

AFAO Community Sector Workshop on HIV Treatments Access, Bangkok, March 2004

“Building Policy & Advocacy Capacity in Southeast Asia”

(17-19 March 2004)

Full Report

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This report is based on reports of the proceedings recorded by Robert Bennoun and Greg Carl. The report was edited by Andy Quan and includes presentations from both participants and presenters. Individual participants also provided us with notes from action plans and discussion sessions, including Glenn King and Karyn Kaplan for the Thailand discussions.

If you have any questions about the workshop, corrections to this report, or other relevant queries or concerns, please contact:

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Executive Summary

The Community Sector Workshop on HIV Treatment Access: “Building Policy & Advocacy Capacity in Southeast Asia”, initiated by the Australian Federation of AIDS Organisations (AFAO), was held in Bangkok, 16 - 19 March 2004. The highly successful meeting was attended by 40 participants, speakers and organizers from Indonesia, Vietnam, Cambodia, Laos and Thailand.

The workshop program was developed by AFAO in conjunction with the Asia Pacific Network of People Living with HIV/AIDS (APN+), AIDS ACCESS Foundation (Thailand), the Asia Pacific Council of AIDS Service Organizations (APCASO) and the Australian Red Cross Asia Regional Office. The workshop was organised primarily by the Australian Federation of AIDS Organisations with support from and collaboration with the Australian Red Cross, AFAO's private donor, the POLICY Project and amFAR's Treat Asia program.

The workshop aimed to build upon and continue the momentum from previous meetings such as the Canberra and Jogjakarta Roundtables, the International Treatment Preparedness Summit in Cape Town, and the Alternative Community Forum in Bangkok.

The focus of the workshop was on the development of policy and advocacy skills to enhance understanding of and advocacy for HIV treatment access in the Southeast Asia region. It included presentations and action-oriented discussions on developing national treatment plans, advocacy strategies and plans, WTO and patent issues, and research-based and generic pharmaceutical companies. It featured a panel discussion on successful treatment access advocacy in Thailand and Cambodia, and access-related case-studies in the workshop's host country of Thailand.

The workshop's key objectives – to engage participants and their organisations on the issue of access to treatment, and to build capacity and knowledge in the area so that both national and regional advocacy for improved treatment access will increase and be more effective – appear to have been achieved beyond expectations.

Before the workshop an introductory session was held on HIV treatments issues to assist selected participants in gaining basic knowledge which would be needed for the rest of the meeting. Kevin Frost of TREAT Asia led a session which looked at areas such as: how does HIV work; classes and names of HIV drugs; names of research-based and generic manufacturers; what is HAART; fixed-dose combinations; dosage; side-effects; first and second-line regimens; treatment failure and PEP.

Day 1 of the Workshop included a review of international progress and obstacles on treatments access, Thailand as a case-study, country presentations from Indonesia, Vietnam, Laos and Cambodia; an overview of treatment access advocacy issues; and a brainstorm on elements of a national treatment plan.

Day 2 started with reflections on Day 1, a chance for participants to hear each other's voices and state some of their hopes for the rest of their workshop. A review of issues related to national treatment plans and advocacy issues was then followed by a brainstorm session by participants divided into country groups to look at whether countries have national treatment plans – if not, how to lobby for one, and if so, how to contribute to improve the existing plan. Presentations followed on WTO and patent issues, and by representatives of pharmaceutical manufacturers, both generic (the

Government Pharmaceutical Organisation, Thailand) and originator (Merck, Sharpe and Dohme). Participants regrouped to consider actions related to these presentations.

Day 3 started with a panel session entitled "What is advocacy?" with Nimit Tienudom from AIDS ACCESS Foundation (Thailand) and Heng Sokrithy from the Cambodian Network of People Living with HIV/AIDS. After in-depth discussion and questions and answers, Don Baxter of AFAO presented on how to develop and implement a comprehensive advocacy strategy for national HIV treatments access. Other regional treatment access initiatives were discussed. The final afternoon was dedicated to the formulation of advocacy strategies by country, and a wrap-up session on what participants would like to see next in relation to treatments access and advocacy.

Participants to the workshop included PLWHA representation from each country, community-based organisations, some medical professionals (in particular as represented by Red Cross Societies) and government officials from Laos, Cambodia and Indonesia. Thai and Vietnamese language translation was provided throughout the meeting.

What will come next? While a future report will be made available from the workshop and a mechanism set up for participants to keep in touch with each other, both organisers and participants look forward to seeing what the outcomes will be. The workshop was designed so that participants would formulate a number of action plans and strategies. Their implementation will depend not only on the participants of the workshop but their working with the other organisations and partners that they bring into this process.

Already, actions are forming. A treatment workshop in Indonesia is being planned with collaboration between the Indonesian Red Cross and community organisations. Exchanges between Thailand and Laos seem likely. The National AIDS Authority in Cambodia has declared a commitment to moving forward national efforts. A community-sector treatments preparedness workshop for East and Southeast Asia is being planned for September, sponsored by the TIDES Foundation - and Vietnam is expecting to host the third regional roundtable on treatment access in late 2004. Regional treatment access discussions will also be continued at the Bangkok International AIDS Conference in July 2004.

Introduction

AFAO organised and planned a 3-day regional workshop for selected Southeast Asian countries - Cambodia, Vietnam, Laos, Indonesia and Thailand - with a focus on building policy and advocacy capacity in the community sector on the issue of increasing access to treatment for PLWHA.

The workshop aimed to be differentiated from other meetings on treatment access by using AFAO's area of expertise – the development of policy and advocacy skills – as applied to regional treatment access issues.

The broad aims of the workshop were to further the treatment access agenda in the region and to evaluate whether small-scale skills-building workshops such as this are useful.

The following report includes notes on the presentations, discussion sessions, and brainstorming and action planning. Powerpoint presentations have also been included as an appendix in addition to the workshop program and a list of participants.

The report is intended to be used by participants as a reference of the discussions and presentations that took place during the workshop, as well as for those who could not attend the workshop but are interested about the proceedings.

The movement to increase HIV/AIDS treatment access around the world is changing quickly, and the reports and discussions here should be considered as a **guide** to what is happening and participants' views on treatments access. If you need information about a particular issue, please do additional research to see if the information in this report is correct or up-to-date.

Finally, we hope that this report is used to advance efforts to increase access to HIV treatments for those PLWHA who need it, particularly in the areas of national advocacy and treatment plans.

Co-sponsors and Organisers

The workshop was sponsored and supported by the following organisations:

- The POLICY Project (funded by USAID)
- TREAT Asia / the American Foundation for AIDS Research
- The Australian Red Cross
- The Australian Federation of AIDS Organisations

We would also like to thank the following partners:

- AIDS ACCESS Foundation
- Asia Pacific Network of People Living with HIV/AIDS (APN+)
- APCASO

This report of the workshop was sponsored by:

- The POLICY Project (funded by USAID)

Rapporteur for this workshop was done with great thanks to:

- Robert Bennoun, UNICEF
- Greg Carl, UNICEF

Background

Access to affordable HIV treatments in the Southeast Asia and Pacific region is difficult to non-existent in most countries in the region, with identifiable progress only beginning to emerge. Effective advocacy by the community sector appears to be an essential strategy to stimulate rapid change to this unsatisfactory situation

AFAO planned this workshop during 2003 and 2004, within the following context:

- The WHO has devised and launched its 3x5 Program to facilitate access to HIV treatments in developing countries
- Decisions of the World Trade Organisation and the development of the TRIPS agreement provide the potential to improve access to affordable HIV treatments in the short and medium term
- There are some generic manufacturers of HIV drugs in and near the region – the capability, infrastructure and demand exists in some other countries within the region to support further generic manufacturers of HIV drugs
- Treatments access issues often appear complex and unsolvable but are susceptible to straight-forward analysis and de-mystification

This workshop series builds on a number of other meetings including the Cape Town International Treatments Preparedness Summit (March 2003), the WHO Bi-regional Meeting on Scaling-up HIV/AIDS Care (May 2003), the Canberra Roundtable on Treatments Access (October 2002), TREAT Asia meetings (Bangkok, September 2002 & Kuala Lumpur, October 2003), the Jogjakarta Roundtable (September 2003), the Barcelona AIDS Conference (July 2002) and the TIDES Foundation Treatments Advocacy and Education Meeting (Bangkok, January 2003)

Participants

Attendance was limited to about 20 participants. Core participants included treatment advocates from NGOs and PLWHA groups from the selected countries within the region with participation from regional Red Cross Societies and two government officials. Selected representatives from the generic and originator pharmaceutical industry attended the workshop as speakers and resource persons. Both participants and resource persons included PLWHA.

Core participants were expected to be in a position to stimulate, shape and undertake treatments access advocacy within their own countries and contribute ideas to on-going regional initiatives.

The number of countries participating in the workshop was kept to a small number to facilitate exchange of experience and ideas between participants, encourage stronger outcomes at the national level, and because of limited funding.

Approximately ten organisers and sponsors attended with an additional ten resource persons, presenters, interpreters and rapporteurs.

Objectives

This workshop's objectives were to:

- Upgrade skills and understanding among participants of the major elements of a national HIV treatments scale-up plan
- Provide participants with direct contact and discussion with key players involved in HIV treatments access scale-up
- Improve participants' skills in understanding and developing an advocacy strategy for HIV treatments access scale-up suitable to their national context
- Contribute to building a regional support and information network on advocacy for HIV treatments access in Southeast Asia, and
- Trial this workshop as a model for treatment access advocacy which may be replicated for other countries and/or regions if successful.

Intended outputs of the workshop included: a conference report; the identification by participants of challenges in treatment access policy and advocacy both at their national level and in relation to issues such as WTO and patents; and action plans on an individual and organisational basis for contributing to national HIV treatments access which identify key activities and likely allies.

Activities

The workshop took place over three full days. The workshop comprised a mix of plenary and small group sessions, and was conducted by facilitators and documented by rapporteurs. Translation services were provided for Thai-English and Vietnamese-English. The workshop was preceded by a skills-building session on basic HIV treatments literacy issues. The workshop included an opening drinks reception, and two dinners in order to give participants the opportunity to share knowledge outside of the formal workshop program.

Introductory Workshop

An introductory workshop was held between 15h – 18h on 16 March 2004 at the office of the Australian Red Cross with the purpose of assisting participants in gaining basic knowledge of treatments which would be used for the rest of the meeting. Kevin Frost of TREAT Asia, a program of the American Foundation for AIDS Research (amfAR) facilitated the workshop. The following issues were discussed:

- How does HIV work?
- Classes of HIV drugs
- Names of drugs
- Names of research-based and generic manufacturers
- What is HAART?
- Fixed Dose Combinations
- Dosage
- Side-effects
- First and second-line regimens
- Treatment failure

Approximately thirteen participants attended this workshop.

Rapporteur's Notes on Day 1: 17 March 2004

Opening: Welcome / Review of Program / Housekeeping

Session time: 930 – 1000

Facilitator/Speaker: Don Baxter, Andy Quan, Surasak (Patrick) Seehanach

1. Welcome Address – Don Baxter

- Governments worldwide have been resistant to increasing access – due to cost & discrimination towards vulnerable people.
- This workshop is to bring together people's knowledge and skills on access, and work on how to bring this about.
- In many Asian countries this is more difficult than in western countries where there is more familiarity with media and advocacy campaigns.
- There is a role as community activists to bring about change.
- 5 – 6 countries and governments are participating and a number of organizations: therefore a number of approaches needed.
- AFAO has been working in the area for 15 years, good experience, with time to analyse the issue.
- Momentum is building in Asia on providing access – some in government, much at community level.
- Tides Foundation will organise a similar meeting in October (but larger).
- Workshop is a trial on how effective we can be in bringing 5 – 6 countries and multiple organisations together on this issue.
- Expected outcomes – overall picture of main issues in access, some ideas on what your country and organisation can do to take the issue of improved access and what you can do to take the issue forward.
- Funders – most from a private donor of AFAO, some from Policy Project, some from Treat Asia amFAR – no government funds. No government [except US through Policy] or UN funds requested – to be able to control the agenda and programme ourselves.

2. Review of Program – Andy Quan

Andy Quan gave an overview of the program. The workshop was structured as follows:

- Presentations to build knowledge
- Discussions to share knowledge
- Discussions to form action plans
- Reflection on how do we go forward and how do we improve what we're doing (our work, this workshop, overall).

After sharing with participants the topics discussed at the introductory workshop, he outlined the main topics of each of the days of the workshop:

Day 1

- Review of international progress and obstacles
- Country presentations
- Overview of treatment access advocacy issues
- National treatment plans – what are they? Do we need them?

Day 2

- Reflections
- Healthcare workers and issues
- WTO issues
- Generic manufacturers
- Originator manufacturers
- Discussions and action plans

Day 3

- What is advocacy? - panel
- National advocacy strategy
- Identifying partners in advocacy
- Case-study: Thailand
- Case-study: Indonesia
- Action plans
- Follow-up / Evaluation / Wrap-up

3. Housekeeping Comments – Patrick Seehanach

Ice-breaker

Thirty minutes were spent with participants in an exercise designed to get participants to interact with each other in a fun and enjoyable way, and to help people to learn each other's names.

Participants were asked to split into two groups and then order themselves according to a certain set of criteria. After that was done, the two lines joined in a circle, and each participant took turns introducing the person to their right. The criteria included: shortest to tallest, youngest to oldest, the day of birthday (from January to December) and alphabetical ordering of first names. The introductions started only with the first name, and then included first name and country, first name and organisations, and finally, first name and how that person was feeling.

Review of HIV treatment access progress internationally

Session time: 1045 - 1130

Speaker: **Andy Quan**

Brief Summary of presentation

A summary of international progress in AIDS treatment access – major developments – to bring workshop up to speed on why AFAO thought the Workshop was timely.

Timeline –

- AZT approved, western activism and advocacy to access drugs;
- early 90's production of generic drugs in Brazil and elsewhere; used to bargain for cheaper prices;
- late 90's triple therapy having an impact;
- 2005 – 5 companies offering differential pricing for rich and poor countries [LDC]
- Access is also about technical and medical issues;
- 2001 – CIPLA announcement of triple regimen at \$ 350 per year;
- 2001 to present – Treatment Access Campaign in South Africa – and achievements in access to drugs for PMTCT;
- Nov 2001 – DOHA Declaration – public health justification for production of generic drugs;
- Aug 2003 – WTO decision allowing countries to import generics – not yet put in place;
- Oct 2003 – Clinton Foundation price reduction to \$ 140 per year for combination for particular countries;
- 2002-4 generic production – Thailand, Indonesia and Viet Nam;
- Dec 2003 – WHO 3x5;
- Community meetings – Canberra Sep 2002, Jogjakarta Sep 2003, WHO consultations, Bangkok IAC Access for All, TIDES meetings
- 2004 – funding to community organisations / people affected.

Achievements:

- ARV prices dropped – generic production & advocacy
- MSF pilots have shown that treatment is possible and cost effective
- Community activism, meetings & education
- International consensus – poorer populations can adhere, treatment can work in poor settings
- Technical progress – cheaper diagnostics
- GFATM funds for drugs

Challenges:

- Health infrastructure in poor countries
- Generics not the full solution – need to move to other regimens as one combination fails
- Finances
- Government leadership needed
- Partnerships needed
- Scaling up and wide spread access – it is time
- Lack of global leadership – WHO 3x5 is not gaining momentum
- Denial of HIV/AIDS epidemics in general
- Stigma and discrimination continue
- Need to build capacity among people living with HIV/AIDS

Questions and comments:

Ms. Karen Kaplan – Thailand

- Issue of lower middle income countries where purchasing power is similarly lacking as in LDC which are accorded cheaper prices.
- How free trade and bilateral trade agreements threaten right to health – i.e. FTA agreement extends patent protection using the R&D argument – although many of the drugs which come out of such R&D are not directed to LDCs.
- Thailand with the upcoming free trade agreement with USA; many Latin American countries

Ms. Alycia Draper – Merck, Sharpe & Dohme Representative:

- Accelerated Access Initiative – individual negotiations by country and company, so countries aren't restricted by income levels to approaching AAI on price negotiation and how things are structured in AAI. Drug companies in AAI cannot talk to each other about drug prices – due to US law. Governments can request participation. Merck uses UNDP HDI and UNAIDS prevalence data in their pricing / country selection decisions.
- AAI – in response to middle income countries in developing world made a commitment to improve access to medicine in the developing world. [Kofi Annan initiative]
- Ongoing programme, Merck is committed

Dr. Suharto – Indonesia is now producing ARV – cost relativity with India.

Case study – Treatment access in Thailand

Session time: 1130-1200

Speaker: **Sri ('Tui'), AIDS Access**

*A fuller overview on treatment access in Thailand, based on this presentation is included as an appendix to this report entitled: **A Short Overview of Thailand's Current AIDS Treatment Philosophy, Policy and Structure***

Brief Summary of presentation

Access to treatment – right to life.

Why advocacy needed?

- People getting sick & dying, lack of access to quality treatment & most care providers believed nothing can be done about AIDS, people infected worthless

- Access as a basic right; 'positive people are human'
- Care system management advocacy, support to involve self-help groups / activists with care providers, establishment of Continuum of Care Centres – training.
- Advocacy on price – previously ARV expensive
- Advocacy to Government of Thailand [GoT] to have GPO produce ARV
- Use of compulsory licensing to produce ARV [ddi]
- Work with AIDS activists, lawyers and parliamentarians

Questions and comments:

Karen – Thailand Describe the court case in Thailand with BMS?

- Won this case on ddi in 2003. Drug company [BMS] tried to negotiate with ACCESS & TNC+ to stop the court case.
- Dr Suharto – Has TNC+ lobbied the GoT to reduce taxes etc on ARV, which would significantly lower the price of ARV?
- Nimit - 30 baht scheme – GoT agreed to include ARV under this – but GoT – NGO / Self Help Group need to set up a committee to consider management of this project. Big budget needed for procurement of ARV. GPO should produce – if they can't, Thailand will have difficulty in providing access to ARV.

Discussion about Thailand 30 Baht scheme – lack of understanding from non-Thai participants.

- Currently ARV is covered by 30 baht scheme – but hospitals have to apply to the Ministry of Health to allow this to proceed – the system is not yet ready to support all hospitals to provide ART under the 30 baht scheme.
- *How many hospitals are ready to provide ART under the 30 baht scheme?*
800 hospitals.
- Tui – advocating to GoT to improve local hospital capacity to provide ART; helping Self-Help Groups [400 in Thailand] to negotiate directly with hospitals to advocate for provision of ART. Self-Help Groups offering to support hospitals in provision of ART and provision of drugs for opportunistic infection. Most Self-Help Groups have support facilities.
- Nimit – need to prepare everything first as the system must be in place, partnership important, working closely with the AIDS Division [Ministry of Public Health], as many doctors still know little about ARV and ART.
- Karen – *what is the coverage for prisoners & drug users, and non-citizens?*
- Reply – about 500 people are covered in prisons; people without identification cards also do not have cards to access the 30 baht scheme.

