CCM Oversight Visit to Sites of Principal Recipients Implementing HIV and TB grants In the Eastern Region

03 – 06 May 2016

CCM OVERSIGHT COMMITTEE SITE VISIT – EASTERN REGION

1. INTRODUCTION/BACKGROUND

The HIV/TB Oversight Committee carried out a four day field visit to the Eastern Region from 3rd to 6th May 2016. The objectives of the mission were

a) Monitor Global Fund supported projects with a view of understanding status of ARV's and other essential commodities and equipment, procurement systems and how effective they were in supporting the treatment program,
b) Assess data and data capture instruments, tools and related issues,
c) Determine level of HIV/TB collaboration, engage in dialogue with key beneficiaries to ensure relevance and adequacy of programs,
d) Gain perspectives of beneficiaries on the levels of stigma and how it affects access to services and follow up issues.
e) Document best practices, challenges and proposed solutions to scale up HIV, TB and Malaria interventions.

The plan was to visit at least one implementing site of all of the five HIV and TB Principal Recipients. The site visit was undertaken primarily in Koforidua, however, several sites were also visited in Fanteakwa district.

2. PARTICIPANTS

- Genevieve Dorbayi (Stop TB Partnership, NAP+)
- Edith Annan (WHO)
- Helen Odido (UNAIDS)
- Damaris Forson (JSI Deliver)
- Samuel Dodoo (Stop TB Partnership)
- Annekatrin El Oumrany (CCM Secretariat)

3. SITES VISITED

- Regional Health Directorate (Briefing and debriefing)
- Regional Hospital Koforidua
- Fanteakwa District Hospital in Begoro
- Tuberculosis community outreach by 4H in Ahomahomaso
- CHPS in Asirebuso
- HTS with FSW in Begoro (ADRA)
- Koforidua prison (PPAG)
- Meeting with MSM representatives in Koforidua
- Regional Medical Store in Koforidua
- PLHIV support group in Nsawam

4. ACTIVITIES

4.1 Visit to the Eastern Regional Health Directorate, Koforidua

Issues discussed

The Eastern Region has 23 districts, 21 hospitals, 149 health centers and 20 ART sites. According to the RHD, the region has the highest HIV prevalence (3.7%) with some districts having a prevalence of 10% and above.

The CCM team briefed the ERHD on the objectives of the visit. Dr Amoah, the Deputy Director of Clinical Care for the region, explained that the previous challenges with stock-outs of HIV commodities which occurred in 2013-2014 had been resolved, leading to a fairly stable and adequate supply of HIV commodities since 2015. This, he said, can be attributed to the Scheduled Delivery System currently being implemented from the central to the regional level. Facilities within the region are then informed of the availability of commodities, for them to pick them up from the RMS. Shortages still occur but are primarily considered to be artificial shortages that occur if a facility is not able to pick up their supplies from the RMS.

Consumption data: Dr. Amoah further said facilities are expected to request for these commodities based on their consumption despite challenges with accessing this data. Data capture and collation is generally a challenge for the region even though staff have been trained on LMIS. This is largely attributed to staff attrition, the multiplicity of tools for data capture, huge work load as well as insufficient supervision and support at sub district and district level. He suggested the region will have to intensify monitoring and supportive supervision to re-inforce knowledge and skills.

HIV: The follow up of HIV positive pregnant women and mothers as well as of their babies remains a big challenge threatening efforts to reach elimination. The region has however made progress with regards to dealing with transportation of EID samples to the regional level for analysis by taking samples to the next bigger district facility, and eventually to the regional laboratory. There is however concern regarding the high defaulter rate in the region, mainly attributed to the promotion of spiritual healing at prayer camps.

TB: TB is primarily a disease of the very poor. The discontinuation of the enablers' package by GF for TB patients who are neither pediatric patients nor have MDR-TB was cited as contributing to the defaulter rate in TB patients. The impact of the distribution of fortified

blended food to poor TB patients to stabilize their health status has not had the desired impact as TB patients have to share the provided food ration with their entire family. Even though the communal care is effective, patients may miss their appointments at the next healthcare facility due to lack of T&T.

Malaria: Even though this site visits targets primarily implementation sites of the HIV and TB grants, the CCM took advantage of the opportunity to assess the status malaria program situation as well RDTs are widely used in the region. The guideline is to confirm a RDT positive test with microscopy. However, hospitals still tend to prefer blood smear tests for primary diagnosis which take longer time to analyze. SP and RDT stock is described as sufficient. Noteworthy is that currently BCC activities are carried out for the use of bed nets; school distribution is expected to start by mid-May.

AOB: The RHD described the difficulties of carrying out the planned activities, especially with the insufficient funds for maintenance of the vehicles. While facilities can generate funds, this is not possible for the RHDs. RHDs depend on GoG funding but have not yet received any amount in 2016 for administration or maintenance. In the past, 1% of the donors' budgets was used to cover this gap, a practice that was prohibited by the auditors. The RHD pleaded with the CCM team to appeal to the Global Fund to factor respective funds in their budgets.

Challenges identified

- Weak data collection and transmission by districts data managers
- Complexity and multiplicity of data collection tools
- Inability of facility level to effectively capture and transmit data
- Poor supervision by district and other managers
- Staff at the regional and district levels are overwhelmed with additional workload due to the increasing number of clients
- High staff attrition rate due to staff wishing to further their education
- High patient default rate at clinical level
- Withdrawal of enablers package for TB clients results in adherence problems among poor clients
- Artificial commodity shortages at facility level though commodities may be available at the RMS
- Lack of resources for administrative support for program implementation
- Lack of transportation, vehicle maintenance etc.
- Lack of funds for follow-up visits

Recommendations

- Improved supervision at regional, district and sub-district level
- District Managers shall be held accountable by their superiors
- GoG shall release funds to the RHD to enable effective program implementation
- Employ information / data officers at sub-district level

Key informants	Job Title	Telephone
Dr. Albert Antobre Boateng	Dep. Director Public Health	020-8133359
Dr. Emmanuel Amoah	Dep. Director Clinical Care	020-6301142
Mr. Vincent Tawiah	Regional Accountant	
Mr. Micah Asare-Bediako	Regional Administrator	
Ms. Angela Quaye	Regional TB Coordinator	024-3132755
Mr. Prosper Agbegbah	Regional Malaria Control Coordinator	024-2720125

4.2 Visit to the ART Clinic at Eastern Regional Hospital, Koforidua

The ART clinic

Since 2005, 2500 HIV positive clients have been treated in this clinic. During clinic days (twice a week) approximately 100 clients are attended to by two prescribers. During clinic days, a doctor needs to be present as well. ART clients may attend clinic on any other day as well, however, certain diagnostic tests are only run during clinic days. The clinic has about 30 seats for clients, which is largely insufficient during clinic days. At a glance, the ART clinic is rather small but looks clean and well maintained. HIV and STI related posters and other IEC materials cover the walls.

Issues Discussed

The discussions centered mainly on the daily routine activities of the clinic and processes aimed at ensuring adequate commodities supplies and adherence to treatment. Madam Opare, the In-Charge of the Counseling Unit, said TB/HIV collaboration was ongoing in the clinic and that clients were tested for TB as well. She further explained that the clinic also serves HIV clients from the prisons.

Defaulters: The defaulter rate is said to be less than 5%[1]. Main reasons cited include lack of T&T to come to the hospital and alternative treatment at prayer camps. However, clients usually return to the ART clinic when their condition worsens. When clients miss their appointments, they are called. About 25% of them cannot be easily traced, so the clinic with the assistance of Models of Hope (MoH) normally gets in touch with emergency contacts to follow up on the client. The clinic telephone is currently not working so that the nurses and MoH use their private funds to charge their own mobile phones. Hospital vehicles cannot be used for tracing of clients. T&T is not available to follow up on clients who in spite of all efforts would not come to the clinic, so that the ART clinic is obliged to limit efforts to phone calls.

HIV/TB collaboration: The ART clinic is right opposite the DOTS center. The collaboration is described as efficient. All PLHIV as well as HTS clients are screened for TB (sputum, x-ray, Gene Xpert). All co-infected clients are put on treatment. The number of co-infected clients is supposedly small but the team was informed that data were not available. All newly diagnosed PLHIV are counseled at the DOTS center on the importance of drug adherence.

