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

**August 24th, 2016 at the CCM Secretariat**

**Attendance:**

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| **No.** | **Name** | **Organization** | **Sector** |
| 1 | Annekatrin El Oumrany | CCM Secretariat | CCM |
| 2 | Kenneth Danso | NACP | PR / Government |
| 3 | James Nii Darko Saakwa-Mante | NACP | PR / Government |
| 4 | Jenevieve Klu | NACP | PR / Government |
| 5 | Kwami Afutu | NTP | PR / Government |
| 6 | Nii Nortey Hansen Nortey | NTP | PR / Government |
| 7 | Franziska Zigah | NTP | PR / Government |
| 8 | Fauzia Masaudu | GAC | PR / Government |
| 9 | Cynthia Adobea Asante | GAC | PR / Government |
| 10 | Daniel Kpogo | GAC | PR / Government |
| 11 | Raphael Sackitey | GAC | PR / Government |
| 12 | Emmanuel Blankson | GAC | PR / Government |
| 13 | Lawal A. Alhassan | PPAG | PR / NGO |
| 14 | Twumasi Ankrah | PPAG | PR / NGO |
| 15 | Anne-Marie Godwyll | PPAG | PR / NGO |
| 16 | Patricia Agyei | ADRA | NGO |
| 17 | Jennifer Asare | ADRA | NGO |
| 18 | Benjamin Kwarteng | ADRA | NGO |
| 19 | Damaris Forson | GHSC-PSM | Co-opted member |
| 20 | Helen Odido | UNAIDS | Multilateral |
| 21 | Genevieve Dorbayi | TB Voice | PLWD |
| 22 | Cecilia Senoo | SWAA | W&Cig |
| 23 | Evans Opata | Coalition of NGOs in Malaria | NGO |
| 24 | Mac-Darling Cobbinah | CEPEHRG | KAP |

**Absence:**

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| **No.** | **Name** | **Organization** | **Sector** | **Reason** |
| 1 | Edith Andrews | WHO | Co-opted member |  |
| 2 | Jonathan Tetteh-Kwao Teye | Dream Weaver Organization | Co-opted member |  |
| 3 | Dr Felicia Owusu-Antwi | WHO | Multilateral | Mission |

1. **Opening:**

The meeting started at about 9:25am with an internal session for OC members only that lasted until 10:00am.

1. **Conflict of interest declaration**

Annekatrin El Oumrany asked the OC members if they had any conflict of interest in relation to the dashboard review or other items of the agenda. All declined. Annekatrin then gave an update on the changes in the oversight committee due to the potential conflict of interest of those members who have become directly involved in program implementation activities as a result of GAC SR/SSR and NMCP/NTP NGO contracting.

1. **Selection of a new chair**

Since Dr. Naa Ashiley Vanderpuye (previous chair of this OC) joined the malaria OC due to a potential conflict of interest, a new chair needs to be elected. A quorum was only reached after the internal session had already finished, i.e. during the actual dashboard review. The OC meeting ended at 6:15pm only so that the election of chair was postponed to the next meeting.

1. **Capacity building**

Upon the question if the OC members can think of any trainings that would enhance their understanding of the grants and/or oversight, Evans Opata declared that he had not participated in the previous PR dashboard training sessions and will thus require some introduction. It was agreed that he would contact Annekatrin El Oumrany for an individual training session.

1. **Tightened oversight**

Due to the non-availability of the PRs and the holiday season, it was not possible to engage in tightened oversight in the quarter before the OC meetings.

1. **GF contest / innovative CCM tools and methods**

The OC members, particularly those who have served on the CCM and possibly OC before, were asked if they could think of innovative tools and methods used at the CCM to enhance CCM performance that could be promoted in the respective GF contest. Cecilia Senoo mentioned that during the past year the OCs have had more voice than before. The management of conflict of interest is taken more seriously, issues are followed up more rigorously, which encourages members to point out challenges. It was also noted that CCM members feel taken more seriously, have their voices heard and consider the CCM meetings as much more relevant than previously. The OC members could however not think of particular innovative tools and methods that could be handed in to the GF contest.

1. **Others**

Additional agenda items, such as

* Overview on the HIV National Strategic Plan
* IBBSS FSW outcomes
* Overview on the most important ARVs and their acronyms
* Next site visits

Could not be discussed due to the last start of the meeting.