Presentation on Vietnam

Speaker: Ms. Ngoc - Vietnam Policy Project representative

Brief Summary of presentation

- Almost nothing happening in Viet Nam. Access, yes, but only 300 people have access nationwide.
- Not all ARV are available in Viet Nam for 1st and 2nd line regimens.
- Most prescriptions are mono and dual therapy
- 3 big hospitals providing ART – when people admit with severe illness – Ha Noi, Hue and HCMC
- No counselling

Obstacles

- Lack of political commitment to provision and treatment, ART and provision of drugs for Opportunistic Infections
- Stigma and discrimination
- Viet Nam will join WTO in 2005

Positive issues

- Viet Nam can produce AZT and 3TC

Main directions

- Advocate for stronger political commitment to provision of financial and human resources for ARV access. New national HIV/AIDS strategy still not approved. There will be an action plan for care & treatment after the strategy is approved.
- Over-reliance on GFATM – approval for Round 1.
- Improve cheap generics.
- Improve health infrastructure to receive & distribute ARV
- Train health staff in ART
- Capacity building for people living with HIV/AIDS on treatment literacy
- Current WHO 3x5 mission – 3 people living with HIV/AIDS are involved in the discussions
- 05 centres for sex workers, 06 centres for IDUs – how to provide ART to people in these camps
- Methadone not legal in Viet Nam – how to move forward on harm reduction

Questions and comments:

Karyn – Thailand *Are there plans to integrate HIV treatment into the TB diagnostic & treatment system?*

TB system very strong in Viet Nam – intention to add HIV treatment into the TB system

Indonesia -- *Responses to co-infection?*

Reply – not much consideration of this.

Dr. Suharto - *How is quality assurance conducted on generic drug production?*

Reply – Not external assessment. When purchasing drugs through GFATM funds have to be from [WHO] pre-qualified companies. When buying using GoVN funds, no need to procure from pre-qualified companies – can be from local companies producing generics.

Health authorities are reluctant to fully include drug users and sex workers into the national estimates.

- *Are changes coming in the social camps?*

No idea – current discussion is to increase stays in the camp from 3 to 5 years, with the additional 2 years being for vocation training.

A step by step progress will take place in Viet Nam. It is a good start to have people living with HIV participating in the 3x5 mission

Karyn – Thailand WHO needs to support civil society involvement more, including involving more countries in WPRO – support is currently provided to Viet Nam but not to Thailand.

Presentations on Indonesia

Brief Summary of presentation

HIV update

- 100,000 – 130,000 people with HIV/AIDS. Rapid increase among IDUs; pregnant women in slum area [Jakarta] 2.67% --- Gol data
- ARV and ART included in the new national strategy and are more accessible.

- Prices falling with local production.
- 1,300 people on ART, 90% self-financed, mortality rate 20%

History of national movement

- 1999 diagnostic and treatment access programme
- Development of services – VCT, health provider training etc.

Goals

- ARV in National Essential Drugs List – Nov 2002
- Local production

Targets

- 10,000 people living with HIV/AIDS

ARV delivery model

- Outline of

Financial support

- 90% self-financed
- Business sector, NGOs, local government
- Future expectations
- More significant Government role

Enrolment criteria

- WHO criteria
- Social criteria
- Counselling before using ARV

Problems of scaling up

- Myths of HIV treatment
- Training for health providers
- New government policy
- Private sector / business involvement
- Legislative role

GIPA

- Drug information
- Support for adherence
- Support from ARV user groups
- Advocacy for price & quality of service
- Fund raising
- Members of enrolment Team

Indonesian response to 3 x 5

- President agreed to provide support
- Role of people living with HIV/AIDS
- Training

Presentations on Indonesia, Second speaker

Brief Summary of presentation

Will focus on the negative side.

2000-2001

- ARV still imported
- Lack of knowledge in HAART & drug treatment / adherence

2002-2003 –

- Prices still high, using expired drugs, beliefs that generics are fake

- CD4 test only in Bali & Jakarta
- Drug stock-out
- Inconsistency in medical advice on when to start ART – CD4 counts different

2003-2004

- No treatment plan
- Limited involvement of NGOs
- High Co-infection of Hepatitis C with HIV
- Relapse rate very high

Questions and comments

- *What is the role of the GoI in ARV / ART?*
- Reply --Coverage still very limited, involvement of local organisations and people living with HIV/AIDS also very limited.
- *What is the social criteria?*
- Reply – If one family has several people infected living with HIV -
- Merck - in the regulatory approval process there are some barriers in government regulatory process for approval – advocacy needed to reduce / remove these barriers – VAT, import taxes, speed of approvals.
- Autonomy at sub-national level, local government is more independent [Indonesia is just completing a significant decentralization and administrative reform process which places more autonomy in the hands of sub-national administration.]

Presentation on Laos

Anouxay Bounthaluexay, Lao Red Cross

Brief Summary of presentation

Treatment limited to:

- (1) pilot in Savannakhet – MSF – supporting the hospital – since 2000, OI, counselling and testing, recently began importing drugs from France for 80 people with a 5-year commitment;
- (2) Some people accessing ARV from Thailand; Worldvision, UNICEF and CARE support this group – involves travel to Thailand.

Obstacles to treatment access:

- Low prevalence, low resource environment
- Small number of people living with HIV/AIDS
- Low level of engagement with people living with HIV/AIDS and their needs
- Low level of advocacy for rights
- Problems in access to the poor, ethnic minorities and sex workers
- Priority is still on prevention

Just established Lao network of people living with HIV/AIDS

No questions or comments

Presentation on Cambodia

Dr. Thith Khimuy, KHANA

Brief Summary of presentation

Update

- 157,000 people living with HIV/AIDS, 2.6% prevalence
- Lack of VCT sites, less than 10,000 people aware of their status
- 22,000 people receiving ART

- KHANA assessment of access to ART in 2003

Current sources of ART

- MSF – France PP
- MdM Calmette Hospital, Phnom Penh
- Centre of Hope, PP
- ESTHER Programme, Phnom Penh, Battambang & Siem Riep - supported by 4 European countries
- MSF Belgium – Siem Riep and Takeo

Approaches for delivery of ART

- Hospital based – MSF France, MdM & Centre of Hope – similar approaches – little involvement in decision-making

Clinic based

- MSF Belgium

Home-based care

- None

Protocols for ART

- WHO protocols – triple therapy
- \$300 p.a.
- AIDS definition – CD4 <200

Knowledge of ARV treatment

- No systematic assessment of knowledge, beliefs, attitudes and beliefs on ART among people living with HIV/AIDS
- Doctors being trained by MSF, MdM and Centre for Hope
- No training of pharmacists

Home care teams

- Some training started in PP

Barrier to accessing ARV treatment in Cambodia

- Financial
- Stigma and discrimination especially amongst marginalized groups
- Health care services not ready / equipped to provide ART
- ART not available in all provinces

Conclusion

- Increasing political will and financial commitment
- GFATM Round 1 & II will provide ART
- Need to strengthen health care provision with HIV/AIDS services
- Use a public health approach for scaling up ARV will require simplifying 1st and 2nd line treatment regimens.

Questions and comments:

- *Why do people drop out of treatment?*
- Reply – late entry onto treatment, die, logistics and travel

Other person comment

- 1,000 people on ART in Phnom Penh, over 300 have died, only 9 to drug failure
- Home-based programme in Svay Rieng
- Karyn – Thailand *Please comment on activism by people living with HIV/AIDS – such as actions by a Battambang physician with hundreds of fingerprints of people living with HIV/AIDS?*
- Reply KHANA has set up a clinic in Battambang recently called 'Friends Tell Friends' [in Khmer].

Presentation: Overview of HIV Treatments Access advocacy issues and agenda

David Lowe, POLICY Project

Brief Summary of presentation

Advocacy targets

- Government must be number 1 priority – public health systems, finance & trade ministries
- Partnership with people living with HIV/AIDS treatment activists, civil society and private sector – large employers, private health care providers – hospitals, clinics and pharmacies

Key access issues

[1] Financing – what happens when GFATM funds run out; while governments need to give greater priority to ARV access, long-term provision of ARV only through the public sector financing is unrealistic.

- Drug & lab cost reduction
- National government funds from tax base
- Graduated people living with HIV/AIDS cost sharing on ability to pay
- Employer treatment scheme
- Health insurance schemes
- Social insurance schemes
- Donor support, including GFATM

[2] Cost sharing with people living with HIV/AIDS

- Negative affect on access & adherence
- Reality – need to develop strategies

[3] Selection of people

- Advocate for more rapid scale-up
- Advocate for equitable and more transparent system for rationing rather than ad hoc decisions

How to ration?

- Civil society and people living with HIV involvement in policy debate on how to ration

Examples of selection criteria

- Health status
- Adherence assessment
- Social – number of dependents, income – preference to poor, HIV disclosure & activism, has a personal treatment assistant
- Learn from other diseases – pneumonia 3.5 m deaths per year, doctors rarely work in poor

[4] Equity in access

- Access by the poor – is cost-sharing practical
- Good outreach by community health workers needed to reach the poor

Equity in access – other groups

- Rural vs. urban
- Specific populations – orphans – street children
- Stigmatised groups, especially sexworkers, IDU and MS
- Gender issues

Reality check

2002 WHO est 43,000 people in Asia on ARV and 1 million needed
A lot less than 1 million will be on ARV by 2005

[5] Community engagement

- People living with HIV/AIDS & their families
- Advocacy
- Planning
- Implementation

[6] ARV scale up effect on prevention efforts

- more people accessing VCT
- reduce viral load
- reduced stigma & discrimination
- diversion of prevention resources
- Need for prevention oriented education to accompany ARV access
- Need to avoid polarization
- Prevention effect
- Data shows that prevention more effective than ARV provision
- Access is a human right
- Cost effectiveness

[7] Reducing stigma & discrimination

- Key to ensuring ARV access
- Stigma & discrimination and lack of confidentiality keep people away from VCT and treatment services; a major focus of scaling up [of 3x5]

Questions and comments:

Dr. Suharto: Have you thought of a strategy to provide good support for people with HIV and on ART? Sustainability has been a key issue – governments have been slow in moving to the tune of the activists and are then blamed by the activists, people living with HIV.

Reply: Food support demonstrates the need to take a comprehensive approach in assessing people's needs comprehensively. Need to look at how to integrate scale up of scale up of ART into [the improvement of] existing health services.

Nimit: When we talk about access in Thailand we talk about rights – when finance is discussed it is necessary to look at costs of access – not the issue of poor people paying / cost-sharing – not fair.

Karyn: People who have to prove they are the poorest – if this is the criteria, are often humiliated by having to prove their poverty.

Nimit: The issue is the price of the drugs, and the ethics of patents.

Alycia: Need to look at the role of major employers in the community.

Karyn: Most people are not covered by employer schemes

Small group discussions: Elements of a National Treatment Plan

Participants grouped randomly – not by country

Group 1

Information, Education and Communication (IEC)

- Clear information about treatment
- Dissemination of IEC materials
- Referral systems
- Standard treatment guidelines

Monitoring, evaluation and supervision

- Databases
- Assessment
- Research

Role of PLWHA

Materials

- Quality control of drugs
- Elimination of taxes and import and customs
- ARV distribution
- Supply

- Laboratories
- Advocacy
 - Involvement of all stakeholders
 - Leaderships and skills to implement clear policies on treatment
- Human Resources
 - Training healthcare and social workers
 - Empowering PLWHAs and their families, CBOs, FBOs, NGOs as peer educators, buddies
 - Identifying roles for all players
 - Involvement of PLWHA from beginning to end in all processes
 - Sustainability
 - Solid committees
- Financial Resources
 - Sustainability of finance in the long-term
 - From private sector, government, individuals
 - Government subsidies
 - Resource mobilization

Group 2

- ARV on essential drugs lists
- National guidelines for AIDS treatment
- Improving health service/system
- Training development for doctors, care providers and PWA
- Internal finance – sustainability
- Scaling up across provinces
- Government support for price reduction
 - Tax issues
 - Patent Issues
 - Local Production
 - Negotiation with drug companies
- Public hearings as part of the development of a national plan
- Workplace access policies
- Patient-oriented
- HIV/AIDS law – antidiscrimination; development and implementation and support for laws
- Political will and commitment
- Effective national communication
- GIPA principle – involving PWA
- Compatible with World Food Program
- Follow up support – role of PWA
- Community awareness and education
- Income generation for PWA
- Drug approval systems
- Monitoring and evaluation
- Medical/clinical infrastructure
- Coordinating structure
- Implementation of plan

Group 3

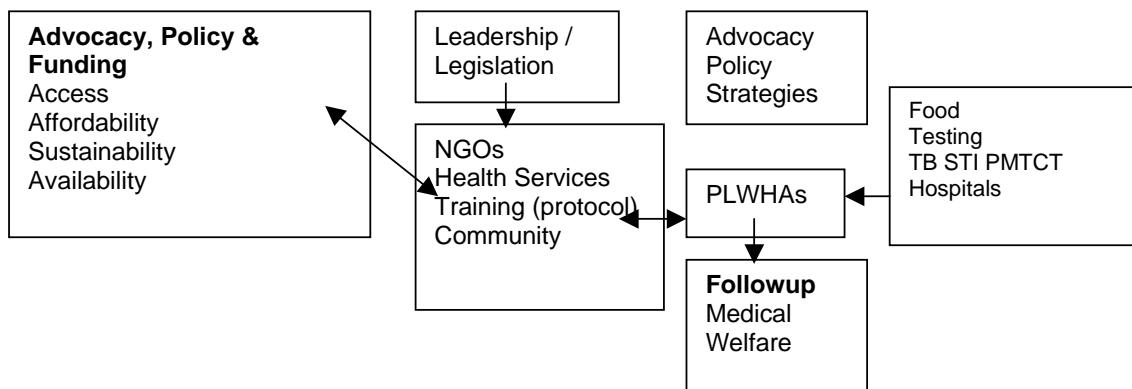
- GIPA
- Standard Guidelines
- Community involvement
 - Broad and target groups
 - PLWHA
 - Caregivers
 - People with authority
 - Affected families
 - Religious groups
- Government engagement

- Broad education
- Voluntary testing centers
- Health infrastructure
- Pharmaceutical companies
 - Local companies
 - Generic companies
 - Research-based companies
- Law Reform
- Supply
- Media: traditional and “non” traditional

Group 4

- National guidelines on care, support and treatment
- Access to ARV – affordable drugs
- Human rights law on HIV/AIDS
- GIPA in government and NGO policies and private sector
- PWA empowerment
- Stigma and discrimination
- Epidemiological reports on HIV/AIDS
- Training and capacity building for health care workers
- Strengthen healthcare infrastructure
- Goals, objectives, targets, monitoring and evaluation, logframes
- Positive after-care: continuing support for PWAs after giving them ARVs
- Budget – financial and human resources
- IEC materials
- Balance between components: prevention and treatment
- Prevention of mother to child transmission
- Advocacy campaign including media
- Continuum of care
- Regional exchange and sharing; also between organisations
- Voluntary testing and counseling
- Public education
- Engage private sector
- Remove taxes and tariffs on ARVs
- Revising patent laws to produce or import generic ARVs
- Schedule of activity / time frame
- Mapping of responsibilities
- Outreach/coverage
- 100% condom campaigns
- Universal precaution
- Partnerships
- Harm reduction

Flowchart included with notes:



Rapporteur's Notes on Day 2: 18 March 2004

Reflections

Session time: 0915-1000

Facilitator: **Andy Quan**

- A revised agenda was distributed to the participants. This agenda should allow for more time for discussion within the sessions.
- All of the participants were asked to express how they are feeling, what they hope for the day and for the rest of the workshop.

Mr. Kamon

As for yesterday, I got to learn about the situations in other countries, but I am wondering what and whether we will be able to do anything after the meeting. Today, I hope to understand the overall picture and coordination in the future

Mr. Anouxay

Yesterday was very good. Received new information through brainstorming. Each country is different from the Lao situation

Dr. Hendra

Interesting to hear two different angles in the same presentation. Both are right but looking at things from different angles. Worried about positive after care. Have drugs but worries about quality of care.

Mr. Glenn

Happy to be here. Happy so see familiar people and to meet some new people. Lots of different views and opinions about how this might work. Partnerships need to be looked at and established in each country

Mr. Andy

What happens outside of meetings is often just as important as what happens in them. So, good to see interaction between participants and that there are potential relationships between organisations as a result of the meeting

Mr. Sokrithy

Open meeting. I think the group [the participants in this room] is already doing advocacy work. NGO are working to improve access to ARV, so we are doing advocacy

Dr. Sok Long

Did not learn much new but learned from the brainstorming about brainstorming.

Dr. Lita Sarana

RC representative. Still learning how RC can play a role. Hope that this role becomes clearer

Ms Ngoc

Learned from different countries. Can learn from each other. Would like to have more concrete information to advocate to the government

Mr. Sam

Do not feel very good this morning. The group discussion inspired me a lot. A lot more work needs to be done. Need a better language about what needs to be done. Most participants in group were doctors so spoke a different "language" – they used different phrases and terminology.

Ms Lawan

Would like to thank the facilitators for all the work that has been done

Ms Karyn

Happy to be here. In a different place than we were in the beginning of the epidemic. The drugs and the commitment are still not there. Many people have worked on the regional or sub-regional level. How would you like to communicate after these meetings?

Mr. Neil

Exchange between Nimit and David made me think the most. The pragmatic compromises we make in terms of services

Mr. Ken

Hope to see a regional coordinating network to exchange experiences

(-----)

Reflections are very good about the workshop. Good approach to learn from each other. Then can have a better basis about the issues to be advocated and about the cycle of issues.

Mr. Don

Impressed with the energy and the ideas. Was a bit intimidated. Underestimated the experiences, ideas and skills. With a mixed group of community people and doctors, community representatives may not be used to communicating their ideas – doctors need to listen more.

Dr. Sala

Yesterday, felt tired but ready to learn from others. Issues of drugs does not sound difficult. There are 5 different countries at five different stages of the epidemic. Some countries can provide ARVs for free, some subsidize, some dependent on outside countries

(-----)

Learned from the different experiences. Learned from the Thailand presentation. Learned in the discussion about how to approach the government

(-----)

Government should have better political will, especially in coordinating with NGO and delivery of drugs

Mr. Van

Facilitation was good but talked very fast. Looking forward to learning more

Ms Frika

Don't really like to see reports. Like to do actions. Looking at the reports was rather boring. On the other hand, learned something from other countries. Want to see concrete steps for action. Advocacy in appropriate staging.

Mr. Sakda

Feel very good. Never thought I would be able to attend a meeting such as this one. I am from one of the 19 NE provinces of Thailand. A meeting between people who are affected and the service providers. I see than many counties are trying to coordinate efforts in relation to advocacy for policy and solution to problems

Dr Phuttary

I enjoy attending workshops with people from many, many counties

Mr. Greg

Glad to have an opportunity to have this type of meeting. Feel that there is a lot of energy in the group. A lot more work needs to be done. Bangkok Conference could be an opportunity to raise some concerns. Recently went to several countries Interesting to see the disparity between groups in the region. Group in HCMC that had no information and one in Cambodia that was well informed.

