

## Viewpoint

## Challenge and co-operation: civil society activism for access to HIV treatment in Thailand

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### Summary

Civil society has been a driving force behind efforts to increase access to treatment in Thailand. A focus on HIV medicines brought civil society and non-governmental and government actors together to fight for a single cause, creating a platform for joint action on practical issues to improve care for people with HIV/AIDS (PHA) within the public health system. The Thai Network of People with HIV/AIDS, in partnership with other actors, has provided concrete support for patients and for the health system as a whole; its efforts have contributed significantly to the availability of affordable generic medicines, early treatment for opportunistic infections, and an informed and responsible approach towards antiretroviral treatment that is critical to good adherence and treatment success. This change in perception of PHA from 'passive receiver' to 'co-provider' of health care has led to improved acceptance and support within the healthcare system. Today, most PHA in Thailand can access treatment, and efforts have shifted to supporting care for excluded populations.

**keywords** HIV/AIDS, antiretrovirals, activism, Thailand, patient empowerment

### Introduction

Since the 1970s, health professionals in Thailand have played an important public role in health sector reform, sometimes risking their professional positions but often emerging with enhanced public standing (Bamber 1997). In 1985, civic groups joined their efforts by lobbying (initially with little success) against increasingly restrictive patent legislation for pharmaceuticals, which in their view limited access to affordable medicines.

In 1998, civil society involvement in health advocacy was reinforced with the establishment of the Thai Network of People with HIV/AIDS (TNP+). Motivated by a combination of despair in front of death, a strong desire to help friends who fell ill, and anger at a system that made life-saving medicines unaffordable for the majority, people with HIV/AIDS (PHA) have developed a central role in advocacy for improved access to AIDS drugs and have also promoted a patient-centred approach to HIV/AIDS care within the public health sector. Their role is recognized by the Ministry of Public

Health as central to the successful expansion of antiretroviral treatment through activities that encourage community education, reduce discrimination, provide peer support, and promote the right of government to make and use affordable generic drugs (Kunaratnapruk 2004).

Treatment activism has brought civic groups (Table 1) together to fight for a single cause, creating a platform for joint action on practical issues to improve care within the public health system. We describe the main activities of three groups over the last decade: AIDS ACCESS Foundation, the TNP+ and Médecins Sans Frontières (MSF). Their efforts have implicated PHA in treatment activism and as co-providers of care within the public health system.

This article, written by representatives of these three groups, aims to complement recent analyses on the engagement of non-governmental organizations (NGOs) in the provision of HIV/AIDS care in Thailand (Lyttleton *et al.* 2007; Tantivess & Walt 2008). The aim of providing this participant-observer's perspective over the

**Table 1** Civic groups promoting access to treatment in Thailand**Governmental actors**

The Government Pharmaceutical Organization is a state enterprise formed in 1966 to provide affordable quality medicines for the public health system. Officials from its Research and Development Institute have, together with other health professionals, taken a public stance on issues of access to medicines at some risk to their professional positions.

The Office of Health Care Reform: In 1996, the Ministry of Public Health started a 3-year initiative to increase equity in access to health care, with patient and community involvement. The initiative identified as major concerns lack of access and affordability of drugs for HIV, both for opportunistic infections and antiretroviral therapy (Nitayarumphong 1996). MSF, TNP+ and ACCESS (see below) co-operated in establishing a standard of prevention and treatment of opportunistic infections at district level.

The National Health Security Office: The national health security scheme, promulgated in 2002, partially replaces three previous public insurance schemes and also covers those who were previously uninsured. AIDS NGOs sit on the governing board, as required under the 1997 constitution (Towse *et al.* 2004).

**Non-governmental groups established by health and other professionals**

The Law Society, established in 1957, provides *gratis* defence of certain human rights cases, such as the legal challenge by PHA to the patent on the antiretroviral drug didanosine.

The PDA, founded in 1974, provides a wide range of support for the rural poor. PDAs humorous and common sense approach has contributed significantly to HIV prevention efforts. In 2004, PDA obtained funding for antiretroviral treatment programmes, implemented by MSF and the Ministry of Public Health, for ethnic minorities and migrant workers from Laos and Myanmar.

