MINUTES OF HIV/TB DASHBOARD REVIEW MEETING

August 24th, 2018 at the CCM Secretariat

Attendance:

No.	Name	Organization	Sector
1	Annekatrin El Oumrany	CCM Secretariat	CCM
2	Kenneth Danso	NACP	PR / Government
3	James Nii Darko Saakwa-Mante	NACP	PR / Government
4	Ivy Okae	NACP	PR / Government
5	Marijanatu Abdulai	NACP	PR / Government
6	Kwami Afutu	NTP	PR / Government
7	Raymund Gockah	NTP	PR / Government
8	Comfort Asamoah-Adu	WAPCAS	PR / NGO
9	Kofi Diaba	WAPCAS	PR / NGO
10	Eric Adu	WAPCAS	PR / NGO
11	Damaris Forson	GHSC-PSM	Co-opted member
12	Nabil Alsoufi	USAID	Co-opted member
13	Ernest Ortsin	GHANET	NGO
14	Genevieve Dorbayi	TB Voice	PLWD
15	Cecilia Senoo	SWAA	W&Cig
16	Evans Opata	Coalition of NGOs in Malaria	NGO
17	Mac-Darling Cobbinah	CEPEHRG	KAP
18	Jonathan Tetteh-Kwao Teye	NAP+	Co-opted

Absence:

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

1. Opening:

The meeting started at about 9:20 am.

a) Conflict of interest declaration

Annekatrin El Oumrany asked the OC members if anyone has or expects conflict of interest. Mac-Darling Cobbinah replied "Possibly" in the context of him being the Executive Director of an SR organization. He was requested to point out any conflict of interest situations once they manifest but such a situation did not occur during the meeting.

b) Recommendations of the ECIC

Annekatrin El Oumrany informed the OC that the ECIC reviewed the OC membership in the light of possible conflict of interest. The ECIC will recommend to the CCM to maintain the OC members but to actively look

for alternatives for those OC members who are involved in GF supported program implementation activities. An interim observer status could be considered for newly proposed members as capacity building period before the current OC member hands over. OC members understood that these recommendations are still subject to CCM approval during the next meeting.

c) Way forward and election of the OC Chair

A quorum necessary for the election of the Chair for the HIV/TB OC was reached. Annekatrin El Oumrany reminded the OC members of the requirements and rules related to the OC Chair election as listed in the CCM framework documents. After clarifying which OC members are eligible and confirming their interest in serving as a Chair on the HIV/TB OC, the OC members agreed on Evans Opata to serve as their OC Chair.

d) Capacity building: RMU/PMU presentation

The OC members were displeased with Mr. Gyabaah's decision to postpone the RMU/PMU presentation. Considering that the RMU/PMU has important coordination responsibility in the MoH grant, it is crucial for the OC members to understand their role and functionality. The OC members agreed that a separate meeting shall be convened for this presentation in September as the next OC meeting will be in the end of November only.

e) Planning of site visits

The OC agreed that the next site visit shall be based on the regional results. Basically, all facilities visited showed great performance in ANC testing and ART enrollment and even EID. The next site visit shall hence be to less performing facilities. Annekatrin will contact the NACP for a facility based overview. WAPCAS listed their implementation sites (MSM: GAR, AR, BAR, CR (soon). FSW: AMA, Kumasi, Techiman, Sunyani, CC, Elmina, Koforidua). The OC decided to conduct a first site visit to a WAPCAS (not the SR ProLink since the team had visited their implementation sites repeatedly under NFM1) implementation site in GAR with the second one possibly combined with a site visit to a different region.