Mr. Nimit

Do not feel comfortable to talk. Advocacy is very hard work. In the past 4 or 5 years there has been no model or example. We just try to do something. I felt that yesterday everyone wanted to see a defined example and guideline for advocacy. In Thailand, there is more experience but it is difficult to share because of the English language barrier. After previous workshops should set up a Mekong or sub-regional network that is not working

Mr. Dhayan

Speak from own perspective as a positive person. Sometimes feel that what is being discussed is too big for me. I have learned that a positive person can play a role but still need support. Need some people who have experience in doing something big. Advocacy, I learned that I can do it but I can't do it alone.

Mr. David

The challenges that we face are complex and at different level. They all need to be addressed. A lot of those are very well reflected. Everyone has different skills in different areas. Feel somewhat optimistic but somewhat daunted

Mr. Khimuy

Learned a lot from the presentations. Could learn from countries like Thailand but also even from Cambodia, my home country because I have never attended a workshop like this.

Mr. Ginan

Feel that we have learned from each other. People with HIV/AIDS need to access ARV. Even countries that have it, it is not enough. Treatment is one problem but then there is stigma and discrimination that come along with it.

Dr. Suharto

Originally worked in prevention. Indonesia is facing a new challenging to set up treatment services. The workshop has been very enlightening. Would like to learn from others more about the problems. Did not know before that the difficulties are so big. Even Thailand has had difficulty in setting up treatment centers

Dr. Tia Palla

Learned from friends from other countries. Today hope to learn from GPO and Ministry of Health in Thailand. Need to have a way to follow-up this workshop.

Mr. Tung

I would like to say thank you to the organizers. I would like to talk more because of the language barrier. I am sorry about this. Before coming here I did not know how to get the drugs. When I came here I just learned about combination therapy. It is something new to me. In some countries, I think the network of people living with HIV/AIDS may be very big. In Cambodia there may more than 1,000 people in the network in my group there are only 16

Mr. Adi

Now, when I am waiting for my turn my heart is beating and am very anxious because of my language. The workshop starts at 9 o'clock but I just work up at 9 so I rushed over. Learned a lot from Thailand because Thailand has worked very hard before. I want to learn what I can do in my province so that people can have easy access to drugs.

Presentation #1: Elements of a National Treatments Scale-Up Plan

Session time: 1005-1040

Facilitator: **Don Baxter**

Summary of Presentation

The purpose of the presentation is to step through and tie together what was discussed yesterday concerning a National Treatment Plan.

The Advocacy Task is:

- *Not* to write the Plan
- Know what the key questions to be asked
- Ensure they are answered

6 key questions that a national treatment plan should be able to answer:

1. What is the rationale for government's investing time and resources in a scaled-up ART response?
- Treatment contributes to prevention

- Reduces deaths and illness
- Maintains productivity in society
- Maintains family and social support structures
- Financial savings in short and long term

Up to each country to decide where there is a national document or strategy and need to coordinate with other strategies (e.g. poverty reduction)

2. Where do we get the drugs from and how do we pay for the drugs and the associated tests?

Key criteria: regular and reliable supply + buffer

- Import or manufacture ourselves?
- Not easy to establish manufacturing
- Even manufacturing countries will have to import eventually
- Clarify TRIPS status of each country by 2005
- Generic drugs or 'Brand name' drugs
- Accurate estimation of requirements

- Funding source(s) identified and negotiated
- Global Fund
- Own government
- Major donors (Gates; Clinton)
- World Bank/Asian Development Bank
- Consumers contribute to the cost
- Other?

Purchasing: national level, provincial or at institution

Summary: develop a National ARV Procurement Plan - Access should be available to all as a statement in the national treatment plan

3. How do we deliver the drugs to the people who need them?

- Existing health system or a new model?
e.g., Haiti, some MSF programs
- District, provincial, state or national system?
- NGOs, private corporations, other clinical services (e.g., TB)
- Minimum infrastructure needed not yet really clear

- Who gets priority access first – equity and eligibility criteria

- Community input to decisions - plan needs to be in consultation with the people who will use the drugs and the medical system that will prescribe the drugs

4. How do we strengthen the health system so it can deliver the treatment effectively?

- A major question and tension
- Sound plans can be thwarted by poor systems e.g., storage and facilities; patient records
- Potential to improve system generally
- Include private sector in system better
- So persons do not have to travel long distances

Starting point: a Preliminary situational analysis of public and private health infrastructure

5. How do we train the staff to deliver the clinical decisions and treatment?

- Educate those with HIV to assist themselves and others to monitor their health: People with HIV/AIDS are one of the most important tools for self-care, provision of information to others and working with families.
 - Simplify HIV clinical management and monitoring: Still a debate on how much monitoring is needed – used as an excuse not to do something
 - e.g., reducing frequency of monitoring for stable and adherent patients
 - Use WHO clinical guidelines
 - Involve other people with HIV and their families and friends
 - Institute a targeted training program (including the private sector, families, healthcare workers)
6. How do we mobilize the community to maximize the uptake of ART
- Leadership program challenging stigma and discrimination - Head of State should start it. It should be an issue of concern.
 - Fostering participation and leadership by PLWHAs
 - Community preparedness for the whole community
 - Encouraging voluntary HIV testing and counselling
 - Training family members and local communities

Questions and comments

Karyn: Clinical trials as a way to access medication. Thailand is a country where a lot of clinical trials are undertaken but there is little community involvement. The more the community is involved the more the program may become more effective. Communities may want to come together and request that trials take place in their communities.

Don: Communities should be involved in the design and delivery of programs. If there is quick enrolment in place = more trials = attractive to pharmaceutical companies

David: Comment about the trials. The pharmaceutical companies will only come to countries that have a well-established infrastructure. The numbers of people able to participate will still be limited. So, trials are not an answer to the overall problem. However, it can help get things moving along.

Drug companies like to have big purchases and are more willing to negotiate cost with larger orders. Maybe one method would be to purchase regionally in order to bring the costs down.

Dr Chettra: Who takes the lead in the National Plan will determine how treatment programming moves along. The government is completely reliant on the Global Fund

Don: Pressure will be on governments on the issues of treatment in the months leading to the Bangkok conference. It is a good opportunity to also push from below.

Dr Suharto: Is there any experience on the issue of tax relaxation?

Karyn: I don't think national commitment and contributions from richer countries are either/or. There is a need for both.

Small Group Discussions: Discussion and Brainstorm on National Treatment Plans

1100 – 1150

1. Do you have a national plan
2. Do you need one?
3. Who should be involved?

4. How?

Brief Summary of Cambodia

1. No, but have national guidelines for ART. GFATM I and II for ART. Networks in place (GPN+, HACC, HBC, CoC, etc). Health services: Referral Hospital/ Op. District. VCCT and PMTCT available.
2. Yes. We need a plan
3. ART working group, CBO, NGO, Ministry of Information, PLWHA, NAA
4. What for?
 - drug availability
 - access to drugs
 - ART working group membership? (MEF, MOC, MOP, NAA)
 - Leadership of ART Working Group
 - ART WG WTO
 - TRIPS
 - PPP (Public-Private partnership)

How?

- Research on impact – social costs, economic costs
 - Advocacy – Aids not a personal issue but a social/development issue (use high level VIP)
 - Parade, roundtable – public opinion (persons living with HIV/AIDS)
 - ART in political agenda of different political parties
 - South to South experiences
- National Commitment to increase budget and replace external donors and the creation of a sustainable response.

Brief Summary of Indonesia

1. Treatment Scale-up is in progress (25%)
2. Yes, the NAC will push that to be out in August 2004, as NAC will be the co-ordinator of the Treatment Scale-up
3. Who should be involved?
 - National AIDS Committee (Central and Local)
 - MOH (P2M & DL(CDC), Medical Services, Community Health, FDA)
 - PMI (Indonesian Red Cross)
 - National Family Planning Board
 - GIPA (IDUs, SW, MSM, Transgender, Affected)- each vulnerable background has the representative.
 - Professionals (medical Association) Pokdisus
 - Donors, International NGO
 - We would like to keep the group small. Not to many people, to make a better progression.
4. How?
 - Ad Hoc committee for CS2T draft
 - National meeting on the National Plan
 - Disseminate and implement in priority provinces (9 priority provinces that has been identified by MoH).
 - We wouldn't want to have the pilot project, as treatment scale-up is a need now in Indonesia, as we are beginning ARV subsidizing in April (hopefully).

Brief Summary of Lao PDR

1. Do we have a national HIV Treatment Scale-up Plan?

Yes. We have a pilot project in Savannakhet and the government of Laos plans to extend this to one more province (Vientiane). Have a plan but no money and few PLWHA open/asking.
2. Should we have one?

- Yes. We should have a plan for the future for the whole country.
3. Who should be involved in preparing it?
 - all stakeholders = National and Provincial Committees for the Control of AIDS (N/PCCAs), health, Department of Communications, etc., Trade Federation, Military, Red Cross
 - The NCCA and PCCA boards have representatives from all 14 government departments and NGOs/UN.
 - Should invite PLWHA to be involved in the future.
 4. How do we persuade the government to do it?
 - each province to report on each to the Ministry of Health on health service and HIV.
 - The NCCA to start a working group on treatment and care to prepare a plan/road map for the future (national level / provincial level)
 - Hold a series of trainings / awareness raising workshops for high level national officials. Followed by similar provincial level workshops to encourage engagement.

Brief Summary of Thailand

See Appendix #4: A Short Overview of Thailand's Current AIDS Treatment Philosophy, Policy and Structure

Brief Summary of Vietnam

1. Yes. National Strategy to 2010 with vision to 2020 completed. Waiting for approval
2. Yes. We should: Contribute to prevention ...
3. Involvement in preparation:
 - MOH - NA - MOSTE - MOF -GO -MPI - Civil Society: PLWHA and community based organizations - Technical Assistance from international organizations
4. Show scientific evidence and reality-based evidence. Show socioeconomic effectiveness (costs), Human rights, Educate government officials.

Presentation #2: Overview of WTO and TRIPS issues

1150 - 1240

Don Baxter

Brief Summary of Presentation

International trade negotiations are not new but in a stage of uncertainty and change

What is new is the HIV/AIDS pandemic

The dynamics of world trade is also new

Intellectual property is a new source of revenue

- Pharmaceutical companies are not the only ones concerned with patent laws. In the US, IT and entertainment industries are also very much involved.
- EU Pharmaceutical Companies are not as politically organized as those in the US
- Patent laws in India are a less strict.
- Vietnam scheduled to join WTO
- US putting more emphasis on bi-lateral free trade legislation. [Strategy to ditch DOHA?]
- Singapore agreement affects Thailand and other countries to follow because the agreement in Singapore sets a baseline.
- Attempts to extend patents.
- Australian Pharmaceutical Benefits Scheme – sets a low baseline price country wide

Questions and comments

Ms Karyn: The Thailand experience of civil society taking an action against BMS (ddl). DOHA declaration used in court to uphold public interest over corporate interest

Ms Lawan: Originally from health background. Encouraged by lawyers at a university to learn about free trade agreements and patents. Karyn already mentioned the case where civil society won. Perhaps there is also some corruption from the government side that may make it difficult to share in a patent. Need to have alliances with agencies in other countries as well. Patents on drugs in each country should be public information. The issue came up again in the free trade negotiations with the US. Often the negotiation process is not revealed. The US government must present a bill to Congress. In Thailand, it is seen as only a concern for administrators, civil society is not informed. Collaborated with other networks also working on free trade issues (farmers, laborers, etc.)

Mr. Nimit: An important point. There are two sides to WTO. Benefits for negotiation. Small countries cannot compete with larger countries. With DOHA, in terms of patent issues, the cost of drugs increases due to compulsory license. In terms of WTO meetings, the US does not like the process because it needs to get the approval of 148 countries. The US has then turned to bi-lateral agreements. Cannot use compulsory license and cannot produce generic drugs. Can use generic drugs for about 5 years, then have to switch to patented drugs

Ms Karyn : Not talking about CDs. Talking about drugs that are essential for life. There needs to be some flexibility for governments to meet the needs of the public.

Ms Nimit: Many activities are talking with the government to initiate public hearings so that civil society can express opinions related to free trade. This needs to be tabled in Parliament. It is not a parliamentary issue. Decisions are only made in senior government.

Ms Karyn: MSF has important information on their web-site. Document on untangling drug costs. Sometimes prices are quoted as the lowest prices but are really not.

Mr. Don: Important to find interested partners – someone who is interested in TRIPS and can work through the documentation with organizations.

Mr. Don: Drug companies are concerned about re-export of drugs.

Thailand may be the only country in the region poised to become an exporter.

AusAID assistance if clarifying country position related to TRIPS

South Africa competition commission. Challenges to excessive pricing

Establishment of a regional purchasing group

Ms Alycia: Glad that things are open for discussion. It is good that we can agree to disagree.

A free trade agreement occurs when other governments approach the US government for an agreement. It was the Thai government that approached the US. The US thought it was a good idea. In making an agreement, each government brings the issues of concern to the table. Each government will put together a list. Usually, the list is very long in the beginning. The agreement will take no less than 12 months and probably not longer than 18. Nothing will happen before the US national election. Issues should be raised with the Thai government. Governments will trade off on issues but it will depend on national priorities.

Politics should not come into play in the beginning. They play a bigger role when an agreement needs to be reached.

Mr. Andy: Experience in Australia that people in government could not get information on trade agreements. What hope do non-governmental organizations have?

Ms Alycia: Do your homework. The best strategy is to provide more information and facts.

Ms Karyn: Free Trade Agreements, such as CAFTA, have had an impact on Public Health. Often the end result is higher costs of pharmaceuticals. Trade Sanctions threatened in Thailand if the government produced ddl. How can you claim Pharmaceutical companies or governments have no impact on Public Health?

Ms Alycia: Patents are an issue for producing medications and securing payment/reimbursement of investments in the research and production of drugs. Have not seen any documentation on the impact on Public Health. Would like to see any documents on this. Patents secure production for a company for a limited period of time. After patents run out, other companies are encouraged to take up production. There is evidence that some companies are not making commitments to research.

Presentation #3: Generic ARV Production

1355 – 1455

Dr. Kamjorn, GPO Thailand

Note: Dr. Kamjorn presented instead of Dr. Thongchai, who was originally scheduled to do this presentation.

Brief Summary of Presentation

Generic ARV production in the Government Pharmaceutical Organization of Thailand

- State enterprise under MOPH, First launched ARV in 1995 – AZT 100 mg capsules
- GPO-VIR introduced in April 2002, S 30 & S40
- Expanding production of ARV drugs in order to fill government objective of providing treatment to PHA, goal of 50,000 in 2004
- Distribution through public sector
- Hoping to launch another fixed dose treatment next year.
- If it is a combination, it is considered a new drug. Clinical trials need to be undertaken according to Thai Law
- Drug Patent Information Center. – only conduct development on drugs that do not have patent in Thailand
- In the future, the government may need to issue some compulsory licensing.
- GPO producing 24 items, tablets, capsules, syrup and power.
- Other products in the pipeline Abacavir, Saquinavir, Ritonavir and Indinavir.
- Producing low cost CD4 test kit
- Producing drugs for Opportunistic Infections
- 78% supplied to government, 19% to Private – by prescription only. Exporting 3%
- Single price for export – net price. Selling at price sold in Thailand
- Trying to increase production capacity
- Setting up new facility linked with WHO-GMP
- Risk – FTA disagreements between Thailand & US on Intellectual Property Right; TRIPS Agreement; effects from the use of Compulsory Licensing

Questions and comments

Mr. Don: What price is GPO looking to market the CD4 test kit?

Dr. Kamjorn: Price has not been determined. Have good collaboration with University in England. May be available at the end of this year.

Ms Frika: Interested in the CD4 test kit. Will Indonesia be able to purchase kits once it is on the market? Have heard that the machinery will be more expensive.

Dr. Kamjorn: The Thai government has invested in the machinery. There are 21 machines in Thailand already.

Mr. Don: The flow-cytometers will have to be bought from the companies.

Ms Frika: Will the cost for the maintenance of the machinery increase?

Dr. Kamjorn: As far as I know the maintenance is not very much.

Ms Ngoc: Efavirenz has a patent in Thailand. How can Thailand go about producing this drug?

Ms Ngoc: Vietnam has not joined the WTO but has already produced 13 drugs

Ms Alycia: Many drugs may be off patent by the time some countries start producing. Or, drugs may only be patented in certain countries. Many drugs in Africa do not have patents.

Mr. Don: In Vietnam, Efavirenz may not be patented in Vietnam because the drug company decided not to patent the drug in Africa

Dr. Kamjorn: The raw materials are imported to Thailand. Sometime from India and other sources. Quality control is conducted on all import items.

Mr. Don: Does Thailand only export only 3% due to capacity to produce only enough for Thailand?

Dr. Kamjorn: Strategy is to produce for Thai markets first. It will take some time to produce more than this.

Mr. Andy: Have there been requests from neighboring governments for GPO-VIR or technical assistance/transfer?

Dr. Kamjorn: There have been no requests from the region. However, Thailand has received a number of requests from governments in Africa for technical transfer.

Mr. Nimit: Does GPO have any policy to export ARV. Countries that do not have capacity to produce can import from other countries.

Dr. Kamjorn: Setting up a WHO-GMP facility. Will have higher capacity to produce ARV. After the facility is finished they will have higher capacity to produce to be able to export

Mr. Don: When will the facility come on line?

Dr. Kamjorn: Maybe next year

Mr. Sam: PHA with Hepatitis B often need to rely on Efavirenz because it is milder to the liver. But since it is under patent in Thailand, does this mean that there is no opportunity to import from Thailand.

Mr. Nimit: Many countries should join hands to conduct compulsory licensing so that the price will be lower than the lowest price set by Merck and others.

Dr. Hendra: Is the CD 4 test kit a home test kit?

Dr. Kamjorn: No, it is for use with the flow-cytometer

Mr. Don: Will the WHO-GMP facility be able to scale up capacity to be able to provide drugs to meet the demand elsewhere in the region? Do you need multi-year contracts before you can move to that level of production?

Dr. Kamjorn: The facility will have to pass the prequalification of WHO. The facilities will have to also pass qualification. If pass first round, the facility may open sometime next year. May be able to produce 60 million tables the first year which is slightly more than the demand in Thailand. Able to produce about 2 times as much

Ms Frika: Is GPO able to produce enough for all those who need it in Thailand?

Dr. Kamjorn: Able to produce enough according to the available budget plus a little more to the private sector.

Ms Karyn: Recommends to link up with US based advocates that can provide information on trade practices

Mr. Don: Has GPO been discussing with generic producing countries/companies about common issues?

Dr. Kamjorn: Do not have a relationship with the other counties. Have some relationship with raw material producing companies

Ms Karyn: Do know the name of Thailand's representative who will be involved talk that are set to discuss restrictions on the production of fixed dose medications? (Botswana meeting) (No answer available)

Dr. Tia Palla: We were talking about the National Treatment Plan. Who outside the working group on ART should be part of the mechanism?

Dr. Kamjorn: The main group is from the Thai CDC. MOPH, university hospitals.

Mr. Nimit: Starting from the 10 exports in the AIDS Division on ARV. GPO-VIR was not the formula. ddl-3TC-Efavirenz, was the first combination. GPO-VIR was the alternative when there was a problem with ddl and Efavirenz. If the government could not support than many people would not be able to access drugs.