The Rural Doctors' Society, founded in 1978 to support rural health services, supports public health initiatives such as the formulation of a national drug policy, and acts as a watchdog to counter corruption and inappropriate administrative behaviour in the health system (Wibulpolprasert & Pengpaibon 2003; Bamber 1997).

The Health and Development Foundation, founded in 1983, has developed expertise in pharmaceutical and patent regulations and challenged antiretroviral patent applications and supported civil society negotiations in the US–Thailand FTAs.

The International Law Association of Thailand, founded in 1984, provides a technical forum for discussion of the impact of patent law and international trade on Thai society.

The CCPN was founded in 1983 to coordinate activities of non-governmental health groups and has successfully overturned some proposed amendments to patent law on pharmaceuticals. In 1994, CCPN set up the Foundation for Consumers, which has become the leading consumer organization in Thailand.

The Thai Red Cross AIDS Research Center began operating in December 1989 and plays a leading role with regard to prevention, counselling, treatment and research on HIV/AIDS.

FTA Watch, a coalition of activists from academic institutions, NGOs and peoples' organizations, was formed in 2003 in response to government plans to negotiate bilateral FTA negotiations with several countries, most notably the US.

**NGOs bringing patients into the movement for access to medicines**

The AIDS ACCESS Foundation (ACCESS), established in 1991, works with the media to promote policies to reduce discrimination. Since 2003, ACCESS has coordinated a Regional HIV/AIDS care and treatment training project (developed together with MSF and TNP+. The 'We Understand' Group was founded in January 2004 under the auspices of the AIDS Access Foundation, and is a collaboration of hospitals, NGOs, PHA groups and volunteers raising public awareness about children and youth living with HIV/AIDS.

MSF, at the request of local NGOs, has been supporting HIV projects in Thailand since 1994. Activities include technical support, lobby for access to treatment, projects to establish a standard of care at district level (since 1997, in co-operation with the Office of Health Care Reform) and treatment projects with the Thai Ministry of Public Health. MSF, using funds from the 1999 Nobel Peace prize, the European Commission and Forum Syd, also supports coordination and infrastructure costs of TNP+ and ACCESS, as other international donors will fund activities but will not support running costs.

The TNP+ was established in 1998 as a response to the isolation of individual PHA groups and their dependency on funding by their hospital. The founding vision of TNP+ was that PHA should be able to live with dignity and play an active role in society. By 2006 there were more than 900 PHA groups with 20 000 TNP+ members nationwide.

FTA, free-trade agreement; MSF, Médecins Sans Frontières; NGO, non-governmental organization; PHA, people with HIV/AIDS; TNP+, Thai Network of People with HIV/AIDS; PDA, Population and Community Development Association; CCPN, Coordinating Committee for Primary Health Care of Thai NGOs.

last 10 years is to contribute a rich historical analysis of the process of policy change in Thailand. Such perspectives have recently been noted as lacking in the health policy literature, particular in relation to community participation in health policy formulation (Gilson & Raphaely 2008).

**Context: government, civil society and HIV/AIDS in Thailand**

Thailand's HIV epidemic began in 1984, with cases initially confined to perceived 'high-risk' groups: gay men, then injecting drug users and then commercial sex workers.

NGOs played an important role in influencing government policy related to HIV/AIDS and in 1990 succeeded in disbanding a proposed 'AIDS Bill' that required mandatory HIV testing of members of 'high-risk' groups (World Bank 2000). In 1991, when more HIV cases were found in the general population, the government vigorously promoted a prevention campaign aiming at 100% condom use in commercial sex establishments (Rojanapithayakorn & Hanenberg 1996). The campaign is estimated to have prevented 2 million subsequent infections (UNAIDS 2000). Nevertheless more than one million people have become infected since the epidemic began and more than 400 000 have died.

The first PHA group was established in 1990 in Bangkok. With time, more groups were established and in 1995 their contribution was officially recognized by Ministry of Public Health policy that encouraged the formation of PHA groups within the hospital system. By 2006, there were 900 PHA groups with more than 20 000 members (Lyttleton *et al.* 2007) mainly supported by government funds channelled through public hospitals.

