Progress Report 2006:

Regional HIV/AIDS *Treatment Acceleration Project (TAP)*

in Burkina Faso, Ghana and Mozambique

Compiled February 2007

"The primary goal of the Treatment Acceleration Project (TAP) is to pilot strategies for strengthening each country's capacity to scale up comprehensive programs providing care and treatment, which is effective, affordable, and equitable."

- from World Bank Report No. 29049-AFR, May 2004, p. 7.

World Health Organization

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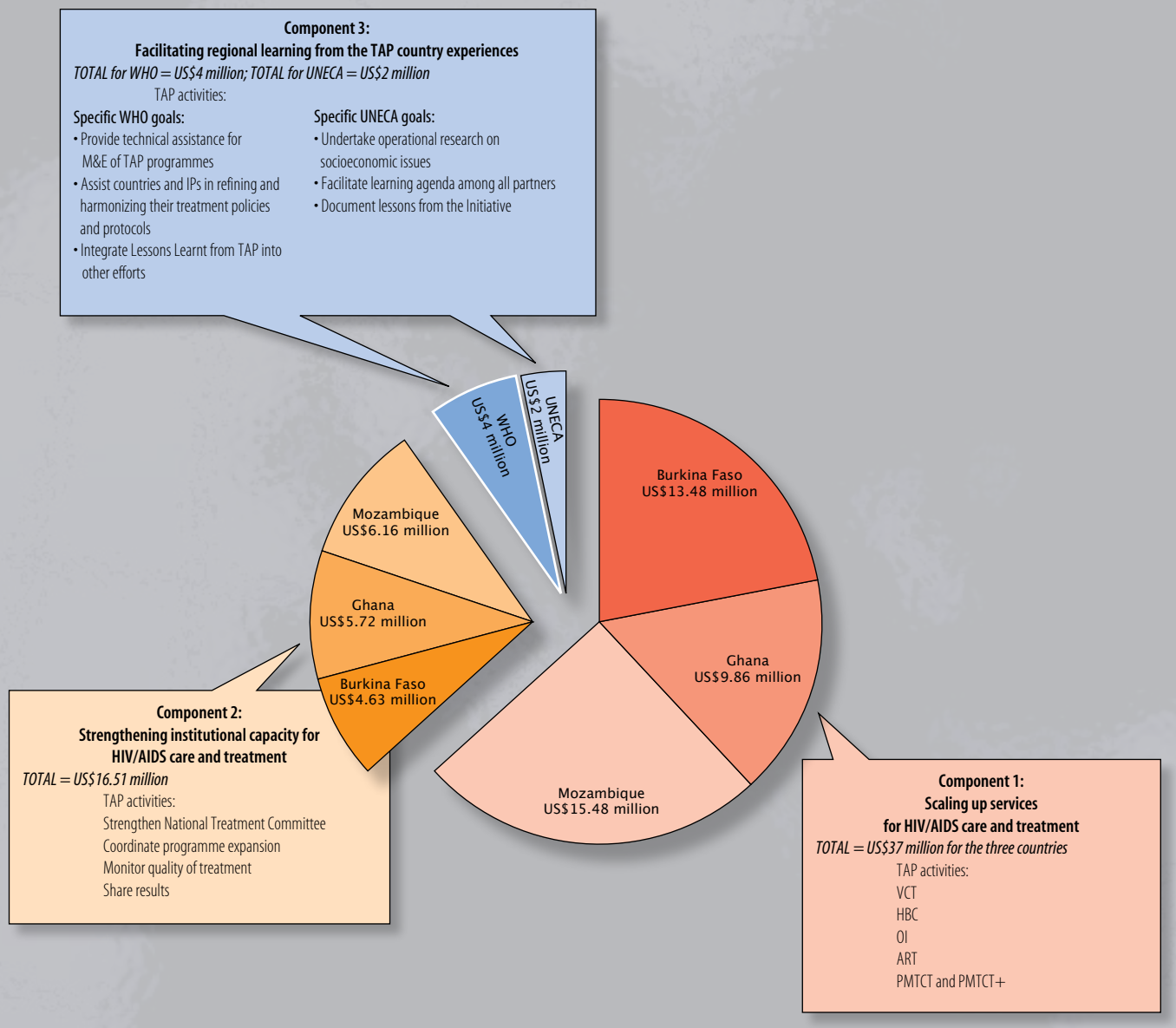
Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral Medication
AU	African Union
CD4	The immune system T-cell which is destroyed by the HIV virus
CSO	Civil Society Organization
DRM	Drug Resistance Monitoring
ECA	Economic Commission for Africa
ETSDS	Expenditure Tracking and Service Delivery Survey
EWI	Early Warning Indicators
FHI	Family Health International
HAART	Highly Active Anti-Retroviral Therapy
HAI	Health Alliance International
HBC	Home-based care
HIV	Human Immunodeficiency Virus
INE	National Institute of Statistics
IP	Implementing Partners of HIV/AIDS Treatment Components
MTCT	Prevention of Mother to Child Transmission
MAP	Multi-country AIDS Program
M&E	Monitoring and Evaluation
NACP	National AIDS Control Program
NCHS	National Catholic Health Service
NEPAD	The New Partnership for Africa's Development
NGO	Non-Governmental Organization
OI	Opportunistic Infection
OPEC	Organization of the Petroleum Exporting Countries
PEF	Private Enterprises Foundation
PETS	Public Expenditure Tracking System
PLWHA	Person Living with HIV/AIDS (both infected and affected)
PMTCT	Prevention of Mother to Child Transmission
PPPs	Public-Private Partnerships
PTS	Patient Tracking System
RAP	Regional Multi-disciplinary Advisory Panel for the TAP
RCCC	Regional Clinical Coordination sub-Committee
TA	Technical assistance
TAP	Treatment Acceleration Programme
TB	Tuberculosis
UNAIDS	United Nations AIDS Program
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
VCT	Voluntary Counseling and Testing for HIV infections
WHO	World Health Organization