Mr. Don: If the Gates Foundation [hypothetical] were willing to buy GPO-VIR for all people needing it in SEA, would you scale up to that production or would you have a strategy to transfer technology

Dr. Kamjorn: Have to first think of the feasibility of the project. Have to first think about the Thai people that need to use the product. We are trying to support other countries meet their needs.

Mr. Nimit: If the Cambodian or Vietnamese request technical assistance, would GPO send technical experts to help them.

Dr. Kamjorn: If it is government to government it should be possible.

Dr. Suharto: There is a Ministerial Meeting each year. Perhaps this issue be brought up for discussion.

Mr. Nimit: Is there any plan for GPO to product ddl?

Dr. Kamjorn: ddl is in the last stage of research and development but it will be produced

Mr. Nimit: Do you have any fear about the upcoming FTA and its impact on drug production?

Dr. Kamjorn: GPO has raised the issue through the MOPH

Mr. Neil: What is certain? What can be produced after the FTA?

Dr. Kamjorn: We don't know what is in the agreement so we cannot say what will happen. We are trying to make the Ministry aware of the possible outcomes.

Mr. Don: You are providing the Ministry with a list of options about the impact of FTA on GPO

Presentation #4: Research-based Pharmaceutical Companies

1455 - 1605

Alycia Draper

Brief Summary of Presentation

Role of the Pharmaceutical Industry: Improving access to Medicines & Health Care in the Developing World

Presentation

- Will focus on Merck –
- Will focus on Public-Private Partnership rather than on patents
- Merck - Primary goal is R&D on medicines and vaccines in the treatment of HIV. Indinavir, Efavirenz are two well known drugs produced by Merck.
- Fostering Infrastructure Development
- Enhancing Care Initiative (ECI):
- Thailand seen as a success story. Team members promoted community centered approaches ... www.eci.harvard.edu

Promoting public-private partnerships

- African Comprehensive HIV/AIDS Program (ACHAP) in Botswana www.achap.org

- Conclusions from this program: there were various barriers to partnerships. Many thought the drug company would only provide money. Many doctors who were trained, left the country. There was a gap in capacity in medical care providers. The third obstacle was that they were assuming that stigma and discrimination were less than they were.

Global partnerships

www.ifpma.org

Engaging with industry

- Industry needs to balance investment in R & D but also commitment to programs that promote access to treatment and commitment to company shareholders.
- Keep in mind what your objectives are when engaging industry
- Collaboration vs. confrontation: open and constructive dialogue is critical
- Partnerships with industry comes in many forms
- Do your research on company strategies, objectives and ongoing initiatives
- Present new or innovative ideas and approaches
- Communicate and demonstrate on results
- Use direct and indirect advocacy

Moving Forward

- Continue dialogue and leverage our unique skills to promote sustainable access to prevention, care and treatment.

Questions and comments

Mr. Don: What would happen if countries joined together if countries ban together to initiate compulsory licensing.

Ms Alycia: There are more senior people to contact on the issue. But I am someone to contact. If someone is thinking of looking at compulsory licensing the first thing to do is have a dialogue with the company. The first step is to approach a company about a voluntary license

Mr. Nimit: In listening. I hear that Merck is doing many things for many people around the world. If Merck would voluntarily reject its patent, the result may be that more people can be helped. It can help GPO because then it can produce the medicines at lower cost.

Ms Alycia: No. They will not reject patents but do offer differential pricing. As far as patent protection, on concern there is a high risk that companies will not invest in research in antiretrovirals. We also need to be concerned about future medicines.

Ms Karyn: Interesting that presented chose not to talk about pricing and on WTO, FTA, TRIPS when these are clearly what the participants in the workshop are clearly interested in. R& D is not transparent. Pharmaceutical spend billions on advertising

Ms Alycia: The choice was made that the focus was not on WTO, FTA, etc. because the trade debate has been going on for a long time.

Mr. Andy: As a point of clarification, Alycia was asked to present on collaboration with pharmaceuticals, and not on the issues Karyn mentioned.

Mr. Nimit: What is your methodology to determine the price of the drug? During the patent period the prices are very high. After the patent has expired, the price of the drugs usually drops significantly. We are told that it is to recoup money spent on R & D – then we also see that a lot of money is spent on advertising

Ms Alycia: No single approach to how companies do their pricing. Merck does not disclose how it prices its products. Products are distributed to countries with a prevalence of more than 1% the medications are distributed free of charge. The reason why the prices are different in a period of patent and after that period was so that a company. What a product comes off patent a generic company can pick up production. Generic companies have fewer costs because they are using other's research. More companies are producing the drug so there is market competition.

Mr. Greg: Meeting with a group of People Living with HIV/AIDS. An open letter was sent to all Pharmaceuticals in China to reduce the cost of drugs. Have you heard what happened to the letter?

Ms Alycia: Know of the letter and would be interested in contacting the group but there was no return address or contact information included. The letter was also sent to the wrong person within the company.

Mr. Greg: They had previously tried to have a dialogue with the Pharmaceuticals but could not. The letter was the last resort.

Ms Frika: If you do not take back the patent, is it possible to apply to Merck for funding to assist in their purchase or ask for donation?

Mr. Alycia: No. Merck has set up a differential pricing structure as a means to help.

Mr. Don: It seems that the drug that is most needed by those infected through drug use in Asia and eastern Europe will not be available, especially when the company will not subsidize the cost or revoke patent. In these countries, it is the level of economy that is important (they would not qualify as poorest countries) but the route of transmission. MSD should take this into consideration.

Small group discussions: participant action plans based on presentation on WTO, generic and brand name pharmas

1630 – 1730

Country Groups

Brief Summary of Thailand

1. WTO/TRIPS

- ⌘ There is a Thai Working Group already working on this issue.
- ⌘ There should not be patents on health issue – rich or poor we all need medicine when we are sick.
- ⌘ Needs to be an amendment to TRIPS.
- ⌘ WTO – should support research on new drugs – so that drug companies do not control patents.
- ⌘ Target the International AIDS Conference (IAC) in July 2004 for action.
- ⌘ Push the GPO to develop a policy on what to do if we can export.
- ⌘ If friends in other countries are interested in buying from GPO they need to push their governments to approach the GPO.

2. Compulsory Licensing

- ⌘ Look at the possibility of a Regional Compulsory Licensing for ARV.
 - ⇒ Need money to educate other countries on Compulsory Licensing.
 - ⇒ Where can the money come from?
 - ⇒ The GPO from each country could talk on how we can produce ARV together cheaply.
 - ⇒ Will need to look at translating documents.
 - ⇒ Develop a skills building workshop on Compulsory Licensing information
 - ⇒ Request people from each country to find out as much as they can on the patents in their countries, also information on price of drugs, patent registration system, health care system and who pays for health care.
- ⌘ It was suggested that APN + Who could organize or coordinate this?

1. Patents on Original Drugs

- ⌘ **Develop Campaign on 'NO PATENT – NO PROBLEM'**
 - ⇒ Continue current negotiations but look at a Global Response.
 - ⇒ Campaign the drug companies to voluntarily revoke the patents in every country.
 - ⇒ Draft a letter to the director of each drug company asking them to sign a letter to revoke their patents – need the names of the directors.

- ⇒ The letter could say “ I am the Managing Director of, and I revoke to patent of for the people of the world.’
- ⇒ What will their reactions be to campaign – need to plan for this.
- ⇒ Invite friends from other countries to be involved, in Africa, Latin America etc
- ⇒ Need clear correct information on this issue for a campaign.
 - ◆ Need to be able to explain issue clearly and well
 - ◆ Need to be able to combat drug company arguments
 - ◆ Need information such as how research and development is linked to pricing, number of infections worldwide, impact the drugs could make if available. How the issue affects people and their lives.
 - ◆ There is a lot of information on this issue already
 - ◆ How can we share the information? One way is to forward to as many activists and organizations as we can
 - ◆ Documents will need to be translated
- ⇒ Launch a website, that will be in many languages, so people can access and send information o the issue. There could also be an on line petition

⌘ **Who should be involved**

- ⇒ Thailand
- ⇒ TTAG
- ⇒ TNP+
- ⇒ ACCESS

⌘ **Campaign at IAC**

- ⇒ Objective
 - ◆ Tell the World that Patents make the price of drugs too high.
- ⇒ Activities
 - ◆ Have an activist room at the Global Village
 - ◆ Go to each drug company booth with placards
 - ◆ Have a petition
 - ◆ Join the conference parade or have our own parade.

⌘ **Messages**

- ⇒ ‘GIVE UP YOUR AIDS DRUG PATENTS - GSK, Roche, MSD, BMS, BI, Abbott, Pfizer’
- ⇒ ‘NO FTA’
- ⇒ ‘NO PATENT – NO PROBLEM’
- ⇒ ‘No Patents and We Will be Alive’
- ⇒ ‘2005 – Fucked by the WTO’

⌘ **Actions**

1. Draft a page about the overall campaign
2. Locate someone who can start to compile the data needed on the issues
3. Send out information to key international activists/organizations to ask what they think and feel about the campaign
4. Ask Tui to reserve a room at the Global Village at the IAC
5. Find a budget – signs, translation, t-shirts etc
6. Draft letter to drug companies
7. Explore developing a webpage, who would manage it, could this be linked to the Thai FTA web page?

Brief Summary of Vietnam

1. Assessment of availability of drugs and their patent status and patent holders, generic drugs. SEI, cost effectiveness study .
2. Action plan based on the results of the assessment.
 - Before 205/WTO: local production, importation/generic drugs. Negotiation with research-based pharma companies to reduce prices for either raw material or finish drugs, or buy, patents jointly with other countries.

- After 2005/WTO membership. Compulsory licensing (manufacturing or importing)
3. Advocacy to the government on the needs and ROI on care and treatment of HIV/AIDS

Other countries

The Indonesian participants had a discussion on the issues which did not result in an action plan. No action plans are available for Cambodia or Lao PDR.

Rapporteur's Notes on Day 3: 19 March 2004

Morning announcements

Session time: 0900 – 0910

Facilitator/Speaker: **Don Baxter**

Review of the day's program

Reminder to fill out evaluation form

What is advocacy?

Session time: 0910 – 1000

Facilitator/Speaker: **Nimit Tienudom, Heng Sokrithy**

Brief Summary of Discussion

Mr. Sokrithy – Experiences from Cambodia

CPN+ is the voice of people living with HIV/AIDS in Cambodia. The network conducts advocacy with the government.

Advocacy efforts

- Advocacy at the National level with support of Red Cross and Policy Project to submit a document to the 2nd National AIDS Conference and the Prime Minister. CPN+ organized a satellite meeting at the Conference to push government to support the statement of CPN+. Many journalists were present so that the efforts were widely reported on.
- Reduction in discrimination and the rights of people living with HIV/AIDS is also a focus of CPN+. On the first day of the Conference, there was a parade of more than 500 PHA at the Conference.
- Proposal to the Global Fund (GFATM) to provide support people living with HIV/AIDS. Support to include the improvement of care delivery at the provincial level. This has involved consultative meetings to set up national guidelines for home-based care and clinical based care.
- CNP+ is also represented on the working groups for Continuum of Care, PMCT and VCT.
- CNP+ has been advocating to the Cambodia Pharmaceutical Enterprise to produce drugs locally in Cambodia.

Current Situation: CPN+ is growing. There are many support groups as members. Currently there are 35 support (14 in Phnom Penh, and 21 in Provinces). 7,200 members. Community mobilization is also growing in rural areas. Collaboration has been established with the National AIDS Authority and NCHADS on activities. Representatives of PHA groups are speaking to the government.

- Advocate for pricing of services, Russian hospital – 3000 Riel (0.8 US dollar). In 2003, the hospital had a plan to increase the price of check-ups. PHA complained to CPN+ Informed key decision makers. Now, PHA are not charged for services.
- PHA involved in the National Planning - National AIDS Authority – NCHADS
- Advocacy efforts in coordination with KHANA to advocate to WFP to provide food for PHA.
- HIV/AIDS Law. Involved with the Legal working group of NAA. Working to improve the HIV/AIDS law.
- During the national election, CNP+ received support from Policy Project to interview key people in the 3 political parties on their support for people living with HIV/AIDS.

Some efforts have been successful while others have not been so successful.

Some of the successes include:

- Support from Global Fund in the first and second round to support treatment of people living with HIV/AIDS.
- Working in collaboration with KHANA, Provincial Networks of PHA were established in 10 Provinces. (Previously only in Siam Riep and Battambang provinces)
- Some strides have been made in the reduction of stigma and discrimination. People in rural areas do not yet have a clear understanding of HIV/AIDS.
- Continuum of Care. Has to be expanded. Plan to set up center similar to the *Friends Help Friends Center*
- World Food Program is providing food to 2,000 families.
- Strengthening of the referral system

Advocacy efforts that have not been so successful

- Stigma and Discrimination is still high
- Continuum of Care has increased but not sufficiently to meet the need.
- Attitudes and behavior of the health care worker are slow to change.
- National budget limited to support ARV. This year only 200,000 is available to support PHA. Budget in this area needs to be increased to 5 or 7 million a year
- Community mobilization in some areas/provinces has not yet taken place.
- Faith-based programming or, involvement of religion is limited
- Workplace policies on HIV/AIDS. To follow the HIV/AIDS law
- 157,000 are living with HIV/AIDS 22 thousand have AIDS. Some 2,600 have received treatment free of charge

Mr. Nimit –The Thai Experience

Mr. Nimit started with a question, *Does everyone in this room know what advocacy is?*

The responses included:

Advocacy, Partnership, Commitment from Leadership, Argument

“Sometimes in my own work I am not sure what is advocacy and what is not. It is generally to make something better. When we have discussions, we have to speak out and tell others what we want to have changed.

In Thailand there are more than 200 NGOs that do work related to HIV/AIDS, in different areas. There are only a few NGOs involved in advocacy work. When doing advocacy work, some government officials are unhappy because we are revealing problems.

When problems are identified for advocacy. We have to make clear what messages we want to give to the government. Focus on one message at a time.

Early efforts in Thailand tried to make society have a clear understanding about HIV infection and living positively with the disease. One effort was the development of the *My Positive Life* exhibition. We had to educate some PHA groups to help with the project. The important messages were to get people to think that anyone in society can be infected and to change the understanding that PHA are not bad people, just human.

When the campaign was finished, we were thinking forward, toward the nature of the disease, immune failure caused by HIV. We looked at what we could do for people living with HIV/AIDS in the future. PHA leadership has changed many times. Before good treatment was available, leadership changed often due to sickness and death. Then, we learned that people in USA, Europe, and Australia could live longer and have a good life through good treatment. At that time, ARV was too expensive. Few doctors knew about treatment. Too many people in the MOH did not think it is cost effective to treat PHA, because from their view, even if PHA were treated they would still die.

Advocacy for access to treatment in Thailand was started. First, there was a need for knowledge. We must know as much as doctors. Some doctors educated us with knowledge of treatment. This is very important in doing advocacy for treatment. Then there was the need to prepare the health structure in Thailand and the need to prepare PHA groups and leaders of NGO. There were OI/ARV workshops for skills development in the provision of treatment.

It used to be that it was impossible to get the treatment. 5 years ago treatment was too expensive. Before ARV, we focused on the promotion of good health. In Thailand, there are three diseases that are killers: TB, PCP, and Cryptococcal meningitis. Workshops were conducted for health care providers who would then teach about OI. The OI workshops were also used to build capacity among the leadership of the PHA group. Leaders can help friends and communicate with hospitals (health services) more effectively.

The method of advocacy is very important. There is the need to use many methods for one advocacy effort and workshops may need to be conducted for many people. There is a need to talk with the media and make media understand our point of view. It is important to develop key contacts.

When switching advocacy efforts to new issues, someone has to maintain advocacy on the old issues so that the messages will not disappear.

People doing advocacy may have different personalities. For example, when advocating for ARV, you may need to have someone who is willing to take the government head on and “bang on the tables.” Then, when attention is raised, someone who is diplomatic is most useful to continue the discussions. Someone who has a lot of knowledge and who can look at the consequences of actions – advantages and disadvantages of the advocacy efforts – is also useful.

It is important to make an advocacy plan – a macro plan that may contain many micro plans, which should be flexible and can change pending the situation. It is difficult to make things that we have asserted become a reality. For example, asking the government to incorporate treatment into the public health scheme (30 baht). To make it real, we must make PHA function as monitors, conduct capacity building workshops, allocate budget to maintain PHA that are working on these efforts, and increase involvement of more people.”

Questions and comments

Mr. Don

Question to Mr. Nimit. Access to treatments campaign in Thailand has been successful. If you were doing it again, how would you do it differently?

Mr. Nimit

I do not think we have succeeded with advocacy in this area. There were many elements that lead to movement and change. If CIPLA did not announce that they could produce medication cheaply, our advocacy efforts probably would not have happened. We also had to look at the quality of the medication. Drugs from CIPLA were imported illegally and trials were conducted among 200 people with appropriate doctor supervision. Then, we talked with GPO who became interested in the idea of producing the drugs locally. If we did not have these components, we may still be in the same situation as Cambodia today. If I were to think back 5 years ago, I don't think that I could change anything.

Mr. Adi

Is the religious sector the barrier to access in Thailand?

Mr. Nimit

We have to work with religious organizations. All religions teach people to behave well. Therefore some may see that people with HIV/AIDS did not follow their teachings and are therefore bad. Some religious groups understand and help PHA. In the south of Thailand we have worked with Islamic groups. In the beginning, the institutions said that if people follow Islamic teaching, there would not be anyone infected. We educated them that there are certain factors that may put people at risk even with their religious teachings. We also had

them look at the importance of sex education and community involvement. Now, they are working together with us.

Dr. Tia Palla

What type of communication behavior is more important for advocacy, hot or cool (passive assertive, or aggressive)?

Drug companies like to find optimal conditions for selling their drugs. If everyone dies, there will be no markets for drugs.

Mr. Nimit

Think that each communication behavior is important. If too passive, things will not happen. If too aggressive, then people will stop listening to us.

Mr. Greg

I am not sure that I got Dr. Tia Palla's point. Would like further explanation.

Dr. Tia Palla

If there is greater demand for drugs, production will increase, then prices should come down. Drug companies and governments should realize that if we close our eyes and let people die, then we cannot maintain the price.

Mr. Greg

CPN+ has an ambitious strategic plan. How do you justify doing the advocacy work when the immediate needs of the members is food, shelter, access to treatment? What kind of advice can you give to a country where there is not a suitable environment to do advocacy work to make some kind of change.

Mr. Sokrithy

Lately, we have received support from the Policy Project and others to do advocacy. We try to make members and others understand that advocacy is necessary to make change. Advocacy is better than care and support. It is long term because if we change the situation the change can become sustainable.

ARV is available but very limited. Advocacy is the best way to push the government and other resources (UN agencies) to increase support and reduce the cost of ARV. Sustainability for people living with HIV/AIDS

Mr. Nimit

Need to have people that are willing to be involved in advocacy continuously.

Have to have clear messages. It doesn't matter whether a government is a democracy or socialist. Need to be able to clarify your point to the government. They need to see the advantages and disadvantages of taking action. Initially, doctors in Thailand did not see the benefits if treating PHA. After seeing the benefits – PHA have a better quality of life.

Mr. Don

I'll leave you with a question to consider for later discussions: What barriers were bigger than you expected and which ones were less of a barrier than you expected?

