



THE GLOBAL FUND

to Fight AIDS, Tuberculosis and Malaria

Geneva, March 2003

For the use of the Global Fund Secretariat:

Date Received:

ID No:

SECTION I: Executive summary of Proposal

General information:

Table I.a

Proposal title	Preventing HIV/AIDS and Increasing Care and Support for Injection Drug Users in Thailand
Country covered:	Thailand
Name of applicant:	Raks Thai Foundation
If the proposal is NOT submitted through a CCM, briefly state why:	<ul style="list-style-type: none"> The government of Thailand, and Thai society in general, does not currently recognize the value of harm reduction; While there are public health officials in government positions who support harm reduction, they are currently unable to express this support publicly given the current policy environment; Representatives from the TDN have made contact with the Thai CCM, and it was indicated that the TDN would not receive the required support from all CCM members; In light of current Thai drug policies, harm reduction programming is urgently needed. However, it is drug users themselves who are in the best position to deliver harm reduction programming as their peers may be reluctant to participate in similar government-initiated programs, as participation could be perceived to carry the risk of arrest, mandatory treatment and HIV testing. This fear could be further exacerbated given many existing practices, such as the sharing of information concerning drug users between hospitals and police; The TDN does, however, firmly believe that the Thai government will permit the proposed pilot project to proceed.

Specify which component(s) this proposal is targeting and the amount requested from the Global Fund:**

Table I.b

		Amount requested from the GF (USD thousands)			
		Year 1	Year 2	Year 3	Total
Component(s)	X HIV/AIDS	502	409	461	1,373
	Total	502	409	461	1,373
Total funds from other sources for activities related to proposal		30	30	30	90

Please specify how you would like your proposal to be evaluated* (mark with X):**

** If the proposal is fully integrated, whereby one component cannot be separated from another, and where splitting budgets would not be realistic or feasible, only fill the "Total" row.

The Proposal should be evaluated as a whole	X
The Proposal should be evaluated as separate components	

Brief proposal summary (1 page) (please include quantitative information where possible):

Describe the overall goals, objectives and main activities per component, including expected results and timeframe for achieving these results:

The goal of the proposed project is to reduce the health impacts of HIV/AIDS and drug use among injection drug users in Thailand. The objectives include:

1. To increase the capacity of injection drug users (IDU) to provide peer-based HIV prevention, care and support to IDU;
2. To prevent HIV infection and other health-related related harms among IDU;
3. To increase uptake of health care among IDU;
4. To increase uptake of voluntary HIV testing among IDU;
5. To reduce AIDS-related morbidity and mortality among IDU;
6. To increase capacity among health care providers, police, and prison staff to provide comprehensive HIV/AIDS prevention, care, treatment and support to IDU;
7. To increase capacity among policy makers to create healthy public policies specific to injection drug use and HIV/AIDS.

This peer-driven project will take place over three years. Core activities will include:

Capacity-building:

- Training of peer leaders within IDU communities;
- Creation of four Harm Reduction Centres (e.g., office spaces) where training, education and outreach activities can be coordinated;
- Provision of education by peer leaders and NGOs to health care providers, police, prison staff, and policy makers.

Behavioural Change and Outreach:

- Provision of peer-based outreach, education, counselling and referral in four communities (including local prisons and youth detention centres);
- Provision of HIV testing support;

Operational Research:

- Project evaluation and monitoring.

Specify the beneficiaries of the proposal per component and the benefits expected to accrue to them (including target populations and their estimated number):

The primary beneficiaries of this program are IDU living in Thailand. The Thai Epidemiology Working Group estimated that there were 160,000 active IDU in Thailand in 2000. Previous estimates of Thai IDU have ranged from 100,000 to 250,000. The Thai Ministry of Public Health reported in 2000 that 47% of IDU in Thailand are HIV-positive. Other beneficiaries include the sexual partners and spouses of IDU.

This project will target IDU in Bangkok, the province of Satun, Chiang Mai, and the Northeast region of Thailand. The precise number of IDU living in these areas is presently unknown. The peer leaders of this project will seek to reach as many of IDU in these regions as possible, including those at greatest risk for HIV infection and other adverse

*** This will ensure the proposal is evaluated in the same spirit as it was written. If evaluated as a whole, all components will be considered as parts of an integrated proposal. If evaluated as separate components, each component will be considered as a stand-alone component.

health consequences. Consistent with findings from other settings, it is expected that the education and information provided by outreach workers will be disseminated and shared widely within IDU social networks, and therefore the impact of these interventions will extend beyond those who make direct contact with outreach workers

The primary benefits accrued to IDU who benefit from this project:

- Reduction in risk for HIV infection;
- Reduction in other health-related harms associated with injection drug use (e.g., soft tissue infections, endocarditis, overdose);
- Increased access to comprehensive and culturally-appropriate health care, including HIV/AIDS treatment, care, and support;
- Reduction in AIDS-related morbidity and mortality.

It is hoped that the results of this pilot project will serve to inform interventions on a national level, leading to a comprehensive peer-driven network in Thailand.

Indicate if the proposal is to scale up existing efforts or initiate new activities. Explain how lessons learned and best practices have been reflected in this proposal and describe innovative aspects to the proposal

The proposed project has been designed as an innovative initiative. The project objectives and activities are based on a wealth of national and international evidence specific to HIV/AIDS and injection drug use. The specific educational, care and support activities will be based on evidence-based practices that have been developed in other settings. The project will ensure that the activities are culturally relevant and effective through its reliance on current and former IDU for program delivery. However, to further ensure success, peer training will involve formal partnerships with public health experts and health researchers from Thailand and abroad, as well as four established and effective drug user organizations in Australia, Canada, the USA, and India.

The project activities are a direct response to recommendations contained in recent assessments of AIDS in Thailand and the government's response to the epidemic among IDU. As well, there is currently a wealth of scientific evidence indicating that it is IDU themselves who are most effective in reaching and providing HIV-related education and care to their peers. This is particularly the case in settings where IDU have been forced into hiding as a result of enforcement-based initiatives. Studies have also shown that traditional systems of care delivery have only limited effectiveness in reaching and sustaining contact and communication with IDU who are at greatest risk for HIV infection.

This project is unique in the current context as there are no other known peer-driven HIV-specific interventions that target IDU networks in Thailand, and because the Thai government and its public health systems have not implemented specific programs that prevent HIV infection and facilitate care among IDU, including those living with HIV/AIDS.

SECTION II: Information about the applicant

Non-CCM applicant

12. Name of applicant: Raks Thai Foundation (RTF)

13. Representative of organisation applying:

Table II.13

	Representative	Alternate
Name	Promboon Panitchpakdi	Pinyo Veerasuksawat
Title	Executive Director Raks Thai Foundation	Program Coordinator, Raks Thai Foundation
Address	185-187 Phaholyothin Soi 11 Samsennai Phayathai Bangkok 10400 Thailand	Samutprakarn province office Thipawan Village, 10 Soi 170/419 Theparak, Muang District, Samutprakarn Province, Thailand
Telephone	+66-2-279-5306/7	6211-755-2-66+
Fax	+66-2-271-4467	6343-755-2-66+
E-mail	carethai@ksc.th.com	

14. Contact persons for questions regarding this proposal (please provide full contact details for two persons – this is necessary to ensure expedient and responsive communications):

Please note: The persons below need to be readily accessible for technical or administrative clarification purposes by the Secretariat or the TRP members.

Table II.14

	Primary contact	Secondary contact
Name	Promboon Panitchpakdi	Paisan Suwannawong
Title	Executive Director Raks Thai Foundation	Director, Thai AIDS Treatment Action Group (TTAG)
Address	185-187 Phaholyothin Soi 11 Samsennai Phayathai Bangkok 10400 Thailand	26/114 Mu 6, Thanakorn Villa 1, Wat Chalaw, Bangkruay, Nonthaburi 11130 Thailand
Telephone	+66-2-279-5306/7	+66-2-883-8556
Fax	+66-2-271-4467	+66-2-883-6505
E-mail	carethai@ksc.th.com	Ott1@ksc.th.com

15. Description of applying organisation

15.1. Indicate what type of organisation the applicant is (mark with X):

Table II.15.1

<input checked="" type="checkbox"/>	Non-Governmental Organisation (NGO) or network of NGOs
<input type="checkbox"/>	Community based Organisation (CBO) or network of CBOs
<input type="checkbox"/>	Private Sector
<input type="checkbox"/>	Academic/ Educational Sector
<input type="checkbox"/>	Faith-based Organisation
<input type="checkbox"/>	Regional Organisation
<input type="checkbox"/>	Other (please specify):

15.2. Provide as attachment the following documentation:

- **Statutes of organisation** (official registration papers) Attached: By-laws, Foundation Registration Authorized Letter
- **A presentation of the organisation, including background and history, scope of work, past and current activities**

The Raks Thai Foundation (RTF) was established in 1997. RTF was founded to take over the work of CARE International in Thailand. RTF staff is mostly staff that has worked for CARE International in Thailand for several years.

RTF programs include:

- Agriculture and Natural Resources – community management of natural resources in watershed areas of northern Thailand (funded by DANIDA);
- Micro-enterprise Development – for rural families in northeastern Thailand through marketing linkages and product development;
- Education – production of the children’s environment and health magazine and community-school education development;
- Living With AIDS in northern Thailand – strengthening community support for affected persons and working with local administration offices;
- HIV/AIDS prevention and care for migrant workers – focusing on seafarers and workers of related industries (various donors including Oxfam, WHO, MOPH, Rockefeller Foundation, UNICEF);
- HIV/AIDS prevention and the workplace (funded by the Ministry of Public Health);
- Women and Children Care and Support – counseling, support for affected women and children in the community, and youth HIV prevention in southern and eastern Thailand (supported by EU)
- Community HIV/AIDS Prevention and Care – a sub-grant program supporting PHA groups and community organizations to implement HIV/AIDS prevention and care projects (funded by Oxfam) with a component to support affected women and children (funded by UNICEF)
- HIV/AIDS Prevention Among Drug Users (funded by WHO)

- **Reference letter(s), if available**

Raks Thai Foundation has applied for the GFATM support in round two under the project titled **Prevention of HIV/AIDS Among Migrant Workers in Thailand (PHAMWIT)**. This project has been approved and RTF as the Principal Recipient is currently being accessed by the LFA. This project has gone through the Country Coordinating Mechanism (CCM).

