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

 **February 19th, 2016 at the CCM Secretariat**

**Attendance:**

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| **No.**  | **Name** | **Organization** | **Sector** |
|  | Annekatrin El Oumrany | CCM Secretariat | CCM |
|  | Kenneth Danso | NACP | PR / Government |
|  | Nii Darko Saakwa-Mante | NACP | PR / Government |
|  | Kwami Afutu | NTP | PR / Government |
|  | Cynthia Adobea Asante | GAC | PR / Government |
|  | Daniel Kpogo | GAC | PR / Government |
|  | Raphael Sackitey | GAC | PR / Government |
|  | Emmanuel Blankson Ofosu | GAC | PR / Government |
|  | Twumasi Ankrah | PPAG | PR / NGO |
|  | Alhassan Lawal Aburi | PPAG | PR / NGO |
|  | Anne-Marie Godwyll | PPAG | PR / NGO |
|  | Phyllis Kudulo | ADRA | NGO |
|  | Cecilia Senoo | SWAA | W&Cig |
|  | Evans Opata | Coalition of NGOs in Malaria | NGO |
|  | Mac-Darling Cobbinah | CEPEHRG  | KAP |
|  | Damaris Forson | JSI Deliver | Co-opted member |
|  | Helen Odido | UNAIDS | Multilateral  |
|  | Dr Naa Ashiley Vanderpuye | Stop TB | NGO |
|  | Genevieve Dorbayi | TB Voice | PLWD |

**Absence:**

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| **No.**  | **Name** | **Organization** | **Sector** | **Reason**  |
|  | Edith Andrews | WHO | Co-opted member |  |
|  | Dr Felicia Owusu-Antwi | WHO | Multilateral  |  |

1. **Opening:**

The meeting started at 9am chaired by Dr. Naa Ashiley Vanderpuye. Annekatrin El Oumrany started with a presentation covering the following topics:

1. **Conflict of Interest declaration**

The CCM Constitution requests that *” 21.2: The Oversight Committees shall be made up of CCM members and non-members who are not directly involved in program implementation activities.”* While this was the case when the oversight committee members were nominated in June, the situation has changed for several oversight committee members during the last quarter 2015 since:

* GAC contracted its SRs and SSRs
* NTP contracted 47 NGOs to become implementing partners
* NMCP contracted 59 NGOs as implementing partners.

The oversight committee members concerned (Dr. Naa Ashiley Vanderpuye – CEO of WAAF, Evans Opata – Implementing Partner of NMCP, Mac-Darling Cobbinah – Executive Director of CEPEHRG, Genevieve Dorbaye – Treasurer at NAP+ and Board Member of Stop TB Partnership) have been requested to renew their conflict of interest declarations and to hand in a document describing to which extent they are now directly involved in program implementation activities. These documents will be forwarded to the new Conflict of Interest Committee who will make a decision on the further procedures.

In this light, the Oversight Committee decided that the members concerned may not contribute to the discussions related to the respective PR. They may however stay in the room to follow the discussions.

1. **Site visits to IHS, SSDM, ADRA and WAAF / NAP+**

The site visits to IHS (Imperial Health Sciences) and SSDM (Supply, Stores and Drug Management of GHS) were not official oversight site visits as Annekatrin El Oumrany accompanied the GMS consultants to these two institutions. However, she wanted to share her experiences with the Oversight Committee since both institutions contribute to the program implementation. She was particularly impressed by the management of the IHS warehouse that stores Global Fund as well as USAID commodities. She informed further about the objectives and functioning of SSDM and suggested an official site visit to SSDM to better understand the reasons behind the partly significant procurement delays (see the presentation in the annex).

The site visits to ADRA and WAAF/NAP+ are covered in the respective reports that were made available to the respective PRs/SRs and SSRs, the HIV/TB oversight committee as well as the GF country team. The Sight Visit team was very pleased with the work of ADRA and its SR Pro-Link. WAAF/NAP+ have just started their activities and the sight visit team wanted to have a better understanding of the Community Systems Strenghtening module implemented under the PR GAC (see the presentation for more information).

1. **Organization of site visits**

Annekatrin El Oumrany suggested to invite at least one other CCM member to future site visits to allow them to have a better insight in various aspects of grant implementation. The Oversight Committee agreed.

1. **ITP, reprogramming, frontloading, status quo of tightened oversight**

While detailed information on the latest developments regarding ITP processes and front loading requests were not available, the oversight committee members were informed about the results of the tightened oversight meetings with NACP and NTP. Annekatrin El Oumrany expressed concern about the delays in the GenExpert procurement (not to be implemented before June), so that the impact of the more sensitive diagnosis will only start to manifest in Q2/2016. However, case finding results are still behind expectations. While NACP improved the results for HTC of pregnant women significantly, progress in terms of enrollment to treatment of HIV+ women is too slow. The EID results particularly in Q4 are alarmingly low (11% compared to target).