Initially, the engagement of PHA groups in HIV care was focused on social support; advocacy was constrained as groups were isolated from each other and depended on funding from their hospital. This changed with the establishment of the TNP+ in 1998. That year, the Office of Health Care Reform (Table 1) identified lack of accessible HIV treatment as a priority (Nitayarumphong 1996), and a pilot project to define a standard of treatment for opportunistic infections at district level was established by the Ministry of Public Health, MSF and TNP+ (Revenge *et al.* 2006).

### **Campaigning for access to antiretroviral treatment**

Publicly funded (mono- and dual-) antiretroviral therapy was first made available for limited numbers of patients in 1992 (Revenge *et al.* 2006). The Ministry of Public Health began to provide triple antiretroviral therapy in 2000 but reliance on expensive brand drugs limited beneficiaries to around 1500 people (Phanuphak 2004). Large-scale treatment only became possible later, after the Thai Government Pharmaceutical Organisation (GPO) began to produce a range of generic antiretrovirals.

The Government Pharmaceutical Organisation had begun research and development of antiretrovirals in 1992, initially for zidovudine and didanosine. Zidovudine was launched in 1995, but production of generic didanosine was blocked when a Thai patent was granted to Bristol-Myers Squibb in 1998. The patented version was prohibitively expensive and provoked the first in a series of

public demonstrations against intellectual property restrictions to medicines (Limpananont 2002; Wilson *et al.* 1999; Supakakunti *et al.* 1999).

At the end of 1999, the GPO submitted a request for a compulsory license, a request backed by public demonstrations in which over 300 PHA gathered outside the Public Health Ministry (Ford *et al.* 2004). This was the first occasion in Thailand that HIV positive people braved stigmatization to stage public demonstrations and proved to be a watershed event in terms of their awareness and self-confidence. However, under pressure from the US government (Hecklinger 1999), the Ministry of Public Health rejected the request. Activists with support from the Law Society (Table 1) then mounted a legal challenge against the patent for didanosine, claiming that the patent had been unlawfully granted (Ford *et al.* 2004). After 2 years, the court ruled in favour of the plaintiffs, opening the way for generic production.

### **Campaigning for universal health care**

Prior to 2001, Thailand's public health system was accessed through three health insurance systems, but this led to significant exclusion: around three-quarters of the population lacked insurance (United Nations Development Programme 2007) and two-thirds of those with health insurance (those holding low-income health cards) could not access the benefits to which they were entitled (Pramualratana & Wibulpolprasert 2002). In 2000, civic groups drew up a petition demanding that parliament debate the introduction of universal health insurance (International Labour Organisation 2008). Under the Royal Thai Government (1997) Constitution, parliament is obliged to debate any petition signed by more than 50 000 voters. TNP+ and the Rural Doctors' Society (Table 1) with their nationwide networks collected the majority of more than 60 000 signatures supporting the petition, forcing a parliamentary debate.

The National Assembly voted against the bill. However, universal health insurance became a key issue in the subsequent election campaign and, fulfilling its election promise, the Thai Rak Thai party introduced health insurance soon after winning the 2001 election, making Thailand one of the first developing countries to provide universal healthcare coverage to their population. Antiretroviral treatment and renal dialysis were initially excluded from the benefits because of their high cost; activists were quick to point out that the constitution prohibits discrimination on account of a particular disease. In October 2001, the Thai GPO manufactured a fixed-dose medicine combination, reducing the price of this regimen from \$US 9600 to \$US 570/patient/year.

NGO networks promptly demanded government action (Tantivess & Walt 2008), and the Minister of Public Health announced that antiretroviral drugs would be included in this universal access to healthcare policy, (Phanuphak 2004). However, it took 4 more years of campaigning before this became a reality (Kiatying-Angsulee *et al.* 2006).

