Conceptual Framework for Financing HIV and AIDS Care and Treatment in ASEAN Countries

January 2008

This publication was prepared by staff of the USAID | Health Policy Initiative, Task Order 1, with input from ASEAN representatives of Cambodia, Indonesia, Lao PDR, the Philippines, and Viet Nam. It was distributed to participants of the ASEAN Regional Meeting on Financing for HIV and AIDS Care and Treatment, January 7–9, 2008, in Bangkok.

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EXECUTIVE SUMMARY

The AIDS pandemic has raised worldwide alarm for policymakers and communities, particularly in countries where poverty tends to stimulate the spread of HIV. Timely government involvement and investment in the right mix of prevention, care, and treatment have the potential to save lives as well as reduce the long-term costs associated with high prevalence.

There are numerous interrelated issues to consider as a country determines how to allocate its finite resources. It will be helpful to consider these issues within a larger conceptual framework that begins with the articulation of a national vision and identifies the steps required for implementation.

When exploring finance options for HIV and AIDS care and treatment, topics for discussion should include system design and structure; sustainability of finance options; prevention and early detection; patient eligibility; service provision and access to care; definition of coverage; trade issues; procurement; and human capacity development. Countries must finance HIV and AIDS care and treatment programs at levels that ensure high-quality care, positive health outcomes, and sustainability. In the absence of a “one size fits all” model, some countries have begun to enact incremental policy changes.

Demonstrating continuing leadership in the fight against HIV, Thailand offers a promising case study. Combining coverage under the 30 Baht Program (now known as Universal Coverage) and a separate, vertical HIV and AIDS care and treatment program currently under the National Health Security Office (NHSO), Thailand continues to work toward its vision of universal healthcare coverage for every Thai citizen; guaranteed access to care; a single, standard benefits package; coverage for HIV and AIDS care and treatment; and adequate and sustainable funding.

As delegates and policymakers of the Association for Southeast Asian Nations (ASEAN) continue to explore finance options for HIV- and AIDS-related care in their respective countries, lessons learned from Thailand will help to inform the planning, design, and implementation of HIV and AIDS programs in other countries. As governments continue to finance HIV and AIDS treatment, sustainable measures will be essential for ensuring continuous, high-quality care and life-saving treatment for people living with HIV/AIDS (PLWHA).
ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
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<td>AMTP</td>
<td>AIDS Medium-Term Plan</td>
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<td>ART</td>
<td>Antiretroviral therapy</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<td>ASEAN</td>
<td>Association of Southeast Asian Nations</td>
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<td>AWP</td>
<td>ASEAN Work Program</td>
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<td>CD4</td>
<td>Cluster of Differentiation 4</td>
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<tr>
<td>CSMBS</td>
<td>Civil Servant Medical Benefits Scheme</td>
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<tr>
<td>CUP</td>
<td>Contracting unit for primary care</td>
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<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>GPO</td>
<td>Government Pharmaceutical Organization</td>
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<tr>
<td>FSW</td>
<td>Female sex worker</td>
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<td>HSS</td>
<td>HIV Sentinel Surveillance</td>
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<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<tr>
<td>IDU</td>
<td>Injecting drug user</td>
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<tr>
<td>IEC</td>
<td>Information, education, and communication</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MOPH</td>
<td>Ministry of Public Health</td>
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<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
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<td>NAC</td>
<td>National AIDS Commission</td>
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<td>NAP</td>
<td>National AIDS Program</td>
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<td>NAPHA</td>
<td>National Access to ARVs for People Living with HIV or AIDS</td>
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<td>NGO</td>
<td>Nongovernmental organization</td>
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<td>NHSO</td>
<td>National Health Security Office</td>
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<td>OFW</td>
<td>Overseas Filipino worker</td>
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<tr>
<td>OIs</td>
<td>Opportunistic infections</td>
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<td>PDR</td>
<td>People’s Democratic Republic (Lao)</td>
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<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<tr>
<td>PLWHA</td>
<td>People living with HIV or AIDS</td>
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<td>PNAC</td>
<td>Philippine National AIDS Council</td>
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<td>PPS</td>
<td>Purchaser Provider Split</td>
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<td>SSS</td>
<td>Social Security Scheme</td>
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<td>STI</td>
<td>Sexually transmitted infection</td>
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<td>UC</td>
<td>Universal Coverage</td>
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<td>UNAIDS</td>
<td>Joint United Nations Program on HIV and AIDS</td>
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<td>UNGASS</td>
<td>United Nations General Assembly Special Session on HIV and AIDS</td>
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<td>VAAC</td>
<td>Viet Nam Administration for AIDS Control</td>
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<tr>
<td>VCCT</td>
<td>Voluntary confidential counseling and testing</td>
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<td>VCT</td>
<td>Voluntary counseling and testing</td>
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<tr>
<td>WCF</td>
<td>Workers Compensation Fund</td>
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<td>WHO</td>
<td>World Health Organization</td>
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INTRODUCTION

This working paper was drafted in preparation for a study tour in Thailand in January 2008. Representatives of ASEAN Member Countries learned about Thailand’s experience to date in financing HIV and AIDS care and treatment and evaluating the country’s approach to sustained coverage. The paper outlines key points to consider when exploring health financing for HIV and AIDS care and treatment in ASEAN countries. It also offers a conceptual framework that policymakers can use when designing finance and coverage schemes. Appendix A includes summaries of the HIV situation of Cambodia, Indonesia, Lao PDR, the Philippines, and Viet Nam; representatives of these countries participated in the tour and prepared these draft summaries.

BACKGROUND

ASEAN Response to HIV

HIV was first reported in the ASEAN region in the early 1980s and has continued to spread at varying rates. By the end of 1999, the Joint United Nations Program on HIV/AIDS (UNAIDS) estimated that 1.63 million people were living with HIV/AIDS in the region, which, at that time, had a combined population of 510 million people.1

The threat of HIV was first addressed as a regional concern at the 4th ASEAN Summit in 1992, when member countries agreed to make a coordinated effort to curb the spread of HIV.2 This agreement led to the establishment of the ASEAN Task Force on AIDS and a regional program to combat HIV. The first ASEAN Work Program on HIV/AIDS Prevention and Control (AWP I) was prepared with assistance from the ASEAN Secretariat and World Health Organization (WHO) and has since continued to evolve. The focus of ASEAN’s second Work Program on HIV/AIDS (2002–2005) or AWP II was on reducing the social and economic impacts of HIV on ASEAN Member Countries.

The third and current ASEAN Work Program on HIV and AIDS (2006–2010) or AWP III builds on previous work to prevent the transmission of HIV and mitigate its impact by improving regional responses and enhancing Member Countries’ development of people-centered initiatives. During a regional symposium in Bangkok in April 2006, several participants raised the issue of health financing for HIV and AIDS care and treatment.3

This paper seeks to address this issue and provide ASEAN delegates with an overview of key concepts in healthcare financing as they relate to coverage for HIV and AIDS prevention, care, and treatment. As background for the paper, we reviewed relevant literature and conducted interviews with government officials from the Thai Ministry of Public Health (MOPH), National Health Security Office (NHSO), the National Access to ARVs for People with HIV and AIDS (NAPHA—now known as the National AIDS Program [NAP]), groups representing civil society, and leading Thai health economists and their colleagues.