2. NACP Dash Board:

a) Follow up:

- **Site visit to CR (Awutu Bereku and Apam Hospital) and UER (Sirigu, Navrongo Memorial, Regional Hospital) in June/July 2018:**
    - Usually 100% HTS rate at ANC, close to 100% ART enrollment rates
    - Info on PMTCT, prophylaxis of baby and EID provided to pregnant women seems adequate. Most women deliver at the same facility. No systematic follow up for those women who deliver elsewhere.
    - Usually compliance during pregnancy but defaulting starts after mothers deliver (10-20% defaulter rate for EID, which is still way above the national average)
    - EID not always done in week after birth but after 6 weeks only (Sirigu, Reg. hosp.)

- EID test results take too long, usually 2-3 months, in Navrongo no result in 2018. Babies have died in the period between end of prophylaxis and receipt of the EID result. Solution needed.
- Problem in Bereku: women receive syrup for only one week. Risk of contaminated bottles used for refill and lots of efforts required for adherence.
- Provider initiated tested is largely not done (except CHAG in Sirigu). OPD staff at CHAG Apam was not informed about the guideline. HTS during labor seems to be done consistently.
- Huge need to enhance male testing / involvement in Apam: 80% of ART clients = female
- Missed opportunity if older children of HIV+ women are not systematically tested. Same: no testing at PNC
- No opportunity of safe disclosure to spouses. Example from regional hospital in VR should be promoted as best practice.
- Apam: no enrollment on treatment without test results (concerns primarily liver function test, all other tests done free of charge at the facility)
- Variety of reporting sheets used, CHAG uses its own registers. NACP: all should use the standard registers and reporting tools
- Review modes of delivery for CHAG facilities, usually not covered by LMD. NACP: CHAG facilities should be covered by LMD for HIV commodities. CR RMS confirmed that CHAG facilities are covered if they hand in a requisition in time.
- VL testing not systematically done (APAM), What is the situation for pregnant women: NACP: 6 months after initiation VL test due. VL test is initiated by the entity where the women receives her medication at this time.
- LMD problems in CR. Only carried out every 3-4 months. Impression that emergency orders are not possible. Affects commodity availability. CCM will follow up with the CR RMS for more information (info from CR RMS: frequency has increased to every other month. Review meeting on 4th Sep where all issues will be discussed. Site visit report shared with RMS for their info)
- Need of training acknowledged, partly offered by nurses/midwives. Sirigu: midwife was NACP trained and has the capacity but did not have training on the job in mind for other midwives.
- Quality of data collection: PMTCT data and data on reporting sheets do not match (reg hospital)
- Stable commodity situation in all facilities visited

- **E-tracker:** June close to 90,000 (appreciated by the OC as this was the August target). SOP developed. Some facilities don't adhere to protocol and carried out migration even for clients who have not come back. By end of year it will be clear if those clients are active or not.
- **PCR machines and VL referral plan:** VL machines all functional. MoH with Ghana Post signed. For HIV only. Stakeholder meeting in August. September start of pilot in GAR. In October roll out to rest of Ghana. Facilities need fridge for sample storage, sample tubes but not enough for all facilities. Start for referral planned for April, then delayed to E/06, now further delayed to October. NACP: harmonization between GHS and Ghana Post took time. OC recommendation to create demand through PLHIV
- **Procurement of PMTCT registers:** need to ask SSDM
- **OC member comment: Stigma prevents many mothers after delivery to continue treatment:** NACP: no resources for contact tracing, only Models of Hope in 4 regions in the past. WAPCAS should clarify the way forward under NFM2.

b) Financial Management Indicators:

Indicator	Observation	Answer / Decision
Absorption rate	66% spent (2% in Q1), catch up primarily through PPM	Not possible to catch up with all activities from Q1. No buffer in disbursement
Absorption rate per intervention/ implementor	Cum MoH and NACP = 70%, 4m for commodities outstanding but no commitments seen in DB NACP burn rate in Q2 95% What about RHD and Equip?	Commitments are treated as expenditures, same procedure in PU/DR. 9.9m spent under the MoH budget line includes orders that have not arrived (=commitments) Disbursement to RHD planned in Q3, Intent to disburse a more significant amount the regions can achieve more with. Discussion how regions can continue M&E without funds
GF disbursement		Disbursements sent for 3 months only, used to be 6 months. No buffer anymore. Planning is hence more difficult. The OC informed NACP that the PR can always request for additional funds, not just based on the QFR.
PSM	0 commitments	No commodities arrived, see above

c) Commitment, Management, and Compliance Indicators:

