

Beyond the Targets: Assessment of Public and Private ARV Treatment Programs

Thailand Country Working Paper

Authors:

Niyada Kiatying-Angsulee, Ph.D.

Luechai Sringernyuang, Ph.D.

Niphattra Haritavorn M.A.

Editing: Joanna Swabe

Cover Design: Deryll Naidoo and Colleen Daniels

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Contact Address:

HAI Europe

Jacob van Lennepkade 334T

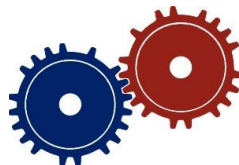
1053 NJ Amsterdam

The Netherlands

Telephone: 31 (0) 20 683 3684

Fax: 31 (0) 20 685 5002

Website: [www.haiweb.org](http://www.haiweb.org)



**Health Action International Group    Public Private Interactions    DANIDA    Drug Study**

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### Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
APN+	Asia Pacific Network of People Living with HIV/AIDS
ART	Antiretroviral treatment
ARV	Antiretroviral drugs
ATC	Access to AIDS Care
BMS	Bristol Myer Squip
CCC	Center of Comprehensive and Continuous Care
CCM	Country Core Mechanism
CDC	Center for Diseases Control and Prevention (US)
CL	Compulsory Licensing
CSMBS	Civil servant medical benefit scheme
DDC	Department of Diseases Control (Thailand)
Ddi	Didanosine
FBO	Faith Based Organizaxtion
FTA	Free Trade Agreement
GFATM	Global Fund to fight AIDS, TB, and Malaria
GP	General Practitioner
GPO	Government Pharmaceutical Organization
HAART	highly active antiretroviral therapy
HIV	Human Immunodeficiency Virus
IAC	International AIDS Conference
IDU	Injecting Drug User
IPRs	Intellectual Property Rights
MoPH	Ministry of Public Health (Thailand)
MSF	Medicins Sans Frontieres
NAPHA	National Access to ARV for People Living with HIV AIDS
NDRA	National Drug Regulatory Authority
NHSO	National Health Security Organization
NIH	National Institute of Health (US)
NNRTI	Non-nucleoside Reverse Transcriptase Inhibitor
NRTI	Nucleoside Reverse Transcriptase Inhibitor
OIs	Opportunistic Infections
PATC	Paediatric Access to Care
PCR	Polymerase Chain Reaction
PHPT	The Program for HIV Prevention and Treatment
PI	Protease Inhibitor
PHA	People Living With HIV AIDS (PLWHA)
PMTCT plus	Perinatal Mother To Child Treatment
Ppy	Per patient year
SSO	Social Security Organization
SSS	Social Security Scheme
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection
TAO	Tambon Administration Organization
TB	Tuberculosis
TDN	Thai Drug User Network
TNCs	Trans-national companies
TNP+	Thai Network of People Living with HIV/AIDS

TRC	Thai Red Cross
TRCARC	Thai Red Cross Aids Research Center
UC	Universal Coverage
WHO	World Health Organization
WTO	World Trade Organization
UK	United Kingdom
UN	United Nations
UNAIDS	United Nations AIDS Program
UNGASS	United Nations General Assembly
USA	United States of America
VCT	Volunteer Counseling and Test of HIV

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## Executive Summary

This project is part of the HAI Europe's Public Private Interactions project on ARV treatment programmes. It was established in order to assess how ARV treatment programmes, including new forms of public and private partnerships and interactions, are providing AIDS patients with access to ARV drugs. With an outcome orientation and efficient lean governance structure, public-private partnerships are expected to move fast in making medicines available to people living with HIV/AIDS. The study was divided into two phases. The first phase (July-December 2005) is about the country situation analysis and the second one dealt with the assessment of these programmes and it was conducted from January to August 2005. Two PPIs were selected for study as GF ATM and MSF, which both also affiliated with NAPHA/UC scheme, a Thai unique of management. Study tools included documentation review, semi-structured interview with 7 policy level personnel, 24 health facility staff, in-depth interview with 62 PLWHA, exit interview with 48 PLWHAs, and group discussion with 23 PLWHAs and NGOs, and brief meetings with organizations. Relevant conferences and workshop were also observed. Altogether 9 hospitals, 2 regional disease control centers and 4 NGOs were involved. Thus this selection may create some limitation to the study since context and coverage differ from other region.s

Thailand has good infrastructure of health care system, from primary care to secondary and then tertiary care. Furthermore, the financing schemes almost cover all patients in need with Universal Coverage (UC) or 30-Baht scheme for everyone, Social Security Scheme for private employees, CSMBS for civil servants, and etc. Hence, with the rapid growth of HIV pandemic, the Thai government has to set up various programmes such as Access to Care (ATC) which adjusted later to NAPHA, and now merged into the UC scheme embedded in the current infrastructure. There are also many other attempts including GF ATM programmes for round 1 and 3 aimed to strengthen the existing ARV provision especially the AIDS diagnosis and training. NGOs and civil society are also very strong and actively participate in all levels of decision for ARV policy and also for action on AIDS prevention and care. The Global Fund and MSF both provide ARV treatment programmes in Thailand. These projects are very different with respect to their size and objectives. The primary objective of the Global Fund/NAPHA programme is to scale up ARVs and to strengthen the infrastructure, while the MSF seeks to develop innovative models of AIDS care. The coverage that both programmes offer is quite dissimilar.

Concerning implementation into the health facility level, quality and satisfaction are also debatable. Numbers of issues were raised by PLWHAs. Firstly the problem is the application to eligibility criteria. There is standard guideline to antiretroviral treatment from MOPH, but some of hospital does not follow that, e.g. the cost of first CD4 test, accessibility for IDU, and etc. At time of data collection, most patients have been treated with ARV for 12 months (mean 18.8 and range 3-96 months). Reasons were the follow up and receive of new batch of ARV. The general process started with the queue request and went to meet nurse, reported the health problem, then checked blood, waited for result, met nurse again, waited for doctor, waited for drugs, and met nurse for next appointment. This led to the length of the whole course of treatment on day of visit to be half to one day depend on the situation and purposes

and hospital. Most were happy with situation but some complained of complication and that they had to leave from work.

Almost all PLWHAs appreciated the services provided by hospitals and felt that their health was greatly improved compared to before receiving ARVs. Only a few complained about the services and these seemed to be related with certain hospitals. Information was given to PLWHA and that they were respected in term of rights. However, most mentioned they were asked and they had to answer and did not have much possibility to ask back. Nurses and counselors are the two almost every one mentioned they have met and that they appreciated. Not every time that PLWHA met doctors.

Since all PPIs are implemented in the public hospitals treatment costs involved are absorbed by either GF/NAPHA, MSF or SSO. No complaint on cost was observed especially among the users under the universal coverage scheme as only 30 Baht per visit is charged. However, all of the users interviewed wish to see all schemes to exist forever or last long enough (more than 5 years). Concerned issue raised by health workers and patients is the sustainability of the program in the future. Most users under MSF supported projects are worried when being informed that the project is about to terminate.

Well developed infrastructure of health services in the country allows PLWHAs to access hospitals easily. Traveling cost is not a big barrier for those who choose to go to the community hospital in their living area but not for those who choose the hospitals far away to avoid their status disclosure. Stigma is found being the main reason for PLWHAs who travel a long distance to get ARV treatment at the hospitals outside their residential area or at private health facility. Fear as well as direct experience of being stigmatized cause some PLWHAs to quit their job or relocate.

Since flowcytometers are not set up in all hospital to detect HIV, the work has been increased for some center especially that in epidemic area. Also, Thai GPO can produce lab substance but it needs the technician to set up which is difficult in some area. This situation led to problem in the screening process.

Most of the informants strongly agree the positive effect after taking antiretroviral, except some faces the bad side effect, but still agree that their opportunistic infection reduces. Taking antiretroviral help them not only get back to work, but also reduce stigma in community. People still believe that having HIV positive means the path to death, but availability of antiretroviral has changed their point of view that they can live like others. Women are more sensitive with the side effect of taking antiretroviral, especially if that changes their physical appearance which is one factor influencing their adherence. The negotiation between doctor and patient in order to change the regimen is difficult. The patients feel that the doctor doesn't listen to them, but at the same time the doctor does not want to use the second regimen because that means decrease their chance of treatment.

Most of the informants do not know which program they enroll. In some area, that they ARV is funded by Global Fund, the informants and as well as health facilities do not know much or heard about Global Fund. They thought that their ARV was funded by Thai government or they are in NAPHA program.

Civil society participation was found in all three levels, CCM at the national policy level, health facility the implementation level, and in the community. This partly the active role of PLWHA group such as TNP+ and some NGOs with the support from academia and international organization such as MSF. Some hospitals provided the PLWHA help group in collaboration with CCC (Comprehensive Care Center). This gave the better environment for PLWHA since they have friends to talk with openly. Obviously, implementing CCC at health facility reduces the workload of health workers. PLWHA network understands the patient both physically and mentally so that PLWHA participation in health facility should be focused and implemented in all health facility that provides ARV. Nonetheless, one hospital deny the policy to let PLWHA group to help this process. Vulnerable and marginalized groups of concern are IDU, sailor, women, children, migrants, and bordered minority group.

Thailand has proved that ARV programme can be set up to provide prevention and care to all patients in need by using innovative strategy. Challenges for the future are inevitably about the future sustainability of the programme, which rely on political commitment since drug resistance already occurred given that adherence is high. The patent situation of second line ARV drugs need attention for making it accessible. The project proposed recommendation in 3 levels – the policy, the implementation, the participation, and the communication. The policy maker clearly should make use of the benefit of PPI and prevent those side effects. Other issues in this level include the standardization of guideline, healing of stigmatization to recruit more marginalization, and etc. This quality of treatment at the field is to be monitored and adjusted by well preparing the sites and to ensure that VCT stimulate more utilization. Participation of civil society and PLWHA are also key factors that should be still strengthened.

### **Acknowledgements**

Many individuals took part in this study that can be all named here. The authors thank MSF team, Professor Dr. Praphan Panupak, Dr. Sanchai Chasombat, Dr. Witaya Petdachai, and the health workers for sharing their information and concerns. Importantly, our thanks also go to People Living with HIV AIDS network and the patients at health facility who spend their time with us.

## I. INTRODUCTION

### 1.1 Research Background

This research is part of the HAI Europe's Public Private Interactions project on ARV treatment programmes. It is divided into two phases. The first phase, the country situation analysis, was carried out during the June-September 2004 period. It aimed to give an overview of the public-private interactions through which access to AIDS medicines and HIV/AIDS diagnostics are being improved in Thailand. The data collected during this phase provided an overview of all the ARV programmes in the country, which involve public-private interactions, and to highlight the benefits and risks of the existing antiretroviral drugs (ARV) supply efforts using the methods developed by that HAI and all 6 country working groups.

The second phase deal with the assessment of these programmes and was conducted from January to August 2005. This evaluation was divided into three levels: policy, health facilities, and ARV patients. It compared governance processes, accountability mechanisms and the legitimacy of the public-private partnerships. The evaluation primarily focused on assessing their effectiveness in improving equal access to HIV/AIDS care and support in the seven recipient countries and the effects of increased access to medicines on existing care arrangements and quality of life of people living with HIV AIDS (PLWHA).

#### *Rationale*

This project was established in order to assess how ARV treatment programmes, including new forms of public and private partnerships and interactions, are providing AIDS patients with access to ARV drugs. With an outcome orientation and efficient lean governance structure, public-private partnerships are expected to move fast in making medicines available to people living with HIV/AIDS. In practice, rapid and effective action has proved difficult, and there is a growing recognition of some of the risks that are involved in employing such strategies. For example, such programmes run the risk of:

- Undermining existing national level structures not only for decentralised health policymaking and programme implementation, but also drug distribution and procurement;
- Distorting health systems by focusing on providing medicines rather than strengthening health systems;
- Being unsustainable. The support is usually only provided for a maximum of five years, which creates uncertainties about what will happen afterwards;
- Contributing to inequalities with respect to access to medicines, because of limited coverage that reaches mainly the affluent;
- Not being accountable to end-beneficiaries. Transparency in decision-making and accountability have been raised as concerns. Who decides on the content of HIV/AIDS programmes? To what extent are there conflicts of interests between private sector profit motives and public health goals?

#### *Project Objectives:*

The objectives of the project are to:

1. Examine and compare governance processes, accountability mechanisms and legitimacy of the ARV treatment programmes, and their effectiveness in improving equitable access to HIV/AIDS care and support in the six recipient countries
2. Analyse the processes that lead to the adoption of a national level of AIDS care and access to AIDS medicines policies
3. Assess the effects of increased access to medicines on existing care arrangements and quality of life of PLWHA;
4. Define guidelines for ARV treatment programmes, including recommendations for governance mechanisms, which facilitate positive outcomes in terms of improved care and quality of life for PLWHA;
5. Define indicators for monitoring of relevance, efficiency, effectiveness, and sustainability of the initiatives;
6. Develop recommendations and operational research methods to assist national level programmes to strengthen their AIDS care programmes in terms of more equitable access to HIV/AIDS medicines and improved quality of life for PLWHA;
7. Strengthen the capacity of NGO health workers and health researchers in the recipient countries for more effective participation in national level policy formulation and implementation.

### **1.2 Research Methodology**

The research tool used in the study was based on HAI guidelines. The study used a contrasting case-study approach. We contrasted the key characteristics of the most important ARV treatment programmes at the national level, and contrasted the way in which they operated in selected health facilities at the local level. The research methods were:

- Document review: reports and guidelines from each treatment programmes, and reports and studies on the antiretroviral situation in Thailand were collected. We also participated in many conferences and meetings on the issue, such as the national aids conference and so forth.

- Semi-structured interviews: these followed an open and informal style. The semi-structured interviews were used for PLWHA, health workers and policymakers. The questions for policymakers were based on their role in each ARV treatment programme. The health worker's questions were related to their responsibility or role in the antiretroviral programme. There were separate questionnaires for doctors, counsellors, and pharmacists. The results from the health facilities' health workers focussed on specific information with respect to access, inclusion and exclusion, quality of counselling, and perceived problems and job satisfaction.

- Group Discussions (GD). These were conducted with PLWHAs. Importantly, the results of the GDs complemented the findings from the semi-structured interviews. Neutral and open-ended questions were used during the FGDs to encourage a lively discussion. FGDs were held in May and the participants were involved in the PLWHA networks of each region; the TNP+ (Thai Network of People Living with HIV/AIDS) representatives also participated. We invited representatives from the Thai People Living with HIV from each region. Most of them are ARV patients and working with partners

for the provision of comprehensive and continuous care. The question was separated into three levels: policy, health facility, and antiretroviral users.

- Interviews with PLWHA for both the exit and in-depth interviews were conducted at health facilities. Each informant was asked for their permission to be interviewed and the purpose of this study was explained clearly.

Nine hospitals in the central region were selected as case studies. All of these hospitals operate under the NAPHA (National Access to ARV for People Living with HIV AIDS), five hospitals include patients who are treated with the support of the Global Fund, and two receive support from Medecins Sans Frontieres Belgium (MSF-B). Large hospitals were also chosen for comparison with small hospital. Details of each hospital's facilities and ARV provision backgrounds are shown in Table 1.1. See Annex for details of questions involved in each method.

This study has some limitations that the data were collected from only hospitals in central Thailand which the context and situation differed from the other part such as in the north where HIV prevalence is the highest in the country. The ARV coverage of the central region is also lower. Action and movement in HIV/AIDS issues are also moving in a very rapid pace thus the information is produced and changed due to policy and created limitation to study. .

This report is divided into 6 sections: introduction, country context, ARV treatment PPI characteristics, implementation, participation of civil society, and challenges.

**Table 1.1: Data Collection Sites**

Hospital	General Information	Number of interviews conducted					
		ARV programme	Doctor	Nurse	Pharmacist	ARV Patients	Exit
Hospital A	Community hospital 30 beds Medical doctors = 4 including director Pharmacist = 7, Registered Nurse = 39, Technical nurse = 9 ARV clinic separate every Thursday and Friday	NAPHA MSF	1	1	1	8 (M 5 + F 3)	7
Hospital B	Community hospital 60 beds, Medical doctors = 6 include director Pharmacist = 5, Registered Nurse = 54, Technical nurse = ARV clinic every day not separate but with 3 groups of PLWHA every second Tuesday of the month (30 cases)There is new cases everyday	NAPHA	-	1	1	7 (M 2 +F 5)	6
Hospital C	General hospital 365 (429) beds Medical doctors = 46 including director Pharmacist = 17, Dentist = 5 Registered Nurse = 336, Technical nurse = 12 ARV clinic very Wednesday (2 times a month)Two groups Adult = 236, Children = 60	NAPHA MSF(Children)	1	1	1	9 (M 3 + F 6)	6
Hospital D	Community hospital 60 beds Medical doctors = 5 including director Pharmacist = 4 , Dentist = 2 Registered Nurse = 70, Technical nurse = ARV clinic very second and fourth Monday of the month Patients 2 groups with 27 in each	NAPHA Global NAPHA GLOBALA Fund	-	2	-	5 ( F 5)	6
Hospital E	Regional hospital 895 (>900) beds; Medical doctors = 102 including director Pharmacist = 28, Dentist = 7 Registered Nurse = 534, Technical nurse = 125	NAPHA-Global Fund	-	1	-	9 (M 4 + F 5)	6

Hospital	General Information	Number of interviews conducted					Exit
		ARV programme	Doctor	Nurse	Pharmacist	ARV Patients	
	ARV clinic						
Hospital F	General hospital 420 beds Medical doctors = 74 including director; Pharmacist = 24 Registered Nurse and Technical nurse = 500 ARV clinic: Tuesday	Napha + Global Fund (PHPT)	1	1	1	6 (M 3 + F 3)	5
Hospital G	Community hospital 30 beds Medical doctors = 5 including director Pharmacist = 5, Registered Nurse = 32, Technical nurse = 4 ARV clinic every Friday 124 patients: 72 in Napha, 52 in MSF and SSO	NAPHA+MSF	-	2	1	6 (M 1 + F 5)	7
Hospital H	Regional hospital 404 beds Medical doctors = 61 including director Pharmacist = 20, Registered Nurse = 341, Technical nurse = 83; nurse assistant = 9; lab and technician = 23 ARV clinic Wednesday	Global Fund	1	1	1	6 (M 3 + F 3)	5
Hospital I	General hospital 120 beds Medical doctors = 21 including director Pharmacist = , Registered Nurse = 184, Technical nurse = ARV clinic appointment 204 patients	Global Fund	1	2	1	6 (M 1 + F 5)	-
Total			5	12	7	62 (M 22 + F 40)	48



## II. COUNTRY CONTEXT

### 2.1. Geographic and demographic context

Thailand is situated in the centre of the South-East Asian peninsula and has a surface area of 513,115 square kilometres. The country is divided into four geographical regions: Central, Northeast, North, and South.

Located outside the typhoon belt, Thailand has a warm and rather humid tropical climate. There are three distinct seasons: rainy from June to October; cool from November to February; and hot from March to May. The average temperature is between 23.7 to 32.5 degree Celsius

The estimated population for 2004 was approximately 63 million. In 2003, the life expectancy of men was estimated at 67.9 years, whereas for women it was 75 years<sup>1</sup>. 94.6% of the total population are Buddhists. Islam is embraced by 4.6%, while others practice Christianity (0.7%), Hinduism (4.6%) and other religions (0.05%).<sup>2</sup>

Aside from being well-known as an agriculturally based country, Thailand is also known for the production of textiles, computers and related parts, plastic products, footwear, and processed seafood. The Thai government has strongly emphasised the need for economic development and has thus introduced a series of five-year National Economic and Social Development Plans from 1st plan (1961-1966)-9<sup>th</sup> plan (2002-2006). With regard to its economic development, the Thai government has joined the WHO and has become a member of the Association of Southeast Asian Nations (ASEAN).

