**MINUTES OF HIV/TB DASH BOARDS REVIEW MEETING**

**February 21st, 2018 at the CCM Secretariat**

**Attendance:**

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| **No.** | **Name** | **Organization** | **Sector** |
| 1 | Annekatrin El Oumrany | CCM Secretariat | CCM |
| 2 | Kenneth Danso | NACP | PR / Government |
| 3 | Rosemond Jimma | NACP | PR / Government |
| 4 | Kwadwo Kodnah | NACP | PR / Government |
| 5 | Zeleke Alebachew | NTP | PR / Government |
| 6 | Kwami Afutu | NTP | PR / Government |
| 7 | Raymond Gockah | NTP | PR / Government |
| 8 | Dr. Yaw Adusi-Poku | NTP | PR / Government |
| 9 | Damaris Forson | GHSC-PSM | Co-opted member |
| 10 | Helen Odido | UNAIDS | Multilateral |
| 11 | Dr Felicia Owusu-Antwi | WHO | Multilateral |
| 12 | Genevieve Dorbayi | TB Voice | PLWD |
| 13 | Cecilia Senoo | SWAA | W&Cig |
| 14 | Evans Opata | Coalition of NGOs in Malaria | NGO |
| 15 | Mac-Darling Cobbinah | CEPEHRG | KAP |
| 16 | Ezra Tessera | Global Fund | n/a |

**Absence:**

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| **No.** | **Name** | **Organization** | **Sector** | **Reason** |
| 1 | Edith Andrews | WHO | Co-opted member |  |
| 2 | Jonathan Tetteh-Kwao Teye | Dream Weaver Organization | Co-opted member |  |

1. **Opening:**

The meeting started at about 9:10 am chaired by Cecilia Senoo.

1. **Conflict of interest (CoI) declaration**

Annekatrin El Oumrany asked all OC members present about instances of actual or potential conflict of interest. Mac-Darling Cobbinah reminded the meeting about himself being the Executive Director of an SSR. It was decided to continue the present practice to mitigate his CoI if and when aspects related to his organizations are discussed. Beyond that, no OC member declared CoI.

1. **Feedback from the field**

Cecilia Senoo pointed out that the Society for Women and AIDS in Africa (SWAA) is concerned about girls and young women who are often victim of sexual abuse in second cycle institutions. Because of their particular vulnerability, they need to have a much stronger focus in the national response as well as in the matching funds proposal.

Mac-Darling inquired if the lubricant procured by GAC has arrived and about the lubricant related situation under NFN2. Furthermore, he pointed out that it partly takes 6 months in GAR to receive a VL result. He was informed about the technical challenges with the PCR machine and plans to replace it with a new one within the next few months.

The OC also had a discussion about integrated monitoring at regional level. One member emphasized that integration covers so much more than just monitoring. It seems however desirable to develop an integration strategy at the level of GHS. Dr. Felicia reported that from her own experience, integration is already comprehensively practiced at district level, while there are more gaps at regional level. In terms of communication between the regional level and the district level, she had also observed that there are conflicting messages coming from different regional officers. It needs to be assured that all officers at the RHD have the same understanding of the national guidelines to ensure their uniform implementation on the ground.

1. **Site visit to BAR**

The information presented by Annekatrin El Oumrany about the site visit to Brong Ahafo in December 2017 related only to organizations that will not be represented at the today’s OC meeting as the findings in the context of NACP and NTP grant implementation will be presented once the PRs are present.

**LMD / availability of commodities:** BAR has fully implemented LMD covering close to 500 healthcare facilities, GHS as well as other NHIS accredited ones. Even CHPS are served directly on a monthly schedule free of charge. The reliable delivery has reportedly eliminated procurement of commodities on the open market even though the team found such commodities (ACTs) in the pharmacy of the Kintampo Municipal hospital. The reliable delivery has increased the commodity volume procured by healthcare facilities to such an extent that the LMD related cost can be fully covered through the usual RMS markup on the commodities. RMS as well as the facilities visited confirmed that the availability of program commodities has been stable across the year with occasional shortages of Oraquick. OC members proposed to promote the BAR example as a best practice.

