# ST. CAMILLUS MISSION HOSPITAL

# ART CLINIC

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# CRS ART PROJECT

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YEAR 7 ANNUAL REPORT

**March 2010 – February 2011**

## 1. INTRODUCTION

### 1.1. Background Information:

The AIDS Relief anti-retroviral therapy (ART) project offers treatment, care and support to people living with HIV/AIDS within Migori and Homa Bay Counties. It was initiated by St. Camillus Mission Hospital (SCMH) in 2002, before the Catholic Relief Services (CRS) assumed overall leadership in 2004 with funding from US Government's Presidential Emergency Plan for Aids Relief (PEPFAR). The project has been instrumental in reducing the HIV prevalence rate within Karungu to 14% while the National rate stands at 7%.

***Fig.1:*** *Part of A.R.T Project Staff as at February 2011.*

In order to successfully attain goals and objectives, all avenues of planning, implementation, and evaluation were carefully monitored. These were observed by using six key indicators: objectives, goals, strategies, achievements, challenges and way forward. For the purpose of effective performance evaluation, the ART Program operates within an annual plan that commences in March of every year and runs through February of the subsequent year. This report covers the just-concluded year seven (March 2010-February 2011).

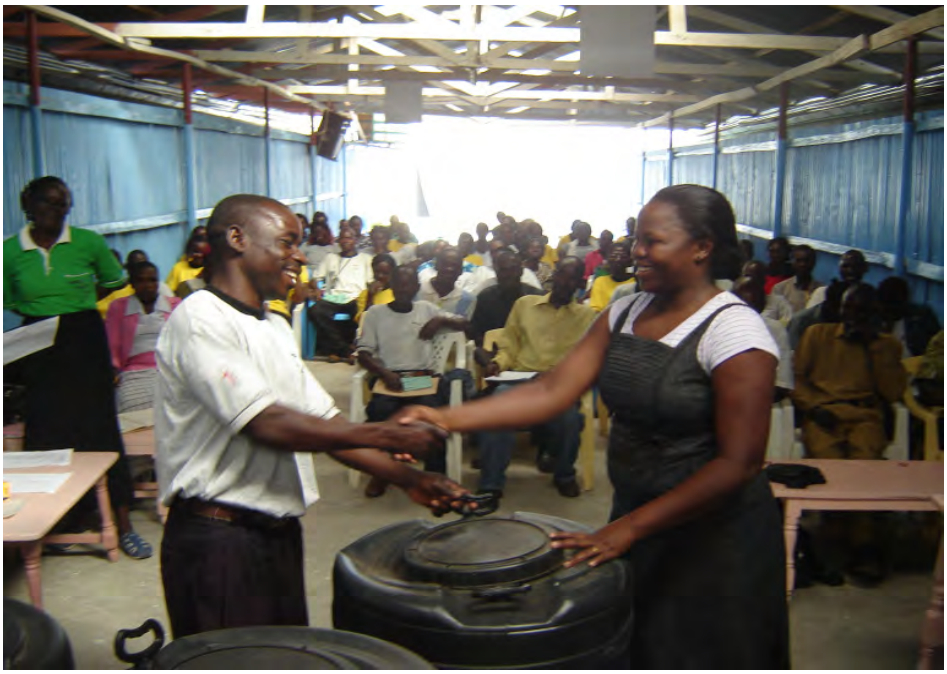

***Fig 2:*** *A Community Volunteer (left) receives a prize for good work.*

## 2. YEAR 7 (March 1-February 28) GOALS & OBJECTIVES

### 2.1. Clinical:

1. Achieve 95% Septrim (CTX) Prophylaxis.
2. Enrol 58 new clients each month.
3. Initiate ARVs on 40 clients per month.
4. Provide post-pharmacy counselling on a daily basis.
5. Retain 85% of the patients.
6. Monitor 95% of the patients with CD4.
7. Emphasize early TB diagnosis and therapy.
8. Conduct Prevention of Mother-to-Child Transmission (PMTCT) testing and disclosure.
9. Collect PCR sample at >6 months.
10. Adhere to Kenya National Guidelines.

### 2.2. Community:

1. Support ART Adherence.
2. Eliminate client defaults through home visits and follow-ups.
3. Conduct regionalized trainings to 85 community health volunteers (CHVs), one discordant Group, one youth peer group and one Patient Support Group Peer Educators.
4. Link newly enrolled/initiated clients to support groups and CHVs.
5. Maintain TB-DOT and defaulter tracking.

