line ministries
5. Social impact – police informed that there are fewer crimes committed as a result of harm reduction efforts. PWID does not need to buy drugs (free methadone), therefore, there is no need to steal. They are stabilized from using methadone hence their jobs are more secure, their income is more stable, and they can reintegrate into society and become a functional part of their families, increasing self-esteem.
6. Community members e.g. health promotion hospitals, village headmen, and village health volunteers recognize the importance of needle and syringe programs and become community-based service providers. However, local health staff should be aware of the latest developments in the Narcotics code.
7. Evidence-based models developed, and services provided by CSOs became more accepted by government hospitals.
8. ISCOM database – detailed drug usage profile including old or new cases, gender and age-disaggregated data, types of services received, drugs currently used, overdose trigger monitoring, and other holistic assistance needed.

Human Resources for Health

Level of maturity	
Contribution to the Health System (more than 1 disease)	
Institutional sustainability	
Financial sustainability	

In the process of integration into the system, but not fully integrated nor sustainable without the external donors' support

Highest level of maturity, integration into the system and sustainable beyond the donors' funds

Over the years, the Global Fund has funded trainings, recruitment of staff and support to programs, support to malaria and TB health workers, migrant community workers. There are several types of community health workers in Thailand. The investments in HR at DDC level represents 16% of the total grant awarded to PR DDC. It is worth highlighting the role of migrant health workers, who complement the community health workers. In Thailand, there are 3 types of migrant health workers:

Village Health volunteers: there are more than 1.04 million village health volunteers across the country, including 15,000 volunteers in Bangkok. Each volunteer receives 1,000 Thai baht (about US$ 32) per month and has received an extra 500-baht incentive during the COVID-19 outbreak. These volunteers have been an integral part of primary health care in Thailand during the past four decades. They undertake health surveys, collect data, maintain family health records, and do disease prevention campaigns to support the public health authorities. In times of outbreaks, their meticulous records of the medical histories of community members are used for contact tracing and health monitoring.
The volunteers have helped protect people from long-familiar diseases throughout their seasonal cycles. During the rainy season, they visit homes to empty containers of still water where dengue-bearing mosquitoes lay their eggs, kill mosquito larvae, and eliminate breeding places. During the summer, they help the rural livestock department give rabies vaccines to cattle and pets.

Health promotion volunteers: they come from the health sector (generally paramedical professions) and carry out promotion and information activities on the main health topics (eye health, nutrition, reproductive health, disability, geriatric health) in the area surrounding the district hospital, with a particular focus on communicable diseases (TB, dengue fever). They conduct follow-up visits to villages following reports of patients who have started treatment at the Health Promotion Hospital, and input data into NTIP for TB. During the COVID-19 period, they were contacted by the hospital when a case was diagnosed and visited the villages to distribute hygiene products such as hydro-alcoholic gel and masks, and to help patients comply with their quarantine.

Migrant Health Volunteers: In the 2000s, in response to the difficulty of communicating with migrant populations due to linguistic and cultural factors, it was proposed to work on the basis of peer educators. 20 years later, this system has become central to prevention and health care activities, particularly in regions hosting large numbers of migrants and refugees.

Community Health Workers are the trained CSOs staff, accredited by DAS, to provide service cascade of RRTTPR. The training is support by the Global Fund

Migrant Health Workers

Thailand, as a destination for workers in Greater Mekong Sub region, has experienced an increasing number of migrant workers and their dependents from the neighbouring countries (estimated at 4-5 million people). Access to healthcare continuously remained difficult due to legal, systematic, cultural, and language barriers. Since 2002, GF grants allowed CSOs to develop and refine HIV, TB, and malaria accessibility by identifying migrant workers and their dependents interested in becoming migrant health volunteers (MHVs). CSOs developed training materials in different languages and contents appropriate for different target groups and backgrounds. CSOs focused on contextualizing and providing them with health information and training to build capacity for HIV, TB and malaria to conduct screening, referral, and interpretation in the hospitals in highly populated migrant provinces. The coordination and interpretation services became invaluable to hospitals and the positions and budget to employ migrant language interpreters were then set up by the hospitals. The establishment of a Migrant Health Volunteer position was accepted by the Ministry of Public Health and then legalized by Ministry of Labour, easing the difficulties of MHVs during referral and travel processes.

