

**UNITED NATIONS
ECONOMIC COMMISSION FOR AFRICA (ECA)**

FINAL REPORT

(January – December 2005)

PROJECT TITLE: Treatment Acceleration Programme (TAP)

PROJECT NUMBER: 7333

YEAR OF THE GRANT: 2004

STARTING DATE: July 14, 2004

ENDING DATE: September 2007

TOTAL BUDGET: SDR 1.4 million

Project funded with the Support of International Development Association (IDA)

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List of acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral Medication
CBO	Community Based Organization
CD4	The immune System T-cell which are destroyed by the HIV virus
CHGA	Commission on HIV/AIDS and Governance in Africa
DRI	District Response Initiative
ECA	Economic Commission for Africa
HIV	Human Immunodeficiency Virus
IDA	International Development Association
IP	Implementing Partners of HIV/AIDS Treatment Components
MTCT	Mother to Child Transmission
MAP	Multi-country AIDS Programme
M&E	Monitoring and Evaluation
NGO	Non-Governmental Organization
PLWHA	Person Living with HIV/AIDS (both infected and affected)
PMTCT	Prevention of Mother to Child Transmission
RAP	Regional Multi-disciplinary Advisory Panel for the TAP
RCCC	Regional Clinical Coordination sub-Committee
TAP	Treatment Acceleration Programme
TB	Tuberculosis
VCT	Voluntary Counseling and Testing for HIV infections
WHO	World Health Organization

I. Executive Summary

On July 14, 2004 the United Nations Economic Commission for Africa (UNECA) entered into a three-years agreement with the International Development Association (IDA). IDA agreed to provide the sum of SDR 1.4 million towards UNECA to facilitate the regional learning of non-clinical issues from the World Bank's Treatment Acceleration Programme (TAP). The TAP will pilot scaling up and decentralizing treatment for AIDS using innovative partnership with civil society and the private sector in three countries, Burkina Faso, Ghana and Mozambique. Thus far, the sum of SDR 607,684.00 (including 10% of programme support cost) has been received by the UNECA.

UNECA will aim of to fully exploit the regional learning potential from the TAP in order to strengthen each country's capacity to implement comprehensive treatment programmes. UNECA will deal with non-clinical aspects of scaling up treatment, including assessing the TAP partnership models between the public sector, civil society and the private sector.

The main vehicle for achieving this objective is the Regional Advisory Panel (RAP). The RAP consists of representatives from the government from each TAP country, the implementing partners, the World Bank, WHO and ECA as well as invited experts and other interested parties on a case-by-case basis. UNECA will host the secretariat for the RAP. The UNECA is in addition charged with the task of informing and consolidating the learning process of the RAP through conducting demand-driven operational research, including stand-alone studies that will inform the meetings and the further work of partners. Topics will include prevention-of-mother-to-child transmission, human capacity building, health systems, gender and equity in treatment.

II. Final Report

A. Summary of present status of project implementation with outputs produced

1. The Regional Multi-disciplinary Advisory Panel (RAP)

1.1. First RAP meeting

The First Meeting of the RAP was held November 30 – December 2, 2004. The meeting brought together partners from Burkina Faso, Ghana and Mozambique, WHO, the World Bank and ECA as well as independent experts and representatives from ITAC and UNICEF. The mandate of the RAP was clarified and the basis for cooperation and future work within the framework of the TAP was consolidated.

The meeting discussed:

- *Operational issues relating to the TAP:* the respective roles of UNECA, World Bank and WHO, the integration of TAP into existing in-country programmes, reporting mechanisms, the role and function of the Regional Clinical Coordination sub-Committee (RCCC) organized by WHO and the role and function of the RAP;
- *Clinical and drug management issues:* systems of prequalification, increased need for second line treatment, treatment for children and youth, generics and collective drug procurement;
- *Health system issues:* human resources, quality of services, decentralization and nutritional support;
- *Monitoring and evaluation:* harmonization of indicators, shortage of qualified staff, data analysis and WHO's integrated approach.

1.2. Second RAP meeting

The second Regional Advisory Panel (RAP) meeting was held in Addis Ababa, Ethiopia on December 12-13, 2005. Implementing Partners (IPs) and government officials from the Ministry of Health from Burkina Faso, Ghana and Mozambique participated in the meeting, as well as representatives from the World Bank, WHO and ECA. The meeting also benefited from the participation of experts from Botswana, Kenya and Malawi.

The meeting discussed:

- *State of implementation of the TAP in Burkina Faso, Ghana and Mozambique:* Each country made a presentation on the state of implementation in their respective country, results achieved so far, difficulties met and the future prospects.
- *Exchange of experiences on PMTCT:* This session provided an update on the progress made to date in the Prevention of Mother-to-Child-Transmission (PMTCT) in Burkina Faso, Ghana and Mozambique: State of implementation, Medical follow-up of pregnant women, Nutritional support of PMTCT programmes.
- *Learning Agenda and exchange of experiences on operational research:* This session aimed at discussing the role of operational research and multidisciplinary studies and following-up on activities that are currently taking place. The meeting also discussed operational research and studies designed to provide countries with effective tools and programme management systems for scaling-up HIV/AIDS treatment. This was an opportunity for the IPs to make suggestions on the type of research they would like the TAP Secretariat to undertake.
- *Challenges of governing the TAP and other issues:* This session gave the opportunity to all partners to raise any challenges they are facing to make the TAP a success, as well as any administrative and financial issues they may have. Moreover, ECA web masters presented a skeleton of the upcoming TAP website. Partners were able to comment on it and to advise on substantive information they would like to be included in the site.

2. RAP Secretariat

A Research Officer has been hired for the period of May 2005 to May 2006 (see TOR in Annex B). In the TOR the Research Officer is expected to produce written outputs and organize meetings and missions under the supervision of the Research Director. An Administrative Assistant (see TOR in Annex G) is in the process of being recruited (instead of a Programme Assistant).

3. Operational Research

Operational research will feed into the regional learning mechanism of the TAP and shape the evolution of the programme in order to maximize its potential for strengthening the treatment capacity of the three countries. Operational research

and its influence on the ongoing programme-development form a distinguishing characteristic of the TAP.

Over the next period three separate research projects will be completed: Baseline profiles of the three countries (see TOR in Annex C); a study of how the TAP contributes to meeting the broader treatment challenges of each country, (see TOR in Annex D), and a study of the state and challenges of mother-to-child prevention programmes (MTCT). The baseline profiles will be discussed in this section, the two other studies will be discussed in section IV: 'Results still to be achieved and timeframe for remaining output.

With a view to establish a solid evidence base for longitudinal comparison essential to operational research, monitoring and evaluation, various baseline profiles has been produced. The baseline studies profiles the capacity of implementing partners in the three countries, and facilitate inter-country operational research and inter-country learning in order to maximize the TAP experience.

4. Tripartite meeting

In order to form an agreement on the remit of the baseline studies and to consolidate a clear TAP regional learning agenda, a meeting was called by UNECA with the TAP Partners (World Bank, WHO, and UNECA), in Nairobi, Kenya on June 23-24, 2005 (see Mission Report in Annex E).

The meeting included the following:

- *Presentation by the UNECA:* Concrete suggestions for a TAP learning agenda, expression of research needs, dissemination of lessons;
- *Presentation by the WHO:* The status and mechanisms for monitoring and evaluation and the status of treatment roll-out in each of the three countries;
- *Presentation by the World Bank:* the roles of routine vs. non-routine monitoring and evaluation, research questions regarding treatment, pediatric ART and ART and TB treatment issues;
- *Presentation by the DEC (World Bank):* Identification of tools required to collect data, the integration of new data collection with already established routines for data collection, ethics such as confidentiality;
- *Discussion of the next step:* consolidation of the TAP learning agenda including the preparation of a document with specific research questions.