Commodity availability: The ART clinic does not always receive the adequate quantity of drugs. The shift from provision of six month supply to a maximum of two months has contributed to a high defaulter rate. Particularly, Nevirapine availability was cited as a problem. The ART client data reveal that the proportion of clients on Efavirenz based regimen was approximately the same as those on Nevirapine based regimen. The suggestion was therefore to actively put majority of new clients on Efavirenz based regimen in line with NACPs policy.

PMTCT: All HIV positive pregnant women are received and treated at ANC clinics, not at ART clinics. The team did not visit the ANC clinic but was informed that the midwife is very good in dealing with HIV positive pregnant women, so that the Models of Hope are hardly ever needed at her end. The team was informed that ARTs are now distributed by the district pharmacist to midwives at sub district level so that pregnant women would not have to come to an ART clinic. After 18 months, the woman can decide if she wants to continue treatment at the ANC facility or at the ART clinic. A challenge at the ANC level might then arise since it is expected that women prefer to stick with the local ANC facility while the workload for the midwife increases over time with the rising number of non pregnant HIV positive women. In March/April 2015, 90 midwives, community health nurses and officers were trained on HIV and its treatment in relation to pregnant women. Since this new system has started only recently, it is too early to speak about experiences.

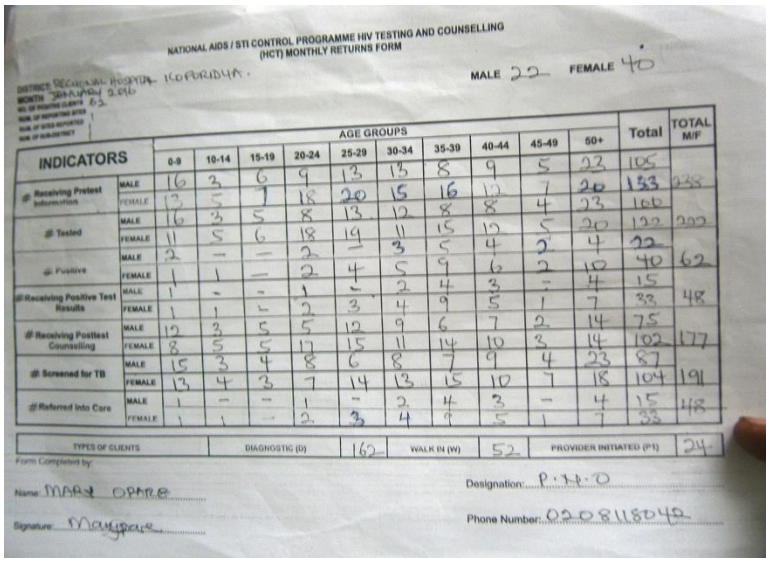
EID: Since February 2016, the laboratory has not had the reagents for EID diagnosis. Some clinics in the region, e.g. Nsawam Government Hospital, have thus stopped taking samples

[1] Calculated as the number of clients who have not come for a consultation during the calendar month of their appointment divided by the total number of clients scheduled for appointments during the same calendar month

that can currently not be analyzed (even though samples can still be collected and analyzed later onwards).

90-90-90: The team inquired with the ART how they intend to handle the increasing numbers of clients that is expected with a change in treatment protocol (CD4 count = 500 and test & treat). The ART clinic staff considers increasing the number of clinic days but points out that this needs to be aligned with the schedule of certain analyses at the lab.

Data collection: Mr. Richard Ansong, Data Manager for HIV took the team through the data capturing tools under his care. He was responsible for capturing raw data from filled patients' records forms. However, HIV information was separately captured on the Hospital Administration and Management System software which has been provided by the NACP.



NATIONAL AIDS / STI CONTROL PROGRAMME HIV TESTING AND COUNSELLING (HCT) MONTHLY RETURNS FORM

MALE 22 FEMALE 40

INDICATORS		AGE GROUPS 0-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50+	Total	TOTAL M/F
# Receiving Pretest Information	MALE	16	3	6	9	13	15	8	9	5	22	105	
	FEMALE	13	5	7	18	20	15	16	12	7	20	133	238
# Tested	MALE	16	3	5	8	13	12	8	8	4	23	100	
	FEMALE	11	5	6	18	14	11	15	12	5	20	122	222
# Positive	MALE	2	-	-	2	1	3	5	4	2	4	22	
	FEMALE	1	1	-	2	4	5	9	6	2	10	40	62
# Receiving Positive Test Results	MALE	1	-	-	1	-	2	4	3	-	4	15	
	FEMALE	1	1	-	2	3	4	9	5	1	7	33	48
# Receiving Posttest Counselling	MALE	12	3	5	5	12	9	6	7	2	14	75	
	FEMALE	8	5	5	17	15	11	14	10	3	14	102	177
# Screened for TB	MALE	15	3	4	8	6	8	7	9	4	23	87	
	FEMALE	13	4	3	7	14	13	15	10	7	18	104	191
# Referred into Care	MALE	1	-	-	1	-	2	4	3	-	4	15	
	FEMALE	1	1	-	2	3	4	9	5	1	7	33	48

TYPES OF CLIENTS | DIAGNOSTIC (D) 162 | WALK IN (W) 52 | PROVIDER INITIATED (PI) 24

Form Completed by:

Name: MARY ORARE

Designation: P.H.O

Signature: Maryare

Phone Number: 0208118042

Models of Hope (MoH): There was a separate meeting with Models of Hope who shared their experiences in working with the hospital staff to provide psychosocial counseling and treatment adherence support to HIV positive clients. There are five MoH at the regional hospital, who generally work at the hospital fulltime (Monday to Friday) and on weekends when needed. All of them have a minimum of 10 years experience in counseling people living with HIV. They receive a monthly allowance of 220 GHC from the hospital and 175 GHC from NAP+ (including 25 GHC for T&T). Only two are on the GoG payroll.

Considering that on clinic days, the ART staff has an average of seven minutes per client, the MoH assistance in counselling especially newly diagnosed clients is of crucial importance. MoH conduct treatment literacy, the importance of treatment adherence, nutrition aspects, among others. They also provide care to clients who do not have any support from their families. On a weekly basis, they follow up on 10-20 defaulters, resulting in about two thirds continuing treatment. The main reasons cited by defaulting clients are alternative treatment in prayer camps which may entail 40 days of fasting during which local religious leaders may ask clients to stop taking their ARVs. Furthermore, the MoH complain about an increasing number of "habitual" defaulters who only return to the clinic after a reminder. Of critical concern is that no T&T is available for community outreach activities, including tracing defaulting clients as well as for community sensitization on HIV. However, they are all aware of PLHIVs in villages who continue their lives as if they were HIV negative. According to the MoH, there is a dwelling HIV epidemic in villages that is not addressed at all. In spite of all anti stigma activities, stigma in the Ghanaian society in general and within families remains a serious issue. Some of the stories told were indeed heartbreaking. Furthermore, they pointed out that police and military staff are still not recruited if they are tested HIV positive. The MoH reported also cases of denial of treatment if the client is not accompanied by a family member as treatment monitor. This does not seem to be an issue at the regional hospital though as the MoH can sometimes double up as the treatment monitor for some of the clients. Furthermore, they have reported cases of inmates who are not given their ARVs on time because the prison's nurses feel too busy with other things.

Challenges identified

- Lack of space at the facility
- Isolation of the clinic from the main stream
- Medical staff has only a few minutes to attend to each client during clinic days
- High rates of stigmatization of HIV clients
- Faith based leader as one root causes of defaulting
- Use of private funds and lack of funds to trace defaulters
- Lack of funds for community sensitization activities
- Lack of EID reagents since February 2016 resulting in discontinuation of EID analysis
- Discrimination of PLHIV in recruitment processes of police and military
- Rumors of denial of treatment in different ART clinics if a client is not accompanied by a family member treatment monitor
- Issues with timely treatment in some prisons

Recommendations

- Increased HIV sensitization and anti-stigma campaigns in the communities
- Expansion of facility and integration into the main hospital system
- Sensitization targeted to religious leaders
- Ensure EID reagent availability

- Sensitize nurses in prisons on the importance of timely treatment
- Review concept of clinic days and/or increase number of clinic, so there would be more time per client

Key informants	Job Title	Telephone
Ms. Gifty Tetebo	Ag. Regional HIV Coordinator	024-4641821
Ms. Mary Opare	In-charge of Counseling Unit	020-8118042
Mr. Richard Ansong	Regional HIV Data Officer	024-2304643
Ms. Agnes Asiedu	Model of Hope	027-4455917
Mr. Alfred Owusu	Model of Hope	024-7690901
Ms. Justine Appiah	Model of Hope	024-4018078
Mr. Dake Kwabena	Model of Hope	024-3433428

4.3 Visit to the DOTS Center at Eastern Regional Hospital, Koforidua

The DOTS center of the Eastern Regional Hospital currently treats 13 patients. The DOTS Center is right opposite the ART clinic and staff confirms a close collaboration with the ART clinic staff. Due to the workload of the ART clinic staff, the DOTS center staff assists with ART adherence counseling.