Indicator	Observation	Answer / Decision
PSM and availability of commodities	14/14 sites with stock out 34/34 product procurements past due Condoms (m): stock out in 5 regions, overstock in 2, 4.6 MoS at central level. Nothing ordered? Condoms (f) stock out in 4 regions, overstock in 3 Good: Redistributions seen in the stock level recommendations report Scheduled distribution is likely to address E/July shortages but how come we still get into these shortages, esp. VR?	TDF+3TC+NVP no fixed dose. Limited by shortage of NVP (2MoS) but stock came in July (8MoS_. No planned procurement for NVP in 2018. Recommendation to increase IHS cycle. RMS cannot take higher supplies. National SH meeting to address min-max

	Stock out and low stock of Nevirapine syrup and Zidovudine syrup everywhere incl. central level (0.16 and 0.24 MoS respectively). Arrival of shipment and distribution? **Expiries:** Estimated 4.8 MoS Atazanavir + Ritonavir, 300mg+100mg in November 2018 at KATH. WR: 6.23 MoS of Efavirenz 600mg expiring in Dec UWR: 26.53 MoS of Zidovudine + Lamivudine 300mg+150mg in Dec 1st response: KATH and WR 26 MoS Jan 19 Oraquick: CR, ER, WR, 14-33 MoH July-Sep 19	Stock arrived for ZDV, NVP dispersible used. NACP will review and address the situation
Commitments	PSM – MA4: Viral Load sample transportation – signed contracts	Responses are in PU-DR
	PSM–MA5: quantification and updates	
	Review of testing yield per pop, testing strategy and region on quarterly basis	
Management	Key positions vacant, add # of key positions	

d) Programmatic Indicators: please insert regional disaggregation for Q1

Indicator	Observation	Answer / Decision
ART pregnant women	79% (Q1: 81%) Reg performance low in CR, NR, UWR <60%, great in BAR, GAR, VR >90% Progress / road map to training add. 400 ANC facilities supposed to start in Q2	7400 HIV+ pregnant women identified. Low performers need particular attention. CR now has a substantive coordinator. Data challenges (lack of registers) persist

		Orientation started in June, resources can take care of 112 facilities only. Try to use close facilities for training on the job. Training finished
# on ART	104%. 13746 enrolled in 2018 (average 2017 per Q: 6250, PEPFAR target annual 26,000)	
HTS pregnant women	82% based on GF target or ANC results? Add # ANC registrants in comments. 139% in ER? GAR = low performer <50%	GF target, targets based on 4% of the population being pregnant 474,176 ANC registrants in Q1+2. 93% of them tested
EID	59%, Q1: 44%. Seems to be primarily due to backlogs in GAR; BAR and AR seem disappointing	National target in PF = 63%
HTS	65%. How many tested at OPD? annual OPD attendance = about 26m people. How many can we realistically to get tested at OPD?	Provider initiated testing (PIT) target 2.7 m per year, HTS result of non-pregnant pop = 415,809. Info to NACP that only one out of 5 facilities visited by OC implemented PIT. OC members complain that targeted population testing needs to be enhanced.
VL suppression	79% achievement = 63% VL suppression. Data based on what? Still inclusion of newly diagnosed?	Indicator based on VL test after 12 months. Result possibly contaminated by results of people on treatment for less than 12 months.
TB screening	284% still double counting? Q1+Q2: 30192 NEW ART clients screened but only 13746 enrolled?	e-tracker will give correct result. Recommendation to drop indicator until reliable results are available.

