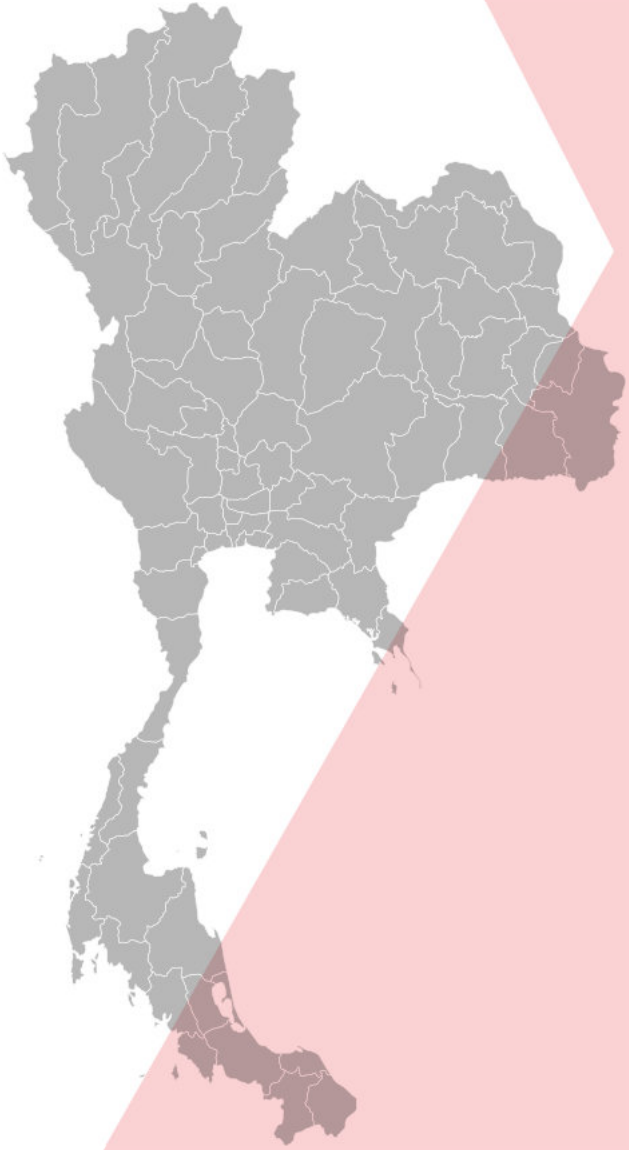
National Situational Assessment of HIV Financing in

THAILAND



SHIFT
Sustainable HIV Financing in Transition

Executive Summary ❯

Sustainable HIV Financing in Transition (SHIFT) Programme is a two-year regional advocacy programme funded by the Global Fund. Beginning in January 2017 the goal is to empower civil society and communities, especially key population communities, to advocate for sustainable HIV financing in four Southeast Asian countries: Indonesia, Malaysia, the Philippines and Thailand.

To better understand the four countries' HIV financing a National Situational Assessment, which studied published data, was conducted in the middle of 2017. A total of 118 resources in English, Bahasa Indonesia and Bahasa Malaysia were reviewed, including National AIDS Spending Assessments (NASA) and Global AIDS Response Progress Report (GARPR). The availability and sufficiency of HIV financing resources, as well as how funding resources are allocated in Indonesia, Malaysia, Thailand and the Philippines was examined. The following findings provides an overview of the key themes across the four countries.

Key Findings

I. Increasing Domestic Financing of National HIV responses

The four SHIFT countries of Indonesia, Malaysia, the Philippines and Thailand are seeing a trend towards more domestic spending on HIV. Between 2010 and 2015, the Philippines' domestic spending rose 286%, the biggest funding increase of any SHIFT country, however, this increase came as new HIV infections doubled over the same period[1].

Malaysia funds the bulk of its HIV programmes, at 96% in 2015. This is followed by Thailand with 89% (2015), Philippines with 74% (2015) and Indonesia with 57% (2014)[2]. Indonesia in particular recorded a shift from mainly international funding to domestic financing beginning in 2013, with more than half of its HIV response funded domestically by 2015[3].

