Progress Report:

Regional HIV/AIDS
Treatment Acceleration Project (TAP)
in Burkina Faso, Ghana and Mozambique

December 2005

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

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

World Health Organization

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Printed by the WHO Document Production Services, Geneva, Switzerland.

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Acronyms

ART	Antiretroviral therapy
CBO	Community-based organization
CDS	Department of communicable disease surveillance and response, WHO
CO	Country office
GIS	Geographic information systems
HBC	Home-based care
HR	Human resources
MAP	Multi-country HIV/AIDS programmes
MoH	Ministry of Health
OI	Opportunistic infections
PMTCT	Prevention of mother-to-child transmission of HIV
RAP	Regional advisory panel
RCCC	Regional clinical coordination sub-committee
UNECA	United Nations Economic Commission for Africa

Background

The World Bank *Treatment Acceleration Project* provides grant funds, through the respective Ministries of Health, to Burkina Faso, Ghana and Mozambique. Funding is provided for a period of three years to scale up antiretroviral therapy (ART) within the context of the scaling up care and treatment.

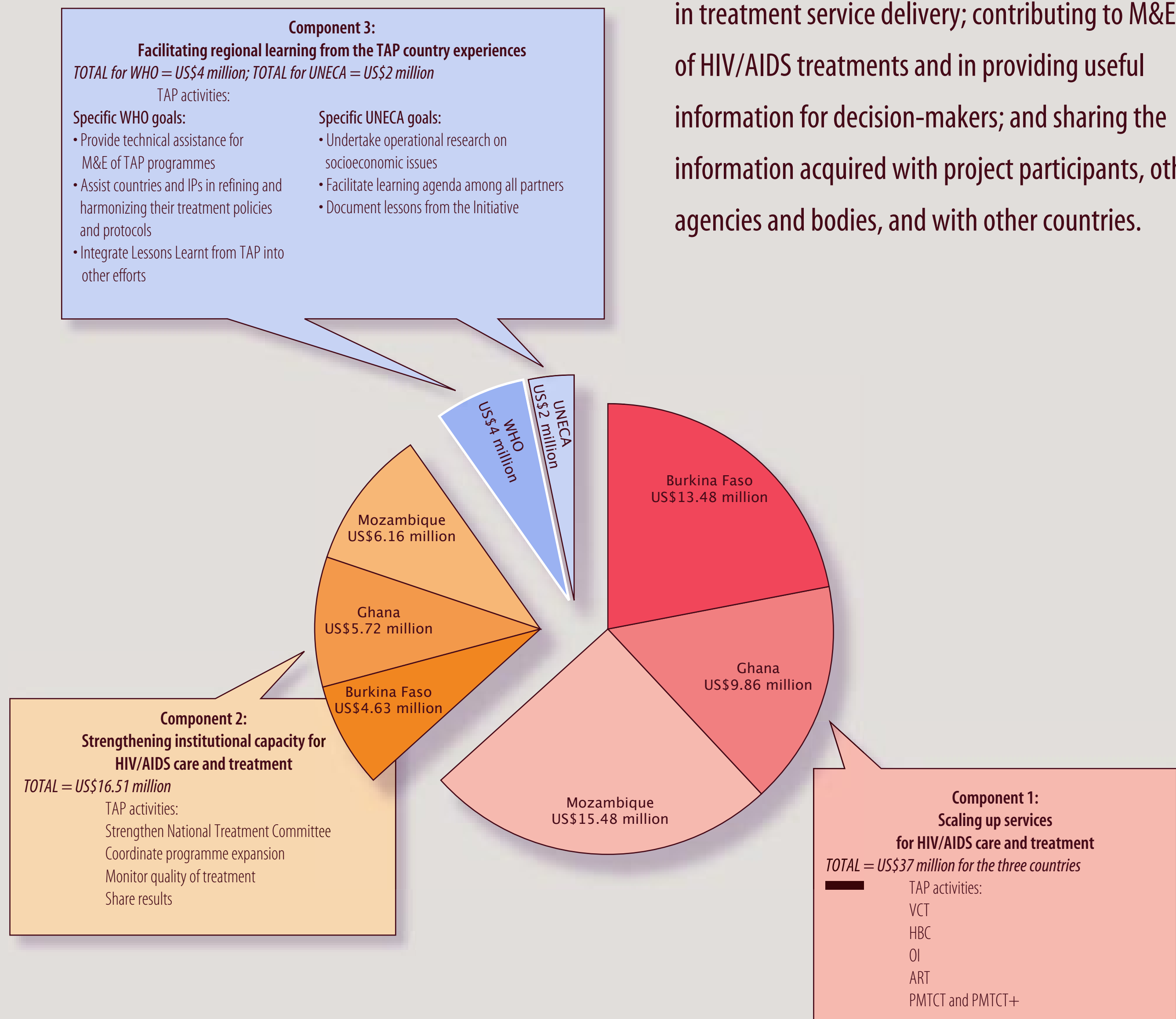
In the three countries, the recipient governments pass significant portions of the grants to other implementing partners (IPs), in the form of sub-grants, financing scale up of ongoing treatment activities and additionally to generate and support a regional effort to share Lessons Learnt with other countries and implementers.