**Table 2.1 National Social Data Set**

<b>Demographic Data</b>	<b>Year</b>	<b>Estimate</b>	<b>Source</b>
Total Population (thousands)	2004	63,465	<b>UN population database</b>
Female Population aged 15-24 (thousands)	2004	5,615	<b>UN population database</b>

<sup>1</sup> Mahidol Population Gazette, Vol. 12. July 2003

<sup>2</sup> Preliminary report of Population and Housing Census, National Statistical Office, 2000.

Demographic Data	Year	Estimate	Source
Population aged 15-49 (thousands)	2004	36,225	UN population database
Annual population growth rate (%)	1992-2002	1.1	UN population database
% of population in urban areas	2003	31.8	UN population database
Average annual growth rate of urban population	2000-2005	1.9	UN population database
Crude birth rate (birth per 1,000 pop.)	2004	17	UN population database
Crude death rate (deaths per 1,000 pop.)	2004	7.1	UN population database
Maternal mortality rate (per 100,000 live births)	2000	44	WHO
Life expectancy at birth (years)	2002	69.3	WHO report 2004
Total Fertility Rate	2002	1.9	WHO report 2004
Infant mortality rate (per 1,000 live births)	2000	27	WHO report 2004
Under 5 mortality rate (per 1,000 live births)	2000	31	WHO report 2004

**Source:** UNAIDS/WHO Epidemiological Fact Sheet-2004 Update

Thailand is governed by a constitutional monarchy with His Majesty King Bhumibol Adulyadej as the Head of State. The parliament and the civil service lead by the Prime Minister and includes 15 major ministries. Thailand's political reform process took place in 2002. The decentralisation policy and plan was introduced and endorsed by the parliament in 2000. This policy allowed the sub-district (Tambon) levels to strengthen their own financial and development management. The 7252 Tambon each formed a Tambon Administrative Organisation (TAO), which comprised local committee members who collaborate with civic groups to develop plans for the community.<sup>3</sup>

## 2.2 Public healthcare provision and policy

<sup>3</sup> UN Thailand, Government: Political Development

The Ministry of Public Health (MOPH) is the core organisation responsible for the Thai public health system. According to the Ministry and Department Reorganisation Act of B.E. 2534 (1991), “The MOPH has the authority and functions related to medical care, public health, health promotion and development, food and drug control, anything toxic or hazardous to the public health, and the Red Cross supervision and support.”

As a result of political and administrative reform in 1996, MOPH has changed its role from being a service provider to a policymaker, establishing services standards, monitoring standards’ compliance, and providing technical support to all public and private health facilities.

In October 2001, the new “30 baht scheme” was initiated to provide universal healthcare coverage. This scheme allows Thai people to access health facilities and medical system by paying 30 Baht for each visit. The coverage of the 30 baht scheme before 1 October 2005 included only treatment for opportunistic infections and PMTCT.

Although the MOPH produces more than 8,000 professional nurses each year, this number is still inadequate to meet healthcare needs. The regions facing this disparity are the North East and North.<sup>4</sup> Thailand’s public health service is divided into five levels with respect to the level of care available.

Self-care level: This level encourages people to provide self-care and make decisions about their health. It aims for the greater utilisation of public and private health facilities.<sup>5</sup>

Primary Healthcare level: This level is the primary healthcare service organised by the community to provide services for health promotion, disease prevention, curative care and rehabilitative care. It is organised by the local people called VHVs or non-governmental volunteers in response to community’s need and culture.<sup>6</sup>

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<sup>4</sup> WHO: Country Health Profile, Thailand

<sup>5</sup> Bureau of Health Policy and Plan, *Thailand Health Profile 1999-2000*, (Ministry of Public Health: Bangkok), 317.

<sup>6</sup> *Ibid.*, 318.

Primary care level: This level of care is provided by health personnel and general practitioners (GPs). The primary care units are classified into 4 categories.

1) Community health post: a village level health service unit in remote areas, covering a population of 500 to 1,000.

2) Health Centres: a sub-district village health service unit or a first-line unit, covering a population of about 1,000-5,000. Under the technical supervision and support of the community hospital, health centre staff organise health programmes according to the standard procedures set down by the MOPH.

3) Health Centres of Municipalities, Outpatient Departments of Public and Private Hospitals at all Levels, and Private Clinics: at these facilities, outpatient care is provided by physicians and other health professionals.

4) Drugstores: primary care level provided by pharmacists or pharmaceutically-trained personnel.<sup>7</sup>

Secondary Care level: This level is provided by medical and health personnel with degree of specification. It is categorised as:

1. Community hospitals: located in a district or sub-district, the hospitals provide 10 to 150 inpatient beds, covering a population of 10,000 or more with doctors and health professionals.

2. General or Regional Hospitals and Other Large Public Hospitals: a general hospital in this category is equipped with 200 to 500 beds, while a regional hospital has over 500 beds and medical specialists in all fields.

3. Private Hospitals: Most private hospitals are operated as a business enterprise with both full-time and part-time staff, and clients are required to pay for the services.<sup>8</sup>

Tertiary Care: With specialised medical and health professionals, tertiary care facilities include regional hospitals, general hospitals, university hospitals, and large private hospitals.<sup>9</sup>

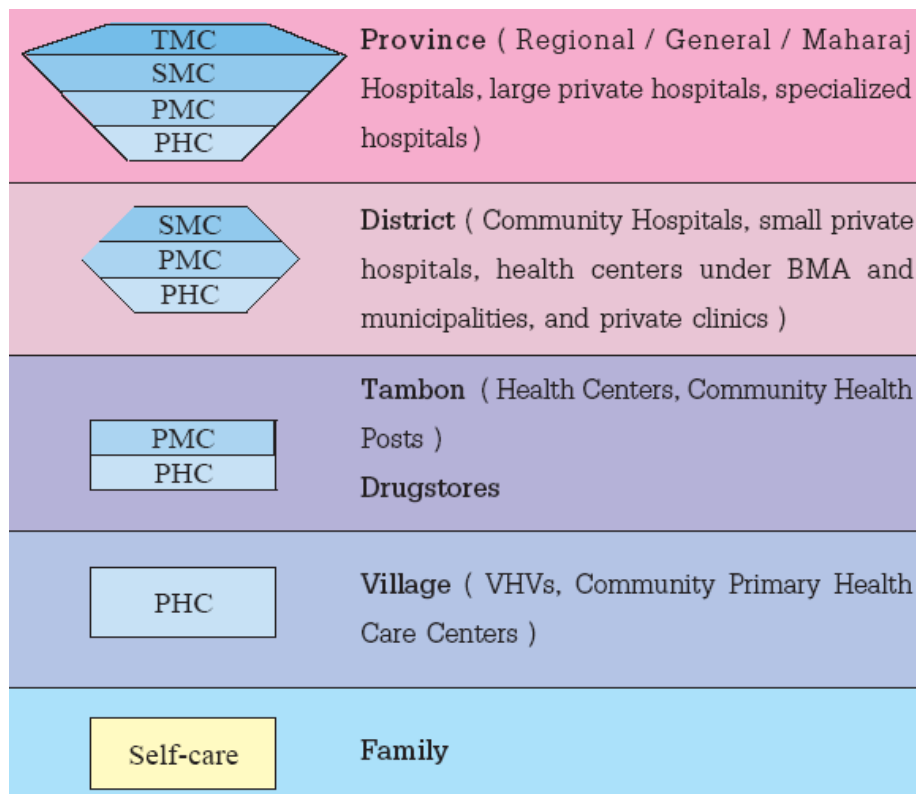
### **Figure 2.1: Level of Health Services in Thailand**

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<sup>7</sup> Ibid.

<sup>8</sup> Ibid.

<sup>9</sup> Ibid., 319.

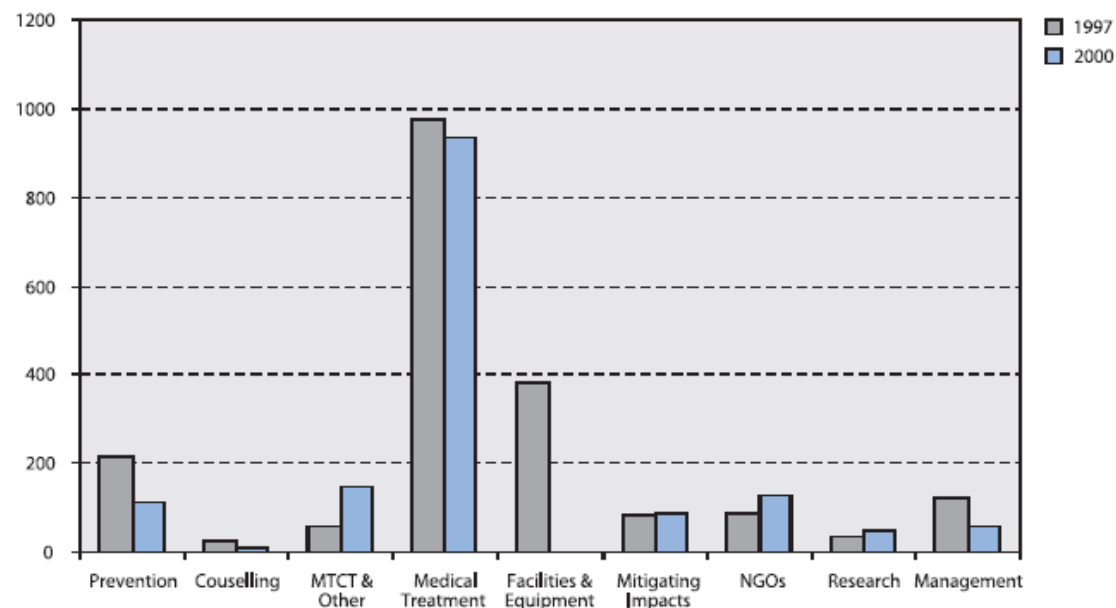


Source: Thailand Health Profile 1999-2000, Bureau of Health Policy and Plan

The Thai health policy is a part of the Health Development Plan, which falls under the National Economic and Social Development Plan. At present, the Thai health policy is part of the 9<sup>th</sup> national plan 2002-2006. This plan emphasises a people-centred development approach. Moreover, it aims to develop health infrastructure and services with new technologies and a universal standard health insurance, to enhance the quality of life, and to extend service coverage to all population groups so as to efficiently respond to people's needs. Integrally, the strategies are inter-linked with the economic, social, political, cultural and environment domains for the implementation of health programmes.

The MOPH budget has been increased throughout the past decade. This was due to the reduction of foreign loan repayment and security expenditure. There was thus more money available to finance social activities until the economic crisis in 1997. As a consequence of the economic crisis, the foreign debt increased from 5% in 1997 to 10.9% in 2001. The Ministry of Public Health was also allocated a smaller budget in 2001; 58,697.2 million Baht was allocated together with 2,400 million Baht to subsidise the health card revolving fund, which was 61,097.2 million Baht or 6.7 percent of the national budget. In real terms, the 2001 budget was less than in 1996 and notably there were a significant number of foreign loans received during the 1997-2001 period. The budget for HIV and AIDS was adjusted accordingly between 1997 and 2000. Figure 2 shows that the highest amount was still spent on medical treatment, whereas the lowest amount of funds probably being used for counselling. Twenty-five million USD was allocated to 50,000 patients enrolled in the NAPHA programme for 2004.

**Figure 2.2: Details of HIV/AIDS budgets, 1997 and 2000**



Sources: The Bureau of the Budget, *The Budget Act* (various years); Ministry of Public Health; and, NESDB

Thailand has adopted the WHO model of national drug policy (NDP) since 1976. The second version of NDP was launched in 1993. The latest essential drug list was approved in December 2004. ARV drugs were included in the list.

The strong policy for equity and access is reflected in the inclusion of ARV drugs in the benefit package of universal coverage, which was due to start 1<sup>st</sup> October 2005.

### 2.3 History of the AIDS epidemic and control

The first AIDS case in Thailand was reported in September 1984. As of 2004, out of the total population of 63 million, 500,000 Thai people had already died from the disease, about one million were known to be infected by the virus and more than half a million are presently living with HIV/AIDS.

#### *Estimated Numbers of HIV/AIDS in the year 2004*

Cumulative HIV infections (adult and children) <sup>10</sup>	1,074,155	
Cumulative Deaths (adults and children)	501,600	
PWHA		572,500
New HIV infections in 2004	19,500	
New AIDS cases in 2004	49,500	
AIDS orphans <sup>11</sup>	34,372	

<sup>10</sup> Thai Working Groups on HIV/AIDS Projection 2000

<sup>11</sup> The Global Orphan Project, MOPH

Thus far five waves of the HIV epidemic have been reported in Thailand. The first began in 1984 when the first case of AIDS was reported in September among homosexuals and bisexuals. The explosive spread of HIV infection among intravenous drug users (IDUS) in 1987 and 1988 marked the second wave. The virus then spread among sex workers and their clients in 1989 to 1990, which meant that heterosexual transmission became increasingly important and began the third and fourth waves. Between 1990-1991, when cases of mother-to-child transmission with increasing numbers of infected newborn were reported from the provinces, the epidemic entered its fifth phase<sup>12</sup>.

In coping with the epidemic during the past 20 years, a lot of work has been done including a 100% condom use campaign and other preventative measure such as 100% condom and syringe exchange. In addition, Thailand has also made some progress in moving towards the National Access to Antiretroviral Programme for PLWHA (NAPHA), which intends to improve the quality of lives of PLWHA.

#### **2.4 ARV Situation in Thailand**

The total number of PLWHA in Thailand in need of ARV drugs is still uncertain. At present, approximately 70,000 of them receive the drugs in the public sector (See Table 2.2). Most of those receiving these drugs fall under the government/public programmes such as NAPHA (change to UC thereafter), SSO, TRC, and others small sources. Several small programmes also provide ARV drugs to PLWHA; the scope and number of patients involved in these are currently unknown. Moreover, it is unclear how many people are receiving ARV drugs through private health facilities.

Table 2.2 shows the chronology of ARV provision in Thailand, including the number of patients that have been reached through each of these initiatives. Number for each year showed already cumulative figure.

#### **Table 2.2 Chronology of ARV treatment programmes and initiatives**

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<sup>12</sup> MOPH (2004) Executive summary HIV/AIDS in Thailand

Year	Activities	Number of Patients (Approximately)
1991/1992	MOPH started ARV provision as pilot and as mono-therapy	
1995	Dual therapy	
1996	Thai Red Cross AIDS Research Centre started MTCT	
1997	Started network of ARV research	
1999	GPO submitted a request for a compulsory licence to override patents and produce generic to the Thai Department of Intellectual Property	
2000	- MOPH started programme development for service and treatment of PLWHA (ATC) - TNP+, Access and MSF began providing education on treatment within their own community and cooperating with healthcare system to prepare for wider availability of treatment. -MSF started ART in Thailand 2000 (home-based care), 2001 (hospital)	
2001	- Access to Care 109 hospitals	3,600
2002	- Expand ATC to 430 hospital - Applied for Global Fund ATM by Thai MOPH as first round - 2 Thai PHA won legal case on Didanosin patent over Bristol-Meyers Squibb	13,000
2003	- NAPHA started with activities as follows 1. Planning 2. Development of guidelines 3. Training 4. Support of ARVs 600 hospitals 5. Support of CD4 6. Health facilities start working 7. Monitoring and evaluation - Started CARE project	23,000
2004	- SSO announced the policy and guideline for PLWHA beneficiary	50,752

Year	Activities	Number of Patients (Approximately)
	- Prime Minister Taksin gave his assurance that people affected by AIDS in Thailand would have access to ARV.	
2004-2005	Global Fund (MOPH) (round 1) and Raks Thai Foundation (round 3) programme implementation	
2005	As of Feb 2005 for NAPHA	52,593
2006	NHSO announced the inclusion of ARV drugs into the national universal coverage scheme (UC)	> 70,000

### NAPHA

NAPHA is considered a major player in the antiretroviral programme in Thailand. It originated from ATC (Access to Care) programme. In 2000, the Thai government, along with Global Fund, designated the ARV programme, NAPHA. The programme aims to give ARV drugs to PLWHA in Thailand. NAPHA is made up of five sub-programmes:

- 1) ATC for adults, both new and experienced cases
- 2) PATC for children
- 3) PMTCT plus (care)
- 4) Co-payment
- 5) Research

### Social Security Office

The Social Security Scheme provides insurance for its members with respect to the suspension or reduction of earnings as result of sickness, maternity, death, invalidity, old age and unemployment, the provision of medical care and the provision of child allowance. On 30<sup>th</sup> June 2004, a regulation on HIV was introduced, which allows SSO members to obtain access to ARV drugs under the registered

hospitals (both public and private hospitals, and private clinics). The process started in August 2004 and approximately 20,000 people are expected to access ARVs in 2006.

### Thai Red Cross AIDS Research Centre

The Thai Red Cross AIDS Research Centre (TRCARC) was established in 1989 by the Thai Red Cross Society to coordinate various HIV/AIDS related activities. TRCARC ARV programmes are divided into two main programmes: MTCTplus (Columbia University + Princess Soamsawali Foundation), and HIV-NAT (Clinical trial).

### MSF

Medecins Sans Frontieres (MSF) started using ARV drugs in the HIV/AIDS programme in Thailand in 2000, as one of the first two MSF programmes in the world. The MSF ARV programme aims to provide a comprehensive package of care to PLWHA. This includes prevention efforts (health education, prevention of mother-to-child transmission of HIV, condom distribution), voluntary counselling and testing (VCT), nutritional and psychosocial support, treatment and prophylaxis opportunistic infections, and ARV treatment. The MSF programme is divided into two programmes: MSF-France, and MSF-Belgium. MSF-France provided ARV in Surin Provincial Hospital and planned to start a treatment programme in Mahasarakam soon, whereas MSF-Belgium provided ARV drug therapy in 4 areas: Prachomkloa Provincial Hospital in Petchaburi Province; Baan Laem Community Hospital in Petchaburi Province; Bang-kruai Community Hospital in Nonthaburi Province; and Guccinarai Community Hospital in Kalasin Province. As of June 2003, only 615 patients had thus far received ART through MSF supported hospital and home-based care. MSF-B also runs a home and community care project in Bangkok for PLWHAs who get limited access to health services. Target groups are women prisoners and migrant workers. ARV are provided together with other palliative care and crisis intervention.

**Table 2.3 Number of PLWH Receiving ARV in Thailand by 2005**

<b>Programme</b>	<b>Organisation</b>	<b>Recruitment</b>	<b>Current Situation</b>	<b>Thai resource</b>	<b>Donor support</b>
NAPHA	CDC	All Thai PLWHA	- Major provider in Thailand - Will be included in universal coverage soon. - Plan to give ARV to 80,000 PLWHA this year.	42,371	10,222 (GFATM)
SSO	Social Security	Social Security Members-	Implement as vertical programme.	10,915	

## Country context

MTCT +	Office Thai Red Cross AIDS Research Centre	PLWHA mothers and their family members	- Plan to sub-contact to CDC. -Columbia University -HRH Princess Soamsawali Foundation	Appx339 currently June 2005	
Civil Servant Medical Benefit Scheme(CSMBS)		Civil servant	N/A	N/A	
MSF	MSF	No new recruitment.	The patients switch to NAPHA programme, but continue giving PI to patient who cannot enrol to NAPHA Programme	-	124 (MSF)
Clinical Trial	HIV-NAT			-	1,800 (HIV-NAT)
	PHPT				1,500 (GF)
	Others				NA (Trials)
Others	Out of pocket	N/A	N/A	N/A	N/A

## 2.5 Strength of civil society - past and present involvement in AIDS issues

The AIDS NGOs have played crucial role in dealing with the AIDS epidemic in Thailand. NGOs have become an influential driving force for social mobilisation in addition to public sector agencies. They have led the public sector to eagerly seek collaboration by exchanging knowledge and operational techniques to maximise operational efficiency.

