

## After Weaning-off the Global Fund's Support-Can Thailand's HIV/AIDS Program Survive?

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### Abstract

Global Fund supported HIV/AIDS program in Thailand since 2002, largely for prevention and treatment of key populations, such as men having sex with men, sex workers, injecting drug users and undocumented migrants who cannot easily access to government health services. Global Fund resources facilitate civil society organizations deliver service to these key populations. To sustain AIDS program after weaning-off from Global Fund support, analysis found that the government is able to mobilize adequate domestic resources and sustain it, as the magnitude of funding from the Global Fund supporting Thailand was relatively small, 7-15% of total AIDS expenditure during 2008-2013. Consensus among key actors was reached to maintain the principle of participatory governance where civil society organizations involved in the whole process of resource mobilization, resource allocation and program implementation. The challenges on the bureaucratic rigidity of not able to use government budget to contract civil society organizations can be overcome by amendment of public financial management rules. Given the strong intersectoral actions and non-state actor roles, there are more enabling factors than barriers, supporting smooth transition and sustaining AIDS program and ending the diseases after weaning off from Global Fund.

**Keywords:** Global Fund's support; HIV/AIDS; Thailand; Transition

### Background

In preparing middle income countries for transitioning from global fund supports, financial sustainability is the main concern by the Global Fund. It introduces several policies including increased counterpart financing, differentiation of support [1]. Thailand, an upper middle income country with the GDP per capita of 5,816 US\$ in 2015, [2] is not eligible for the Global Fund's support. Hence, Thailand's transition plan has been prepared since 2014.

Despite the fact that Thailand can be financially self-reliance, comprehensive transitional phasing is needed to prevent program disruption from the curtailment of the Global Fund's support and ensure good governance. A successful transition needs to apply a few principles: maintain the past achievement on prevention and treatment, apply the comparative advantages of Global Fund Country Coordinating Mechanisms (CCM) where all stakeholders including the civil society organizations (CSO) are fully engaged in the governance, resource allocation and program implementation, to suit the Thai context.

After transition, the national policy goals need to sustain HIV/AIDS program in three dimensions (a) financial sustainability-by mobilizing adequate domestic funding, (b) programmatic sustainability-by effective use of resources to reach out the key populations (KP), and (c) governance-the principle of CCM in particular full engagement of non-state actors.

This commentary uses HIV/AIDS program in Thailand, as a tracer to analyse the policy discourses on the three dimensions of sustainability: financial, programmatic and governance. HIV/AIDS program has much to learn from as it consumes more resources and

has more active CSO involved in the program implementation than the other two diseases (TB and Malaria).

### Financing sustainability

Since 2002, Thailand has achieved Universal Health Coverage (UHC), which covered nearly 100% of the whole 67 million populations. Every Thai citizen is covered by one of the three public health insurance schemes; Civil Servant Medical Benefit Scheme (CSMBS) covering around 6 million civil servants and dependants, Social Health Insurance (SHI) Scheme covering around 10 million workers in private sector and Universal Coverage Scheme (UC Scheme) covering the rest of 48 million populations who are not members of the other two schemes.

During the first year of UC Scheme, the benefit packages did not include anti-retroviral therapy (ART) because of the high cost of medicines and fiscal constraints [3]. Thailand succeeded in introducing universal ART in 2003 as a result of strong national leadership, active CSO [4]; the universal ART was included in the benefit package for all three schemes in 2003. HIV/AIDS prevention, care and treatment, such as voluntary counselling and testing (VCT), diagnostic, treatment, monitoring of CD4 count and viral load, are fully covered in the benefit package by all three public health insurance schemes. Literally, there is no co-payment at point of services.

HIV/AIDS still remained the highest leading causes of DALY loss between 1990 and 2010 in Thailand [5] however, it became the sixth and seventh rank of total DALY loss in male and female in 2013 after Universal ART was introduced [6]. UNAIDS Gap Report 2016 estimated 440,000 people living with HIV in Thailand, HIV prevalence among pregnant women attending antenatal care was 0.63% and 6,900 new HIV infections a year in 2015. High HIV prevalence found in

several key population groups in particular men having sex with men (MSM), sex workers, transgender women (TW), people who inject drugs (PWID) and migrants who are mostly undocumented.

The expenditure on HIV/AIDS accounted for 1.5% of total health expenditure or US\$ 555 per capita people living with HIV/AIDS (PLWHA) in 2015. Domestic source took the majority share around

85-93% of total AIDS spending while international sources had a smaller share, around 7-15%, see Table 1. This indicates that Thailand has less reliance on donor financing for HIV/AIDS program. Of them, Global Fund was the key player, more than 70 % in the year 2008-2014 and sharply decreased to less than 50 % of small funding from international sources in the year 2015 [7].