- **Main sources of funding**

European Community
 Rockefeller Foundation
 Ford Foundation
 Ministry of Public Health Thailand
 CARE International
 WHO
 UNICEF
 Department of Industrial Promotion, Thailand
 DANIDA (supporting 2 CARE projects administered by RTF)

16. Justification for applying outside the CCM

16.1. Indicate reasons for not applying through the CCM (Explain clearly the circumstances, conditions and reasons) (1–2 paragraphs):

- The government of Thailand, and Thai society in general, does not currently recognize the value of harm reduction;
- While there are public health officials in government positions who support harm reduction, they are currently unable to express this support publicly given the current policy environment;
- The applicants have made contact with the Thai CCM, and it was indicated that the proposal would not receive the required support from all CCM members;
- Current Thai drug policies make harm reduction essential. However, it is drug users themselves who are in the best position to deliver harm reduction programming as their peers may be reluctant to participate in similar government-initiated programs, as participation could be perceived to carry the risk of arrest,

mandatory treatment, and HIV testing. This fear could be further exacerbated given many current practices, such as the sharing of information concerning drug users between hospitals and police;

- The applicants do, however, believe that the Thai government will permit the proposed pilot project to proceed for the following reasons:
1. In recent months the government has officially recognized drug use as health issue;
 2. The government has previously allowed pilot studies of harm reduction programs, including syringe exchange and methadone maintenance;
 3. The proposed program does not include activities that can easily be viewed as promoting drug use, but rather does include activities that promote cessation of drug use and the uptake of abstinence-based programs;
 4. The project is consistent with several of the stated objectives contained in the National Plan for the Prevention and Alleviation of HIV/AIDS in Thailand 2002-2006;
 5. The proposed project has the support of recognized NGOs, and academic partners who will independently and rigorously monitor and evaluate the project.

16.2. Have you been in contact with the CCM in your country or other relevant governmental agencies (e.g., Ministry of Health, National AIDS Council)? If so, what was the outcome? If not, why?

The applicant has made contact with the CCM. Several incidents involving the applicant indicated that a proposal targeting injecting drug users would not be supported, nor would the entire CCM committee be willing or able to give such a proposal fair consideration. For example, when the applicant proposed to integrate the needs of injectors into Thailand's first round GFATM grant application when it was being developed, CCM members expressed that working with IDU was "too complicated" and thus IDU were omitted from that proposal. A second time CCM members articulated to the applicant that a proposal from Thailand targeting injectors was "not necessary" and did not merit requesting funding.

16.3 Include letters from supporting organisations (e.g. human rights groups, NGO networks, bilateral or multilateral organisations, etc) supporting your reasons for not applying through a CCM as attachment.

See attached letters of support for bypassing CCM from:

1. Senator Jon Ungphakorn, The Senate, Thailand
2. Mr. Somchai Homlaor, Secretary General, Forum-Asia
3. Mr. Aryeh Neier, President, Open Society Institute (OSI)
4. Ms. Joanne Csete, Director, HIV/AIDS and Human Rights Programme, Human Rights Watch (HRW)
5. Dr. David Wilson, Medical Coordinator, Medecins Sans Frontieres-Belgium (MSF -Belgium)/Thailand
6. Dr. Chris Beyrer, Director, Johns Hopkins Fogarty AIDS International Program, Johns Hopkins School of Public Health
7. Ms. Ana Oliveira, Executive Director, Gay Men's Health Crisis (GMHC)
8. Mr. Kamon Uppakaew, Chair, Thai Network of People Living with HIV/AIDS (TNP+)
9. Ms. Aree Kumpitak, Committee, Thai NGO Coalition on AIDS (TNCA)
10. Mr. Allan Clear, Executive Director, and Mr. Donald Grove, Operations Director, Harm Reduction Coalition (HRC)

SECTION III: General information about the country setting

*Please note: For **regional proposals**, the information requested in this section should reflect the situation in all countries involved, either in an aggregated form or by individual country.*

*For **sub-national proposals**, the information requested should reflect the situation in the particular sub-national area within the overall country context.*

For further guidance, refer to Guidelines Part III

18. Describe the burden or potential burden of HIV/AIDS, TB and /or Malaria:

(Describe current epidemiological data on prevalence, incidence or magnitude of the diseases; its current status or stage of the diseases; major trends of the diseases disaggregated by geographical locations and population groups, where this data is available and/or relevant) (1 – 2 paragraphs per disease covered in proposal):

According to the UNAIDS 2002 Update, there are approximately 670,000 adults and children in living with HIV/AIDS in Thailand (1). The adult rate of HIV/AIDS is estimated to be 1.8% (approximately 2% among men and 1% among women) (2). Since the first case of AIDS was detected in 1984, it is believed that 1 million Thais have been infected with the HIV virus, and an estimated 289,000 have died of the disease (1). Approximately 26,000 new HIV infections occurred in Thailand in 2001, and approximately 55,000 individuals died of AIDS in the same year (1). It is estimated that only 20,000 individuals are currently receiving antiretroviral therapy (2), and there have been no known systematic evaluations of access to and quality of care and treatment for individuals living with HIV/AIDS, including services provided by NGOs and community-based organizations. Recent evidence has indicated a sharp rise in HIV-related morbidity and mortality, particularly in the Northern region of Thailand (2). It is believed that approximately 50,000 individuals will develop serious AIDS-related illnesses each year for the next five years, and equal numbers are expected to die of AIDS during this same period, with 90% of deaths occurring in the 20-44 age group (3).

The epidemic spread of HIV/AIDS among IDU in Thailand was first observed in Bangkok in 1988 (2). Within a six-month period between 1988-89, HIV prevalence among IDU in Bangkok rose from 2 to 40% (4). In 2000, sentinel surveillance from 39 sites in the North, Central, and Southern regions of Thailand have revealed HIV prevalence rates among IDU as typically being in the order of 40-60% (1). The epidemic of among IDU was Thailand's first major wave of HIV infection (5). Transmission of HIV from IDU to non-IDU has been observed in Thailand, and it is projected that IDU will continue to be key vectors of disease transmission to the rest of the population, with the potential to undermine national prevention efforts and ignite new epidemics in the general population (3,4). Although needle-sharing is believed to account for a substantial proportion of new infections among IDU (6), with an estimated 20% of the population engaged in needle sharing (3), a previous study also indicated low rates (12%) of condom use among active IDU (7).

Despite the fact that HIV prevalence among other populations at risk (sex workers, STD patients, and military recruits) peaked during the years 1994-1996, and have been declining steadily and substantially since this time, HIV prevalence rates among IDU in 1999 were the same or higher than they were ten years ago (4). According to the Thai Working Group on HIV/AIDS Projections, the proportion of new infections due to injection drug use, including women infected by IDU partners, is projected to be 21% in 2000, and may rise to 41% by 2005 in the absence of targeted prevention measures (3).

19. Describe the current economic and poverty situation (Referring to official indicators such as GNP per capita, Human Development Index (HDI), poverty indices, or other information on resource availability; highlight major trends and implications of the economic situation in the context of the targeted diseases)

(1–2 paragraphs):

The economic crisis in 1997 negated many of the gains of the early/mid 1990s when Thailand had one of the highest GDP growth rates in the world. During this time the HDI rank climbed to 59th and its Human Poverty Index (HPI) had been reduced to 12%. While the economy seemed to start picking up in 2000, there is still much to be done to reverse the impact of budget cuts on social, health, educational and economic development. Thailand's current (2002) HDI rank is 70th and its HPI value is 14%. In the year 2000, GDP per capita was \$ 6,402, life expectancy at birth was 70.2 years, the adult literacy rate was 95.5% and the combined gross enrolment ratio was 60%.

In the immediate period following the economic crisis (1997-1999), total funding in Thai Baht for AIDS programmes declined by 27.8% and the current (2002) government HIV/AIDS budget of US\$ 35 million remains below the 1996 and 1997 government budget allocations. Prevention expenditure has been hardest hit both in terms of absolute monetary value and proportion of the total AIDS budget (currently 8% of national AIDS program budget, at 2 baht or 5 US cents per capita). Another effect of the crisis was to cause a surge in numbers of those living under the poverty line to 9.8 million people in 1999 (15.9% of the population), of whom 5.8 million were defined as 'ultra-poor', and a further 3.4 million people 'living on the edge'. Poverty remains a disproportionate problem for rural populations (21.5% of people living in rural areas are poor), the farming sector (in 1999, 59.8% of farmers fell under the poverty line) and children (37.3% of the 'poor' in 1999). Such poverty increases the vulnerability to HIV/AIDS of those already most affected by the epidemic. HIV/AIDS continues to undermine further efforts for economic recovery and epidemic control by reducing productivity across all sectors and placing significant burdens on affected households (increased costs, reduced income, impaired education).

20. Describe the current political commitment in responding to the diseases

(indicators of political commitment include the existence of inter-sectoral committees, recent public pronouncements, appropriate legislations, etc.) (1–2 paragraphs):

In January 1990, Prime Minister of Thailand announced the official campaign to control and prevent HIV/AIDS, making HIV/AIDS control a national policy. This was the first clear-cut government policy stance on AIDS. Since 1991, the Royal Thai Government has allocated significant resources for domestic HIV/AIDS efforts, with an annual 1996 budget exceeding US\$ 80 million (1 US dollar = 26 Baht at that time). One of the most important events leading to the subsequent rapid response to HIV/AIDS was the appointment in 1991 of the National AIDS Prevention and Control Committee with the Prime Minister as the Chairman. Thai society rapidly expanded its response to HIV/AIDS and multisectoral collaboration was established. All relevant government agencies were provided with funding to implement their own AIDS plan. The National AIDS Committee (NAC) directs the policy and plan of the national AIDS programme. Under the NAC, there are 11 sub-committees established to look after the work on various strategies, plus 76 Provincial AIDS Sub-committees. All the committees and sub-committees are comprised of representatives from multisectoral agencies.

Thailand's political commitment and the multisectoral involvement in AIDS prevention and control programme led to a substantive achievement in reducing new infections from 143,000 in 1991 to 29,000 in 2001. Recently, the government created a policy to include the prevention and treatment of opportunistic infections into the 30 baht universal coverage health scheme. The inclusion of ART into this scheme is being explored. However, there are currently obvious shortcomings in the current provision of treatments for HIV/AIDS, as approximately one fifth of the national AIDS program budget is being used to finance ART for 2% of all patients at an average cost of US \$3,449 per patient annually. Recently, the Global Fund gave Thailand approximately \$30,000,000 (USD) to fight AIDS among migrant workers, mothers and their children.

Despite considerable investment and political commitment devoted to addressing HIV/AIDS in the Thailand, the government has not implemented measures that address the specific HIV prevention and care needs of injection drug users (2,4). Currently, none of the national prevention budget is allocated for prevention of HIV infection by injection drug use (2,4). Despite the overwhelming scientific evidence supporting the efficacy of interventions such as syringe exchange (8,9,10,11), methadone maintenance (12,13,14,15), and outreach (16) in reducing sero-incidence and sero-prevalence, harm reduction programs such as these have not been implemented in Thailand. A recent report by the Thai Epidemiological Working Group indicated that a decline in needle sharing from 20% to 10% among Thai IDU would avert 21,774 new infections by 2006, and 81,761 infections by 2020 (3). By 2006, approximately 3,800 of the 22,000 infections prevented by this approach would be among female sex partners of IDU. According to the authors, this would represent the largest number of infections averted for any one intervention strategy.

