ST. CAMILLUS MISSION HOSPITAL

ART CLINIC

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CRS ART PROJECT

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ANNUAL REPORT

March 2009 – February 2010

1. INTRODUCTION.

1.1.Background Information.

The St.Camillus Mission is routed to the principles of hearty service to the sick and the vulnerable. It is on this foundation that her establishment at Karungu along Lake Victoria in Kenya hosts numerous projects aimed at improving the very human dignity as necessitated by the socio-demographic influences.

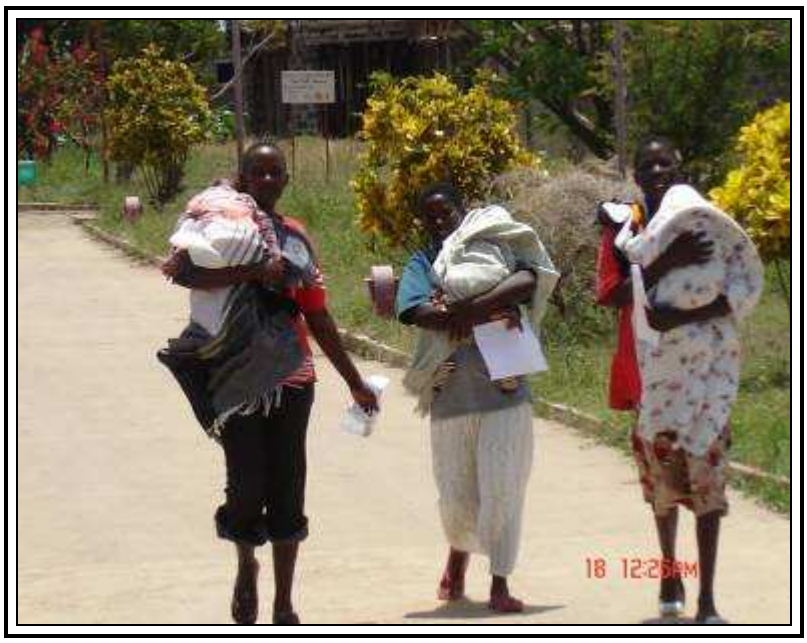

Fig. 1: Paediatric day.

AIDSRelief is one such dedicated initiative that exists under St. Camillus Mission Hospital boldly addressing HIV/AIDS related challenges within this community. It was born out of mature partnership between the Camillians and Catholic Relief Services (CRS)-Kenya with funding from US-Presidential Emergency Program for AIDS Relief (PEPFAR). Since August 2004, the core objective has been treatment, care and support to the people living with HIV AIDS (PLWHAs). A task that has been so far well achieved looking at the realization of preset periodical targets.