	2008	2009	2010	2011	2012	2013	2014*	2015*
Total Health Expenditure, Billion Thai Baht	356.3	371.8	384.9	434.2	512.4	524.3	512.1	539.4
Total Health Expenditure, per capita US\$ current price	232	230	259	306	336	355	336	354
Total AIDS expenditure								
Billion Thai Baht	6.9	7.2	7.7	9.9	8.8	8.8	8.7	8.2
Domestic sources, %	85	93	85	86	90	89	85	89
International sources, %	15	7	15	14	10	11	15	11
Per capita PLWHA, US\$	390.5	407.0	488.7	675.4	628.6	636.6	605.5	555.3
AIDS expenditure, % of GDP	0.08	0.08	0.07	0.09	0.08	0.07	0.07	0.06
AIDS expenditure, % of Total Health Expenditure	1.9	1.9	2.0	2.3	1.7	1.7	1.7	1.5

Source: data in 2008-2013 from National AIDS Spending Assessment 2008-2013, Thailand, and World Development Indicators, various years while data in 2014 and 2015\* from Thai Working Group on National AIDS Spending Assessment: National AIDS Spending Assessment Report 2014-2015 [7].

**Table 1:** National AIDS spending in Thailand, 2008-2015.

A majority share of total AIDS spending, 50% in 2015, was used for ART [7] as a result of rapid expansion of ART coverage. The international funding was largely for HIV prevention [1], accounted for 29-42% of total international funding during 2008-2013. However, international partners spending had shifted to Systems Strengthening & Programme Coordination which increased from 32% in 2014 to 41% in 2015. Domestic source focused on care and treatment, which accounted for 71-87% of total domestic funding in 2008-2015 [7] through the three public health insurance systems.

Global Fund's support focuses on key areas such as prevention among key population groups, such as men having sex with men, injecting drug users, sex workers and undocumented migrants, who are not eligible for social health insurance benefits. The Global Fund funded program for KP was largely delivered by contracting CSO as they have comparative advantage than government service in reaching out these target population. Also the limitations of contracting CSO using government budget resort to the use of Global Fund resources.

Though it was agreed among all Thai key stakeholders, in several consultations, that it is the government responsibility to fully support Thai KP, unsettled debates remain on whether or not government budget should be used to support non-Thai KP and if it should, how to deliver services to these non-Thai KP targets.

The proponents in favour of using public resources to finance non-Thai KP are based on humanitarian and health security as infections from non-Thai KP can transmit to Thai population; in particular when the HIV/TB co-infections are left undetected and untreated. Arguments also support the fact that migrant workers contribute to the Thai economy both production and consumption; migrants are paying consumption tax similar to Thai citizens; they should be eligible for public resources. Also migrant labour is indispensable to fill the gap of

critical labour shortage in certain sectors in Thailand. The conservative opponents are budget officials in the Ministry of Finance and national security agencies. It should be noted that the Migrant Health Insurance managed by the Ministry of Public Health had fully covered HIV services [8], though it only cover 1.15 million (33.7%) of total 3.40 million migrant labour. Significant coverage extension is required.

During 2010-2016, the amount of Global Fund's support to HIV/AIDS program was between 13.8 and 33.8 million US\$. Of this relative small size of funding, domestic resources can fill the gaps of retrenchment of the Global Fund. The authors estimated that it would be only 0.11-0.30% of total public spending on health (Table 2) and it would be within the government annual fiscal capacity and health budget allocation. The relative low level of financial reliance on the Global Fund facilitates smooth transition to domestic resources. Despite the relative small domestic resources, challenges remain in the context of fiscal constraints due to slow GDP growths, less than 2% per annum between 2014 and 2015. Also World Bank forecasts the growth of 2.9 to 3.3% for 2016-2018 [2].

### Programmatic sustainability

During the past years, three out of four principal recipients (PR) of the Global Fund's support were non-state actors; the other one is the Disease Control Department of the Ministry of Public Health (MOPH). The majority of spending by PR who were non-state actors was for out-reaching services to key population groups, in particular prevention programs. The government services have limitation to reach these KP. The CSO who are PR or sub-PR working with the affected communities have comparative advantages in out-reaching both Thai and non-Thai KP, also the Global Fund has more flexible procurement than the government regulations.

