ST. CAMILLUS MISSION HOSPITAL

ART CLINIC

P.O BOX 119 – 40401 KARUNGU

www.karungu.net

CRS ART PROJECT

ANNUAL REPORT

March '07 – February '08

INTRODUCTION

St. Camillus Mission Hospital is situated along Lake Victoria in Karungu Division, Migori District of Kenya's Nyanza Province. The institution which is a brainchild of the Camillian Community was established in 1997. St. Camillus is a home to a number of community focused organizations namely; Medical Hospital, ART Clinic, Hope and Life, AWAKE, Foster Home, Pastoral Program, Community agricultural support initiative, primary and secondary level schools etc.

ART Project was incorporated into this facility in August 2004 with the primary aim of treating and caring for those who had been infected by the deadly scourge, HIV/AIDS. Being neighbored by both Tanzania and Uganda along the lake coupled with the fisher folk free sex culture, the residents around are exposed to an alarming risk of HIV/AIDS contraction.

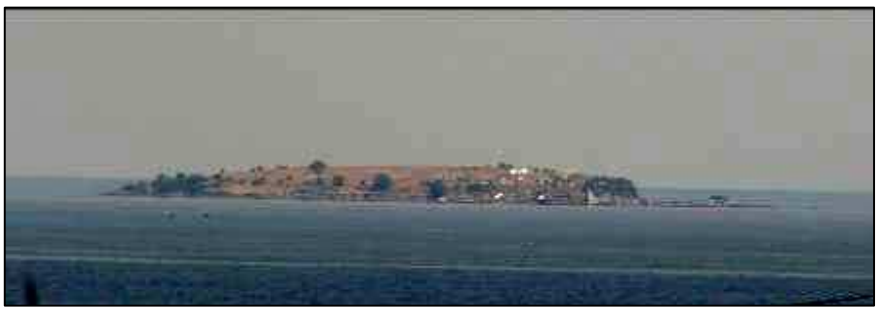

Fig: 1. ***A view of Aluru Fishing Island in Lake Victoria from St. Camillus***

This project is funded by US Presidential Emergency Program for AIDS Relief (PEPFAR) through CRS-Kenya. The donor financial year runs from March of every year to end of February of the subsequent year. Basically the intended catchments area was meant to be Nyatike Constituency of Migori District and Southern Gwassi in Suba Distinct. Due to increasing demand for this rare and essential service, we widened our boundaries to include two Divisions of Homabay District and the whole of Gwassi Division. These are administrative districts and divisions.
Before the end of every Project year, the staff converges to draw plans for the succeeding year. This is done in terms of targeted enrollments, Human Resource needs and Community activities.

1. YEAR 4 (March, 2007 to Feb.2008) PROJECTIONS

- **On Enrollments:**

TARGETED ENROLLMENTS	PER MONTH		TOTAL YEAR 4 (2007/08)	
	On Care	On ART	On Care	On ART
ADULTS	90	55	1080	660
PAEDIATRICS (<14)	13.5	8.25	162	99

- **On Human Resource:**

STAFF CADRE NEEDED	ADDITIONAL NUMBER PROJECTED
1. Social Worker	1
2. Nurses	4
3. Pharmacists	2
4. Doctor	1
5. Data Processor	1
6. Accountant	1
7. Labtech	1

- **On Community Activities:**

1. Collaborators meetings were proposed for year 4 to help identify other ways our patients would be assisted since the ART Project does cater for all human needs. These collaborators are Foster homes, Government of Kenya, other service providers in the community e.g. World Vision.
2. Patient Support Group trainings were seen to be of vital attention being it empowers their understanding on therapy.
3. 60 patients were also scheduled for treatment preparation 'adherence class' on monthly basis before initiation to ARVs.
4. Project Management Committee (PMC) is a unit constituted by the Project to include community opinion leaders to oversee our activities in the community and advice accordingly. They were suggested to be meeting on quarterly basis.
5. Community Health Volunteers (CHVs) monthly meetings.
6. World AIDS was to be celebrated in December.
7. Lastly were the routine outreach services like patient home visits and follow-ups which are normally conducted by our community staff on daily basis alternately.

