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

**February 22nd, 2017 at the CCM Secretariat**

**Attendance:**

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| **No.** | **Name** | **Organization** | **Sector** |
| 1 | Annekatrin El Oumrany | CCM Secretariat | CCM |
| 2 | Stephen Ayisi-Addo | NACP | PR / Government |
| 3 | Kenneth Danso | NACP | PR / Government |
| 4 | James Nii Darko Saakwa-Mante | NACP | PR / Government |
| 5 | Ivy Okae | NACP | PR / Government |
| 6 | Rowland Adukpo | NACP | PR / Government |
| 7 | Kwami Afutu | NTP | PR / Government |
| 8 | Dennis Annang | GAC | PR / Government |
| 9 | Daniel Epeh | GAC | PR / Government |
| 10 | Raphael Sackitey | GAC | PR / Government |
| 11 | Kojo Asamoah Boateng | PPAG | PR / NGO |
| 12 | Anne-Marie Godwyll | PPAG | PR / NGO |
| 13 | Henry Kwasi Addo | ADRA | NGO |
| 14 | Benjamin Kwarteng | ADRA | NGO |
| 15 | Jonathan Tetteh-Kwao Teye | Dream Weaver Organization | Co-opted member |
| 16 | Evans Opata | Coalition of NGOs in Malaria | NGO |
| 17 | Genevieve Dorbayi | TB Voice | PLWD |
| 18 | Cecilia Senoo | SWAA | W&Cig |
| 19 | Edith Andrews | WHO | Co-opted member |

**Absence:**

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| **No.** | **Name** | **Organization** | **Sector** | **Reason** |
| 1 | Damaris Forson | GHSC-PSM | Co-opted member | Mission |
| 2 | Dr Felicia Owusu-Antwi | WHO | Co-opted member | Mission |
| 3 | Mac-Darling Cobbinah | CEPEHRG | KAP | Mission |
| 4 | Helen Odido | UNAIDS | Co-opted member | Mission |

1. **Opening:**

The meeting started at about 9:15 am with an internal session for OC members only that lasted until 10:00, followed by the review of the five HIV/TB dashboards.

1. **Conflict of interest declaration**

Annekatrin El Oumrany inquired with the OC members if anyone wishes to declare actual or potential conflict of interest related to the topics to be discussed during the meeting but this was not the case.

1. **Selection of a new chair**

With five OC members present, a quorum was reached to elect a new OC Chair. Annekatrin El Oumrany presented the related rules and regulations and Cecilia Senoo was elected as the HIV/TB OC Chair. Congratulations!

1. **Reasons for charging PLHIV for lab exams**

The OC members were informed by Annekatrin El Oumrany on the variety of reasons why PLHIV still have to pay for their HIV related lab exams although those should be free of charge. The OC members agreed that NACP should adopt a different approach to maintenance to ensure that any break-downs can be fixed with minimal interruptions. They also pointed out that the insufficient functionality of NHIA contributes to a number of challenges. Much more advocacy is needed in this direction. It shall be discussed with the Global Fund if this aspect can become part of the contributions to be ensured by GoG.

1. **Overview on ART**

In collaboration with Damaris Forson of PSM, an overview on the first and second line ARTs was developed and shared with the OC members present in order to better understand the acronyms and relative importance of each regimen.

1. **Feedback from the field**

According to a few OC members, big challenges exist with 2nd line treatment. It seems that some service providers fail to recognize when the first line treatment is not effective and wait too long before they propose additional tests while the patient’s health may be already in a very bad state. The OC members also feel that ART clients need to be well informed about the possibility of treatment failure and encouraged to point out any health concerns during their checkups. This aspect should also be part of information provided by the models of hope. The OC decided to discuss this issue with NACP later during the meeting.

(Later addition: a CCM member who runs an ART clinic confirms the NACP statement that service providers are well trained on possible treatment failure and subsequent actions to be taken. Furthermore, models of hope inform ART clients specifically about treatment failure and the necessity to inform service providers about an aspects of deteriorating health. It seems that the above mentioned experience is one of those unfortunate exceptional cases.)

1. **Reprogramming requests and next site visits**

While the HIV and TB reprogramming requests were shared with the CCM and OC members before, the internal session meant to offer an opportunity to discuss those. Unfortunately, time was not sufficient to exploit this opportunity. The same applies to the discussion of the next site visits that will have to be postponed.

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

* **Activities from reprogramming request – way forward:** budgets are drawn up. Stigma reduction with MoH: Discussions with NAP+ last week, about to draw a roadmap. Meeting planned with NAP+ and Prison Services. PE training scheduled for March. PPAG is commended for the prompt action.
* **Outcomes of discussions with NTP re TB screening support:** Collaboration with NTP, are part of PPAG review meetings. New way forward: Selected PEs will handle the TB screening in each prison (not all PEs). PPAG has stock of sputum containers to be given to infirmaries. Refresher training on TB screening during visits of the program officers to the prisons.