	2010	2011	...	2015	2016
1. Global Fund's support on Thai HIV/AIDS (Million US\$)	25.9	33.8	...	14.7	13.8
2. Global Fund's support on Thai HIV/AIDS (Million Thai Baht)*	777.4	1,015.5	...	441.0	414.0
3. Public spending on health (Million Thai Baht)	285,934	335,519		415,338**	441,456***
4. Domestic resources to replace the Global Fund (% of public spending on health)	0.27%	0.30%		0.11%	0.09%

Note: \*estimated of the exchange rate at US\$ 1=30 Thai Baht  
 \*\*estimated from Total Health Expenditure 539,400 million Thai Baht (Table 1) x 77% financed by public sources [7]  
 \*\*\*estimated total health expenditure = 573,320 million Thai Baht from the growth of total health expenditure in Table 1 multiplied by 77% which was financed by public sources

**Table 2:** Global Fund's support to HIV/AIDS programs.

Preventing disruption of program activities currently managed by CSO is essential during the transition period. There is a need for amendment of rules and regulations on public financial management in order to facilitate contracting CSO who have better capacities and comparative advantages to deliver services to KP. The bureaucratic rigidity on using government budget to contract CSO should be resolved [9].

From the policy discourses in the last two years, it is clear that a "Thai Fund" should be established to address the three diseases, not only replacing GF support, but aim to end AIDS, TB and Malaria as committed in the Sustainable Development Goals. The Thai Fund will pool all sources of funding: government budget, philanthropic contributions and others, and is able to support CSO activities for the KP.

In 2014, a national policy was adopted to apply the Detect and Treat strategy, to enroll PLWHA into ART program at any level of CD4 counts; the locally innovated practical implementation concept of Reach, Recruit, Test, Treat and Retain (RRTTR) has been tested and gradually scaled up as a main strategy for ending AIDS. The RRTTR is applied to both general population and certain specific geographical targets [8]. Operation researches are in place to improve the function of RRTTR.

### Program governance

The crucial factors to move forward the transition are the strong engagement by multi-stakeholders, political commitments embraced by a good governance mechanism. From the policy discussions during last two years, policy makers, program implementers and other non-state actors appreciate and recognize the merits of CCM which has been tested for more than a decade. Consensus was reached to sustain the principle of ownership, participation and engagement by all stakeholders in the governance of AIDS program.

The CCM of the Global Fund model demonstrated clearer and better accountability framework between the funding and implementing partners, through an explicit contractual agreement and rigorous monitoring and evaluation of the performance of the implementing partners. Such good governance and accountability should be applied and replaced the current integrated model where MOPH plays two roles: funding and implementation agency where there is limited accountability [1]. The Thai UC Scheme where National Health Security Office is the financing agent which purchases

services from the public and private health care providers had demonstrated better accountability to the citizens [10].

Governance also means the involvement by all stakeholders in the whole process of resource mobilization, resources allocation, effective delivery of appropriate HIV interventions targeting KP and improvement of monitoring and evaluation. Country ownership in leveraging adequate resources and using them efficiently for fighting HIV/AIDS at the national, sub-national and local levels are essential [11]. At the end game stage of ending AIDS, comprehensive program efforts are required to foster prevention which reduces number of new infection, detect and enroll all HIV infections into ART, ensure adherence to ART and remove social stigmas. Inclusiveness of all relevant key stakeholders: healthcare providers, academia, private sectors, CSOs as well as PLWHA, would collectively achieve the ambitious goals of zero new HIV infection, zero discrimination and zero AIDS related death.

### Political commitment and context in 2016

The global recognition of Thailand as the first country in Asia to eliminate mother-to-child transmission of HIV and Syphilis in 2016 [12] reflects health systems capacities as well as the high level government commitment to address HIV/AIDS epidemics since the early 1990s, and subsequently on Universal Health Coverage in 2000s in ensuring equitable access to health services by all citizens.

The 2016 global recognition on ending vertical HIV transmission bolsters the Health Minister and the Prime Minister further commitment towards ending the three diseases [13]. In addition to political commitments, the pro-poor policy and outcomes of Thailand's Universal Health Coverage [14] and the strong health system [15] are strong foundations for meeting the challenges of ending the disease by 2030.

### Conclusion

Based on these analyses, it is likely that AIDS program would continue to maintain its momentum of the past achievement contributed by successive government as well as the Global Fund, and further bring down new HIV infection through effective prevention, early diagnosis and enrolment of more vulnerable population into the treatment program, through the application of RRTTR and the contributions by the civil society organizations. A few enabling factors for smooth transition are not too large total resource required to replace Global Fund; also UHC covers prevention and treatment in its

benefit package for the whole population, universal ART launched in 2003 and detect and treat policies in 2014. Thailand can fill up the Global Fund gaps through national pooled financing mechanism from various sources, adapting the strengths of the Global Fund CCM model of good governance and also strong collaboration with intersectoral and non-state actors in ending the diseases.

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