TAP

Treatment Acceleration Programme

Regional Advisory Panel (RAP) Meeting

Addis Ababa, Ethiopia

12-13 December 2005

Final Report

TAP Secretariat
ECA, Addis Ababa, Ethiopia

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List of acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral Medication
CD4	The immune System T-cell which are destroyed by the HIV virus
CHGA	Commission on HIV/AIDS and Governance in Africa
ECA	Economic Commission for Africa
FHI	Family Health International
HAART	Highly Active Anti-Retroviral Therapy
HIV	Human Immunodeficiency Virus
IP	Implementing Partners of HIV/AIDS Treatment Components
MTCT	Prevention of 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
UNAIDS	United Nations AIDS Programme
VCT	Voluntary Counseling and Testing for HIV infections
WHO	World Health Organization

Executive Summary

The second Regional Advisory Panel (RAP) meeting was held in Addis Ababa, Ethiopia on December 12-13, 2005. The discussions were very fruitful and successful in moving the learning agenda of the TAP forward.

The meeting provided an opportunity to discuss progress and challenges encountered during the early stages of the TAP implementation process. Most partners are now well on their way and have accumulated extensive domestic experience within the programme. This has enhanced the potential for regional learning which the meeting exploited. In addition to country presentations on current results, difficulties and future prospects, the meeting discussed the progress and role of operational research and multidisciplinary studies. The meeting also served the purpose of informing the ECA, World Bank and WHO on the support and needs anticipated by countries in the coming quarter.

The first part of the meeting focused on countries' presentations and discussions on their state of implementation in general and more specifically on their prevention of mother-to-child-transmission (PMTCT) programmes, some of the challenges they are facing like for example children access to treatment and care, the importance of routine testing, laboratory and human capacity and cost. The meeting was enriched with the experience of experts from Kenya and Malawi who presented their own PMTCT national programme, success and challenges they faced during the implementation period and the benefit to their country. Moreover, a presentation from Botswana stressed the importance and the benefit of paediatric treatment and provided valuable information that could be used in the TAP countries. The dialogue between TAP and non-TAP countries brought a lot of answers to many questions that were put on the table.

The second part of the meeting brought clarifications on the learning agenda and the role of operational research in the context of the TAP. The originality of the TAP is really to document the benefit of treating people rather than the numbers. The success of the TAP will be measured by the quality of the services and the benefit to the people. Several ideas on the type of research that would bring value added were shared during the meeting.

Finally, the meeting addressed issues that were still unclear in relation to the various roles and responsibilities to both the IPs and the facilitating partners.

1. State of implementation of the TAP in Burkina Faso, Ghana and Mozambique

The countries (Burkina Faso, Ghana and Mozambique) presented their state of implementation, results achieved so far, challenges and future prospects.

A. Burkina Faso

Burkina Faso reported that the number of PLWAs on treatment went up from 1,514 at the end of 2003 to 6,630 at the end of September 2005. The number of treatment sites went up from 7 in 2003 to 44 in 2005. 23 of these sites are from the TAP. The proportion of districts with at least 1 treatment site increased from 4% to 36% and the number of laboratories with a CD4 machine went up from 5 in 2004 to 13 in 2005 which is a 62% increase.

These results did not happen without any challenges. One of them was the late procurement of goods and services due to heavy bureaucracy. The reorganization of the services and the establishment of durable links between public structures and associations were also a challenging process, as well as the harmonization of management tools.

B. Ghana

As of today there is only one implementing partner in Ghana that is the Family Health International (FHI). FHI is 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. Sub-agreements between FHI and the 4 sites were developed and signed. The sites were assessed in the accreditation process to identify areas for upgrading and refurbishment. Service providers (doctors, nurses and pharmacists/dispensary technicians, 21 in all) from each site were trained in VCT, PMTCT, OI Management and ART using National Guidelines and Protocols. Ghana also reported that the Health Management Information System for patient tracking was upgraded at the sites and a comprehensive HIV care, including ART, is expected to begin before the end of 2005 in the FHI facilities.

The main challenge for Ghana is the delay in bringing other IPs on board to facilitate the effective take off of TAP. The National Catholic Health Service (NCHS) and Private Enterprises Foundation (FEF) are expected to come on board soon.

C. Mozambique

Mozambique is using an established MOH Information System, and has put in place standardized protocols, guidelines, forms, log-books and patient ID cards. Procurement systems of ARV drug have been centralized. In order to ensure a good coordination of all activities, meetings are organized weekly with representatives of HIV/AIDS programmes, NGOs and donors.