21. Countries classified as “Lower-Middle Income” or “Upper-Middle Income” by the World Bank are eligible to apply only if they meet additional requirement (Guidelines Para 8). The sections below are required for proposals from these countries.

21.1 Co-financing: describe in both narrative and quantitative terms how domestic or external resources will be used to co-finance the activities described in this proposal, indicating the source and the extent of co-financing (i.e., what percentage of the budget for the proposal is covered by other resources and what percentage is being requested from the Global Fund) (2–3 paragraphs)

There are no public funds directly co-financing the project activities listed in this proposal. However, many partner organizations are directly contributing to the project by providing infrastructure and equipment, which will be used during the course of this project. In addition, TDN and TTAG will make a positive financial contribution to this project, but 100% of the applicant’s budget for the proposed project is requested from GFATM.

21.2. Focus on poor or vulnerable populations: describe how underserved populations of poor and vulnerable groups will be targeted by the proposal (2–3 paragraphs)

The proposed project aims to exclusively target a population that is highly vulnerable to HIV/AIDS, and an array of other health-related harms. Injection drug users are particularly vulnerable given the government’s current emphasis on a “War on Drugs” approach. Evidence from various settings has indicated that enforcement-based approaches to addressing problems associated drug use typically force IDU into more remote or hidden areas (17, 18). This makes IDU harder to reach with prevention, care and support that are critical to maintaining health and averting the spread disease (18).

This project will target highly vulnerable IDU through peer-based outreach initiatives. IDU peer leaders familiar with the local context(s) will be trained to locate their marginalized peers for the purpose of providing them with prevention, care, and support. As well, these IDU will be provided with HIV prevention information that will have a secondary and protective benefit for their partners and families.

21.3. Greater reliance on domestic resources: describe in both narrative and quantitative terms how over the duration of the proposal the activities described will be increasingly financed using domestic resources, including the changes in the percentage of the budget covered by domestic vs. Global Fund resources (2–3 paragraphs)

It is presently difficult to forecast how the proposed activities will be increasingly financed by domestic resources. It is hoped that the results of this pilot project can be used to advocate for domestic investment in similar programs and initiatives. Through dissemination of results and partnerships with Thai-based NGOs, it is hoped that this work will be expanded and perpetuated beyond this pilot phase.

22. National context

22.1. Indicate the percentage of the total government budget allocated to health (optional for NGO applicants):

Between 1969 and 2000, the proportion of the Ministry Of Public Health (MOP) budget ranged from 2.7 to 7.7 percent of the overall national budget or 0.4 to 1.0 percent of the gross domestic product (GDP). It is noteworthy that the MOP budget had risen substantially during the past decades, resulting from a decline in foreign debt payments and a drop in the national security expenditure. Thus the budget for social programs had been rising remarkably. However during the economic crisis, the proportion of the MOP budget has declined to 1,351.7 million US\$ in fiscal year 2000 or 7.1 percent of national budget.

22.2. Indicate national health spending for 2001, or latest year available, in the Table III.22.2 (optional for NGO applicants):

Table III.22.2

	Total national health spending Specify year: 2,000 (USD)	Spending per capita (USD)
Public	4,544.3 million US\$	72.1
Private	1,485.3 million US\$	23.6
Total	6,029.6 million US\$	95.7
From total, how much is from external donors?	n.a.	n.a.

22.3. Specify in Table III.22.3, if possible, earmarked expenditures for HIV/AIDS, TB and/or Malaria (expenditures from the health, education, social services and other relevant sectors):

Table III.22.3

Total earmarked expenditures from government, external donors, etc. Specify Year:	In US dollars:
HIV/AIDS : Year 2001	33.79 million US\$
Tuberculosis	-
Malaria : Year 2001	-
Total	33.79 million US\$

22.4. Does the country benefit from external budget support, Highly Indebted Poor Countries (HIPC) initiatives, Sector-Wide Approaches? If yes, how are these processes contributing to efforts against HIV/AIDS, TB and/or malaria? (1–2 paragraphs) (optional for NGO applicants):

Due to the widespread HIV/AIDS epidemic, supports from various resources flow to Thailand in order to address this disease. The results of the collaboration between the Royal Thai Government and NGOs have been shown by the decrease of the HIV/AIDS prevalence in selected populations. However, the huge number of persons with HIV/AIDS and the number of new infections will increase if the effective preventive activities do not covered the total target population, including injection drug users.

The three factors contributing to Thailand's current program are:

- Encouraging and scaling-up of appropriate and effective approaches that strengthening health infrastructure
- Support for innovation and provision of resources
- Promotion of technology exchange.

22.5. Describe the current national capacity (state of systems and services) that exist in response to HIV/AIDS, TB and/or Malaria (e.g., level of human resources available, health and other relevant infrastructure, types of interventions provided, mechanisms to channel funds, existence of social funds, etc.) (2–3 paragraphs):

The National AIDS Programme mobilizes staff from all governmental agencies concerned (public health, education, labour and public welfare, defence, interior, university affairs, foreign affairs, etc). These involve personnel from all levels, from the central departments to the regional, provincial and district offices of all ministries concerned. The Provincial AIDS Sub-committee mobilizes personnel within the province to work on HIV/AIDS.

Governmental funds approved by the Cabinet and the Houses of Senates and Parliamentarians are designated to support the work of governmental and non-governmental organizations for the fight against AIDS. Funds are disbursed from the Bureau of the Budget to various ministries. Funds for NGOs are channeled through the Department of Communicable Disease Control. These funds will be disbursed to the peripheral health offices and to the Provincial AIDS Committees according to the developed workplan. Monitoring and evaluation is conducted at all levels and the Department of Communicable Disease Control is responsible for monitoring and evaluation at the national level.

	Number	Types of Personnel	HIV Related services
Regional/ General Hospitals	25/67	Doctors, nurses, specialist	ARV at large hospitals, OI at all hospitals
Community Hospitals	715	Doctors, nurses	OI (few hospitals with ARV)
Health Centers	9,704	Midwives	Some OI

It is considered that one factor facilitating the success of the national AIDS programme for Thailand is the active roles of PWA and NGO organizations. The Thai NGO Coalition on AIDS (TNCA) represents 168 non-government organizations working on AIDS throughout Thailand, while the Thai Network of People Living with HIV (TNP+) has a network of 589 PWA organizations throughout the country. Both networks are represented in the National AIDS Committee. Both TNCA and TNP+ have their own networks in each region of Thailand, with coordinating units in Bangkok. Major objectives of these two networks are to strengthen the capacity of their members in order to effectively respond to community needs, as well as identifying appropriate strategies for policy development at the national level.

22.6. Name the main national and international agencies involved in national responses to HIV/AIDS, TB and/or Malaria and their main programmes (NGO applicants should specify partner organisations):

Name of Agency	Type of Agency (e.g., Government, NGO, private, bilateral, multilateral, etc.)	Main programs (for example, comprehensive HIV/AIDS prevention; DOTS expansion over 3 years, etc.)	Budget US\$ yr 2001 (Specify time period)
Ministry of Public Health	GO	Comprehensive HIV/AIDS prevention and care, malaria control, coordination	27.003
Ministry of Labour and Public Welfare	GO	Public welfare	1.97
Ministry of Education	GO	Educational programme	0.52
Ministry of Interior	GO	Community Program	0.45
Care/Raks Thai Foundation	NGO	Comprehensive HIV/AIDS prevention and care	1.5
PATH	International NGO	Comprehensive HIV/AIDS prevention and care	0.52
Thailand NGO Coalition on HIV/AIDS	NGO	Comprehensive HIV/AIDS prevention and care, coordination	0.25
Thailand Business Coalition on AIDS	NGO	Prevention of HIV/AIDS in the workplaces	0.4
Thai Network for People Living with HIV/AIDS	NGO	Comprehensive HIV/AIDS prevention and care, coordination	0.25
Thai Red Cross	NGO	Research and development, training	0.1
WHO	UN	Communicable diseases, health systems, health promotion	0.2
UNAIDS	UN	Advocacy, coordination	0.32
UNFPA	UN	Comprehensive prevention and care for mothers and children	0.28
US CDC	UN	Comprehensive HIV/AIDS prevention and care	1.5

22.7. What is the total budget required for the different diseases, list the sources and amounts available and needed including amount requested from the Global Fund.

Table III. 22.7

Source/Agency	Amount In US dollars:						
	2000	2001	2002	2003	2004	2005	2006
HIV/AIDS							
(Government)		33.79 million		unknown	unknown	unknown	unknown
Global Fund request*					502,597	409,018	461,806
Unmet need**							
Total need							

* Amounts indicated are for this proposed project and do not refer to past Global Fund proposals

**It is beyond the scope of this project to calculate the unmet need for IDU prevention and care

22.8. Describe the major programmatic intervention gaps and funding gaps that exist in the country's current response to HIV/AIDS, TB and/or Malaria (2-3 Paragraphs)

Despite considerable investment and political commitment devoted to addressing HIV/AIDS in the Thailand, the Thai government has not implemented measures that address the specific HIV prevention and care needs of injection drug users (2,4). Although HIV prevalence among other populations at risk (sex workers, STD patients, and military recruits) peaked during the years 1994-1996, and have been declining steadily and substantially since this time, HIV prevalence rates among IDU in 1999 were the same or higher than they were ten years ago (2,4). Currently, none of the national prevention budget is allocated for prevention of HIV infection by injection drug use (4). Unfortunately, the HIV epidemic among IDU has not been addressed with government monies or programs since it was first detected 15 years ago (i.e., 1988) (4).

Given current drug policies in Thailand that emphasize incarceration, mandatory drug treatment, and the sharing of information between hospitals and police, many IDU vulnerable to or living with HIV/AIDS do not access HIV prevention, treatment, or care. While a few NGOs have implemented some small scale harm reduction programs, the reach of these programs may be limited given that the current policy environment forces many IDU into hiding, and evidence from other settings demonstrating that service providers have difficulty reaching and maintaining contact with the most "at-risk" drug users (19, 20). Currently, there are no known IDU-specific peer-driven HIV interventions in Thailand, and despite the success of previous pilot projects (19,20), there are no syringe exchange or methadone maintenance programs in Thailand (4).