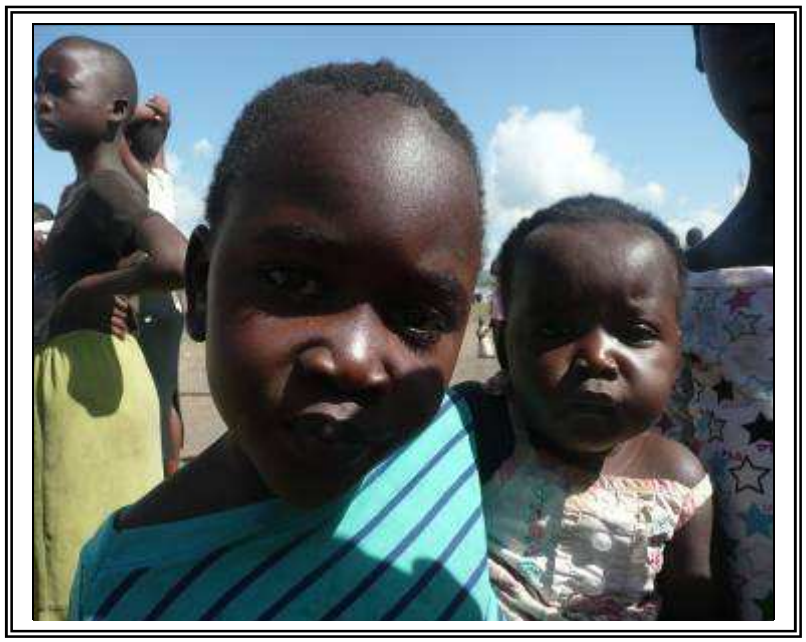

Fig 2 Where there is no Mother

To successfully maximise such ambitions, all avenues of planning, implementation, monitoring and evaluation have to be deeply exhausted within available resources and timeline. These are observed

under key indicators namely, Objectives, Goals, Strategies, Achievements, Challenges and Way forward. For the purpose of effective performance evaluation, AIDSRelief ART Program operates within an annual plan that commences from March of every year through February of the subsequent year. Going by that, this report narrates the just concluded year six (March 2009-February 2010) performance.

2. YEAR 6 (March 1-February 28) GOALS & OBJECTIVES.

2.1. Clinical:

1. 95% CTX Prophylaxis.
2. New enrolments at 140 clients per month.
3. Initiation on ARVs, 71 clients per month.
4. Post Pharmacy counselling on daily basis.
5. 85% patient retention.
6. 95% patients monitored with CD4.
7. TB diagnosis and therapy.
8. PMTCT testing and disclosure.
9. PCR sample collection at >6 months.
10. Cervical Cancer Screening to females aged 30-50 years.
11. Adherence to Kenya National Guidelines.

2.2. Community:

1.Supporting ART Adherence.

2.0% reduced defaulter rate through home visits and follow-ups.

3.Regionalised Community trainings to 85 CHVs and 52 Patient Support Groups(PSGs).

4. Linking newly enrolled/initiated clients to Support Groups and CHVs.

5.TB-DOT and defaulter tracking.

6.Home Based Counselling and testing(HBCT).

7. World AIDS Day Participation.

8.Decentralization of Services.

2.3. Administration:

1. Personnel development through external trainings and internal CMEs.
2. Staff motivation and retention.
3. Efficient Capital Management.
4. Activating a full time treatment satellite-Mirogi.

3. YEAR 6 PERFORMANCE ANALYSIS.

3.1. Clinical:

To successfully attain this intended plan, the clinicians with the able mentorship of our Project Medial Officer (MO), Dr. Bertha, they were cable of starting all patients on Cotrimaxazole (CTX) on first visit. All exposed children were put on Septrin at 6 weeks and this was not to exclude patients on ARVs who were to continue their septrin prophylaxis.

Management of opportunistic Infection (OIs) among our patient has been inevitable at the nascent stages of our interventions. However this has been met with a number of challenges since some clients come when their disease progression has developed to higher stages with multiple symptoms. The low economic status equally limits their access to specialised treatment outside ART Clinic.

Fig. 3:Clinicians observing twin babies of a client.

Fig.4: Government District Head introduces his team in a joint public function

Adherence to treatment is another clinical angle that has been of immense importance in this process. To achieve this, Post Pharmacy Counselling (PPC), patient home visit, linkage to regional Patient Support Groups (PSG),transfer to mobile clinics, clinical follow ups, enrolling patients within our geographical area and generating defaulter list daily are some of the vital approaches we have always implemented and with good results in enhancing adherence. Though we had started a kids club as another measure, this posed difficulties as during the year we decentralised our paediatric care to mobile clinics as well. In the next year, we plan to roll over this service to the regions with a new outlook.

We also have to acknowledge the Government of Kenya (GoK) support in provision of updates on guidelines in relation to acceptable drugs, PMTCT protocol, TB management etc.