**WAPCAS:** The site visit team was very impressed with the WAPCAS project in Sunyani. The work with the PEs is tremendously organized. PEs meet every morning at the office for reporting before they move on to their microsites. Most of the PE work is done during the day when FSWs have time to listen, complemented by night outreaches on Friday and Saturday when they reach out to new FSWs. PEs estimate that only about 20% of new FSWs to the project know how to use condoms, many don’t even know their benefits; most have no knowledge of STIs and believe that oral or anal does not result into STIs. The DIC is open from Monday to Saturday from 10 to 4. During the four days that the nurse offers among others HTS and STI screening, the center receives about 30 clients, with 5-6 clients on the other days. The successes the PEs reported (90% use condoms consistently even with NPP, high HTS rates (86%) due to its embedding in a general health screening) were confirmed by beneficiaries of the project on the field.

1. **GHS review meeting / January 2018**

Annekatrin only attended and reported on the HIV and TB related sessions. The meeting placed a strong emphasis on greater regional responsibility, proactiveness, creativity and communication across all programs.

**HIV**: an estimated 20,000 new infections 15,000 deaths were reported. While nationwide test and treat was officially out in September 2017, many regional participants had not received respective communication from the central level which is likely to have affected the numbers of PLHIV enrolled. For the 2018-2020 period, NACP announced that most of the test kits will be provided by MoH that has also budgeted for them. Prayer camps and herbalists will be increasingly integrated in the national response. The

HIV rate in infants was reported as 12% at 6 weeks and 17% at 18 months, which the OC members perceived as much too high.

**TB: Case Finding:** NTP had informed about the national case detection rate of 32%, which is the second lowest in Africa (global average: 61%). In spite of the improvement in the testing rate of eligible OPD clients identified through intensified case finding from about 50% to >70%, the number of clients notified remained stable at 14,600 clients. Also NTP plans to increasingly target prayer camps to find the cases. A sample referral system is being developed in collaboration with NACP. Also both programs collaborate to provide comprehensive service to PLHIVs reducing duplication, e.g. repeating HIV test for PLs at the DOTS centers. **Drug Resistant TB:** There is a budget of GHS5000 per person for the first 12 months of treatment for all drug resistant TB patients (enablers package) administered by service providers. The approach to handling MDR-TB enablers package at the facility level was found to be not uniform, contrary to the respective NTP guideline. NTP emphasized to the regional meeting participants to ensure that the amount is used in a transparent and accountable manner; patients need to be aware that they receive the enablers package and not just a personal support from the nurse.

While some OC members wished that they are invited for the subsequent GHS review meetings, others pointed out that some of them were invited through their organizations (e.g. WHO, UNAIDS). OC members agreed that a representation of the OCs at GHS review meetings needs to be ensured and also suggested to get a short slot for a presentation on main findings of CCM oversight.

1. **Meeting with NTP**

Annekatrin El Oumrany met on behalf of the OC with NTP to discuss challenges related to procurement and performance. She informed the meeting that while shipment delays did occur, NTP had acknowledged that the orders for TB medicines and sputum containers were placed late (March 2017) considering the stock levels[[1]](#footnote-1). The NTP reported that a PSM officer was recruited who will be responsible for logistics to ensure timely orders in future. The new clearing / tax exemption procedures have further significantly delayed the availability of pediatric TB medication and sputum containers in the regions. A general exemption for all program commodities for the entire grant period is being prepared but needs to be approved by parliament, which is expected to take more time. Until then for each shipment a specific exemption is required that needs to be processed by the new RMU at MoH. Because of the lack of experience of the RMU, NTP emphases the importance of a meeting of the programs with the RMU to provide the RMU with an understanding of the urgency of certain processes.