SECTIONS IV – VIII: Detailed information on each component of the proposal

PLEASE COMPLETE THE FOLLOWING SECTIONS FOR EACH COMPONENT
Please copy sections IV – VIII as many times as there are components

SECTION IV – Scope of proposal

23. Identify the component that is detailed in this section (mark with X):

Table IV.23

Component (mark with X):	X	HIV/AIDS
		Tuberculosis
		Malaria
		HIV/TB

24. Provide a brief summary of the component (Specify the rationale, goal, objectives, activities, expected results, how these activities will be implemented and partners involved) (2–3 paragraphs):

IDU in Thailand continue to be greatly affected by HIV/AIDS. In 2000, sentinel surveillance from 39 sites in the North, Central, and Southern regions of Thailand revealed HIV prevalence rates among IDU as typically being in the order of 40-60% (1). According to the Thai Working Group on HIV/AIDS Projections, the proportion of new infections due to injection drug use, including women infected by IDU partners, was projected to be 21% in 2000, and is expected to rise to 41% by 2005 in the absence of targeted prevention measures (3). The project activities are a direct response to recommendations contained in recent assessments of the impact of AIDS in Thailand and the government's response to the epidemic among IDU. The goal of the project is to reduce the health impacts of HIV/AIDS and drug use among injection drug users in Thailand. The project objectives include:

1. To increase the capacity of injection drug users (IDU) to provide peer-based HIV prevention, care and support to IDU;
2. To prevent HIV infection and other health-related related harms among IDU;
3. To increase uptake of health care among IDU;
4. To increase uptake of voluntary HIV testing among IDU;
5. To reduce AIDS-related morbidity and mortality among IDU;
6. To increase capacity among health care providers, police, and prison staff to provide comprehensive HIV/AIDS prevention, care, treatment and support to IDU;
7. To increase capacity among policy makers to create health public policies specific to injection drug use and HIV/AIDS

This peer-driven project will take place over three years. Core activities will include:

Capacity-building:

- Training of peer leaders within IDU communities;
- Creation of four Harm Reduction Centres (e.g., office spaces) where training, education and outreach activities can be coordinated;
- Provision of education by peer leaders and NGOs to health care providers, police, prison staff, and policy makers.

Behavioural Change and Outreach:

- Provision of peer-based outreach, education, counselling and referral in two communities (including local prisons and youth detention centres);
- Provision of HIV testing support;

Operational Research:

- Project evaluation and monitoring.

The project will be implemented in community and prison settings in Bangkok, the province of Satun, Chiang Mai, and the Northeast region of Thailand. The principal recipient Raks Thai Foundation will oversee financial disbursements and management. Peer training and educational materials will be developed and delivered by the Thai Network of Drug Users in collaboration with several Thai-based and internationally-based NGOs. The training and outreach centres will be co-managed by the Raks Thai Foundation and the Thai network of Drug Users. Peer-based interventions will be delivered exclusively by trained peer leaders within the Thai Network of Drug Users (TDN). Evaluation and monitoring will be coordinated and overseen by a Monitoring and Evaluation Advisory Committee, and will be conducted by the Research Institute for Health Sciences at Chiang Mai University, the British Columbia Centre for Excellence in HIV/AIDS (Canada), and TTAG in collaboration with TDN. The entire project will be overseen by a Project Coordinating Committee (PCC) consisting of representatives from each of the partner organizations.

25. Indicate the estimated duration of the component:

Table IV.25

From (month/year):	January/2004	To (month/year):	December/2006
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26. Detailed description of the component for its FULL LIFE-CYCLE:

26.1. Goal and expected impact (Describe overall goal of component and what impact, if applicable, is expected on the targeted populations, the burden of disease, etc.) (1–2 paragraphs):

The goal of this project is to reduce the health impacts of HIV/AIDS and drug use among injection drug users in Thailand. It is anticipated that this peer-driven project will impact upon HIV incidence, progression to AIDS, and AIDS-related deaths among IDU. As well, the project will aim to impact positively upon hospital utilization among IDU living in Thailand.

There is currently very limited health-related data specific to injection drug users in Thailand. Baseline data collected during this project will serve to inform future targets. Project targets listed below represent only crude estimates. HIV incidence among IDU in Thailand has been estimated to be between 5 – 10% (23,24,25). Therefore an interim target of < 5% HIV incidence has been selected. The number of new AIDS cases is currently unknown, and therefore it is impossible to select an appropriate target for this indicator. Baseline data collection efforts will include attempts to obtain new AIDS case data stratified by injection drug use, which will then be used to create an appropriate target for this particular impact indicator. Similar constraints apply to creation of appropriate targets for AIDS-related deaths among IDU. Again, baseline data will be used to select appropriate targets for this particular impact indicator. Although little is known about hospital utilization among IDU, is anticipated that many preventable injection-related infections result in numerous hospitalisations among IDU. Therefore is expected that hospitalisations among IDU will decrease by at least 25% by the completion of this project.

Table IV.26.1

Goal:	To reduce the health impacts of HIV/AIDS and drug use among injection drug users in Thailand.	
Impact indicators	Baseline	Target (last year of proposal)
	Year: 2004	Year: 2006
HIV incidence among IDU	Approx. 5-10%	< 5%
New AIDS cases among IDU	Unknown	To be determined following year 1
Deaths due to AIDS among IDU	Unknown	To be determined following year 1
Hospitalisations among IDU	Unknown	↓ 25%

26.2. Objectives and expected outcomes (Describe the specific objectives and expected outcomes that will contribute to realizing the stated goal) (1 paragraph per specific objective):

Objective 1.

Given the absence of HIV-specific programming for IDU in Thailand and the current enforcement-based policies of the Thai government, the proposed pilot project will consist primarily of a peer-driven education and support initiative. HIV-focused peer interventions have been studied in a variety of settings and have been found to be highly effective in reaching and maintaining contact with marginalized drug users who typically fall outside of the traditional health care system (26). These interventions have been found to be easily implemented, relevant to a variety of health interventions, inexpensive and cost-effective (19,27,28,29,30,31,32). Therefore, the first objective is to increase the capacity of IDU to provide peer support. The proposed project currently includes a plan to develop peer support networks in four settings: Bangkok, the province of Satun, Chiang Mai, and the Northeast region. There are currently no known peer-driven interventions in Thailand, and given the effects of current government policies, it is believed that it is drug users themselves who are best positioned to provide care and support to IDU who are vulnerable to or living with HIV/AIDS. In order to assess the degree of success in meeting this goal, the number of peers trained to provide peer support and the number of communities with peer-support networks will be determined.

Objective: 1	To increase the capacity of IDU to provide peer support		
Outcome/coverage indicators	Baseline	Targets	
	Year: 2004	Year 2:	Year 3:
Number of peers able to provide peer-based HIV/AIDS prevention, care, and support	0	30	60
Number of communities with a IDU peer-support network	0	2	4

Objective 2.

The second objective is to prevent HIV infection and other health-related harms among IDU. There is currently an absence of harm reduction programs for IDU in Thailand. Consequently, HIV incidence and prevalence remains high among Thai IDU, and many IDU also suffer other injection-related harms (e.g., overdose, abscesses). Several reviews of the HIV epidemic in Thailand have concluded that national HIV prevention efforts could be greatly compromised if prevention activities specific to IDU are not implemented immediately (2,3,4). Therefore, a range of peer-driven outreach

and educational strategies will be employed to address these outstanding issues. Consistent with findings from other settings, it is expected that the education and information provided by outreach workers will be disseminated and shared widely within IDU social networks, and therefore the impact of these interventions will extend beyond those who make direct contact with outreach workers (19,31). In this way, the intervention will alter the culture and practices of IDU social networks by introducing new information that is passed on from peer to peer. Success in meeting this objective will be measured through assessment of the number of IDU who: know how HIV is transmitted, share syringes, engage in indirect sharing, use condoms, know how to inject drugs safely, know overdose pre- and post-intervention, have abscesses, and experience non-fatal overdoses.

Objective: 2	To prevent HIV infection and other health-related harms among IDU		
Outcome/coverage indicators	Baseline	Targets *	
	Year: 2004	Year 2:	Year 3:
Number of IDU who know how HIV is transmitted and prevented	Unknown	↑ 15%	↑ 50%
Number of IDU sharing syringes	20% **	15%	10%
Number of IDU engaged in indirect sharing (e.g., sharing cookers, etc.)	Unknown	↓ 15%	↓ 30%
Number of IDU using condoms	Unknown	↑ 15%	↑ 30%
Number of IDU who know how to inject drugs safely	Unknown	↑ 15%	↑ 50%
Number of IDU who know overdose pre-post intervention	Unknown	↑ 15%	↑ 50%
Number of IDU with injection-related abscesses	Unknown	↓ 10%	↓ 15%
Number of IDU experiencing non-fatal drug-related overdoses	Unknown	↓ 5%	↓ 5%

* All increases and decreases expressed as percentages represent percentage of change from baseline figure.

** Figure is based on a Thai Working Group on HIV/AIDS Projections estimate of the proportion of IDU who share syringes.

Objective 3.

The third objective of this project is to increase uptake of health care among IDU. Consistent with findings in other settings, IDU in Thailand are known to avoid health care, including primary health care (19,33,34,35). The avoidance of health care among IDU is believed to be a result of both the lack of knowledge among IDU about sources of care, but also the current government policies that make IDU reluctant to seek care out of fear of being identified as a drug user. Success in meeting this objective will be measured by ongoing assessment of the number of IDU who know where and how to access drug treatment, primary health care, and mental health care, as well as the number of IDU who successfully access drug treatment, primary health care, and mental health care.

Objective: 3	To increase uptake of health care among IDU		
Outcome/coverage indicators	Baseline	Targets	
	Year: 2004	Year 2:	Year 3:
Number of IDU who know where and how to access drug treatment	Unknown	↑ 15%	↑ 50%
Number of IDU who know where and how to access primary health care	Unknown	↑ 15%	↑ 50%
Number of IDU who know where and how to access mental health care	Unknown	↑ 15%	↑ 50%
Number of IDU accessing drug treatment	Unknown	↑ 5%	↑ 10%
Number of IDU accessing primary health care	Unknown	↑ 15%	↑ 50%
Number of IDU accessing mental health care	Unknown	↑ 5%	↑ 10%

Objective 4.

The fourth objective is to increase uptake of voluntary testing among IDU. Voluntary testing options are quite limited in Thailand and testing is provided for a fee. With recent government crackdowns on drug users it is believed that an increasing number of IDU are not being tested for HIV. Many IDU may also avoid testing simply because of the expense associated with the test, and logistical challenges associated with the getting to testing centres. Success in meeting this objective will be measured through ongoing assessment of the number of IDU who know where and how to get access to HIV testing, the number of IDU who access voluntary HIV testing, and the number of IDU who are aware of their HIV serostatus.

Objective: 4	To increase uptake of voluntary HIV testing among IDU		
Outcome/coverage indicators	Baseline	Targets	
	Year: 2004	Year 2:	Year 3:
Number of IDU who know where and how to access HIV testing	Unknown	↑ 15%	↑ 50%
Number of IDU accessing voluntary HIV testing	Unknown	↑ 5%	↑ 10%
Number of IDU aware of their HIV serostatus	Unknown	↑ 15%	↑ 50%

Objective 5.