Province	Mapping HIV			Mapping TB		
	Community	KPs	MHV	Community	KPs	MHV
Raks Thai-SKN	1,503	2,164	1,051	1,709	200,503	1,107
Raks Thai-SPK	108	139	141	225	134,847	215
Raks Thai-NPT	290	1,919	148	433	26,640	227
Raks Thai-CBI	381	1,893	188	262	23,891	207
Raks Thai-RYG	186	1,038	30	385	5,331	71
Raks Thai-TRT	154	564	2	218	241	26
Raks Thai-SNI	265	817	497	265	10,103	644
TOTAL	**2,887**	**8,534**	**2,057**	**3,497**	**401,556**	**2,497**

Fig. 19. Number and profile of community health workers funded by the GF through the community PR

This network of community players is highly effective and can be mobilized at any time. Their contribution to preventing the transmission of COVID-19 and detecting and monitoring cases is a case in point. According to one study, VHVs went to more than 14 million households during March and April 2020. VHVs also identified and monitored over 809,000 unemployed workers returning to their hometowns. By mid-July 2020, the Village Health Volunteers had referred to about 3,340 symptomatic patients to hospitals. In June 2020, as the country's initial wave of cases was subsiding, Thailand performed active laboratory-based sentinel surveillance in all 77 provinces. The surveillance focused on health workers who monitored new prison inmates, workers in high-exposure occupational groups, such as public transport and postal delivery, and other groups prioritized by the provincial communicable disease control committee.

Medicine and Technology

Level of maturity	
Contribution to the Health System (more than 1 disease)	
Institutional sustainability	
Financial sustainability	

In the process of integration into the system, but not fully integrated nor sustainable without the external donors' support

Highest level of maturity, integration into the system and sustainable beyond the donors' funds

During the 20 years of funding from the Global Fund, numerous investments have been made in the laboratory sector, in particular to provide the country with the equipment required for molecular diagnostics. Today, the country is equipped with 254 GeneXpert machines throughout the country, and carried out 237,650 TB tests in 2024, enabling the detection of 35,027 patients, including 3,612 multidrug-resistant patients.