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

* Projection of your savings: current program savings: 9000 GHC + exchange savings: 44,600 USD. Plan: 12 laptops (11300 USD) and external drives for program officers. Considering that according to the dashboard, a higher amount seems to be unused (gap between cumulative budget and expenditures amounts to about 150,000 USD), PPAG is requested to review the situation.
* HIV related stigma: Advocacy sessions at regional and national level revealed that there is a similarly high level of stigma in other prisons. Strategy proposed by PPAG: intensify stigma education. Drama will focus more on stigma. Stigma is not only an issue among inmates but also among officers. While inmates during the site visit pointed out their desire to act as an ambassador, this approach involves risks. Inmates can also not be transported around easily for sessions at other prisons for security reasons. Also when their status becomes known, their security cannot be guaranteed. Proposal to start with a two phase ambassador approach: 1) external PLHIV as ambassador 2) HIV+ inmates as ambassador. The OC points out the success chances are best if stigma is given a human face.
* Distribution of pen drives with films on HIV to PEs: has to be dealt at higher prison level. Issue was raised, PPAG will follow up.
* Level of collaboration of PPAG zonal staff with models of hope in those hospitals in which inmates are treated: not yet initiated
* Food supplements for infected people: Discussion with officers. Privileges difficult to accord. About to identify options.
* Untimely medication by prison nurses: Highlighted at advocacy meetings. Officers denied it. PPAG is recommended to continuously follow up by exchange with Models of Hope.
* Proposal to EJAF: Handed it. Focus: stigma and food issues in prisons. No feedback yet.

1. **Financial Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **Absorption rate** | none |  |

1. **Management Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **Key position vacant** | 1/16 | M&E Manager. Recruitment has started |
| **Availability of commodities** | Test kits 14 MoS. Quarterly allocation? | Wrong number. Now need to request allocation for next six months. |

1. **Programmatic Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **% HTS** | Low results with TfSC and middle zone | Strategy: 1st quarter focus on larger prisons, 2nd prisons with smaller population and mop up in larger prisons. Prison population dwindling due to amnesties. |
| **# referrals after HTS** | How is the indicator defined? | CCM will follow up after the meeting |
| **# hygiene kits distributed** | 53% (= >4000) more distributed than planned? | 80% target. But distribute to everyone who is there. Possibility of double-counting. Has always been like this. |
| **# inmates reached drama** | No drama in Northern and Southern? | Drama prisons are randomly selected. 9 prisons per quarter ideally across regions. For logistical reasons sometimes concentration of one zone |
| **# film shows** | Only in Southern? | Strategy = more drama than film shows. Film shows at selected prisons, e.g. high security or very small prisons. |

1. **Recommendations:**

* PPAG recommended to get more information on CCE for an enhanced stigma approach (e.g. ADRA or GAC). Look into external PLHIV ambassadors first for stigma sessions.
* PPAG recommended to exchange with Models of Hope at hospitals where inmates are treated.

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

* Proposal to EJAF: submission via website didn’t work out and proposal could not be handed in. Topics planned: FSW prevention, HTS, STI, psychosocial counselling and food supplements (integrated services), primarily in E/R, GAR, V/R, A/R covering additional hotspots
* Condom quality complaints: mixed experiences, incorrect use (many FSW seem to use all sorts of creams as a lubricant), ADRA adjusted IEC accordingly. Desire to offer a larger variety of condoms. CCM requested to look into DKT and GSMF condoms and to facilitate a meeting.
* Lubricant: according to a first USAID feedback, the annual supply of ADRA with lubricant is expected to cost less than 10,000 USD of which about 1/4 can be recovered from the sales. Considering that lubricant supply is part of the condom and lubricant strategy and the demonstrated need of lubricant by KPs which will not negatively impact condom quality, and the low price of lubricant, ADRA is proposed to list lubricant in a reprogramming request.

1. **Financial Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **Absorption rate** | 92% |  |

1. **Programmatic Indicators:** TB screening at which level? PEs do preliminary screening, while DICs do the extensive screening.

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| **Indicator** | **Observation** | **Answer / Decision** |
| **HIV prevention** | Drop in achievement from 181% to 76% among all SRs | Strategy: try to meet as many as possible in first quarter and follow up in second quarter on services not received. Semester results >100% |
| **HTS** |  | 71% of those reached by IEC engaged in HTS |
| **Condom distribution** | Pro-Link: lack of commodity? ADRA shared condoms with GAC  MIHOSO: 19%: Concern that not every FSW/PE may have stocked up during the first quarter. Condoms need to be available continuously. | First quarter enough condoms available. P4: shortages. ADRA still shared condoms with GAC for the conviction that the little available should be shared with those in need.  ADRA takes note |
| **Referral by PEs** | Very low achievement by MIHOSO, Pro-Link great results | Pro-Link very experienced. Have more DICs due to partnership with USAID. MIHOSO expected to learn from Pro-Link |
| **Condom activation sessions** | Low achievement @ Pro-Link and MIHOSO | Reasons same as for condom distribution. |
| **# DIC** | How are KPs informed about availability and services of DIC? | Consistent info during outreach. |

