

PERSPECTIVES AND PRACTICE IN ANTIRETROVIRAL TREATMENT

INVOLVEMENT OF PEOPLE LIVING WITH HIV/AIDS IN TREATMENT PREPAREDNESS IN THAILAND

CASE STUDY



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INTRODUCTION

In 2001 the Thai Ministry of Public Health (MOPH) launched an antiretroviral therapy (ART) programme. A decentralized approach was adopted and treatment was initially provided to 1500 people living with HIV/AIDS (PLHA) in 112 government hospitals (1). Previously, health care for PLHA had been provided from specialist centres. By February 2004, 23 000 PLHA were being treated in 860 hospitals.

In 2003 the Ministry undertook to provide 50 000 people with ART by 2005 and it is intended that 20 000 more will receive ART through a social insurance scheme. This amounts to close to complete coverage and exceeds the WHO "3 by 5" target.

In parallel with these efforts, patient groups and nongovernmental organizations (NGOs) have been working to provide PLHA with enough knowledge to make informed decisions on treatment and to play a central role as partners in the provision of care. This began in November 2000 as a nationwide community response to inadequate access to the prevention and treatment of opportunistic infections (OIs), and has prepared the ground for PLHA to provide practical support for the rapidly increasing access to antiretroviral drugs provided by the government.

The change in the role of PLHA from being passive consumers of health care to becoming partners in care provision

has helped to build their confidence and pride as well as gaining them greater respect from public health service staff. The present case study outlines the work of PLHA and their NGO partners over the last four years.

CIVIL SOCIETY AND AIDS IN THAILAND

The PLHA movement in Thailand is a movement of the rural poor, most of whom are farm or factory labourers, housewives or unemployed people. PLHA groups were first established in the early 1990s as a means of providing mutual support. There are about 600 of them, mostly hospital-based with a nurse supervisor and receiving funding from the MOPH or from local government.

NGOs and PLHA groups have played a key role in Thailand's response to HIV/AIDS since the first cases were notified over 15 years ago (2, 3). An early advocacy effort by NGOs focused on persuading the government to abandon legislation that would have required compulsory HIV testing. In 1998 a coalition of local and international NGOs and PLHA groups began to challenge the high price and monopolistic situation of antiretroviral (ARV) drugs in Thailand (4). Action has included the provision of legal and political support for generic drug production. A major victory was gained in 2002 when PLHA won a court case against a multinational pharmaceutical company, overturning a patent on the ARV drug didano-

Box 1. Comments by key stakeholders

"In government we treat people living with HIV/AIDS as partners... they have a very important role in educating people and communities, helping to diminish stigma and discrimination, and giving mutual support. They are very important in some of our decision-making. We recognize their outstanding work."

*Dr Sombat Thanprasertsuk,
Director, Bureau of AIDS, TB and STI, Ministry of Public Health, Bangkok.*

"Treatment is not only an issue for doctors. People living with HIV/AIDS should be in the driving seat."

*Mr Kamon Upakaew,
Chairman, Thai Network for People Living with HIV/AIDS.*

"People living with HIV/AIDS (PLHA) have a lot of information about opportunistic infections and about antiretroviral therapy. This makes health staff more active as they have to stay ahead. It's good if PLHA can screen themselves and help their friends: health staff need to discuss treatment with PLHA, but now they don't need to spend a lot of time explaining basic information ... These trained PLHA are good to work with. They are expert trainers of their friends, they can plan their work and they can carry out their plans."

*Ms Porntip Kemngern,
Nurse, northern Thailand.*

"If I were not HIV-positive I would still be a housewife and be working in the rice field. I would never have learnt how to say what I want or how I feel. I would never have learnt how to discuss health problems with my doctor."

Ms Buarian, north-east Thailand.

sine (5). NGOs and PLHA groups have also lobbied for universal access to ART for all PLHA who need it.



A rally to lobby for access to treatment

Advocacy alone is not enough. In 2000, as part of a problem-solving approach to the inadequacy of access to treatment, two NGOs and a network of PLHA groups began providing education on treatment within their own communities and cooperating with the health care system to prepare for wider availability of treatment (Box 2).

