

ST. CAMILLUS MISSION HOSPITAL

ART CLINIC
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CRS ART PROJECT



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ANNUAL REPORT

March '08 - February 2009

1. INTRODUCTION

1.1. General Background

Recognizing that HIV/AIDS is a global pandemic, the US- Government empathetically initiated an implementation forum referred to as PRESIDENTIAL EMERGENCY PROGRAM FOR AIDS RELIEF (PEPFAR). This has been the financial hub of HIV related services universally. Within 14 countries worldwide and 28 sites in Kenya, the PEPFAR implementer consortium for the last five years has been AIDSRelief.

High prevalence rate of Nyanza Province in Kenya especially along the shores of Lake Victoria attracted the need for establishment of ART Clinic at St. Camillus Mission Hospital - Karungu in August 2004. Since then the communities that have so far benefited are Karungu, Nyatike and Muhuru Divisions of Migori District, Nyarongi and Ndihiwa Divisions in Homabay District and Gwasssi Division in Suba District.

In Karungu alone the prevalence rate has regressed to 14% within the period. This directly translates to improved health and prolonged life not only to the infected but also to their family members as well. As the saying goes, *“If you are not infected, you are affected”*.

For enhanced quality of service, the program has been on annual planning, implementation, monitoring and evaluation. This runs from March 1 to February 28 of the subsequent year. These are highlighted in form of Objectives, Goals, Strategies, Achievements, Challenges etc



Fig. 1: Karungu Fishing Beach

1.2. YEAR 5 OBJECTIVES

- Patient scale up more so on Pediatrics.
- Enhanced adherence for maximized viral load suppression.
- Staff Retention.
- Therapy knowledge to the communities around.
- First Line Drug as long as possible.

2. GOALS & STRATEGIES

As afore mentioned, it is common that before rolling over to the next year, goals are set to guide intended activities having critically analyzed the performance of the preceding year. To deeply address every level of service, we segmented our approach focusing three key areas namely; Clinical, Community and Administrative components.

2.1. Clinical:

The clinical outlook of the HIV/AIDS scourge is equally vital among other interventions. In our year 5 plan, with the assistance of the qualified Clinicians, a few areas were identified for improvement as well as new approaches. To ensure quality treatment to patients on prophylaxis, primary diagnosis on suspected Opportunistic Infections (OIs) was a key priority before any treatment is decided. Conducting CD4 tests at baseline and after six months was also to be given more attention in year five.

Treatment Preparations (TP) are to continue with a lot of emphasis especially to those due for initiation to ARVs. Two classes to be conducted on a monthly basis targeting sixty patients per session. Where applicable, one to one counseling was also identified fit for patients exhibiting good understanding and are marked for start on ARVs.



Fig. 2: Clinician at Work

Prevention of Mother to Child Transmission (PMTCT) was prioritized with strong interventions like insisting on delivery under medical care for the expectant mothers. After delivery, the exposed newborns to be presented for DNA-PCR at six weeks to determine HIV status.

Decentralization of clinical services to go on in the form of Mobile Clinics and where possible increase of visits per month would be considered. Target for year 5 was to move up to 10 from 8.

Year 5 Targets:

	NEW ENROLLMENTS PER MONTH	END OF FEB. 2009 (CUMMULATIVE)
Non ARVs	140	5136
Adults on ARVs	60	2059
Peds on ARVs	11	304

Table 1. Statistical targets as was focused at the end of year 4 to be achieved at the end of year 5 (February 2009)

2.2. Community:

HIV/AIDS management requires a comprehensive care that does not stop at the clinic but traces the client to socio-economic background. For the success of this, strong community integration strategies were identified and put in place in support of our medical perspective. The Community Team (Community Nurses, Social Workers and Counselors) were able to come up with the following Work plan for the year 5:

ACTIVITIES	MARCH	APRIL	MAY	JUN	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB
1. Collaborators Meeting (50 participants)			Yes									
2. Teachers Workshop (40 participants)				Yes								
3. Support Group Trainings (60 patients/ 4 day Session)		Peds & Caretakers.	Adults	Adults	Adults	Youths	Adults	Adults	Adults	Youths	Adults	
4. Project Mgt. Committee			Yes			Yes			Yes			Yes
5. CHV Meetings	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
6. Home Visits/ Follow-ups	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
7. CHVs End Year Joint Meeting (83 Participants)										Yes		
8. World AIDS Day									Yes	Yes		

Table 2. Work plan for community activities

2.3. Year 5 Administrative Projections:

For the desired end of proposals born out of Clinical and Community plans, any program similarly has to be highly proactive to smoothly blend expectations geared towards betterment of client quality service. Key angles of our Administrative focusing were based on three principles namely; Finance and Human Resource.