Background

The Initiative was designed around the three components described below:



TAP: progress to date

WHO, together with the World Bank and UNECA through its Regional Advisory Panels (RAPs), advises countries on strategies for effective management and monitoring of country and regional progress in prevention, care and treatment towards universal access by 2010.
In addition to supporting countries, in the implementation phase, WHO made technical contributions through various RAP meetings:

1st RAP meeting: Addis Ababa, Ethiopia

- Finalization of terms of reference of RAP and RCCC
- Methodology developed for sharing lessons learnt among countries

2d RAP meeting: Addis Ababa, Ethiopia

- Framework for Monitoring and evaluation of Initiative indicators for evaluation of three components
- Country reporting format developed

3d RAP meeting in Maputo, Mozambique

- Meeting of first Regional Clinical Coordination sub-Committee (RCCC) RCCCs benefit from WHO/AFRO and WHO/HQ expertise in patient tracking systems, drug resistance and adherences issues
- Field visit review feedback with recommendation for Mozambique MoH to consider

4th RAP meeting in Accra, Ghana

- RCC integrated session on TB/HIV and Strategic orientation from WHO on care and support of tuberculosis patients
- Agreement on extension of implementation
- Improved disbursement
- Revised programme objectives based on lessons learnt from the Initiative

Conclusions and recommendations

The implementation of WHO's technical assistance component of the TAP has been slow and difficult, owing largely to complex and stringent conditions accompanying World Bank disbursement of funds. The agreement had been that World Bank disbursement to WHO would be based on a pre-funding principle, namely, that of refunding of real disbursement undertaken and justified by WHO, through a formal request. As a result of this agreement, countries have been forced to rely on WHO/AFRO to fund activities, staff and documentation of the Initiative. The compiled totals of unliquidated funds for the three countries, as seen in the financial statement as 30 November 2007, highlight the impact of the funding delay on the availability of funds for implementation.

