

TAP
Treatment Acceleration Programme

Sixth Regional Advisory Panel Meeting (RAP)

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DRAFT REPORT

TAP Secretariat
ECONOMIC COMMISSION FOR AFRICA (ECA)

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List of acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral Medication
ATS	Counseling & Testing in Health Services (Portuguese abbreviation)
ANC	Antenatal Care
AU	African Union
CD4	The immune System T-cell which are destroyed by the HIV virus
CSO	Civil Society Organization
CT	Counseling and Testing
DBS	Dried Blood Spots
DPS	District Provincial Services
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
HIVDR	HIV Drug Resistance
IP	Implementing Partners of HIV/AIDS Treatment Components
IPT	Isoniazid Preventive Therapy
MAP	Multi-country AIDS Program
MCH	Maternal Child Health
M&E	Monitoring and Evaluation
MOH	Minister of Health
MTCT	Mother to Child Transmission
NACP	National AIDS Control Program
NCHS	National Catholic Health Service
NEPAD	The New Partnership for Africa's Development
NGO	Non-Governmental Organization
NSF	National Strategic Framework
OI	Opportunistic Infection
OPEC	Organization of the Petroleum Exporting Countries
PCR	Polymerase Chain Reaction
PEF	Private Enterprises Foundation
PITC	Provider Initiated Testing and Counseling

PETS	Public Expenditure Tracking System
PLWHA	Person Living with HIV and AIDS (both infected and affected)
PMTCT	Prevention of Mother to Child Transmission
PPP	Public-Private Partnership
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 and AIDS
VCT	Voluntary Counseling and Testing for HIV infections
WHO	World Health Organization

Executive Summary

The Sixth meeting of the regional advisory panel (RAP), which took place in Nairobi, Kenya, on December 6 and 7, 2007 was opened by Kenyan Ministry of Health officials, with opening remarks from ECA, World Bank and WHO. Representatives from Burkina Faso, Ghana and Mozambique (TAP Pilot countries) gave an overview on the status of implementation of TAP activities.

IPs' presented on relevant research findings of the TAP programme. Specifically, W.H.O shared their field study research on adherence to social determinants in non- TAP countries; World Bank representatives presented their household, biomedical follow-up and health care facility ongoing research studies and; ECA presented on PPPs and lessons learned from monitoring and evaluation missions in TAP countries.

Insightful discussions following the presentations pointed out a number of issues that could not be overlooked such as focusing on expanding pediatric care and pediatric access to treatment; sustainability of privately sponsored ARV centers; strengthening monitoring and evaluation systems and; patient tracking.

Integration of services, particularly HIV/ TB linkages, was discussed as a benefit and way of maximizing the impact of HIV treatment.

Participants unanimously agreed that the role of TAP in increasing the number of ARV centers was significant in all three countries despite the challenges. Another positive outcome of the TAP programme was the opportunity created by the RAP meetings to share experiences, best practices and lessons learnt. It is therefore important to identify a platform in order continue these kind of exchanges after TAP.

SESSION 1: Overview and Update on the State of Implementation of TAP in countries

Presenters from Ghana and Burkina Faso gave an overview of the TAP implementation, while Mozambique TAP Partners: Pathfinder and Health Alliance International presented on Increasing Access to HIV/AIDS Care and Treatment among Adolescents and Partnerships with Manica and Sofala Provincial directorates of Health respectively.

1.1 Status of implementation: Ghana

The estimated national HIV/AIDS prevalence in Ghana was 2.22% in 2007. Despite failure to achieve VCT targets in September 2007 (255,173 centers provided VCT but the goal was 270,000), PMTCT targets were exceeded (target was 90,000 but 109,344 were achieved).

In addition, 91 facilities provided ART in the country, 10 of which were TAP sites. One of the major challenges reported, was monitoring of the various treatment sites and the low uptake of CT services, which was lower than expected.

ART targets (20,000 patients) were not reached in September 2007, only 11,534 patients received treatment. Some of the reasons why the ART targets were not achieved include: discontinuation of treatment due to adverse drug side effects; loss during follow-up and; deaths. Pediatric data also indicates that there were challenges in increasing number of patients into care. Out of 21,800 HIV positive Ghanaian children, only 469 received ARVs in 2007.

