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Contributions of ART scaling-up to the strengthening of health systems in the framework of support provided by GFATM: the case of Tanzania, Chad and Burkina Faso

Short case study
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by
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Abbreviations

ART	Anti-retroviral Therapy
ARV	Anti-retrovirals
CCM	Country Coordinating Mechanism
EQUINET	Southern African Regional network for Equity in Health
GF	Global Fund
GFATM	Global Fund to fight HIV/AIDS, Tuberculosis and Malaria
NGO	Nongovernmental Organization
PHRplus	Partners for Health Reform*plus*
PSI	Population Service International
SSA	Sub Saharan Africa
SWEF	System-wide Effects of the Fund
UNICEF	United Nations Children's Fund

1. Summary

Major initiatives currently support the scaling-up of Anti-Retroviral Therapy (ART) in low income countries of sub-Saharan Africa. While these programs have allowed to substantially increase the number of People Living with AIDS (PLWA) receiving ART, it was criticized that these initiatives do not put enough emphasis on general health systems strengthening through the integration of ART services into routine health services at district level. The USAID funded project Partners for Health Reformplus (PHRplus) and the Southern African Regional network for Equity in Health (EQUINET) have both started to review country experiences.

Complementary to work so far undertaken by these initiatives, the following case study, tries to identify to what extent support provided by the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM) to ART has so far contributed to health systems strengthening through a desk review. Based on three country examples including Tanzania, Chad and Burkina Faso, the following case study aims to: (1) Outline a possible approach to assess/measure health system strengthening, (2) Review main programme activities funded by the GFATM with a special focus on funding provided for ART and general health systems strengthening, and (3) Analyse contributions of scaling-up ART through GFATM funding to health systems strengthening.

In order to identify effects of Global Fund support in the field of scaling up ART on the broader health care systems, this document uses the WHO definition of 2000 and reviews enhancing and detrimental effects along: (1) Stewardship and policy, (2) Resources and resource development, (3) Financing, and (4) Service delivery.

The GFATM funds various important programs in Tanzania, Chad and Burkina Faso. More precisely, in Tanzania four programs focusing on HIV/AIDS prevention and treatment are supported with a budget of over than US$ 120 millions. In Chad one program is funded with a budget of more than US$ 7million and in Burkina Faso one with a budget of 16 US$ million. Theses programs aim, among else, at a better access to ART, strengthening the capacity of community based responses to HIV/AIDS epidemic, providing psychosocial support to patients living with HIV/AIDS and aiming at expanding the Prevention of Mother-to-Child Transmission (PMTCT).

With regard to stewardship it can be observed that GFATM funding for scaling up HIV/AIDS prevention and treatment in Chad, Burkina Faso and Tanzania has allowed further interactions between relevant actors by promoting the strategic role of the CCM as a body representing all relevant stakeholders. The large and sudden amount of funding for AIDS treatment happened without a detailed policy dialogue and prioritisation across different interventions at national level. With regard resource development GFATM funding has made substantial contributions for the purchase of anti-retroviral drugs and supplies and the upgrading of lab- and clinical infrastructure, mainly at the level of referral and tertiary care hospitals. These resource developments would otherwise not have been possible but did not alleviate prevailing human resource shortages. Main reasons for this are the absence of broader national policies for human resource development and fragmented approaches to training. With regard to service utilisation it is observed that rates through the enrolment of large numbers of new patients into ART and of pregnant women into Prevention of Mother to Child Transmission programs have substantially increased. Evidence is scarce on impact to utilisation patterns of routine health services. With regard to financing it is observed that at this point in time no definitive strategies are available for sustaining the financial sources once GFATM funding comes to an end.

2. Introduction

The Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM) puts three priority diseases at the forefront of funding and supports in an important way the scaling-up of anti-retroviral treatment (ART) to people living with AIDS.

Some have strongly criticized the GFATM as well as other initiatives assisting the scaling-up of ART for not putting enough emphasis on general health systems strengthening and integrating ART services into routine health services at district level. More recently the GFATM has taken up this critic and explicitly allowed – within round 5 - the submission of proposals with a general health system strengthening component. Unfortunately only one proposal with an explicit focus on health systems strengthening in Rwanda and a preliminary budget of US$ 33 million was approved for funding in September 2005. Few published evidence is available looking at how, to what degree and whether at all ART has contributed to health systems strengthening and if and in which way, ART has been integrated into routine health services at district level.