While the trend is moving towards greater domestic government support, a significant amount of that expenditure goes towards provision of care and treatment, ranging from 33% in Indonesia for 2014 to 67% in Thailand for 2015[4]. Compared to investing in prevention, especially for key populations, healthcare provisions for HIV care and treatment remains the predominant expenditure categories. The obvious utility of treating diseases aside, healthcare provision fits well within the mandate of the government and state as providers of healthcare, without the political sensitivity of spending on stigmatised or criminalised populations. However, this overshadows the importance of the prevention approach needed to stall and reverse the epidemic, and especially the gains made possible when investing in the most affected populations.

1. UNAIDS (2017). Press Release: UNAIDS report indicates new HIV infections in the Philippines have doubled in the past 6 years, 1st August 2017.
2. UNAIDS DataHub (2017). Country Snapshots 2017.
3. NASA Indonesia (2015)
4. UNAIDS DataHub (2017). Country Snapshots 2017.

II. Allocative Efficiency and the Issue of Investing in Key Populations Prevention

Despite the growing epidemic and the financial burden of HIV, investment in prevention spending for key populations is low. Figure 3 illustrates prevention spending across the three key populations in the four SHIFT countries. Of note in advocating for efficient, targeted investment is the current MSM prevention spending. Although 50% to 80% of new infections affect MSM in the four SHIFT countries[5], only an average of 10% of domestic HIV prevention investment is spent on MSM.

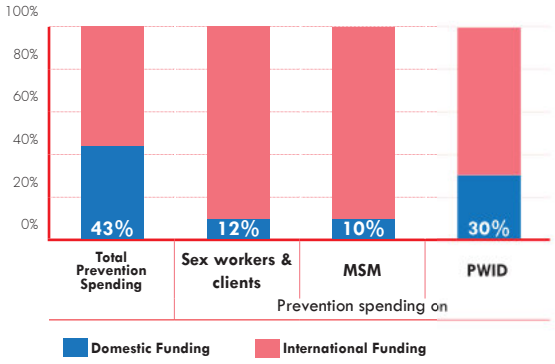


Figure 3: Distribution of prevention spending by financing source in 4 SHIFT countries, latest available year, 2014-2015 [6]

HIV prevention activity delivers the biggest impact and return on investment if it is targeted at the key populations of MSM, sex workers and PWID who are disproportionately affected by the epidemic. However, countries in the region fail to allocate appropriate resources for key populations, with an estimated 8% of overall HIV spending in Asia and the Pacific going towards prevention for key populations[7]. A case worth noting is the response in the Philippines to the rapidly growing epidemic. Four out of five new HIV infections are MSM, but despite the disproportionally high risk of infection, only 8% of HIV spending was allocated to MSM prevention programmes[8].

As seen in Figure 3 above, the bulk of prevention spending in key populations is supported by international donor funding. This raises the issue of sustainability and the potential impact on the epidemic once international donors exit and countries transition to domestic financing. This has been observed in Romania by the Eurasian Harm Reduction Network. A dramatic increase in HIV prevalence among PWID was recorded, with it rising from 1.1% in 2009 (prior to end of Global Fund support), to 6.9% in 2012 and spiking at 53% in 2013 in the years after Global Fund exit [9]. The risk of prevention for key populations to fall through the cracks in this transition stage warrants an urgent allocative efficiency analysis and evidence-based advocacy to ensure an effective response to HIV.

III. Accessibility of Domestic Financing Sources

In the SHIFT countries, with the exception of Malaysia, civil society access to domestic financing remains an ongoing challenge. Prohibitive conditions such as stringent registration criteria, CSO accreditation, absence of enabling laws and policies as well as government attitudes towards CSOs further complicates the issue.

Feedback from country partners noted key constraints between CSOs and governments. There is a lack of government trust in CSOs, largely due to concerns over financial management and issues of corruption. In the Philippines the pork barrel corruption scandal involving government officials establishing fake NGOs to channel funds illegally has resulted in a crackdown and tightening of NGO laws[10], resulting in more stringent rules and barriers to CSO registration[11]. CSO and country partner representatives distrust government agencies to make evidence-based decision in HIV financing, especially when it relates to financing key populations who are potentially criminalised or marginalised.