2.3.1. Finance:

Patient enrollment targets for year 5 and the Action Plan for the same were instrumental in helping us draw up the monetary budget for the Fiscal Year. Summed projected direct cost for the 12 months was US\$ 366,164 (Ksh. 25,262,306). This was exclusive of ARVs which are usually donated in kind. Key cost categories had a percentage breakdown of the total budget proposal as under:

1. <i>Staff Salaries, wages and benefits</i>	39.0%
2. <i>Equipments</i>	1.9%
3. <i>Lab & Pharmaceutical Supplies</i>	32.79%
4. <i>Travel & Per Diem</i>	6.4%
5. <i>Other Direct Costs</i>	18.8%

2.3.2. Human Resource:

Additional manpower was foreseen as tied to the number of patient scale-up and the enhanced quality of service intended. For this matter, we proposed additional recruitment of new staff as under:

❖ <i>Nurses</i>	2
❖ <i>Social Workers</i>	1
❖ <i>Clinical Officers</i>	2
❖ <i>Data Processors</i>	1
❖ <i>Pharmtech</i>	1
❖ <i>Counselor</i>	1

All the above were budgeted for 10 months within the Projects Financial Year.

Staff trainings were not sidelined either both on site and externally as they would be organized by AIDSRelief or NASCOP.

Internally, AIDSRelief Technical Assistance (TA) were scheduled on quarterly basis as determined by the Headquarters. Further. ONE day per month internal CPD was planned to be co-ordinated by Clinic MO. This was to ensure regular updates on staff capacity.

3. YEAR FIVE PERFORMANCE ANALYSIS

Even though year five has been characterized by ups and downs, our dedicated efforts ensured we sailed through to the better expectation of our esteemed clients as well as the donor community.

To achieve the full end of our planned activities, fundamental systems of our services were first independently monitored and evaluated to ascertain the umbrella success of the Project.

3.1. CLINICAL ACTIVITIES

Our dependable team of five Clinical Officers (COs), one Medical Officer (MO), Pharmacists and Nurses constantly referred their daily operations to the preset goals and guidelines that had been designated for in-depth exploitation. To uphold this, the Continuous Quality Improvement (CQI) team was rejuvenated and empowered to oversee desired clinical outputs. Project MO took the lead and ensured that reviews were conducted on monthly basis and Project Co-ordinator briefed accordingly.

3.1.1. Patient Enrollment:

At St. Camillus, quantity is not a priority but quality hence new enrollments to the ART Clinic were restricted to a maximum of six patients daily. This was in harmony with the Social Workers who were responsible for receiving new clients, registering and forwarding to Nurses for taking of parameters before being enrolled by the Clinicians. Only clinically stable (ambulatory) clients were qualified for enrollment. Weak ones were recommended for in-patient care at the Hospital Wards or anywhere else before HIV/AIDS management would start. This is bestowed in the Principle of ; *HIV IS NOT AN EMERGENCY*.

3.1.2. Care and Treatment for the Prophylactics:

Clinical care and treatment was never independent of Government of Kenya protocol. To enable the COs/MO make reputable examinations on patients, Nurses made proper use of the availed clinical equipments for collection of vital signs from patients. All these continued to be appropriately entered into patient Initial Evaluation Form. Any conflicting entry as would be detected by the clinicians could be drawn to the responsible Nurse for repeat. Accuracy was the word. New patients were subjected to mandatory baseline CD4 cell count, OI diagnosis when suspected and all put on Cotrimoxazole (CTX) awaiting initiation into ARVs.