The rapid progression of the epidemic has put a lot of pressure on the government and IPs in Mozambique. The lack of skilled human resources at all levels and the deficient conditions of the infrastructures had to be dealt with aggressively. The National Laboratory Policy, however, is still under development and getting all the IPs to follow the national guidelines also appears to be a challenge. On top of the above challenges, there was some misunderstanding/misinterpretation of the World Bank procurement procedures that needed to be sorted out.

D. Discussions

Major issues that came out from the countries' presentation were: 1) children access to treatment and care, 2) routine testing and opt out, 2) laboratory capacity, 3) costs and financing, and 4) capacity building.

a) Children access to treatment and care

Managing HIV infected children in resource-limited settings is a fact: according to TAP countries, children continue to receive low priority with regard to HIV care and access: in their countries, the proportion of children benefiting from ARV is less than 5% (300 children in Burkina Faso), considering that the target for children to be on treatment is 15% to 20% of all the people who need to on therapy. This is mainly due to the lack ARVs adapted to children, lack of access to early HIV diagnosis, poor follow-up of mothers in PMTCT, and weak linkages between PMTCT and ART programmes.

In some countries, like Burkina Faso, PMTCT is the only entry point for children, consequently a real effort has to be done to promote it as a way of avoiding the infection of newborn infants. Should these newborn infants be infected, they should be carefully monitored and treated immediately. According to Dr. Gabriel Anabwani, BBCCCOE, Botswana, with no intervention, 30% to 40% of infected infants would die by the end of their first year.

Recommendations:

- Need for political leadership, commitment and continued advocacy;
- Infrastructure, drugs and health professional training are essential for successful scale-up;
- Improve access to early HIV diagnosis;
- Improve follow-up of mothers in PMTCT;
- Better linkages between PMTCT & ART programmes;
- Training of health professionals in paediatric HIV care;
- The BBCCCOE has had considerable success in providing comprehensive care for HIV infected children and their families and can provide guidance to TAP countries.

b) Routine testing and opt out approach

The meeting underscored the importance of routine testing. An increasing number of countries have started adopting it and they have noted its positive impact on behavioral change of the population. It also proved to be very important in improving access to care and reducing stigma.

Voluntary HIV testing systems, or opt-in programs, do not "work as well" as opt-out systems that do not "specifically ask for consent." This relatively new strategy calls for all pregnant women to be tested for HIV, along with a battery of other routine tests already conducted on pregnant women. If a woman refuses the HIV test, it is suggested that newborn infants get tested for the virus so that they can be treated immediately if necessary.

Mozambique is currently promoting opt out approach for TB and would like to introduce routine testing for PMTCT by integrating antenatal care. Burkina Faso has not yet applied it for PMTCT, while Ghana is now trying it at all PMTCT sites.

Recommendations:

- TAP to look at the benefit of routine testing and opt out approach and support countries to move forward with these.

c) Laboratory capacity

Laboratory capacity has been discussed at great length as a critical issue not only to improve and expand treatment, but also to have an impact on the cost of essential treatment packages. In Mozambique, since 2004 the DREAM programme was successful in reaching affordable prices both for reagents and equipments. Moreover, CD4 and viral load tests are also free of charge for ART patients. But unfortunately, this is not the case in all the countries.

On the procurement issue, still in Mozambique, NGOs are currently using different methods of procurement of reagents and equipments for laboratories. This makes it difficult to control the stocks and the need of distribution. The government is currently working on a policy to harmonize and centralize their procurement systems.

Training of laboratory personnel is also a major issue. According to Ghana training all midwives within facility settings would help minimizing disruption of programmes when staff are transferred out of the district or when they leave the service. This strategy is particularly helpful in settings where shortage of health personnel is a major problem. Moreover, frequent updates of knowledge and skills of health workers are necessary to ensure quality of care. Mozambique has been successful in offering training to all laboratory technicians in order to be self sufficient for the maintenance of the

laboratories. Burkina Faso, with the support of WHO, developed a policy of reinforcement of laboratories and training of laboratory technicians.