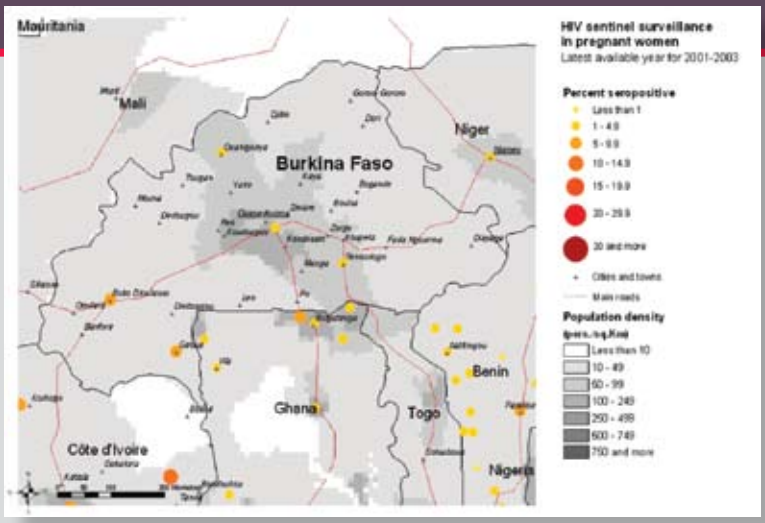
WHO's programmatic and financing structures do not easily accommodate its pre-funding of TAP activities; such pre-funding has required the re-apportioning of monies previously intended for other programmes, to the detriment of both the TAP and the other affected programmes. We recommend strongly that this critical issue be considered by the Bank and, as an alternative to the present approach to funding, that the annual submission of approved workplans by countries be agreed as the basis for disbursement of funds by the Bank.

Successful completion of the TAP requires its integration within the universal access goal and for its linkage with the overall prevention strategy in Africa. The proposed next phase in 2007 - 2008, on evidence-based documentation of good practices, should provide valuable insights into the benefits, risks and management modalities for anti-retroviral treatment.

Country profiles Burkina Faso, Ghana, Mozambique

Burkina Faso

ART target declared by country: 20, 000 by the end of 2005: 20,000



Source: WHO/UNAIDS Epidemiological Fact Sheets and US Census Bureau
Map production: Public Health Mapping & GIS, WHO/CDS

Situation analysis

Burkina Faso is one of the most severely affected countries in Africa, with a generalized epidemic. The first case of HIV/AIDS was reported in 1986. As of mid-2005, according to UNAIDS and WHO data, an estimated 150 000 adults (15-49) and children (0-14) are living with HIV/AIDS in Burkina Faso. Based on UNAIDS estimates, HIV prevalence among adults (15-49 years old) is 2%. Rates of infection for women and men are approximately equal. HIV-related deaths totaled approximately 12 000 as of mid-2005. New HIV infections among adults and infants (0-49) total 25 000.

Demographic and socioeconomic data

	Date	*Estimate*	*Source*
Total population (millions)	2004	13.4	United Nations
Population in urban areas (%)	2003	17.6	United Nations
Life expectancy at birth (years)	2002	41.7	WHO
Gross domestic product per capita (US$)	2002	259	IMF
Government budget spent on health care (%)	2002	9.2	WHO
Per capita expenditure on health (US$)	2002	13	WHO
Human Development Index	2002	0.302	UNDP