Box 2: Key community-based organizations and NGOs working on treatment advocacy and treatment education in Thailand

The Thai Network for People Living With HIV/AIDS (TNP+) was formed in 1998 in order to coordinate the activities of PLHA groups, which were isolated and lacked the ability to push for change. Before 1998, PLHA had not been active on health care issues.

The AIDS Access Foundation (AAF), a Thai NGO established in 1991, focuses on social and cultural aspects of HIV/AIDS. Through social campaigns and work with the media, this body advocates for policies aimed at reducing the stigma associated with HIV/AIDS. It also has extensive experience in counselling and training.

Médecins sans Frontières (MSF) began working on HIV/AIDS in Thailand in 1994, lending technical support to local NGOs and providing home-based care for PLHA in Bangkok. Pilot programmes supporting care and treatment for PLHA in district hospitals began in 1997 and ART was introduced in three hospitals in 2000.

PROMOTING PREVENTION AND TREATMENT OF OPPORTUNISTIC INFECTIONS

Inadequate access to treatment is a major problem in addressing the HIV/AIDS epidemic throughout the developing world. The political focus over the last few years, both internationally and in Thailand, has been on increasing access to ART. However, the prevention and treatment of OIs is also essential. *Pneumocystis carinii* pneumonia (PCP) is the second commonest cause of death among PLHA in Thailand, accounting for 18.4% mortality in 1999 (6). The disease is preventable and treatable with co-trimoxazole, an inexpensive antibiotic. The two other major OIs are tuberculosis (TB) and cryptococcal meningitis (hereby referred to as meningitis). In 1999, TB and meningitis accounted for 26.4% and 16.9% of deaths among PLHA respectively. The MOPH treatment guidelines include co-trimoxazole prophylaxis for PCP, standard six-month anti-TB therapy and fluconazole secondary prophylaxis for meningitis (7).

While advocating for lower prices of ARV drugs, Thai PLHA continued to see their friends dying of PCP and other preventable OIs. A decision was taken in 2000 by TNP+, MSF and AAF to launch a campaign aimed at increasing access to co-trimoxazole prophylaxis. This was thought to be a concrete and feasible goal that would benefit large numbers of PLHA relatively quickly and would counter a feeling of hopelessness among them.

ASSESSING COVERAGE OF CO-TRIMOXAZOLE PROPHYLAXIS

MSF's home-based care programme in Bangkok demonstrated that inadequate knowledge of and access to the prophylaxis and treatment of OIs were major causes of death among PLHA. In order to assess the situation in other areas of Thailand, MSF and partners carried out two surveys of PLHA activists early in 2000. It emerged that of the people with medical indications for co-trimoxazole prophylaxis fewer than half were receiving it. A common reason for this was that people believed AIDS to be untreatable (Box 3).

Box 3: Lack of access to prophylaxis and treatment for OIs

MSF programme in Bangkok

- ▮ Of 501 adults with AIDS or symptomatic HIV infection enrolled in the MSF home-based care programme up to mid-2000, 302 (60%) were not receiving co-trimoxazole prophylaxis at the time of enrolment.
- ▮ Of 229 PLHA with recently diagnosed TB, 137 (60%) had discontinued treatment before completion.
- ▮ Of 68 PLHA with previously diagnosed cryptococcal meningitis, 59 (87%) were not receiving secondary prophylaxis with fluconazole as recommended in MOPH guidelines.

Nationwide

MSF and TNP+ carried out two surveys to assess the situation in other areas of Thailand.