There was a lot of progress on HIV/TB linkages after the appointment of a TB/HIV coordinator in each programme. Main collaborative activities include routine HIV counselling and testing services provided to all TB suspects and patients; screening for TB at ART sites and; surveys on HIV prevalence in TB clients.

Successes

- Increased country-wide access of VCT and PMTCT sites;
- A new PMTCT policy and guidelines were put in place;
- Increased accessibility to ART hence strengthened health facilities;
- TB/HIV guidelines and policy in place and;
- Improved collaboration with partners.

Challenges

- Low admission of pediatric HIV cases into care;
- Delayed operations of ART programmes at sites despite personnel training;
- Data management and reporting from sites;
- Monitoring of VCT and PMTCT sites;
- Low uptake of counseling services and;
- Infection prevention and control.

Way forward

- Improve monitoring of PMTCT and VCT sites;
- Strengthen linkages between service points regarding ANC, VCT/PMTCT, adult and pediatric ART clinics;
- Implement the PMTCT policy;
- Promote enrolment or more paediatric HIV cases into care;
- Ongoing scale up of ART sites to all district hospitals;
- Ongoing capacity building for TB/HIV co-management to facilitate one stop shopping and;
- Integrate ART into the pre-service curricular.

Discussions

Questions raised after the Ghana presentation required explanations of why there were low numbers of PMTCT and delays in ART programme operations after staff training. Other discussions were centered on the use of PCR technology, and HIV/TB linkages.

The delay in the commencement of ART programmes despite staff training was largely attributed to provider fear although this was compounded by some logistical challenges. Service providers therefore needed to be encouraged and mentored in order to effectively perform their duties.

HIV/TB linkages challenges associated with the detection of TB rates, were addressed by putting new measures in place to increase number of TB/HIV detection rates.

Ghana was also considering scaling-up treatment by using the PCR test kit technology with the general screen ultra instead of the standard PCR because it

was cheaper and readily available. Early diagnosis (at 18 months) is also encouraged in order to effectively manage and treat the cases.

Since early diagnosis has cost implications in training and procurement of materials, pediatricians were offered specialized training to manage sero-positive children.

In support of Ghana's decision to scale-up treatment with PCR technology, W.H.O guidelines endorse making PCR essential for children. Despite the initial costs, PCR technologies can also be used for other purposes like detection of drug resistance in TB and malaria making it cheaper in the long run.

Currently, W.H.O is reviewing treatment guidelines, which entail initiating treatment from 350 CD4 count. This might ultimately be cheaper in avoiding mortality and morbidity despite the implications in countries with a high prevalence. Ghana is currently promoting initiating treatment at a CD4 count of 250 for the rest of the population and 350 for pregnant women to enable early diagnosis and better treatment results.

1.2 Status of Implementation: Burkina Faso

In Burkina Faso, a drop in the prevalence rate from 3.6% in 2000 to 2% in 2007 was reported as one of the successes in the fight against HIV/AIDS. At the same time, PMTCT programmes went from three in 2003 to fifty-three in 2007. Only two districts out of fifty-five had no access to ARVs, and 8031 patients were on ARVs before the end of 2007 there by exceeding the TAP target of 7,000 patients. In total, 15,888 patients or 60% of patients were receiving ARVs from TAP sites. The TAP PMTCT target of 17,000 cases was also exceeded when 101,751 women were reached in 2007.

In Burkina, TAP was also considered as a test approach to ART in PPP.

Successes:

- Increased medical care in district facilities;
- Purchase of lab equipment;
- Technical support from W.H.O for drug resistance and operational research;
- Increased number of people on ART (ARV cases rose from 3% in 2003 to 76% in 2007);
- Capacity building / training for MOH health officials;
- Regular care to PLWHA through ART;

- Provision of nutritional and psychosocial support for PLWHA and;
- Improved ART reporting and planning.

Challenges:

There is need to:

- Make available lab equipment beyond the central region in Burkina;
- Strengthen skills in information dissemination;

Way forward:

- Ensure regular activities of quality treatment and care;
- Conduct more M& E activities;
- Train workers in pediatric care and;
- Reinforce of patient follow-up.