One major initiative/institution which so far has been reviewing the relation between the scaling-up of priority interventions and health systems strengthening is the USAID funded project Partners for Health Reformplus (PHRplus). A conceptual framework has been established and country case studies on Benin and Ethiopia have been initiated. The conceptual framework maps out the potential system-wide effects of Global Fund supported interventions on health care systems (for further information on the framework see section 3) (Bennett and Fairbank, 2003). Taking Benin as a country example, it becomes apparent that the Benin health care system has generally benefited from the Global Fund activities. While the budget for health spending has risen by approximately 15%, the range of health actors, activities and competencies in the three focal diseases have increased considerably (Smith et al., 2005). However, opinions of health actors vary considering the work burden on providers through additional Global Fund activities. Some believe the workload has increased whereas others claimed to have noticed no difference.

A stronger embedding of “health systems-strengthening” within the provision of ART has also been suggested by the Southern African Regional network for Equity in Health (EQUINET). The argument is that such an approach would not only contribute to equitable health care, but would also support a more long-term sustainable provision of ART programs. Due to the role of the Global Fund, its large-scale involvement in the fight against HIV/AIDS and its poverty reduction mandate, the Global Fund holds great responsibility to ensure equitable and sustainable ART services and health systems. This is especially the case in Sub Saharan Africa (SSA), where “10% of the world’s population hosts two-thirds of all people living with HIV” (EQUINET 2004) and where health systems are generally poor, under-funded and under-resourced. Since the foundation of the Global Fund a rapid-scale up of ART has taken place demanding functional and effective health care systems. This includes the development of an adequate health infrastructure with functional laboratory and treatment facilities, skilled human resources and sustainable and cost-effective treatment programs which are accessible even in remote rural areas.

Fears therefore are that a rapid ART treatment access might result in the development of vertical treatment programmes leading to a further fragmentation and weakening of existing health care systems. Uncoordinated donor presence may also increase the risk of unsustainable ART programmes and a stronger pro-private approach to health care provision is expected to have significant policy implications. Furthermore, if ART programme expansion does not go hand in hand with overall health system strengthening, unintended opportunity costs for the most basic health care services might occur.

3. How to assess health system strengthening?

Since its foundation in 2000, the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) has had an exceptional positive impact on the world's major communicable disease – HIV/AIDS, Tuberculosis and Malaria. Up to November 2005, grants worth 4.4 billion USD have been approved to support disease programs in 128 countries. Around 56% and 61% of these funds have been allocated to HIV/AIDS prevention and treatment and sub-Saharan Africa respectively. In terms of program strategies applied to fight HIV/AIDS, the most common intervention types include preventive measures such as behavioural change communication followed by condom promotion, Voluntary Counselling and Treatment (VCT) and treatment measures such as ART.

Despite an explicit disease focus, the GFATM also places importance on general health system performance. In actual fact, enhancing "system strengthening" is explicitly mentioned as a support area in the GF guideline for proposals (Global Fund 2005). However, due to the magnitude and rapid implementation processes of GF programs, the definite impact of unintentional and intentional system-wide effects is not known.

In order to identify both enhancing and detrimental effects of Global Fund activities on the broader health care systems, various organisations like the PHRplus group and EQUINET suggest to assess the effects of the Global Fund upon the broader health care system by measuring among others, (a) process effects upon the functioning of the health care system, (b) Health system performance such as equity, efficiency, access, quality, and sustainability of non-focal services, and (c) the burden of disease from non-AIDS, TB, and malaria illness (Bennett and Fairbank, 2003).

Depending on the country context, effects with negative or positive consequences are expected to occur for health system related equity, efficiency, access, quality and sustainability issues. Based on the WHO definition, health care system effects can be classified into four basic functions (Murray and Frenk, 2000; WHO 2000):

- **Stewardship and policy:** Stewardship is defined by the WHO as a "function of a government responsible for the welfare of the population and concerned about the trust and legitimacy with which its activities are viewed by the citizen". It is the most important of the four pillars of a health system as it is the ultimate responsibility of the government to assure a well-functioning health system. Good or bad stewardship will always have an impact on overall health system performance and hence on the other three health system key functions. Stewardship can basically be described as involving three key aspects: 1) setting, implementing and monitoring the rules for the health system, 2) assuring interactions between all actors and 3) defining strategic directions for the whole system as a whole.
- **Resources and resource development**: Resources and resource development in health refers to human, financial and material resources. Staff, equipment and facilities in adequate number and financial support are basic to the functioning of a health system.
- **Financing:** Health system financing is the process by which revenues are collected from primary and secondary sources, accumulated in fund pools and allocated to provider activities (Murray and Frenk 2000). Health system financing can further be divided into revenue collection, fund pooling and purchasing.
- **Service delivery**: The main function of a health system is service provision including those consumed by an individual such as preventive, curative, diagnostic and rehabilitative and non-personal health services. Resources of all kinds, adequate financing mechanisms and a selection of general and priority services, provider incentives need to be considered for efficient and well-targeted service delivery