WHO participates in *Component 3* of TAP (*see diagramme*), providing technical support for scale up. WHO's capacities are brought to bear from three levels of the organization: first, at WHO/HQ, where the HIV Department's Scale up team provides overall coordination of project support activities; second, at the WHO Regional Office (AFRO), which is responsible for monitoring and allocation of technical support; and lastly, through each country's WHO Project Technical Officer, whose task is to maintain linkage to the recipient countries and to ensure sustained technical assistance for scaling up care and treatment.

Beyond the project's significant contribution to accelerate the scale up of treatment of HIV+ individuals in need of ART, the *Treatment Acceleration Project* is also a pilot initiative, as it marks the first time that the World Bank has provided grant funds directly to the UN organizations, through a Memorandum of Understanding between World Bank and UNDP (United Nations Development Program), enabling WHO to leverage their comparative advantage in relation to the project. It is also the first IDA project focusing primarily on treatment. Through the World Bank grant, agreed in July 2004 for US$4 million, WHO is to provide technical support on care and treatment to the countries through RAP and RCCC. Lessons Learnt will be documented and shared by UNECA and WHO, as will operational research in the context of scaling up treatment programmes.

Based on the above agreement and in anticipation of project startup activities, WHO provided an initial US$450,000 of pre-financing funding to the TAP, in order to quickly initiate technical support of TAP in Burkina Faso, Ghana and Mozambique. Specific activities to be undertaken by WHO are described on the following page.

At the end of the three-year term of the project, it is envisaged that WHO will have supported countries in: filling the normative gaps in HIV/AIDS treatment and facilitating the scale up of treatment in the context of the 3 x 5 Initiative; strengthening partnerships among all participating entities, including World Bank, WHO, UNECA, NGOs and other IPs, civil society and in the communities; ensuring the increased capacity of IPs and communities to participate effectively in treatment service delivery; contributing to M&E of HIV/AIDS treatments and in providing useful information for decision-makers; and sharing the information acquired with project participants, other agencies and bodies, and with other countries.



WHO notes several possible concerns for successful implementation of TAP:

- lack of platforms at country level for regular sharing of progress among partners;
- slow implementation owing to difficulties in recruitment of expertise and staff;
- slow implementation related to later-than-expected disbursement of grant funds to implementing partner;
- slow implementation due to competing demands for time of IP personnel;
- risk of vertical programme of TAP instead of integration in national scale-up plan;
- lack of coordination among key partners at country and global level; and,
- not enough feedback in Lessons Learnt to improve implementation.

While none of these threatens implementation or final success, each can cause unwelcome delay.

