SAVING LIVES, IMPROVING HEALTH

Twelve stories of how MSH is helping women and children around the world

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Management Sciences for Health

SAVING LIVES AND IMPROVING THE HEALTH OF THE WORLD'S POOREST AND MOST VULNERABLE PEOPLE BY CLOSING THE GAP BETWEEN KNOWLEDGE AND ACTION IN PUBLIC HEALTH.

This collection of stories represents the lifesaving work MSH and the frontline health workers we partner with perform every day, all around the world. These 12 incredible stories of hope and perseverance highlight MSH's 2012 work in Botswana, Democratic Republic of the Congo, Ethiopia, Guyana, Haiti, Kenya, Lesotho, Nigeria, Peru, Rwanda, and Uganda.

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Cover: Mother and child in Ethiopia/Cactus Communication

CONTENTS

1 SKILLS TRAINING HELPS BIRTH ATTENDANT SAVE MOTHER AND BABY

—By Woodline Gedeon

W. Gedeon / MSH

Tilma, a traditional birth attendant in rural Haiti, holds Ilionelle's healthy baby boy.

One April night, 19-year-old Ilionelle was struggling to give birth at her home in rural northwest Haiti. After several hours, she began having seizures, a clear indication of eclampsia, a severe medical disorder that can lead to the death of the mother, the baby, or both.

Tilma, the traditional birth attendant (TBA) helping Ilionelle, quickly identified these life-threatening symptoms and arranged for her transport to Beraca Hospital for emer-

gency obstetric care. After being carried on a stretcher for four hours along a steep and treacherous road, Ilionelle arrived at Beraca Hospital where she safely delivered a healthy baby boy. "If it wasn't for Tilma, both my son and I could have died," she said.

Tilma has been delivering babies in her community for 22 years with basic skills training that she received from her late mother, who was also a TBA. Through the US President's Emergency Plan for AIDS Relief (PEPFAR)-funded, US Agency for International Development (USAID)-implemented *Santé pour le Développement et la Stabilité d'Haïti* (SDSH) project, Tilma received additional training on performing safe deliveries, identifying signs of high-risk pregnancies, and referring at-risk pregnant women to health facilities for care. This training was vitally important for Tilma who works in Port-de-Paix, a region of Haiti where just 37 percent of births take place at a health facility.

> "Thanks to the project, now I know the procedures for a successful delivery."
>
> **—Tilma**

Tilma is grateful to SDSH and its implementer, Management Sciences for Health (MSH), for facilitating monthly trainings that teach her new clinical skills. "I didn't know I had to wash my hands before and after delivering a baby. I also didn't know the importance of wearing gloves before each delivery, but thanks to the project, now I know the procedures for a successful delivery," she said.

Haiti has the highest maternal mortality rate in the Western hemisphere, with 350 deaths per 100,000 live births. To improve maternal health in Haiti, SDSH has trained 732 traditional birth attendants. Trainees each receive 40 hours of training over five months, empowering them with the knowledge and skills to provide quality care to pregnant women and newborns. SDSH plans to train 2,000 additional traditional birth attendants in 2013. ■

Woodline Gedeon is a former communications consultant for MSH's SDSH project.

2 CELLPHONE-BASED COMMUNITY HEALTH INFORMATION SYSTEM IMPROVES MATERNAL HEALTH

—By Candide Tran Ngoc

In 2011, Drocelle gave birth to her fourth child, and, for the first time, delivered at a health center. Throughout her pregnancy, Drocelle had been monitored by a community health worker, Elizabeth, who regularly visited her at home and encouraged her to go to the Musanze Health Center for antenatal care. When Drocelle went into labor, she contacted Elizabeth, who sent a RapidSMS text message to the Musanze Health Center requesting an ambulance. Without the ambulance, it would have taken Drocelle three hours to walk there.

Candide Tran Ngoc/MSH

Using RapidSMS, a community health worker requested an ambulance to transport Drocelle to the Musanze Health Center, where she delivered a healthy baby.

RapidSMS is a cellphone-based technology being used throughout Rwanda to improve community maternal and child health. This tool helps community health workers track women's antenatal care visits, identify women at risk, refer women at risk to health facilities, and improve communication with health facilities in the event of an emergency. The system also requires community health workers to send simple text messages to the Ministry of Health reporting significant events during a woman's pregnancy, delivery, and the first year

after the infant's birth. Once received by the central level, these messages are stored in a web-enabled database and used to inform the Ministry's strategic planning, technical supervision, monitoring and evaluation, and resource coordination.

Promoted and funded by UNICEF, RapidSMS was first pilot tested in Rwanda in Musanze District. After proving feasible, the Ministry of Health began a national roll-out of the system in June 2010. The USAID-funded Integrated Health Systems Strengthening Project (IHSSP), managed by MSH, helped the Ministry to develop a roll-out plan and budget, design a training curriculum, and train over 1,000 community health supervisors who, in turn, trained over 10,000 community health workers throughout Rwanda. IHSSP also procured and distributed cellphones to the 10,000 community health workers in 30 districts.