### **Increasing the availability of treatment**

While efforts were being made to lower the cost of treatment, parallel efforts aimed at increasing its availability. The involvement of PHA in the provision of health care beyond pilot projects began in May 2000, with a Buyers' Club established by TNP+, MSF and ACCESS. While the public health system was relying mostly on brand name drugs, TNP+ purchased generic antiretrovirals from GPO and channelled these drugs to public hospitals via PHA groups; these drugs were prescribed by government doctors, paid for by patients and dispensed by PHA with supervision from the hospital pharmacists (Kreudhutha *et al.* 2005; Uppakaew 2008). This programme established the principle of partnership at a grassroots level between NGOs and public healthcare providers, and also gave GPO its first orders for several generic antiretrovirals, thus kick starting production. The Buyers' Club was able to scale down its activities as the government programme scaled up.

Concurrently, there was a push to increase access to basic, low-cost medicines for opportunistic infections, which were poorly available prior to their inclusion in the national health insurance scheme in 2001. Surveys carried out by MSF and TNP+ in 2000 found that less than half of symptomatic PHA received co-trimoxazole prophylaxis; access to treatment for other opportunistic infections such as tuberculosis was also limited.

In November 2000, TNP+, MSF and ACCESS launched a project to increase access to prophylaxis and treatment for opportunistic infections, referred to as the 'AIDS can be treated' campaign. It was considered essential that PHA should participate actively in their own treatment and care if they were to develop the knowledge and understanding necessary to stop believing that AIDS was a death sentence. Therefore, the project began by training PHA from 150 groups across the country to recognize symptomatic disease and to support each other in accessing health care. An internal evaluation 2 years after the project began found that access to correct therapeutic interventions for the commonest life-threatening opportunistic infections had increased from less than 50% before the project began to more than 80% (Kumphitak *et al.* 2004).

These experiences showed that with appropriate training and support PHA could develop a role as partners in provision of health care. MSF, ACCESS and TNP+ capitalized on the experiences by developing accessible health education materials and training modules; these were subsequently used to support the government's treatment programme. The chronology of access to HIV treatment is summarised in Table 2.

### **PHA support government scale up of antiretroviral therapy**

Collaboration between civic groups and government expanded considerably in 2002 when Thailand obtained financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria for its ambitious scaling up of antiretroviral treatment. This required NGO participation at both policy decision and operational levels of the national HIV programme (Tantivess & Walt 2008). TNP+, MSF and ACCESS jointly developed a strategy for central involvement of PHA in the programme. A 'Comprehensive and Continuous Care Centre' (CCC Centre) model (Figure 1) was developed in which PHA activists, working within the hospital system, provide accessible care and support, activities that formal health providers have limited capacity to undertake. (Kumphitak *et al.* 2004; Tantivess & Walt 2008).

Most PHA group members in Thailand are farm labourers, factory workers or unemployed with only primary education. PHA members working in CCC Centres, in addition to appropriate training to develop their knowledge and skills in provision of care, also need ongoing practical support with such matters as record keeping, teamwork and coordination with the hospital. The training and support is provided by TNP+, MSF and ACCESS.

In addition to providing care and support, the CCC Centres are an attempt to ensure a central involvement of grassroots PHA in the government rollout of antiretroviral therapy. The group must have sought permission from the hospital director, been assigned a room in the hospital to do their work, and hospital staff must have agreed that the PHA can join their HIV care and treatment team. One activist can normally manage a caseload of 15 to 20 clients. Activists are expected to recognize common side effects of antiretroviral drug regimens available in their hospital, about prevention and treatment of three common opportunistic infections (TB, *Pneumocystis carinii* pneumonia and cryptococcal meningitis) and to be able to provide 'first aid' for symptoms such as fever and diarrhoea, and evaluate treatment adherence. A support team, staffed by members of TNP+, ACCESS and MSF provides training,

