

TAP

Treatment Acceleration Program

Report of the

**3rd Regional Advisory Panel (RAP) and 1st Regional Clinical
Coordination Committee (RCCC) meetings**

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Table of Contents

	Page
List of acronyms	3
I. EXECUTIVE SUMMARY	4
II. STATUS REPORT	5
1. Status of implementation of the TAP in Burkina Faso, Ghana and Mozambique	5
2. Exchange of experiences on HIV drug resistance monitoring and M&E patient tracking	10
3. Exchange of experiences on Operational Research and up-coming activities	12
4. Recommendations	15
5. Way forward	19
III. ANNEXES	
Annex A: Burkina Faso action points	20
Annex B: Ghana key action points	20
Annex C: Mozambique action points	21
Annex D: List of participants	22

List of acronyms

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

I. EXECUTIVE SUMMARY

The 2nd Regional Advisory Panel (RAP) meeting was held in Addis Ababa, Ethiopia during December 12-13, 2005 and focused on countries' presentations and discussions on the status of implementation in general and more specifically on their PMTCT programs. The meeting also brought clarifications on the learning agenda and the role of operational research in the context of the TAP.

The 3rd RAP meeting was held in Maputo, Mozambique during June 22-23, 2006. Per recommendations from the last meeting the First Regional Clinical Coordination sub-Committee (RCCC) meeting, composed mainly of experts from TAP and non-TAP countries, was held in parallel to allow in depth discussions on identified clinical issues and challenges. It was agreed by the countries and agencies involved that the focus of these meetings would be on (i) drug resistance monitoring and adherence issues and (ii) patient tracking and monitoring systems. The RCCC meeting benefited from the experience of experts from WHO-AFRO and WHO-HQ and discussions were specifically centered on exchange of experience on patient tracking and monitoring and evaluation (M&E) systems for HIV/AIDS prevention, treatment and care programs.

The 3rd RAP meeting provided an opportunity for the Implementing Partners (IPs) from Burkina Faso, Ghana and Mozambique to discuss progress and challenges encountered since the 2nd RAP meeting. Each country made a presentation on the status of implementation in their respective country highlighting: i) The situational analysis (overview of current situation with facts and figures – services provided, prevalence, people on treatment, cost of treatment per patient, and different approaches by different IPs; ii) Lessons learned; iii) Key issues and challenges; iv) Questions in general related to treatment; v) Pertinent issues relating to patient tracking system and drug resistance.

RAP and RCCC participants met on June 23rd to share their views and recommendations of their respective discussions, and to discuss the learning agenda, next steps for the countries and the way forward for the TAP.

II. STATUS REPORT

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

The 3rd RAP meeting mainly focused on getting a comprehensive picture with regard to the monitoring of drug resistance - one of the potential threats to the ART programs and a corporate risk and tracking systems and monitoring patients. Burkina Faso, Ghana and Mozambique presented their status of implementation, results achieved, challenges and lessons learned.

1.1. Burkina Faso

1.1.1. Main results

Burkina Faso reported that the number of VCT centres rose from 56 at the end 2004 to 95 at the end of 2005. Forty three of these are supported by TAP (46% of the total number). About 190,263 people were tested at the end of 2005, including 81,183 supported by TAP (43% of the total number).

With regard to PMTCT the number of sites has more than doubled from 63 sites at the end of 2004 to 152 at the end 2005. 82% of these PMTCT sites are benefiting from TAP support. 25,023 women benefited from antenatal care and HIV testing in 2005. The number of ARV treatment sites, including those supported by the network of associations, went up from 24 in 2004 to 46 at the end of 2005. The number of PLWAs on treatment went up from 3,867 at the end of 2004 to 8,136 at the end of 2005, and subsequently rising by almost 20% to 9,538 in the first half of 2006. Among these 9,538 PLWAs on ARV, TAP has provided support to 5,515 patients, which represents 57.8% of all ART patients in Burkina Faso. At the end of 2005, TAP had supported 2,520 patients with ARVs representing 31.08% of the target number of patients (7,000) expected under the TAP by 2007.

Psychosocial and nutritional care have been provided to HIV patients mainly by the network of associations and NGOs which has greatly contributed to the quality of treatment: for example, 255 nutritional educational sessions were organized by the networks in 2005 and 1,922 people have been trained in correct nutritional care. The number of people benefiting from nutritional support has more than doubled from the first to the second half of 2005 going from 2,932 to 7,593 people.

