Strategic Framework of Thailand TB/HIV Funding Request of the 2023-2025 Allocation Period

A. Background

As Thailand has been allocated US$68,196,555 for HIV, tuberculosis (TB) and building resilient and sustainable systems for health (RSSH) for the implementation period of 1 January 2024-31 December 2026, CCM Thailand decided to submit the TB/HIV Funding Request in the window of 29 May 2023.

The writing team has been assigned to coordinate the development of the funding request through transparent and documented processes that engage a broad range of stakeholders, including CCM members and non-CCM members. The composition of the writing team includes national program authorities for HIV and TB programs, representatives from the Partnership Committee, development partners, HIV/TB technical persons and consultants, selected PRs (joining after PR selection) and the CCM Secretariat.

The strategic framework of the Funding Request is developed with the purpose to guide the writing team and stakeholders in working on the Full Funding Request.

B. Direction of the TB/HIV Funding Request

- Use the Global Fund grants as catalytic and coordination support to complement country owned prioritization of national HIV and TB responses and health system strengthening.
- The interventions should be guided by National Strategy Plans for HIV and TB, health system development strategies, health financing strategies, national program reviews, assessments, national technical guidelines and should be aligned with the 2023-2028 Global Fund Strategy.
- Put people and communities at the center, in particular key and vulnerable populations.
- Put greater focus on equity, sustainability, coordination efficiency, management capacity, program quality and innovation. Advance gender equality and tackle human rights and gender-related barriers for lasting impact.
- Demonstrate the consideration of pandemic preparedness and maximizing of C19RM investments to support integrated health system according to country needs.

C. Key gaps of the HIV responses

- **Priority populations**

Youth is considered a priority population to be explored. Based on the estimation using the Spectrum-AEM mathematical model (revised, April 22, 2022), the age group 15-24 years accounted for half of all new infections. This proportion has not changed significantly in the past 15 years. Among youth aged 15-24 years, from 2006 to 2021, overall STI rate increased from 49.3 cases per 100,000 population in 2006, to 124.4 in 2019, though the rate decreased to 106.2 in 2021, possibly an effect of the Covid pandemic and its attendant restrictions.

The prevalence of HIV among key populations is still higher than among adults aged 15-49 year (1%). Results of Biological Behavioral Surveillance (BBS) in the latest survey of each group of key populations were 7.8% (PWID, 2020), 7.3% (MSM, 2020), 4.2% (TGW, 2020), 3,8% (MSW, 2018), 1.1% (non-venue FSW, 2021)

Though data on HIV prevalence among non-Thai migrant workers are limited, it does appear that access to HIV and TB services is limited, particularly for undocumented migrants, who are not included in the social security scheme as are documented migrants. In addition, the increasing number of undocumented migrants following the Covid epidemic could lead to an increase in the number of migrants needing HIV and TB services.

The HIV and TB services provided to prisoners are extensive. However, evidence from the records in the NAP database shows that 77% of newly diagnosed PLHIV in prisons in 2022 received ART, lower than ART coverage in the general population (79%) and among other key population groups and even migrants, for which the coverage exceeds 80%.

- **Priority HIV services**

Late access to ART: 50% of PLHIV presented with CD4 count of less than 200 cell/mL, which may contribute to the higher-than-expected number of reported deaths among PLHIV. As all Thai people are eligible to benefit packages for HIV services in the Universal Coverage Scheme, Social Security Scheme and Civil Servant Medical Benefit Scheme, limited access is unlikely to be the cause of this unacceptably high death rate.

Stigma and discrimination might be one major cause of late access to HIV diagnosis and treatment. The Health Survey using a Physical Examination in the 2019-2020 round found that nearly half (48.6%) of Thais still had a negative attitude towards PLHIV. The situation of PLHIV who experienced stigma or discrimination related to sexual and reproductive health has not changed during the latest three rounds of the hospital-based survey. In 14 pilot provinces, over 500 cases of discrimination related to HIV and gender and rights violation of PLHIV and KPs in workplace, education and community setting reported in national crisis responses system (CRS).