TAP: Progress to date

WHO, with the World Bank and UNECA, participated in one Regional Advisory Panel meeting (RAP), advising on preparedness and institutional arrangements for implementing the TAP Initiative. WHO provided input on strategies for effective management and for obtaining an accurate overview of country and regional progress in care and treatment, as well as reviewing terms of reference for RAP and Regional clinical coordination sub-committees. At the global level, WHO has assisted in the guidance for M&E for TAP through the development of a generic framework for TAP along with recommended indicators to be used as TAP performance-based indicators. These indicators should have been adapted at country level based on the particular data collected. In addition, a reporting template was proposed to countries in order to standardize reporting between countries and to allow for cross-country comparisons. At the regional level, a status review of both existing guidelines and guidelines presently under adaptation was presented to the first RAP group meeting in Addis. Technical resources have been made available, including treatment and protocol information, and are already in-country, with some presently under adaptation. WHO has collaborated, and will continue so doing, with the respective MoHs in the compilation of reports, in the harmonization of work plans with IPs, and in areas of policy, guidelines and HR capacity.

The Lessons Learnt from the above inquiries, as well as from the longer list of draft questions resulting from the 23-24 June 2005 meetings in Nairobi, provide the basis from which acceleration activities of other entities (countries, ministries, IPs, NGOs, international organizations) can be informed and undertaken.

WHO at both HQ and AFRO continues to contribute to the learning agenda of TAP, through careful elaboration of Lessons Learnt. Building on the draft questions of the TAP learning agenda, particular emphasis is being given to sharing of country information in such areas as:

- how service delivery coverage affects quality and treatment access;
- how cost sharing of ART compares to free access to ART;
- whether a focused/targeted scaling up (for example, among youth or in areas of high HIV prevalence) is as effective as nationwide scaling up;
- whether patient recruiting works best on a 'first come/first served' basis or whether other models are better;
- whether associations of PLWHA's are able to satisfactorily monitor drug resistance;
- whether triple therapy in PMTCT is more effective than Nevirapine-only therapy;
- the stage of illness at which patients, including children, begin ART, and subsequent benefit (if any).

The table below reflects WHO/AFRO areas of on-going support, in collaboration with the country offices (COs).

Areas of on-going support, as provided by WHO/AFRO in collaboration with country offices		
Policy	Guidelines	Reinforcement of HR capacity
• Supporting the accreditation process, by defining comprehensive criteria and assessing needs of treatment centres. • Assisting in developing national policy for care and treatment, and • Ensuring quality assurance systems for drug procurement, testing and laboratory procedures.	Assisting the revision of treatment guidelines and protocols for: • ART guidelines • Opportunistic infections (OIs) • Prevention of mother-to-child transmission (PMTCT) and PMTCT Plus • Voluntary counselling and testing (VCT) • Nutrition and infant feeding options • Drug resistance	• Reinforcement of human resources capacity through assistance with the national training plan for care and treatment with ART, as well as adherence counselling to avoid resistance.

Conclusion and Recommendations

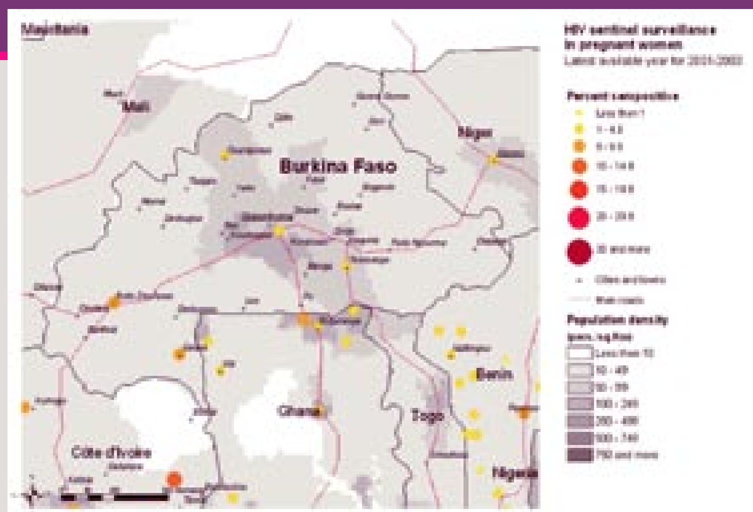
WHO's Technical Assistance component of the TAP has been difficult to implement, owing primarily to lack of staffing, and secondarily to higher-than-expected costs for supervision and monitoring of activities. The three countries have determined their budgets and workplans for two years, and funding is now needed for effective implementation. Recruitment of international staff at country and regional level remains an on-going need, to ensure coordination and regular reporting on the implementation.

