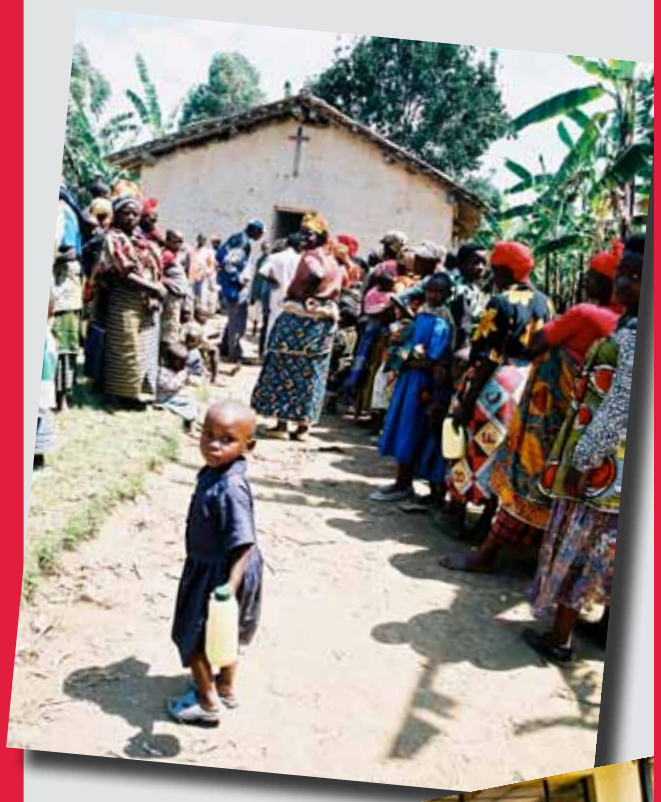
Completion report of TAP 2005-2008



Treatment Acceleration Project (TAP)

- Burkina Faso
- Ghana
- Mozambique

February 2009

World Health Organization

"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.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AIDSETI	Aid Empowerment and Treatment International
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral Medication
CD4	The immune system T-cell which is destroyed by the HIV virus
CICDOC	Centre d' Information, de Conseil et de Documentation sur le VIH/Sida
CMLS	Santé-Comité Ministériel de Lutte contre le VIH/SIDA
CSE	Community of Santo Egidio
DSF	Health and Family Direction
EWI	Early Warning Indicators
FHI	Family Health International
GHS	Ghana Health Service
HAI	Health Alliance International
HBC	Home-based care
HIV	Human Immunodeficiency Virus
HIVDR	HIV Drug Resistance
IP	Implementing Partners of HIV/AIDS Treatment Components
ITAC	International Treatment Coalition
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NACP	National AIDS Control Program
NCHS	National Catholic Health Service
NGO	Non-Governmental Organization
OI	Opportunistic Infection
PEF	Private Enterprises Foundation
PFI	Pathfinder International
PLHIV	Person Living with HIV/AIDS (both infected and affected)
PMTCT	Prevention of Mother to Child Transmission
PPP	Public-private partnership
RAP	Regional Multi-disciplinary Advisory Panel for the TAP
RCCC	Regional clinical coordination sub-committee
TA	Technical assistance
TAP	Treatment Acceleration Project
TB	Tuberculosis
TWG	Technical Working Group
UNAIDS	United Nations AIDS Program
UNECA	United Nations Economic Commission for Africa
VCT	Voluntary Counselling and Testing for HIV infections
WB	World Bank
WHO	World Health Organization

Introduction

The Treatment Acceleration Project (TAP) was a pilot initiative set by the World Bank (WB) in partnership with the World Health Organization (WHO), the United Nation Economic Commission for Africa (UNECA), and three participating country governments (Burkina Faso, Ghana, and Mozambique), and their respective implementing partners (IPs), aimed to attest the feasibility of scaling up existing HIV/AIDS treatment programmes while promoting cross-country learning. The TAP was seen as stimulus to assist health institutions toward realization of the Universal Access Vision for HIV/AIDS Care and Treatment in these countries.

The overall objective of the TAP was to strengthen individual country capacity to provide comprehensive, quality HIV/AIDS treatment and care, which is effective, affordable, and equitable. TAP activities were carried out primarily through IPs working in partnership with their respective Ministry of Health (MOH). TAP supported MOH in building national capacity for efficient management of HIV/AIDS treatment, regulating public/NGO/private partnerships, strengthening public hospitals serving as treatment referral centers, upgrading human resources, and monitoring programme implementation. These partnerships aimed to expand and strengthen a continuum of care and treatment for HIV/AIDS.

The Principle Components of the TAP Initiative included:

1. Testing approaches for scaling-up service delivery for HIV/AIDS care and treatment
   - » Voluntary Counseling and Testing (VCT)
   - » Prevention of Mother to Child Transmission (PMTCT)
   - » Antiretroviral Treatment (ART) for HIV/AIDS
   - » HIV Drug Resistance (HIVDR)
   - » TB/HIV Collaboration
2. Strengthening institutional capacity for HIV/AIDS care and treatment
3. Facilitating regional learning from the TAP country experiences

Burkina Faso, Ghana and Mozambique were selected to participate in the TAP based on the existence of promising ongoing treatment activities and representing a variety of systems and epidemiologic conditions. Each country offered a suitably different context for: (a) assisting governments and their NGO/private sector partners to refine national treatment policy and adapt WHO-approved treatment protocols to country situations; (b) supporting decentralized, cost-effective, and equitable treatment activities managed by NGOs and other private sector partners; and (c) learning important lessons for scaling up treatment programmes in other countries.