Regarding PrEP services, the coverage was only 13.2% of the proposed target in 2022. Overall, the great majority of PrEP services were provided through community-led health services, i.e., 67.8%, 80.7% and 68.9% in the year 2020, 2021 and 2022 respectively. With the recent ruling that such organizations cannot deliver PrEP, the most commonly used distribution mechanism for PrEP has been curtailed and the coverage of this important means of prevention will surely be lower than in 2022.

- **Co-morbidities**

Tuberculosis was still the first cause of AIDS-related deaths among PLHIV. Meanwhile the number of PLHIVs receiving Treatment Preventive Therapy is still very low.

The BBS among PWID in 2019 has revealed that 38.1% of PWID were positive for anti HCV and 4.9% were positive HBsAg.

D. Key gaps of the TB responses

- **Priority populations**

Thailand's TB operational plan 2021-23 identifies intensive TB case detection among seven high-risk populations, including • close contact to pulmonary TB • inmates/ disabled persons/ helpless persons, • HIV infected persons, • DM patients (HbA1C > 7)/ CKD patients/ persons taking immunosuppressant drugs, • elderly > 65 years old who smoke or have comorbidities, e.g. COPD, DM, • illicit drug users or chronic alcoholics, and • medical personnel.

Among seven risk groups, the percentage of TB case found among screened TB contacts was always highest, which was2.33% in 2021. However, the coverage of screening for TB contacts was only 62.5%. TB case finding among PLHIV is the second rank (1.1%) and only 38% of population size were screened for TB.

Although the percentage of TB case found among migrants in 2021 was only 0.48%. the coverage of TB screening among this group was very low (5.9%). Considering the high number of population size (2.2 million people), understanding the migrants at risks for TB should be identified.

- **Priority TB services**

TB case detection, diagnosis and treatment

More service units are able to conduct TB testing using molecular technology (Xpert, MTB/RIF and PCR) – from 172 to 255 units (2023), clear policies and implementation guidelines are in place and AI has been applied to CXR to expedite screening and diagnosis. However, funding from NHSO should be secured to procure enough molecular test kits to accommodate increasing number of machines and service units along with policy support and close monitoring - to ensure service units are using more molecular testing.

As coverages of TB screening among at risk groups were quite low, more mobile CXR should be procured and provided to service units with capacity to conduct ACF/screening in close contacts and other at-risk population in communities as well as expanding screening to informal settlements with high TB burden and move policy efforts for health insurance reimbursement for risk groups.

Increase community roles for TB services by capitalizing on Thailand's strong and extensive network of community health volunteers in sub-urban and slums areas, remote population and other risk groups (household contact, elderly etc.) as well as demand for TPT linked with TB screening and adherence support. Empower (with compensation) migrant health volunteers (MHV) to identify and map target migrant clusters and support planning for TB case detection, referral and follow up.

Provide dietary supplement to all patients suffering from malnutrition to reduce death rates, as well as living support to ensure the adherence to TB treatment, particularly MDR TB.

TPT in LTBI cases

There is policy support on TPT from MoPH. LTBI guidelines have been developed, IGRA testing centers have been established at 10 Health Regions and BMA. However, to effectively operationalize the policy, certain issues should be improved, including policy communication, training on management of LTBI cases, IGRA test provision.

RR/MDR & XDR-TB

More cases of TB drug-resistant cases can be detected by using molecular technology (Xpert, MTB/RIF and PCR) e.g., RR-TB. Shorter regimens and discontinuing injectable medications, initiation of BPALs regimen to increase efficiency of XDR-TB treatment.

Adoption of universal DST policy and conduct training for clinicians and nurses to revisit RR/MDR & XDR-TB Screening and Treatment CPG. Encourage NHSO package to include RR/MDR & XDR-TB testing using 10-color Xpert instruments, as well as revise methods to detect RR/MDR & XDR-TB and procure enough supporting supplies for 10-color Xpert instruments.