3.1.3. Initiation to ARVs and Management:

Patients qualified for ARVs were initiated having undergone the Treatment Preparation Sessions (TPS). While we tried to achieve our targets, we were at times limited by unexpected clinical conditions of some patients. Staff turn over was another challenge that greatly frustrated our efforts since the new staff could not steadily track patients due for initiation amidst orientation process. As a whole, we managed 112% of our internal targets 87% for AIDSRelief Targets. CD4 at six months was well adhered to. However, periodical tests such as ALT/SGOP, Creatinine and HCT/Hb were not effective on patients seen at Mobile Clinics due to some logistical complications like collecting blood specimen and availing to the Laboratory in time. This weakness has so far been gotten a solution due for implementation in Year Six.

During the year, we managed an average of 60 adults per session. Only one session was conducted monthly in contrary to two per month as was planned. This drawback was as a result of high turnout of clinically unstable patients from the community.



Fig.3: Kids day at Clinic

3.1.4. PMTCT Intervention:

Albeit the treatment focused attention we gave to our clients, prevention was never sidelined especially to unborn and the pediatrics. Life has to continue though multiple pregnancies are clinically discouraged. As compared to other years, the number of pregnancies among our female patients went up. Our attempts on limiting it is often met by challenges hence managing ANC becomes inevitable. Towards deliveries, clients were advised to deliver under medical attention for preventive measures such as giving Nevirapine drops to the newborns before expiry of 72 hours of delivery.

To track children exposed to HIV, Clinicians used a Family Information Form which captures children <15years born by HIV+ mothers . HIV+ mothers were encouraged to forward their children below the age of <15years for HIV tests. The positive ones were started on treatment. This helped scale up our pediatric enrollments from 326 by Feb.08 to 521peds at the close of year five (Feb '09).

3.1.5. Pediatric Data Up to and Including Feb. 2009:

	MALES <15yrs	FEMALES <15yrs	TOTALS
On ARVs	123	110	233
Non ARVs	149	139	288
TOTAL PEDS	272	249	521

Table 3. Pediatric enrollments by end of February 2009

3.1.6. Drug and Food By Prescription (FBP) Management:

Like other years, the flow of drugs from the supply chain to patients has been relatively commendable. No major interruption was noted. But at times we were challenged where we could be asked not to buy certain OI drugs as they would be donated by either Kenya Medical Supplies Agency (KEMSA) or AIDSRelief only to realize that such donations would take long to arrive thus exposing us to uncalled for scarcity.

As we stock and dispense ARVs, OI drugs and Food By Prescription (FBP) at the same time, storage space still remains a concern though we appreciate the Hospital Administration that has always provided at least what is available.

3.1.7. Statistical Representation of our Enrollments:

With the assistance of the International Quality Care (IQ-Care) tool, designed and installed by the AIDSRelief M&E Team, we are capable of generating accurate data of our performance at any time. This data has been for consumption by the Government of Kenya, Donor and for facility as well. In comparison to the set targets at the start of the year, we have fallen short by 40% on enrollments and 13% on initiations into ARVs. Reason for this is attributed to highly set targets by the funding agency (AIDSRelief) which ignores real situation at the ground.

	End of Year One (Feb 2005)	End of Year Two (Feb 2006)	End of Year Three (Feb 2007)	End of Year Four (Feb 2008)	End of Year Five (Feb 2009)
New Patient Enrollments	413	1377	2277	3456	4490
Total Patients Active on ARVs (Adults)	127	417	810	1339	1668
Total Patients Active on ARVs (Peds)	13	33	92	172	238
Transfer outs	0	8	13	26	176
Defaulters	0	7	27	15	0
Died	14	25	62	95	100

Table 4. Patient statistics by end of every financial year since February 2005



Fig. 4: ART Waiting Bay

3.2. COMMUNITY ACTIVITIES

The success of HIV management is inclusive of other socio-economic magnitudes of patient care and treatment. The smooth marrying of the Psycho-social and Clinical wellbeing of a patient is a strategy that has never failed to bare desired fruits. Under community angle, the below are the systems that have been engaged for a better outcome.