The Institutional arrangements of the TAP Initiative were as follows:

- Three Participating Countries: Burkina Faso, Ghana and Mozambique, and their respective governments represented by MOH
- Diverse range of IPs: local and/or international NGOs working with communities, associations of PLWHA, faith-based organizations, the private sector, and/or public-private partnerships to deliver HIV/AIDS treatment outreach programmes
- Three International Facilitators:
  - » World Bank
  - » UNECA: coordination of inter-country learning
  - » WHO: technical support at country-level and cross-country activities

The WHO was selected as the lead agency for providing technical assistance to participating TAP sites. The role of WHO is threefold:

1. Technical support at country level through its headquarters and regional offices, and within each MOH TAP unit;
2. Documentation of in-country achievements including regular provision of indicators
3. Facilitation of learning agenda among TAP countries through contribution to the various Regional multi-disciplinary Advisory Panels (RAP)
   a. invitation of expert in various level
   b. incentives on integration of lessons learnt into programme

Initially the World Bank funded pilot initiative was for a 3 year period effective November 2004 to September 2007. After consideration of implementation status, the TAP was extended to September 2008 owing to work plan completion requirements.

This synthesis is based on final country reports submitted by the respective WHO Country Offices. Programmes in Burkina Faso, Ghana and Mozambique will be assessed by WB to verify the level of effectiveness and efficiency of their strategies, as well as identify challenges in the institutional arrangements for HIV/AIDS care and treatment activities.

This report is intended to support decisions in the World Bank's future commitments, and equally to aid the TAP partners in identifying any gaps and challenges in their programming efforts. It identifies lessons learned which should provide the framework to transfer demonstrated and refined models to other geographic settings. Global recommendations are provided to improve the relevance, efficiency, and efficacy of ongoing and future activities.

Country information

- Burkina Faso
- Ghana
- Mozambique

Burkina Faso

Introduction

As of 2007, and estimated 130 000 adults (15-49) and children (0-14) were living with HIV/AIDS in Burkina Faso. Prevalence rates among adults aged 15-49 years was estimated at 1.6%. Women aged 15 and up living with HIV was estimated at 61000. The prevalence rate among males and females 15-24 years was 0.5% and 0.9%, respectively. HIV-related deaths were estimated at 9200. The number of orphans (0-17) due is approximately 100 000. By 2007, 76 sites were offering antiretroviral therapy with estimated antiretroviral coverage at 35%. Though still considered "generalized," these results indicate lower than expected levels of infection among adults and potential benefits to be obtained by treating the epidemic at its current level. Large gender and geographic disparities remain.

Overview of progress in TAP implementation

In Burkina Faso, technical coordination of the TAP is provided by the Comité Ministériel de Lutte Contre le Sida (CMLS/Santé) and Health and Family Direction (DSF) with overall responsibility to review TAP implementation progress, make strategic decisions and approve the annual work plan. CMLS/Santé is the focal point for partnerships linking the MOH and the Implementing Partners. Twenty-one out of the 55 districts at the peripheral level were targeted for TAP activities with NGO participation from Aid Empowerment and Treatment International (AIDSETI), Centre d' Information, de Conseil et de Documentation sur le VIH/Sida (CICD) and Saint Camille as Implementing Partners.

The primary objectives of the TAP in Burkina Faso include:

1. Support the delivery of the full continuum of care through outreach with NGOs:
   a. Voluntary Counseling and Testing (VCT);
   b. Anti-retroviral Treatment (ART);
   c. Home based care (HBC); and
   d. Prevention of Mother to Child Transmission (PMTCT and PMTCT plus)
2. Strengthen the national capacity of MOH and all partners to ensure effective public and private oversight of the treatment scale-up process
3. To facilitate regional learning from TAP experience

Testing approaches for scaling-up service delivery for HIV/AIDS care and treatment.

With the strengthening of human resource and logistical capacity of the Implementing Partners - AISETI, Saint Camille and CICDOC – via recruitment of staff, training and new equipment, more people have accessed VCT and sensitization services. Among the 170 facilities set up in Burkina Faso, 511658 people participated in VCT services (prevalence rate of 4.3% - 5.4%) by 2007 with 26,604 testing positive (5.2%). PMTCT coverage was expanded from 211 to 413 sites with the extension of PMTCT services to 50 districts. 157,300 (40%) of pregnant women attending ANC were tested for HIV with prevalence among pregnant women at 2.78%. Of the 1762 pregnant women tested HIV positive, 1538 benefited from ARV. PMTCT activities were based on the WHO protocol. Of the 1874 children identified with HIV, 1401 began treatment. DSF ensured the monitoring of PMTC services with 21 districts offering comprehensive PMTCT services. Nutritional and other support services offered breast feeding kits and substitute milk provided through IP sites. 9464 PLWHA accessed nutritional and psychological support services. 5358 home visits were organized with 11,196 benefiting from nutritional and peer support activities.

Strengthening institutional capacity for HIV/AIDS care and treatment.