5. Joint Mission

In house operational research have been initiated through a joint mission with the World Bank to Burkina Faso from October 3-8, 2005 (see Mission Report in Annex F). Information gathered will consolidate the work on the baseline profiles and serve as reference material for research outputs. An additional purpose of the mission was to consult the Burkinabé government, research organizations active in Burkina Faso and implementing partners to secure that research is driven by demand. The following was achieved:

- Discussed the learning agenda under the TAP with the Burkinabé government and research organizations active in Burkina Faso (WB/DEC to take the lead);
- Agreed on a common view/joint plan for the implementation of the learning agenda;
- Reviewed implementation progress of national treatment programme, including TAP and MAP, in terms of number of persons under treatment, waiting lists, accomplishment and continued difficulties;
- Reviewed progress in partnership and coordination arrangements for treatment, including among Ministry and associations (accreditation, conventions between NGOs and hospitals), coordination among partners and various treatment, care and support programmes (including with WFP and nutrition programmes);
- Reviewed progress in integrating treatment related HIV/AIDS issues into the health system and health services, including tuberculosis, PMTCT;
- Assessed strengths and weaknesses of current procurement and logistic systems for medicines, laboratory supplies and HIV test kits;
- Review status of human resources, including with regarding to availability, training, and motivation of treatment personnel;
- Review of financing situation for ARVs and policies for cost recovery and exemption systems for the poor;
- Undertook in-depth technical review and support for the M&E system for treatment programme.

6. Other missions

In conjunction with the joint mission to Burkina Faso, a separate information-gathering mission went to Ghana October 8-11, 2005 to follow up on the progress of the implementation of the TAP (see Mission Report in Annex F). Progress was reviewed and information for operational research was gathered. Ghana has had a slower start than the other countries, but is currently catching up.

7. TAP website

The TAP website will be a crucial vehicle for regional learning, and as such forms an essential element of the TAP. It will serve the double purpose of disseminating information to the wider public and between partners. The website can only be fully operational once all the TAP countries are up and running, and preliminary research results and information have been produced. The baseline studies will be important building blocks for the substantive content of the website. Other website items will include information from countries, the World Bank, the WHO as well as results from ongoing research. In order to collate and prepare substantive information for the website, a short-term research consultant will be recruited. The RAP secretariat has currently constructed a dummy website in-house for review with partners. According to plan the website will be up and running by the end of February 2006.

B. Results still to be achieved and timeframe for remaining output

UNECA's work with regard to the TAP is largely demand-driven, and therefore responding in nature. It is as a result difficult to map an exact timeline for output, but crucial to ensure flexibility and efficiency in responding to sometimes quite urgent requests from countries. Moreover, because of the nature of demand-driven operational research, there will always be a time lag between programme implementation and the initiation of studies. Programmes need to be operating before research needs can be defined. Some programme experience must also be accumulated to form sufficient material for research. The demand-driven operational research of the TAP needs to track the evolution of the programme. Some of the countries had a slower start-up than others, which for these reasons hold consequences for the initiation of operational research. Also, because of this countries have yet to make any further request for UNECA research and some baseline studies have not yet been initiated.

Three research projects will be completed over the next period:

1. The baseline profiles of implementing partners have been completed and the final report has been submitted to UNECA (see above and TOR in Annex B).
2. Study of how the TAP contributes to meeting the broader treatment challenges of each country, (see TOR in Annex C): The TAP is not and should not be an isolated programme rigidly adhering to a global template and unfazed by the local context in which it is implemented. The TAP seeks to adapt to the socio-economic challenges and institutional arrangements peculiar to each of the three countries in

order to serve as a wedge in overcoming bottlenecks to scaling up treatment. The study will look at the broader treatment challenges that face each country, including assessments of health system capacity, socio-economic context, integration of TAP with other programmes, present and future ART demand and national policy environment, with a view to maximize how TAP can contribute to meeting the broader national treatment challenges.

3. Study of PMTCT in the three countries: PMTC remains a pertinent issue in sub-Saharan Africa. The risk of MTCT has dropped to as low as 2% among the limited number of HIV-infected women in developed countries. In developing nations, particularly Sub-Saharan African countries where the vast majority of HIV-infected women of childbearing age live, MTCT rates remain high. Such high rates persist mostly because of the lack of access to existing prevention interventions, including HIV voluntary counseling and testing (VCT), replacement feeding, selective caesarian section and antiretroviral drugs. The study will seek to assess the progress made to date in PMTCT in Burkina Faso, Ghana and Mozambique, and how lessons can be incorporated into the TAP. It will include discussions of the state of implementation, medical follow-up of pregnant women and nutritional support of PMTCT programmes.

C. Major challenges encountered during project implementation

Regrettably, the rules for procurement and the time frame for delivery have not been synergistic. This has caused some delays in initiating studies. The consequences of such delays are counter-productive to the rationale of the TAP regional learning process; the purpose of the regional learning process is to inform the *ongoing* development of the TAP based on lessons across the three countries at the different stages of programme implementation. In order to secure the optimization of the TAP learning process, the result of studies needs to be disseminated in a timely manner.

One way of overcoming these obstacles would be to revise the budget lines to enable resident consultants within the UNECA to conduct research. This would also serve the second purpose of building capacity at the UNECA.

Challenges encountered include:

- The rules of procurement have caused delays in initiating studies, with adverse consequences for the regional learning process of the TAP. This can be overcome by revising the budget lines to enable resident consultants within the UNECA to conduct research;

- Some participants were unable to attend the First Meeting of the RAP because of elections in their country and logistical problems;
- As expected, disbursements have been slow during this first period. This is explained by the nature of operational research.

**UNITED NATIONS
ECONOMIC COMMISSION FOR AFRICA (ECA)**

FINANCIAL NARRATIVE REPORT

(Bilateral)
(January – December 2005)

PROJECT TITLE: Treatment Acceleration Programme (TAP)

PROJECT NUMBER: 7333

YEAR OF THE GRANT: 2004

STARTING DATE: July 14, 2004

ENDING DATE: September 2007

TOTAL BUDGET: SDR 1.4 million

Project funded with the Support of IDA

I. Explanation of the major line items

1101 Research Officer: A Research Officer has been hired for the period of May 2005 to May 2006 (see TOR in Annex B). In the TOR the Research Officer is expected to produce written outputs and organize meetings and missions under the supervision of the Research Director.

1102 Programme Assistant: An Administrative Assistant is in the process of being recruited instead of a Programme Assistant. The process has been initiated (see TOR in Annex G).

1151 Short-term consultants: no short term consultants have yet been recruited.

1152 Inter country operational research support: the baseline studies of TAP Implementing Partners (IPs) have been contracted. The Burkina Faso and Mozambique baseline profile studies have been initiated. The Ghana one will follow shortly.

1501 Travel: On June 23-24, 2005 a tripartite meeting was held in Nairobi, Kenya. George Alibaruho, Nana Poku and Virginie Mongonou traveled for the meeting (see Mission Report in Annex E). On October 3, 2005 Virginie Mongonou traveled to Burkina Faso and Ghana to meet all the IPs and discuss the learning agenda (see Mission Report in Annex F).

2101 Sub-contracting (publishing, dissemination, etc): no publishing or dissemination has been conducted as of today.

2102 Web site construction: Web site constructed by UNECA web masters.

3401 TAP meeting: The First RAP Meeting of the TAP was held November 30-December 2. The Second RAP Meeting was held on December 12-13, 2005.

4701 Procurement supplies: A laptop to be purchased.

II. Request for additional grant disbursement (if any)

A budget for the coming period will shortly be presented. This will include the Third Meeting of the RAP and also travel to the three countries in excess of the current budget lines.

III. Other

Regrettably, the rules for procurement and the time frame for delivery have not been synergistic. This has caused some delays in initiating studies. The consequences of such delays are counter-productive to the rationale of the TAP regional learning process; the purpose of the regional learning process is to inform the *ongoing* development of the TAP based on lessons across the three countries at the different stages of programme implementation. In order to secure the optimization of the TAP learning process, the result of studies needs to be disseminated in a timely manner.

One way of overcoming this obstacle would be to revise the budget lines to enable resident consultants within the UNECA to conduct research. This would also serve the second purpose of building capacity at the UNECA.