1. **Final burn rates**

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| --- | --- | --- | --- | --- |
| **Disease** | **Total budget** | **Expenditures** | **Burn rate**  **2015-2017** | Burn rate  last grant |
| **HIV** | **98.5** | **91.0** | **92%** | 83% |
| *NACP* | *80.7* | *75.6* | *94%* | *79%* |
| *GAC* | *12.9* | *11.1* | *86%* | *96%* |
| *ADRA* | *3.3* | *2.9* | *89%* | *100%* |
| *PPAG* | *1.6* | *1.4* | *86%* | *100%* |
| **TB** | **25.6** | **20.7** | **81%** | 90% |

According to the malaria dashboards, the total overall burn rate for 2015-2017 is at about 87%, which is significantly increased compared to the final burn rate of 79% in 2015. However, it was found in the malaria OC meeting that the NMCP final burn rate was much higher than reported.

1. **PPAG Dash Board:**Because PPAG will not continue as a PR and since performance was usually A-rated, the OC team did not see the necessity of a meeting. The comments below derive from an email exchange on a few minor issues
2. **Follow up:**

* **Distribution of certificates to all PEs:** Distributed in December
* **Way forward for prison interventions:** the NMCP has contacted the Ghana Prisons Head Quarters on a planned IRS in the prisons. The HIV Programme Manager (Ghana Prisons Head Quarters) has also been introduced to the Programme Managers of NACP and NTP respectively for possible interventions in the prisons under their respective programs.

1. **Financial Indicators:**

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| --- | --- | --- |
| **Indicator** | **Observation** | **Answer / Decision** |
| **Absorption rate** | 86% |  |
| **Disaggregated absorption rate by grant objective** | >60,000 spent for products and equipment – what for? | Procurement of hygiene kits |

1. **Management Indicators:**

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| --- | --- | --- |
| **Indicator** | **Observation** | **Answer / Decision** |
| **Availability of commodities** | Q3: 7MoS for hygiene kits and test kits. | All distributed to prison authorities. Infirmary nurses continue HTS on their own |

1. **Programmatic Indicators:**

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| --- | --- | --- |
| **Indicator** | **Observation** | **Answer / Decision** |
| **% HIV prevention** | 102% |  |
| **% HTS** | 86% Middle zone and Southern zone had consistently much higher achievement rates than TfSC and Northern. Why? Similar for drama: much lower in these two zones while MZ and SZ had an overachievement. | MZ and SZ: those prisons with highest inmate numbers >> easier to reach out to more prisoners at a time than in northern zone and TfSC. |
| **# inmates reached through 1:1 or small group discussion** | 101% |  |
| **# referrals after HTS** | 90% |  |
| **# referrals TB** | 26% Three of the zones had a <50% performance across the last semester. Since prison nurses were trained on the screening tool, why did performance not improve? | They did not identify many cases |
| **# hygiene kits distributed** | 227% |  |
| **# supervisory and monitoring visits** | 100% |  |
| **# officers reached with advocacy sessions** | 92% |  |
| **# PE meetings** | 100% |  |
| **# inmates reached drama** | 62% |  |
| **# film shows** | 100% |  |
| **# review meetings staff** | 100% |  |
| **# drama performances** | 100% |  |

1. **Other observations:** None
2. **ADRA Dash Board**

Because ADRA will not continue as a PR and since performance was usually A-rated, the OC team did not see the necessity of a meeting.