The fifth objective is to reduce AIDS-related morbidity and mortality among IDU. It is believed that HIV/AIDS-related knowledge among IDU is generally low. For example, few IDU know how HIV/AIDS progresses or are aware of the availability of AIDS treatment and care systems, and therefore few seek treatment or care for HIV/AIDS-related illnesses. Success in meeting the fifth objective will be measured through ongoing assessment of the number of IDU who: know their rights to HIV/AIDS treatment, care, and support; know how HIV/AIDS disease progresses; know how HIV/AIDS is treated; are receiving HIV/AIDS care (e.g., treatment of opportunistic infections, palliative support); and the number of IDU who are receiving antiretroviral therapy

Objective: 5	To reduce AIDS-related morbidity and mortality among IDU		
Outcome/coverage indicators	Baseline	Targets	
	Year: 2004	Year 2:	Year 3:
Number of IDU know their rights to HIV/AIDS treatment, care and support	Unknown	↑ 15%	↑ 50%
Number of IDU who know how HIV/AIDS disease progresses	Unknown	↑ 15%	↑ 50%
Number of IDU who know how HIV/AIDS is treated	Unknown	↑ 15%	↑ 50%
Number of IDU receiving HIV/AIDS care (e.g., treatment of opportunistic infections, palliative support)	Unknown	↑ 5%	↑ 10%
Number of IDU receiving antiretroviral therapy	Unknown	↑ 5%	↑ 10%

Objective 6.

The sixth objective is to increase capacity among healthcare providers, police and prison staff to provide or support comprehensive HIV/AIDS prevention, care, treatment and support to IDU. There is currently a lack of IDU-specific HIV/AIDS programming in Thailand, and incarceration has been identified as risk factor for HIV infection in this setting (25). In order to ensure an optimal response to the dual epidemics of injection drug use and HIV/AIDS, capacity to provide comprehensive HIV/AIDS prevention, treatment, care, and support to IDU must be increased among health care providers, police, and prison staff. Therefore, the proposed project includes the provision of educational workshops focused on IDU and HIV/AIDS for these target groups. Success will be measured through tracking of the number of health care facilities and prisons that provide IDU specific programs and services.

Objective: 6	To increase capacity among health care providers, police, and prison staff to provide or support comprehensive HIV/AIDS prevention, care, treatment and support to IDU		
Outcome/coverage indicators	Baseline	Targets	
	Year: 2004	Year 2:	Year 3:
Number of health care facilities providing IDU specific HIV/AIDS programs and services	Unknown	20	40
Number of prisons providing IDU specific programs and services	Unknown	2	4

Objective 7.

The seventh objective is to increase capacity among policy makers to create healthy public policies specific to injection drug use and HIV/AIDS. There is currently a lack of healthy public policies specific to IDU and HIV/AIDS in Thailand, and the government of Thailand does not currently devote any funding to HIV/AIDS prevention, treatment, care or support for IDU. Therefore the proposed project will include the delivery of presentations and dissemination of reports on issues HIV/AIDS and injection drug use to policy makers. Success will be measured through tracking of new government-funded initiatives designed to specifically address HIV/AIDS among IDU and new healthy public policies specific to injection drug use and HIV/AIDS

Objective: 7	To increase capacity among policy makers to create healthy public policies specific to injection drug use and HIV/AIDS		
Outcome/coverage indicators	Baseline	Targets	
	Year: 2004	Year 2:	Year 3:
Number of new government-funded initiatives designed to specifically address HIV/AIDS among IDU	Unknown	5	10
Number of healthy public policies specific to injection drug use and HIV/AIDS	0	2	5

26.3. Broad activities related to each specific objective and expected output

(Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

Please note: Process/output indicators for the broad activities should directly reflect the specified broad activities of THIS component.

Specify in Table IV.26.3 below the baseline data to measure process/output indicators. Targets need to be specified for the first two years of the component.

For each broad activity, specify in Table IV.26.3 who the implementing agency or agencies will be.

Several activities have been designed to address the first objective of increasing the capacity of IDU to provide peer support. Following the establishment of harm reduction centres in four locations (Satun province, Bangkok, Chiang Mai, and the Northeast region), a number of peer-based training initiatives will be undertaken. These initiatives will focus on training peers in the areas of harm reduction, peer counselling and referral, outreach, and HIV/AIDS education. The training will rely on various methods of education, including: (1) study tours in settings with successful IDU peer-driven organizations (e.g., the Vancouver Area Network of Drug Users, Vancouver, Canada); (2) facilitator-led training workshops and programs provided by national and international partners (e.g., Harm Reduction Counseling, the Harm Reduction Coalition Training Institute); (3) development of educational materials with local NGOs and health authorities (e.g., Centre for AIDS Rights, Thai NGO Coalition on AIDS). The peer-based training will also utilize several existing training sources and best practice documents throughout the peer training component (36).

Objective:1	To increase the capacity of IDU to provide peer support				
Main activities	Process/Output indicators (indicate one per activity; refer to Annex A)	Baseline	Targets		Responsible/Implementing agency or agencies
		(Specify year) 2004	Year 1	Year 2	
Establishment of harm reduction training and outreach sites	Number of Harm Reduction Training and Outreach Sites established	0	2	4	TDN, TTAG, Alden House
Creation of Peer Training Manual	Number of peer training manuals created	0	1	N/A	TDN, TTAG
Peer-based harm reduction training	Number of peers trained to provide harm reduction education and intervention	0	30	60	TDN, TTAG, Alden House

Peer-based counselling & referral training	Number of peers trained to provide counselling referrals to treatment and care	0	30	60	TDN, TTAG, Alden House
Peer-based outreach training	Number of peer trained to provide outreach	0	30	60	TDN, Alden House
Peer-based HIV/AIDS education training (e.g. disease process, prevention, treatment, care, and support)	Number of peers trained to provide HIV/AIDS education training (e.g. disease process, prevention, treatment, care, and support)	0	30	60	TDN, Alden House

In order to fulfil the second objective of preventing HIV infection and other health-related harms among IDU, a series of educational and outreach activities will be undertaken by trained peers with the support of NGO partners. Educational activities will focus on the creation and dissemination of harm reduction and HIV education materials (e.g., brochures, posters, stickers, match boxes). Educational activities will be developed by TDN in collaboration with Raks Thai Foundation, and will be informed by materials gathered during study tours. Outreach activities will focus on the provision of harm reduction (e.g., overdose prevention, safer injecting) and HIV prevention education, and peer-based counselling. Outreach will be provided in both community and prison settings, and outreach workers will also be accessible from the Harm Reduction Centres.

Objective: 2		To prevent HIV infection and other health-related harms among IDU			
Main activities	Process/Output	Baseline	Targets		Responsible/Implementing agency or agencies
	indicators (indicate one per activity; refer to Annex A)	(Specify year) 2004	Year 1	Year 2	
Creation and dissemination of harm reduction education materials	Number of harm reduction brochures created *	0	1	1	TDN, TTAG
	Number of harm reduction posters created*	0	3	3	
	Number of harm reduction stickers created*	0	3	3	
	Number of harm reduction postcards created*	0	5	5	
	Number of harm reduction match boxes created *	0	3	3	
	Number of harm reduction fact sheets created *	0	2	2	
	Number of harm reduction newsletters created *	0	4	4	

	Number of harm reduction education materials disseminated	0	5,000	20,000	TDN, TTAG
	Number of IDU receiving harm reduction education materials from peer outreach workers	0	5,000	20,000	TDN, TTAG
Creation and dissemination of HIV education materials	Number of HIV education brochures created *	0	1	1	TDN, TTAG
	Number of HIV education posters created *	0	3	3	
	Number of HIV education stickers created *	0	3	3	
	Number of HIV education postcards created*	0	5	5	
	Number of HIV education match boxes created *	0	3	3	
	Number of HIV education fact sheets created *	0	3	3	
	Number of HIV education newsletters created *	0	4	4	
	Number of HIV prevention education materials disseminated	0	5,000	20,000	TDN, TTAG
	Number of IDU receiving HIV education materials from peer outreach workers	0	5,000	20,000	TDN, TTAG
Peer outreach harm reduction and HIV prevention	Number of IDU reached by peer outreach workers	0	10,000	20,000	TDN, Alden House
	Number of IDU receiving harm reduction education from peer outreach workers	0	10,000	20,000	TDN, Alden House

education & counselling	Number of IDU receiving HIV prevention education from peer outreach workers	0	10,000	20,000	TDN, Alden House
	Number of IDU receiving counselling and psychosocial from peer outreach workers	0	1,800	7,200	TDN, Alden House

* refers to the number of educational materials (i.e., posters, stickers) designed/created not the total number of educational materials printed or disseminated

Activities designed to meet the third objective of increasing uptake of health care among IDU include the creation and dissemination of referral cards, and peer-based referrals to drug treatment, primary health care, and mental health care. Referrals will also be provided during peer-based outreach activities and by telephone from the various Harm Reduction Centres. Lists of resources to which IDU can be referred will be developed in partnership with local NGOs.

Objective:3 To increase uptake of health care among IDU					
Main activities	Process/Output	Baseline	Targets		Responsible/Implementing agency or agencies
	indicators (indicate one per activity; refer to Annex A)	(Specify year) 2004	Year 1	Year 2	
Creation and dissemination of referral cards	Number of referral cards created *	0	12	12	TDN, TTAG
	Number of referral cards disseminated	0	10,000	20,000	TDN, TTAG
	Number of IDU receiving referral cards from peer outreach workers	0	5,000	10,000	TDN, TTAG
Peer-based referrals to drug treatment, primary and mental health care	Number of IDU receiving referrals to drug treatment, primary and mental health care from peer outreach workers	0	5,000	10,000	TDN, Alden House

The activities designed to address the fourth objective of increasing uptake of voluntary HIV testing include the provision of referrals to voluntary testing sites and logistical support for HIV testing. Logistical support will include transportation to testing sites, and financial support (e.g., cost of test). This work will be undertaken by trained peers working out of the Harm Reduction Centres.

Objective: 4	To increase uptake of voluntary HIV testing				
Main activities	Process/Output	Baseline	Targets		Responsible/ Implementing agency or agencies
	indicators (indicate one per activity; refer to Annex A)	(Specify year) 2004	Year 1	Year 2	
Peer-based referrals to voluntary HIV testing	Number of IDU provided with referrals to voluntary HIV testing	0	2,500	5,000	TDN, Alden House
Logistical support for HIV testing	Number of IDU receiving logistical support for HIV testing	0	120	480	TDN, Alden House

Activities designed to address the fifth objective of reducing AIDS-related morbidity and mortality among IDU include the provision of peer-based education pertaining to: rights to HIV/AIDS treatment, care, and support; HIV/AIDS disease processes (disease progression, side effect management); and HIV/AIDS treatment, care, and support information. This work will be undertaken during the course of peer-based outreach, and will be offered through the various Harm Reduction Centres.