2. SYSTEMS MANAGEMENT AND PERFORMANCE DURING THE YEAR

Every year has witnessed an increase of patient enrollment with dynamic presentations necessitating installation of strong systems within the program to ensure efficient and sustainable care for this vulnerable class of patients. These systems are categorized into Human Resource, Community Activities, Infrastructure and Statistics.

2.1. HUMAN RESOURCE

Staff Recruitment

Two events have always influenced our need to hire staff. One is the increase in the number of patients we enroll which is a result of the versed geographical area we are compelled to encroach into. Second is the replacement of the staff attracted by attrition. During this year, we recruited staff as follows:

- Nurses 2
- Social Workers 3
- Pharmacists 2
- Clinical Officers 2
- Patient attendant 1
- Driver 1
- Co-ordinator 1

Staff Capacity Building

Fig: 2. ***ART Staff in an internal mentorship session***

A number of our staff have greatly benefited from both internal and external trainings offered by AIDSRelief and the Kenyan Government. Thanks to the Hospital Administrator who has always seen the necessity in manpower development and consented to such trainings.

During this Project's Year 4, our resource persons managed to attend to the following trainings:

	TRAINING	DATE	VENUE	ATTENDANCE
1.	Effective Mgt Of ART commodities for health care workers in primary health care settings	28th Jan-3rd Feb,'07	PCEA-Nairobi.	Samson Opiyo
2.	Food by Prescription(FBP)	19th -20th April,'07	Ukweli-Kisumu	Siso, Wandigu, Cheledi, Paul Oganga, Merceline Kwelu.
3.	HIV/ART Nurses Training in Kijabe	25th March-6th April,'07	AIC-Kijabe	Benter Polo
4.	Mgt of HIV/AIDS & related Conditions.	22nd -28th April,'07	PCEA-Nairobi.	Lavender Ogallo
5.	.HIV/ART Nurses Training in Kijabe	7th-19th May,'07	AIC-Kijabe	Linet Mboya
6.	Hospital Management.	5th-12th May,'07	PCEA-Nairobi	Dr. Bertha & Benter
7.	Continuous Medical Education	8th-9th June,'07	Ukweli-Kisumu	George, Patrick, Dr.Bertha, Nyagilo, Samwel Oyugi, Obillo,
8.	Strategic Planning For Health Services.	3rd -9th June,'07	Rosa Mystica-Nairobi	Dr.Bertha & Patrick Alando
9.	.AR COs/Nurses Training(Pediatrics)	4th -16th June,'07	AIC-Kijabe	Raphael O. On'garo
10.	.HIV/ART Nurses Training in Kijabe	2nd -14th July,'07	AIC-Kijabe	Samwel Oyugi
11.	Managing of ART Pharmacy.	5th -11th August,'07	PCEA-Nairobi.	Lillian Wandigu
12.	HIV/ART Lab screening & monitoring	19th -24th August,'07	PCEA-Nairobi	Cleophas Marita
13.	Kijabe Nurses ART Training	20th Aug-7th Sep, '07	Kijabe AIC	Lewis Oriema
14.	Continuous Professional Dvpt.	22nd Sept. '07	Ukweli – Kisumu.	Grace Cheledi, Benter Polo, Obillo Meshack, George Ochieng, Charles Ogada.

15.	Peds Clinical Mgt.	22nd-26th Oct,'07	PCEA-Nairobi.	Samwel Oyugi
16.	Provider Initiative Testing & Counseling	22nd-26th Oct,'07	AID-Kisumu.	Derrick Kaoga
17.	Finance and Compliance.	12th-14th Nov,'07	K.Milimani – Nairobi.	Obillo Meshack George Ochieng
18.	Psychosocial Care and Counseling for HIV infected children and adolescent	21st-30th Nov,'07	Jumuia Centre-Limuru.	Benter Polo

Further Six, Internal Technical Assistance (ITA) were also conducted by the AIDSRelief team. This has always been perceived as cost effective and time saving on the side limited labor.

