**MINUTES OF HIV/TB DASHBOARD REVIEW MEETING**

**May 23rd, 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 | James Nii Darko Saakwa-Mante | NACP | PR / Government |
| 4 | Kwadwo Kodnah | NACP | PR / Government |
| 5 | Dr. Nyonuku Akosua Baddoo | NACP | PR / Government |
| 6 | Dr. Yaw Adusi-Poku | NTP | PR / Government |
| 7 | Kwami Afutu | NTP | PR / Government |
| 8 | Susuana Bruce | NTP | PR / Government |
| 9 | Henry Brown | NTP | PR / Government |
| 10 | Comfort Asamoah-Adu | WAPCAS | PR / NGO |
| 11 | Patricia Agyei | WAPCAS | PR / NGO |
| 12 | Kofi Diaba | WAPCAS | PR / NGO |
| 13 | Eric Adu | WAPCAS | PR / NGO |
| 14 | Damaris Forson | GHSC-PSM | Co-opted member |
| 15 | Nabil Alsoufi | USAID | Co-opted member |
| 16 | Ernest Ortsin | GHANET | NGO |
| 17 | Genevieve Dorbayi | TB Voice | PLWD |
| 18 | Cecilia Senoo | SWAA | W&Cig |
| 19 | Evans Opata | Coalition of NGOs in Malaria | NGO |
| 20 | Mac-Darling Cobbinah | CEPEHRG | KAP |
| 21 | Jonathan Tetteh-Kwao Teye | NAP+ | Co-opted |

**Absence:**

|  |  |  |  |  |
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| **No.** | **Name** | **Organization** | **Sector** | **Reason** |
| 1 | Edith Andrews Annan | WHO | Co-opted | excused |

1. **Opening:**

The meeting started at about 9:10 am.

1. **Way forward and election of the OC Chair**

Annekatrin El Oumrany, Program Officer for Oversight and Communication at the CCM, explained that the term of office of the OC members is three years resulting in the need for a reconstitution of the oversight committee and the election of a new chair. Since the OC members need to be approved by the CCM, the election is postponed to the next OC meeting.

1. **Capacity building**

NACP, NTP and WAPCAS prepared a presentation on their grant as an introduction for the OC members. Most OC members had participated in a separate training on the dashboards carried out by consultants as part of their mission to configure the fresh dashboards for all PRs and programs. Annekatrin encouraged OC members to articulate any need for capacity building at any time.

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

Annekatrin provided the OC members with an overview on the concept of conflict of interest and reminded them of the necessity to manage potential, actual and perceived CoI professionally to maintain the impartiality, credibility or trustworthiness not only of the OC members but also of the OC and the entire CCM.OC members present who had not signed the CoI declaration did so during the meeting. The OC were reminded that CoI declarations could be made any time during the meetings but it was omitted to specifically inquire about CoI in relation to the day’s meeting. No OC member declared CoI throughout this OC meeting.

1. **Planning of site visits**

The OC members agreed to have a few day site visits to facilities in the proximity of GAR within the month of June. During those day site visits, the focus shall be on one disease component only while visiting different types of facilities.

1. **MoH participation in programs review**

It was proposed that MoH as the PR participates in the dashboard review for a good overview on the progress of grant implementation. The OC members considered this as a good idea to be proposed to the CCM.

1. **Regional disaggregation of indicators**

OC members opted strongly for a regional disaggregation of programmatic indicators to have a better overview on the regional performance. Since time was not sufficient for a final decision, Annekatrin will provide a proposal for the OC members’ email discussion.

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

* **Acceleration plan for 90-90-90:** no info
* **E-tracker:** 68,000 on e-tracker as 22nd May. 90,000 clients expected to be integrated by BG08.
* **PCR machines and VL referral plan:** VL machines expected to be fully functional by BG06. Start for referral, planned for April, delayed. Ghana Post will do courier services (sole sourced) covering currently 372 ART sites only. Start of sample transport expected for E/06.
* **Procurement of PMTCT registers:** FHD has recently distributed 2900 copies.

1. **Financial Management Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **Absorption rate** | 2%. 14m USD budget. 355,000 spent. | No problems to separate budgets according to program. Problem is with GF disbursement: not clear which amount is for which program.  Disbursement delayed. Monitoring, HR delayed. Chunk = commodities. Procurement processes delayed, a lot will arrive in Q2. PMTCT training will start in Q2. |
| **PSM** | 0 expenditures | No commodities arrived, see above |