5. UNAIDS DataHub (2017). Men Who Have Sex Men 2017 Slides.
6. UNAIDS DataHub (2017)
7. WHO (2016). HIV financing status in selected countries of the Western Pacific Region (2009-2015).
8. UNAIDS DataHub (2017). Philippines Country Snapshot 2016.
9. Eurasian Harm Reduction Network (2016). The Impact of Transition from Global Fund Support to Governmental Funding On The Sustainability of Harm Reduction programmes.
10. Francisco, K & Geronimo, J (2013). Why fake NGOs got away. https://www.rappler.com/newsbreak/41913-why-fake-ngos-got-away
11. Philippines country partner ACHIVE noted that organisational registration can take up to 2 years.

Furthermore, understanding budget processes and meaningful engagement in budget advocacy has been limited. This is reflected in the complex structures and power brokers of the budgetary process that CSOs have traditionally been excluded from. However, in Indonesia and the Philippines budget advocacy and accountability NGOs, such a Seknas Fitra and Social Watch Philippines, have led community level engagement to 'democratise' the budget process. This has made complex information more widely accessible allowing CSOs to undertake and engage in budget advocacy.

An exception to the rule of domestic financing channels is the case in Malaysia, where a government-operated NGO - the Malaysian AIDS Council (MAC) was set up to allocate funds to CSOs[12]. However, even as MAC supports CSOs and actively includes key population representatives in its decision-making structures, many CSOs who are recipients question MAC's ability and willingness to advocate on complex issues and to represent civil society in its engagement with the government. As noted by other SHIFT country partners, a principle function of CSOs rests in its ability to advocate on behalf of the communities it represents, as well as serving as a watchdog to hold governments to account on delivering meaningful CSO engagement on national HIV responses.

Government funding may create a conflict of interest and put the CSO's independence at risk and make it a toothless watchdog. As one community respondent put it: "you don't bite the hand that feeds you"[13].

12. Ministry of Health Malaysia (2016). The Global AIDS Response Progress Report 2016.
13. Pers. Comms. (2017). Regional Forum on CSO Financing Mechanisms and Progress Review, 4 – 6 September 2017.
14. Human Rights Watch (2017). "License To Kill". https://www.hrw.org/report/2017/03/02/license-kill/philippine-police-killings-dutertes-war-drugs
15. Azlee, A. (2016). Anthropologist: Solidarity the only way to stop victimisation of LGBT. The Malay Mail Online. http://www.themalaymailonline.com/print/malaysia/anthropologist-solidarity-the-only-way-to-stop-victimisation-of-lgbt
16. Hutton, J (2017). Indonesia's Crackdown on Gay Men Moves From Bars Into the Home. The New York Times. https://www.nytimes.com/2017/12/20/world/asia/indonesia-gay-raids.html
17. Kingston, J. (2017). Civil society across Asia if flowering but fragile. The Japan Times. https://www.japantimes.co.jp/opinion/2017/04/29/commentary/civil-society-across-asia-flowering-fragile/#.WiDvyBOCzOQ

IV. Socio-Cultural and Political Contexts

In Asia, and especially in the SHIFT countries, illiberal governments and populist policies impact the ability of CSOs to advocate for their needs. Elements of military and religious governance operate in the SHIFT countries, hampering the ease of advocacy especially for key populations who are criminalised or discriminated against.

Criminalisation further marginalises key populations. It prevents organisations representing them to fully engage, both on the legislative front, where they are unable to legally participate as political citizens, as well as on the socio-political front, where perceptions and conservative ideologies dominate the decision-making and resource-allocation table.