6. Provide home-based counseling and testing (HBCT).

7. Participate in World AIDS Day.

8. Decentralize services.

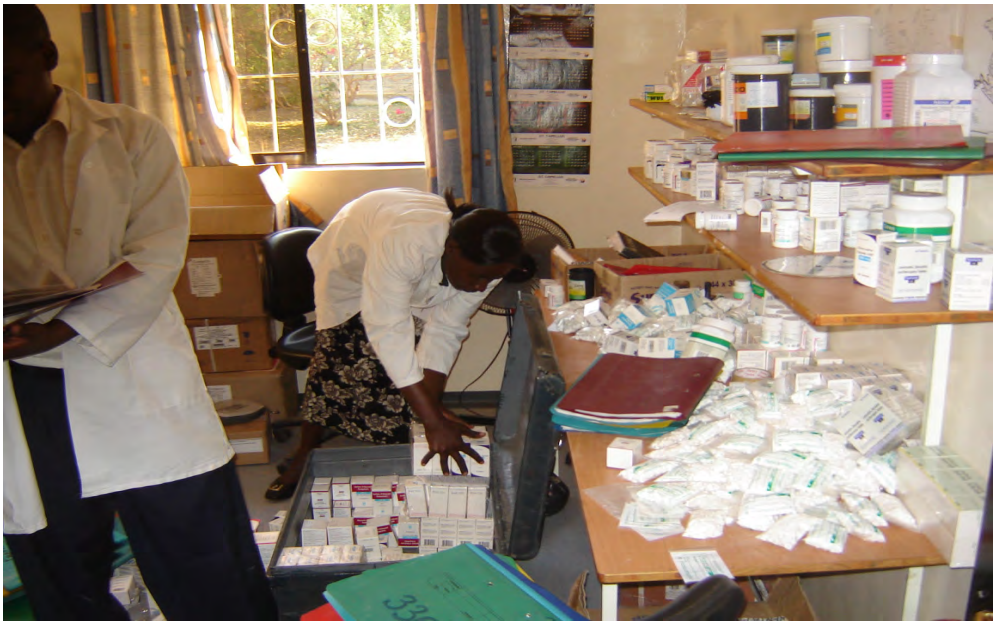

***Fig.3:*** *Pharmtechs prepare drugs for Mobile Clinic.*

**2.3. Administration:**

1. Promote personnel development through external trainings and internal CMEs.
2. Maximize staff motivation and retention.
3. Emphasize efficient fiscal care and responsibility.

***Fig 4****: Newly expanded Finance/Data room*

## 3. PERFORMANCE ANALYSIS.

### 3.1. Clinical:

Management of opportunistic infection (OIs) among our patients has been a key objective beginning at the nascent stages of our interventions. With enhanced community awareness, this year we were able to reduce the percentage of clinically weak clients as compared to previous years.

- *A.R.T. Adherence:*

Strict adherence to treatment is of immense clinical importance in the delivery of anti-retroviral therapy (A.R.T). To achieve this, post-pharmacy counseling (PPC), patient home visits, linkage to regional patient support groups (PSGs), transfer to mobile clinics, clinical follow ups, enrolling patients within our geographical area and generating defaulter lists daily are some of the vital approaches we have always practiced with good results in enhancing adherence. We also acknowledge the Government of Kenya (GoK) support in provision of updates on guidelines in relation to acceptable drugs, PMTCT protocol, TB management etc.

**Fig 5**: A Staff mentors kids in psychosocial session.

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

Table 1: ART Treatment Summary

| CLINICAL INDICATOR | TARGETS FOR THE YEAR | ACHIEVED | COMMENTS |
|---|---|---|---|
| New Enrollments | 621 | 1597(257.2%) | High numbers attributed to testing exposed family members of patients and decentralized enrolments. |
| Initiation to ARVs. | 435 | 956(219.8%) | Weekly Treatment preparations and enrolment of ambulatory patients has contributed to this |
| CD4 monitoring | 95% | 55% | Documentation process had some problem some time hence some data were lost. |

| | | | |
|---|---|---|---|
| CTX uptake | 95% | 91.2% | Target missed as a result of enrolling all exposed children though not due for Septrin prophylaxis (CTX) <6 months. |
| Started on second line treatment | All patients failing on 1st line. | 47(1.4%) | Low chances of resistance due enhanced assessment at early stages. |
| Patient retention | >85% | 87% | Result of stringent adherence sessions & follow-ups. |
| DNA-PCR Sample Collection & Testing of exposed children | All children born to mothers on HIV care. | 100% | Only 21(6.81%) turned HIV positive & enrolled, an indicator of strong PMTCT. |

### 3.2. Community:

This is the psychosocial and economic element of patient care. It is aimed at linking the clinic and the patient at the place of the patient's residence and/or daily life. Personnel with this responsibility are social workers, community nurses and counselors. At the community level, community health volunteers enhance staff capacity.