Antiretroviral therapy was provided to 17263 patients including 649 children across 77 sites. Among the 21 districts involved in the TAP the percentage of PLWHA receiving ARV were as follows: Region du Centre 61.9%; Region des Hauts Basins 17.8%; Region du Nord 4.2%; and Region du Centre Ouest 3.3%. A national training plan for treatment teams was financed by the TAP with WHO technical support. The WHO assisted the MOH in in-service training and supervision of NGO's HIV/AIDS treatment programs. Additionally, WHO provided technical support and supervision to these committees at the treatment sites to ensure the quality and standardization of first and second line drug regimes used and the protocols followed by all health facilities within Burkina Faso. TAP also funded the procurement of drugs needed to treat patients enrolled in the sites operated by the implementing partners. Twelve sites were selected for HIVDR sampling using protocol for HIVDR surveillance. Six training sessions were organized by the national reference laboratory in collaboration with foreign laboratories accredited by the WHO for genotyping. Laboratory equipment was procured.

Facilitating regional learning from the TAP country experiences.

The results of all surveys conducted through the TAP were presented at the RAP including the preliminary results for PMTCT. These surveys include: Risks and benefits of antiretroviral treatment at household level; outcomes of ART on households and health facilities; survey on treatment and care practices for PLWHA in Burkina Faso; survey on infant HIV residual transmission in PMTCT; and Behavioural surveillance Survey on HIV/AIDS.

Challenges

- Early testing among children with HIV exposure remains a challenge
- Integration of PMTCT into health services
- Stock out of substitute milk due to flaws in procurement system
- Development of surveillance system for drug resistance needs improvement
- Training of health providers in pediatric care and treatment
- Translating decision making data so that it is operational for monitoring and evaluation of PLWHA and the analysis of cohort
- Not enough sensitization of women especially pregnant women

Lessons Learned

Many lessons have been learnt during the implementation phase. The most important include:

- The increase demands of services in care and treatment since 2005. This could be explained by the availability and accessibility of services and the quality of services provided to PLWHA.
- The incentives of associations and NGOs to contribute to the scale up of care and treatment as well as prevention in Burkina Faso
- The integration efforts of VCT services in public health structures as strategy for testing.
- The documentation of TAP including strengths and weaknesses in order to improve the national programme of HIV in health structures.
- The strong collaboration between private and public health structures including NGOs in the scaling up of care and treatment of PLWHA

Achievements

Table 1: TAP performance indicators

1. Household surveys conducted, baseline data collected and analyzed?	Risks and benefits of antiretroviral Treatment at household level evaluated during 2006-2007 (ISSP/ World Bank)
2. Facility surveys conducted, baseline data collected and analyzed?	- Outcomes of ART on households and health facilities (World Bank 2006) - Survey on treatment and care practices for PLWHA in Burkina Faso (IRSS/OMS 2006). Final report available - Survey on infant HIV residual transmission in PMTCT (MOH/OMS) results not yet published
3. Behavioral sentinel surveys conducted, and data analyzed?	Behavioural surveillance Survey on HIV (NAC/WHO, 2008). Final report available.
4. Findings presented and discussed during Regional Advisory Panel (RAP) meetings?	The results of all the surveys have been presented, including the preliminary results for PMTCT.
5. Public-private partnership (PPP) evaluation studies conducted, and data analyzed?	- Burkina Faso public-private partnership evaluation (UNECA, Dec 2006-Apr 2007). - Synergies and collaboration between NGO/associations and the public sector for ART scale-up in Burkina Faso. Best practice documentation (WHO, 2007).
6. Studies of the social determinants of antiretroviral treatment conducted?	The study on the social economic determinants of antiretroviral treatment observance was conducted in Burkina Faso, and presented at country level even though it was not presented during the 7th RAP meeting in Addis Ababa. The study was focusing on the social determinant factors affecting/ influencing the antiretroviral treatment adherence/support in Burkina Faso.

Tables 2: Burkina Faso tap performance indicators by implementing partner

A. Empowerment and Treatment International (AIDSETI)

Indicator	2006	2007	Sept 2008	Total
7. Annual number of people accessing counseling and testing services in project supported sites	24,802	15,626	13,263	53,691
8. Annual number of mother-infant pairs accessing PMTCT services in TAP supported sites	NA	NA	NA	NA*
9. Annual number of PLHIV receiving cotrimoxazole prophylaxis in project supported centers	NA	NA	NA	NA*
10. Annual number of eligible PLHIV under ARV in project supported centers	2,013	2,682	3,002	3,002

* Was not directly supported by TAP funding

B. Centre d' Information de Conseil et de Documentation sure le VIH/SIDA (CICDOC)

Indicator	2006	2007	Sept 2008	Total
7. Annual number of people accessing counseling and testing services in project supported sites	26,387	17,990	6,447	50,824
8. Annual number of mother-infant pairs accessing PMTCT services in TAP supported sites	NA	NA	NA	NA*
9. Annual number of PLHIV receiving cotrimoxazole prophylaxis in project supported centers	9,939	11,371	NA	21,310
10. Annual number of eligible PLHIV under ARV in project supported centers	934	1,392	1,253	1,253

C. Saint Camille

Indicator	2006	2007	Sept 2008	Total
7. Annual number of people accessing counseling and testing services in project supported sites	1,159	1,400	571	3,130
8. Annual number of mother-infant pairs accessing PMTCT services in TAP supported sites	1,611	1,400	571	3,582
9. Annual number of PLHIV receiving cotrimoxazole prophylaxis in project supported centers	NA	NA	NA	NA*
10. Annual number of eligible PLHIV under ARV in project supported centers	480	525	441	1,446