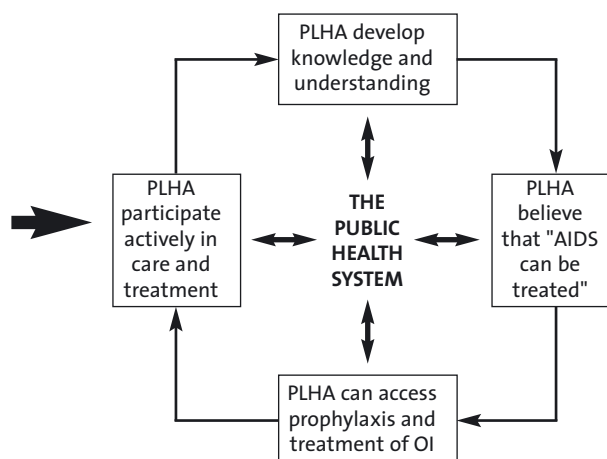
- ▮ The first was conducted in March 2000 among 170 PLHA from all parts of Thailand who were attending a national TNP+ conference. A questionnaire was distributed to determine how many people with symptomatic HIV infection were receiving co-trimoxazole prophylaxis. Of the 134 who completed the questionnaire, 81 had reported a symptomatic infection but only 40 of these were receiving the prophylaxis. Of those not receiving co-trimoxazole prophylaxis, 32 (78%) had not heard of it and 17 (41%) did not believe that AIDS-related conditions could be treated.
- ▮ In May 2000, similar results were obtained in a second survey conducted during an NGO forum in northern Thailand. Of 66 PLHA examined at an MSF mobile clinic, 63 had symptomatic infection but only 29 (46%) were receiving co-trimoxazole prophylaxis. Two of six PLHA with a recent diagnosis of TB had discontinued treatment before completion because they felt better. Four of six PLHA with previously diagnosed meningitis were not receiving secondary prophylaxis.

These surveys, showing co-trimoxazole coverage of under 50%, were conducted among relatively knowledgeable PLHA attending conferences. It was thought that coverage would be even lower among the general population of less knowledgeable PLHA.

THE CO-TRIMOXAZOLE PROPHYLAXIS CAMPAIGN

A project was launched to increase access to the prophylaxis and treatment of OIs, focusing on increased awareness of the use of co-trimoxazole for the prophylaxis of PCP. It was essential that PLHA should participate actively in their own treatment and care if they were to develop the knowledge and understanding necessary to believe that AIDS could be treated. The caring role of PLHA was therefore developed within the public health care system (Fig. 2). Seven full-time NGO staff supported the project, which was coordinated by seven PLHA from TNP+.

Fig. 1: The strategy of the Co-trimoxazole Prophylaxis Campaign



The following objectives were laid down for the period from November 2000 to October 2002.

1. Members of PLHA groups participating in the project would have information on the prophylaxis, care and treatment of OIs.
2. All members of participating groups who had symptomatic infection would be taking co-trimoxazole prophylaxis by October 2002.
3. All members of participating groups who developed TB would complete the correct treatment in accordance with MOPH guidelines.
4. All members of participating groups who developed meningitis would receive secondary prophylaxis with fluconazole.
5. PLHA participating in the project would be able to recommend the correct treatment for common symptoms and OIs.
6. Coordination would occur between the public health system, NGOs and PLHA on care and treatment.

157 interested PLHA groups were indentified, each having at least two core members who could dedicate time to work on the project. The core members' main responsibility was to ensure that all other members with AIDS or symptomatic infection in their group were receiving co-trimoxazole prophylaxis by October 2002.

Core members were made responsible for:

- (1) screening other members of their group for signs and symptoms of immune deficiency,¹ and referring them to hospital if they were not receiving co-trimoxazole prophylaxis;
- (2) providing first aid for PLHA with common symptoms such as acute diarrhoea, fever and rash;
- (3) referring PLHA to hospital if they had symptoms of OIs, such as chronic cough, chronic fever, chronic diarrhoea and headache.

The initial training programme

The project began with the training of PLHA core members so that they could fulfil their tasks of screening, basic treatment of OIs and referral. Eight training courses were held

across the country. On average, 34 core members from 20 groups participated in each session. An outline of the workshops is given in Box 4.