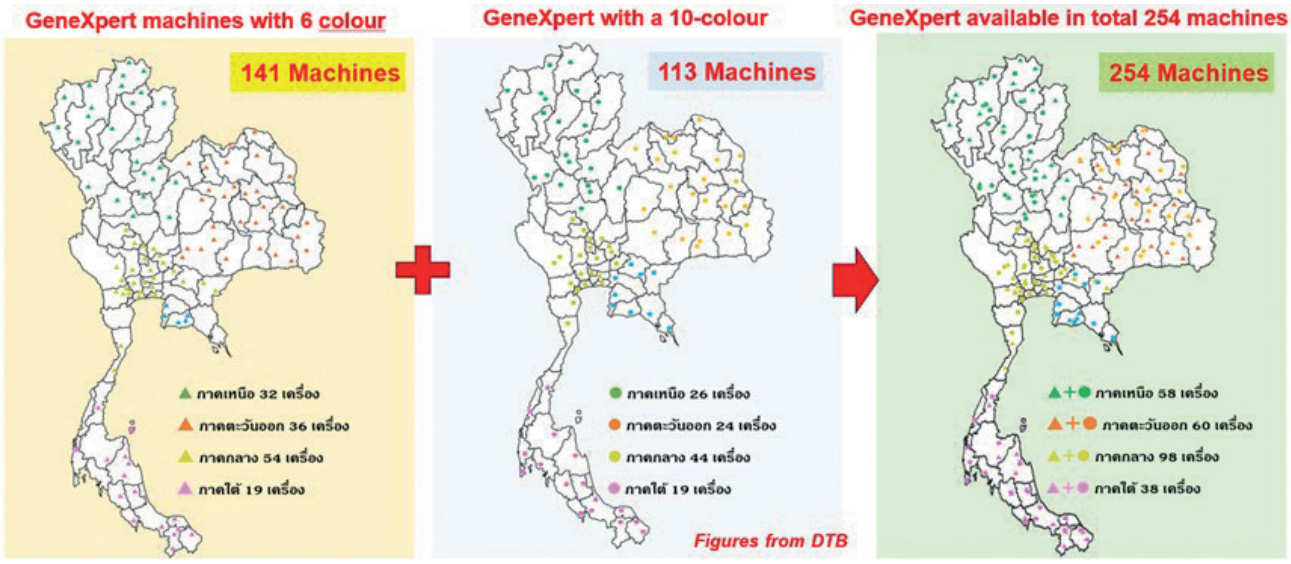


Fig.20 GeneXpert machine distribution in Thailand

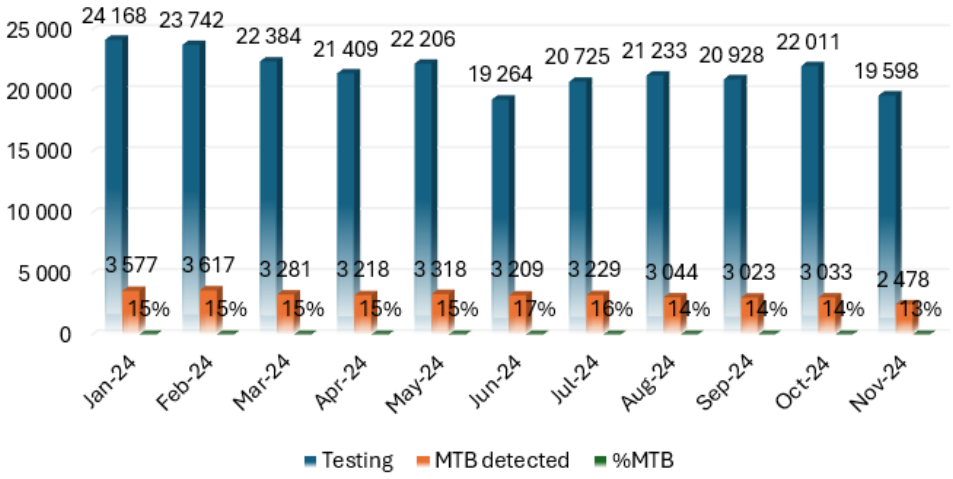


Fig 21. Number of TB tests performed in 2024 in Thailand, source: DDC 2024

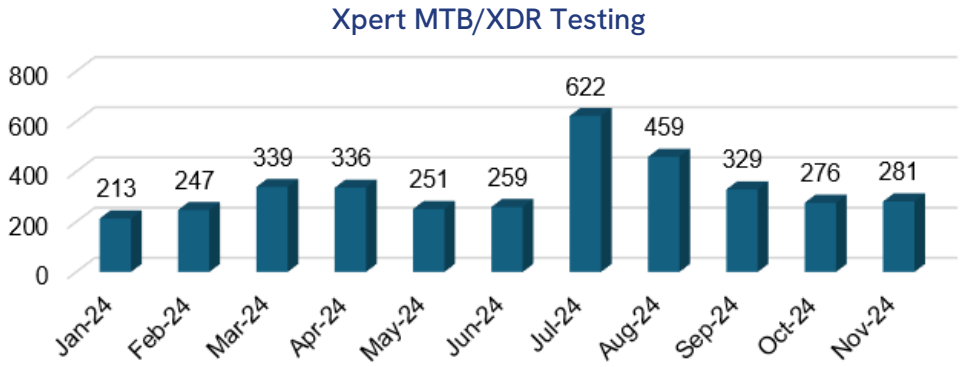


Fig 22. Number of MTB patients tested in 2024 in Thailand, source: DDC 2024

This territorial distribution has enabled Thailand to ensure good surveillance between 2020 and 2022 during COVID-19. The country's screening figures are well above those of neighbouring countries, for two main reasons: the contribution of community actors, who have played a major role in raising awareness and collecting samples, and the availability of the molecular biology equipment needed for test confirmation. Early in 2020, officials deployed some 1,000 established surveillance and rapid response teams of field epidemiologists and public health nurses to identify provinces with clusters of infection and testing.

The provision of innovative tests and medication recommended by WHO helped NTP provide clear evidence and unit cost from GF grants pilot projects. NTP successfully introduced these innovations into UHC schemes: shorter drug regimens, GeneXpert cartridges, and XDR-TB medicines. GF funding turned out to be key to implementing WHO recommendations that would have taken much longer to be implemented in case it had only relied on domestic funding.

Lessons learned from the RETROSPECTIVE ANALYSIS

The case of Thailand is interesting in many respects, and the way in which the Global Fund has supported the country over the past 20 years bears witness to a clear understanding of the issues at stake, and a cost-effective and ingenious use of Global Fund investments. At the end of this study, it appears that Global Fund grants have played or continue to play 3 main roles: filling existing gaps, promoting innovation, and positioning civil society as a key player and interlocutor on health policies.

Financing the gaps

The Global Fund began working with the country in the early 2000s, when the HIV epidemic was at its height. Despite efforts to finance the testing and care package, the Thai government was not able to provide funding commensurate with needs. The contribution of the Global Fund, as recognized by NHSO in its guide to HIV financing, has proved crucial in HIV care and prevention, particularly in mother-to-child transmission.