The table below summarizes the TAP contribution using indicators in key areas of the TAP.

Burkina Faso: Indicators in TAP key areas

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

1.1.2. Challenges and lessons learnt

Challenges

Challenges remaining are basically the same as reported during the 2nd RAP meeting and mainly relate to the late procurement of goods and services due to heavy bureaucracy. A new challenge that has appeared recently is that with greater availability of treatment through TAP support, there is higher demand for care. This is slowly eroding the capacity of certain health centres and they will therefore require more support.

Lessons learnt

It is clear in the Burkina Faso context that strengthening the capacity of TAP beneficiaries has contributed to improve treatment of PLWAs and the involvement of associations and NGOs has contributed considerably to scale up access and adherence to ARTs. Another lesson is that frank collaboration between PLWA associations and public health structures appears feasible when properly initiated.

Unquestionably TAP funding has contributed to accelerate the inclusion of eligible PLWAs to ART, at the national level. Special attention, however, needs to be given to the monitoring of drug resistance and the sustainability of TAP in order to capitalize on these fulfilling experiences.

1.2. Ghana

The TAP in Ghana is piloting public-private partnerships through engagement of international for-profit NGOs as well as private clinics in scaling up treatment for HIV patients. In keeping with that, Ghana has contracted the National Catholic Health Service (NCHS) for provision of treatment services under the TAP. NCHS will work with the Family Health International (FHI)'s implementation that was previously initiated. Discussions are still ongoing with the Private Enterprises Foundation (PEF) as a prospective IP and are centered on the revised proposal that was submitted in May 2006.

1.2.1. Main results

Four FHI supported sites began comprehensive HIV treatment in March 2006 after health personnel were trained in all the aspects of HIV care (VCT, PMTCT, management of ARTs, STIs and OIs, good laboratory practice, LMIS and HMIS). 97 patients have been enrolled in clinical care since the beginning of TAP and 38 are now receiving ART. Six NCHS sites are under preparation and will begin providing comprehensive care in July 2006.

The table below summarizes the TAP contribution using indicators in key areas of the TAP.

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

	-Proportion of women - Number of young people under 25			
	Number of operational research activities undergoing	N/A	N/A	

*N/A – not available

1.2.2. Challenges

The major challenge of the Ghana TAP has been its slow implementation. This was mainly due to the change of IPs and the delay in signing on a third IP which among others has the responsibility for mobilizing surrounding communities to utilize services at TAP sites.

Other challenges encountered in the past 6 months include the high charges for consultation in private health institutions and this has been a barrier to increase clients' enrollment. Moreover it was noted that the level of collaboration between public health institutions and TAP facilities seems to be an issue requiring some attention.

1.3. Mozambique

At the end of April 2006, a total of 23,956 patients in Mozambique were getting ARVs in 45 treatment sites. Of these 23,956 registered ART patients, children accounted for 8.6%, youth accounted for 9.6% and adults constituted the majority of patients at 81.8%. 40% of the ART patients are treated at sites where TAP funds are being used by Sant'Egidio, Pathfinder and Health Alliance International.

In the past 12 months the uptake of ARV delivery has increased by 5.91% each month. However, Mozambique needs to increase the capacity for new inclusions by 11% per month to meet the national target of 55,000 ART patients by the end of 2006.

1.3.1. Main results

Mozambique reported that since the beginning of the TAP, there has been a significant increase in uptake of services like VCT, management of OIs, HBC, PMTCT and ART. Moreover, Coordinators for HIV/AIDS, TB and Malaria were recently appointed to assist in the process of decentralization of the program at the provincial level.

It was also reported that personalized services in youth friendly clinics have been effective in encouraging HIV positive young people to seek treatment and care and the role of "activistas" has been important with regard to adherence support and tracking of defaulters by ensuring better provision of care and minimizing the risk of drug resistance.

Extensive training of medical officers and health personnel in ART management has been completed and a center for Operational Research has been established.

Finally, simplification of procurement procedures for OI drugs and introduction of national forms have been initiated by the Ministry of Health in almost all treatment sites.

There is now a mechanism for regular reporting of ART activities from treatment sites to the provincial and central levels.

The table below summarizes the TAP contribution using indicators in key areas of the TAP.