Box 4: Outline of workshops on basic health care and knowledge of OIs in people living with HIV/AIDS

Objectives

1. Participants should be able to provide care at home for PLHA with common symptoms and some common OIs.
2. Participants should know which symptoms have to be referred to hospital.
3. Participants should understand the natural history of HIV infection and the relationship between the CD4 count, the level of immunity and the occurrence of OIs.
4. Participants should be able to screen themselves and other PLHA for indications to begin co-trimoxazole prophylaxis.
5. Participants should understand the need for continuous co-trimoxazole prophylaxis, for completing TB treatment and for continuous secondary prophylaxis with fluconazole in cases of meningitis.
6. During and after the training, necessary support should be given to participants who become newly aware that they have immune suppression. Confidentiality should be maintained.

Basic information on ART was added to the training in 2002.

Objectives

1. Participants should be able to help PLHA to make informed decisions on whether and when to start ART.
2. Participants should understand the importance of good adherence, should know about common side-effects and should understand that OIs can continue to occur until immunity has improved.

Training approach: participatory; case studies; sharing of experience.

Duration of training: three days.

Adapted from the curriculum developed by AAF, MSF and the ASEAN Institute of Health Development of Mahidol University, Bangkok, 1999.

¹ The signs and symptoms of immune deficiency were those listed in the MOPH guidelines for the prevention of PCP, including a list of clinical conditions that many PLHA were already familiar with: pruritic papular eruption, oral candidiasis, herpes simplex, herpes zoster, chronic diarrhoea, TB, Cryptococcal meningitis and others.

An expected outcome of the training was that core PLHA members would learn to recognize symptomatic HIV infection and would therefore know when to refer their friends to a doctor for the commencement of co-trimoxazole prophylaxis. The outcome was assessed in the following way: before each training course, participants volunteered to be screened by an MSF nurse for signs of symptomatic HIV infection. On the last day of each training session the participants interviewed each other and carried out a simple history-taking and a physical examination.

Of the 195 PLHA screened in this way, 122 were diagnosed as having symptomatic HIV infection by MSF nurses while 131, including all those diagnosed by nurses, were diagnosed as having symptomatic HIV infection by PLHA. The PLHA core members overdiagnosed symptomatic HIV infection in three cases of skin disease that was not HIV-related and in three cases of asthma. However, they discovered two cases of recurrent herpes simplex genitalis, about which their friends had not informed the MSF nurses.

Core PLHA members who had gained experience in screening their peers and wanted to develop a role as peer educators were offered places on a course for the training of trainers, and eventually 188 were trained from all regions of Thailand. In 2002 these PLHA trainers conducted a total of 66 three-day workshops on OIs and ARV treatment, each attended by 20-30 participants (the training sessions were monitored by MSF or AAF).

ADDITIONAL HEALTH AWARENESS ACTIVITIES

In March 2001, MOPH announced that drugs for the prevention and treatment of OIs would be covered by the state health insurance scheme. MSF and AAF subsequently conducted 11 workshops on OI prevention and treatment for 290 health care staff and facilitated three seminars in provincial health offices with a view to raising awareness among health planners.

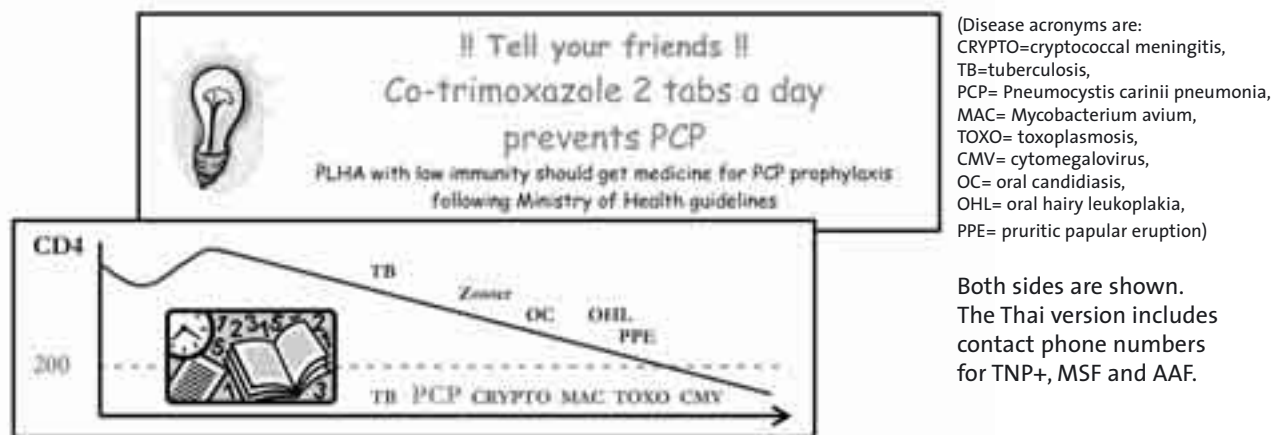
Despite the wide acceptance in Thailand of the role of PLHA in community education and the provision of mutual support, it was sometimes necessary to justify their new role as partners in care provision to hospitals. Advocacy was provided by MSF and AAF during discussions with hospital staff.