In 1989, the Thai NGO Coalition on AIDS was initially formed in order to exchange experiences and information, to reduce duplication of work and assemble a stronger collaboration and to sponsor campaigns. As a result of the AIDS epidemic, the number of AIDS NGOs has steadily increased. In 1984, there were just 50 AIDS NGOs. By 2001, 248 of such NGOs had registered with the MOPH.<sup>13</sup> The number of NGOs have thus increased, along with the networks for PLWHA.<sup>14</sup>

Both NGOs and PLWHA networks have tried hard to reduce the level of social discrimination. Moreover, there are NGOs that deal specifically with groups that are vulnerable or hard to reach: intravenous drug users, men who have sex with men, and migrant workers. These organisations pioneered community based efforts at the local level.

Unlike other nations, AIDS NGOs in Thailand participate in the process of AIDS policymaking and programme design. In addition to being funded by international donors, AIDS NGOs also receive funding from the AIDS division budget, which has been allocated to support NGO projects.<sup>15</sup>

Since the 1980s, AIDS has been recognised as a serious health issue in Thailand and has thus been made a priority. As a result, the National AIDS Prevention and Control Committee was established in 1991. The National Committee also formed provincial (in 1992/1993) and regional (in 1994/1995) committees to help manage the response, and has also drawn up a consolidated HIV/AIDS action plan for public agencies.<sup>16</sup>

The first five-year National AIDS Plan (1992-1996) was introduced. This was the result of the collaborative efforts between Thai government and NGOs. Anticipating the link between AIDS and the country's social economic development, the AIDS plan was integrated into Thailand's five year development plan.<sup>17</sup>

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<sup>13</sup> Bureau of Health Policy and Plan, *Thailand Health Profile 1999-2000*, (Ministry of Public Health: Bangkok) p. 383.

<sup>14</sup> According to Penjan Pradamuk's work on AIDS NGOs in Thailand (1996), AIDS NGOs in Thailand are categorised into 7 groups: Public organisations, Development organisations, Professional associations, People's organisations, Academia and official associations, Networks, and NGO support organisation.

<sup>15</sup> The AIDS Division allocated 87.5 million baht to the 465 projects of 373 organisations in 1999. Although that funding diminished to 60 million baht the following year, the shortfall was made up by the AIDS component of the World Bank loan under its Social Investment Programme, which steered another 27 million baht to projects in six main NGOs. (Source: Thailand's Response to HIV/AIDS: Progress and Challenges: UNDP, 2004.)

<sup>16</sup> UNDP, *Thailand's Response to HIV/AIDS Progress and Challenges*, 2003.

The Thai government's response to AIDS was presented in the 8<sup>th</sup> National Economic and Social Development Plan (1997-2001). This plan corresponded with the existing national AIDS plan. It called for the collaboration of all sectors: government, NGOs and local communities. In particular, it aimed to reduce the AIDS epidemic and factors that effect socio-economic. The concept of civil society was introduced along with the community-based development.

In 2002, the 9<sup>th</sup> National Economic and Social Development was launched (2002-2006). It aimed to substantially strengthen the capacity of community-based development in collaboration with other sectors. This new national AIDS plan focuses on developing the capacity of human resources - family and community - to prevent AIDS; creating health facilities and care; increasing international collaboration; and using holistic management.

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<sup>17</sup> Ibid

### **III. MAJOR CHARACTERISTICS OF TWO SELECTED ARV TREATMENT PROGRAMMES**

#### **3.1 Introduction**

The Thai country study focused specifically on the ARV treatment programmes supported by the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) and Medicins San Frontieres (MSF). Other agencies supporting ARV provision in Thailand are the Social Security Scheme (SSS), and Charity organisations (Faith Based Organisation (Camillian Centre), Foundation (ACCESS, ALDEN), and etc.).

Both the Global Fund and MSF interact closely with NAPHA (National ARV Access Programme for People Living with HIV/AIDS), the MOPH's national public programme. Indeed, NAPHA provides the bulk of funding for the THAI treatment programmes. The Global Fund programme aims to strengthen the public service provision in the infrastructure to ensure that the treatment programme will be sustainable. The MSF programme played a key role in developing the ARV programme with technical specialist support.

ARVs were included in the NAPHA in 2000 and since October 2005, ARVs in Thailand are covered by the national 30 baht scheme or universal coverage. This was promised by the Prime Minister or Health Minister at the World AIDS conference in Bangkok in 2004. At the time, drugs to treat opportunistic infections had already been included in universal coverage but ARV treatment was not considered in the UC budget managed by MOPH.

#### **3.2 Global Fund/NAPHA involvement in Thailand**

The Thai CCM submitted the first proposal in 2002. In total, the Thai government and NGOs have received the funding in three rounds (Round 1, 2 and 3). Interestingly, only one NGO applied during round 3. Round 5 proposals from the MOPH coordinating mechanism were sent from the CCM and underwent review by Global Fund. Thailand has two principal recipients - MOPH and Raksthai Foundation. Although this is not uncommon, some people raised concerns about the collaboration between these two principal recipients and the cooperation of all stakeholders with them. All programmes approved from Global Fund for Thailand are shown in Table 3.1.

**Table 3.1 All programmes in Thailand supported by Global Fund ATM (round 1-3)**

## PPI Characteristics

Grant number (Click for Grant Data Sheet)	Round	Disease component	Applicant	Principal Recipient	Grant Title	Grant Amount, Years 1-2	Rating: Months ahead of or behind schedule
<a href="#">THA-102-G01-H-00</a>	1	HIV/AIDS	CCM	The Department of Disease Control, Ministry of Public Health of the Royal Government of Thailand	Strengthening National Prevention and Care of HIV/AIDS	\$30,933	B: 0.3 months behind
<a href="#">THA-102-G02-T-00</a>	1	Tuberculosis	CCM	The Department of Disease Control, Ministry of Public Health of the Royal Government of Thailand	Strengthening National Prevention and Care of Tuberculosis	\$6,999	D: 8.8 months behind
<a href="#">THA-202-G03-H-00</a>	2	HIV/AIDS	CCM	RAKS THAI FOUNDATION	Prevention of HIV/AIDS Among Migrant Workers in Thailand (PHAMWIT)	\$5,993	D: 8.7 months behind
<a href="#">THA-202-G04-H-00</a>	2	HIV/AIDS	CCM	The Ministry of Public Health of the Government of Thailand	Enhancing HIV-Related Care and Treatment (ECAT) for HIV-infected Mothers and their Partners and Children	\$14,079	D: 15.4 months behind
<a href="#">THA-202-G05-M-0</a>	2	Malaria	CCM	The Ministry of Public Health of the Government of Thailand	National Prevention and Control Programme on Malaria in Thailand.	\$2,280	D: 9.1 months behind
<a href="#">THA-304-G06-H</a>	3	HIV/AIDS	NGO	RAKS THAI FOUNDATION	Preventing HIV/AIDS and Increasing Care and Support for Injection Drug Users in Thailand	\$911	C: 4.7 months behind

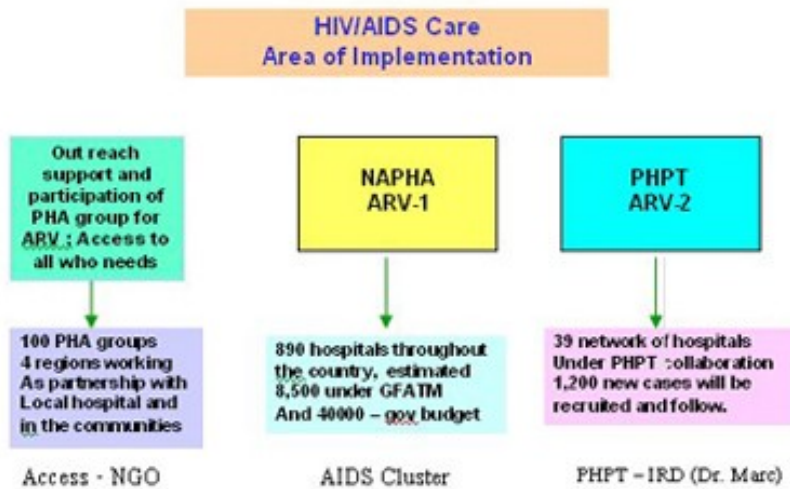
Source: <http://www.aidspace.org/grants/thailand.htm>

### 3.2.1 Brief History of GF ATM/NAPHA

Programmes that applied for HIV/AIDS include those for care of AIDS patients (Figure 3.1) and AIDS prevention (Figure 3.2). HIV/AIDS Care includes 3 areas of implementation

- Outreach support and participation of PLWHA group for ARV: access to all who need these drugs. The implementer is the Access foundation, which is an NGO. This programme was run in collaboration with others such as MSF
- NAPHA ARV-1 is implemented by AIDS cluster of the Bureau of AIDS, TB, and STI of Department of Disease Control (MOPH)
- PHPT (Program for HIV Prevention and Treatment) ARV-2 is run by PHPT-IRD (Dr. Marc based in Chaing Mai province). Activities include a network of 39 hospitals under PHPT collaboration. Approximately 1,200 new cases will be included.

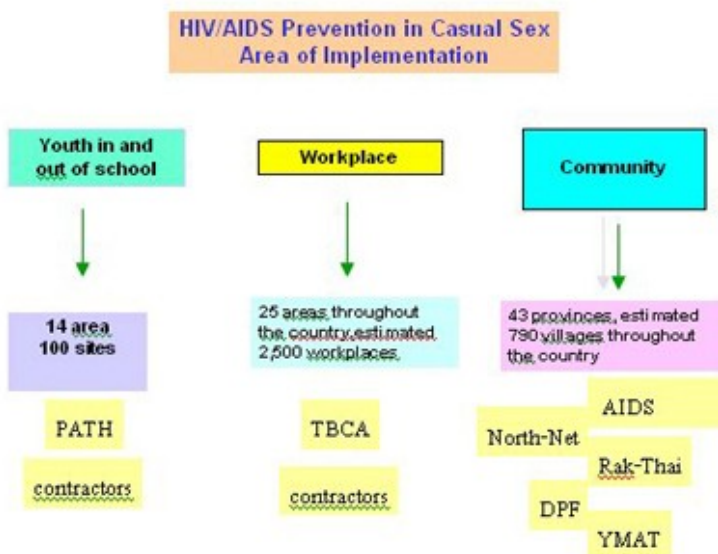
Figure 3.1 HIV/AIDS Care Area of Implementation in Thailand (Round 1)



Source: [http://www.aidsthai.org/globalfun\\_new02.html](http://www.aidsthai.org/globalfun_new02.html)

Figure 3.2 HIV/AIDS Prevention Programme of Global Fund in Thailand

ภาพที่ 3 แสดง การดำเนินงานโครงการด้าน HIV/AIDS Prevention

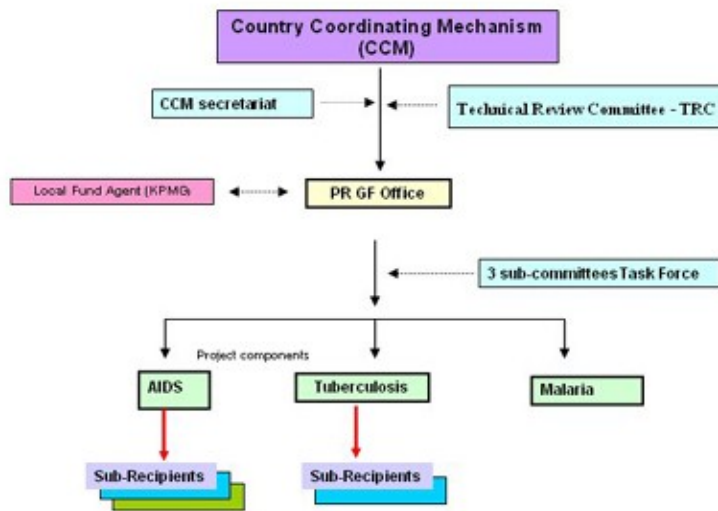


Source: [http://www.aidsthai.org/globalfun\\_new02.html](http://www.aidsthai.org/globalfun_new02.html)

### 3.2.2 Structure and Objectives

Figure 3.3 depicted the relationship between country coordinating mechanism and principal recipient in the MOPH. There is also secretariat section in the Bureau of AIDS, TB, and STI.

**Figure 3.3 Structure of Global Fund in Thailand**



[http://www.aidsthai.org/globalfun\\_new04.html](http://www.aidsthai.org/globalfun_new04.html)

The purpose of the Global Fund is to attract, manage and disburse additional resources through a new public-private partnership, which will make a sustainable and significant contribution to the reduction of infections, illness and death, thereby reducing the impact of HIV/AIDS, tuberculosis and malaria on countries in need, and contributing to poverty reduction as a part of the Millennium Development Goals. **The Global Fund does not implement programmes directly**, instead it relies on the knowledge of local experts<sup>18</sup>.

The key objectives of the Global Fund include:

- Operating as a financial instrument, not an implementing entity.
- Ensuring the availability and controlling additional financial resources.
- Supporting programmes that reflect national ownership.
- Operating in a balanced way in terms of different regions, diseases and interventions.
- The pursuit of an integrated and balanced approach to prevention and treatment.
- Evaluating proposals through independent review processes.
- Establishing a simplified, rapid and innovative grant-making process and operating transparently, with accountability.

The goal of the Global Fund programme round 1 (CARE section) submitted by the Thai MOPH is to strengthen and maintain the prevention of disease transmission, particularly with respect to the youth, the itinerant population and workplaces and to integrate, strengthen and expand services of comprehensive care/support, including ARV treatment.

Moreover, it ensures that the funds are utilised for the following activities:

<sup>18</sup> <http://www.theglobalfund.org/en/about/how/>

- Institutionalised commitment to policymaking and the development of strong collaboration among all stakeholders in Thai society;
- Improving access to and the use of services including ARV treatment, reproductive health and condom provision;
- Integrating, strengthening and expanding a sustainable system of ongoing comprehensive care and support, including ART delivery within the national health system;
- Providing a supportive social environment to PLWHA.

*Objectives of HIV/AIDS care include:*

- Comprehensive HIV/AIDS care and support throughout the continuum
- The improvement of the technical and healthcare system capacity
- Supporting and strengthening the PLWHA network so that its members have the necessary knowledge, skills and resources to be able to participate as equals

### *3.2.3 Treatment coverage vis a vis targets, and estimated need*

The projected results of this care component include an increase in the number of HIV infected people taking ARV from a baseline of 3,000 to 69,337 in 2006.

The Global Fund/NAPHA's present activities aim to accelerate the expansion of services to all medically eligible HIV/AIDS patients by establishing an achievement benchmark for ARV expansion. By 2004, a target of 50,000 patients was set. The government's budget for medicines covers 40,000 patients, and the remaining 10,000 patients are supported by the Global Fund. In March 2004, there were 30,430 people receiving ARV through NAPHA. It is anticipated that by the end of 2005, the target will have been achieved.

**Table 3.2 ARV provision in Thailand**

ARV Programme	Number of patients	As of
NAPHA and Global Fund	52,593	Feb 2005
Social Security Office	8,000	(apx)
HIV-NAT	1,850	Jan 2005
MSF	615*	as of 2003
MSF-PDA	60	
TRC-1 MTCT Plus	678 currently	March 2005
TRC-2 PMTCT	328 currently	March 2005
Others/ clinical trial/ private clinic	n/a	

Note: \* now partly included into NAPHA programme

These figures provide a summary of the country's capacity, including NAPHA and Global Fund programmes.

- ARV sites expanded to > 900 hospitals

- 54 out of 76 provincial hospitals had a CD4 facility in 2004. Seventy machines were already in place. CD4 facility expanded from 19 to 53 hospitals with US\$1.25M for reagents
- Viral load only in Bangkok, Chiang Mai, Khon Kaen and Udorn Thani (14 in public and 7 in private)
- Genotypic resistance was found only in 3 university hospitals in Bangkok (One at Chulalongkorn University, and two at Mahidol University)
- TDM was only available at HIV-NAT (Bangkok)
- Large scale training of doctors and nurses with the accelerated training of ARV prescribers

The channels, through which ARV drugs are reported to be provided using Global Fund ATM resources, are the network of public health facilities in selected provinces (Table 3.3). In sum, 10 regional hospitals, 12 general hospitals, and 174 community hospitals were enrolled, providing 10,222 patients for this programme.

**Table 3.3: Global Fund province and number of PLWHA in 2004**

No.	Provinces	Number of hospitals			Number of patients
		RH	GH	CH	
1.	Ayudhaya	1	1	14	374
2.	Pathumthani	-	1	7	471
3.	Saraburi	1	1	10	532
4.	Suphanburi	1	1	8	509
5..	Ratchaburi	1	3	6	762
6.	Prachuab Kirikhan	-	1	7	418
7.	Chaiyaphume	-	1	14	587
8.	Surin	1	-	12	952
9.	Kon Kaen	1	-	21	1,792
10..	Udornthani	1	-	18	804
11.	Roy Ed	-	1	16	630
12.	Nakorn Sawan	1	-	12	544
13.	Naan	-	1	12	474
14.	Pukhet	1	-	2	386
15.	Songkla	1	1	15	987
	Total	10	12		10,222

RH = Regional hospital (>500 beds include also university hospital), GH = General hospital (160-500 beds), CH = Community hospital (10-149 beds), \* = DC centre

However, the NAPHA has already been implemented in the MOPH network as shown in table 3.4.

**Table 3.4: NAPHA network in 2004**

RDCC	Province Centre	Number hospitals				Number patients	
		RH	GH	CH	OH	Expect	Result
1	BKK	1	5	36		4,020	1,774
2	Saraburi	2	8	39		2,337	1,316
3	Cholburi	3	4	54		5,304	2,829
4	Ratchaburi	2	9	43		4,679	2,678
5	Nakorn Ratchasima	2	3	82		2,821	2,110
6	Kon Kaen	2	6	95		2,286	3,160
7	Ubon Ratchathani	nil	6	82		2,701	2,527
8	Nakorn Sawan	1	6	42		1,988	1,150
9	Pitsanulok	2	4	53		2,817	1,754
10	Chiang Mai	3	4	67		7,232	7,232
11	Nakorn Srithammarat	2	7	65		3,224	2,063
12	Songkla	3	7	63		2,815	1,564
BKK	-	0	0	0		5,830	3,060
PHPT	ChiangMai	0	0	0		1,500	756

Note: RDCC = Regional Disease Control Centre

BKK not under MOPH rather covered by local authority (BMA) and universities

RH = Regional hospital, GH = General hospital, CH = Community hospital

Table 3.3 and 3.4 demonstrates that NAPHA supports around three times more patients than the Global Fund. In Thailand, the government pays the bulk of the ARV programme.

### 3.2.5 Structure and role of CCM

According to the Global Fund, the Country Coordinating Mechanism (CCM) is central to its commitment to **local ownership** and **participatory decision-making**. These **country-level partnerships** develop and submit grant proposals to the Global Fund, which are based on priority needs at the national level. After grant approval, they oversee the progress of projects during the implementation process.

The Global Fund believes that the CCM should include representatives from both the **public and private sectors**, including governments, multilateral or bilateral agencies, non-governmental organisations, academic institutions, private businesses and people living with the diseases. Figure 3.4 depicted the model in Thailand as public/civil society model proposed by GF.

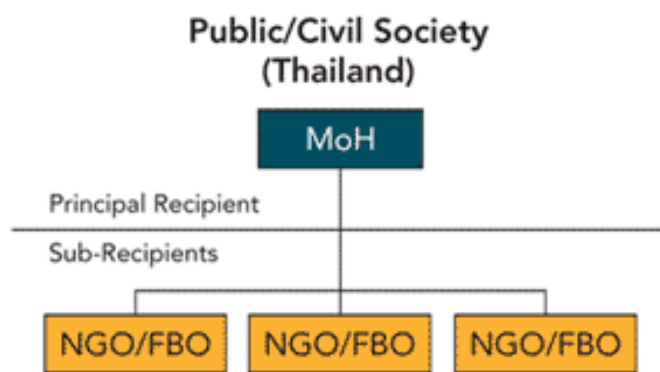
There are 2 principal recipients in Thailand: the MOPH and Raks Thai Foundation which differ from the other countries. So there are 2 Country Coordinating Mechanisms, one from MoPH which acts as nation CCM, and the second is Raks Thai Foundation Project Advisory Committee (PAC) is the non-CCM status.