Mozambique: Indicators in TAP key areas

		Baseline at the end 2004	Results reached at the end of 2005	TAP contribution
VCT	Number of Health District with at least 1 VCT centre	N/A	67	
	Total number of VCT centres	113	223	
	Number of people tested	294,567	685,239	
	- Proportion of women: - Number of young people below 25	67% 118,324	61% 305,749	
PMTCT	Proportion of districts with at least 1 PMTCT centre	N/A	N/A	
	Total number of PMTCT centres	51	88	
	Number of women seen and tested during antenatal care	46,583	99,835	
	- Number of mother-children under ¹ PMTCT treatment - Number of mothers under ARV	3,182 (m) 3,335 (c) 197	7,690 (m) 5,437 (c) 554	
ARV treatment	Number of health districts with at least one ARV centre	17	30	
	Number of structures providing treatment and care	23	39	
	Total number of PLWAs under ARV	6,500	19,754	
	- Proportion of women	N/A	54.7%	
	Number of people benefiting from prophylaxis/OI treatment ² - Proportion of women - Number of young people under 25	N/A	N/A	
	Number of people receiving home care - Proportion of women - Number of young people under 25	11,355 N/A	27,582 N/A	
	Number of operational research activities undergoing	N/A	9	

In relation to the 3rd column (TAP contribution) it is not possible to give this information. The three IPs have been working in the National System long before the implementation of the project and are not exclusively funded by TAP. The Ministry of Health will work with the IPs in order to provide in the future the portion of their budget that is financed by the World Bank under TAP.

1.3.2. Challenges and lessons learnt

Challenges

Although the TAP has been very helpful in providing treatment and care in Mozambique, there are still many challenges. In particular, there is still a need to (i) strengthen program management capacity at the provincial level, (ii) expand treatment sites to the North and Center regions of Mozambique (improved infrastructure, human resources, laboratory equipments, etc), and (iii) strengthen the M&E system especially in data

¹ Current PMTCT monitoring systems in Mozambique provide information on individuals (mothers or babies) who are given ARV prophylaxis but not on those cases where both the mother and her newborn child together receive prophylaxis. It is therefore impossible to calculate exactly the percentage of HIV-positive pregnancies in which a complete (i.e. to both mother and child) ARV prophylaxis is provided.

² In process of revision of the log book and monthly reporting form in order to capture this information.

collection, analysis and interpretation in health facilities, health districts, NGOs and CBO levels.

Another challenge is the lost opportunities to recruit patients from other components of health services (TB, PMTCT, STIs and in-patients) and the Ministry is hoping to better integrate these components soon. Monitoring of drug resistance is still rather weak and the development and adoption of one national patient tracking system are key for improving treatment programs in Mozambique. Finally, there is a need to develop more culturally appropriate prevention messaging.

Lessons learnt

A key lesson is that nutritional support should be used as an incentive, only initially, for patients to get medicines. Guidance on proper nutritional care should be provided to all patients so that they can maintain their nutrition even without nutritional support.

Another lesson is that the adoption of norms and procedures for contracting NGOs has contributed to the reduction of risks and deviation during implementation of programs. Mozambique also learned that with additional funds and the involvement of NGOs it is very feasible to increase the number of ART patients without compromising the quality of services.

2. Exchange of experiences on HIV drug resistance and M&E patient tracking

2.1. Monitoring HIV Drug Resistance

All three TAP countries have recognized that development of drug resistance is a significant risk for their treatment programs and have put in place initial mechanisms to monitor potential development of drug resistance. The three countries are at different stages of this process and discussions during the RAP and RCCC meetings enabled them to share experiences and ideas on approaches for monitoring resistance in their national settings.

In Burkina Faso, research was conducted on 127 HIV-1+, consisting of 97 ART patients (mostly on first line regimens) and 30 treatment naïve patients in Bobo Bioulasso and Ouagadougou. Initial results indicate that 77 patients tested resistant to at least one ARV, 17 are still undergoing analysis and 3 have to be re-tested.

A pilot study on drug resistance monitoring was also conducted in Ghana in October 2005 where 54 samples were collected from treatment naïve patients. As Ghana still needs to build its local capacity and improve skills for monitoring drug resistance, analysis were done in Spain and showed no resistance. Since then, a Sequencer has been purchased using TAP funds, to allow future in-country analysis. At the same time, a proposal is being developed to form a drug resistance expert committee to facilitate research and establishment of a monitoring system through support from the Global Fund, OPEC and the NACP.