1. **Follow up:** none
2. **Financial Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **Absorption rate** | 89%, unspent balance 374,635 |  |

1. **Management Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **Availability of commodities** | 0.1 MoS male condoms, 1.9 MoS female condoms, 3.9 MoS test kits |  |

1. **Programmatic Indicators:**

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| --- | --- | --- |
| **Indicator** | **Observation** | **Answer / Decision** |
| **HIV prevention** | 77% but 103% cum achievement in 2017 |  |
| **HTS** | 111% |  |
| **Condom distribution** | 143% |  |
| **Stigma health workers** | 129% |  |
| **Stigma FSW** | 117% |  |
| **Referral by PEs** | 154% |  |
| **PE reporting** | 95% |  |
| **# referred KPs receiving services at DICs** | 85% |  |
| **Monitoring sessions** | 100% |  |
| **Trust & Love sessions** | 113% |  |
| **Condom activation sessions** | 100% |  |
| **# DIC** | 100% |  |

1. **Other observations:** None
2. **GAC Dash Board**

Because GAC will not continue as a PR and because of the limited time available for the OC meeting, GAC was not invited to the meeting.

1. **Financial Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **Absorption rate** | 86% |  |
| **Disaggregated absorption rate by SR** | 91% WAPCAS FSWs,  55% WAPCAS MSM  55% WAAF |  |

1. **Management Indicators:** no observations
2. **Programmatic Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **FSW HIV prevention** | 19% but average 2017 = 105% |  |
| **FSW HTS** | 77% but average 2017 = 123% |  |
| **MSM HIV prevention** | 69% but average 2017 = 106% |  |
| **MSM HTS** | 162, average 2017 = 115% |  |
| **MoH** | 116% |  |
| **Reg. NAP+ offices** | 100% |  |
| **SAMC** | 100% |  |
| **FSW Condoms** | 28%,average 2017 = 105% (shortage in Q4) |  |
| **MSM Condoms** | 90%, average 2017 = 105% |  |
| **FSW on NHIS** | 0%, average 2017 = 86% |  |
| **MSM on NHIS** | 154%, average 2017 = 238% |  |
| **Clients enrolled in programme** | 346%, average 2017 360% |  |
| **HBC PLHIV** | 346% |  |
| **PLHIV on NHIS** | 204%, average 2017 = 618% |  |

1. **NACP Dash Board:**
2. **Follow up:**

* **Condom procurement:** 5m USAID under FDA testing, 10m be safe USAID to be expected in 2 tranches (April, May), UNFPA still needs to register ) started already
* **PCR machines:** discussions with facilities about maintenance and set up. Three machines, have not arrived yet, expected Feb/March, installed by E/March in Korle Bu, KATH, Sunyani. Old machines will go to UWR, Kumasi South and Ridge hospital. Machines are not leased, too expensive. New: improve documentation of equipment challenges to monitor equipment performance
* **Sample transport:** draft contract with GHS. April start in all regions. GF will cover 5 regions, CDC the other 5. Private logistics to carry out sample transport.
* **Procurement of VL sample tubes:** contract awarded in late Dec to supply within 60 days, company asked for extension
* **Procurement of PMTCT registers:** FHD has received 4000 copies (3000 ANC facilities). Not enough to fill the gap. Procurement takes about 5 months. PPME and FHD in charge shall take up the next ones. Engage PMS
* **Strengthen focus on low performing regions and facilities:** Review meeting: regions saw their performance. Data capturing = one of the challenges, requires more resources for monitoring (slightly more than 1000 GHS per quarter per districts) = systemic challenges. Some ANC facilities still use old registers that lack capturing of certain data. However, a direct comparison of pregnant women tested positive and their enrollment (compared to the generic GF target) showed a different picture of the regional performance.