Attrition

Within the year, we suffered a major blow by the sad demise of our Project Co-ordinator, Mr. Patrick Alando, who has been in control since 2004. Besides this, the under mentioned staff also managed to tender their resignations for other organization at their own volition:

NAME	YEAR OF RECRUITMENT	DESIGNATION
1. David Siso	2004	Social Worker
2. Emily Nyagilo	2006	Clinical Officer
3. Grace Cheledi	2006	Clinical Officer
4. Lavender Ogallo	2006	Nurse

Rate of staff turnover for the year stood at 20%.

Internship

As is practicable in the entire Hospital, the Project has been keen not to ignore students pursuing relevant courses in learning colleges and have shown interest in having their industrial attachments with us. Besides practicing with us for their own benefit, they also boost our Human Resource during their time at the facility. This is how we have had within the period:

STUDENT	COLLEGE	COURSE PURSUED	DEPARTMENT ATTACHED	PERIOD OF INTERNSHIP	EVALUATION
1.Jackson Ochieng	Migori Inst.of Tech.&Meds Scs.	Cert. in Community Health	Community	1 months	Self discontinued but poor in performance.
2.Milka Atieno	Kisumu Polytechnics	Dip. in Social Work.	Community	3 months	Bellow average.
3. Akungu Evans Otieno	Consolata Shrine Nbi.	Cert. in Pharmacy	Pharmacy	3 months	Good
4. Obora A. Maurine.	Eldoret Cllg of Profnl Studies.	Cert.in Comm. Dvpnt&Soc. Work.	Community	3 months	Above average
5. Beatrice A. Odira.	Nakuru Medical Inst.	Cert. in Pharmtech.	Pharmacy	3 months	Good
6. Irene Akiyi Ogallo	Moi Inst. Of Technology	Dip. in Social Work.	Community	3 months	Good
7. Beatrice A. Odede.	Moi Inst. Of Technology	Cert.in Social Work & Comm.Dvpnt.	Community	4 months	Very Good

2.2. COMMUNITY AND PATIENT SERVICES

This is the core of our existence which we have at all times tried to burn our energy towards at all cost irrespective other eventualities which at times frustrate our efforts. Every attention that has been successfully directed towards this area always yields abundantly to the benefit of the clients we are meant to dedicatedly serve. To smartly reap under this category, a number of activities were either inovated or continued with during the year. Most notable ones can be discussed as under on their achievements and challenges realized.

Patient Enrollment on Care

Multiple approaches were put in place to help in uptake of new cases to ensure a good number accessed the service in time. Spouses were encouraged to disclose to their partners their HIV/AIDS status and to assist them come forward for VCTs and if HIV positive to turn out for care at the appropriate time. We also managed to collaborate with local VCT service providers to intensify their campaign in the community. Since we are hosted in a Medical facility complete with inpatient care, our effort was equally extended to the hospital wards sourcing for patients whose Diagnostic Testing and Counseling (DTC) proved positive to HIV/AIDS.

Pediatric Concern

As we facilitated patient mothers on PMTCT at different forums, we also empowered them on the benefits of subjecting their newborns to HIV tests at an early age of six months. This greatly contributed to a reasonable number of children enrolled for HIV care as is evident in our statistics. On continuous care, a Peds day was set aside on Wednesdays when kids and their mothers are served together to avoid a mix up with other adult patients. On the same day caretakers are taken through an empowering session by an adherence nurse. However, our attempt was not devoid of shortfalls.