Objective: 5	To reduce AIDS-related morbidity and mortality among IDU				
Main activities	Process/Output	Baseline	Targets		Responsible/ Implementing agency or agencies
	indicators (indicate one per activity; refer to Annex A)	(Specify year) 2004	Year 1	Year 2	
Peer outreach HIV treatment, care, and support education	Number of IDU receiving right to treatment, care, and support education from peer outreach workers	0	10,000	20,000	TDN, Alden House
	Number of IDU receiving HIV/AIDS disease education from peer outreach workers	0	10,000	20,000	TDN, Alden House
	Number of IDU receiving HIV/AIDS treatment, care, and support information from peer outreach workers	0	5,000	10,000	TDN, Alden House

In order to meet the sixth objective of increasing capacity among health care providers, police, and prison staff to provide or support comprehensive HIV/AIDS prevention, care, treatment and support to IDU, capacity-building workshops will be designed and delivered to the aforementioned target audiences. All workshops will be facilitated by a trained peer and a representative from a local NGO. Topics covered will include, but will not be limited

to: the determinants of drug use, illicit drugs currently in use, IDU peer driven interventions, interventions and policies specific to injection drug use, and rights to HIV/AIDS treatment, care, and support.

Objective: 6	To increase capacity among health care providers, police, and prison staff to provide or support comprehensive HIV/AIDS prevention, care, treatment and support to IDU				
Main activities	Process/Output	Baseline	Targets		Responsible/Implementing agency or agencies
	indicators (indicate one per activity; refer to Annex A)	(Specify year) 2004	Year 1	Year 2	
Workshop leader training	Number of workshop leaders trained	0	30	60	TDN, TTAG, Alden House
Delivery of workshops to health care providers, prison staff, and police	Number of educational workshops delivered	0	6	40	TDN, TTAG, Alden House
	Number of health care providers, prison staff, and police attending educational workshops	0	60	400	TDN, TTAG, Alden House

In order to meet the seventh objective of increasing capacity among policy makers to create healthy public policies specific to injection drug use and HIV/AIDS, information concerning the epidemics of injection drug use and HIV/AIDS will be presented directly to policy makers. Presentations and reports will focus on a variety of topics, including: the determinants of drug use, illicit drugs currently in use, IDU peer-driven interventions, interventions and policies specific to injection drug use, and rights to HIV/AIDS treatment, care, and support. As well, information obtained during the evaluation of this project will be used to formulate reports and presentation materials.

Objective: 7	To increase capacity among policy makers to create healthy public policies specific to injection drug use and HIV/AIDS				
Main activities	Process/Output	Baseline	Targets		Responsible/Implementing agency or agencies
	indicators (indicate one per activity; refer to Annex A)	(Specify year)	Year 1	Year 2	
Presenter training	Number of presenters trained	0	6	12	TDN, TTAG
Delivery of presentations to policy makers	Number of presentations delivered	0	1	12	TDN, TTAG
	Number of policy makers attending presentations	0	5	60	

Creation and dissemination of reports documenting the epidemics of injection drug use and HIV/AIDS in Thailand	Number of reports written and submitted	0	2	4	TDN, TTAG
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27. Describe how the component adds to or complements activities already undertaken by the government, external donors, the private sector or other relevant partner: (e.g., does the component build on or scale-up existing programs; does the component aim to fill existing gaps in national programs; does the proposal fit within the National Plan; is there a clear link between the component and broader development policies and programmes such as Poverty Reduction Strategies or Sector-Wide Approaches, etc.) (2–3 paragraphs):

The proposed project will serve to add to and complement other government initiatives focused on HIV/AIDS. The project is additive as it will fill an obvious gap in existing HIV/AIDS programming. Despite a longstanding and well-documented HIV epidemic among IDU, there are no known programs or policies in Thailand that address HIV/AIDS among IDU. Therefore the project will add to existing HIV/AIDS programs by addressing the specific HIV/AIDS prevention, treatment, care and support needs of Thai IDU.

The proposed project is also complementary as it is consistent with several of the stated objectives of the National Plan for the Prevention and Alleviation of HIV/AIDS in Thailand 2002-2006:

- First, the National Plan strongly emphasizes the need to increase the participation of communities and people affected by HIV/AIDS in the response to HIV/AIDS, including prevention, treatment, care, and support. The proposed peer-based project is highly participatory in nature, and will rely on the active involvement of current and former drug users, including IDU living with HIV/AIDS;
- Second, the National Plan states that it will support the establishment of “health and social welfare services for the prevention and alleviation of the HIV/AIDS problem” for selected target groups, including drug users. This project aims to develop prevention initiatives and support the creation of health programs and services that meet the needs of IDU;
- Third, the National Plan emphasizes “holistic community based” approaches that address the specific needs of target group affected by HIV/AIDS. The proposed project is community-based in formation and structure, and is holistic in that it addresses a range of outstanding health issues through various approaches (harm reduction, prevention, treatment, etc.), health service delivery, and policy development;
- Fourth, the National Plan recognizes the importance of establishing mechanisms that protect the rights of people living with HIV/AIDS. This project will incorporate human rights-based approaches that address the right to HIV/AIDS treatment and care in both outreach and capacity-building initiatives;
- Fifth, the National Plan also emphasizes the value of cooperating with various countries and international partners in exchanging information, technology, and in working together to prevent and alleviate problems of HIV/AIDS. This project will incorporate international partnerships in a variety of activities, including peer training, evaluation and monitoring.

28. Describe innovative aspects to the component: (1–2 paragraphs)

The proposed project is highly innovative in the current Thai context in that it will involve IDU peer leaders in delivery of HIV/AIDS programs and capacity-building initiatives. The project will be the first of its kind in Thailand because of its focus on HIV/AIDS issues among IDU and its involvement of IDU in all project activities. The project will also be

unique in that it will utilize a community-based HIV/AIDS research approach to evaluation and monitoring.

29. Briefly describe how the component addresses the following issues
(1 paragraph per item):

29.1. The involvement of beneficiaries such as people living with HIV/AIDS:

This project is peer-based in nature and therefore IDU living with HIV/AIDS will be involved in all aspects of the project, including program development, delivery, evaluation and monitoring. The Thai Network of Drug Users (TDN) is key partner in this project, and all IDU contacted by TDN outreach workers will be provided with opportunity to participate in the organization as members, volunteers, or staff.

29.2. Community participation:

This project will seek the participation of the IDU community in all activities. As well, the project will include several NGOs and community-based organizations as project partners. It is hoped that collaborations between the TDN, NGOs, and community-based organizations will be synergistic in nature and will result in partnerships that will extend beyond the proposed project, and thereby help to ensure a sustained and effective response to the HIV/AIDS epidemic among IDU in Thailand.

29.3. Gender equality issues

Research has indicated that up to 80% of IDU in Thailand are male (4). However, this project will seek the involvement of female IDU in project activities to ensure that the unique needs of this segment of IDU population are addressed. This work will initially involve careful analysis and program planning, as the needs of female IDU in Thailand have not yet been fully characterized. As well, the female partners of male IDU have been identified as population at heightened risk for HIV infection. Therefore, the proposed educational and outreach activities will also target the partners of IDU with information about HIV prevention and methods for supporting IDU partners.

29.4. Social equality issues

Injection drug users are highly socially marginalized within Thai culture. This marginalization has been reinforced recently with the advent of national policies that emphasize the criminalization of drug users. This peer-driven project will counter this dominate cultural narrative by empowering drug users to make health promoting contributions to their local communities. It is hoped that this project will lead to creation of alternative identities and the increasing recognition of the basic rights of Thai IDU.

29.5. Human Resources development:

The proposed project will support human resource development in several ways. Through the various peer-based project activities several paid positions will be created for local IDU, including outreach, educator, research, coordination and management positions. As well, several peer positions (e.g., maintenance, drivers) will be structured in a low threshold format, allowing for the increasing involvement of IDU who have not worked recently. These tasks will be structured so that initial task demands and time commitments will be minimal, but will increase over time, leading to increasing responsibility, training, and skill acquisition.

Other more indirect forms of human resource development include capacity-building initiatives aimed at health care providers, police, prison staff, and policy makers. Through workshops, presentations, info sheets, and reports, these target groups will gain capacity to provide/support comprehensive HIV/AIDS prevention, treatment, care and support for IDU.

SECTION V – Budget information

30. Indicate the summary of the financial resources requested from the Global Fund by year and budget category:

Table V.30

Resources needed (USD)	Year 1	Year 2	Year 3 (Estimate)	Total
Human Resources	108,332	190,139	229,852	528,323
Infrastructure/ Equipment	191,142	22,428	26,000	239,570
Training/ Planning	70,214	81,071	83,643	234,928
Monitoring and Evaluation	64,500	37,500	35,500	139,500
Administrative Costs	55,933	72,308	81,025	209,266
Other: Educational Materials	12,476	5,571	3,786	21,833
Total	502,597	409,017	461,806	1,373,420

31.2. In cases where Human Resources (HR) is an important share of the budget, explain to what extent HR spending will strengthen health systems capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over (1 paragraph):

The human resources spending will greatly strengthen health systems at the target population level in several ways. First, a significant portion of human resources spending associated with this project is dedicated to outreach worker positions (i.e., individuals who make direct contact with IDU). Second, there is currently a lack of health care services/programs directed toward addressing issues associated with HIV/AIDS and injection drug use, and therefore the expenditures on human resources will represent a significant addition to the current health system. Third, a portion of the human resources spending is dedicated to workshop leaders who will work to improve the capacity of health professionals, prison staff, and police to provide and/or support comprehensive HIV/AIDS prevention, treatment, care and support for injection drug users. It is hoped that once the success of this project is demonstrated, opportunities for more sustained funding from national and international sources will arise.

32. If you are receiving funding from other sources than the Global Fund for activities related to this component, indicate in the Table below overall funding received over the past three years as well as expected funding until 2005 in US dollars:

Table V.32

	1999	2000	2001	2002	2003	2004	2005
Domestic (public and private)							
External					5,500 US\$	35,000 US\$	40,000 US\$
Total					5,500	35,000	40,000

Please note: The sum of yearly totals of Table V.32 from each component should correspond to the yearly total in Table 1.b of the Executive Summary. For example, if Year 1 in the proposal is 2003, the column in Table 1.b labelled Year 1 should have in the last row the total of funding from other sources for 2003 for all components of the proposal.

33. Provide a full and detailed budget as attachment, which should reflect the broad budget categories mentioned above as well as the component's activities. It should include unit costs and volumes, where appropriate.

See attached detailed budget

34. Indicate in the Table below how the requested resources will be allocated to the implementing partners, in percentage:

Table V.34

Resource allocation to implementing partners* (%)	Year 1	Year 2	Year 3 (Estimate)	Total
NGOs/ Community-Based Org.	60%	60%	60%	60%
People living with HIV/TB/ malaria	30%	30%	30%	30%
Academic/ Educational Organisations	10%	10%	10%	10%
Total	100%	100%	100%	100%
Total in USD	502,597	409,017	461,806	1,373,420

- If there is only one partner, please explain why.