1. **Other observations:** Have still not received condoms. Have not received any info from Claudette on allocation. ADRA had to follow up themselves. ADRA requested to inform CCM if challenges sustain. Enough test kits available.
2. **Recommendations:**

* CCM to look into different condom brands and GSMF and DKT
* CCM informs ADRA in which RMS female condoms are available (done 29th August)
* In order to promote female condoms better, vagina model needed (ADRA contacted USAID but cost was not budgeted). ADRA proposed to look for local producer and to look into reprogramming requests as a possibility to finance the models.

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

* Projection of savings and status quo of reprogramming request (1.3m USD): Increased T&T, additional MoH and PEs to cover all regions. CT gave feedback in July and requested evidence, which was provided. Last week GAC sent a reminder to GF CT.
* Equipment of regional NAP+ offices with furniture: In spite of the WAAF/NAP+ budget that contains 120,000 GHC for furniture and other items, GAC explains that no respective budget line is available under the NFM. Consequently, funds will only become available if the GAC reprogramming request is approved. GAC confirms however that WAAF/NAP+ are authorized to use overhead savings for the procurement of furniture. Since this issue could not be resolved at the level of the OC, a meeting with GAC, WAAF, NAP+ and CCM will be organized asap to get clarity on the way forward.
* Recruitment of NAP+ staff and consultant: NAP+ candidates shortlisted. Consultant not recruited yet.
* MoH funds for community sensitization and follow up of defaulters: part of the reprogramming request
* Feedback from SR on condom quality issues: GAC has inquired with WAPCAS and was informed that there are no condom quality issues. CEPERGH claims that they have not been contacted by WAPCAS or GAC in this context and that they do have quality issues. GAC is requested to follow up again with WAPCAS
* Condom procurement from RMS: RMS have stock but RMS have also other actors in the regions who need condoms and are not willing to hand out the quantities requested. Issue to be followed up through the condom committee and CCM.
* EJAF proposal: Yes, survey on PWID. No feedback yet.

1. **Financial Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **Absorption rate** | Low absorption rate (cum: 58%, P4: 76%) | Saved one million in 2015 due to late start. P4 performance: commitments for laptops. Next quarter >100% expected. 3 new DICs need to be equipped (WAPCAS). |
| **Disaggregated absorption rate by grant objective** | BCC P4: 80%  Particularly low CSS (P4: 62%) | Home Based Care has not started. Consultant for NAP+ constitution not recruited yet. |
| **Disaggregated absorption rate by SR** | WAAF 57% | See above. |

1. **Management Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **Key position vacant** | 3/10 | 1 at GAC, 2 at NAP+  GAC: procurement mgr., interviews conducted, will be recruited in P5  NAP+ did shortlisting, shared report with GAC for people to be interviewed (Data/M&E) |
| **Availability of commodities** | Stock out of all commodities | Severe lack of condoms, all efforts to obtain condoms from those RMS with stock were unsuccessful. ADRA shared a few carton boxes but this helped only a bit. |

1. **Programmatic Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **FSW HIV prevention** | Drop in achievement from 278% to 59% | Strategy: great enthusiasm in PEs in first quarter. 2nd quarter: Mop up for people initially reached in the first quarter, reach out to new FSWs. |
| **MSM HIV prevention** | Drop 124% to 64% | Same explanation as above |
| **Reg. NAP+ offices** | 4/11 functional | No budget line for furniture |
| **SAMC** | GF approval? | GF approved |
| **FSW Condoms** | Drop from 80% to 43% | Severe shortages |
| **MSM Condoms** | Drop from 526% to 95% | Severe shortages |
| **Clients enrolled in programme** |  | Indicator not in use yet but will be in future. NACP needs to provide data, confidentiality form needs to be signed. Pending approval of the reprogramming |
| **HBC PLHIV** | Consistently 0% | NACP discussion on data sharing form, targets are not set yet. Pending approval of the reprogramming |

1. **Recommendations:**

* Set up intensified oversight for GAC
* GAC asked to share ToR for NAP+ consultant by 31 Aug
* Follow up on condom quality
* Meeting with GAC, NAP+ / WAAF and CCM to solve NAP+ furniture issue within September