Screening: All OPD patients and ward patients are automatically screened for TB if they have couched for more than two weeks or if they have been in contact with someone who suffers from tuberculosis. This intensified screening has started in March 2016 with the appointment of the task shifting officer. Since December 2015, the following number of people were screened and diagnosed:

Month	Screened	Tested	TB confirmed
December	405	159	12
January	366	209	12
February	356	243	29
March*	396	120	14
April	485	193	21

*Start of task shifting officer. Initial problems in March with the correct comprehension of his task.

Considering that the task shifting officer started in March 2016 only and faced a few initial challenges, no judgement can be made about his impact at this point.

Mass community screening may be added to the activities of the community health nurses when they visit communities for other purposes, such as child welfare clinics. No data are however available on the percentage of TB clients identified through these community outreach activities.

Esther Ba-Iredire, the Disease Control Officer, confirms that treatment starts right after diagnosis, with the exception of MDR-TB clients who can currently not be enrolled due to lack of medication. Contact tracing is ideally undertaken the same day that a TB patient is diagnosed.

MDR-TB: MDR-TB patients are managed only at the regional hospital. While clients take their medication under supervision in their communities, they need to come to the regional hospital in certain intervals for further diagnosis. Currently, five MDR-TB patients are awaiting treatment. Most MDR-TB patients were previously treated. Only one case of a girl who acquired MDR-TB directly is known. Treatment of MDR-TB may come with significant side effects, including hearing loss, severe bleedings from the injection sites and vomiting which significantly contributes to the risk of defaulting.

Defaulters: The main reasons for defaulting mentioned include alternative treatment promoted by religious leaders as well as lack of T&T for the visits of the hospital for the three interim checkups particularly for poor clients ever since the enabler package was discontinued.

Isolation ward: Since January 2016, the hospital also has an isolation ward for the treatment of those TB patients who are in a critical condition. The team was informed that the staff at this isolation ward uses ordinary masks since recommended respirators are not available.

4.4 Visit to the pharmacy and laboratory at Eastern Regional Hospital, Koforidua

a) Pharmacy

The pharmacy usually requests for commodities from the RMS. The ARVs, TB and Malaria medicines are stored at the pharmacy stores, whereas the laboratory stores the HIV test kits. Due to lack of space at the medicine store and unavailability of certain medications, requests to the RMS are done on a monthly basis. The facility usually submits its returns (logistics data) to the RMS on a monthly basis. Copies of submitted logistics reports were made available to the CCM oversight team. The pharmacy upon taking into inventory its medications will issue ARVs to the ART center and TB medications to the DOTS center.

Stock status:

- Most adult firstline Efavirenz based formulations and pediatric ARVs: adequate stocks
- Adult firstline Nevirapine based formulations i.e. Lamivudine 150mg+Zidovudine300mg +Nevirapine200mg: stock out
- Nevirapine 200mg: very low stocks forcing the ART clinic to ration stocks for clients on these formulations.

The ART client data suggested that the proportion of clients on Efavirenz based regimen was approximately the same as those on Nevirapine based regimen. The suggestion was therefore to actively put majority of new clients on Efavirenz based regimen in line with NACPs policy.

Inventory control: The pharmacy makes use of inventory control cards to manage its stocks. These cards are updated as and when issues are made to the dispensary and ART clinic. The data captured on the inventory control cards is used to fill the HIV monthly logistics report submitted to the RMS. The e-LMIS software deployed by the NACP is not functioning thus actual consumption data for ARVs not available. The facility has plans to incorporate program medicines into a facility acquired software in order to capture actual consumption data.

Storage conditions: The storage conditions at the pharmacy stores were adequate. The commodities were kept at the appropriate temperature and inventory control cards had been updated.

Challenges

The list of ARVs on the monthly ARV report submitted to the RMS has not been updated to include recently introduced formulations especially pediatric formulations.

Recommendations

The monthly logistics report that is submitted to the RMS needs to be updated to include new formulations especially pediatric dispersible tablets recently introduced.

b) Laboratory

The team visited TB Lab facilities and diagnostic equipment including Gene Xpert. Mr. Roger Laryea, Deputy Head of Bacteriology and Mr. Francis Ussher, Laboratory Manager took the team through the various diagnostic processes and presented various commodities and suppliers which they confirmed were in adequate supply, incl. GE cartridges, reagents, sputum containers and laboratory items. They also had special diagnostic tools to detect pediatric TB.

HIV test kits and laboratory reagents obtained from the RMS are stored in the laboratory. HIV test kits are issued from the laboratory to the ART, PMTCT and blood banks respectively where HIV tests are conducted. The laboratory reagents used to perform HIV tests such as EID which require cold storage are kept at the Koforidua regional Hospital. All EID test samples within the region are thus referred to the hospital.

The main laboratory tests for tuberculosis include sputum smear tests (focus on fluorescent microscopy, Gene Xpert as well as bacteria culture). Since June 2014, a Gene Xpert has been available that is increasingly used (first six weeks: 10 samples tested, April 2016: 43 samples tested, which is equivalent to 22% of all of the samples tested). The team was informed that Gene Xpert can detect resistance only to Rifampicin. To test for resistance to other antibiotics, a culture is still necessary, that however takes six weeks. A big advantage of Gene Xpert diagnosis is that it can detect extra-pulmonary TB as well. Four samples can be tested with Gene Xpert at a time (test duration: 2 hours) and laboratory staff confirms that they run an analysis whenever a sample comes in (Begoro district hospital believes that the lab waits for a minimum of 25 samples in order to run a test). This means that this Gene Xpert runs still below its capacity. The laboratory staff says that they have not yet received any indication, training or cartridges to use Gene Xpert for other diagnoses than tuberculosis. When asked for their recommendations, lab staff informed the team that they would like to use the Mantoux test on children since they hardly have the capacity to produce sputum.

Stock status: On the day of visit, the laboratory did not have any stocks of HIV test kits since all had been issued out to the satellite clinics. The facility was however not stocked out of first response test kits, since the HTS unit had stocks when visited. Stocks of CD4 reagents, viral load reagents and hematology reagents were available. There were no usable stocks of EID reagents on the day of visit since the ones available in the facility expired in February, 2016. This was collaborated by the Begoro District hospital which indicated that results of EID samples sent to Koforidua regional hospital in March had not been received.

Recommendations:

- Evaluate possibilities to use Gene Xpert for different diagnoses than TB
- Ensure continuous availability of EID reagents
- Evaluate usefulness of the use of the Mantoux test for TB

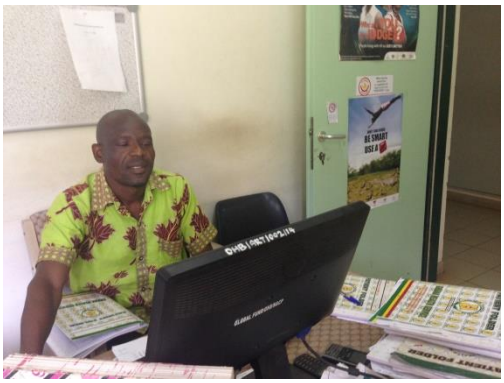
Key informants	Job Title	Telephone
Roger Laryea	Deputy Head of Bacteriology	
Kwaku Obiri-Yeboa	Head of Pharmacy	
Kwaku Anim Omenako	Pharmacist	
George Danquah Damptey	Regional Biomedical Scientist	
Francis Ussher	Head of Laboratory	

4.5 Visit to the DHD and District Hospital in Begoro, Fanteakwa District

Fanteakwa district has a population of about 123,000 people. There are 23 healthcare facilities, including 12 CHPS, two private facilities and one ART clinic at the level of the district hospital in Begoro. The district hospital also contains the district's only DOTS center. All 23 facilities serve as PMTCT and HTS sites.

Since the District Health Director participated in the 90-90-90 launch in the Western Region organized in Koforidua, Isaac Tandoh Obeng and Ransford Baah-Mensah were available for the CCM team's questions.