Coming to measurable facts of the clinical performance, this is how we realised our goals against the set targets**(Statistics)**:-

CLINICAL INDICATOR	**TARGET**	**ACHIEVED**	**COMMENTS**
New patient enrolments	878	1349 (153.4%)	Target surpassed due decentralized enrolments)
Initiation to ARVs.	740	463 (62%)	Target missed to some clients opting for transfers after initiation.
CD4 monitoring	95%	72%	Recurrent turnover of clinicians hampers the process.
Started on second line treatment	All patients failing on 1st line.	1.3%	Low chances of resistance due enhanced assessment at early stages.
Patient retention	>85%	91%	Result of stringent adherence sessions & follow-ups
Cervical Cancer Screening(CCS)	1000 within 4months	411	
DNA-PCR Sample Collection & Testing of exposed children	All children born to mothers on HIV care.	119 tested.	Only 14 turned HIV positive & enrolled, an indicator of strong PMTCT.

3.2. Community:

This is the backbone of all the patient aimed activities as patients primarily belong to the community. It basically established to provide a reflection and paint a picture of the how the client can be well served at their residential surroundings since here is where they spend a good portion of their life which equally influences their daily behaviour.

At the clinic, community office comprises of staff with professional background in Social Work, Community Health and Counselling. This team is tasked with the responsibility of ensuring maximum

adherence to treatment. As it is said, drugs don't work when not taken, they see in to it that the patient in question is psychosocially prepared to pursue care and treatment. This is done through a number of well defined techniques.

When a patient fails to take drugs as prescribed or even fail to honour a clinic appointment, this is referred as default. We had aimed at achieving 0% defaulter rate. On evaluation we can happily rank our performance at only 9 % patient failed to turn up even after vigorous follow-ups and home visits. This in itself is a true plus to boosting adherence.

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To effectively control stigma and enhance patient and care taker education on HIV management, clients at the community level are linked to form support groups. These extend further to be utilized for purposes of economic empowerments as well. We had planned to join neighbouring groups for seven Support Group regional trainings. Along with this, one Discordant Couple, Youth patients and CHV trainings were factored in our work plan for the year.

The table bellow details on figures as captured by our data tools:

TRAINING TYPE	**No. OF SESSIONS**	**ATTENDANCE**		**TOTAL TRAINED**	**TARGETED PARTICIPANTS.**
		MALES	**FEMALES**		
Patient Support Groups	7	96	315	411	280
HIV Discordant Couples	1	25	25	50	40
Youth Clients	1	20	30	50	40
CHVs	1	25	31	56	80
TOTALS	**10**	**166**	**401**	**567**	**440**

Going by Government of Kenya policy in assisting citizens to know their HIV status, we equally initiated Home Based Counselling and Testing (HBCT) along with DNA-PCR tests to exposed children aged six months and bellow as supported by US G Centre for Disease Control (CDC)-Kisumu. To a little extent did we achieve it since we were challenged by personnel deficit hence we only limited it to families of our clients. But then we were still able to test as bellow:

TOTAL TESTED	**NON REACTIVE (HIV NEGATIVE)**	**REACTIVE(HIV POSITIVE)**
Adult Males 84	39	45
Adult Females 109	51	58
DNA-PCR Tests to children <6months 119	126	8(indication of timely PMTCT intervention)
Total 193	90	103

World AIDS day is another opportunity on December 1 every calendar year where the project joins the community in commemoration of those who lost their lives out of the scourge and celebrate with the infected.

Fig. 5: CHVs at a close of the year community session

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Fig.6: World AIDS 2009 Procession.

At St. Camillus there is a tradition of starting the celebration three days before the climax one. This year we had it for two days that is November 27 &28, 2009. We gave our budgetary contributions which made the whole occasion a success. Our Support Groups participated with educative skits, songs and dramas. In the same spirit we joined two administrative Districts on December 1 where we did the same.

The essence of this project is drug provision to the low income group. Since the local infrastructure does not economically favour our patients, we have modality of reaching to them at selected nearby clinics for mobile services. During the year we have continued with six mobile sites. Only one visit was added to one site where we now attend four times a month. In total we do eleven visits a month to all the sites seeing 1102 patients up from 440 we saw in the previous year.