In the following sections case studies of GF funded HIV/AIDS programs in Tanzania, Chad and Burkina Faso are presented and assessed in terms of their impact on the four pillars of the health system.

4. Main characteristics of programs funded by the GFATM

Main programme activities funded by the GFATM in Tanzania, Burkina Faso and Chad were assessed with a special focus on funding provided for ART and general health systems strengthening.

In **Tanzania**, the GFATM supports various programs since 2003, among them four program focusing on HIV/AIDS prevention and treatment. The programs vary in their objectives but all try to contribute to a health system-wide approach by scaling-up HIV services. The characteristics of these programs are:

1) **Scaling up effective district HIV/AIDS response with a community perspective, (2003), Budget: 5,400,00 USD, Expenditure by November 2005: 4,674,00 USD.** The program aims to consolidate and improve a community driven district response to HIV/AIDS. It is planned to increase community participation in the planning of preventive, curative and follow-up services of HIV/AIDS activities and strengthen local governments. A special emphasis is hereby placed on young people in 12 districts and outreach activities for deprived population groups in urban and peri-urban areas.
2) **Improved HIV/AIDS care and treatment (2004), Budget: 13,180,952 USD, Expenditure: 34,036,797 USD by November 2005.** The program focuses on reducing the adverse impact of HIV/AIDS through support to the national care and treatment plan. The expected outcome of the program is to expand ART and VCT services delivery to more regional, district and non-governmental hospitals. Concrete target areas include capacity strengthening of non-governmental partners, especially of private hospitals to support the national care and treatment intervention strategy and close collaboration with the Ministry of Health and other governmental institutions at the district and community levels.
3) **Scaling-up access to quality VCT for Tuberculosis and HIV/AIDS in Tanzania, Budget: 23,951,034 USD, Expenditure: 9,674,708 USD by November 2005.** This overall goal of the 5-year programme is to scale up VCT and care and support services for HIV/AIDS and related TB in Tanzania mainland. At the end of the programme, all members of Tanzanian population should benefit from improved access to VCT services, a reduction in the stigma associated with HIV/AIDS, and established networks of community care and support. Defined objectives are to decrease morbidity from HIV/AIDS and TB and reduce mortality of TB. A set of care and support services have been designed to achieve the defined objectives through a combined HIV/AIDS and TB approach. The phasing-in of expanded VCT services are planned throughout the 5-year support period.
4) **Improved HIV/AIDS impact mitigation for orphans & vulnerable children, condom procurement, care & treatment, monitoring and evaluation and national coordination. Budget: 79,741,826 USD, Expenditure: 34,036,797 USD by November 2005.** The program focuses on five aspects to achieve a scaling up the national response to the HIV/AIDS epidemic in Tanzania. These comprise: (1) Impact mitigation for orphans and vulnerable children (OVC), (2) Increased condom supply drawing upon the country's own public and marketing sector with the aim to prevent new infections; (3) support for the National Care and Treatment Plan, incorporating the WHO 3x5 Initiative to scale up antiretroviral therapy (ART); (4) Development and

implementation of a system for monitoring ART program impact and uptake that could be applied in the whole of Tanzania, (5) National coordination of multi-sectoral partners in response to the epidemic, including the Global Fund Country Coordinating Mechanism (GFCCM) and monitoring & evaluation by the Tanzania Commission for AIDS. The program complements and is a scale up of Round 3 HIV/AIDS/Tuberculosis activities. National policies and programs aimed at promoting the rights and security of OVC represent an additional component.