4.5.1 HIV treatment and care



ART clinic: All HIV positive clients are managed at the level of the district hospital, the district's only ART site. As of December 2015, 256 PLHIV were on ART in the district. This number may not be entirely consistent with the results from the NACP ART data cleaning as also the number of clients on ART as of end of August differed (233 vs 249 adults). In 2015 alone, 84 clients were enrolled on ART. There is one clinic day per week during which on average about 45 clients are attended to, primarily during the morning. The worry of the team that this may be too many to provide quality services, especially to newly diagnosed clients was reinforced when the team reviewed a few client folders and found that in most, a lot of the information, incl. the information on TB screening was not filled in. The data officer explained that time per patient is too short in order to ask all these questions and to write down the answers, even for new clients. The regular schedule for ART clients is monthly

visits. Considering poverty, this may contribute to the defaulter rate as lack of T&T was mentioned as the prime reason for loss to follow up.

The team was glad about the organization of the ART clinic that combines all the hospital's patients in the same waiting area before they are called into the various consulting rooms. MoH support the ART clinic staff during clinic days. On other days, they do sensitization activities in the various communities.

PMTCT: The district's estimation of pregnant women per year is 4922. During the first quarter 2016, 718 women have attended ANC, partly in healthcare facilities, partly through community outreach. During community outreach, all pregnant women are tested; first response test kits are availability while there are shortages of Oraquick. Out of these 718 women, eight were tested HIV positive. In 2015, 39 out of the 42 pregnant women with a positive HIV test result were enrolled in treatment. Through PMTCT, between 60 to 70 HIV positive women are currently on treatment. All HIV positive pregnant women are requested to return for EID after birth, and most actually do so, however not necessarily within the time frame of two months. It is estimated that 60% of the women come within the first two months after birth; the missing women are followed up. EID samples are sent to the regional hospital for diagnosis, however, since February 2016 they have not been tested because of lack of reagents.

Challenges

- Huge number of ART clients per clinic day
- TB screening of ART clients does not seem to take place consistently or respective data are not captured
- Lack of EID reagents at regional hospital
- Shortages of Oraquick

Recommendations

- Review and/or expand concept of clinic days to ensure that clients get their questions answered from the medical providers as well
- Review implementation of TB screening of ART clients and ensure correct data capturing
- Compare outcomes from data cleaning with data base at the ART clinics as data do not match
- Improve ART availability so that clients do not have to come to the ART clinic on a monthly basis
- Ensure consistent and adequate stock of EID reagents in all regions and inform PMTCT providers how to pursue in cases of non-availability of the test.

4.5.2 TB screening and treatment

Screening and diagnostics: All regular TB clients are managed at the district hospital's DOTS center with the exception of MDR-TB clients who are managed by the regional hospital in Koforidua. Since March 2016, every patient in OPD is informed about TB and screened if s/he has symptoms or has been in contact with a person with tuberculosis. Through this route, two TB clients have been identified. Pregnant women as well as diabetes patients are screened systematically. There is no routine screening outreach in the communities, however, durbars, such as of church or women groups, are used to inform about TB and to screen the participants. The last outreach activity took place in February when about 50 people were screened but none was tested TB positive. The only NGO in the district is 4H – a few team members have joined them during a community outreach in Ahomahomaso (see next chapter). 4H started its activities during the second half of 2015 and has contributed five TB clients so far. However, the nurses at the DOTS center are not aware of this NGO.

The DOTS center pointed out that Gene Xpert analyses, which are usually undertaken on AFB negative but still suggestive clients, are sent to the regional hospital where it takes about one week to get the results. It is believed that Gene Xpert analyses are only run when 25 samples have accumulated, however the lab personal confirmed that samples are diagnosed as they come in.

Treatment: Clients receive their medication from their local healthcare facility so that they only have to come to the DOTS center in Begoro for their diagnostic tests after the 2nd, 5th and 6th month. According to the prevalence survey, one would expect 111 TB clients in the district, however, currently 25 cases, including three MDR-TB cases and six HIV co-infected clients, were on treatment at the time of the visit. 15 of those are followed up by the DOTS center of the district hospital.

The DOTS center is a relatively large room with open windows on both sides. The place where the patient is seated is at a 1m distance from the nurse's desk. The nurses still feel at risk of an infection. They would prefer that each patient wears a mask and they tend to cough and sneeze without covering their mouth. However, masks are not available. TB medication is said to be available, however, Oraquick for HIV confirmation tests is stocked out.

Other aspects: While this particular DOTS center is not having major problems with defaulters, the nurses pointed out that they do not have any funds available for contact tracing or home visits and they are partly forced to use their private funds in order to do their job correctly. The hospital vehicle is hardly available (only in 20% of the instances when needed) and while the DHD may provide one if its motorcycles, the nurses still do not have the funds for the fuel. Furthermore, in cases of drug sensitive TB, the patient is not to sleep in the same room with other people, however, poverty does not offer them a choice. TB related stigma is still a serious issue due to the link to HIV. However, considering the screening of all contacts, a TB infection can hardly be hidden from other household members. Language can be an important barrier since the nurses do not understand all of the local languages. In such a case, an interpreter is identified, who may disclose the person's TB to others. The hospital collaborates with a person who knows sign language and who is able to communicate with deaf clients. The DOTS center points out that their register does not have a section for Gene Xpert analyses. Furthermore, the DOTS center would like to be equipped with thermometers, BP meters and glucometers to take vital parameters themselves. Currently, those are only available at the OPD level.

Challenges

- Hospital vehicle hardly available for contact tracing and home visits
- Nurses use private money for contact tracing and home visits
- DOTS nurses do not feel sufficiently protected from TB infection

Recommendations

- Encourage better collaboration between DOTS centers and implementing partner NGOs of NTP; could also contribute to a better accessibility of certain communities by the nurses
- Inform DOTS nurses about funds available for contact tracing and home visits. Ensure that they do not have to use their private funds, which is supposedly part of the staff attrition problem
- Inform DOTS staff about adequate staff protection measures and address respective rumors to reduce staff attrition
- Implement national campaign on cough/sneeze hygiene

4.5.3 Malaria

The DHD staff informed the team that a lot more is done in the district to scale up malaria prevention and care than for other disease components. RDTs and SPs are said to be always available. Deaths resulting from malaria have dropped significantly over the last years. The major challenge is still that people with symptoms tend to go to a chemical seller first. Chemical sellers do not test for malaria but will still sell ACTs.

4.5.4 Pharmacy

Obtaining supplies: The hospital indicated that it obtained its stocks of program medicines from the RMS. The need of ARVs and TB medication in the district is forecasted by the district pharmacist who also ensures their availability. HIV test kits are obtained from the District Health Directorate which collects test kits on behalf of all the facilities who offer HIV Testing Services (HTS) within the district.

Inventory control procedures: The laboratory captures data on test kits usage in the HIV Rapid test logbook. Logistics data on HIV test kits is collated by the laboratory and submitted to the district health directorate on a monthly basis. The pharmacy makes use of inventory control cards to manage its stocks. These cards are updated as and when issues are made. The data captured on the inventory control cards is used to fill the ARV monthly logistics report submitted to the RMS. The e-LMIS software deployed by the NACP is not functioning thus actual consumption data for ARVs not available. Consumption data are available for ACTs, TB medication and HIV tests. However, data on TB medication are not always reported.

Stock status: On the day of visit, the pharmacy had stocks of both Efavirenz and Nevirapine based formulations for adult firstline although the pharmacist indicated that Nevirapine based formulations i.e. Zidovudine 300mg+ Lamivudine 150mg + Nevirapine and Nevirapine 200mg tablets stocks were low. The facility had adequate stocks of TB cat I+III and TB paediatric medicines and malaria medicines.

4.5.5 Other challenges

Transport and outreach: Each community shall however be visited by one of the district's 60 community health nurses, mostly using public transport or by foot. It is however described as difficult to reach out this regularly to the hard to reach communities where walking is the only option to reach them. Part of the CCM got an idea of difficult road conditions when they went to Ahomahomaso and Asirebuso but they were informed that these roads were comparatively good. Only 14 motorcycles of the district hospital are functional. The team counted another 12 that have broken down and that are parked on the hospital compound.

Confidentiality: The CCM team was informed about rumors that staff of the district hospital discloses the status of patients to their communities. The DHD assured the team that they would follow up on those rumors.

Staff attrition: More healthcare staff, especially in the communities is needed. It is difficult to recruit and retain them especially in those hard to reach areas and those without electricity or network connectivity.