The Thai CCM consists of 25 members and is dominated by the government representatives: 10 members are from the government, 4 are specialist experts, 7 are from NGO/FBOs, 3 are from international organisation, and 1 member was from the industrial sector. In 2002 (round 1), the CCM chairman was a former deputy Minister of Public Health, but now (round 3) this position has been filled by the Permanent Secretary of the

MOPH. Some interviewees contended that the CCM is not really a collaboration between stakeholders. It was dominated by governmental representatives (MOPH), rather than PLWHA groups or civil society. While one interviewee regarded this as a flexible and practical form of management, another deemed the Thai CCM to be an honorary committee with a bureaucratic approach, which has a conflict of interest and is not independent given that it is controlled by the MOPH

The Raks Thai Foundation PAC consists of 16 members that represent government, NGOs/CBO, PLWHA groups, and multilateral or bilateral development partners in the country. Academia, private, and FBO are not included yet.

**Figure 3.4 Public/Civil Society Model of CCM in Thailand**



Source: <http://www.theglobalfund.org/en/apply/mechanisms/structures/#ccm12>

### 3.2.5 Management of Global Fund/NAPHA

For each grant, the CCM nominates one or a few public or private organisations to serve as the **principal recipient**. This principal recipient will be legally responsible for the local implementation of the grant, including the management of sub-recipients' grant funds and communications with the CCM with respect to grant progress.

The principal recipient also works together with the secretariat to develop a two-year **grant agreement**, which identifies the programme **results to be achieved** over time. Over the course of the grant agreement, the principal recipient requests additional **disbursements** that are based on **demonstrated progress** towards achieving the projected results. This **performance-based system** of grant allocation is key to the Global Fund's commitment to achieving results.

The Global Fund Office at the MOPH has 4 sectors (see Figure 3.5)

- Programme and interventions management
- Financial management system
- Procurement, logistic and supply system
- Technical support, monitoring and evaluation

All four sectors are run by a general administration sector.

#### Implementing partners

- Government: Ministry of Public Health, Ministry of Education, Ministry of Interior, Ministry of Labour and Social Welfare.
- NGOs: Thai Network for People Living with HIV/AIDS, Thai NGO Coalition on AIDS, and so forth.
- Civil society: National Youth Bureau, Community Base Organisation, and etc.
- Private sector: Factory owner, The Employers’ Confederation of Thailand (ECOT), and Labour Confederation of Thailand
- International agencies: UN agencies, i.e. WHO, UNAIDS, UNFPA), TUC, FHI

**Figure 3.5 Global Fund Management Office for Principal Recipient (MOPH)**



Raks Thai Foundation however has different management system. Four programme representatives are included in non-CCM PAC and met among the four programmes separately. However, most of the work are about prevention and not that much on ARV provision and will not be included in the study.

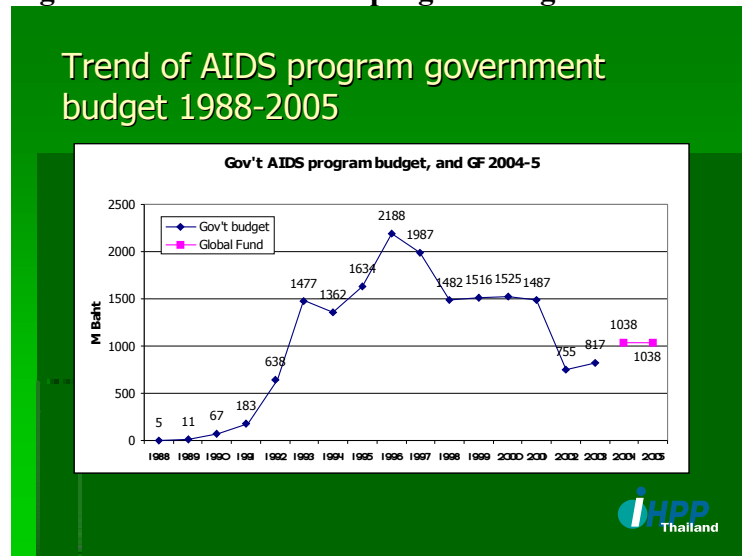
### **3.2.6 Plan and resources for Global Fund ARV treatment programmes**

Although the round 1 proposal was approved in 2002, budget disbursement and the implementation of ARV provision only began in 2004. One key informant complained that payment was delayed by the Global Fund, but the country was nevertheless still required to report on their planned activities without the new allocation time being taken into account. This led to problems with respect to programme management.

The governmental budget for AIDS showed an increase in expenditure until 1996 to a total of 2193 million Baht. This then gradually declined to under 1,000 million Baht. In 2004 and 2005, the Global Fund provided a similar amount, see figure 3.6. In contrast, the government’s ARV drug budget increased gradually. By 2004 and 2005, it had

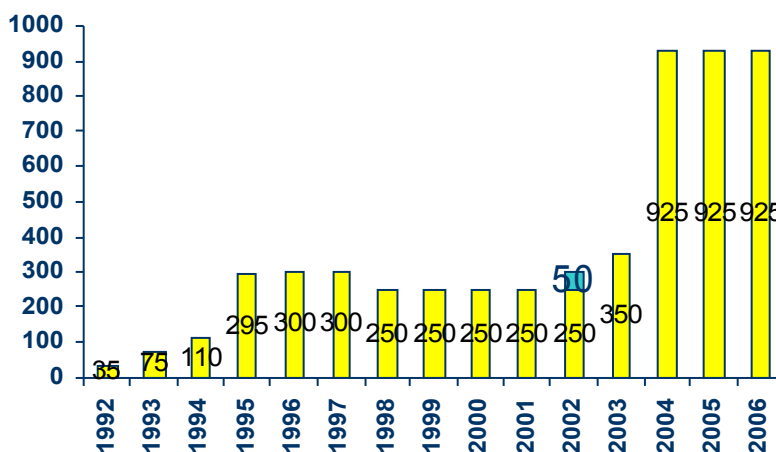
doubled, and is expected to remain at the same level in 2006 (Figure 3.7). It was also found that percentage of OI drugs in total HIV/AIDS expenditure decreased from 48.6 in 2000 to 32.8 in 2003 while ART increase from 19.3% in 2000 to 45.6 % in 2003<sup>19</sup>.

**Figure 3.6 Trend of AIDS programme government budget FY 1988-2005**



Source: Waranya Teukul et al (2004)<sup>20</sup>

**Figure 3.7 ARV budget 1992-2003 and projected budget for 2004-2006, Thailand**



Source: Praphan Panupak (2004)<sup>21</sup>

<sup>19</sup> Waranya Teukul et al (2005) Thailand National AIDS Account 2000-2003, access from [www.ihpp.thaigov.net/7\\_September\\_2005/Thai\\_NAA\\_2000-3-07sep05.ppt](http://www.ihpp.thaigov.net/7_September_2005/Thai_NAA_2000-3-07sep05.ppt)

<sup>20</sup> Waranya Teukul at al (2004) National AIDS Account 2000-2003

The MOPH's ARV budget is divided into 3 categories. ARV drugs account for around 40-60 % of the total budget. The remaining funds were spent on training, database management and laboratory facilities.

**Table 3.5 Budget for ARV Programme**

Main activities	Budget (Million Baht)				
	Training, database management, monitoring & evaluation, and public relations	ARVs	Labs	Others	Total
FY2001	132	363	294		789
FY2002	138	167	129		434
FY2003	121	356	149		626
FY2004	194	664	131		989
FY2005	63	996	29	100	1,208

Source: Panumas Yanwessakul *et al* (2005)<sup>22</sup>

### **3.2.7 Selection, procurement and distribution of ARVs in Global Fund PPI**

All selection, procurement, and distribution are carried out by the NAPHA. There was no separate process for the Global Fund.

In October 2002, the Global Fund's third board meeting made recommendations about the selection and rational use of fund resources. These may only be used to procure medicines, which are found in current national, institutional or World Health Organisation (WHO) standard treatment guidelines (STGs) or essential medicines lists (EMLs) or for Thailand called EDL (Essential Drug List). The relevant STG or EML should be included in the proposal submitted to the Global Fund. Unlisted products may only be procured if appropriate and specific grounds are presented in the proposal, which will be assessed by the Technical Review Panel (TRP).

Thailand incorporated the aforementioned Global Fund's protocol for ARV selection into its national guidelines. The list of drugs used in Global Fund and NAPHA is thus the

<sup>21</sup> Praphan Phanuphak (2004) Ensuring ART for TB patients: experiences from Thailand, access from [www.who.int/docstore/gtb/TBHIV/4thglobalwgmtg/strategic\\_issues/phanuphak\\_ensuring-art-tb.ppt](http://www.who.int/docstore/gtb/TBHIV/4thglobalwgmtg/strategic_issues/phanuphak_ensuring-art-tb.ppt)

<sup>22</sup> Panumas Yanwessakul *et al* (2005) Access to treatment for PLWHA with ARVs (in Thai)

identical. A committee was established to produce treatment guidelines and select the ARV drugs to be used in the national programme (Table 3.6).

As of 31<sup>st</sup> December 2004, there were only 13 items of ARV drugs registered in Thailand as conditioned new drugs which mean that the drugs required safety monitoring programme for safety study. In contrast, there were much higher numbers of non-conditioned new drugs used for treating HIV. These ARV drugs are not required to have compulsory safety study. See annex 6 for details of these two groups of ARV. The latest product catalogue is categorised into 4 groups. The costs of ARV and diagnostics produced by the GPO are indicated in July 2004 price list (see Table 3.6) and are claimed to have lower price compared to the newly launched drugs.

**Table 3.6 NAPHA ARV list FY 2004**

Generic name	Abbreviation	Package	Price (Baht)	EDL / NEDL
1. Zidovudine 100 mg Capsule	AZT 100 mg	Bottle (100 Cap)	600.00	ED
2. Zidovudine 300 mg Capsule	AZT 300 mg	Bottle (100 Cap)	1,700.00	ED
3. Zidovudine syrup 10 mg per ml	AZT syrup 10 mg/ml	Bottle (60 ml)	50.00	ED
4. Zidovudine 300 mg + Lamuvidine 150 mg	AZT 300 mg + 3TC 150 mg	Bottle (60 Tab)	1,500	NED
5. Didanosine buffered Powder for Oral Suspension 115 mg	ddi 115 mg	Box (30 sachet)	600	ED
6. Didanosine buffered Powder for Oral Suspension 167 mg	ddi 167 mg	Box (30 sachet)	840	ED
7. Nevirapine 200 mg + Lamuvidine 150 mg + Stavudine 30 mg	GPO vir S 30	Bottle (60 Tab)	1,200	ED
8. Nevirapine 200 mg + Lamuvidine 150 mg + Stavudine 40 mg	GPO Vir S 40	Bottle (60 Tab)	1,320	ED
9. Lamivudine 150 mg tablet	3TC 150 mg	Bottle (60 Tab)	600	ED
10. Lamivudine syrup 10 mg/ml	3TC syrup 10 mg/ml	Bottle (60 ml)	60	ED
11. Nevirapine 200 mg Tablet	NPV 200 mg	Bottle (60 Tab)	900	ED
12. Nevirapine Powder for Oral Suspension 10 mg/ml	NPV suspension 10 mg/ml	Bottle (60 ml)	36	ED
13. Stavudine 15 mg Capsule	d4T 15 mg	Bottle (60 Cap)	150	NED
14. Stavudine 20 mg Capsule	d4T 20 mg	Bottle (60 Cap)	150	ED
15. Stavudine 30 mg Capsule	d4T 30 mg	Bottle (60 Cap)	210	ED
16. Stavudine 40 mg Capsule	d4T 40 mg	Bottle (60 Cap)	270	ED
17. Stavudine Powder for Oral Suspension 1 mg/ml	d4T suspension 1 mg/ml	Bottle (60 ml)	25	NED
18. Stavudine Powder for Oral Suspension 5 mg/ml	d4T suspension 5 mg/ml	Bottle (60 ml)	38	NED
19. Efavirenz 50 mg Capsule	EFV 50 mg	Bottle (30 Cap)	187	NED
20. Efavirenz 200 mg Capsule	EFV 200 mg	Bottle (90 Cap)	2,140	ED
21. Efavirenz 600 mg Tablet	EFV 800 mg	Bottle 30 Tab()	1,722	NED
22. Indinavir 200 mg Capsule	IDV 200 mg	Bottle (360 Cap)	2,803	ED
23. Indinavir 400 mg Capsule	IDV 400 mg	Bottle (180 Cap)	2,803	ED
24. Ritonavir 100 mg Capsule	RTV 100 mg	Bottle (84 Cap)	2,735	ED
25. Saquinavir Soft Gel 200 mg Capsule	SQV 200 mg	Bottle (180 Cap)	4,852	ED
26. Lopinavir 133.3 mg + Ritonavir 33.3 mg Capsule	LPV 133.3 mg + RTV 33.3 mg	Bottle (180 Cap)	17,547	NED

EDL = Thai Essential Drug List, NEDL = Non-Essential Drug List

Further to this, the Global Fund's third board meeting recommended that products procured using the fund's resources should be subject to authorisation by the National Drug Regulatory Authority (NDRA) in the country in which they are to be used, following the national standard practices for the registration of pharmaceutical products. For products that have passed the UN Pilot Procurement Quality and Sourcing Project review, as described in above, NDRA's are encouraged to expedite registration by accepting WHO pre-qualification inspection and supporting dossiers instead of national requirements.

The sixth board meeting, which took place in October 2003, concluded that National Drug Regulatory Authorities (NDRA) laboratories, or laboratories recognised by the NDRA, should be used for quality monitoring by the principal recipient. To ensure that the respective laboratories have adequate capacity for full pharmacopoeial testing, they must meet at least one of the following criteria:

- Acceptance for collaboration with a WHO pre-qualification project;
- Accredited in accordance with ISO17025 and/or EN45002;
- Accepted by a stringent authority. For the purposes of this policy, a stringent drug regulatory authority is defined as a regulatory authority in one of the 28 countries, which has participated in either a Pharmaceutical Inspection Cooperation Scheme and/or the International Conference on Harmonisation.

The Thai systems for the local production of ARV drugs, drug registration, and quality assurance are recognised as competent ones. However, Thai GPO products are not included in the WHO pre-qualification list and the grace period or interim period for using local GPO products ended April 2005. This is one problem that Thailand must still overcome. The Thai Government Pharmaceutical Organisation (GPO) new plant had only just opened and was still under assessment by the WHO, which must approve the plant for each ARV products. The process of WHO approval also took time. Thus far only US and UK pharmaceutical plants have been approved under the WHO scheme. The use of patented ARV drugs will be a huge burden for Thai ARV programme.

At present (2005), imported drugs and some diagnostic agents are purchased through a bid for tender. On the one hand, this channel is prone to diversion; on the other it reduces the price if the tender is well-managed. The NAPHA's role in procuring ARV drugs was very strict and involved considerable negotiation. This was dealt by the NAPHA manager, but claimed to be transparency. One key informant claimed that that he had to use many tricks when negotiating for lowest price, especially when patented drugs were involved. It is uncertain about the ARV procurement after ARVs were included into UC package.

One example of ARV drug shortages concerns is Efavirenz. This drug is still under patent. The media, NGOs, and NAPHA report that in 2004, there were shortages in certain areas of the public sector, but not in the private sector. Because of monopoly (under patent) only patent holder import the drugs and can control the price as well as the amount and recipients. The government thus intends to issue a compulsory licence for this drug, to allow the GPO (public enterprise) to also produce and provide it to those patients in need. Now SSO has announced a working group to study the possibility.

In 2004, the ARV drug distribution chain of NAPHA was processed via 2 routes. Firstly GPO drugs were distributed from the GPO to the Regional Disease Control Centre

(RDCC). There are currently 12 RDCCs throughout the country. Each RDCC then distributed ARV drugs to the provincial health offices, which then sent them to each hospital according to the plan or on request. Other imported ARV drugs were distributed to the RDCCs by the drug companies.

The second drug distribution route, VMI (Vendor Managed Inventory) purchasing (Vendor Managed Inventory), allows purchaser (each hospital) to order or adjust amount of required ARV via internet and that GPO send ARV drugs directly to each hospital. Some ARV drugs are not produced by the GPO, e.g. imported drugs are purchased centrally at DDC (Department of Disease Control), MOPH and sent to the Regional Disease Control Centres, provincial health office, and health facilities respectively.

The rate of purchase depends on rate of consumption. This VMI system has only been introduced recently to NAPHA and subsequently to SSS. In the past, procurement was done centrally and the medicines were distributed in the same way as the imported ARV drugs. The consumption-based systems should lead to a reduced risk of drugs being out of stock.

### ***3.2.8 Monitoring and evaluation for Global Fund ARV treatment programme***

The indicators of HIV/AIDS Care (Global Fund) include:

1. The number of Healthcare facilities providing opportunistic infection (OI) prophylaxis and treatment
2. The number of Healthcare facilities providing ART
3. The number of patients who received ART
4. The number of staff trained to provide comprehensive care, including ART
5. The amount of personal training, supervision and support of the PLWHA leaders and outreach workers that is carried out
6. Number of PWHA outreach workers group carrying out activity in participating hospitals

The NAPHA Monitoring and Evaluation studies includes

1. An evaluation of the ARV provision system development in Thailand. Community medicine department, Faculty of Medicine, Chiang Mai University 2004
2. Development of HIV/AIDS treatment in Thailand: 1992-2003. Bureau of AIDS, TB, and STI, 2005
3. An analysis and synthesis study of policy and implementation of treatment of HIV/AIDS by ART for universal coverage. Bureau of AIDS, TB, and STI, 2004

Global Fund programme monitoring and evaluation has been introduced to the government's round 5 proposal.

Since Thailand implemented the Global Fund programme by merging with NAPHA, there has been no differentiation with respect to who got what ARV drugs from which programme. However, according to the proposal, the Global Fund requires a specific number of beneficiaries. As a consequence, the Thai AIDS cluster had to hire staff to

create a clear reporting system to meet the Global Fund's requirements. This proved a big hurdle for implementation and the budget. Furthermore, merging the programme into current system vertically is more practical. Respondents noted that the Global Fund even required specific patient names to ensure the non-diversity of the budget.

### **3.3 Médecins Sans Frontières (MSF)**

The Médecins Sans Frontières (MSF) programme for HIV/AIDS and ARV provides antiretroviral treatment to more than 40,000 patients, who are spread across 56 projects in 29 countries. MSF has been caring for people living with HIV/AIDS in developing countries since the mid 1990s. Moreover, Thailand is one of the first of two countries in which MSF began ARV treatment project in 2000; the other is South Africa. Now working in 29 countries, MSF aims to include ARV treatment as part of a package of comprehensive care. Projects include prevention efforts (health education, prevention of mother-to-child transmission of HIV), voluntary counselling and testing, treatment and prevention of opportunistic infections, ARV treatment and nutritional and psychosocial support. In nearly all of its ARV programmes, MSF provides treatment free of charge. This is important because it ensures that even the poorest people have access to life-saving treatment. The global programme for ARV provision is aimed at accessing networks and improving training.

#### ***3.3.1 Brief history of MSF programme***

MSF's central office in Thailand is located in Bangkok. Its programme for HIV/AIDS includes varieties of activities, such as home-based care for HIV/AIDS patients, campaigns and collaboration for access to medicines, as well as ARV provision.

One major focus of MSF's work in Thailand has been to help strengthen PLWHA organisations, which are the strongest networks of people living with HIV/AIDS in developing countries. However, MSF in Thailand does not solely aim to provide full scale ARV treatment programmes, but instead a parallel project. Thailand was chosen to test 2 models of technical support and comprehensive care. The aim was to assess the feasibility of ARV provision in small scale hospitals. Following this pilot programme, almost all small public facilities adopted the ARV treatment programme. MSF's next step was to target marginalised groups.

Instead of setting targets for scaling-up ART, the MSF HIV/AIDS programmes provide the comprehensive package of care mentioned above. Furthermore, MSF also works toward achieving better access to essential medicines and has many collaborations with other organisations working on IPR, TRIPS, and FTA issues.