1. **Commitment, Management, and Compliance Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **Availability of commodities** | Stock out in all 14 facilities  Product procurement past due 45/45  Stock levels don’t correspond with SSDM stock levels  Low stock levels of pediatric zidovudine and in-country stock out of nevirapine syrup expected to occur in May due to in-country product expiry.  Expiries April-June 2018: First Response, Efavirenz 600, , adult 2nd line (ATV/r) in some RMS. | Means that all facilities had stock out of at least one HIV commodity (10 RMS and 4 TTHs)  Based on regimen, not individual formulation  Zidovudine shipment delayed and currently expected to arrive in August. 2520 bottles NVP syrup about to arrive next week and will be shipped immediately to RMS. Stocks of 5903 (GF) and 2000 (PEPFAR)packs of NVP 50mg dispersible tables expected in May and June respectively to augment stocks.  Redistribute stocks especially from UER and ER RMSs for commodities with short shelf lives |
| **Commitments** | PSM – MA4: Viral Load sample transportation – signed contracts | MoU is for signature at Ghana Post, has not been returned yet |
|  | PSM–MA5: quantification and updates | Done |
|  | PSM – MA6: SOPs for cost effective stock keeping and distribution |  |
|  | Review of testing yield per pop, testing strategy and region on quarterly basis |  |
| **Management** | Key positions vacant, add # of key positions |  |
| **Compliance** |  |  |

1. **Programmatic Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **ART pregnant women** | 81%. Since Q3/2017 significant improvement in enrollment rate.  Progress / road map to training add. 400 ANC facilities | PMTCT training will start in Q2 |
| **# on ART** | 7000 enrolled (average 2017 per Q: 6250, PEPFAR target annual 26,000)  NACP PPT: 1st 90: 70%. 70% of 313,000 = 219,000. 84,000 know their status but do not come for treatment? |  |
| **PMTCT/HTS** | 80% but much higher target than NFM1, highest # of pregnant women since BG/NFM1. Problem for 90-90-90: 20-25% of pregnant women possibly not tested / reported. ANC registrants: 242,522. 225,584 tested = 93%. |  |
| **EID** | 44%. Situation of EID reagents? Has info about EID within first 2 months been recommunicated? | Reagents should be available. Equipment functionality was major issue |
| **HTS** | 2.6m in stock since E/Dec plus GF deliveries in 2018. Why underachievement? | Only provider based, no funds for community testing. DSD testing mainly for KPs but not general population. USAID: Ghana does well on the first 90 in international comparison. |
| **VL suppression** | 51% of those on ART for 12 months + seems low. Denominator = how many people? Why low VL suppression? | Incomplete data. 2017 data. 51% Viral suppression currently includes people newly diagnosed. With e-tracker more accurate data. |
| **TB screening** | Based on ART target, not PLHIV on ART. Achievement equals exactly #PLHIV on ART. How is this measured? Do we still have double counting? |  |

1. **Challenges expected within next 6 months:**

* A lot of pressure on healthcare personnel. Joint training plan was developed but gets mixed up when delays occur

1. **Recommendations:**

* Detailed catch up plan with documented challenges to be provided by NACP by E/May
* CCM to inquire with NAP+ on information disseminated on test&treat
* Clarity needed about procurement processes. Who is involved in new processes? NACP will provide detailed information about information need.
* Salary issue need to be resolved
* PPME requested to participate in the HIV/TB oversight committee meetings
* MoH rep to participate in GHS program review
* CCM to inquire about procurement of test kits being budgeted

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

* **Status quo E-tracker, how many currently in place and functional?** 113, most not functional currently. Requirement of online data capturing makes it difficult for some facilities and staff moved on – no capacity currently in the facilities. New offline mode available. Plan to revamp the initial 113 and equip/train the remaining 103.
* **Short term MDR-TB treatment schedule:** Refresher training ongoing but short term treatment available in all 10 regions
* **Costed, detailed acceleration plan for the additional $3.2M by July 2018:** plan will be developed in collaboration with GF in July
* **Status quo sample referral plan:** development of anational sample referral plan planned to incorporate the NACP one too. NTP convinced to start alongside with NACP in collaboration. However, CCM inquiries with SSDM showed that the NACP sample referral plan is based on HIV samples only.
* **Outcomes of TB patients that are not treated (two third of those in Ghana):** 50% expected to die, 25% get healed naturally, 25% become chronic
* **Case finding:** 
  + GeneXpert detects 95% of TB cases (sensitivity)
  + ICF was expanded to 216 district hospitals in place but quality still varies significantly
  + Case finding in rural areas:
    1. Community pharmacies asked to refer coughing patients for a TB test in Accra and Kumasi metropolitan areas = heavily fund driven.
    2. Reprogramming once funds become available: ICF in 20 districts at community level.
  + 48 digital X-rays across the 10 regions

1. **Financial Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **Absorption rate** | 87% based on local NTP budget 606,000 only. Actual budget = 3.6m USD = 14%  Biggest outstanding expenditures: 1.7m for GeneXpert equipment and 581,000 for procurement agents | NTP will base DB budget on signed GF budget  Most procurement moved to Q3. But budget kept for Q1 |
| **PSM cost** | Expenditures for lab reagents, consumables, procurement agents not listed. What about commitments? |  |