Rationale for Government Intervention in HIV and AIDS

Health systems have the potential to improve the quality of life and standard of living for individual citizens as well as entire populations. Healthier communities are more likely to experience economic gains, which in turn, can increase the resources that institutions and households need to invest in health.4 However, the unfortunate reality around the globe and particularly in resource-poor countries is that the health of individuals and communities is continually threatened by a cycle of poverty and disease.
The HIV pandemic has raised worldwide alarm for policymakers and communities, particularly in countries where poverty tends to stimulate the spread of HIV. An unequal distribution of income, increases in human migration, urbanization, and cultural modernization are among the determinants that contribute to the spread of HIV. Increases in AIDS-related deaths fuel household-level poverty and social inequality and create a vicious cycle where increased poverty and inequality then give rise to climbing infection rates. Stemming the tide of infection requires designing and implementing policies that address this cycle.

Timely government involvement and intervention are essential. Investment in the right mix of prevention, care, and treatment programs has the potential to save lives as well as reduce the long-term costs associated with high prevalence. Though national governments are not always viewed as being the main providers of healthcare, they are seen as being primarily responsible for financing healthcare, particularly for subsets of the population that cannot afford high-quality care and/or basic services. Policymakers continue to face an urgent call to consider various health financing schemes that both prevent HIV transmission and provide much needed HIV and AIDS care and treatment. It is important to understand that there is no “one size fits all” model. Instead, within a given country context, decisionmakers must determine how to maximize use of available resources to benefit the most people and improve equity and access to high-quality care.

CONCEPTUAL FRAMEWORK

There are numerous interrelated issues to consider as a country determines how to allocate its finite resources. It might be helpful to consider these issues within a larger conceptual framework that articulates a national vision, identifies the appropriate steps for implementation, and addresses any unintended consequences that may arise.

Vision

For many countries, the burden of disease, the devastation experienced by communities, and the urgency to respond to health crises like HIV have inspired dialogue to swiftly identify and implement policies to prevent transmission while also ensuring access to care for those who need it most. While developing and implementing needed financing schemes, policymakers must consider how to provide HIV programs within the larger context of a vision or goal for the country.

William Savedoff outlines a framework on healthcare spending, particularly for HIV and AIDS, in an issue of *Health Affairs*. Care and treatment for HIV and AIDS will require a significant commitment of resources—which highlights the importance of investing in prevention. Furthermore, sustainable funding sources are needed to continue HIV prevention programs while ensuring that patients adhere to treatment. To use scarce resources effectively, policymakers must determine whether the national goal is to ensure coverage for specific subsets of the population, such as the elderly, children, and the extreme poor; or to provide universal healthcare coverage or something in between.

In defining a healthcare vision, policymakers should consider the epidemiological profile of their country and the desired health status. Understanding the needs of the population and articulating clear goals will help identify the necessary health inputs. However, before allocating resources, policymakers should also consider how effective those inputs will be toward improving health—given, for example, the current capacity of health personnel, the level of technology, and the quality of drugs and equipment. Note that before this process is begun, it is essential to identify and engage key stakeholders to ensure buy-in from
all spheres of influence, including other sectors competing for funding, strategic partners in the private sector, nongovernmental organizations (NGOs), donors, and civil society. Stakeholders must recognize that the investment in and financing of health are as essential to development as investments in other sectors such as education, agriculture, housing, public infrastructure, and industry.11

Implementation

Designing a national program that reflects a country’s vision of health requires identifying clear goals and objectives. Integral to that process is developing an understanding of the operational environment. Regarding HIV and AIDS, policymakers should carefully consider their level of engagement; the associated costs of funding prevention, care, and treatment programs; and measures to ensure sustainable outcomes. The following section highlights key issues for consideration to help guide the planning process.

System design and structure. Strategic planning is essential to the process of designing and organizing HIV and AIDS care and treatment programs. Engaging stakeholders and conducting environmental analyses are among the many steps required to ensure proper planning and strategy development. Countries should consider issues related to appropriately housing the program within the broader government structure, securing budget lines to ensure the inviolability of funds once they are assigned, and identifying secure funding channels to ensure that monies are disbursed effectively. Thoughtful strategic planning should also include continual monitoring, assessment, and evaluation of the system. Though extensive planning upfront has the potential to save time and money and should limit the need for complete overhauls, the introduction of new structures could require a willingness to fine-tune processes and procedures to ensure efficiency.

Prevention and early detection. Policymakers should not overlook the importance of strong prevention and early detection programs when funding HIV and AIDS care and treatment. Patients are often identified as being eligible for antiretroviral therapy (ART) when their CD4 counts have already fallen below the threshold of benefiting from care.12 This presents a strong argument for investment in and promotion of voluntary counseling and testing (VCT) as a way of engaging patients in the early stages of infection. Likewise, the high cost of sustaining treatment makes a strong case for securing funding for prevention.

Sustainability. As the number of AIDS patients living longer as a result of ART increases, the cost associated with supporting their care and treatment will also increase, further burdening the healthcare system. Once a commitment to starting patients on antiretrovirals (ARVs) has been made, it cannot be reversed due to the role of adherence in reducing the potential for drug resistance. Before creating an entitlement program, it will be important for governments to think about the availability of resources and competing needs in order to ensure sustainability of the program.

Financing. As the cost of healthcare continues to increase, alternative sources of funding for HIV care and treatment might be needed to supplement the national budget, ensure access to basic health services, improve quality of care, and create incentives for providers and consumers to deliver and use services efficiently.13 Policymakers should identify not only what the national government is willing to spend but also additional sources of sustainable funding.

As noted by the World Bank,14 though numerous financial models and methods of implementation exist, the majority of approaches seek to address variations of three basic objectives:

- Objective 1: Generate revenues to provide individuals with a basic package of essential services and financial protection against catastrophic medical expenses caused by illness and injury in an equitable, efficient, and sustainable manner.
- Objective 2: *Pool risk* to enable individual members to share collective health risks and protect them from devastating health expenditures.

- Objective 3: Guarantee *prepayment* to enable members of a *pool* to pay for average expected costs in advance, relieving them of uncertainty and ensuring compensation in the event of a loss.

The national budget is the most common method of finance for government-run health services, and monies are typically based on public revenues. Direct taxation of individuals and businesses; direct or indirect levies; license fees; and property, sales, or market taxes all serve as sources of public funds.

Foreign donors are another common source of funding. Typically, this form of *external funding* supports a particular initiative, program, or project; and might cover costs such as personnel, supplies, or vehicles. In many ASEAN countries, the Global Fund for AIDS, Tuberculosis and Malaria (Global Fund) or NGOs have covered HIV and AIDS care and treatment programs; however, external funding can only be relied on for a limited time.

*User fees*, or payment for health services at the time of delivery, are another means of collecting revenues, which are channeled back into the system to improve conditions for healthcare staff and patients alike.

*Health insurance* has also attracted attention as a means of collecting revenues, pooling risk, and offering prepayment. *Risk pooling coupled with prepayment* form the basis for insurance and redistribute health spending between high- and low-risk individuals and high- and low-income individuals. The World Bank outlines four types of health insurance that are widely used to pool risks, foster prepayment, raise revenues, and purchase services:

- State-based systems funded by the government
- Social health insurance
- Community-based health insurance
- Voluntary health insurance

(For more information on these financing methods, please see the World Bank report titled *Health Financing Revisited: A Practitioner’s Guide.*)

**Eligibility.** Determining who is eligible for coverage for HIV and AIDS care and treatment can be challenging. Policymakers should consider the nature of the epidemic and the most cost-effective approach to averting new infections in the face of scarce resources. Clear articulation of eligibility requirements is essential to ensure sustainable initiatives. Countries might consider targeting vulnerable groups including children, the extreme poor, and people exhibiting high-risk behaviors.