Today, the Global Fund continues to finance the gaps, from the purchase of reagents for GeneXpert machines to treatments for unregistered migrant populations and services for PWIDs. This is the strategy recommended by the Global Fund, and the very meaning of the new funding model, which requires national authorities to assess their needs and demonstrate the complementarity between funding already available and that requested from the Global Fund. This is the very meaning of the partnership so dear to the Global Fund. But it is also the least sustainable and riskiest investment in the transition process.

Promoting innovation to be a game-changer

Global Fund financing has made it possible to support innovative approaches in several areas:

- Programmatic innovations, i.e. new ways of carrying out activities, new models of care carried out by CSOs for example
- Technological innovations, such as the introduction of molecular tests in their day
- Innovations and advances in treatment protocols, such as that for drug users suffering from hepatitis C.

C-FREE Study

Background: Hepatitis C virus (HCV) and human immunodeficiency virus (HIV) disproportionally affect people who use and/or inject drugs (PWUD/PWID). Limited data exists on models of community-based HCV treatment among PWUD/PWID in low- and middle-income countries.

Methods: The C-Free Study in Thailand enrolled people with active or prior drug use and their partners into a prospective cohort study at community drop-in centres providing harm reduction services. Participants were screened for HIV, HCV, hepatitis B virus (HBV), syphilis, Neisseria gonorrhea (NG) and Chlamydia trachomatis (CT). Participants with HCV received a twelve-week course of sofosbuvir/velpatasvir. The primary effectiveness outcome was sustained virological response (SVR), measured 12 weeks after treatment completion; primary safety outcome was serious adverse events (SAEs).

Results: Between June 2019 and April 2023, 2,871 participants enrolled across ten sites; 1,275 (44.4%) had HCV, 846 (29.5%) had HIV, and 221 (7.7%) had HBV. Of those with HCV, 620 (48.6%) were coinfected with HIV. Of 1,134 participants who started treatment with sofosbuvir/velpatasvir, 939 (82.8%) achieved SVR in the intent-to-treat analysis. Among those who completed treatment and attended the SVR visit (n=987), the SVR rate was 95.1%. 34 SAEs occurred during treatment with sofosbuvir/velpatasvir; 6 led to treatment discontinuation, including 5 non-treatment related deaths.