In **Chad**, the GFATM supports one program since 2004 aiming for improved prevention and treatment of HIV/AIDS. Characteristics of this program are:

- **Project to Fight AIDS, Tuberculosis and Malaria, (2004), Budget: 7,3380,156 USD, Expenditure: 3,861,555 USD by November 2005.** The program aims at reducing HIV transmission and the impact of HIV/AIDS in Chad. A multi-strategy approach has been chosen focusing on the promotion of safe behaviour of vulnerable groups, improvement of HIV/AIDS case management and ART, strengthening of community based psychological support and VCT services, expansion of the pilot program for prevention of mother to child HIV transmission and improvement of HIV/AIDS management of orphans and vulnerable children. The following target groups have been specified: People leaving with HIV/AIDS, health care professionals, commercial sex workers and their customers, mobile populations, youth (15-24 years old) and women.

In **Burkina Faso**, the GFATM supports one program since 2004 aiming for improved prevention and treatment of HIV/AIDS. Characteristics of this program are:

- **Project for the enhancement of HIV/AIDS control, (2003), Budget: 16,417,522 USD, Expenditure: 5,493,448 USD by November 2005.** The Program targets inadequate funding of scale up programs, in particular medical treatment, including anti-retroviral drugs (ARVs), it tries to accelerate access to ART, strengthen the capacity of Community Based Organizations (CBOs) that provide medical and psychosocial treatment of patients living with HIV/AIDS and aims at expanding the National Program for the Prevention of Mother-to-Child Transmission (PMTCT).

5. Contributions of scaling-up of ART through GFATM funding to health systems strengthening

Following a general assessment of the Global Fund and its system-wide effects on stewardship, resources, financing and service delivery, the impact of GF activities in three example countries will be provided.

Stewardship and the Global Fund

The role of the GFATM in the stewardship is subsequently looked at through 3 key aspects:

- *Assuring interactions between all actors*: Typically, projects and programs are/were jointly developed and negotiated between a bi-or multilateral donor or an NGO and the project beneficiary be it either a governmental body such as the Ministry of Health or a local NGO. The rules of the GFATM stipulate that proposals are submitted to the GFATM by the CCM. If approved, the CCM is in charge of steering the program implementation. The CCM in turn is conceived as a body in which all main stakeholders of a given country are being represented. In all three countries reviewed - Tanzania, Chad and Burkina Faso – private/public partnership and transparency has thereby been promoted by the inclusion of different constituency groups in the CCM. Initially the governmental sector was nevertheless more or less dominating the CCM. Further, the

CCM was often not functional and not met more than once a year. New rules established at the beginning of 2005 by the GFATM and approval of program request tied into the condition of the functionality of the CCM, promoted a stronger role of non-governmental representatives in the CCM for example through requesting that the presidency and vice-presidency of the CCM belong to two distinct interest groups and increased the frequency of CCM meetings. The GFATM also insists that at least one person with HIV/AIDS is representing interest of affected persons. These rules were to a good extent respected in Burkina Faso, Chad and Tanzania.

- *Defining strategic directions for the system as a whole*: Burkina Faso, Chad and Tanzania all have established national policies which provide the strategic orientation of the health system as a whole. Combating the three priority diseases of the GFATM, HIV/AIDS, tuberculosis, and malaria are in all three countries a strategic priority. However national policies are by far more comprehensive and do entail many other priority developments and include also many elements of broader national and local health system strengthening such as improving district management systems, health information systems or the development of human resources. In consequence, the GFATM has the tendency to selectively define the strategic direction of the whole system for example towards HIV/AIDS prevention and treatment. In Chad, Burkina Faso and Tanzania, policy reforms without a detailed policy dialogue and prioritisation have occurred due to the large and sudden amount of funding available for HIV/AIDS and the other two priority diseases.
- *Setting, implementing and monitoring the rules for the health system*: An important characteristic of GFATM funding consists in the fact that funding is tied into performance. Performance is judged through the quarterly review of attainment of jointly agreed on targets with initially have been proposed by the beneficiary country. This in turn requires robust monitoring system. Typically it can be observed that program monitoring systems in Chad, Burkina Faso and Tanzania do not rely on pre-existing health management information system as these systems tend to not be able to make available timely (quarterly) information necessary for progress judgments. In consequence, programs have set-up distinct and specific monitoring and evaluation systems and do not contribute to the strengthening of national health management information systems. Opposite, the quarterly progress reports compiled by main program beneficiary ("principal recipient") are handled in a transparent way and can all be consulted on the website of the GFATM.