Workshop session: Developing and Implementing an advocacy strategy for National HIV Treatments Access

Session time: 1105 -1210

Facilitator/Speaker: **Don Baxter**

- **Identifying major elements of an advocacy Strategy**
- **Identifying likely barriers and/or opponents**

Brief Summary of Session

The session will identify the important elements of an advocacy strategy

Two stages to an advocacy strategy: Planning Phase and Implementation Phase

Elements: (many of these need to happen simultaneously)

1. Goal and Message: Brief, clear and agreed - have to be clear goal and clear messages [for people we want to influence]. Messages have to be agreed
2. Preparing "The Case"
3. Analyzing the Decision-Making Process. Understanding how the decisions are going to be made and where in the government will be made (health dept, cabinet, PMs office, the party (Vietnam and Laos)), steps to get there.
4. Identifying allies. PHA, Health care providers, Academics, AIDS activists, Politicians, other people's networks, International activists (list taken from Thai presentation). Talking with people who have a particular connection [personal] – can be productive or counter productive.
5. Identifying the possible opponents and the arguments. Anticipate the arguments of your opponents and devising responses
6. Preparing allies for mobilization. Other people need to be involved (especially PLWHA groups and supporters)
7. Media strategy and homework. Often you will not be in control of the timing. Have to know people in the media to initiate an immediate response. Difficulty in the turnover among journalists. Beneficial to have a really well informed journalist. Developing a relationship can be helpful because you can talk to them
8. Public action/demonstration strategy (hot or cool approach). In terms of a strategy you need to plan a hot response, whether or not you need to use it. Don't threaten more than you can deliver. You can get away with this only once.
9. Implementation of lobbying strategy.

Questions and comments

Ms Ngoc In Vietnam, the Ministry of Health, Ministry of Planning and Investment and Ministry of Finance are key stakeholders. The media, some newspapers, can advocate to the government. It is accepted to show a better image of PHA. Other issues, however, are not, such as PMCT and the cost of Navirapine, because these sound too political.

Mr. Greg Should be wary when dealing with the media. Some journalists are unscrupulous. They sometimes just want a story. Sometime, we should have a 3 day workshop on this!

Mr. Don Have to do your home work with the media.

Ms Frika Media likes the dramatic scenes from our lives. Training is necessary for the media on how to write about HIV/AIDS. The ones who are writing the stories are not the editors so the stories can always change before print.

Ms Frika Guidelines on doing a demonstration in Thailand. What is the timeline from provoking a response (such as greater understanding) to discussion and action?

Mr. Nimit Need to have friends. So, many NGOs were invited to participate and were involved in different stages.

Dr. Suharto On point number 5. Identifying possible opponents. This sounds like looking at the person rather than the problem, such as a person having the wrong perception.

Mr. Don It is probably both the person and the problem. In National treatment plans, the focus is probably more on the arguments. We need to think through the power blocks so that the government will make the response that we would like them to

Ms Frika It is also good to write to the editor. To start to get them to focus on language.

Mr. Don How can advocacy be done where the governments are overly restrictive?

Ms Ngoc Have to use every opportunity and chance. Family friends, telephone, meetings. Sometimes use international organizations. WHO has a very close relation to the National Drug Administration. Try to incorporate something into their meeting schedules. We also hold regular meetings with the UN agencies. We meet regularly to discuss what has been done and what will be done. Ideas put on paper and shown to government partners.

Mr. Don Therefore, advocacy can happen in Vietnam but not through public demonstration.

Mr. Kamon In working with the media. Provide information to the media. Need to prepare the message and the points that we would like to have them write. If we want to change policy, we need to have a political message. To change in stigma and discrimination we need to have a broader message. Identify PHA to provide information to the media. If we want people to know about the drugs we have to inform them why it is important to their lives. We have to get people to think about the message in order for change to occur.

Dr. Phuttary In Lao PDR. The government did not understand about the AIDS problem. Now, there is data and information from national partners, such as National Committee for the Control of AIDS (NCCA – a government agency) so that the government understands better and creates policies that can help. When funds are not available, the government requests NGOs to help. NCCA provides the data. Sometimes NCCA invites PHA to speak on World AIDS Day to the government. In Laos, journalists cannot write on an issue without government clearance and data.

Dr. Tia Palla There is a need to understand the motives on both sides. When we have advocacy, we are asking for something. Looking for equity. In the environment. Transparency. Problem of affiliation. Need to have logic. Based on human rights. Approach, problem of drugs. The government is very committed in Thailand. Full support. Three approached. Case of supply reduction, demand reduction, harm reduction.

Mr Don Yes, we have to logical. But we should not expect decisions made on logic. Decisions are made based on values.

Ms Karyn What is evidence and what is not? Evidence is often created by people in power and therefore not necessarily the truth.

Mr. Nimit 3 barriers

1. Attitudes – many health care providers have an negative attitude toward treating PHA
2. Knowledge – updated knowledge about HIV/AIDS
3. Health System – when we need to provide access to treatment. It is important to use the community hospitals (800). If we cannot use this system, we cannot provide treatment to people in rural areas. The director is the center point and the ultimate decision maker. We need to empower the nurses. Try to break the barrier for behavior change for health care provider and PHA group. Training for knowledge.

Support was given to some hospitals to develop a committee for ARV treatment that could be used as a model for other hospitals.

In the beginning, the numbers needed were a surprise. We did not anticipate the numbers would become as big as they did and the number of hospitals that would be needed. [Originally, we thought that maybe 100 would be sufficient]. Greater action was needed. The government got “face” and a good name so efforts were accepted.

- Distribution of National Treatment Plan discussion
- Country groups were requested to make additions or changes to the notes pages

Case-study: Thailand: How the government works with CBOs and community organizations on treatment access

Session time: 1225 - 1315

Speaker: Dr. Petchsri Sirinirund, Thai MOH

Brief Summary of Case Study

Initially, the government and NGOs did not work together. Government looked at NGOs as being aggressive. NGOs looked at the government sector as being very slow, bureaucratic and not working in the interest of the people. AIDS has made us think and work together. Many of our friends who are positive were known to us before they were infected so there has been a personal stake. The government sector has learned how to work with NGO and PHA in looking at health problems.

The image of Western Countries is that there is always groups of patients and families of patients working to solve the problems. These types of groups have not functioned well - except for groups of PHA. These groups are able to work with NGOs and with the government. It was not easy to start. When we started, it was difficult. We now understand each other much better than before.

Formerly, I thought I understood what the patients thought. I learned that what I thought was not what the patients were thinking. Doctors have a tradition of only telling patients what to do. Patients are reluctant to tell the doctor what is happening in relation to ARV. They are afraid that doctors will get angry if they are not following the prescribed regimen. Example of micro level assistance for care.

50,000 symptomatic/AIDS cases on ARV

ARV is one component of care for PHA

- Communication to PHA for their own decision

- Long term plan for care

- Holistic care

[Real objective of the ARV – expect that ARV is core component that will provide quality of life for PHA]

- Care team (Hospital-health station-NGO-PHA gr.-DHO-PHP) [for ARV need doctors to be involved in the team]

- Capacity of the Team

- Management

In the North the health stations – PHA are willing to start

In the South PHA are unwilling to go to the health station.

ARV is not the only need. The needs for care are different in different stages from infection to AIDS. There are many things that need to be done before a person needs to have ARV

HIV/AIDS Prevention and Care Network Development

- Government level

- NGO/Business – Government – PHA groups

- Three parties need to work in the same direction

Local/provincial Level

Health sector cannot work alone. Have to work with other sectors – NGO, Business (Rotary, Lions), and PHA groups

Health stations and hospital were under different authority. Now, they have to work together

Health stations had to report to District Health offices. Hospitals to the Department of health

National AIDS Program

Chaired by the Prime Minister

Members

Government Senior Officials
Representatives from Academic Institutes
Non-governmental Organizations
People with HIV/AIDS

Currently the 3rd national AIDS plan. Approximately one year is needed to develop the 5 year AIDS plan.

Information system

Partnerships in planning. Sometimes when working together, partners do not see what needs to be done more. Sometimes good intentions are not enough to work together. When people don't know what to do, they will treat HIV/AIDS as lower priority. The first step is having a good attitude and the willingness to work together. Partners need to have enough information to understand the situation. This will help reveal which party should do what.

Civil Society involvement

Thai Government provides technical and financial support to civil society orgs working in HIV/AIDS

Approximately 2 million US dollars are allocated to support the work performed by NGO and PHA Groups
Decision making lowered to the provincial level
At present 410 NGO and 534 groups of PHA

Access to HIV/AIDS medical care in Thailand

Treatment of opportunistic infections
Monotherapy 1992-1995
Dual therapy 1995-1996
HIV Clinical Research Network – dual and triple therapy 1997-2000
Access to care (triple ARV and OI prevention and treatment from 2000)

ACT – access to care project

NAPHA

System development, infrastructure of health services training, monitoring system, medical care, drug stock, evaluation,

ART Team

Government-NGO-PHA Networking

National Level

National AIDS Committee

Working group – strengthen the service system for ART

How to integrate the ART in the universal health insurance program
[government cannot do internally – up to the NGO and PHA groups]

Budgeting support

Technical information sharing

Can help each other when understanding each other

Local level

Provincial/District AIDS Committee

Working group – strengthen the service system for ART

How to recruit PHA for ART

Monitoring

Budgeting support

Technical information sharing

Questions and comments

Mr. Greg What are the biggest challenges to scaling up?

Dr. Petsri We have to be ready – readiness of health services system. But, it is also the challenge of how we will make the health providers want to provide the services – not only ARV.

Mr. Greg Are there any guidelines/efforts from the government to get more people on ARV?

Dr. Petsri No, because the government has had to think about the pros and cons of the actions to take. For example, the incorporation of provision of ARV in the universal health insurance scheme. It may not be appropriate at this time since the scheme has only just started and there are many problems to be worked out.

Dr. Hendra At the national and provincial level who is responsible for the training of the health providers?

Dr. Petsri This is done at two levels – actually three - National – Regional and Provincial (sometimes at District level). Due to this, we have to standardize the contents of the training. The government is not used to conducting training on an individual need basis. Mass trainings were the norm.

Dr. Hendra Who coordinates training efforts?

Dr. Petsri There are many aspects. The Department of Communicable Disease Control coordinates health aspects. Counseling is coordinated by the Department of Mental health

Presentation: Identifying partners in advocacy

- **Identifying major allies for the advocacy strategy**
- **Partnerships / Other initiatives including:**
 - **WHO 3 x 5 initiative**
 - **TREAT Asia**
 - **TIDES Foundation**

Session time: 1415 - 1440

Speakers: **Don Baxter, Greg Grey, Nguyen Thi Minh Ngoc, Karyn Kaplan**

Brief Summary of Presentation

WHO 3 x 5 Initiative

The workshop was hoping to have a presenter from WHO but this was not possible. There is concern about 3 x 5 because it has not received the funding expected. Visits and assessments have been conducted for 3 x 5 in Vietnam, Indonesia, and Cambodia. There is an on-line 3 x 5 discussion group for those that want to keep informed about the developments. By the time of the Bangkok Conference, we should know more about where 3 x 5 is situated and how effective it will be.

TREAT Asia

TREAT Asia is a program sponsored AmFAR in the United States. The program now has 500,000 Euro to develop treatment literacy among community groups. APN+ is coordinating efforts and will focus on Cambodia and Vietnam. A proposal will be submitted to AmFAR to get some staff to look at monitoring, coordination, sustainability. More information is available on the web-site www.AmFAR.org

World Community Advisory Board

In February in San Francisco, at the World Community Advisory Board, activists with experience in negotiation, working with, and protesting against initiator drug companies came together to share experiences. The WCAB conducted a training on how to negotiate with some of the drug companies. The focus of the training was on drug pricing policies, clinical trials, and efficacy issues. The group had an opportunity to meet with actual policy makers from Roche, Smith Kleine, and Glaxo Wellcome. It was a good learning experience.

Analysis will be undertaken examining the experiences and what have activists learned to see what would be useful in the different Regions. Notes from Chris Green are available. The meeting was only over a short period, just 3 or 4 days. The WCAB may expand to look at other issues, such as ethical standards developed in Europe when PHA are involved in clinical trials. Follow up with some of the drug companies will be conducted.

Hanoi ARV Roundtable

Policy Project is organizing an Annual ARV Roundtable meeting in Hanoi later this year. By that time 3 x 5 should be moving a bit. The meeting will bring stakeholders concerned with ARV together. Country experiences from the Region will be presented to the stakeholders about scaling up.

TIDES Foundation

In March 2003 there was a summit in South Africa, a community driven project to bring together PHA and community based advocates. The point of the summit was to look at education and resources for people who want to do action for scale-up, treatment education and advocacy skills. The TIDES Foundation will be supporting regional and sub-regional meetings to follow up on the summit. Efforts are totally community driven in that local communities will decide the content and participation of the follow up meetings.

It will also look at how to set up a community-controlled grant-making mechanism. There will hopefully be funding available for treatment education projects. Discussions are taking place on how to turn the mechanism into an on-going fund. This Region will hopefully hold a meeting in September. The Bangkok meeting will be used as an opportunity to meet and discuss plans for the sub-regional meeting here.

Small group discussions: National advocacy plans

Session time: 1440 – 1545

Participants divided into country groups and then discussed the key questions of: what is the decision-making process in your country for moving treatment access ahead; who are possible opponents; what is a good media strategy; what are the next steps (homework)

Summary of Cambodia

Decision-making process

- ART working group – establish plan and convincing info (advocacy tools) and number of options

- Submit case to council of ministers through NAA
- (And national Assembly and Senate)
- NAA leads the process
- Advisor of Prime Minister
- Leads to National ART Plan

Opponents (possible)

MoC, MoF, MoH, some ART members, National Treasury, CO, Journalists, (National priority)

Media Strategy and Homework

Roundtable (na tie) and media coverage

Case study on the impact of ARV

Roundtable debate and spots

Press conference

Elite (influential speakers)

H.M. King

Other notes:

National ART Plan, which takes into considering WTO issues and the COC, feeds into the ART Working Group, which needs to convince opponents of the feasibility of the plan. Public opinion must be taken into account. The main case is the WHO target of 10,000 by 2004. COM and NA and SENATE must also be involved.

Summary of Indonesia

Analysing the decision-making process

- Put the people on the same "platform"
 - ARV specialists
 - Legislators and members of parliament
 - Grassroots
 - Government official related to this issue (ministry of health)
 - National AIDS Commission
 - ARV importers and producers
- Develop mutual agreement
- Formulate agreement

To cover:

- Magnitude
- Coverage
- Target
- Budget Required

Possible opponents

- National planning agency
- Government institutions
- Medical community
- Religious groups
- Traditional healers
- Politicians

Media Strategy and homework

- Advocate with media owners and shareholders
- Training workshops with editors and journalists

Regular sharing of research findings and info (especially to promote GIPA)

Summary of Lao PDR

National Treatments Plan 2005- 2010: an advocacy strategy to start this planning process

Treatment and care working group under NCCA

Decision Makers

- National Committee Control of AIDS Bureau (NCCA/B)
- NGO's (MSF, UNICEF, UNAIDS, REDX, WHO)
- To hold regular meetings to discuss the issues and make mutual decisions

Possible opponents (and anticipated arguments)

- NCCA and NGOs
 - Some may have higher or other priorities
 - Some may not have the capacity or mandate to act
 - None would actively oppose
- Report to NCCA/B on this meeting – request the formation of a working group on treatment and care
- Raise it for discussion at the next NCCA meeting

Education strategy to raise awareness among and engage decision-makers

- PLWHA – treatments literacy
- NCCA/B – workshop on treatments issues (WTO/TRIPS/ARVs/Generics etc)
- High Level Officials (Ministers department)

3 Round table meetings over 6 months – meet PLWHA groups, learn and discuss treatment

Summary of Thailand

Developing and Implementing an Advocacy Strategy – Brainstorming

1. Analyzing the Decision Making Process.

- ⌘ Where is the starting point ? – Dr Sombhat who is the Secretary to the National AIDS Committee.
- ⌘ Need to know the people who have the authority to draft and implement policy and to make the decisions on the policy, and the process on how decisions are made.
- ⌘ Who makes decisions on budgetary issues: who is the Senate Committee that manages this
- ⌘ Where in parliament do policies go for final decisions
- ⌘ At a local, provincial level – need to understand how authority works and fits into the decision making process.
- ⌘ Need to know who has the power to make the final decision at each level.
- ⌘ Analysis - Process - Decision Making
- ⌘ Analysis should include
 - ⇒ Information on drugs, pricing, treatments, HIV disease, and capacity to work on issue from stakeholders, MOPH, Academics, NGOs, PHA
- ⌘ How to work
 - ⇒ Use pressure
 - ⇒ Have meetings
 - ⇒ Conduct negotiations
- ⌘ Role of media
 - ⇒ Can help society to understand issue
 - ⇒ There will be people who agree, disagree and who are indifferent.
 - ⇒ Being indifferent does not mean people do not care, so how can we change the indifference to becoming those who agree
- ⌘ Working group
 - ⇒ Will take information from stakeholders
 - ⇒ Must have a key person involved who can work in the political environment
 - ⇒ Working group must feed to the person or group who makes the final decision.

- ⌘ Final Decision
 - ⇒ Must know whom this is and how to influence or get all of the correct information to them, to enable them to make their decision.
- ⌘ Opponents and Allies
 - ⇒ Must identify who the opponents and allies are at each step of the process, including the media.

2. Media Strategy and Homework

- ⌘ Introduce ourselves to the media
- ⌘ Involve media owners, as journalists need the support of them to print accurate and appropriate stories
- ⌘ Have a media workshop
- ⌘ Analysis the affects and advantages – and how the media can help
- ⌘ ‘The media do not say any more than what people want to believe’
- ⌘ If the media know about issues before the government makes decisions, they can question decisions and possible outcomes. They will be able to ask direct important questions.
- ⌘ In society there will be positive and negative attitudes to this issue, most people will have a negative attitude to HIV/AIDS
- ⌘ The media is no different and will also reflect these values
- ⌘ This means someone with a negative attitude is more likely to write a negative article
- ⌘ We need to change this but need to understand why they think like that to make a change.
- ⌘ ‘Good news is free but bad news will cost’
- ⌘ What do we need to do
 - ⇒ More training with the media and to do it more often as there is a regular turn over of journalists
 - ⇒ Enable discussion and information sharing more often
 - ⇒ Some media will see the issue only as a ‘flash’, will see it quickly and forget about it once it is not there. So we need to have ‘hard hot issues’ to draw their attention
 - ⇒ Develop good press release
 - ⇒ Could we have our own media outlet?
 - ⇒ Need a core number of speakers who are experts that the media can call upon when they want to ask questions about issues, such as Nimit, Kamon, and Ajarn Jon. Need to send a press release to inform them of these contacts.
 - ⇒ Encourage media to be more informed on issues, invite them to activities such as study tours
 - ⇒ Inappropriate terminology used in the media is still a big issue
 - ⇒ There is already a set of guidelines on HIV and the Media
 - ⇒ Look at doing more letters to the editor.