**Table 2** Chronology of access to HIV treatment in Thailand

1984	First Thai HIV case
1985	Process patents introduced under United States Government pressure
1988	Increase in numbers of HIV cases in at risk groups (injecting drug user and commercial sex worker)
1990	Bill proposed to introduce mandatory HIV testing for people suspected of belonging to an 'at risk' group. Disbanded under civil society pressure.
	First PHA group (Wednesday Friends) established by Thai Red Cross
1991	Sentinel surveillance first detected a significant level of HIV in the general population (3% amongst army conscripts) prompting a national campaign promoting 100% condom use in commercial sex establishments
1995	Ministry of Public Health introduces policy to encourage formation of PHA groups within the hospital system
1998	TNP+ established.
	MSF, ACCESS and TNP+ begin working together on supporting access to ART, and join the first public demonstrations in Thailand against high prices of ART, organized by the Thai Consumer Foundation
1999	MSF wins Nobel Peace Prize; donates some of the prize money to TNP+ for infrastructure development.
	MSF, ACCESS and TNP+ and other civil society organizations support a request by the Thai GPO to the Minister of Public Health to issue a Compulsory License for didanosine (Request refused.)
2000	MSF start to provide ART in Thailand in one of the organization's first treatment programmes
	TNP+, MSF and ACCESS launch campaign to increase access to opportunistic infection medication
	ART Buyers Club established
2001	Universal health insurance scheme introduced. ART and treatment for renal failure are initially excluded. Civil Society lobbies for inclusion of all treatments. NGOs and PHA appointed to various National Health Security Office subcommittees.
	In October, the GPO manufactures a fixed-dose combination of ARV (GPO-vir). Following NGO lobbying for government action, minister of Public Health announces that GPO production capacity would be increased and that antiretroviral drugs would be included in the universal access to healthcare policy.
	CCC Centre model, with PHA as co-providers of care, piloted in two public district hospitals, under MSF supervision.
2002	Thai government includes GPO-vir in national ART programme, and scales up treatment nationwide
	PHA file legal claim against Bristol Myers Squibb and the Dept. of IP, contesting the Thai didanosine patent in the IP Court. The Thai Law Society, the Health and Development Foundation, MSF and ACCESS support this action.
	CCC Centre model agreed by TNP+ and first 30 centres established in public hospitals, with Global Fund support, to provide formal role for PHA in health system.
	Health and Development Foundation files pre-grant opposition to zidovudine + lamivudine patent application which is withdrawn following demonstrations by PHA in Thailand and India.
2003	180 CCC Centres functioning across the country
2004	Didanosine patent overturned in IP court.
2005	ART included in universal health insurance scheme.
2006	TNP+ wins UNAIDS Red Ribbon Award
	Zidovudine + lamivudine patent application withdrawn following civil society challenge
	Compulsory licence issued for efavirenz
	10 000 protestors mobilize against the US–Thai FTA
	World Bank study concludes CCC Centre model is cost-effective and recommends compulsory licensing as an option to control ART costs
	National Health Security Office agrees to fund an additional 70 CCC Centres, establishing government support for patients as co-providers of care
2007	Minister of Public Health issues Compulsory License for the antiretroviral drug efavirenz, supported by civil society
2008	Minister of Public Health issues Compulsory License for the antiretroviral drug lopinavir/ritonavir, supported by civil society
	MSF hands over HIV/AIDS care and treatment activities to local partners, but continues advocacy for access to medicines

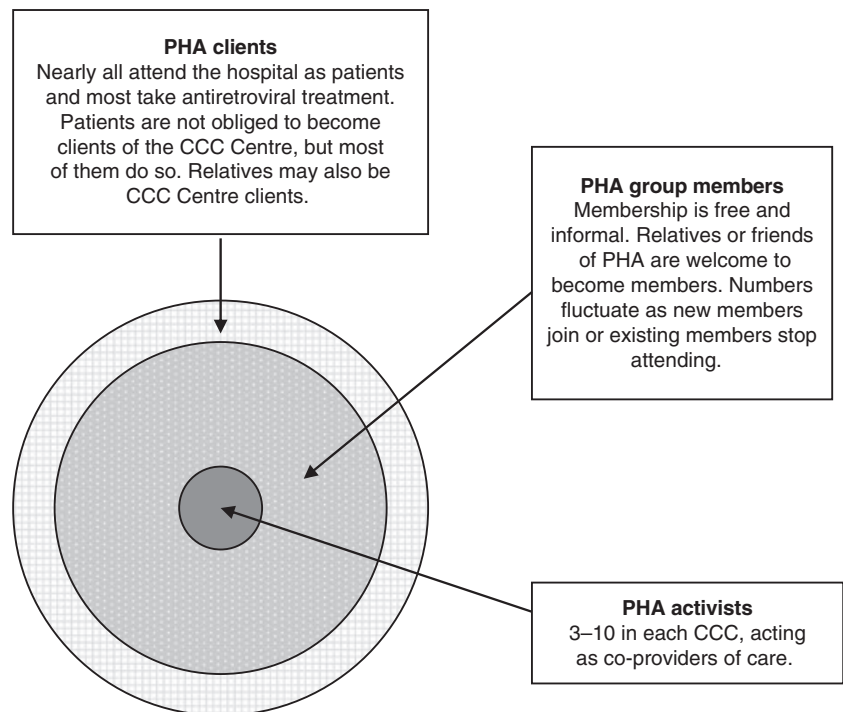
ART, antiretroviral therapy; CCC, Comprehensive and Continuous Care; FTA, free trade agreement; GPO, Government Pharmaceutical Organisation; MSF, Médecins Sans Frontières; NGO, non-governmental organization; PHA, people with HIV/AIDS; TNP+, Thai Network of People with HIV/AIDS; IP, Intellectual Property.