SECTION VI – Programmatic and Financial management information

Please note: Detailed description of programmatic and financial management and arrangements are outlined in Guidelines Para. VI. 67 – 74, including the main responsibilities and roles of the Principal Recipient (PR).

35. Identify your Principal Recipient(s) (PR)

Table VI.35

Name of PR	Raks Thai Foundation	
Name of contact	Promboon Panitchpakdi	
Address	185-187 Phaholyothin Soi 11 Samsennai Phayathai Bangkok 10400	
Telephone	66-2-279-5306/7	
Fax	66-2-271-4467	
E-mail	carethai@ksc.th.com	

Please note: If you are suggesting having several Principal Recipients, please copy Table VI.35 below.

35.1. Briefly describe why you think this/these organisation(s) is/are best suited to undertake the role of a Principal Recipient for your proposal/component (e.g. previous experience in similar functions, capacity and systems in place, existing contacts with sub recipients etc) (1–2 paragraphs)

The Raks Thai Foundation is a relatively large organization and has been implementing HIV/AIDS prevention and care projects in all regions of the country. The Executive Director of Raks Thai Foundation is also the chairperson of the Thai NGO Coalition on AIDS (TNCA). He also sits on the current Thai CCM.

The Raks Thai Foundation has also initiated a small project in one central province that works with former drug users, supporting them to become peer educators.

Finally, the Raks Thai Foundation (RTF) has applied for the GFATM support during the second round and there is the likelihood that RTF will be approved as the PR. It is hoped that this will provide assurance to the GFATM that the PR has the capacity to manage this project.

35.2. Briefly describe how your suggested Principal Recipient(s) will relate to the CCM and to other implementing partners (e.g., reporting back to the CCM, disbursing funds to sub-recipients, etc.) (1 paragraph)

The Executive Director of Raks Thai Foundation, Promboon Panitchpakdi, is a member of the CCM on behalf of the Thai NGO Coalition on AIDS (TNCA).

36. Describe the proposed management arrangements (outline proposal implementation arrangements, roles and responsibilities of different partners and their relations) (1–2 paragraphs)

The Raks Thai Foundation will serve as PR for the project and will be responsible for the overall financial management and program/financial reporting. RTF will enter a contract with the Thai Drug User Network based on an overall plan developed by the TDN. RTF will continue to monitor the project activities and will disburse funds directly to various sub-recipients based on sub-recipient reports. Sub-recipients are TDN, Thai AIDS Treatment Action Group, and Alden House. Other key partners will be AIDSNet,

Raks Thai Foundation, Thai Network of People Living with HIV/AIDS (TNP+), and international organizations such as the Harm Reduction Coalition, and Vancouver Area Network of Drug Users (VANDU).

RTF monitoring activities will be integrated into the Monitoring and Evaluation plan. M&E partners are the BC Centre for Excellence in HIV/AIDS and the Research Institute for Health Sciences.

36.1. Explain the rationale behind the proposed arrangements (e.g., explain why you have opted for that particular management arrangement) (1 paragraph)

The above-mentioned relationship balances the responsibility that is borne by RTF and the need for flexibility in the project management of TDN and partners.

37. Briefly indicate links between the overall implementation arrangements described above and other existing arrangements (including, for example, details on annual auditing and other related deadlines). **If required, indicate areas where you require additional resources from the Global Fund to strengthen managerial and implementation capacity** (1–2 paragraphs)

RTF will invite an auditor to audit the Raks Thai Foundation at the end of each fiscal year. The auditor will also conduct a review of the financial systems that are practiced by the sub-recipients.

SECTION VII – Monitoring and evaluation information

38. Outline the plan for conducting monitoring and evaluation including the following information (1 paragraph per sub-question).

38.1. Explain the overall approach to M&E

The M & E approach will involve a variety of methodologies to track both disease impact, project outcomes, and programmatic progress associated with this project. The four primary approaches will involve: (1) use of existing sources of epidemiological data (e.g., HIV prevalence data, new AIDS cases) to measure disease and other health impacts; (2) data linkages; (3) community-based research methods to track programmatic progress (e.g., reach, output/process data) and outcomes not tracked by current sources (e.g., risk behaviour and knowledge indicators); (4) review and analysis of HIV/AIDS programs/services, policies and government-funded initiatives. Community-based research methods will include the use of program logs, and surveys incorporated into the proposed outreach activities. Additional focus groups will be conducted at the fixed sites (i.e., Harm Reduction Centres) where the outreach workers will be based to ensure client satisfaction with project interventions. In the final year, an intrinsic case study methodology will be used to describe two of the four Harm Reduction Centres. These case studies will be incorporated into the project's final report. A variety of computer software packages will be used to track process and outcome data collected throughout the project. Ongoing data collection will serve to monitor progress and inform interventions as they are being developed, and will form the basis of quarterly reports submitted to the funder.

REPORTING:

Year	Documents	Responsible Parties
Year 1	First Quarter Report	Principal Recipient & Monitoring & Evaluation Advisory Committee
	Second Quarter Report	
	Third Quarter Report	
	Financial Audit	
	Annual Report (Includes: impact, outcome, process evaluation)	
Year 2	First Quarter Report	
	Second Quarter Report	
	Third Quarter Report	
	Fourth Quarter Report	
	Financial Audit	
	Annual Report (Includes: impact, outcome, process evaluation)	
Year 3	First Quarter Report	
	Second Quarter Report	
	Third Quarter Report	
	Financial Audit	
	Final Report (Includes: impact, outcome, process evaluation, case studies, & lessons learned)	

38.2. Describe how the beneficiaries will be involved in M&E

Using an established community-based research method, a substantial portion of the M & E component will be undertaken by trained peer researchers (e.g., IDU, including those living with HIV/AIDS). Peer researchers will assist in all phases of the community-based M & E component, including developing evaluation questions and recruitment strategies, data collection, data analysis, and dissemination of results. Individual IDU who are contacted through educational and outreach activities will also be given opportunity to participate in peer research initiatives.

38.3. Describe how the CCM or other partners will be involved in M&E (e.g., oversight, data review, capacity building, quality control and validation of data).

The M & E component will be undertaken by TDN with the support of two academic partners and one community-based organization who will assist with the development and management of M & E systems. Collectively, representatives from these four organizations and the Principal Recipient organization will form an M & E Advisory Group. Collection, management, and storage of existing epidemiological and health service data will be overseen primarily by the Research Institute for Health Sciences at Chiang Mai University. The Research Institute for Health Sciences has extensive experience in producing and monitoring epidemiological data relevant to HIV/AIDS and injection drug use. TDN will work in partnership with the Research Institute for Health Sciences in identifying new key indicators and participating in dissemination. The community-based research methodology will be developed and monitored by the CHASE Project team from the British Columbia Centre for Excellence in HIV/AIDS (Vancouver, Canada) in collaboration with TDN. The CHASE Project team has vast experience and expertise in community-based research design and program evaluation. The CHASE Project team has worked successfully on several funded peer-based research projects with the Vancouver Area Network of Drug Users (VANDU). VANDU is drug user organization with over 1,000 members that is actively involved in delivery harm reduction programs and services in Vancouver's Downtown Eastside (30). The CHASE Project team will work with TDN in developing a community-based research design to assess programmatic progress and project outcomes, and will provide statistical analysis, as well as ongoing monitoring of evaluation activities to ensure optimal data quality and management. Evaluation and analysis of HIV/AIDS program and policy developments will be overseen by TTAG. TTAG will work with policy makers, public health officials, and local NGOs, TTAG staff will monitor and analyse developments in HIV/AIDS program delivery as well as the creation of new policies and government initiatives focused on HIV/AIDS and injection drug use. Reports produced by TTAG will be submitted to relevant experts for reviews.

38.4. Describe what already exists. How does the existing health information system work and how it will be used to manage and/or report proposal data (e.g., Demographic Health Surveys, Living Standards Measurement Surveys)

There are currently few data sources specific to injection drug users in Thailand. However, there is reasonably good HIV surveillance data (e.g., HIV prevalence, AIDS deaths) that is reported to UNAIDS by the Ministry of Public Health (MOP). Twenty-five sentinel sites in Thailand contributed IDU-specific HIV data to the 2002 UNAIDS Epidemiological facts Sheets on HIV/AIDS and Sexually Transmitted Infections (1). This existing data will be used to track HIV prevalence, incidence, and new AIDS cases among IDU. However, efforts will have to be made to gain data that is stratified by injection drug use as a risk category. This stratified data is not currently available. These sources will be used to track deaths due to AIDS among IDU and hospital utilization among IDU. Although there are some systems that allow for data linkage and sharing in Thailand, linkage processes can be slow. Efforts will be made to increased capacity to perform timely health service utilization linkages during this project. However, obtaining quick and comprehensive linkages may prove challenging. These data will collected and monitored by the Research Institute for Health Sciences at Chiang Mai University. Consent for linkages will be collected during outreach activities. There are currently plans to initiate new prospective cohort studies of IDU in Thailand, and there are also plans to initiate studies to estimate the size of the out-of-treatment IDU population in Thailand. Efforts will be made to incorporate these data sources when they become available.

38.5. Prepare a table showing the following for each impact, coverage and process indicator listed in section 26: i) the source of data, ii) periodicity of data collection, iii) how the quality of data will be determined/ensured, iv) who (the entity) will be primarily responsible for each indicator, v) and what indicators will be reported through partner organisations.

