



# Report of Effective Contracting Model for HIV Service Delivery in Thailand

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## Effective Contracting Model for HIV Service Delivery in Thailand

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## Abbreviations

AEM:	Asian Epidemic Model
AIDS:	Acquired Immunodeficiency syndrome
ARV:	Antiretroviral
BATS:	Bureau of AIDS, TB and STIs
BMA:	Bangkok Metropolitan Administration
CBO:	Community-Based Organisation
CCM:	Country Coordinating Mechanism
CGD:	Comptroller General's Department
CSMBS:	Civil Servant Medical Benefit Scheme
CSO:	Civil Society Organization
DDC:	Department of Disease Control
FHI 360:	Family Health International 360
FSW:	Female Sex Worker
HITAP:	Health Intervention and Technology Assessment Program
HIV:	Human Immunodeficiency Virus
IDPs:	International development partners
IHPP:	International Health Policy Program
KP:	Key Population
KPLSH	Key Population-Led Health Services
MSM:	Men who have Sex with Men
MOPH:	Ministry of Public Health
MSW:	Male Sex Worker
NAC:	National AIDS Committee
NAP:	The National AIDS Program
NGO:	Non-Government Organisations
NHSO:	National Health Security Office
OST:	Opioid Substitution Therapy
PEFFAR:	The President's Emergency Plan For AIDS Relief, USA
PEP:	Post-Exposure Prophylaxis
PrEP:	Pre-Exposure Prophylaxis
PLHIV :	People Living with HIV/AIDS
PR-DDC:	Principal Recipient (of Global Fund)-Department of Disease Control
PWID:	People Who Inject drugs
RRTR:	Reach-Recruit-Test-Treat-Retain



RTCM:	Real Time Cohort Monitoring
SDG:	Sustainable Development Goal
SHI:	Social Health Insurance
SR:	Sub-Recipient (of Global Fund)
SSO:	Social Security Office
STI:	Sexually Transmitted Infection
TG:	Transgender
TNCA:	Thai NGO Coalition on AIDS
TNP+:	Thai Network of People Living with HIV/AIDS
UCS:	Universal Coverage Scheme
UIC:	Unique Identifier Code
UNAIDS:	The Joint United Nations Programme on HIV/AIDS
USAID:	The United States Agency for International Development

## Executive summary

### Background

Thailand has made outstanding progress in reversing the AIDS epidemic. To achieve the government's commitment on Sustainable Development Goal 3.3 to end AIDS by 2030, several challenges remain particularly ensuring that key populations (KPs) are the focus of interventions. Evidence has shown that civil society organisations (CSOs) are more capable of reaching out and maintaining connections with KPs than public healthcare providers. Funding support from the Global Fund for HIV/AIDS, tuberculosis and malaria (Global Fund) and other international development partners (IDPs) for addressing HIV/AIDS is gradually diminishing.

To address this, the Thai government since 2016 has allocated an annual budget of 200-million THB to the National Health Security Office (NHSO) to support public health care providers and CSOs to address HIV/AIDS. A prominent service model in Thailand's Operational Plan is based on "Reach-Recruit-Test-Treat-Retain (RRTTR)" cascades which provides continuity of services from prevention to long-term engagement with HIV care, specifically supporting the needs of KPs and their partners. However, based on limited domestic resources, what is the most effective contracting model(s) with CSOs to deliver HIV services targeting KPs?

### Objectives and methods

With World Bank and UNAIDS support, International Health Policy Program (IHPP) conducted a study from May-December 2019. It assessed the NHSO's financial management of contracting CSOs to provide HIV/AIDS services, identified enabling factors and barriers of CSO performance (e.g. case findings of new HIV positive cases, ART initiation and retention), and recommends the most effective contracting model suitable for Thailand. The study employed a mixed methods design, using qualitative methods as the dominant approach. Researchers conducted comprehensive document and scoping reviews on contracting models and carried out in-depth interviews with key stakeholders in selected sites, synchronized with a previous cost study conducted by HITAP. Stakeholders included eight domestic and international funders, twelve CSOs, four regional NHSO/Department of Disease Control managers, and six public hospital officers.

### Key findings

- The 'contracting model' covers two dimensions. **Service delivery** describes service providers and which services are contracted and provided. **Financial arrangement** describes the fund manager who issues contracts and makes payments to service providers.

- In Thailand, three HIV **service delivery models** apply the RRTTR approach: (1) A hospital-based contract with public providers; (2) CSOs providing Reach/Recruit services and public hospitals providing Test/Treat/Retain services; and (3) Key population-led health services, where CSOs provide Reach/Recruit and CSOs and hospitals jointly provide Test/Treat/Retain services.
- Two types of **financial arrangement** were identified: (1) Per capita KP payment based on RRTTR achievement, managed by the NHSO; and (2) Project-based payment based on project activities, managed by DDC and IDPs.

### **Specific financial arrangement findings**

Comparing per capita KP payment and project-based payment, key findings are as follows:

#### **Advantages of per capita KP payment by NHSO:**

- It is measurable as the number of KP individuals who received HIV services across the RRTTR cascade is counted.
- It encourages wider engagement with all sizes of CSOs across all provinces.
- The NHSO funding gives more flexibility to create or adjust activities to reach the maximum number of KPs.

#### **Disadvantages of current per capita KP payment system by NHSO:**

- Most of the contracting challenges concerned the governance and management system. Also, to date there is no systematic approach to assess capacity of CSOs in terms of technical and organization capacity before they are eligible to apply for the grant.
- Operational challenges require attention, such as slow payments to CSOs from the NHSO reduce the timeframe of the project, and a lack of effective information system results in duplicate cases of testing.
- The selection criteria for CSOs and a subsequent reporting system are unclear.
- CSO selection via competitive bidding may not be suitable for small or low burden provinces or those with limited competent and available CSOs.
- The role of the funding manager is limited, and there is no effective monitoring and evaluation (M&E) system as it is mainly on financial audit. The NHSO does not have mandate and technical capacity to carry out CSO performance audit.

- Funding functionalities are limited; NHSO funding can only be used for service provision.
- A significant number of CSOs are unable to spend all the NHSO funds within the timeframe and need to return money.
- Local CSOs are currently not inclusive to discuss about the national target for the HIV response whether or not the proposed target set at the national level is appropriate for local implementation areas.

### **Other findings**

- Some CSOs, especially the small ones, struggle with resource mobilization to support their work, apart from NHSO funding support.
- No CSOs in the study areas (either big or small) can maintain their organisations with only one source of funding.

### **Conclusions**

The NHSO budget is the largest domestic and sustainable source of funding for RRTTR activities delivered by Thai CSOs. The RRTTR approach is a key policy instrument and effective approach to achieve the commitment to end AIDS by 2030. Under present rules and regulations, payments to CSOs based on a successful RRTTR per capita KP and managed by the NHSO is both measurable and more accountable when compared with project-based payment. It holds both funding agency and contract providers accountable.

Despite facing several limitations, the NHSO has demonstrated that it supports public providers and CSOs in local communities to work synergistically and reach out to more KPs. Both public providers and CSO are indispensable partners in the path towards ending AIDS through this RRTTR approach. It is important to improve the performance of the NHSO in its vital role as a source of domestic funding to help maximize CSO contributions in combatting HIV/AIDS. The NHSO should solve operational challenges sooner rather than later.

Building CSO capacity is also important. Thailand needs greater numbers of qualified and competent CSOs to deliver work on HIV/AIDS in the longer term. Therefore, CSOs need capacity building support in both technical capacity and funding mobilization and management. This support could come through a domestic funder (DDC) and international funders (GF and USAID). Networks and alliances where larger CSOs can assist the small ones are also important.

## Recommendations

To end AIDS by 2030, the Thai government needs to ensure adequate budget for the NHSO so it can continue its crucial role of social contracting with CSOs. This will demonstrate Thailand's commitment to address HIV/AIDS, in the context of the Global Fund's curtailment of financial support in the near future.

Evidence from this study suggests that an effective social contracting model suitable for Thailand should follow these characteristics.

1. **Clearly identified national targets with the involvement of all related partners**, including DDC (or MOPH), NHSO, CSOs, and other identified partners. Consensus should be reached on:
  - a. Annual targets of KPs to be detected and treated;
  - b. Total annual budget required for RRTTR approach and the contracting of CSOs and public healthcare facilities to deliver these services;
  - c. Appropriate distribution of the budget in relation to per capita KP and geographical locations; and
  - d. Roles and responsibilities of each key stakeholder in terms of supporting effective social contracting in Thailand such as financial support, M&E, and capacity building in both technical capacity and organisational management.
2. **A clear and transparent selection process** to ensure competent and effective CSOs.
3. **Pre-assessment of CSOs' capacity** to ensure competency in providing quality service delivery and achieving targets.
4. **An effective, transparent, and timely payment system** to provide funding to CSOs.
5. **Monitoring and evaluation** of CSOs' performances **as well as capacity building** to ensure quality of works (not via the NHSO but through other organisations).
6. **Competent national contracting project manager** to ensure good governance of social contracting processes and oversight of CSOs' performances.

These key recommended characteristics as well as their proposed options for actions are summarized in Table ES 1 in the following page.

**Table ES 1:** Recommended key characteristics of an effective social contracting for Thailand

Key characteristics and options	Pros and Cons
<p><b>1. Clearly identified national targets with the involvement of all related partners, including DDC (or MOPH), NHSO, CSOs, and other identified partners to discuss and reach consensus on:</b></p> <ul style="list-style-type: none"> <li>a) Annual targets of KPs to be detected and treated;</li> <li>b) Total annual budget required for RRTTR approach and the contracting of CSOs and public healthcare facilities to deliver these services;</li> <li>c) Appropriate distribution of the budget in relation to per capita KP and geographical locations; and</li> <li>d) Roles and responsibilities of each key stakeholder in terms of supporting effective social contracting in Thailand such as financial support, M&amp;E, and capacity building in both technical capacity and organisational management.</li> </ul>	<p><b>Pro:</b> Create mutual understanding and agreement</p> <p><b>Con:</b> None</p>
<p><b>2. Clear and transparent selection process</b> in order to have competent CSOs for working.</p> <p><b>Option 1: Simplified procedure based on local context</b></p> <p>The NHSO currently applies this method by inviting all available CSOs to have a contract according to their certain capacity and readiness.</p>	<p><b>Pro:</b> Suitable for the current Thai context, particularly small/low burden provinces as it appears that there are limited numbers of local CSOs with good track records in each province.</p> <p><b>Con:</b> 1) Available CSOs, either strong or not so strong, will receive the grant to work with the NHSO; however, there is a risk of non-performing CSOs, where close monitoring is recommended.</p> <p>2) Lack of competition may lead to a lack of motivation or efforts to improve the performances of less strong CSOs.</p>

Key characteristics and options	Pros and Cons
<p><b>Option 2: Competitive bidding via an open call for proposal</b></p>	<p><b>Pro:</b> 1) Can be suitable for densely populated and high burden provinces with more numbers of competent CSOs.</p> <p>2) Creates competition - each CSO has to put more effort into writing a good proposal as well as improving its capacity and reputation in order to win the bidding.</p> <p>3) May indirectly push smaller CSOs to work together as a network (either with several small CSOs or with bigger CSOs) in order to increase their capacity and power to compete with other organisations.</p> <p><b>Con:</b> 1) Likely that only larger CSOs with higher capacity and good track records (history of good levels of performance/experiences determined by any funders) will win the bids, while small CSOs are unable to compete with them.</p> <p>2) Not suitable for provinces with specific KPs of interest, and limited number of competent CSOs working on that issue such as PWID.</p> <p>3) Seems difficult for certain small CSOs with their own unique profiles to work with or form alliances with other organisations.</p> <p>4) Some CSOs may require assistance in writing a proposal (e.g. India invites CSOs from the shortlist of potential organizations to participate in a proposal-writing workshop before contracting).</p>
<p><b>Option 3: Simplified procedure and competitive bidding via an open call for proposals</b></p>	<p><b>Pro:</b> This option can be applied to different provinces with different contexts by maintaining the strengths of Option 1 and Option 2.</p> <p><b>Con:</b> N/A</p>

Key characteristics and options	Pros and Cons
<p><b>3. Pre-assessment of CSOs' capacity</b> to ensure their competency in providing quality service delivery and achieving targets.</p> <p><b>Option 1:</b> The NHSO conducts the pre-assessment process before contracting (e.g. USAID practice could be used as an example)</p> <p><b>Option 2:</b> Establishment of an accreditation organisation for CSO registration and accreditation (only certified CSOs will be contracted by the NHSO)</p>	<p><b>Pro:</b> Having qualified CSOs available for working</p> <p><b>Con:</b> 1) The NHSO has to invest time and money to create this structure within its organisation by hiring a person or team to do this job. However, the outcome of assessment and accreditation may last for a few years before another assessment. 2) Good planning is required to prevent delayed contracting as the assessment must happen before selection process.</p> <p><b>Pro:</b> 1) Having qualified CSOs available for working. 2) The NHSO can comfortably select a qualified CSO certified by this organisation.</p> <p><b>Con:</b> 1) Need to identify the responsible organisation for initiating/processing its establishment. 2) It would take some time to have a good, trustworthy accreditation organization to register adequate number of qualified CSOs.</p>
<p><b>4. Effective, transparent, and timely payment system</b> to provide funding to CSOs.</p> <p>a) Responsible unit for payment</p> <p><b>Option 1:</b> Payments managed by regional NHSO office</p>	<p><b>Pro:</b> CSOs receive an advanced budget of 50% immediately after signing the contract with a 12-month period of working</p>



Key characteristics and options	Pros and Cons
<p><b>Option 2: Payments managed by central NHSO office</b></p>	<p><b>Con:</b> None. <b>BUT</b> there are several things that must be improved as follows:</p> <ul style="list-style-type: none"> <li>- Start the selection process and/or call for proposals three to six months in advance (which means decision making process about country targets also needs to be planned in advance)</li> <li>- Reduce paper work/documents to be sent back and forth between central and regional NHSO offices</li> <li>- Transfer 50% of budget to CSOs immediately upon signing the contract</li> </ul> <p><b>Pro:</b> CSOs receive an advanced budget of 50% immediately after signing the contract with a 12-month period of working</p> <p><b>Con:</b> 1) Need to provide a clear role and responsibility of the regional NHSO office; for example, will it still need to set up a meeting with provincial stakeholders?  2) Need establishment of an accreditation organisation for pre-assessment of CSOs (refer to the recommendation no. 5 below) as the NHSO will sign a contract with CSOs that have been certified only.  3) It would take sometimes to have a good, trustworthy accreditation organisation to register an adequate number of qualified CSOs.</p>
<p><b>b) Payment methods</b></p> <p><b>Option 1: Input-based payment</b>  (CSOs receive money to work based on line item or lump sum, but line items are much more common than lump sums.)</p>	<p><b>Pro:</b> Most commonly used - Governments are comfortable with this payment method as it is easier for them to control total amount of budget.</p> <p><b>Con:</b> 1) Does not promote more service delivery or higher quality.  2) It is fairly rigid - does not promote innovation (e.g. ways to increase positive case findings, ART initiation, and retention).</p>

Key characteristics and options	Pros and Cons
<p><b>Option 2: Output-based payment</b> (It is performance-based financing e.g. fixed price paid to a contractor for a specific service such as an HIV test or number of KPs completing the RRTR activities)</p> <p><b>Option 3: Mixed methods of payment (both input and output)</b></p>	<p><b>Pro:</b> 1) Easier to use for services that are easy to define and measure. 2) Could be used to incentivise lagging services e.g. finding HIV+ cases, putting people on ARVs, ensuring HIV viral load is suppressed.</p> <p><b>Con:</b> CSOs may focus on reimbursable activities only, which progressively narrowed the focus from working towards long-term social and political change and offering comprehensive HIV education and prevention services to performing ever-greater numbers of HIV tests.</p> <p><b>Pro:</b> More flexible - could be adjusted based on different circumstances.</p> <p><b>Con:</b> 1) Requires specific regulation and/or different types of documents and reports to ensure achievements. 2) Possibly create some confusion for NHSO officers due to different details of measurement before payment.</p>
<p><b>5. Monitoring and evaluation of CSOs' performances as well as capacity building to ensure quality of work.</b></p> <p><b>Option 1: Performance monitoring and capacity building by DDC, MOPH which has technical expertise on HIV/AIDS.</b></p> <p><b>Option 2: Performance monitoring and capacity building by DDC, MOPH and other international development partners, such as USAID (while they are still in the country).</b></p>	<p><b>Pro:</b> CSOs can improve their performance or the quality of their services</p> <p><b>Con:</b> Requires policy dialogue between all relevant stakeholders to reach consensus on different roles of stakeholders based on their comparative advantage, avoid duplication, and ensure synergies.</p> <p><b>Pro:</b> CSOs can improve their performance or quality of their services.</p> <p><b>Con:</b> Requires policy dialogue between all relevant stakeholders to reach consensus on different roles of stakeholders based on their comparative advantage, avoid duplication, and ensure synergies.</p>

Key characteristics and options	Pros and Cons
<p>6. Competent national contracting project manager to ensure good governance of social contracting processes and oversight of CSOs' performances.</p> <p><b>Option 1:</b> The NHSO recruits an experienced project manager to work specifically on social contracting.</p> <p><b>Option 2:</b> The NHSO outsources an experienced organisation that already has a competent teamwork</p>	<p><b>Pro:</b> More effective contracting processes are expected as this person does not have to work on something else and so is more focused on this.</p> <p><b>Con:</b> 1) Requires budget to hire this person, which could mean deducting from the budget to be used for social contracting, or the NHSO's central management budget could be used.</p> <p>2) Need to set up transparent process for recruitment of a competent manager.</p> <p>3) A manager cannot work alone, but needs to build a team for effective management.</p> <p><b>Pro:</b> 1) More effective contracting processes are expected.</p> <p>2) No need to waste time in building up management capacity as the outsourced agency should be ready to work.</p> <p><b>Con:</b> 1) Requires budget to outsource this person or agency, which could mean deducting from the budget to be used for social contracting; or else use the NHSO's central administrative budget.</p> <p>2) Need to set up transparent process for recruitment of a competent manager.</p>



## **CHAPTER 1 INTRODUCTION**

## Chapter 1 Introduction

### 1.1 Background

Thailand has committed to ending AIDS by 2030. To achieve this goal, it has made progress through implementing its new 2017–2030 National AIDS Strategy. This provides a road map for ending AIDS by 2030<sup>(1)</sup> and since October 2014<sup>(2)</sup> provides antiretroviral treatment to all people living with HIV (PLHIV) nationwide regardless of their CD4 level. The new strategy commits to a fast-track phase, where an all-out effort is made to reach the global 90–90–90 targets by 2020; this is where 90% of people living with HIV know their HIV status, 90% of people who know their HIV-positive status are on ART and 90% of people on treatment are virally suppressed<sup>(1)</sup>. Thailand also adopts a strategic approach, the Reach-Recruit-Test-Treat-Prevent (PrEP)-Retain (RRTTPR), as the framework to address gaps in the system between prevention and life-long treatment through these five critical service components<sup>(2)</sup>. Currently, Thailand has already achieved the first 90 target and the other two goals are expected to be met<sup>(1)</sup>.

Despite Thailand's outstanding achievements in tackling AIDS in the Asia-Pacific region, some challenges remain particularly in ensuring that key populations (KPs)<sup>(3)</sup> are the focus of health policy interventions. Community-based work to reach KPs is an important factor to ensure they can access HIV services<sup>(4)</sup>. In Thailand, service provision, including HIV services, is dominated by the public sector<sup>(5)</sup>. However, some members of KPs prefer to use private services to avoid stigmatization and for other reasons. With funding support from the Global Fund and United States Agency for International Development (USAID), civil society in Thailand continues to be the backbone for delivering community services, safeguarding treatment access, providing case management for retaining KPs in key services, providing substantive involvement in programme design and planning, and improving the policy and legal context for these groups<sup>(2)</sup>. Following Thailand's weaning of Global Fund support, there is a need to ensure both a sustainable domestic budget and management support for Civil Society Organisations (CSOs) with community involvement in health service delivery to KPs.

Acknowledging that Thailand will soon graduate from international funders' support, the National Health Security Office (NHSO) (the fund manager for Universal Coverage Scheme (UCS)), with endorsement from the National AIDS Committee (NAC) agreed to establish a prevention service category in the AIDS Care Fund. NHSO will allocate a designated budget of 200 million THB per year for providing health service interventions for men who have sex with men (MSM) and female sex workers (FSW)<sup>(2)</sup>. However, this amount of funding is still inadequate to cover other groups of KPs.

Local evidence-informed policy decision making is critical. In particular, how the public sector and CSOs should perform their roles for the best programme outcomes among KPs

is a crucial part of the ending AIDS goal. In order to ensure sustainable HIV service delivery for KPs in the long run, financing management and contracting conditions between the Ministry of Public Health (MOPH) and CSOs must be defined. This contracting model should be designed to allow CSOs to deliver services effectively and efficiently.

To address these challenges, continued engagement of CSOs and communities in the delivery of appropriate HIV interventions targeting KPs is needed. Moreover, effective contracting model(s) of services targeting KPs should also be identified to ensure that Thailand can achieve the goal of ending AIDS by 2030.

## **1.2 Research questions**

1. What contracting models are currently available for HIV services in Thailand?
2. What are the enabling factors and obstacles affecting the outputs of HIV services?
3. What is (are) the promising practice contracting model(s) for HIV services?

## **1.3 Objectives**

The overall aim of this study was to assess the NHSO's financial arrangement (public financing) in contracting CSOs; identify the enabling factors and barriers of CSOs' performances; and recommend the most effective contracting model for the Thai context. Specific objectives are as follows:

1. To understand the current situation of all available contracting models in Thailand in selected sites of HIV services
  - a. To review the profile of CSOs which provide HIV service delivery to KPs
  - b. To review the key historical public financing profile of the Department of Disease Control (50 million THB) and NHSO funding support (200 million THB) for CSO activities related to HIV service delivery to KPs
  - c. To obtain an entire picture especially on budget management of block grants and/or contracting models and others that are relevant in Thailand in selected sites
2. To analyze the legal, policy and management factors that are facilitators or obstacles for the financial management of KP-targeted HIV service delivery
3. To determine effective contracting model(s) and provide policy recommendations for possible options of effective HIV service delivery for KPs and provide recommendations on application of unit costs across RRTTPR services in the context of UHC and relevant public funding sources for CSOs in Thailand.

## **1.4 Scope of the Study**

This study focused on analysing financing management for Reach-Recruit-Test-Treat-Prevention (PrEP)-Retain (RRTTPR) services and providing policy recommendations on promising contracting model(s) for KP-targeted HIV services in Thailand.





## **CHAPTER 2** METHODS



## Chapter 2 Methods

This chapter provides details about methods used for data collection and analysis.

### 2.1 Research Design

This study applied a mixed method design consisting of qualitative and quantitative analyses. The qualitative methodology was the dominant part of this study undertaken to understand the pictures of existing HIV care models, their main funding sources for implementation especially in the selected studied sites, and facilitating factors of and barriers to HIV service delivery in relation to the contracting model used in each site. The quantitative element was limited to information on costing and cost effectiveness of HIV services from previous research, the profile of the Bureau of AIDS, TB and STIs, and the NHSO funding allocation to CSOs.

### 2.2 Research Framework

The study aimed to find effective contracting model(s) through a mix of methodologies. The data collection and synthesis were conducted by following the study framework (see Figure 1), which included both secondary data from other studies and related documents; and primary data collected in our survey and in-depth interviews. Data were analyzed and linked to possible contracting models for the Thai context. All proposed models derived from this study were presented to key concerned stakeholders during consultations to identify effective contracting model (s) for HIV service delivery in Thailand.

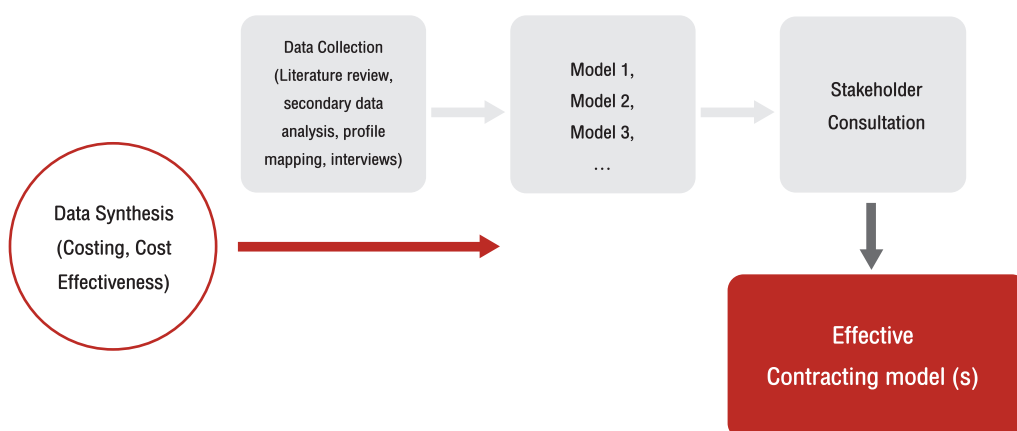


Figure 1.1: Study framework

## 2.3 Objectives and methodology crosswalk table

The three objectives were addressed by a document review, scoping review, questionnaire survey, secondary analysis and in-depth interviews. Table 1 presents a mapping of objectives and methodologies in this study.

**Table 1.1: Objectives and Methodology crosswalk table**

Objective	Methodology
To understand current situation of all available contracting models in Thailand in selected sites of HIV services	Document review, in-depth interviews, survey and secondary analysis
To identify enabling factors and obstacles of financial management in HIV service delivery for KPs	Document review, scoping review and in-depth interviews
To determine effective contracting model(s) and provide policy recommendations for possible options of effective HIV service delivery for KPs in Thailand	Stakeholder consultation and data analysis

## 2.4 Data collection

This study employed the following methods for data collection and synthesis:

### 2.4.1 Document review

This review aimed to understand existing HIV care models currently available in Thailand based on published papers in peer review journals, grey literature obtained from all relevant stakeholders as well as legal, policy and management documentation. All enabling factors and obstacles of financial management in HIV service delivery for KPs were also investigated. There were five topics for document reviews, including:

1. Current situation of HIV/AIDS in Thailand, including the implementation of strategic plan for ending HIV/AIDS
2. HIV services targeting KPs including outcomes, gaps, and challenges
  - a. KPs in Thailand and available HIV services
  - b. HIV services for KPs and key players
3. Contracting models for KPs
  - a. Existing models in Thailand

- i. Hospital-based services
  - ii. CBOs outreach/recruitment for hospitals
  - iii. Key-population-led health services, hospital collaboration
  - iv. Others
- b. Key success factors
- 4. Legal, policy and management aspects, including enabling factors and obstacles of financial management in HIV service delivery for KPs
- 5. Budget used for HIV prevention and control in Thailand.