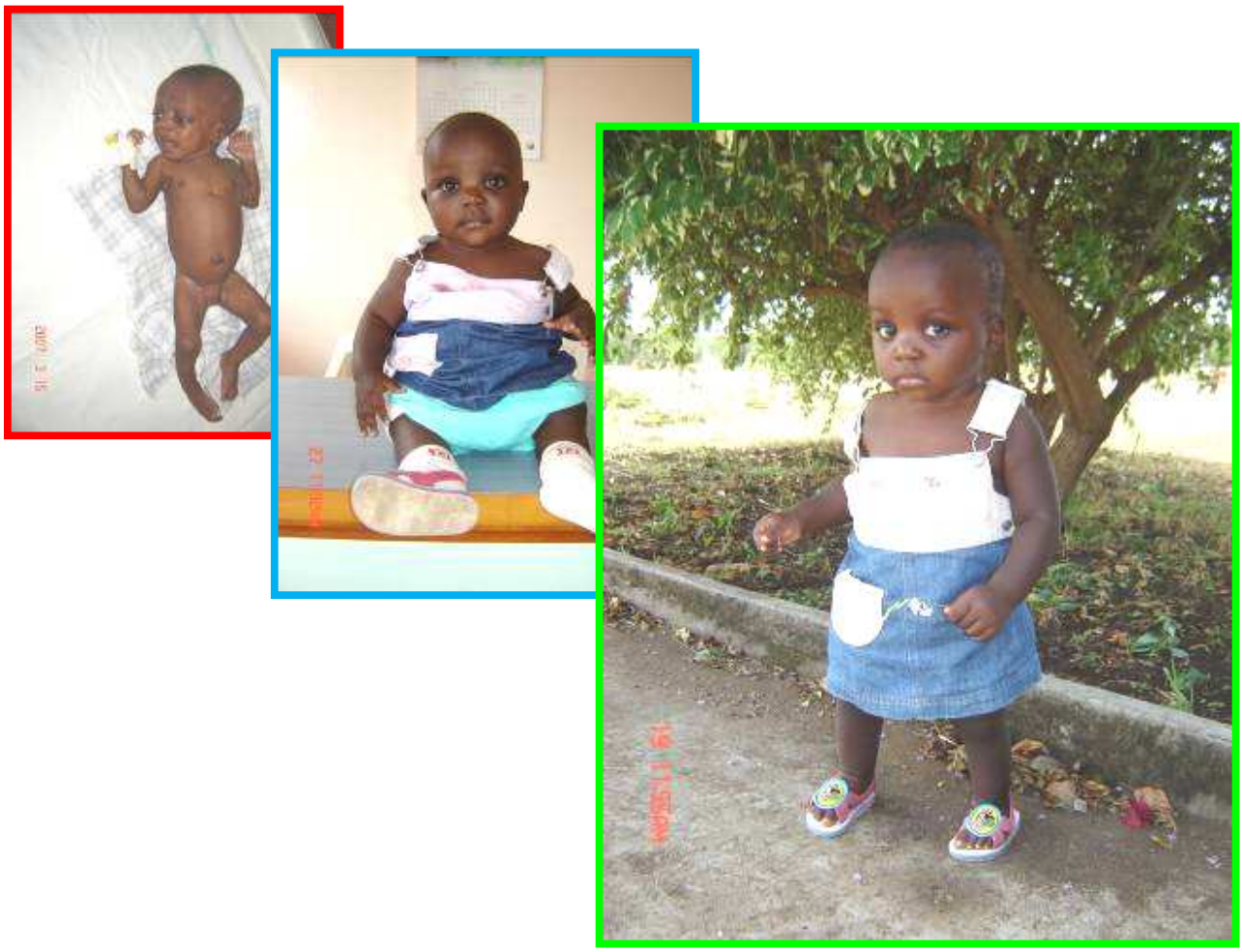

Fig: 3. ***A Living testimony on the power of ARVs is baby Nelly now 1year 3 months***

Many female patients still find it economically unbearable to access maternal care in health clinics during deliveries. This limits administering of drugs necessary for controlling mother to child transmission. Some children are also under the care of their old grandmothers who might not be keen on treatment procedures thus reducing prompt adherence to therapy.