TAP's successful implementation calls for regular monthly meetings, to be attended by MoH staff, the IPs, the World Bank and WHO, to review progress to exchange information and to generate consensual solutions to problems and potential bottlenecks. An other challenge will be the timely sharing of reports produced by various partners involved in the TAP Initiative. A standardized template should be adopted by all MOH and all Implementing Partners at country level and see how those report could inform WHO and UNECA which should compiled a comprehensive report for documentation of TAP Initiative.

Country profiles Burkina Faso, Ghana, Mozambique

Burkina Faso

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



Map Data Source: WHO/UNAIDS Epidemiological Fact Sheets and the United States Census Bureau
Map production: Public Health Mapping & GIS, Communicable Diseases (CDS), World Health Organization

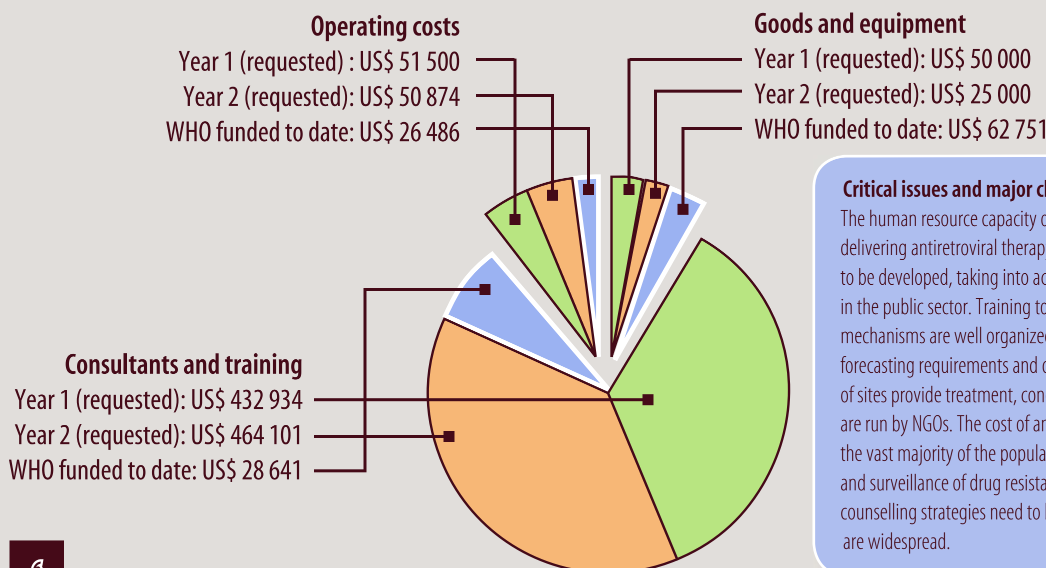
Situation analysis

Burkina Faso is one of the most severely affected countries in Africa, with a generalized epidemic. The first case of HIV/AIDS was reported in 1986. As of mid-2005, according to UNAIDS and WHO data, an estimated 180 000 adults (15-49) and children (0-14) are living with HIV/AIDS in Burkina Faso. Based on UNAIDS estimates, HIV prevalence among adults (15-49 years old) is 2.3%. Rates of infection for women and men are approximately equal. HIV-related deaths totaled approximately 17 000 as of mid-2005. New HIV infections among adults and infants (0-49) total 25 000.

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

Care and treatment		
	End 2004	*Sept 2005*
Total number of PLWHA on ART	3867	6630
Total number of ART centres	24	44
Proportion of districts with at least one ART centre	20%	36%
Total number of VCT centres	56	77
Proportion of districts with at least one VCT centre	40%	55%
Proportion of districts with at least one PMTCT centre	9%	51%
Number of laboratories with CD4 counter	5	13
Ave. cost (monthly) for treatment (US$)	10	10