### 2.4.2 Scoping review

This approach was used to explore HIV care models applied in different country contexts and based on international experiences; and to understand finance-related factors affecting HIV service delivery.

*Research questions for scoping review were:*

1. What are the factors affecting delivery of HIV services for key populations?
2. What contracting models are used for HIV services for key populations?
3. What are the gaps or challenges of contracting models, which are used to deliver HIV services for key populations?

*Inclusion criteria:*

1. Papers published in English language
2. Papers published since 1 January 2009 until 19 June 2019
3. Papers conducted on HIV services for KPs<sup>1</sup> relat to contracting model only
4. Full texts are available

*Exclusion criteria: Clinical research studies*

*Search strategy and terms*

There were three domains for searching documents, including HIV service, contracting model, and key populations. This was done via two international electronic databases, which were Pubmed and Web of Science. Details of search terms used in this study can be seen in Table 2.

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<sup>1</sup> Key populations (KPs) are defined as the dynamic populations in HIV transmission and an effective response to the epidemic, and include most-at-risk and vulnerable populations. Most-at-risk populations are considered as the populations affected by HIV the most. These populations include men who have sex with men (MSM), sex workers both male and female (MSW and FSW), transgender people (TG), and people who inject drugs (PWID). Beyond most-at-risk populations, vulnerable populations might be due to a vulnerable situation or context of HIV infection, such as spouses of KPs and PLHIV, migrants and prisoners.

**Table 1.2: Domains and search terms for scoping review**

Domains	Search terms
HIV service	HIV, HIV/AIDS, AIDS, HIV service, HIV services, Reach Recruit Test Treat Retain, Reach Recruit Test Treat Prevent Retain, RRTR, RRTTPR, Voluntary counselling and testing, VCT, Pre-exposure prophylaxis, PrEP, Prep HIV, Post-exposure prophylaxis, PEP, PEP HIV, condom, Sexually transmitted infections, STI, Prevention of Mother to Child Transmission, PMTCT, Antiretroviral*, ART, ARV, Outreach
Contracting model	Contracting model, Payment, Financ*, Financial model, Pay for performance, P4P, Fee-for-service, Fee for service, FFS, Capitation, Result based payment, Fee schedule, Itemize, Reimburse, Contract, Public private partnership, PPP, Claims, User fee, User charge, Governance, Civil Society Organi*ation, CSO, Non-governmental Organi*ation, Non governmental Organi*ation, NGO, Community Based Organi*ation, CBO, Faith Based Organi*ation
Key populations	Key populations, Key affected populations, People who inject drugs, PWID, Injecting drug users, IDU, Men who have sex with men, MSM, Female sex workers, FSW, Male sex workers, MSW, Transgender, LGBT, Gay, Migrant, Prisoner

As well as finding documents via the electronic databases, researchers also collected data from some important grey literature. The grey literature included in this study were:

1. Studies conducted by MOH or Bureau of Disease Control
2. International networks e.g. World Health Organization, UN agencies, FHI 360

*Data extraction:*

1. Author
2. Year of study
3. Title
4. Objective
5. Country of study
6. Study population (type of KPs)
7. Key players
8. Key success factors/obstacles in providing HIV services to KPs
9. Type of HIV contracting models
10. Gaps and challenges of different contracting models used for KPs

### **2.4.3 Questionnaire survey and secondary data analysis**

The brief questionnaire survey aimed to describe the overall profile of HIV-related CSOs working with KPs. It focused on CSOs that received funding support from the National Health Security Office (NHSO) in the last three years (2015-2018). Researchers also took into consideration related data of other public financing in relation to HIV/AIDS provided by Department of Disease Control (DDC), MOPH, and a prior study of cost analysis conducted by the Health Intervention and Technology Assessment Program (HITAP). This contributed to research synthesis, discussion, and conclusions (integrated, not done in a separate section).

### **2.4.4 In-depth interviews**

In-depth interviews with various groups of stakeholders such as policy makers, funders, providers and CSOs were undertaken in order to understand the whole process of conducting HIV service provision for KPs. This aimed to describe the legal and policy framework, and financial management that could be enabling factors and any obstacles affecting the performance of public funding mechanisms for CSO health service delivery for KPs. It helps provide an understanding of how the selection process works from beginning to end. Important information from the interviews included suggestions for improvement, exploration of other sources of public financing that could be used to support CSO activities at national and sub-national levels, and others areas such as organisation management, capacity building and system strengthening to support CSO health services. Limitations and the possible best options were also identified. Key stakeholders and frontline officers included in the study were:

1. National level - Bureau of AIDS, TB and STIs (BATS); NHSO; Social Security Offices (SSO); Central budget Bureau, Department and Unit concerning legal issues, and CSO working on KPs.

2. Sub-national levels: Regional NHSO; Regional Disease Control Offices; Provincial health offices; Local Administration units; CSOs, and KPs (if possible).

3. Frontline/implementation unit/organisations in selected studied sites, including:

- MFRIEND Udontani
- OZONE Tak (Mae Sot)
- PPAT Khon Kaen
- MREACH Khon Kaen
- RAKS THAI Samaut Prakan
- MPLUS Chiang Mai
- RSAT BKK
- SWING BKK
- SWING Chonburi (Pattaya)
- SISTERS Chonburi (Pattaya)
- RSAT Songkla (Hat Yai)

Note that the semi-structured interview guidelines of each group can be seen in Annex A. A summary of the main components for interviews with each group is detailed below.

1. Funder
  - General information on organisation of HIV activities
  - Source of budget
  - Budget transfer and disbursement policy
  - Budget allocation and contract with CSOs
  - M&E process
2. Provider
  - General information on organisation of HIV activities
  - HIV/AIDS services provision
  - Budget management and engagement with CSOs
3. CSOs
  - General information on organisation of HIV activities
  - HIV/AIDS services provision
  - Sources of funding and types of contracting
  - Challenges and limitations of each type of contracting
4. Other relevant stakeholders at a regional level e.g. Regional NHSO/DDC managers
  - General information on organisation of HIV activities
  - Budget management and engagement with CSOs
  - M&E process

#### **2.4.5 Stakeholder consultative meeting**

After the main information was collected and analyzed, the results were presented to key stakeholders in order to brainstorm and determine appropriate HIV service delivery and future directions of contracting models to be used in Thailand. In collaboration with FHI 360, promising models from some selected countries based on FHI 360 experiences were also used for discussion to help determine the most suitable model for Thailand.

##### *List of key stakeholders*

1. Bureau of AIDS, TB and STIs (BATS)
2. The representatives from health insurance schemes: NHSO; Social Security Offices (SSO); Central budget Bureau
3. CSOs working with KPs
4. The World Bank
5. UNAIDS
6. FHI 360
7. HITAP
8. Others

## **2.5 Data analysis**

Descriptive analysis, such as frequency, mean, and percentage, was used for analysing the quantitative information, while thematic analysis was used for the qualitative information. All data information was analysed side-by-side and synthesised in order to suggest possible contracting mechanisms, including suggestions of HIV contracting model(s) for KPs services appropriate for the Thai context, and recommendations for improving HIV contracting model(s) in Thailand.

## **2.6 Ethical considerations**

The project was submitted to and approved by the Institute for the Development of Human Research Protection (IHRP) in Thailand before carrying out the data collection (Date of the ethical approval: 22 Aug 2019).



## **CHAPTER 3** DOCUMENT REVIEW



## Chapter 3 Document review

This chapter provides the results of the document review, which focused only on issues related to HIV service delivery in Thailand through RRTTR cascades, including the general situation of HIV/AIDS in Thailand, HIV services provided to KPs, HIV financing, and law and regulations in relation to HIV contracting models.

### 3.1 Situation of HIV/AIDS in Thailand

HIV/AIDS has been recognized as a major public health issue globally due to its impact on population health, social and economic development. Several attempts to combat HIV/AIDS have been made through international agreements, including the Sustainable Development Goals (SDGs) in September 2015<sup>(6)</sup> and the Political Declaration on HIV 2016 in June, 2016<sup>(7)</sup> by the United Nations General Assembly. In 2018, it was estimated there were 37.9 million people living with HIV around the world; however, new infection numbers in 2018 were about 1.7 million, and HIV-related deaths were 770,000 people<sup>(8)</sup>. In Thailand, in 2017, there were 439,610 known cases of HIV. Among these, it was found that 5,529 were newly infected cases, and 14,731 people had died from HIV-related causes<sup>(9)</sup>.

Thailand has over 30 years of experience in facing the HIV epidemic. Despite a better HIV/AIDS situation than before, it remains a prioritized public health issue in the country. Therefore, Thailand has implemented several policies and strategies to end AIDS by 2030. The Thailand National AIDS Strategy (2014-2016) mainly focused on dealing with groups at high risk of new infections<sup>(10)</sup>. Later, the Operational Plan for Accelerating Ending AIDS (2015-2019) was launched with more focus on providing comprehensive and effective services to KPs who were at higher risk or to vulnerable groups generally<sup>(11)</sup>. The National Strategy to end AIDS 2017-2030 also set three main goals to tackle HIV/AIDS including: (1) decreasing the numbers of new infections to fewer than 1,000 cases per year; (2) decreasing HIV/AIDS-related deaths to fewer than 1,000 cases per year; and (3) decreasing the level of discrimination due to HIV/AIDS to be 90%<sup>(12)</sup>. The National Strategy also aligns with the 20-year National Strategy framework of the National Development Plan (2017-2036)<sup>(12)</sup>.

### 3.2 HIV services provided to Key Populations in Thailand

#### 3.2.1 Key populations in Thailand

Key populations are defined as dynamic populations in HIV transmission and effective response to the epidemic, and include most-at-risk and vulnerable populations. There are five key populations, including men who have sex with men (MSM), transgender people (TG),

people who inject drugs (PWID), sex workers (both male and female), and people in closed settings including prisons. In parallel to KPs, vulnerable populations are groups of people who are in situations or contexts that lead them to be vulnerable to HIV infection, including migrants and mobile workers<sup>(13)</sup>. KPs and their partners are particularly vulnerable to the dynamics of HIV transmission<sup>(14)</sup>.

The most common route of infection among KPs is through unprotected or unsafe sex (~90%). Moreover, sexual risk-taking is different among transgender subgroups; for example, a transgender person who has sex with both men and women may have higher risk than a transgender person who has sex with women only<sup>(15)</sup>. The PWID population is potentially at risk of HIV infection due to using unsafe drug injection methods or blood-contaminated injection equipment. Among prisoners, the HIV burden may be up to 50 times higher than in the general population because they live in an overcrowded place, and there is a lack of HIV prevention and harm reduction programmes, which increases vulnerability to HIV infection<sup>(16)</sup>. Among non-Thai migrants, there are various barriers, such as language difference, financial barriers and frequent migration journey, resulting in poor access to HIV/AIDS information and services<sup>(17)</sup>.

Despite the decline of new HIV infections in Thailand, the number of infected cases remains high among KPs. In 2017, there were 439,610 PLHIV<sup>(9)</sup> and it was estimated that three-quarters of new infections are MSM, TG, and MSW (40%) and sero-discordant spouses (45%)<sup>(18)</sup>. In general, the most prevailing mode of transmission among new HIV infections is spousal (31.3%), followed by casual sex (13.3%)<sup>(18)</sup>.

### **3.2.2 HIV services provided to KPs**

As laid out in the 2015-2019 Operational Plan for Accelerating Ending AIDS, ending AIDS by 2030 requires a specific approach working with specific groups. Targeting higher-risk populations and ensuring an effective innovative system will increase the likelihood of success. Therefore, the new direction of the Thailand Operational Plan is based on 'Reach-Recruit-Test-Treat-Retain (RRTTR)' cascades, and aims to fill the gaps in the prevention and treatment processes that prioritize KPs and their partners<sup>(11)</sup>. This service package will be tailored according to the needs of each KP as well as the local context.

#### **a. Reaching**

Reaching KPs, including MSM, TG, MSW, FSW, and PWID, means providing comprehensive packages of HIV prevention services, and increasing awareness of behaviours and demands

to know HIV status. This indicator is measured by the number of key populations having access to preventive services through the following approaches;

1. Outreach workers or peer networks
  - a. Information on HIV and STI prevention and harm reduction from using drugs for PWID
  - b. Health hardware including condoms, lubricants and needles or syringes
  - c. Information on health facilities availability to receive the services
  - d. Registration with membership number
2. Social media
  - a. Information on HIV and STI prevention and harm reduction from using drugs for PWID
  - b. Information on health facilities availability to receive the services
  - c. Registration with membership number
3. Self-access or through appointments at health facilities or mobile services
  - a. Information on HIV and STI prevention and harm reduction from using drugs for PWID
  - b. Health hardware including condoms, lubricants and needles or syringes
  - c. Information on health facilities availability to receive the services

## **b. Recruiting**

Recruitment of KPs into essential services including prevention, pre-HIV test counselling, STIs services or opioid substitution therapy (OST) through government and private providers in order to increase awareness and recruitment of target populations. This indicator measures the progress of the number of KPs being recruited for HIV or STI services through the following methods:

1. Referrals to outreach workers, peer networks, drug stores, or through social media to health facilities, Drop-in Centres or mobile services
2. Self-access and appointments at health facilities, Drop-in Centres or mobile services

## **c. Testing**

A test approach focuses on early diagnosis, regular testing, and same-day-result HIV testing to improve patient convenience. In addition to increasing HIV testing coverage, service packages are expanded to be available at health facilities, mobile sites, and CBOs. These efforts aim to increase the numbers of KPs who receive the HIV test and know the result in order to have an early diagnosis and referral for treatment. This indicator is counted for those who received an HIV test and knew the result at the following services:

1. Government health facilities, including
  - a. Regional hospitals, general hospitals or community hospitals under the MOPH
  - b. University hospitals or big government hospitals under other ministries and the Bangkok Metropolitan Administration (BMA)
  - c. Sub-district health promoting hospitals or BMA health service centres
2. Private healthcare facilities including hospitals and clinics (including those managed by NGOs)
3. Civil society services units, such as Drop-in Centres
4. Mobile services organized by government, private or civil society organisations.

#### **d. Treating**

The treatment approach among KPs focuses on early initiation of ART at any CD4 levels in order to have those who have higher CD4 to entry into care as soonest. This indicator measures the number of KPs who initiated ARV treatment and enrolled at following service sites:

1. Government health facilities, including:
  - a. Regional hospitals or general hospitals or community hospitals under the MOPH
  - b. University hospitals or big government hospitals under other ministries and the BMA
  - c. Sub-district health promoting hospitals or BMA's health services centres
2. Private healthcare facilities including hospitals and clinics (including managed by NGOs)

#### **e. Retaining**

Retaining focuses on keeping those who are diagnosed with HIV to adhere to treatment and ensuring that those with a negative result remain negative through viral load suppression and re-testing for negative KPs.

For those with a HIV-positive result, the retaining indicator measures the number of KPs who initiated ART and were retained for continuous treatment. These people remained on ART at 12, 24, 36, and 60 months after initiating ART.

For those with a negative result, this indicator focuses on the progress of the system that keeps KPs retained in the system in parallel with maintaining safe behaviours. For the person who receives a repeated HIV test and knows the result, the number of cases retained are counted as the following:

1. The second HIV test in the same year for those who tested for HIV for the first time in that year; and
2. The first HIV test of that year for those who had a HIV test in the previous year.

### 3.2.3 Key players in HIV services

According to Thailand's National strategy and guidelines to accelerate ending AIDS 2017-2030, achieving the goal of ending AIDS and aligning with the SDGs and Political Declaration on HIV 2016, requires multisectoral and multidisciplinary collaboration<sup>(12)</sup>. Therefore, several sectors play a role in HIV services as follows:

- a. Government sectors
  1. Ministry of Interior
  2. Ministry of Social Development and Human Security
  3. Ministry of Justice
  4. Ministry of Labour
  5. Ministry of Public Health
- b. Private sectors
  1. Business sector
  2. Community Organisations
- c. Civil society sector
  1. Thai NGO coalition on AIDS (TNCA)
  2. Civil Society organisations (CSO)
  3. Thai Network of People Living with HIV/AIDS (TNP+)

## 3.3 HIV financing in Thailand

This section provides information related to HIV financing in Thailand, starting with available HIV care models that have been used nationally (corresponding to a previous study by HITAP of the cost of HIV services) and financial sources.

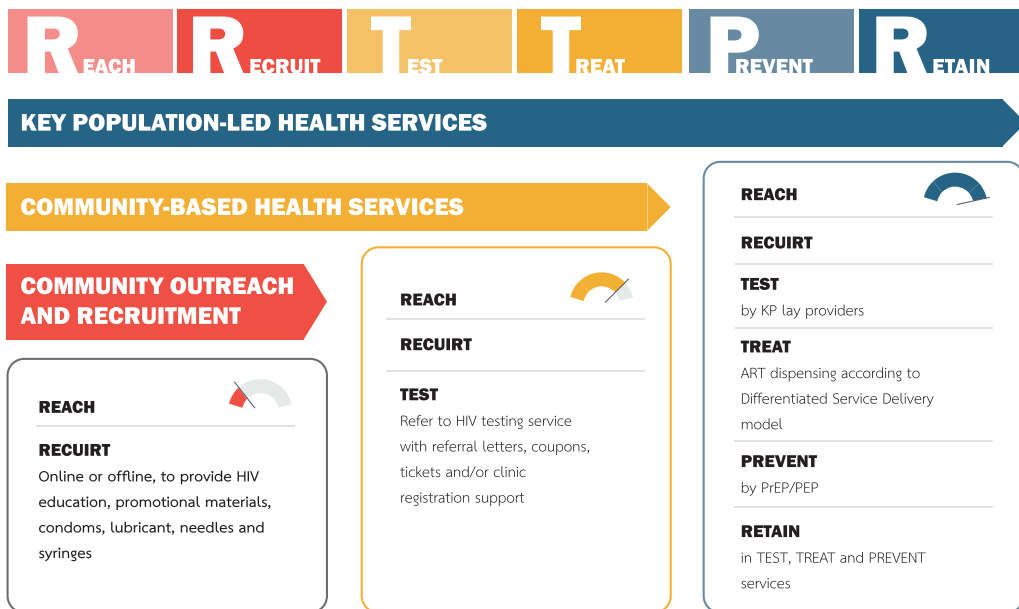
### 3.3.1 Models of HIV service provision in Thailand

As mentioned earlier, this study has been linked with the cost analysis study on RRTR services conducted by HITAP<sup>(19)</sup>. There are three base models as follows:

1. **Model 1: Hospital-based services.** For this model, a public hospital provides or manages the RRTR services delivered to KPs. There are some hospitals using NHSO funding to support outreach workers who can reach, recruit and make hospital referrals for HIV testing including counselling, antiretroviral treatment (ART) and Pre-exposure prophylaxis (PrEP).
2. **Model 2: Government facility-led health services with outreach and recruitment led by CBOs.** For the second model, CBOs play a lead role in reaching and recruiting

KPs so that KPs are referred to HIV testing in a hospital and/or mobile HIV testing unit and offered counselling services in convenient locations. Then, treatment including ART and PrEP will be offered in a hospital.

**3. Model 3:** Key population-led health services (KP-LHS) in collaboration with government hospitals. There is collaboration between a KP-LHS unit and a public hospital to provide services to KPs. CBOs conduct outreach with teams through events and/or social media to encourage KPs to seek HIV testing and counselling at a community clinic operated by CBOs. People diagnosed as HIV positive are aided by peer navigators to access ART at a hospital and to retain their adherence accordingly. Some CBOs also conduct community clinics by themselves to initiate clients on ART and maintain close collaborations with hospitals to handle more complicated cases.



**Figure 3.1:** Three base models for HIV service delivery based on RRTTR approach in Thailand

### **3.3.2 HIV/AIDS operational expenditure**

HIV/AIDS operational expenditure in Thailand decreased from 8,710 million THB in 2014<sup>(20)</sup> to 7,914 million THB in 2016, but increased to 8,436 million THB in 2017, which was about 3.8 USD per capita<sup>(21)</sup>. This operational expenditure accounted for 1.4% of Total Health Expenditure (THE) in 2017. Concerning task characteristics, HIV/AIDS prevention costs decreased from 21.7% in 2008 to 17.3% in 2015 and continuously decreased to 14.9% in 2017. HIV/AIDS treatment costs increased from 65.8% to 70.5% in 2017. Domestic sources, mostly providing for HIV care and treatment, are managed by three institutions of: (1) the Comptroller General's Department (CGD) that administrates Civil Servant Medical Benefit Scheme (CSMBS), (2) the Social Security Office that manages Social Health Insurance, and (3) the National Health Security office that manages the Universal Coverage Scheme. Some other sources provided for HIV prevention and control including the MOPH, other ministries, and local government. Oversea finances (such as from the Global Fund and others) are generally used for disease prevention (30.3%), for project operational costs and administration strengthening (35.7%), and for care and treatment and others (34.0%)<sup>(20)</sup>.

### **3.3.3 Sources of funding in HIV/AIDS services and activities**

There are three domestic sources of funding for HIV prevention and control activities in Thailand as follows.

#### **1) Ministry of Public Health (MOPH)**

In 1992, the MOPH initiated a project to support NGOs for public health development by using a national budget of about 11.9 million THB for HIV/AIDS prevention and control activities<sup>(22)</sup>. Of this amount, approximately 6.9 million THB was allocated for HIV/AIDS prevention and control through the Bureau of Art of Healing, Office of the Permanent Secretary, while about 5 million THB was managed by the Department of Disease Control (DDC). It was found that DDC had supported further budget to NGOs, reaching 75 million THB in 1995 and 90 million THB in 1997. Later on, this decreased to 50 million THB, and DDC assigned the Bureau of AIDS, TB, and STIs to manage the budget. Recently in 2019, this budget dropped to 45 million THB (See Figure 3.2).

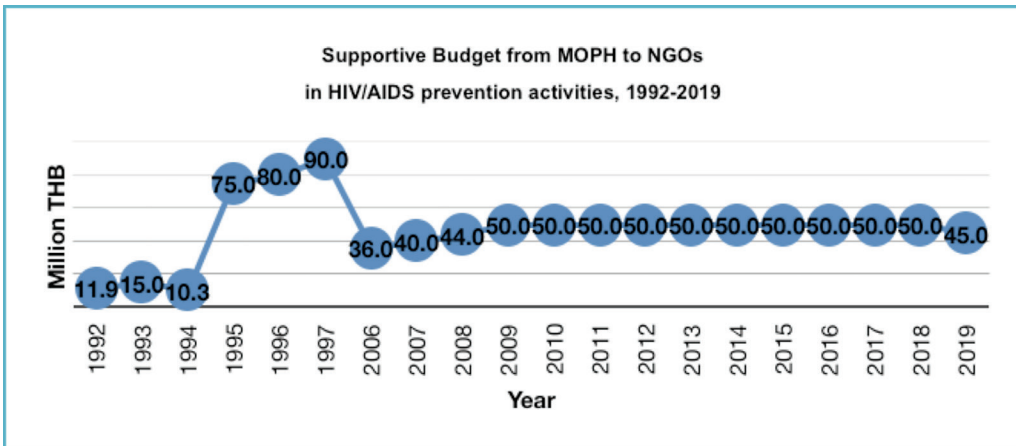


Figure 3.2: Supportive Budget from MOPH to NGOs in HIV/AIDS prevention activities, 1992-2019

Summary of the MOPH budget allocation for HIV/AIDS prevention and solutions are detailed below.

**Objective:** To support NGOs in operating HIV/AIDS prevention and solutions

**Grant recipients:** NGOs conducting HIV/AIDS activities, which are for a juristic person or a non-juristic person. In the case of a non-juristic person, the Provincial Health Office, hospital, or institute operating HIV/AIDS activities has to guarantee their capability for working.

**Goals aligning with the National Strategy on AIDS:** 1) Zero new infection,s 2) Zero AIDS-related deaths, and 3) Zero stigma and discrimination.

**Target group:** General population who have risky behaviours

#### Budget management

- NGOs write project proposals to request budget support following project expenses reimbursement guidelines of DDC
- Committee considers projects and appropriation
- Project expenditure includes: 1) management fee (worker payment and utility cost); 2) activity cost (meeting, seminar, training, HIV patients and family subsidy such as powdered milk cost, occupational training cost, herbal medicine cost, and transportation cost); 3) internal meeting costs; 4) home visit costs; and 5) field worker payment
- After the budget is allocated, NGOs have to report project progression and payments as received tranches according to the contract. If a budget remains but the project is complete, it is allowed to request approval to add more activities that meet the objectives. In case of project dissolution, NGOs have to pay back the funds to DDC.



## Monitoring and evaluation

- In an on-going process, operational report, supervision, and project progression presentation is undertaken.
- After the project is completed, evaluation of project progression and summary is done.

## 2) National Health Security Office

The NHSO provides HIV/AIDS patients service statements, aiming to decrease the numbers of HIV/AIDS related sickness and deaths, new infections, mother-to-child transmission, and to increase service accessibility of KPs as well as ART accessibility of PLHIVs(23).

There are three main budgets allocated to HIV/AIDS services by the NHSO, including ART and related services (2,808 million-THB), HIV infection prevention services (200 million-THB), and service prevention and promotion for HIV/AIDS patients (38 million-THB). This review focuses on HIV infection prevention services (200 million THB) as related to RRTR only. The scope of work and expense of the 200 million THB budget are detailed below.

**Objective:** To support public health administration, health promotion and HIV infection/transmission prevention following RRTR cascade activities.

The 2019 budgets are distributed to two main groups, including: 1) 172 million THB allocated to HIV infection prevention services in high-risk behaviour KPs; and 2) 28 million THB allocated to health promotion, HIV prevention and monitoring services through people living with HIV volunteers who work in a Continuum of Care Centre (CCC).

### 2.1) HIV infection prevention services in high-risk behaviour KPs (172 million THB)

- Target groups: people with Thai nationality having an identification number and being in KPs including MSM, TG, FSW, MSW, and PWID
- Budget allocated mechanism: a board committee makes decisions on HIV/AIDS activities; committee members come from various key stakeholders at national, regional, and local levels.
- Eligible organisations must be HIV service networks, community-based organisations, non-profit organisations, and government sectors.
- The scope of work
  - Proactive services (Reach, Recruit and Retain) among MSM, TG, FSW, and MSW will be paid at 1,800 THB per capitation, whereas services among PWID will be paid at 4,000 THB per capitation.
  - Clinical services (Test [VCT, screen STI] and Treat [ARV, STD]) will be paid in accordance with the cost of service provisions, for which the data are recorded in the National AIDS Programme (NAP).
- Expensing criteria and delegation
  - Proactive services: a proposal is submitted to requests for funding. The funding is paid in three installments, including: (1) the 1<sup>st</sup> installment is

paid at 50% of the budget after the contract has been signed; (2) the 2<sup>nd</sup> installment is paid at 30% of the budget after project progression report submission (with RR reached 50% or above); and (3) the 3<sup>rd</sup> installment pays the remaining budget after the final report submission.