Patient Support Group (PSG)

This was an initiative established in the second year of the Project for patient network, collaboration, self adherence monitoring and socio-economic interdependence in terms of Income Generating Activities (IGAs) . 2007 witnessed the number of support groups rise to 37 across six administrative divisions we have invested our interest majorly. Like the previous year, we trained all the support groups in six regional centers within our great catchment area. Forty (40) discordant couples and sixty five (65) youth patients had an opportunity to be trained for the first time in the history the project. The trainings focused on best practices in adherence to treatment. Four days were spent for groups of a given training centre. Here we were challenged to see ways we could help source for nutritional support as many patients are on drugs on an empty stomach. Another exciting experience noticed was that members of such PSGs who were on treatment in other Care Centres begun lobbying for transfer into our Project as our kind of community model is lacking in their facilities.

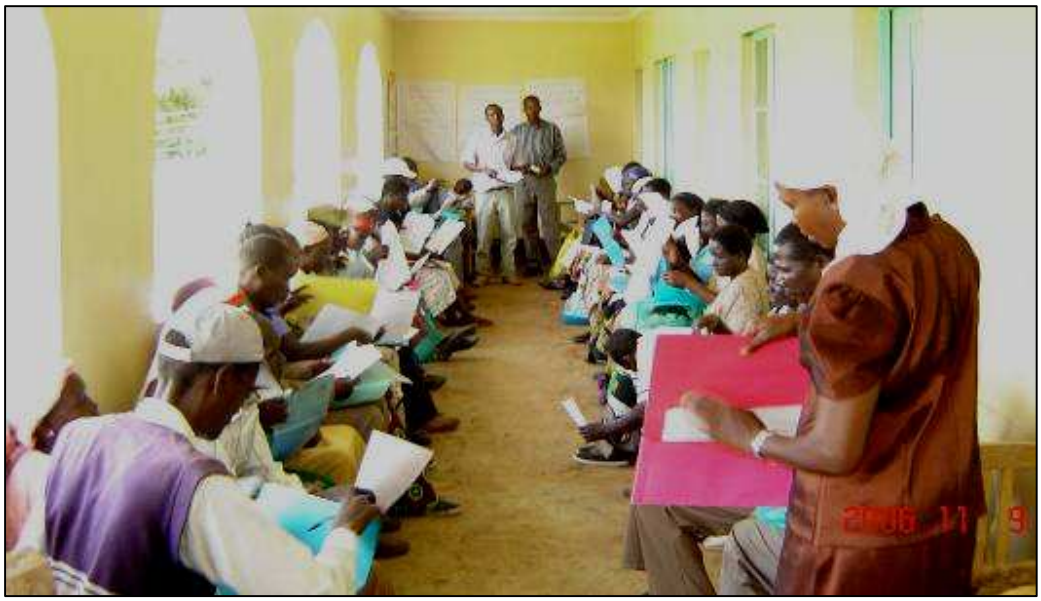

Fig:4. ***A patient support group in training***

Outreach Activities

We have two outreach services directly related to patient therapy segmented into two key items namely:

a. Patient Homevisits and Followups:

This was successfully carried out to ensure number of defaulters is reduced and patients newly initiated on ARVs get good start as patronized by our competent nurses and social workes.

b. Mobile Clinic Visits.

Monthly visits went on in four designated sites for drug provision and clinical observation to some of our patients who qualified for the service which is a preserve of only clients on ARVs. This special service is meant to reduce traveling cost of patients as well as decongesting the mother clinic. While crossing to last year, only one site had two visits per month, the rest had one each. Come year 4, one more clinic was created at Osani in Homabay District as Onger and Kiasa sites went up by one additional visit each. At the close of the year, we had eight visits in five sites.
All these were necessitated by increase in our enrollments and the quality of the service we offer.