**Service provision and access to care.** Countries should also consider how eligibility requirements will be communicated, the methods for identifying qualified recipients, and the administrative structure of the program. Clear and well-publicized public health messaging is needed for patients to understand where to go for care and treatment and the extent of the services available to them. Patient registration and identification cards can be useful tools for identifying eligible recipients. However, given the implications of stigma and discrimination associated with disclosure, portions of the population may resist seeking care. Likewise, administrative processes that are time intensive and/or pose an undue burden on program participants (e.g., high travel costs to facilities, income lost for missed work days) can inhibit those in need of services. System design should therefore address the many possible barriers to access. Engagement with stakeholders upfront, such as groups of people living with HIV or AIDS (PLWHA), can help identify potential challenges and corresponding solutions.
**Coverage.** Policymakers should also carefully determine the extent of HIV- and AIDS-related services to be provided. A standard package of care that includes prevention, diagnosis, and treatment of opportunistic infections (OIs) and routine tests associated with ART will have implications for the health outcomes of participants as well as the overall cost of the program. Countries should also assess the feasibility of providing coverage for second-line regimens, as the associated costs are high and have implications for sustainability.

**Trade issues.** As the cost of ARVs continues to remain high and the number of patients needing treatment increases, it will be important to explore methods of cost containment. Compulsory licensing and the purchasing and manufacturing of generics have helped some countries to control the high cost of enrolling patients on ARVs; however, for some countries, this has come at a price.20 Drug companies and some governments have threatened penalties, including the halting of drugs already in the licensing process as well as trade sanctions.

**Procurement.** ARVs are a cornerstone of any successful care and treatment program. In addition to ARV distribution and supply chain management, countries must carefully consider which formulations to provide, the source of funding to purchase the drugs, the purchasing agent, and the methods of procurement.

**Human capacity.** A high-quality care and treatment program requires that medical staff have a strong working knowledge of the side effects of therapies, the expertise to determine when changes in regimens need to be made, and the ability to request additional testing or referral when necessary. The time-intensive nature of providing care for existing patients combined with an increase in new entrants to the health system have the potential to place a burden on staff. To ensure high-quality care and treatment, policymakers should assess staff capacity throughout the system as well as identify training needs.

Countries must think through all the above issues in order to finance HIV and AIDS care and treatment programs at levels that ensure sustainability, high-quality care, and positive health outcomes. In the absence of a “one size fits all” model, some countries have begun to work through this strategic process and enact incremental policy changes. The following section highlights one country’s experience and preliminary lessons learned in funding HIV care and treatment.

**THAILAND: PROVIDING COVERAGE FOR HIV AND AIDS PREVENTION CARE AND TREATMENT**

**Overview of the Thai Epidemic**

Thailand has demonstrated a strong commitment to providing comprehensive care and support to PLWHA. Since 1984, more than 1 million people in Thailand have contracted HIV and over 400,000 of them have died.21 In 2004, it was estimated that 572,500 people in Thailand were living with HIV/AIDS and that among this group an estimated 49,500 people would die of AIDS-related complications.22

As a result of both strong political commitment and an active civil society, Thailand has been at the forefront of countries in its approach to committing monies for prevention; ensuring access to care and treatment for those in need by successfully developing a domestically produced, generic triple-drug combination therapy and offering it as the standard of care; supporting the development of ART delivery programs; and building on existing health insurance schemes to guarantee universal access to basic healthcare, including coverage for those in need of HIV and AIDS care and treatment.23
Thailand’s Vision

The road to universal healthcare coverage in Thailand has been three decades in the making. In 1974, Thailand began incrementally expanding health insurance to cover targeted portions of the population. Though addressing specific diseases was considered important, from the beginning, policymakers at the national level envisioned designing and implementing national health insurance as the approach to ensuring that all citizens have access to a basic package of services.24

Implementation

History of coverage schemes. In 1974, Thailand began to introduce incremental insurance schemes. Each subsequent scheme covered a targeted segment of the population with specific eligibility criteria and defined service coverage.

The Workers Compensation Fund (WCF) was the first insurance scheme designed to provide coverage for workers in high-risk settings.25 Funding for WCF was generated by taxes paid by employers. Under this scheme, physician and hospital fees were paid for on a fee-for-service basis and work-related injury or illness services were provided in either a hospital or clinic setting. The hospital filed a report, and the government provided reimbursement.

In 1980, Thailand introduced the Civil Servant Medical Benefits Scheme (CSMBS), which followed a predecessor program titled Social Welfare.26 CSMBS guaranteed medical care coverage for all permanent government officials and their families. Due to substantial cost escalation, the program was restructured in 1997 with cost containment being the primary goal.

After introducing additional coverage schemes, in 1990, the Social Security Scheme (SSS) was instituted for workers in the formal sector and served as a complement to the WCF and CSMBS, allowing Thailand to provide comprehensive healthcare for public servants and workers in large enterprises.27, 28 SSS was contribution-based—workers and employers each paid 1.5 percent of the workers’ monthly wage, and the government contributed another 1.5 percent to the fund. Beneficiaries could choose to register at a hospital or hospital network for primary care. Hospitals received annual capitation rates of 1,500 baht (2004) from the Social Security Office for every person under the scheme who registered at that site.29 SSS covered any health services or health needs that were not directly related to work-inflicted injury or disease.

Despite this layering of schemes that targeted various population segments, many people still remained without coverage in the mid-1990s.30 Following the election of the Thai Rak Thai Party, in 2001, the government introduced its most ambitious insurance scheme, the Universal Coverage (UC) scheme, with the purpose of filling the coverage gap left by preceding incremental health insurance.31 In support of this scheme, the MOPH launched the “30 Baht Universal Health Care Policy,” which included three objectives: to provide universal coverage to every Thai citizen and guarantee access to care; provide a single, standard benefit package; and ensure adequate and sustainable funding.32

Implementation of the 30 Baht policy extended coverage from about 25 million (40% of the population) in 2001 to above 59 million (95.5% of population) by 2004.33 The government achieved this full coverage under one of three schemes: UC scheme, CSMBS, or SSS/WCF.34 Although the original policy design called for a single fund, the government decided to delay merging the three public insurance schemes. Achievement of 30 Baht therefore relied on a patchwork of new and old schemes with different financing mechanisms.35
**Introduction of PPS and CUPs.** Financing for 30 Baht introduced a unique way of channeling funds to public hospitals—a purchaser-provider split (PPS). Under the PPS, an autonomous purchasing agency called the National Health Security Office (NHSO) was established separately from the MOPH. The NHSO assumed responsibility for purchasing or channeling funding through local contracting units for primary care (CUPs). However, this system was revisited, and instead, funds were redirected to district hospitals, which began to assume the role of the CUPs. Under this new system, funding was channeled in the following way: from the Ministry of Finance to the NHSO; from the NHSO to the provinces; and from the provinces to the district hospitals.

Whereas under the old system, providers were reimbursed for the services they delivered, under the 30 Baht PPS system, provider participation was voluntary and funding was capitation-based. Each CUP was to receive funding based on the number of patients or members registered with the local health district. The CUPs were to use this capitation-based funding to support local service units and pay for referrals. In other words, facilities that registered patients received resources relative to their registered population; those that did not register patients were in danger of facing budget constraints. Secondary and tertiary hospitals were to receive payment from primary care units on a referral basis. They were also to receive payment through provincial funds for inpatient care. ARVs and funds for several other expensive drugs are received as an addition to the capitation payment.