Terms of Reference Research Officer

Context of Post

In partnership with the Economic Commission for Africa and the World Health Organization, the World Bank Board has formally approved US\$60 million in Development Assistant Grant to support programmes in Burkina Faso, Ghana and Mozambique; aimed at scaling up treatment and care for PLWHA. The Treatment Acceleration Programme (TAP) is conceived as a programme to assess the scalability of decentralized, cost-effective equitable treatment in three countries, which have small-scale treatment activities, supported by NGOs and/or by a public/civil partnership. It has three components: (i) country specific HIV/AIDS and MTCT-plus treatment activates; (ii) cross country learning via intensive monitoring and evaluation and the fostering of a community of practice; and (iii) to influence next generation programmes in decentralizing access to complex medication through public/private partnerships.

Through CHGA, ECA will support the work of TAP through a small secretariat. Senior management of CHGA will offer guidance and support to the TAP Secretariat, and the Research Director of the Commission will oversee the day-to-day administration of the secretariat. The TAP Coordinating Unit will serve as the secretariat for the Regional Advisory Panel (RAP) and will have the overall responsibility for coordinating the Recipient's activities under the Project, including: (i) liaising with the Association and WHO on the implementation and policy related aspects of the Programme; (ii) coordinating the financial management, audit and accounting for the Project; (iii) receiving and reviewing Programme implementation reports from each Participating Country and dissemination of quarterly reports based thereon for the benefit of all Participating Countries and RAP; (iv) commissioning and managing the carrying out of research and studies; and (v) convening and hosting RAP and RCCC meetings, and disseminating outcomes of RAP and RCCC meetings to Participating Countries, WHO and the Association.

I. Duties and Responsibilities

Under the overall supervision of the Research Director of CHGA, the incumbent will help coordinate the research planning and execution of the research projects of the Treatment Acceleration Programme including administrative support. The following are the main duties and responsibilities:

- Must be able to write detailed, scholarly, analytical papers based on primary data from operational research.
- Prime researcher for TAP work of CHGA, taking stock and adding value to the existing literature and ongoing work in the core countries of study.
- Identifying and producing reports on the state of TAP activities for the meeting of the Regional Advisory Panel.
- Provide support for research coordination and evaluation of the Treatment Acceleration Programme (TAP).
- Preparation of various written outputs relating to the TAP initiative.
- Participate in field missions, including provision of administrative support, data collections.
- Over see the planning and organization of TAP Technical Committee meetings.
- Perform other duties as required by the Research Director.

II. Education

Advanced University degree (Masters Degree or equivalent) preferably in Development Studies or related field

III. Work Experience

Work experience on the dynamics of the HIV/AIDS pandemic, preferably on African societies.

IV. Skills and competencies

- Proven ability to undertake multidisciplinary approaches to research.
- Excellent writing skills and experience in producing reports and evaluations.
- Good communication and interpersonal skills and ability to work closely with ECA's partners and counterparts in governments and civil society.

V. Languages

Fluency in oral and written English and French.

VI. Duration of Post

12 months

TERMS OF REFERENCE

Baseline Profiles: Capacity of the Implementing Partners for the TAP

(Burkina Faso, Ghana and Mozambique)

I. Background to the TAP

Within the context of WHO's global aim to treat 3 million persons living with HIV/AIDS by 2005, the International Development Association (IDA) has provided development grants to three Sub-Saharan African countries (Burkina Faso, Ghana and Mozambique) to test the feasibility of strengthening and scaling up ongoing HIV/AIDS treatment initiatives. This Regional Treatment Acceleration Programme (TAP), with technical support from the World Health Organization (WHO) and the United Nations Economic Commission (UNECA), will finance a public/private/NGO partnership in each of the participating countries to assure rapid increase in the number of people living with HIV/AIDS who receive a comprehensive and integrated range of effective, efficient, affordable and equitable health and related social services. In accordance with national HIV/AIDS treatment norms and implementation agreements established between the respective Ministries of Health and their partners, the TAP initiative will assist participating governments and the Africa region over a three-year period (2004-2007) to: (a) test approaches for scaling up HIV/AIDS treatment covering a continuum of four comprehensive treatment elements focused on (a) antiretroviral therapy; (b) strengthening of the institutional capacity of national HIV/AIDS treatment committees and programme coordination; (c) monitoring of the quality of HIV/AIDS treatment; and (d) facilitating TAP inter-country regional learning activities.

II. Context for the Baseline Profiles

TAP is conceived as a programme to assess the scalability and international transferability of decentralized, cost-effective equitable treatment in resource-limited settings. An important foundation for the work programme of the TAP secretariat will centre on guiding and supporting, in consultation with the RAP

and national officers, the Implementing Partners (IPs) responsible for in-country delivery of care. In order to make this support effective and to assure maximum potential for learning from the care delivery experience, it is necessary to undertake such preliminary surveys and information-gathering as are required to build a comprehensive baseline profile of each IP so as to understand the nature of these organisations and their programmes of activity (present and projected). These profiles will identify opportunities for capacity enhancement, characterise the organisations for subsequent analysis of outcomes, and create a baseline against which to assess achievements through the TAP. The baseline profiles will support both the clinical and non-clinical aspects of TAP. They recognize that TAP is a pilot that is time-limited to three years and implementation-limited to three countries, and thus offer a characterisation of the operational organisations that will enable the achievements of the programme to be extended in time and space.

III. Overall Responsibilities and Tasks

The specific objectives of this study are:

- i. To identify critical issues influencing supply dimensions of HIV/AIDS treatment and care in rural and urban areas of various provinces in the country.
 - To what extent is the current health infrastructure in rural and urban areas capable of providing AIDS treatment and care to different population groups (e.g., old, children, ethnic sub-groups and marginalised communities)? How could the limitations of the health infrastructure be addressed in relation to scaling-up ART in rural areas? What are the options including private sector participation?
 - To what extent do current human resources for health (e.g., trained AIDS physicians, nurses, care providers) in rural and urban areas offer sufficient capacity for providing AIDS care to different population sub-groups? What are the critical issues in relation to skill mix and numbers of staff both the short and long term? Are staff numbers increasing? If not what are the short and long term human resource and training plans? What are the rural/urban differentials and provincial level variations? To what extent do development levels influence the supply of health manpower in various provinces?
 - To what extent are the requirements of ART drugs and supplies met in the country and what are the important logistic issues. What is the current level of access to ART, especially for the rural population? What are the problems of procurement, storage and distribution of drugs? What is the

management training needs of the Health Administration at various levels?
Can evidence be seen of policies for making ART programmes sustainable?

- How are people using drugs provided under ART programmes? Are there issues with regard to stigma leading to reluctance to seek care, and family dynamics, such as drug sharing? How are women responding to advice regarding MTCT and breast-feeding?

ii. To what extent will future demand for ART differ from the current levels?
What are the drivers of demand?

- To provide an estimate of the number of people infected with HIV in rural and urban areas up to 2010.
- To provide an estimate of the number of people with AIDS needing treatment and care in rural and urban areas up to 2010.
- How the cohort survival effect due to ART will impact on the treatment burden of the health system?

iii. To examine demographic, social, and economic situation in the country and its various provinces by rural and urban division.

- To study rural-urban differences in education, employment, income, and access to health care.
- To present population distribution by age by rural urban and provinces.
- The social context of HIV/AIDS. What are the special social/economic conditions that favour spread of HIV in rural and urban areas and provinces?

iv. To understand the major policy environment in the country that influences AIDS treatment and care policies, administration of AIDS funding, accountability and transparency in AIDS programme management at national and provincial level.

- To what extent the provincial level governments' are engaged in AIDS care and treatment programmes?
- Review national and provincial level policy documents related to HIV/AIDS.

IV. Scope of Work and Deliverables

- 60 page report with the following clear sections:
- 5-page specification and evaluation of the survey procedure and the selected indicators
- 5-page summary baseline IP profile for each of the three countries
- Accompanying database holding the raw data collected

V. Supervision/Oversight

The Research Director will provide guidance and oversight.

VI. Work Plan and Payments

Activity	Institution	Time-frame	Deliverables	Payments
Contract Effectiveness				
Prepare a detailed Table of Content of Final report – annotated.		End week 2	Research Plan	Upon approval of the Table of Content, TAP will release 50% of the agreed funds.
Draft Final Report		Forth month from contract	Draft Final Report	First Draft, TAP will release an additional 25% of the remaining funds.
Final Report and database		Sixth month from contract	Final Report	Upon approval of the Final Report, TAP will release the remaining 25% percent of the funds.

