MINUTES OF HIV/TB DASHBOARD REVIEW MEETING

27th February 2019, at the CCM Secretariat

Attendance

No.	Name	Organization	Sector
1.	Abdul-Rahman Osuman	NACP	PR / Government
2.	Dr. Nyonuku Akosua Baddoo	NACP	PR / Government
3.	Kwami Afutu	NTP	PR / Government
4.	Henry Brown	NTP	PR / Government
5.	Kofi Diaba	WAPCAS	PR / NGO
6.	Eric Adu	WAPCAS	PR / NGO
7	Edward Adade	WAPCAS	PR/NGO
8.	Nabil Alsoufi	USAID	Co-opted member
9	Ernest Ortsin	GHANET	NGO
10.	Evans Opata	Coalition of NGOs in Mal.	NGO
11.	Mac-Darling Cobbinah	CEPEHRG	KAP
12.	Edith Andrews Annan	WHO	Co-opted
13.	Annekatrin El Oumrany	CCM Secretariat	CCM
14	Benjamin Spears N. Cheabu	CCM Secretariat	CCM

Excused

No.	Name	Organization	Sector	Reason
1	Damaris Forson	GHSC-PSM	Co-opted member	Excused
2	Genevieve Dorbayi	TB Voice	PLWD	Excused
3	Cecilia Senoo	SWAA	W&Cig	Excused
4	Jonathan Tetteh-Kwao	NAP+		

1. Opening:

The meeting started at 10: 04 am and chaired by Mr. Evans Opata

a) Conflict of Interest (CoI) declaration

The Chairman of the OC provided information on Conflict of Interest and requested members to declare any CoI given the agenda of the meeting. Members were also reminded to declare any conflict of interest during proceedings if the need arose. Mac Darling Cobbinah indicated a potential CoI in relation to the review of the WAPCAS dashboard. The OC decided to address the CoI as and when it materializes.

b) Updates from PEPFAR MoU

The Chairman invited Mr. Nabil Alsoufi to provide a brief understanding of the PEPFAR MoU. He explained that the PEPFAR MoU with the Government of Ghana signed in 2016 was $23.5 million to support Ghana with commodities as the treat all policy was adopted given the anticipated rise in clients needing treatment over three years. Of this amount GoG accessed $4.2m on signing then MoU. Subsequently, GoG had financial and programmatic obligations to fulfil. Ghana had achieved most programmatic expectations. However, the anticipated increase in the number of patients needing ARVs did not materialize. This meant the need to support commodities cost with MOU funds was not there. In addition, the core intent of the MOU was accelerate progress towards the 90/90/90 by scaling up the number of people on treatment. Because such acceleration did not materialize, the funds were reallocated to other countries with clear path to epidemic control.

2. NACP Dash Board:

a) Follow up

As follow up to matters arising from Quarter 3 review of dashboards, the following responses were provided by the NACP on progress thus far:

I. **Disparities in GAR PMTCT data:** Strategic Information Team (SIT) currently on the field to solve the problem holistically since 2nd February 2019. Focus is on all NACP data and not only PMTCT and also matching source data with DHIMS data. The OC recommended a review of validation rules on DHIMS 2 to be able to avoid potential errors. Similarly, it was recommended that a standard reporting which would include basic analysis and color codes be developed; this is anticipated to assist district and

regional disease control officers with the analysis of their data for timely follow up of low performing health facilities

II. **Lack of HTS registers in the facilities:** 8,235 copies of the HTS register were procured in 2018. Processes towards the procurement of a similar quantity in 2019 has commenced.

III. **Involvement of private facilities in trainings:** In the interim some private facilities have reached out for the NACP on-site trainings. Private facilities are yet to be written to as an organization to ask about interested private facilities who may be interested in providing HIV care. Once this is done, the NACP will include all those who expressed interest and accepted in all NACP programmes.

IV. **NHIS uptake of HIV services:** This is being discussed at the level of DG and Minister of Health. UNAIDS also advocated for it especially the labs. The discussion is therefore beyond the remits of the NACP.

V. **Acceleration plan:** With the abrogation of the PEPFAR MoU, the NACP is repositioning itself to fill the gap through the reprogramming activities.

VI. **DSD:** DSD seeks to improve the cascade of treatment and management of HIV clients (incl. task sharing, etc) 10 facilities were done in GAR in December 2018. Currently been rolled out in four facilities in each region of the four regions (GAR, AR, BAR and ER) with funding from UNICEF. Selection of regions was based on high burden regions and facilities that are not covered by EQUIP. There are also plans to roll out self-testing for HIV. HIV ST will be rolled out after guidelines revision and dissemination and passing of LI on the GAC act by parliament.