The primary purpose of the PPS system was to provide incentives to strengthen primary care. Capitation was designed to reduce the geographic inequalities in spending that had posed challenges for the Thai health system, whereby certain geographic regions were “overfunded.” Capitation was, therefore, an attempt to reallocate resources and empower facilities providing care.

**Eligibility for 30 Baht.** The 30 Baht program offered coverage for a comprehensive benefits package that included basic care and treatment. Registered members received a gold card, entitling them to care near their place of residence. Patients received coverage for in- and out-patient care at a registered primary care facility. They were also granted referrals for secondary and tertiary care facilities (except in the event of an emergency), dental care, health promotion and prevention services, and drug prescriptions. The only out-of-pocket payment was a 30 Baht (less than US$1) co-payment per visit; the very poor, elderly, and children were exempt. However, following the coup in September 2006, the 30 Baht fee was dropped, and the new government declared that universal coverage would be free for all.

**Intersection of HIV/AIDS vertical programming and 30 Baht.** Though ART was not part of the original 30 Baht program, Thailand continued to demonstrate its commitment to providing coverage for HIV and AIDS prevention, care, and treatment by introducing a separate, vertical program that filled the gaps that 30 Baht did not cover. Though 30 Baht provided coverage for preventive and curative care for OIs, it did not cover the cost of clinical monitoring associated with care and treatment such as CD4 and viral load tests. Instead, coverage for routine tests and access to ART were channeled through a separate, vertical program that began evolving under the MOPH in the 1990s, initially focusing on prevention.

**Investing in prevention.** In 1990, the Thai government began devoting a substantial amount of its national budget to HIV and AIDS programs. Public spending continued to expand between 1987 and 1997, reaching approximately US$82 million annually; the government financed 96 percent of this total. This amount was equivalent to one-quarter of the total expenditure on HIV and AIDS programs in the developing world at the time. Currently, the Thai government’s investment in prevention among most at risk populations (with increasing HIV prevalence) is very limited.

As a result of this investment, Thailand was able to avert an estimated 7.7 million HIV cases and 850,000 AIDS cases in 2005. Through investing in prevention between 1991 and 2002, Thailand has avoided
having to spend an estimated US$18.6 billion (745 billion Baht) on treatment over the decade through 2012. Though treatment is essential for prolonging the lives of PLWHA, the Thai experience illustrates the high return on HIV prevention dollars.

Investing in care and treatment. Thailand began publicly funding ART in 1992. After multiple iterations of program design, the MOPH introduced a new initiative in 2003. This redesigned program, known as the National Access to Antiretrovirals Program for People living with HIV/AIDS (NAPHA), was financed by monies from the Global Fund and the Thai government through the combined coverage offered by the UC scheme, CSMBs, and SSS. As a result of Thailand’s willingness to constantly reassess and redesign its system, through incremental efforts and by the end of 2004, more than 80 percent of PLWHA had gained access to publicly financed ART.

NAPHA ran until April 2007 when it was absorbed by the NHSO and became the National AIDS Program (NAP). With this integration, Thailand’s vertical HIV and AIDS program moved closer in its intersection with what was by then known as UC. As a result of these changes in structural design, by 2007, all HIV and AIDS services flowed from the NHSO. HIV and AIDS programs continued to run under a separate budget, which was distributed to provincial, district, and local hospitals. All of the money for ART was funded by public tax revenues, offering coverage for both first- and second-line treatment. In turn, hospitals offered patients an array of services including ARVs, VCT, CD4 and viral load testing, and coverage for many OIs. Providers billed the NHSO for the services rendered. As of early 2008, the majority of services are covered under UC (with individual capitation payments having increased to 2,200 baht per patient), while ARVs and other high-cost drugs are funded by the AIDS fund.

Eligibility for ART. PLWHA that met the national ART eligibility criteria and registered at their local or district health facilities were able to access care and treatment. After paying for a baseline CD4 test, the NHSO covered all other monitoring and testing. Despite this system, a number of HIV-positive people continued to lack access to care and treatment; many were migrant workers, refugees, or individuals that never received identification cards. To cover these population segments, under the NAPHA, Thailand applied for an extension to use Global Fund monies to cover these costs. This extension was time-limited and provided coverage for one year.

Manufacturing and procurement of ARVs. Thailand also invested in building the country’s capacity to manufacture generic drugs. The Government Pharmaceutical Organization (GPO) began producing a triple drug combination regimen in a single tablet called GPO-vir. This combined approach—ensuring the availability and affordability of ART—made scale-up of ART to eligible patients a reality.

Under the re-organization, NAP assumed responsibility for procuring first- and second-line regimens from the GPO. While the organization continued to produce GPO-vir, all other drugs were procured from a generic drug company based in India.

Trade agreements and compulsory licensing. In a bold move to contain costs associated with an increase in the number of patients needing first- and second-line regimens, Thailand issued compulsory licensing as a means of ensuring that it could continue to afford efavirenz. Using this approach, Thailand was able to legally issue GPO a compulsory license to manufacture efavirenz at a lower cost based on the argument that the country was suffering a health emergency.

Thailand’s efforts to regain control over the high cost of ARVs staked new ground. However, drug companies like Abbott Laboratories responded by withdrawing their application to sell seven new life-saving drugs including a new version of Kaletra; an antibiotic; a painkiller; and medicines to treat blood clots, arthritis, kidney disease, and high blood pressure. The company believed that the Thai
government’s decision to break the patents was a move away from innovation.\textsuperscript{65} Other editorial comments suggested that it demonstrated support for stealing intellectual property.\textsuperscript{66} Characterized as a “rational business decision” by business editors, Abbott’s decision will stand until the Thai government changes its position.\textsuperscript{67}

**Challenges**

**Stigma and discrimination.** Despite Thailand’s impressive efforts to continually re-assess and redesign their HIV and AIDS programs, many eligible individuals do not access available care. One challenge that continues to inhibit many PLWHA from seeking treatment is the fear of stigma and discrimination associated with disclosing their status at their local health facility. Though the patient might incur substantial costs because of time, distance, and fees for services, fear prompts many individuals to seek care outside of their district hospital at NGO clinics or in the private sector.\textsuperscript{68}

**Administrative processes.** Treatment can be delayed due to the lengthy administrative process of confirming a positive diagnosis and registration.\textsuperscript{69} As care and treatment are postponed, CD4 counts diminish, resulting in an increased risk of OIs and a reduction in overall health status. By the time patients are put on treatment, efficacy is greatly reduced, limiting their ability to achieve positive health outcomes and live with a chronic condition.

**Provider participation.** Another factor that can inhibit availability and access to treatment is providers’ unwillingness to participate in the national program. Given the voluntary nature of hospital participation, PLWHA may be left without convenient access to care, forcing them to seek services at a higher cost.\textsuperscript{70}

**Human resources.** A lack of skilled human resources poses yet another challenge. Even where hospitals provide ART, the ability of healthcare providers to prescribe appropriate regimens may be limited. Likewise, though local hospitals are eligible to receive funds from the NHSO, many continue to lack the proper infrastructure and/or skilled staff to provide high-quality care and treatment.\textsuperscript{71}

**Capitation and disincentives for providers.** The structure of the current capitation system also serves as a disincentive for providers to refer patients elsewhere for care and treatment. Facilities receive money based on the number of registered patients accessing services at that site. Therefore, it is in the provider’s interest to retain patients even when services are best provided elsewhere. Though the intent of capitation was to introduce equity in funding distribution, in some cases, it has unintentionally affected the quality of care.