Some medications for longer regimens cannot be procured domestically or are not part of the insurance package. Enough supply should be procured through GF funding.

- **Co-morbidities**

TB-HIV service policies and implementation guidelines are clear. more than 80% of TB cases got HIV tested (Positive rate of TB-HIV = 8-10%) and more than 80% of TB cases who are HIV positive received ART, policy exists to provide prevention drugs for PLHIV population. The coordination of TPT in TB/ART clinics should be improved. NTIP and TPT-HIV databases should be integrated to facilitate use of data.

With current rates of screening, annually approx. 7,000 cases of TB detected among diabetics and elderly with co-morbidities. Addressing upstream determinants like malnutrition, smoking, alcohol and diabetes

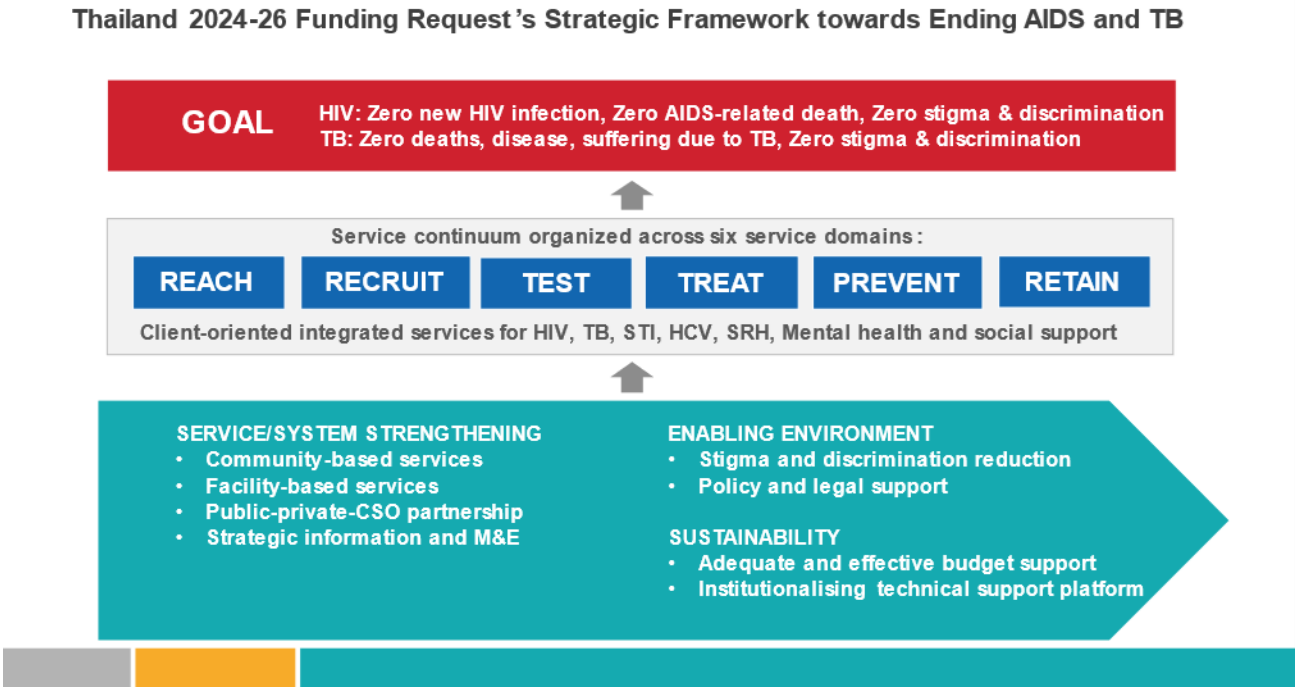
control: through integration of service, i.e., linking NCD clinics to TB testing, smoking/alcohol cessation clinics etc. could be suggested approaches hence reducing TB mortality due to co-morbidities and potentially reducing TB positive cases over time.