VII. **Implementation of IPT for TB:** Included in the DSD and working in collaboration with the NTP. NTP is leading the roll-out of IPT in one facility in all 10 regions so training has been done in those selected facilities for this and Isoniazid has also been procured for use. This will then be gradually scaled-up. Meanwhile, NACP is continuing with IPT orientation at ART sites.

VIII. **Viral load sample referral:** All regions except for Northern and Western Regions have been trained for VL sample referral. Trainings for the Northern and Western regions will be done pending approval from reprogramming

IX. **High EID positivity rate in central region**: NACP aware of the problem and strategies in place to mitigate by increasing ART sites with support from UNICEF. The shift in HIV regimen will also improve suppression rates provided clients adhere to treatment.

b) Financial Management Indicators: Separate expenditures and commodities

Indicator	Observation	Answer / Decision
Absorption rate	Cum 76% compared to Q3 63%	

	Q4 52% compared to Q3 48%	
Disbursement	77%	
Absorption rate per intervention **MoH 81% cum** **NACP 69% cum** **= 94% of budget**	I. Treatment, care and support (33% of budget) with 37% burn rate II. NACP (63% of budget) with 62% burn rate) III. Prog. Mangt (cum 46% burn rate)	
PSM	Expenditure:	

c) Commitment, Management, and Compliance Indicators:

Indicator	**Observation**	**Answer / Decision**
Availability of commodities	Status of GoG procurement?	A procurement request for ARVs estimated to cost $7,959,766.25 was sent to the MoH in January and currently undergoing administrative processes at MoH. Regarding activating a Certificate of Urgency, it is the Minister of Health who takes the decision and carries it out.
	Shortage of Condoms at the regions but high: BAR/CR/GAR/UE/WR	Even though desirable levels are available in-country, they have been placed in quarantine pending testing and clearance by FDA which usually takes several months. Until this is obtained, they cannot be distributed to the Regions

Commitments	PSM –	In Q4 of 2018, NACP had no commitments. So expenditures were actual and reported as such.
Management		
Compliance		

d) Programmatic Indicators:

Indicator (Q4)	**Observation**	**Answer / Decision**
# on ART ↑ **+1%**	Q4 70% compared to Q3 71% Actuals: Q3= 104, 901 Q4= 113,171 113,171 on treatment (Dec 2018) Enrolled Q4 8270. Is this the net increase?	To achieve the target of number on ART, DSD will improve this figure and it also includes a budget for communication to enable health staff reach to ART patients to retain them in care and to follow clients up on phone. Look at data more closely for accurate reporting and the possibility of using facility internally generated funds to enhance communication. Yes, it is the net increase meaning attrition has been taken out. Attrition is calculated as the sum of all the deaths, LTFU, stopped medicine
ART pregnant women ↑ **+5%**	Q4 83% compared to Q3 78% Actuals: Q3= 8,102 Q4= 11,236 Q4 alone enrolled 99%	Figures were low in CR because they do not have enough ART sites . For this reason, UNICEF is supporting NACP and the Central Region to deal with this by training 16 more PMTCT sites to provide ART in March 2019. DSD has a component for peculiar attention to data and initiating action on data issues.

	13,550 tested HIV+, 11,236 on treatment [missed 17% (2314)] Central region @ 51% NR/UWR ~ 70% What is the way forward? Which facilities are the biggest contributors?	It is possible that these women were lost during referral from PMTCT sites that do not provide ART services. Decentralizing ART and strengthening those facilities providing ART is the way forward so that we have improved data to show better what has been Teaching hospitals and high volume sites like regional hospitals, Atua Government Hospital, Tema General Hospital are the biggest contributors achieved.
Preg. With HIV status result ↑ **+1%**	Q4 81% compared to Q3 80% Actuals: Q3= 638,337 Q4= 867,263 ANC registrants: 92%	

# HIV risk infants < 2 months old tested (EID) ↑ **+6%**	Cum Q4 70% compared to Q3 64% Q4 alone 92% UWR: @ 10%?? Availability of machine? AR:@49% NR@31% CR @47% Any best lessons from GAR & UER??? EID least performing [Sept -Nov] (testing): GAR/NR/ AR as compared to the expected number of new borns EID highest positivity rate: CR/NR	NR: the big size of region is an influence which has affected supervision and data challenges. AR/NR: Sample referral system yet to be functional UWR: machine yet to be installed. The UWR is currently waiting for the service provider (Roche) to ship down the preventive maintenance kits installation. The Wa Regional Hospital has expressed readiness to receive the machine. All data issues taken up with the team currently on monitoring. GAR and UER are catching up on their samples which had been taken but not worked on so were not reported. With the sample referral plan, GAR has greatly improved. Leadership structures in UER are supportive of HIV care which reflects in their data as they catch-up. This is being closely monitored and have asked our service providers to check the data. The recent monitoring done by SI team is also looking at these challenges.
# 15+ tested and with known HIV status	Cum Q4 65% compared to Q3 62% Q4 alone =72%	