3.2.1.Mobilization:

Year by year since the inception of this Project, mobilization has been employed differently depending on the intensity of awareness in the community. But as a whole its main intention is to scale up the numbers. In year five, previous sources of clients continued though others had to be stimulated a bit. For example, this time we actively took part in marking World AIDS Day both internally at St .Camillus Dala Kiyе grounds as well as at the District level held at Wath Og'er-Kadem.

Songs, live testimonies and dramas performed by our Patient Support Group (PSG) representative from 28th Nov to 1st Dec,08.induced those who had not known their HIV status to do so and those positive now knew where to seek refuge.

At the ART Clinic, we equally tested children of our patients just to ensure the HIV positive ones are brought to care. A tool in the name of family tracking form has greatly boosted our efforts in this.

On a daily basis we had also planned to have one Nurse visit the peds ward to identify suspected cases, advice on DTC and discuss with parents on possible ways of enrolling the positive ones at the ART Clinic.

3.2.2.New patient uptake (Registration)

This is a responsibility bestowed upon the Social Workers who are stationed in room one within the Clinic. They receive new clients referred from our various levels of HIV diagnosis. To balance the demand for rapid scale up and quality of care expected of us, they assessed initial requirements such as disclosure, patient residence, and ambulatory situation of the patient just to ensure only the right clients are registered and forwarded to the Triage Nurses. As such, they maintained a target of only six (06) patients per day for registration at their desk and subsequent enrollment by the clinicians.

3.2.3. Patient Support Groups (PSG)

Patient collaboration has always existed with us and championed towards stigma reduction, enhancing adherence to therapy, and economic empowerment within the community. As such our clients were assisted to form support groups within their villages. Social workers are mandated with the formation and coordination of such units. We were able to establish 14 more PSGs in year five alone which made it to 51 by the close of the year. PSG trainings went on as usual though not at the same venues within the community. A total of 604 patients enrolled within the year benefited from such trainings across our catchment's area. Compared to year 4, this was an increment of 18%. One persistent challenge still realized during these trainings was high expectation over provisions of sitting allowances which our policy disregards. Otherwise, they appreciated the educational facilitations from our able, competent and dependable staff.



Fig. 5: Patient Support Group Meeting

3.2.4. Utilization of Community Health Volunteers (CHVs):

This is a voluntary team that boosts efforts of our community staff in close monitoring of the patient welfare. Throughout the year they smoothly carried out their part and made reports during their monthly meetings. Despite the increment we made on their transport reimbursements from Ksh 400/- to Ksh 500/- monthly, we still felt threatened as a number of organizations who have sprung up in the community do draw them by promising higher remuneration packages. This lends credence to the fact that they are competent and need retention.

As a motivation, we held an end year joint review meeting on December 17, 08 where we awarded them with dinning plates and mugs with HIV message printed on them in local Luo language. The message was:

- ❖ *'Tuo maduong irito kod yath matin'* (A prevalent disease is managed by a small drug)
- ❖ *'Rit kod kony ne jogo modak kod kute mag ayaki'*(Care and support to the people living with HIV/AIDS)

During the year, we replaced three who died and the other two were terminated due to under performance. In addition to the 80 we had in the previous year, we added three to the number to cater for the areas which were poorly represented as there were new catchment areas. Our current strength is 83 CHVs.

3.2.5. Service Decentralization (Mobile Clinics):

In the spirit of moving quality services closer to our esteemed clients, our mobile clinic visits at designated health facilities across the versed catchment area has so far been successful. The demand kept on rising thus necessitated establishing a new site and increasing the number of visits as well to sites where bookings had surpassed the intended manageable number per visit. Basically, between 35-45 is the number of patients who are suppose to be seen at one site per visit.

In respect of this, upper Karungu qualified to get one mobile clinic at Otati Depe Community Dispensary during the month of April 2008. Equally, visits at Osani (Kwabwai) were split into two visits a month. Mobile Clinic sites at the end of the year stands at six with a total of 10 visits per month to respective sites.



Fig. 6: Otati Satellite Site

To some extent, we are still challenged by the community advocating comprehensive care during such visits but our efforts are limited to basic requirements such as a well equipped laboratory for baseline diagnosis. For this reason we only see stable patients on ARVs. To the same patients we were also capable of collecting their blood specimen for CD4 count an activity which required personal visit of the client to the mother clinic at St. Camillus. This was indeed a plus to our cost reduction service delivery to our economic embattled patients.