Training: While NTP and NMCP have provided a lot of training sessions for healthcare staff recently, it has been 3-4 years that nurses were trained on HIV and counselling.

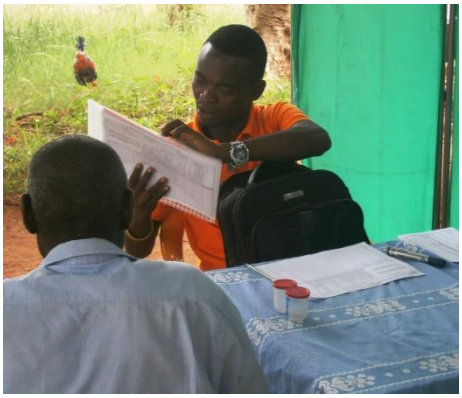
Key informants	Job Title	Telephone
Ransford Baah-Mensah	Staff nurse RCH	024-5793316
Isaac Tandoh Obeng	District Health Information Officer	020-8410898
Ampofo Oteng Seth	Biomedical scientist	
Richard Oduro Aboagye	Pharmacist in charge	024-4149210
Akoalima Stephen Abaale	ART Data Manager	024-9741253
Gifty Nugbienyo	Enrolled nurse, DOTS	024-5278521
Anita Addy	Community health nurse	054-2615883
John Anom	District TB Coordinator	024-3504600

4.6 Visit of the Ahomahomaso health center and participation in a TB community outreach in Ahomahomaso organized by 4H, Fanteakwa District

The Ahomahomaso health center serves over 21 communities. Wednesday is a market day at Ahomahomaso and at the same time a clinic day. The team witnessed over 100 clients who had come for the various services.

Tuberculosis: Information gathered indicated that community mobilization had been done for the TB screening. However, due to the high level of stigmatization related to TB, community members were not told about the TB screening but were only informed about a general outreach service. While diagnosis of TB is provided by the district hospitals, the local health center offers DOTS for TB clients, so that they continue treatment in their community. When clients are referred to the district hospital for further diagnosis or follow up some may not able to go there because of transportation difficulties. The staff indicated difficulties of obtaining sputum containers for TB patients as well as of transporting sputum samples to the district. It was indicated that only one TB client was being supported with enablers by 4H Ghana. It was impressive to find out that no TB patient had been lost to follow-up. The volunteers have been helping and reminding the patients to come to the clinic. Medicines are available all the time for the patients.

- Sub district (21 communities) TB target = 9 cases per quarter
- In 2016 the sub district has submitted 7 sputum samples. Three tested positive and are under treatment.



The OC team then observed a community screening event organized by 4H Ghana. The exercise was largely successful with over 100 persons being screened with 14 referrals.

HIV: Currently there are two pregnant women who are HIV positive. The health center receives ARVs and HIV test kits on a quarterly basis from DHD. If necessary, additional requests can be made at all times. The facility dispenses ARV on a monthly basis to the pregnant women. The nurse in charge was however not sure if they will be given the medications for the pregnant women after they have delivered.

Data collection: Monthly returns are sent to DHD by the facility. There is a monthly data validation meeting at DHD.

Challenges

- Funds to assist patients under treatment with transportation and food
- Bad road networks
- Lack of access to clean water. There are only 2 boreholes serving the whole area of which one was not functioning properly.
- No training schedule – training list selected from RHD
- Non availability of Sputum containers
- Lack of computer for data processing, all data handled manually

Key informants	Job Title	Telephone
Gifty Terkper	Midwife	024-3076979
Abayaa Ebony	Project Nurse for TB and Malaria	
Gloria Fremaa	Community Health Nurse	
Fynn Steven	Community Health Nurse	
Beatrice Biney	Staff Nurse	
Fiagbor Kwame	Assembly Member for Ahomahomaso	
Francis	4H	024-9405006

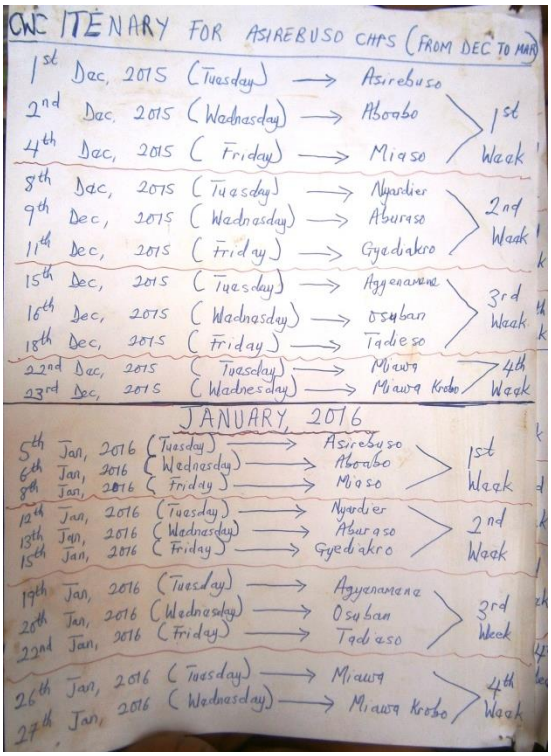
4.7 Visit of Asirebuso CHPS Compound in Fanteakwa District

The Asirebuso CHPS compound provides 24 hour call service and offers primarily:

- Expanded Programme on Immunization,
- Ante Natal and Post Natal Care,
- Child Welfare Clinic (CWC),
- Sexual and Reproductive Health, and
- Family Planning.

The road to Asirebuso was particularly bad. Even though the CCM team was informed that this was one of the better roads, the team got a little insight in the meaning of "hard to reach areas".

Each Tuesday, a CWC is organized attracting an average of 50 clients. The CHPS has no electricity. The CHPS manages with solar panels of which the only one working services the fridge containing the vaccines etc.



The CHPS serves 10 communities and collaborates with one volunteer in each of the communities. For outreach services, a motorbike is available. The CHPS had drawn weekly itinerary for community visits but are unable to go by it because of transportation problems. It also depends on when the community communicates to them to come. As these are spread out they rely on the volunteers to give them a date to visit. Daily activity reports were not available for scrutiny. Neither could the CHPS produce a report or other data to indicate implementation of community outreach activities.

Staff at the facility were interviewed on their operations. Data capturing sheets were inspected. These included: EPI Tally Sheet, Antenatal Care Register, Monthly Facility Report for HIV Testing, Monthly Midwife Return Book (Form A), Community-based surveillance report form. Most of the forms had been filled to date. Clinic staff was in the process of transferring data into their books at the time of the visit.

<u>HIV and tuberculosis:</u> in 2016, 26 people were screened for TB with no positive case. The nine persons tested for HIV were all negative. Three CHOs had been recruited at the beginning of the year and data available to them indicated that there were no cases of TB and HIV in the communities they were serving. This sounded unconvincing to the team. However, the staff also indicated lack of HIV test kits.

Malaria: The CHPS use RDTs to test for Malaria. When clients test positive, they are given Artesunate-Amodiaquine tablets. The facility does not have Artemether Lumefantrine tabs. During the previous month they had 74 clients who were tested and 64 were confirmed and treated. The CHPS compound received ITNS which were distributed to clients.

Challenges

- Lack of HIV test kits
- Language barrier: There are 3 dominant languages (Krobo, Grushie, Frafra). None of the CHOs at the CHPs compound speak these languages and therefore cannot communicate well with the community members. They rely heavily on the volunteers for translation
- Lack of ANC Drugs: CHPS are not authorized by GHS to administer drugs, such as fersolate and folic acid, to pregnant women. As a consequence, pregnant women prefer to go to the District hospital for their ANC where they receive the before mentioned medications.
- The Fulanis who are many in the communities do not come to the clinic because of ongoing misunderstanding between them and the community members. They are being encouraged to attend the clinic

Key informants	Job Title	Telephone
Jones Tweeneboa-Kodua	Community Health Nurse	024-1395734
Benedicta Ajakameh	Community Health Nurse	
Mary Asare	Community Health Nurse	

4.8 Participation in a HTS activity for FSWs carried out by Christian Council Ghana in Begoro

The team met a group of about 30 FSWS, including their peer educators, as well as representatives of Christian Council Ghana and ADRA at Adom Hideout Spot, a small bar in Begoro. Christian Council Ghana is one ADRA's sub recipients and works with FSWs through trained peer educators in the following seven districts in the Eastern Region:

1. Lower Manya,
2. Upper Manya,
3. Yilo Krobo,
4. Asuogyaman,
5. Akwapim North,
6. West Akim and
7. Fanteakwa Districts.

The CCG has a Project Coordinator, M&E officer, seven field officers and fifty-five peer educators. The peer educators provide education to female sex workers (FSWs) on consistent use of condoms, HIV Testing Services, Sexual and Gender Based Violence, Sexually Transmitted Infections and Tuberculosis using the one-on-one approach and making referrals if need be. The majority of the FSWs are roamers. The talks are partly difficult to carry out since not every FSW sees their relevance. PEs also talk to violent partners of FSW with the objective of a behavior change.