1. **Site visit to BAR:**

* 4 HSS sites do not seem to be representative of the HIV prevalence in the region, DHIMS prevalence is much lower
* Good availability of commodities, hardly any shortages except for Oraquick
* Best practices: Best practices: all pregnant women get their HTS at the PMTCT unit and those HIV+ their treatment but midwives inquire about adherence and remind women of EID: NACP answer: *requires even more additional registers*
* 99% of ANC registrants are tested for HIV but regional ANC coverage is 74% - one possible reason: fear of mistreatment by midwives, particularly among the younger women as reported by malaria NGOs
* Instant enrollment on ART
* Disclosure to spouses remains a big challenge
* Systematic testing during labor if HTS result cannot be produced
* VL testing: info has not spread to all facilities but those that send samples receive the results within a week. Cross cutting VL suppression rate = about 50%. PMTCT forms do not foresee capturing of VL result. *NACP answer: Patient folder contains space for VL result*
* Kintampo Municipal: No reagents for years for hematology and chemistry analyzers, no VL
* EID: not much information since different ward but staff emphasized the importance of more intense education on PMTCT and EID at all levels but particularly at churches.
* Kintampo ANC staff still informs pregnant HIV+ women about EID at 18 months, not after birth. *NACP recommends to inquire during site visit about for how long staff interviewed has been working there – may be new and not yet have to complete information*
* Repeated statement that achievement rates are less than actual due to data challenges
* Kintampo Municipal: about cum. 50% LTFU but no info about reasons. MoH are not paid and not able to follow up on them effectively, also problem of areas without network coverage
* PCR machine in great shape, received a few samples from the three northern regions, >5000 VL tests and about 1100 EID tests in 2017, reagents always available since May 2016, same for DBS but liaise with other facilities if stock outs occur. Results communicated via email, WA, phone, hard copy

1. **Financial Management Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **Absorption rate** | 94%, 4m USD more spent than disbursed.  How come pharma expenditures are 32% above the budget? | Most is PPM procurement  NACP specific expenditures: 82%, PPM: 107%,  Some activities postponed to 2018 (Laboratory systems strengthening, EQUIP). Late disbursement from GF came late, late disbursements to regions. |
| **Disaggregated absorption rate by SR** | Status quo of regions’ retirement? 9 regions red | late disbursement, financial monitoring on regions, extension granted to finalize |

1. **Management Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **Availability of commodities** | Risk of expiry of Efavirenz 600mg, pediatric Zid/Lam and 2nd line Lop/Rit. How to avoid expiries?  High stock levels in UER  TLE: WR short  Test kits first response look short  Many green but even more yellow. Next scheduled delivery?  6 months outlook?  110,000 in demurrage charges – what happened? | Next PSM meeting: push for 8 MoS as min national stock level. Advocate to regions to have the full complement available at all times. Better monitor availability in the regions. RMS managers receive central stock levels and have insight and need to endorse each shipment – their complaint that they don’t have insight into central stock levels before preparing the requisition is not substantiated.  Nevirapine (very old stock) consumption pattern has changed. Discussions with GF on the way forward. Some pediatric ARV shifted to Gambia to avoid expiries. Attitudes of prescribers is a problem, continue to break up adult doses for children. NACP assured the OC members that they have a close eye on expiries.  TLE ensured for rest of year. Good commodity situation. Challenge: Regions shall store bigger volumes because of huge storage cost at HIS but some RMS refused bigger quantities.  Scheduled distribution was delayed. Just finalized last week – Jan stock report does not represent current stock situation. Next one: E/March. 2017 five emergency distributions. Question why RMS tend to have stock levels of less than 3 MoS in weeks before next scheduled delivery: RMS can always request what they need. There are a guidelines for requisitions but they are not binding. RMS may request what they really need. |