Objectives of TAP	Achievements in WHO technical assistance	Next tasks in technical assistance
1. Testing approaches for scaling-up services delivery	• Situation analysis was undertaken for quality control of VCT. Based on this analysis, quality control recommendations were made.	• Assessment of strategies and activities of VCT put in place • Support to reference and accreditation for VCT and Care and treatment
2. Care and treatment of PLWHA	• A draft plan for training was developed with participation of all partners. • Assist in developing operational plan for the Burkina Faso TAP • Revise training model in care and treatment	• Facilitate training and update training modules
3. PMTCT and PMTCT plus		• Situation analysis on services, infrastructures and associations involved in PMTCT
4. Strengthening institutional capacity for HIV/AIDS care and treatment	• In collaboration with partners, develop an operational plan for WHO technical assistance. • Technical support provided by regional office and HQ in procurement, surveillance for resistance, and monitoring and evaluation for care and treatment.	• Computerized data collection for patients tracking
5. Facilitate regional learning from TAP experience	• Prepare update on progress made • Participate in RAPP meeting • Assist in development of protocols for operational research in care and support practices for HIV/AIDS	• Assist in the development of a reporting system • Assist in reporting to all partners • Organize regular and systematic meetings with IPs

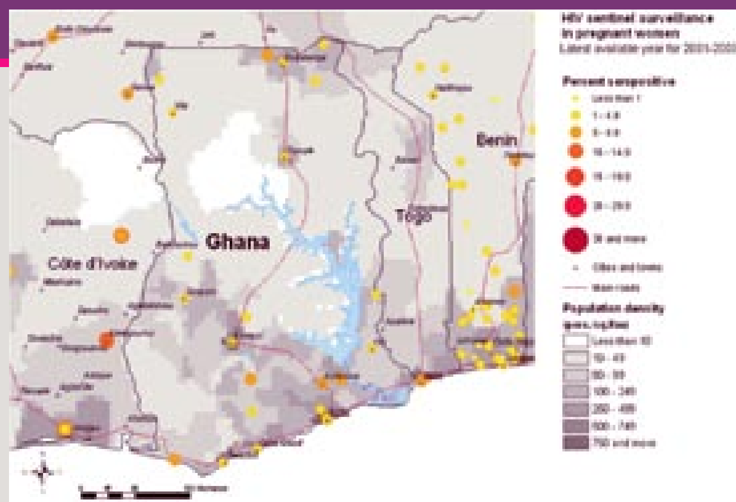


Critical issues and major challenges

The human resource capacity of the health sector is limited, especially in delivering antiretroviral therapy. A comprehensive human resource plan needs to be developed, taking into account adequate incentives for health workers in the public sector. Training tools also need to be developed. Procurement mechanisms are well organized, but clear criteria need to be established for forecasting requirements and distributing antiretroviral drugs. A limited number of sites provide treatment, concentrated in hospitals in urban areas. Other sites are run by NGOs. The cost of antiretroviral drugs makes them inaccessible to the vast majority of the population. Mechanisms for monitoring and evaluation and surveillance of drug resistance need to be strengthened. Testing and counselling strategies need to be developed further. Stigma and discrimination are widespread.

Ghana

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



Map Data Source: WHO/UNAIDS Epidemiological Fact Sheets and the United States Census Bureau
Map production: Public Health Mapping & GIS, Communicable Diseases (CDS), World Health Organization