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

* Projection of savings / GF budget revisions: exchange rate adjusted. Savings mainly from HR and PSM, there will be more HR savings until the end of the grant. Warehouse cost savings since taken over by NMCP. No contract signed yet for servicing lab equipment – sorted out.
* Reprogramming request was sent to GF for health data strengthening and trainings for HC personnel. Annual enrollment into treatment under 90-90-90: 25,000: more trainings and refresher trainings to be undertaken.
* Status quo HBC: GAC brought their data collection tools that did not sufficiently consider confidentiality requirements. About 2 months since last meeting. CCM to contact the data manager at NACP Mr. Eko Wiah for more information. Update: Eko Wiah informs the CCM that NACP handed over the data sharing agreement to GAC about 3-4 weeks ago but has not yet received a signed copy.
* Status quo of plans to provide ART at CHPS level. 50 DOTS centers trained. CHPS level for PMTCT only. >2000 PMTCT centers out of which about 50% = CHPS.
* Denial of treatment if no family member as treatment monitor. Adjusted guidelines. Must have treatment monitors. If no monitor, initiation will depend on care giver. The treatment guidelines wre reviewed recently, final version is not launched yet. The OC inquired of the review involved PLHIVs. NACP confirms that NAP+ was not represented. The OC recommends NACP to discuss the treatment guidelines with NAP+.
* 90-90-90 / plans for expansion: Increase of HR capacity in ART clinics. CHPS currently do not have the capacity to administer ART (e.g. requirement of a lab). The OC suggests to review if CHPS can be trained on similar approach as for NTP (clients only come to central facility for lab analyses but get their meds locally).
* How to get PLHIV on treatment who were previously not eligible? NACP: People will come after official announcement. The OC recommends an enhanced collaboration with CSOs to inform other PLHIV. Contact data of PLHIV who are not yet on treatment available.

1. **Financial Management Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **Absorption rate** | 142% |  |
| **Disaggregated absorption rate by grant objective** | 259% absorption rate in P4. Local absorption rate? | Local absorption rate: 58%. Price reductions for PPM commodities, e.g. expected that GeneXpert cartridge prices will come down |
| **Disaggregated absorption rate by SR** | No SR expenditures in P1 and P3? Why absorption rate exactly 100% always? | Only M&E funds. No implementation initiated by the regions. NACP is requested to fill in regional absorption rates based on actual retirement of advances. |

1. **Management Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **Availability of commodities** | Definition of stock out. Why only 14 sites defined for stock out?  0/42 stock reports past due?  No stock data for various commodities?  Large stock available at IHS but stock out in RMS  Large stocks in some RMS (that are about to expire) while other RMS stocked out  Status quo of Monotherapies that are phased out | Regional, not facility level (10 RMS + 4 TH). If a single molecule is missing 🡺 considered as stock out  Not clear, NACP requested to review the total number of stock reports expected  Redistribution planned. |

1. **Programmatic Indicators:** NACP requested to make use of comment section for a better understanding of the data provided.

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| **Indicator** | **Observation** | **Answer / Decision** |
| **# on ART** | Numbers after data cleaning?  By E2016 27,000 to be enrolled: how? (Increase from P3 = 4000 only) |  |
| **ART pregnant women** | Drop from 58% to 55%, particularly due to GAR and W/R  Extreme regional variation UW/R: 8% vs. GAR 86% | Review in Kumasi with regional coordinators and asked about the challenges. Service providers have retired, new don’t stay for long before they move on for training. Regional teams proposed to check on local competences during the M&E trips. Needs a mentoring strategy. |
| **EID** | Drop from 39% to 30%.  P1: contradiction to previous dashboard. Extent of backlogs? See comments to NACP | See above |
| **HTS pregnant** **women** | P2: 80%. Drop over time in E/R, C/R, GAR, N/R. In 6 regions results have been stable or declining since P1 |  |
| **HTS** | 9 MoS coming in July/Aug: Plans? GAC 1m test kits when? |  |
| **TB screening** | Who no regional data? P3/4 much worse than P1/2 |  |

1. **Recommendations:**

* NACP requested to involve NAP+ and other KPs whenever international guidelines are domesticated
* Consult NAP+ before new treatment guidelines are launched
* CCM ask WHO about task shifting strategy in Ghana
* NACP requested to send a monthly stock report to the CCM. CCM sends an official request to the PM.
* Regional directors and district directors must take more interest in ART stocks and redistribution and other HIV activities.
* NACP requested to list major systemic challenges