MSF and AAF also negotiated with hospital pharmacists to increase stocks of co-trimoxazole, assisted PLHA to gain access to TB control programmes, and informed health service management about the availability of generic fluconazole at reduced cost. Fluconazole ceased being a monopoly product in Thailand in 1998. The price of one 200-mg capsule of fluconazole fell from more than US\$ 10.00 in 1998 to \$0.30 in 2001 but many hospitals and provincial health offices were unaware of this.

The following documents were produced and distributed in order to inform PLHA about treatment.

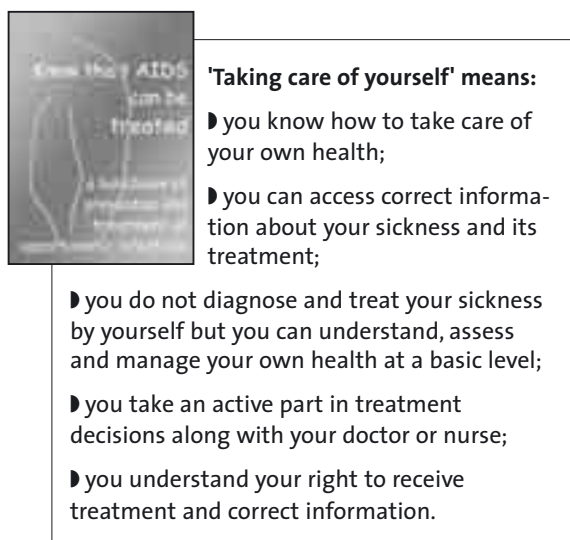
- ▶ 4000 bookmarks for distribution at meetings, summarizing the natural history of HIV infection and raising awareness of the need for co-trimoxazole prophylaxis. (Fig. 2 shows an English language version.)

Fig. 2: Bookmark summarizing the natural history of HIV infection and raising awareness of the need for co-trimoxazole prophylaxis



- ▶ 20 000 posters for display in hospitals and PLHA meeting rooms, giving information about the prophylaxis and treatment of PCP, TB and meningitis.
- ▶ 60 000 copies of a booklet entitled *Know that AIDS can be treated* (Fig. 3), based on MOPH guidelines for the prophylaxis and treatment of OIs. All PLHA group members received copies.

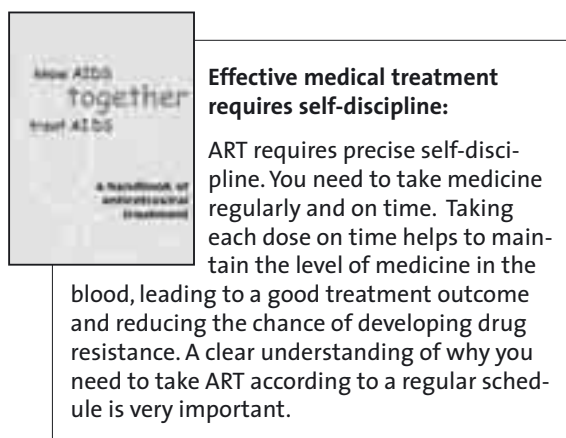
Fig. 3: Front cover of the booklet: *Know that AIDS can be treated* and an excerpt explaining the concept of 'taking care of yourself' (English translation)



- ▶ 3000 cards illustrating medicines commonly available in Thailand for the prophylaxis and treatment of OIs, to be used by PLHA core members as a practical tool.