In Mozambique, drug resistance monitoring is being done through collaboration between the Ministry of Health and the Communita di Sant' Egidio DREAM program. Professor Leonardo Palombi presented some initial findings from their research on "HAART and resistance viral mutations monitoring in Mozambique" that is currently underway. The objectives of the study were to i) Assess whether virus strains circulating in Mozambique are naturally resistant to antiretroviral therapy; and ii) Define clade specificity of viral strains.

Conclusions on naïve patients:

- HIV-virus strains circulating in Mozambique belong to clade C (the most common in the world);
- Primary mutations affecting the efficacy of antiretroviral drugs are absent in this cohort of patients, thus suggesting that (in principle) antiviral therapy is effective;
- Clinical results confirm the great activity of antiretroviral regimens used so far;
- Nevertheless, the presence of a substantial number of polymorphisms (typical of subtype C virus) suggests the importance of carefully monitoring long-term efficacy of antiretrovirals, that may somewhat be different than that found in Europe and America where subtype B is prevalent;
- Monitoring resistance to antiretrovirals in patients failing therapy remains crucial also in Africa.

Conclusions on pregnant women:

- Development of resistance to antiretroviral drugs is limited in pregnant women treated with triple therapy, lower than the prevalence reported for treatment with nevirapine alone.

Conclusions on patients failing ART:

- Resistance to antiretroviral drug is relatively common at the time of failure;
- Resistance is mainly confined to drugs with low genetic barrier (3TC and NNRTI), that do not compromise the efficacy of the second therapeutic regimen;
- Thymidine associated mutations (TAMS) that confer cross resistance to many antiviral drugs are rare at the time of failure;
- Protease mutations conferring resistance to antiretroviral drugs are also rare, and related to the use of protease inhibitors not-boosted with ritonavir. Conceivably, the introduction of boosted protease inhibitors will increase efficacy and further decrease the rate of resistance.

The main conclusion of the study is that salvage therapies can be foreseen as effective in African settings where therapies are properly given and followed-up.

2.2. Patient Tracking Systems and Monitoring

Similar to the monitoring of drug resistance, the development of patient tracking systems in the TAP countries is still lagging behind implementation and most patient tracking systems in use are piecemeal efforts. However, all the countries recognize that one patient tracking mechanism should be used in order to ensure that patients can be referred or transferred to other facilities with ease and for better tracking of key treatment indicators at the national level.

In Burkina Faso, a comprehensive patient tracking system (PTS) has not yet been developed. But with WHO technical assistance, a workshop was held on March 27-31, 2006 in order to elaborate the first draft of monitoring ARV resistance protocol. All organizational requirements are in place and an operational PTS should be ready by December 2007.

A comprehensive PTS is in progress in Ghana and this locally generated PTS is being piloted at the regional hospital level with plans to roll it out to other ART sites in the coming months. The PTS will be networked between ART sites and the National AIDS Control Program (NACP) so that the data can be aggregated and monitored against national targets. Data to be entered will include patient demographic and clinical management information. This new PTS will facilitate access to data at national level and inter-site referrals.

In Mozambique there is no one uniform PTS. Sant' Egidio, HAI and Pathfinder are using a different one. However, the Ministry of Health has created a task force to have a look at these PTS and develop a national system to be used in the public sector based on the positive aspects of the systems currently used by the IPs. In public facilities all registrations are done manually and based on the old-fashioned registry system of hospitals.

3. Exchange of experiences on Operational Research and up-coming activities

3.1. Operational Research

3.1.1. Socio-economic impact of treatment

In order to gain lessons on the socio-economic impact of treatment, the Research Department of the Bank (DECRG) is conducting operations research to evaluate two dimensions of the TAP: (i) benefits to patients' well-being and to households; and (ii) effects, both beneficial and adverse, of treatment availability on risky sexual behavior. The two research questions will be addressed by implementing longitudinal (3 rounds) household surveys among households with HIV/AIDS patients and other households from the general population in the three countries. The same questionnaire will be administered to both types of households.

The questionnaire will be used to assess the socio-economic impact of treatment. Measured outcomes will include poverty measures, labor force participation, earnings, children's education, health and other indicators of well-being.

In addition, by following patients who received their treatment under different types of delivery modes (community based, hospital based) it will be possible to identify the key determinants of treatment adherence and reducing the risk of resistance. Data on the inputs (costs, human resources) involved for each delivery mode will also be collected, together with medical records of the patients (anonymously linked).