Situation analysis

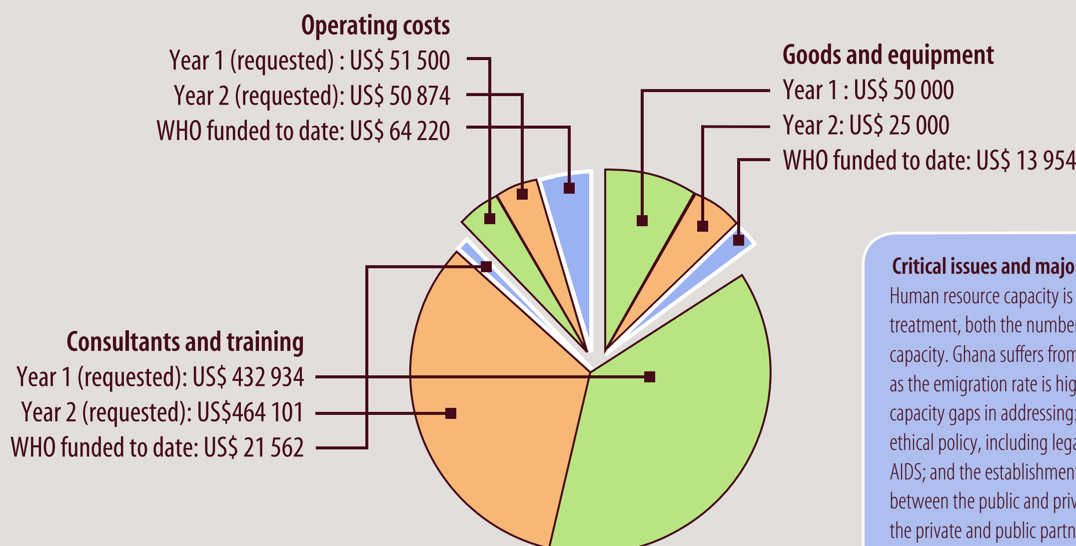
Current surveys in Ghana show a prevalence of HIV infection among adults 3.1% in 2004. WHO/UNAIDS estimated that the prevalence was between 1.9% and 5.0% in 2003. The prevalence is highest in the Eastern Region and lowest in the Northern Region. Rates are generally higher in densely populated areas,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

Critical issues and major challenges

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

Care and treatment		
	End 2004	*June 2005*
Total number of PLWHA on ART	2028	2930
Total number of ART centres	4	4
Proportion of districts with at least one ART centre	2.2%	2.2%
Total number of VCT centres	88	107
Proportion of districts with at least one VCT centre	43%	47%
Proportion of districts with at least one PMTCT centre	43%	47%
Number of laboratories with CD4 counter	2	5
Ave. cost (monthly) for treatment (US$)	6	6

Objectives of TAP	Achievements in WHO technical assistance	Next tasks in technical assistance
1. To assist Ghana to scale-up comprehensive treatment programmes for persons living with HIV/AIDS.	• Support the assessment of all 4 TAP sites. • Facilitate training the team of doctors, pharmacists, dispensary staff and nurses from TAP sites in ART and adherence counseling • Comprehensive HIV care under way • Accreditation system put in place	• Support the agreement process between IP and TAP sites • Refurbishing of TAP sites initiated • Provision of treatment and care services (ART, VCT, PMTCT)
2. To strengthen the institutional capacity for HIV/AIDS care and treatment	• Support revision of guidelines and manual • Provide technical assistance and support for training implementing partners, ranging from assessment of sites to proposal writing • Recruitment of TAP NPO	• Advocate for adaptation of IMAI training modules at district level • Organize all training in care and treatment as needed by NACP and IPs
3. To facilitating regional learning from the TAP country experiences.	• Ongoing compilation of TAP activity • Provided technical input to various stakeholder meetings on on-site monitoring	• Participate in RAP meetings • Organize regular and systematic meeting every month with partners

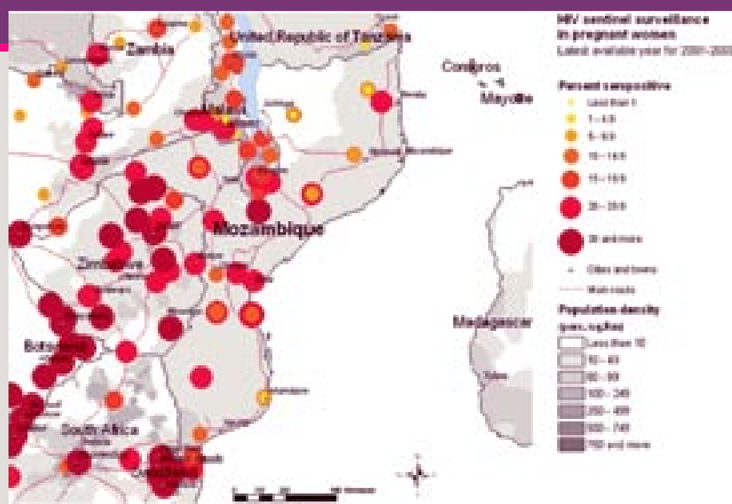


Critical issues and major challenges

Human resource capacity is the major bottleneck for scaling up treatment, both the numbers of health care workers and technical capacity. Ghana suffers from high turnover of highly skilled personnel, as the emigration rate is high. Domestically, there are significant capacity gaps in addressing: treatment, support and care; legal and ethical policy, including legal protection for people living with HIV/AIDS; and the establishment of links, networking and referral systems between the public and private sector. The TAP's challenge is to use the private and public partnership to carry out the scale up of HIV care and treatment.