Before 2006 MSF treated more than 1,100 patients in seven projects throughout Thailand: Bang Kruai community hospital at Nonthaburi province, Baan Laem community hospital (Petchaburi province), Kuchinarai community hospital of Kalasin province, and in Surin and Srisaket provinces (Sikhraphum, Thatum, Prasat and Sangha). In addition, two prisons were also included into the ARV programme in 2005.

At the outset of the pilot programme, MSF Thailand sent technical team to the site to train all staff and then continuously followed up meetings with staff and patients. One

hospital complained that patients listened to more to MSF than to those who actually worked at the site.

The hospitals in the ARV programme funded by MSF must report to the centre periodically and the visiting team can also help by discussing and solving problems. The established reporting system was not designed to be target-based, but to assess objective based outcomes.

Laboratory tests and ARVs were provided free of charge to all MSF patients. They were thus supplied with information about the tests and drugs used. This practice was reported during the in-depth interview with MSF patients during the site visit.

### ***3.3.2 Plan and resources for the MSF ARV treatment programme***

It seemed that there was no problem of budget provided by MSF. After having successfully implemented an ARV provision programme in 4 hospitals, MSF has evaluated and drafted a plan for a new provincially based pilot programme in Petchaburi province. All health facilities will be coordinated to provide full scale collaboration in the prevention and care of HIV AIDS. In 2006 there are 6 main projects to provide ARV to various patients, e.g. Bangkok home care, Bangkok prison project, cross border project, ethnic minority, and pilot project in 4 hospitals as already set up. But the latter focus only on second line drugs since all first line ARV patients are taken care by UC scheme.

The hospitals say that the MSF support team has a strong approach. However, staff from one hospital complained that patients always called MSF instead of directly consulting them.

### ***3.3.3 Selection, procurement and distribution of ARVs in MSF ARV treatment programme***

MSF Thailand created its own ARV list by inviting experts to discuss suitable drugs with the MSF medical and health team since at that time the MOPH had not yet developed a drugs list. However, the MSF list has been gradually changed to the NAPHA list, with the exception of some second line drugs (Interview with MSF Thailand 4<sup>th</sup> August 2005). PIs are still provided to patients that are allergic or resistant to the first line drugs.

**Table 3.8 MSF ARV list**

<b>Types of ARV and AIDS diagnostics provided</b>	<b>Manufacturer</b>
First line: d4T/3TC/NVP	GPO
Second line: ZVD+ddi+SQV/r	GPO
NFV 250 mg/tab	Roche
EFV and IDV	Merck Co
LVP/r and SQV	Abbot
ABC	GSK
Lab:	

Note: ABC = Abacavir, LVP = Lopinavir, NFV = Nefinavir, EFV = Efavirenz, SQV = Saquinavir, ZVD = Ziduvodine

With only approximately 1,000 patients MSF has stocked its ARVs at its headquarters in Bangkok. There were no budgetary problems relating to their purchase since MSF receives donation worldwide. The drugs were bought in a big lot, since MSF Thailand also provides ARV drugs to the region. Both the GPO and transnational drug companies were asked to supply drugs.

Distribution of ARVs was carried out according to the plan. No incidences of drug shortages have been reported. Sometimes the NAPHA borrowed the MSF's drugs when it suffered shortages, but these drugs were subsequently returned to MSF.

### **3.3.4 Monitoring and evaluation for the MSF ARV treatment programme**

Both a report and data collection plan were required for the MSF sites. These were tested to ensure user friendliness. The report aimed to provide information about monitoring and improvements. The qualitative approach of outcome mapping was applied to evaluate the success of the programme according to its objectives.

In 2005, MSF focused specifically on child cases, since these patients have thus far received less attention. Antiretroviral treatment guidelines were developed as well as a campaign to draw attention from all the stakeholders, especially those responsible for research and the development dosages that are suitable for this group.

### **3.4 Comparisons and contrasts between the two ARV treatment programmes**

The Global Fund and MSF both provide ARV treatment programmes in Thailand. These projects are very different with respect to their size and objectives.

The primary objective of the Global Fund/NAPHA programme is to provide ARVs and to strengthen the infrastructure, while the MSF seeks to develop innovative models of AIDS care. The coverage that both programmes offer is quite different.

**Table 3.8 Contrast between two PPI: Global Fund/NAPHA and MSF/NAPHA**

	<b>Global Fund/NAPHA</b>	<b>MSF/NAPHA</b>
Objective	- Targets to scale up ARV provision - Strengthen infrastructure	- Does not have numerical targets - Develop new models of care
Coverage PLWHA	10,000++	615
Coverage Facility	185	4
M & E	In House and external	In house

## IV. IMPLEMENTATION OF ARV TREATMENT PROGRAMMES

### 4.1 ARV distribution channels and kinds of ARVs distributed

ARV drugs in Thailand are channelled to patients through two major routes, namely public and private health facilities. Public facilities involved in providing ARVs range from community hospitals to regional and university hospitals, and include around 900 hospitals (from the total of... ) all over the country. There is currently no national data available on private sector's role with regard to ARV drug provision. The actual numbers of patients receiving ARV drugs from the private sector are unknown, but data from interviews reveal suggests that this sector is the main source of ARVs for affluent people who wish to avoid disclosing their HIV positive status.

The NAPHA (government budget), Global Fund and MSF are the major sources of support for the public facilities. The Social Security Fund, which is managed by the Social Security Office (SSO), is responsible for its contributors being able to obtain ARVs from both public and private facilities.

The ARV drugs provided through public facilities are prescribed according to the national guidelines. However, the procedure for prescribing these drugs in the private sector is unclear. Reports from public hospital staff indicate that they are likely to include branded, imported drugs. From late 2004 onwards, ARVs provided by the Global Fund are channelled through the network of public health facilities in 10 regional hospitals, 12 general hospitals, and 174 community hospitals, through which 10,222 patients have been targeted (Table 3.4).

**Table 4.1 Public Hospitals where ARVs are provided (2004)**

	Number of facilities		
	Global Fund	NAPHA	MSF
community hospital	174	721	3
general hospital	11	69	1
regional hospital	10	24	0
special hospitals	0	?	0
university hospital	0	6+	0
BMA hospitals	0	2+	0
Total	185	822++	4

In theory, the MOPH has set up guidelines and updated for the list of ARV drugs that may used in the NAPHA and Global Fund programme. However, it appears that in reality some of the hospitals may not provide all of the drugs due to the shortage of medicine.

**Table 4.2 Types of ARVs and AIDS Diagnostics Provided in NAPHA-supported Hospitals**

Types of ARV and AIDS diagnostics provided	Manufacturer
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ATC first line : d4T+3TC+NVP (GPO vir)	GPO
ATC second line: d4T+3TC+EFV, AZT+3TC+NVP, or AZT+3TC+EFV	GPO
ATC third line: d4T+3TC+IDV/RTV or AZT+3TC+IDV/RTV	GPO
PATC first line: d4T+3TC(AZT+3TC)+NVP	GPO
PATC second line: d4T+3TC(AZT+3TC)+EFV	GPO
PATC third line: d4T+3TC+IDV/RTV or AZT+3TC+IDV/RTV	GPO
PMTCT first line: AZT	GPO
Diagnostic facilities	
- CD4 count	Import
- Viral load	

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#### 4.2 Accessibility and *eligibility*

Both medical and non-medical criteria are employed for the inclusion and exclusion of PLWHAs in the ARV programme. These criteria have been developed by the MOPH for all public facilities. Patients are found to be eligible if they meet the following criteria:

- Being diagnosed as having AIDS defining illness
- Having a CD4 count  $\leq 250$  and either one of these symptoms
  - o Unknown chronic fever
  - o Chronic diarrhoea longer than 14 days with an unknown cause
  - o Weight loss of more than 15% within 3 months
- Having no symptoms, but a CD4 count of less than 200

Excluded patients are those who:

- Have lung cancer and a CD4 count  $>250$
- Have CD4 count of more than 200 and no symptoms
- Have record of adverse reactions to ARV drugs
- Are not ready for continuous treatment and follow up

Thailand is the first country to introduce a CD4 level of less than 200 as an inclusion criterion. In principle, although only naïve cases are eligible for the programme, it appears that all experienced cases are in fact accepted into both the Global Fund/NAPHA and MSF/NAPHA programmes if their symptoms positively respond to the first line ARV drug treatment. In practice, among all of the criteria, however, a CD4 level of less than 200 and the presence of related OI symptoms have been given priority.

Patients with TB are treated by TB medicines such as INH (Isoniazid) for 3 months, before the ARV (Efavirenz) treatment is started. According to the MOPH's guidelines, being an intravenous drug user is not an exclusion criterion. Yet, in reality this varies from one facility to another. In some facilities, intravenous drug users are excluded given

that they are considered to be less disciplined and thus unlikely to effectively adhere to the treatment regimens.

The presence of buddy as a criterion was not observed in the facilities studied. Preparing the PLWHAs to receive treatment was emphasised in some facilities, especially those supported by MSF, but this was not a systematic focus of most NAPHA hospitals. The MSF facilities spent time screening and preparing the prospective PLWHAs. In addition to conducting medical interviews and checkups, the prospective PLWHAs are also introduced to the PLWHA group's activities, given pre and post-testing on their HIV/AIDS knowledge, informed about the do's and don'ts for participating in the programme and taught about ARVs (i.e. what are ARV drugs, why and how they are used, their side-effects, and the importance of being prepared etc.).

It is interesting that the costs of the initial CD4 count testing, which is necessary for screening eligible cases, must be paid by the PLWHAs at the rate of 200 Baht for NAPHA and 500 Baht for SSO programmes respectively. The researcher views such a requirement as a barrier for those PLWHAs who cannot afford the test to be able to gain initial access to the service. However, the tests for the routine follow-up (CD4 test, viral load, and kidney function test) after being included in the programme are without charge.

### **4.3 Quality of Health Services**

#### **4.3.1 Health Facilities**

Nine hospitals were selected as case studies, all of which are from central Thailand. Details of the administrative structure and ARV provision backgrounds of each hospital are given in Table 1.1.

##### **4.3.1.1 Hospital A**

Hospital A is a hospital with a 30 bed capacity, which is situated in the northeast of Petchaburi Province along the Siam Gulf. During the period of data collection, the hospital was staffed by 4 doctors, 7 pharmacists, 3 dentists and 47 nurses. Hospital A has become widely known in the region as a success story with respect to AIDS care and ARV provision.

Hospital A provided AIDS treatment and care several years before its participation in the ARV programme began in late 2001. During the initial period most of the services provided were related to counselling, blood test, and unsuccessful OIs treatment. Its first experience with ARV provision came about when the hospital was involved in a pilot project on decentralising HIV/AIDS treatment by providing comprehensive AIDS care. This project was a collaboration between MSF Thailand and a Thai AIDS NGO-ACCESS.

MSF has played a significant role in transforming Hospital A into a successful and experienced provider of ARV therapy. A variety of support from MSF, which includes technical advice on OIs treatment, medical supplies especially second-line ARV drugs, and financial assistance for the PLWHA group, has contributed significantly to the development and strength of the hospital's ARV team. Medical training as well as journal

and textbooks supplied by MSF has helped to update the staff's knowledge and boost their confidence with respect to dealing with HIV/AIDS related problems.

The core staff of Hospital A's ARV clinic comprises two doctors, two pharmacists, nurses, counsellors, and PLWHAs. The nursing staff in this clinic have been trained to be so capable that it is possible to run the ARV clinic even in the absence of a responsible doctor. Technically and administratively, the staff has been teamed up in a very effective way, although the hospital director does not play significant supportive role. The medical staff responsible for this ARV clinic, especially the counsellor, pharmacist and nurses, are highly enthusiastic and committed to their work. In essence, their motivation derives from their direct experience in witnessing the progress of the PLWHAs after they have been treated with ARV drugs. As the following interview illustrates:

*“The first year they [PLWHAs] came on the bed, blackish and skinny. After one year had past, we came to know all about them - real names, nicknames - as they came often. While they were in serious condition, they came with relatives whom we had gradually built a relationship with. Later their health improved; they could go work and have a happier life; their faces looked prettier and better. This has made us realise the value of our devotion to them - the value that arises from seeing those who were about to die but can get back to a normal life. Most of us in the AIDS team are like this.”* (pharmacist interview).

The ARV clinic at Hospital A opens every Thursday and Friday in a separate building from the OPD (outpatients department). It is arranged as one-stop service clinic where medical check-ups, blood testing, counselling, doctor's consultations, drug prescription and PWA group activities are undertaken separately. The consultation process is detailed. Data from PWA interview show that the PLWHAs know the names of the ARV drugs they are taking and also the complications or side-effects that have occurred.

The PLWHA group is well-organised and prepared. PLWHAs are being actively involved in assisting the medical team with the provision of services, especially with regard to medicine checking, health education and counselling support. Home visits are carried out by the PWA members to ensure drug adherence. The relationship between the group and the hospital is good. The head of the PLWHA group has even been hired by the hospital as a security officer. The PLWHA group receives a part of its financial support from MSF.

There were 140 ARV patients registered in the clinic at the time of data collection. Access to the clinic was apparently unlimited as new patients were readily accepted. Interview and observation data reveal that the majority of the patients were from the area. They were mainly from poor families and a large proportion of worked as sailors. Many of these patients first came to the hospital in a critical condition, but later recovered after having receiving ARV treatment and were thus able to resume their normal lives. It is interesting that the stigma surrounding HIV/AIDS, which is still prevalent, has forced PLWHAs who do not want to disclose their HIV status to seek medication from facilities outside their own area. This leaves those who cannot afford to go elsewhere or who can cope with the stigma to use the clinic. Support from the PLWHA group and hospital staff, as well as their improving state of health, has greatly contributed to their acceptance of their fate and their commitment to adhere to the treatment regimens.

However, a flexible approach is necessary to ensure adherence. In this hospital, the doctor's appointment schedule has been successfully adapted to suit to the PLWHAs' working conditions. With empathy and a deep understanding of the PLWHAs' lives, in particular the sailors, the medical team usually sets the PLWHAs' appointments for seeing the doctors and refilling their prescriptions when they are due to be on shore leave. Such an approach, together with other efforts like the involvement of PWA group and the emphasis on patient's preparedness to embark on the treatment, has meant that adherence is not a problem in this hospital.

### 4.3.1.2 Hospital B

Hospital B is located further south in Petburi Province, just a half an hour away from Hua Hin, which is a popular beach resort. Hospital B has 60 beds and is staffed by 6 physicians, 5 pharmacists and 54 professional nurses, in addition to other non-technical personnel.

Like other public hospitals, in addition to the PMTCT project, Hospital B began its care programme for PLWHA by opening a 'counselling clinic'. This was designed as a place where the PLWHA could seek advice for their problems, such as those related to blood testing, stress management, psychological support as well as economic and domestic ones. However, in late 2002 CAPH also started to provide ARV therapy. By being voluntarily involved in the NAPHA project, Hospital B began its ARV provision service with about 5-6 patients. Later on, in response to the NAPHA's national target of increasing access to ARV patients to 50,000 in 2004, CACH set its own target at 25. At present, the hospital has 82 patients, with 5-6 new cases reporting for treatment each month.

Some of the ARV patients in Hospital B are referred to the clinic by other clinics in the same hospital; some are put forward by other PLWHAs and others just come in seeking treatment voluntarily. The patients' backgrounds vary considerably; their occupations are mixed, they are aged between 20 and 40, mostly married, and female. The majority are resident in the surrounding areas.

Hospital B, like other hospitals participating in NAPHA, includes the ARV patients by following the MOPH's guidelines, which consist of the following criteria: 1) patients diagnosed having AIDS-defining illness, except TB, regardless of their CD4 level; 2) HIV patients with a CD4 count of less than or equal 250 cell/cu.mm with opportunistic infections, such as unidentified chronic fever, unidentified prolonged diarrhoea (>14 days) and weight lost >15% in 3 months and; 3) HIV+ patients with CD4 <200 cell/cu.mm. However, the most important criterion for inclusion is the patient's own willingness to join the programme. A suspected HIV case will usually be advised to take the HIV test. If the result is positive, the patient will be informed about the ARV programme and asked to join. Generally speaking, the process of being included into the clinic was not particularly strict. In contrast to the other hospitals studied, there was no process to ensure the seriousness and preparedness of the patients to adhere to the treatment regimens.

Like other hospitals, Hospital B, following the MOPH's guidelines, has set up a multidisciplinary team of staff comprising one doctor, one pharmacist, one laboratory technician, two nurses to run the ARV clinic. The patients are given appoints for 5

sessions a month, which are held mostly on Tuesdays. 2 to 20 patients participate in each session, depending on their willingness to disclose their HIV status. Those who do not want to meet other PLWHA are given individual appointments.

The ARV clinic was not established as a separate unit. The patients came to the OPD for registration before being sent to meet the nurses for routine check-ups and interviews. Adherence to the drug schedule was monitored through tablet counting and interviews. Advice on problems encountered, especially side-effects, was given. However, only those who had complications (i.e. side-effects or OIs), were sent to see the doctor. Only GPO-Vir was provided, which the patients did not have to pay for in addition to the standard 30 Baht fee. Interestingly, the data from the patient interviews reveal that most of the ARV patients could not remember what medicines they were taking. Their knowledge about why to the should strictly follow the regimen and the side-effects thereof was rather limited.

The effective monitoring of adherence was one of the main concerns of the nurses interviewed. Although most of the patients are healthier after taking the medicines and report that they strictly follow the regimens, some are found to not be fully adhering to the drug schedule, by either adjusting their own schedule or not showing up on the date appointed. This frequently occurs among patients who are sailors. In this nurse's view, relying only on self-reported data to monitor drug adherence seems to lead to a lack in confidence with respect to the effectiveness of the programme in enforcing drug adherence.

“if possible, there should be effective ways to monitor whether they really take medicines as prescribed. So far, we can rely only on trust and encouragements trying to convince them to see its benefits. if asked whether it can be confident, I think it cannot”. (a responsible nurse)

The preparedness of the ARV clinic team in this hospital was not in a good shape, especially in comparison to the other hospitals studied. Most of the clinic's activities were carried out by the nurses. The only doctor who was actively involved in the ARV clinic was about to move to Bangkok to continue his studies.

In terms of technical preparation, there are usually a few workshops each year, which are organised either by the MOPH (once/year) or the Provincial Medical Office (2-3/year). Generally speaking, the way in which Hospital B runs the ARV clinic are similar to how other 'typical' public hospital do, at least in the sense that the clinic is just an addition to the routine provision of services. However, with a disproportionate number of doctors, when compared to the workload of 250-300 outpatients a day and 60 inpatient beds, there was a deficit in the time and attention that doctors could spend on ARV patients requiring special care. The situation has been exacerbated by the frequent turnover of physicians, which is a common phenomenon in community hospitals. Indeed, this was one of the reasons why a special ARV clinic was not separately setup.

No PLWHA formed a support group in this hospital. Most of them only loosely got together when they were at the clinic. Their role in helping each other to increase adherence was, therefore, non-existent.

### 4.3.1.3 Hospital C

Compared to Hospital A and Hospital B, Hospital C has extensive experience in providing specialised services for HIV infected people. Hospital C has 429 beds and is staffed by 46 doctors, 17 pharmacists, 5 dentists, 82 laboratory technicians, and 350 nurses. At the time of data collection, there were 236 adult and 60 child ARV patients attending the ARV clinic, which opens twice a month on the second and fourth Wednesday.

Hospital C originally became involved in ARV provision through its collaboration with MSF. Like BLCH, the development of its experience in ARV provision has been influenced significantly by the support it has received from MSF.

HIV/AIDS services and the provision of ARV drugs in Hospital C have been well-structured at the hospital level. Apart from the Hospital's AIDS Committee and Hospital's AIDS Taskforce, HIV/AIDS coordinators are appointed in all hospital service groups, i.e. medical, nursing, social medicine, psychiatric, health education etc. The system is designed to be a mechanism that helps to ensure that all HIV infected patients admitted to the hospital are channelled to appropriate treatments, which include ARV therapy.