TERMS OF REFERENCE

Study: TAP and the Broader National Challenges of Scaling Up Treatment (Burkina Faso, Ghana and Mozambique)

I. Background to the TAP

Within the context of WHO's global aim to treat 3 million persons living with HIV/AIDS by 2005, the International Development Association (IDA) has provided development grants to three Sub-Saharan African countries (Burkina Faso, Ghana and Mozambique) to test the feasibility of strengthening and scaling up ongoing HIV/AIDS treatment initiatives. This Regional Treatment Acceleration Programme (TAP), with technical support from the World Health Organization (WHO) and the United Nations Economic Commission (UNECA), will finance a public/private/NGO partnership in each of the participating countries to assure rapid increase in the number of people living with HIV/AIDS who receive a comprehensive and integrated range of effective, efficient, affordable and equitable health and related social services. In accordance with national HIV/AIDS treatment norms and implementation agreements established between the respective Ministries of Health and their partners, the TAP initiative will assist participating governments and the Africa region over a three-year period (2004-2007) to: (a) test approaches for scaling up HIV/AIDS treatment covering a continuum of four comprehensive treatment elements focused on (a) antiretroviral therapy; (b) strengthening of the institutional capacity of national HIV/AIDS treatment committees and program coordination; (c) monitoring of the quality of HIV/AIDS treatment; and (d) facilitating TAP inter-country regional learning activities.

II. Context for the Baseline Profiles

TAP is conceived as a programme to assess the scalability and international transferability of decentralized, cost-effective equitable treatment in resource-limited settings. An important foundation for the work programme of the TAP secretariat will centre on guiding and supporting, in consultation with the RAP, national officers and the Implementing Partners (IP), the integration of TAP into

the overall national response to HIV/AIDS, and the maximisation of its potential for meeting the treatment needs of the participating countries. In order to make this support effective and to assure maximum potential for learning from the care delivery experience, it is necessary to undertake such preliminary surveys and information-gathering as are required to build a comprehensive baseline profile of the broader treatment challenges that face each country, so as to understand the scale and nature of treatment needs and the adequacy of ART delivery (present and projected). These profiles will provide a context for the TAP, identify treatment challenges specific to each country and create a baseline against which to assess achievements through the TAP. The baseline profiles will inform the TAP and ensure that the programme achieves the flexibility required to successfully adapt to specific country and provincial challenges. The profiles recognize that TAP is a pilot that is time-limited to three years and implementation-limited to three countries, and thus offer a characterisation of the continued treatment delivery challenges that will enable the achievements of the programme to be extended in time and space.

III. Overall Responsibilities and Tasks

The specific objectives of this study are:

i. To identify critical issues influencing supply dimensions of HIV/AIDS treatment and care in rural and urban areas of various provinces in the country.

- To what extent is the current **health infrastructure** in rural and urban areas capable of providing AIDS treatment and care to different population groups (e.g. old, children, ethnic sub-groups and marginalised communities)? How can the limitations of the health infrastructure be addressed in relation to scaling-up ART in rural areas? What are the options including private sector participation?
- To what extent do current **human resources for health** (e.g., trained AIDS physicians, nurses, care providers) in rural and urban areas offer sufficient capacity for providing AIDS care to different population sub-groups? What are the critical issues in relation to skill mix and numbers of staff in both the short and long term? Are staff numbers increasing? If not what are the short and long term human resource and training plans? What are the current strategies for managing the brain drain, and how can they be improved? What are the rural/urban differentials and provincial level variations? To what extent do development levels influence the supply of health manpower in various provinces?

- To what extent are the requirements of **ART drugs and supplies** met in the country and what are the important logistic issues? What is the current level of access to ART, especially for the rural population? What are the problems of procurement, storage and distribution of drugs? What is the management training needs of the Health Administration at various levels? Can evidence be seen of policies for making ART programmes sustainable?
- How do people in need of treatment gain **access to ART programmes**? What is the social context access to treatment? What are the selection criteria for treatment? Are there issues with regard to stigma leading to reluctance to seek care, and family dynamics, such as drug sharing? How are women responding to advice regarding MTCT and breast-feeding?

ii. To what extent will future demand for ART differ from current levels? What are the drivers of demand?

- How many people are likely to be infected with HIV in rural and urban areas from now to 2010?
- How many people with AIDS will be in need of treatment and care in rural and urban areas up to 2010?
- How will the cohort survival effect due to ART impact on the treatment burden of the health system?

iii. What is the demographic, social, and economic situation in the country and its various provinces by rural and urban division?

- What are the rural-urban differences in education, employment, income, and access to health care?
- What is the population distribution by age by rural urban and provinces?
- What is the social context of HIV/AIDS? What are the special social/economic conditions that favour spread of HIV in rural and urban areas and provinces?

iv. What is the major policy environment in the country that influences AIDS treatment and care policies, administration of AIDS funding, accountability and transparency in AIDS programme management at national and provisional level.

- To what extent is the provincial-level governments' engaged in AIDS care and treatment programmes?

- Are national and provincial-level policy documents and implementation related to HIV/AIDS adequate?
- Is the institutional organisation of the national HIV/AIDS response coherent, transparent and efficient?
- Which groups provide the strongest check on government at the various levels with regards to scaling up and implementing policies of treatment? What are the political drivers of reform?
- Is funding for HIV/AIDS sustainable?

v. How well does the TAP integrate within the overall national response to HIV/AIDS?

- To what extent is the TAP harmonised with other existing donor programmes?
- How well is the TAP integrated with domestic programmes and policy, including initiatives for enhancing health system capacity and programmes of prevention?
- How will TAP research be linked with other research initiatives and policy information networks?

IV. Scope of Work and Deliverables

60 page report with the following clear sections:

- 5-page specification and evaluation of the survey procedure and the selected indicators
- A section on each of the five components as outlined above
- Accompanying database holding the raw data collected

V. Supervision/Oversight

The Research Director will provide guidance and oversight.

VI. Work Plan and Payments

Activity	Institution	Time-frame	Deliverables	Payments
Contract Effectiveness				
Prepare a detailed Table of Content of Final report – annotated.		End week 2	Research Plan	Upon approval of the Table of Content, TAP will release 50% of the agreed funds.
Draft Final Report		Forth month from contract	Draft Final Report	First Draft, TAP will release an additional 25% of the remaining funds.
Final Report and database		Sixth month from contract	Final Report	Upon approval of the Final Report, TAP will release the remaining 25% percent of the funds.

TAP

Treatment Acceleration Programme

**Tripartite Meeting (World Bank, WHO & UNECA)
Nairobi, Kenya
23-24 June 2005**

1. Introduction

1.1 Following a discussion between UNECA and the World Bank, it was agreed that the TAP Partners (World Bank, WHO and UNECA) should meet in Nairobi, Kenya on June 23-24, 2005. The mission had three core objectives: 1) to agree on how the three Partners were going to work together; 2) to determine how success or failure will be measured; and 3) to develop some clarity and agreement on the learning agenda.

1.2 Present at the meeting were:

World Bank:

Albertus Voetberg
Cassandra de Souza
Mead Over
Damien de Walque

WHO:

Cyril Pervilhac
Christine Sidibe
Emil Asamoah-Odei
Georges A. Ki-Zerbo

UNECA:

Nana Poku
George Alibaruho
Virginie Mongonou

2. Initial briefing by Agencies

2.1 At the start of the meeting, the three agencies provided a full briefing on the status of their work.

(a) World Bank

2.2 The World Bank is particularly eager to develop the learning agenda of the TAP, and to find ways to measure success or failure of the project at the end of the 3 years.

(b) WHO

2.3 All three countries are taking M&E seriously: Burkina Faso has a national M&E officer that will be working with WHO to collect M&E data from implementing partners and MOH. Ghana has a National Programme Officer at the WHO office working on M&E issues, and Mozambique intends to hire a consultant to work on M&E issues as needed. WHO is planning to recruit a TAP Coordinator at WHO-AFRO that will coordinate the 3 country programs and manage processing issues with WHO-Geneva? WHO is hoping to use the TAP as a method of moving towards the 3x5 goal? An indicator of success for WHO would be the percentage of persons on treatment under the TAP. WHO is also interested in the operational research agenda in terms of the clinical efficiency, service delivery mechanisms, and other related types of research?