The behavioral component of the questionnaire will cover knowledge, attitudes and behavior related to the HIV/AIDS epidemic. It will also develop a measure of proximity to antiretroviral treatment to assess how attitudes and behavior change when antiretroviral treatment becomes available in a community.

The Bank will use two surveys to address this set of questions. The first survey is a household survey of patients and their families plus control households. The Bank has published a call for expressions of interest for the implementation of the survey and is currently evaluating the proposals received from firms. The research proposal was submitted to the National Ethics Committee and their comments and questions have been addressed.

The Bank will also be able to use the National HIV Survey as the National Institute of Statistics (INE) has agreed to include questions about ART (treatment availability and perception). These questions will allow looking at the issue of behavioral change. The survey is expected to be conducted in the second part of 2006.

In Ghana, data related to behavior and knowledge of HIV/AIDS has been collected as part of Ghana's Behavioral Sentinel Surveillance and is at the data entry stage. Several meetings have been held to discuss the modalities of the anticipated household survey.

3.1.2. Quality of Service Delivery

A measure of the quality of service delivery in the HIV/AIDS sector is also crucial in assessing success, and learning from the experiences of the TAP. In 2002, a combination of a QSDS and PETS (Public Expenditure Tracking System) was implemented in health facilities in Mozambique in 2002 under the name of Expenditure Tracking and Service Delivery Survey (ETSDS). The set of health facility surveys that the Bank proposes would be a follow-up on the 2002 survey, with an added focus on HIV/AIDS and ART service delivery. Ireland has agreed to provide financing of US\$150,000 to that effect. The next steps are to finalize the financial arrangements and start the contracting process.

3.1.3. Public-Private Partnerships (PPPs)

PPPs supported under TAP are formalized through contracts between the Ministries of Health in the TAP countries and their respective Implementing Partners (IPs). The objective for supporting PPPs is to strengthen the countries' capacity to scale up comprehensive treatment, including anti-retroviral therapy, in an effective, affordable and equitable manner. ECA will hire a research institute to assess four areas in the design

and functioning of the PPPs supported under TAP: governance, costs, performance and sustainability. All IPs will be assessed, using both qualitative and quantitative instruments. Findings of this research will be shared at the next RAP meeting.

3.1.4. Other areas of research

WHO is conducting the following research in the TAP countries:

- Practices used in treatment patients with ARV (Burkina Faso).
- Demonstration of national program's efficiency in treating patients with ARV (Burkina Faso).
- Innovative financing methods for accelerated access to HIV/AIDS care, treatment and prevention in the health sector (Burkina Faso, Ghana, Mozambique).

In Mozambique, Health Alliance International (HAI) is currently doing research on the development of indicators that will improve the monitoring and evaluation system and analyze routinely collected data to identify bottlenecks in the system (flow analysis).

HAI is also working on better integration of HIV services into the regular health system. Recently published documents and presentations are posted on HAI's website:

<http://depts.washington.edu/haiuw/html/programs/mozambique/>

3.2. Communication strategy to disseminate lessons learnt from the TAP

ECA presented during the meeting a synopsis of a communication strategy for TAP, consisting of unique penetration/dissemination strategies, media relations, M&E, etc. It will employ two primary mechanisms: the UN regional consultative mechanism and broad partnerships (with governments, IPs, CSOs, NGOs and other stakeholders). The objective would be to distill 2-3 key lessons from each pilot case (in Mozambique, Burkina Faso and Ghana) for dissemination across Africa. Some of the key areas may include:

- Drug resistance and adherence;
- Patient dropout;
- Drug stockout;
- PMTCT;
- Patient monitoring;
- Patient management;
- Sustainable Financing; etc.

As part of its effort to bring the African Union Commission and UN organizations abreast of its comprehensive programs on HIV/AIDS, especially, TAP, ECA will hold a retreat with key partners like the World Bank, UNAIDS, WHO, and the African Union. The retreat will be based on key regional instruments including the Abuja Call for Accelerated Action on HIV/AIDS, Malaria and TB, the Brazzaville Commitment on Scaling up Towards Universal Access to HIV Prevention, Treatment, Care and Support, the Gaborone Declaration and Africa's Common Position on HIV/AIDS Malaria and TB, etc. The following is a summary of issues to be explored:

- The AU Strategy on HIV/AIDS;

- Key African and Global documents, accords, commitments and agreements (e.g. Brazzaville Commitment, Abuja Plan of Action, UNGASS Political Statement, etc);
- NEPAD and the APRM relative to HIV/AIDS;
- The Treatment Acceleration Program – lessons from Burkina Faso, Ghana and Mozambique;
- Resource mobilization;
- Advocacy and Communication;
- Modalities for inter-organization partnerships and collaboration.