Mozambique

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



Map Data Source: WHO/UNAIDS Epidemiological Fact Sheets and the United States Census Bureau
Map production: Public Health Mapping & GIS, Communicable Diseases (CDS), World Health Organization

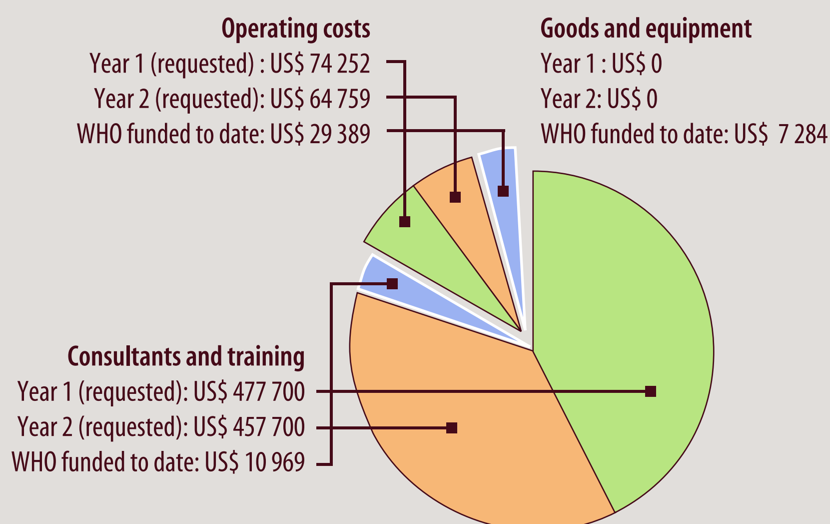
Situation analysis

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

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

Care and treatment		
	End 2004	*Sept 2005*
Total number of PLWHA on ART	6,500	15,900
Total number of ART centres	19	31
Proportion of districts with at least one ART centre		76.2
		5.3
		3.4
% health facilities sites offering ART		12.4

Objectives	Achievements in WHO technical assistance	Next tasks in technical assistance
1. Scaling up care and treatment programmes focusing on VCT, home-based care, prevention, OIs, ARV and PMTCT	• Support accreditation process by defining criteria and assessing needs of treatment centers • Revision of guidelines of ART, OIs, PMTCT, VCT , drug resistance, nutrition and infant feeding options.	• Staff training and improved quality services
2. Strengthening the organization of referral services	• Technical assistance plan has been finalized and made available to partners • Rapid assessment of factors affecting treatment adherence • Terms of reference has put prepared for TAP coordinator and a short list is available • National training plan for care and treatment with ART as well as adherence counseling	• Need agreement on new implementation schedule • Finalize the restructuring of GACOPI and the revision of the policy on Day Hospitals • Patient tracking system
3. Facilitate regional learning from TAP experience	• Preparation of 6 months reports on achievements	• Participation in RAP in Addis Ababa • Organize regular and systematic meeting every month with partners, MoH, and district planning services leader



Critical issues and major challenges

Mozambique lacks trained human resources and requires considerable investment in the health care infrastructure to increase geographical coverage and facilitate access in remote areas. The challenge is to improve equity in order to ensure scale up of care and treatment. Drug procurement and management systems are complex, and fear of stock outs is widespread. Policies and strategies need to be strengthened to address such issues as care for and protection of orphans and other children affected by HIV/AIDS. For example, PMTCT needs to be integrated into ante-natal prevention strategy. Coordination needs to be strengthened between the National AIDS Council, the Ministry of Health and other partners, including nongovernmental organizations.

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