Recommendations

- Increase the number of laboratories with capacity to provide HIV support services (CD4, hematology, biochemistry and other equipment)
- Support reagent costs/procurement
- Improve the procurement of OI drugs
- Strengthen systems of quality assurance
- Improve human capacity
- Strengthen and support MOH procurement and distribution systems

d) Costs and financing

There was a long debate on free ARVs. Scaling up ART require assured long-term political support and funding. Once a government begins to finance a patient's AIDS treatment, that access becomes an entitlement that cannot be sacrificed to budget cycles without incurring large political costs. Moreover, continuing to support existing ART patients for the rest of their lives and absorbing new one while maintaining other health programmes, will require an important increase in the budget. Consequently, governments are hesitant to declare gratuity without the assurance of being able to sustain this decision and the duration of projects financed by internationals organizations (2 or 3 years) does not allow a long-term vision for the treatment of patients.

Another issue is that as AIDS treatments scale up in Africa, Asia and Latin America countries, patients will increasingly move towards more complex, expensive regimens including patented drugs. A major challenge for ART programmes will be to attain and sustain high levels of adherence among their patients. In Mozambique, for instance, it is estimated that about 2% of the people on the second line regimen would increase the Government's budget to about 17%.

Recommendations:

- Consideration to increase total budget amounts depending on 2006 experience (costs of drugs, 2/3 line usage rates, expansion rates)
- Greater flexibility in revising budget lines due to increasing treatment needs and high degree of uncertainty around programme costs (TB/HIV integration, expansion to underserved areas/populations, 2nd line drug costs)

e) Human capacity

It is assumed that to qualify to manage one or more ART patients, any facility must train a minimum number of providers in ART protocols and in order to keep them abreast of the rapidly changing technology of ART must be re-train every year.

In the ECOWAS region discussions are currently taking place among medical faculties to find ways to include courses on HIV/AIDS in the initial training of physicians. Countries

are also developing their own initiatives to introduce HIV/AIDS training into a pre-service process. Dr. Winnie Mutsotoso, PMTCT Technical Advisor reported that Kenya has been successful in introducing HIV/AIDS in one of its National training universities for physicians. Physicians acquire the knowledge and skills needed to manage ART patients.

To alleviate the need for more health personnel, steps are underway to train midlevel health service providers. In Burkina Faso, there is also a national training plan to allow all health providers to get the necessary training to manage ART patients. However, it appears that health providers getting such trainings do not get much recognition. This brings up the issue of lack of motivation.

In the Central Region, Mozambique has been successful in building human capacity by introducing an exchange programme among treatment facilities that are well established and those that are just starting. Health personnel can be trained in just two weeks. Through the TAP, Mozambique has become a training centre for other countries and all their laboratories are ran by local staff.

Health Alliance International (HAI) has requested, through the TAP, to have some money put aside specifically for training to improve their local human capacity. So far, HAI has trained 100 health personnel, biologists, physicians and nurses. HAI can also provide training to health personnel from neighbouring countries.

Recommendations:

- Develop and support innovative training strategies
- Support decentralization of training
- Improve content and capacity of basic training for health providers (nurses, clinicians, paramedical staff, etc)
- Promote and support exchanges between health staff with the regions
- Look into the issue of motivation of health providers

2. Exchange of experiences on PMTCT

This session provided an update on 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, and nutritional support of PMTCT programmes. The meeting also benefited from the experience of Kenya, Malawi and Botswana.

A. Discussions

The presentations were followed by discussions on:

a) Stigma

In some countries, like Botswana, routine testing started in 2004 and had a tremendous impact on PMTCT and the acceptance rate increased from 30% to 95% in six months. But the meeting recognized that social and cultural factors should not be taken lightly. A woman's decision to get tested, for example, is linked to several social and cultural factors like: influential family members' input, belief about the treatment, concerns about infant's future, woman's emotional state, trust in health services, clinic staff, cultural norms, health beliefs and male partner's attitudes. Routine testing can be very successful in breaking cultural barriers.

ARVs have improved the quality of life of people significantly. Patients go on working normally and interacting with their friends and families, which in the long run, represents the most powerful weapon against the very foundations of stigma and discrimination.

b) Toxicity

The meeting raised a concern regarding toxicity linked to nevirapine. However, several studies conducted both in the United States and in Africa proved that the toxicity rate was very low indeed. In 1990 a lot of women, including pregnant ones, were given HAART (which contains nevirapine) with no noticeable evidence of increased toxicity.

Another study has been conducted in Niger and showed that about 18% of the people had an increase of transminase of up to between 2% to 5% above normal. The study specified that there were other factors, like malaria or hepatitis B or C that could have intervened. There was no record of grave toxicity. It seems that nevirapine continue to be the easiest and cheapest treatment and there is not enough evidence to stop it. Toxicity would do less harm than the number of children who would be infected in a long run if the mothers weren't treated and who would require treatment for all their lives. Moreover, there are ways to monitor toxicity.

c) Side effects

There was an extensive discussion on side effects in ART patients and the difficulty of detecting some of them, particularly in small children who cannot express themselves. Unfortunately, all drugs, including ARVs, have side effects. Some side effects are more difficult to deal with than others, and may require changing the therapy.