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

* Update on budget revision and reprogramming: Reprogramming approved. Not sure if budget / savings are sufficient for all activities approved. Rates used in revised budget not necessarily agreed by NTP.
* Status quo scale up to 50 additional districts between April and June: Not started yet, based on reprogramming. Scale up will start in Oct.
* Status quo GeneXpert and trainings. % GeneXpert operational: 90 GeneXperts have arrived in E/05 / BG06. Had to wait for next scheduled delivery in order to distribute them to the regions (IHS is responsible for distribution of commodities that arrive in their warehouse. Are currently delivered to RMS/districts. 15 core trainers trained. Trainings of labs has not started. Significant delay because of waiting for scheduled delivery.
* NGO results, Collaboration NGOs with GHS: first reporting, disbursements made for second period. Increased reporting requested. Some NGOs didn’t find cases in spite of the efforts. Others did not refer enough cases. No penalties for underperformance yet. May discontinue funding for some NGOs subject of performance reported in next report. Stronger STBP needed. Strong secretariat needed. Some staff have been interviewed, incl. national service staff, to support STBP secretariat.
* Availability of funds at GHS level for contact tracing and home visits: strategy to be reviewed. Meeting planned (3 hospitals in each region) to identify bottlenecks. Planned to better integrate community health nurses. Already have basic TB knowledge and visit the communities on a regular basis. NTP insists that lab results shall be available the same day, so that patients will not have to come back for results (which results into a certain loss to follow up). DHD currently links up NGOs with district hospitals to enhance their collaboration.
* Task shifting officers: working at OPD, may double up at ART clinic but focus remains on OPD.
* Hospital for MDR-TB: Koforidua isolation unit at regional hospital not ideal for respiratory infections, Takoradi has set up an MDR-TB unit, which is not enough. Need one unit in each high priority area as transporting MDR-TB patients has its own challenges.

1. **Financial Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **Absorption rate** | 26%. Consistently low and falling | 90 GeneXpert not accounted for yet even though they have arrived. Next week: next cycle of med procurement. |
| **Disaggregated absorption rate by grant objective** | Low expenditures at all levels |  |
| **Disaggregated absorption rate by SR** | 0 expenditures in all regions? Same situation in most regions in previous periods. | Funds disbursed to districts to be acquitted within 6 months. Regions do not report = fundamental problem. |

1. **Management Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **Availability of commodities** | Capreomycin still stocked out. Last info: Air delivery E5  Ped. Meds in RMS stock levels?  Stocks and planned arrivals. How are low stocks handled by medical providers?  What will be done with products that seem to be discontinued?  Cat I+III 1.6 MoS | Yesterday received 56 patient doses covering the entire treatment, 50 patients on waiting list. In 3 months another 52 patients supply expected. Will be sufficient since supply will be shared among more clients than 56 / 52 (due to short shelf life, deliveries need to be staggered)  Only in CMS, therefore not listed in reg/central stock levels  Facilities have stock even though RMS may not  Single medicines kept to address drug reactions.  Delivery expected in 4 weeks. Orders placed late. NTP has learnt the lesson. |

1. **Programmatic Indicators:**

| **Indicator** | **Observation** | **Answer / Decision** |
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| **# notified cases all** | 58% only insignificant increase from P3 in spite of intensified screening, task shifting officers etc. (P2 = 64%) | Challenges with screening at OPDs. Officer goes to one hospital to observe task shifting officer for a few days to improve procedures. Household contact investigation was not systematically done. Outreach teams shall take care of contact tracing or forward follow up to officers of close-by CHPS compounds. |
| **Success rate** | P2 = 85%, P4: 76%. Very low rates in W/R and E/R, significant improvements in all other regions | E/R did not submit report. W/R submitted a wrong report |
| **# RR/MDR-TB notified** | 123%. Why is result so much better than case notification? | Most are relapses who have been treated before. They know the symptoms and where to go to get treatment. Not passive case identification, patients come in themselves |
| **# RR/MDR-TB who started treatment** |  | No treatment without drug resistance test for relapses as the way forward |
| **# notified cases bacteriological** | 59%, Drop in results even in absolute numbers | Seasonality. Seasonality is not the same across the regions, therefore different level of targets |
| **# Labs EQA** | Drop from 138% to 90% | Semester target. Fewer facilities visited than planned. 300 labs that do smear microscopy. Close to 100% pass rate of the labs examined. |
| **# HTS** | No increase since P1 | Drop in number of cases. |
| **# ART** | 20%, dropping results since P1 | NACP has trained 84 DOTS centers to initiate ARVs, 37 were qualified to start administering ARVs since E/07. Results should improve in the future |

1. **Recommendations:**

* NTP is requested to make use of the comment section for a more accurate interpretation of the results
* CCM to contact PR Finance department for a solution re regional reporting
* NTP to list challenges at GHS level
* Follow up on STBP reporting tool

1. **Closing**

The meeting came to a close at about 18:15.