However, one site known as Lwanda dispensary in Gwassi the management never honored our agreement hence for three months during the year derailed the smooth flow of our service delivery. We had to serve the patients under a tree as the doors of the premises remained under locks. With the intervention of ART Project Coordinator who managed to approach the concerned management, things were restored to the desired normalcy. They apologized to the incident. Total number of decentralized patients is currently 440 which is 30% of the total number of our active patients on ARVs.

SUMMARY OF CURRENT MOBILE CLINICS:

DECENTRALIZATION SITE	ADMINISTRATIVE REGION (DIVISION)	NUMBER OF VISITS PER MONTH	NUMBER OF PATIENTS SEEN PER MONTH
1. WATH ONGER HEALTH CENTER	NYATIKE	3	139
2. MUHURU SUB. DIST. HOPITAL	MUHURU	1	44
3. KIASA DISP.	NYARONGI	2	75
4. OSANI DISP.	NDHIWA	2	68
5. OTATI DISP.	KARUNGU	1	58
6. LWANDA DISP.	GWASSI	1	56
TOTAL		10	440

Table 5. Summary of Current Mobile Clinic Visits

3.2.7. Patient follow ups and home visits.

This is the responsibility of Project Social Workers, Counselor and Nurses. Need for follow ups are primarily based on patient failure to turn up for specific clinic appointments. Other purpose of follow up may also be communicating a diagnosis result that would call for a timely action like positive TB results.

Home visits are also carried out by the same team for psychosocial and clinical monitoring of certain patients with questionable adherence under their respective house holds.



Fig. 7: Home Visit by ART Staff

CHVs have also played a vital role in this. As they are the ones who live with the patients in the villages, theirs is more frequent as compared to that done by the staff. Our numerical strength of the CHVs has always made our community fabrics closely knit. In this year alone, home visits done by CHVs went up to 20,916 from 14,280 which was reported in the 2007-2008 Project Year.

3.2.8. World AIDS Day 2008:

ART Project had a unique participation at two levels of 2008 World AIDS Day. Within St. Camillus we customarily marked the occasion for three days i.e. on 28th, 29th and 30th Nov, 2008. The Project contributed Ksh 40000/- worth of stationeries to make the occasion a success. Further, six PLWHAs Support Groups were sponsored to come and give live testimonies, dramas, and songs.

Another level is at the District where same Support Groups were sponsored for the similar activities at Wath Ong'er grounds. Logistically, two tents and 200 chairs were hired by the Project for use at this District function on 1st Dec, 08. Words of appreciation were showered by the District Commissioner to St. Camillus which made remarkable contributions.

4. PROGRAM MANAGEMENT

This is the cornerstone for the smooth blending of all the activities planned for the year. It can be analyzed in terms of Finance, Human resource, Adherence to structural policies and collaboration.

4.1. FINANCE

The project's budget is fully dependent on US Government donor funding hence all compliance was in line with their requirements.

Year five had a relatively comprehensive budget as all that was proposed was given positive consideration.

Approved budget was US Dollars 369,016/- (Ksh 25,462,100 /-). Our percentage expenditure on cost categories was computed as bellow:

1. <i>Staff salaries, wages, fringe benefits and allowances</i>	= 40.31%
2. <i>Equipments</i>	= 3.92%
3. <i>Laboratory Supplies</i>	=14.32%
4. <i>Drug & Pharmacy Cost</i>	=13.47%
5. <i>Travel and Per Diem</i>	= 4.24%
6. <i>Other direct cost</i>	= 23.73%

At the close of the year (Feb 28th, 2009), we had achieved an overall use rate of 86.32 %.

The reason behind not spending the whole amount is good stewardship and market fluctuation during the period. Being that the budget focus was tied to the patient targets which we were slightly short of, we could not spend the variance of 13.68%.

Cash flow was averagely good on a quarterly basis though little delays could be spotted. Where budget amendments were requested from our side, approvals were faster. Our request for purchase of Fume hood, Microscope, Printer, Furniture, Bicycles and conducting CHV refresher training all were granted with the fastest speed possible.