D. National level (situation with BFA District Sanitaires of TAP)

Indicator	2006	2007	Sept 2008	Total
7. Annual number of people accessing counseling and testing services in project supported sites	199,767	141,065	42,536	383,368
8. Annual number of mother-infant pairs accessing PMTCT services in TAP supported sites	1,615	Mothers: 1538 Infants: 1401	3016 (mere enfant traitès avec shèmas ARV en 2006 et 2007)	
9. Annual number of PLHIV receiving cotrimoxazole prophylaxis in project supported centers	9,939	11,371	NA	21,310
10. Annual number of eligible PLHIV under ARV in project supported centers	7,882	8,037	NA	NA*

* Was not directly supported by TAP funding

Measurement of outcomes at country level : indicators in TAP key areas

	Before TAP: (baseline)	With TAP		
Year	2004	2007	1st semester 2008	Total 2005 - 2008
Cumulative number of health districts with at least one centre offering HIV testing	8	50	58	58
Cumulative number of PMTCT sites	31	413	520	520
Number of women attending the antenatal centres (CPN1)	30369	200429	179069	538448
Number of women tested for HIV	11594	87478	75461	232761
Percentage of HIV positive among women tested	38.2%	43.60%	42,14	43.23%
Number of pregnant women (F. E.) tested HIV positive	801	2432	1570	6935
Percentage HIV positive	6.90%	2.80%	2,08 %	2,98 %

Ghana

Introduction

As in other countries in Sub-Saharan Africa, HIV/AIDS is recognized a serious public health threat in Ghana. WHO/UNAIDS estimates that the prevalence of HIV infection among adults aged 15 – 49 was 1.9% in 2007. The prevalence is highest in the central and southern regions and lowest in the northern region. Rates are generally higher in densely populated areas. The epidemic is primarily spread through heterosexual transmission, which accounts for up to 80% of infection. In 2007 it was estimated 264,481 persons were living with HIV/AIDS and an estimated 86,500 required ART.

Overview of progress in TAP implementation

In Ghana, the National AIDS/STI Control Programme (NACP) of the Ghana Health Service/Ministry of Health (GHS/MOH) is responsible for the coordination and implementation of the health sector response to HIV/AIDS. The TAP was implemented by the NACP in collaboration with its IPs: Family Health International (FHI), National Catholic Health Service (NCHS) and Private Enterprise Foundation (PEF). FHI and NCHC served as the main clinical Implementing Partners with a combined 12 private and non profit health facilities across the Ashanti and Greater Accra Regions:

- Analo-Gold Hospital
- Odorna Clinic
- Narh-Bita Hospital
- Bomso Clinic
- St Martin de Porres Hospital
- St John of God Hospital
- St Patrick's Hospital
- St Michael's Hospital
- Holy Family Hospital
- St Dominic's Hospital

The Private Enterprise Foundation served in a community advocacy role, working closely with the NACP, FHI and NCHS to stimulate private sector support for HIV/AIDS activities.

The primary objectives of the TAP in Ghana include:

1. Rolling-out comprehensive HIV/AIDS care including VCT, PMTCT, HBC, OI and ART management in both public and private sector institutions;
2. Strengthening capacity of the MOH to provide standardized, quality HIV/AIDS care and treatment;
3. Providing a forum for cross-country learning and documentation of lessons learnt in the implementation of TAP.

Testing approaches for scaling-up service delivery for HIV/AIDS care and treatment.

Ghana made significant improvements increasing access to comprehensive testing approaches for scaling up service delivery for HIV/AIDS care and treatment. TAP financing allowed for the expansion of services to 6 protégé private health facilities (in the Ashanti and Greater Accra Regions) and 6 public hospitals (in Eastern, Ashanti and Western regions). A total of 16,560 persons utilized VCT services (FHI 3318 counseled, 3294 tested; need breakdown of #s tested and #s counseled at NCHS facilities). An estimated 1,200 PLHIV received treatment of opportunistic infections and 1,545 persons started ART. 19,787 pregnant women enrolled in PMTCT. HIV/AIDS management training was provided to 480 health care workers. Eighty peer educators were trained in ART/OI management with 30 peer educators participating in ongoing workshops. PEF's advocacy work with private sector institutions toward the adoption of HIV/AIDS work place policies was further strengthened as a result of the TAP. Sensitization workshops were offered to employees through work place programs and media outreach. Local NGOs engaged in outreach programs with schools, churches, mosques and youth groups. The creation of referral networks, through the organization of inter-site meetings, was also enhanced. Lastly, the procurement of 10 CD4 machines and a sequencer for monitoring HIVDR served to improve the quality of testing and counseling services.

Strengthening institutional capacity for HIV/AIDS care and treatment.

Ghana made significant progress toward strengthening institutional capacity for HIV/AIDS care and treatment. With technical support from 3 WHO Officers, Ghana was able to reinforce governmental commitment to collaboration with the private sector, and build human resource and logistical capacity to deliver care and treatment across sites. Capacity building of the IPs and their sites to provide comprehensive care was facilitated through training of service providers, provision of logistics, linkages with public sector facilities to assess gaps in care, and monitoring and evaluation of implementation activities. Accreditation teams were organized to assess the sites readiness to offer ART. Activities were monitored via quarterly meetings coordinated by the NACP providing a forum for IPs and other relevant stakeholders to share information. TAP funds were also used to procure ART for regional medical GHS facilities and other sites to access as needed. Exit interview were conducted to assess provision of care. Lastly, the establishment of a Technical Working Group (TWG) provided the NACP Program Manager with support on matters related to treatment and care including accreditation and monitoring of prospective and operating ART sites; training of health workers in ART/OI management; technical backstopping to sites earmarked for accreditation and all accredited sites; and to provide relevant material based on local and non-local clinical experiences and research including the revision of national guidelines.