This is especially observable in the Philippines with the "War on Drugs" – a populist policy criminalising drug use - effectively rules out any investment and advocacy for PWID and their programmes[14]. In Indonesia and Malaysia, gay people and LGBT issues are routinely targeted under conservative Islamic justifications, in addition to being used as political instruments to demonise and advance dominant political influence during election periods[15][16]. This situation presents a major challenge for CSOs to advocate for investment in key populations, especially MSM and transgender people. It makes these communities, and their need for greater domestic HIV financing, invisible.

A further socio-cultural challenge is governments viewing CSOs with suspicion. CSO are often perceived, as antagonistic towards governments, given that successes generated by CSOs imply a certain loss of face for the government and implies the government failed to meet the needs of their citizens[17]. This demonstrates the need for an advocacy strategy that shifts the relationship from adversarial to a mutually beneficial one, focused on the bottom line of controlling the country's HIV epidemic.

In particular, the economic argument for investment in key populations, the return on investment and the potential to mitigate the epidemic escalating are advocacy in-roads that warrant further exploration. The SHIFT programme will explore these ideas by analysing the cost of criminalisation and country case studies, in order to inform advocacy initiatives in the SHIFT countries and will share findings across the region with key partners and stakeholders.

Thailand

THAILAND

I. Background Trends

Health expenditure per capita (current USD)	**2014**	**360.38**
Share of public health expenditure in **government expenditure**	**2014**	**23.25%**
Share of public health expenditure in **total health expenditure**	**2014**	**86%**
Share of total health expenditure in **GDP**	**2014**	**6.5%**

Table 1: Thailand background data (World Bank, 2016)

One of the most developed nations in Southeast Asia, Thailand has strong economic resources to invest in healthcare. With a population of 69 million, the health expenditure per capita is USD 360.38, ranking second after Malaysia among the SHIFT countries. With strong support from the government, the bulk of medical costs in the country are covered under comprehensive UHC schemes, with highly subsidised access to HIV treatment, comprehensive HIV continuum care policies, and a comparatively better legal environment for key populations that does not explicitly criminalise them.

II. HIV Financing: Domestic vs. International

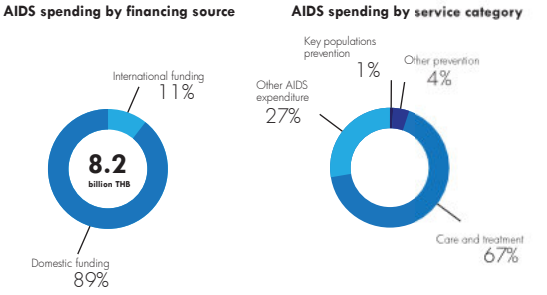


Figure: Proportion of HIV expenditure by financing source and service category, latest available data [72]

Second to Malaysia in terms of domestic HIV financing, Thailand funds 89% of its HIV programmes. The government has committed to transition to a fully domestically funded HIV and TB response in 2017. However, for 2017 of the total of USD 436.1 million required, it is estimated only USD 378.7 million will be funded domestically - including USD 332.3 million from government revenues, USD 46.3 million under social health insurance and USD 0.1 million from the private sector. In addition, external funding from Global Fund will contribute USD 6 million, leaving a gap of USD 51.4 million[73]. Currently, only THB 50 million (approximately USD 1.4 million) is available on an annual basis for all CSOs and key population-based HIV programmes in the country through the NHSO fund.

III. Key Populations Epidemiology vs. HIV Expenditure

Thailand is among the most severely affected countries by HIV in region. The country has a population of more than 68 million with an estimated 445,000 people living with HIV in Thailand in 2014 with around 7,800 new infections annually[74]. HIV infection is estimated to continue declining but at a slow pace, and with high proportion of new infections attributed to MSM, PWIDs, and sex workers. The HIV prevalence in 2014 was 19% among PWID, 11.7% among MSW, 9.2% among MSM, and 1.1% among venue-based FSW[75]. Recent survey results as well as the most updated estimates and projections of HIV suggest an explosive rate of infection among MSM is driving the epidemic. MSM HIV prevalence was 8% in 2010, 7.1% in 2012, and 9.2% in 2014 (figure below). Among new infections occurring in 2012-2016, MSM account for 44%[76].