together with ongoing support for transparent financial management, timely submission of reports, record keeping and problem solving within the CCC Centre teams. One support team member can manage around 25 CCC Centres.

This support model is a good investment in terms of treatment success and life expectancy (Over *et al.* 2007).

As of mid-2008, antiretroviral treatment was available at all government hospitals, with 180 000 PHA under treatment. One-third (327) of hospitals had established CCC centres, each with 3–10 PHA activists. A Ministry of Public Health/World Bank study estimated that systematically providing PHA peer support in treatment sites throughout Thailand would increase the cost per life year saved by less





**Figure 1** The CCC centre model.

than \$US 40 (triple-therapy costs \$US 360/year) (Revenge *et al.* 2006).

Initially, the CCC Centres were financed by the Global Fund (95%) and MSF (5%), but an external review of the health sector response to HIV/AIDS in Thailand recommended that community-based organizations should be more effectively financed by domestic sources (Ministry of Public Health, Thailand & World Health Organisation 2005). From 2006 Global Fund money was matched by the National Health Security Office, which has since committed to supporting all individual CCC Centre costs from 2009, when the current Global Fund grant expires. But the National Health Security Office has not yet agreed to cover support costs of the support teams, raising doubts about how to maintain the quality of the services they provide.

#### Further efforts to increase access to medicines

Civic groups continued pressing for wider access to medicines. An important victory was gained in 2006 when 500 people protested outside the offices of GlaxoSmithKline in Bangkok, forcing withdrawal of a patent application for the drug combination of lamivudine + zidovudine (Ford *et al.* 2007).

Eight years after the GPO requested a compulsory licence for didanosine, the Thai government finally issued compulsory licenses in 2007 and 2008, including for the

second-line antiretroviral lopinavir–ritonavir. This followed a WHO evaluation forecasting that the cost of antiretroviral therapy with second-line regimens could cost the country US\$ 500 million/year by 2020 unless action was taken against drug prices (Ministry of Public Health, Thailand & World Health Organisation 2005).

In addition to these actions against specific patents, civil society groups have worked to promote public health within trade negotiations by mobilizing against US trade pressure for further restrictions via the US–Thai free trade agreement (FTA) (Ford *et al.* 2007). In 2006, nearly 10 000 protesters gathered outside the venue of the free-trade talks demanding, in line with UN recommendations, that Thailand should not accept any further reinforcement of intellectual property protection proposed in the FTA (Ministry of Public Health *et al.* 2005). In response, the Thai Government declared that demands by the United States for Thailand to tighten up drug patenting were ‘unacceptable’ (Hongthong & Thalang 2006).

#### Expanding support to other countries/diseases

In 2003, ACCESS, MSF and TNP+ set up a project to train participants from Vietnam, Cambodia and Laos, later expanding to Nepal, Myanmar and Yunnan (southern China). While these countries have wide differences in their level of access to HIV/AIDS care and nature of their civil

society, it has been possible to modify and apply some lessons learned in Thailand in all of these other countries, notably the need to develop a broad network of health workers and NGO staff to ensure ongoing support for PHA.