- Clinical services: the cost of HIV and STI testing can be reimbursed through NAP data records (generally, by hospitals).
- Reporting system
  - Reach, Recruit, and Retain data are recorded in the Real Time Cohort Monitoring (RTCM) programme.
  - Test and Treat data are recorded in the NAP programme.
- Monitoring and evaluation is conducted at provincial, district, central, and national levels, mainly focusing on financial management only.

## **2.2) Health promotion, HIV transmission prevention and monitoring services through HIV infected volunteers who work in holistic care centres (28 million THB)**

- Target groups: 1) HIV/AIDS patients' partner or family; 2) people at high risk of HIV infection such as pregnant women and partners in antenatal care service; 3) HIV/AIDS patients who register with holistic care centres; and 4) new HIV patients who are referred to a hospital.
- Received services: 1) group or individual education and counselling services in antenatal care clinic, TB clinic, ARV clinic, and community; 2) retaining HIV/AIDS patients in adherence for ART treatment; and 3) home visiting in people initiating ART or changing formula, TB co-infection HIV patients, and people who have problems living in society or whose rights have been violated
- Grant recipients: PLHIV networks that work in holistic care centre.
- Expense criteria and delegation is the same as the budget of 172 million THB mentioned above.
- Monitoring and evaluation
  - Monitor following operational indicators of the NHSO
  - Overall achievement report
  - There is a monitoring mechanism at provincial and regional levels through the Thai network of people living with HIV/AIDS (TNP+) and an evaluation conducted by NHSO and hospitals.

### **3) Family Health International (FHI 360)**

The USAID has provided the budget for contracting CSOs to support their HIV/AIDS activities through FHI 360. The LINKAGES, as a part of FHI 360, has taken responsibility for the oversight of CSO project management and performances.

**Objective:** To implement specific HIV/AIDS activities corresponding to USAID interests/targets.

**Grant recipients:** The CBO whose proposed project successfully fulfilled the requirements of Pre-Award Assessment (PAT) process conducted by FHI 360, will be granted the budget. According to the PAT process, the managerial and administrative capacity of the CBO will be evaluated to ensure that it will follow standards of responsibility, financial management, property standards, procurement standards, and report and records.

**Target group:** Key populations such as MSM, TGs, FSWs, MSWs.

**Activity:** RRTTR

**Budgets management:**

The standard grant (STG) is applied. The STG payment is based on the cost reimbursement. After signing a contract, FHI 360 will transfer the two-month cash advance (based on approved budget) to CBO. The CBO must submit a monthly financial report and supporting documents. FHI 360 check on-hand balances in the submitted financial report and then transfer requested amounts for planned activities covering two months (the current and following month of activities).

**Monitoring and evaluation**

- Collect routine project monitoring and evaluation data according to the LINKAGES/ Thailand Performance Management Plan.
- Develop a dashboard including key indicators (including metrics illustrating the HIV cascade) to follow-up monthly trends.
- Discuss the findings of supervision visits and analyze monitoring data during monthly site-level Quality Assurance and Quality Improvement (QA/QI) meetings with Thai Red Cross and FHI 360 as well as in quarterly provincial-level coordination meetings.
- CBO submits a monthly financial report and supporting document including a monthly activity report.

**4) Global Fund**

In 2014-2016, the Global Fund investment in Thailand was around 63.2 million USD, which comprised HIV/AIDS disbursements of 22 million USD and TB/HIV disbursements of 41.2 million USD. In 2017-2019, GF invested 16.7 million USD on TB/HIV<sup>(24)</sup>. The Principle Recipients (PR) in Thailand were the Department of Disease Control (DDC), Ministry of Public Health and the Raks Thai Foundation. Each PR had its own sub-recipients (SR). The selection process for PR and SR was conducted by the Country Coordinating Mechanisms (CCM), Thailand.

**Objective:** To support a country to operate HIV/AIDS activities

**Grant recipients:** PR and SR were both government and non-government organisations

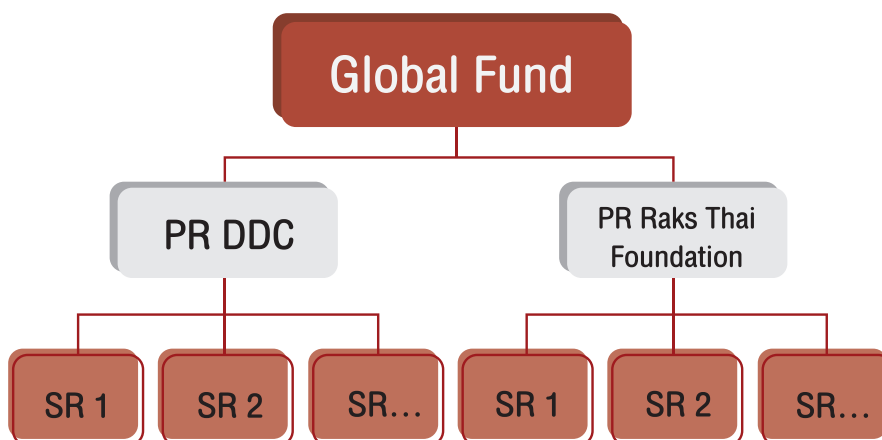


Figure 3.3: Management of Global Fund

**Target group:** Key populations include MSM, TG (especially TG women), sex worker, PWID, people living with HIV, people in prison and detention; however, KPs were based on those indicated in Thailand’s national strategy.

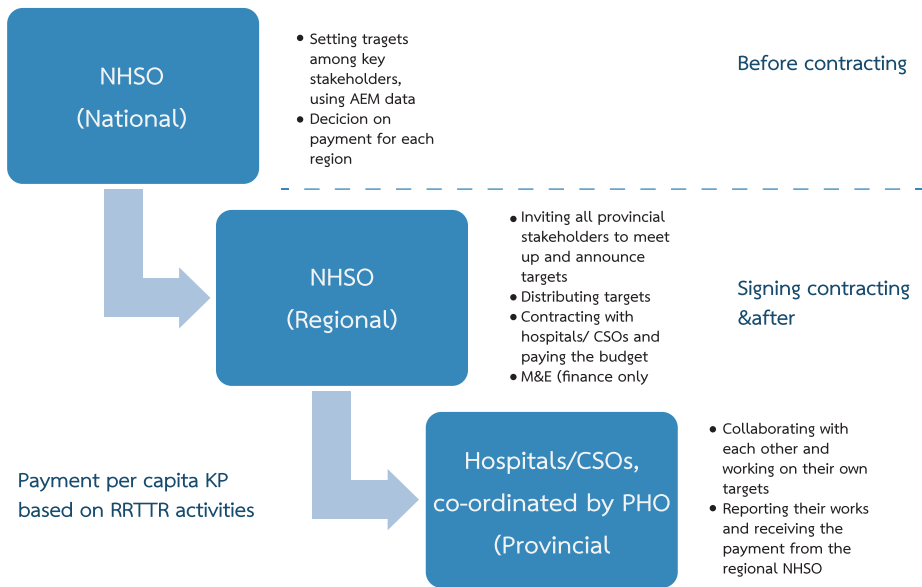
**Budgets management**

The Global Fund provided a handbook explaining financial management for grant implementers to support them to understand financial management as well as meet the requirements of the Global Fund<sup>(25)</sup>. The financial management included three key components of institutional and oversight management, financial controlling, and financial reporting and auditing. The contracting between PR and SR was based on project activities. The Global Fund also clearly indicated a budget line for each activity, such as prevention activities, and capacity building for staff.

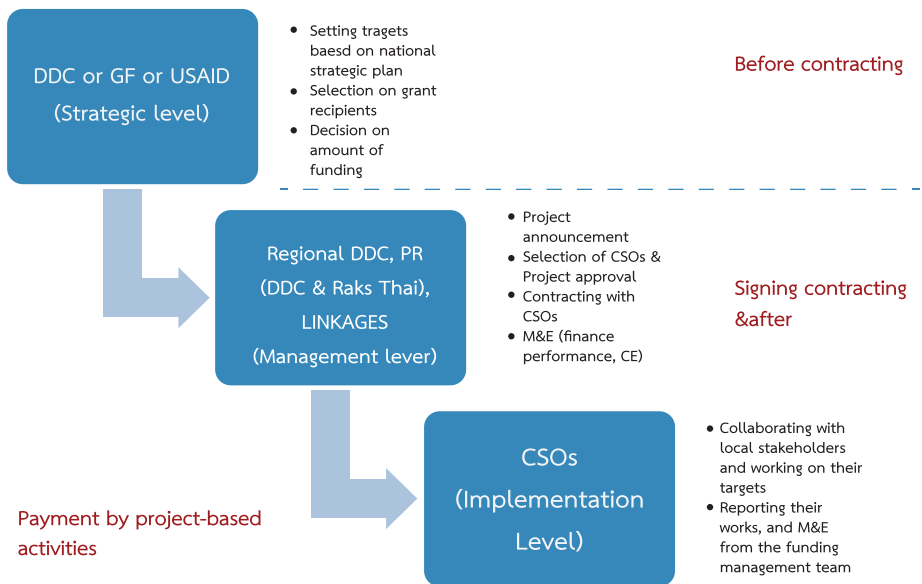
**Monitoring and evaluation**

A Finance and Audit Committee took responsibility for monitoring the stewardship of the accounting function to ensure the effectiveness of all aspects of the financial management, including monitoring the integrity of risk management, combined assurance, compliance with relevant laws and regulations, financial reporting and the associated required disclosures and communication to multiple stakeholders.

In summary, based on the document review, there are two types of payment for the HIV contracting model in Thailand: (1) payment per capita KP (RRTTR achievement) of NHSO; and (2) payment by project base of other organisations such as DDC, GF, and USAID. Financial management can be seen in diagramme 3.3 (per capita KP) and 3.4 (by project base).



**Figure 3.4:** Financial management per capita KP by NHSO



**Figure 3.5:** Financial management by project base

## **3.4 Law and regulations in relation to HIV services**

### **National health budget for CSOs' HIV prevention projects**

The concept of collaboration between public and non-public organisations has been emblematic in the Ministry of Public Health of Thailand for several decades. CSOs have taken a crucial role in tackling several public health problems in the country; for example, primary health care, family planning, tobacco control, universal health coverage, and HIV/AIDs. Recognizing the importance of having CSOs as a partner, the Thai Government has provided support to strengthen CSOs by granting them budgets for health-promotion projects<sup>(26)</sup>. For instance, the Department of Health Service Support annually grants its fiscal budget to local CSOs to strengthen community health systems. In addition, significant numbers of budgets from the Thailand Health Promotion Foundation are also allocated to community projects for health promotion programmes. Furthermore, since the National Health Security Act B.E. 2549, the NHSO has granted a Local Health Fund to CSOs for health promotion projects in their communities. Today, in attempting to end AIDs by using a multi-sectoral approach, two main budgets from the Thai government are available to fund CSOs for HIV/AIDs projects, including the NHSO and the DDC of the MOPH. Both sources have different concepts, but aim to provide support for CSOs working on HIV/AIDs or key populations as an integral part of the country strategic plan to end AIDS.

### **Universal Health Coverage Fund for HIV/AIDs**

According to Article 5 of the National Health Security Act B.E. 2545, the Thai population is guaranteed a right to access standard health services<sup>(27)</sup>. The act comprehensively defines health services as either medical or public health services to promote, prevent, diagnose, treat, and rehabilitate, that are provided for Thai people<sup>(27)</sup>. It is important to note that Article 4, section 38 (p.15) establishes a 'Universal Health Coverage Fund', aiming to provide financial support to promote the management of health services to increase access to and efficiency of health services<sup>(27)</sup>. Since this Article clearly indicates that financial support is specific to a health service provider, the NHSO interprets that it is unable to use this funding to pay for CSOs as they are not health service providers. However, after the Military Coup in May 2014, Thailand's National Council for Peace and Order (NCPO) used its authority under section 44 of the temporary constitution to release a series of orders for administration and management to keep the country harmonized, peaceful, and running business smoothly. The NCPO issued the Order 37/B.E 2559, on the topic of: "Payments that are related and needed for supporting and promoting health service provisions and other payments corresponding to the National Health Security Act"<sup>(28)</sup>. Section 1 of the Order had dissolved the limitation of UHC Fund and therefore the NHSO could sign a contract with CSOs and pay for their performance.

In 2016, the NHSO launched the notification of a service registration for transferring cases for medical technology<sup>(29)</sup>. This has allowed key population-led health services (KP-LHS) to provide HIV testing under the supervision of a health facility (as a node of that facility). However, requirements of this collaboration have not yet been universal and, at the time of this study, only a few sites are fully functioning. Currently, the NHSO has further developed this regulation, aiming to have certified community health workers (CHWs) that can provide HIV screening, dispense PrEP and provide ART to stable or uncomplicated cases. Thus, the MOPH is working to establish a CHW Certification system according to this regulation.

To support the national strategic plan to prevent HIV transmission, the NHSO provided a budget for HIV prevention of about 25 million THB in 2014 and 12 million THB in 2015 for HIV prevention, particularly among MSM and SW. The funding focused on three main aspects: (1) providing services such as HIV testing, screening, and treatment; (2) facilitating proactive actions and quality of services; and (3) improving service management. Encouraging Thai people to have free HIV testing twice a year also took place during this period, corresponding with Thailand's National Guidelines on HIV/AIDS Treatment and Prevention 2014<sup>(30)</sup>. Later on, the NHSO Board officially endorsed the list of health promotion and prevention services for beneficiaries in the Universal Coverage Scheme. The list of the benefit packages included HIV voluntary counselling and testing (VCT) services, mother-to-child transmission prevention, and other STDs prevention; however, it still focused only on the general population<sup>(31)</sup>. About one year later, the Board also endorsed an additional list of HIV prevention services that put more emphasis on key populations, including MSM/TG, MSW, FSW, PWID, prisoners, juvenile delinquents, and spouses of people living with HIV or key populations. The list provides broadened and specified details of HIV promotion and prevention services for this niche population. The services consist of: (1) health education, counselling, and advice in changing risky behaviours; (2) action of referral to access healthcare services; (3) provision of HIV prevention tools, including condoms, lubricant, and sterile needles and syringes; (4) VCT services; (5) retention of negative cases; (6) STDs screening; and (7) action of referral for ARV and STDs treatments<sup>(32)</sup>.

The NHSO, along with the Board, has a responsibility to manage the UCS Budget. In 2019, the cabinet approved the UCS budget for HIV/AIDS services accounting for 3,046 million THB with 200-million THB earmarked for HIV prevention services. The 200-million THB budget is divided into two parts: (1) 172 million THB is allocated for HIV prevention in key populations (MSM/TG, MSW, FSW, and PWID), while the remaining budget of 28 million THB is used for health promotion and HIV transmission prevention among people living with HIV and their spouses<sup>(23, 33)</sup>. Accordingly, the NHSO endorsed the Guideline and Criteria for HIV Prevention Budget Management for the fiscal year 2019, which explained the detailed information for budget management (see Table 3.1).

## Department of Disease Control Budget for HIV/AIDS

Apart from the UC fund, since 1992, the government has annually allocated a 50-million THB budget to CSOs for HIV prevention campaigns through the DDC of MOPH, which is the CSO Financial Supporting Programme for preventing and ending AIDS. The budget is organized by the Bureau of AIDs, Tuberculosis, and Sexual Transmitted Diseases, and the Department of Disease Control. With over three decades of experience in working with CSOs to combat the AIDs epidemic, the Bureau has issued the Manual of the CSO Financial Supporting Programme, with detailed information for budget management<sup>(22)</sup> (see Table 3.1).

**Table 3.1:** Comparison of NHSO Budget and DDC budget

Topic	UHC Fund		DDC budget
	HIV prevention	Continuum of Care for Network of PLHIV	
Responsible organisation	NHSO	NHSO	Bureau of AIDs, Tuberculosis, and Sexual Transmitted Diseases
Objective	HIV prevention	HIV transmission prevention	<ul style="list-style-type: none"> <li>• HIV prevention</li> <li>• Increasing access to healthcare</li> <li>• Reducing stigmatisation</li> </ul>
Target group	<ul style="list-style-type: none"> <li>• MSM/TG</li> <li>• MSW</li> <li>• FSW</li> <li>• PWID</li> </ul>	<ul style="list-style-type: none"> <li>• People living with HIV and their spouse</li> <li>• Other high-risk populations</li> </ul>	<ul style="list-style-type: none"> <li>• MSM/TG</li> <li>• MSW and clients</li> <li>• FSW and clients</li> <li>• PWID</li> <li>• Prisoner and juvenile delinquents</li> <li>• Migrant</li> <li>• Spouse of people living with HIV</li> <li>• Other high-risk populations</li> </ul>
Governance structure	<ul style="list-style-type: none"> <li>• <b>Central:</b> Working Group on HIV Services Development which includes NHSO, USAID, UNAIDS, DDC, Global Fund, and others</li> <li>• <b>Region:</b> Regional Health Security Sub-board or Regional AIDs Committees</li> <li>• <b>Province:</b> Provincial Subcommittee on AIDs Prevention and Control</li> </ul>	<ul style="list-style-type: none"> <li>• NHSO</li> <li>• Thai Network of People Living with HIV/AIDS</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Central:</b> Committee on Project Approval and Budget Allocation which includes DDC, local governments, and CSOs</li> <li>• <b>Region:</b> Regional Committee on Project Approval and Budget Allocation which includes Regional Office of DDC, Provincial Health Office, CSOs, and academia</li> <li>• <b>Province:</b> Provincial Health Office</li> </ul>



Topic	UHC Fund		DDC budget
	HIV prevention	Continuum of Care for Network of PLHIV	
Service	<ul style="list-style-type: none"> <li>• Reach</li> <li>• Recruit</li> <li>• Test (only STDs)</li> <li>• Refer to test (HIV) and treat</li> <li>• Retain (negative cases)</li> </ul>	<ul style="list-style-type: none"> <li>• Provide health education and counselling within clinics and communities</li> <li>• Retain (positive cases)</li> <li>• Home visit for complicated HIV cases</li> </ul>	<ul style="list-style-type: none"> <li>• Provide health education</li> <li>• Provide prevention equipment</li> <li>• Test</li> <li>• Refer to treat</li> <li>• Retain (negative and positive cases)</li> <li>• Normalize HIV and decrease stigmatisation</li> </ul>
Service provider (grantee)	<ul style="list-style-type: none"> <li>• Health care units and their networks</li> <li>• Community organisations, CSOs, or local government organisations</li> <li>• Other state agencies</li> </ul>	<ul style="list-style-type: none"> <li>• Networks of people living with HIV working within a health service unit</li> </ul>	<ul style="list-style-type: none"> <li>• CSOs with experiences on HIV/AIDs</li> </ul>
Total budget in fiscal year 2019	172 million THB	28 million THB	45 million THB
Reimbursement	<p><b>Reach, recruit, and retain services</b></p> <ul style="list-style-type: none"> <li>• MSM/TG, FSW, and MSW: 1,800 THB per case</li> <li>• PWID: 4,000 THB per case</li> </ul> <p><b>STDs Screening services</b></p> <ul style="list-style-type: none"> <li>• Free schedule: 100 THB/test</li> </ul>	Project-based budget varied by the number of people in the network	Project-based budget with limited cost per activity
Monitoring and reporting	Electronic record <ul style="list-style-type: none"> <li>• RTCM</li> <li>• NAP</li> </ul>	Paper-based report	Paper-based report

**Sources:** 1) NHSO, and 2) Bureau of AIDs, Tuberculosis, and Sexual Transmitted Diseases

In addition, under the Notification of the National Health Security Office Board B.E. 2559: Type and Scope of Public Health Service (Issue 10), CSOs are allow to purchase some commodities necessary for their HIV prevention services, including condoms, needles and syringes<sup>(34)</sup>.

## Thailand Tax Law applied for CSOs

The Code of Revenue is a key tax law in Thailand. According to section 39 in the code, CSOs are defined into three types of taxpayer status<sup>(35)</sup>.

1. A CSO as 'a charity organisation' is not a taxpayer

**A foundation or association approved by the Minister of Finance in accordance with Section 47 (7) (๑)** as 'a charity organisation' is not a taxpayer due to exception from the code. The Ministry of Finance announced eligibility criteria for CSOs to be prescribed as this type of organisation. The key principles are: (1) the organisation must not spend less than 60% of its revenue; and (2) Not less than 75% of the organisation's expenses must be spent on charities<sup>(36)</sup>. At the time of this present study, 973 foundations are approved by the Ministry of Finance to be a charity organisation in respect to the Announcement of Ministry of Finance No.2<sup>(37)</sup>.

2. CSOs as 'a juristic person' must pay 10% of income for tax

**A foundation or association with revenue generating business is prescribed as 'a juristic person'**, but has not been approved to be a charity organisation. A juristic person is a legal entity that is recognized by law as the subject of rights and duties other than a natural person (human being), the common example being a company. In Thailand, a juristic person can come into existence only by virtue of the civil and commercial code or other laws (section 65 civil and commercial code)<sup>(38)</sup>. Although most CSOs working on health issues are generally non-profit organisations, this CSO type is a taxpayer stated in the code, unless having been approved as a charity organisation mentioned above. According to section 67 in the Code of Revenue (amendment in B.E. 2562), 10% of the total income of this organisation before spending its expenses must be paid for through tax<sup>(35)</sup>.

3. CSOs as 'a non-juristic body of person' must pay tax as an individual person

CSOs as a group of persons are defined as **a non-juristic body of person**. This taxpayer status is required to pay tax similar to an individual person; a progressive tax rate, between 5% and 35% of assessable income, is applied (35).

## 3.5 Thailand CSO profiles

This section presents an overview of CSOs in Thailand that have received funding from different sources to provide HIV prevention and promotion activities, mainly about RRTTR.

### 3.5.1 Overview of funding sources and CSO profiles in Thailand

In general, CSOs in Thailand receive funding support from four main institutions, including the NHSO, DDC, GF and USAID. Therefore, this study will provide detailed information in relation to these four funders. According to the records derived from funders, 545 CSOs received funding from them and can be divided into four types, namely: (1) Association; (2) Foundation; (3) Networking/Group/Club; and (4) Others (see Table 3.2). Note that the group types are simply based on their registration for operation. As can be seen, most CSOs received budget from DDC, accounting for 471 organisations and were mainly the Networking/Group/Club group, followed by NHSO (50 organisations). The types of organisations that received NHSO budget seemed to have similar numbers of about 12-14 organisations in each group.

**Table 3.2:** Number of CSOs received funding support from four main funders in 2017-2019

Funding sources	Year of data	Association	Foundation	Networking/Group/Club	Others	Total
NHSO	2019	12	14	12	12	50
DDC	2017	10	26	349	86	471
GF	2018	1	11	7	0	19
USAID*	2019	1	3	1	0	5
<b>Total</b>		<b>24</b>	<b>54</b>	<b>369</b>	<b>98</b>	<b>545</b>

*\*Five CSOs received budget from LINKAGES Thailand/ FHI 360 under the support of USAID and employed RRTTR approach via project-based payments.*

When examining the number of CSOs having received funding, it appeared that the majority of CSOs (75-98%) had received funding from only one of these four sources. Only three organisations had received funding from all four funders.

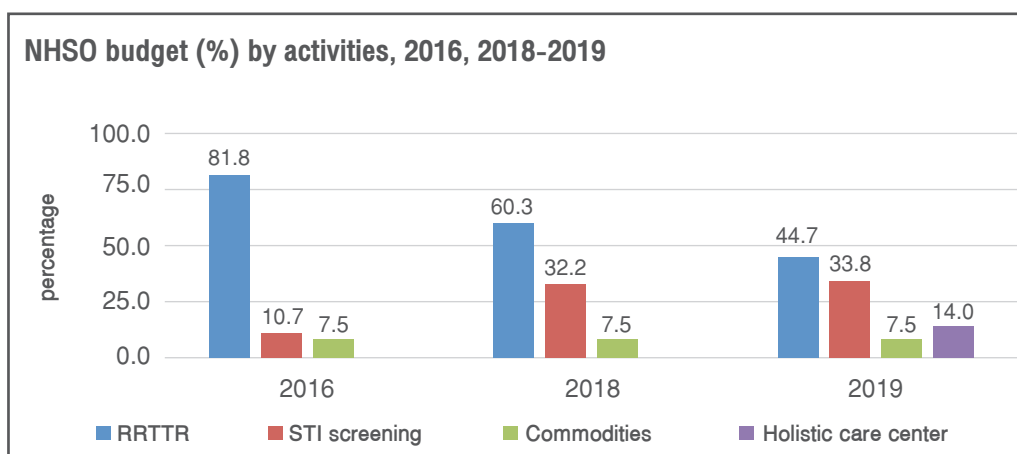
**Table 3.3:** Proportion of CSOs received funding from each of four main funders

Type	# CSOs	Funding source (%)								Total
		NHSO alone	DDC alone	GF alone	NHSO+ DDC+GF +USAID	NHSO+ GF+ USAID	NHSO+ DDC+GF	NHSO+ DDC	NHSO+ GF	
Association	24	37.5	43.8	0.0	6.3	0.0	0.0	12.5	0.0	100.0
Foundation	54	20.7	31.0	17.2	6.9	3.4	17.2	3.4	0.0	100.0
Networking/ Group/Club	369	1.4	94.5	1.1	0.3	0.0	0.3	2.2	0.3	100.0
Others	98	9.7	88.2	0.0	0.0	0.0	0.0	2.2	0.0	100.0

Note: None of CSOs received funding from USAID alone.

### 3.5.2 CSOs that received funding from NHSO

As previously mentioned, the NHSO 200-million-THB budget started in 2016, mainly for RRTR activities, followed by STI and commodities (condoms and lubricants), and in 2019, 28 million (14%) were provided for the Holistic care centre (home visits etc.) as shown in Figure 3.6. There was a decline of NHSO funding to CSOs overtime, which was partially explained by the fact that the numbers of CSO projects submitted to NHSO have been decreasing. Note that 2017 information was not available.



**Figure 3.6:** NHSO budget used for HIV/AIDS by activities 2016, 2018-2019

In 2016, all recipients were hospitals (280) as due to the regulation of the Universal Health Coverage Fund, only healthcare providers were eligible to receive the funding. However later, Order no.37/2559 made by the National Committee for Peace and Order allowed for the paying of budgets to CSOs and the Provincial Health Office (PHO) in addition to hospitals. Information about funding allocations in 2018 was more complete than in other years, and provided an overview of budget spending for different NHSO recipients. It was found that CSOs received almost half of this budget (43.3%), followed by PHOs (34.6%) and hospitals (22.1%) (Figure 3.7). Note that under PHOs, CSOs are included as PHOs' sub-contractors.