Up to one-third of people with HIV may get some symptoms of peripheral neuropathy. In Botswana, 15%-20% of children have been diagnosed with this condition. Peripheral neuropathy is caused by damage to the nerves in the peripheral nervous system. It is usually felt at first as tingling and numbness in the hands and feet. Symptoms can be

described as burning, shooting pain, throbbing and aching. Neuropathy is very painful and thus very easy to identify.

There has been much debate over what cause lipodystrophy in ART patients. Some manifestations of lipodystrophy, like wasting in the face, arms, and legs, have been common since the earliest days of the epidemic. Or, it may even be due to the immune system becoming more aggressive once the onslaught of HIV is slowed down in response to therapy. Finally, it may be due to a combination, or different combinations, of these factors. Some researchers have proposed that it's due to direct effects of the protease inhibitors, and it certainly has become more common since they were made available. Others say that some of the nucleoside analogue drugs may be a contributing factor.

d) Resistance

On the issue of resistance to nevirapine in the cohort of women, the meeting disagreed that resistance would fade with time. There were two studies on the issue: one from Thailand which shows that people who are exposed to nevirapine (whether resistance was demonstrated or not) responded much less to nevirapine containing highly active antiretroviral regimen. The second study, from South Africa, is currently going on and shows that up to 55% to 60% of women who are exposed to one dose of nevirapine develop resistance.

There is a general consensus that nevirapine is still the best option for up-scaling PMTCT. But it was recognized that combination therapy is better than mono-therapy as it would compromise the future treatment of the mother and the child. Besides, there is ample evidence that identified women with HIV/AIDS, and a low CD4 count, should be put on HAART for at least six months.

e) Adherence

Participants discussed the issue of adherence among children. Adherence is to be taken seriously, especially on the first-line regimen. Poor adherence to first-line therapy will speed the development of viral resistance to those drugs and hasten the day when the patient must move to second-line therapy.

Few reasons that may be causing low adherence among children have been raised during the meeting: the high turnover of children's caregivers, lack of pediatric formulation and the difficulty of treating children, especially teenagers. Public intervention to support adherence can limit the spread of resistant virus; in particular, parents' support group & adolescent peer support proved to be efficient in providing additional psychosocial support to parents and children. Caregivers are also encouraged to disclose the child's status because one major problem with a child taking therapy is when he does not know why.

Recommendations:

- Develop programmes to reinforce adherence (health education, peer education, etc).

3. Learning Agenda and exchange of experiences on operational research

With regard to the learning agenda, the World Bank emphasized the need to not only look at numbers in terms of beneficiaries but at the benefit of up-scaling treatment. For example, one of the benefits of PMTCT is to prevent a further increase in the number of orphans by keeping the mothers alive as long as possible. Documenting how many children are surviving without HIV/AIDS on the PMTCT would be easy. However, documenting how many orphans have been prevented under the TAP appears to be more challenging as it relates to the survival time of the mothers. Another example would be to look at how many live-years have been saved under the TAP. If 30,000 people have been put on treatment for 2 years and all survived, there will be a benefit of 60,000 life-years. But if the 30,000 people die there would be no benefit.

The role of Associations in Burkina Faso, for instance, could also be an interesting issue to look at as it can determine the different types of services, decentralization, the issue of team spirit and motivation. Looking at how these questions can be translated into benefits could be interesting to document.

Each country should set itself for success and it depends on where each country is in the epidemic. The benefit to the household of keeping a member alive on treatment is definitely a benefit that could be measured. However, to translate it into a benefit at national level will not happen in a country like Ghana that has a very small prevalence rate but might work in Mozambique. Countries are recommended to look at benefits that can make an argument to scale up.

Burkina Faso currently has four research projects:

1) A research on resistant strains in pregnant women;
2) A clinical observatory to look at the different medical practices. This research was originally planned in 2005 but was aborted for lack of resources;
3) Together with WHO, a research on the medical practices used for providing treatment to PLWAs, both in public and private sites, free or not, and in the sites managed by the associations. Although all these settings are using the same national protocol, the approach used is different and can either improve or worsen the quality of treatment;
4) A household survey: what is the benefit to them? What is the behaviour? What is the adherence both at the household and clinical levels? The World Bank, as well as the Medical Institute of Amsterdam, is willing to support this research.