(c) UNECA

2.4 UNECA has the responsibility to support learning among the three countries and to disseminate the lessons to the wider audience. In that context, UNECA would like to clarify the learning agenda in order to get a better grasp on where the TAP can be supported. In order to do this, UNECA needs to know what will be learned first, and then the lessons learned can be collated and shared throughout the continent to improve the AIDS response on that level. UNECA is also interested in the TAP learning agenda to identify what makes this project distinctive from other regional and treatment initiatives on HIV/AIDS.

(d) DECRG (World Bank)

2.5 DECRG is the research arm of the World Bank. They have received almost \$1 million from BNPP funds for operational research and will be getting

additional support for operating expenses from DEC to further the research agenda on the TAP.

3. Country Status Reports from WHO

3.1 This session focused on the ongoing research in the countries and it seems that, from a WHO-Harare meeting, some of the research questions have already been looked at by countries. Mead indicated that the NIH would not fund operational research on HIV/AIDS besides clinical and biological research issues although CDC is involved in some operational research.

3.2 Cyril made a presentation (Annex A) on various research questions that were discussed at the WHO Harare meeting, including: 1) improving treatment and uptake of VCT and ART services; 2) dispensing ARVs and support adherence; 3) economic issues; 4) scale up of clinical regimens; and, 5) health systems issues.

3.3 It was indicated that there is a need for continuing education for health system personnel and an adaptation of the actual national guidelines (the guidelines exist but it is not known how they are being implemented at the district and regional centers, etc.). The issue of incentives also came up as very relevant to which outcomes of treatment will result from patients, supporters and the health providers.

Eg. Compared in a table such as that below:

	Patient	Community	Health Facility
Incentives			
Guidelines			
Impact Analysis			

3.4 The meeting discussed that it might not be helpful to demarcate learning by the field of technical expertise but rather perhaps to look at cross-cutting issues at each level of the patient, community, health facility, district, etc. and then to extrapolate the analyses from there.

3.5 The various tools exist with which to answer most of the questions, but which tools, when, and how to use them are the goal of the meeting. Countries will need to be consulted on what is of interest to them, in synergy with the TAP's objective.

4. Treatment Rollout Status in Countries (as known by the WHO team)

(a) Ghana

4.1 Dr. Asamoah-Odei, WHO-Afro, reported that:

- 1) Ghana is still developing ART scale-up plan, training staff of all regional hospitals, and all facilities have to use the prepared national guidelines;
- 2) The Government of Ghana will commit funding for ART in its national budget: US\$350 is the average cost for a 1-year supply of ART per patient, with cost recovery of 50,000 cedis for a treatment package of drugs and labs per patient;
- 3) M&E available now can indicate how many people are on treatment and how many people are tested, but not which proportion of tested people come back for follow-up testing or treatment;
- 4) There is very little operational research at this point, and Ghana is not presently a WHO-priority country;
- 5) Funding from the USG is available for some areas but details are not known yet;
- 6) Church-related NGOs have ART scale-up in large hospitals;
- 7) In March 2005, the Ghana AIDS Commission organized a research roundtable and is encouraging the development and use of methodologies to identify the high-risk areas in which to target prevention messages, but there was no defined research evident from the roundtable;
- 8) Potentially the Noguchi Institute may be doing clinical research involving the use of traditional medicine and nutrition supplements, but details are not known yet;
- 9) US\$120,000 of the US\$400,000 of retroactive financing available to WHO has been spent in Ghana.

4.2 Discussions: WHO is planning to use SAM-P methodology to see opportunities to test how service delivery coverage affects quality and treatment access. Available expertise and interest in research in Ghana is impressive. It should, thus, be possible to move the research agenda quickly once the research areas are determined and agreed upon for sponsorship.

4.3 Noguchi Research Institute interface would be useful, and in particular, since Ghana has a cost-sharing component, it would be useful to see how incentives work in the context of cost sharing.

4.4 WHO had a policy statement from Geneva encouraging free access to ART in countries? However, this policy received a lukewarm response from the countries, especially from Burkina Faso. Learning how cost sharing has worked in Ghana would be very useful to all countries that need guidance in this area.

4.5 Ghana could also be useful in learning lessons from scaling up: 1) Scaling up only in the geographic areas of high prevalence vs. nationwide scaling up, regardless of prevalence; 2) Utilization of regional hospitals vs. mission hospitals and private sector institutions; 3) The current strategy in Ghana is to recruit patients into ART on a first-come, first served basis, but should this strategy be revised to recruit parents and caregivers first? The DRI concept in Ghana combined with the focus of the TAP in 4 regions only could be useful to make additional comparisons and learn lessons.

(b) Burkina Faso

4.6 Dr. Georges Ki-Zerbo, WHO-Afro, reported that:

- 1) In Burkina Faso there is collaboration between the public sector and communities;
- 2) ART rollout plan was drafted and received consensus approval;
- 3) Targeting 20 districts for the TAP;
- 4) Building links between the district teams and community associations, particularly in Ouagadougou and Bobo Dioulasso, where existing collaborative efforts are in place;
- 5) Burkina Faso participated in the Kampala meeting on operational research issues – the organizing multi-disciplinary team from the Research Institute and NAC on utilization of services want help on methodology to use for a clear picture of all ARV initiatives in the country;
- 6) Burkina-Vie project from the World Bank is also looking at simplified models of care with collaboration from ESTHER, which has now started in Ouagadougou;
- 7) UNDP conducted household impact surveys, particularly in the education sector;

- 8) AIDSETI and Stanford University have also shown interest in identifying the additional benefits of treatment scale-up for beneficiaries;
- 9) One laboratory in Burkina Faso is doing some drug resistance research already and could expand to include the TAP;
- 10) The University of Ouagadougou and DSS Dept. is also doing some research related to ART.

4.7 Discussions: DECRG, with support from the MAP, will support more operational research such as baseline surveys on prevention, care and support, how communities are mobilizing to mitigate the impact of HIV, as well as surveys on CSWs in Burkina Faso and how to measure the prevalence among them. Input from the Burkina Faso team already indicated the areas highlighted above as the issues of operational research they would like to pursue.

4.8 The Burkina Faso TAP model could be very useful for research because the PLWHA associations would also want to reduce resistance. Thus, a comparison could be done on how this PLWHA associations' interest in keeping resistance low could translate into adherence patterns among their beneficiaries and their adherence campaigns – eg. How does the inclusion of PLWHAs support or hinder the linkage of treatment and prevention, when they are part of the treatment provision team? Does the involvement of PLWHA associations in treatment provision encourage or discourage the involvement of the community by generating further stigma? What does the introduction of ARV into the list of services available from PLWHA associations do to their other work and services?

(c) Mozambique

4.9 It was reported that in Mozambique:

- 1) The TAP model is using public and international NGO partnerships;
- 2) Training of trainers at the provincial and district levels is done;
- 3) In early 2005, there was some harmonization completed of the treatment guidelines;
- 4) Using integrated management of adult patient health (IMAI) with tools built into the patient card (similar M&E testing done in Uganda and WHO will have data using these tools coming in the next few months from 1 year of testing);
- 5) Patient tracking cards of integrated management of adult illness (IMAI) have core variables on the card and indicators related to those variables, which provide light M&E on how many patients are on

treatment and accessing other services, with some cohort analysis on adherence, transfer, etc. It is in use in Mozambique now, but Burkina Faso will also start using patient tracking cards in July;

- 6) Recruitment of patients in Mozambique already has explicit/implicit choices on who receives treatment – Pathfinder implicitly recruits only youth because they operate in youth centers, and Sant’Egidio recruits explicitly mothers and children since 75% of those on treatment are women – this can be used to demonstrate to governments that different policies (implicit or explicit) can translate into different beneficiaries of treatment programs;
- 7) Sant’Egidio’s decision to use triple therapy for PMTCT is a natural experiment vs. the nevirapine-only PMTCT being used in other countries, which raises both cost and ethical issues in PMTCT coverage.