Previously our priority was attending to those stable and on ARVs only. Having analysed other factors, we arrived at decision to incorporate VCT services, enrolment of new clients and attending to

paediatrics which used to be a preserve of the mother clinic. With this a good turnout was seen on scale up and reduced defaulter rate on peds besides offloading patient load at the mother clinic.

A new satellite with staff on full board was also activated referred as Mirogi, 20km from St. Camillus M. Hospital. Here the doors are open all working days.

With the effort of Hospital Administration, CRS positively responded to our pleas with a brand new car, KBH 633Q (double cab) in the month of July to facilitate mobility to these sites.

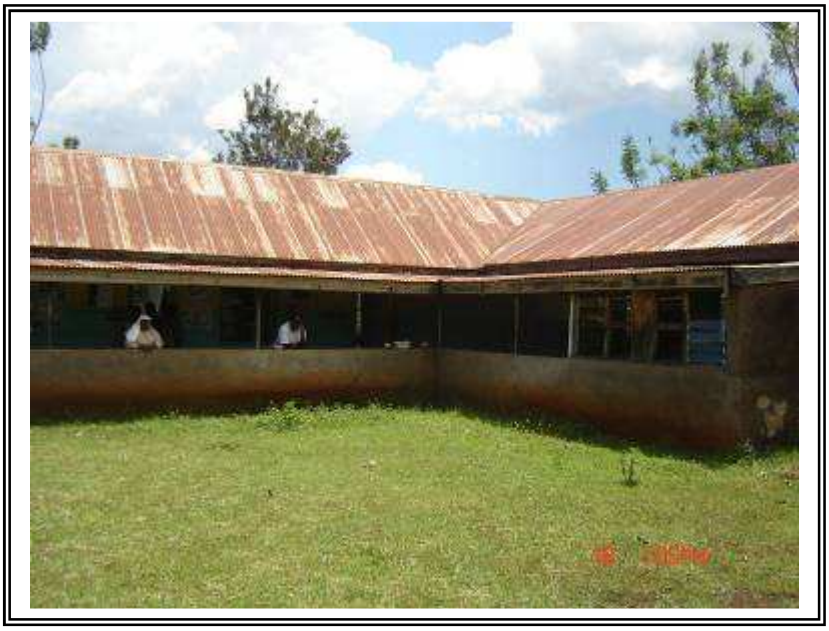

Fig. 7: Mirogi satellite of St. Camillus

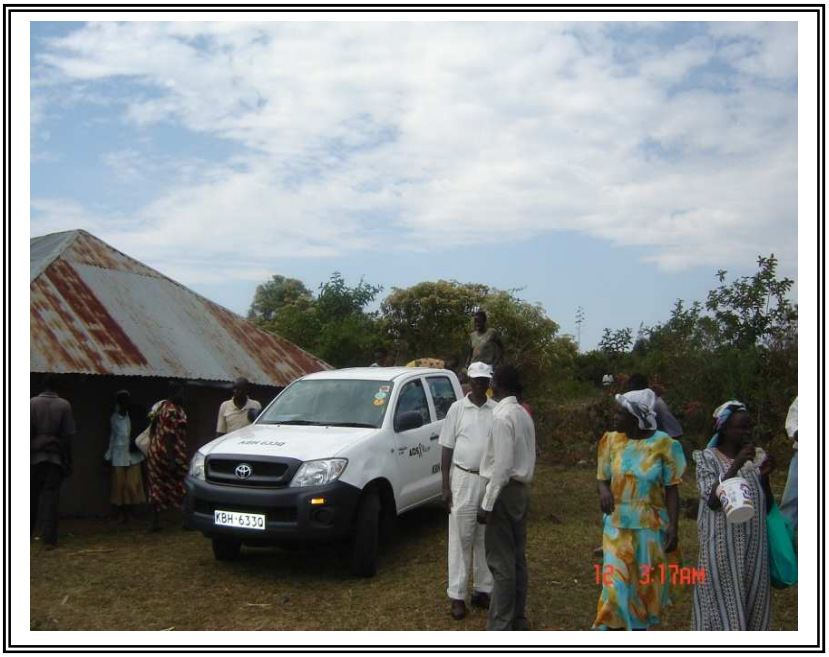

Fig.8: Community Out Reach

Tabulated Summary of Decentralized Clinics.