The retreat is expected to yield a plan of actions that will dwell on the achievable priorities that can be jointly pursued and implemented by the principal tripartite organizations with the support of other collaborators. This will be done through a thorough examination of the key documents.

3.3. Sustainable financing

All three countries raised this issue with regard to the risks to their national treatment programs involving the long-term sustainability. Once started, anti-retroviral treatment is required to continue for life and without interruption. Part of the sustainability issue relates to the questions of the development and transmission of drug-resistant HIV strains, higher cost implications of second-line drugs and the resulting evolution over time of high program costs per patient. The second part of the sustainability question relates to the long-term financing of ART programs. Current financing mechanisms for ART programs seem highly inadequate to provide long-term, predictable financing and even inappropriate mechanisms with regard to programs that require life-long support for even the existing cohorts of patients on treatment, before one can consider the future cohorts of patients that need to be enrolled on ART. The World Bank and ECA have proposed to look into the issue before the next RAP meeting.

4. Recommendations

4.1. At the end of the two days of fruitful deliberations, the RAP participants came up with a list of recommendations that will be useful to advance the implementation of their national programs, especially in relation to PTS and HIVDR. The following recommendations were made from the RAP:

4.1.1. Strengthening Health systems

- The Ministers of Health should talk to the Ministers of Finance to ensure that the overall health system needs are met;
- The Procurement & Distribution Systems should be strengthened in order to guarantee availability of drugs & reagents at all levels;
- Ensure that quality meets basic minimum standards per WHO guidelines in treatment scale up and that it continues through regular in-service training and

pre-service training and training of other cadres at all levels to cope with increased patient load;

- Conduct analysis of flow of patients at facility level to identify bottlenecks, eg. Initiation of ART on clinical criteria while waiting for CD4 test results per WHO guidelines;
- Integration of HIV services into primary healthcare, particularly with TB and MCH, should be reflected through setting of ARV and VCT targets for better sustainability of HIV care & to avoid losing opportunities;
- Find the right balance between activities and services that need to be centralized and those that need to be decentralized, in addition to finding the right balance between prevention and treatment activities particularly to ensure that the benefits of treatment are not lost or reduced by early development of drug resistance in ART patients, and that HIV+ people do not advance to ART-stage too soon.

4.1.2. Information, Education and Communication

- Improve communication with traditional healers to ensure their active cooperation & referral of HIV patients. This would encourage more community acceptance of HIV testing & can avoid the use of herbal remedies that could be contra-indicative with ART;
- Community involvement is crucial, especially involvement of PLWAs (through sharing of personal stories), community groups/associations, husbands (to allow wives to go for testing & uptake of PMTCT), in order to ensure greater utilization of services particularly at the rural level. Also allow adaptation of services to meet community expectations;
- Incorporate necessary public information and education strategies to support a balance between prevention and treatment, especially addressing PMTCT, nutrition and other available services, and targeting males in community, public and private sectors;
- Ensure nutritional support is not only an adherence incentive but also as motivation for improvement of self socio-economic status in order to ensure efficacy of treatment regimens (eg. PMTCT for infant). Education on the benefits and importance of good nutrition should be included in nutrition support in order to ensure continued good nutrition after the end of support;
- Operational research for improvement in understanding patient drop-outs and loss to follow-up.

4.1.3. Financing

- Countries have the responsibility to provide evidence of benefits & progress of treatment scale-up, efficiencies gained, lessons learned & financing gaps. Analysis of these should begin now so that information will be available before TAP comes to a close and can be used to develop a transition plan. The World Bank & partners will then have the responsibility to finance gap or mobilize resources;

- Improve planning & budgeting for HIV interventions in order to ensure sustainable and predictable financing for ART patients through inclusion in national development plans & health strategies;
- Improve quantification & efficiency of treatment costs (covering drugs, management of Ols, home-based care, adherence, human resources, M&E supervision, infrastructure, laboratory costs, etc.);
- Grants are preferable to loans, but discussions on available options for sustainable financing must begin now within countries and at regional level (through AU and other fora).