**Sustainability of patients on ART.** Today, more than 100,000 people receive treatment in Thailand.\textsuperscript{72} While the majority of patients are on first-line regimens, approximately 10 percent have developed resistance and moved to second-line treatment. Given these numbers, many of the individuals interviewed expressed concern regarding sustainability. Despite current ART availability, many activists fear that the increasing number of people receiving ART will result in an insurmountable burden for the government, leading to future cutbacks.

**Need to refocus on prevention.** Finally, despite early efforts on the part of the Thai government to invest in prevention, recent surveillance results indicate an increase in the incidence of HIV, implying that future ART costs will continue to remain high.\textsuperscript{73} Policymakers in Thailand continue to focus their efforts on providing ART without sacrificing the benefits of prevention and public health messaging, particularly among high-risk groups.\textsuperscript{74} The independent Commission on AIDS in Asia’s 2008 report reveals very high HIV prevalence rates among most at risk populations in Thailand, calling for a larger focus on prevention for those most at risk.\textsuperscript{75}
LESSONS LEARNED FROM THE THAI EXPERIENCE

Thailand has demonstrated tremendous leadership and commitment in its continuing efforts to expand access to HIV and AIDS care and treatment. The country’s lessons learned can help inform processes currently underway in other ASEAN countries.

- Funding for care and treatment should not override the importance of continuing efforts for prevention.
- Engaging stakeholders in strategic planning is important to ensure access and availability of services. Issues such as stigma, discrimination, and fear of disclosure should be considered when designing a system.
- Consideration should also be given to cost containment options, including compulsory licensing and use of generics—though careful thought should be given to trade issues and related consequences.
- Anticipation of provider disincentives is needed when introducing new financing schemes. Expert analysis is important to anticipate and address these issues during the design and strategic planning processes, as well as during the monitoring, assessment, and refinement phases.
- Providing care and treatment for large numbers of PLWHA presents challenges to the public health system. Once the government begins to finance AIDS treatment, programs cannot be sacrificed to budget cuts and competing priorities due to the deadly implications for adherence and the potential development of resistant viral strains. Cost and revenue projections might help to identify an appropriate level of commitment.

Fellow ASEAN countries that participated in the January 2008 study tour face similar challenges and should take into account these lessons learned. Appendix A summarizes the current HIV situations of Cambodia, Indonesia, Lao PDR, the Philippines, and Viet Nam. Most of these countries are aiming to provide ARVs to 70 percent of patients; the majority is close to meeting this target. One notable exception is Lao PDR, which is primarily focusing on prevention and will provide treatment to AIDS patients with the remaining funds. Most ASEAN countries (excluding Brunei) currently receive external financing for ARVs. Participants recognize that to obtain future sustainable financing for ARVs, it is important to be able to project the associated costs—much like Thailand has done.
APPENDIX A. COUNTRY BRIEFS: CAMBODIA, INDONESIA, LAO PDR, THE PHILIPPINES, AND VIET NAM
I. CAMBODIA

The HIV Epidemic in Cambodia

Cambodia has the highest HIV prevalence in the WHO Western and Pacific Region. Data from the HIV Sentinel Surveillance (HSS) in 2002 estimated the number of adults living with HIV (ages 15–49) to be 157,500 (2.6%). However, Cambodia is one of the few countries in the region that has recently experienced a decline in HIV prevalence—from 2.6 percent in 2002 to 1.2 percent in 2003 and to 0.9 percent in 2006 (according to HSS data). This decline has been attributed to an investment in and scale-up of effective HIV prevention programs and a large number of deaths during the early years of the epidemic when life-sustaining treatment and care were unavailable.

The HIV epidemic in Cambodia is concentrated among most-at-risk groups and is primarily driven by the sex industry—although there are indications of rising prevalence among injecting drug users (IDUs) and men who have sex with men (MSM). As shown in the figure below, HIV prevalence among adults ages 15–49 living in urban areas remains higher than the prevalence among those living in rural areas. Cambodia’s National HIV/AIDS Strategy 2006–2010 acknowledges the gender dimensions of the epidemic. Forty-three percent of new infections are occurring among married women. Using the Asian Epidemic Model, the projected number of people living with HIV in Cambodia in 2007 is 61,400 (32,200 women and 29,200 men) and, in 2010, will be 51,200 (26,800 women and 24,400 men).

**Estimated HIV prevalence among adults ages 15–49 by urban and rural areas in Cambodia, 1995–2006**

![Estimated HIV prevalence chart]

The HIV Response

The government’s strong political commitment and leadership, the financial support of various sources, and a vibrant civil society response have contributed to the decline in HIV prevalence. The success of the
The national HIV and AIDS program can be attributed to a comprehensive HIV prevention package—100% condom use, condom social marketing and effective behavior change interventions, and voluntary confidential counseling and testing (VCCT) services—linked to the scale-up of ART and care through the Continuum of Care program. As of September 2007, Cambodia has 203 VCCT sites and 47 opportunistic infection/ART treatment centers; and 25,353 patients have received antiretrovirals, including 2,372 children (see adjacent figure).

In reflection of international commitments to universal access to HIV prevention, treatment, care, and support, sustaining political commitment and expanding on high-quality and cost-effective approaches will remain priorities for the government.

**Implementation Challenges**

Although HIV prevalence has been declining, the number of HIV-positive people in need of treatment and care is increasing. This situation requires the allocation of substantial resources to the HIV sector (both human and financial) and thus poses a challenge because significant resources are also needed to address other health priorities, such as tuberculosis and malaria. Another challenge is the heavy workload of existing healthcare staff at all levels, especially in hospitals.
II. INDONESIA

Overview of the HIV Epidemic

The HIV epidemic in Indonesia is among the fastest growing in Asia, although HIV prevalence among adults (ages 15–49) is still low at 0.16 percent.

As of 2006, an estimated 193,000 people were living with HIV. The epidemic remains concentrated among groups most at-risk of transmission, such as those using drug injecting equipment or engaging in unprotected sex. For example, HIV prevalence has reached high levels among vulnerable populations, with 48 percent prevalence among IDUs in East Java, 22 percent prevalence among sex workers in Papua, and 25 percent of prisoners in Jakarta.76

Recent data show that Papua has been experiencing an emerging generalized epidemic, with HIV prevalence several times the national average. Since the first AIDS case was reported in 1987 in Bali, HIV has affected all the geographical locations of Indonesia. By 2006, 32 provinces and 169 districts had reported AIDS cases.77

The HIV Response

The national commitment to respond effectively to the epidemic is strong. However, while the response to the epidemic has been scaled up in the last two to three years, major challenges remain: geographical disparities in coverage, the evolving nature and increasing size of the epidemic, lack of health systems capacity, and limited available resources. Several sound strategies and interventions were established to control the epidemic but, overall, coverage remains insufficient.

The Minister of Health established the National AIDS Committee in 1987. A Short-Term Plan and a Medium-Term Plan were implemented from 1988 to 1994, with assistance from WHO’s Global Program on AIDS. Presidential Decree No. 36/1994 expedited the establishment of the National AIDS Commission (NAC), a multisectoral body. The decree named the Coordinating Minister for People’s Welfare as the commission’s chair and the Minister of Health as one of the vice-chairs. It also stipulated the formation of AIDS commissions at the provincial, district, and municipal levels.

The NAC formulated the first National AIDS Strategy and a Five-Year Program Plan for AIDS Prevention and Control (1995–2000) as part of the Sixth National Development Plan. However, because of the country’s economic crisis, the government could not allocate the necessary budget; however,
several international donors provided support. The Minister of Health signed the Declaration of Commitment of the UN General Assembly Special Session on HIV and AIDS (UNGASS) in June 2001. Subsequently, Indonesia drafted the National HIV and AIDS Strategy (2003–2007) and the National Strategic Plan on HIV and AIDS Control (2003–2007).