1. **Financial Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **Absorption rate** | Quarterly 107%, quarterly 82%. Full implementation of reprogramming request on 72.8T USD brings burn rate to 90% | Program salary schemes recently approved by PPAG council. Burn rate will hence improve. |

1. **Management Indicators:** no comments
2. **Programmatic Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **% HIV prevention** | Numbers look very high considering current prison population (13.068) | Errors in reported numbers. Revised dashboard has been sent (applies also to the following indicators) |
| **% HTS** | Numbers look very high considering current prison population | Inmates moved temporarily to other prisons, possibility that they get tested twice in the reporting period. Also errors in reported numbers. |
| **# referrals TB** | 28%, increased but still low results. No TB screening with TfSC and Northern zone | Different approach will be adopted using dedicated screening PEs (see follow up above). |
| **# hygiene kits distributed** | 18,000 hygiene kits distributed in second semester but currently only 13,000 inmates | Hygiene kits distributed twice per semester |

1. **Recommendations:** None
2. **ADRA Dash Board**
3. **Follow up / feedback from the field:**

* **Status quo lubricant request:** Benjamin wanted to follow up
* **Low frequentation of DIC:** Most DICsdo usually not treat STIs, which is however considered as one of the most important reasons to visit the DIC.FSWs do notsee the benefit of visiting the DIC only to be referred to a different healthcare facility. ADRA is encouraged to review services offered (e.g. STI treatment, HTS on a daily basis) and opening hours (make services available at least one evening during the week) and ways to better promote the DICs to FSWs and their non-paying partners. An OC member pointed out that even clients who just come to the DIC to socialize should automatically be offered services, e.g. information on HIV, TB and STIs, HTS, TB screening, condom demonstration etc.

1. **Financial Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **Absorption rate** | 89%, lowest for prevention programs 82%. | E/Dec: slightly more than 90,000 USD in account. BG Feb: GF disbursed buffer 185,000, sufficient until E/Mar |

1. **Management Indicators:** no comments
2. **Programmatic Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **HIV prevention** | 59%. Lowest results ever across all SRs | Program activities cut in December in preparation of the PU/DR. Activities will be back to normal in Q1/2017. Count only new clients but SRs have additional targets for reaching out to existing clients that not shown on the DB. |
| **Referrals by PEs** | Consistently low results for CCG: “Peer led without filling a referral sheet” | Stigma in health care facilities is a barrier to healthcare. Therefore, many FSWs get accompanied to healthcare facilities by PE who often do not fill a referral sheet in this case = no evidence for referral. PEs have been reminded to always fill a referral sheet. |
| **# referred KPs receiving services at DICs** | Low results for CC and Pro-Link, sharp drop | Only Pro-Link DICs treat STIs (trained by GHS). The others can’t provide treatment. Interest of FSWs in DIC services has dropped. |
| **Trust & Love sessions** | 75% | Conducted at hotspots for FSWs and NPP. Not full results because of budgetary constraints. |

1. **Recommendations:**

* Enhance frequentation of DICs. Consider additional services, e.g. daily HTS, STI treatment, and different opening hours. Get feedback from target groups which services are most needed.
* Offer services to each client who enters the DIC.

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

* **Status quo lubricant request:** No news. GAC is informed that this is the last time the CCM follows up on this issue. The Global Fund informed all relevant PRs in September 2016 that they are willing to consider procurement of lubricant once a detailed and costed proposal is submitted. The CCM has reminded the PRs repeatedly over the past five months – the ball is now in the court of the PRs, SRs and SSRs. GAC adds on the 8th March that GAR has agreed to procure lubricant for CEPEHRG considering the relatively small value of the order of 12,000 GHC. GAC is however reminded that this is not the long-term solution we should be looking at considering that all FSW projects point out lubricant need.
* **CCM website, outstanding info and files:** Please send outstanding information and files, so the CCM can finalize the GAC pages on the CCM website.
* **Feedback from SR on condom quality issues:** Still no feedback from WAPCAS on any quality issues. Email proposed to GAC, CC’ing SRs and SSRs as a last opportunity for the projects to speak up.
* **Challenges with condom procurement from RMS in case of shortages at TCMS:** Issue is currently not on the agenda of the condom committee. Raphael (GAC) will follow up on this issue to have written procedures in place that are known and observed by all stakeholders.
* **Follow up on delayed payment of NHIS premiums through hospital accountants:** Genevieve will send the names and locations from facilities with this problem for GAC to follow up.
* **Inadequate compensation of Models of Hope / inadequate T&T vs. budget available (allowance available in the budget = 100 USD monthly while MoH receive 200 GHC only):** Initial allowance was based on allowance paid during the previous grant and slightly increased over time. Even though a much higher amount is in the budget, GF approval needs to be sought for any increase of the allowance.