Before this system was in place, residents living in remote areas of Rwanda could not easily access health care facilities, as Drocelle did. Patients were often carried long distances to health facilities on stretchers, and most pregnant women preferred to deliver at home or occasionally delivered on the way to the health center. Now health centers are aware of the number of pregnant women in their community, community health workers can easily communicate with health centers during emergencies, and patients urgently needing care can receive ambulance transportation to health facilities.

By May 2011, one year after initiating the RapidSMS system, prenatal care visits in Musanze District had increased by 25 percent, home deliveries had decreased by 54 percent, health facility deliveries had increased by 26 percent, and under-five mortality had decreased by 48 percent.

Nationwide data are now being collected from the other 29 districts and will be used to inform future roll-out efforts in Rwanda and dissemination of these results to the global public health community. ■

Candide Tran Ngoc is a senior communications specialist for MSH's Integrated Health System Strengthening Project (IHSSP) in Rwanda.

3 KANGAROO MOTHER CARE SAVES LIVES OF SMALLEST BABIES

—by Dr. Lucie Zikudieka

Weighing less than three pounds at birth, tiny Mardochet Ulunga might have become another infant mortality statistic, but for one thing: he was born in a health facility where the staff had just been trained in kangaroo mother care.

Low birth weight babies are not uncommon in Democratic Republic of the Congo (DRC). In January 2012, for example, 24 of 536 babies born at Dipeta Health Center in the Fungurume health zone were low birth weight. These infants—often born prematurely—are at increased risk for complications including respiratory problems, impaired vision or hearing, and other issues. Such babies must often spend weeks in an incubator while they struggle to gain weight, and in communities such as Dipeta, incubators are scarce and often hooked up to unreliable sources of electricity.

Skin-to-skin contact helps keep an infant's body temperature stable, promotes mother-to-baby bonding, and provides easy access for regular breastfeeding.

Kangaroo mother care takes the emphasis off technology and places it on the human touch—especially that of the baby's parents. Mardochet's mother, Imukalayi Eponga, was taught the basic principles of kangaroo mother care: skin-to-skin contact helps keep an infant's body temperature stable, promotes mother-to-baby bonding, and provides easy access for regular breastfeeding.

Born two months premature on January 11, at just 2 pounds, 7 ounces, Mardochet was soon snuggled against Imukalayi's bare chest, wearing just a diaper and a knitted cap. Imukalayi would then close her generous cloth *pagne* (wrap) around herself and her son, holding him there for hours, shifting him only when he needed to nurse. His weight stabilized and he started gaining slowly but steadily, reaching 4 pounds, 13 ounces by February 5, just three weeks later. Imukalayi and her son are now at home, and his weight will be monitored regularly until his first birthday.

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Imukalayi Ulunga holds her son, Mardochet, in Democratic Republic of the Congo's Katanga Province.

Health workers in Dipeta were trained in the kangaroo mother care approach in October of last year, as part of the USAID-funded Democratic Republic of the Congo Integrated Health Project (DRC-IHP). Led by MSH with partners the International Rescue Committee and Overseas Strategic Consulting, DRC-IHP is working to improve the basic health conditions of the Congolese people in 80 health zones across 4 provinces, including access to, and quality of, maternal and child care services. ■

Dr. Lucie Zikudieka is the maternal and neonatal health advisor for DRC-IHP.

4 A LIFE TRANSFORMED AT FATSIE HEALTH CENTER

—By Genaye Eshetu and Bud Crandall

Abeba's partner left her when she told him she was pregnant with their second child. Soon after, she went to a nearby health center for antenatal care and discovered that she was HIV- positive. Without a source of income or her partner's support, Abeba asked her family for help, but they refused her. Abeba eventually could not afford to feed her young daughter, and overcome with despair, she tried to end her life more than once. When her friends learned of these suicide attempts, they were concerned for Abeba's safety and recommended that she visit Fatsie Health Center for health services and psychological support. Having nowhere else to turn, Abeba and her young daughter boarded a bus to Fatsie.

G. Eshetu / MSH

Abeba smiles at her new son, Fikadu.

When Abeba reached Fatsie, she was too sick to walk. As she stumbled through the rain, some community outreach workers noticed her and took her to Fatsie Health Center. The health care team began treating Abeba for HIV and helped her get counseling from the clinic's mother support group for HIV-positive women.

Moved by Abeba's story, the outreach workers and mother mentors also found free housing for her and her daughter and collected money from the community to buy them

groceries. They continued to check on Abeba to ensure that she had adequate care and counseling so that she would not attempt suicide again.

Equbay is one of the case managers at Fatsie who helped Abeba. "We are satisfied to see Abeba's life transformed through our counseling and support. It is delightful to see how people's lives are improved by our interventions," she said.