Discussion

Discussions following the Burkina Faso presentation focused on sustainability and ownership of the process, versus dependency on World Bank funds. In response, the team from Burkina Faso emphasized the use of government funding and the role of CSOs. Strategies have been in place to help with sustainability issues and a number of activities will be integrated with MOH activities. However, because of the magnitude of the problem, Burkina requested the Global Fund to consider taking on ARV scale-up after TAP.

In response to the use of mono therapy, versus tri- therapy in Burkina Faso, presenters mentioned the PMTCT protocol had been changed based on W.H.O's recommendation, which encouraged a Tri-therapy approach. Outcomes from PMTCT were found to be better with a triple combination than the single dose-Nevirapine. W.H.O asserted that the recommendation towards combination therapy and move away from mono therapy was because of the fear of resistance for Nevirapine.

1.3 Status of implementation: Mozambique

Pathfinder International

In 2007, Mozambique reported an estimated 1.6 million HIV infected people with youths representing half of the number. Despite the significant number of youth

infections, prevention and treatment programs rarely account for youth specific needs. For example, less than 10 percent of youths were beneficiaries of the ARVs that were made available in the country at the beginning of 2007.

Pathfinder International therefore designed an intervention programme targeting the youth according to the “integrated health care” principle where by prevention, support, and treatment in communities and hospitals would be linked.

Although the integrated health care system responds to the needs of the users, several challenges remain because the model focuses on prevention and a relatively “clinical” preventive intervention with poor considerations of the social context and the specific needs of affected groups, especially the youth.

In addition, there are insufficient interventions targeting youth and resistance to condom use remains a major obstacle in youth prevention.

Health Alliance International (HAI)

According to HAI, the prevalence rate in Mozambique reported to be dropping from 16.2% to 16% based on the announcement that was made on December 1, 2007. The southern region was found to have a higher prevalence rate.

HAI has worked for 20 years in partnership with MOH focusing on Sofala and Manica provinces (central region) with expansion to Tete and Nampula in 2007. HAI focus has been on expansion and integration of HIV services into primary health care. HAI has also strengthened the health care system in Mozambique by providing technical, financial and logistical support and working closely with health managers at national, provincial, district and health facility levels.

Despite several successes such as increased VCT Testing sites (exceeded goals of 85 to 88 sites in 2007) and full coverage of PMTCT programmes in Manica and Sofala provinces, challenges like the lack of human resources; high patient loss to follow-up; delayed reporting of lab results; poor health facilities and infrastructure and; medication stock-outs still remain.

Discussion

According to HAI, PPP some challenges in ART scale up were associated with liaising with public facilities that have the equipment to do CD4 counts. Other challenges cited included the Ministry’s limitation to intensify supervision, which

put HAI in a lead supervisory role. This unfortunately led to requesting of incentives from HAI health care providers.

SESSION II: Monitoring and Evaluation (M&E) lessons learned PPPs

The presentation focused on lessons learned and challenges identified in the M&E missions conducted by the HIV/AIDS learning group in two TAP countries, namely Ghana in September 2007 and Mozambique in June 2007. During the M&E missions focus was placed on social determinants of adherence, monitoring and evaluation systems in patient tracking, sustainability, the role of the private sector, and the overall role of ECA, which was to identify and disseminate best practices.

Burkina Faso's M&E would also be conducted in the same context like the other TAP countries and evaluation of the interventions would be based on the implementation of the TAP programme.

ECA's evaluated TAP programmes implemented by Ghana and Mozambique in order to identify challenges, lessons learned and best practices, which could be replicated and presented during RAP meetings among other platforms. In addition to RAP meetings, ECA would use its comparative advantage as a regional body and convening power to facilitate dissemination of lessons learned.

Ghana

Best practices:

- High-level commitment of government and traditional authorities;
- The focus on expansion seemed to be on "learning by doing" which has provided a significant platform for improvement within the expansion framework.

Challenges:

- Sustainability;
- Implementation of the National Health Insurance Scheme;
- In proper and inefficient coordination and;
- NACP accreditation system is systematically applied to health care facilities even though it guarantees minimum quality standards, which may delay the process.

Mozambique

Best practices:

- Activists and volunteers have bridged the gap between patients and health centers;
- Individual and group counseling during pre and post testing has increased adherence;
- Internal exchange of experiences in Beira-Maputo were beneficial for mutual learning;
- Pregnant women were easily enrolled in ART through ante-natal care and;
- Demonstrated government ownership and overall excellent coordination of the programme.