Resources and resource development

The majority of GF proposals aim at improving resource issues of any kind comprising human resource development through training initiatives, drugs, supplies, infrastructure and equipment. In all three countries reviewed, a significant part of GFATM money is spent on the purchase of new drugs and supplies and the upgrading of lab- and clinical infrastructure. In Burkina Faso for example, 41% of program funds have so far been spent for ARV whereas in Chad 44% of funds were used for the procurement of new equipment and infrastructure (for further details see annex 1). Important investments were also made in training activities. For example, Burkina spent so far 26% of funds for improving skills of health workers. Do to the absence of broader national policies for the development of human resources, these activities remain fragmented and do not contribute to a more broader development the health workforce. Particular concern is raised where GF programs may cause a redistribution and reallocation of already scarce resources- in particular with regards to health professionals. Indeed, in all three countries under study, human resource shortages are a major constraints to scaling-up priority interventions. GFATM funding has not contributed to alleviate these shortages. Opposite, there is rather a tendency to that the considerable amounts of funding for the improvement of AIDS care draw away human resources from other health services. Monetary benefits provided to program workers make it often more attractive for health personnel to work for ART as salary levels tend to be higher than conventional salaries in the

public sector. Increased budgets for the scaling-up of ART have also attracted new technologies and treatment methods which were introduced at tertiary health care level rather than primary level. Therefore, a tendency can be observed that ART treatment attracts disproportionate share of skilled health personnel, drugs and medical equipment. New resources also come at price, suggesting that equity issues need to be taken into account in order to also benefit the poorer population groups.

Service Utilization

GFATM funding allowed substantial increase in coverage of the population and specific target groups in Chad, Tanzania and Burkina Faso. For example, within the first two program years in Burkina Faso, nearly 4000 new patients were enrolled in ART, and around 1000 seropositive women were treated with Nevirapine. These patients and their families often also benefit from psycho-social support measures from community-based organisations. In Chad and Tanzania these numbers are similar and important percentages of persons affected by AIDS are benefiting today from treatment. Opposite to many other health conditions service coverage rates of persons living with AIDS is reasonable given the prevailing context in the beneficiary countries. Less is known about indirect effects on general service utilisation patterns and coverage of non focal diseases. As in all three countries ART services tend not to be integrated into routine district services nor are part of basic service packages at primary or district health service level judgments of effects of scaling-up ART on patterns of service utilisation are difficult to establish. This is clearly a field for additional research as both is possible: positive effects on general service utilisation as patients have more trust in the quality and availability of health services delivery due to the availability of ART or no effects on utilisation patterns as ART services are organised separately (not integrated into routine health services) and people not relating the availability of ART services with other type of services.

Financing

The most apparent impact of system-wide effects can be observed in the area of financing of the three focal diseases- especially for HIV/AIDS. Substantial amounts of money are spent on ARV drugs. In actual fact, the GF's own estimates indicate, that "an 8.2-fold increase in the use of highly active anti-retroviral treatment (ART) in Sub-Saharan Africa and a 1.6 –fold increase in the rest of the developing world" (PHRplus 2003) has been achieved already in the GF rounds 1 and 2. Average percentage of expenditure for HIV/AIDS reaches 24% for commodities, 13% for both training and infrastructure, 9% for human resources, 5% for monitoring and evaluation etc. The question arises how the new established programs with new equipment, new staff members etc. can be maintained and sustained once the GF has ceased its funding. Especially the continuation of lifelong ARV therapy and the switch to second line treatments may pose a problem. In Chad, Burkina Faso and Tanzania programs will not end before another 2 to 4 years, but currently no strategies are available for sustaining. In Chad and Burkina Faso, patients have to pay a monthly co-payment (in both countries this amount has been set in 2005 to FCFA 5000 per month or around US$ 7.5) for treatment. This money is being collected by governmental providers but no clear strategy is yet available on what for the money will be allocated to. More generally ways forward for sustaining the financing of ART are seen in the implementation of cost-sharing elements and in the additionality approach propagated by the GFATM, where proposal developers are required to look for additional funding sources. Such health financing changes would however require an impact analysis on household economics.

6. Conclusions

This brief review on the scaling-up of ART supported by the GFATM and its relations with broader health system strengthening, allowed several tentative conclusions.

With regard to stewardship it can be observed that GFATM funding for scaling up HIV/AIDS prevention and treatment in Chad, Burkina Faso and Tanzania:

- Has allowed further interactions between relevant actors by promoting the strategic role of the CCM as a body representing all relevant stakeholders. Opposite to the national level, less evidence is available on how GFATM funding assures interactions by all actors at regional and local level by involving key government stakeholders and other partners;
- Has made available large and sudden amount of funding for HIV/AIDS prevention and treatment without a detailed policy dialogue and prioritisation across different interventions at national level;
- Requests for the set-up of distinct monitoring systems which are not tied into pre-existing health management information systems for judging on progress against jointly agreed on targets.