4.2. The RCCC meeting included experts from WHO-AFRO and WHO HQ and discussion were focused on the clinical aspect of PTS and HIVDR. The following are the main recommendations from the RCCC:

4.2.1. Recommendations related to the implementation of ART Information System

- Harmonize the public and private sector information, paper and electronic systems;
- Get information from the private sector and learning from them;
- Evaluate patient follow-up from HIV diagnosis to HIV care to ART, including adherence and community tracking;
- Adequately track patients between registration and pharmacy (numbers do not match);
- Sensitize clinicians to fill patients files correctly;
- Improve adherence tracking;
- Increase, train and retain human resources;
- Strengthen planning and forecasting of ARV, including pediatric ARV;
- Adequately prepare patients to adhere to ART;
- Organize central level to evaluate decentralized level to follow national treatment protocols;
- Availability of pediatric ARV formulations and when available ensure they are adapted to the African context.

4.2.2. Recommendations related to ART patient tracking

- Harmonize toward common information system through training, use of same logistics, same drug supply (regulations- essential list), same treatment protocol (can be based on WHO guidelines with local adaptation);
- Multidisciplinary team (health, community, pharmacy) at the HC to complete patient and clinic information and prepare follow up of patients on treatment;
- Information system should follow decentralization of care and treatment;
- Simplify registration and record keeping systems and make them user friendly;
- Supervise regularly, standardize reporting system and provide timely feedback;
- Provide competitive salaries/benefits/better working conditions in the public sectors and opportunities of training in both public and private sectors;

- Assist countries in developing good planning and forecasting for ARV including pediatric ARV;
- Regular meetings should be held between different units to track and monitor the flow of patients;
- Advocate internationally for adapted pediatric ARV formulation that can be user friendly.

4.2.3. Recommendations related to HIVDR prevention surveillance and monitoring

- Some data from research projects is becoming available however the applicability to population ART program decisions remains unclear;
- Some TAP countries have started HIVDR Surveillance (BF);
- An HIVDR Laboratory network is developing in Africa that can be used for quality assured genotypic testing;
- It is possible to start collecting relevant data on HIVDR immediately (EWI) to be followed by more specific HIVDR Surveillance and Monitoring;
- WHO protocols, tools, available and technical assistance also available from other partners;
- HIVDR National W/G and Plan linked to quality ART scale up and clinical monitoring;
- Involve private and public partners to contribute data to annual HIVDR situation report and recommendations;
- Develop and assure lab capacity for HIVDR specimen handling and possibly for genotyping;
- Use of EWI;
- Plan for Transmission surveillance and for HIVDR Monitoring;
- Encourage interventions that promote adherence.

4.2.4. Recommendation specifically related to laboratories

- Involve laboratories in the elaboration of program budget and sustained financial support;
- Guide countries to develop national protocols and adapted infrastructures. Help countries to develop timeline;
- Reduce the cost of laboratory expenses and advocacy for the reduction of costs related to laboratory reagents, consumables and equipments (customs, shipment, etc);
- Use of laboratories at regional or local level to scale up ARV treatment;
- Develop tools for decentralization and centralization;
- Take laboratory issues into account at the beginning of setting up ART programs;
- Assist TAP countries to adapt and use existing WHO Laboratory guidelines and protocols;
- Accelerate, scale up the decentralization of laboratories test (tools for good nationwide network of laboratories, human resources, equipment & reagents, maintenance, QC/QA, local sample transportation, stock, data management, etc);

- Promote utilization of Regional laboratory tests (tools for regional laboratories HR, equipment & reagents, maintenance, QC/QA, sample transportation, stock, data flow, limitations and programmatic issues, etc).

5. Way forward

Actions	Organizations/IPs	Date
Prepare and finalize the report of the RAP meeting.	ECA	July 2006
Prepare and finalize the report of the RCCC meeting.	WHO	July 2006
Planning and organizing the next RAP/RCCC meetings in Ghana during December 2006: - Themes suggested for the RCCC: (i) update on HIVDR; (ii) update on laboratory development. - Keep RAP and RCCC meetings parallel followed by a joined meeting.	ECA/WHO/ World Bank	Dec. 2006 (tbc)
Baseline study on HIVDR strategy and implementation: Follow-up in one month time.	WHO	Tbd
Launch of a research study on Public-Private Partnerships (PPP): write the TORs, hire a research institute, oversee the research, review the report.	ECA/World Bank	Process to be started ASAP
Conduct research on the Socio-Economic Impact of Treatment.	DECRG (WB)	September 2007
Conduct an operational research on adherence,	WHO	Tbd
Initiate discussions on sustainable financing.	ECA/WB	Tbd
Organize a retreat with ECA's partners (WHO, World Bank, ADB, UNAIDS and the AU) to discuss a strategy to disseminate the lessons learnt from TAP.	ECA	November 6-9, 2006
Finalize and maintain the TAP website: www.uneca.org/tap	ECA	Ongoing