4.2. HUMAN RESOURCE:

4.2.1. Recruitment and Placement:

All the additional staff / volunteers projected for year five were brought on board though not at the same time.

They were:

<i>Clinical Officer</i>	<i>1</i>
<i>Nurse Aides</i>	<i>3</i>
<i>Social Worker</i>	<i>1</i>
<i>Data Processor</i>	<i>1</i>
<i>Pharmtech</i>	<i>1</i>
<i>Counselor</i>	<i>1</i>
<i>CHVs</i>	<i>3</i>

4.2.2. Attritions:

Irrespective of additional staff, we still suffered some elements of staff turnover. A phenomenon which we are now compelled to adjust with. The magnitude was felt at a rate of 20%. To contain this threat, we replaced immediately though it was a great compromise of our quality.

4.2.3. Staff Trainings:

To enhance the capacity of our staff, we managed to facilitate a number of our staff to attend trainings that came up during the year as organized by NASCOP, AIDSRelief and other organizations. AIDS Relief sponsored trainings came in three phases. Quarterly CPDs in Kisumu, weekly and fortnightly trainings in Kijabe and Nazereth Hospitals etc.



Fig. 8: ART Staff in a Training Session

TRAININGS ATTENDED	DATE	VENUE	TRAINED STAFF
56.IQ Care Basics	April 7-10, 2008	Ukweli Patoral-Kisumu.	Hillary Olola & John Mwomboshi.
57. Malaria Microscopy	April 28-May 2, 2008	Kisumu Hotel.	Cleophas Maarita.
58. Basic ART	May 12-24,2008	AIC Kijabe Hsp.	Baffin Alando
59. CPD	May 24,2008	Jumuia Resort-Kisumu.	Niccolate Awuor, Dericks Kaoga,Obillo Meshack, Benter Pollo.
60. Drug Therapeutic Committee Orientation.	May 23-24,2008.	Jumuia Resort-Kisumu.	Obillo Meshack, Samson Oketch, Dr. Bertha.
61. Effective Mgt of ART Commodities for Health Care Workers in Primary Health Care Settings.	July 21-25,2008	PCEA Guest Hse-Nairobi.	Benard Buyu & Melda Nyamkindo.
62. Costing/Budgeting From Management Perspective.	August 23,2008.	Jumuia Resort - Kisumu.	Obillo Meshack &George Ochieng.
63. HIV Nutrition.	August 11-15,2008/	Jumuia Resort-Kisumu.	Charles Ogada.
64. Quality Improvement Program (QIP)	August 4-8,2008.	Ukweli Pastoral-Kisumu.	Stanley Maina & Cleophas Maarita.
65. Cervical Cancer Screening(CPD)	August 23,2008.	Jumuia Resort-Kisumu.	Dr. Bertha.
66. Adolescent Counseling. (CPD)	August 23,2008.	Jumuia Resort-Kisumu.	Mary Oloo & Linet Mboya.
67. Basic Comprehensive HIV/AIDS Care& Mgt.	September 1-13,2008.	Nazareth M. Hsp.	Lynn Mania.
68. Pediatric ART	September 15-19,2008.	St. Anne's Guest Hse-Kisumu.	Samson Oketch & Evans Oddly.
69. PMTCT Training	October 13-19 2008.	Kolping Voc.Tr. Centre.	Dr. Bertha.
70. CPD	November 8,2008.	Jumuia Resort-Kisumu.	Obillo Meshack, Tabitha Pollo, Evans Ondiek, George Muga, Consolata Wabui, Irine Akinyi.
71. OI Management	November 3-7, 2008.	Sunset Hotel-Kisumu.	Consolata Wamboi.
72. Laboratory Supplies Mgt.	November 24-28, 2008.	PCEA Guest Hse-Nairobi.	Cleophas Maarita.
73. Food By Prescription.	November 23-25,2008.	Tom Mboya Labour College-Kisumu.	Benter Pollo, Samson Oketch, Dr. Bertha.
74. CPD	January 31,2009	Jumuia Resort-Kisumu.	Obillo Meshack, Asumpta Apondi, Cleophas Maarita, Joseph Ongutu, Otieno Evans Dr. Bertha.