Goals and Objectives

Proposed key targets in the national strategic plan for 2010 are as follows:

1. Comprehensive prevention program reaches 80 percent of most-at-risk populations
2. Behavior change occurs among at least 60 percent of the most-at-risk populations
3. Eighty percent of those in need receive ART and care and support services
4. Sixty percent of pregnant women have access to antiretroviral prophylaxis
5. Civil society participates actively: prevents and fights against stigmatization and discrimination, making the emergence of an enabling environment possible
6. By 2008, domestic and international resources reach the estimated needs

The formulation of a comprehensive health sector response is now underway, involving many partners within and outside the health sector. Promulgation of the new health sector plan through the Ministry of Health (MOH) and other ministries should guide partners in their work.

The MOH sub-directorate of HIV and AIDS meets annually with provincial health administrations and drafts workplans with budgets. The provinces prepare their plans based on inputs received from each district.

Coverage and Achievements

The provision of care, support, and treatment for HIV-positive people is among the priority areas of the National HIV and AIDS Strategy (2003–2007) and the National Strategic Plan on HIV and AIDS, Ministry of Health (2003–2007). In keeping with the strategies, the government has supported (1) the provision of free ARVs and other drugs for the treatment of OIs and (2) the training of healthcare providers on HIV and AIDS clinical management and counseling in hospitals of provinces with high HIV prevalence. The government’s targets are to provide free ARVs to 12,000 eligible people by the end of December 2006 and another 14,000 by the end of December 2007.

In 2004, the MOH identified 25 hospitals as “ART referral hospitals” and, by the end of 2006, increased the number to 75 hospitals. The goal is to have an ART hospital in every district by 2009 (about 445 hospitals). These hospitals can provide ART to satellite sites, such as health centers and treatment sites in prisons. Staff of these satellite sites have been trained to receive ART from the referral hospitals.

The HIV care, support, and treatment program started in four provinces with high numbers of reported HIV and AIDS cases and has since expanded to 32 other provinces. The Global Fund supplied funds for the provision of ARVs and drugs for OIs in 17 provinces. In the remaining provinces, only ARVs are provided free. HIV care is integrated into the existing public healthcare system in government facilities in Jakarta, as well as in some other provinces and districts. The cost of care for poor people will be covered by Askeskin, the national social insurance scheme.

Although financial commitment to the national HIV and AIDS control programs increased markedly following the President’s decree on HIV and AIDS, resource allocations are not sufficient to scale up activities to the level required to make an impact on the HIV epidemic. While the MOH’s budgets are increasing, budgets for other government agencies are expanding more rapidly. It is uncertain whether the
projected increase in the MOH budget for 2007 will be realized. Furthermore, based on the NAC’s projected funding needs for 2007–2010, only 21 percent of these resources are likely to be available for the four-year period; and the HIV and AIDS program remains donor dependent, raising concern about the program’s sustainability.
III. LAO PDR

Lao PDR continues to experience low HIV prevalence (estimated at 0.1%). The virus was first detected in 1990; by the end of 2006, 2,182 AIDS cases had been reported (of whom 731 had died). Of those living with AIDS, 670 individuals were receiving ART. HIV transmission is concentrated among heterosexuals at more than 85 percent.

Estimated Projections and the HIV Response

Lao PDR’s economy is becoming increasingly intertwined with those in other countries in the region, leading to an increased risk of HIV transmission due to migration, travel and tourism, infrastructure projects, and increased disposable income. An estimated 9,000 female sex workers (FSWs) and 2,300 MSM living in Lao PDR are potential drivers of an epidemic. Second-generation surveillance shows an increase in HIV prevalence among FSWs from 0.9 percent in 2001 to 2.0 percent in 2004. The rate of sexually transmitted infections (STIs) is also high among FSWs at 25–50 percent among those not receiving treatment; data for MSM is still in the process of being analyzed.

Second-generation surveillance showed that although coverage is improving, there is no comprehensive package of services targeting sex workers, either male or female. AIDS treatment is available only at two sites in Lao PDR, thus patients have to travel long distances or forego therapy. An estimated 1,590 people will need ART over the next five years.

The country’s National HIV and AIDS Strategy (2006–2010) describes the necessary interventions in prevention and care and treatment and includes targets for the implementation of activities. Priority provinces are identified according to the risk of HIV transmission in those locations.

Donor-funded initiatives—such as those funded by the Global Fund and the Regional Communicable Disease Control Project funded by the Asian Development Bank—have supported STI prevention and behavior change among sex workers, condom social marketing, the expansion of VCT, outreach to vulnerable groups, and program management. With the support of the Global Fund, Round 6, the following activities will be scaled up:

- Increase safe sexual behavior among FSWs
- Increase safe sexual behavior among MSM
- Strengthen the coordination, monitoring, and management capacity of selected provincial committees for the control of AIDS
- Strengthen the monitoring, evaluation, and reporting system of the national program, with a specific focus on AIDS treatment, care, and support
- Strengthen the second-generation surveillance system
- Increase voluntary blood donation and establish four additional district blood units
- Scale up HIV counseling and testing in 11 priority provinces
- Increase access to HIV and AIDS care and support and treatment by expanded coverage in selected provinces
- Increase participation of HIV-positive people in the HIV and AIDS response, especially at district, provincial, and central levels

The number of care and treatment sites providing access to ART will be increased from two to five in the next two years. These five sites will aim to cover the needs of the majority of the country’s population, as a hub system will be established whereby provinces will refer their patients to other provinces as appropriate. The capacity of networks of people living with HIV and AIDS in Lao PDR (self-help groups)
for management, income generation, and so forth is being strengthened to increase social support for PLWHA.

The basic package of HIV and AIDS and STI prevention, care, and treatment services, including the provision of ART and drugs for OIs, is free to clients and patients, including for sex workers, their clients, and MSM. Counseling and testing services are also free. Some specialized exams and drugs require payment from the patient, but the minimum package of services and treatment covers most of the patient’s needs. The service delivery model in Lao PDR will identify the minimum package for free ARV treatment.

A key component of the national program is the coordination of activities, which is one of the most challenging because most HIV and AIDS funding comes from donors that each have their own implementation and contractual requirements.

Lessons Learned

Lao PDR has to respond quickly to the challenge of increasing access to HIV and AIDS prevention, care, and treatment. However, with the technical and financial support from the Global Fund and other donors and organizations, the country is meeting this challenge. Capacity development of staff and technical assistance are key factors in the successful implementation of national program activities.
PHILIPPINES

Overview of the Epidemic

The first AIDS case in the Philippines was reported in 1984. The Philippine AIDS Registry estimated a cumulative total of more than 3,000 people living with HIV from 1984 to 2007. Because almost half (47%) of these cases were detected during 2001–2006, the epidemic, characterized as “low and slow” until 2000, is now characterized as “hidden and growing”; the rate of increase in 2000 is at least twice than that observed in the 1990s.

The Philippine National AIDS Council (PNAC) reports that the number of HIV infections in the country has increased significantly since 2000, with the highest number being reported in 2006 (309). The AIDS registry estimated a monthly average of 26 new HIV cases for 2006, compared with a monthly average of 16 in the last five years. In May 2006, the total number of HIV cases since January had already exceeded the number reported for 2005. The first five months of 2007 show the highest monthly average to date (27 new HIV cases per month).