Conclusion: Community-based HCV treatment of PWUD/PWID in Thailand, within harm reduction settings, is safe and highly effective. Integration of this strategy into national programs could enhance HCV elimination among PWUD/PWID.

The portfolio features many innovations that have followed the classic multi-step process: testing a new approach, measuring impact and cost-effectiveness, promoting scale-up through Global Fund financing, and then introducing it into the health insurance system. As a matter of examples:

- **M-Fund**, the mutual insurance scheme for unregistered migrants, covers around 40,000 people (unregistered migrants and stateless people) and has reached 88,000 people since 2018. The insurance entitles them to free or low-cost healthcare against payment of a monthly co-payment. Today, active in 26 provinces. M-Fund was financed by the GF and supported by the health authorities and has opened up access to healthcare for unregistered migrants. It is publicly recognized by the MOPH as complementary to the system as a healthcare coverage scheme.

- **The Tuberculosis Initiative** (**TTBI**), which is a TB detection, treatment and control program conducted by the Shoklo Malaria Research Unit (SMRU), in collaboration with the Tak Province Public Health Office (PHO), among Myanmar displaced/migrant persons and Myanmar Refugees living along the Thai Burmese border. The initiative aims to address the challenge of TB test and treat among a mobile population, hiding from traditional health facilities. The very good treatment outcomes observed in this program (91% success rate in 2022), and the cost-effectiveness of the components of the intervention have encouraged the Global Fund to take over the funding from DFID and considers opening a second site as the clinic's capacity is already saturated.

- **Development of the community-based harm reduction package:** DiC registration for harm reduction service according to the law. The service includes integrated HIV and health services, community MMT, NSP, overdose prevention, mental health services, relapse prevention. With policy and guideline advocacy, the PMNIDAD has recently published 21 service packages for harm reduction service to all drug users including opiod and ATS users.

Positioning civil society at the heart of the healthcare system

Global Fund financing has enabled the community system to be strengthened in the long term, through more than 20 years of support for civil society organizations working with the most vulnerable. Three major impacts can be identified from this long-term support:

- **NGOs are now regarded as key players in the healthcare system and recognized as such by both the Ministry and hospital providers.** There is no competition for resources or authorship of interventions, as is sometimes the case, but rather a search for complementarity and an acute awareness of the added value of each stakeholder in the prevention and care of HIV and TB patients. This is why their intervention package has gradually been enriched by activities initially reserved for subsystem providers (HIV and TB screening, community care, opioid substitution therapies). This is also why CSOs can now be certified to join the database of institutions reimbursed by the NHSO for their services. In the fight against COVID-19, community players were soon empowered to carry out awareness-raising, prevention and screening activities, particularly among migrant factory workers, and key populations such as PWIDs, who sometimes live in extremely precarious conditions.

- **Active advocacy by CSOs, supported by the Global Fund, has led to major legal and financial advances.** The Narcotic Code, which enables a harm reduction package including access to Naloxone, safe consumption room, drug checking, distribution of pipe, and OST, creates a momentum to advocate for a human-rights-based approach, respectful of patients' rights, and not as a criminal issue.

Future for CSOs after GF: the elephant in the room

Since GF's funding has been supporting Thailand continuously, CSOs full implementation and administrative costs were reliant on GFA as the main funding source. In 2014, CCM Thailand decided to transition out of GF to ensure the country's fiscal feasibility to absorb all the costs borne by the key international donors for HIV, TB, and malaria. In 2015, the Thailand Transition plan was developed with the objectives of ensuring enough and a continuous budget for ending AIDS, TB, and elimination of malaria, not only to replace GF support and to accelerate continuous implementation for all people living in Thailand to end 3 diseases. GF provided funding for Thailand to prepare for the transition process e.g. domestic funding mobilization, identify and provide capacity building for CSOs to access funds and the introduction of innovative financing models such as social contracts.