1. **Financial Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **Absorption rate** |  | Liquidity challenge. All cumulative disbursements spent. Only 100,000 in the account currently. 700,000 disbursement, was disbursed to SRs. CCM requested to follow up with GF. Disbursements at 80% only. |
| **Disaggregated absorption rate by grant objective** | Lowest cum. burn rate for MSM 54%  Finance indicators Excel vs DB don’t match | Liquidity challenge at GAC, could not disburse for MSM interventions appropriately during past quarter. Disbursement to SRs also depends disbursement requests. GAC has intensified monitoring of SR/SSR expenditures to avoid any liquidity challenges in the future  GAC requested to revise either file |

1. **Management Indicators: no comments**
2. **Programmatic Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **FSW HIV prevention** | 28% WAPCAS FSW prevention: after a great start in P2/3, performance has been significantly under 100%. | New definition of indicator: record only new KPs (previously: new and existing contacts). Targets remain the same. |
| **FSW HTS** | Performance consistently significantly above 100%. Which is the main methodology to reach FSW for HTS? |  |
| **MSM HIV prevention** | 57%: for the past three quarters, performance always <70% and decreasing | New definition of indicator: record only new KPs (previously new and existing contacts). Targets remain the same. |
| **MoH** | Increasing numbers. Which is the scale up plan? Status quo of increase in allowance. | Initial MoH allowance of MoH was tied in with previous rates before NFM. Even though higher rates are agreed upon in the budget, any change needs approval from CT. |
| **SAMC** | One outstanding. Which one and why? | National level, first meeting will take place 3rd March. |
| **FSW on NHIS** | Cumulatively at 57%. Which is the strategy? Justification? | Lack of funds at GAC level. |
| **Clients enrolled in programme** | Last quarter info: Based on reprogramming request. Some funds available to start now. 400 clients expected in the 4 regions. Why no progress? | Models of Hope trained on use of data collection tool as initial step. Implementation starts in Q1/2017 |
| **PLHIV on NHIS** | 7993 PLHIV reached, target = 2500. Which is the strategy? 33,000 USD additional expenditures above plan. | GAC does not see any problems with the overspending. |

1. **Recommendations:**

* CCM requested to follow up on outstanding disbursement from GF

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

* **Experiences with Test&Treat? How many people are enrolled in an average month in the four priority regions, how many enrolled between Oct-Dec?** NACP will follow up with data.
* **NHIS does not cover transport of blood samples to lab, cost implications for PLHIV:** Need to look at the functionality of NHIA since it affects program implementation at many ends.
* **Status quo GeneXpert for EID and VL?**

1) Existing PCR machines currently underused. One more PCR machine requested for UW/R to cover all 10 regions (Reprogramming).

2) GeneXpert could theoretically be used for EID for which only qualitative analysis (=HIV present or not) is required. For viral load, quantitative analysis necessary that is not yet approved by WHO for GeneXpert.   
3) Transport of samples to lab should not be an obstacle to testing – this is necessary for many other diseases and a sustainable solution needs to be identified.   
4) NACP’s objective to combine trainings on HIV qualitative and quantitative analysis, therefore GeneXpert HIV analysis only expected to be available from 2018.

* **Situation of second line ARVs, not available at Accra RMS (lopinavir, ritonavir):** NACP will follow up
* **Feedback from field (see internal session):** **service providers need more training on second line treatment:** NACP states that service providers have all the knowledge necessary.

1. **Financial Management Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **Absorption rate** | 107% burn rate  Quarterly local absorption rate: 128%. Cum 69% = significant increase. Value of PPM commodities and other expenditure for rest 2017 (another 20m in budget)? | Confusion about the PPM cost. The budget shows 61m, however, NACP is only informed about 49m.  (The latest implementation letter seen later seems to indicate that 9m have been shifted from PPM to NACP local. Furthermore, there are now not only the categories NACP and PPM but also IHS, JSI, and Chemonics (about 3m) that may have distorted the PPM budget previously). |
| **Disaggregated absorption rate by grant objective** | Cum: 58% for M&E but 20% of budget (3m unspent). Way forward for regions / districts  Q3: Treatment care and support: 49% burn rate but 57% of quarterly budget  Consistently low program mgmt. cost | E-tracker M&E, will be spent  Misperceptions about what falls in this category. Should be resolved soon |

1. **Management Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **Availability of commodities** | Dec: 1m test kits has arrived. What is the way forward  Auditing of RMS planned to check on expiry dates.  (Stock report arrived too late in order to be discussed) | First response test kits have arrived. Will be tested soon by FDA. Problem: Oraquick needed to confirm positive tests have not been ordered even though their procurement was agreed upon. Oraquick 1.5 MoS at central level, partly low stocks at regional level. May 2017: 9MoS expected.  Efavirenz more effective than Nevirapine. Focus here, = also WHO guideline. Advantages: few regiments are better manageable, lab tests can be better forecasted. Works out well. Shall be increased to 60%  Partly RMS do not have sufficient space. Might have to move to district warehouse system. Match consumption data with order data = priority. |

