MANAGING A HEALTH PROJECT:
HIV/AIDS IN THAILAND

November 1, 2010

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Presentation Overview

- Case Introduction - Magan
- Project Design - Eric
- Environment and Culture - Janelle
- Health Program Competencies - Lisa
- Health Program Evaluation - Suzanne
- Conclusion - Janelle
Background

- Thailand’s Extensive National efforts
  - First reported case in 1984
  - Condom Promotion, 1991
  - National Committee, 1997
  - Greatest social and medical problem
Precursors

- ~ 33,413 AIDS cases in Thailand (1996)
  - ~ 16,707 cases in upper Northern Thailand

- Negative impacts
  - Family, economy, discrimination

- Urgent agenda for the government
Key Stakeholders

- Thai Team – headed by Dr. Phannee
- PHA groups and NGOs
- Project Advisory Board
- Japanese Team
- Doctors and Specialists
- Community
- HIV/AIDS patients
- Government
Project for Model Development of Comprehensive HIV/AIDS Prevention and Care

- Project Length – 1998 through 2003
- Purpose – to develop a model to cope with HIV/AIDS at the local level
- Core counterpart –
  Phayao Provincial Health Office
Project Design
Project Development

- Collaborative effort
  - The Japan International Cooperation Agency (JICA)
  - The Thai Ministry of Public Health (MOPH)

- Super Goal
  - Reduction of HIV/AIDS
  - Focus on quality of life, prevention and treatment

- Overall Goal
  - Model development
  - Potential for scaling up
Stakeholder engagement:
- Dr. Phannee, Director of Phayao Provincial Health Office
- Japanese experts stationed in Phayao from JICA
- Major topic of discussions
  - Conflicting views on interventions
  - Proposal of new intervention
Original Project Design

- Primary view of interventions
  - Retain original design model with focus on:
    - Establishing and standardizing medical service packages
    - Technical improvement of prevention and care
  - Japanese team supported this view
    - Lack of access to quality care in Phayao
    - Feared that suspending other activities to focus on manpower would cause a wider spread of infection
Addition to Original Project Design

- Secondary view of interventions
  - Add another intervention
    - Focus on developing health manpower
    - Included conducting training courses
  - Purposes of adding this intervention
    - Change perspective of health staff
    - Health staff “do not dare…”

- Dr. Phannee wanted top priority for manpower development
Final Project Design

- JICA Headquarters had to choose
  - Japanese vs. Thai views

- Project additions
  - Health manpower development intervention
  - Suspended standardizing of care and network development

- Japanese team adopted another intervention
  - Participatory course

- Focus on processes, not outcomes
  - Decision based on complexity of HIV/AIDS
Environment and Culture
Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals and enable the system, agency, or professionals to work effectively in cross-cultural situations” (NASW, 2000b, p. 61)
Country Statistics

- Thailand
  - Population 65 million

- Japan
  - Population 126.5 million
Phayao Province

- Population 517,700
- 9 Districts
  - 68 Sub-districts
  - 632 Villages
Historical Impact

- WWII Japan invaded Thailand
- Allied to regain Territories
  - Kept Anti-Japanese resistance
- Emerged allies of the United States
- Bred mistrust
Society Structure

- Eastern community focus
- Hierarchical
- Thailand King
Discrimination

- Religion
- Good versus Bad HIV/AIDS
- Homosexuality
- Private culture
The Past Efforts

- Japanese taught AIDS as a human rights issue
- Thailand had previous medical interventions which failed
Health Program Competencies
Capacity Building: Common Goals

- Thai
  - Local health provider development

- Japanese
  - Community facilitator training; PHA engagement

- Both clinical and behavioral objectives represented
Improving Quality of Life for People Living with HIV/AIDS

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Education &amp; Outreach</th>
<th>Disease Management &amp; Treatment</th>
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<tbody>
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<td>Patient population benefit</td>
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<td>Timeliness</td>
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<td>Cost/economics of model</td>
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<td>Ethics/equity</td>
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<tr>
<td>Patient compliance</td>
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<tr>
<td>Preventing spread of HIV/AIDS</td>
<td>8</td>
<td>3</td>
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<tr>
<td>Community capacity impact</td>
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<td><strong>Total</strong></td>
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Adapted from John Hopkins University Public Health Model. Scale of 1-10.
Monks’ Mission: AIDS Education
Benefits of Capacity Building in Health Program Planning