Burkina Faso is also interested in learning from Ghana how to involve the private sector in the fight against HIV/AIDS. The information would help to reinforce the involvement

of employers and employees. Moreover, Burkina Faso shared some concerns with regard to taking effectively a census of HIV/AIDS orphans, orphans and vulnerable children, and would like to learn the strategies Ghana put in place.

Another household survey is scheduled for 2006, financed by the World Bank, but has nothing to do with HIV/AIDS projects. There will be questions on education, on economy, on health, but nothing related to HIV/AIDS. Burkina Faso is currently discussing with the National Institution of Statistics to add 15-20 questions related to HIV/AIDS.

More proposals from Burkina Faso:

1. Benefit of the involvement of associations and communities (WHO – case study)
2. Contribution of nutritional PEC to adherence (WHO/World Bank – case study)
3. Contribution of the reinforcement of effective data collection to identify effectively people in need of treatment (WHO – routine data collection)
4. What happen to the lost to follow up? (analytical study at the national level)
5. (WHO – study in the context for health training)

Ghana would be interested in undertaking the following research:

a. Looking at the private-public partnerships in the context of ART;
b. The effect of differential pricing in ART services at TAP sites;
c. Exit interviews/surveys to measure the quality of services and adherence;
d. Review clinical data collected to monitor the response of both adults and children to treatment;
e. VCT/PMTCT services in the private sector;
f. Resistance monitoring;
g. Other clinical trials of national and global interest.

In Ghana a behavioural survey is currently under preparation. It was suggested to add a few questions related to HIV/AIDS that will hopefully give some indications on how people change their sexual behaviour in the context of antiretroviral treatment.

The meeting learned that a lot is being done in terms of research at the country level. The challenge for the institutions, IPs and Ministries of Health is to use their respective comparative advantages to extract as much as possible results from these researches, in terms of lessons learnt, and to share them widely.

A. <u>The role of ECA with regard to the Operational Research</u>

An important foundation for the ECA work programme centres on guiding and supporting, in consultation with WHO, World Bank and the RAP, the lessons learnt from the TAP process. 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 required to build a comprehensive baseline profile of each IP so as to understand the nature of these organizations and their programmes of activity (present and projected). These profiles will identify opportunities

for capacity enhancement, characterize the organizations 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.

Regarding the operational research, ECA offered to undertake any research on a need basis and welcome any suggestions from countries.

ECA is tasked with collecting quarterly reports from countries, the analysis of the data and dissemination of the results to other countries. The TAP website was presented to the countries as a tool to exchange information and post quarterly reports;

B. The role of the DECRG (World Bank) with regard to the Operational Research

DECRG is a research arm of the World Bank that has received some fund for operational research and is supporting the TAP.

Proposal for a learning agenda for the TAP: a set of questions was prepared during a joint WB/WHO/ECA meeting in Nairobi in June 2005. There is a need to adapt it to the needs and realities in Burkina Faso, Ghana and Mozambique.

1) What is the full socio-economic benefit of treatment for the patient and his family?
2) What is the impact of treatment availability on prevention in both HIV positive and HIV negative people?
3) How to avoid the development and spread of resistance?
4) Adherence
5) How are ART beneficiaries identified? How to encourage timely uptake?
6) How to assure the quality of HIV/AIDS service delivery?
7) How to encourage capacity building to reinforce the sustainability of ART delivery?
8) Technical issues

C. The role of WHO with regard to the Operational Research

WHO shared with the participants some of the support provided to countries in terms of M&E. There were some technical consultations in June in Harare in which many countries participated and technical assistance missions were conducted wherever countries requested support. WHO also looked at the M&E system at country level and looked at the weaknesses and the ways to strengthen the system. TAP is an opportunity to strengthen the overall M&E at country level and this is important in term of service delivery because M&E starts with patient tracking.