At the end of 2001 there was a significant increase in investment in the production of generic ARV drugs by the Thai Government Pharmaceutical Organization. ART became cheaper and access was possible for increased numbers of PLHA. Information on ART was therefore included in the training of PLHA and health care staff during the second year of the campaign (Box 4) and a booklet entitled *Know AIDS together, treat AIDS together*, giving basic information on ART, was produced and distributed to all PLHA groups in Thailand (Fig. 4).

Fig. 4: Front cover of the booklet *Know AIDS together, treat AIDS together* and an excerpt explaining the need for good adherence (English translation)



An outline of campaign activities is presented in Box 5.

Box 5: Summary of activities of the Co-trimoxazole Prophylaxis Campaign (November 2000 to October 2002)

- ▶ Recruitment of PLHA groups interested in becoming pilot groups for the project.
- ▶ Expanding the knowledge of PLHA, NGOs and public hospital staff through the development and implementation of training on the care and treatment of OIs.
- ▶ Evaluation of training sessions, and further training and ongoing support as required.
- ▶ Linking with hospitals, including the organization of workshops for health service personnel.
- ▶ Organization of seminars at provincial health offices with involvement of health care planners.
- ▶ Production and distribution to PLHA of documents giving information on OIs.
- ▶ Development of training of trainers curriculum for PLHA on the care and treatment of OIs.
- ▶ Recruitment of PLHA trainers and provision of training of trainers courses. (Trainers provide training to other members of PLHA groups in their areas.)
- ▶ Introduction of basic information about ART during the second year.
- ▶ Monitoring and supporting the work of the PLHA pilot groups through the TNP+ network.

members were unavailable at the time of the survey). Questionnaires were distributed at PLHA group meetings during November and December 2002.

Among the core group members, 55% (42) had symptomatic HIV and 88% of these (37) were receiving co-trimoxazole prophylaxis. The proportions were similar among the other members of the groups: 65% (312) had symptomatic HIV and 85% (266) of these were receiving co-trimoxazole prophylaxis. Of those not receiving co-trimoxazole the main reason cited was that their doctors did not prescribe it.

Of the PLHA surveyed, 89 had been diagnosed with TB in the preceding year (21 core members and 68 others). All the core members and 54 other PLHA (84%) with a TB diagnosis had completed six months of TB treatment or, if they were still undergoing treatment, knew that it should last for six months.

Fourteen core members and 45 other PLHA had a previous diagnosis of meningitis. All core members were taking fluconazole secondary prophylaxis, while 36 other members (81%) were taking secondary prophylaxis.

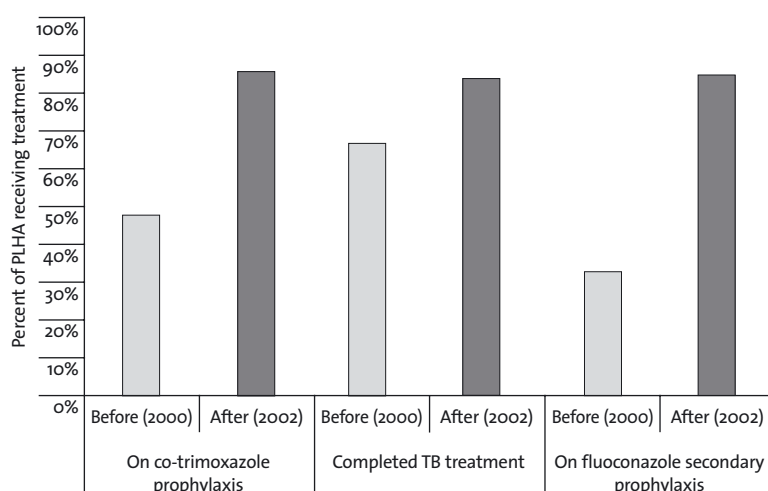
These results indicate a significant increase in coverage of correct therapeutic interventions for the three OIs, from less than 50% before the project began to above 80%. Fig. 5 shows only a general trend because the percentages given for PLHA receiving correct treatment for TB and secondary prophylaxis of meningitis during 2000 are based on small numbers.