Progress to date of WHO support

Objectives	Achievements	Next steps
1. To support planning and development of action plans	• Situation analysis was undertaken for quality control of VCT • Based on this analysis, quality control recommendations were made • All TAP components have been taken into account in districts plans	• Assessment of strategies and activities of VCT put in place • Support to reference and accreditation for VCT and Care and treatment • Validation of guideline on infants feeding in HIV/AIDS setting
2. To support the strengthening of national capacities	• A draft national roll-out plan for training was developed with participation of all partners • Adaptation of training modules for care and support: country adaptation of IMAI • Reference procedures agreed upon and put in place • Training of patient trainers and physicians	• Assistance in all training plan for health services providers at all • Support on the revision of tools in training in care and support and M&E
3. To support the strengthening of the M&E national system	• Situation analysis on services, infrastructures and associations involved in PMTCT • Collect of baseline data undertaken for TAP programme • Indicators revised and agreed (CDV, PTME, Care and Support, etc) • Tools for collect of data hare available • Elaboration of Drug resistance Plan • Joint mission undertaken for M&E	• Support the working group on drug resistance protocol , training and the implementation of the plan • Support the implementation of software for tracking patients on ART
4. To support the strengthening of management and follow-up of the programme	• Recruitment of staff (M&E officer, driver and secretary) • Situation analysis on existing capacity (infrastructures, equipment) for care and treatment sites involved in the TAP Initiative • In collaboration with partners, develop an operational plan for WHO technical assistance • Technical support provided by regional office and HQ in procurement, surveillance for resistance, and monitoring and evaluation for care and treatment	• On-going support to MoH is operational
5. To facilitate regional learning from TAP experience	• Compile update on progress made • Participation to RAP in Addis • Organize regular and systematic meeting every month with partners to share progress made and constraints • Assist in development of protocols for operational research in care and support practices for HIV/AIDS	• Support Behavior Surveillance Survey on HIV/AIDS • Support operational on-going research activities such as use of surveillance protocols • Agree with WB on documentation of the learning agenda

Financial information

Year 1 (USD)			Year 2 (USD)		
Requested	Expended	Percent completion	Requested	Expended	Percent completion
534 434	117 878	22%	539 975	215 357	40%

Year 1
Rate of implementation: 22%

Year 2
Rate of implementation: 40%

Overall year 1 + 2 (USD)		
Requested	Expended	Percent completion
1 074 409	333 235	31%

Overall rate of implementation: 31%

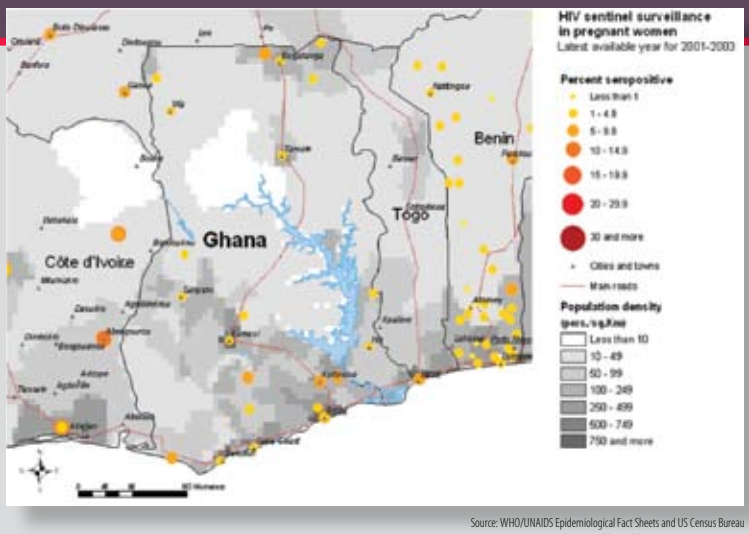
Measurement of outcomes at country level: Indicators in TAP key areas				
		Baseline at end 2004	Results reached at end 2005	TAP contribution
VCT	Number of Health District with at least 1 VCT centre	22	31	19 (61%)
	Total number of VCT centres	56	93	43 (46%)
	Number of people tested - Proportion of women: - Number of young people below 25		19,0263 68%	81,813 (43%)
PMTCT	Proportion of districts with at least 1 PMTCT centre	14	37	21 (57%)
	Total number of PMTCT centres	63	152	125 (82%)
	Number of women seen and tested during antenatal care		25,023	20,518
	- Number of mother-children under PMTCT treatment - Number of mothers under ARV		856	156
ARV treatment	Number of health districts with at least one ARV centre	11	28	21 (75%)
	Number of structures providing treatment and care		46	32
	Total number of PLWAs under ARV - Proportion of women	3,867	8,136 (in 2005)	2,520 (19%)
	Number of people benefiting from prophylaxis/OI treatment - Proportion of women - Number of young people under 25		20,677	3,151
	Number of people receiving home care - Proportion of women - Number of young people under 25		8,189	8,189
	Number of operational research activities undergoing		2(2006)	1 (2006)

Challenges and opportunities

The involvement of NGOs in the Care and Support programme has significantly increased the number of people under ARV. The proportion of women under ARV represents 60% in AIDSETI and CICDOC has had a rate of implementation equivalent to 130% more that the number of patients planned by the NGO. The nutritional and psychological support provided to PLWHA has been shown as an effective strategy for supporting the adherence rate. The streamlining of mechanisms used for patient tracking in various centres needs to be done systematically and throughout the country. Computerization of data collection has been suggested as a possible sustainable solution. The link between TB and HIV should have been considered at the planning stage of the Initiative.