WHO also informed the meeting that a number of tools are currently being developed. Some of them will be available in the first trimester and may be useful:

Up-coming tools

- PMTCT and various tools
- Training: IMAI treatment and care at district level
- Drug supply management and HIS
- Most at Risk Populations (MARP) guidance
- Evaluation (e.g. Burkina Faso)
- Operations Research (Generic tools)
- Data use and analysis, triangulation (e.g. Botswana)

Example of tools in development: PMTCT

- PMTCT training module for IMAI
- Programming guide for scaling-up PMTCT programme
- Brochure on minimum package of PMTCT
- Revised PCPNP
- Operational guide for the implementation of WHO guidelines on ARV for treating pregnant women and preventing HIV infection in infants and Operation guide for the provision of follow-up services (PMTCT)
- M&E (addendum to national guide, draft distributed)

4. Challenges of governing the TAP and other issues

During the first part of this session, partners raised some of the challenges they are facing in making the TAP a success, and the administrative and financial issues they have. The second part of the session allowed ECA to present a skeleton of the upcoming TAP website. Partners were able to comment and to advise on substantive information they would like to be included in the site.

A. Challenges of governing the TAP

a) Reporting format

The issue of the reporting format was clarified. A template (Annex B) has been designed by WHO and shared with participants. This template will be useful in getting standard reporting format from the countries.

b) Reporting mechanism

Regarding the issue of reporting mechanism, it was clarified that the IPs should send their report, on a quarterly basis, to the TAP Coordinator appointed by WHO and located in the Ministry of Health of each country. The IPs' reports would be reviewed by the Ministry of Health, combined and sent to the World Bank office in the country. The World Bank would then send the report to the TAP Secretariat located in ECA.

c) Coordination mechanism

The meeting shared a common concern on the need to look at a coordination mechanism to ensure synergy between the various research efforts. If there are two similar research approaches done at the same time they can complement each other in order to maximize resources.

d) Timeliness and quality of the data collection

Another concern was related to the timeliness and the quality of the data collection. Any time a new indicator is added it takes time away from the implementation and it compromises on the quality of the work.

The meeting was encouraged to get down to the grassroots of the data collection and look at how to improve the capacity of the data collection.

e) Format of the RAP meetings

It has been unanimously decided that the format of the RAP meeting should be maintained. There will be two meetings (2 days long) per year. It has been agreed that there is no need for a separate RCCC meeting. However, the experts who will participate in the initial thematic discussions will have a parallel session where they could elaborate and have in depth discussions on technical issues and challenges. At the end of the RAP meeting there would be a feedback session where the operational and technical issues would be brought together for the next steps and the way forward.

The meeting recognized the importance of having experts from non-TAP countries to come and share their experiences.

It was also suggested that the agenda of the next RAP meetings should be more countries-driven and that countries should be more involved in setting the agenda. The TAP coordinator at the country level, around whom all the partnerships evolve, could be the best person to take charge of this.

Examples of themes for the next meeting could be: 1) TB/HIV integration, 2) How to integrate HIV services into the health system and into other services globally or 3) themes of adherence and resistance that are related to each other.

Finally, it was suggested to hold the next RAP meeting in June/July 2006 in Mozambique and to coincide it with a joint World Bank/WHO/UNECA mission. Mozambique will confirm whether the timing is suitable to them.

B. Website

The meeting agreed that the TAP website, if used well, can be a useful tool to share information among all the partners. A private portal will be available to allow the IPs and their respective Ministry of Health to exchange useful information privately.

The website should also be used for continuous capacity building and for promoting best practices and strategies that are validated during the meetings. For example, guidelines proposed by WHO in term of harmonizing practices for clinical care and community-based care should be on the website.

ECA stressed the importance for the countries to post their quarterly reports on time on the website.

It was strongly recommended that the website be in French and English in order to make people feel welcome.

Finally, ECA will inform partners and countries when the website will be launched.

5. Key recommendations and the way forward

- ECA will make operational the website for TAP at http://www.uneca.org/tap/ where all related plans, progress reports, implementing partners, and materials would be posted.
- WHO would make available guidelines and relevant documents for easy reference.
- The template (0 draft) for quarterly reporting for TAP activities at country level (at RAP) was presented by WHO and discussed. This reporting format will be distributed by the World Bank and discussed at country level by NACP, WHO and World Bank -TAP Coordinators for feedback and consolidated into the final version. It will then be used and sent by the country TAP coordinator to the WB with copies to WHO and ECA.
- The Next RAP meeting is planned for June 2006, preceded by a joint country review. Maputo was suggested as venue but Mozambique needs to send confirmation after further internal consultation.
- It was agreed that RAP should combine technical issues and administrative/financial and managerial issues. This option was reinforced by the success of the PMTCT thematic session at this RAP/RCCC Meeting.
- It was also decided that parallel sessions for the experts should be envisaged in addition to plenary sessions involving programme managers and partner institutions. WHO should play a lead role in involving experts from its Technical Resource Network Specific.
- The TAP countries were invited to refine their research needs and to work with ECA to initiate the studies as required.