↑ **+3%**	Non pregnant population: improved 247 318 compared to Q3 172 153	
On ART, undetectable viral load at 12 months (VL suppression) ↑ **+3%**	Q4 83% compared to Q3 80% Good improvement of results. What accounted for the success? Samples in waiting @ WR,VR and KBTH? Lowest testing coverage: NR/WR /VR Least VL suppression: NR/VR/CCTH	The sample referral has contributed to this success. Currently, the machines at Ho and Takoradi are down and the engineer is working around the clock to resolve them but in the meantime we are moving samples around to ensure continuity of service. For example we moved 442 viral load samples from Ho to Korle Bu two weeks ago for testing and 117 EID were sent from Ho to KATH for testing. Over 500 VL samples were moved from Tarkoradi early February to Korle Bu for testing. Viral suppression is dependent on adherence to medication, with the implementation of DSD, facilities will pay closer attention to their clients to improve upon suppression.
Enrolled in HIV care/Tx screened for TB (TB screening) ↓ **-207%**	Q4 66% compared to Q3 267% What clear steps have been taken to engage prescribers to deal with documentation?	At the review meeting, prescribers were sensitized on the need to document properly. Feedback report sent every month also reminds prescribers about gaps in the data.

e) Challenges expected within next 6 months:

I. Given that some activities (e.g. DSD) is included in the reprogramming budget, a delay in approval will affect roll out of activities and results.
II. E tracker roll out and functionality

f) Recommendations:

I. Even though the NACP has submitted HTC validation rules to the PPME and the EID summary form currently worked on by the PPME, the NACP should follow up to ensure that the March 2019 deadline is realized without any delay.
II. The NACP and PPME should encourage regional and district data analysis for decision making by including basic analysis and color codes to assist district and regional disease control officers analyze data for timely follow up of low performing health facilities
III. NACP to include private facilities currently providing HIV care in the DSD orientations
IV. NACP to involve partners like KPs, EQUIP in deciding on the protocol for HIV self-testing.
V. NACP to learn from other best practices and research findings especially on the need for counselling to enhance the Ghana model of HIV self-testing
VI. NACP should write to the CCM Secretariat on progress thus far on procurement of ARVs specifying what support might be needed to fast track the process.

3. NTP Dash Board

a) Follow ups

As follow up to matters arising from Quarter 3 review of dashboards, the following responses were provided by the NTP on progress thus far:

I. **Updates on e-tracker:** All within the remit of RSSH.TB uses the online e-tracker in 113 facilities. Plan to cover additional 103 districts. The PPME has the tablets and awaiting funding to roll out. Anticipated fully functional e-tracker by Jan 2021 when e-tracker data are automatically copied into DHIMS 2.

II. **Short term MDR-TB treatment schedule – zonal reorientation and actual start? Way forward until then?** Refresher training ongoing but short-term treatment available in all 10 regions. Last training with a WHO consultant among clinicians in all 10 regions. This was based on the new WHO treatment guideline. This informs the use of Bedaquillin.

III. Status of NTP sample referral system: Difficulty to incorporate into the current NACP model given the differences in coverage and end points for testing. The decision is to enhance already region-specific TB referral system. The OC recommended a more centralized referral system.

IV. **Review counselling skills at DOTS (~ 2000 DOT facilities) for TB and HIV:** Currently been done by the NACP. NTP has no self-plan to implement.

V. **NHIS:** The NHIA and GHS has agreed to enroll all TB patients free of charge starting January 2019 and existing MDR and pre-XDR - TB. Region as expected to provide the NHIA periodically.

b) Financial Indicators:

Indicator	Observation	Answer / Decision
Absorption rate	Disbursed 87% (target 90%) Expensed 44% (target 90%)	
PSM cost		

c) Commitment, Management, and Compliance Indicators:

Indicator	Observation	Answer / Decision
Availability of commodities	Months of stock TB Cat I + III patient Kit A: 4.6 Sputum containers: 5.0 GeneXpert Cartridges: 10.5 Moxifloxacin 400mg: 2.9	
Commitments		
Management		

Compliance		

d) **Programmatic Indicators:**

Indicator	Observation	Answer / Decision
# notified cases of all forms of TB	Cum: 65% Low performers: AR 54%/ VR 56%	Expected to improve with especially for Volta region data quality. Program suspects apathy in the Ashanti region. Performance contracts with medical superintendents which include TB as an indicator. This is expected to improve the situation
Treatment success rate for TB pat. With confirmed bacteriology	88% GAR: 43%??	Suspects that GAR is underreporting.
# of confirmed RR/MDR-TB notified	92%	
# RR/MDR-TB who started treatment	48% Target 50 // actual 24	Can be attributed in delay in baseline tests.
# HIV+/TB pat, given ART during	37 %: target 574/ actual 211	Recording in DHIMS. A team in each region currently to validate the data.