Challenges:

- Shortage of skilled human resources;
- Poor infrastructure;
- Distance from health facilities;
- Poverty (beneficiaries can barely provide basic needs) and;
- Shortage of supplementary food, drugs, and laboratory equipment.

Discussion

Discussions following the presentation focused on herbal treatment, which was found to effectively address some OIs. (Herbal treatment is not used in combination of ART).

A need to define cross cutting lessons that could be learned from M&E missions considering that TAP will be ending soon, and a stronger engagement of regional partners such as the African Union (AU) and the African Development Bank (AfDB) in order to create platforms that address issues of learning and sustainability was realized.

Other significant points following the discussion included the need to:

- Engage and apply what has been learned beyond the TAP agenda;
- Explore means of other dynamics of learning besides the RAP meetings;
- Reflect more on M&E and research including herbal treatment;
- Make ART coverage targets at national level;
- Involve other regional commissions like SADC and ECOWAS;
- Take advantage of all players – regional organizations and;
- Re-think strategies for tracking of couples.

Session III: Concrete Research Studies from the Field: Quality of Management of PLWHA in Burkina Faso.

The operational research conducted was supported by W.H.O giving a situational analysis including involvement of many partners.

Despite the multiple and diverse centers provided care including NGOs, 'Good practices' were not often practiced by stakeholders.

The main objective of the research was to identify and test strategies to define the "package" of AIDS care and treatment and to improve the performances of the programme in order to ensure scaling up by identifying applicable consensual strategies. The research was also meant to improve collaborations between public, private, faith- based, NGO's/CBO's health providers.

The methodology applied was participatory cross-sectional studies in facilities at various levels across the country.

Results showed that approximately 78–80% benefited from free treatment and 15% paid subsidized rates. Differentials along types of service e.g. lab and patients had difficulty in paying (62%) for OI medication, transport costs, nutrition and ARVs and lab tests.

Other findings from the study showed that there was social and nutritional support, and reduced stigma in private facilities even though the services were provided by the same clinicians from public clinics. Similar standards of care were however observed in both public and private clinics.

Ten percent of clients were taking other treatments in addition to ART and 77% were taking Cotrimoxazole prophylaxis. Community and home support resulted in increased stigma and patients were not willing to take up home care support services.

Other factors affecting the quality of care in PLWHA included poverty; mobility of clinicians; client practices to access care; non-standardized follow- up for care without ART and; package for ART clients and stigma.

Discussion

Questions and comments focused on key factors enhancing care of PLWHA.

Overall, investigators pointed out that the studies were ongoing hence the results regarding patient educational levels, physician to patient ratio and proportion of patient care in private clinics were still inconclusive.

The major factor found to affect the quality of life of PLWHA was the extensive travel to other treatment locations, which was associated with the need to remain incognito.

In conclusion, although the study results were inconclusive, some indicators and thematic areas in which quality measures could be developed and applied to both the infected and affected

Session IV: State of implementation of HIV/AIDS Treatment in Kenya, PMTCT Lessons learned

Women constitute the majority of PLHIV in Kenya. The Women to Men ratio of PLHIV is 13:10 and the HIV prevalence rate among pregnant women is eight percent.

PMTCT programmes were started in 1999 in three sites namely: Nairobi, Karatina and Homabay. In 2000, a Technical Working Group (TWG) was formed and in 2002, the PMTCT national guidelines were developed and the PMTCT program launched. In the same year, 3,432 pregnant women were counselled and tested. This increased drastically to 637,032 over a seven-year period.

The PMTCT target for 2006 was 1,200,000 and by 2010, eighty percent of all pregnant women should be counselled and tested for HIV. By September 2007, 637,032 persons were counselled and tested. It was also anticipated that by the end of 2007, 5,700 health facilities would offer PMTCT services. However, by September 2007, only 2,077 facilities were offering PMTCT implying that only twenty-four percent of the exposed infants received Single Dose Nevirapine syrup.

The PMTCT approaches either are done by counselling and testing or opt out approach.

The four pronged intervention approach adopted entails:

- Primary prevention of HIV infection;
- Prevention of unwanted pregnancy on women infected with HIV;
- PMTCT among infected pregnant women and;
- HIV treatment care and support for mother infected with HIV and their family and partners.