1. **Commitment, Management, and Compliance Indicators:**

|  |  |  |
| --- | --- | --- |
| **Indicator** | **Observation** | **Answer / Decision** |
| **Availability of commodities** | Stock situation sputum containers?  Cat 1+3: sufficient for rest of the year: Risk of stock out in 2018/19  Pediatric stocks?  Stock out of Capreomycin?  Kanamycin 0 stock in stock levels?  46 MoS of GeneXpert cartridges (stock levels)? Is AMC correct? Risk of expiry – Aug 2019? Zero stock in most regions. How come we don’t have a buffer stock? | 6 MoS at national level, similar level at RMS = sufficient stock  Emergency order (6MoS) placed, expected by 30th June. In June regular order placed to arrive in December  RHZ 75/50/150 2 MoS for combination with etambutol. But large stocks of RHZ 75/50/150. Request to Nigeria to get etambutol stock. DG signature needed. System has changed. FDA reacts much faster nowadays. In the meantime NTP checks on stock levels in facilities to redistribute stock to facilities in need.  Some quantities delivered in Feb and sent directly to Reg hospitals. More stock delivered in mid May. Emergency order pending approval DG.  All distributed to reg hospitals. Order arrived in mid May. Enough stock. Emergency order pending approval DG.  AMC needs to be reviewed. Reporting on commodity consumption generally needs to be improved. |
| **Commitments** | PSM–MA5: quantification and updates | Done |
|  | PSM – MA6: SOPs for cost effective stock keeping and distribution |  |
| **Management** | Key positions vacant, add # of key positions, review denominators for other indicators |  |
|  | Sites with stock out: capreomycin? Why not based on 14? |  |
|  | Sites with product delivery past due: all for NACP?! |  |
| **Compliance** |  |  |

1. **Programmatic Indicators:**

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| --- | --- | --- |
| **Indicator** | **Observation** | **Answer / Decision** |
| **# notified cases all** | 3980 = 84% = best result since beginning of NFM, but drastically reduced target compared to NFM1  ICF: only 38% of suspected cases tested (GF report)  15% of those diagnosed not enrolled  What is the % of children? Huge gap according to Ezra | DHIMS data quality not optimal. Hard copy data show much higher testing rates. 70% coverage rates previously reported taken from hard copies  Usually 10% max of TB patients = children, Ghana treats 5% => gap = 5% |
| **Success rate** | 85.3% achieved vs target of 86%  Ultimate target = 90%  Provide absolute numbers in comment section |  |
| **# RR/MDR-TB notified** | 154% = 71 cases, one of the best results since BG NFM1. |  |
| **# RR/MDR-TB who started treatment** | Why target = 46 and not 71?  Only 31 enrolled = less than 45%. What about the remaining?  Comment that baseline test package not free. Should be free if TB is not mentioned | Not complete data |
| **# notified cases bacteriological** | No data |  |
| **# DST** | No data |  |
| **# Labs EQA** | 0% | Due semester wise |
| **# HTS** | 74% but why is the target = 4743 and not real number of clients notified? |  |
| **# ART** | 23% 216 out of 948 – source for the target? Lowest result since BG NFM1 | Purely DHIMS data. Previous data = hard copy based. TB = last disease to shift to DHIMS reporting. For other indicators gap between DHIMS and hard copy reporting decreased from 29 to 5% |
| **# non NTP providers** | No data |  |
| **# district hospitals with no stock out** | 100% |  |
| **RR/MDR TB treatment success rate** | 0%. Target 66.8%. How is this measured? |  |

1. **Challenges expected in next 6 months:**

* System is improving, incl. PMU/RMU

1. **Recommendations:**

* PPME shall play in strong role in monitoring DHIMS data quality
* NTP will correct previous quarter data in all subsequent dashboards

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

* **Survey of lab/reagent availability in target areas**: ongoing, report will be shared with CCM
* **Condom procurement**: currently getting quotes from different organization to cover need until USAID condoms are released

1. **Financial Indicators:**

|  |  |  |
| --- | --- | --- |
| **Indicator** | **Observation** | **Answer / Decision** |
| **Absorption rate** | 81% based on budget 512,000 |  |
| **SRs** | MSM: 72%  FSW: 63% |  |
| **PSM** | According to budget 650 per quarter PSM |  |

1. **Commitment, Management, and Compliance Indicators:**

|  |  |  |
| --- | --- | --- |
| **Indicator** | **Observation** | **Answer / Decision** |
| **Availability of commodities** |  |  |
| **Commitments** | 1 commitment: monthly capacity assessments |  |
| **Management** | Sites with stock out: Number of sites must be >0 |  |
| **Compliance** |  |  |

1. **Programmatic Indicators:**

| **Indicator** | **Observation** | **Answer / Decision** |
| --- | --- | --- |
| **MSM linked to care** | 17%. 4 / 24 |  |
| **FSWs linked to care** | 85%. 69 / 81 |  |
| **MSM prevention package** | 61%. 1058 / 1748 |  |
| **FSW prevention package** | 92%. 3465 / 3770 |  |
| **MSM HTS** | 20%. 321 / 1573. Test kits were available, why not more? |  |
| **FSW HTS** | 30%. 1015 / 3393. Test kits were available, why not more? |  |

1. **Challenges expected in next 6 months:**

* Condom situation

1. **Recommendations:**

* Discuss situation of initial lab tests with NACP

1. **Closing**

The meeting came to a close at about 3pm.