EVALUATION

Impact on coverage of prophylaxis and treatment of OIs

After two years of the campaign, a survey was conducted on the coverage of co-trimoxazole prophylaxis, the treatment of TB and secondary prophylaxis for meningitis among PLHA. Data were collected by means of questionnaires and random sampling. Eighty of the 157 participating PLHA groups were selected. In each group, data were obtained from one PLHA core member who had received direct training through the project and from six other members. The total sample size was 556 (76 core members and 480 other members; four core

Fig. 5: Coverage of OI prophylaxis and treatment before and after the Campaign



Impact on the PLHA network

On completion of the campaign the participating organizations observed that communication and teamwork between different groups had improved and that PLHA had become much more motivated to take care of their own health and that of their friends. Many pilot groups had developed a clearer understanding of health issues and of their role. Many felt that this had led to an overall strengthening of the PLHA network.

Inadequate supervision and lack of ongoing support were identified as the main weaknesses of the campaign, attributable to a shortage of personnel with adequate skills and to insufficient funds. There were frequent changes of core members after training, most often because they needed to find full-time work in order to support themselves and their families. This necessitated the recruitment of new core members and more work for the training teams. The absence of a uniform system for recording data made it difficult to report on the campaign.

The Co-trimoxazole Prophylaxis Campaign showed that, with appropriate training and support, PLHA could develop a role as partners in the provision of health care, supporting access to the prophylaxis and treatment of common OIs.

PLHA received better health care and their confidence increased. The value of this role to health care providers is evident in one of the comments in Box 1.

Using the experience of this campaign and the stronger networking that emerged, the participating organizations are helping to prepare PLHA to support access and adherence to treatment within the national ART programme of MOPH. A regional Co-trimoxazole Prophylaxis Campaign, targeting community-based organizations in Cambodia, Laos, Myanmar, and Viet Nam was launched in July 2004 at the Fifteenth International AIDS Conference in Bangkok.

Antiretroviral treatment as part of comprehensive and continuous care: developing the role of people living with HIV/AIDS as partners in care provision

In April 2002, MOPH expanded access to ART and invited all interested hospitals to apply for treatment slots. In each participating hospital a Centre of Comprehensive and Continuous Care (CCC) was to be established in which ART would be provided by a multidisciplinary team, viz. doctor, nurses, pharmacist and laboratory technician.

In July 2002, TNP+, MSF and AAF decided to utilize the experience of the Co-trimoxazole Prophylaxis Campaign in order to develop the role of PLHA as partners in the provision of comprehensive and continuous care. The CCC Centres were viewed as a tool not only enabling PLHA to access treatment but also allowing PLHA core members to provide treatment support. Some services in the CCC Centres, such as psychological and social support provided by means of individual or small-group counselling and home visits (Fig. 6), were not new, having previously been available through peer support groups, but there was now an additional goal of supporting access to treatment.

As well as having knowledge of OIs and ART, PLHA core members had to develop skills in adherence support. ART projects, including a TNP+ Buyers' Club (8) and pilot projects in district hospitals supported by MSF, had led to an understanding of the importance of certain key steps in the ART information and counselling process and of ongoing adherence support (Box 6). Core PLHA members needed training on counselling skills. In order to plan their work and manage a case-load of clients, each with her or his problems, they had to understand the concept of the care continuum. Appropriate workshops were designed and implementation began.