Success:

Key elements of success included:

- Political commitment;
- Integration of PMTCT in MNCH/RH including PITC;
- Availability of ARVs and other supplies;
- Aggressive community involvement including campaigns from PLHIVs and media;
- Large scale training (50% of 30,000 H/W trained);
- Strong partnership engagement including NGOs, CBOs;
- Linkage of PMTCT to care, treatment and support services centres and;
- District approach to PMTCT.

Lessons learned:

Key lessons to avoid include:

- Verticalization of PMTCT and MNCH services;
- Training without plans for retention;
- Assumption that follow-up will happen automatically;
- Underestimation of male involvement;
- Lack of decentralisation;
- Over reliance on donor funding and;
- Funding too specific to be earmarked.

Recommendations:

- Roll out ART for pregnant women who need treatment;
- Increase access to early infant diagnosis;
- Improve ANC;
- Implement PMTCT in a human rights context;
- Combine community efforts with social and health workers;
- Enforce Implementation using the 4 prong intervention areas;
- Decentralise services;
- Roll out DBS for early infant diagnosis;
- Create strong linkages to treatment, care and support and;
- Build strong primary prevention interventions.

Challenges:

- Weak health systems;
- Lack of comprehensive strategy;
- Weak linkages and coordination;
- Implementation of Infant feeding policies;

- Low Male involvement and;
- Stigma

Way Forward

- Advocacy and partnerships;
- Improved resource mobilisation;
- Technical assistance in community based interventions and;
- Improved strategic information.

Session V: Role of Public Private Partnerships (Ghana) Role of Private Sector in Scaling UP ARV treatment (Burkina Faso)

In Ghana the private sector started providing care even before national guidelines were developed.

Challenges

- Standardization and quality of care with national protocols and guidelines;
- Cost of drugs and care and financial sustainability of accessing ART and;
- Provision and Scale up of care.

In Burkina Faso, some facilities provide care for profit in both private and public settings.

Role of private sector in scaling up

PPPs enhance the private health sector response to HIV/AIDS and the role of public sector in managing the response through:

- Capacity development;
- Networking;
- Advocacy;
- M&E;
- Information sharing;
- Enhanced knowledge bases and;
- Improved coordination.

Conclusion

Generally, PPPs have provided an excellent forum for sharing that has been subjected to peer review and critique. PPPs have also provided an advocacy platform which expedites processes and policy formulation/ implementation. The Private sector is strategically placed to support achievements and objectives of the NSF, MDGs and UA while by virtue of its mandate, the public sector manages HIV/AIDS therefore PPPs need to be sustained.

Discussion

Some of the partnership challenges encountered in Ghana include:

- Inadequate dialogue in PPPs;
- Sustainability;
- Limited interest in HIV/AIDS activities by the private sector;
- Stigma in private health care settings and;
- Inadequate integrated HIV services.

In conclusion, TAP has had a significant impact on the level of coordination, and has strengthened the regulatory role of the state.

Session VI: Research Studies on adherence and some social determinants in non-participating countries

W.H.O research indicates that since adherence was one of the most important components in ART it needed to be at least 95%.

Adherence changes over time for several reasons such as: recovery; side effects of drugs and; treatment fatigue.

Some adherence studies revealed that Sub Saharan African patients on ART were more adherent than patients from the industrialized world. However, despite the high level of adherence, patients from Sub Sahara African do not remain in care (Information was based on a case study done in Cameroon where there were large drop out rates). This could be attributed to transportation challenges (long distance commutes) which were also found to be a significant factor for patients who opt out of care.

High rates of adherence could be obtained from applying a comprehensive approach of counseling, supported treatment, home care delivery and medical reminders.

Despite the several methods, for measuring adherence, there is no real gold measure hence adopting multiple interventions would be the best strategy.

Currently, W.H.O is developing guidelines that will be used in the field to improve adherence.

Session VII: WHO Regional learning agenda

WHO strategic direction

- Increase knowledge of HIV status;
- Maximize prevention care and treatment outcomes;
- Scale up access to HIV services;
- Strengthen health systems and;
- Strengthen strategic information.