4.10 Discussions: There is a need to harmonize the data collection systems and software applicability across each country and across the 3 TAP countries as well. WHO and UNAIDS are developing an M&E guide for communities, but the interesting issue is how to measure success at the community level, besides that directly relevant to the patient. Large number scale up in use in Mozambique to see what are the saturation points in numbers of people treated by a hospital or clinic and how many volunteers can provide home-based care and support before it becomes too much for them to manage efficiently and with good quality. How is adherence affected by issues like the socio-economic class of the patient, when the patient was recruited (stage of disease), the efficacy/legitimacy of the NGO/support group?

4.11 We need to know that variations will exist in adherence anyway and resistance development. Mead presented an example from Thailand and China where it was observed that in Thailand ART results in 5 extra life years for a patient vs. in China where ART results in 6 months extra life years for a patient and it was unclear to the Chinese why. Existence of Immune Reconstitution Syndrome (IRS) has an impact on the success of ARV treatment of patients.

4.12 It is more likely that in Africa, nutrition and ARVs is a more critical question – particularly issues like whether food supplements are shared with the rest of the family and/or acts as a positive incentive for patients to come and access/receive their drugs regularly in order to improve adherence. Sainte Camille in Burkina has a nutrition package that could be examined in detail for these issues.

5. Monitoring and Evaluation (M&E)

(a) Bert's presentation

5.1 Bert made a presentation on the roles of routine vs. non-routine M&E, and the potential questions of treatment research that should be examined. Issues of analysis, collection of data, sharing practices, and who is responsible for collection of M&E need to be clarified. Indicators – national vs. TAP, common across all the TAP countries but limited in number; we need some measures of TAP additionality to use as a comparison basis for the TAP contribution vis-à-vis other options. Data validation – who validates M&E results, and to what extent do we need validation of data? Where does the data get analyzed and discussed – at country level or RAP meetings?

5.2 Questions on Pediatric ART – Africa is in the forefront because pediatric ART is not really in great demand in the developed countries. Any lessons learned from the African experience will be highly useful to the rest of the world, and of course, we need to do something on pediatric ART in Africa because there are many babies who are getting infected from their mothers and need to be on treatment.

5.3 Recruitment practices for ARV treatment – TIDES Foundation is also developing something along these lines.

5.4 Research into the inter-relationship of ART and TB treatment issues; ART and pregnancy (what would be the safest and more reliable approach to use)?

(b) Damien and Mead's Presentations

5.5 Identification of the tools required to collect data for operational research will be important, as will the identification of the policy and research questions to examine. We should be selective on what we want to evaluate using the rigorous economic survey tools available to DECRG, because instances of multiple funders of one intervention can only tell us the results of having the evaluation but not from which funder, and multiple regression analysis is too difficult to sell for evaluation although it could provide more answers.

5.6 Some data will be collected routinely so it is important to make sure that new data collection can be merged with the routinely collected data without overburdening the IPs and health facilities or households involved in the TAP –

basically building additional modules of evaluation on specific information, on an as needed basis.

5.7 Ethics of methodological tools, such as confidentiality, etc. will be relevant – Burkina and Ghana have national ethic committees regarding HIV issues and they would need to look at any research proposals before they can proceed. WHO also follows international ethics guidelines emanating from the Durban conference.

5.8 How the TAP will support the IPs for routine M&E data collection so that they can use it to guide their implementation progress?

6. Discussions

6.1 Discussion around identification of where the treatment questions, as presented by Bert and Cyril, would fit into the survey matrix presented by Damien and Mead to capture the data needed to answer those questions.

6.2 WHO putting together M&E for pediatric ART, testing to start in Malawi in July ART and pregnancy, ART and TB issues are faced by all IPs or practitioners but there is a need to identify the protocols that are being used by the IPs and compare these across the IPs – tools and data collection need to be sufficiently different to be able to capture the subtle differences in the protocols being used by the IPs.

6.3 UNECA will prepare a survey and send consultant/survey questions to the IPs in all 3 countries to come up with a comprehensive report on the practices and protocols being used by the IPs that identifies differences and similarities for discussion at the next RAP meeting.

6.4 Through collection of data in the bio-medical records, we can tease out the answers to some of the questions eg. cost questions can be collected through questions asked in 3 of the surveys in the matrix.

6.5 Service Provision Assessment (SPA) tool developed by USG; LMIS supply chain management tool used by all 3 countries; other tools already being used by IPs and governments in Africa.

6.6 DEC should probably develop adapted version of KAP surveys for ART.

6.7 The matrix will be expanded to fit the expanded questions and a version can be prepared and presented to the countries to see what their own priorities and opinions are on these questions in the coming weeks. Bert will present them to MOH and ask them to have a meeting with IPs, WHO, and WB to come back with their preferences.

6.8 Community involvement in treatment programmes missing from matrix perhaps can be added as a column asking for qualitative questions of communities rather than quantitative data collection. Disaggregate questions and tables so that it is clear to the countries what the benefits of getting the answers will be for the country's treatment scale up.

6.9 Developed a mechanism for outlining how the learning agenda can be achieved but there is a need to break this down further to make it explicit, what the questions are in each broad category, what optional tools are available of answering these questions, and who has the responsibility for preparing and using those tools at the country level to prepare a report.

6.10 Are there different sub-types emerging over time of the virus? Are putting people on treatment helping or hindering the development of mutations of the virus and does this cause problems or benefit people trying to develop a vaccine for HIV?

6.11 The next RAP meeting will have the learning agenda as a separate agenda item, with an additional day that includes discussion of the tools to be used to respond to the learning items.

6.12 DECRG is already involved with MOH in Ghana and Burkina Faso on research questions 1 and 2 to get some idea of what and how they can get data to respond to those questions.

6.13 Broad learning agenda can be derived from 7 questions of DEC survey table. But there is a need to develop them further to get the IPs interested and willing to be involved in doing the requisite data collection and obtaining the answers to the questions?

7. Next Steps

7.1 UNECA will take up the issue of having clarity on all the IPs in the 3 countries by preparing a report that outlines the protocols, drug regimens, human resource capacity, facility sites, etc. for all the IPs before the next RAP meeting.

This way, it would be easier to identify areas of comparison or natural experiment issues that lend themselves towards further research.

7.2 Bert Voetberg will send the reporting format from Burkina Faso to Cyril Pervilhac and WHO will combine this with the reporting format they were developing to propose a formal country reporting format that we can use for all 3 countries, to be sent out by Bert to country counterparts.

7.3 UNECA is in the process of updating a website so that sharing documents and information for the 3 TAP countries can be facilitated.

7.4 The World Bank will take the responsibility of sending the preliminary learning agenda questions to the 3 countries with the guidance that, wherever possible, they should start considering their perspectives on the learning agenda prior to scheduled country visits by UNECA/WHO/WB in the near future.

7.5 The three agencies will coordinate efforts so that missions can be undertaken together to build consensus on the learning agenda and allow UNECA and WHO to get an overall country and regional picture of the TAP.

Draft Questions for the TAP Learning Agenda

1. Full socio-economic benefit of treatment for patients and their household:
 - # of life years saved for patient
 - Costs to households (direct and indirect) of treatment provision/availability
 - Impact on household economics – income and savings (either through additional payment for treatment or increased ability to be productive/unproductive)
 - Impact on labor force participation of patient and household members (reduced absenteeism)
 - Children's wellbeing (education, health, psychosocial, etc.) as result of parent not dying
2. What is the impact of availability of treatment on prevention in HIV positive and negative people?
 - Changes in knowledge and attitude towards C&T and ART
 - Willingness to be tested and VCT uptake?
 - Impact on stigmatization?
 - Impact on risky sexual behaviour?
 - Impact on HIV transmission and prevalence? Discordant couples?
3. How to avoid the development and spread of resistance?
 - Utilization of effective/efficient methods of measuring resistance at national level?
 - Determinants of resistance to treatment? Biological, behavioral and health systems? (Health workers being trained to use 1st line regimens, possibilities of drug stock-outs)
 - Timeliness of detection
4. Adherence
 - Adherence tracking systems?
 - What are the determinants of adherence?
 - What are the best models to promote/encourage adherence?
 - What is the level of involvement of the community? and benefits and at what costs?
5. How are ART beneficiaries identified? How to encourage timely uptake?
 - Who gets recruited and why? How is it practiced and how do we monitor recruitment choices?