Table 6. Trainings attended by ART Staff during the year

4.2.4. Compliance and Collaboration:

Donor policies, procedures and regulations were equally honored. Government guidelines were over and above. Evidence of the same could be realized by the number of government procedures we got from time to time as was directed by the funding agency.

A number of six government stakeholders meetings were attended both at the District and Provincial levels.

Various local government agencies like the chiefs and D.O.s were supportive within the period.

Still on the effort of collaboration, we cannot forget to congratulate Mission for Essential Drugs and Supplies (MEDS) for their donation of 4000 environmental friendly medicine bags for distribution to our clients.



Fig 9: Joint Photo of ART Staff & CRS visiting Technical Team

5. SUMMARY

CRITICAL ANALYSIS OF YEAR FIVE UNDER KEY INDICATORS

5.1. Achievements:

1. Zero defaulter rates maintained throughout the year.
2. All Community activities accomplished as planned during the year.
3. Percentage of Children enrolled for treatment went up by 16%
4. Program has successfully survived for 5 years the first patient as well as the first hired staff remaining.
5. We are the first site to successfully use MSH tool in dispensing OI drugs as well as ARVs.
6. Uninterrupted stocking and dispensing of drugs.
7. Timely monthly reports to relevant authorities including the 5th deadline of every month for AIDSRelief reports.
8. Enhanced communication by subscription to Internet services.
9. Reducing cost of travel to 13% of our patients by moving services closer to them through mobile clinics.

5.2. Challenges Faced:

1. Data wizard not capable of responding to some equally vital queries.
2. Software not able to link families in data.
3. Limited training opportunities for staff.
4. Unsecured drug store at the Clinic.
5. Limited space at the Clinic for dispensing drugs and observation of patients.
6. Scheduling of patients still not harmonized.
7. Targets not achieved in terms of patient scale-up.
8. Suspected treatment failure on patients who have been on treatment for more than three years.
9. Appropriate filing system of patient files.
10. Slow response to behavior change among patients.
11. Lab tests at Mobile Clinics.
12. TB-HIV Integration.
13. Poor access to Family Planning Services by clients.
14. Sustaining active peds club.
15. Staff Turnover.
16. High cost of maintenance for our ageing Vehicle.

5.3. Lessons Learnt :

1. Couple Counseling effective on Family Collaboration.
2. Follow-up within one week on missed appointments reduces defaulter rate.
3. Use of Family Information Form helpful in pediatrics for care.
4. Internal CPDs essential for staff capacity development.
5. Ever changing HIV scenario requires frequent updates on staff capacity.
6. Machine and Personnel very vital for quality service.
7. Collaborative management results in Collective responsibility which is healthy for success.
8. Some clients not literate enough to master some treatment instructions given during Treatment Preparation Sessions (TPSs).
9. Patient Support Group Trainings reduces stigma and improves patient awareness on therapy.
10. Liquidation reporting by 5th of every month facilitates prompt Wire-in Transfers .
11. ARV Works.

5.4. Way Forward :

1. Staff Capacity building to continue.
2. Use of data for decision making.
3. Staff retention.
4. Family collaboration.
5. Continuous patient follow-ups and home visits.
6. Attaching new clients to Support Groups.
7. Initiation of functional Kids Clubs.
8. Additional Dispensing Desks.
9. Zero Returned Vouchers.



Fig. 10: Wachara Village Market

6. YEAR SIX TARGETS

Though targets are externally set by the funding agency, they might not be very conducive with the implementers at the ground. Since we did not meet our high set targets, we are under the obligation to re-adopt Year 5 targets, double our efforts and see it a success.

Below are the Targets for Year Six:

	PER MONTH	END OF FEB 2010 (COMMULATIVE)
NEW PATIENT ENROLLMENTS	140	5276
ADULTS ON ARVs	60	2618
PEDS ON ARVs	11	362

Table 7. Targets for year six (Feb. 2009 to Feb. 2010)

Conclusion:

We promise to expound on the identified weaknesses to help shape our Year Six Performance.

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