***Fig.6:*** *Wangaya Patient Support Group at Farm.*

- *Patient Home Visits/Follow ups:*

An average of 870 home visits were conducted monthly during the year by staff and CHVs which resulted into zero defaulter rate for a good part of the period. A number of psychosocial issues were also addressed.

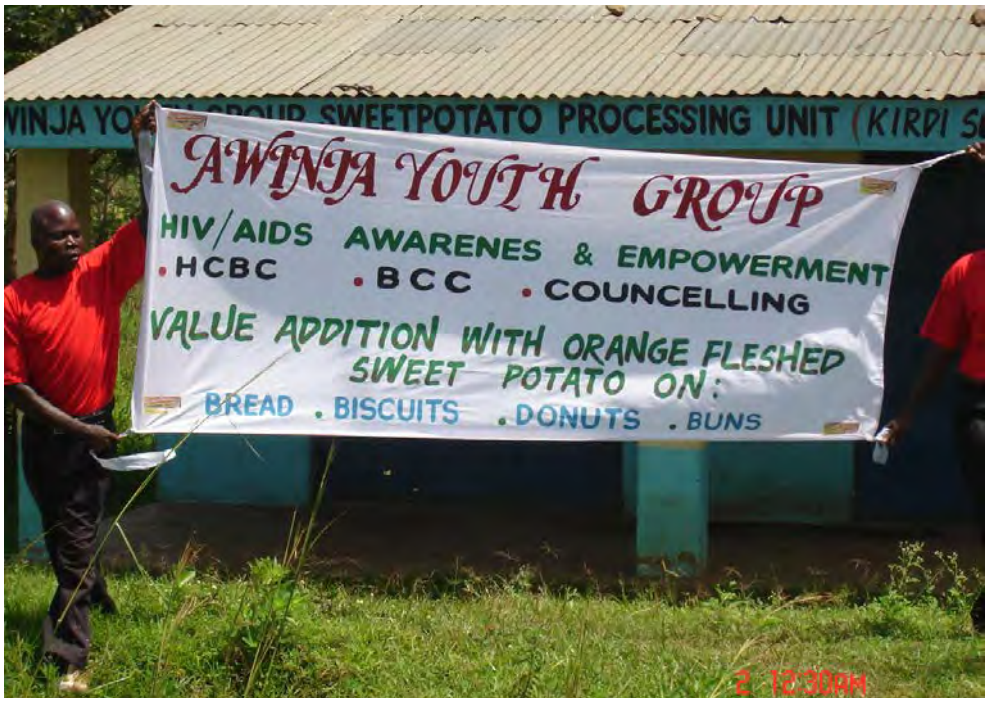


***Fig 7:*** *A banner for one of our Patient Youth groups.*

Table 2: Peer Leaders Training Summary:

| **TRAINING TYPE** | **No. OF SESSIONS** | **ATTENDANCE** | | **TOTAL TRAINED** | **TARGETED PARTICIPANTS.** |
|---|---|---|---|---|---|
| | | **MALES** | **FEMALES** | | |
| Patient Support Group Peer Educators. | 1 | 21(36.2%) | 37(63.8%) | 58 | 60 |
| HIV Discordant Couples | 1 | 24(53%) | 21(47%) | 45 | 30 |
| Youth Peer Leaders | 1 | 19(46%) | 22(54%) | 41 | 30 |
| CHVs | 1 | | | 41 | 40 |
| **TOTALS** | **4** | | | **185** | **160** |

- *HIV Counselling &Testing:*

Following government policy regarding assisting citizens to know their HIV status, we equally initiated home-based counseling and testing (HBCT) along with DNA-PCR tests to exposed children aged six months and below, as supported by the US Centre for Disease Control (CDC)-Kisumu because of limited resources. We were only able to provide this service to SCMH clients.

*Table 3: HIV Counselling and Testing Results*

| **TOTAL TESTED** | **NON REACTIVE ( HIV NEGATIVE)** | **REACTIVE( HIV POSITIVE)** |
|---|---|---|
| Adult Males 100 | 59 | 41 |
| Adult Females 104 | 56 | 48 |
| DNA-PCR Tests to children <6months 329 | 308 | 21 |
| Total | 423 | 110 |

❖ *World AIDS Day 2010:*

We joined others in celebrating 2010 World AIDS Day at St. Camillus grounds for two days before December 1. Our patient support groups presented educative, informative and entertaining activities during the official day at two separate government-organized functions.