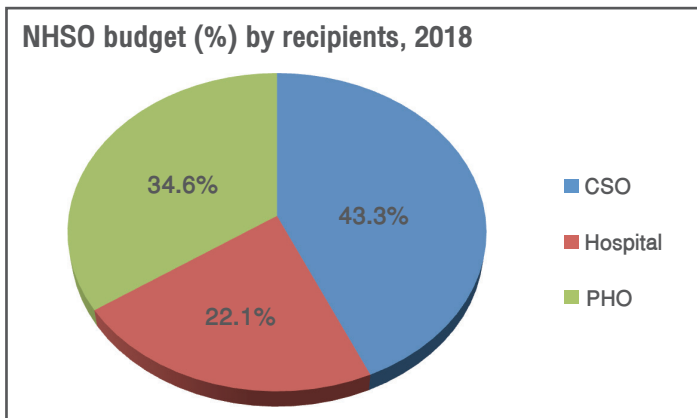


Figure 3.7: NHSO budget by recipients in 2018

When considering only CSOs, it was found that during 2018-2019, 42 CSOs and 50 CSOs respectively, had received this budget managed by the NHSO. Most of them were registered as a foundation, followed by association and networking/group/club (see Figure 3.8).

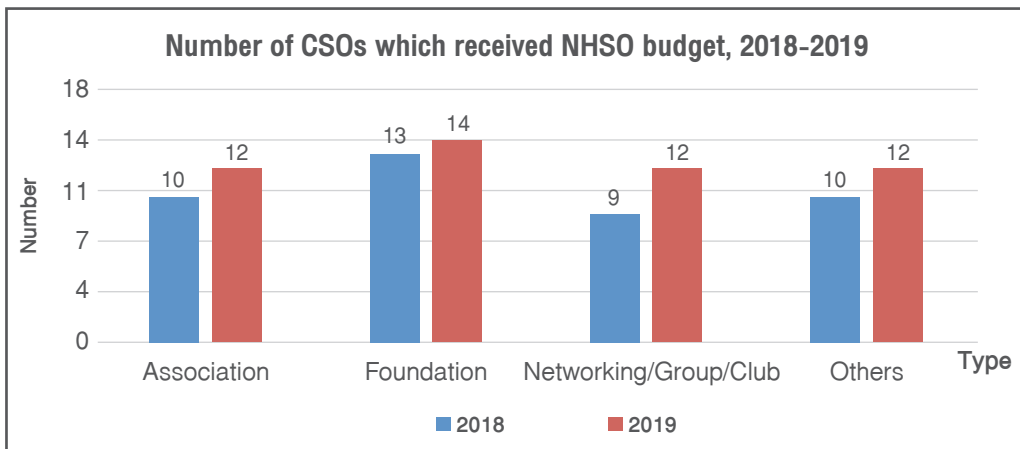


Figure 3.8: Number of CSOs which received NHSO budget in 2018-2019

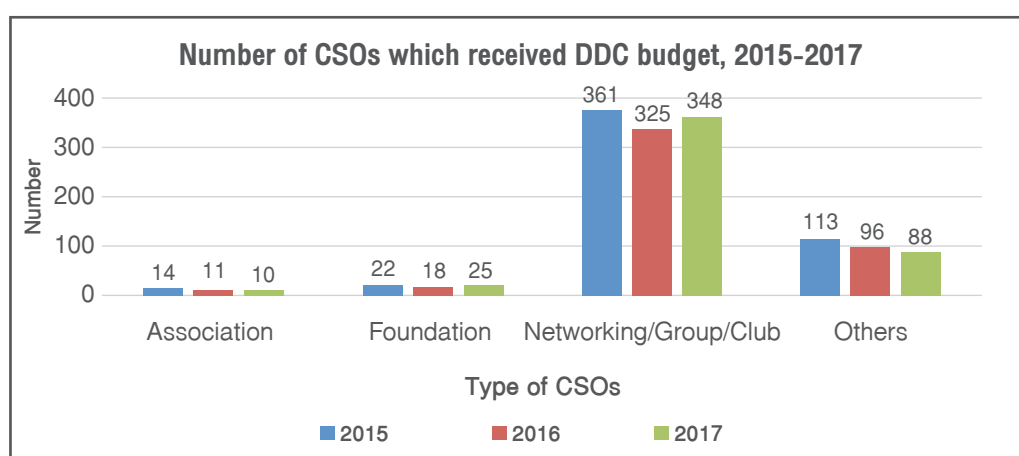
In addition, it was found that the NHSO supported CSOs for RRTTR to the level of about 52.2 million THB in 2018, and 89.3 million THB in 2019. CSOs that were registered as associations and foundations received more budget than others categories, at almost double in 2019 as shown in **Table 3.4**.

**Table 3.4:** NHSO budget allocated to CSOs for RRTTR in 2018-2019

Type of CSOs	2018 (THB)				2019 (THB)			
	Total	Min	Max	Average	Total	Min	Max	Average
Association	13,801,800	560,000	8,961,800	2,760,360	32,719,000	400,000	28,755,000	6,543,800
Foundation	15,054,300	100,000	5,330,000	2,150,614	31,048,000	180,000	17,820,000	3,881,000
Networking/ Group/Club	13,256,400	700,000	2,000,000	1,472,933	15,368,000	180,000	4,898,000	1,280,667
Others	10,135,000	370,000	3,260,000	1,266,875	10,233,000	180,000	2,466,000	1,023,300
<b>Total</b>	<b>52,247,500</b>				<b>89,368,000</b>			

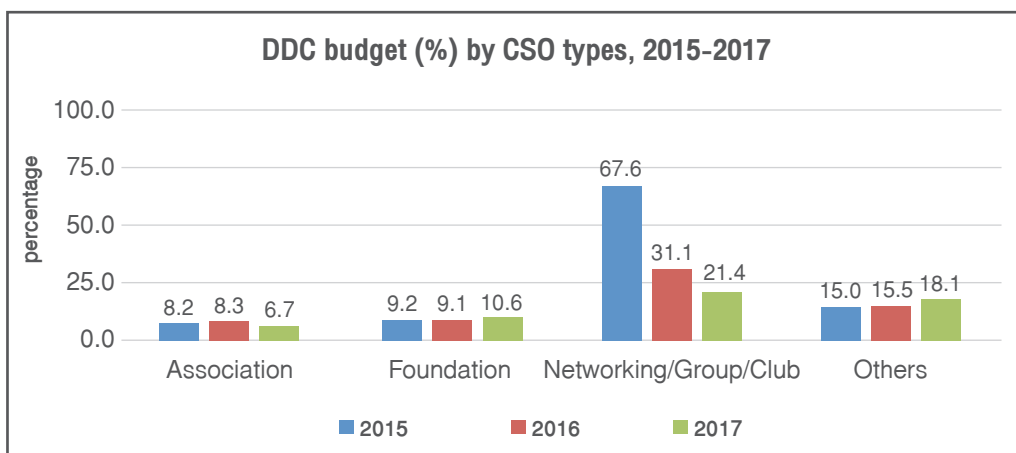
### 3.5.3 CSOs that received funding from DDC

An annual budget of about 50 million THB from DDC supports CSOs for Reach and Recruit both in KPs and the general population by type of programme. Note that the proposed project submitted by CSOs are considered by the DDC committee before funding in both their program activities and target population at the same time without separation. As can be seen in Figure 3.9, more numbers of CSOs registered as a networking/group/club had received the DDC budget, compared with other types of CSOs.



**Figure 3.9:** Number of CSOs which received DDC budget in 2015-2017

When looking at the proportion of DDC budget allocated to different types of CSOs, it was also found that CSOs as networking/group/club received a higher proportion of funding than the other types. Figure 3.10 shows the DDC budget spending allocated to different types of CSOs.



**Figure 3.10:** Percentage of DDC Budget allocated to different types of CSOs in 2015-2017

In addition, the smallest amount of money that CSOs received from DDC was about 9,000-10,000 THB, while the largest amount was about 10-16 million THB in the networking/group/club types of CSOs (see Table 3.5).

**Table 3.5:** DDC Budget allocated to different types of CSOs in 2015-2017

Year	Type of CSOs	Number of CSOs	THB			
			Total amount	Min.	Max.	Average
2015	Association	14	4,058,200	28,200	2,339,750	289,871
	Foundation	22	4,560,100	30,000	652,000	207,277
	Networking/ Group/ Club	361	33,512,351	16,000	7,842,295	92,832
	Others	113	7,452,508	10,000	826,685	65,951
	<b>Total</b>	<b>510</b>	<b>49,583,159</b>			
2016	Association	11	4,515,553	25,000	1,453,000	410,505
	Foundation	18	4,937,983	25,000	779,400	274,332
	Networking/ Group/ Club	325	36,291,457	10,000	11,484,928	111,666
	Others	96	8,398,170	16,350	1,129,500	87,481
	<b>Total</b>	<b>450</b>	<b>54,143,163</b>			
2017	Association	10	3,256,461	50,000	708,100	325,646
	Foundation	25	5,148,363	45,000	1,000,000	205,935
	Networking/ Group/ Club	348	10,385,320	9,000	7,091,804	90,150
	Others	88	8,799,424	9,100	2,690,000	99,993
	<b>Total</b>	<b>471</b>	<b>48,576,421</b>			

### 3.5.4 CSOs that received funding from Global Fund

Two principal recipients (PR) take responsibility for management of the Global Fund budget in Thailand, which are PR-DDC and PR-Raks Thai Foundation.

#### a) Global Fund managed by PR-DDC

Only one CSO had received Global Fund funds managed by PR-DDC, and this was a foundation that provided RRTTR among migrants. The total amount of funding each year was approximately 10-12 million THB, 7 million of which, for some reason, had to be returned in the first year (2015). But the amount of returning money reduced in the following years to about four million THB (2016) and only one million THB in the last year (2017).

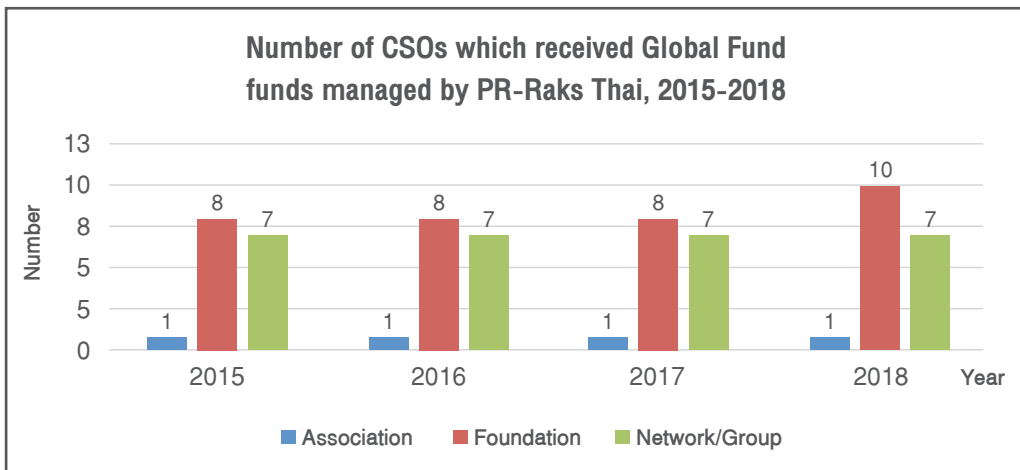
**Table 3.6:** Global Fund budget CSOs received from PR-DDC for RRTTR in 2015-2017

Year	Services	THB	
		Total amount	Return
2015	Reach-Recruit	2,091,008	2,688,652
	Test	230,392	199,939
	Treat	7,679,088	3,120,022
	Retain	278,234	267,486
	Others	1,629,711	723,481
	<b>Total</b>	<b>11,908,433</b>	<b>6,999,580</b>
2016	Reach-Recruit	1,792,152	1,236,126
	Test	232,983	163,542
	Treat	8,549,158	1,805,254
	Retain	248,455	267,434
	Others	1,000,354	745,173
	<b>Total</b>	<b>11,823,102</b>	<b>4,217,528</b>
2017	Reach-Recruit	1,539,585	596,068
	Test	245,838	65,640
	Treat	7,111,822	525,002
	Retain	229,828	13,795
	Others	1,798,840	18,669
	<b>Total</b>	<b>10,925,913</b>	<b>1,181,836</b>



**b) GF managed by PR- Raks Thai Foundation**

During 2015-2018, PR-Raks Thai Foundation provided a budget from the Global Fund to support CSO activities on HIV/AIDS in Thailand. It was found that the CSO group of foundation received the largest portion of the budget from the Global Fund through PR-Raks Thai Foundation. In 2018, 18 CSOs received funding (see Figure 3.11). In general, the Global Fund budget is used for health promotion and prevention across RRTTR, and this budget can cover the salary for management staff as well as equipment, insurance, and maintenance of CSO offices.



**Figure 3.11:** Number of CSOs that received Global Fund funds managed by PR-Raks Thai Foundation in 2015-2018

In addition, it was found that, from 2015-2018, the networking/group of CSOs had received the lowest budget of Global Fund funds from PR-Raks Thai Foundation, accounting for around 5,500-28,000 THB, whereas the foundation group of CSOs had received the majority of this budget, ranging from 2,000,000-4,800,000 THB (see Table 3.7).

**Table 3.7:** Global Fund budget that CSOs received from PR-Raks Thai Foundation in 2015-2018

Year	Type	THB			
		Total	Min.	Max.	Average
2015	Foundation	2,503,709	34,988	1,205,792	312,964
	Association	337,822	337,822	337,822	337,822
	Networking/ Group	402,708	28,319	125,916	57,530
	<b>Total</b>	<b>3,244,239</b>			
2016	Foundation	4,147,064	103,682	2,054,978	518,383
	Association	593,022	593,022	593,022	593,022
	Networking/ Group	727,760	54,944	252,320	103,966
	<b>Total</b>	<b>5,467,846</b>			
2017	Foundation	4,275,083	103,380	2,154,211	534,385
	Association	687,763	687,763	687,763	687,763
	Networking/ Group	772,053	66,024	275,491	110,293
	<b>Total</b>	<b>5,734,899</b>			
2018	Foundation	6,356,572	9,296	4,804,002	635,657
	Association	261,550	261,550	261,550	261,550
	Networking/ Group	464,105	5,461	349,889	66,301
	<b>Total</b>	<b>7,082,227</b>			

### 3.5.5 CSOs that received USAID budget

During 2016–2019, USAID provided a budget to support CSO activities, which was managed by LINKAGES/FHI 360. Five CSOs received USAID budget, which were one association, 3 foundations and one network (see Table 3.8). When looking at the proportion of each organisation type, all five CSOs had received budgets from USAID together with Global Fund and the NHSO. Comparing the USAID budget and other budgets (NHSO and GF) in the same area, CSOs received a larger amount of USAID budget at almost 90% of all the funding that they received in 2016. However, in the following years, CSOs received increased budget from the NHSO and Global Fund and so the amount of USAID budget they received was about half to two-thirds of these three sources.

**Table 3.8:** Comparison of USAID budget and other budgets provided to CSOs in a particular area in 2016-2019

Organisation	Funding Sources (%)											
	2016			2017			2018			2019		
	NHSO	USAID	GF	NHSO	USAID	GF	NHSO	USAID	GF	NHSO	USAID	GF
Association	0	93	7	22	23	55	22	62	17	55	45	0
Foundation I	44	52	4	30	28	43	21	65	15	60	40	0
Foundation II	0	98	2	13	58	29	12	82	6	22	78	0
Foundation III	0	100	0	17	83	0	18	82	0	57	43	0
Network	0	98	2	13	54	33	22	65	14	23	77	0



## **CHAPTER 4 SCOPING REVIEW**

## Chapter 4 Scoping review

This chapter presents the results of scoping reviews from published literature on social contracting for HIV services. Facilitating factors and barriers affecting the performances of HIV service delivery are identified.

### 4.1 Manuscripts for scoping review

This scoping review aims to explore HIV contracting models applied in different country contexts and based on international experiences; and to understand financing-related factors affecting HIV service delivery.

The search from two academic databases (namely Pubmed and Web of Science) yielded 2,782 records. Ten abstracts were not available leaving 2,772 to screen. Titles and abstracts screening excluded 2,612 records as they were not relevant. A total of 159 full papers were retrieved and then assessed for eligibility. 148 papers did not meet inclusion criteria leaving 11 articles to be included in the full analysis. The paper recruitment process is described in the PRISMA flow diagramme below (Figure 4.1).

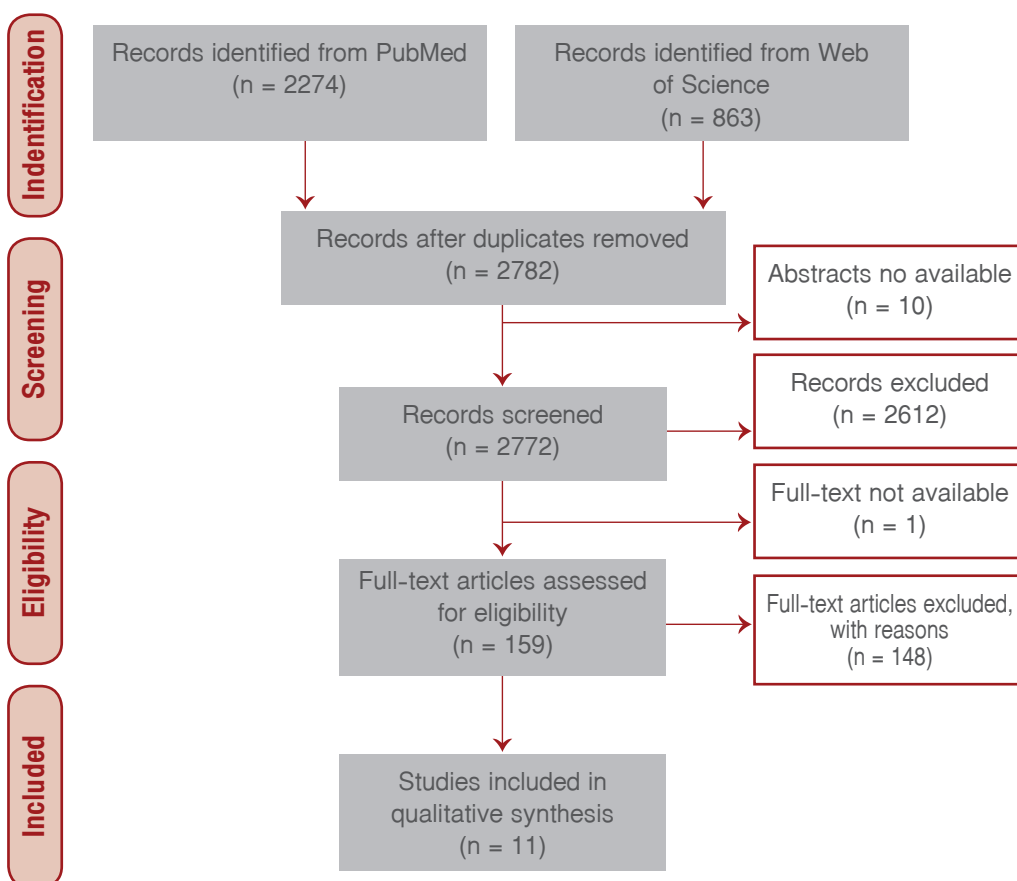


Figure 4.1: PRISMA flow diagramme

## **4.2 Characteristics of included studies in the scoping reviews**

The included papers were published from 2012-2019. Of the 11 articles, there is 1 study from a low-income country, 3 studies from lower middle-income countries, 6 studies from upper middle-income countries, and 1 study from a high-income country. For key populations, there is 1 study focusing on migrants (1/11), 2 studies (2/11) on PWID, 4 studies (4/11) on sex workers, and 8 studies (8/11) on MSM.

Table 4.1 summarizes the characteristics of the 11 included articles. As shown in the table, about half of the studies were conducted in China, with only one study in USA. MSM remained the main target KP for addressing HIV/AIDS in many countries.

## **4.3 Contracting models and HIV coverage outcomes**

The 11 studies included in this scoping review identify three distinct contracting models for HIV services based on the types of service contractor provider: (1) government providers; (2) non-governmental providers including NGOs, CSOs, and CBOs; and (3) hybrid models of government and non-government providers. The outcomes in terms of HIV service coverage are mixed regardless of the type of contracting provider models. Details of different models used and their outcomes are presented in Table 4.2. These outcomes reported in this table, either successful or failed, are measured by considering outcomes against designed objectives of the projects' interventions as suggested by the authors. For those papers where outcomes of the intervention are not assessed, researchers indicate 'not mentioned'. As can be seen, the contracting models with CSOs alone or hybrid (public-CSOs) demonstrated a comparative advantage and resulted in more successful outcomes.

**Table 4.1:** Characteristics of the studies included in the scoping review

Authors	Countries	World Bank income group	Study objectives	Study design	Key affected populations
Chakravarthy et al (2012) <sup>(39)</sup>	India	Lower middle income	To describe the development process of community mobilisation in an HIV/AIDS intervention programme in Andhra Pradesh.	Mixed method : Descriptive design	Female sex workers
Patcharanarumol et al (2013) <sup>(40)</sup>	Thailand	Upper middle income	To compare the programmatic and financing natures between the Global Fund and government funded programmes, assess the potential impacts and the coping mechanism if the Global Fund supports were to cease	Qualitative method using document reviews, in-depth interviews of key informants and a brainstorming session.	Migrants, PWID, Sex workers, and MSM
Semini et al (2013) <sup>(41)</sup>	Benin	Low income	To investigate the programme design and the implementation efficiency of the HIV/STI programs in the sex work context in Benin.	Mixed method: Qualitative method using on-site observation Quantitative method using questionnaire and secondary data analysis	Female sex workers
Fan (2014) <sup>(42)</sup>	China	Upper middle income	To examine the emergence of contracting with social organisations to provide social services in the HIV/AIDS sector in China	Qualitative method using participatory field research	MSM

Authors	Countries	World Bank income group	Study objectives	Study design	Key affected populations
Tucker et al (2014) <sup>(43)</sup>	China	Upper middle income	To examine organisational and financial characteristics of conventional HIV/syphilis testing systems for MSM and new pilot programmes focused on revenue-generation for sustainability	Qualitative method using one-on-one semi-structured interviews	MSM
Yan et al (2014) <sup>(44)</sup>	China	Upper middle income	To assess the feasibility and effectiveness of the task shifting from government facilities to CBOs in China	Mixed method: interventional design	MSM
Qureshi (2015) <sup>(45)</sup>	Pakistan	Lower middle income	To explore how the World Bank-sponsored public-private partnership sought to restructure the government's bureaucratic management of HIV along the lines of an efficient business, and the repercussions of this restructuring for bureaucratic culture in government departments	Qualitative method using ethnographic fieldwork	PWID, sex workers, MSM
Miller (2016) <sup>(46)</sup>	China	Upper middle income	To contribute to a deeper and more nuanced understanding of the complicated and perhaps unintended consequences of Global Health Initiatives	Qualitative method using ethnographic study through participant observation, in-depth interviews, and focus group discussions	MSM



Authors	Countries	World Bank income group	Study objectives	Study design	Key affected populations
Fan (2017) <sup>(47)</sup>	China	Upper middle income	To examine the use of performance-based financing to scale up HIV testing in MSM by global health initiatives in China	Qualitative method using ethnographic study	MSM
Khalid and Fox (2019) <sup>(48)</sup>	Pakistan	Lower middle income	To explore how policy actors tasked with implementing HIV programmes navigate the competing demands placed upon them by development targets and national politics, particularly in the current context of waning international investments towards HIV	Qualitative method using semi-structured, key informant interviews and group interviews	PWID
Burgess et al (2019) <sup>(49)</sup>	USA	High income	To determine aggregate quantitative results of HIV/STD testing and engagement in HIV care	Quantitative method using secondary data analysis	MSM

**Table 4.2:** Different HIV contracting models and their outcomes

Authors/Countries	KPs	Service	Contractor Providers	Contracting models	HIV service outcomes
Chakravarthy et al (2012)/India	Female sex workers	HIV prevention (encouraging health check-ups and service adherence, demonstrating condom use, planning activities at drop-in centres)	CBOs	<p><i>Sources of funding:</i> The Bill &amp; Melinda Gates Foundation and local NGOs</p> <p><i>Payment methods:</i></p> <ul style="list-style-type: none"> <li>Community guides received a monthly honorarium of Indian rupees 1500 (approximately US\$35) for outreach activities and informational contacts with their peers. Each community guide was required to work with at least 50 FSWs.</li> <li>Committee members of sub-districts level received an incentive of Indian rupees 750 per month and are to work for 6 days in a month.</li> </ul> <p><i>Requirements:</i> Local NGOs give training on HIV prevention to the FSWs recruited to be community guides.</p>	Not mentioned
Patcharanarumol et al (2013)/Thailand	Migrant, PWID, Sex workers, and MSM	HIV prevention and treatment	Two models: <ul style="list-style-type: none"> <li>Public providers</li> <li>CSOs</li> </ul>	<p><i>Sources of funding:</i> <i>For Thai KP:</i></p> <ul style="list-style-type: none"> <li>Prevention from Government and Global Fund</li> <li>Treatment from Thai public insurance</li> </ul> <p><i>For non-Thai KP:</i></p> <ul style="list-style-type: none"> <li>Prevention and treatment from Global Fund</li> </ul>	<p><i>Government programs:</i> doubtful effectiveness of intervention such as public media</p> <p><i>Non-state actors:</i> success</p>

Authors/Countries	KPs	Service	Contractor Providers	Contracting models	HIV service outcomes
Semini et al (2013)/Benin	Female sex workers	HIV prevention, refer to test, treat, VCT and other health services, behaviour change communication	NGOs and public health centres	<p><i>Payment methods:</i></p> <ul style="list-style-type: none"> <li>Government programmes: Pay by input in line with procurement rules and regulation</li> <li>GF supported programmes: A proposal-based payment focused on result and performance (result-based financing)</li> </ul> <p><i>Requirements:</i></p> <p>NA</p> <p><i>Sources of funding:</i></p> <p>External donors</p> <p><i>Payment methods:</i></p> <p>Most of the contractual agreements with the NGOs run for either three to six months or 12 months.</p> <p><i>Requirements:</i></p> <p>NA</p>	Failed
Fan (2014)/China	MSM	Reach, Recruit, Test, Retain	CBOs	<p><i>Sources of funding:</i></p> <p>The Chinese Center for Disease Control (CCDC)</p> <p><i>Payment methods:</i></p> <p>Outsourcing service with a defined set of outputs.</p> <p>One example in the paper is that the CBO was paid 25,000 RMB per 6 months (approximately US\$4000) directly from government budgets by their local CCDC in return for organising one training workshop a month, to reach a total of 2000 MSM, and testing 400 MSM.</p> <p><i>Requirements:</i></p> <p>NA</p>	Success