Learning agenda

- Treatment outcomes: to identify factors contributing to improving health outcomes; Retrospective studies and surveys are being conducted in Burkina Faso, Ghana and Mozambique.
- HIV drug resistance: to assess existing and potential emergence of ARVs drugs resistance; Research studies are being conducted in Ghana, Mozambique and Burkina Faso
- Sustainability of treatment outcomes. Currently two case studies are taking place in Ghana and Mozambique.
- TB/HIV collaboration: TB/HIV collaboration activities are being implemented in Ghana, Burkina Faso and Mozambique
- Other studies like patient flow up within integrated health system are currently going on in Burkina Faso and Mozambique.

Twenty-eight studies (12 in Burkina Faso, 6 in Ghana and 10 in Mozambique) were conducted as part of the WHO Regional learning agenda in 2007 the studies were broadly household retrospective studies, case studies and research surveys. It was anticipated that the research studies would be concluded by March 2008, analyzed between April and June 2008 and findings disseminated by July to September 2008.

Existing indicators

There are existing indicators for each of the following areas of treatment and prevention services:

- VCT;
- PMTCT;
- ART and;
- Prophylaxis for OIs.

Observations

Many studies in progress were at various levels of implementation with the following observations;

- Countries had a broader learning agenda beyond the TAP scope;
- There was a need to look at how well lessons learned were gathered during implementation;
- There is a need to support monitoring and evaluation, cross country exchanges and dissemination of lessons learned;
- Resources should be mobilized at all levels (local, national, international) in order to ensure sustainability of the good results from TAP.

Discussions following the presentations pointed out the need for a “fluid” definition of adherence and highlighted the importance of ownership in the research agenda as outcomes of TAP lessons learned must be owned and sustained by individual countries. Concrete recommendations were also made regarding:

- Proposed steps which should be taken by countries to sustain gains on the agenda of the next RAP meeting;
- NACPs should list key research issues from TAP for funding consideration by Global Fund and other donors;
- Indicators in VCT services should be modified to reflect age group particularly the youth;

In conclusion, the learning agenda should account for country needs and total ownership. Since learning entails people issues, which have no cost implications except for equipment and drugs, countries need to take up ownership of the processes, partnerships and lessons learned from TAP and integrate them into the health care system.

Session VIII: UNECA Learning Agenda Models for Enhancing PPPs in HIV/AIDS

The presentation focused on different partnerships models and highlighted the different characteristics and challenges of PPP models.

HIV partnerships objectives include:

- Strengthening coordination by involving other organizations; engage work place leaders; involve national and international pharmaceutical industries for testing techniques/vaccines/ drugs and establish sustainable partnership with media

Best practice models include:

- Corporate model;
- Treatment model;

- Funding model and;
- Media model.

Countries use Participatory Need Analysis (PNA) by engaging stakeholders e.g. negotiating partnerships with organizations, youth, women, advocacy groups and vulnerable groups to fight against HIV.

The discussion raised issues related to successful outcomes of cooperation and partnerships particularly especially in HIV campaigns.

Critical success of PPPs depends on:

- Good governance;
- Finance;
- Human resource capacity and;
- Coordination and collaboration.

The challenges of PPPs include:

- Funding;
- Coordination and monitoring.

The future of PPPs should be creative and imaginative.

PPPs Lessons learned

- Private companies might not be willing to be associated with HIV or might not always have philanthropic objectives;
- Legislation should be considered carefully these implications;
- Need to utilize the capacity of the public sector utilized;
- Need to consider limitations regarding ethical issues and legislations in given countries for HIV/AIDS campaigns;
- Consider the use of celebrities in a sustained manner in Africa;
- Strengthen public and private sector trust/ relationship regarding resource mobilization;
- Need to acknowledge donor fatigue but experiences do not fatigue corporations and;
- Need to sustain what was already started, realizing that all PPPs have a life span.

Session IX: World Bank Learning Agenda Status

After an introductory session that invited participants to reflect on the crucial aspects of the learning agenda in the TAP programme, another World Bank presentation focused on the lessons learned from the TAP learning agenda by sharing information from specific ongoing household surveys, biomedical follow-up and health facility surveys.

Measuring the impact of treatment on the welfare of patients and family members provided information on:

- Lives saved and health outcomes;
- Labor supply of patient and family members;
- Schooling of children and;
- Other welfare indicators.