1. **Programmatic Indicators:** Please make use of comment section!

| **Indicator** | **Observation** | **Answer / Decision** |
| --- | --- | --- |
| **# on ART** | 100,665 on ART: adjusted for loss to follow up? | Not adjusted yet. Will use a formula to calculate loss to follow up. No agreed method to use with GF. Progress 90-90-90: Stephen will send summary. Refill should be possible on a daily basis in most facilities and spread new enrollments on particular days. |
| **ART pregnant women** | Quarterly increase from 58% to 66%. Biggest progress in BA/R, E/R, N/R. Big drop in GAR: data challenges? | Data issues will be solved through using new harmonized ANC registers: objective: higher reporting coverage. New tool also helps with the determination of # of HIV+ women. Pharmacists should take ARVs to PMTCT sites but are holding on to them. Several fears, incl. correct documentation. Lots of advocacy necessary.  Some regions have taken steps to resolve the issues. |
| **EID** | Quarterly increase from 29% to 45%, but primarily achieved in GAR (70% to 85%). C/R, E/R and UE/R showed some improvement; all other regions remain pretty stable. | New maternal and child health card will mark HIV+ mothers for easier identification by MCH healthcare workers to test babies concerned on the spot. Impossible to do EID right after birth, midwives too burdened. Sensitivity not at 100% after birth (much higher at 6 weeks). Specimen transfer needs to be improved. New additional testing opportunity after 7 days. |
| **HTS pregnant** **women** | Quarterly increase from 76% to 82%. Enormous increase in E/R (+150%). Enormous drop in GAR. Other regions pretty stable since the beginning of the NFM. What are the challenges in those regions?  Number of reporting facilities: according to PPME data, stable number of PMTCT facilities but while new facilities were trained, others stopped reporting. | Not discussed, time ran out. |
| **HTS** | Stagnating results. Plans? |  |
| **TB screening** | Enormous quarterly improvement from 29% to 340% | Reporting issues in the past. Integration of DOTS/ART contributes to improved results |

1. **Recommendations:**

* CCM to follow up with GAC on the non-ordered Oraquick.
* NACP recommended to redistribute regional Oraquick stock to ensure that all RMS have stock available as long as possible.
* NACP requested to provide an overview on the % of PMTCT facilities trained in each of the regions by 15th March.

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

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| **Indicator** | **Observation** | **Answer / Decision** |
| **Absorption rate** | 406% quarterly burn rate, 76% cum burn rate | GeneXpert (arrival in May/June 2016) financially accounted for |
| **Disaggregated absorption rate by grant objective** | Lowest cum burn rate for MDR-TB 61% (14% of budget)  TB care & prevention: 71% (33% of budget) |  |

1. **Management Indicators: no comment**
2. **Programmatic Indicators:**

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| **Indicator** | **Observation** | **Answer / Decision** |
| **# notified cases all** | Still low. 56% | Revised diagnosis algorithm proposed using GeneXpert + digital x-ray. Will also pick up more DR cases. Official start: within 6 weeks. Print of algorithm for prescribers. No big training budget, only for DR TB management, to which new diagnosis algorithm will be added on.  OPD screening not consistently accomplished. Opportunities for improvements in procedures identified and recommended to healthcare facilities. First week in March: next supervisory meeting to see if recommendations from Dec. meeting are implemented |
| **Success rate** | 82% | Too many people die. Based on all diagnosed patients, incl. clinically diagnosed. Includes misdiagnosed cases who are treated for TB but who die of something else.  Treatment success of those bacteriologically confirmed: 87%, death rate 7.7% mostly due to late reporting, which is partly due to late diagnosis (clients have reported symptoms before which were not initially diagnosed as TB). Good adherence rate. Death rate below 5% would be acceptable. |
| **DR-TB** | 26% | Target is cumulative 171. 107 cases identified. 63%. Annual increase of 49% compared to 2016. |
| **Treatment DR-TB** | 33% | 77 cases = 72%. 4 months stock. Lost 11 patients during non-availability of Capreomycin. Some patients are awaiting enrollment once tests are completed. |
| **DST** | 88% | Rif-Resistance testing using GeneXpert. Positive cases are additionally tested using culture to test for other resistances. |
| **# HTS** | 59% | 85% of diagnosed TB cases tested for HIV. |
| **# ART** | 38% | 2838 PLHIV diagnosed, 1078 are on treatment. |

1. **Closing**

The meeting came to a close at about 16:45.