❖ *Decentralization of Activities:*

Mobile clinics continued under our decentralization of services initiative. While the community praised our efforts, we met hurdles with same-service providers who were not at home with our visits within the same facilities. An integrated, common-place approach promotes more efficient, harmonious patient service. One new site was added to the list, Kadem TB & Leprosy. 28 Decentralized Children Interactive sessions were successfully conducted within 8 months.

*Table 4: Summary of Decentralized Clinics:*

| Decentralization Site | Number of visits per month | Patients Attached. |
|---|---|---|
| 1.Wath Onger Health Centre | 3 | 398 |
| 2.Muhuru Sub District Hospital | 1 | 118 |
| 3. Kiasa Dispensary | 2 | 225 |
| 4.Osani Dispensary | 2 | 279 |
| 5.Otati Dispensary | 1 | 156 |
| 6.Lwanda Dispensary | 1 | 116 |
| 7.Kadem TB &Leprosy | 1 | 58 |
| 8.Mirogi M. Health Centre. | Operational daily | 735 |
| Total | 11 | 2,085 |

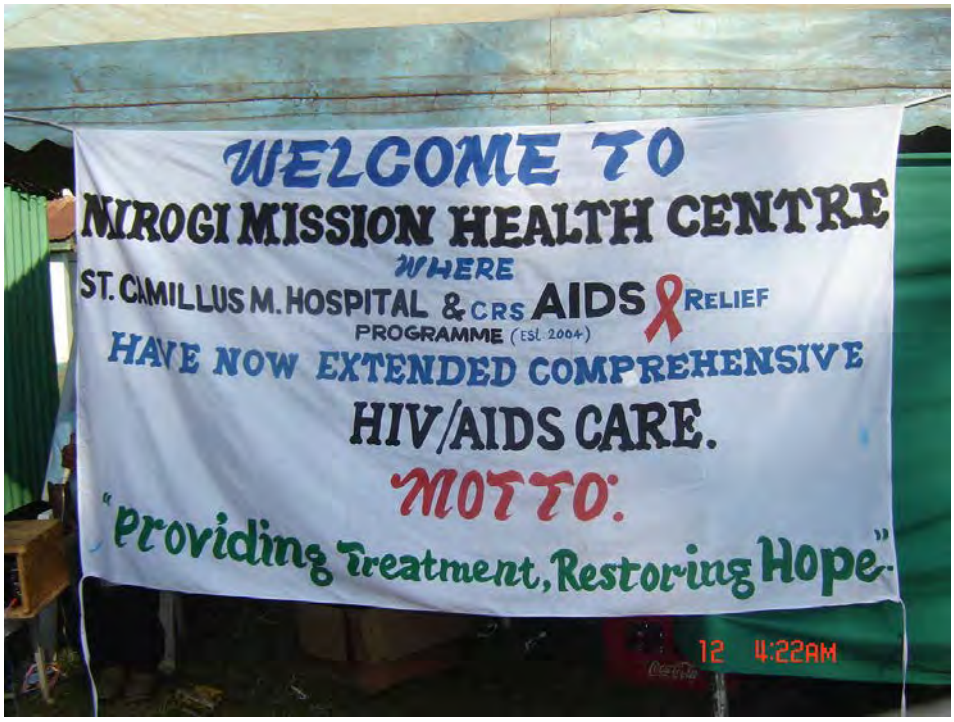


***Fig.8:*** *A Satellite mobilization banner at Ndhiwa.*

### 3.4. Project Administration:

Administration at the Project is done by the Project Co-ordinator. The office oversees planning, budgeting, implementation, monitoring and evaluation activities of the Project.

Because of the global economic meltdown, some of the activities that had been planned could not be funded by the donor during the first 3 quarters. Fund flow, however, was consistent throughout the year. Collaboration between the Project, CRS, relevant government ministries and the hospital administration went on very well with our concerns being addressed well in time. A preliminary report on fund audit revealed no anomalies in the resource management.

Structurally, pharmacy, data and finance space were expanded, and a second intercom line was installed.

With regard to human resources, we can report that:

I. An average of 25 staff members were trained in various internal and external programs arranged under our personnel capacity building plan.