According to the National Epidemiology Center, since 1998, national HIV prevalence among adults has remained less than 0.01 percent. The majority of HIV cases (58%) are found among adult Filipinos in their productive years (ages 25–39). Current data indicate that young adults, MSM, sex workers, IDUs, overseas Filipino workers (OFWs) and the partners of all these groups are particularly vulnerable to HIV infection. Sexual activity remains the most common mode of transmission (87% of all cases), and returning OFWs account for about 35 percent of the reported cases.

Note, however, that prevalence data remain incomplete. HIV testing is systematically conducted among OFWs as a requirement of employers and/or the host country; but, in general, because of a lack of knowledge and information, few individuals get themselves tested for HIV. In addition, data from the AIDS registry are limited because the registry only records reported cases. These limitations aside, the stipulation that the number of HIV cases is increasing seems to complement the WHO and Department of Health’s estimates that HIV prevalence among Filipinos is slowly but steadily increasing.

The HIV Response

Wary of the unfolding epidemic among its neighbors in Southeast Asia in the 1980s, the Philippines quickly recognized its own vulnerabilities to HIV and AIDS and immediately responded to the threat. The response included the following:

- Creation of the National AIDS and STI Prevention and Control Program within the Department of Health in 1988.
- Issuance of Executive Order No. 39 in 1992 that created the PNAC, a multisectoral body that advises the President of the Philippines on HIV and AIDS policy issues. PNAC members are representatives of government agencies, NGOs, professional groups, and groups of PLWHA.
- Establishment of the HIV Surveillance System to monitor HIV prevalence and guide planners and implementers.
- Enactment by Congress of Republic Act 8504 or the Philippine AIDS Prevention and Control Act of 1998. The law mandates the promulgation of policies and prescription of measures for HIV prevention and control in the Philippines, institutionalization of a nationwide information and educational program, establishment of a comprehensive AIDS monitoring system, and strengthening of the PNAC.
• Drafting of AIDS medium-term plans (AMTPs) to guide policymakers and program planners to determine where resources for AIDS would make the most impact and what strategies and interventions are needed given the current situation. The country is now on its fourth AMTP (2005–2010) and has prepared a costed Operational Plan for 2007–2008.

• Implementation of a National Workplace Policy, developed by the Department of Labor. A tripartite committee issues guidelines for workplace policymakers and ensures implementation of the policies. Some companies have now established their HIV and AIDS workplace programs.

• Design of HIV and AIDS modules for integration in the school curricula at all levels, including non-formal education. Training of trainers on the use of these modules has been conducted.

• Preparation of guidelines, standards, and protocols for HIV case reporting, media reporting, treatment, care, and support—including the provision of antiretroviral drugs.

• Implementation of community-based interventions, ranging from information dissemination to behavior change strategies targeting vulnerable groups.

• Capacity building of healthcare providers and the creation of the HIV and AIDS Core Team, comprising doctors, nurses, medical technologists, and social workers in government hospitals, as well as NGOs based in the community.

• Creation of local AIDS councils in local government units where the presence of most-at-risk groups has been documented.

• Creation of regional AIDS assistance teams to help PNAC and local government units establish local AIDS councils.

• Integration of AIDS and migration issues in the curriculum of the Foreign Service Institute of the Department of Foreign Affairs.

• Establishment of the National Monitoring and Evaluation Unit on HIV and AIDS housed at the Philippine National AIDS Council Secretariat.

Goals and Objectives for Providing Treatment, Care, and Support

The national response to the AIDS epidemic is embodied in the AMTP IV (2005–2010), which aims to prevent the further spread of HIV and reduce the impact of AIDS on individuals, families, and communities. The objectives, with corresponding resource requirements, are detailed in the Operational Plan (2007–2008). Both documents were prepared after a series of consultations with stakeholders. The Operational Plan reflects priority activities to accomplish before 2010.

The AMTP IV accounts for different population groups and sectors in addressing HIV and AIDS. Interventions will focus on (1) registered and nonregistered sex workers and their clients, (2) IDUs, and (3) MSM. All programs and interventions focused on most-at-risk groups, including scale-up efforts, will cover not only people living with HIV but also those affected by the disease. The provision of HIV prevention information and services will continue among the workforce, in-school youth, and the general public. The AMTP IV will give ample attention to population groups becoming more vulnerable to HIV and AIDS and STIs, such as OFWs, young people, and children.

Strategy 3 of the AMTP IV embodies the country’s commitment to scale up and improve the quality of treatment, care, and support services for those infected with and affected by HIV. Its operational strategies will endeavor to increase access to services through the following:

• Support for the establishment of three subnational STI/HIV/AIDS centers in the three major island groups of the Philippines

• Review and redefinition of the procurement scheme for ARVs and medicines for OIs

• Presentation of procurement options to the PNAC leadership

• Assessment and improvement of the quality of care, treatment, and support provided by hospital facilities and other institutions
Continual identification of ways to instill respect for HIV-positive people and gender sensitivity among service providers

Reviews of turnaround times in obtaining confirmatory test results and the improvement of protocols, as necessary

Continuous training/retraining of the core hospital teams, as a priority

These two key results are expected after the above is accomplished:

1. High-quality diagnostic, treatment, and care services are provided to people infected with and affected by HIV.
2. HIV-positive people are provided with support services and referred for additional services.


Services and Coverage

The country has 11 treatment centers throughout the Philippines:

1. San Lazaro Hospital, Manila
2. Philippine General Hospital, Manila
3. Research Institute for Tropical Medicine, Manila
4. Vicente Sotto Medical Center, Cebu City
5. Davao Medical Center, Davao City
6. Corazon Montelibano Memorial Hospital, Bacolod City
7. Zamboanga Medical Center, Zamboanga City
8. Western Visayas Medical Center, Iloilo City
9. Ilocos Regional Training Hospital, San Fernando City
10. Baguio General Hospital, Baguio City
11. Bicol Regional Training Center, Legaspi City

The Department of Health’s central office provides all the hospitals with ARVs and antibiotics for OIs, which are free for eligible patients. Eligibility is determined by a baseline CD4 count and clinical assessment. Patients with CD4 counts of 350 and below—with apparent symptoms of tuberculosis, pneumocystis pneumonia, toxoplasmosis, and other OIs—are eligible for free treatment.

The Global Fund has been providing ARVs since 2006. The Department of Health plans to purchase ARVs this year.

The Operational Plan (2007–2008) requires a total of P849 million (about US$20 million) for its implementation. Most of the funding will go to preventive measures specifically targeted to most-at-risk populations. Treatment, care, and support constitute about 14 percent of the total financial requirements. Given that the government’s funds are limited, the majority of the financing for the country’s HIV response comes from external sources (donor agencies and international NGOs).

Lessons Learned

Being a low-prevalence country has both its pros and cons. A prevalence of less than 0.01 percent means that the disease is still uncommon in a country of almost 90 million. AIDS also has to compete with other diseases with higher mortality rates such as TB, dengue, malaria, and measles. Convincing government executives to fund HIV and AIDS programs is difficult given the low overall prevalence rate. Despite this challenge, the Philippine response to the epidemic demonstrates the country’s recognition that an explosion of new cases could occur at any time. The government’s efforts may be viewed as lacking or
lukewarm, but its efforts are often a reflection of low budgets. However, the robust involvement of civil society (persistent advocacy and activism) in all aspects of the response deserves much of the credit in continuing a focused response to the epidemic.

The PNAC includes 17 government organizations and 6 civil society organizations. Although these civil society organizations constitute only 30 percent of the council, their participation is what makes the council the main actor in the country response.