With regard resources and resource development it can be observed that GFATM funding for scaling up HIV/AIDS prevention and treatment in Chad, Burkina Faso and Tanzania:

- Has made substantial contributions for the purchase of anti-retroviral drugs and supplies and the upgrading of lab- and clinical infrastructure. These resource developments would otherwise not have been possible.
- Has allowed in a first instance to improve resources at the level of referral and tertiary care hospitals rather than primary care level
- Has not contributed to alleviate prevailing human resource shortages due to absence of more broader national policies for human resource development and fragmented approaches to health workforce development.

With regard to service utilisation it can be observed that GFATM funding for scaling up HIV/AIDS prevention and treatment in Chad, Burkina Faso and Tanzania:

- Has substantially increased utilisation rates through the enrolment of large numbers of new patients into ART (including the provision of psycho-social support to them and their families) and of pregnant women into Prevention of Mother to Child Transmission (PMTCT) programs. Opposite to many other health conditions, treatment coverage of persons living with AIDS is relatively high
- Evidence is scarce on the relation between increases in service coverage for people living with AIDS and utilisation patterns of routine health services.

With regard to financing it can be observed that GFATM funding for scaling up HIV/AIDS prevention and treatment in Chad, Burkina Faso and Tanzania:

- Has substantially increase available funding for anti-retroviral treatment. At this point in time no definitive strategies are available for sustaining these financial sources once GFATM funding comes to an end.
- Has alleviated financial pressure on household of affected persons. Nevertheless, patients in Burkina Faso and Chad have to make modest monthly co-payments for adhering to treatment.

In complement to existing initiatives, such as the system-wide effects of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) program of the USAID

funded project Partners for Health Reformplus (PHRplus) and the Southern African Regional network for Equity in Health (EQUINET), there is a need to collect further evidence on the contribution of scaling-up of ART to the strengthening of health systems. In view of allowing more definitive judgments.

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Annex 1. Main characteristics of programs funded by the GFATM for the scaling-up of ART in Chad and Burkina Faso

Country	Chad		Burkina Faso	
Title	Project to Fight AIDS, tuberculosis and malaria		Project for the enhancement of HIV/AIDS control	
Approved budget (US$)	Phase 1: 7,380,155 Phase 2: 11,201,790 Total: 18,581,945		Phase 1: 5,924,150 Phase 2: 9,287,121 Total: 15,211,271	
Expenditure (US$) such as listed in most recent progress report	2'695'077		5'317'458	
Human Ressources	66'805	2%	60'478	1%
Infrastructure / Equipment	1'182'847	44%	1'284'986	24%
Training / Planification	710'562	26%	318'583	6%
Goods and products	99'339	4%	816'383	15%
Drugs	195'363	7%	2'158'194	41%
Monitoring and Evaluation	182'104	7%	298'183	6%
Other / IEC			180'747	3%
Administrative costs	258'057	10%	199'905	4%
Type of interventions (only major lines)	▪ IEC activities targeting priority vulnerable groups; ▪ Introduction of anti-retroviral treatment; ▪ Improvement of blood transfusion services; ▪ Strengthening of psychosocial services and voluntary counseling; ▪ Extension of services for the prevention of mother to child transmission; ▪ Social services for vulnerable children and orphans		▪ IEC activities targeting priority vulnerable groups; ▪ Scaling-up anti-retroviral treatment; ▪ Strengthening of psychosocial services and voluntary counseling through CBOs; ▪ Extension of services for the prevention of mother to child transmission; ▪ Social services for orphans	
Principal recipient	FOSAP (Fonds de Soutien aux Activités en Matières de Population) an independant entity reporting the Ministry of Economic Affairs		UNDP (it is planed that the inter-sectorial committee to fight HIV/AIDS becomes the PR in 2006)	
Main sub-recipients	▪ National HIV/AIDS control program ▪ Different entities of the MoH ▪ Different hospitals ▪ CBOs		▪ National HIV/AIDS control program ▪ Different entities of the MoH ▪ Different hospitals ▪ CBO coordination structure and CBOs	
Start	01. Aug 04		01-Dec-03	