Summary of Vietnam

1. How to increase access to ARVs – the message: It is a human right to access ARVs
2. Preparing “the case”
3. Decision making process: Ministry of Health submits the proposal the government who forwards it to other ministries for comments and international agencies for technical assistance and funding. Aim for a consensus workshop between the government ministries (notes say: consensus W/S)
4. Allies: non-government organisations, government organisations (mass - organisations), PLWHAs – need to get agreement on the proposal
5. Drug companies, BTA, WTO, Ministry of Finance
6. SEI Study, educate
7. Media forum, organise field study, provide information on other countries
8. World AIDS Day, public holidays, social marketing

Wrap-up session – sharing of thoughts by individual participants

Session time: 1615 - 1700

Facilitators: Don Baxter / Andy Quan

What would participants like to see next after this workshop?

Responses

- E-mails from participants telling what they are doing and have accomplished
- That discussions that took place before the break in developing an advocacy strategy will take place after everyone goes back home
- Action to take place at country level. Regional Forum for support country level
- More collaboration in country and in the region
- Create real action in each country
- See greater national action toward the provision of ARV
- Regional campaign against drug prices
- Coordination between Thai and Lao networks
- Meeting with National Committee for Control of AIDS for a National Treatment Plan
- At country level, would like to see PHA have greater access to medications
- Would like to see PHA groups with greater strength
- Should be workshops like this from time to time to share information and for policy development
- Would like to see peace and friendship in working for ARV in a concrete manner
- New advocacy to get drug companies to revoke patents. Would like to see cooperation on this.
- Would like to see active collaboration in this region – to provide greater access to medication in each country
- Would like to go back to home country and share what is learned in this workshop and start some efforts in my own community. Would like to see services close to home. PHA groups in good collaboration with National and Provincial AIDS Committees
- Would like to see ARV everywhere – like cigarettes
- Would like to see the strengthening of all the participants in this room, especially those from Indonesia.
- Would like to see collaboration in the Indonesian team so we can have good team work when we go back home.
- Would like to have the next meeting in another country
- Will disseminate information to PHA around Ho Chi Minh City and discuss advocacy at the district and local level.
- Would like to see the national AIDS strategy approved
- The workshop was a great opportunity to learn from everyone. Two main targets: government offices and drug companies. Will need support from others here for information and other technical support.
- Hope contact is maintained through e-mail.
- Would like to see advocacy training programs everywhere in the region for access to treatment so that this can be achieved.
- Hope we are not all talk but take action.
- Strengthened care, support and treatment. Expect to learn from both the successes and the failures
- Hope Cambodia team will carry out advocacy efforts
- More people will have access to ARV in the region.

- Efforts incorporated into country planning efforts to support decisions for the provision of ARV.
- ARV should not be a humanitarian effort but should be a right for all.
- Hope that Dr. Tia Palla will lead the Cambodia team in developing a national advocacy strategy.
- Would like to have continued support from everyone here.
- Hope the energy continues. If this happens, different issues can be discussed next year.

Closing words and thanks

Don Baxter gave closing words and thanked participants, sponsors, and organisers.

Don Baxter closed the workshop by first praising the participants for the spirit with which they approached the program, the respect with which they listened to one another - but not avoiding expressing differences of view - and their dedication over the three days of intense work on complex issues.

"Whether you realise it or not - you are now the HIV treatments access activists network for Southeast Asia", he said.

He also thanked the funding sponsors, the POLICY Project, TREAT Asia and AFAO's private donor, the translators and the rapporteurs, all of the presenters - and particularly Nimit Tienudom and Kamon from Thailand and Sokrithy from Cambodia for their extensive contributions - and the logistics team from Australian Red Cross Asia Regional Office in Bangkok. And he concluded with a special commendation for Andy Quan, who had carried most of the programmatic and administrative load for the development, oversight and facilitation of the Workshop.

He urged all to link with one another at the Bangkok Conference and for those from the community organisations to attend the TIDES Foundation follow-up meeting in September.

Appendix 1: Program

PROGRAM:

Community Sector Workshop on HIV Treatment Access: “Building Policy & Advocacy Capacity in Southeast Asia”



17 - 19 March 2004, Bangkok

Meeting Location:

Amari Boulevard Hotel, 2 Sukhumvit Road, Soi 5, Bangkok 10110, THAILAND

Sponsors:

This workshop is sponsored and supported by the following organisations:

- The POLICY Project (funded by USAID)
- TREAT Asia / the American Foundation for AIDS Research
- The Australian Red Cross
- The Australian Federation of AIDS Organisations

We would also like to thank the following partners:

- AIDS ACCESS Foundation
- Asia Pacific Network of People Living with HIV/AIDS (APN+)
- APCASO

PROGRAM:

- Unless otherwise noted, all sessions took place at the Amari Boulevard Hotel.
- The program was designed to be flexible. If discussions were going well, they were extended. Some sessions were cut so that the days would not be too long. The program below represents what actually happened rather than what was proposed before the workshop. The timings of sessions listed are not precise.

16 March 2004 – Tuesday: Pre-workshop: Australian Red Cross Office

Arrivals and Introductory Workshop –

<u>Time</u>	<u>Agenda Item</u>	<u>Facilitator/Speaker</u>
All Day	Arrival of participants	
1500 - 1800	Introductory Workshop on treatments issues: location: Australian Red Cross Office - Unit 1701, 17th Floor, One Pacific Place, 140 Sukhumvit Road	Kevin Frost, TREAT Asia
1800 – 1830	Registration / Per Diems	Patrick
1830 - 2000	Welcome drinks – Amari Boulevard Hotel - Poolside	AFAO / all

17 March 2004 – Wednesday: Day 1: Amari Boulevard: Panaroma 2, 4th floor

<u>Time</u>	<u>Agenda Item</u>	<u>Facilitator/Speaker</u>
930 1000	– Opening: Welcome (Don) Review of program (Andy) Housekeeping (Patrick)	Don Baxter Andy Quan Surasak (Patrick) Seehanach
1000 1030	- Welcome exercise – icebreaker	Andy Quan
1030 1045	– BREAK	
1045 1115	– Review of HIV treatment access progress internationally	Don Baxter / Andy Quan
1115- 1145	Case study – Treatment access in Thailand	Sri, AIDS Access
1145 1230	- Presentations on Vietnam, Indonesia, (15 minutes each with 5 min question periods)	Ms. Ngoc (Vietnam) Indonesian representative
1230 1400	- LUNCH	
1400 1445	– Presentations on Laos, Cambodia	Lao Red Cross Cambodian representative
1445 1545	– Overview of HIV Treatments Access advocacy issues and agenda	David Lowe, POLICY Project
1545 1645	– Small group session – brainstorming – what should a national treatment plan include?	All participants – mixed group 3 facilitators
1645 1700	- Participants circulate to read presentations by groups.	All participants
1700 1715	- Distribution of written materials about national treatment plans / Housekeeping	Don Baxter / Andy Quan
2000 finish	– Welcome dinner for participants: Seafood Centre – meet at lobby at 19h45	All participants

Day 2 – 18 March 2004 Amari Boulevard: Panaroma 1, 4th floor

<u>Time</u>	<u>Agenda Item</u>	<u>Facilitator/Speaker</u>
900 – 945	Reflections	Andy Quan
945 – 1030	Presentation #1: <ul style="list-style-type: none">• Review of issues from yesterday: national treatment plans and advocacy strategies	Don Baxter
1030-1045	BREAK	
1045 –1145	Small group sessions by country: Discussion and brainstorm: 1/ do we have a national treatments plan? 2/ if No, how do we lobby for one; if yes, how do we want to improve it?	All participants – grouped by country Groups choose their own facilitator
1145 - 1230	Presentation #2: WTO issues – overview <ul style="list-style-type: none">• What obstacles exist in each country relating to patent issues• What advocacy needs to be done within each country?	Don Baxter
1230 - 1330	LUNCH	
1330-1430	Presentation #3: Generic drugs <ul style="list-style-type: none">• Presentation on generic drug production, and advocacy for production of generic drugs.• how communities can work with generic companies	Dr. Kamjorn, Substitute speaker for Dr. Thongchai, Generic Pharmaceutical Organization (GPO) Thailand
1430 - 1530	Presentation #4: How to negotiate with, collaborate with and meet with research-based pharma companies	Originator pharmaceutical representative: Alycia Draper (MSD)
1530-1545	BREAK	
1545 – 1645	Small group discussions – participant action plans based on presentations on WTO issues, and generic and originator pharmas	All participants – grouped by country
1645 –1700	Presentation of discussions – participants circulate	All participants
1900 finish	– Dinner for participants – chance to talk with presenters and each other: Rosabieng Restaurant – meet at lobby at 19h45	All participants

Day 3 – 19 March 2004: Amari Boulevard: Panaroma 1, 4th floor

<u>Time</u>	<u>Agenda Item</u>	<u>Facilitator/Speaker</u>
900–1000	What is advocacy: what is advocacy; what is an example of good advocacy?	Panel discussion: Nimit Tienudom; Heng Sokrithy
1000–1030	Discussion and question and answers	
1030-1045	BREAK	
1045–1115	More discussion on advocacy	
1115–1200	Workshop session: Developing and Implementing an Advocacy strategy for National HIV Treatments Access - Identifying major elements of an advocacy Strategy • Identifying likely barriers and/or opponents • Identifying major allies for the advocacy strategy	Don Baxter
1200–1300	Case-study: Thailand: How the government works with CBOs and community organizations on treatment access	Dr. Petchsri Sirinirun, Ministry of Public Health, Thailand
1300–1400	LUNCH	
1400–1430	Other initiatives including: <ul style="list-style-type: none">○ TREAT Asia (Greg Gray)○ World CAB (Karyn)○ Hanoi Roundtable (Ngoc)○ TIDES Foundation (Greg, Karyn)○ WHO 3x5	Various participants
1430–1530	Small group session by country – <ul style="list-style-type: none">• Advocacy strategy – politicians, partnerships, opponents, media	All participants – grouped by country Groups choose their own facilitator
1530-1545	BREAK	
1545–1615	Discussion on follow-up for individual participants and countries, closing speech and thanks.	Don Baxter
1615–1700	Wrap-up session – what we want next – (final housekeeping / evaluation)	Andy Quan

20 March 04, Saturday: Participants depart

Appendix 2: List of Participants

Participants (21)

Cambodia:

1. Ty Chettra/Dr-Mr (Dr Chettra), POLICY Project
2. Heng Sokrithy/Mr (Sokrithy), CPN+
3. Dy Many/Ms., GIPA
4. Tia Phalla/H.E. Dr-Mr, NAA
5. Thith Khimuy/Dr-Mr, KHANA
6. Sok Long/Dr, Manager, Cambodian Red Cross
7. Mom Chanthy/Ms, Cambodian Red Cross

Vietnam:

1. Nguyen Thi Minh Ngoc/Ms, (Ngoc) POLICY
2. Pham Thanh Van/Mr., (Mr. Van) PLWHA group, HCMC
3. Ong Van Tung/Mr., (Mr. Tung) Bright futures, Hanoi

Indonesia:

1. Frika Iskander/Ms., (Frika) Spiritia Foundation
2. Dhayan Dirgantara, (Dhayan) Bali plus
3. Derajat Ginanjar Kusmayadi (Ginan) BANDUNG plus support
4. Samuel Nugraha/Mr., (Sam) PITA
5. Kurniawan Rachmadi/Mr., (Adi) Pokdisus Working Group on HIV/AIDS
6. Lita Sarana/Dr-Ms, Head of Community Health & Social Services Division / Indonesian Red Cross Society
7. Hendra Widjaja/Dr., FHI Indonesia
8. Suharto/Dr. from the National AIDS Commission
9. Danang Legowo/Dr., Budi Kemuliaan

Laos:

1. Phuttary Keomoukda/Dr-Ms, National Committee for Control of AIDS (NCCA)
2. Anouxay Bounthaluexay, Senior P.O. Home Community Care, Lao Red Cross
3. Neil Poetschka/Mr. Lao Red Cross

Resource People / Presenters (10)

Thai resource people:

- Nimit Tienudom/ Mr. (Nimit) ACCESS
- Sangsiri Teemankan/ Ms. (Tui) ACCESS
- Glenn King/ Mr. (Glenn) ACCESS
- Karyn Kaplan/Ms., (Karyn) TTAG
- Kamon Upakaew/Mr., (Kamon) TNP+
- Sakda Chompoolert/Mr. , TNP+, North East Region
- Lawan Sarovat/Ms., (Lawan) MSF Belgium/Thailand

**note: Thai workshop participants were considered both as “participants” and as “resource people”*

Thai presenter

- Dr. Petchsri Sirinirun, MOPH Thailand (Day 3)

Generic Pharma Representative:

- Dr Kamjorn, GPO representative (Day 2)

Originator Pharma Representative:

- Alycia Draper/Ms, (Alycia) Merck, Sharpe & Dohme

Organisers/Sponsors: (9)

AFAO

- Don Baxter/Mr. (Don)
- Mark Bebbington/Mr. (Mark) (but not day 2)
- Andy Quan/Mr. (Andy)

Australian Red Cross

- Surasak Seehanach/Mr/ (Patrick)
- Tasanee Kongtrakultam/Ms/ (Yui), Accounting & Administrative Assistant
- Siroat Jittjang/Mr. (Ken), Project Assistant / Australian Red Cross, Asian Regional Office

TREAT Asia

- Kevin Robert Frost /Mr. (Kevin) *pre-workshop and day 1

Regional:

- Greg Gray/Mr. (Greg), APN+

POLICY Project:

- David Lowe/Mr. (David)

Translators

- Khun Suchat – Thai - (17th)
- Khun Ohm – Thai - (18th and 19th)
- Ms. Tam – Vietnamese
- Mr. Khang – Vietnamese

Rapporteurs

- Robert Bennoun – (17th)
- Gregory Carl – (18th)

Number of participants:

- 22 workshop participants
- 10 resource people and presenters
- 9 Organisers/Sponsors
- 4 translators, 2 rapporteurs

- 21 Local (Thailand)
- 26 overseas

Total: 47

Appendix 3: Powerpoint Presentations

Powerpoint Presentation: Access to AIDS Treatment: International Progress

Andy Quan – AFAO

Access to Treatment

"Why should I have the privilege of purchasing my life and health when 34 million people in the resource poor world are falling ill, feeling sick to death, and are dying? That to me... seems a moral inequity of such fundamental proportions that no one can look at it and fail to be spurred to be thought and action about it."

Justice Edwin Cameron, South Africa, 14 July 2000

The following is a subjective summary of major events relating to treatment access as well as a summary of major achievements and obstacles. It is meant to provide background information and stimulate discussion, rather than to be considered an "expert" or "factual" account.

Timeline

- 1987: AZT approved as a an antiretroviral
- Late 80s - mid 90s – Western activism
- Early 90s: production of generic AZT in Brazil and elsewhere
- 1996 International AIDS Conference in Vancouver: Combination Therapy Works
- May 2000: 5 originator pharmas announce a private/public partnership and offer differential pricing for ARVs
- July 2000: Durban World AIDS Conference
- Nov 2000: Trizivir, first fixed dose combination of 3 ARVs approved in the USA
- Feb 2001: CIPLA announces a triple combination for USD\$350
- 2001 to present: Treatment Action Campaign in South Africa – wins court cases against government and pharmaceutical companies
- Nov 2001: DOHA Declaration: affirming the right of countries to act in the interest of the health of their population (countries can issue compulsory licenses to produce generic drugs)
- March 2003: International Treatment Preparedness Summit (ITPS), Cape Town
- Aug 2003: WTO decision: developing countries can import generic drugs from other countries
- Oct 2003: Clinton foundation achieves price reduction to \$USD 140/year for combo
- 2002-2004: generic production announced in countries like Vietnam, Indonesia
- 1 Dec 2003: WHO launches 3 x 5 plan

Community meetings

- Canberra Roundtable – Sept 2002
- Jogjakarta Roundtable – Sept 2003
- WHO consultations that included NGO/CBO representatives - 2003
- Bangkok IAC – July 2004
- TIDES meetings – 2004
-

A2T Success

- Price reductions through negotiations, generic production.
- Small programs run by MSF and others that prove that treatment is possible.
- Broad statements at the level of the WTO in support of health
- Community activism, meetings, education
- International consensus – the old excuses have been proved wrong

- Technical progress: FDC, cheaper diagnostics.
- Global Fund – ARV programs

A2T Challenges

- Health infrastructure in poor countries
- Generics – not the full solution
- Finances
- Government leadership
- Partnerships
- Scaling-up & wide-spread access
- Lack of global leadership (WHO 3x5 is not gaining momentum)
- Denial of HIV/AIDS epidemics in general
- Stigma and discrimination
- Need to build capacity in PLWHA

Powerpoint Presentation: Reflections

Andy Quan – AFAO

30 minutes of reflection – WHY?

- Encourage reflection
- Help us improve
- Hear from each other
- Introduce a process that you might use in other workshops

3 processes

3 processes that have been found to promote better responses to HIV

- Inclusion: the inclusion of people with different experiences in working out what do about the HIV epidemic
- Reflection: reflection on our experiences, thinking about how we see things
- Listening for differences: Listening to other people's ways of describing things.

What we're going to do

- Think for 2 minutes about what we might say to the group
- Take turns saying what we want to say

Rule 1

We all have a chance to tell each other what we're thinking about this morning.

Examples:

- What happened yesterday
- How we feel right now
- What we hope for today
- What we've been thinking about
- It is OK to talk about ANYTHING

Rule 2

- It is important for us to talk in our own voices. If someone says something similar to what I think, then I am NOT to say "I agree." I will say the same thing again, in my own words.

Rule 3

- Listen for difference. We can learn a great deal about how others might come to have different views.
- We will not debate or argue about these views. We will simply listen.

OK. Does everyone understand what we're doing?