Fig: 5. ***Patients bidding bye to ART Team at Kiasa Dispensary on one of our Mobile Clinic Days***

Community Health Volunteers (CHVs)

This is a class of personnel recruited and trained in the community to help monitor adherence on our clients who live with them in the same villages. They primarily belong to the community. They owe their existence to the inception of the Project. Besides a little token of Ksh.400/= at the end of the month and a bicycle to ease mobility, their service is purely voluntary and not compensable. We have eighty in number cutting across the region. Ten had to be replaced for incompetence. Two regional trainings were conducted for them for updates. Throughout the year they meet at the end of every month for submission of reports. At the end of the year we held a joint meeting where dedicated efforts were rewarded with gifts. For the first time we agreed to try this kind of motivation.

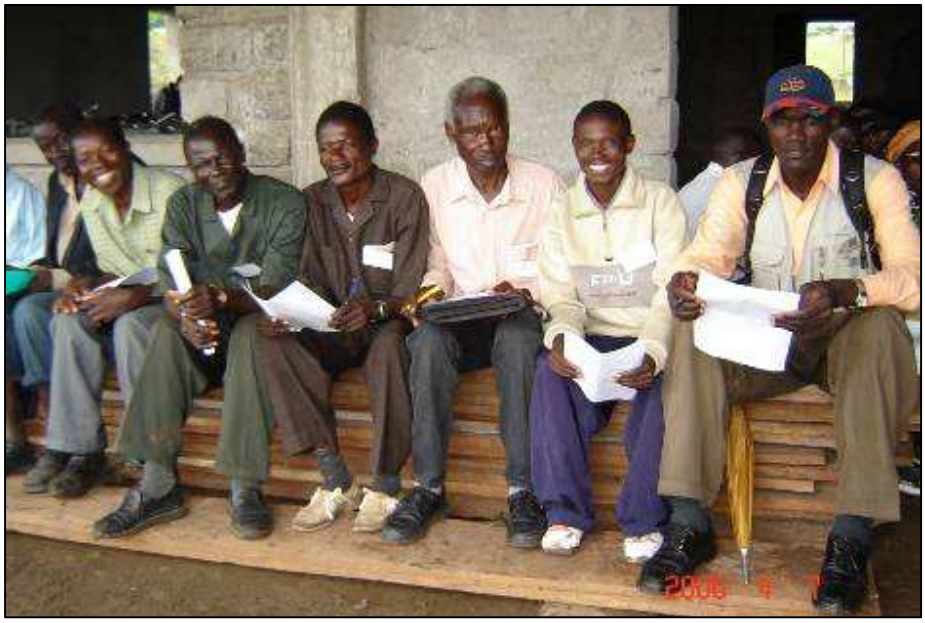

Fig.6: ***A section of CHVs in one of their monthly meetings***

Project Management Committee (PMC)

As customarily, our PMC members met on quarterly basis to review performance of the Project in the community. This time all round they reinvented a new product whereby a CBO was registered in the name of NASURA (Nyatike, Suba, Ratanga) ART SUPPORT INITIATIVE as an umbrella body to help solicit relief funds and food by way of posting proposals to different organizations on behalf of the ART Patient Support Groups

Crises Management during Kenyan Post Election Violence and uptake of Internally Displaced Patients (IDPs)

Our dedicated staff braved the time when Kenya was experiencing political violence and ensured that attention to patients continued amidst the turmoil. At the same time we registered 29 patients on ARVs who were displaced in other regions hence could not access care in those places.