Apart from the MSF and NAPHA projects, the ARV provision in the hospital also includes PATC, CARE, SSO, and co-payment schemes.

The process of inclusion of ARV patients in Hospital C is very well organised. In addition to the clinical criteria for inclusion and exclusion recommended by the MOPH, the preparedness of the patients to comply with the regimens is systematically assessed. Activities for screening and preparing potential ARV patients include interviews to evaluate their life history and illness experience, activities to introduce them to the PLWHA support group, workshops to improve knowledge on AIDS and ARV with the carrying out of pre and post-testing.

The core staff in charge of the ARV provision projects forms a well-organised team. For the adult ARV clinic, the responsible team includes doctors, pharmacists, nurse/counsellor, health educator, lab technician and the PLWHA.

### **4.3.1.4 Hospital D**

Hospital D is a 60 bed hospital located in Rachaburi Province, which is approximately 140 km south of Bangkok. It is staffed by 5 doctors, 4 pharmacists, 70 nurses and 2 dentists. The ARV clinic opens twice a month on the second and fourth Monday.

Prior to 2002, Hospital D provided AIDS services to PLWHA by emphasising alternative medicines and VCT. However, in August 2002 it began to offer ARV treatment after the hospital had been included in the NAPHA Project and a target to provide ARV medicines to 15 patients was assigned to the hospital. To meet quota set, the hospital sought appropriate recipients for this ARV drug therapy through various channels starting from the patient records and then tracking them down in the community through the hospital's network, using techniques like home visits, snowballing via village health volunteers and using public campaigns. Each HIV positive person was informed about the ARV programme and then being asked if they were willing to join it.

Due to the policy pressure (to meet the targets assigned), the patient inclusion criteria were not strictly enforced. The focus was put more on CD4 level than the readiness of the patients to commit to the treatment regimens.

As the time of data collection, there were 52 patients registered. 90% of them are from the local vicinity. The rest were migrant workers and residents of nearby provinces. In general, based on the official statistics, 192 PLWHAs were estimated to be living in the area. It was thought that fear of disclosing HIV status and being stigmatised was the main reason why many potential HIV infected people in the area did not attend the clinic voluntarily.

The ARV clinic, which was located in a separate building, opened twice a month for patients with appointments. All services including general health screening, blood testing (if any), medical consultations, adherence monitoring (by tablet counting), and group and individual counselling were arranged in one place. CD4 count, in accordance with the MOPH's recommended guidelines, was carried out every six months for ARV patients with stable/increased CD4 and every 3 months for those with non-improved CD4 counts. The ARV medicines provided in Hospital D are d4T + 3TC formula (or formula 3), which are available free of charge since they are included in the 30 Baht health security scheme. In terms of adherence, there were occasional drop-outs due to many reasons (i.e. the patients moving out from the area, death). However, the patients' CD4 test results generally show a steady improvement.

A support group of PLWHA was also formed here, but it has a limited role and was loosely organised. Members of the group took part in some home visits and gave advice to their fellow members. They were also encouraged to start an income generating activity (a souvenir shop opened at the front gate of the hospital) in order to help with the group's long-term survival.

### **4.3.1.5 Hospital E**

Hospital E is the largest hospital that was included in this study. It has more than 900 beds with nearly a thousand personnel: 102 doctors, 28 pharmacists and about 650 nursing staff. As a regional, tertiary-level hospital, its clients do not come only from the Ratchaburi Province where it is situated, but also from other provinces in the western region. This is also the case with HIV/AIDS patients. Every day, the hospital's outpatient department is congested with the influx of patients, including the PLHWA, who have to queue up early in the morning. Hospital E has served as a tertiary medical unit in the region since it is staffed by specialists in various fields and equipped with advanced laboratory facilities. It is where the complicated or critical conditioned patients are referred to and where complex laboratory tests (including viral load and drug resistance test) are sent to be carried out.

At the time of data collection, there were 300 ARV patients registered in Hospital E. This number was twice as high as the quota that had been assigned to the hospital (the assigned quota was 142). With such a large number of patients, the ARV clinic had to open every Wednesday. The patients had to be grouped into about 10 groups (20-50 patients in each) and 50-60 patients were given appointments to visit the clinic each Wednesday. Due to the large number of patients and also the complex system of the

hospital, it was difficult for the clinic to closely monitor its services. To cope with this, the frequency of appointments was extended to every two months for patients who reported that they were experiencing no problems or were steadily improving. However, the patients were allowed to contact the counsellors by mobile phone in the event of emergencies. Compared to Hospital A, the PLWHA groups here were not closely organised and their roles were limited. The large number of members and their varied and unrelated historical backgrounds are one of the reasons for this.

The set up of the ARV clinic at the Hospital E is, to some extent, similar to the other public hospitals. It has a core team comprising doctors, pharmacists, nurses, counsellors, and laboratory technicians. Nonetheless, due to the complex structure of the hospital, the teamwork was not as tightly knitted as the small hospitals (especially in the case of Hospital A). The many ongoing activities or projects that simultaneous occur in such a large hospital also prevented the team to being tightly formed. Here, although ARV patients could meet and get treatment from many doctors, the patients widely understood that there is only one long-term and highly experienced senior doctor working on ARV and HIV/AIDS in the hospital. Because of this, for those patients who really wanted to see this specialist doctor who only scheduled appointments with just 20 patients a day, they had to arrive at the hospital, for some, as early as 2 o'clock in the morning to compete to join the first 20 queues. Patients usually have to devote the whole day to each visit to the ARV clinic.

The complexity of the ARV clinic here is also aggravated by the diversity of its clients who come from outside the area. Beside the technical advancement, which attracts the ARV patients, its being further away as well as its complex service structure also help conceal identity of those who want to avoid disclosing their HIV status. Such a situation, when combined with the small number of hospital staff, was found to critically hamper the effectiveness of the ARV clinic team when making close follow-ups of the problem ARV patients. Losing follow-up and discontinuing or irregular use are, thus, a major concern for the staff responsible. Four major factors are found to affect the problems of adherence. From the patient's side, transportation, lack of money and a stronger health condition are the most important ones. Yet, from the hospital's side, a lack of community network, especially in the area outside its main responsibility or in the other provinces, has prevented the hospital team from being able to effectively monitor adherence. The fact that these patients come to the Hospital E because they want to avoid stigma, means that any attempt to reach them through a community network is almost impossible.

Although about 70-80% of the ARV patients are viewed acceptable in their treatment outcomes when their CD4 level is measured, many experienced patients have been found to face drug resistance. Side-effects such as lipodystrophy, increased cholesterol, are also apparent.

### **4.3.1.6 Hospital F**

As general hospital with a 450 bed capacity, Hospital F is staffed by 70 doctors, 40 pharmacists and hundreds of nurses. The hospital became to involved in the NAPHA Project just a year ago, the most recent compared with the other public hospitals in the Province. During the earlier period, most of the HIV cases were referred to a national HIV/AIDS specialised hospital nearby. However, because it is the only general hospital of the province, it could not avoid eventually participating in the NAPHA Project.

In addition to NAPHA, SSO and PHPT/CARE are among the HIV/AIDS projects that have taken place in this hospital. From the records, there are 50, 20-30, and 13 ARV patients belonging to the NAPHA, SSO and PHPT projects respectively.

The HIV clinic at Hospital F is not a separate one, but is instead integrated into the outpatient department service. The patients pass through the normal routes and spend the entire day for each visit, registering and undergoing routine health checkups (including blood tests) in the morning and waiting to see the doctor around 2 o'clock in the afternoon. The clinic opened every Thursday (but this has been changed to every Tuesday). No PLWHA support group has thus far been established.

The team of staff who runs the ARV clinic is still not very well-organised. The participation of doctors, a crucial element of the team, is limited. An impression gained from the hospital staff interviewed is that doctors here on the whole have less or even a negative motivation for working with PLWHAs and within the community. They also have little experience in working through the community network in strengthening patient's follow-up system. Usually, most of the HIV infected cases or AIDS-related activities fall under the responsibility of a nurse. Some doctors at Hospital F have an unfavourable attitude towards the ARV provision to PLWHA, regarding the PLWHAs' longer lives as a way that more people will be infected by the virus through their relationships with those PLWHAs. Such an attitude is said to be the reason why some of the doctors fail to show up or are late when they are due to see PLWHAs as appointed. Participation from the pharmacist is also limited due to a high workload. In this hospital, it is almost the sole responsibility of a nurse in charge of the clinic to take care of everything, including stocking drugs and prescribing them to the patients.

### **4.3.1.7 Hospital G**

Hospital G, located in Nothaburi Province, is one of the hospitals involved in the MSF's AIDS care decentralisation project. It has 30 beds and is staffed by 4 doctors together with other health professionals. The ARV clinic here serves 124 clients: 72 under the NAPHA project, 52 under MSF and the rest SSO. The clinic opens every Friday and Thursdays are reserved for home visits. Although Hospital G is community hospital, the ARV patients are from different places, including Bangkok, and from province far south, such as Prachuabkirikhan. As has been learned from other hospitals, fear of stigma is the major reason why HIV infected people seek ARV treatment so far away from home.

Hospital G is the first hospital that was implemented by MSF. In the first stage, the MSF doctors and nurses will come to the hospital to treat the patient and also train the Thai doctor and nurses. This became the advantage for the hospitals staffs after MOPH implanted NAPHA since they already experience ART by MSF.

There are 4 staffs in the ART program: 2 nurses and 2 counsellors. Every week they will visit the patient's homes in order to see if they have problems with adherence and medication or not. Obviously, the program here is dominated by one nurse who has long been working in this program. Since she grew up in this area and her father is well-known person in the area, other staffs including doctors give her priority to run ART program. Eventually, MSF is not satisfied with ART program here that forced the patient to disclose themselves by home visit but they still give the second line drug to patient.

### 4.3.1.8 Hospital H

Hospital H is located in Ayudhaya Province, one and a half-an-hours way from Bangkok to the North. There are 21 doctors, 184 nurses and a number of health professionals working in this 120 bed hospital. The HIV clinic is included in the OPD, but the ARV provision is arranged through an appointment with the nurse.

Hospital H started the ARV programme in last few years During the fieldwork period, there were 104 ARV patients participating in the hospital's NAPHA project. The ARV clinic team comprised 5 doctors and 2 counsellors and is well-coordinated. Community work has been well developed.

The ARV program was run by one nurse as main person who is very active, progressive and hard-working person. When the ARV program was first implemented, the doctor refused to treat the patient by being fear of AIDS. With nurse's encouragement, their attitude has been changed and then accepted to work with AIDS patient.

*“When I first know that MOPH will run the ARV program, I was very interested in. I asked the hospital whether the ARV can be implemented here. At first, the doctors don't want to work in this program by being fear of AIDS. He even treated patient in another room in order not to be touch. After giving ARV to patient, we can see great improvement and it reduced the workload of PI treatment so he agreed to join this project.”*

When Hospital H enrolled into the NAPHA programme, she made an announcement that the hospital now has a antiretroviral treatment programme and posted this information in the community

Hospital H used to have PLWHA network, but last year the funds to hire a PLWHA were cut off so the PLWHAs has moved to work at the Ayudhaya PLWHA network instead. Sometimes, she will come and help the nurse to do home visits, etc.

### 4.3.1.9 Hospital I

Hospital I is provincial hospital, which provides ARV drugs to about 80-90 HIV infected people. All of them fall under NAPHA and SSO projects. The team that runs the ARV clinic comprises 1 doctor, 2 nurses and one pharmacist. All of them are praised for being devoted and active in the eyes of the clinic's clients.

The PLWHA group named 'Fa Sang Tee Panf Aroon' has been formed to help with the running of the clinic. The PLWHA group is not officially organised, because the hospital director does not agree with allowing a PLWHA to work as a nurse's assistant, for medicine counts or home visits. So one of patient, who is working as STI officer at another hospital, volunteers his services to help the nurse and take care of other patients.

The anonymous clinic is located separately from other departments. Here, there is strong team made up of a nurse, pharmacist and doctor. The doctor has only recently graduated and is very active in the antiretroviral programme. When they visit the doctor, the patient will first be asked questions by the nurse in the morning and then the doctor will come to

the clinic and ask each patient about their physical problems. After inspection, the pharmacist will give a detailed explanation of the medicine, the need for adherence and possible side-effects.

#### 4.3.2 Patients' view of the services

The data from the exit interviews and group discussions presented below show how the ARV provision is viewed by the PLWHAs.

Forty eight PLWHAs were interviewed from 8 hospitals using the interview guide. Details of respondents are described in Table 4.3.

**Table 4.3 Details of PLWHA in exit interview in 8 hospitals**

Hospital	Number			Age Mean (range)	Duration of visit** Mean
	Female	Male	NI*	Years	Minutes
A	2	4	1	36 (31-40)	283
B	6	0		35 (27-44)	144
C	3	3		37 (33-47)	276
D	5	1		36 (30-51)	240
E	6	0		33 (22-43)	270
F	2	3		37 (25-52)	405
G	1	6		39 (27-55)	117
H	2	3		39 (27-60)	408
			1		

Note: \* NI = not identify, \*\* exclude travel time

The ARV patients interviewed in Thailand have been using ARV drugs for a relatively long period, with an average of 18.8 months and a range between 3-96 months. The ARV patients were interviewed at the health facilities where they were for follow ups and to receive of new batch of ARVs. The general process started with the queue request, they then went to see the nurse, reported their health problems, then had blood tests, waited for the results, met the nurse again, waited for the doctor, waited for the drugs, and met nurse again to arrange their next appointment.

Almost all PLWHA appreciated the services provided by hospitals with some degree of satisfaction. They felt that their health had improved greatly as compared to their condition before receiving ARVs. Some had a zero CD4 count and others came up to more than 100. Only a few complained about the services and these seemed to be related to certain hospitals.

Information was given to PLWHA and they felt that they were respected. However, most mentioned they were asked questions and they had to answer, but did not have many opportunities to ask more questions

Nurses and counsellors are the two people that almost everyone mentioned they had met and appreciated. PLWHA did not always meet doctors during each visit.

Apart from the general health professionals that the PLWHA met with during their visits, some hospitals provided the PLWHA with help group in collaboration with the CCC (Comprehensive Care Centre). This created a better environment for PLWHA since they had friends with whom they could talk openly. Nonetheless, it was reported that one hospital did not have the policy of forming PLWHA group to help this process.

The lengthy duration of hospital visits seemed to be the greatest source of dissatisfaction. In general, these visits took between half and one day, depending on the hospital, the patient's situation and their purpose of visit. The earliest time of that the hospital was reached was four o'clock in the morning.

Although majority still accepted this situation, some complained that it was too complicated and that they had to take too long off work. Most complaints related to the waiting time for receiving ARVs, although some noted that this was very quick. In certain hospitals, PLWHA had to wait and then doctors did not show up on time and that new doctors had to come and that took more time.

Since all ARV treatment programmes have been implemented in the public hospitals, the treatment costs involved are absorbed by either the Global Fund/NAPLWHA, MSF or SSO. No complaint about costs was observed, especially among the patients who fell under the universal coverage scheme for which only 30 Baht per visit is charged. However, all of the patients interviewed wished to see all schemes continue indefinitely or last long enough (more than 5 years). Most patients under MSF supported projects are worried about being informed that the project is due to come to an end.

The well-developed infrastructure of health services in Thailand has made it easier for PLWHAs to access hospitals. Travelling costs do not pose a major barrier for those who choose to go to community hospitals in own vicinity, but not for those who choose hospitals that are located far away in order to avoid their status being disclosed.

The prevailing stigma on HIV/AIDS was still found to hinder the PLWHAs from gaining access to the ARV services available. Stigma is found being the main reason for PLWHAs to travel long distances to get ARV treatment at hospitals outside of their residential area. Fear, as well as the direct experience of being stigmatised, may cause some PLWHAs to quit their jobs or relocate.

### ***4.3.3 PLWHAs' view: data from group discussion***

Twenty-two PLWHAs representing all regions and provinces in the country were interviewed as a group to understand their experiences - direct and indirect - of using the ARV treatment services. Table 4.5 below summarises the main findings.

**Table 4.4 Issues raised by PLWHA**

Policy	Facility	PLWHA
- Standard treatment is needed in every health facilities	The attitude of health workers toward PLWH is not	- The accessibility of marginalised

<p>providing ARV treatment programme.</p> <ul style="list-style-type: none"> <li>- Quality assurance of GPO is needed</li> <li>- Improve monitoring and evaluation, management system</li> <li>- Provide CAP (Community Advisory Participatory) in clinical trial. Ethical standards are needed.</li> <li>- Lack of EFV in some areas. Urgently need National negotiation with drug companies.</li> <li>- Implement ART in universal coverage.</li> </ul>	<p>good.</p> <ul style="list-style-type: none"> <li>- Health workers have a heavy workload.</li> <li>- Lack of enough doctors especially specialist or experienced doctor in ARV.</li> <li>- Quota of ARV patients in each hospital, limiting access when the quota has been reached</li> <li>- Less quality of private hospital in Social Security Office programme.</li> <li>- Insufficient of EFV in some area.</li> </ul>	<p>people/vulnerable groups such as migrant workers, IDU, children and hill tribes.</p> <ul style="list-style-type: none"> <li>- Side effect of antiretroviral</li> <li>- Expand the role of PLWH network in health facilities.</li> <li>- Stigma in community</li> <li>- Most of PLWHA do not know which programme they are in, especially the difference between NAPHA and Global Fund</li> </ul>
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4.3.3.1 PLWHA Involvement

With the funding from Global Fund in 2002, the PLWHA networks implemented a Centre of Comprehensive and Continuous Care at the 140 health facilities. CCC aims to provide treatment support to other PLWHA in the area. It also arranges some activities and encourages the PLWHA participation in health centre. Importantly, they presumably plan to implement CCC at all hospitals providing antiretroviral therapy in the NAPHA programme in 2006.

CCC was first initiated by TNP+, Access, and MSF and aimed to implement PLWHA participation in health facilities. The health workers mention that having PLWHA in the hospitals reduces their workload. Most of the CCC usually trained the PLWHA to help others, inform and teach knowledge about treatment, medicine counts, home visits, and so forth. Some of the CCC are located inside of hospital, which is usually one small room, whereas others are located outside of the hospital. This depends on the hospital policymakers, and the area in which the health facility is located.

4.3.3.2 Testing Facility

Since Thailand does not have a flow-cytometer at all hospitals, the work has been increased for lab monitor at the central test centres. This also means that patients must often wait a week for their tests results. Furthermore, Thai GPO can produce laboratory materials, but the problem is in fact a lack of laboratory technicians who can do the tests.

4.3.3.3 Treatment Facility

Due to the fact that the ARV programme has expanded from 118 to 890 hospitals in a year, there have been problems with the preparedness and willingness of health facilities. Firstly, there is a lack of doctors, especially specialists in HIV/AIDS. Secondly, the health workers are not well-trained in either ARV treatment or counselling. Moreover,

the health workers feel that the ARV treatment programme only increases their workload. Indeed, some hospitals refuse patient because of their heavy workload.

The TNP+ pointed out that the treatment team should be a multidisciplinary team composing of doctors, nurses, counsellors, pharmacists, laboratory technicians, and PLWHA. This is clearly difficult to achieve in the Thai context. Due to the number of patients that visit the governmental hospital each day, it is difficult for the doctor to see all of the patients. In this situation, the nurse usually plays an important role in the treatment programme.

### 4.3.3.4 Eligibility Criteria

The application of the eligibility criteria is currently a problem. There are standard guidelines for antiretroviral treatment drawn up by the MOPH, but some of hospitals do not follow it. The guidelines clearly state how much the PLWHA have to pay for first CD4 test (200 baht), but some hospitals have charged 300 or 500 baht for them. These are only the costs for government run hospitals. In case of private hospitals, the costs for testing blood, CD4, and viral load vary. The application of eligibility criteria does not only concern the cost of the CD4 test, but also the criteria for recruiting PLWHA. Even though the standard guidelines state that access should be given to the socially vulnerable, some health facilities refuse to provide the service for them, especially to intravenous drug users.