Then: start thinking

Powerpoint Presentation: Thai Case Study - Access to Treatment

Ms. Sangsiri Teemankan – AIDS ACCESS FOUNDATION, THAILAND

THE RIGHT TO LIFE

Why we needed to push access to treatment

Because

- more people were getting sick and dying
- people were not receiving quality treatment
- care providers believed that “ Nothing can be done” AIDS = Death

What did we do

AIDS is the right

- Establish an understanding among the public that “ AIDS is about life” and everybody should have a right to have access to treatment

What we have done

- a message campaign “ being positive still means you are a human being” ,”AIDS can be treated”

System management

What we believe

- PLWHA can be part of the health care service
- Empowering PLWHA leader ,to strengthen PLWHA group and network
- Developing training curriculum for PHA and care providers
- Conducted training on basic counseling , OIs ARV treatment and comprehensive and continuum care to develop an action plan
- Set up the comprehensive Continuum Care Centre (CCC)

Access to ARV

- Advocate for the lower price of ARV
- Demand the government to support the Government Pharmaceutical Organization (GPO) to produce ARV
- Increase understanding on “ patent law”, “Free trade agreement” , “WTO issue” among PLWHA and NGOs working on AIDS
- Urge the government to use compulsory licensing to produce ARV
- Urge the government to provide health care service for all (including ARV)

Our partnerships

- PLWHA group and network
- Health care providers who believe that “AIDS can be treated”
- Academics (Pharmacists, Lawyers, Doctors)
- AIDS activists
- Politicians (Senator)
- Other people networks (farmer’s network , globalization network)
- International activists

Powerpoint Presentation: Vietnam Treatment Access

by Nguyen Thi Minh Ngoc
POLICY Project

Access to ARVs

- Very low access: about 300 nation-wide
- National budget: 50-100 patients/year
- Out-of-pocket
- NGOs
- Not all ARVs available
- Mono and dual therapies are usually prescribed

How PLWHA get ARVs

- When people get sick and admitted to SOME hospitals as out- or in-patients
- No pre-counseling, usually no advise for life long use

Obstacles

- No strong political commitment or prioritisation of access to HIV/AIDS treatment
- OI drugs and ARVs are usually expensive and unavailable

Other issues

- Vietnam expects to join WTO in 2003: WTO / TRIPS issue
- Vietnam can produce generic drugs (2 ARVs for now but potential for more)
- Neighbor country-Thailand- has greater access to ARVs

Main directions

- Advocate for stronger political commitment to increase financial and human resources for HIV/AIDS treatment
- Develop national strategy and action plan for care and treatment
- Import generic, cheap drugs
- Negotiate with pharmaceutical companies
- Produce locally

Thank you

Powerpoint Presentation: Indonesian Movement on Improved Access to HIV/AIDS Treatment

Samsuridjal Djauzi
Kurniawan Rachmadi

HIV current situation

120.000 – 130.000 HIV/AIDS (estimated)

Rapid increase among IDU:

-Kampung Bali 200 IDUs, 93% positive

-Roxy 200 IDUs, 76% positive

2,6% of 520 pregnant women in Jakarta's slum areas are positive (Pelita Ilmu Foundation)

Number of AIDS Cases, as of Dec. 31, 2003

Total number = 4091

By sex: male/ female = 3 : 1

AIDS care and ART (Anti Retroviral Therapy)

- AIDS care and ART already included in New National Strategy (2003)
- Public Health Centers in Kp. Bali & Dharmais Hospital: around 30% of PLWHA in a dire need of ART
- Admitted cases in hospital (Cipto & Dharmais) with median CD4 = 32

Availability of ART and OI drugs

- 3TC + AZT + NVP
- D4T + AZT + NVP
- 3TC + AZT + EVR
- D4T + AZT + EVR
- ddI
- Nelvinavir
- OI (opportunistic infection) drugs mostly available

Sources: India, Thailand, local production, & patent

Triple ARV price ± US\$70/month before Dec 2003

now ± US\$40/month after Dec 2003

Affordable price

Graph showing that cheaper prices for ARVs achieved through local generic production and special price patent

ARV present situation & adherence

- 1.300 participants
- 90% self-financed
- Mortality rate 20%
- Survivor: 75% adherence after 1 year
- Reasons for Drop Out: financial constraint, mobility, traditional medicine, side effects.

History of National Movement

- November 1999, diagnostic and treatment access program
- June 2001, Visit Indian generic manufacture
- November 2001, ARV generic available
- September 2002, Canberra Roundtable Meeting
- October 2002, National Movement
- September 2003, Jogjakarta Roundtable Meeting

ARV Access, distribution, & monitoring

(flowchart displayed)

Programs

- Voluntary Counseling Test (VCT) Service
- Health provider training
- Drugs information
- Advocacy
- Greater Involvement People Living with AIDS (GIPA)
- Fund raising
- Mother To Child Transmission (MTCT)
- Evaluation & monitoring

Goals

- ARV drugs in National Essential Drugs List November 2002
- Local production (December 8, 2003)
- Subsidized ARV (1.2 million US\$ 2004)
- Insurances cover ARV treatment 2003 (Jakarta, participation from local Government)
- Target
 - "WHO 3 by 5"
 - 2005 = 3,000,000 PLWHA treated

ARV delivery model

- Sources: generic (imported & local production) & patented
- Delivery system through hospitals supervised by Pokdisus (working group on AIDS)
- Status of ARV special access: periodical report to National FDA
- Health personnel training by Pokdisus & local hospital AIDS Team
- Trained Doctors treat patients (responsible for indication and monitoring) supported by counselors
- Pokdisus: backing up treatment program, collecting data.

Client distribution by location: (Indonesia Map)

Financial support

- Present situation:
- 90% self-financed
- Donation: NGO, Business sector, local government (Jakarta, West Java, Bali, Papua)

Future expectation:

- Role of Government more significant
- Business sector involvement
- Global fund (not yet disbursed)
- International/National NGOs

Enrolment criteria

- WHO criteria
- Social criteria
- Counseling before using ARVs
- Established enrollment team; especially for free ARV service

Problems of Scaling Up

- Myths of HIV treatment
- Training for health providers
- New government policy
- Private sector, business involvement
- Legislative role

Health provider trainings

- 30 Big cities
- In-house trainings and on the job trainings in Jakarta
- Doctors, nurses, counselors, buddies

- Hospitals
- Public health centers in Jakarta
- Until April 2004: a significant number of ARV services is available

GIPA

- Drugs information
- Support for adherence
- Support from ARV user groups
- Advocacy for price, quality of service
- Fund raising
- Members of enrollment team

Jogjakarta Roundtable Meeting: (some photos)

Indonesia's response to 3 by 5

- Presidential speech on care and support for PLWHA (Dec. 8, 2003 in conjunction of AIDS Day)
- Launching local ARVs (Dec. 8, 2003)
- Reflection for 3 by 5 (Dec. 31, 2003)
- Role of PLWHA in 3 by 5 (Jan. 24, 2004)
- Training (counselors, case management, on the job training) Jakarta, 10 times in one year
- Mobile training (Semarang, Solo, Yogyakarta, Lampung, Palembang, Balikpapan, Batam, Tanjung Balai Karimun, Cirebon, Bandung, Ujung Pandang, etc).

Indonesia's expectation to this meeting

- Collaboration in health provider training
- Guideline publication
- Research and evaluation
- Multilateral or bilateral partnership
- Equal partnership to ensure self-reliance

Sawasdee...

- Everyday is AIDS Day
- Immediate actions can save thousand lives ...act now!!!

Powerpoint Presentation: Indonesian Community Experiences of Access to Treatment 2000 - 2004

Prepared by:

Frika (Spiritia), Dhayan (Bali Plus), Ginan (Bandung Plus Support), Sam (PITA)

2000 - 2001

- ARV IMPORTED: MOSTLY PATENTED: DIFFICULT ACCESS
- A LOT OF OUR FRIENDS (PLWHA) DIED BECAUSE OF RARE ACCESS TO TREATMENT
- A LOT OF PEOPLE DIED OF AIDS BUT NEVER DONE HIV TEST
- WE HEARD ABOUT HAART BUT WE HAD NO IDEA ABOUT IT
- MYTH: AIDS = DEATH

CASE STUDY

Some PLWHAs took patent drugs, very low income, low economy, couldn't afford, so they stop, bad supply until now we don't know whether they're resistance or not

2000 - 2001

- LACK OF KNOWLEDGE ON HOW TO TAKE DRUGS
- NO KEY DOCTORS IN OTHER PROVINCES
- DOCTORS WERE NOT UP TO DATE
- ONLY SMALL NUMBERS OF DOCTORS (3 TO 4) WHO UNDERSTAND ABOUT ARV (BALI & JAKARTA ONLY)

2002 - 2003

- BALI, JKT, Bandung, Jayapura PLWHA GROUP STARTED PROFILAXIS CAMPAIGN
- ARV PRICE STILL HIGH
- SOMETIMES WE GOT EXPIRED ARV DRUGS: IMPORTED
- MYTH: GENERIC = FAKE DRUGS
- CASE STUDY
- 'PLWHA who take patent drugs couldn't exchange to generic one': quote from doctor/professional in Kalimantan (Borneo)
- In Papua 6 people get free ARV, 3 of them died because lack of info & monitoring, no treatment plan
- CD4 TEST ONLY IN BALI & JAKARTA, VL ONLY IN JAKARTA AND TOO EXPENSIVE
- LOW SUPPLY.... Lack of ARV stock, sometimes our friends have to stop a few weeks/months because there are no ready stock.

2003-2004

- NO STANDARD GUIDELINES IN WHEN TO BEGIN ARV
- Ex. In Bandung-> start ARV when CD4 is 200, Jogja -> CD4 300, and no explanation on WHY
- There are more access to treatment (end of 2003, Kimia Farma start producing generic ARV)
- Some "Provinces AIDS Commission" give free ARV, especially to AIDS activists but NO monitoring and the bureaucratic stuff is too complex - > this becomes a good excuse for them to start action
- Key doctors playing their own role -> they don't want to involve PLWHA, CBO /NGO
- PLWHA still being seen as an object/token "Just take it! This is free drugs, Just take it!"

- Cotrimoxazole/INH/Profilaxis/fluconazole are very very cheap, even it's free
- Mostly PLWHA in Indonesia are IDU, and co-infected with Hep B/C
 - Drugs regiments are not being concerned, since Nevirapine is more toxic
 - Body Weight is not being concern by doctors
- Methadone patients have no info about drugs interaction, methadone can reduce ARV effectiveness.
- We have no 2nd regiments.

Powerpoint Presentation: Access to Anti-Retroviral Treatment in Cambodia

Presented by:

Dr. Tith Khimuy - Program Manager, KHANA

Current ARVs situation

- Cambodia is estimated to have 157,000 people living with HIV/AIDS (2.6% prevalence in the adult population)
- Lack of VCT - less than 10,000 people are aware of their status
- It is estimated to have 22000 AIDS patient and half of these require for ARV treatment
- Only around 2,600 people are currently receiving ARV treatment
- KHANA conducted assessment of access to ARV treatment in Cambodia in November 2002

Current Sources of ARV Treatment

- MSF-France, Sihanouk Hospital (Phnom Penh) All medicines, lab-tests etc are provided free.
- MDM, Calmette Hospital (Phnom Penh) A free service with some cost recovery
- Center of Hope (Phnom Penh) Provides free ARV triple therapy; uses GPOvir triple therapy.
- Private Sector (Phnom Penh) It is impossible to know exactly how many people have received or are receiving ARV treatment. Many people are on bi-therapy but increasing numbers are on triple therapy. It is believed significant numbers buy inappropriate therapy.
- ESTHER Programme (Phnom Penh, Battambang, and Siem Reap) - Supported by 4 European countries; aims to increase delivery of care and access to ARV treatment.
- MSF-Belgium (Siem Reap and Takeo) Opened 2 chronic disease clinics predominantly providing treatment for HIV, diabetes and hypertension. The first patients started treatment in September and October 2003.

Current Approaches for Delivering ARV Treatment

- Hospital-based
 - MSF-France, MDM, and Center of Hope have similar approaches. Patients are selected from those attending hospital HIV clinics. The community, PLHA and NGOs supporting the patients have little involvement in decision- making regarding treatment.
- Clinical-based
 - MSF-Belgium select patients from those attending the chronic disease clinic.
- Home care based
 - There are no home care based programs providing ARV treatment in Cambodia

Protocols for ARV treatment

- Following the national and WHO guidelines:
- Treatment is based on triple therapy (2 nucleosides and 1 non nucleoside)
- The cheapest treatment is around \$300 annually
- People with HIV are eligible for treatment if they have AIDS defining illness or CD4 count of less than 200
- Those presenting with OIs will first need to have the infections treated before being considered for ARV treatment
- Before treatment begins, the patient has to visit the hospital outpatient clinic for three preparatory appointments. Lab tests and counselling will be carried out

Knowledge about ARV treatment

- No systematic assessment of knowledge, beliefs, attitudes and experiences about ARV treatment among PLHA, their families or others involved in providing the treatment
- Doctors- Those doctors involved in providing HIV/AIDS care through MSF, MDM and Center of Hope are receiving full training on ARV treatment. There is no clear training in the use of ARVs provided elsewhere either in public or private hospitals
- Pharmacists- No training in the use of ARVs for pharmacists outside the above programs. In Phnom Penh some pharmacists provide ARV to PLHA, the vast majority without providing advice around use of the drugs. Some training for pharmacists is planned under the GFATM proposal
- Home care teams- There is no formal education on ARV treatment provided to home care staff or their supervisors. Some of the home care groups in Phnom Penh have recently begun training on these issues.
- People with HIV- The majority of people with HIV who belong to the home care team have some awareness of ARV treatment. Generally they are aware that the drugs need to be taken for life and that they prolong life rather than cure the disease. However, there has not been any formal education on ARV treatment to people with HIV.

Barriers to accessing ARV treatment

Financial:

- Cheapest effective ARV therapy, based on 2 NRTI and Nevirapine currently costs \$1/day.
- For those requiring protease inhibitors the cheapest treatment cost rises to between \$3 to \$10 per day.
 - 70% of Cambodians have spend from their pockets to access to health services; > 60% used private health services, and 36% living below the poverty line – and the PLHA are among those
- Costs of travel to clinic and for laboratory tests are barriers for patients even if they receive free ARVs.
- Very poor patients may sell some or all of their drugs to buy food or pay rent.
- Main funding to buy ARVs is from donors

Social and Physical barriers:

- Stigma and discrimination is a leading factor of not accessing to health care services among PLHA in particular the marginalized groups,
- Poverty prevents PLHA to buy ARVs and access to health care
- Health care services has not been ready or fully equipped to respond to the need of ARVs treatment
- ARV treatment is not available in all provinces ~ it is difficult for people to travel to where treatment is available.

Conclusion

- There is increasing political will and financial commitment – GFATM Round I & II will provide ARVs to an additional 1597 PLHA in Cambodia
- Challenges remain to make ARV treatment accessible and ensure safe/effective treatment
- Need to ensure that resources for HIV/AIDS are integrated with drive to strengthen health care provision in general
- Using a public health approach for scaling up ARVs will require simplified first and second line treatment regimens, simplified monitoring and meaningful involvement of a range of stakeholders, including PLHA and community

Powerpoint Presentation: Overview of HIV treatment access Issues & Suggestions for the Advocacy Agenda

David Lowe - POLICY Project

POLICY Project

Working with Governments and civil society to create pathways to enabling environments for HIV/AIDS programs:

- Strategy and policy formulation
- Stigma and discrimination reduction
- Capacity building
- Multisectoral engagement
- Resource allocation
- Country HIV/AIDS programs: Cambodia, China, Nepal & Vietnam + regional presence

Advocacy targets

- Governments number 1 priority
 - public health systems
 - finance and trade ministries
- Partnership approach needed with PLWHA treatment activists, civil society, government and private sector
- Large employers
- Private health care providers

1. Financing

Or what's going to happen when Global funds money is all spent??

Governments need to give greater priority to ARV access, but ...

Long term provision of ARVs only through public sector financing is unrealistic

Financing strategies

- Drug and laboratory cost reductions
- National government funds from tax base
- Graduated PLWHA cost sharing based on ability to pay
- Employer treatments schemes
- Health insurance schemes
- Social insurance funds
- Donor support, including GFATM

PLWHA cost sharing

Negative affect on access and adherence documented

But it's a reality and will be for some time. Choice is no cost sharing and less people on ARV's OR more people on ARVs through cost sharing

Need to develop strategies, tailor made to each country, to minimise negative impacts

2. Equity in access

Access by the poor

- Is cost sharing practical?
- Graduated approach to cost sharing based on ability to pay
- Good outreach by community health workers needed to reach the poor

Equity in access – other groups

- Rural vs urban
- Specific populations (orphans/street kids)
- Stigmatised groups, especially sex workers, IDU and MSM
- Gender issues

Reality check

In 2002 WHO estimated that 43,000 people in Asia were on ARVs, but ...

1 million needed them

Even if 3x5 succeeds, a lot less than 1 million in Asia will be on ARVs by 2005

3. Selection of people

If drugs aren't going to be provided to everyone (at least for a couple of years) we need to:

- Advocate for more rapid scale up
- Advocate for equitable and transparent systems for rationing rather than ad hoc decisions

Ad hoc selection will result in better access by richer and more socially powerful and poor access by stigmatised groups

How to ration?

PLWHA/civil society involvement in policy debate on how to ration and in the actual selection process

Selection criteria:

- Medical factors
- Social factors

Example of selection criteria

- Health status
- Adherence assessment
- Social:
 - number of dependents
 - income (preference to very poor)
 - HIV disclosure and activism
 - Has a personal treatments assistant

4. How to provide access to ARVs

Service delivery models:

- Central hospitals (capital or provincial cities)
- District level
- Community

Model you use has access implications

Treatment to be provided

Where it's needed

When it's needed

Delivered in a patient-oriented way

Let's learn from other diseases:

- Pneumonia 3.5 m deaths a year
- Doctors rarely work in poor districts

- But good impact in places where community-based health providers are trained to provide services
- AIDS care more complex but lessons here

5. Community engagement

PLWHAs and their families:

- advocacy
- planning
- implementing
- treatments education
- support
- Monitoring

Needs PLWHA network capacity building

6. ARV scale up effect on prevention efforts

ARV's potential impacts on prevention:

- more people accessing VCT
- reducing viral load
- reduced stigma and discrimination
- treatments complacency or 'hooray' effect
- diversion of prevention resources: tangible services

Need for PLWHA prevention oriented education to accompany ARV access

Prevention effect

- Data to show that prevention programs are more cost effective than ARV provision
- Access to life saving medicines are increasingly considered a human right
- Cost effectiveness is just one factor
- Also need to take account of the savings from ARV investment
- Need to engage in the debate

Need to avoid polarisation

7. Reducing stigma and discrimination

A key to ensuring ARV access

Stigma and discrimination + lack of confidentiality:

- Keeps people away from VCT
- Drives PLWHA away from treatment services
- Is very common in health care services

This needs to be a major focus of scale up

Summary

"Finally, we need systems, not just clinical interventions. AIDS treatment scale up will call for one of the most ambitious efforts ever undertaken in the developing world to make sure that ALL the necessary elements – from supply to management, from training to supervision, from social mobilisation to manpower planning – are all developed in concert and mutual support"

Nils Daulaire
Global Health Council

Presentation: WTO, TRIPS and HIV Treatments Access in the Asia Pacific Region

Current Status and Issues

(17 March 2004)

Don Baxter, Australian Federation of AIDS Organisations

Introduction

Complexity of intellectual property and international trade legislation

Technical analysis versus Political analysis

- **This presentation – the ‘big-picture’ political dynamics**

Overall State of Uncertainty:

- **Doha – paragraph 6**
- **Cancun failure and follow-up**
- **US Pharma strategy**
- **Malaysian compulsory licensing for importing**
- **Canadian proposed legislation for exporting**
- **Looming 2005 deadline for TRIPS compliance**

- **Overall “Moral framework”**

Summary Timeline

1998 Seattle WTO debacle

2000 Doha meeting – ‘Paragraph 6’ : public health emergencies

2002 Cancun meeting: stalemate

August 2003 Paragraph 6 attempted rescue

Over-arching Strategic Setting

US Trade Strategy

US strategy is three pronged:

- **WTO**
- **Free Trade Agreement of the Americas**
- **Bi-lateral “Free Trade Agreements” (FTAs)**

Basic driver of US trade policy is using Intellectual property to ensure revenue flows into the US from royalties and license fees

US pharmaceutical industry a major driver of it (though others as well (e.g., Hollywood))

US Pharma industry body has a large lobbying force in Washington, intimately involved in trade negotiations, big donors to political parties

European pharma companies supportive but not as politically organised

TRIPS was basically aimed at Indian generics manufacturers

- **US wants to see product patents in India because it has the biggest generics industry;**

- India has long history of exporting to Canada, etc
- It is therefore likely that the US would bring a case against India if it does not comply with TRIPS

India

- Major generic manufacturers: Cipla, Ranbaxy, Martix
- Has a 1970 Patent Act (only patents the manufacturing process)
- From 1 January 2005, it will have to have legislation covering product patents that are TRIPS compliant
- India will draft best possible compulsory licensing + “creative compliance”

If legislation not done another WTO member will challenge, especially the US, so India will have to act

2005 deadline for TRIPS compliance – Significance of this

- Relative importance is speculative at this stage
- Depends on:
 - deals done by the generic manufacturers with the brand name pharma.s
 - legislative framework of existing countries, especially what flexibility their domestic patent regime allows
 - how the US, EU, and Japan respond

US Current Strategy

US has “lost interest” in the WTO’s TRIPS Council because it is basically stymied there - so it’s focussing on developing a range of bi-lateral agreements with a range of countries, and then will eventually go back to the WTO and argue that a standard has effectively been set and jettison Doha paragraph 6 (which was intended to allow response to public health emergencies, etc.)