Authors/Countries	KPs	Service	Contractor Providers	Contracting models	HIV service outcomes
Tucker et al (2014)/China	MSM	HIV/syphilis testing services	<p>Three models:</p> <ul style="list-style-type: none"> <li>• Independent CBO</li> <li>• Independent Clinic (hospitals, Center for Disease Control-based testing)</li> <li>• CBO-Clinic hybrid</li> </ul>	<p><i>Sources of funding:</i></p> <ul style="list-style-type: none"> <li>• Government subsidized both clinic and CBOs</li> <li>• Ad hoc support to CBOs from global biotechnology companies or foundations which created a culture of CBO dependency</li> <li>• Own revenue generation in four piloted hybrid CBO-clinic.</li> </ul> <p><i>Payment methods:</i></p> <ul style="list-style-type: none"> <li>• Clinic: fee-for-service,</li> <li>• CBOs: government-funded through public health clinics directly providing tests or through subcontracts to CBOs (payment methods not mentioned)</li> <li>• pilot CBO-Clinic: sell products (condoms, STD test, clothes, books, etc) or sell services (private clinic tailored to FSW, online advertisement, partnership with business)</li> </ul> <p><i>Requirements:</i></p> <p>CBOs must pay exorbitant fees for official registration process to be officially registered as non-profit-organisation which is a district-specific requirement (cannot register in one district and work in another district). Being a non-profit organisation allows fundraising.</p>	Success (Hybrid CBO-clinic model)

Authors/Countries	KPs	Service	Contractor Providers	Contracting models	HIV service outcomes
Yan et al (2014)/ China	MSM	HIV prevention (knowledge dissemination, risk reduction counselling, condom use promotion, refer to test, rapid HIV testing)	CBOs	<p><i>Sources of funding:</i> Jiangsu Province Preventive Medicine Association (JSPMA)</p> <p><i>Payment methods:</i> 'Cash on service delivery' - 10 USD per most-at-risk population had HIV/syphilis testing with result informed; additional 82 USD per newly HIV positive case. Cash was paid to CBOs every six months by Jiangsu Province Preventive Medicine Association (JSPMA), based on verified core indicators retrieved by respective local CDCs and Nanjing Municipal CDC.</p> <p><i>Requirements:</i> Local CDCs and hospitals as well as well-established CBOs provide trainings to CBOs as capacity building package. This includes knowledge on HIV/sexually transmitted diseases, risk behaviour change communication, administering rapid HIV test, maintaining confidentiality and procedures for referral and follow-up for PLHA according to national guidelines.</p>	Success

Authors/Countries	KPs	Service	Contractor Providers	Contracting models	HIV service outcomes
Qureshi (2015)/ Pakistan	PWID, sex workers, MSM	HIV prevention	NGOs	<p><i>Sources of funding:</i> 15% from the government and 85% from the World Bank</p> <p><i>Payment methods:</i></p> <ul style="list-style-type: none"> <li>• Output-based contract where the success of contract was to be measured by a decrease in the infection rates among targeted groups calculated on a yearly basis, not focus on inputs.</li> <li>• The payment covered HR costs which were big market-based salaries and incentives. The 'market-based' staff were hired on short-term renewable contracts with no pension or other benefits.</li> </ul> <p><i>Requirements:</i> The programme obliged the government to hire a management consultancy firm to teach NGOs business management and rules to follow. This firm also performed monitoring and reviews of NGOs' performance.</p>	Not mentioned

Authors/Countries	KPs	Service	Contractor Providers	Contracting models	HIV service outcomes
Miller (2016)/ China	MSM	HIV testing and treatment	Local NGOs	<p><i>Sources of funding:</i> Global Health Initiative (GHI) grants which come from Global Fund and Gates Foundation</p> <p><i>Payment methods:</i></p> <ul style="list-style-type: none"> <li>• Payment methods - 60-62 RMB per HIV test with 300 RMB for each HIV positive blood samples. The target number increased every year regardless of previous performance.</li> <li>• Performance incentives - the CCDC ranked NGOs according to the number of HIV tests and the percentage of HIV-positive blood samples. The groups who performed more tests and discovered more HIV-positive MSM given larger, more lucrative contracts in the future.</li> <li>• Flow of Funds - Grassroots NGOs are unable to legally register with the government, they cannot accept funds directly from GHIs. Therefore, government-operated NGOS act as "trustees" by funneling funds from donor agencies to local civil society recipients while diverting some of the resources to support themselves.</li> </ul> <p><i>Requirements:</i> NGOs that can accept funds from GHI must legally register with the government otherwise they have to be sub-contracted by 'government-operated NGOs' which act as trustees.</p>	Not mentioned

Authors/Countries	KPs	Service	Contractor Providers	Contracting models	HIV service outcomes
Fan (2017)/China	MSM	Test	CBOs	<p><i>Sources of funding:</i> Multiple sources including Chinese CDC, Global Funds, Gates Foundation</p> <p><i>Payment methods:</i> Performance-based financing at different rate for across projects and funders.</p> <ul style="list-style-type: none"> <li>• Global Fund paid 60 RMB per vial of blood.</li> <li>• Gates paid 9 USD per HIV test and additional 44 USD for positive case.</li> <li>• Chinese CDC paid 7 USD per test &amp; 90 USD per positive case. Another case by local CCDC paid 15 USD per test and 75 USD per infection.</li> </ul> <p><i>Requirements:</i> NA</p>	Not mentioned
Khalid and Fox (2019)/Pakistan	PWID	HIV prevention and treatment	NGOs	<p><i>Sources of funding:</i> Global fund and the government</p> <p><i>Payment methods:</i> NGOs are hired on contracts by the provincial AIDS control programmes through a competitive bidding process.</p> <p><i>Requirements:</i> NA</p>	Failed



Authors/Countries	KPs	Service	Contractor Providers	Contracting models	HIV service outcomes
Burgess et al (2019)/USA	MSM	HIV/STD testing and care engagement activities	The Louisiana Department of Health STD/HIV Program's Wellness Centers which works as collaborative effort between Louisiana Department of Health, a CBO, and local providers of community services.	<i>Sources of funding:</i> The U.S. Centers for Disease Control and Prevention (CDC) <i>Payment methods:</i> Project-based <i>Requirements:</i> NA	Success

## 4.4 Contracting models and factors affecting HIV service delivery

The enabling factors and/or challenges for the contracting models identified in each study and included in this scoping review can be seen in Annex B. The summary of enabling factors and challenges by different contracting models for HIV service delivery is presented in Table 4.3 below.

**Table 4.3:** Enabling factors and challenges by different HIV contracting models

Performance	Enabling factors	Challenges
<b>I. CBO model or CBO-public (hybrid) model</b>		
Success	<p><u>Service design</u></p> <ol style="list-style-type: none"> <li>1. The comparative advantage of CBOs in reaching key-affected populations which can ensure their continued participation in service.</li> <li>2. Hybrid CBO-clinic testing sites effectively integrate the client-friendly environment of the MSM.</li> <li>3. A specialised and holistic approach to health for gay and bisexual men and transgender persons.</li> <li>4. CBOs have the technical competence and facilities of a public health clinic.</li> </ol> <p><u>Governance and management</u></p> <ol style="list-style-type: none"> <li>5. Mapping of CBO service providers and assessment of their capacity, supplemented with timely and targeted capacity building, appeared to strengthen the CBOs' capacity to deliver quality services.</li> <li>6. The Global Fund model has clear accountability framework under the distinct 'Principal Agent' relationship through contractual agreement.</li> </ol> <p><u>Financial issues of the CBO</u></p> <ol style="list-style-type: none"> <li>7. Social entrepreneurship initiatives where CBOs can generate their own incomes make them more financially sustainable. (Tucker et al, 2014).</li> <li>8. An effective and transparent payment system to ensure predictable resources to CBOs, for example, actual cash payment based on independently verified results through web-based national HIV/AIDS information system (Yan et al, 2014)</li> </ol> <p><u>Impacts</u></p> <ol style="list-style-type: none"> <li>9. The sustained public health impact.</li> </ol>	<p><u>Governance &amp; Management</u></p> <ol style="list-style-type: none"> <li>1. Better resource management, democratic functioning and other components of collective actions are required.</li> <li>2. Excessive fees associated with the official registration process for non-governmental organisations precluded CBOs from being officially registered as non-profit organisations, limiting their fundraising capabilities and contribution to HIV/AIDS services</li> </ol> <p><u>Financial issues among the CBO</u></p> <ol style="list-style-type: none"> <li>3. No mechanisms to ensure CBO financial sustainability.</li> <li>4. CBOs generally struggled to mobilise additional funds needed to cover their operating expenses (e.g. testing space rental, phone lines, outreach cost, staff stipends/salaries). Restrictions on hiring staff or paying for other administrative fees and operating costs as part of many external funding schemes compromised the ability of CBOs to maintain or scale up testing programmes. It is important to obtain all needed supplies and equipment before implementation of the service model.</li> </ol> <p><u>Impacts</u></p> <ol style="list-style-type: none"> <li>5. The social entrepreneurship model could create confusion among testers unless clearly rebranded these social enterprises from existing CBO contract with government HIV services (paying for a test that had traditionally provided through</li> </ol>

Performance	Enabling factors	Challenges
		<p>public sector would commercialise the service); misunderstanding a new social entrepreneurship project as a purely profit motivated enterprise. (Tucker et al, 2014).</p> <p>6. For the model that allow user charge, paying for services would either discourage utilisation of services or decrease the frequency of utilisation.</p>
Failed		<p><u>Service design</u></p> <p>1. Tackling exclusively the individual risk is likely to have a limited impact. Structural interventions that address societal causes such as social exclusion, police harassment, stigma, and unfriendly legal environment coupled with programme ownership by FSWs and communities, can remove barriers for access to services and enable FSW to have greater control of their work condition and seek counselling and HIV services</p> <p><u>Governance &amp; Management</u></p> <p>2. Governance challenges included strained state and non-governmental organisation (NGO) relations creating a hostile service delivery environment, weak bureaucratic and civil society capacity contributing to poor regulation of the health infrastructure, and resource mismanagement on both the part of the government and NGOs.</p> <p>3. Low and inconsistent political commitment for HIV and a conservative legal environment that contributed towards a ban on opiate substitution therapy, creating low treatment coverage among PWID.</p> <p><u>Financial issues of the CBO</u></p> <p>4. Irregular financial flow has resulted in interruptions of community-based services for KP.</p> <p>5. Mismatch between allocated resources (funding &amp; staff) and KP needs at the regional level.</p>

Performance	Enabling factors	Challenges
Not mentioned		<p><u>Governance &amp; Management</u></p> <ol style="list-style-type: none"> <li>1. The situation where the state is unable to work with such 'quasi-legal' groups put forward as the rationale to contract out to NGOs, which weakened the state's social and regulatory operations and deprived the state of any opportunity for capacity development.</li> <li>2. The flexible bureaucracy and the CBO's social entrepreneurial governance of the HIV programme without government regulatory capacity to scrutinise inputs allowed the money to end up in the pocket of a few powerful individuals. For example, greater capacity NGOs (national or international NGOs) can register with the Chinese government and receive GHI funds directly giving them greater financial incentives over grassroots, unregistered local NGOs. (Miller, 2016)</li> <li>3. The HIV programme management agency lacked expertise in the HIV sector.</li> <li>4. The social entrepreneurial model by CBO turned the HIV response into a market, turned employees into selves. The myth of 'efficiency', enacted in the rituals of 'flexible governance', turned institutions into hatcheries of private interest, where CBO employees became proprietors of their positions.</li> <li>5. Performance-based financing turned/narrowed the focuses of NGOs towards reimbursable &amp; measurable activities such as numbers of HIV tests rather than comprehensive HIV education and prevention services which aim for health outcomes as well as long-term social and political change.</li> <li>6. Increased competition between charismatic leaders and NGOs, by encouraging them to compete for project contracts and monies that they became increasingly reliant upon to survive.</li> </ol>

Performance	Enabling factors	Challenges
<b>II. Independent public facility model</b>		
Doubtful		<u>Service design</u> 7. Limitation to address preventions among non-Thai KP, doubtful effectiveness of some interventions e.g. public media  <u>Management &amp; governance</u> 8. Skills and competencies to work effectively for KPs varied across CSO implementing agencies 9. Government programmes have rigidity, legal/budgetary constraints and limited capacity in outsourcing/contracting services to competent non-state actors. Government integrated model limits accountability due to conflict of interests as the national health authority played dual roles of Principal and Agent

In summary, the key success factors for the social contracting model of HIV services, drawn from this scoping review are: (1) The involvement of competent CSOs in HIV service delivery; (2) The provision of a clear accountability framework across relevant actors in particular the Principals and the Agents; (3) Relationships among relevant key stakeholders; and (4) An effective, transparent payment system. The barriers and challenges highlighted in this scoping review mainly relate to the governance structure, management system and financial issues. The most challenging issue concerns what mechanisms are needed in order to sustain the involvement of CSOs in HIV service delivery over the long term. Most CSOs are non-profit organisations and this legal status has limited their capabilities in fund mobilization to sustain their organisations; with the exception of CSOs which initiated social entrepreneurship. Therefore, CSOs seem to struggle with looking for additional funding for their own survival to cover the organisational expenses and operational costs. The mismatch between allocated resources (funding and staff) and KPs' needs could also hinder the achievement of the service. More importantly, one study pointed out that performance-based financing could make CSOs concentrate on reimbursable and measurable activities, such as numbers of HIV tests, rather than comprehensive HIV education and prevention services and social and structural changes.

## 4.5 Experiences of social contracting models in China, India, and Malaysia

As well as looking at published literature in the scoping review, researchers conducted a brief review of some international experiences of social contracting models. This review is based on experiences of providing a social contracting model in three countries, namely China, India, and Malaysia, which have been shared by the FHI 360<sup>(50)</sup>. The key messages derived from their experiences are described below.

A social contracting model refers to mechanisms for certain parts of government funds to flow directly to CSOs to implement specific activities; this can be done through various methods including grants, procurement and contracting, and/or third-party payments.

It has been accepted that CSOs play a complementary role in addressing HIV/AIDS, in particular identifying and working with KPs who are most vulnerable population groups, due to their unique characteristics. This level of support cannot be found in public sectors and includes: (1) A deep understanding of the problems in accessing services and closeness to KPs; (2) An ability to introduce effective innovative responses, such as self-testing and providing PrEP interventions; and (3) High flexibility and responsiveness in understanding and addressing the specific needs of KPs. Therefore, CSOs are indispensable partners and should engage with the full process of the social contracting model at all stages from priority-setting to service delivery to monitoring and evaluation.

Table 4.4 presents the summary of important lessons learned from China, India, and Malaysia in establishing a social contracting model for implementing HIV/AIDS activities, which could possibly be applied by Thailand and others countries.

**Table 4.4:** Lessons learned from China, India, and Malaysia in providing social contracting model

Topic	China	India	Malaysia
Amount of funding	8-10 million RMB (1.16-1.46 million USD) per year (2014-2017)	Over 3 billion Indian Rupees (US\$ 42.5M) per year (2015-2018)	Over RM100 million (US\$25 million) over 5-year period (2012-2017)
Contracting level	Province	State/District	Central
Managed by	<ul style="list-style-type: none"> <li>National HIV/STI Association</li> <li>Provincial AIDS Bureaus</li> <li>Prefectural/county leadership</li> <li>Chinese Centers for Disease Control</li> <li>ART Hospitals</li> </ul>	<ul style="list-style-type: none"> <li>National AIDS Control Organisation (NACO)</li> <li>State AIDS Control Societies (SACS)</li> <li>District AIDS Prevention and Control Units</li> </ul>	Malaysian AIDS Committee (MAC) and MOH
Application process	<ol style="list-style-type: none"> <li>Pre-announcement preparation</li> <li>Open advertisement</li> <li>Proposal submission and review</li> <li>Decision on awards</li> <li>Agreement on scope</li> <li>Implementation</li> </ol>	<ol style="list-style-type: none"> <li>Open advertisement</li> <li>Preliminary screening</li> <li>Appraisal visit</li> <li>Partner selection</li> <li>Proposal writing workshop</li> <li>Proposal review and shortlisting</li> <li>Contracting</li> </ol>	<ol style="list-style-type: none"> <li>Submission of applications</li> <li>Initial review of applications</li> <li>Submission of proposals</li> <li>Approval</li> <li>Disbursement (three months of advanced funding)</li> <li>Reporting</li> </ol>
Performance evaluation	<ul style="list-style-type: none"> <li>Biannual site visits</li> <li>Review of quarterly reports</li> <li>Data quality assessments</li> <li>An annual review of achievements.</li> </ul>	<ul style="list-style-type: none"> <li>Biannual evaluation, using a standard set of indicators, including the number of individuals reached, the number of prevention commodities distributed, KPs screened for HIV and other STIs, KP PLHIV linked to ART, and others.</li> </ul>	<ul style="list-style-type: none"> <li>MAC regularly and consistently monitors its CSO members and their programmes and provides technical assistance to its partners wherever possible.</li> </ul>

Topic	China	India	Malaysia
Strengths	<ul style="list-style-type: none"> <li>Provincial grants (e.g. in Yunnan) specify that up to 45% of the grant can be used to support overhead costs.</li> <li>Support for skills building in prevention, care and treatment, project management, monitoring and onsite supervision.</li> </ul>	<ul style="list-style-type: none"> <li>Clear criteria to determine CSO shortlists:               <ol style="list-style-type: none"> <li>Submission of requisite documents</li> <li>Experience implementing HIV interventions</li> <li>Past record working with specific key populations</li> <li>Organisational integrity (e.g., history of malpractice or complaints)</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>Technical Support Unit (TSU) visit each NGO monthly to provide supportive supervision.</li> <li>Timely access to technical expertise among its network,</li> <li>Strategic information that is timely and consistent, advocating with a unified voice</li> <li>Grant coordination efficiency.</li> </ul>
Challenge	<ul style="list-style-type: none"> <li>A lack of resources for the provision of regular onsite supervision and technical monitoring.</li> </ul>		

In summary, the government of each country established an organisation to take responsibility for co-ordinating and supporting both government and non-government sectors to continue working together on HIV/AIDS. All three countries recognised the important role of CSOs and strategically used the social contracting model to engage CSOs in addressing HIV/AIDS in line with each country goal and specific context. Experiences from these countries suggest that the provision of a social contracting model through transparent application processes, mutual understanding about the scope of work between government and local organisations, regular and monitoring and evaluation and technical supervision, CSOs can demonstrate good performance in enhancing HIV case findings, leading to an increase in overall HIV testing among KPs. CSOs are therefore key strategic partners in the quest for ending AIDS.







**CHAPTER 5** IN-DEPTH  
INTERVIEWS

## Chapter 5 In-depth interviews

This chapter provides the results of in-depth interviews conducted among four main groups of key concerned stakeholders including funders, CSOs, providers, and the Regional Office of Disease Prevention and Control. The interviewees were selected in relation to their roles in HIV contracts for providing activities under RRTTR cascades.

The qualitative results form the main part of this study, the in-depth and group interviews, were applied in order to collect data from four main stakeholder groups. The list of interviews can be seen in Table 4.1 below.

**Table 5.1:** List of interviews regarding an effective HIV contracting model for Thailand

Code	Date of interviews	Involvement with HIV contracting model
Funder		
F1	31-May-19	Manage 50-million-THB budget for HIV/AIDS activities of DDC
F2	14-Jun-19	Select CSOs for HIV prevention project at NHSO regional office
F3	19-Jun-19	Provide technical support to hospital, provincial health office, and CSOs in the province as well as monitor and evaluate their performances
F4	3-Jul-19	Manage 200-million-THB budget for HIV/AIDS activities of NHSO
F5	8-Jul-19	Manage budget on HIV/AIDS supported by the Global Fund
F6	3-Sep-19	Manage budget on HIV/AIDS supported by the Global Fund
F7	3-Sep-19	Manage budget on HIV/AIDS supported by USAID
F8*	25-Sep-19	Manage budget on HIV/AIDS supported by USAID
Provider		
C1	7-Jun-19	Provide HIV prevention and control activities, targeting MSM, TG, and FSW, including laboratory clinic (RRTTR)
C2*	19-Jul-19	Provide HIV prevention and control activities, targeting MSM and TG (including MSW and FSW); (RR, refer to test, and mobile clinic with hospital)
C3	19-Jul-19	Provide HIV prevention and control activities, targeting FSW (RR, refer to test)
C4*	2-Aug-19	Provide HIV prevention and control activities, targeting SW both female and male (including MSM and TG), including laboratory clinic (RRTTR)

Code	Date of interviews	Involvement with HIV contracting model
C5	9-Jul-19	Provide HIV prevention and control activities, targeting MSM, PWID FSW, TG, and Migrant (including migrant SW)
C6	4-Jul-19	Provide HIV prevention and control activities, targeting MSM, Lesbian, and TG, including laboratory clinic (RRTTR)
C7*	15-Aug-19	Provide HIV prevention and control activities, targeting MSM, including laboratory clinic (RRTTR)
C8*	16-Aug-19	Provide HIV prevention and control activities, targeting PWID
C9*	16-Aug-19	Provide HIV prevention and control activities, targeting MSM and TG (RR refer to test, and retain)
C10*	16-Aug-19	Provide HIV prevention and control activities, targeting TG, including laboratory clinic (RRTTR)
C11	12-Nov-19	Provide HIV prevention and control activities, targeting MSM and sex workers (RR, refer to test, and retain)
C12	20-Nov-19	Provide HIV prevention and control activities, targeting MSM and TG (RR, refer to test, and retain)
<b>Regional Office of NHSO</b>		
R-NHSO1	12-Nov-19	Manage 200-million-THB budget for HIV/AIDS activities of NHSO
R-NHSO2	18-Nov-19	Manage 200-million-THB budget for HIV/AIDS activities of NHSO
<b>Regional Office of DDC</b>		
R-DDC1	5-Jun-19	Technical support and M&E of HIV/AIDS activities in the region
R-DDC2	7-Jun-19	Technical support and M&E of HIV/AIDS activities in the region
R-DDC3	27-Jun-19	Technical support and M&E of HIV/AIDS activities in the region
<b>Health Providers (Hispitals)</b>		
P1	7-Jun-19	Provide ART services in a hospital (including PrEP and PEP)
P2	7-Jun-19	Provide ART services in a hospital (including PrEP and PEP), and working with CSOs in the province to provide RR and refer to testing
P3	16-Aug-19	Provide one stop service for HIV at a hospital and work with CSO and community to provide RR, targeting FSW and MSM
P4	23-Aug-19	Provide ART service in a hospital, focusing on Test, Treat, and Retain only
P5	10-Oct-19	Proactive RRT, working with local NGOs (refer positive cases to ART clinics)
P6	10-Oct-19	Provide ART services in a hospital, and work with CSOs in the province to provide, RR and refer to testing

\*Group interview

Based on the interviews, five themes emerge from the analysis as follows:

## Theme 1: CSOs demonstrated strengths in case findings

It was found that there is no doubt about the strength of CSOs in terms of finding HIV cases, particularly in the areas of 'Reach', 'Recruit' and 'Refer to test' as all key informants acknowledged this. All of them believed in the strength of CSOs as they can reach their target groups or KPs, where public providers (hospitals) may not be able to do so. Examples of statements that confirm the strength of CSOs are as follows.

- CSOs understand their KPs better than the public sector does. Thus, they can reach, recruit and refer people to test more in greater numbers and with more specific targets than the public sector. One interviewee pointed out that CSOs are also more adaptive to changing situations than public providers as public providers may have to stick within the rules and regulations and be unable to change.

*"Workers need to understand the context (e.g. behaviour) of the target group and also be able to adapt themselves accordingly, which is the NGO's attractive characteristics, while public provider cannot do it (เป็นเสน่ห์ที่ NGO ทำได้ แต่รัฐทำไม่ได้)." -- C4*

- There is no limitation in working hours as CSOs can work overtime or during the time period that suits best for meeting up with their targets. For example, working late hours in order to meet with sex workers who usually work at night time.

*"Most NGOs do not limit their working hours (compared to public officers). So, they can work at any time in order to meet up with their KPs." -- P5*

- Working with CSOs is important in tackling HIV/AIDS. Therefore, it is necessary for the government to maintain relationships with CSOs.

*"The government should not give up on them, if the government stops working with them, we may lose them (ภาครัฐต้องไม่ปล่อย ถ้าปล่อยจะหลุด)." -- F2*

- To move forward in implementing some policies and/or country strategies, the government may need CSOs to help and work together more deeply.

*"In the future, CSOs may be the key implementer to move public policies/ strategies forward. More insightful or in-depth work must help CSOs to get inside or close to the target." -- C3*

## Theme 2: Teamwork, rapport, and trust are key to combatting HIV/AIDS

Most key informants mentioned that working as a team is more effective in combatting HIV/AIDS. Good relationships and trust between the NHSO, provincial health office, public hospitals, and CSOs are important in establishing an effective HIV contracting model. There are several benefits when working together. For instance, the provinces can achieve their targets more effectively and precisely by having CSOs to reach, recruit, and refer to test; hospitals can do more HIV testing and provide proper care management to PLHIV people; and more importantly, through regular meeting and information sharing, patients can access care wherever and whenever they need as well as maintain their adherence to ART. The overlaps of working on duplicated HIV cases can also be solved.

Below are some statements highlighting the important of good relationships and strong collaborations among key concerned stakeholders.

*“Capacity in working with other institutions should be developed, particularly in the big provinces, which may have some overlaps of target groups. Working standards, funding, and information should be the same. Identified target groups according to responsible areas of each institution must be clear and follow the same strategic direction.” -- C2*

*“NGOs must not be too arrogant, while government (or public sectors) must not have too much conviction (NGOs ต้องไม่หังการเกินไป รัฐก็ต้องไม่ทึล).” -- C4*

## Theme 3: Some work difficulties occurring in the field require attention and solutions

Some work difficulties that public providers and NGOs face within the field require attention from the government or relevant stakeholders to appropriately respond to those problems or find the best solution, including:

- o **Duplicated cases** could happen if there is no clear separated area of working and no good ‘real time’ database to verify it promptly. The NHSO will not pay for ‘Reach’ if it is duplicated, but in the NGOs’ view, there are opportunity costs incurred for certain work that has already been conducted.

*“Money should be paid for their actual activities (should not be determined by target achievement only) as they have really spent time and effort with it already.” -- F8*

- o **Retain is the most difficult** area as the high mobility of KPs and the cycle of the working period is relatively short (5-6 months due to the delay of the funding process, which will be explained in Theme 5: areas of improvement regarding adjustment of funding allocation.)