2.3. INFRASTRUCTURE

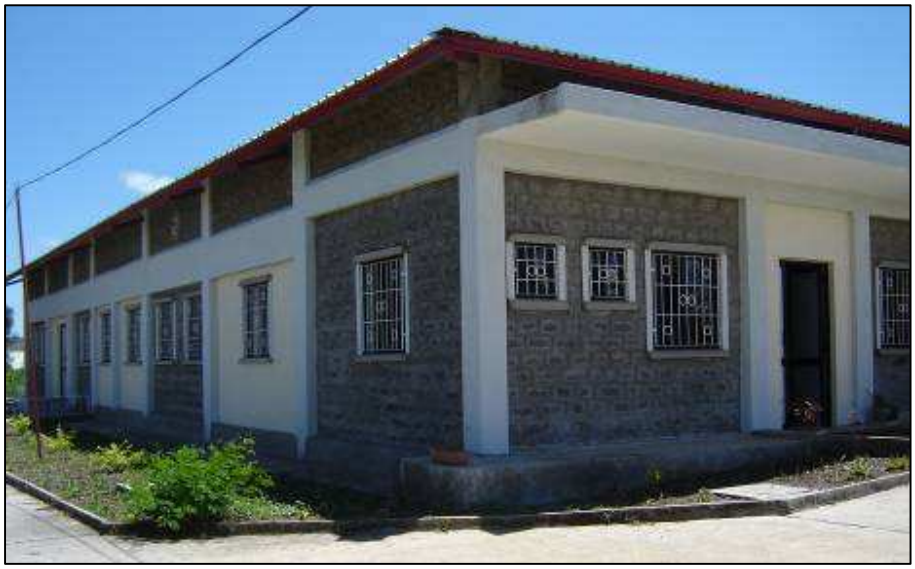

Fig.:7. ***The block that now hosts the ART Clinic at St.Camillus***

With the effort of the Hospital Administrator, this period we moved to a more spacious building with partitioned offices as opposed to the previous years where we converged in some 9kind of hall not very comfortable to the kind of patients we serve. This year has also been a blessing in the sense that the CRS managed to provide us with a vehicle to ease our mobility towards mobile clinics. Despite this, we still propose to establish satellite stations with staff permanent on board to enable our patients in the versed region continue with care nearby to their residences.

2.4. STATISTICS

Our team of two data processors is very vital for the entry of information, analysis and production of data for consumption by the hospital, funding agency and the Government of Kenya.
This is how it was at the end of last year (cumulatively):

	End of Year One (Feb-2005)	End of Year Two (Feb- 2006)	End of Year Three (Feb-2007)	End of Year Four (Feb-2008)
Total Enrollments	431	1.256	2.282	3.456
Total Active on ART(Adults)	126	369	789	1.339
Total Active on ART on (PEDS)	14	34	69	172
Transfer outs	0	8	13	26
Defaulters	0	7	27	15
Died	14	25	62	95

3. SUMMARY OF YEAR FOUR UNDER KEY INDICATORS

Challenges Faced:

1. Like other previous years, we are still incapacitated on how to address cost of inpatient care for our clients as a number of them still can't afford even the subsidized monthly contributions towards National Hospital Insurance Fund (NHIF) arranged by the St. Camillus Administration.
2. Most of our patients hail from poverty stricken backgrounds coupled with long illness thus limiting their access to recommended diet.
3. Female Patients with child bearing ability often regain their normal health status after successful treatment and end up in pregnancies despite their fragile medical status.
4. The lots we serve are also over represented on illiteracy and poverty circles hence hinders maximum adherence to therapy since they cannot be able to follow instructions well.
5. African traditional and religious healers are still a menace in this community since some of our patients believe they can find solace under such primitive interventions. This results into them terminating their HIV/AIDS care in the clinic.
6. High staff turnover has persisted and for the year 2007 it stood at 20%.

Achievements:

Despite the above notable drawbacks, we equally managed to make good strides towards the success of this institution as mentioned under:

1. Our vibrant field activities in the name of Patient Support Group formation and trainings have greatly yielded to stigma reduction in the entire community.
2. Rate of mortality and morbidity levels has also been significantly reduced in the area and members of this society openly testif to this effect.