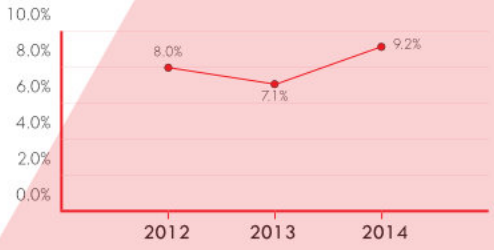


Figure: HIV prevalence among MSM 2010-2014[77]

72. UNAIDS Datahub (2017). Country Snapshot: Thailand
73. Thailand TB and HIV concept Note (2016), p43.
74. National AIDS Committee of Thailand (2016). Thailand Global AIDS Response Progress Report. Reporting period: 2014.
75. National AIDS Committee of Thailand (2015). Integrated Biological and Behavioral Survey (IBBS) in 2014
76. Thailand Working Group on HIV/AIDS Projection (2014). Projection for HIV/AIDS in Thailand 2010 -2030.
77. National AIDS Committee of Thailand (2015). Integrated Biological and Behavioral Survey (IBBS) in 2014

Studies conducted in cities indicate a much higher HIV prevalence for MSM. In Bangkok, cross-sectional HIV prevalence assessments reveal an increase of the HIV prevalence from 17.3% in 2003 to 31.3% in 2010. In Phuket, the HIV prevalence increased from 5.5% in 2005 to 20% in 2007 and 24.7% in 2014. In Chiang Mai, the prevalence was as high as 15.3% in 2005 and increased to 17% in 2007. In Udonthani and Pattalung, the HIV prevalence was 5%.

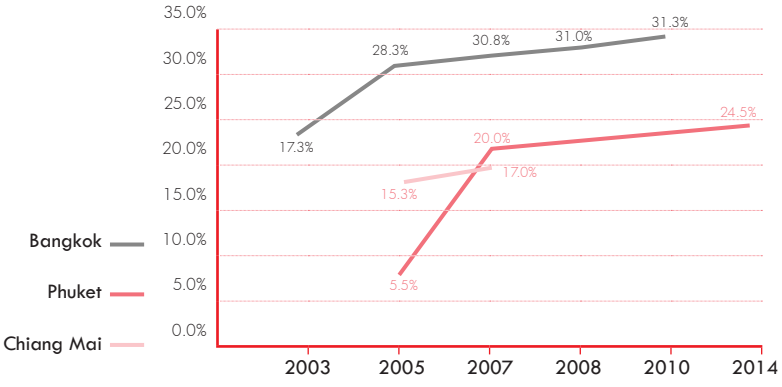


Figure: HIV prevalence among MSM in Bangkok 2003-2010 [78]

Compared to the epidemic trends, latest disaggregated 2013 data from AIDS Info Online indicates a bulk of key populations investment coming from international donors, except for PWID with a marginally higher 32% coming from domestic sources.

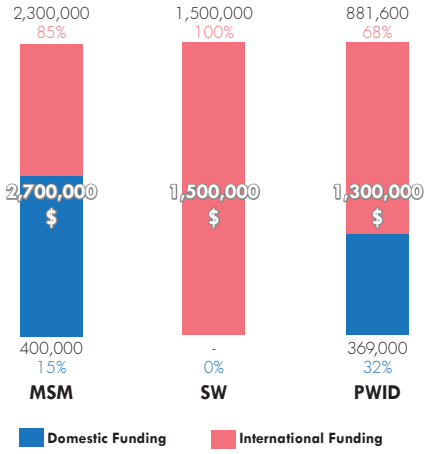


Figure: Share of Prevention Investments in Key Populations (Thailand), latest available data[79]

IV. HIV Financing Mechanisms

Trends in health expenditure based on the National Health Accounts reflects a steady increase from USD 11,794 million in 2012 to USD 20,260 million in 2017. As an upper-middle income country, Thailand does not receive a large amount of external donor funding, and the vast majority of health spending is from domestic resources.