- WHO financial issues. A side meeting was organized with WB representatives to get clarification. The common was that WHO could get its disbursement of funds if the following two conditions are fulfilled:
    - WHO technical plan (activities and budget) should be discussed with MOH/NACP Coordinators, revised if necessary and cleared by WB at country level. A clearance letter from WB representative should be sent to Bert Voetberg at WB regional office- Action focal point of TAP at WHO/CO.

Annex A

TAP
Treatment Acceleration Programme
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TREATMENT ACCELERATION PROGRAMME

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Addis Ababa, Ethiopia - 12-13 December 2005

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Annex B

COMPARATIVE TABLE AND SUGGESTIONS TO COUNTRIES FOR COMMON REPORTING OF TAP PERFORMANCE INDICATORS:
PAD and June 05 Nairobi meeting reference to International Guidelines (Vers. Sept. 05)

Categories	**Project Appraisal Document (PAD): Key TAP-Performance Indicators (p. 90), and Nairobi June meeting (see*)**	**International Standards Reference to International Guidelines**	**Defini-tions (ref internat. Guidel.)**	**Methods (source) and Frequency**	**Comments** The indicators referenced in the International Guidelines are for the national level, and need for the TAP to be adjusted accordingly (to report numbers and %)
Process	**- Number of TAP regional publications reflecting lessons learned and best practices disseminated within TAP countries and other countries to facilitate learning**	no standard M&E reporting		Ref. publ. 1/ trim.	8 different questions for the learning agenda have been defined for TAP (Nairobi, Jun 05) and will be reflected in UNECA plans (see below)
	- Number of learning agenda questions addressed*	no standard M&E reporting		Ref. plans and reports 1/ trim.	8 different questions for the learning agenda have been defined for TAP (Nairobi, Jun 05) and will need to be reflected in the national plans
	- Number of ongoing operational research activities (out of planned)	no standard M&E reporting		Ref. plans and reports 1/ trim.	Countries are to determine and spell out the nb of O.R. for the project (2nd sem 05)
Outputs (Sites Nb)	**- No of existing/ VCT sites**	In "Guide to indicators for M&E national HIV T&C programmes": "The percent of facilities that have	Ouput indicator nb 5, pp.	Record or program. review,	

		the capacity to provide an HIV test, including: policies or guidelines for informed consent and confidentiality, adequate supplies, a client register, and documentation for recording whether results were given to the client."	18-9	1/ 6 mo., or SAM 1/ 2 years	
	- Number of facilities upgraded to provide comprehensive prevention, diagnosis, treatment and care services **a. Nb of treatment teams trained and operational (nb of teams per site?)**	In "NAP A Guide to indicators for M&E national ARV programmes": % of health facilities with ART services which also provide comprehensive care, including prevention services, for HIV-positive clients a. Nb of health workers trained on ART delivery in accordance with national or int standards	Output indicator nb 6, pp. 22-3 Process indicator (core) nb. 4 pp. 18-9	Record or program. review, 1/ year, or facility survey or SAM 1/ 2 years Annually, training pgms	
	- Number of facilities providing treatment and care in: **a. rural** **b. poor urban** **c. peri-urban areas**	In "NAP A Guide to M&E HIV/AIDS Care and Support": % of health facilities with systems and items for provision of ARV therapy services" (linked to Care and Support Indicator 7)	Output indicator nb. 5, pp. 23	Record or program. review, 1/ year, or facility survey or SAM 1/ 2 years Annually, training pgms	- Each country will have to set criteria to categorise rural, poor urban, and peri-urban based on their national criteria
		In C&T "Guide to indicators for	Output	HIS	The international guideline suggests