1. **GF performance ratings – changes under the NFM**

The performance rating under the new funding model is based on the average of the programmatic achievement rates and can be downgraded in case of serious management issues. Contrary to the previous GF round, all indicators used to calculate performance rating have the same weight.

1. **“I speak out now” campaign of the Global Fund**

This GF Campaign shall encourage staff and grant implementers to report fraud, corruption, waste and human rights violations that prevent the health commodities and services from reaching the people who need them. Reporting options include online form, phone, voicemail, email, letter, and fax, thereby allowing confidentiality or anonymity. More information is available on [http://www.ispeakoutnow.org](http://www.ispeakoutnow.org/); the link is also available on the CCM website [www.ccmghana.net](http://www.ccmghana.net/).

1. **CCM website**

A lot of content has been added to the CCM website [www.ccmghana.net](http://www.ccmghana.net). Particularly the section on “About us” is more or less complete, while other parts are yet to be completed. The OC members were invited to have a look at the website and to inform their constituencies about the wealth of information available and particularly the forum where questions on the Global Fund and CCM will be answered and where constituencies can also provide their feedback on program implementation.

1. **PPAG Dash Board**
2. **Financial Indicators:**

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| **Indicator** | **Observation**  | **Answer / Decision**  |
| **F2** | **PR budget/disbursements:** KP1 very low burn rate in P2 (21%) while 148% on KP3. Burn rate in P2 125% (P1 = 60%) | KP1 = budget line for hygiene kits and drama performance. In P1 40,000 USD primarily spent on hygiene kits. Only 3292 USD used in P2 even though drama performances were carried out according to work plan (and 148% on respective programmatic achievement).  |

1. **Management Indicators:**

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| **Indicator** | **Observation**  | **Answer / Decision**  |
| **M6** | Explain table | Explanation to be provided, content of the table is not understood. Confirmation test not undertaken anymore, thus no longer relevant. No test kits available. Quarterly request was made to NACP but they have not yet received their allocation. PPAG will inform OC if allocation is not sufficient. Prisons have not yet reported any stock outs. The central and regional level stocks for test kits used for screening as at the end of Jan was 3.4 MOS and about 3.3 MOS expected in March. No stock outs are therefore expected before next shipment arrives. |

1. **Programmatic Indicators:** Significant improvements compared to P1 but on Pr1 much more than on Pr2.

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| **Indicator** | **Observation**  | **Answer / Decision**  |
| **Pr1** | **HIV prevention**: 34/43 prisons not reached in first quarter. 2nd quarter?  | All prisons reached in P2. |
| **Pr2** | **HTC**: 148% vs budget spent but 93% achievement  |  |

1. **Recommendations:**
* PPAG requested to check if 3292 USD were really sufficient in P2 to cover all the drama performances.
* PPAG is requested to provide an explanation for the calculations in the table re M6.
* HIV+ prisoners do not receive the food needed (1.80 GHC per day). If PLHIV do not receive enough quality food, they may not take their ARVs. Food supplements needed. UNAIDS will take up discussions. Shall also be discussed with GAC in order to ensure compliance with treatment regimen.
* Inform CCM if NACP is not able to deliver full quarterly allocation.
1. **ADRA Dash Board**
2. **Financial Indicators:**

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| **Indicator** | **Observation**  | **Answer / Decision**  |
| **F2** | **PR budget/disbursements:** Significant improvement of absorption. Very positive trends in P2: P1: 46%, P2: 129%, biggest gap re prevention programs (cum: 69% but P2 alone: 108%) |  |

1. **Management Indicators:**

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| **Indicator** | **Observation**  | **Answer / Decision**  |
| **M1-4** |  |  |

1. **Programmatic Indicators:**

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| **Indicator** | **Observation**  | **Answer / Decision**  |
| **Pr3** | **IEC for FSWs**: Why not similar improvements as for condom distribution? | FSWs need to be reached with 4 services to be counted as “reached”. Difficult to reach an FSW with all services in the same quarter. Activities actually only started in P2.  |
| **Pr4** | **FSWs: HIV Stigma Reduction Activities**: | Against self stigma |
| **Pr5** | **Healthcare Providers HIV Stigma Reduction Activities:** How are activities carried out?  | Compare situation before and after a stigma activity. Done after work hours, not interrupting activities. Trained some of the health workers, so they can continue while the PR/SR teams are not around |

1. **Recommendations:** Status quo tax exemption: Used a different garage that asked for a much lower price. Tax exemption will not be pursued due to the long and expensive processes required and the small likelihood that similarly big expenditures will arise in the future.