Results from the studies provided:

- Satisfaction levels which varied by gender and type of facility;
- In Ghana and Burkina Faso, access to ART was positively associated with testing.

Despite funding issues and closure of TAP, there would be added value if some studies such as cohort of patients in the long term were continued.

Closing remarks

In her closing remarks the ECA representative thanked UNECA staff and participants, new partners UNAIDS and AfDB for making the meeting a success.

She acknowledged the richness of presentations/ discussions and level of progress in the implementation in TAP countries.

Participants were encouraged to consider the following issues before the next meeting:

- Re-thinking continuation of ART after TAP;
- Strengthening on-going monitoring and evaluation in the different countries. (Two reviews that need to take in Ghana and Mozambique) and;
- Dissemination of lessons learned and knowledge sharing.

After the closing remarks, it was agreed upon that the next RAP meeting would be in Addis Ababa in June 2008.

TAP

Treatment Acceleration Programme

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TREATMENT ACCELERATION PROGRAMME

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TREATMENT ACCELERATION PROGRAMME (TAP)

PROVISIONAL PROGRAMME

REGIONAL ADVISORY PANEL (RAP) MEETING

Nairobi, Kenya, 6-7 December 2007
Nairobi Safari Club hotel

THURSDAY 6 DECEMBER 2007

09:00 – 10:00

OPENING CEREMONY

Statement by ECA

Statement of the Representative of World Bank

Statement of the Representative of WHO, Kenya

Statement of the Representative of AU

Opening Speech by the Minister of Health, Kenya

Adjournment of the meeting

Objectives of the meeting by ECA

Administrative matters by ECA

10:00 – 10:15

TEA/COFFEE BREAK

10:15 – 12:00

Session I:

Overview and update on the state of implementation of TAP in Countries by Ghana, Burkina Faso and Mozambique

Moderator: WHO

Rapporteur: ECA

Open discussions

12:00 – 13:00

Session II:

State of implementation of HIV/AIDS Treatment in Kenya (Non-TAP country) by Kenya MoH

- Lessons learned on PMTCT

Moderator: Mozambique

13:00 – 14:00	Rapporteur: Ghana Open discussions LUNCH
14:00 – 15:00	Session III: WHO Concrete research studies from the field Quality of care for PLWHA by Burkina Faso Moderator: Ghana Rapporteur: WHO Open discussions
15:00 - 16:00	Session IV: WHO Concrete studies from the field HIV/AIDS Drug resistance on pediatric population by Mozambique Moderator: Burkina Faso Rapporteur: World Bank Open discussions
16:00 – 16:15	TEA/COFFEE BREAK
16:15 – 17:45	Session V: WHO Concrete research studies from the field Role of Public and Private Partnerships by Ghana Role of the Private Sector in Scaling Up ARV treatment by Burkina Faso Moderator: WHO Rapporteur: ECA Open discussions
17:45 – 18:45	Session VI: Monitoring and Evaluation lessons learned PPPs by ECA Moderator: World Bank Rapporteur: Burkina Faso Open discussions
19:00	Cocktail

FRIDAY DECEMBER 7 2007

- 09:00 – 10:00 **Session VII:**
Research studies on adherence and some social determinants in non-participating countries by WHO Expert
- Moderator: Ghana
Rapporteur: ECA
Open discussions
- 10:00 – 11:00 **Session VIII:**
WHO's regional learning agenda and implementation plan by WHO
- Inventory of on-going research in the three countries and implementation status (treatment outcomes, HIV resistance)
 - Gaps to be filled
 - Questions for investigations/issues being addressed
 - Key indicators and results to be achieved by September 2008
- Moderator: ECA
Rapporteur: Ghana
Open discussions
- 11:00 – 11:15 TEA/COFFEE BREAK
- 11:15 – 12:00 **Session IX: ECA learning agenda: Models for Enhancing PPPs in HIV/AIDS** by ECA Expert
- Moderator: Burkina Faso
Rapporteur: Mozambique
Open discussions
- 12:00 – 13:00 **Session X:**
World Bank learning agenda status (household surveys, sustainability.)
- Lessons learned from efforts to learn
 - Actions and recommendations for way forward for documentation and dissemination.
- Moderator: WHO
Rapporteur: ECA
Open discussions
- 13:00 – 13:30 **CLOSING CEREMONY**