- Are pro-active recruitments drives practiced to maximize the social impact/benefits e.g. parents, mothers, youth?
- If so, what are the additional benefits, and how are they realized?
- What is the impact of cost-recovery on patient uptake and adherence?

6. What are the determinants of and how to encourage the quality of HIV/AIDS service delivery?

- What are the determinants of good and poor treatment outcomes?
- Effect of different models of ART delivery and financing on patient outcomes, efficiency and sustainability (optimization)?
- Community involvement (NGOs, CBOs, Associations of PLWHAs) and support in provision of ART?
- Impact of health worker attitudes, behaviour, skills, incentives, etc.?
- Effectiveness of referral systems? (Public-private partnerships)
- Efficiency of procurement/supply chain management systems nationally and locally?
- Cost and cost effectiveness of clinical guidelines and care interventions (and technical questions nb 8)?

7. How to encourage capacity building to reinforce the sustainability of ART delivery?

- Identification of the right mixes in number, skills, and category of health workers? What does this do for quality and efficiency?
- Community involvement (NGOs, CBOs, Associations of PLWHAs) and support in provision of ART?
- Identification of opportunities and bottlenecks to scaling up?
- Financing and co-financing arrangements for ART provision?
- Cost of ART vis-à-vis the cost of other public health priorities? Does it lead to distortions in provision of other public health issues or does it supplement it?

8. Technical issues needing further clarifications:

- General – morbidity and side effects of ART; mortality, treatment failure rates, frequency of changes in treatment protocol?
- Differences in PMTCT practices and experiences and what do we learn from this?
- Pediatric ART – What are the most effective options learned from experience?

- ART and pregnancy
- ART and TB
- ART and nutrition
- Aggregated cost projections?

TAP

Treatment Acceleration Programme

Official Mission to Burkina Faso and Ghana 3-11 October 2005

I- MISSION TO BURKINA FASO

1. Introduction

1.1 The overall objective of the field mission was to contribute to the amelioration of the implementation of the national plan to scale-up anti-retroviral treatment and the reinforcement of the monitoring and evaluation of the treatment of people living with HIV/AIDS (PLWHA).

1.2 Specific objectives of the joint mission were to:

- a. Look at the state of advancement of the treatment of PLWHA, in particular in relation to the TAP and the Global Fund;
- b. Look at progresses accomplished on prevention of mother to child transmission (PMTCT);
- c. Get a better understanding of the tools used in the field;
- d. Look at the data collection and management system of the PLWHA under ARV;
- e. Identify the difficulties met by the actors in the field in relation to the implementation of anti-retro viral (ARV) treatment;
- f. Offered recommendations for a better organization of ARV treatment.

1.3 A joint WHO/UNECA/World Bank team held discussions with Burkinabé officials from October 3 to 8, 2005 to review the progress made in the anti-retroviral therapy (ART) scale-up programme in the country, with a special emphasis on the monitoring learning and research aspect of the Treatment Acceleration Programme (TAP). The team worked closely with the Ministry of Health AIDS Commission officials, the Implementing Partners (IPs) as well as with other stakeholders involved in ART scale-up in Burkina Faso: Global Fund/UNDP, UNICEF, French Cooperation, Finish Cooperation, PAMAC, REGIPIV, DGPML, etc.

1.4 Under the leadership of the Permanent Secretary of the National AIDS Committee the group divided into 4 teams assigned public and private treatment sites to each team, as well as associations involved in the TAP.

- Team A, in which I was involved would visit Bobo Dioulasso
- Team B: Koudougou
- Team C: Ouahigouya
- Technical team working in Ouagadougou specifically on M&E

2. Findings

2.1 General findings:

- The information level of the principal implementing partners (IPs) on the politics regarding the medical treatment of the PLWHA is very high. However, the interpretation of the directives for treatments and the form of the financial cost of the medical treatment and the biological follow-up doesn't always seem to be the same. In collaboration with social services and the public treatment sites, the status of the indigenous are still in question and a certificate stating their status has to be issued to give them free access to treatment and biological follow-up. This can cause some delays. Free ARV are most often given by the Associations where public treatment sites are still charging for them;
- Most of the visited associations have established some kind of relationship with the public/private sites for the biological follow-up of patients and offer a package of services including awareness, voluntary counseling and testing (VCT) and psycho-social follow-up of patients taking ARV. It was noted that public treatment sites seem to have difficulties in establishing a global framework for medical treatment including prevention, treatment and care and to develop interfaces with the community through the associations;
- In the field, the integration of the different initiatives for medical treatment (Multi-Country HIV/AIDS Programme for Africa (MAP), TAP, Global Fund) seems to have been done without too much difficulty;
- The associations of PLWHA have important active lines. The TAP initiative seems to have motivated them toward ARV treatment under the supervision of young medical doctors who have been recruited for this purpose. In the long term, this implied the necessity of a regular supervision by the health services to oversee the quality of care provided by the associations;

- The Regional Hospital of Koudougou follows an active line of 183 patients (in which 45 are under ARV). That is relatively small compared to the estimated need according to the national indicators. In this active line, 118 (60% of the patients) are waiting for treatment while 61 additional treatments were available. This is because patients have to travel to Ouagadougou to make a pre-therapeutic test as the recently purchased equipment was not yet functioning;
- Most of the associations in the framework of the TAP (through AIDSETI or CICDOC) receive help from the Associational and Community Support Programme (PAMAC).

2.2 On the staff

- All the visited treatment sites have multi-disciplinary teams for medical treatment composed of at least a medical doctor, a pharmacist biologist, a laboratory technician, a pharmacist responsible for the stock, a nurse, a psychologist, an Assistant and a social educator;
- Most of the members of the teams have received training on medical treatment in the area of ARV.

2.3 On the services

- A number of the associations involved are offering a package of care (VCT, treatment and care, psycho-social and nutritional support).

2.4 On management

a) Management of the drugs:

- The availability of ARV does not seem to be a real issue, but the regional treatment sites have a hard time anticipating the needs that impacts the stock level;
- The medical treatment of the opportunistic infections (OIs) seems to cause problems because of unavailability/shortages.

b) Management of equipment and reagents:

- The lack of biomedical equipment in Regional Hospitals delays ARV treatment of PLWHA in need and impose on them additional constraints;
- The absence of reagents and the high cost of screenings are major factors in delaying putting patients under ARV;

- The lack of relationship between PMTCT services and/or the treatment sites offering VCT shows the importance of reinforcing consultations between the various treatment sites.
- c) Tools and mechanism:
- The data collection and management tools provided by the Ministry of Health AIDS Commission are often available;
 - Therapeutic and eligibility committees exist but are not functioning all the time;
 - Observation clubs and consultations exist in most of the treatment sites;
 - All the visited associations put in place talking groups to help PLWHA to express themselves.

3. Recommendations:

3.1 Below is a set of recommendations offered to the Burkinabé officials. It is recommended to:

- Strengthen the capacities of the National AIDS Committee to ensure the supervision of the associations involved in medical treatment of PLWHA as well as overseeing the quality of care they receive;
- Strengthen the role of Regional Health Districts in the implementation of programmes;
- Establish systematic links between the entry points and the management of the active lines, especially PMTCT/VCT under supervision of NGOs and Associations;
- Reinforce consultation mechanisms between the treatment sites and develop partnership between the various actors;
- Improve supply of drugs for the treatment of OIs;
- Put in place a follow-up mechanism for resistance according to the definition of protocols by including University Hospital Centers of Ouagadougou, Bobo Dioulasso under the coordination of the Ministry of Health AIDS Commission;
- Finalize the M&E tools and put in place a computerized system for the management of the data;
- Formalize the link between PAMAC & the Ministry of Health AIDS Commission for the M&E of activities of Associations under the TAP;

- Monitor the implementation of the training plan that has just been initiated and formulated in collaboration with the Research and Training Centre.

II- MISSION TO GHANA

4. Meeting with the World Bank

4.1 I paid a courtesy visit to the colleagues working on the TAP at the World Bank office in order to introduce myself and to exchange views on the programme. The World Bank officials met assisted me in confirming an appointment with the WHO Representative, Dr. George Melville.