Ghana

ART target declared by country: 20, 000 by the end of 2005: 30,000



Source: WHO/UNAIDS Epidemiological Fact Sheets and US Census Bureau
Map production: Public Health Mapping & GIS, WHO/CDS

Situation analysis

Current surveys in Ghana show a prevalence of HIV infection among adults 3.1% in 2004. WHO/UNAIDS estimated that the prevalence was between 1.9% and 5.0% in 2003. The prevalence is highest in the Eastern Region and lowest in the Northern Region. Rates are generally higher in densely populated areas, especially in regional capitals, such as Kumasi, Koforidua and Accra. The female-male ratio was 6:1 in 1987 and an estimated 2:1 in 2001. The epidemic is primarily spread through heterosexual transmission, which accounts for up to 80% of infections.

Demographic and socioeconomic data			
	Date	*Estimate*	*Source*
Total population (millions)	2004	21.0	Ghana Statistical Service
Population in urban areas (%)	2004	45.0	Ghana Statistical Service
Life expectancy at birth (years)	2004	57.6	Ghana Statistical Service
Gross domestic product per capita (US$)	2004	450	MOFEP Budget statement & economic policy
Government budget spent on health care (%)	2004	13.5	MoH
Per capita expenditure on health (US$)	2002	17	WHO
Human Development Index	2002	0.568	UNDP

Progress to date of WHO support		
Objectives	**Achievements**	**Next steps**
1. To assist Ghana to scale-up comprehensive treatment programs for persons living with HIV/AIDS.	• Assessment of all 4 TAP sites completed and accreditation completed • Doctors pharmacists, dispensary and nurse from TAP sites trained in ART, adherence counseling • Complete agreement between IP and TAP site • NCHS- All sites have started ART • FHI- All 4 FHI have started ART • PEF- agreement as IP duly signed • ART Scale-Up plan was launched in September 2006	• Continue patient recruitment for HIV services • Intensification of monitoring and supervision visits to all ART sites of IP by NACP and WHO technical officers
2. To strengthen the institutional capacity for HIV/AIDS care and treatment	• 21 health workers (4 teams per TAP site) trained in ART and adherence Counseling Training • Training of laboratory personnel in all sites on use of FACSCount (CD4) machines and other laboratory procedures • Training of trainers in PMTCT	• Adaptation of IMAI and PMTCT training modules at district level • Building capacity at all sites to support scale up programme • TB/HIV policy guidelines ready for printing
3. To facilitating regional learning from the TAP country experiences.	• Compilation of TAP activities in progress report • Participate in next RAP meetings • Organize regular and systematic meeting every months with partners	• On-going documentation on lessons learnt • Modalities and protocols have been finalized for TAP household Survey and pilot recruitment of survey interviewees is in progress • promote greater public and private partnership

Financial information

Year 1 (USD)			Year 2 (USD)		
Requested	Expended	Percent completion	Requested	Expended	Percent completion
603 500	99 736	17%	470 912	117 642	25%

Year 1
Rate of implementation: 20%

Year 2
Rate of implementation: 25%

Overall year 1 + 2 (USD)		
Requested	Expended	Percent completion
1 074 412	217 378	20%