E. Strategic Framework of Thailand TB/HIV Funding Request of the 2023-2025 Allocation Period

The strategic framework of the TB/HIV Funding Request is guided by

- CCM's policy on direction of the TB/HIV Funding Request of the 2023-2025 allocation period;
- Thailand National Strategy to end AIDS. 2017-2030;
- Drafted Thailand National Accelerated Operational Plan towards ending AIDS, 2023-2026;
- Thailand HIV Program Review 2022;
- Thailand TB National Operational Plan 2017-2020;
- 6th JIMM on tuberculosis in Thailand, 2022
- WHO Regional strategic plan towards ending TB in SEARO
- The country dialogue for TB/HIV Funding Request on 9-10 Feb 2023
- CCM – Partnership Committee meeting on 16 Feb 2023 and CCM Review Committee meeting on 17 Feb 2023

The strategic framework is aligned with the strategic framework of the national operational plan towards ending AIDS and TB, as shown in the figure below.



F. Focuses of the TB/HIV Funding Request

As stated in the direction of the TB/HIV Funding Request, the grant should put emphasis on ***catalytic interventions*** rather than conventional direct service deliveries, which should be supported from the domestic fundings. Therefore, the Funding Request should focus on development of resilient, coordinated and sustainable system for health, particularly on community-led health services, which will increase

accessibility, availability, acceptability and quality for key populations and maximize the impact towards country goals to end AIDS and TB.

***What is catalytic approach/interventions for Thailand*?**

In order to ensure the achievements of the goals to end AIDS and TB, catalytic approaches should be a front-loaded investment. Considering the current responses, key catalytic interventions for Thailand include:

- Rapidly scale up of modernized interventions, i.e., PrEP, HIV Self Testing and virtual and digital interventions.
- People centered approaches across priority services delivery and response;
- Non-stigmatized Integrated services for HIV, TB, STI, HCV, SRH and mental health.
- Expansion of community-led Heath services.

In addition, targeted interventions should be based on granular data for approaches tailored to sub-group populations, e.g.

- Negative higher risk individuals,
- PLHIV who are not yet on ART and who are CD4 < 200
- PLHIV who have not received same-day ART
- PLHIV who are not VL > 1000

Overall focuses

The HIV programs should focus on interventions which result in early HIV diagnosis, rapid ART, adherence to treatment to the goal of undetectable viral load. HIV self-tests and PrEP as well as TB screening and treatment of TB infections have to be scaled up.

The TB programs should focus on interventions which increase early TB diagnosis and successful treatment as well as efficiency of DR/MDR TB case finding and complete treatment. Treatment of TB infections has to be scaled up as core element to end TB.

Specific focuses for each program are as follows:

PWID program:

- Increase emphasis on preventing transition from using drugs to initiating drug injecting or preventing the return to injecting for people who transitioned to other modes of administration.
- Considering client-centered services, harm reduction services should be integrated with drug treatment and care program.
- Strengthen community-based OST services and networking of community and hospitals; promote of Buprenorphine as option to methadone for OST.
- Scale up integrated community-based services of HIV, TB, hepatitis and STI.

Migrant program:

- Clarify factors which contribute to HIV risk for migrants to drive better design of approaches.
- Include both documented and undocumented migrants.
- Align and collaborate with regional TB grant (TEAM grant)

MSM/TGW/SW program:

- Cover multiple risks for HIV infection e.g., chemsex
- Integrate with sexual reproductive health services

Vulnerable young populations program:

- Increase access to youth-centered integrated sexual reproductive health services by youth participation

- Use innovations, virtual and digital technology

Prisoner program:

- Continuity of treatment after discharging from prisons.