1. **NACP Dash Board:**
2. **Financial Management Indicators:**

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| **Indicator** | **Observation**  | **Answer / Decision**  |
| **F1** | **GF budget/disbursements**: | P1 disbursement = 7.8m carried over from previous round. Additional disbursements to PPM in both periods (P1: 3.5m, P2: 2.6m) need to be added to the disbursements.  |
| **F2** | **PR budget/disbursements:** NACP specific burn rate 48%, including 1.2m commitment >> 71% Which care and support services provided (= one of the budget lines)???Health & Community work force? 2.7m unused. 1.2m committed | Not the complete package that Ghana used to have. = Counselling and testing. People do not take their drugs since they cannot afford the food. Food supplements needed for PLHIV. Majority of budget goes into training for management of ARVs for pharmacists and staff of dispensaries in all the regions. Local PSM cost. Not all of the PPM commodities delivered >> respective PSM cost not used. Trainings postponed = 425,000. Regular review of quarterly planned activities. Assurance that major activities are carried out by the end of the grant cycle. Saving of 390,000 in HR. NACP is requested to come up with a plan on what to do with the unused funds. A proactive NACP approach is highly encouraged.  |

1. **Management Indicators:**

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| **Indicator** | **Observation**  | **Answer / Decision**  |
| **M5** | Obligations?  | NACP is requested to provide an updated dashboard |
| **M6** | Stock levels | NACP: First line: 90,000 PLHIV on treatment, 2% on second line. No stock challenges. 4 MoS (=below min level). Triple therapy was not available in RMS but scheduled delivery in BG2. Stock should now be fine. Additional delivery arrives in April. NAP+ complains about shortages. Constant shortage for pregnant women. NACP response: Although ARVs may be available at the RMS, facilities may prefer to pick up meds from RMS that generate money and leave ARVs behind. Activities are being implemented to ensure scheduled deliveries of programme medicines from RMS to healthcare facilities. It is hoped that when implemented this will largely address this problem of intermittent HIV commodity shortages. The OC members suggested that in addition to this NACP identify measures in the interim to help address this problem. |

1. **Programmatic Indicators:**

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| **Indicator** | **Observation**  | **Answer / Decision**  |
| **Pr1** | **ARV**: Annual target not achievable. Interim results data cleaning? How to avoid loss to follow up? From when on effective?  |  |
| **Pr2** | **HTC among pregnant** **women**: significant increase in Q4 = 144%. cum result = 80% | Assurance of further improvements |
| **Pr3** | **ARV among pregnant women**: increase in Q4 = 53% vs 49% in Q3 | Option B+ started. All HIV+ pregnant women to be initiated for life on ARV. Chunk of PMTCT facilities at lower levels but ARVs not available there. NACP collaborate Family Health Departments. ARVs shall be made available on CHPS level. Has started in some places. Shall be implemented on the ground: NACP will inform about timelines. Community health nurses brought on board: Data mgrs./ nurses get the ARV at regional level and distribute them at local level.Denominator: new prevalence data available.  |
| **Pr4** | **EID**: 11% achievement in Q4 = significant drop | Initially only 25% of healthcare facilities able to do EID. Trainings in order to enable more facilities to do EID.  |
| **Pr5** | **HIV/TB**: significant improvement | Screenings are done but challenges with documentation in the past – is being resolved.  |

1. **Recommendations:**
* OC requests that NACP recalculates number of PLHIV due to population growth + increasing prevalence (DHS 2014). This will be particularly important for 90-90-90
* NACP will inform about planned time lines re implementation of ARV distribution at CHPS level
* NACP is requested to come up with a plan what to do with the unused funds.
* NACP shall develop guidelines for what PLHIV can expect free of charge in healthcare facilities to be shared with NAP+ and GHS and private sector and other actors.
1. **NTP Dash Board**
2. **Financial Indicators:**

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| **Indicator** | **Observation**  | **Answer / Decision**  |
| **F2** | **PR budget/disbursements:** 24% burnrate, 39% burnrate for TB care (=32% of the budget)Line 41: budget too small for 38 GenExpert | Budget line “Other” = fully for 52 GenExpert procurement. FDA registration: will test a machine available at Korle Bu. Shall be done within Feb. Test results will be available within a week. 11 weeks from dispatchment until GenExpert will actually be used (transport and training, training takes 3 days per site, 4 teams available). Great concern about case finding results affected by GenExpert diagnostics. Dispatch planned for 1st week March. Improvement of programmatic results not expected before E/June. 38 GenExpert under HIV/TB, will be frontloaded, which is why current budget line is not sufficient. 100 TB Task Shifting Officers will start 1st March (delayed recruitment). = budget under TB care/prevention. Are volunteers and were supposed to be on the ground from July 2015. Some people already on their post. Savings are reprogrammed. CSO M&E delayed due to delayed contracting. CSOs deliver reports by E2. Stop TB Partnership will be on the ground for M&E from March onwards.  |