IMPACT INDICATORS:

Impact Indicator	Data Source(s)	Timing of Collection	Data quality Management	Responsible parties	Reporting Body
HIV incidence	MOP/ UNAIDS	Annual	Data quality will be managed at source. Data will be checked against data obtained from prospective cohort studies (as this data becomes available).	Institute for Health Sciences	RTF*/Institute for Health Sciences
New AIDS Cases	MOP/ UNAIDS	Annual		Institute for Health Sciences	RTF*/Institute for Health Sciences
Deaths due to AIDS	MOP/ UNAIDS	Annual		Institute for Health Sciences	RTF*/Institute for Health Sciences
Hospital Utilization	Regional hospital linkages	Annual or as frequent as possible (every two years)		Institute for Health Sciences	RTF*/Institute for Health Sciences

* RTF = Raks Thai Foundation

OUTCOME INDICATORS:

Outcome Indicator	Data Source(s)	Timing of Collection	Data Quality Management	Responsible parties	Reporting Body
Number of peers providing peer-based HIV/AIDS prevention & care	TDN Program/- Training Logs	Ongoing, quarterly analysis	The BC Centre for Excellence staff will work with TDN outreach workers to develop data collection instruments and peer research skills. Where appropriate, validated measures will be implemented. Training methods based on social learning models will be employed. A TDN research coordinator will	TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS
Number of communities with IDU peer-support networks	TDN Program Logs	Ongoing, quarterly analysis		TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS
Number of IDU who know how HIV is transmitted and prevented	TDN Outreach Survey – HIV/AIDS Knowledge Survey	Baseline, & semi-annually thereafter		TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS
Number of IDU sharing syringes	TDN Outreach Survey	Baseline, & semi-annually thereafter		TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS

Number of IDU engaged in indirect sharing	TDN Outreach Survey	Baseline, & semi-annually thereafter	work with BC Centre for Excellence staff in reviewing data quality on ongoing basis. Booster training sessions will be provided as needed to ensure data quality.	TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS
Number of IDU using condoms	TDN Outreach Survey	Baseline, & semi-annually thereafter		TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS
Number of IDU who know how to inject safely	TDN Outreach Survey – Harm Reduction Knowledge Survey	Baseline, & semi-annually thereafter		TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS
Number of IDU who know overdose pre- and post-intervention	TDN Outreach Survey – Harm Reduction Knowledge Survey	Baseline, & semi-annually thereafter		TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS
Number of IDU with injection-related abscesses	TDN Outreach Survey	Baseline, & semi-annually thereafter		TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS
Number of IDU experiencing non-fatal overdoses	TDN Outreach Survey	Baseline, & semi-annually thereafter		TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS
Number of IDU who know where and how to access drug treatment	TDN Outreach Survey – Knowledge of Health Care Survey	Baseline, & semi-annually thereafter		TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS
Number of IDU who know where and how to access primary health care	TDN Outreach Survey – Knowledge of Health Care Survey	Baseline, & semi-annually thereafter		TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS
Number of IDU who know where and how to access mental health care	TDN Outreach Survey – Knowledge of Health Care Survey	Baseline, & semi-annually thereafter		TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS
Number of IDU accessing drug	TDN Outreach Survey	Baseline, & semi-annually thereafter		TDN/BC Centre for Excellence in	TDN/BC Centre for Excellence

treatment	Referral Postcards ¹	Ongoing, quarterly analysis		HIV/AIDS	in HIV/AIDS
Number of IDU accessing primary health care	TDN Outreach Survey	Baseline, & semi-annually thereafter		TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS
	Referral Postcards ¹	Ongoing, quarterly analysis		TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS
Number of IDU accessing mental health care	TDN Outreach Survey	Baseline, & semi-annually thereafter		TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS
	Referral Postcards ¹	Ongoing, quarterly analysis		TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS
Number of IDU who know where and how to access HIV testing	TDN Outreach Survey – Knowledge of Health Care Survey	Baseline, & semi-annually thereafter		TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS
Number of IDU accessing voluntary testing	TDN Outreach Survey	Baseline, & semi-annually thereafter		TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS
	Referral Postcards ¹	Ongoing, quarterly analysis			
	TDN Program Log				
Number of IDU aware of their HIV serostatus	TDN Outreach Survey	Baseline, & semi-annually thereafter		TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS
Number of IDU who know their rights to HIV/AIDS treatment & care	TDN Outreach Survey	Baseline, & semi-annually thereafter		TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS
Number of IDU who know how HIV/AIDS progresses	TDN Outreach Survey – HIV/AIDS Knowledge Survey	Baseline, & semi-annually thereafter		TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS

Number of IDU who know how HIV/AIDS is treated	TDN Outreach Survey – HIV/AIDS Knowledge Survey	Baseline, & semi-annually thereafter		TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS
Number of IDU receiving HIV/AIDS care	TDN Outreach Survey	Baseline, & semi-annually thereafter		TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS
	Referral Postcards ¹	Ongoing, quarterly analysis		TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS
Number of IDU receiving antiretroviral therapy	TDN Outreach Survey	Baseline, & semi-annually thereafter		TDN/BC Centre for Excellence in HIV/AIDS	TDN/BC Centre for Excellence in HIV/AIDS
Number of health care facilities providing IDU specific HIV/AIDS programs and services	TTAG HIV/AIDS Program & Services Review ²	Semi-annually	TTAG reports will reviewed by relevant experts and stakeholders (e.g., policy makers, public health authorities, NGOs) to ensure accuracy and updated based on these reviews.	TTAG	TDN/ TTAG/ CARE
Number of prisons providing IDU specific HIV/AIDS programs and services	TTAG HIV/AIDS Policy & Program Review ²	Semi-annually		TTAG	TDN/ TTAG/ CARE
Number of new government funded initiatives designed to specifically address HIV/AIDS among IDU	TTAG HIV/AIDS Policy & Program Review ²	Semi-annually		TTAG	TDN/ TTAG/ CARE
Number of healthy public policies specific to injection drug use and HIV/AIDS	TTAG HIV/AIDS Policy & Program Review ²	Semi-annually		TTAG	TDN/ TTAG/ CARE

¹ The “Referral Postcard” methodology is data collection approach that was successfully implemented during the evaluation of a supervised injection facility in Sydney, Australia. In brief, each time an individual is referred to a program/service, he/she is provided with a prepaid post card. Upon arrival to program/service, the postcard is given to a service provider who is asked to complete basic information about the agency and indicate

whether or not the individual was admitted into the program/service. The postcard is then put in the mail and received at the study office as data.

² The HIV/AIDS Policy & Program Review will consist of an ongoing review of HIV/AIDS programs and policies. Working with policy makers, public health officials, and local NGOs, TTAG staff will monitor and analyse developments in HIV/AIDS program delivery as well as the creation of new policies and government initiatives focused on HIV/AIDS and injection drug use. Reports for the purpose of the present evaluation will be submitted semi-annually.

38.6. Describe how data will be analyzed and used by the PR, CCM, and others

Data collected during the project will be analysed and utilized by all members of the M & E Advisory Group. Analysis will involve both cross-sectional and longitudinal evaluation of IDU reached by the program and matched controls who are not reached the project. Existing sources of epidemiological and health service utilization data will be analysed and disseminated by the Research Institute for Health Sciences at Chiang Mai University in collaboration with TDN. TDN will use this data to inform interventions as they are being developed, and the Research Institute for Health Sciences at Chiang Mai University and TDN will both participate in the dissemination of the results at conferences and in academic publications. Epidemiological data will be particularly useful in determining targets for reach (e.g., location and population targeted by interventions). Health service utilization data will also be used to target audiences for capacity-building interventions, and will also be used as content in related activities (e.g. workshops, reports). For example, hospitals treating large numbers of IDU will be identified as sites for capacity building workshops. The community based research data will be analysed by TDN in partnership with the CHASE Project team from the B.C. Centre for Excellence in HIV/AIDS. The CHASE Project team will be responsible for all statistical analysis (descriptive data, univariate and multivariate analyses). This data will also be used to inform the development of the project interventions and capacity-building initiatives (e.g., workshops, reports). This data will be disseminated by TDN and the CHASE Project Team in popular reports, conferences, and academic publications. All data collected during the project will be used by the PR and TDN to monitor programmatic progress and incorporated into quarterly reports that will be submitted to the funder.

39. Recognizing that M & E plans will make use of existing monitoring systems especially for impact and coverage indicators, national information systems may require strengthening. Please specify activities, partners and resource requirements for strengthening M&E capacities.

Table VII.39

Activities (aimed at strengthening Monitoring and Evaluation Systems)	Partner(s) (which may help in strengthening M&E capacities)	Resources Required (USD)			
		Year 1	Year 2	Year 3	Total
Data linkages, epidemiological data collection and analysis	Research Institute for Health Sciences, Chiang Mai University	20,000	10,000	10,000	40,000
Community-based research & evaluation (survey development, training, focus groups, case studies, statistical analysis, report writing)	BC Centre for Excellence in HIV/AIDS & research Institute for Health Sciences, Chiang Mai University	32,000	15,000	15,000	62,000
Program and policy analysis	TTAG	5,000	5,000	5,000	15,000
Data entry	TDN	7,500	7,500	7,500	22,500
Global Fund M&E request		64,500	37,500	37,500	139,500
Total resources needed		64,500	37,500	37,500	139,500

LIST OF ATTACHMENTS

Please note:

The list of attachments is divided into two parts: the first part lists the attachments requested by the Global Fund as support for Sections III and IV.

The second part is for applicants to list attachments related to other Sections such as the Information on applicants (Section II), Detailed Budget (Section IV), or other relevant information.

Please note which documents are being included with your proposal by indicating a document number.

General documentation:	Attachment #
1. Poverty Reduction Strategy Paper (PRSP)	
2. Medium Term Expenditure Framework	
3. Sector strategic plans	
4. Any reports on performance	
HIV/AIDS specific documentation:	Attachment #
5. Situation analysis	<u>1a, 1b</u>
a. "Reducing HIV transmission among IDU in Thailand," Chris Beyrer	
b. "AIDS and public policy: the lessons and challenges of 'success' in Thailand," Martha Ainsworth, Chris Beyrer, Agnes Soucat	
6. Baseline data for tracking progress [†]	
7. National strategic plan for HIV/AIDS, with budget estimates	<u>2</u>
8. Results-oriented plan, with budget and resource gap indication (where available)	<u>3</u>
"Annex B"	
General documentation:	Attachment #

HIV/AIDS specific documentation:	Attachment #
9. Raks Thai Foundation By-Laws, Foundation Registration	<u>4a-b</u>
10. Reference Letters	<u>5a-l</u>
Letters from Supporting Organizations and Individuals to Bypass CCM:	
a. Senator Jon Ungphakorn, The Senate, Thailand	
b. Mr. Somchai Homlaor, Secretary General, Forum-Asia	
c. Ms. Aree Kumpitak, Committee, Thai NGO Coalition on AIDS (TNCA)	
d. Mr. Aryeh Neier, President, Open Society Institute (OSI)	

[†] Where baselines are not available, plans to establish baselines should be included in the proposal.

- e. Ms. Joanne Csete, Director, HIV/AIDS and Human Rights Programme, Human Rights Watch (HRW)
- f. Dr. David Wilson, Medical Coordinator, Medecins Sans Frontieres-Belgium (MSF-Belgium)/Thailand
- g. Dr. Chris Beyrer, Director, Johns Hopkins Fogarty AIDS International Program, Johns Hopkins School of Public Health
- h. Ms. Ana Oliveira, Executive Director, Gay Men's Health Crisis (GMHC)
- i. Mr. Kamon Uppakaew, Chairman, Thai Network of People Living with HIV/AIDS (TNP+)
- j. Mr. Allan Clear, Executive Director, and Mr. Donald Grove, Operations Director, Harm Reduction Coalition (HRC)

Letters of General Support:

- k. Ms. Supatra Nacapew, Director, Centre for AIDS Rights (CAR)
- l. Mr. Nimit Tien-Udom, Director, AIDS Access Foundation

References:

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