The peer educators and field officers who manage the projects in the various districts also carry out stigma reduction activities within the FSWs community and at the Health facilities. HIV Testing and Services are also conducted for the FSWs. Recently, information on TB has been added to the PE agenda. The actual screening is usually carried out by a drop-in center.

Condoms: Peer educators indicated that they buy no logo condoms from the Christian Council at a subsidized price and sell to their peers. At the time of the visit, these were the ones donated by UNFPA. The no logo condoms have been largely available and that they have not experienced any stock out at least not during the past 6 months. FSWs prefer male condoms as according to them, female condoms can't be used for all sex positions, which makes them less appropriate in the sex business. Some the FSWs complained about their quality stating that those get torn easily. When the CCM team enquired about whether it was a matter of not knowing how to use it, FSWs indicated that they have been trained appropriately. A representative of the CCG pointed out that the condom quality issue has also been raised by FSWs from different sites. The team also inquired about consistency of condom use and was informed that the majority of sex workers would accept unprotected sex if the price is high enough. Unprotected sex seems to be more common with anal sex,

even though several FSWs complain about the sore back. The FSWs furthermore complained about the price of the condoms. Even though each of them is only a few Pesewas, while the regular price for intercourse is 30 GHC, the FSWs feel that the condom price is a barrier to its use.

HTS: HIV testing and counseling services are also conducted and each FSW who is reached is expected to be tested at least twice a year. The CCM visit coincided with such service. The nurse in charge of the outreach indicated that HIV screening test kits have been largely available. Clients tested HIV positive are referred to the Begoro District hospital to an FSW friendly nurse who conducts the confirmatory test and links positive clients to care.

Stigma: The team was informed that due to the anti-stigma activities with healthcare staff at the district hospital in Begoro, stigma is not an issue anymore. The FSWs present agree that they are treated just as everyone else. However, the peer educators pointed out that some FSWs would still not go for STI treatment in spite of all good arguments.

Challenges

- Complaints by FSW about low quality condoms
- Unprotected sex with clients is a matter of price
- Sale of condoms to FSWs was limiting their interest in purchasing and applying them.
- Anal sex seems to be often carried out without a condom

Recommendations

- Provide treatment support services to peers who test positive for HIV
- ADRA and CCG should hold a FGD with FSWs to adequately understand how they use the condoms and under what circumstances it breaks to ensure that it is not an inappropriate use issue.
- Check condom storage conditions within warehouses and where FSWs keep these condoms to ensure that the manufacturers' storage conditions are being adhered to.
- Link up with other projects that distribute condoms to exchange on the experiences.
- Consider post market surveillance by FDA, where FDA can sample and test no logo condoms kept by the PR, SRs and FSW along that chain and come out with recommendations.
- Intensify sensitization on the risks of non protected anal sex.

Key informants	Job title	Organization	Telephone
Manuel Addy	M&E Officer	Christian Council Ghana	024-3836666
Joyce Steiner	Project Director	Christian Council Ghana	024-4253656
Charles Asiedu Bani	Field Officer	Christian Council Ghana	027-6232532
Albert Tamatey	Field Officer	Christian Council Ghana	024-5072581
Patricia Agyeiwaa	Technical Supervisor	ADRA	020-8868768
Ransford Baah-Mensah	Staff Nurse	Dist. Hosp., Begoro	024-5793316

4.9 Visit to the Koforidua Male Prison

While PPAG has provided HIV prevention activities to the Koforidua prison since 2010, Global Fund supported activities started in 2012. PPAG works in collaboration with Theater for Social Change. Their activities include monthly visits to the prison, training of 25 Peer Educators, provision of hygiene kits (tooth brush, tooth paste and disposable razors), TB screening, HIV testing and counseling services, as well as treatment support services through the Prison Infirmary. Test kits for this exercise are obtained by PPAG from the national program.

The CCM team first had a meeting with prison officials, including the medical assistant, and representatives from PPAG and its Sub Recipient Theatre for Social Change before engaging in a discussion with the 22 peer educators. The team also visited the prisons wards as well as an isolation block. Moreover, the team could have a look at the prisons infirmary and examined the conditions under which ARVs and TB medicines were being kept.

The Koforidua Male Prison currently detains 683 inmates, including 12 people living with HIV, 2 TB clients and no co-infected men. None of the men living with HIV has disclosed his status publically. The prison is supposed to have 25 peer educators, however, currently only 22 are active. The PEs pointed out that three of them will be released by the end of 2016.

Peer educators: All peer educators (PE) received a five day training on HIV, TB and data capturing from PPAG and TfSC about eight months prior. Each PE is responsible for one cell with usually 70-100 inmates. They shall run their activities on a daily basis, using the 1x1 and small group discussion approach. They pointed out that to date, they have not yet received their training manuals, flip charts and other IEC materials for effective outreach and education that help in the sensitization activities but also clarify certain aspects that they are not too sure of. They are further highly interested in HIV/TB related films that need to be provided on a pen drive (not a CD or DVD). Several of them pointed out that they would like to continue their PE activities and requested to keep these materials once they are released from prisons. This also explains their desire to be equipped with a PE certificate. Being a PE is not always without challenges. Some inmates are hard to convince to listen to them. Rumors, such as the ones that the inmates' blood samples taken for an HIV test, are sold outside the prison or that PE withhold hygiene kids for themselves, further impedes

their activities. The PEs expressed additional concerns on the lack of hygiene kits. Other challenges expressed included excessive congestion and heat within the cells.

Screening and referral to treatment: The medical assistant in charge of the infirmary indicated they had not experienced any shortage of test kits (first response). HTS is well accepted. While the HIV test is fully voluntary, about 400 inmates were tested during the last HTS. Inmates who are reactive are referred to the Koforidua Regional Hospital for confirmatory testing. Positive clients are then linked to treatment at the ART center. Inmates who cough by more than two days are screened for TB and those suspected to have TB are referred to the Koforidua Regional hospital for diagnosis and treatment. Referral to the regional hospital is said to function without any difficulties. A vehicle for the transport of concerned inmates is always available. Currently all positive clients are on medication and their medications have been largely available.

HIV treatment of inmates: All inmates who require medication, independently of their condition, are made to take their drugs under supervision at the infirmary at the same time every morning. Those who need additional doses later in the day, receive those equally in the morning. This procedure reduces suspicion and has allowed those inmates so far to avoid stigma and discrimination. This procedure further maximizes the possibility of timely medication (MoH at the regional hospital pointed out that in other prisons, PLHIV only get their dose whenever it is due and sometimes the prison's nurses are too busy to take care of PLHIV in a timely manner). However, adherence to treatment is a big problem since PLHIV need to eat well when taking their medication. Obviously, 1.80 GHC are largely insufficient to provide three nutritious meals per day, especially since this amount needs to cover the profit margin of the caterer as well. Prisoners may buy their own food but not everyone has this possibility. The prison also has small cells that can be used for isolation of infectious TB cases.

Drug use and sexual activities among inmates: Prison officials as well as peer educators confirmed that drug use, especially the injecting type, as well as sexual activities among inmates are very rare. Sexual activities are prohibited among prisoners and highly stigmatized among the inmates. Any attempt will raise significant publicity, the offender will be heavily beaten by other inmates as one peer educator pointed out. In fact, the prison does not offer any hidden places either.

Stigma: Even though anti-stigma activities are part of the PEs' sensitization activities, PEs pointed out that they would not disclose their status if they were tested HIV positive. They claim that stigma would kill them right away. In fact, the status of the 12 inmates living with HIV is largely unknown to others. The team interacted with four PLHIV inmates of the Koforidua prison. One team member was particularly shocked about the fear in their eyes. They expressed frustration of the fact that they had to hide their status due to perceived

stigma. One of them pointed out that he would like to be an ambassador in order to fight HIV related stigma in prisons.