The National AIDS Spending Assessment in 2014 reveals that total AIDS spending was USD283 million in 2012 and increased to USD 287 million in 2013. Growing country ownership for prevention interventions has been documented. Domestic funding has risen as a share of total investments from 85% (in 2011) to 89% in 2013. Notably, there is a small but discernible increase in prevention spending from less than 13% in 2011 (USD 43 million), to 17% (USD 49 million) in 2013.

External donor assistance from multi-lateral and bi-lateral partners (excluding the Global Fund) is limited to technical assistance, research support or demonstration activities relating to MSM Test and Treat strategies. The total combined assistance for HIV/AIDS in Thailand during 2012-2013 was USD 3.2 million.

Thailand proposes to strategically invest in the Global Fund country grant to 'front-load' investment for 'Ending AIDS' while domestic resources are being secured. In addressing the funding need, there is the aim to diversify domestic financing through budgetary provisions and funding across various Ministries (Health, Education, Social Welfare, Human Security), as well as local administrations, private sector, civil society and communities.

The HIV prevention sub-committee of the NAC is discussing a HIV prevention fund partly financed by the government. In addition, Thai National AIDS Foundation (TNAF) is exploring various channels of funding to support CSO activities beyond the Global Fund country grant, including reviewing and engagement with corporate social responsibility (CSR) and local administrations.

The National Health Insurance Office will provide USD 6.6 million (as a start-up fund), for CSO-led HIV prevention activities including Community Strengthening Systems for task shifting and sharing to reduce reliance on health facilities.

Additionally, in 2015 the National Health Security Office allocated USD 9.5 million to the National AIDS Management Center to implement prevention activities for KP, including peer-led interventions, community mobilisation, and demand generation for testing; and to improve linkages and quality of services at the district, sub-district and community levels[80].

Thailand

Funding Source	Investment in HIV (US$ million)		Projected resources for 2014 - 2017 (US$ million)			
	2012	2013	2014	2015	2016	2017
Domestic Source - Goverment revenues	221.0	227.1	260.6	309.7	4,523	44%
Domestic Source - Social Health Insurance	32.7	29.5	35.3	43.4	5,810	56%
Domestic Source - Private Sector Contribution	0.3	0.1	0.1	0.1	18	0.2%
Total Domestic	**253.9**	**256.8**	**296.0**	**353.2**	**10,351**	**100%**
United States Government (USG)	1.0	1.9	4.2	4.2	4.2	4.2
World Health Organisation (WHO)	0.0	0.1	0.2	0.2	0.2	0.2
World Bank (WB)	0.1	0.4	0.1	0.1	0.1	0.1
UN agencies	0.9	0.9	1.5	1.6	1.6	1.6
Total External - Excluding Global Fund	**2.0**	**3.2**	**6.0**	**6.1**	**6.0**	**6.0**
Total External - Global Fund	**27.0**	**27.3**	**39.2**			
TOTAL	**282.9**	**287.3**	**341.1**	**359.3**	**367.7**	**384.7**
Resource needs according to NSP and Ending AIDS Plan approved from NAC 2014 - 2016 and estimated for 2017			393.9	422.5	450.4	472.9
RESOURCE GAPS			**52.8**	**63.2**	**82.6**	**88.2**