1. CSO Social Contract

In 2015 onwards, the Department of AIDS and STI (DAS), in conjunction with CCM Thailand proposed funding for CSOs to apply a social contracting model to establish contacts between the National Health Security Office and CSOs with an initial budget of 200 million Baht to support Public Health Offices and government hospitals in the provinces without GF grants to pilot the model.

HIV cascade of RRTTPR (Reach-Recruit-Test-Treat-Prevention-Retain) was used for HIV budget requests to focus on Reach and Recruit cascades implemented by Public Health Offices and the hospitals to cover GF key activities implemented by CSOs. After a few years of implementation, DAS recognized the challenges of hospitals and PHOs staff in conducting outreach activities, which were the strengths of CSOs. NHSO then faced fiscal limitations, barring them from providing direct funding to CSOs due to their lack of medical expertise as part of healthcare service nodes.

Recognizing this shortcoming, CSOs then collaborated with International HIV Research and Innovation (IHRI) and DAS to develop a standard for community-based HIV and STI service delivery as capacity-building modules for CSOs to become accredited healthcare service nodes. DAS took over the capacity-building role of CSOs (supported by GF) and provided accreditation to CSOs to enable them to be registered under NHSO as part of the healthcare service providers.

NHSO recognizes the importance of CSOs that have undergone capacity-building modules conducted by DAS. The objectives are to support CSOs to provide standardized, legal and contextualized community-based HIV and STI services based on 95-95-95 goal. The approach entails the development of a standard for community-based HIV and STI service delivery, the creation of appropriate legal mechanisms and the elaboration of CSO volunteers accreditation standards.

1.1 Levels of health service providers recognized by NHSO

There are 4 levels of service providers recognized by NHSO to provide health services and reimburse costs incurred.

- Level 1. Regular Health Service Providers
- Level 2. Primary Health Care Service Providers
- Level 3. Service delivery nodes providing specialized referral mechanism
- Level 4. Joint Care Service Providers

Once the CSO staff/volunteers have undergone CSO volunteer capacity building and are accredited, the organization could apply as "a service delivery node for specialized referral mechanism" under Article 3 of NHSO Act BE 2543.

In this level, the role of CSOs can cover:

- Reach - Provide HIV outreach activities to 5 key populations: MSM, TGW, MSW, FSW and PWID, HIV education, screening, and referral to government facilities for HIV test and treat
- Recruit key populations for HIV testing
- Provide supervised HIV self-testing or provide clients with self-test kits for home-use.
- Follow up key populations for repeat testing for positive retention and negative prevention

CSOs can also reach Level 4 health service provider Joint Care Service Providers

For many CSOs entrusted by KP communities to provide further services, e.g. ART initiation and PrEP distribution, there are high requirements to be registered as Joint Care Service Providers under NHSO. The CSOs require in-house medical, pharmaceutical and medical technology, certified by agreed Joint government hospitals and NHSO offices in the communities. This was a challenging step for CSOs to comply with due to limitations in hiring said staff with adequate and continuous funding and very high standards set out by NHSO. CSOs acting as Joint Care Service Providers would also be reimbursed for additional services such as Hepatitis C, ART treatment and PrEP services set by NHSO.

1.2 Payment upon contract

The CSO social contracting model with NHSO is for NHSO to reimburse CSOs upon delivery of targets set out annually. Monthly reimbursement for CSO implementation is upon accrued data entry into NAP system. The capitation for the new case is 1,800 Baht for MSM/TG/FSW/MSW and 4,000 Baht per PWID, which the rate is divided into:

- Reach of a new case – 800 Baht for MSM/TG/FSW/MSW and 1,800 Baht for PWID.
- Recruit to be tested - 550 Baht for MSM/TG/FSW/MSW and 1,200 Baht for PWID
- Retain negative – follow up for repeated test after 6 months - 450 Baht for MSM/TG/FSW/MSW and 1,000 Baht for PWID.