Overall rate of implementation: 31%

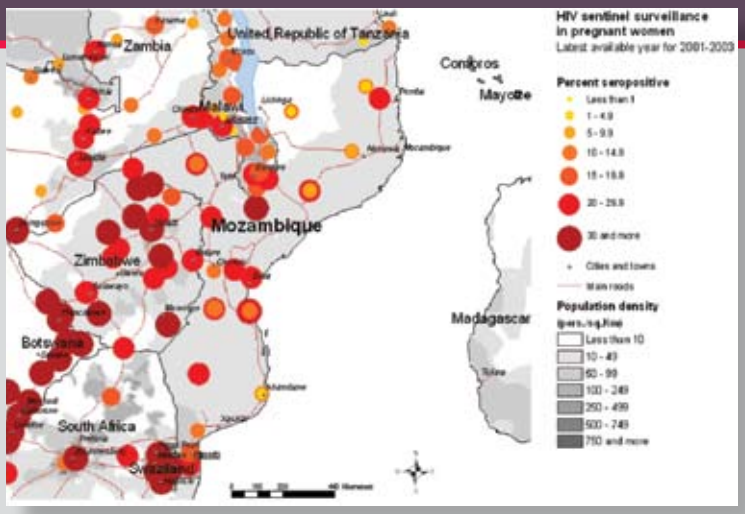
Measurement of outcomes at country level: Indicators in TAP key areas				
		Baseline at end 2004	Results reached at end 2005	TAP contribution
VCT	Number of Health Districts with at least 1 VCT centre	40	82	N/A
	Total number of VCT centres	59	145	N/A
	Number of people tested - Proportion of women: - Number of young people below 25	15,490	45,536	N/A
PMTCT	Proportion of districts with at least 1 PMTCT centre	52	82	N/A
	Total number of PMTCT centres	52	138	N/A
	Number of women seen and tested during antenatal care	8,490	20,296	N/A
	- Number of mother-children under PMTCT treatment - Number of mothers under ARV	493	1,078	N/A
ARV treatment	Number of health districts with at least one ARV centre	3	4	N/A
	Number of structures providing treatment and care	4	5	N/A
	Total number of PLWAs under ARV - Proportion of women	2,028	4,060	N/A
	Number of people benefiting from prophylaxis/OI treatment* - Proportion of women - Number of young people under 25	4,054 2,360 N/A	9,396 5,938 N/A	N/A N/A N/A
	Number of people receiving home care -Proportion of women - Number of young people under 25	N/A	N/A	
	Number of operational research activities undergoing	N/A	N/A	

Challenges and opportunities

The slow implementation of the TAP in Ghana owes to the presence of multiple stakeholders. Even though the principle of public private partnerships is actively promoted, obstacles remain in working with private sector facilities, including the assessing of user fees and the limited trained human resources. The public sector is hampered by slow procurement of drugs and logistics, and a lack of incentives for collaboration with other public health institutions. The cost of care is a barrier to patient enrollment.

Mozambique

ART target declared by country: 20, 000 by the end of 2005: 29,000



Source: WHO/UNAIDS Epidemiological Fact Sheets and US Census Bureau
Map production: Public Health Mapping & GIS, WHO/CDS

Situation analysis

Mozambique faces a serious and expanding HIV epidemic, with an adult prevalence of 16.2% in 2004 and an estimated 500 people becoming infected every day. According to the Ministry of Health, 1.4 million people were estimated to be living with HIV/AIDS in 2004. The epidemic is fuelled by structural factors such as poverty, gender inequality, cultural conditions and high levels of labour mobility. An estimated 57% of all adults affected are women. Among women 15–24 years old attending antenatal clinics in 2002, 15% in Maputo City and 12% at other sites were HIV positive. The national prevalence of HIV infection masks considerable regional differences, with estimated adult prevalence rates of 18.1% in the south, 10.4% in the centre and 9.3% in the north in 2004.