Bi-Lateral Free Trade Agreements – US approach

Bi-lateral FTAs started with Jordan, Chile and Singapore Agreements:

- precedent setting
- trend to ‘TRIPS plus’ tighter provisions in each progressive negotiation

Now negotiating with Australia and starting with Thailand soon

- US is taking very tough line; e.g. the Singapore Agreement:
 - Wrote in basically what the US Pharma wanted because Singapore does not have a generic industry
 - restricts technology transfer
 - says Singapore cannot parallel import
 - contradicts WHO advice to developing countries
 - has pissed-off the Thais because US Congress will not approve any bi-lateral that reduces latest benchmark – and Thailand does have a generics industry

At Cancun, the ‘G21-group’ was led by Brazil & India. Since Cancun, US is actively undermining the G-21 – using divide and conquer strategy
e.g. in effect forcing Ecuador out of G-21; actively trying to isolate Brazil

Australia – US FTA

- Negotiated but not yet approved in either country
- Some chance that Australia’s Parliament will not approve
- Not much US wants in terms of patent laws themselves – most patent protection powers are already in place (data protection, etc)
- Probably wants extensions to the life of patents - but not spelled out in the agreement (900 pages); may be in the detail of implementation

- Risks are around Australia's Pharmaceutical Benefits Scheme (sets base-line price for many drugs because one of world's largest single purchasers and assess cost-effectiveness)
- US tried to undermine; may have had some success but appears minor at this stage

Thailand

Negotiations to start soon

Nimit Tienudom of AIDS ACCESS Foundation provided details for this part of the presentation.

Vietnam & Indonesia

- Should stay out of bi-lateral trade agreements with US.
- If they do engage in bilateral agreements, should say that TRIPS is sufficient OR refuse to have IP as part of the bi-lateral agreement, (but then US probably not interested)

China

- has problems getting access to technology because of 1990s trade agreements, conditional accession to WTO
- not on top of some basic intellectual property bureaucratic regime operations, e.g., did not know how to issue a compulsory license

WHAT SHOULD COUNTRIES BE DOING NOW?

Decide whether they will be Importing or Exporting
Some may do both

Importing Countries – should:

- Ensure their legislation takes advantage of flexibility that exists within TRIPS
- look at solution to Paragraph 6:
 - if it has to import it has to:
 - issue a notification to WTO
 - have legislative framework and a bureaucracy to move quite quickly in particular circumstances (as the US will demand scrutiny of certain shipments)
 - Malaysia is the first country to move on 'importing' within the Doha paragraph 6 rescue framework
 - Government has announced intention to issue compulsory license to import from India (1 March 2004)

Importers Action List:

- Notify TRIPS Council of intent to import
- Establish in documents that it lacks manufacturing capacity
- Bureaucracy has to issue a compulsory license
- Has to develop Mechanisms to prevent re-exportation
 - special packaging
 - policing of deliveries
 - lodge information on a WTO web-site (if they can find it)
- There is extensive detail which importers need to know about and to monitor

Exporting countries

Depends on legislation and TRIPS requirements

Canada's attempt:

- 44 pages (!) legislation to allow Canada to export to countries that want to import.
- This Bill is still to be passed by Parliament.

Process:

- Canadian generic manufacturer has to issue a '*Notice of Intent to Supply*'...[to provide drugs to Indonesia] – this has to include the price
- Commission forwards notice to patentee
- Patentee has 30 days to respond; has two choices:
 1. Patentee or their agent will supply the drugs “at terms no less favourable”. If so, the generic manufacturer is not allowed to supply.

OR

2. Patentee agrees to voluntary license providing they get paid a 2 per cent royalty.

In either case the patentee can then supply.

If the patentee does not respond within 30 days the Commission issues an Authorisation – which lasts for two years. But this only covers the amount or deal to which the authorisation relates, so ‘lot by lot’ approvals may be required

Therefore there is a strong incentive for patentee to respond – in effect they can supply an already negotiated contract and that action effectively blocks the generic competitor.

Canadian legislation limited to WHO essential medicines list so doesn't extend to cancer, diabetes etc.

Certainty is key commercial principle: Generic manufacturers need certainty (as do big pharmas).

Australia's role in TRIPS and Treatments Access

- Position of Australian Government: seems to have supported US all through TRIPS
- Australia could do a much better version of the Canadian legislation (e.g., not allow the brand-name company to in effect steal the generics contract with the importer; plus not limit the drugs to only those on the essential medicines list)
- Depends on Australian generic manufacturers being interested, but they are not that keen because:
 - The Thais are much better organised, have good technology, and good supplies of raw materials. Similarly India has better supply lines.

Advocacy Points/Actions for Treatments Activists:

1. that legislation is enacted in developing countries which is TRIPS flexible (not as prescriptive and limiting as the draft Canadian)
2. Urge their government's to request of AusAID legal assistance with clarifying their position under WTO and TRIPS
3. Potential exporting countries should draft export legislation that improves on the Canadian legislation e.g. Thailand
4. Point out to your government that bureaucratic structures and legislation must be in place
 - otherwise the brand-name companies will challenge the whole system through the TRIPS Council
5. Promote links between China, Thailand, India, South Africa
 - could collectively agree a deal on supply, or at least supply of raw materials
6. Promote South African Competition Commission case of investigating breaches of GSK and Boehringer Ingelheim; found them guilty on 3 counts including excessive pricing . Outcome:
 - referred to Tribunal
 - before the Tribunal decision GSK and B/I caved in and allowed four generic companies to make a single dose combination
 - can also export to sub-Saharan Africa
 - Advice to Asia Pacific countries: look at the South African Competition Law, incorporate excessive pricing concept into domestic competition laws if they have such laws
7. Establish a "Regional Purchasers Group" (invite the Australian PBS negotiator).

Individuals of Potential Assistance

International Consumer Groups

Satchi Rachagan (Asia Pacific Regional Office - Malaysia)
Assistance from some foundations (e.g. James Love CPTECH) for technical legal analysis

Kathleen Kay (FHI India)

Judy Rudland (AusAID Regional IDU Project – Myanmar, Vietnam, China))

Jamie Love: www.cptech.com

Victor van Spengler (working on WTO/TRIPS framework for AusAID PNG project)

APPENDIX 1

How the US Pharma Industry influences US Trade Policy:

Trade negotiations are conducted by the US Congress IFAC-3 (Industry Functional Advisory Committee in Intellectual Property Rights for Trade Matters Committee 3)

- Advises US Congress on all Free Trade Agreements
- Sets framework for US negotiations on objectives and positions
- It reviews and re-writes draft agreement
- Congressional guidelines require that no negotiating position can be worse (from the US point of view) than any previously negotiated one
- comprises 7 pharma lobbyists (plus others) – Pfizer, Merck, Biotech reps

IFAC represents 3,000 US bio-tech companies

US Trade Authorisation Act of 2002 prohibits the US Trade Rep from negotiating a deal any worse than that already prevailing - so once a benchmark is set, future deals must meet that benchmark or be even more restrictive.

APPENDIX 2

Developing Model Legislation – possible exercise for Australian-funded project

- Determine which Acts need to be amended
e.g. in Canada:
 - Therapeutic Goods Act
 - Foods Act
- Do a process map of step-by-step

Possibly do a couple of countries as a model e.g. PNG, Malaysia as importers; Thailand as exporter

Powerpoint Presentation: Generic ARV Production in the Government Pharmaceutical Organization Thailand

Dr. Thongchai Thavichachart, Managing Director - 18 March 2004

Overview

- GPO - State enterprise under ministry of public health
- First launch of ARV in 1995 - AZT 100 mg capsules
- Launch the GPO-Vir S30 & S40 in April 2002
- The access will be increase to 50,000 patients nationwide in 2004

Community organization and civil society

- Thailand's AIDS Access Foundation , Medicins sans Frontiers (MSF), etc.
- Pool / Share ideas from the communities and societies to find out what drugs are needed.
- Previous experience and great success on supporting the production of "Fixed dose combination"
- GPO-VIR (d4T + 3TC + Nevirapine)
- AZT + 3TC + Nevirapine (Available in 2005)
- Due to difficulties in registration the GPO-Vir which is classified as a new drug in Thailand, communities and societies could help and support the GPO for the information and their needs to the Thai FDA.

Patent problems

"Drug Patent Information Center" was established under the Research and Development Institute to follow the patent situation in Thailand including the ARVs

Patented ARVs in Thailand

- ddl tablet : Bristol-Myers Squib (BMS) already returned the patent
- ddl pellet : Under examination (GPO is calling for an objection.)
- Efavirenz : Already patented
- Lopinavir : Under examination

ARVs produced by GPO

- Manufacture both adult and pediatrics medication
- Manufacture 24 items / formulations including tablet, capsule, syrup, oral powder
- 2 fixed-dose combination : GPO-Vir, Zilarvir
- 6 active ingredients:
 - NRTIs : Zidovudine, Didanosine, Stavudine, Lamivudine
 - NNRTIs : Nevirapine
 - PI : Nelfinavir (latest product)

Pipeline products

- Abacavir (NRTIs)
- Saquinavir (PI)
- Ritonavir (PI)
- Indinavir (PI)

HIV/AIDS related products:

- CD4 test kit
- Opportunistic infection drugs : Fluconazole, Ketoconazole, Rifampicin, Ethambutol, Isoniazid, Clarithromycin, Co-trimoxazole

GPO's ARV market is:

- 78% government
- 19% private

- 3% export

Export of ARV

- Humanitarian purpose
- Single price [the international selling prices are offered the same as the price in Thailand]
- Mostly distribute to private sector in Cambodia, Myanmar, Indonesia and Nigeria

Future development

- Increase the production capacity to serve the increasing demand in the country and our neighboring countries
- WHO-GMP in 2005 / join the "Pilot Procurement Quality and Sourcing Project"

Risk

- Free Trade Agreement (FTA) between Thailand & US : Intellectual Property Right
- TRIPS Agreement
- Effects of the use of Compulsory licensing

Powerpoint Presentation: Training on Access to HIV/AIDS Therapy - Indonesia

Pokdisus AIDS FKUI/RSUPN-CM / Pelita Ilmu Foundation / Dharmais National Cancer Center

Note: This presentation was not given during the workshop due to a lack of time. Our apologies to Adi and Pokdisus. If you would like more information about this presentation, or a copy of the actual powerpoint presentation, please contact: pokdisus@centrin.net.id

Log Frame
(diagram of training approach)

Public Health Approach in HIV/AIDS therapy

- Standardize ARV treatment
- Easy to conduct effective training
- Easy to maintain drugs availability
- Easy to assess treatment results
- Easy to monitor side effects

Training program
(photos of program)

Who need training program?

- Doctors
- Nurses
- Counselors
- Buddies
- PWLHA
- others?

How to identify

- Passive
- Active

Partnerships

- Monthly meeting:
 - PLWHA, Family, Health Professionals, NGO activists & journalists
 - Health Professionals & providers
 - Case conference of counselors & buddies
- Health education program to community: religious & community leaders, schools, medical associations, academicians, etc.

Develop training

- Trainer: experts & have high commitment
- Module:
 - Standardized, use WHO guideline
 - Combined with local system
 - Applicable

Develop networking

- Build support system:
 - information: brochures/leaflets, hotline service, e-mail address, baseline data (institutional address, contact number), etc.
 - easier access to get Post Exposure Prophylaxis (PEP) drugs
 - Open 7 days a week: 09.00 - 15.00
- Regular educational program: seminar, workshop, etc.

Districts/Cities

- As of March this year, the training has been conducted to more than 30 Districts/ Municipalities in Java, Sumatra, and Kalimantan. It will be held in some parts of Sulawesi and other Eastern regions in Indonesia.
- There are already more than 1,000 health professionals have been trained, so far.

Publication

(image of publications)

1. Training on HIV/AIDS Counseling

- Training Curriculum:
 - Introduction to Counseling
 - Effective Communication
 - Values and Cultural Background
 - Assessment of Risk Behavior, etc
- Length of Training: 5 days
- Fee: Rp 1,500,000/participant

2. Training on Managing HIV/AIDS Cases

- Training Curriculum:
 - o Universal Precaution
 - o AIDS Epidemiology
 - o HIV Test
 - o HIV/AIDS Diagnosis
 - o Managing IDU Patient
 - o ARV Treatment
- Length of Training: 3 days
- Fee: Rp 1,000,000/participant

3. Internship on Managing HIV/AIDS Cases

- Venues of Internship Program:
 - o Outpatient Unit
 - o Inpatient Unit
 - o Pharmacy
 - o Clinical Pathology Unit
 - o Networking with Puskesmas & Clinics
- Length of Training: 5 days
- Fee: Rp 3,000,000/team

4. Training on Empowering & Giving Support for PLWHA

- Training Curriculum:
 - o Medical, Psychological, and Social Aspects
 - of HIV Infection
 - o Care, Support and Treatment
 - o Adherence of ARV Intake
 - o Advocacy to Family and Community
 - o Cooperation with Health Care Providers
- Length of Training: 2 days
- Fee: Rp 500,000/participant

Kampung Bali

(photos)

Thank you. Pokdisus AIDS FKUI/RSCM

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Appendix 4: A Short Overview of Thailand's Current AIDS Treatment Philosophy, Policy and Structure

March 18, 2004

As recorded by Karyn Kaplan for the Thai Country Group/Community Sector Workshop on HIV Treatment Access: "Building Policy and Advocacy Capacity in Southeast Asia"

Underlying Thailand's treatment model is the premise that treatment is a right, which is an outcome of 5 years of PLWHA and ally organizing, lobbying, and commitment to working with the government to make AIDS treatment an immediate reality.

Currently the AIDS Division of the MOPH oversees treatment provision. The policy is to provide 70,000 people with ART by 2005 (50,000 covered by MOPH/GFATM funding with 20% coming from GFATM, and 20,000 from Dept. of Social Welfare program). The current major debate is whether to integrate the management of the ARV program into Thailand's universalized health care plan (the '30-Baht Scheme') (and out from under the AIDS Division's jurisdiction) or to have it managed under a separate and new program. Financing and management of Thailand's ART program are the two major concerns. There is a Working Group exploring these options, with representation from key NGOs and the national PLWHA network, the Thai Network of People Living with HIV/AIDS (TNP+). This committee, linked to the AIDS Division closely, decides national treatment guidelines, selection criteria, the role of PLWHA in the ART scale up, and other directly relevant issues.

The current plan aims to provide ART at all 800 government hospitals, through new model "Continuum of Care Centers (CCCs)" (described later in the document). Currently, approximately 20,000 Thais receive free ART through the government program. Pilot projects providing ART to prisoners (500) and resident non-citizens and migrants are underway.

48 million Thais currently avail themselves of services under the 30 Baht Scheme (that includes a special gold card status for those meeting certain low-income criteria), and the government commits 1,302 Thai Baht per person per annum under this system. There is currently no co-payment, and the concept is not under consideration by the government.

A big question is what the 2nd line standard regimen will be. Currently, the fixed-dose combination, 'GPO-vir' (d4T/3TC/NVP), is the standard first line, of which 80% of those eligible avail themselves, and is priced at 1,250 Thai Baht/month. The Thai government has seriously considered compulsory licenses for key drugs (Efavirenz/MSD, for ex.). The government currently imports drugs and negotiates with major pharma company producers of AIDS drugs. A special committee is involved with researching second-line drug issues. GPO, or the government pharmaceutical company, is currently producing a number of HAART and OI drugs. Post-2005 TRIPS (and potential US FTA) barriers/issues are as yet unresolved. Under the current ART scale-up program, participants receive free cd4 counts twice a year and viral load tests once every 2 years. There are 19 cd4 flow cytometers in the country now, and more (4-5) being purchased with Global Fund monies.

Other issues under consideration by relevant committees are standards of treatment at private hospitals (how to ensure), whether and how to centralize

procurement/management because there is varying demand/volume in different areas, how to address problems of stigma, negative doctor attitude (and awareness) about treatment, continuous exodus of doctors from practicing in rural areas, cost effectiveness issues, drug procurement/supply/distribution issues, and how to manage projects on a large scale.

A proposed solution to the lack of adequate treatment providers (numbers, quality) is to move the focus from doctors to nurses, who circulate much less often and have stronger community ties.

CCCs

Each of Thailand's 800 hospitals will have one. Currently there are 104 in place, with an aim to establish 200 by the end of 2004. The involvement of people living with HIV/AIDS is crucial. Currently their involvement is covered through Global Fund monies and ideally these costs will ultimately be absorbed by the government. Each CCC has a fundamental team that will include doctors, nurses, lab technicians, pharmacists, the hospital's AIDS team and at least three people living with HIV/AIDS.

They are trained in 3 curriculum which includes Counselling, OI and ARV treatment, and the concept of CCC: how to plan, how to follow-up PLWHAs not only on health issues but how to take care of other problems. They will be involved in activities such as: 1) giving info to incoming PLWHA, and determine medical criteria vis a vis ART eligibility 2) providing ARV awareness according to readiness to uptake treatment, and 3) home visits, plus support bimonthly visits to the CCC.

After the people mentioned above are trained, they will create plans for each CCC such as reviews for CCC members which will ask how many PLWHA are in their group/hospital, how is their health, how many PLWHA fulfil criteria to get ARV, how is it promoted for PLWHA to come and check their CD4s and get ARV etc).

PLWHA who are CCC officials will be the persons who help the hospital to screen PLWHA and will follow up each PLWHA who starts ARV (home visits, appointments at the hospital, monthly group meetings, counselling services which are to open in the hospital (the service hours will depend on how many cases they can handle). The hospital will refer their patients to CCC officials and will also organise monthly team meetings which will discuss cases, particular problems and solutions, and forward planning for the next month.

AIDS ACCESS is also creating a CCC form for each CCC to fill out and this form will be used by AIDS ACCESS to evaluate and monitoring the work of the CCC. Adherence is tracked at all CCCs, as well as other information.

TNP+, which comprises 600 groups across the country, plays a major role in CCCs yet the capacity to fulfil this role in all 800 hospitals remains a significant challenge.