Decentralization Site	Number of visits per month	Patients Attached.

1.Wath Onger Health Centre	4	371
2.Muhuru Sub District Hospital	1	99
3. Kiasa Dispensary	2	217
4.Osani Dispensary	2	180
5.Otati Dispensary	1	138
6.Lwanda Dispensary	1	97
7.Mirogi M. Health Centre.	Operational daily	270
Total	11	1102

3.4: Project Administration:

At the top of the project oganogram is the Project Co-ordinator who is charged with all the administrative issues that pertains the Project and reporting directly to the Hospital Director. This office is responsible for planning, implementation, monitoring and evaluation of laid goals and objectives.

Fig.9 ART Project Co-ordinators' office.

HIV management presents with dynamism hence personnel professional update must be given a worthy attention it deserves. Though crippled with financial limitations, we were still able to train our staff both within and offsite. Thanks to Hospital Administration, funding agency and Ministry of Health Services for smooth collaboration for the success of this endeavour.

A total number of 30 staff were trained at various levels and venues just to boost the capacity of their service to the patients.

However, this initiative has been frustrated due to staff turnover hence loosing the very trained personnel. Efforts of staff retention are in progress. At the close of the year, our staff turnover rate stands at 17.14%.

Administration is also tasked with ensuring efficient use of project resources and good custody of assets. Records don't reveal any major damages but the little that would be reported were reinstated in time. An external audit done by CRS in the course of the year shows no discrepancies realized. Cash flow from CRS was however not very timely during the first three quarters hence delays would not only derail activities but also demoralised staff as it here that their salaries are drawn.

A major administrative milestone achieved in patient care was the activation of full time satellite clinic at Mirogi Health centre in the month of September 2009. A total of four dedicated staff were posted there and at close of the year patient enrolments had reached 270.This success is owed to promising partnership between St. Camillus Mission Hospital and Mirogi Parish.

4. SUMMARY.

CRYTICAL ANALYSIS OF YEAR SIX UNDER KEY INDICATORS.

4.1 Achievements:

- Surpassing annual patient enrolment targets at 153.4%
- Decentralized responsibility.
- Early defaulter patient tracking.
- Staff training and development at 82.9%
- Activating a new satellite-Mirogi.
- Weekly patient preparation sessions (TPS).
- Patient identification for repeat CD4 control.
- Shorter time taken by patients at the clinic.
- Patient retention at 95%.
- Timely management of opportunistic infections.
- Timely reporting to various stakeholders.
- Hospital administration very supportive to the Project.

4.2 Challenges:

- Inconsistency in supply of some ARVs.
- Delayed fund wire transfer from CRS.
- Poor communication form Government of Kenya relevant offices.
- Clinical staff turnover affecting quality of patient care.
- Patients bargaining admission for in patient care.
- Space for ever increasing patient files and drugs.
- Delay in DNA-PCR results for CDC-Kisumu.
- Sustaining a functional kids club.

The above identified challenges will be referred to from time to time to ensure an improved way forward for the betterment of patient care at this facility.

Conclusion:

The project continuous to appreciate the mutual and warm partnership that has always existed between St. Camillus M. Hospital and CRS-Kenya for the very best of this venerable cluster of society. It is true that without this kind of serous intervention, numerous and vital lives could have been lost within this region of Karungu and its environs. Our prayers will remain focused on more strength and spirit to enable us serve efficiently.

Report compiled by: Obillo Meshack
Project Co-ordinator.