3. Though not fully achieved, some of our patients now are enrolled with NHIF and enjoying the benefits.
4. During the year we successfully identified youth patients and discordant couples for special adherence training.
5. Attention to peds was equally enhanced and a special day is set aside within every week for empowering and treatment.
6. On patient cost reduction and decongestion in the clinic, we had five mobile clinic sites where 1050 patients were seen on monthly basis.
7. A number of our staff had the opportunity to attend trainings organized across the country.

Lessons Learnt:

1. Mobile Clinics only serve the interests of those on ARVs and this is just a minority lot among our patients.
2. Relevant trainings to our staff have only exposed them to other organizations for employment hence retention modalities should be identified to check the turnover.
3. Patients organized in support groups have the potentiality of participating in Income Generating Activities (IGAs) except they lack seed money.
4. HIV/AIDS management works better when the whole family is collaborated into therapy.
5. Females present themselves for HIV/AIDS management in large numbers as compared to their male counterparts.
6. Pediatrics find it uncomfortable staying at clinic for long hours during appointments without some form of meals.
7. CHVs work better when motivated like we did last year by distribution of T-shirts to them.

Way Forward:

1. Establishment of two satellite clinics at Ndhiwa in Homabay District and another one at Nyandiwa in Suba District is being worked on to start late 2008.
2. Collaborating Patient Support Groups with other relief providers in the community is underway.
3. We plan to start feeding our peds on snacks during their appointments on Wednesdays.
4. Recruitment of additional staff to correspond to the ever increasing number of patients.
5. Introduction of soft terms of payments to the very poor clients who still don't have NHIF cards but require in-patient care and can't meet the cost.
6. Identifying special needs of the disables pursuing HIV/AIDS with us.

4. YEAR FIVE TARGETS.

At the end of year 4 (Feb 2008), we gave ourselves targets on the number of patients to be absorbed in various categories of care. This kind of focus gives direction on efforts required and internal evaluation. The table bellow entails period and figures:

	PER MONTH	END OF FEB 2009 (YEAR 5 ONLY)	END OF FEB 2009 (CUMMULATIVE)
GENERAL ON CARE.	80	960	4.375
ADULTS ON ART	45	540	2.344
PEDS ON ART	10	120	352

CONCLUSION

The spirit is in place from the three cornerstones (Staff, CRS and The Hospital Administration) of this ART PROJECT. We hope and believe our strength will back us swim across.

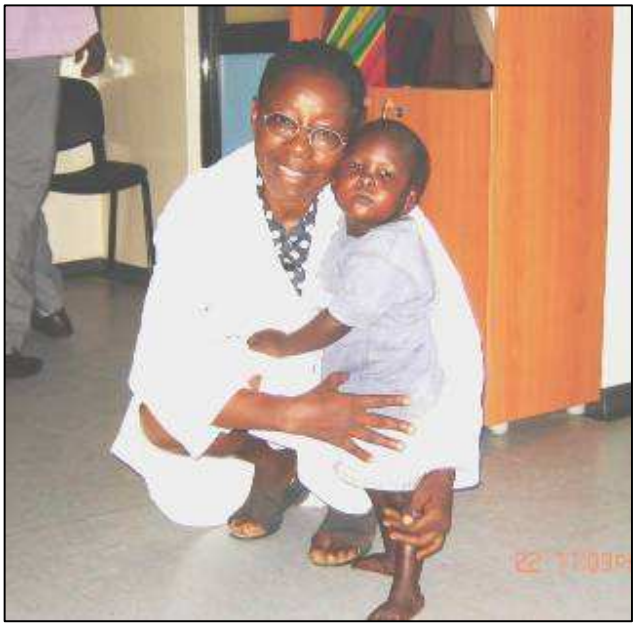

Fig: 8. ***Dr. Bertha with Baby Fidel who is direct beneficiary of our Pediatric HIV/AIDS management***

Prepared by: *Obillo Meshack (CRS-ART Project Co-ordinator)*
Under Supervision of: *Fr. Emilio Balliana (Hospital Administrator)*