Multisectoral involvement and the realization that HIV and AIDS issues are not just health issues are key factors that help the country to maintain its low prevalence.
VIET NAM

Overview of the HIV Epidemic

Viet Nam has a population of 84.1 million people, inhabiting 64 administrative units (provinces and cities), 671 districts, and 10,876 communes over a land area of 3,293,145 km². Since the first HIV case was detected in 1990, the number of reported infections has increased every year.

As of August 31, 2007, the number of cases reported nationwide was 132,628, including 26,828 AIDS cases and 15,007 deaths. Eighty-one percent of reported cases are among adults 20–39 years old; 1.1 percent are among those under age 13. Ninety-six percent of districts and more than 65 percent of communes report HIV and AIDS cases. In some provinces and cities, 100 percent of communes or wards are reported to have HIV and AIDS cases.

According to the MOH, UNAIDS, and the WHO, HIV and AIDS estimates and projections from 2001 indicate that, by 2010, Viet Nam will have 350,970 people living with HIV, with an average of 12,000–18,000 new infections every year.

The HIV epidemic in Viet Nam is still concentrated among most-at-risk groups, such as IDUs and FSWs. HIV prevalence among these groups remains high and continues to increase. From 1996 to 2006, HIV prevalence increased from 9.4 percent to 23.2 percent among IDUs and from zero to 4.1 percent among FSWs. Needle and syringe sharing among IDUs is still high (37% in Ho Chi Minh City and 33% in An Giang). The rate of consistent use of condoms among FSWs is low (37% in Quang Ninh and 56% in Hanoi). Results from HIV sentinel surveillance also indicate a 2.2 percent HIV prevalence among male patients with STIs.

Recent data show that HIV is spreading from most-at-risk groups to the rest of the population. According to results of the HIV sentinel surveillance, prevalence among pregnant women has increased every year and was 0.4 percent in 2006, with higher rates in some urban areas. On average, about 2 million babies are delivered every year, leading to an estimated 6,000–8,000 infants at risk of HIV annually.

The HIV Response

The government has demonstrated a strong commitment to HIV and AIDS prevention and control. In 2000 and 2005, it established the National Committee on Control of AIDS, Drugs, and Prostitution (chaired by the Deputy Prime Minister); and the Viet Nam Administration for AIDS Control (VAAC), respectively. The VAAC assists the Minister of Health with HIV and AIDS program implementation nationwide. At the provincial level, the minister established centers for HIV and AIDS prevention and control, which assist the Provincial Health Department with the implementation and coordination of HIV and AIDS prevention and control activities in each province. On March 17, 2004, the Prime Minister approved the National Strategy on Prevention of HIV and AIDS Infection until 2010, with a Vision to 2020. On June 29, 2006, the National Assembly of Viet Nam passed the Law on HIV and AIDS Prevention and Control.

The state budget allocated for HIV and AIDS prevention and control has increased every year, rising from US$3.4 million in 1995 to US$5.1 million in 2006.

The prices for ARV regimens in Viet Nam are US$250–377 per person per year for first-line regimens and US$2,680–2,900 per person per year for second-line regimens.
Goal and Objectives of the National Strategy on HIV/AIDS

The goal of the national strategy is to maintain or reduce the current rate of 0.3 percent HIV prevalence among the total population; and to reduce the adverse impacts of HIV and AIDS on socioeconomic development.

The strategy’s objectives include the following:

- To ensure that 100 percent of administrative units across the country incorporate HIV and AIDS prevention and control activities as a priority in their socioeconomic program
- To improve knowledge about HIV transmission
- To control HIV transmission from spreading from most-at-risk groups to the rest of the population through implementing comprehensive, harm-reduction intervention measures; all people exhibiting behavior that puts them at risk of contracting HIV shall be covered by intervention measures
- To ensure the provision of care and appropriate treatment for HIV-positive people: 90 percent of HIV-positive adults, 100 percent of HIV-positive women, and 100 percent of HIV-positive or affected children shall be provided with appropriate treatment, care, and counseling; and 70 percent of AIDS patients shall be treated with ARVs

Results of Care and Treatment

Care and treatment services have been expanded. As of the end of the third quarter in 2007, more than 43,400 HIV-positive people have access to care and treatment services. Access to ARVs has increased from 50 patients in 2000 to 15,000 patients in 2007.

Care and Treatment Targets for 2010

- 90 percent of HIV-positive people have access to palliative care services
- 70 percent of adults have access to treatment
- 100 percent of infected and affected children have access to care and treatment services
- By law, 100 percent of children receive free formula
- 100 percent of HIV-positive pregnant women receive care and treatment

Major sources providing care and treatment in Viet Nam

- Government of Viet Nam
- Global Fund to Fight AIDS, Tuberculosis and Malaria
- President’s Emergency Plan for AIDS Relief (PEPFAR)
- Esther
- Clinton Foundation HIV/AIDS Initiative

Programming gaps

- Inadequate geographic coverage
- Information, education, and communication (IEC) campaigns do not reach all populations at risk of HIV
- Care and treatment services only available in 12.5 percent of districts (84/671 districts).
- VCT only available in 75 percent of provinces (48/64) and 21.3 percent of districts (143/671)
- Prevention of mother-to-child transmission interventions only focused on six PEPFAR focus provinces
- Limited coordination:
  - Lack of a national strategy for the coordination of resources to respond to the epidemic.
  - Lack of a national strategy for training (all areas)
Weak capacity at all levels for management, implementation, coordination, and monitoring and evaluation
Limited human resources at all levels, with high turnover

To deal with the limitations and challenges, the MOH proposes these priority programs:
- Focus IEC campaigns on populations at risk of HIV
- Expand geographic coverage and increase access to treatment by HIV-positive people in need of ART
- Focus harm-reduction interventions on populations at risk, including condom distribution, sterilization and needle exchange, and so on
- Establish a national standard system for data collection and reporting on HIV and AIDS.
- Devise a national strategy for building capacity through training

Lessons Learned

- Identify needs to close the programming gaps for care and treatment
- Develop specific objectives and a strategic plan to solve these gaps
- Collaborate with other donors to obtain their technical and financial support
- Locate the budget for care and treatment in the national program
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49 Ibid.
50 Ibid.
51 Some still receive ART through NGOs like MSF, the Thai Red Cross, and HIV-Netherlands Australia Thailand Research Collaboration (HIV-NAT), and PLWHA support groups.
52 Revenga, A., et al., The Economics of Effective AIDS Treatment.
53 Interview with Dr. Somsit, Deputy Director of Bamras. November 5, 2007.
54 Ibid.
55 Other OIs, such as TB, are funded through a vertical TB program. Source: Interview with Dr. Somsit, Deputy Director of Bamras. November 5, 2007.
56 Ibid.
57 Interview with Dr. Sorakij, Manager, AIDS Management Fund, NHSO, January 11, 2008.
58 Ibid.
59 Interview with Dr. Somsit, Deputy Director of Bamras. November 5, 2007.
60 Ibid.
61 Ibid.
63 Ibid.
65 Ibid.
66 Ibid.
67 Ibid.
68 Ibid.
69 Interview with Dr. Somsit.
70 Revenga, A., et al., The Economics of Effective AIDS Treatment.
71 Ibid.
72 Ibid.
73 Revenga, A., et al., The Economics of Effective AIDS Treatment.
74 Ibid.
75 UNAIDS. 2008. Redefining AIDS in Asia: Crafting an Effective Response.
77 Ibid.