Malaria: The prison setting does currently not allow for malaria prevention activities, such as insecticide treated bed nets. There are about 70-100 inmates in each cell. Because of the congested cells, it is impossible to hang up bed nets. The whole prison is cemented, so that the place is very hot. It is probably not acceptable to screen doors and windows, which would reduce the little ventilation in the cells even further. So far, no IRS has taken place. Malaria RDTs are not available at the prison level. Inmates who are suspected of having malaria are thus always referred to Koforidua regional hospital for diagnosis and treatment. It would be preferable to test feverish inmates at the infirmary level of the prison and administer ACTs accordingly, especially since malaria is one of the main health problems at the prison.

Challenges

- Lack of IEC materials incl. training manuals
- Inadequate food supply for inmates with HIV and/or TB
- Hygiene kits does not adequately cover actual needs
- High level of HIV related stigma
- Prison's infirmary poorly equipped
- Lack of malaria prevention, RDTs and ACTs

Recommendations

- Provision of barbering salon for inmates to avoid sharing of blades
- Provision of adequate nutritional support for inmates on TB and HIV treatment
- Provision of Scenarios of Africa on a pen drive to PE (short films on HIV/STIs available on the internet free of charge)
- Re-stocking and equipping of infirmary
- Discuss possibilities of malaria prevention, diagnosis and cure at the prison level with NMCP

Key informants	Job Title	Organization	Telephone
ADP Benedict Bob-Dery	Assistant Director of Prisons / Officer-In-Charge	GPS	024-4526457 050-6232978
CSP Joseph Asabre	Chief Supt. of Prisons	GPS	024-4206901
CO Samuel Ahwireng	Physical Assistant	GPS	050-6232978 024-4576957
Grace Safoah Amenyegah	Programmes	TSC	024-3151003
Anne-Marie	Prog. Coordinator	PPAG	057-3133954
22 peer educators		GPS	

4.10 Meeting with a MSM group

While Koforidua was listed as one of the sites for MSM activities supported by the Global Fund, no project was being implemented at the time of the visit. In the past, USAID had a number of activities, incl. services at a drop-in center, however, this project folded up around mid-March. Since the site visit team still wanted to have more insight in the MSM specific attitudes, behaviors, needs and expectations, they invited a group of MSM for a discussion. The contact was provided by CEPEHRG.

The CCM team met five MSM at the Capital View Hotel for a two hour conversation. The MSM group was very unhappy about the lack of MSM activities ever since the USAID funded project closed in March. The drop-in center closed as well, leaving the MSM community with a single MSM friendly nurse in Koforidua and no possibility to obtain subsidized condoms and lubricant. For stigma and discrimination issues prevalent in the Ghanaian society, MSM fear purchasing particularly lubricant as it is considered to be used primarily by MSM. The previous DIC also offered a secure meeting space for MSM.

MSM behavior patterns: There seems to be a big difference between younger and older MSM in their behaviors. Younger MSM often like to go out and have fun and new exciting experiences. Promiscuity is very common, particularly among the younger MSM. Older MSM (40+) tend to live their homosexuality much more discreetly. The key informants rejected the claim that the older MSM prefer the younger MSM. Younger and older MSM do not tend to mix a lot and young MSM hardly ever get their aspiration fulfilled to find a "sugar daddy". The key informants' comments seem to indicate that older MSM are much more risk averse than youngers in their sexual behaviors. Many MSM also have relationships or marriage bonds with women, partly because the non-suspecting family arranged a wedding, partly to cover up for their homosexuality. A bisexual preference is a rather rare reason for a relationship with a woman. In most heterosexual relationships, the woman would not be aware of the man's preference for men.

Stigma and discrimination remains one of the key issues of MSM. It is largely believed that homosexuality per se is illegal in Ghana, a claim that is not supported by the law. The MSM group pointed out that the MSM friendly nurse is of a great help, however, some health problems need to be addressed by a doctor, who do not tend to be MSM friendly or neutral. Furthermore, stigma and discrimination is an enormous problem at the level of the police. MSM hardly have a possibility to file their complaints against third parties. Once the third party points out that the complainant is homosexual or had anal sex, the initial complaint risks to be disregarded and the complainant may end up in jail himself. While the law can be applied in favor of the MSM concerned, many MSM fear the publicity attached to the legal procedures and prefer bribing themselves out of jail. Stigmatization and discrimination have reached such an extent that blackmailing MSM has become an easy and successful business.

The CCM team heard several stories about third parties disclosing homosexuality of a man to family members and even employers if demands are not met.

Safer sex: The respondents declared that the lifestyle, particularly of younger MSM, tends to be very much fun oriented. They like to party and to drink, some consume drugs, and may drop their caution under the influence of alcohol and others. Lubricant is considered crucial in sexual relations. If lubricant is not widely available (as in the current situation), many MSM would not use a condom either. The key informants also pointed out that many MSM would not even engage in safer sex once they are married. The MSM community talks a lot, so many MSM feel that insisting on a condom could make others suspect that they are HIV positive. MSM who are HIV positive may not insist on condom use for the same reason. Some key informants declared that they can be easily talked into unprotected sex, especially if they feel a strong urge for sex. Transactional sex is very common and seems to follow a different logic than traditional sex work. A man who pays for sex today may be a man who gets paid for sex tomorrow. The transactional direction seems to depend on who has the stronger sex drive on this particular day. The one with a stronger sex drive may then be more easily convinced to go bareback. On the other hand, there is the perception that the man who is paid has a weak bargaining power when it comes to safer sex.

Health seeking behaviors: Due to the large extent of inconsistent condom use, STIs are relatively common. As much as possible, these tend to be self-managed among MSM considering the extent of stigma and discrimination of MSM in the Ghanaian society, including healthcare personnel. Some of the STIs can be treated free of charge under NHIS coverage, others require partly significant out of pocket payments (e.g. warts).

Targeting MSM with STI/HIV projects: Community mobilization is primarily done using the snowball principle. Social media are among the most appropriate channels for IEC, such as Facebook, Grindr ("the largest gay social network"), Badoo, WhatsApp, and group chats. A main challenge for effective reach of MSM is their mobility. Especially the younger MSM do not tend to work and engage in a very flexible lifestyle that yields the maximum fun. Therefore they may change their locations frequently. Therefore, most efforts (60%), according to the key informants, should be directed to electronic media, while 40% should consist of interpersonal communication.

Challenges

- No HIV/STI projects targeting MSM in place in Koforidua, thus no subsidized condoms and lubricant available either
- High level of stigma and discrimination among healthcare workers posing a barrier to healthcare services
- High level of stigma and discrimination among police officers resulting in human rights violations of MSM
- High level of stigma among MSM leading to reduced emphasis on condom use

- High MSM mobility making sustained interpersonal approaches more difficult
- Common promiscuity coupled with low condom use

Recommendations

- GAC to implement MSM project in Koforidua asap
- Provide drop-in center
- Implement anti stigma and discrimination activities targeting healthcare personnel and police officers

Key informants	Telephone
5 MSM, names and telephone numbers are known at the level of the CCM Secretariat but are withheld in this report to avoid further stigma and discrimination of the key informants	

4.11 Debriefing with the Regional Health Director and her team

Dr. Charity Sarpong, Regional Health Director of the Eastern Region, and her team received the CCM team for a comprehensive debriefing session and constructive discussion. The CCM team presented their main findings as elaborated in this report. Dr. Sarpong agreed on the need to especially reinforce the following activities:

- Intensified collaboration between prisons and RHD/GHS
- Train more nurses and doctors on stigma and discrimination related to MSM
- Ensure that sufficient funds are available to healthcare facilities for follow-up visits, contact investigation and contact tracing
- Ensure maintenance of vehicles
- Improve records keeping and documentation at facility level
- Provision of computers at district and facility level for effective data capturing and enhanced emphasis on consumption data capturing

Name	Job Title	Contact
Dr. Charity Sarpong	Director, RHD	020-8140751
Dr. Albert Antobre Boateng	Dep. Director Public Health	020-8133359
Dr. Emmanuel Amoah	Dep. Director Clinical Care	020-6301142
Micah Asare-Bediako	Regional Administrator	024-3132755
Angela Quaye	Regional TB Coordinator	
Stanley ???	National TB Control Programme	

4.12 Visit of the Eastern Regional Medical Stores Koforidua

Obtaining programme medication and test kits: Compared to other RMS, the Koforidua Regional Medical Stores are rather spacious. The Eastern Regional Medical Stores obtain its supplies of HIV; TB and malaria medicines through the IHS scheduled delivery system. As per the schedule on a quarterly basis, the RMS generates orders and submits to the Procurement and Supply unit of the Ministry of Health. The generated order is based mainly on the distribution pattern of the RMS since not all facilities within the region submit their monthly returns or consumption data. The RMS indicated that orders placed for ARVs, TB and Malaria medicines were supplied to a very large extent. Test kits (HIV and Malaria) are however allocated to the regions by the regional biomedical scientist and thus not necessarily supplied based on their requisitions. Rationing is particularly common with Oraquick. In the past the Eastern RMS did not always receive the HIV test kits quantities ordered. However, for the recent Know Your Status campaign, NACP helped out with additional quantities.