TB treatment		
# TB pat. With known HIV status	91%: target 3346/actual 3031	
Treatment success rate for RR/MDR TB	97% target 62/actual 60 Where lies the 3%? Region?	
Units reporting no stock out	100%	
Notified TB cases from non-NTP providers	No data	
# HTS	74% but why is the target = 4743 and not real number of clients notified? Regional data	
# ART	23% 216 out of 948– source for the target? Lowest result since BG NFM1 Regional data	Purely DHIMS data. Hard copy data. Previous data = hard copy based. TB = last disease to shift to DHIMS reporting. For other indicators gap between DHIMS and hard copy reporting decreased from 29 to 5%

RR/MDR TB treatment success rate	0%. Target 66.8%. How is this measured?	

e) Challenges expected in next 6 months:

- Quarterly disbursement of funds from Global Fund not ideal for program activities

f) Recommendations:

- NTP and PPME should liaise in reviewing validation rules to enhance data capture. It is also recommended that an automated report with color codes for analysis be provided for district and regional TB coordinators; this is intended to support them in identifying low performing facilities and to initiate timely action.
- National Sample referral system rather than region specific.
- Review HIV counselling skills at DOT centers to enhance treatment uptake
- Follow up on implementation of NHIA package for TB clients.
- NTP to inform health facilities in writing on the modifications in the NHIA package.
- NTP will correct previous quarter data in all subsequent dashboards

4. WAPCAS Dash Board

a) Follow up:

- **Survey of lab/reagent availability in target areas** Reagents related to ART initiation for positive cases and the issues have been resolved in most of the regions. GAR not fully resolved.
- **Condom procurement**: Condom procurement put on hold because the Family Health division of the GHS had assured the Global Fund of consistent supply hence no need for WAPCAS to procure independently. And have 6 months of condom stock.
- **Social Accountability Monitoring Committees**: Plans on-going to kick-start activities of Social Accountability Monitoring Committees (SAMCs).

b) Financial Indicators:

Indicator	Observation	Answer / Decision
Absorption rate	67% Low burn rate for Q 4	Unimplemented activities: Low burn rate in quarter 4 is attributed to delay in IBBS, scale up of stigma and discrimination in EQUIP facilities and funds for condoms not utilized. 1. IBBSS delayed due to delay in obtaining clearance from GAC. Clearance obtained now, Scientific Advisory Committee in place and consultant secured 2. An amount of $282k was ringfenced to expand the stigma and discrimination training and its intervention in additional 8 EQUIP facilities. Approval was received in October, 2018 however the organization implementing the first 7 had not finished so activities could not begin. 3. An amount of $222k was ringfenced for purchase of condoms, however the Ghana Health Service assured the PR and CT that they had condoms with the FDA and was going to supply us which they did.
SRs	MSM: 77% FSW: 70% HFFG 56% (low burn rate)	Low HFFG burn rate: HFFG is the SR implementing the CSS intervention, their low burn rate is mainly as a result of late start of activities due to late approval of the intervention. It was planned that activities were to start in April

		but had approval in September and activities started in October.
PSM		

c) Commitment, Management, and Compliance Indicators:

Indicator	Observation	Answer / Decision
Availability of commodities	No stock outs for condoms, lubricated gel and HIV test kits	Had low stocks as at December 31, 2018. In February they have 6 months of stock of condoms, and 3 months of stock for lubricated gel and 3 months of stock for test kits What is the way forward particularly for the gel? PR is in discussion with CT to ensure constant supply throughout the year.
Commitments		No commitments
Management		None indicated
Compliance		None indicated

d) Programmatic Indicators:

Indicator	Observation	Answer / Decision
MSM linked to care (CEPHERG)	67% Target 248/ actual 166	The miss in target can be attributed to stigma and cost of laboratory tests. However, with the implementation of the human rights intervention, we expect a positive impact on the KP intervention.

FSWs linked to care	91% WAPCAS (93): target 240 / actual 224 Pro Link (82) target 78 / actual 64	Female patronage higher compared to males
MSM prevention package CEPHERG	102% Target 1748/ actual 1784	
FSW prevention package WAPCAS/Pro – Link	116%	
MSM HTS **(CEPHERG)**	135% Target 1573/ actual 2129	
No. notified cases of all forms of TB	3%	CSS intervention started in Q4 with the training of 28 TB champions. 534 persons were screened and 37 were referred for confirmatory test; 3 turned positive
FSW HTS WAPCAS Pro – Link	136%	

g) Challenges expected in next 6 months:

- In spite of the roll of the human rights component for KPs and efforts in engaging the Ghana Police Service on the human rights of KPs, we still expect some abuses since the human rights component is at its nascent stages.

h) **Recommendations:** None indicated

5. Closing

The meeting came to a close at 4:20pm