e) Challenges expected within next 6 months:

- Not asked

f) Recommendations:

- Address anticipated expiries timely, so that RMS and facilities can push the commodities out without pressure. Target: no threat of expiries within the next five months
- Scale up PIT as it does not seem to be implemented by a lot of facilities
- Identify solution for those babies whose EID result does not come timely
- Actively engage NAP+ to promote VL testing and EID and the new sample referral system
- Develop a system to engage spouses, possibly based on practice in Volta Reg. Hospital
- CCM to engage CHAG for enhanced integration of CHAG facilities into LMD

- CCM to follow up with CR RMS on mode of LMD
- CCM to follow up with SSDM on procurement of registers and other reporting forms

3. NTP Dash Board

a) Follow up:

- **Site visits:**
    - Usually clients referred to facility providing sputum tests, not the sample resulting in loss to follow up
    - Sample transport system in place for NACP but not for NTP. NTP: 20 GHC for about 5000 cases = envelop to send samples to diagnostic facility. No evaluation how this money was spent.
    - Systematic TB screening at ART facilities but not at ANC
    - Diagnostic guidelines not always known, prescribers request for microscopy, which is usually not questioned.
    - Best practice: TSO is amazing in Apam, use him to improve performance in other facilities. General: reward for outstanding performance possible?
    - No IEC materials
    - Documentation of contact tracing – NTP: all index cases and their contacts to be listed, not only those eligible for testing. Immediate household members to be covered. Definition: those who eat from the same plate. Working environment except teachers currently not covered
    - Inconsistent provision of contact tracing funds. NTP: Each region supposed to have contact tracing funds. Last disbursement in April.
    - Contact tracing: ideal if teams has sputum containers. NTP: no reason why contact tracing team should not have sputum containers
    - Order management great problem, linked to lack of training on the job
    - Apam GeneXpert: almost 100% increase in use between 2017 and 2018 but average still at 50 samples per month
- **Outcomes July stakeholder meeting, plans for 3.2m USD:**
    - Priorities: regional activities confirmed to enhance case finding
    - Movement of sputum samples, regional approach
    - Increase in commodities following the expected improved case finding rates
- **New MDR-TB treatment schedule without injections:**
    - New drugs require admission, higher risks for clients
    - Quantification revised for 2019
- **SOP Enablers package**
    - Afutu will follow up
- **TB Reach project**
    - Not much information but priority to work in private hospitals

b) Financial Indicators:

Indicator	Observation	Answer / Decision
Absorption rate	25% cum. 167% on Q2.	
Absorption rate per intervention/ implementor	NTP 79% (24% of budget) MoH 0% (71% of budget) Comment from May OC: Most procurement moved to Q3.	If commodities had arrived, absorption rate would have been 90%+
PSM cost	Expenditures for lab reagents, consumables, procurement agents not listed. Add the commitments. No PSM cost?	Local warehousing and distribution paid by malaria grant NTP will follow up on past expenditures for lab reagents, consumables and possibly correct DB

c) Commitment, Management, and Compliance Indicators:

Indicator	Observation	Answer / Decision
Availability of commodities	No data in stock status reports? Stock levels seem fine. Risks of expiry?	All needed commodities available. Some deliveries in Nov/Dec for Cat I+III, 5% for pediatrics. Stock Ethambutol from Nigeria obtained. High stocks for GeneXpert cartridges: OC recommendation to stagger deliver No risk of expiries
Management	Review product procurement past due	

d) **Programmatic Indicators:**

Indicator	Observation	Answer / Decision
# notified cases all	69% = 3287 drastic drop vs. Q1 Q1 results reviewed? Exactly the same Do reg. targets make sense?	Same reasons as previously. More people screened, yield decreases. 75% of samples tested on GeneXpert. Quality issues being reviewed. Certain amount of double testing. 125 GeneXpert functional (2 in private facilities, excl. CHAG) Challenges to access DHIMS Calculated based on past performance
Success rate	75% achieved vs target of 86%, sharp drop from Q1. Low performer: NR 45%, others CR, GAR, VR	Reportage of 50% on this indicator. Purely DHIMS related. Follow up with regions. Consequences for facilities that do not report appropriately