1. **Programmatic Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **# on ART** | 125,667 vs target 140,084 = 90%, only 3820 enrolled in Q4 in spite of nationwide test & treat, NACP response in Nov: Marvelous improvement expected in Q4  Are those results adjusted for LTFU?  Status quo e-tracker implementation, resolution of problems with e-tracker, what happened to discussion of proposed mass communication? | Not yet adjusted for LTFU. Data cleaning exercise in 2015  **Proposed discussion of mass communication on nation-wide availability of test & treat, promotion of PMTCT and EID with GAC/NAP+**: Challenge was presented at review meeting, NACP specific deliberations with stakeholders. >> all organizations are informed. Mass communication is not a mandate of NACP. GAC needs to be in charge! Suggestion to prepare a fact sheet for NAP+ with key messages to bring across. |
| **ART pregnant women** | 63%, Q4 only: 75% = best result across NFM. Last semester much improved enrollment rates of those tested positive. During NFM strong variation of % enrolled in treatment. Average across NFM = 58%  Way forward for higher enrollment rates? |  |
| **EID** | Cum 48%, Q4 alone: 57%, in 2017 about 50% of babies of tested HIV+ mothers missed. |  |
| **HTS pregnant** **women** | Cum 88%, Q4 alone: 95%. About 20% of the women either missed or not reported (820,191 vs 1.1m expected pregnant women). Quarterly achievement rate for the first time >90% (95%) |  |
| **HTS** | Cum 48%, Q4: 57%; 25% increase in Q4 compared to otherwise flat results in 2017. HTC program with inadequate results. Proposal to engage civil society (JSI) much stronger. | KYS campaigns needed but comes at a cost. Low couple testing = low: encouraged through fast consultation. Research being conducted on barriers of couples testing. More non-pregnant women (271479) than men (179677) tested in 2017. Important to reach more men. Systems in place to encourage disclosure: More work must be done to enhance education. |
| **TB screening** | Significant overachievement (517%) due to double counting but might mask significant variations among facilities |  |
| **Add** | OC statement: HIV prevention has been neglected during the past 6 years, esp. general population | Suggestion OC: use savings to put it in prevention |

1. **Recommendations:**

* Liaise with GHS/FHD to scale up ANC coverage to previous levels
* Review the direct comparison of pregnant women tested positive and their enrollment (compared to the generic GF target) to have a more accurate picture of the regional performance
* Ensure adequate availability of ANC registers
* Ensure that national guidelines are adequately communicated by the RHDs to DHDs and SDPs
* CCM to follow up with GAC and NAP+ on mass communication on test&treat, PMTCT and EID

1. **NTP Dash Board**
2. **Follow up:**

* **MDR-TB facility:** GIZ initiated an Ebola clinic in Cape Coast or Takoradi/Secondi that was not handed over to GHS since it was not finalized. Annekatrin will get more information for NTP to decide if this facility could be used for MDR-TB clients
* **Clearance of sputum containers:** Friday: promise to clear by Monday but has not happened. MoH does not reply calls, CCM promised to follow up
* **General tax exemption:** to be presented at next cabinet meeting (last week) but no information on outcomes
* **Prison interventions:** Discussion with Mathilda of Prison Services: NTP can’t do all 43 prisons. New grant: no budget initially. Need to make adjustments for prisons – plan to combine with small scale mining. Still at concept stage. Program will include HTS. More health staff at prisons deployed. Regions shall train prison infirmaries to carry out interventions on their own.
* **Status quo E-tracker, how to deal with online requirement:** Resources available at PPME to provide tablets for the remaining 103 districts. NTP is looking for funding for training (not in NFM2 budget)
* **Short term MDR-TB treatment schedule:** Medicines have arrived in Feb. Training for all 10 regions (August) funded by Green Light Committee / WHO. Plan: from March zonal reorientation. Plan to decentralize the commodities.
* **Status quo mass communication on TB:** World TB Day, recently meeting with press and TB ambassador. Press agreed to champion World TB day through print, TB and e-media and provide lots of media space across the year. Low case detection among children (diagnosed by pediatricians): discussion with Pediatric Society of Ghana to sensitize pediatricians. GAR annual review meeting finding: civil society not felt. Should really assist in addressing the gaps in case finding. Recommendation to STBP to register with RHDs.

1. **Site visit to BAR**

* Time did not allow the discussion of the main findings. NTP received them in a subsequent email.