The amount of 1,800 Baht or 4,000 Baht per case may seem manageable if CSOs have a large enough annual target and all cases receive reimbursement. However, some cases may have already been identified and reported into the NAP system by other service providers and costs incurred could not be reimbursed.

Although this system is not fully adapted to the needs of CSOs, this is a step forward to propel Thailand towards sustainability mode before the full transition from GF. Thai CSOs have proven their importance as the main linkage to reaching vulnerable and hard-to-reach populations to domestic funding sources and Thai policymakers. However, this model has yet to be perfected to cover all CSO implementation and administrative costs since the reimbursement method depends on the economy of scale for CSOs to identify new cases. Further adjustment is needed to ensure the sustainability of HIV program in Thailand with CSO as the key driver in reaching and maintaining the goal in 2030.

2. Social Enterprise

Another approach for financial sustainability for CSO is to transition into a Social Enterprise (SE). Thailand Social Enterprise Promotion Act BE 2562 has been established to support groups of people or companies as social enterprises to provide products or services to benefit society by solving societal issues or developing the community, society or the environment.

The key difference between foundations and social enterprises is the variety of services or products rendered by the organization and how the income earned can be used for the betterment of society. If the foundation produces products or services to generate income, it will not be eligible to apply for a donor tax deduction incentive. Social enterprises give more flexibility to generate income and are still eligible for 2 times tax deduction incentive for donors.

Some CSOs have already applied for capacity building to transition from a foundation into a social enterprise or establish a parallel system. Sex Workers IN Group (SWING) Foundation, a CSO has requested for funding to establish a social enterprise and learn how to conduct fundraising. Financial planning and analysis will be necessary for successful implementation as a business to survive without international support. Financial staff should be trained in business planning and setting up annual and quarterly goals to be achieved. The senior leadership team should also be trained in Returns on Investment (ROI) calculation and business management aspects with a paradigm shift to business mindsets.

3. CSO Staff as Government contract staff

CSO staff are one of the most important assets and resources for public health, especially in vulnerable and hard-to-reach populations. HIV and TB program implementation requires several years for staff to understand and gain adequate experience in order to provide good quality services. Retention of human resource in any setting should be prioritized. In many countries, grants were transitioning out and the loss of high-quality CSO staff who understand community context at length was a blow to the remaining disease program. In some countries in the past, the government and CSO have worked together to identify possible channels where CSO staff could transition and become employed by the government as a contract or a permanent healthcare worker in the community. Thailand could explore venues to retain the hard-earned experiences in program management, M&E, procurement, and inventory from CSO to be within the government public health system rather than letting them go and having to identify more resources for capacity building in the future.

Recommendations for future investments and progressive phasing out

Thailand is now a middle-income country and is embarking on a process of transition. Plans for this have begun, but there are still gaps where the question of financial and operational sustainability arises, particularly in the financing of care for unregistered migrants and PWIDs. A constant effort of dialogue and advocacy is made by civil society organizations to find ways of financing these interventions through national funding, but the stakes are political and legal rather than financial. Social contractualization is excellent news, but we cannot ignore the fact that it is very demanding in terms of certification conditions, and that the amounts reimbursed to CSOs are far from covering their costs and guaranteeing their survival.

The huge investments and efforts made by Thai actors with GF support to ensure a comprehensive and accessible Harm Reduction program could rapidly be lost as:

1. Ineffective HIV and harm reduction programs such as distribution of clean needle and syringe and smoking paraphernalia are not yet supported by NHSO, not they are not yet legal in Thailand.

2. Most hospitals (about 80%) are sceptical about providing harm reduction programs and may not have the technical capacity to deliver it, should there be the political will.

3. Non-Thais such as those without ID cards, ethnic groups, migrants will no longer receive ARVs.

4. Inaccessibility of PWID/PWUD to access healthcare as they rely on CSO staff to accompany them to hospitals due to stigma and discrimination.