The following criteria were used to select PLHA groups with the capacity to participate actively in CCC centers:

- The groups had to have at least two core members committed to working on a regular basis.
- Before starting work, each core PLHA member was required to have attended three training workshops on OIs and ART, counselling and the care continuum.
- There had to be a working link between each PLHA group and a hospital. A work plan was required to have been drawn up and to have been approved by the hospital director. There had to be a forum for case discussion, the sharing of information and problem-solving.
- A budget had to be available for project activities, together with transparent financial management and reporting.

Box 6: Key points in ensuring adherence to ART

A: THE PRE-ENROLMENT INFORMATION AND COUNSELLING PROCESS

The process of offering information, counselling and adherence support must be carried out by staff (counsellors and/or PLHA) who understand the problems in the lives of PLHA. There are 3 steps in this process. In some cases all 3 steps may be carried out during one session. In other cases, several sessions may be needed.

Step 1 – Giving information

Clients are given basic information enabling them to understand the need for a high level of commitment to treatment and adherence. Information can be provided to a group of PLHA clients if the facilitator has some understanding of group dynamics and is able to stimulate group discussion.

Step 2 – Counselling – in one or more individual sessions

During this step, the counsellor must do the following:

- ▶ Help the client explore his/her feelings. Many clients will be preoccupied with problems related to family, job, relationships etc., and cannot focus on strict adherence until they have released negative feelings about these problems.
- ▶ Help the client explore his/her options. Many will have no private place to store their medicines and will not be able to take them in secret. Not wanting others to know their HIV status is by far the commonest reason we come across for poor adherence. The client needs to be realistic about who needs to know their HIV status and how to tell them.

Step 3 – Solving practical problems and creating a treatment plan

Where will the ARV drugs be stored? At what time will it be taken? Who will remind the client to take it if he or she forgets? What will the client do if her or his normal routine is interrupted? A time should be arranged to meet or telephone the client within a few days in order to discuss any problems.

B: FOLLOW-UP AND ADHERENCE SUPPORT

People's lives and circumstances change. PLHA may get new jobs, meet new friends and form new relationships. These are the commonest reasons for the discontinuation of treatment. Ongoing nonjudgemental support is necessary in order to ensure that adherence to ART continues when such changes occur. Support can be provided by telephone, in one-to-one counselling sessions, group meetings and during home visits.

The funding was requested from the Global Fund to Fight AIDS, TB and Malaria in 2002 and received a year later. This delay held back the implementation of many activities. By May 2004, however, PLHA core members were participating in care and support for 7086 PLHA (adults and children) receiving ART in 105 public hospitals (19 at provincial level and 86 at district level) and in one women's prison. This represented 31% of the PLHA taking ART in 12% of the hospitals in the government programme. The number of PLHA followed in each CCC Centre ranged from six to 347 (median = 42). Fig. 7 shows the distribution of these Centres. Most are in the north and north-east of the country, where the PLHA movement has traditionally been strongest and where the regional public health offices have been most open to PLHA participation.

Fig. 6: CCC Centers with PLHA participation in provision of health care in Thailand



CONCLUSIONS

The role of PLHA in providing peer support has been widely accepted and encouraged in Thailand for many years. Their role as health care providers in coordination with professional health workers gained acceptance in many hospitals and by many health planners during the course of this work.

Knowledge and understanding of the importance of co-trimoxazole prophylaxis has been successfully used as a tool for changing attitudes to AIDS. The increased involvement of PLHA as co-providers in care has also contributed to a positive change in the attitude of health care staff. A few years ago, health care for AIDS was mainly provided from specialist centres; many staff at district level were unable to provide even basic care. Today, nearly every hospital in Thailand sees it as its responsibility to provide care for PLHA. Furthermore, there are now greater opportunities for PLHA to work in health care provision, although this role is not yet accepted throughout the country.

Thailand has a unique network of NGOs and PLHA groups working on treatment issues. By influencing the design of the MOPH programme and involving themselves in its implementation, PLHA are ensuring that a key element of the "3 by 5" strategy is in place. As the comments by key stakeholders at the beginning of this case study show, participation by PLHA as partners in care provision has important spin-offs for both health care providers and PLHA themselves.

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