		M&E national HIV T&C programmes": % of persons who complete the HIV T&C cycle in the last 12 months	indicator, nb 7, pp. 23.4	1/ trim.	a coverage indicator through surveys (this can be reported if surveys are done). We recommend the use of the routine reporting with the breakdown requested at svce delivery sites through the HIS
Outcomes (Coverage)	**- Total number of persons tested annually** **(as "number of persons utilizing VCT:** **a. % female** **b. Nb youth under 25 (in total of which female")**	In "Guide to indicators for M&E national HIV T&C programmes": The percentage of the general population receiving an HIV test, the results, and post-test counselling, in the last 12 months	Outcome indicator, nb 7, pp. 24-25	HIS 1/ trim.	- The international guideline provides info only through general population survey. We recommend to collect the indicator suggested in the PAD at svce delivery sites through the HIS
	- Number of mothers and infants (mother and baby pairs) under PMTCT care **a. Nb of mother-baby pairs on ARV ttmt.**	In PMTCT "NAP for the Prevention of HIV in Infants and Young Children": - Antiretroviral prophylaxis in HIV-positive pregnant women, and - HIV-infected infants born to HIV-infected mothers (both UNGASS indicators)	Core indicator nb 5 (p. 17), and nb 6 (p. 18)	HIS 1/ trim.	- The international guidelines give methods to calculate these UNGASS indicators through programme monitoring and estimates. We recommend to collect these 2 indicators with the Nb of mother-baby pairs under PTMTC care prophylaxy (mother, baby), and treatment (mother, baby)
	- Number of persons being treated with ARVs	In "NAP A Guide to indicators for M&E NAP ": % of people with advanced HIV infection receiving	Core indicator nb 7 (pp	HIS	- Need to add the age breakdown to report on TAP (by sex and age is also standard international practice)

	a. % female **b. Nb of youth under 25 (total, nb female, and shown by age groups)**	ARV combination therapy (UNGASS indicator)	24-5)		
	- Total estimated number of PLWHA eligible for ART	In IMAI: "Enrolled in HIV care and eligible for ART" (but not yet ready)	Indicator (IMAI)	HIS	- Will need a careful set-up of patient tracking, including HIV Care/ Pre-ART registers (not all encompassing of access to ART) - This is the denominator calculated in Core indicator nb 7 (p. 24)
	"Continuation of first-line regimen at 6, 12 and 24 mo after initiating treatment"	In " NAP A Guide to indicators for M&E NAP"	Core indicator nb 8 (p. 26)	HIS	Tracking early drug resistance early warning signs of treatment failure (added indicator, not on the PAD but quite valuable and should be available)
	Survival at 6,12,24,36, etc. months after initiation of treatment **(for definition - "Number of people on ARVs who have died")**	In " NAP A Guide to indicators for M&E NAP "	Core indicator nb 9 (p. 27) with "lost to follow-up which will include those who have died	HIS	Sub-part of the survival indicator but difficult to determine the exact nb of those who have died The survival indicator calculates: - nb people initiating ART - nb of people continuously on ttmt at different intervals, and - nb of people who have stopped ART, transferred out, people lost to follow-up, and those who have died.
	Case fatality of people on ARVs	Ref IMAI		HIS (Patient tracking)	
	- Number of persons	In IMAI, for prophylaxis: Nb on co-	IMAI	HIS	Receiving prophylaxis for OIs who

	(PLHIV) receiving OI prophylaxis **a. % female** **b. nb. Youth under 25 (in total of which female)** **(original definition "receiving OI prophylaxis/ treatment")**	trimoxazole, fluconazole, INH prophylaxis at end of month	indicator 4. a (p. 32)		are not on treatment for OI (need to separate OI prophylaxis and treatment). An increase in this nb would show that the programme is improving (in comparison to the next indicator)
	Number of persons (PLHIV) receiving treatment for OIs **(original definition: "with access to prophylaxis/ treatment of OIs")**	In upcoming 2006 Guidelines on OI treatment	Number of persons (PLHIV) receiving OI prophylaxis/ treatment	Number of persons (PLHIV) receiving OI prophylaxis/ treatmen	A decrease in this nb would show that the programme is improving (in comparison to the indicator above)
	- Patients on ART: "Percentage of people with advanced HIV infection receiving ART" (core indicator 7) **(original definition: "Total sero-positives registered and regularly monitored")** **or Number of eligible PLWHA being treated**	In "NAP A guide to indicators for M&E national ARV programmes" (In IMAI, one can see breakdown of Indicators related to "current on ART" (start, substituted, switched)	See guide core indic 7 (IMAI Indicators related to patient current on ART)	HIS	- Will need a careful set-up of patient tracking, including HIV Care/ Pre-ART registers

	with ART				
	- Number of persons receiving home-based care **a. % female** **b. nb of youth under 25 (in total &of whichfemale)**	In "NAP A Guide to M&E HIV/AIDS Care and Support": external support for chronically ill people	Core indicator 9 (CS 9) (p. 27)	HBC reporting	Further breakdown may be considered for any HBC or HBC for those living with HIV
	- Number of people eligible for treatment who cannot afford it and are exempt from user fees (Ghana only)	No standards		HIS	- Specific to Ghana (x-check in-country)