III. ANNEXES

Annex A

Burkina Faso action points

Activities	Time lines	Observation
Put together a team to design a draft protocol	26-31 March 2006	Done
Need assessment		Done
Finalisation of a first draft	May 2006	
Workshop on consensus	June 2006	
Finalisation du protocole	August 2006:	
Sensibilization of actors and Mobilization of resources	September 2006	
Needs satisfied	February 2007	
Training of actors	March 2007:	
Mise en œuvre des activités de surveillance	April 2007:	
Supervision	April 2007:	

Annex B

GHANA KEY ACTION POINTS

KEY ACTION POINTS	ROLES	INDICATORS	AGENCY RESPONSIBLE	TIME-LINES
Patient Tracking System (PTS)	<ol style="list-style-type: none"> Finalize patient tracking system Operationalize PTS Provide TA 	Patient tracking system operational	MOH MOH, IPs WHO	Dec 2006
Drug Resistance Monitoring	<ol style="list-style-type: none"> Form National Expert Committee on HIVDR Develop/adapt HIV DR protocol Provide TA Conduct HIVDR monitoring Dissemination 	HIV-DR information disseminated	MOH MOH WHO MOH, IPs Research Institutions UNECA, MOH, WB, WHO, IPs	Dec 2007
Integration of HIV/AIDS prevention, care and support including nutrition into health delivery	<ol style="list-style-type: none"> Multi-stakeholder involvement in design and implementation of integrated HIV service delivery Pre-service training of all cadres of health workers in HIV care In-service training for all health workers 	Stakeholder meeting conducted	Country AIDS Commissions, MOH, Private sector etc MOH, MOE MOH	Long Term

	4. Integrated service provision		MOH, Ips	
Research/Learning Agenda	1. Catalogue research topics and share	OR disseminated	MOH, IPs, WB, UNECA	Dec 2006
	2. Conduct operational research		MOH, IPs, WB, UNECA	
Sustainability	1. Estimate cost of treatment up to 2010	Additional funds available	MOH, MOF	Dec 2006
	2. Define available resources		MOH, MOF	
	3. Identify gaps		MOH, MOF	
	4. Explore financial options		MOH, MOF	
	5. MAP funding for TAP activities		MOH, MOF, WB, AIDS Commissions	

Annex C

MOZAMBIQUE PRIORITY RECOMMENDATIONS TO BE IMPLEMENTED

Recommendation	Responsible	Indicator & target	Chronogram & target
1. To intensify the implementation of a comprehensive package on prevention, treatment & care (important for "treatment availability in prevention")	MOH & IPs	22% of PMTCT integrated in all SMI sites;	Dec. 2006
		100% of condoms distributed in all HIV and related diseases sites;	Dec. 2006
		20% of eligible PLWA are on ART	Dec. 2006
2. To accelerate treatment programs by strengthening entire health system in infrastructure and capacity building including the integration of services with other diseases (PHC)	MOH & IPs	Funds and HR and rehabilitation of infrastructure development plans	Dec. 2001
3. To build uniform and national information system, monitor and evaluation, including supervision for adherence (adherence, identification of ART beneficiary)	MOH/INS & IPs	Tools and forms for monitoring and evaluation developed; Supervision checklist developed	Dec. 2006
4. To develop the agenda for research at national and provincial level	MOH/INS	Agenda for research at national and provincial level developed	Dec. 2006
5. Strengthening procurement and distribution system to guarantee availability of drugs and reagents at all levels	MOH/CMAM	Procurement and distribution system strengthened;	Dec. 2006
		Decentralized distribution of drugs and reagents at provincial level	Dec. 2007
6. Develop a tool and system for national surveillance of ART resistance	MOH, INS, National Lab of Reference and IPs	System for national surveillance of ART resistance in place	Dec. 2007

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3rd Regional Advisory Panel (RAP) and Regional Clinical Coordination sub-Committee (RCCC) Meetings

Maputo, Mozambique
June 22-23 2006

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