GHANA

Facilitating regional learning from the TAP country experiences.

TAP financing allowed for considerable improvements to the regional learning process in Ghana facilitated by in-country technical support by WHO officers and the establishment of the multi-disciplinary Regional Advisory Panel (RAP) organized through UNECA. WHO provided a range of technical assistance support including the training of health workers; assessment, accreditation and monitoring of treatment sites; updating and refining of guidelines and manuals; and membership and participation in key committees and meetings at the national level. Additionally, WHO collaborated with implementing partners and sites to further develop and refine research efforts; program monitoring and evaluation frameworks; and documentation and timely incorporation of best practices.

Challenges

Several challenges presented themselves over the course of the TAP in Ghana. Bottlenecks and constraints in the availability and flow of funds resulted in a delayed implementation of activities and inability to execute all planned activities. There were delays in initiating VCT, PMTCT and ART services in some facilities even after capacity had been built to provide services. Competing priorities and programs further complicated timely implementation of activities as did delay in renewing WHO staff contracts six months before the end of the TAP.

Stigmatization and low community involvement initially hampered uptake of services . Second, some TAP facilities initially faced challenges accessing specialized laboratory services at public sector facilities. Third, survey fatigue was expressed among several private sector institutions during the implementation of PEF's activities .

Lessons Learned

- Private-public sector can collaborate effectively to scale up ART care and treatment
- When equipped with the relevant information, private sector enterprises can be galvanized to support HIV activities, but efforts are needed to raise, broaden, and sustain commitment to HIV/AIDS care and treatment among private sector entities.
- Strengthening institutional capacity is critical to the effectiveness of the national AIDS response.
- Implementing TAP activities resulted in IPs gaining operational experience that should be harnessed to strengthen capacity building in HIV care.
- Implementation capacity for HIV/AIDS programs cannot be taken for granted. Projects need to invest in the capacity of both public and private stakeholders and develop more flexible project implementation procedures to engage it more effectively.
- Mainstreaming of TAP activities into established hospital services fosters ownership, integration and sustainability.
- Innovation is critical to ensure effective program implementation (please explain example of patient recruitment).
- Integration of HIV services and confidentiality processes reduces stigmatization

Achievements

Table 3: TAP performance indicators

1. Household surveys conducted, baseline data collected and analyzed?	Data for the Household Survey was collected over 18 months in 3 phases, with the phases starting and ending as indicated below: Phase 1: Apr 2007 – Sep 2007 Phase 2: Oct 2007 – Feb 2008 Phase 3: Mar 2008 – Aug 2008 Data entry for phase 1 is complete and that for phase 2 is currently on-going.
2. Facility surveys conducted, baseline data collected and analyzed?	The facility based survey on the treatment outcomes of persons living with HIV on ART has been conducted in 4 ART sites. Data collection is complete and analysis is currently ongoing.
3. Behavioral sentinel surveys conducted, and data analyzed?	The BSS in Ghana was conducted in 2006. Highlights of the survey have been disseminated at national fora. The hard copy of the report is in draft form and will be printed.
4. Findings presented and discussed during Regional Advisory Panel (RAP) meetings?	The following papers were presented at the RAP meetings: - Evaluation of Public Private Partnerships in Ghana Under the Treatment Acceleration Programme. - Social and economic determinants of adherence to HIV treatment in Ghana.
5. Public-private partnership (PPP) evaluation studies conducted, and data analyzed?	The Ghana TAP Public-private partnership (PPP) evaluation studies were conducted and data analyzed. The final report is with UNECA and has not yet been made available.
6. Studies of the social determinants of antiretroviral treatment conducted?	The Ghana TAP Studies of the social determinants of antiretroviral treatment were conducted. The final report is with UNECA and has not yet been made available.

Tables 4: Ghana TAP performance indicators by implementing partner

A. Family Health International (FHI)

Indicator	2006	2007	Sept 2008	Total
7. Annual number of people accessing counseling and testing services in project supported sites	VCT = 831 PMTCT = 1,064	VCT = 1,417 PMTCT = 2,158	VCT = 1,045 PMTCT = 1,706	VCT = 3,293 PMTCT = 4,928
8. Annual number of mother-infant pairs accessing PMTCT services in TAP supported sites	5	21	23	49
9. Annual number of PLHIV receiving cotrimoxazole prophylaxis in project supported centers	278	375	184	837
10. Annual number of eligible PLHIV under ARV in project supported centers	158	260	181	599

B. National Catholic Health Service

Indicator	2006	2007	Sept 2008	Total
7. Annual number of people accessing counseling and testing services in project supported sites	VCT = 1,093 PMTCT = 1,679	VCT = 4,344 PMTCT = 8,622	VCT = 7,371 PMTCT = 8,474	VCT = 12,808 PMTCT = 18,785
8. Annual number of mother-infant pairs accessing PMTCT services in TAP supported sites	55	122	174	351
9. Annual number of PLHIV receiving cotrimoxazole prophylaxis in project supported centers	322	3,788	3,694	7,804
10. Annual number of eligible PLHIV under ARV in project supported centers	113	473	548	1134