Some statements confirm that ‘Retain’ is the critical concern as it is the most difficult to achieve and requires collaborations of key concerned stakeholders. This is shown in the statements below.

*“NGOs cannot do “Treat” and “Retain” on their own, but they receive money for these activities ... and so do not know what to do with the remaining amount of money as there is no clear method of management as well as very limited time left for this remaining activity.” -- C2*

*“Retain will happen if only there is a request for help ... local workers just voluntarily help each other.” -- C3*

- o **No funding for services delivered to migrant (non-Thais)** is problematic as local hospitals and NGOs must provide care and treatment according to health needs. In some areas, KPs have migrant status and these people are not covered by the NHSO budget. Since healthcare services delivered to these people cannot be reimbursed by the NHSO, it means a certain amount of financial burden has been shouldered by health providers and NGOs.

*“If we are moving towards to ending AIDS, we just cannot take care of Thai people only. This is due to the fact that Thailand does have migrants in the country.” -- C3*

*“The goal of ending AIDS does not allow us to choose the nationality (of KPs).” --C8*

#### **Theme 4: Despite facing with work difficulties, some good interventions have emerged.**

##### **1) Same day ART**

‘Same day ART’ has been initiated by the Thai Red Cross and FHI 360 with the idea that an HIV positive person will receive ART as soon as possible at any CD4 level e.g. as soon after knowing the HIV test result or within two to three months. Thus, after testing for HIV and knowing that he or she is HIV positive, the clinic will instantly give ART for around one month, which corresponds to the policy of treating at any CD4 levels.

In doing so, it allows time to change his or her UC contracting provider (hospital). About 19 hospitals in Chiang Mai, Chiang Rai, Ubon Rajchathani, Chonburi, and Songkhla have been working with the Red Cross and FHI 360 as a network. It has been found that viral suppression is better when receiving ART on the same day of HIV testing than receiving it later, which may be because the patients feel strong as they did not visit a hospital when severely ill (like other walk-in patients).

It should be noted that although this initiative is called “Same day ART”, not all clinics or hospitals can provide ART on the same day as the HIV testing date. In reality, PLHIV may receive ART as early as possible, which could be within a week or, in some cases, could be one to three months depending on circumstances. Nevertheless, this initiative has led to the important suggestion that promoting CSOs to detect a HIV positive patient and to provide ART before getting sick would help reduce the cost of treatment compared to providing treatment when a patient is severely sick.

## **2) The use of social media to reach specific target groups**

Since the use of social media is highly prevalent among new generations, CSOs have tuned into case findings through social media, such as Facebook and Twitter, resulting in a higher reach in their target populations.

For example, several MSM tend to use different kinds of drugs for pleasure. Therefore, an NGO working with PWID has reached out via Twitter to MSM who use drugs. After talking for a while and gaining trust from these people, the NGO can deliver clean syringes and needles to MSM drug users through the post (by using a code for sending and making it look like items used for training).

Another example is about finding HIV-positive MSM via the Internet. An NGO working with MSM reported that by talking with MSM via the Internet, they could reach greater numbers of MSM than before. Moreover, more HIV positive cases were found in MSM whom they met online and successfully convinced to take HIV testing. These MSM also received ART more quickly. People want to receive treatment soon after knowing the results as they do not want to get severe ill.

“They (MSM) don’t want other people to know who they are or what their sexual preferences are. Thus, they choose to do anything as quickly as they can to prevent signs or symptoms from manifesting, and so they agree to take medicines very quickly.” -- C4



## Theme 5: Several areas of improvement are highlighted

### 1) Setting a target together among all relevant stakeholders is crucial

Most key informants suggested there was a need to set targets together among all relevant stakeholders. This would help solve several issues, including:

a) Making the target more realistic and suitable to the local context.

Some key informants viewed targets set by the NHSO as too numerous and impractical. Thus, meeting together among stakeholders and discussing intensively may lead to more appropriate targets. Several CSOs shared their opinions on this issue. Someone suggested that “the bottom up approach” may be more useful and would provide targets that were suitable for local context.

*“Setting a target should not be done by the top down, but should be done by the bottom up. Right now, it seems we just have to divide our work like distributing a piece of cake in the field (ตอนนี้เหมือนต้องมาแบ่งเค้กกันในพื้นที่).” -- C4*

Another expression of frustration was that funding allocation should be more focused with better value for money.

*“The money available should be effectively allocated; meaning that it is given to the right target and for the right solution” (เงินที่มีควรวางให้ได้อย่างมีคุณภาพ ตรงจุด และตรงกับสิ่งที่ควรจะเป็น).” -- C4*

b) Setting targets together will promote teamwork, leading to more effective performance.

There should be a participatory process between funders and those working in the field. This will help promote a more effective way of working as a team.

*“We feel deeply disappointed that we, as field workers, do not have a chance for setting the target, but just receiving it. Why can't a small NGO like us not have the right to negotiate anything?” -- C2*

Having said that, the stakeholder further explained that, actually, NGOs did not feel too strongly about the assigned target if funding had been given sufficiently in correspondence to the field activities. The NGO's income had generally been attached to the target. If they received low numbers of targets, it might also mean they would not get enough money to work on those activities.

One NGO stakeholder suggested that it might be good to have an NGO working in the field as one of the members of the NHSO committee (or sub-committee) to make justifications on the 200-million-THB budget for HIV prevention and promotion activities. Here, they can get a chance to voice their opinions and the financial allocation for HIV activities in the field would be more appropriate to their local context and real working situation.

*“Having representatives of NGO or CSOs and listening to their opinion will be good for the budget management; NGOs that are on the Board might do different work (different from NGOs working in the field).” -- C6*

c) Setting targets together will help solve the overlap of work and duplicated cases.

As mentioned previously, sometimes there are overlapping working areas and some duplicated HIV cases. Meeting and setting the target together will help solve this problem as each CSO will be clear about its target to be achieved and its responsibility for working.

*“Mapping working areas together with other local institutions will let us know which one takes responsibility for which area and so there will be no duplicated efforts.”*

*-- C4*

## **2) Adjustments of funding allocation are necessary**

Most interviewees felt positive with the 200-million-THB budget managed by the NHSO as they had tried to adapt to the contracting model, which was also designed by the NHSO. None of them proposed a new model. However, they raised several issues which need to be adjusted or changed in order to make it more effective:

a) The slow funding process is really problematic.

All CSOs and some providers mentioned the slow funding process, which means CSOs received funds to carry out the work very slowly. In this case, they have less time for conducting their work plan as although the contract states 12 months, by the time the funds arrive there is only 5-6 months left. Therefore, most of the time, CSOs need to return an amount of money in the third installment as they do not have time to complete the work as planned.

*“To receive the budget from the NHSO has certain conditions and a relatively slow process. It takes so long to get money, which create a hiccup of working. So, we have to hurry to get the job done in order to get the payment that does not include our monthly salary.” -- C1*

To get the money slowly is really problematic for small or new NGOs. A small organisation may not have savings to pay for their work in advance, but needs to wait until it gets funding from the NHSO. Therefore, they have a short period of time for working.

*“To get the money slowly, if it is a small organisation, it will not be able to get the job done in time. For ... (a big/long-time organisation)..., we can use our own savings. So we can work continuously by using our own money.” -- (C3)*

b) Funding should be allocated according to a list of activities (depending on the local context)

Some interviewees suggested providers (hospitals) should be allowed to do the things they are best placed to do. On the other hand, CSOs should be allowed to do what they are best at. For example, laboratory testing and treatment should be done by a hospital, whereas case findings and retaining should be done by CSOs.

*“NGOs’ work may be more advanced than hospital services. Thus, it might be better, if we know that NGOs do RRT mobile better, to let them do it!” -- C2*

In addition, funding should be allocated according to activities, rather than focusing on targets only. Therefore, there was a suggestion that it may be better for the NHSO to provide funding as a project base.

*“Funding should be allocated as a project base, but this requires a funding manager as well as M&E process, which includes capacity building.” -- F8, C4*

c) The installment could be reduced from three to two installments

Reducing the installments from three to two might help NGOs work more efficiently as they do not need to be worried about preparing the progress report in the middle of a period of work, and so can focus on their activities in the field.

*“Reducing the installment from three to two would help us work more efficiently (ลดงวดการจ่ายเงินให้เหลือสองงวด เพื่อให้คล่องตัวมากขึ้น).” -- C3*

d) Although NHSO funding is relatively flexible and allows for some local adjustments, it should have certain standard requirements at the central level.

Due to the fact that “one size does not fit all”, each local area (province) may have differences in: (1) CSO capacity; (2) Support received from outsiders (oversea funders or local government); and (3) Some other specific contexts such as the prevalence of specific KPs or the cause of HIV infections. These would lead to different strategies needed to address HIV/AIDs. However, clear standard regulation, particularly the same payment method, is still important to guide work.

*“It’s good in terms of freedom. But the documents used for payment seem not so clear and not in the same format. Right now, it seems hospitals and NGOs use different documents for the payment.” -- C2*

e) Operational costs should be taken into consideration

Unlike government sectors, CSO workers do not have monthly salary and the organisation itself must have operational costs to run offices as well as work continuously. If there is intermittent funding allocation, it would affect their performance as they cannot work continuously as planned.

*“The cost per head (from the NHSO) does not include operational costs and it is designed to suit public sector work. This is because the public sector already has a monthly salary to support their work, while NGOs need to have funding to cover their operational costs. Moreover, the funding has been intermittently allocated, resulting in an inability to create jobs in responding to their actual need.” -- C4*

One interviewee also mentioned the cost study previously done by HITAP showing a limitation that it might not include the investments that NGOs had made in advance.

*“The HITAP study focused on the cost in one year, but previously there were several investments or costs (related to RRTTR performances), such as training...etc.” -- F8*

f) Incentives are needed to attract or motivate local NGOs for working in the field because work on RRTTR is not that easy and requires long-term effort. Therefore, the introduction of incentives to attract or motivate CSOs to continue working in this field should be considered. This was a view from both funders and CSOs.

*“The model of payment sometimes needs to take into account investment for the worker.” -- C4*

*“Incentives may be useful for having more numbers of CSOs to work.” -- F7*

### **3) Criteria for selecting CSOs should be clear and standardized**

Available criteria exists for selecting CSOs before signing a contract, such as previous engagement, experience in the field, and timely delivery. However, there is still a need to clarify the standard selection criteria as well as communicate it to all stakeholders to clearly understand the issue.

*“Selection criteria for any organisation or NGOs should be a clear standard. It is necessary to have a certified standard as to which organisation can receive the funding. This would help prevent fighting among them in field.” -- C2*

However, while requesting standard criteria for selecting CSOs, some people also raised a concern that to use the same contracting model may not be applicable to all CSOs. Some flexibilities or adjustments to suit the local context are still important.

*“To apply the same model for all organisations may not be practical. We need to consider the capacity of each organisation and how much they can do; for example, some organisations may be able to do “Test”, and some may be able to do “Treat”. If they can, we should let them do it.” -- C4*

#### 4) Coaching as well as monitoring and evaluation (M&E) systems are required

In order to maintain or improve the quality of CSOs' work, coaching and M&E systems are required. Most interviewees did mention the importance of regular coaching as well as M&E systems in order to refresh their knowledge and understanding, and ensure the quality of work delivered by CSOs was high.

*“A monitoring and evaluation process is the key to control the quality of working performances (of CSOs); otherwise they may not pay attention to the quality (กระบวนการกำกับติดตามสำคัญ ไม่งั้นเขาจะไม่เน้นคุณภาพ.)” -- F2*

#### 5) Improvement of information system is needed

One of the important components in establishing RRTTR is a good information system. RRTTR activities are generally reported via the National AIDS Program (NAP) for test and treat and the Real Time Cohort Monitoring (RTCM) programme as an e-cascade for monitoring RRTTR activities. Currently, there is an attempt to link these two databases via a Unique Identifier Code (UIC), which is on-going.

Regarding the RTCM, it does not completely operate in real time; for example, it needs some time for a patient to get the UIC and the information of each individual may not show up quickly to help solve the problem of duplicated cases. Also, it has been pointed out that the RTCM may not be so useful for working as it cannot show the whole package of work such as is done by the dashboard provided by Linkages (USAID's funding project).

*“RTCM may not be useful like the LINKAGES's dashboard, which provides the overview of the work success/ performances better than RTCM (but it is for those under LINKAGES's fund).” -- C1*

There is also a difference in M&E processes in relation to feedback information between activities undertaken by the NHSO and those undertaken by Linkages.

*“There is a difference in the quality and comprehensiveness of monitoring and evaluation between NHSO and Linkages. While the NHSO provides one-way information, Linkages provide two-way information, which allows ...(NGO organisation) ...to see its own data” -- C4*

In brief, a good and timely information system will help hospitals and CSOs improve their work as they can avoid duplicated work and see their progress and weakness (or gaps) throughout the RRTTR cascade.

**Table 5.2:** Summary of the results from the thematic analysis

Theme	Supportive information
<p><b>Theme 1:</b> CSOs demonstrated strengths in case findings</p>	<ol style="list-style-type: none"> <li>1) CSOs understand their KPs better than public sectors.</li> <li>2) CSOs have no limitation in their working hours.</li> <li>3) To tackle HIV/AIDS, it is necessary for the government to maintain relationships with CSOs.</li> <li>4) Government need CSOs to implement some policies and/or country strategies</li> </ol>
<p><b>Theme 2:</b> Teamwork, rapport, and trust are key to combatting HIV/AIDS</p>	<p>Good relationships and trust among NHSO, provincial health office, public hospitals, and CSOs are important to establish an effective HIV contracting model.</p> <ul style="list-style-type: none"> <li>• Can achieve specific target suitable for local context</li> <li>• Through regular meeting and information sharing, patients can have access to care wherever and whenever they need as well as maintain their adherence to ART.</li> <li>• Can help solve problems regarding duplicated cases</li> </ul>
<p><b>Theme 3:</b> Some work difficulties occurring in the field require attention and solutions</p>	<ol style="list-style-type: none"> <li>1) Duplicated cases could happen if there is no clear separated area of working and no good “real time” data base to verify it promptly.</li> <li>2) Retain is the most difficult activity due to the high mobility of KPs and the cycle of the working period is relatively short (5-6 months due to the delay of funding process).</li> <li>3) No funding for services delivered to migrants (non-Thais) is problematic as local hospitals and NGOs must provide care/treatment according to health needs.</li> </ol>
<p><b>Theme 4:</b> Despite facing work difficulties, some good interventions have emerged.</p>	<ol style="list-style-type: none"> <li>1) “Same day ART” It has been initiated by Red Cross and FHI 360 with the idea that a HIV-positive person will receive ART as early as possible at any CD4 level e.g. soon after knowing the HIV test result or within two to three months.</li> <li>2) “The use of social media to reach specific target groups”</li> </ol>

Theme	Supportive information
	<p>CSOs have tuned into case findings through social media, such as Facebook and Twitter, reaching more numbers of their target populations.</p> <ul style="list-style-type: none"> <li>• An NGO working with PWID has reached out to MSM who use drugs via Twitter. After talking for a while and gaining trust from these people, an NGO can deliver clean syringes and needles to MSM drug users via posting (by using code for sending and making it look like items used for training).</li> <li>• An NGO working with MSM reported that more HIV positive cases were found in MSM whom they met online and successfully convinced to take HIV testing. These MSM also received ART more quickly.</li> </ul>

**Theme 5:** Several areas of improvement are highlighted.

- 1) Setting targets together among all relevant stakeholders is crucial.
  - Targets will be more realistic and suitable with local context.
  - Promote teamwork, leading to more effective performances.
  - Solve the problem of overlapping of work and/or duplicated cases.
- 2) Adjustments of funding allocation are necessary.
  - The slow funding process is really problematic.
  - Funding should be allocated according to a list of activities (depending on local context)
  - The installment may reduce from three to two installments
  - Although NHSO's funding is relatively flexible and allow for some local adjustments, it should have certain standard requirements at central level.
  - Operational costs should be taken into consideration
  - Incentives are needed to attract or motivate local NGOs for working in the field
- 3) Criteria for selecting CSOs should be clear and standardised.
- 4) Coaching as well as monitoring and evaluation (M&E) system are required.
 

Improvement of information system is needed.



**CHAPTER 6** DISCUSSION  
AND CONCLUSIONS



## Chapter 6 Discussion and Conclusions

This chapter presents the discussion based on the results presented in previous chapters, focusing on the financial arrangements process from before contracting to signing the contract to after signing the contract, including M&E process and technical supervision. Key facilitating factors and barriers specific to the Thai context are highlighted. Conclusions and recommendations for an effective HIV social contracting model in Thailand are provided.

### 6.1 Current contracting models for HIV service delivery in Thailand

Three contracting models for HIV service delivery using RRTTR approaches identified by this study are similar to those in the previous cost study conducted by HITAP. The three models are: (1) Hospital-based model using public providers; (2) CSOs are responsible for Reach/Recruit and the remaining activities (Test-Treat-Retain) mostly fall under the responsibility of MOPH hospitals; and (3) Key population-led health services, where CSOs and their KP networks are responsible for Reach/Recruit and the remaining activities (Test-Treat-Retain) are done by the joint collaboration between CSOs and hospitals. The predominant model is model 2.

To achieve effective implementation of RRTTR, key success factors are that: targets are consistent with the local epidemiology context; there is a clear understanding of the scope of work and responsibility between hospitals and CSOs; and there is strong collaboration between local stakeholders (both public providers and CSOs). These points have been highlighted by most key informants in the study.

In addition, there are two types of financial management in Thai government-led mechanisms to finance CSOs through formalized contractual channels<sup>(51)</sup> for HIV/AIDS services, namely; (1) payment based on per capita KP by the NHSO; and (2) payment by project base by DDC, Global Fund and USAID. According to the literature, these two mechanisms have different advantages and disadvantages. Payment by per capita KP is more accountable and measurable as it is based on a number of key population members who successfully completed RRTTR services. Despite its merits, the downside of this payment is the CSO's narrow focus only on measurable activities, such as the number of HIV tests, rather than providing comprehensive HIV education and prevention services as proposed by one study in China<sup>(47)</sup>. Payment based on a project does not focus on the actual number of KPs with successful completion of RRTTR packages; however, it may indirectly support the KPs to show up and engage in testing. This is because project-based activities emphasise raising awareness among KPs, which could gradually encourage them to reorient towards safe sex behaviours. Additionally, in the project-based approach, the provision of capacity building and mentoring of CSOs during project implementation appears to be meaningful

for CSOs to strengthen their competency and performance in managing HIV/AIDS challenges in the longer term<sup>(39)</sup>. The merits of project-based payments can complement the strengths of per capita KP payments.

## **6.2 Process before contracting: setting targets**

This study found that the most important process before establishing the contract either by per capita KP or by project base is about setting the right target of KPs for RRTTR approaches; this is a stepping stone towards ending AIDS by 2030.

This process needs to be done at the national or strategic level and be based on the epidemiological evidence of HIV burden. The total people living with HIV (PLHIV), minus the total number of PLHIV who are on treatment, plus the annual incidence of new infections form the total targets of PLHIV for the RRTTR approach. The primary focus should be on KPs. Thus, it is essential to involve all key stakeholders in order to brainstorm and make the most appropriate decisions on the targets, not only at national, but sub-national, regional and provincial levels, and on the amount of funding allocated to different local areas. Province-specific target setting is not a straight-forward exercise; as the UNAIDS epidemiological updates cannot be broken down by geographical regions or provinces. This challenge can be overcome by applying local epidemiological profiles through local knowledge vested by MOPH Regional CDC Offices and Provincial Health Offices. We identified two main challenges in the NHSO contracts based on the number of KPs:

- 1) Lack of involvement from frontline health providers and CSOs who work in a local province at the targets-setting stage.

Based on the in-depth interviews, some CSOs raised this issue. Target setting by NHSO headquarters might not be suitable for the local situation as they may not have an adequate understanding of the local context or experience from the field. Moreover, target setting based on epidemiological data (such as AEM modeling and site estimation) per se may not match with the changes or dynamic circumstances in a real situation. Some other factors from the field, such as the internal migration dynamic among KPs, may have to be taken into consideration during the decision-making process.

- 2) Insufficient communication between the NHSO and local CSOs on how and why targets were chosen and needed to be achieved.

NHSO provides operational guidelines on financial management that CSOs should follow. The decision on province-specific targets is made through consultative meetings at the national level with limited engagement with local CSOs. Although the Regional NHSO

managers invite all key stakeholders including CSOs from each province to meet and agree upon their targets, there are still some complaints from CSOs about target distribution in relation to national epidemiological data. Thus, having CSO representatives to voice their concerns at the national level workshop, where decisions on province-specific targets are made, can prevent misunderstandings and build trust. At the regional level, a face-to-face meeting between the NHSO regional office, hospitals and CSOs is also helpful to clarify any outstanding issues. More communication channels should also be introduced, such as through websites or by telephone, in order to provide clear messages and address any issues of concerns from local stakeholders. In brief, by having clear identified national targets through close involvement of all stakeholders, social contracting in Thailand will be more effective.

### **6.3 Signing and after signing of contract**

#### **Target announcement and selection of hospitals/CSOs**

International experiences from China, India, and Malaysia suggest that open calls for project application may lead to a wider range of CSOs being contracted<sup>(46)</sup>. However, this method may not be applicable to all provinces with variations on the number of CSOs and their competencies, and different local contexts in each province. For large populated provinces such as Bangkok, Chiang Mai or Chonburi with high numbers of experienced CSOs, it is possible to apply competitive bidding through requests for proposals as several competitive applications can be expected. For smaller provinces (such as Payao and Lamphun), there is a lack of good numbers of CSOs who have experience with HIV/AIDS. Moreover, in some provinces, there might be no CSOs who work with people who inject drugs (PWID). In this context, long-term engagement by the NHSO with CSOs (called the simplified method) is preferable to contracting through competitive bidding.

A study in South Africa demonstrates the difference between 'classical' and 'relational' contracts. Formal aspects of the contract such as design, monitoring and resort to sanctions were found to offer little control over its outcome; while the relational rather than classical model of contracting offered a more meaningful framework of analysis, with social and institutional factors found to play an important role on the outcomes of the contract<sup>(52)</sup>.

Our findings show that, at regional level, there is no open announcement which requests proposals from public hospitals and CSOs. Instead, NHSO regional offices invite all relevant stakeholders (public hospitals, provincial health offices, and CSOs) to attend a meeting at the regional level in order to discuss and agree on KP targets to be achieved in each province. This seems to be sensible since the numbers of experienced CSOs with good records from previous works are not high. At the operational level, the target of KPs for a package of RRTTR was distributed to each local stakeholder, hospital or CSO according to the provincial targets and the capacities of hospitals and CSOs in each province to

accommodate these targets. Hence, the provision of technical support throughout the contracting period to ensure high quality work is needed. This will be discussed in the follow up and accountability section. In the researchers' view, this relational approach and collaborative relationship across actors - NHSO, hospitals, CSOs - where competent and willing CSOs and hospitals are allocated with targets better suits the contextual environment. This is better than a competitive relationship. Arguably, this process is difficult to measure and there is a risk that non-competent CSOs are contracted. The focus should be on measuring the outcomes and capacity to deliver in line with contractual agreements, rather than on the process of competitive bidding.

Thailand can therefore possibly apply two methods of CSO selection: (1) competitive bidding through calls for proposals in high burden or densely populated provinces with significant numbers of competent CSOs; (2) a simplified procedure in low burden or small provinces as well as in some specific areas with certain KPs of interest, which has limited numbers of CSOs to do the work (e.g. PWID).

### **Pre-award assessment prior to selection**

To ensure that the selected CSOs are capable of providing quality HIV services, a pre-award assessment should be undertaken in order to determine their capacity before funding is given. For example, after open advertisement, India conducted preliminary screening of all applications and an appraisal visit to CSOs to assess their organisation structure and capacity<sup>(50)</sup>. Pre-award assessment is also a common practice of USAID to identify issues that could possibly hinder service quality and achievements; areas explored include financial management capacity (procurement, banking, expenses, authorisation structures and assets etc.), human resource management (such as number of staff working in the office and in the field, written guideline in doing specific job or standard operational procedure), and history of performance (how well they achieved in the past?)<sup>(53)</sup>.

The study found that the NHSO did not follow this process. Nevertheless, CSOs that are eligible to apply for NHSO funding must have certain capacities, which are guaranteed by a hospital or a provincial health office in the province. In order to have more reliable and competent CSOs, this process could be strengthened. NHSO may establish this process by using the example of India or FHI 360. By doing so, there would be more numbers of qualified CSOs to work on ending HIV/AIDS than at present. However, it could also mean that the NHSO may have to invest time and resources to create this structure within its organisation and hire a person or team to do the assessments. Alternatively, instead of establishing this structure by itself, NHSO could possibly select the certified CSOs from a trustworthy, accreditation organisation. At the time of this study, Thailand does not have

such a CSO accreditation organisation or mechanism. If Thailand would like to upgrade its CSO standard to become more professional, the establishment of an accreditation organisation for CSO registration and accreditation should be a long-term policy option.

### **Installment and reimbursement**

There are three installments in the NHSO contracting process with CSO or hospitals; 50% of total funding on signing the contract and submitting the project proposal; 30% when CSOs submit the progress report and accomplish approximately 50% of “Reach and Recruit” targets; and final payment of 20% is made after completing the remaining work. Overall, most CSOs agreed that 1,800 THB per capita KP for RRTR package was reasonable and is sufficient for their work. However, there were several problems at the operational level in relation to disbursement.

First, all CSOs reported that the process of payment from NHSO was relatively slow as, most of the time, they received the first installment when they had only five to six months remaining to complete the working on RRTR activities. Second, there were challenges from duplicated HIV testing cases (provided by CSOs), which was the consequence of the delay in payment as well as the lack of real-time data information system for checking and preventing duplication of HIV tests. Due to the limited timeframe, CSOs were in a hurry to find cases and the information of a KP individual in the computing system was not done in real time in order to verify and prevent duplication with others. Thus, there were unintentionally duplicated cases of HIV testing. Third, as a consequence of duplicated testing cases, CSOs could not get the reimbursement from the NHSO even though they had already invested both time and money for these cases. Finally, some CSOs had to return the money to the NHSO as the shortened working period made them unable to complete their work throughout the cascade.

This complex issue can be solved by accelerating the payment process, improving the data information of KPs, setting clear targets with hospitals and CSOs and defining geographical areas between two contractors in order to avoid overlapping.

### **Follow up and accountability**

An accountability framework should cover two important aspects: (1) financial audit; and (2) performance audit. Also, the capacity building of CSOs can improve their performance. International experiences from China, India, and Malaysia show a rigorous M&E process covering all these important aspects. Each country has a main organisation that is responsible for contracting at different levels; provincial (China), state/district (India), and central or national (Malaysia)(50). Nevertheless, these countries share similarities in the M&E process, as they have a technical support unit/team to make a regular visit to audit

the financial management, assess CSOs' performances, and provide capacity building to CSOs when necessary.