5. Meeting with UNAIDS

5.1 I paid a courtesy visit to the colleagues in UNAIDS. UNAIDS is involved in the TAP as they are helping the National AIDS/STI Control Programme (NACP) to develop a software that will be used to follow-up PLWHA under ARV. UNAIDS Representative assisted me in getting an appointment with Dr. Nii Addo from NACP.

6. Meeting with Dr. Nii Addo, NACP and the Family Health International Ghana (FHI)

6.1 The objective of the meeting was to exchange views on the TAP to get a better understanding of their role. Below is a summary of the issues discussed:

6.2 As of today there is only one implementing partner in Ghana that is the FHI. FHI will be supporting activities in four private clinics/hospitals, namely Narh-Bita Hospital and Odorna Clinic in the Greater Accra Region and Bomso Clinic and AngloGold Hospital in the Ashanti Region.

6.3 FHI has already received 6-month of funding from the TAP. FHI made an assessment of the treatment sites and trained the Doctors, Nurses and Pharmacists on all FHI treatment sites

6.4 FHI is active in 2 regions: the Accra and the Ashanti regions. FHI has not yet started providing ARV as they are waiting for sub-contracts to be signed with their lawyers at the Headquarters in the United States.

6.5 Two IPs will join the TAP soon:

- **National Catholic Health Service (NCHS):** Two hospitals each from the Western (St Martin's de Porres Hospital, Eikwe, St John of God Hospital, Sefwi Asafo), Eastern (St Dominic's Hospital, Akwatia, Holy Family Hospital, Nkawkaw) and Ashanti (St Michael's Hospital, Pramso, St Patricks' Hospital, Offinso) Regions of Ghana belonging to the NCHS will be joining the TAP.
- **Private Enterprises Foundation (PEF):** PEF will provide linkages between the TAP sites and the surrounding communities. PEF also has the role of working with businesses and trade associations to create workplace HIV/AIDS awareness and encourage utilization of TAP's comprehensive care services at the facilities.

6.6 The Ministry of Health has done district level clinic procurement (CD4 machines and a machine for resistance monitoring)

7. Meeting with WHO

7.1 The focus of the discussion was on the following:

7.2 In Ghana, TAP is being implemented by the NACP of the Ghana Health Service, in partnership FHI and soon with NCHS and PEF.

7.3 A TAP Technical Officer (TO) has been recruited as part of WHO's technical support for the implementation of TAP. The TO liaises with and provides support to the Ministry of Health service programme involved in TAP, the NACP in the performance of the following:

- Involvement in organizing training and other capacity building as relates to the programme;
- Provision of technical assistance in the planning, implementation, monitoring and evaluation of an effective accelerated treatment programme for AIDS;
- Providing support for the building of capacity and supervision of Civil Society Organizations involved in the implementation of TAP; and
- Supporting activities related to the revision of guidelines and manuals.

7.4 WHO activities so far are:

- Scale up comprehensive care in TAP sites
 - Ongoing support to IPs to operationalize TAP activities
 - ✓ Four FHI-supported TAP sites assessed to identify areas for upgrading and refurbishment;
 - ✓ Service providers (doctors, nurses and pharmacists/dispensary technicians) from each FHI site trained in VCT, PMTCT, OI Management and ART using National Guidelines and Protocols;
 - ✓ Sub-agreements between FHI and sites being developed and finalized;
 - ✓ Proposals from prospective IPs, NCHS and PEF to join TAP being reviewed and finalized.
- Strengthening institutional capacity
 - Ongoing technical support to NACP in the country's scale up of comprehensive HIV care to PLWHA:
 - ✓ Support for operations;
 - ✓ Capacity building;
 - ✓ Revision of manuals/guidelines

7.5 Next steps for WHO

- Scale up
 - Refurbishment in FHI sites
 - Initiation of comprehensive care in FHI sites
 - Complete NCHS and PEF paperwork
 - Assessment of NCHS sites
 - Training of NCHS service providers
 - Initiation of PEF activities
- Strengthening institutional capacity
 - Adapt training manuals for chronic HIV care and ARV
 - Capacity building
 - Technical support

TERMS OF REFERENCE

Administrative Assistant- G5 post

I. Summary of functions

Under the direct supervision of the Administrative Officer and the overall supervision of the Project Manager of the Secretariat for the Commission on HIV/AIDS and Governance in Africa (CHGA), the incumbent will assist in coordinating the planning and execution of the administrative work of CHGA including human resources, management of finance, office management including supplies and administrative support.

II. Major Duties and responsibilities

Within delegated authority, the Administrative Assistant will perform general office administration duties as follows:

- Prepares processes and follows up all mission travels, amendments of Travel Authorizations and claims of all professional staff of the Division as well as for consultants and participants
- Prepares and follows up in the processing of Special Service Agreements (SSAs) for consultants/contractors and processes their payments.
- Keeps record of official and personal international calls made by the staff and consultants, and verifies the correctness of the bills and submits them to the relevant office.
- Maintains necessary budgetary control and allotment records of the project.
- Maintains attendance and leave records of the staff of the project
- Liaise with other support units to initiate travel arrangements, acquire equipment and supplies and submits requests for maintenance and repair services.
- Maintains stock of office supplies, orders office furniture/equipment and keeps inventory records.

- **Performs various other office management duties such as:**
 - Reviews correspondence typed by secretaries, etc.;
 - Drafts routine letters, memoranda, faxes for the signature of the director for style and format conformance;
 - Opens all incoming mails and forwards them to the secretary of the director;
 - Distributes personal and official mails to all staff of the project as and when required request overtime work, maintain overtime records and submits overtime records for payment action;
 - Maintains a comprehensive record keeping and retrieval system;
 - Maintains good public contact for the director by responding to inquiries and making available general information on administrative related and general matters.

- **Provides, coordinating and monitoring administrative support in reparation for meetings, conferences and other for a organized by the project as follows:**
 - Submits timely conference documents and materials for translation, editing and reproduction and follows up on progress including their appropriate distribution to participants;
 - Submits and follows up on requests for conference facilities and logistics;
 - Initiates and follows up on the hiring of translators and interpreters for conferences, meetings, workshops, etc. to be organized by the projects, as and when required;
 - Initiates and follows up on travel arrangements for participants/consultants/resource persons/staff of the project attending/servicing the conference;
 - Co-ordinates the necessary secretarial services for the preparation of conference documents including the finalization and distribution of conference reports to participants, liaising with other offices as necessary.
 - Carry out any other administrative assignments as and when requested.

- **Budget and Finance**
 - Assist in the preparation and review of financial and human resource proposals/requirement. Consolidate budget/work programme with respect to various budgets, trust funds, grant and other funds on a regular basis, suggest reallocation of resources, and implement the reallocations as necessary;
 - Monitor expenditures and compare with approved budget; prepare adjustments as necessary;

- Assist managers in the elaboration of resource requirements for budget submissions;
- Assist in preparation of budget performance submissions and finalization of budget performance reports, analyzing variances between approved budgets and actual expenditures;
- Prepare or customize financial reports from IMIS system generated reports
- Monitor XB resources, including review of agreements and cost plans, ensuring compliance with regulations and rules and established policies and procedures;
- Co-ordinate with other finance and budget staff on related issues during preparation of budget reports.

III. Qualifications and Experience:

Education: Diploma in Secretarial Science. Knowledge of Office Administration is highly desirable combined with computer application skills.

Experience: Five or more years of specialized experience in progressively responsible work in office administration or secretarial duties.

Other Skills: Extensive knowledge of UN systems and in particular the IMIS.

Languages: Fluency in English or French (written and oral), plus working knowledge of the other, is optimum.

The following core and managerial competencies will be required:

Planning and Organizing – Demonstrated organizational skills and ability to handle a large volume of work in an efficient and timely manner. Ability to prioritize work.

Technological Awareness - Keep abreast of available technology, understand applicability and limitations of technology to the work of the office, actively seek to apply technology to appropriate tasks and show willingness to learn new technology.

Client Orientation – Ability to identify client’s needs and determine appropriate solutions; ability to establish and maintain productive partnerships with clients.

Ability to work in a multicultural environment -