### 4.3.3.5 Disclosure

PLWHA choose not to disclose their status, especially within the community. Most of them have told their parents about their HIV status and choose to receive the treatment at a provincial hospital instead of their community one. In southern Thailand, which has a large Muslim community, people are willing to die rather than disclosure their HIV status to the community. Most of them, therefore, buy antiretroviral drugs themselves and visit private clinics. Moreover, the governmental officials who have health insurances benefits prefer to buy medicines instead of using the benefits because they do not want their supervisors to know about their HIV status

### 4.3.3.6 Side-effects

Women may experience stronger side-effects than men. Women are more sensitive to the side-effects of taking antiretroviral drugs, especially if they alter their physical appearance, which is one factor that influences their adherence to the drug regimens. The negotiation between doctor and patient in order to change the regimen is difficult. The patients feel that the doctor does not listen to them, but, at the same time, the doctor does not want to use the second regimen because that means decreasing their chance of successful treatment.

### 4.3.3.7 Vulnerable Groups

#### A. Injecting Drugs User (IDU)

Intravenous drug users are the vulnerable group currently requiring access to antiretroviral treatment. In many countries, IDUs are routinely excluded from ARV treatment due to the belief that they are less likely to adhere to treatment. IDUs are thus

viewed as non-compliant, untreatable, and undisciplined, which means that they are usually refused to access to treatment. As one of health worker contended, “I won’t give treatment to an IDU unless he stops using drugs. How can I trust him? He cannot even stop using drugs so how can they adhere to the medicine?”

IDUs not only have to contend with the negative public attitude towards them as a barrier to accessing treatment, but also face the problem of drug interactions between methadone and antiretrovirals.

**Case 1**

*When I was a kid, I was taught to behave like a Thai traditional woman as the phase, “men are front leg of elephant whereas women are back leg.” That is typical expectation toward women in Thai society. I dreamt about happy family with a lot of children. After being infected with HIV, my family has changed expectation toward me. They do not want me to get married. They said it is sin if I myself spread the disease to others.”*

*known that he  
h methadone  
n the two  
e there is  
ask the nurse*

*for more methadone, but she hasn’t trusted me. Now I am still using some drug, but in small amount. If I can choose between methadone and antiretroviral, I am surely will choose methadone first.”*

**B. Seafarer**

Seafarer are a vulnerable group that have been hard-hit by HIV. Our one sampling sites is a community hospital close to the sea, which means that almost male patients are sailors who have a low income. Even though the sailors may not face difficulties with access as Thai citizens, they have often have problems with adherence.

**Case 3:**

*My work and taking medication do not get along. When I am on boat, I cannot take medicines on time. Sometimes, I cannot follow up doctor appointment because I was on abroad.*

**C. Women**

Women and men have equal access to ARVs, but these drugs have a greater impact on women than men. Firstly, there are the side-effects of antiretroviral. Women are more sensitive to the (stronger) side-effects of taking antiretroviral drugs, especially if they change their physical appearance (e.g. lipid dystrophy).

Secondly, there is the cultural and norm in society with respect to gender-related behaviours. In Asia, women are expected to be faithful and submissive. They are expected to perform their duties as good daughter, wife, and mothers.

**Case 5**

*I knew that I had HIV since I pregnant my first child. At that time there was no medicine. Luckily, my son hasn't infected. I married the second time, but this time I was not plan to pregnant. This time, I took ARV during my pregnancy. My husband doesn't know that I am HIV positive as well as our child. He is too young and I don't think he can accept this. I do not dare to tell him about HIV even though sometimes he asked for my blood test. I lost my job because I have to go to hospital so often. How can I loose him?*

Motherhood is one factor that strongly influences women to gain access to treatment. All of the informants who have children say to that the reason they need to survive is to take care of their children. Sometimes, motherhood is the most powerful force and the important reason why they put up with their lives.

**D. Children**

The restricted child access to ARV treatment is primarily due to the lack of paediatrics ARV formulations and, in some rural area, there are no paediatricians at all, which means that their parents or guardians must take their children to the provincial hospital creates a barrier to them.

**Table 4.5 Access to paediatric ARV formulations “Limitations due to regulations” Experience from the field MSF**

<b>Medicine</b>	<b>Thailand Case</b>
AZT : 100mg, syrup	100 mg caps and syrup registered, not patent protected and generically produced (GPO Thailand) –On the field 100 mg caps often lacking (poor stock management, stiff regulations)
3TC: tablet 150 mg, syrup	Syrup and tablet: registered, not patent protected and paediatric formulation (scored tablet, syrup) available generically.–Only syrup provided within National ARV programme but children prefer tablets
d4T 15, 20 mg and syrup	Syrup and tablet: registered, not patent protected and paediatric formulation available generically (Syrup, 15 and 20 mg caps)
ddI	Patent: Court case challenging breath of patent delaying production of generic version–CL not applied (political pressure)–Patent was revoked (out court agreement)–ddI25, 50, 100 and 200 mg sachets now available (but SE, disclosure)–Scored tablets of 50, 125 and 200 mg produced soon–Enteric coated: originator applied for patent but not issued (yet), objection from generic producer (pending)
NVP: syrup, 200 mg tablet	Patent for syrup formulation under investigation Generic formulations = dry powder
EFV: syrup, 50 mg caps	150 mg was registered but not marketed (not distributed by local supplier) 2–syrup is not available 3–600 mg available, still poor availability of 50 mg caps.,

paediatricians are told to break 600 mg tabs.
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Source: Access to Paediatric ARV Formulations “Limitations due to regulations” experience from the field MSF.

ARV treatment for children is not as straightforward as for adults. It is more sensitive and is dependent on many factors, such as their guardians. Guardians must be responsible for children, including following up doctor’s appointments, adherence etc. The main obstacle for children to gain access to treatment is their guardian.

Unlike adults, children are entirely dependent on their guardians to take them to hospital, remind them to take medicine and give them psychosocial support. Many children whose parents have died live with grandparents who need to know the about the ART and supervise their children. The most important thing for children is psychological support.

The important challenge for treating children is this psychosocial dimension. Policymakers, health workers, and others involved in the treatment process must realise that antiretroviral treatment is not just a medical phenomenon. Certainly, they will give them a better quality of health, but there the surrounding and social context is also a strongly influence on them. Children with HIV must live like normal children. They will grow up, attend school, have girlfriends or boyfriends. How can they adapt themselves with the surrounding? Shall they reveal that they are HIV positive to their friends and others? We have to find the way to answer these questions.

***Grandmother as Caretaker***

*My granddaughter has infected HIV from her mother. Their parents passed away a few years ago so now I am taking care of her. She is 12 years ago and attends school as normal children, but sometimes the teacher won’t allow her to play some musical instrument believe that it will infect other student. I am worried about her. (crying) If I pass away, who will take care of her? She took some expensive medicine costs 10,000 baht per month. I told all my children that I will give them my house unless they promise to take care my granddaughter.*

E.

Other vulnerable groups

Other marginalised people who are confronted with the barriers to access ARV treatment are prisoners, the mobile population (People who rapidly from place to lace) migrant workers, and the hill tribes. Prisoners not only face the difficulty to gaining access to antiretroviral therapy, but also other health problems. The mobile population and migrant workers face the access to health facilities because they do not have Thai citizenship. Hill tribes-people have a limited knowledge about HIV and medical treatment. Moreover, their language and cultural belief systems create a huge obstacle for them with respect to gaining access to treatment.

4.3.3.8 *Life of PLWHA after taking ARV*

Most of the informants strongly agreed on the positive effects after taking antiretroviral drugs, except in some cases the strong side-effects, but they still agree that they experience a reduction in opportunistic infections. Taking antiretrovirals help them not only get back to work, but also reduce the stigma attached to HIV/AIDS in the community. People still believe that having HIV positive means a pathway to death, but availability of antiretroviral drugs has changed their point of view and they realise that they can live like others without the virus.

### 4.3.3.9 Cost

The cost of treatment is not major problem for PLWHA since the ARV programme in Thailand is free of charge. However, the cost of viral load testing and drug resistance is problematic. Some of informants say that the transportation costs are a problem, since they must travel to provincial hospitals to receive the treatment.

### 4.3.3.10 Status

Most of the informants do not know which programme they are enrolled in. In some areas in which ARV treatment is funded by the Global Fund, both the informants and the health facilities do not know much about or have even heard of the Global Fund. They thought that their ARV treatment was funded by the Thai government or they were in a NAPHA programme.

The implementation of CCCs at health facilities clearly reduces the workload of health workers. The PLWHA network understands the patient both physically and mentally, which means that PLWHA participation in health facilities should be a key focus and implemented in all health facilities that provide ARV drugs.

## **4.4 Conclusion**

At present, vulnerable or marginal groups such as intravenous drug users, seafarer, women, migrant workers, and children, experience problems with respect to gaining access to ARV treatment. Consequently, guidelines on how to treat each group should be produced with an understanding of the cultural and social context of each group.

Even though the availability of ARV drugs has reduced the image of AIDS as terminal disease, the stigma associated with HIV/AIDS in the community is a key factor that influences the patients' decision to seek and receive the treatment in a hospital outside their own community.

There are many factors that influence the access to ARV drugs, such as the cost of transportation, having to take time off from work, side-effect and so forth.

Both policymakers and the health workers, and others involved in the treatment process should focus on care for children. In Chiang Rai province more than 200 children are currently receiving ARV treatment. These children, especially the teenager, face the difficulties of having to adapt to various environments or social context, such as school and their peer group. They do not know when they should disclose their HIV positive status to others. How can they tell others why they are taking medicine?

The children concerned pointed out that the problem of adapting to the social context for those receiving ARV treatment should be raised, such as PLWHA who want to marry and have a family. After the PLWHA receive the ARV drugs, the opportunistic infections are reduced and their appearance improves, they want to live like everybody else, to marry and have children.

In sum, the barriers that hinder or prevent access to ARV treatment include lifestyle, the cost of tests and/or transport, ARVs, stigma, gender, marginalisation and being a member of a vulnerable social groups.





## V. PARTICIPATION OF CIVIL SOCIETY

The civil society plays a crucial role in the response to the AIDS epidemic in Thailand. NGOs have become an influential driving force for social mobilisation, in addition to the public sector's agencies. They have led the public sector to eagerly seek collaboration as regards the exchange of knowledge and operational techniques, which may maximise operational efficiency. Civil society in Thailand not only stands structurally for the community level, but also for policy and health facilities.

Initially, in 1989 the Thai NGO Coalition on AIDS was formed in order to exchange experiences and information, to reduce the duplication of work and assemble a stronger collaboration, and to advocate campaigns. As a result of the huge AIDS epidemic, the number of AIDS NGOs has increased steadily. In 1984, there were 50 AIDS NGOs, whereas by 2001 248 of NGOs had registered with the MOPH.<sup>23</sup> The number of NGOs increases, along with the network of PLWHA.<sup>24</sup>

Unlike other nations, AIDS NGOs in Thailand have participated in both AIDS policymaking and the programme design process. Besides being funded by international donors, AIDS NGOs also receive funding from the AIDS division budget, which is allocated to support the projects being launched by NGOs.<sup>25</sup>

### 5.1 CCM, National Policymakers

In the CCM mechanism, the six members are NGO representatives<sup>26</sup>. Even though there are two or three time fewer people than those of government, they are still voices of the civil society.

In Thailand, government and civil society has worked together. They have realised that in order to solve the HIV/AIDS problem successfully, they must rely on each other.

**Table 5.1 List of non-governmental organisations receive funding from Global Fund**

Name of Agency	Type of Agency	Main programme
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<sup>23</sup> Bureau of Health Policy and Plan, *Thailand Health Profile 1999-2000*, (Ministry of Public Health: Bangkok) p. 383.

<sup>24</sup> According to Penjan Pradammuk, 's work on AIDS NGOs in Thailand's movement, in 1996, AIDS NGOs in Thailand are categorised into 7 groups: Public organisations, Development organisations, Professional associations, People's organisations, Academia and officials association, Networks, and NGO support organisations.

<sup>25</sup> The AIDS Division allocated 87.5 million baht to 465 projects of 373 organisations in 1999. Although that funding shrank to 60 million baht the following year, the shortfall was made up by the AIDS component of the World Bank loan under its Social Investment Programme, which steered another 27 million baht to projects in six main NGOs. (Source: Thailand's Response to HIV/AIDS: Progress and Challenges: UNDP, 2004.)

<sup>26</sup> Dr. Praphan Phanuphak (Thai Red Cross AIDS Research Center); Dr. Thavisakdi Bamrungrakul (Anti-Tuberculosis Association of Thailand); Dr. Krongthong Thaimasarn (Malaria Association of Thailand); Mr. Chernporn Teang-amnuay (Thai Pharmaceutical Manufacturing Association); Mr. Promboon Panitchapakdi (Thai NGO Coalition on AIDS); Mr. Kamon Uppakaew (Thai Network for People living with HIV/AIDS)

Care/Raks Thai Foundation	NGO	Prevention of HIV/AIDS among migrant workers in Thailand
PATH	International NGO	HIV/AIDS prevention in school
Thailand NGO Coalition on HIV/AIDS	NGO	HIV/AIDS prevention in the community programme
Thailand Business Coalition on AIDS	NGO	Prevention HIV/AIDS in the workplaces
Thai Network for People Living with HIV/AIDS	NGO	Outreach support and participation of PLWHA group for ARV as partnership with local hospital and the communities
Thai Red Cross	NGO	Research and development training
PHPT	Research	HIV care

Moreover, at the Regional Disease Control Centre, there is funding to develop the private sector with respect to HIV/AIDS. The committees are made up of government and non-governmental representatives. The preliminary policy results showed that NGOs have become part of HIV working groups and are accepted by the Thai government.

The cooperation between governmental and non-governmental institutions was also illustrated by the case of the revoking of the Thai patent on ARV drug, ddI. The Legal battle to revoke the patent on the ARV drug Videx in Thailand is considered to be an important event, since it is the first time that patients were legally allowed to file a law suit against a company in a Thai court, arguing that an unlawfully obtained patent was preventing their access to a medicine, which was necessary for treating their condition.<sup>27</sup>

In this case, Thai people with HIV-1 won an important legal battle to increase access to medicines. In its judgment in the Didanosine patent case against Bristol-Myers Squibb, the Thai Central Intellectual Property and International Trade Court ruled that, because pharmaceutical patents can lead to high prices and limit access to medicines, patients are injured by them and can challenge their legality.<sup>28</sup>

## 5.2 Health Facilities

At the health facility level, the role of PLWHA is to provide peer support in coordination with health workers. In July 2002, TNP+, MSF, and AAF designed the peer programme called Comprehensive and Continuous Care centre (CCC). This centre is managed by

<sup>27</sup> Wisartsakul, W (2004). Civil Society Movement to revoke the Thai Patent on ddI.

<sup>28</sup> Ford, N et al. (2004) The role of civil society in protecting public health over commercial interests: lessons from Thailand. *Lancet* 363:

PLWHA and provides treatment support such as psychosocial support, home visit, and medication taking, etc.

With the funding from Global Fund in 2002, the PLWHA networks have implemented the Centre of Comprehensive and Continuous Care in 105 hospitals: 19 at a provincial level and 86 at the district level. CCC aims to provide treatment support to other PLWHA in the area. It also arranges some activities and encourages the PLWHA participation in the health centres.

The design of CCC is adapted based on the health facility context. Based on our findings, the CCC has designed:

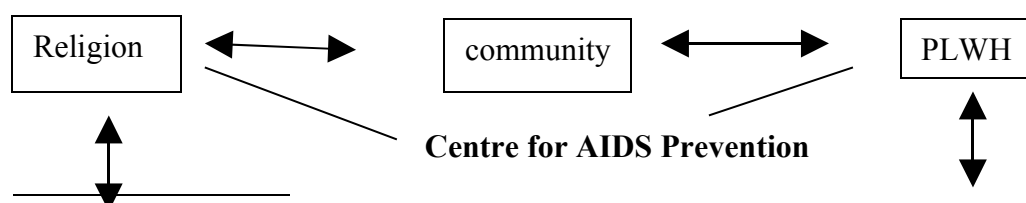
- Formal centres: This CCC is located in the hospital with the acceptance from the hospital director. The PLWHA work as part of medication team. They joined the counsellors meetings and have disclosed their HIV status in the community.
- Informal centres: This centre is located outside the hospital or may not even exist as a physical space. The reason for it not being located in the hospital is the lack of approval by the hospital director or the limitation of space.

The success of the CCC has been accepted both nationally and internationally. The NGOs not only plan to implement this programme in all health facilities providing antiretroviral treatment, but also in neighbouring countries.

### 5.3 Support groups in communities

There are many support groups working in communities in Thailand. Firstly, since the epidemic of HIV has exploded, the community itself has tried to empower HIV+ people by, for example, selling hand-made products, etc.

**Figure 5.1 Map of collaboration and network of actor in Chiang Rai<sup>29</sup>**



<sup>29</sup> Taoprasert, Y. The Lessons and Experiences in AIDS Solution of Upper Northern Communities, p.39.



Another notable support group is faith-based organisation, which plays role for HIV patients as a caregiver for the sick and dying. Some of them also offer small hospices to care for fully-blown AIDS patients.

In order to reduce stigmatisation, many organisations foresee the importance of working at a community level. For example, the Population and Community Development Association (PDA) , in cooperation with the District Offices, is developing the project Family Planning, Healthcare and AIDS Prevention, by selecting and training volunteers from the community who were well-liked and well-respected. These people were supplied with an initial stock of contraceptives for distribution within their villages.

## VI. CHALLENGES FOR THE FUTURE

### 6.1 ART in the future: Political commitment

Since ARV drugs have been discovered to be the best way to prolong the life of PWLHA, it has become a challenges for researchers to make the medicines more effective, for the NGOs to find ways to allow people to gain better access to them, and for the government to manage the national programme effectively. Faced with the pressing challenge of making ARV drugs more accessible, the HIV/AIDS situation will be changed in a few years.

It is assumed that the inclusion of the ARV treatment programme into universal coverage will be beneficial to Thai PWLHA. Unlike universal coverage, NAPHA itself does not have legislative law so that universal coverage will be more guaranteed for the long term sustainability than NAPHA. On the other had, how this should be included in the 30 bath health plan will still be hotly debated. The majority of the government is concerned with this financial issue, since the 30 baht programme itself faces financial constraints.

As universal coverage is considered, political schemes, which the political parties have used for election, universal coverage is based mostly on a political decision made due to budget constraints rather than on evidence of a utilisation rate and unit costs. After arguing for a long period about the NHSO budget, the subsidy has finally been increased from 1,396 to 1,510 baht (around 35\$ per person). Without the exact figure relating to universal coverage debt, some papers claims that the cumulative debt would be more than 2,000 million baht. As a result of such huge debt, it is questionable whether the ARV provision will be sustainable in the long run after being pushed into the universal coverage scheme.

After ARV universal coverage is formed, it would require HIV/AIDS programme managers to join forces with other counterparts to identity the common societal dynamics that they are encountering, and to increase the potential for coordinating their interventions. Equipped with the advantage of a well-organised and capable health system, NAPHA management programme and human resource has proved successfully under the rate of adherence as well as the Horizon Report on ATC evaluation.

The MOPH is currently using more than around 20 million USD (assuming from the first line regimen, GPO vir, at the price of 360\$ per person per year) to cover 50,000 PLWHA. The source of funding for ARV treatment is still questionable. How can the Thai government cover this huge amount? In a few years, the money from Global Fund, a major international funding resource, will be curtailed.

It is worth noting that to cope with the rising need for on-going treatment, the Infrastructure needs to be well-equipped; thus, the DDC uses the Global Fund money to invest in infrastructures such programme start up, training of cadres of human resources, central purchasing of ARVs and laboratory reagents and the procurement and distribution of medical devices e.g. flow-cytometres.