Demographic and socioeconomic data			
	Date	*Estimate*	*Source*
Total population (millions)	2004	13.4	United Nations
Population in urban areas (%)	2003	17.6	United Nations
Life expectancy at birth (years)	2002	41.7	WHO
Gross domestic product per capita (US$)	2002	259	IMF
Government budget spent on health care (%)	2002	9.2	WHO
Per capita expenditure on health (US$)	2002	13	WHO
Human Development Index	2002	0.302	UNDP

Progress to date of WHO support		
Objectives	**Achievements**	**Next steps**
1. Scaling up care and treatment programmes focusing on VCT, home-based care, prevention, OIs, ARV and PMTCT	• Support accreditation process by defining criteria and assessing needs of treatment centers • Revision of guidelines of ART, OIs, PMTCT, VCT , drug resistance, nutrition and infant feeding options.	• Staff training and improved quality services
2. Strengthening Institutional capacity	• Technical assistance plan has been finalized and made available to partners • Rapid assessment of factors affecting treatment adherence • Terms of reference has put prepared for TAP coordinator and a short list is available • National training plan for care and treatment with ART as well as adherence counseling	
3. Facilitate regional learning from TAP experience	• Document progress made and constraints • Preparation of 6 months reports on achievements	

Financial information

Year 1 (USD)			Year 2 (USD)		
Requested	Expended	Percent completion	Requested	Expended	Percent completion
551 952	47642	9%	522 459	275 879	40%

Year 1
Rate of implementation: 22%

Year 2
Rate of implementation: 40%

Overall year 1 + 2 (USD)		
Requested	Expended	Percent completion
1 074 411	323 521	30%

Overall rate of implementation: 31%

Measurement of outcomes at country level: Indicators in TAP key areas				
		Baseline at end 2004	Results reached at end 2005	TAP contribution
VCT	Number of Health District with at least 1 VCT centre	N/A	67	
	Total number of VCT centres	113	223	
	Number of people tested - Proportion of women: - Number of young people below 25	294,567 67% 118,324	685,239 61% 305,749	
PMTCT	Proportion of districts with at least 1 PMTCT centre	N/A	N/A	
	Total number of PMTCT centres	51	88	
	Number of women seen and tested during antenatal care	46,583	99,835	
	- Number of mother-children under PMTCT treatment - Number of mothers under ARV	3,182 (m) 3,335 (c) 197	7,690 (m) 5,437 (c) 554	
ARV treatment	Number of health districts with at least one ARV centre	17	30	
	Number of structures providing treatment and care	23	39	
	Total number of PLWAs under ARV - Proportion of women	6,500 N/A	19,754 54.7%	
	Number of people benefiting from prophylaxis/OI treatment - Proportion of women - Number of young people under 25	N/A	N/A	
	Number of people receiving home care - Proportion of women - Number of young people under 25	11,355 N/A	27,582 N/A	
	Number of operational research activities undergoing	N/A	9	

Challenges and opportunities

Strengthening of the programme management capacity at the provincial level remains a large challenge. Expansion of the geographical coverage of treatment sites in the north and centre is slow due to lack of infrastructure, limited human resources, laboratory equipment, and other problems. The MoH should support and encourage one national patient tracking system and strengthen M&E systems through data collection, analysis and interpretation. With involvement of NGOs, it would be possible to increase the number of ART patients without compromising quality.

Expenditures for 2006 as of 13 February 2007

Total of disbursement and unliquidated expenditures as 30 November 2006					
Items	Burkina Faso	Ghana	Mozambique	AFRO	
Operating costs					
	38,050.31	101,369.04	15,616.00	129,928.23	
	88,470.48	8,324.14		4,356.18	
	12,051.00	5,949.00		53,316.06	
	15,752.00	3,350.82		34,752.02	
		6,659.00		75,333.87	
		-8,010.00		53,098.20	
				29,618.00	
				-12,425.00	
Sub-total	154,323.79	117,642.00	15,616.00	367,977.56	
Consultants and training					
	6,000.00			26,235.75	
	4,598.50		260,263.00	26,337.64	
	1,465.79			18,682.00	
				1,940.00	
	15,248.76			1,800.00	
				21.33	
				5,999.94	
Sub-total	27,313.05			81,016.66	
Goods and equipment					
	33,720.00			2,619.68	
				15,009.67	
				56,621.53	
Sub-total	**33,720.00**			**74,250.88**	
Grand total	**215,356.84**	**117,642.00**	**275,879.00**	**523,245.10**	**1,132,122.94**

World Health Organization