1. **Management Indicators:**

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| **Indicator** | **Observation**  | **Answer / Decision**  |
| **M5** | Obligations not consistent with TOC report | Include first line medicines (550,000 not included in TOC report for Cat 2/3) |
| **M6** | Less than 3 months safety stock? | Stock received in Jan.: 4.5 months. Procured by GDF. Next delivery in April. No low stock levels to be expected.  |

1. **Programmatic Indicators: Denominators sorted out with GF?**

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| **Indicator** | **Observation**  | **Answer / Decision**  |
| DOTS-1a | **# notified cases**: Result in P2: 67% = increase from 59% (=cum. result in P1) | Slightly less than 2014 results. No reorientation of GHS staff until E2015 in priority districts only.  |
| DOTS-1b | **# bacteriologically confirmed cases**:  | Significant increase: 89% achievement in P2. However, cum. result = 72%  |
| DOTS-2a | **Treatment success**: Still same value even though in P1 reports were missing? Make results consistent with P1. List absolute data in comment section if result expressed in % | NTP requested to provide a revised DB version  |
| DOTS-7a | **Contribution case finding private and CSOs**: why result not available? | CSO reports expected in Feb. Will reflect in next DB. Tool developed for data capturing of CSOs. NTP requested to insert results of private facilities.  |
| MDR-TB1 | **DST**: Why significant decrease (still above 100%)? | Holiday season, less sputum containers transferred for diagnosis.  |
| MDR-TB2 | **Cases MDR-TB**: 82% achievement in P2 |  |
| MDR-TB3 | **Treatment MDR-TB**: | 97% of diagnosed patients enrolled - very good. 2 persons not enrolled. Concern over their potential to infect others.  |
| TB/HIV-1 | **HTC among TB cases**: Make it consistent with P1 :  |  |
| TB/HIV-2 | **ARV for HIV+ TB cases**: Compare with PF – something seems wrong. Make it consistent with P1. P1: 77%, P2: 60%. Why decrease? = Loss to follow up? | Administered by ART clinics. No shortage of ARV. TB centers do not administer ARVs.  |

1. **Recommendations:**
* NTP is requested to provide a revised DB that reflects the results of private facilities and to review TB/HIV-2 targets. Please ensure that data reporting is consistent across the periods. If % are reported, add absolute data in the comment section for a better understanding.
* NTP shall ensure that GenExpert implementation, incl. training, is realized as quickly as possible to prevent further diagnostic delays
1. **GAC Dash Board**
2. **Financial Indicators:**

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| **Indicator** | **Observation**  | **Answer / Decision**  |
| **F2** | **PR budget/disbursements:** 37% burn rate Out of target of 3302 FSWs / MSM, 2264 were tested (=69%). However, HTC expenditures = 1% of budgetFSW targets achieved (100%) and overachieved (180%) but only 49% of budget usedWhy is condom distribution so low? | SR engagements from November only. HR savings. Jan-Mar: 70% burn rate targeted. Is all under BCC outreach. Only salary of nurses covered under HIV HTC. Savings because of the integrative approach compared to separate activities. 3 sites added. Prudent program management. Only PSM cost, not distribution cost by the PEs. Discussion on condom stigma. Global Fund project in Kenya that distributes colored and flavored condoms to MSM.  |

1. **Management Indicators:**

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| **Indicator** | **Observation**  | **Answer / Decision**  |
| **M1-6** |  |  |

1. **Programmatic Indicators:**

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| **Indicator** | **Observation**  | **Answer / Decision**  |
| **Pr3** | **MSM: HIV prevention programs**: activities started in Q3. Why not better results in Q4? | One SSR lost CEO. 1SR in Q3. Only when GF approved SR and SSR, NGOs really took off. Currently trainings going on.  |
| **Pr5** | **FSW on NHIS**: what about the non-Ghanaian?  | Only Ghanaian.  |
| **Pr7** | **PLHIV on NHIS**: why such low performance in Q4? Was much better in Q3 | GF requested that every account used be zero before the money could be disbursed.  |
| **Pr8** | **MoH trained and active**: how do you define “mobilizing”? | Indicator agreed with WAAF. No GF indicators for this. Only two regions (E/R and A/R) covered. No specific targets for various activities – indicator will leave much to individual judgment. Review indicator for a better definition.  |
| **Pr9** | **Regional NAP+ offices established and functional**: How do you define “Functional”? | Submit monthly reports to SR. Keep record of all activities.  |
| **Pr10** | **SAMC established and functional**: How do you define “functional”? | Approved ToR, fully occupied positions. Documentation of minutes. National: 4 meetings per year. Regional: monthly meetings. Periodic reporting of activities.  |

1. **Recommendations:**
* Projection of the savings.
* Please do not hand over large amounts of cash to SRs.
* Review definition of Models of Hope indicator
1. **Closing**

The meeting came to a close at about 16:15.