Obtaining lab commodities: Orders of lab commodities are not placed by the RMS but by the regional biomedical scientist (based at the Regional Hospital) in collaboration with the regional HIV and TB coordinators. In case of a stock out, the regional biomedical scientist is informed, however, the region will have to wait for the next delivery.

Distributing supplies to healthcare facilities: Currently the RMS does not deliver commodities to the facilities. Facilities within the region are expected to place requisitions and collect their commodities from the RMS. However, the region is mapping out plans and strategies and stakeholder consultations are ongoing to pilot scheduled delivery to some selected facilities and hard to reach districts/facilities within the region from June onwards. Considering especially the hard to reach areas, it is planned to deposit the commodities at

district level, so the facilities will collect them from there. A delivery van, financed by the Global Fund, is available for these intraregional scheduled deliveries.

Collection of consumption data: Whenever the healthcare facilities collect their commodities, they are expected to hand in their report on consumption data. However, some facilities present excuses repeatedly. The RMS will supply them anyhow considering the ethical dilemma that otherwise patients would not receive their much needed medication. The RMS indicated that although there are 20 ART centers within the region, on the average only about eight sites submit reports on a monthly basis. The aggregated reports sent to the central level are thus incomplete as they contain only those data reported. Some of the reasons attributed to non-reporting include:

- Pharmacists are expected to submit HIV logistics reports to the RMS although most of them do not manage ART sites.
- Lack of adequate human resource capacity at facilities such that staff providing services are overworked and can't keep pace with recording data as well.
- The tools for capturing data are too many, thus becomes too laborious if a single person has to enter data. Tools thus need to be harmonized.

The issue of non-reporting has been discussed with Gifty Tetebo, the acting regional HIV coordinator, however, no solution could be identified up to date.

HIV stock status: On the day of visit the RMS had

- Most Efavirenz based first line adult ARVs: available.
- Lamivudine 50mg+Zidovudine300mg +Nevirapine200mg and Nevirapine 200mg tablets: stock out (= key ingredients of HIV adult first line regimen)
- Lopinavir + Ritonavir Tablet, 200 mg +50 mg: stockout (key ingredient of second line regimen)
- Atazanavir + Ritonavir, 300mg+100mg: available (=alternate regimen). Facilities which are stocked out of adult Lopinavir could benefit from Atazanavir until stocks are replenished with the next cycle of distribution expected in the second week of May.
- First line pediatric ARVs: adequately stocked.
- HIV test kits First Response: stock out (used for HIV screening). Healthcare facilities did have stocks
- HIV test kits Oraquick: critically low stocks (used for confirmation tests).

The shortage of HIV test kits at the RMS was attributed to increase in consumption as a result of the Know Your Status campaign which was carried out in March during the Kwahu Easter festivities. The region expects to take delivery of commodities from the central level in the second week of May.

TB stock status: There were stocks of TB Cat1&III, Cat II used for adult TB treatment. TB pediatric kits were largely available with the exception of kits for the age band 21-30kg

which was stocked out. MDR-TB medication was only available for clients already on treatment.

Malaria stock status:

- Stock outs of Arthemeter Lumefantrine 20/120mg for the age groups 3-8years,(12s) < 3years(6s) and adult ALs (24s). Stocks of Arthemeter Lumefantrine 20/120mg (18s) were largely available and can be used to treat any of the age/weight bands.
- All the age bands of Artesunate-Amodiaquine were available with the exception Artesunate-Amodiaquine 6-13years which was stocked out.

The acting RMS manager explained that most of the stocked out commodities had short shelf lives. The RMS had thus devised a strategy to push these commodities to the facilities so that they can be utilized before they expire somewhere in July.

- Although there were stocks of SP for IPT, the RMS indicated that they have been allocated to facilities who are yet to come in for their stocks.

Inventory control procedures: The RMS makes use of inventory control cards to manage its stocks. These cards are updated as and when issues are made to the facilities.

Storage conditions: On the day of visit the air condition in the ARV and TB medicines stores had broken down thus affecting optimum storage conditions for these commodities. The RMS explained that they were in the process of getting it repaired and in fact someone had been to the facility the previous day to have a look at it.

Challenges

- Stock out of HIV test kits, Niverapine and Isoniazid
- Non-submission of consumption reports by certain facilities
- Consumption data for malaria commodities not available
- No clear cut protocols for commodities distribution

Recommendations

- Establish effective reporting mechanisms at the facility level
- Regular monitoring and supportive supervision to ART sites to reinforce knowledge and skills in logistics management, understand their challenges and together agree on the way forward with respect to monthly reporting of consumption data.
- Consider task shifting where other cadre of staff are trained to be able to collect and report on needed data
- Thermometers shall be placed at various locations in warehouses to monitor the temperature
- Install ceiling fans or extra air condition to be used as alternate measures to ensure correct storage conditions at all times
- Consider an air-condition service plan which will maintain them in good condition and hopefully avoid a total breakdown of equipment.

Key informants	Job Title	Contact
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Frank Osafo-Takyi	Global Fund Regional Logistics Support Officer	024-4616635
Samuel Boachie	Accountant	024-9842935

4.13 Visit to Nsawam Government Hospital

On the way back to Accra, the CCM team stopped in Nsawam to meet the Acting NAP+ president and HIV support group members at the Government Hospital. The team visited first the ART clinic. The nurse explained that she is the only one taking care of the numerous ART clients. There is one 5 hour clinic day per week, during which she receives about 100 clients, resulting in an average of 3 minutes consultation time per client. She pointed out that since no EID reagents were available at the Eastern Regional Hospital lab in Koforidua, they had stopped taking samples in January 2016.

On the day of visit, the nurse in charge indicated that the ART clinic was short of First Response and Oraquick test kits; however, they were available at the laboratory and PMTCT centers. The Model of Hope also indicated that test kits challenges are affecting the Know Your Status campaigns expected to be embarked upon within the communities.

Majority of the patients seen at the clinic are on Efavirenz based formulations which was largely available on the day of visit. There was however a stock out of Nevirapine tablets.

The team also met a woman living with HIV who takes care of three orphans who lost their parents due to AIDS. She pointed out that she raises these children entirely on her own means as there is no support available.

The team then met with 22 PLHIV who are all members of the local support group. They meet usually once a month in a room provided by the hospital to discuss striking issues around the life with HIV, such as stigma and disclosure and adherence to medications. Although the monthly meetings are fairly attended by PLHIV, not all members are able to participate due to financial constraints. The situation has become difficult, especially for the poorest, when the nutritional support was discontinued in 2007. The group has limited support to teach its members revenue generating activities, such as raising bees and rabbits and growing mushrooms, mangos or oranges. The members confirmed their satisfaction

with the treatment at the Government Hospital. According to them, there are no major challenges. One aspect that they would like to see improved is procedures for obtaining their ARVs. Currently, they need to carry their HIV patient folder to the pharmacy – other hospital patients may recognize those as being HIV patient folders and report the status of the person concerned to others.

Challenges

- Very short consultation time per person on clinic days (3 minutes)
- EID samples have not been taken since January due to non-availability of reagents
- No support available for those raising orphans

Recommendations

- Review concept of clinic days
- Inform facilities on procedures in cases of non-availability of certain tests
- CCM to inquire about support available for orphans related to AIDS

Key informants	**Job Title**	**Contact**
Charles Tetteh	Act. NAP+ Regional Chairman MoH at Government hospital Nsawam	024-2714698 020-8729720
Cecilia Paddy	Nurse in charge of ART clinic	
Caroline Annor	Nurse in charge of TB clinic	
Joyce Barbarin	HIV data manager	
22 PLHIV	Members of PLHIV support group	