Financial sustainability is also critical to maintain investments in laboratory and molecular biology screening capabilities. The costs of these technologies are high and do not appear to be sustainable without external support for the time being. Legal changes are necessary to approve the purchase of equipment's and cartridges on the international market which turn out to be much cheaper.

Finally, a few low-key health crises are currently visible, such as the abnormally high incidence of STIs or the transition from injecting drugs such as heroin to other substances such as ATS or methamphetamine. The responses required are urgent and still rely in part on financing from the Global Fund.

BIBLIOGRAPHY

- Independent evaluation of the UNAIDS Joint Programme's Work with Key Populations at the country
- Level, Thailand country study: final report, 24 January 2022, EuroHealth Group
- Thailand Performance Indicators Results 2015-2023, The Global Fund
- Programmatic Monitoring, yearly published Results 2018-2022, The Global Fund
- OIG, Thematic Audit Report, Global Fund's Grants for TB/HIV to Vietnam, Thailand and Lao PDR Republic, GF-OIG-24-009, 28 May 2024, Geneva, Switzerland
- OIG, Diagnostic Review of Global Fund Grants to the Kingdom of Thailand, GF-OIG-13-010 2, 3 May 2013
- Funding Requests and budgets TB and HIV from Round 1 to GC7
- Thailand Public Revenue and Spending Assessment: Promoting an Inclusive and Sustainable Future, The World Bank Group, June 2023.
- Overview of Universal Coverage Scheme and NHSO governance, Presentation, 2023
- Governance of the Universal Coverage Scheme in Thailand, NHSO, 2023
- Thailand UHC & Overview of the Universal Coverage Scheme of the National health Security Office, NHSO, 2023
- Health Promotion & Disease Prevention (P&P), NHSO, 2021
- Management of the National Health Security Office HIV/AIDS Fund, 2021
- Fifth Joint International Monitoring Mission and Review of the National Tuberculosis Programme, Thailand, 13 27 August 2013, WHO.
- Report of the 6th Tuberculosis Joint International Monitoring Mission Thailand, 29 May to 6 June 2022, Division of Tuberculosis, DDC, Ministry of Public Health, Supported by WHO Country Office for Thailand
- Pakpoom Saengkanokkul, Le système de santé en Thaïlande et l'origine des inégalités en matière de santé : une analyse politico-économique, Economies et finances. Université Sorbonne Paris Cité, 2018
- Harm Reduction Policy Advocacy in Thailand: Opportunities for the Future, Raks Thai Foundation, December 2017
- Susanne Schardt, M.A. Patricia Kramarz, M.Sc., Assessment to improve the Harm Reduction Program in Thailand, March 2017
- Lianping Ti, Kanna Hayashi, Thomas Kerr, Improving Harm Reduction Program in Thailand: An Assessment of the STOP TB and AIDS Through RRTTR (STAR) Program, March 2017
- Dr Lincoln Choudhury, The impact of COVID-19 on harm reduction in seven Asian countries, Harm Reduction International, UK, 2020
- Interviews of different stakeholders of the Government, Civil society and UN Agencies and International Development

Thank you to all the people who have been interviewed to make the production of this report possible.

L'Initiative
Sida, tuberculose, paludisme
linitiative.expertisefrance.fr/en

Expertise France
40 boulevard de Port-Royal
75005 Paris
01 70 82 70 82

ef.linitiative
ef_linitiative
linkedin.com/company/ef-linitiative/

L'INITIATIVE
sida, tuberculose, paludisme

IMPLEMENTED BY EXPERTISE FRANCE GROUPE AFD

FUNDED AND UNDER THE SUPERVISION OF MINISTÈRE DE L'EUROPE ET DES AFFAIRES ÉTRANGÈRES
Liberté
Égalité
Fraternité

AS PART OF THE FRENCH CONTRIBUTION TO LE FONDS MONDIAL