In 2007, ACCESS and TNP+ expanded the scope of their work by helping patients with chronic renal failure to lobby for access to treatment, and the next year the National Health Security Office began discussing plans to include renal dialysis in the health insurance scheme. This reflects a broader understanding among both government and NGO that access to expensive medicines is not a problem limited to HIV/AIDS drugs: the Thai government has also investigated the possibility to source generic versions of medicines for cancer, cardiovascular and neuropathic drugs and antibiotics (Cawthorne *et al.* 2007).

### Conclusions

This paper provides a participant-observers' perspective of the role of civil society activism for access to HIV treatment in Thailand. Such 'insider' perspectives carry the risk of certain biases, in particular in relation to the issues the researcher focuses on and the framing of lessons-learned towards policy-relevant conclusions rather than generalizable, theoretical themes. We acknowledge that such biases exist in this account, and do not claim this to be a historical perspective of all actors involved in the policy-setting process. Nevertheless, participant observation holds a critical place in health policy analysis as it allows for a degree of access to information, understanding of culture and authenticity that is not readily available to an external researcher (Walt *et al.* 2008).

As our account illustrates, PHA have made an essential contribution to overall provision of treatment and care in Thailand, to the point that some have concluded that the scale up and sustainability of antiretroviral therapy (ART) in Thailand would not have been possible without the engagement of civil society networks (Tantivess & Walt 2008). The role of these groups has been one of both co-operation (providing concrete support for patients and for the health system as a whole) and challenge (advocating for increased access to treatment as a human right). Their efforts contributed substantially to the availability of affordable generic medicines, early treatment for opportunistic infections and an informed and responsible approach towards antiretroviral treatment that is supportive of good adherence and treatment success.

Since 1990, the role of PHA in providing peer support has been increasingly accepted and encouraged in Thai-

land. A change in perception of PHA from 'passive receiver' to 'co-provider' of health care came about due to their own action, with significant support from local and international NGOs. Improved acceptance of and support for PHA by the healthcare system followed. A few years ago, health care for PHA was mainly provided by specialist centres; today, nearly every hospital in Thailand accepts its responsibility to provide care for PHA and the gap between doctors and patients has been markedly reduced, with over one third of all hospitals including a formal role for PHA through the CCC model. Increased control over their own health has also brought benefits for PHA in terms of self-image, confidence, and dignity. Empowerment has come from the recognition that many of the barriers to care – lack of access to affordable medicines, lack of national drug supply and lack of peer support – are barriers they have been able to overcome themselves. These successes have firmly established the role of patients not just as beneficiaries of the health system, but stakeholders in its development.

With Thailand virtually reaching the goal of universal access to antiretroviral treatment, the access to medicines crisis that TNP+ confronted in 1998 is largely resolved. But access for unregistered groups, principally ethnic minorities and migrant populations, who account for more than 2 million people in Thailand, remains very limited. Specific vulnerabilities make these groups at high risk from contracting HIV/AIDS. Other high-risk groups such as sex workers and injecting drug users continue to have difficulty accessing the health system (Ainsworth *et al.* 2003). TNP+ and ACCESS are advocating to extend the reach of the public ART system to these marginalized groups, and have negotiated with the Thai government to ensure that a proportion of the Global Fund grant goes towards supporting these groups.

Successful campaigning for access to affordable medicines has depended on strong working relationships between PHA, academics, NGOs, key government officials and journalists who have been willing to take the time to understand complex issues. This activism has been supportive of, rather than antagonistic towards, government: pushing the government to increase availability of affordable antiretrovirals, and then providing practical support to the implementation of treatment programmes when the medicines become available.

However, with first-line treatment available nationwide and with PHA taking a formal role in policy formulation, there is no longer a single urgent common cause for which to fight. Challenges now faced by Thai civic groups, and which need to be prioritized, include lack of a once-daily first-line regimen, of fixed-dose combinations of ART for children and of TB medication, of wider access to

second-line treatment, treatment for Hepatitis C and harm reduction programmes for injecting drug users. Perhaps, most pressing however, is how to maintain the quality of CCC Centre services if funding for their support system is withdrawn.

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