

TAP

Treatment Acceleration Program

**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 more clarity and agreement on the learning agenda.

1.2 The meeting included participants from the World Bank ACTAfrica and DEC teams, WHO-Geneva and AFRO, and UNECA. The draft learning agenda developed at the end of the meeting is attached in Annex 1. A list of participants with contact details is attached in Annex 2.

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 who will be working with WHO to collect M&E data from implementing partners and MOH. Ghana has a National Program 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 who will coordinate the 3 country programs and manage processing issues with WHO Geneva. WHO hopes to use the TAP as a method of moving towards the 3x5 goal. **An indicator of success for WHO would be the improvements over time of the agreed TAP performance indicators.** 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 the learning agenda among the three countries and to disseminate the lessons to the wider African 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 because it will serve to highlight what makes this project distinctive from other regional and treatment initiatives on HIV/AIDS.

(d) DECRG (World Bank)

2.5 DECRG is a research arm of the World Bank. They have received almost US\$1 million from BNPP funds for operational research and will get additional support for operating expenses from DEC to further the research agenda on the TAP.

3. Country Status Reports from WHO: to highlight research questions (Cyril's presentation on O.R.)

3.1 This session focused on the ongoing research in the countries and it was indicated by WHO that some research questions have already been identified by countries during a meeting in Harare. Mead Over of DECRG (MO) informed the team that the NIH will not fund operational research on HIV/AIDS besides clinical and biological research issues although CDC is involved in some operational research.

3.2 Dr. Cyril Pervilhac of WHO Geneva (CP) made a presentation (Annex 3A) on various research questions that were discussed at the WHO Harare meeting, including: i) improving treatment and uptake of VCT and ART services; ii) dispensing ARVs and support adherence; iii) economic issues; iv) scale up of clinical regimens; and, v) health systems issues.

3.3 It was noted 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 is 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 (**ref. section 5**).

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

(a) Ghana

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

- Ghana is still developing ART scale-up plan, training staff of all regional hospitals, and all facilities have to use the prepared national guidelines;
- 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;
- 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;
- There is very little operational research at this point, and Ghana is not presently a WHO-priority country;
- Funding from the USG is available for some areas but details are not known yet;
- Church-related NGOs have started ART scale-up in large hospitals;
- 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;
- Potentially the Noguchi Institute may be doing clinical research involving the use of traditional medicine and nutrition supplements, but details are not known yet;
- 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 An interface with the 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 District Response Initiative (**DRI**) concept in Ghana combined with the focus of the TAP in 4 regions **in Ghana** only could be useful to make additional comparisons and learn lessons.

(b) Burkina Faso

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

- In Burkina Faso there is collaboration between the public sector and communities;
- ART rollout plan was drafted and received consensus approval;
- Targeting 20 districts for the TAP;
- Building links between the district teams and community associations, particularly in Ouagadougou and Bobo Dioulasso, where existing collaborative efforts are in place;
- 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;
- Burkinavi project from the World Bank is also looking at simplified models of care with collaboration from ESTHER, which has now started in Ouagadougou;
- UNDP conducted household impact surveys, particularly in the education sector;
- AIDSETI and Stanford University have also shown interest in identifying the additional benefits of treatment scale-up for beneficiaries;
- One laboratory in Burkina Faso is doing some drug resistance research already and could expand to include the TAP;
- 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 the risks for drug resistance development. Thus, a comparison could be done on how this PLWHA associations' interest in keeping drug 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:

- The TAP model is using public and international NGO partnerships;
- Training of trainers at the provincial and district levels is on-going;
- In early 2005, there was some harmonization completed of the treatment guidelines;
- 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);
- 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;
- Recruitment of patients in Mozambique already has explicit/implicit choices on who receives treatment – Pathfinder implicitly recruits 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;
- Sant'Egidio's decision to use triple therapy for PMTCT can be used to compare this protocol against the Nevirapine-only PMTCT protocol being used in other countries, raising clinical, cost and ethical issues in the approach to the PMTCT(+) program.

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 is considering developing an M&E guide which could be applied to the work executed among communities reached by the TAP. 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 The meeting agreed that we need to know that variations will exist in adherence anyway and resistance development. DECRG (MO) 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) The Bank's presentation

5.1 Albertus (Bert) Voetberg from the World Bank 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; there is need to have 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 Pediatric ART – Africa is in the forefront on this issue because pediatric ART is not in as great a problem in the developed countries as compared to the African continent. Any lessons learned from the African experience will be highly useful to the rest of the world, and there is a high demand and unmet need for pediatric ART services in Africa.

5.3 Research into the effectiveness and benefits of various recruitment practices for ARV treatment was flagged as an area of particular interest, exploring the question

whether the benefits of the ART program can be extended to include benefits related to prevention.

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) remain very relevant to all countries as experience is limited and questions remain unanswered.

(b) DECRG'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 intervention 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 BV and CP, would fit into the survey matrix presented by DECRG to capture the data needed to answer those questions.

6.2 WHO is putting together M&E guidelines for pediatric ART, the testing of which is to start in Malawi in July 2005. ART and pregnancy, **and afterwards in Rwanda**, 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 the answers to some of the questions can be teased out eg. cost questions can be collected through questions asked in 3 of the surveys in the matrix.

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

6.6 DEC should probably develop an 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. BV 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 programs is missing from the matrix, perhaps this can be added as a column asking for qualitative questions of communities rather than quantitative data collection. Disaggregate questions and tables would be used 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 A mechanism needs to be developed 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 Without treatment programs and an unlimited replication of the virus it is obvious that different sub-types of HIV continue to emerge over time. Is scaling up treatment helping or hindering the development of mutations of the virus and does this cause problems for -, or benefit the development of a vaccine for HIV?

6.11 The next RAP meeting (**tentative week of October 17**) 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 (Mozambique to follow after the Nairobi meeting) 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 The 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 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 The World Bank (BV) will send the reporting format from Burkina Faso to WHO (CP) 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 the Bank 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, behavior, 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 mix 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?

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