This study found that the NHSO had taken responsibility in financial management only. This can be explained by the fact that the NHSO has a national mandate in funding management which is accountable to the Thai population. Furthermore, the NHSO might not have technical expertise on HIV/AIDS. Nevertheless, in some areas, CSOs which received other sources of funding such as from GF, USAID, and DDC, also received technical support and capacity building from these additional sources. Thus, the NHSO could provide matched fund with other organisations in order to provide technical assistance to CSOs.

The M&E of CSO performance and capacity building to improve their performance are very important, and discussion among key stakeholders to reach consensus on agreement in different roles and responsibilities for supporting CSOs should be undertaken. This could be done through the support of a domestic funder (DDC) and international funders (Global Fund and USAID), the formation of networks or alliances for mutual support, and having larger and more experienced CSOs assist others. Additionally, capacity building should be done in technical areas and fund mobilization and management in order to help CSOs deliver good quality services and sustain their organisations in the long run. With this contribution, Thailand could expect to have increasing numbers of qualified CSOs to continue combatting HIV/AIDS.

## **6.4 Key facilitating factors and barriers of HIV contracting**

The study found that most of the challenges around the social contracting of HIV/AIDS were effective engagement with stakeholders in the processes of setting targets and operational challenges. This is consistent with findings from the scoping review. Literature suggested that the key facilitating factors for effective contracting include: (1) The involvement of competent CSOs in HIV service delivery; (2) The provision of a clear accountability framework; (3) Relationships among key concerned stakeholders; and (4) An effective, transparent payment system.

Some CSOs, especially small ones, struggle with mobilizing adequate funding to recover their operating costs. Small CSOs are characterised by limited experience (newly established), limited number of staff (less than five to seven people), a few domestic sources of funding with no international funding, and limited or no savings from the previous year's operation. This situation is supported by previous literature indicating that the non-profit status of most CSOs limit their capabilities in fundraising to be able to sustain their organisations<sup>(43)</sup>. Therefore, several CSOs may have to look for additional funding to cover the organisational expenses and operational costs<sup>(43)</sup>.

## **6.5 Comparison of contracting CSOs between per capita KP payment versus by project-based payment**

Based on information derived from in-depth interviews and perceptions of key informants, the comparison of funding management by four main institutions is shown in Table 6.1. NHSO funding applies contracting by per capita KP payment, whereas DDC, GF and USAID funding apply contracting by project-based payment.

### **Advantages of per capita KP payment by NHSO**

First, the NHSO payment per capita KP is measurable as it refers to the actual number of KP individuals who received HIV services across the RRTTR package; while the project-based payment is based on the number and nature of activities that have been accomplished. Comparative studies between areas with and without project-based funding for a certain period of time can demonstrate the true impact of project-based funding. Without a proper study research design, it is difficult to state that the increased numbers of HIV testing in some areas with project-based payment was attributed to these projects. There are confounders in provinces where project-based activities are implemented. For example, there are also several other HIV/AIDS projects supported by different sources of funding from either domestic or international sources, which can also contribute to improved outcomes.

Second, NHSO funding has been distributed to all provinces, although the provinces with a high burden of HIV/AIDS receive more budget, whereas the funding by other institutions (Global Fund and USAID) only focused their support in a few priority provinces such as high burden provinces or provinces with the KPs of their interest. The NHSO has a comparative advantage in addressing KPs in all provinces. The DDC budget may be provided to all provinces, but its project activities are not specific to RRTTR or KPs.

With this funding arrangement, the NHSO model has somehow fulfilled the important role of engaging with CSOs, either large or small, in all provinces nationwide. On the other hand, project-based funding is more likely to operate with larger CSOs with good track records in specific provinces as it cannot accommodate broad-based CSO involvement in particular by smaller CSOs. This is also supported by the evidence found in this study that smaller CSOs can maintain their operations with low levels of domestic funding, notably from NHSO per capita payments for each successful RRTTR, and function without international funding sources. Thailand may have to explore the trade off between investing money only in big specific CSOs and high priority provinces and keeping engagement with either large or small CSOs in order to build a bigger pool of professional CSOs to work in the field of HIV/AIDS on a long-term basis. This requires further policy dialogue among all relevant stakeholders to reach consensus as to which solutions should be taken.

Third, most key informants reported that NHSO funding gives them more flexibility in creating or adjusting their activities with the aim of achieving measurable numbers of KPs who successfully complete the RRTR service package. While the project-based funding, particularly through the Global Fund, is strict with its pattern of programme activities; there is less room for creativity from the CSOs' point of view.

### **Disadvantages of per capita KP payment by the NHSO**

Despite several merits discussed above, NHSO funding has some weaknesses. First, the CSO selection criteria and reporting requirements are not clear to the stakeholders compared with requirements by other funders. Most CSOs reported that they did not know how the NHSO selected CSOs to receive the funding and, after signing the contract, many of them also did not know what kind of reporting documents they needed to submit. This could possibly be due to lacking of clear communication between NHSO and CSOs. These operational challenges should be solved sooner rather than later.

Second, the lack of an effective M&E system in NHSO funding mechanisms is another weakness. The interviewees pointed out that there was lack of regular M&E from the NHSO (once or never in some areas) and its main focus was on financial issues only, whereas the M&E conducted by other institutions would cover all important aspects, including both financial and performance audits. More importantly, other funders had provided capacity building in responses to CSOs' needs, which helped them improve their performances; the NHSO has legal limitations in supporting the capacity building of CSOs.

Third, NHSO funding can be used for service provision only, while funding received from other funders can be used for other important elements for CSOs, such as staff training or paying KPs for the cost of their travel to use services. The limitation of using NHSO money makes it difficult for several CSOs due to the fact that completing the whole range of RRTR activities requires more investment in the training of their staff, keeping up connections and activities with KPs, as well as providing some incentives to the KP targets. These activities have to be sustained (even in advance before signing the contract with the NHSO). Hence, in order to confirm if 1,800 THB/capita KP is adequate for RRTR requires further investigation when taking into account the full cost of operation.

It should be noted that the NHSO is subjected to regular external audit by the State Audit Office, which applies 'super rigid' rules and regulations on public financial management. It neither understands the critical role of CSOs' contribution to HIV care or the need for flexibility in achieving the goal of ending AIDS.



Finally, the risk of returning unspent money to the NHSO was relatively higher than with other types of funding. Since the payment to CSOs is based on the number of KPs who had completed the RRTTR package, an inability to complete all services means that CSOs have to surrender the budget to the NHSO. According to the record of the NHSO financial unit, during 2018-2019, money was returned to NHSO on both years and accounted for 4,586,487.52 THB (23.84% of total national contracts) in 2018, and 25,828,800 THB (29.17%) in 2019. It considered only the contracts with CSOs and the amount is expected to be smaller in coming years if the delayed payment process is accelerated and resolved by reducing the paper works as well as the bureaucratic system in sending the document back and forth between central NHSO and regional NHSO. That means that CSOs will have a one-year period of working, not just five to six months as currently happens.

### **How to improve the NHSO payment mechanism?**

Regarding improving the NHSO payment mechanism, there are two important issues to consider.

The first issue is whether the NHSO central or regional office should be the responsible unit in signing the contract and releasing money to CSOs. Currently, CSOs sign the contract with the regional office, but wait for the money from the central office to be transferred to the regional office. The delay occurs due to lots of paperwork sent back and forth between the two offices. Thus, reducing this bureaucratic inertia is urgent. The roles and responsibilities between these two offices must be discussed and clarified with the purpose of a prompt release of an advanced budget of 50% to CSOs immediately after signing the contract as well as making sure that CSOs have a 12-month period in which to work.

The second issue concerns the method of payment and whether the current payment is effective enough for contracting with CSOs? In general, the NHSO applies an output-based payment. That is performance-based financing such as a fixed price paid to a contractor for a specific service such as HIV testing or a completion of the RRTTR activities. This method is preferable as it is easier to define and measure the outputs of services such as finding HIV positive cases, putting people on ARVs, and ensuring that HIV viral loads are suppressed and can also be used to incentivise lagging services. However, as previously mentioned in section 6.1, CSOs may focus on reimbursable activities only, which progressively narrows the focus from working towards long-term social and political change and offering comprehensive HIV education and prevention services to performing ever-greater numbers of HIV tests.

Another commonly-used method is the input-based payment, meaning CSOs receive money to work based on line-items or a lump-sum on completion of a set of activities; line items are much more common than lump-sums. Most governments are comfortable with this

method as it is easier to control the total amount of budget spending. However, this method is relatively rigid and does not allow for innovation or the promotion of more service delivery or better quality of work.

The mixed methods of payment with a combination of both inputs and outputs are possible. The method provides flexibility in adjusting service delivery or packages based on different circumstances. However, it requires good planning with specific guidelines and regulations to ensure there is no confusion among NHSO officers regarding the different detailed requirements for determining CSOs' achievements before payment.

### **National contracting project manager**

One important element of effective social contracting is to have a competent national (or central) project manager to play a vital role in ensuring good governance throughout the contracting process as well as overseeing CSOs' performance. Since project governance is determined by accountability it is necessary for any project to employ a competent manager to take responsibility for: (1) Creating, reviewing, and reporting the use of funding; (2) Overseeing the financial details corresponding to specific goals including reimbursement and ensuring that legal reporting standards are followed; (3) Seeking to control risk by judging the probability of loss and analysing related data; and (4) Supervising a team in terms of budget analysis for the most appropriate use.

This issue appears to be weak point of NHSO management when compared to that of the DDC, Global Fund and USAID, which was partially explained in above section (follow up and accountability). To solve this problem, there are two possible options.

First, the NHSO could recruit an experienced project manager to work specifically on social contracting. They can work efficiently and oversee any specific issues of the project as a whole and take immediate action. However, this would require financial investment that could mean deducting some amount of money from the national budget of 200-million THB. The recruitment of the project manager should be done in a transparent manner through the Board committee. Also, no manager can work alone, no matter how competent and it would take sometimes to build a good team.

Second, the NHSO could alternatively outsource an experienced organisation that already has a competent team. This would help reduce the time needed to build management capacity. However, issues of money for investment, as well as a transparent recruitment process still remain the same. Either option will face questions by the State Audit Office.

**Table 6.1:** Comparison of funding management by institutions based on the perceptions of key informants

Topic	NHSO	DDC	GF	USAID (Linkages)
Payment	Per capita KP	By project base	By project base	By project base
Main focus	number of KPs	activities related to identified targets	country strategic targets	activities related to identified targets
Area for working	any provinces (high burden provinces will receive more budget)	any provinces with general population who have risk behaviours	high burden or priority provinces	provinces with specific KPs of interest
Contract level	Regional	Regional	Central with Principal recipient	Central with Project manager
Central funding manager*	yes, financial only	yes	yes	yes
CSO Selection	not clear 1. Decision of national targets and their distribution by a central office 2. Announcement for proposal by regional offices (and provincial stakeholder meeting) 3. Proposal submission 4. Proposal considered by a regional AIDS committee (RAC) 5. Approved by a regional director and contracting	clear 1. Announcement for proposal 2. Proposal submission 3. Proposal considered by a committee 4. Contracting	clear 1. Announcement for proposal 2. Proposal submission 3. Selection of sub-recipient (CSO) by principal recipient 4. Contracting	clear 1. Announcement for proposal 2. Proposal submission 3. Pre-award assessment 4. Sub-agreement (contracting)
Allow for operational cost e.g. staff training and salary or travelling cost for KPs	no	yes	yes	yes

Topic	NHSO	DDC	GF	USAID (Linkages)
M&E: Financial management	yes	yes	yes	yes
Performance Monitoring	no	yes	yes	yes
Capacity building to CSOs	no	yes	yes	yes
Documents required for reporting	not clear	clear	clear	clear
Risk to return money back (if targets not achieved)	high	none (allow for adding more activities to use up the remaining money)	none	none
Flexibility to adjust activities (CSOs' perspective)	+++	++	+	++
Can a small CSO** work?	yes, under local public hospital	yes, under regional office of DDC	yes, under principal recipient	yes, under project manager

*\*Funding manager* refers to a person that takes responsibility for: (1) Creating, reviewing, and reporting the use of funding; (2) Overseeing the financial details correspond to specific goals, including reimbursement, and ensuring that legal reporting standards are followed; (3) Seeking to control risk by judging the probability of loss and analysing related data; and (4) supervising a team in terms of budget analysis for the most appropriate use.

*\*\*A small CSO* is defined by its limited amount of experience (new or newly established), limited number of staff (less than five to seven people), some domestic sources of funding with no international funding, and limited or no savings.

## 6.6 How do CSOs diversify different types of funding for their survival?

Thailand is an upper-middle-income country and as its GNI per capita has gradually grown, it is not eligible for funding support from the Global Fund and other international partners. CSOs have to adapt in order to continue working on HIV/AIDS as well as maintain their organisational survival. As previously discussed, in some priority provinces, CSOs have received funding from different domestic funders and international sources. For low HIV burden provinces, CSOs received few domestic funding sources. Therefore, it is interesting to understand how CSOs in each province can maintain their survival under different types of funding received. This section discusses information about this issue derived from in-depth interviews with CSOs.

For priority provinces, most CSOs reported that the major source of funding was from the NHSO, accounting for 70%, and international sources such as the Global Fund, USAID, and others accounted for 30%. For low HIV burden provinces, smaller CSOs, which usually prefer working in their local areas or in a familiar environment, had received funding from a few domestic sources with the NHSO as the largest source; there is no international funding among these smaller CSOs. Small CSOs reported that the main source of funding was from the NHSO (75-80%), and the rest is from DDC, ThaiHealth Foundation, or a local municipality (20-25%), without any international funding. Hence, at the time of this study, none of the organisations can survive by depending on a single source of NHSO funding, but which currently is the major source.

Additionally, most CSOs stated that, due to the strict rules of the NHSO about payments corresponding to the service provided to each KP individual, they must use NHSO budget for RRTTR activities even though the completion of the RRTTR requires additional funding support. This might be things like maintaining connections and working relations with KP groups during special events and training field staff. Most of the time, CSOs use other non-NHSO budgets for paying staff salaries and for organizing special health promotion events. However, it is difficult to provide the exact amount of resources required for these non-RRTTR activities, as it depends on the context of each CSO (such as size, working activities, number of staff members, number and sources of funding). Another solution is for the NHSO to minimize its rigidity and micro-management over how CSOs spend NHSO resources. The NHSO should also monitor the accomplishment of the number of KPs completing RRTTR activities.

## **6.7 Conclusions and recommendations**

### **Conclusions:**

- The NHSO budget is the largest domestic and sustainable source of funding for RRTTR activities currently delivered by Thai CSOs. The RRTTR approach is a key policy instrument for achieving the SDG commitment to end AIDS by 2030. Thailand is on the right track using the RRTTR strategic direction, although regular assessments of RRTTR effectiveness are recommended. Under present rules and regulations, payment to CSOs based on a successful RRTTR per capita KP managed by the NHSO is measurable and more accountable when compared with project-based payment. It holds both funding agency and contract providers accountable. Note that at the time of this study and from the perspectives of CSOs, 1,800 THB per capita KP (US \$ 60) seemed adequate to cover the cost of services.

However, CSOs, particularly smaller size CSOs, may have to mobilize additional domestic sources for running their offices such as from DDC, ThaiHealth Foundation and local government such as municipalities and Tambon (sub-district) administrative organisations.

- Despite facing several limitations (including inadequate CSO engagement at the target setting processes, operational challenges such as delayed payment and inability to use the NHSO budget for CSO capacity building), NHSO-funded projects have demonstrated support to public providers and CSOs in the local communities who work synergistically as a team to reach out to more KPs. This is one of the entry points of the policy to end AIDS. While CSOs have the capacity to reach more KPs than public providers, public providers fill the CSO capacity gap on clinical service provision and can provide technical supports and supervision to CSOs. Both public providers and CSOs are indispensable partners on the path towards ending AIDS through the RRTTR approach. Thus, improving the performance of the NHSO in playing a vital role as a domestic funding source to help maximize CSOs' contributions in combatting HIV/AIDS for the country is an important policy choice. These operational challenges should be solved sooner rather than later by the NHSO.
- Besides improving NHSO performance through solving operational challenges, building CSO capacity is also important. Increasing numbers of qualified CSOs in Thailand receiving capacity building support in both technical management and funding mobilization management is much needed. This could be done through the support of a domestic funder (DDC) and international funders (Global Fund and USAID) as well as the formation of a network or alliance so that larger CSOs can assist smaller ones. With the contribution of all key stakeholders, Thailand could have more numbers of qualified CSOs than at present, in order to sustain HIV/AIDS prevention in the longer term.

### **Recommendations:**

To achieve the target to end AIDS by 2030, an adequate investment of the Thai government in allocating budget to the NHSO to continue its crucial role in social contracting with CSOs should be continued. This will demonstrate Thailand's commitment in addressing HIV/AIDS problems despite the fact that the Global Fund will curtail its financial support to Thailand in the near future.

Evidence from this study suggests that an effective social contracting model suitable for Thailand should follow these characteristics:

**1. Clearly identified national targets with the involvement of all related partners**, including DDC (or MOPH), NHSO, CSOs, and other identified partners to discuss and reach consensus on:

- a) Annual targets of KPs to be detected and treated;
- b) Total annual budget required for RRTTR approach and the contracting of CSOs and public healthcare facilities to deliver these services;
- c) Appropriate distribution of the budget in relation to per capita KP and geographical locations; and
- d) Roles and responsibilities of each key stakeholder in terms of supporting effective social contracting in Thailand such as financial support, M&E, and capacity building in both technical capacity and organisational management.

**Pro:** Create mutual understanding and agreement

**Con:** None

**2. Clear and transparent selection process** in order to have competent CSOs for working.

**Option 1 Simplified procedure based on local context**

The NHSO currently applies this method by inviting all available CSOs to have a contract according to their certain capacity and readiness.

**Pro:** Suitable for the current Thai context, particularly small/low burden provinces as it appears that there are limited numbers of local CSOs with good track records in each province.

**Con:** 1) Available CSOs, either strong or not so strong, will receive the grant to work with the NHSO; however, there is a risk of non-performing CSOs, where close monitoring is recommended.

2) Lack of competition may lead to a lack of motivation or efforts to improve the performances of less strong CSOs.

**Option 2 Competitive bidding via an open call for proposal**

**Pro:** 1) Can be suitable for densely populated and high burden provinces with more numbers of competent CSOs.

2) Creates competition - each CSO has to put more effort into writing a good proposal as well as improving its capacity and reputation in order to win the bidding.

3) May indirectly push smaller CSOs to work together as a network (either with several small CSOs or with bigger CSOs) in order to increase their capacity and power to compete with other organisations.

- Con:** 1) Likely that only larger CSOs with higher capacity and good track records (history of good levels of performance/experiences determined by any funders) will win the bids, while small CSOs are unable to compete with them.
- 2) Not suitable for provinces with specific KPs of interest, and limited number of competent CSOs working on that issue such as PWID.
- 3) Seems difficult for certain small CSOs with their own unique profiles to work with or form alliances with other organisations.
- 4) Some CSOs may require assistance in writing a proposal (e.g. India invites CSOs from the shortlist of potential organizations to participate in a proposal-writing workshop before contracting).

### Option 3 Simplified procedure and competitive bidding via an open call for proposals

**Pro:** This option can be applied to different provinces with different contexts by maintaining the strengths of Option 1 and Option 2.

**Con:** N/A

- 3. Pre-assessment of CSOs' capacity** to ensure their competency in providing quality service delivery and achieving targets.

Option 1 The NHSO conducts the pre-assessment process before contracting (e.g. USAID practice could be used as an example)

**Pro:** Having qualified CSOs available for working

- Con:** 1) The NHSO has to invest time and money to create this structure within its organisation by hiring a person or team to do this job. However, the outcome of assessment and accreditation may last for a few years before another assessment.
- 2) Good planning is required to prevent delayed contracting as the assessment must happen before selection process.

Option 2 Establishment of an accreditation organisation for CSO registration and accreditation (only certified CSOs will be contracted by the NHSO)

**Pro:** 1) Having qualified CSOs available for working.  
2) The NHSO can comfortably select a qualified CSO certified by this organisation.

- Con:** 1) Need to identify the responsible organisation for initiating/processing its establishment.
- 2) It would take some time to have a good, trustworthy accreditation organisation to register adequate number of qualified CSOs.



#### 4. Effective, transparent, and timely payment system to provide funding to CSOs.

##### a) Responsible unit for payment

###### Option 1 Payments managed by regional NHSO office

**Pro:** CSOs receive an advanced budget of 50% immediately after signing the contract with a 12-month period of working

**Con:** None. **BUT** there are several things that must be improved as follows:

- Start the selection process and/or call for proposals three to six months in advance (which means decision making process about country targets also needs to be planned in advance)
- Reduce paper work/documents to be sent back and forth between central and regional NHSO offices
- Transfer 50% of budget to CSOs immediately upon signing the contract

###### Option 2 Payments managed by central NHSO office

**Pro:** CSOs receive an advanced budget of 50% immediately after signing the contract with a 12-month period of working

- Con:**
- 1) Need to provide a clear role and responsibility of the regional NHSO office; for example, will it still need to set up a meeting with provincial stakeholders?
  - 2) Need establishment of an accreditation organisation for pre-assessment of CSOs (refer to the recommendation no. 5 below) as the NHSO will sign a contract with CSOs that have been certified only.
  - 3) It would take sometimes to have a good, trustworthy accreditation organisation to register an adequate number of qualified CSOs.

##### b) Payment methods

###### Option 1 Input-based payment

(CSOs receive money to work based on line item or lump sum, but line items are much more common than lump sums.)

**Pro:** Most commonly used-governments are comfortable with it is easier for them to control total amount of budget.

- Con:**
- 1) Does not promote more service delivery or higher quality.
  - 2) It is fairly rigid-does not promote innovation (e.g. ways to increase positive case findings, ART initiation, and retention).

### Option 2 Output-based payment

(It is performance-based financing e.g. fixed price paid to a contractor for a specific service such as an HIV test or number of KPs completing the RRTTR activities)

- Pro:** 1) Easier to use for services that are easy to define and measure.  
2) Could be used to incentivise lagging services e.g. finding HIV+ cases, putting people on ARVs, ensuring HIV viral load is suppressed.

**Con:** CSOs may focus on reimbursable activities only, which progressively narrowed the focus from working towards long-term social and political change and offering comprehensive HIV education and prevention services to performing ever-greater numbers of HIV tests.

### Option 3 Mixed methods of payment (both input and output)

**Pro:** More flexible - could be adjusted based on different circumstances.

- Con:** 1) Requires specific regulation and/or different types of documents and reports to ensure achievements.  
2) Possibly create some confusion of NHSO officers due to different details of measurement before payment.

**5. Monitoring and evaluation of CSOs' performances as well as capacity building** to ensure quality of work. As the NHSO does not have technical capacity on HIV/AIDS, particularly the RRTTR approach, and capacity building is not its legal mandate, it is necessary to seek support from other organisations. There is a need for the NHSO to clarify its institutional mandate to CSOs to prevent false expectations; CSO cannot expect the NHSO to conduct performance audit and capacity building. The NHSO needs to clarify the rigid interpretation by the State Audit Office on the use of NHSO resources outside its mandate.

### Option 1 Performance monitoring and capacity building by DDC, MOPH which has technical expertise on HIV/AIDS.

**Pro:** CSOs can improve their performance or the quality of their services

**Con:** Requires policy dialogue between all relevant stakeholders to reach consensus on different roles of stakeholders based on their comparative advantage, avoid duplication, and ensure synergies.

**Option 2** Performance monitoring and capacity building by DDC, MOPH and other international development partners, such as USAID (while they are still in the country).

**Pro:** CSOs can improve their performance or quality of their services.

**Con:** Requires policy dialogue between all relevant stakeholders to reach consensus on different roles of stakeholders based on their comparative advantage, avoid duplication, and ensure synergies.

6. Competent national contracting project manager to **ensure good governance** of social contracting processes and oversight of CSOs' performances.

**Option 1** The NHSO recruits an experienced project manager to work specifically on social contracting.

**Pro:** More effective contracting processes are expected as this person does not have to work on something else and so is more focused on this.

**Con:** 1) Requires budget to hire this person, which could mean deducting from the budget to be used for social contracting, or the NHSO's central management budget could be used.

2) Need to set up transparent process for recruitment of a competent manager.

3) A manager cannot work alone, but needs to build a team for effective management.

**Option 2** The NHSO outsources an experienced organisation that already has a competent teamwork

**Pro:** 1) More effective contracting processes are expected.

2) No need to waste time in building up management capacity as the outsourced agency should be ready to work.

**Con:** 1) Requires budget to outsource this person or agency, which could mean deducting from the budget to be used for social contracting; or else use the NHSO's central administrative budget.

2) Need to set up transparent process for recruitment of a competent manager.



## REFERENCES

## References

1. UNAIDS. Thailand launches new national strategy to end the AIDS epidemic by 2030. 2017. Accessed on 19 Dec 2018. Available from: [https://www.unaids.org/en/resources/presscentre/featurestories/2017/september/20170915\\_Thailand\\_NSP](https://www.unaids.org/en/resources/presscentre/featurestories/2017/september/20170915_Thailand_NSP).
2. National AIDS Committee. Thailand AIDS response progress report 2015. 2015. Accessed on 19 Dec 2018. Available from: [http://www.unaids.org/sites/default/files/country/documents/THA\\_narrative\\_report\\_2015.pdf](http://www.unaids.org/sites/default/files/country/documents/THA_narrative_report_2015.pdf).
3. AVERT. HIV and AIDS in Thailand, 2017. 2017. Accessed on 23 Dec 2018. Available from: <https://www.avert.org/professionals/hiv-around-world/asia-pacific/thailand>.
4. Nyberg R, Tanchaisawat M. Dressed to teat: Empowered communities take HIV services to the street. The Thai Red Cross AIDS research center. Accessed on 22 Dec 2018. Available from: <http://en.trcarc.org/?p=1925>.
5. Jongudomsuk P, Srithamrongsawat S, Patcharanarumol W, Limwattananon S, Pannarunothai S, Vapatanavong P, et al. The Kingdom of Thailand Health System Review. Manila: World Health Organization, Regional Office for the Western Pacific; 2015. Available from: [https://apps.who.int/iris/bitstream/handle/10665/208216/9789290617136\\_eng.pdf?sequence=1&isAllowed=y](https://apps.who.int/iris/bitstream/handle/10665/208216/9789290617136_eng.pdf?sequence=1&isAllowed=y).
6. United Nations. Resolution adopted by the General Assembly on 25 September 2015 (A/RES/70/1). Transforming our world: the 2030 Agenda for Sustainable Development. 2015. Accessed on 25 September 2019. Available from: [https://www.un.org/ga/search/view\\_doc.asp?symbol=A/RES/70/1&Lang=E](https://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E).
7. United Nations. Resolution adopted by the General Assembly on 8 June 2016 (A/RES/70/266). Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030. 2016. Accessed on 25 September 2019. Available from: [https://www.unaids.org/sites/default/files/media\\_asset/2016-political-declaration-HIV-AIDS\\_en.pdf](https://www.unaids.org/sites/default/files/media_asset/2016-political-declaration-HIV-AIDS_en.pdf).
8. UNAIDS. Fact Sheet-Global Aids Update. 2019. Accessed on 25 September 2019. Available from: [https://www.unaids.org/sites/default/files/media\\_asset/UNAIDS\\_FactSheet\\_en.pdf](https://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf).
9. Bureau of AIDS TB and STIs. Thailand national guidelines on pre-exposure prophylaxis hiv-prep 2018. Nonthaburi, Thailand: Bureau of AIDS, TB and STIs, Department of Disease Control, Ministry of Public Health; 2018 [in Thai].
10. Thailand National AIDS Committee. Thailand national operational plan accelerating ending aids, 2014-2016. 2013.
11. Thailand National AIDS Committee. Thailand national operational plan accelerating ending aids, 2015-2019. Nonthaburi; 2014.