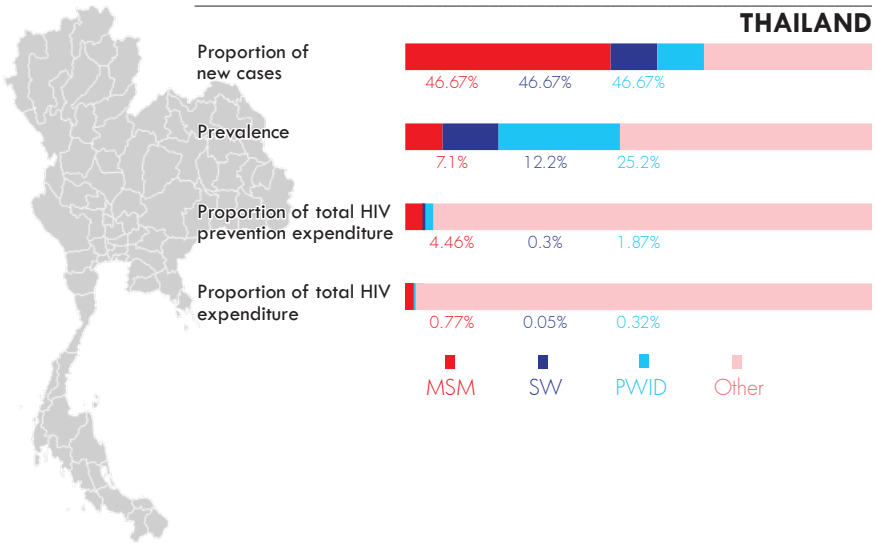
V. National Budget Mechanisms

Thailand's national budget mechanisms, especially under the current military government, present limited inroads for civil society advocacy. As national budgets are pre-determined in a top down process, there are no provisions for civil society to influence decision-making. The work to advocate for better engagement of civil society and key populations needs instead rests on scaling up civil society organisation's ability to receive government funding. With the only legal requirement for CSOs to access HIV-related government resources is legal recognition as an established entity, the Thai government has been wary about contracting or funding CSOs because of alleged misappropriation of government-issued funds. Currently, there is no system in place to evaluate CSOs for their organisational capacity, accountability or ability to deliver services effectively and efficiently.

Starting in 2017, there has been a move to formalise a CSO accreditation process led by Raks Thai Foundation. RTF has been working to develop CSO accreditation guidelines that aim to promote accountability and increase the management capacity of CSOs, leading to better government confidence in funding CSOs for HIV prevention services.

78. National AIDS Committee of Thailand (2015)
79. UNAIDS (2017). AIDSinfoonline Key Population Atlas
80. Thailand TB and HIV concept Note (2016), p44.

VI. Analysis



2015 data shows almost half of the proportion of new cases coming from MSM, however prevention spending on MSM is only 4.5% of total expenditure. While Global Fund and USAID funding will continue to support MSM- and PWID-based programmes, especially prevention, in the current round of funding, there is an urgent need to improve CSO's access to domestic funding, especially for key population-based organisations.

CSOs in Thailand are seen as key partners to the national programme, having a long history of setting epidemic control and being prioritised for resource allocation, as well as monitoring service quality and performance. The Thailand National Operational Plan Accelerating Ending AIDS 2015-2019 recognises CSOs as central to strengthening its health system strategy to close the gap between the current and optimal response.[81] However, a main barrier identified is the general low managerial capacities in CSOs with few actors being able to lead implementation without external technical support. Absorption capacities of CSOs also remain a problem, with a lack of investment in capacity development and sustainability of organisations due to funding constraints and emphasis on client-centred deliverables. The above mentioned CSO accreditation process led by Raks Thai Foundation seeks to address these issues[82].

In response to transition from external funding, the government and CSO are conducting parallel initiatives to expand the resource base for HIV programmes. The government has created a fund called the 3 Disease Fund (previously known as the 'Thai Fund'), which is largely designed to mobilise resources from the private sector. The 3 Disease Fund will be led by a multi-stakeholder committee, including both business sector and civil society leaders.

The CSO Resource Mobilisation (CRM) Platform is a CSO led initiative, also aiming to raise resources from the private sector. A work plan of transition activities has been developed in negotiation with Global Fund to support a range of initiatives in capacity building and advocacy engagement. These activities aim to strengthen civil society implementation of HIV services, advocate the government and support the 3 Disease Fund and CRM work to mobilise resources.

81. Siraprapasiri T, Ongwangdee S, Benjarattanaporn P, Peerapatanapokin W, Sharma M. The impact of Thailand's public health response to the HIV epidemic 1984–2015: understanding the ingredients of success. Journal of Virus Eradication. 2016;2(Suppl 4):7-14.
82. For more information, please refer to APCOM (2018). Civil Society Accreditation In Pursuit of Improving CSO Access to Domestic Funding: The Case of Thailand.

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