Measurement of outcomes at country level : indicators in TAP key areas

Ghana		Baseline 2004	December 2005	December 2006	December 2007	2008
VCT	Number of districts with at least one centre offering HIV Testing and Counselling	40	82	131	138	NA
	Total number of VCT centres	59	175	341	422	NA
	Number of people tested Proportion of women Number of young people below 25	15,490 NA NA	30,046 55% NA	71,307 77% NA	131,903 NA NA	150,499 NA NA
PMTCT	Total number of PMTCT centres	52	175	327	408	NA
	Number of districts with at least one PMTCT centre	52	82	131	138	NA
	Number of pregnant women tested for HIV	8,490	20,296	36,155	109,334	109,531
	Proportion of HIV positive women who received ARV prophylaxis	NA	78%	90%	87.8%	NA
	Number of labs with CD4 counter	NA	23	36	80	NA
	Average cost for treatment (monthly) Ghana Cedis	NA	5	5	Free	NA
ARV treatment	Reported number of people receiving ART Proportion of women Number of children (<15 years)	2,028 NA NA	3,800 60% NA	6993 62% NA	13,357 NA 4%	14086 NA NA
	Total number of ART centres	4	28	46	90	NA
	Number of districts with at least one ART centre	NA	4	32	NA	NA
	Number of people on prophylaxis/OI treatment Proportion of women Number below 25	4,054 NA 2,360	9,396 63% NA	15,563 62% NA	27,111 NA NA	30,989
HBC	Number of people receiving home based care	NA	NA	649	NA	NA

Mozambique

Introduction

Mozambique faces a serious and expanding HIV epidemic, with an adult prevalence of 16% in 2007 and an estimated 500 people becoming infected every day. According to the MOH, 1.7 million people were estimated to be living with HIV/AIDS in 2007, with 105,000 of these children under 15. The epidemic is fuelled by poverty, gender inequality, cultural conditions and high levels of labor mobility. Around 60% of people living with HIV in Mozambique are women and it was estimated that there were 150,995 HIV positive pregnant women in the country. The national prevalence of HIV infection masks considerable regional differences, with estimated adult prevalence rates of 22.0% in the south, 17.75% in the centre and 10.5% in the north in 2007.

Overview of progress in TAP implementation

Prior to the TAP, the Mozambican MOH was implementing ART – and continues to do so - with the support of 10 functioning Implementing Partners involved in increasing access to ART to persons living with HIV/AIDS. The MOH plays a key role in strengthening of the national treatment committees, quality control, coordination of program expansion via improved planning of the infrastructures, drug procurement, human resource development, and monitoring of access to services.

Oversight of the TAP is ensured by the MOH with Health Alliance International (HAI), Community of Santo Egidio (CSE) and Pathfinder International (PFI) selected as the Implementing Partners based on their experience delivering antiretroviral therapy (ART), emphasis on prevention of mother to child transmission (PMTCT) and youth friendly health services:

- **CSE:** ART with emphasis on PMTCT (8 sites)
- **HAI:** ART (5 sites); PMTCT (23 sites) including VCT and HBC across sites
- **PFI:** ART, PMTCT and VCT integrated with Youth Friendly Health Services (2 sites)

The primary objectives of the TAP in Mozambique include:

1. Scaling up services for HIV/AIDS care and treatment
2. Strengthening institutional capacity for HIV/AIDS care and treatment committees/program coordination
3. Monitoring of the quality of HIV/AIDS treatment
4. Facilitating TAP in country /regional learning activities.

Testing approaches for scaling-up service delivery for HIV/AIDS care and treatment.

Mozambique strengthened testing approaches for scaling-up service delivery for HIV/AIDS care and treatment. Efforts focused primarily on VCT and PMTCT services. (Under the existing Mozambican HIV Plan, VCT and PMTCT services, in addition to Diagnosis and Treatment of STIs, Safe Transfusions, Adolescent and Youth Health Services, OI Treatment and Prophylaxis, and ART services were already being offered through 10 partners, of which 3 served as TAP Implementing Partners.) Among the 3 IPs a total of 33 sites benefited via the TAP. Financing allowed these sites to expand their testing approaches with a focus on pregnant women and youth friendly health services. More than 140 youth participated in VCT via the youth friendly clinics. As the number of VCT sites offering ART increased, so did the numbers of people visiting these sites. The annual number of mother-infant pairs accessing PMTCT services in project supported centers was 8,490. A high level of interaction between the IPs and the MOH facilitated the creation of referral networks and timely response to implementation challenges. More than 500,000 young people have benefited via Geracao Biz – "Busy Generation" – increasing awareness of sexual and reproductive health issues and to encourage the adoption of safe, gender-sensitive sexual behavior.

Strengthening institutional capacity for HIV/AIDS care and treatment.

The delivery of HIV/AIDS care and treatment increased in Mozambique as a result of TAP and the geographical reach of IPs across adult, youth and child programs. Decentralization of programs and strengthening of ARV procurement and supply contributed to rapid scale up of ART with approximately 90,796 persons starting therapy across Implementing Partners. Strong political will also contributed to the achievement of TAP objectives, redefining a national strategic plan with clear roles and responsibilities in addition to addressing important gaps ART care delivery systems. Input from TAP partners enhanced the ability of the MOH to procure drugs and resolve drug procurement and supply issues.

Facilitating regional learning from the TAP country experiences.

The WHO contributed to a range of activities such as updating and adaptation of guidelines and protocols; national standards, criteria and assessment tools; quality assurance systems for drug procurement and testing; training programs; national monitoring and evaluation framework; management and education of PLHIV; and system for clinical monitoring of ART. The development of information systems to deliver improved statistical results under TAP also contributed to institutional strengthening by providing a practical and reliable data base for project monitoring.