- Self-efficacy emerges
- Burdens are shared
- Economies of scale are realized
- Transformative changes result
- Sustainability is achievable
Capacity Supports Intervention

Outcomes

- Japanese team expected
  - Effectiveness and efficiency
- Thai team desired
  - Relevance and sustainability
- Self-efficacy influential component in capacity-driven outcomes
Self-Efficacy’s Role in Capacity Building

- Beliefs formed through cognitive, motivational, affective, selective processes
- Drives specific actions or behaviors
- Encourages accountability
- Necessary to grow and sustain capacity
Albert Bandura’s Social Cognitive Theory (SCT)

- Learning theory
- Focused on thought, motivation, human action
- Self-efficacy
  - One component of SCT
Albert Bandura, PhD
Goal Attainment

- Perceived self-efficacy... is a better predictor of performance than skills alone.”

-- Albert Bandura, 1997
Bandura: Influences on Self-Efficacy

- Enactive mastery experiences
- Vicarious experiences
- Verbal persuasion
- Physiological and affective states
Cross-Sectorial Capacity Building

- All can be affected by efficacy loop
  - Provider Level
  - Patient Level
  - Healthcare Systems Level
  - Community Level
Developing Capacity to Treat AIDS through Provider Self-Efficacy

- Confront and allay provider’s fears
- Increase knowledge of disease management
- Build skills to coach patients in behavioral change
- Create support networks and learning loops
- Become advocate for patients, families, providers
Nurse caring for AIDS patient in Thailand
Developing Capacity to Manage AIDS through *Patient Self-Efficacy*

- Acknowledge patient’s fears
- Give patient a “safe place”
- Increase health literacy
- Involve family in care
- Foster peer and community support
- Put patient in control of his/her disease
Developing Capacity to Control AIDS through *Health Systems Efficacy*

- Determine adequacy of current capabilities and facilities
- Assess staff competencies; apply training interventions
- Evaluate effects on other disease models
- Keep eye on bottom line
- Promote wellness, cultural competence, self-efficacy in staff, provider, patient
Developing Capacity to Accept AIDS through Community Collective Efficacy

- Do outreach and education
- Recruit champions, publicize successes
- Put human face to disease
- Engage supporters, opponents in dialog
- Provide support networks, service safety nets
- Pay attention to cost-benefit aspects
“The combined influence of a community's commitment, resources and skills that can be deployed to build on community strengths and address community problems and opportunities.”

--The Aspen Institute
Return on Investment

- "Investment in AIDS will be repaid a thousand-fold in lives saved and communities held together."
  -- Dr. Peter Piot, Executive Director, UNAIDS
Health Program Evaluation
Program Evaluation

- Thai Perspective
  - Program was a success
  - Decentralizing health system
  - Local districts given responsibility and authority over health services
  - HIV/AIDS and other health issues addressed at local level
Japanese Perspective

Dr. Hayashi and Group

- Should have focused on care and prevention of HIV/AIDS

Dr. Ishi and Group

- Initial statistics showed program was a success
Program Evaluation (cont.)

- Definition of Success
  - 2,000 health practitioners in Phayao
  - 363 completed training
  - 12 training courses provided
    - 30 people per training class
Program Evaluation (cont.)

  - Drop from 5.3% to 2.3%
  - National average: 1.7%
Conclusion
Lessons Learned

- Consider cultural competence issues in International collaborations
- Stakeholder congruence outcome measures
- Build consensus for change
- Understand the magnitude of the intervention
- Evaluation fidelity
## Impact

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<th>Year</th>
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<th>LPN</th>
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<th>PR</th>
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<th>PY</th>
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<td>474</td>
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Decline in number of new cases.

(CM- Chiang Mai, LPN-Lampun, LP-Lampang, PR –Prea, NN-Nan, PY-Phayao, CR –Chiangrai, MHS- Meahongson, YST-Yasoton)