II. Salary increments were awarded to clinical officers, nurses and nurse aides in a midyear remuneration review.

III. Vacant positions were filled well in time.

IV. Staff turnover rate was 28.5% (compared to 17.2% in year six) due to mass recruitment of nurses by the government.

V. Three college students were welcomed and trained for industrial attachments during the year

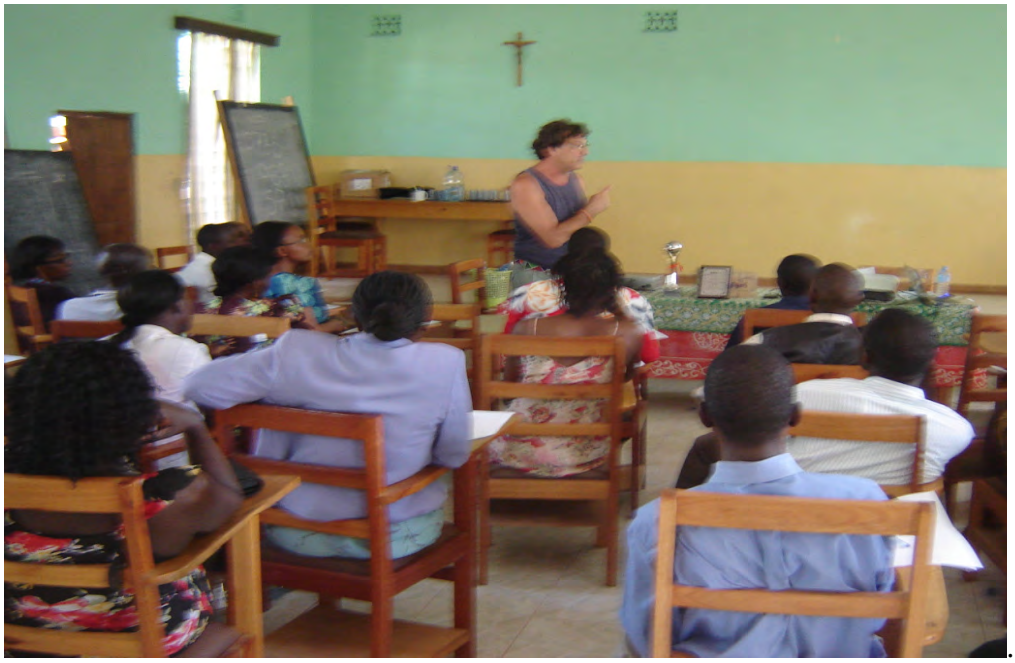

***Fig.9:*** *Fr.Emilio Addresses ART Staff at close of Year 7 annual review meeting.*

## 4. SUMMARY.

**Critical Analysis of Year Seven under Key Indicators.**

### 4.1. Achievements:

- Surpassed annual patient enrolment targets at 157.2%
- Won trophy Award as the best nationally in Clinical HIV care and treatment.
- Aided Kenya's move to the World Health Organization (WHO) map for Drug Adverse Reaction (ADR)/Pharmaco-vigilance Reporting.
- Provided staff training and development at 82.8%.
- Recruited more patients for National Hospital Insurance Fund (NHIF).
- Activated a new satellite--Kadem TB.
- Reduced the amount of time taken by patients at the clinic.
- Expanded data, finance and pharmacy Space
- Achieved patient retention at 87%.
- Established timely management of opportunistic infections.
- Maintained timely reporting to various data consumers.
- Adopted good leadership model from the hospital administration.

### 4.2. Challenges:

- Need for improved communication from relevant Kenyan government offices.
- Clinical staff turnover affecting quality of patient care.
- Integration of activities at mobile sites.
- Persistent electric power interruptions.

Compared to the last reporting year, we have improved on most of the challenges we faced and achieved more.

**Conclusion:**

The project leadership appreciates and benefits from the mutual and warm partnership that has always existed between St. Camillus Mission Hospital and Catholic Relief Services-Kenya, as we continue our efforts to serve the needs of those affected by HIV-AIDS. Without this kind of important intervention, numerous and vital lives could have been lost within Karungu and its environs. Our prayers will remain focused on more strength and spirit, so that we will be enabled to continue to serve efficiently and effectively.

***Fig.10**: Dr.Kabira (left), AIDSRelief-Kenya Co-ordinator awards **N0.1** Trophy to*

St Camillus-Karungu at Pan Afric, Hotel Nairobi.

***Fig.11:** Sr.Monica (far left) and Dr.Obwogo (middle white) of AIDSRelief join Karungu staff in celebrating the trophy immediately after the ward at Pan Afric Hotel, Nairobi.*

Report compiled by:

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**Project Co-ordinator**