12. National AIDS Prevention and Alleviation Committee. Thailand national strategy and guideline accelerating ending aids, 2017-2030. 2017.
13. World Health Organization. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations Policy brief - 2016 update. Geneva: World Health Organization; 2017. Available from: <https://apps.who.int/iris/bitstream/handle/10665/258967/WHO-HIV-2017.05-eng.pdf;jsessionid=0C0953C84F31BBE783437219DE7D57A4?sequence=1>.
14. World Health Organization. Global health sector strategy on HIV/AIDS 2011-2015. Geneva: World Health Organization; 2011. Available from: [https://apps.who.int/iris/bitstream/handle/10665/44606/9789241501651\\_eng.pdf?sequence=1](https://apps.who.int/iris/bitstream/handle/10665/44606/9789241501651_eng.pdf?sequence=1).
15. World Health Organization. HIV prevention in generalized epidemics : optimal interventions for Global Fund applications : recommendations for a public health approach - 2011. Geneva: World Health Organization; 2011. Available from: [https://apps.who.int/iris/bitstream/handle/10665/44736/9789241502467\\_eng.pdf?sequence=1](https://apps.who.int/iris/bitstream/handle/10665/44736/9789241502467_eng.pdf?sequence=1).
16. United Nations Office on Drugs and Crime. Fast track to end aids by 2030: For people in prisons: United Nations; 2017. Available from: [https://www.unodc.org/documents/hiv-aids/2017/Factsheet\\_-\\_HIV\\_in\\_Prisons.pdf](https://www.unodc.org/documents/hiv-aids/2017/Factsheet_-_HIV_in_Prisons.pdf).
17. UNICEF. Situational Analysis of Young People at High Risk of HIV Exposure in Thailand: Synthesis Report. UNICEF Thailand 2014. Available from: <https://www.unicef.org/thailand/media/1076/file/Situational%20Analysis%20of%20Young%20People%20at%20High%20Risk%20of%20HIV%20Exposure%20in%20Thailand.pdf>.
18. National Monitoring and Evaluation Unit. Thailand AIDS response progress report 2018. Nonthaburi: Bureau of AIDS TB and STIs, Ministry of Public Health; 2018 [in Thai].
19. Health Intervention and Technology Assessment Program (HITAP). Cost Analysis Study of Key Population Interventions to Fast Track the End of HIV in Thailand. Nonthaburi: Health Intervention and Technology Assessment Program; 2019.
20. Thai Working Group on National AIDS Spending Assessment. Thailand's National AIDS Spending Assessment (NASA) 2014-2015. Nonthaburi, Thailand: International Health Policy Program; 2016. Available from: [https://www.researchgate.net/publication/312091575\\_Thailand's\\_National\\_AIDS\\_Spending\\_NASA\\_2014-2015](https://www.researchgate.net/publication/312091575_Thailand's_National_AIDS_Spending_NASA_2014-2015). [in Thai].
21. Viriyathorn S, Patchanee K, Prakongsai P. Thailand's National AIDS Spending Assessment (NASA) 2016-2017. Nonthaburi, Thailand: International Health Policy Program; 2018. [in Thai].
22. Bureau of AIDS TB and STIs. Guideline manual for providing the funding support to non-government organizations to implement HIV/AIDS interventions. Nonthaburi: Department of Disease Control, Ministry of Public Health; 2013 [in Thai].

23. National Health Security Office (NHSO). National Health Security Fund Management Manual, Fiscal Year 2019. Bangkok: National Health Security Office; 2019.
24. The Global Fund. Thailand HIV/AIDS Results Profile 2019. Available from: [http://docs.theglobalfund.org/010/tha-h\\_result\\_profile\\_en.pdf](http://docs.theglobalfund.org/010/tha-h_result_profile_en.pdf).
25. The Global Fund. Financial Management Handbook for Grant Implementers. Geneva 2017. Available from: [https://www.theglobalfund.org/media/7034/financial\\_grantimplementers\\_management\\_handbook\\_en.pdf?u=637066556720000000](https://www.theglobalfund.org/media/7034/financial_grantimplementers_management_handbook_en.pdf?u=637066556720000000).
26. Strategy and Planning Division. The Public Health of Thailand 1999-2000. Wibulpholprasert S, editor. Nonthaburi: Strategy and Planning Division, Ministry of Public Health; 2002 [in Thai].
27. Office of the Council of State. National Health Insurance Act B.E. 2545. Bangkok; 2002 [in Thai].
28. Office of the Council of State. Notification of the National Health Security Office Board B.E. 2559: Type and Scope of Public Health Service (Issue 60). Bangkok: Cabinet and Royal Gazette Publishing Office; 2017 [in Thai].
29. Office of the Council of State. Notification of the National Health Security Office Board B.E. 2560: Assessment criteria to register as a health service unit. Bangkok: Cabinet and Royal Gazette Publishing Office; 2017 [in Thai].
30. Bureau of AIDS TB and STIs. Thailand National Guidelines on HIV/AIDS Treatment and Prevention 2014. Nonthaburi: Department of Disease Control, Ministry of Public Health; 2014.
31. Office of the Council of State. Notification of the National Health Security Office Board B.E. 2559: Type and Scope of Public Health Service (Issue 10). Bangkok: Cabinet and Royal Gazette Publishing Office; 2017 [in Thai].
32. Office of the Council of State. Notification of the National Health Security Office Board B.E. 2561: Rules of Implementation and Management of Universal Health Coverage Fund (Issue 11). Bangkok: Cabinet and Royal Gazette Publishing Office; 2017 [in Thai].
33. National Health Security Office. Guideline manual for Management of the National Health Security Office Fund B.E. 2562. Bangkok: Sahamit printing and publishing company Ltd.; 2019 [in Thai].
34. Office of the Council of State. Notification of the National Health Security Office Board B.E. 2560: Type and scope of health service (Issue 11). Bangkok: Cabinet and Royal Gazette Publishing Office; 2017 [in Thai].
35. The Revenue Department. Revenue Code, B.E 2481. 1938 [in Thai]. Accessed on 31 October 2019. Available from: <https://www.rd.go.th/publish/5937.0.html#mata39>.
36. The Revenue Department. Announcement of the Ministry of Finance No. 704, B.E.2561. 2018 [in Thai]. Accessed on 31 October 2019. Available from: [https://www.rd.go.th/publish/fileadmin/user\\_upload/kormor/newlaw/mfv704.pdf](https://www.rd.go.th/publish/fileadmin/user_upload/kormor/newlaw/mfv704.pdf).

37. The Revenue Department. Announcement of the Ministry of Finance: Income Tax and Value Added Tax (No. 2), B.E.2535. 1992 [in Thai] Accessed on 31 October 2019. Available from: <https://www.rd.go.th/publish/2644.0.html>.
38. Thailand lawyer online. Juristic person [November 1, 2019]. Available from: <https://www.thailandlawonline.com/10-juristic-person>.
39. Chakravarthy J, Joseph S, Pelto P, Kovvali D. Community mobilisation programme for female sex workers in coastal Andhra Pradesh, India: processes and their effects. *J Epidemiol Community Health* 2012;66(Suppl 2:ii78-86).
40. Patcharanarumol W, Thammatacharee N, Kittidilokkul S, Topothai T, Thaichinda T, Suphanchaimat R, et al. Thailand's HIV/AIDS program after weaning-off the global fund's support. *BMC Public Health*. 2013;13(1008).
41. Seminia I, Batonab G, Lafranceb C, Kessoue L, Gbedjie E, Ananif H, et al. Implementing for results: Program analysis of the HIV/STI interventions for sex workers in Benin. *AIDS Care*. 2013;25(1):30-9.
42. Fan E. HIV testing as prevention among MSM in China: the business of scaling-up. *Global Public Health* 2014;9(1-2: HIV Scale-Up and the Politics of Global Health).
43. Tucker J, Muessig K, Cui R, Bien C, Lo E, Lee R, et al. Organizational characteristics of HIV/syphilis testing services for men who have sex with men in South China: a social entrepreneurship analysis and implications for creating sustainable service models. *BMC Infectious Diseases*. 2014;14(601).
44. Yan H, Zhang M, Zhao J, Huan X, Ding J, Wu S, et al. The increased effectiveness of HIV preventive intervention among men who have sex with men and of follow-up care for people living with HIV after 'task-shifting' to community-based organizations: a 'cash on service delivery' model in China. *PLoS One*. 2014;9(7: e103146).
45. Qureshi A. AIDS Activism in Pakistan: Diminishing Funds, Evasive State. *Development and Change*. 2015;46(2).
46. Miller C. Dying for Money: The Effects of Global Health Initiatives on NGOs Working with Gay Men and HIV/AIDS in Northwest China. *Medical Anthropology Quarterly*. 2016;30(3).
47. Fan E. Counting results: performance-based financing and HIV testing among MSM in China. *Critical Public Health*. 2017;27(2).
48. Khalid H, Fox A. Political and Governance Challenges to Achieving Global HIV Goals with Injecting Drug Users: The Case of Pakistan. *International Journal of Health Policy and Management*. 2019;8(5):261-71.
49. Burgess S, Beltrami J, Kearns L, Gruber D. The Louisiana Wellness Centers Program for HIV/STD Prevention Among Gay and Bisexual Men and Transgender Persons. *Journal of Public Health Management and Practice*. 2019.



50. FHI 360. Improving Social Contracting to End HIV in Thailand: Experiences from selected countries and implications for the national response. Bangkok, Thailand; 2019.
51. UNDP. The Guidance Note for the Analysis of NGO Social Contracting Mechanisms The Experience of Europe and Central Asia. 2019. Available from: [https://www.eurasia.undp.org/content/rbec/en/home/library/hiv\\_aids/guidance-for-ngo-social-contracting-mechanisms.html](https://www.eurasia.undp.org/content/rbec/en/home/library/hiv_aids/guidance-for-ngo-social-contracting-mechanisms.html).
52. Palmer N, Mills A. Classical versus relational approaches to understanding controls on a contract with independent GPs in South Africa. Health economics. 2003;12(12): 1005-20.
53. FHI 360. The Essential NGO Guide to Managing Your USAID Award. Washington, DC: Capable Partners Program, FHI 360; 2010.



## **ANNEXES**

## Annexes

### Annex A: Semi-structured interview guidelines

#### A1 Interview guideline: Funder

##### *General information of organisation*

- Overall roles of organisation in relation to HIV/AIDS
- Your organisation allocate budget to whom and for what objectives?
  - Selection process
  - Type of contract e.g. annual or biannual and requirements
  - M&E
  - In case their performance didn't reach the agreed target, what would you do?  
Are there any organisations that you need to terminate before the contract ended?

##### *Budget*

- Overall budget during the last 3 year (2017-2019)
  - i. Source of funding
  - ii. How much? (request for details of spending if possible)
- Budget spending in prevention and promotion on HIV/AIDS mainly uses for which activities? Covering what areas? Any problems/challenges?

##### *Installment and reimbursement*

- Whether budget from different sources spend differently?
- Whether payment for each activity is different?
- Budget used for HIV/AIDS services
  - iii. To which organisations and for what activities? (request for organisation lists and activities if possible)
  - iv. Contracting with CSOs:
    - a) Directly or through other organisations? e.g. through hospitals How much budget allocate to CSOs each year?
    - b) During the past 3 years, whether the conditions/agreements are different?
    - c) Objectives of contracting?
    - d) Are there any specific requirements? e.g. target groups, types of activities.
    - e) Selection criteria
    - f) Installment, contracting, conditions and agreements are the same for each CSO? Explain.
    - g) Having guideline for M&E of performance, financial audit or not?
    - h) Have the results of performance evaluation used for improvement?
    - i) Key success factors/barriers in contracting with CSOs

## **A2 Interview guideline: CSOs**

### *General information of organisation*

- Type/characteristics (group, network, institute, association foundation...) Is it a juristic person?
- Vision mission and role of organisation
- Does it operate under control of other organisations?
- How many employees whose work related to HIV/AIDs? (Full time, Part time, Volunteer...)

### *Role in providing HIV/AIDS services*

- How your organisation play a role in HIV/AIDS? Which KPs?
- Which KP group is the most difficult to reach and what do you do?
- Have your organisation worked with other organisations to provide HIV/AIDS e.g. public/private hospitals, local government organisation, other CSOs and any others
- Whether the current type/model of HIV/AIDS service provisions with others is suitable? Any there anything to change or improve? What would be the future direction?
- How is the outcome of providing HIV/AIDS services among your target KPs? What are key success factors/barriers?

### *Funding management*

- How many funds your organisation has received during the last 3 year (2017-2019)? From which sources? If there are several sources of funding, whether they have different conditions/requirements (e.g. activities, KPs)?
- Does your organisation have your own guideline of working? Are there any specific conditions to agree with the funder before working? Whether different sources of funding have different conditions/requirements? How many models of contracting that you have been done? Whether they affect your organisation differently?
- Whether different types/models of contracting lead to different quantity and quality of your work on HIV/AIDS and your target KPs? How?
- Based on your experience, what would be limitations of the contracting model that you think it should change/improve for efficient and effective outcomes?

## **A3 Interview guideline: provider**

### *General information*

- What type of your hospital based on service plan of MOPH
  - i. P (S,M,L)
  - ii. F (F1,F2,F3)
  - iii. M (M1,M2)
  - iv. S
  - v. A
- HRH
  - i. How many health professionals (e.g. doctors, nurses)?
  - ii. Number of health professionals working on HIV/AIDS
    1. Prevention
    2. Treat
    3. Whether the current number of health professionals are sufficient for working? Are there any specific health professionals that you need?
- How many populations that your hospitals have been responsible for (every type of health insurance)? How many HIV/AIDS patients? Are there any KPs or vulnerable populations (e.g. migrant) in your area?

### *Roles of HIV/AIDS provision*

1. What type of HIV/AIDS services?
  - i. RRTTR
- (If does RR) are there any far remote areas to reach and recruit your targets?
  - ii. HIV/AIDS treatment
  - iii. home visit, outreach, community-based programme
  - iv. In-house and mobile services
  - v. Manage alone or working with others
2. What types of HIV/AIDS services that patients come for? e.g RRTTR ARV or others (home visit, outreach, community based programme)
- What are your key populations? How many? Whether they can access the service you provide?
- Problems of your key populations?
- Outcomes of your work on key populations? Are you satisfied with it?
  - i. Key success factors
  - ii. Barriers
  - iii. Do you provide different services to different groups?
  - iv. Recommendations for improvements

### ***Budget and management on HIV/AIDS***

- Funding sources? How much in each year? Sufficient?
- Budget used for what activities? Are there any specific KPs?
  - i. Activities
  - ii. Sources? Type of contracting? Conditions/Requirements?
  - iii. KPI? Reporting systems? Any problems?
  - iv. If you work with other organisations, what are agreements that have been done? Advantages and disadvantages? M&E system used?
- Based on your experience, what are key success factor/barriers? What should be areas of improvements?

## **A4 Interview guideline: Regional NHSO/DDC Officers**

### ***General information***

- Type of organisation, vision, mission, employees
- How many people working on HIV/AIDS?
- Proportion of working on HIV/AIDS compared to other type of working

### ***Role of HIV/AIDS services***

- Overall implementation on HIV/AIDS
- Source of budget/funding? How much?
- What kind of policy you receive from the national level? Are there any problems with implementation?
- How your office plays a role in HIV/AIDS service provisions? Which KPs?
- Have you work with other organisation in relation to HIV/AIDS? How?
- Have you work with CSOs?
- In what role that you work with CSOs? What kind of contract or relationship?
- How did you fund CSOs for HIV/AIDS services?
  - i. Funding sources
  - ii. Condition/requirements for contracting with CSOs OR passing the fund to CSOs via any other providers? If so, how much in each year
  - iii. Are there any differences of contracting during the last 3 years?
  - iv. What are objectives of contracting with CSOs?
  - v. Are there any specific objectives e.g. KPs?
  - vi. Selection criteria for CSOs
  - vii. Whether different contracts used for different CSOs?
  - viii. Guideline for M&E? How?
  - ix. Whether the M&E results have been used for improvement?
  - x. Key success factors/barriers?
  - xi. Whether your current model in contracting/working with CSOs and others is suitable? Any improvements?

## Annex B: Enabling factors and challenges of the contracting models in each included manuscript in the scoping review

Authors/ Countries	KPs	Contracting models	HIV service outcomes	Enabling factors/Strengths	Challenges/Limitations
Chakravarthy et al (2012)/ India	Female sex workers	<i>Providers:</i> CBOs  <i>Payment methods:</i> Monthly honorarium	Not mentioned	NA	<ul style="list-style-type: none"> <li>The CBO structures still need to work towards better resource management, democratic functioning and other components of collective action.</li> <li>The variations in success of the CBOs could be attributed to several factors: types of sex work structures, social and political environments of the districts, and difference in implementation performance by NGOs.</li> </ul>
Patcharanarumol et al (2013)/ Thailand	Migrant, PWID, Sex workers, and MSM	<i>Providers:</i> <ul style="list-style-type: none"> <li>Public providers</li> <li>CSOs</li> </ul> <i>Payment methods:</i> <ul style="list-style-type: none"> <li>Government programmes: by input</li> <li>GF supported programmes: result-based financing</li> </ul>	<i>Government programmes:</i> doubtful effectiveness  <i>Non-state actors:</i> success	GF model has clear accountability framework under the distinct Principal Agent relationship through contractual agreement.	<ul style="list-style-type: none"> <li>Skills and competencies to work effectively for KP varied across implementing agencies where non-state actors had comparative advantages.</li> <li>Government integrated model limits accountability where MOPH played dual roles of Principal &amp; Agent</li> <li>For government programmes, limitation to address preventions among non-Thai KP</li> <li>Government programmes have rigidity and capacity in outsourcing/contracting services to competent non-state actors.</li> </ul>

Authors/ Countries	KPs	Contracting models	HIV service outcomes	Enabling factors/Strengths	Challenges/Limitations
Semini et al (2013)/Benin	Female sex workers	<i>Providers:</i> NGOs and public health centers  <i>Payment methods:</i> Contract 6-12 months	Failed  NA		<ul style="list-style-type: none"> <li>• Financing irregularities have resulted in interruptions of community-based services.</li> <li>• Mismatch of allocated resources (funding &amp; staff) and FSWs needs at the regional level.</li> <li>• Tackling exclusively the individual risk is likely to have a limited impact. Structural interventions that address societal causes like social exclusion, police harassment, stigma, and legal environment coupled with programme ownership by FSWs and communities, may remove barriers for access to services and enable FSW to have greater control of their work condition and seek health services.</li> <li>• Disconnection between community activities and health services resulted in limited utilisation of STI services, VCT, and ART.</li> <li>• Weak management system at national level &amp; limited capacity to supervise or provide technical support.</li> <li>• The monitoring system did not capture the FSW as individuals resulting in the overlap of data.</li> </ul>



Authors/ Countries	KPs	Contracting models	HIV service outcomes	Enabling factors/Strengths	Challenges/Limitations
Fan (2014)/China	MSM	<p><i>Providers:</i> CBOs</p> <p><i>Payment methods:</i> Outsourcing service with a defined set of outputs</p>	Success	The comparative advantage of CBOs in reaching MSM because MSM fears of registering their identity if they go to public facilities and less judgement at CBO's facilities.	The sustainability of CBOs is inextricable from the scaling-up of testing.
Tucker et al (2014)/China	MSM	<p><i>Providers:</i></p> <ul style="list-style-type: none"> <li>Independent CBO</li> <li>Independent Clinic (hospitals, Center for Disease Control-based testing)</li> <li>CBO-Clinic hybrid</li> </ul> <p><i>Payment methods:</i></p> <ul style="list-style-type: none"> <li>CBOs: government-funded through public health clinics directly providing tests or through subcontracts to CBOs (payment methods not mentioned)</li> </ul>	Success (Hybrid CBO-clinic model)	<ul style="list-style-type: none"> <li>Hybrid CBO clinic testing sites effectively integrate the client-facing inclusive environment of the MSM CBO with the technical competence and facilities of a public health clinic.</li> <li>Social entrepreneurship initiatives can help reorganize sexual health services in order to make them more sustainable and community-driven.</li> </ul>	<p><i>For CBO:</i></p> <ul style="list-style-type: none"> <li>No mechanisms to ensure sustainability of CBO. CBOs generally struggled to find the additional funds needed to cover their operating expenses (e.g. testing space rental, phone lines, outreach, staff stipends/salaries)</li> <li>Cutbacks in external support for STD testing services were forcing organisations to reduce or alter testing services. (only do what donors want)</li> <li>Restrictions on hiring staff or paying for other administrative fees and operating costs (e.g. space rental fees, phone lines, etc.) as part of many external funding schemes compromised the ability of CBOs to maintain or scale up testing programmes</li> </ul>

Authors/ Countries	KP's	Contracting models	HIV service outcomes	Enabling factors/Strengths	Challenges/Limitations
		<ul style="list-style-type: none"> <li>• Clinic: fee-for-service</li> <li>• pilot CBO-Clinic: sell products (condoms, STD test, clothes, books, etc) or sell services (private clinic tailored to FSW, online advertisement, partnership with business)</li> </ul>			<ul style="list-style-type: none"> <li>• Exorbitant fees associated with the official registration process for non-governmental organisations precluded all mainland MSM CBOs from being officially registered as non-profit organisations, limiting their fundraising capabilities</li> </ul> <p>For social entrepreneur model (piloted hybrid):</p> <ul style="list-style-type: none"> <li>• A social entrepreneurship project could create confusion among testers unless clearly re-branded from existing CBO and government services i.e. paying for a test that had traditionally provided through public sector would commercialise the service.</li> <li>• Paying for testing would either discourage testing or decrease the frequency of testing</li> </ul>
Yan et al (2014)/ China	MSM	<p><i>Providers:</i> CBOs</p> <p><i>Payment methods:</i> Output-based fee schedule/ performance based funding</p>	Success	<ul style="list-style-type: none"> <li>• Mapping of CBO service providers and assessment of capacity of potential CBO service providers, supplemented with timely and targeted capacity building, appeared to well prepare the CBOs to deliver quality services.</li> <li>• The actual cash payment made by JSPMA was based on independently verified results through webbased national HIV/AIDS information system.</li> </ul>	NA

Authors/ Countries	KPs	Contracting models	HIV service outcomes	Enabling factors/Strengths	Challenges/Limitations
Qureshi (2015)/ Pakistan	PWID, sex workers, MSM	<i>Providers:</i> NGOs  <i>Payment methods:</i> Output-based contract	Not mentioned	NA	<ul style="list-style-type: none"> <li>When the state's inability to work with such 'quasi-legal' groups was put forward as the rationale to contract out to NGOs which weakened the state's social and regulatory operations and deprived them of any opportunity to evolve.</li> <li>The flexibility bureaucracy and the entrepreneurial governance of the HIV programme without regulatory role of the government to scrutinise inputs allowed the money to end up in the pocket of a few powerful individuals.</li> <li>The management consultancy firm was appointed due to its previous links with the Bank despite lack of expertise in the HIV sector.</li> <li>An entrepreneurial model of governance turned employees into selves. The programme turned the HIV response into a market.</li> </ul>

Authors/ Countries	KPs	Contracting models	HIV service outcomes	Enabling factors/Strengths	Challenges/Limitations
Miller (2016)/ China	MSM	<i>Providers:</i> Local NGOs  <i>Payment methods:</i> Output-based fee schedule/ performance based funding	Not mentioned	NA	<ul style="list-style-type: none"> <li>• NGOs only focus on reimbursable activities which progressively narrowed its focus from working towards long-term social and political change and offering comprehensive HIV education and prevention services to performing ever-greater numbers of HIV tests.</li> <li>• The model encourages NGOs to compete for project contracts and monies that they became increasingly reliant upon to survive.</li> <li>• Greater capacity NGOs (national or international NGOs) can register with Chinese government and receive GHI fund directly giving them greater financial incentives over grassroots, unregistered NGOs.</li> </ul>
Fan (2017)/China	MSM	<i>Providers:</i> CBOs  <i>Payment methods:</i> performance- based financing	Not mentioned	NA	<ul style="list-style-type: none"> <li>• Performance-based financing reinforces the production of results rather than focusing on health outcomes that might not return such measurable results.</li> </ul>

Authors/ Countries	KPs	Contracting models	HIV service outcomes	Enabling factors/Strengths	Challenges/Limitations
Khalid and Fox (2019)/Pakistan	PWID	<i>Providers:</i> NGOs  <i>Payment methods:</i> Contract-based	Failed  NA		<i>Governance challenges:</i> <ul style="list-style-type: none"> <li>Limited healthcare infrastructure, poor regulation and management across the health sector</li> <li>Resource mismanagement and shortage</li> <li>NGO-state relationship management complicates service provision</li> </ul> <i>Political challenges:</i> <ul style="list-style-type: none"> <li>Limited &amp; heterogeneous political commitment for HIV</li> <li>The conservative legal environment adds complexity to treating IDUs due to the ban on opioid substitution therapy</li> </ul>
Burgess et al (2019) USA	MSM	<i>Providers:</i> Collaborative effort of Department of Health, CBOs, local providers  <i>Payment methods:</i> Project-based	Success	<ul style="list-style-type: none"> <li>a specialized and holistic approach to health for gay and bisexual men and transgender persons.</li> <li>Sustained public health impact.</li> </ul>	<ul style="list-style-type: none"> <li>Obtaining supplies (eg, examination tables, centrifuges, and cold storage equipment). It is important to obtain all needed supplies and equipment before services are promoted to clients.</li> </ul>



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