	Provide regional data for Q1	
# RR/MDR-TB notified	124% = 57 cases. Q1 data not updated	
# RR/MDR-TB who started treatment	Why target = 46 and not 57 (those diagnosed)? Cum: 128 diagnosed but only 60 enrolled = 47% Q1 info that data not complete but was not completed now either	Transfer to shorter regimen 9-11 months. BG 2018 few facilities enrolled on longer regimen. 50 enrolled on shorter regimen. More lab and different tests for short regimen necessary. Capacity at facilities is built. Most are not MDR-TB resistant but rifampicin resistant. Lots of people waiting to be enrolled but some also died. Since training in Sep regimen has changed. OC: Plan needed when regimens change to ensure that commodities in stock available are fully used
# notified cases bacteriological	No target, regional disaggregation?	
# DST	79% Target should be number of previously treated clients	
# Labs EQA	0% Why no data if measured semesterly?	
# HTS	87% Clients enrolled Q2: 3287 vs. 4127 tested??? Why is the target not the actual number of clients? Reg. disaggregation?	
# ART	25% Use HIV+ client as target. Reg. disaggregation?	
# non NTP providers	7% STBP only contributed 26 clients? Used to be several hundred	From private hospitals only, not STBP

# district hospitals with no stock out	100%	
RR/MDR TB treatment success rate	55% How is this measured?	

e) Challenges expected in next 6 months:

- System is improving, incl. PMU/RMU

f) Recommendations:

- NTP to develop functional sputum sample referral and reduce extent of patient referral
- NTP to enhance facility based awareness of screening and diagnostic guidelines
- NTP to provide monitoring checklist to OC
- NTP to provide information on status quo of the enablers package
- NTP to promote on the job training
- NTP to consider involving OC members in monitoring missions, share monitoring timelines
- NTP to allow enhanced CSO contribution
- CCM to follow up with CR on functioning of LMD

4. WAPCAS Dash Board

a) Follow up:

- **Survey of lab/reagent availability in target areas**: Finalized, report will be shared
- **Condom procurement**: no local procurement. Condoms were released in July.
- **Models of Hope status quo**: was approved for 108 facilities and 216 MoH (33 districts). Initially 15 districts (GAR, AR, CR, BAR, NR) in 2018. +18 districts year 2 based on assessment of results
- **CSS status quo**: final version submitted. Forecast approved.

b) Financial Indicators:

Indicator	Observation	Answer / Decision
Absorption rate	36% (Q1: 81%)	IBBSS implementation has not started. Delay in approval from Natl Coordination Body. Approved in June. MoU finalized for signing. Next Monday advert published. CSS did not start in Q2. Budget includes CSS budget. Without IBBSS and CSS burn rate would have been 81%

c) Commitment, Management, and Compliance Indicators:

Indicator	Observation	Answer / Decision
Availability of commodities	No condoms No lubricant	Condoms released in July CEPEHRG got directly from GAC, WAPCAS is going to get 5000 units. Looking at procurement using savings to avoid stock out, approved by GF
Commitments	1 commitment: monthly capacity assessments	
Management	Sites with stock out: Number of sites must be >0	

d) Programmatic Indicators:

Indicator	Observation	Answer / Decision
MSM linked to care	87%	
FSWs linked to care	91%	
MSM prevention package	163%	
FSW prevention package	123%	
MSM HTS	131%	
FSW HTS	169%	

e) Challenges expected in next 6 months:

f) Recommendations:

5. Cross cutting recommendation

At least once per year PM needs to be present in OC meeting.

6. Closing

The meeting came to a close at about 3:30 pm.