The Regional multi-disciplinary Advisory Panel (RAP) created a platform for information-sharing including PMTCT, HIVDR and long term financing of HIV care and treatment by TAP stakeholders and experts in the field. The RAP established a regional clinical coordination sub-committee (RCCC) to work with the International Treatment Coalition (ITAC) and WHO to maintain regular review of treatment regimens and protocols as lessons from country treatment programs were gathered and shared at the regional level. The RCCC was comprised of clinical experts recognized for their work in HIV/AIDS treatment, to enable African countries to share experiences, to review clinical results, and to recommend policy reforms in participating countries. WHO served as the rapporteur of the RCCC. RAP meeting were held biannually at various locales throughout Eastern and Western Africa.

Challenges

After the initial challenges of adapting to new financial systems (i.e., fund disbursement process), and programmatic challenges (i.e., clarifying activity benchmarks), the TAP progressed smoothly with technical input from WHO. The WHO was instrumental in improving service delivery and strengthening monitoring and evaluation capacity across sites.

The project also experienced human resources challenges with an organizational restructuring in the HIV Department at the MOH resulting in a change of TAP Coordinators. This change briefly interrupted regularly scheduled meetings between the MOH and IPs. Lack of well trained pharmacists was another human resource challenge.

Poor stock management of ARV drugs, and poor linkages between HIV programs and the need to integrate HIV programming into the general health system were major challenges. WHO recognized the limitations of laboratory capacity as a significant barrier to reaching target objectives and goals. The accelerated roll-out of ART could have led to the emergence and transmission of drug-resistant viruses. However, WHO worked with the immunology laboratory to build capacity to perform genotyping testing to detect HIVDR.

In regard to laboratory services, the major problems were with centralized testing at limited pediatric sites, including difficulties in transporting samples. Significant investment in the laboratory infrastructure had been critical in accelerating the pace and sustainability of roll-out.

Lessons Learned

- Public private partnerships are possible with a shared vision
- Political will and support is critical for treatment success
- Integrated HIV/AIDS care packages – including nutrition, PEP and infection control and prevention practices – are cost-effective and lead to efficient service delivery
- Regular availability of ART drugs fosters adherence and prevents emergence of drug resistance
- Optimized functionality of laboratory services, drug procurement and supply management is critical to scaling up services
- Expansion of services to rural areas increases access to services, enhances community awareness and reduces stigma and fears/ taboos
- Cascade training maximizes availability of services; language training improves sharing of best practices
- Regular quality control helps to ensure improved standards of HIV care
- Staff HIV/AIDS screening strategy had positive impact in identifying strengths and weaknesses of care delivery offered by the health unit
- Extra funds must always be kept aside for the unexpected (natural disaster, etc.)
- Regularly scheduled meetings between MOH and IPs are essential for clarity and status of programs
- Social marketing strategies complement HIV/ AIDS programs
- Local anthropometric and operations research are valuable tools for improved service delivery
- Strategic role of civil society has contributed positively to strengthen the MOH.
- Adolescents and Youths are Pivotal to provide HIV/AIDS Care Within the same Group.
- Best advocates for education, support and social networking are PLHIV and PLHIV associations

Achievements

Table 5: TAP performance indicators

1. Household surveys conducted, baseline data collected and analyzed?	NA
2. Facility surveys conducted, baseline data collected and analyzed?	NA
3. Behavioral sentinel surveys conducted, and data analyzed?	NA
4. Findings presented and discussed during Regional Advisory Panel (RAP) meetings?	NA
5. Public-private partnership (PPP) evaluation studies conducted, and data analyzed?	NA
6. Studies of the social determinants of antiretroviral treatment conducted?	NA

WHO was unable to get any update from the country.

Measurement of outcomes at country level : indicators in TAP key areas

		Baseline 2004	December 2005	2006	November 2007
VCT	Number of districts with at least one centre offering HIV Testing and Counselling	NA	67	144	144
	Total number of CTH (Counseling and Testing for Health) centres	359	223	359	554
	Number of people tested Proportion of women Number of young people below 25	294,567 67% 118,324	685,239 61% 305,749	401,303 63% 43.7%	430,662 NA NA
PMTCT	Proportion of districts with at least 1 PMTCT centre	NA	NA	144 (100%)	144 (100%)
	Total number of PMTCT centres	51	88	222	350
	Number of pregnant women tested for HIV	46,583	99,835	194,117	366,281
	Number of mother-children under PMTCT treatment Number of mothers under ARV	3,182 (m) 3,335 (c) 197	7,690 (m) 5,437 (c) 554	12,150 950	8,947 1,541
ARV treatment	Number of health districts with at least 1 ARV centre	17	30	NA	NA
	Number of structures providing treatment and care	23	39	NA	NA
	Reported number of people receiving ART Proportion of women Number of children (<15 years)	6,500 NA NA	19,754 54.7% NA	44,100 59% NA	85,822 62% 7%
	Number of people benefiting from prophylaxis/OI treatment Proportion of women Number of young people under 25	NA	NA	NA	NA
HBC	Number of people receiving home care Proportion of women Number of young people under 25	11,355 NA NA	27,582 NA NA	48,000 NA NA	50,000 NA NA
	Number of operational research activities undergoing	NA	9	NA	NA

Overall recommendations

The fight against AIDS requires both rapid action and determined long-term building of capacity and sustainability. The following recommendations are drawn from the TAP experience:

- Continue to focus multisectoral support for implementation on those sites whose activities have the greatest potential impact on the epidemic.
- Lessons learned should be widely disseminated to non-participating sites to serve as a learning model or for replication – and may create opportunity for continued support and funding by other stakeholders
- A forum for the MOH, IPs and WHO Country Offices should be established to build upon the TAP experience, share best practices and discuss emerging issues and challenges.
- Operational and fund disbursement bottlenecks should be addressed to ensure fewer disruptions
- Significant investments are recommended to build the capacity of a broad range of local technical and managerial expertise, from laboratory personnel to procurement strategists to supervisory personnel and trained nurses.
- Standard operating procedures are recommended for dissemination to the laboratories and urgent MOH supervision for quality control is needed.
- The delivery of quality ART requires dedication of the necessary funds and other resources to the enormous task of securing and delivering effective drugs.
- Members of PLHIV associations should be integrated into the social support systems for VCT, PMTCT and HBC.
- Dedicated resources and processes will be needed to establish and maintain harmonized monitoring and evaluation systems that will not only measure the effectiveness of ART programs and outcomes, but also inform the ongoing improvement and optimization of the clinical and management operations of scale-up.
- WHO should continue to provide comprehensive technical assistance as scale up continues in both the private and public sectors.

WHO Collaboration with TAP Initiative

The design of the TAP Initiative was based on drawing upon the existing WHO country and regional arrangements and expertise, WHO's comparative advantage to work closely with Ministries of Health, and ability to provide a broad range of technical assistance. Due to time constraints with the implementation of TAP in 2006, WHO had to realign the staffing at the country, regional and global levels to support the various requests, especially in documentation of the activities undertaken in the three countries. In Burkina Faso, a M&E officer was recruited to assist the MOH, in Ghana a programme manager and three regional focal points for M&E were recruited, and in Mozambique 10 additional staff were recruited and posted at the provincial and district levels for data collection and analysis.

At Country Level:

WHO backstopped in-country technical capacity to provide ARVs and to adopt WHO generic guidelines to address the local realities for an effective ART program. Additionally, WHO was responsible for the documentation of implementation progress for sharing at the various RAP meetings; strengthening of monitoring and evaluation systems used to document data for decision-making in the three countries; enhancing the overall learning processes; and improving the quality of services. The MOH was the main implementer and was fully responsible of funds disbursement, synchronisation of activities and negotiation with WB concerning the Initiative implementation

At Regional Level:

In addition to supporting countries, WHO made technical contributions through various RAP meetings:

- **Participatory.** RAP meetings were used as platforms to agree on way forward in a collaborative format. Issues included performance indicators, disbursement process and bottlenecks, revised objectives for program extension, and process for program evaluation at completion of TAP.
- **Capacity Building.** RAP meeting also provided an opportunity for information-sharing among countries participants and technical experts, and discussion of country-specific challenges and solutions across sites. Experts were invited across Africa to discuss pertinent issues including:
  - » patient tracking systems, drug resistance, adherence, HIV/TB integration, PMTCT, pediatric care, operational research, etc.

At Global level:

Delays were experienced due to some misunderstanding of the system of funding to WHO. Since agreement was already signed, the organization had to find innovative ways to meet the conditions imposed by WB. Systems being not always as flexible, it took some time to get adjusted. WHO took the lead in assisting TAP countries to adapt the tools used in other countries to local situations, and to apply global experiences to strengthen implementation.

- Documentation of the Initiative
- Programmatic guidance to countries
- Monitoring of financial disbursements
- Supervision of mission

Proposed arrangement for future operation

Detailed performance indicator data indicate that testing approaches, capacity building and regional learning activities financed through the TAP have had significant impact on improving access to and strengthening of HIV/AIDS prevention and control activities. All TAP programmes at the completion of the Initiative have been integrated into their respective national HIV programme. WHO continues its role of advising on policies and supporting the development of tools and guidelines. However, there is still work to be done. Adopting the TAP findings and lessons learned in Burkina Faso, Ghana and Mozambique through future dedicated resources would enable country operations to:

1. Solidify the design and implementation of their respective country response to HIV/AIDS (using the National HIV/AIDS Strategic Framework as the base document upon which the sector response was developed);
2. Expand services and increase access to quality HIV/AIDS testing approaches and care services for associations or NGOs through increase capacity in programme management;
3. Strengthen evidence base on impact and effect of testing approaches;
4. Strengthen ability of MOH, Implementing Partners and health care workers to provide reliable data through adopted reporting mechanisms;
5. Reinforce linkages to the National Monitoring and Evaluation Framework, and building and operationalizing M&E at the country, regional and global levels;
6. Participate in essential operational research
7. Increase capacity among public and private sector partners and institutions to deliver quality HIV/AIDS services and improve standards of care;
8. Strengthen Public-Private Partnerships; and
9. Reduce HIV/AIDS burden and prevent emergence of HIV drug resistance.

Feedback on the quality of World Bank's contribution, from identification to supervision

Many aspects of the World Bank's contribution to the TAP Initiative are strong; however, there were weaknesses. For instance, the Bank's role and responsibilities did not allow for timely understanding of and response to results. Additionally, there were gaps in information sharing where reports at country level were not systematically shared with all partners. Lastly, the countries reported feeling compelled to apply Bank recommendations regardless of the decision-making process undertaken to reach that decision.

Treatment Acceleration Project (TAP)

Completion report of TAP : 2005-2008

Burkina Faso, Ghana and Mozambique
February 2008