TB program:

- Scale up contact case finding for all target populations with special focus on children, elderly and other vulnerable groups.
- Scale-up management of TB Infection and M&E capacity as to describe the TPT cascade of Care.
- Increase community roles for TB case finding and treatment, including village/urban health volunteers, migrant health workers/volunteers, elderly association and CSOs working on HIV program.
- Collaborate with local administrative organizations for living support to TB patients to ensure the success of treatment.
- Strengthen capacity to enhance operational research on TB and TB/HIV
- Advance towards zero transmission of airborne diseases

Elimination of human rights and gender related barriers to access HIV and TB services program:

- Use multi-sectoral approach to operationalize the national multisectoral and costed action plan to eliminate all forms of HIV-related stigma and discrimination, which include both human rights promotion and protection.
- Promote and integrate U=U as a critical intervention to reduce stigma and discrimination across settings and nationally.
- Scale up system-wide interventions to reduce stigma and discrimination in the healthcare, workplace, and education settings, including community-led health services
- Strengthen the human rights protection system, scale up a fully-functional Crisis Response System (CRS), and maximize access to justice across settings of healthcare, community, workplace, education, and justice, led or driven by a paralegal and multi-disciplinary team
- Leverage, align, and adapt proven innovations to be implemented across settings (e.g., training of teachers, law enforcement, workplace human resources administrators, etc.). Interventions can include e-learning, U=U, CRS, and others.
- Empower people living with, affected by, and vulnerable to HIV/TB with human rights, gender equality, U=U, etc., to overcome self-stigma and discrimination, and increase access to essential services and improve quality of life.
- Institutionalize, strengthen, and scale up the community-led response by addressing human rights, stigma and discrimination, and gender equality in HIV/TB, and scale up community-owned platforms such as community-led monitoring and the Community Think Tank to provide feedback and monitor the dismantling of human rights and gender-related barriers to access to HIV, TB, and other essential health services, with support for a community-led CRS.
- Remove counter-productive laws, policies, and regulations by working in collaboration with Members of Parliament and national rights protection organizations, and create a social movement to reform laws and policies on anti-discrimination and decriminalization, including the Sex Work Act, the Drug Use Act, and the Migrant Health Insurance Act, among other laws.
- Promote human rights literacy including harm reduction, U=U, gender, and TB.

RSSH program:

- Establish community-led health services as part of country health system including institutionalized capacity building for community health workers, community-led monitoring and community financing.
- Develop a national standard for client-centered HIV, TB, STI, Hepatitis, SRH, mental health and social support services, including laboratory systems and reorient existing services to the new standard.

- Strengthen public-private-community partnerships to be a network providing services as well as capacity building.
- Strengthen the establishment of quality insurance system for HIV, TB and related services in the hospital accreditation system.
- Strengthen strategic information and M&E system, particularly the use of data and information at both policy and implementation levels as well as for strengthening district and provincial management systems, enabling integrated services and multisectoral collaboration, including resource mobilizations from local administrative organizations.
- Identify issues needing advocacy, develop a comprehensive advocacy plan and implement with the plan-do-check cycle.
- Assess the current health insurance programs for migrants, including Social Security Scheme for documented migrants, MOPH health insurance and M-Fund and assess potential interventions to increase coverage of migrant population in Thailand.
- Preparedness for future epidemics/infection control in order to mitigate the disruption of access to HIV, TB and related services: design and development of early warning surveillance systems and network of supportive laboratories.

G. Implementation arrangement

There will be 2 Principal Recipients (PRs) to be legally responsible for programmatic results and financial accountability, including 1 government PR and 1 civil society PR.

Apart from the execution of services provided by government organizations, the government PR has to put emphasis on function as a key mechanism in coordination with related government agencies for sustainability of the service system.

The civil society PR will execute the programs on services provided by communities, capacity building of the community service providers, enabling innovations by communities and advocacy on issues affecting community services.

Due to the focus of the Funding Request towards the sustainable public- civil society service systems, certain programs should be executed by single SRs working with both PRs, i.e., the RSSH program and Elimination of human rights and gender related barriers to access HIV and TB services.

Critical roles of PRs for success of the grant executions include:

- PRs should expect the contributions of performance towards the outcome and impact levels towards ending AIDS and TB;
- PRs must be responsible for strategic issues, not just only managing the SRs to implement the grant;
- PRs must ensure equity, sustainability, efficiency and quality of the implementation; and
- Government and CSO PRs must work in effective collaboration to advocate on establishing community services as part of country health system