Furthermore, to meet the current demand, what was and is still fundamentally required is Thailand's treatment and care strategy related to drug-resistant strains, biomedical monitoring and research, and VCT, which should be formed and enhanced. Moreover, the urgent scaling up of AIDS treatment should be included in a comprehensive HIV prevention and care programme. Even though the adherence level of ART in Thailand is high, the barrier to adherence such as the influence of socio-demographic factors, the number and severity of side-effects, and stigma and fear of disclosure should be treated.

Overcoming the HIV/AIDS epidemic requires strong efforts from top level to the grassroots. The political leaders should pay attention and treat HIV as an urgent issue, enhancing the facilities that are needed. Importantly, at the grassroots level there should be a link to or involvement with the government programme.

## **6.2 Sustainability**

Crucial factors for sustainability are the integration of ARV treatment into the regular healthcare system, sufficient and proficient supporting infrastructures, political commitment, resource mobilising, and reliable sources of drug supply. However there is projection study that proposed that after 2010 most costs of the public ARV drugs will be second line ARV drugs<sup>30</sup>.

## **6.3 Drug Resistance**

The drug resistance was brought into discussion because of adherence and the self-adaptability of the virus itself. The government took action by establishing a policy to study the impact and preparation. It was proposed that in 5 years time, such drug resistance would emerge. Thus IPRs discussed whether this will be the cause of high cost drugs and whether the CL would have to be used.

## **6.4 Scale Up:**

### **6.4.1 Gap in Public Interaction**

Thailand's achievement in managing its HIV/AIDS programme is that of raising awareness among the general public and international organisations. While Thailand's effort in managing its HIV/AIDS problem has been less dependent on external assistance than in other countries, the formation of the fund, if available to Thailand, would help to reduce the disproportionate gap between domestic financial availability and the increasing number of PLWHAs who need support.

The major programmes mostly are in the public sector. What is lacking in the programme is their collaboration. NAPHA as initiator is considered to be well-established with both human resources and a good infrastructure, especially with the funding from Global Fund. However, physicians, pharmacists and nurses have

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<sup>30</sup> MOPH WB joint study (2004) and Viroj Tangcharoensathien and Waranya Teokul (2006) Sustainable Financing HIV/AIDS and ART programme, access from [www.hivnat.org/download/04\\_sustable\\_ARV\\_18\\_Jan\\_2006\\_Viroj\\_Waranya.ppt](http://www.hivnat.org/download/04_sustable_ARV_18_Jan_2006_Viroj_Waranya.ppt)

complained about their increasing workload since NAPHA expansion from 10,000 to 50,000 this year, and the SSO programme.

In this way, the providers reported that the repetitive work of NAPHA and SSO wasted their time; for example, keeping the GPO vir in 2 stocks both for NAPHA and SSO. In addition, there is concern about the management system for the patients, now there is no central information system that links all the sectors together. For example, the patient must switch the programme from SSO to NAPHA after quitting their job. What about the patient's medical history? Moreover, the patient currently claims for the treatment of their OIs via universal coverage, and ARV via NAPHA. Due to the limited quota in each area, some patients noted that they must spend both time and money travelling to two hospitals in order to receive one drug for OI and another for ARV therapy.

Further to this, the guidelines for standardised regimen are quite scattered in different way. With a large amount of money, Social Security Office tends to allow the PLWHA more beneficial treatment. For instance, if the PLWHA is resistant to the first and second line regimen, the SSO would pay 5,000 baht per month (125\$) for the extra regimen whereas NAPHA is limited with its funding.

In a few years time, it is assumed that the ARV treatment programme will fall under the national coverage scheme, which means all Thai PLWHA can be treated by ARVs. Importantly, the collaboration between public sectors should be enhanced and the cost sharing by concerned parties and training should be established so that the public sector can share costs of infrastructure and training of human resources.

#### 6.4.2 Effectiveness approach versus process approach

To give access to ARVs, some important topics are needed: compulsory licensing, parallel importing, generic production, negotiation with bulk purchasing, and access to an initiative programme. The experience of process and model development approach need to be kept in mind when planning the new plan.

#### 6.4.3 Toward upon more prevention concept

The balance between prevention and care is to be considered by utilizing NGOs capacity and network as well as the existing infrastructure through VCT plan. Hence good strategy and technique is to be planned with support from academia for the study of risk behaviour and intervention feasibility.

#### 6.4.4 Stigma

Stigma from society is one major obstacles for implementing the ARV programme, thus public-private initiatives should focus more in this issue. Stigma hinders both prevention and care.

#### 6.4.5 New concept: Merger between two ARV treatment programmes

The concept of merging all ARV treatment programmes into one scheme is being discussed as a basic human right. The existing ARV treatment programmes will move to more specialised area of interest and concern.

## **6.5 RECOMENNDATIONS**

In general the provision of ARV to all patients in Thailand is on the agenda. The proposal of recommendation is to further strengthening the quality and sustainability.

### **6.5.1 Policy Part**

- Adjust all schemes of ARV provision into same national protocol
- Make use of GF ATM programme for long term implementation is great and should be continuing set especially for second line drugs
- Long term plan for resistant and patient s with serious adverse effects that require second line ARV
- National measure to alleviate problem of high cost ARVs and shortages by using compulsory licensing and parallel imports
- Standard treatment in every health facilities providing an ARV treatment programme.
- Assure quality of GPO drugs to include in the WHO qualification scheme
- Improve monitoring and evaluation, and management system at all levels
- To ensure that ARV are provide to all patients in need
- Utilization of private and charity in the provision
- Provide CAP (Community Advisory Participatory) in clinical trail. Ethical standards are needed.
- Policy to reach those of vulnerable and marginalized groups

### **6.5.2 Implementation**

- Prepare the health facilities to ensure quality of treatment
- Standardization of practice at health facility level
- Management of overloaded work
- Improve quality of life and will of staff in the field
- Implement of comprehensive care
- Effective utilization of CAP to help work in the facility
- Search for those marginalized groups in the area
- Ensure of VCT to increase utilization

### **6.5.3 Communication**

- Political communication from the center to the field has to be clear and thoroughly convey to all level
- Sharing of experience between areas of implementation
- Policy dialogue among schemes of ARV provision to ensure coverage and same quality of treatment and practice

## VII. REFERENCES

- NAPHA implementation workshop (14, 23 September 2004)  
Interviewed Dr.Petchsri Sirinirun (Department of Diseases Control, MOPH) (Januray 31, 2005)  
Interviewed Mr.Kamon Uppakaew (Chair, TNP+) (.....)  
Meeting with TNCA (March 4, 2005)  
Meeting with Dr.Wiwat (A2 Project, East-West Center) (March 28, 2005)  
Group Discussion with TNP+ (May 5, 2005)  
10<sup>th</sup> National AIDS Conference (13-15 July, 2005) Powerpoint and document  
Interviewed Dr.Viroj Tangcharoensathien, Director IHPP, MOPH (July 15, 2005)  
Interviewed Dr.Sanchai Chasombat (Manager of NAPHA, AIDS Cluster, Bureau of AIDS, TB, and STI, MOPH) (July 26, 2005)  
Interviewed Professor Dr.Praphan Panupak, Director Thai Red Cross Research Centre (August 1, 2005)  
Interviewed Mr.Paul Cawthorn (Director, MSF Thailand) (August 4, 2005)  
Interviewed Ms.Lawan Sarovat, Cummuncation coordinator MSF Thailand  
Meeting and discussion with staff at 2 Disease Control Regional Centres  
Meeting and discussion with staff at 2 provincial health offices  
Interviewed staff at 9 hospitals in the provinces

## ANNEX 1: Facility information

Facility No. \_\_\_ Name \_\_\_\_\_

### Facility Background

Size \_\_\_\_\_ Number of Bed \_\_\_\_\_

Number of Doctor \_\_\_\_\_ Nurse \_\_\_\_\_ Pharmacist \_\_\_\_\_

Director \_\_\_\_\_

Address \_\_\_\_\_

Tel \_\_\_\_\_ Fax \_\_\_\_\_

### ARV Background

Provided by MOPH \_\_\_\_\_ (years) MSF \_\_\_\_\_ SSO \_\_\_\_\_ Others \_\_\_\_\_

Number of health workers involving in ARV program

Doctor \_\_\_\_\_ Nurse \_\_\_\_\_ Counselor \_\_\_\_\_ Pharmacist \_\_\_\_\_

HIV Clinic: M T W Th F Others \_\_\_\_\_

Home Visit: M T W Th F Others \_\_\_\_\_

Number of HIV/AIDS patients \_\_\_\_\_ Number of ARV users \_\_\_\_\_

HIV Test CD4 \_\_\_\_\_ Viral Load \_\_\_\_\_

Provided Treatment/Prevention:

- IEC on Prevention \_\_\_\_\_
- Provision of Condoms \_\_\_\_\_
- Treatment of STIs \_\_\_\_\_
- Treatment of TB \_\_\_\_\_
- PMTCT \_\_\_\_\_
- Others \_\_\_\_\_

Have PLWHA network involves in the program? Yes No

Guideline Cover (Y/N): Developed from?

- How ARVs work \_\_\_\_\_
- How to use them \_\_\_\_\_
- The need to continue treatment \_\_\_\_\_
- What to do if a pill is forgotten \_\_\_\_\_
- Possible interactions with other drugs \_\_\_\_\_
- Which side effects can occur & what to do if they occur \_\_\_\_\_
- (Breast) feeding requirements \_\_\_\_\_
- When and where to get re-supply \_\_\_\_\_

Program Requirement

- do you require partner notification? \_\_\_\_\_
- disclosure? \_\_\_\_\_
- do patients need to present a buddy to support them in treatment? \_\_\_\_\_
- do they have to prove that they can be adherent first? \_\_\_\_\_  
With (other drug) \_\_\_\_\_
- do they have to follow counseling or other training sessions? \_\_\_\_\_
- quit smoking/drinking/drug \_\_\_\_\_

- anything else Please explain details on what is required. \_\_\_\_\_

Others \_\_\_\_\_

## **ANNEX 2: Guidelines for semi-structured, key informant interview PPI administrative/policy workers**

Selected PPI and national AIDS implementation policies.

1. What were the original goals and objectives for the PPI? Have these goals/objectives been met? Any obstacles to achievement? What are the treatment gaps?
2. Have the goals been amended during implementation? What changes were made and at which stages of implementation?
3. Who developed the guidelines? What processes were used to develop them? Were PLWA involved? Was the National AIDS program involved? Was the Ministry of Health involved?
4. Has there been disagreement on technical issues? Which issues? How were these resolved?
5. What monitoring and evaluation processes are in place? Who monitors and evaluates the PPI? Do you have any evaluation and monitoring reports for us as reference?
6. Is there a national AIDS policy on treatment and care? Is your treatment policy in line with this national policy? If not, what are the differences?
7. What were the selection, procurement and distribution procedures? Are these in line with national regulatory procedures and treatment protocols? Have there been any problems in procurement and distribution and how have they been resolved?
8. Does your PPI benefit from any discounts, subsidies and donations for medicines and tests? Please describe
9. Which point of entry to care does your program use (TB, PMTCT, others)
10. Do you also have an adherence support program? Please describe it. Does it work well? What are problems? Do you have any monitoring data on adherence?
11. What are in your view the main opportunities and challenges facing the PPI program.
12. What is your future plan? Do you plan to scale up? Any difficulties?

### **ANNEX 3: Interview with health worker**

Name of Informant \_\_\_\_\_ Anonymous  
Date \_\_\_\_\_ Name of Facility \_\_\_\_\_  
Position in the facility \_\_\_\_\_  
Role in ARV program \_\_\_\_\_  
Have you ever been trained about ARV? Yes when \_\_\_\_\_ No  
The training is about \_\_\_\_\_  
by \_\_\_\_\_

#### **PPI Question (Only facility with MSF)**

1. What is your role in this program? How long have you been involved in ARV program? How do you feel about working in the ARV treatment programme? In what way has the availability of AIDS medicines for people living with HIV and AIDS affected your routine work?
2. Do you have any contact with family and community members about your treatment program? In what ways do you do this? How does this function? Should community involvement be strengthened in your view? If yes, How?
3. Has availability of ARVs in your view diminished stigma related to HIV-AIDS in this community? How?
4. What is your process of receiving medicine? In what ways do you inform and prepare AIDS patients for ARV treatment? What kind of information do they receive?
5. In your opinion, what are the differences between public and private program? What are the differences working with private like MSF and public (Napha) such as enrollment condition and collaboration?
6. Since MSF is going to fade out pretty soon, what will you do after that? How can you deal with the patient who receive third regimen or the patient who cannot enroll Napha? How many patient of this group do you have?
7. Are there any activities in your health center to support health workers who treat AIDS patients? If yes, what kinds of activities?
8. Are you involved in decisions about the way the program is organized and about ways to confront the problems that occur? If yes, what kind of involvement? Would you like to be involved more in decision-making?

*Adherence and Scale-Up*

9. Does your clinic aim to scale-up treatment over time? Have any targets been set? Which? Were the treatment goals for the past year/or half year achieved? Will you achieve them this year/half year? What are the gaps?
10. What are the levels of non-adherence to ARV regimes in your centre? How do you monitor adherence? What do you think are the main reasons for non-adherence? Probe on which groups adhere best/worst.
11. Does the health facility have a system to follow-up ARV users? If yes, how is this organized?
12. Are there any specific problems related to scaling up of treatment? Can your health center cope with increases in number of patients? How will this affect quality of care?

#### *Treatment*

13. Do you use written treatment guidelines? Can I see them? Who developed the guidelines? Do you use them (Yes/No)? How often (per month)? Do you always prescribe in accordance with the guidelines (Yes/No)? If not, in what cases / for what reasons do you sometimes deviate from the guidelines? Request a copy of the guidelines.
14. Specifically, what medical criteria and conditions are used to decide which patients should start using ARVs? Who has decided on these criteria and conditions? Do you always apply them, or do you sometime adjust them? If yes, why? And when?
15. Are there groups of patients who are excluded from treatment? (for example drug users, children etc). In your view are there any other groups that should not be treated? Why not?
16. Are there any other problems that affect whether people come to the clinic and how they use ARVs?
17. What do you see as major problems in your ARV treatment programme?

#### *Pharmacist*

18. Have there been stock-outs of these ARVs in the past three months? What kind of medicine? How can you deal with it?
19. Are any of these ARVs at present expired? What did you do when the ARVs expired?
20. What do the patients pay for the third line treatment? Please specify. And how much – approximately - do they have to spend in additional costs, including transport and related costs for diagnostics, etc.?
21. Do you think costs are a problem for the ARV-users? Please explain.

#### **ANNEX 4: Interview with PLWHA, using ARVs**

Name of Informant \_\_\_\_\_ or Anonymous  
Date \_\_\_\_\_ ARV Facility \_\_\_\_\_  
ARV Medicine \_\_\_\_\_ Program \_\_\_\_\_  
Sex: F M Others Married/ Single/Separated/ Divorced  
Occupation \_\_\_\_\_ Involved with PLWHA Network Y N  
House: Rent Own or living with parent  
Partner with HIV Death Taking ARV where \_\_\_\_\_ unknown  
Children with HIV Y N how many? \_\_\_\_\_ if infected with HIV, have you taken  
Medicine during your pregnancy? Yes NO

#### *Medical background*

CD4 Before taking ARVs \_\_\_\_\_ CD4 after taking ARV \_\_\_\_\_  
When were you diagnosed with HIV/AIDS? \_\_\_\_\_

Where did you get tested for HIV, specify kind of facility, and kind of health service  
(PMTCT, TB, others)? \_\_\_\_\_

Did you request the test? Yes/No Or, was it done as a routine? Yes/No. If yes, were you  
informed about the test? Could you have decided not to have it done?

Did you receive counseling before/after the test?

Did you know at the time that there were AIDS medicines available for treatment?

When did you start coming to the center for AIDS medicines? \_\_\_\_\_

Have you had any treatment for HIV/AIDS in another center before? If yes, which medicines  
did you receive there, when and where? Why did you change the facility?

Were any tests done to decide if you should have the treatment? Which tests? And do you  
know the results? \_\_\_\_\_

Did you miss a dose in the past three days? Probe on when and why, and what happened.

1. How do you feel since you are taking the ARV treatment? Any side effect?
2. Before taking ARVs, have you ever tried other kinds of treatment? What were they?
3. Do you think it is safe to take the ARV treatment? If not, why not?

4. How many times a day have you taken medicine? What is it like for you to take the medicines everyday? Have you experienced any problems? Probe, when you go to your work, to school, to town, or when you travel?
5. Is the cost be problem for you to access the medicines such as transport cost or additional cost (diagnostic test) or other expenses?
6. Do you discuss any problems related to taking the medicines with your health workers? If yes, what have you discussed with them, please specify? Were they able to help you?
7. Was there anything you had to do to qualify for treatment at your current center for example go to counseling, have a buddy, disclosure status to anyone, have to inform the partner, prove adherence, or others? Do you think these are your difficulty to access medicines?
8. What do you think of the way you are treated in your current centre? What do you think is good, and what do you consider problematic in the way you are treated? More in particular:
9. Are there any other things you want to say about the way you are treated in this clinic?
10. Do family members, friends or others outside this clinic know that you are taking ARVs? Yes/No who knows about it? Do they provide support? If yes, what kind of support?
11. Are you or any other family or community members involved in the way the health center provides care? In what way are you/they involved?
12. What in your view are the biggest benefits of taking AIDS medicines?
13. Have you feel your life has been changed since you taking ARVs? How?
14. What are your biggest problems related to the AIDS medicines you are taking? What can be done to deal with these problems?
15. Have you discussed these problems with the health workers/counselors at the center? When, and in what circumstance?
16. Has availability of ARVs in your view diminished stigma related to HIV-AIDS in this community? How?

17. What is your expectation toward ARV program in the future?

18. Is there anything else you would like to tell us or ask us?

**ANNEX 5: Guideline for exit interviews with PLWHA using ARVs**

Name interviewer: .....

Interview number: .....

Date: .....

**1. Background information on client**

a) Sex	M / F
b) Age	Years
c) Educational level	
d) Occupation	
e) Community	

**Note** \_\_\_\_\_

**2. Whom did you consult/visit today?**

- Counselor
- Nurse
- Medical doctor
- Pharmacist
- Other:.....

**3. What was the reason for your visit today?**

- To start using AIDS medicines
- Routine follow-up, if yes: when did you start using the AIDS medicines?
- Other reason: .....

**4. What was the result of the visit?**

- I got AIDS medicines for the first time
- They gave me a refill of my medicines

- They gave me a different kind of medicines  
If yes, why did the doctor prescribe different medicines?.....
- Others .....

**5. If the client was given AIDS medicines for the *first time*, or was given a *new kind of AIDS medicines*, ask if the health worker told them:**

- How ARVs work
- How to use them
- The need to continue treatment
- What to do if a pill is forgotten
- Possible interactions with other drugs
- Which side effects can occur & what to do if they occur
- (Breast) feeding requirements
- When and where to get re-supply

**6. If the clients was given a *repeat* prescription, ask him/her:**

- What did the heath worker ask or say? What did you discuss with the health worker?  
Probe:
- Were you asked about the way the medicines are affecting your health?  
Were you asked about any problems that you have experiences in taking the medicines?
- Did you mention any problems? Which?
- Were you specifically asked about adverse effects?
- Did you mention any adverse effects? Which?
- Did the health worker ask you if you had missed a dose?

**5. Quality of care in the centre**

I would like to ask you some more questions about the way you were treated in the centre today.

- a. How long did you have to wait before being attended to?... .. minutes
- b. Do you feel you got the chance to ask questions  
about the treatment Yes / No
- c. Do you feel you got the chance to ask questions  
about any effects of the treatment on your body and life? Yes / No
- d. Do you feel you are listened to? Yes / No
- e. Do you feel you are treated with respect and sympathy? Yes / No
- f. Do you feel you can trust the health workers? Yes / No  
Did you receive any written information? Yes / No

**6. Perceived problems and possible solutions**

- a. What do you perceive as most problematic regarding taking the ARV treatment?
- b. What do you think could be done to improve this?

**7. Anything else to say or ask?**

Is there anything else you would like to tell us or ask us?