1. **Financial Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **Absorption rate** | 79%. Big increase from 61% in Q3 but what happened to the statement in Nov that the final burn rate will be around 90%? | Cancellation of GeneXpert procurement. |
| **Disaggregated absorption rate by SR** | Have all regions really retired exactly 100% of their advances? |  |

1. **Management Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **Availability of commodities** | Clearance situation  0 MoS Capreomycin  Outlook stock next 6 months  Implications of new incoterms | Sputum containers still not cleared. Specific exemption will be signed today.  Capreomycin has arrived  Stock will adequate for next six months Kat I-III: 15 months, children 7 or 8 MoS  CIP: MoH must clear, not a clearing agent.  New people at MoH. Needs to be avoided to be in similar situation re tax exemption next year |

1. **Programmatic Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **# notified cases all** | 3428 = 48%, exactly at the level of the previous quarters  Ghana reached 14550 in 2017 = < 1/3 of cases  How did the mobile vans contribute to result? | Significant improvement in ICF: higher testing rates among those eligible. However, still low achievement, total number of clients did not improve. Very ambitious targets. Way forward: cartridges will not run out, medications will be available to have no excuse (some facilities stop screening during the period where they cannot provide medication).  Monthly meeting with program officers. Program officers at regional level must check before DHIMS is locked that all data were entered.  GeneXpert 95% correct results |
| **Success rate** | 83% (DB) = 85% of those bact. confirmed (target = 89%),  Low performers: CR and UER |  |
| **# RR/MDR-TB notified** | 78% = 39 cases  In 2017 200 cases diagnosed = <1/3 of cases  Status quo short term regimen announced for October? | GF target more or less achieved. Goes together with general challenge of case identification. 103% sites with GeneXpert. Collaboration with NACP to enhance sample transport. More samples will be tested on GeneXpert and hopefully detect more MDR-TB |
| **# RR/MDR-TB who started treatment** | 23 clients = 46% (DB) and 59% of those diagnosed. What happened to the remaining 16 clients?  Out of 200 cases diagnosed in 2017, 70 are LTFU (=100 for entire NFM) – reward for successful tracing?  Number of deaths | Shortage of Capreomycin in Q4 resulted in backlog. Due to software (GS Alert) better overview at central level on confirmed MDR-TB clients. Can better inform regional level to follow up, better follow up from central level possible.  Shorter regimen hopefully enhances treatment enrollment, will be reported on DHIMS.  Many baseline tests for MDR-TB clients taking about a month. Baseline tests not free, NHIS doesn’t cover every test. Often funded by enablers package (5000 for 12 months per client). |
| **# notified cases bacteriological** | 91% achievement rate according to DB, 97% of all notified cases  What is being done to harmonize diagnosis on the ground (GeneXpert as first means where it exists) |  |
| **# DST** | 42% = 136 clients |  |
| **# Labs EQA** | 44% |  |
| **# HTS** | 56% (DB) but 3136 out of 3428 TB cases tested = 92% (target = 80%) |  |
| **# ART** | 30% (DB) but 305 out of 613 tested positive enrolled = 50%, entire 2017: 53%, increase in NFM until Q2/2017, thereafter drop | NACP does capacity building DOTS/ART integration. Better referral system needed. Build capacity for more DOTS centers. One stop shops will improve the situation, Suggestion to look into counselling skills. OC member: HIV counselling often does not take place. Counselling even for TB sometimes inadequate. |
| **# non NTP providers** | 32% STBP reporting not clear. What is the situation, how successful are NGOs. What do they need to improve? |  |
| **# district hospitals with no stock out** | 86% |  |

1. **Recommendations:**

* Annekatrin to follow up on GIZ supported Ebola clinic
* Review functionality of microscopes used for TB diagnosis and the quality of related reagents
* Define more clearly the interventions of NGOs. Better collaboration between NTP, STBP and TBVN, proposal to include STBP in the OC meetings
* Review counselling skills at DOTS centers to enhance ART coverage among co-infected clients
* CCM to follow up on tax exemption
* Review / revise indicators on DB

1. **Closing**

The meeting came to a close at about 13:30.

1. New information recently provided by NTP revealed that the order process was initiated in the end of January 2017 [↑](#footnote-ref-1)