Abeba is grateful for the assistance she received from the staff at Fatsie. "They took care of me like a mother would care for her newborn baby." said Abeba.

> "We are satisfied to see Abeba's life transformed through our counseling and support. It is delightful to see how people's lives are improved by our interventions."
>
> **—Equbay, case manager**

Fatsie Health Center is supported by the PEPFAR- and USAID-funded program, Ethiopia Network for HIV/AIDS Treatment, Care & Support (ENHAT-CS), which is implemented by MSH. In its first year, the program trained and mentored over 2,500 health personnel in 206 health centers, increasing their capacity to provide quality, integrated HIV & AIDS services.

ENHAT-CS also provides mentoring support to 59 mother support groups and has conducted clinical and counseling skills training for 236 mother mentors and the support groups' coordinators. Furthermore, the program manages 350 community-based outreach workers through its subcontractor, the National Network of Positive Women Ethiopians. Since ENHAT-CS started in September 2011, these mother mentors and outreach workers have reached more than 23,000 adults and 4,000 adolescent children with HIV prevention messages and have enrolled over 450 HIV-positive mothers in Mother Support Groups, like the one that helped Abeba.

Abeba now plans to become a community outreach worker and mother mentor herself to help other HIV-positive women transform their lives. ■

Genaye Eshetu is the communications officer for ENHAT-CS. Bud Crandall is the ENHAT-CS project director.

5 ÁGUIDA: A LEADER WORKING FOR THE HEALTH AND DEVELOPMENT OF HER COMMUNITY

—By Eliana López

Peru's maternal mortality rate remains among the highest in the Americas. Access to health care workers who speak indigenous languages such as Quechua is almost nonexistent. Chronic child malnutrition affects close to half of children under five years of age. And men pay little attention to areas considered "women's issues," such as maternal, child, and reproductive health.

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Águida Curo Vican, at right, visiting a new community member to share information on healthy practices.

Fortunately, all of this is changing in the rural Peruvian community of Tutumbaru, thanks to Águida Vicaña Curo and the Local Development Committee (LDC).

Águida's efforts to improve her community's health began in 2005 under the USAID-led project Healthy Communities and Municipalities (HCM), led by MSH, with the aim of improving maternal and child health throughout Peru. HCM staff met with the 96 families in Águida's community to form, train, and coach the LDC, which is comprised of men and women dedicated to improving the lives of their neighbors.

As part of the LDC, Águida routinely visits all the families in Tutumbaru to encourage them to adopt healthier lifestyles. The LDC also leads community information meet-

ings to educate the families about basic healthy behaviors, such as cooking nutritious meals, chlorinating water to make it safe for drinking, and giving birth in the local health facility.

Águida and the LDC have seen their efforts take root: now all of the children in Tutumbaru under 6 months are exclusively breastfed, all children between 6 and 23 months are drinking safe water, and pregnant women are regularly attending prenatal visits.

Two years after the LDC was created, the people of Tutumbaru elected Águida as its president, and, in 2009, she was elected mayor of Tutumbaru. Her election marked a milestone in the history of the community—Águida became the first woman to hold such an important position.

Under her leadership, women are encouraged to participate in decision-making and men are encouraged to take an active role in monitoring and improving the health of the community, which the LDC routinely surveys every six months. "Before, the men did not meddle in women's health; that was seen as wrong. Now men and women work together as one body," says Juan Coronado, a member of the LDC.

Águida's accomplishments were recognized internationally in 2012 by the Pan American Health Organization (PAHO), which selected her experience as one of four winners in the Fifth Contest for Best Practices that Mainstream Gender Equality in Health. The second phase of the HCM project, HCM II, published the experience in Tutumbaru, thus disseminating the story of Águida's triumphs to new audiences.

Águida notes that her greatest satisfaction comes not from the accolades but from the knowledge that every day, the women and children of her community are growing healthier and have the opportunity to lead better lives. ■

Eliana López is a behavior change communication specialist for HCM II.

6 PEPFAR HEALTH PROFESSIONAL FELLOW DRIVES COMMUNITY SERVICE

—By Adebisi Aderonke Arije

Sister Catherine Okpa (also known as Sister Kate), a Catholic nun and medical practitioner, served as Medical Director of the Catholic Maternity Hospital in Ogoja, Cross River State, Nigeria until August 2009. Earlier that year, she participated in the PEPFAR Health Professionals' Fellowship Program, facilitated by MSH through the Program to Build Leadership and Accountability in Nigeria's Health System (PLAN-Health).

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Dr. Osondu Ogbuoji, a former PLAN-Health associate director, listens as Sister Catherine Okpa shares her story in the MSH Nigeria office in Abuja, Nigeria.

The training program inspired her to conduct rescue missions in hard-to-reach communities. "The MSH training ignited a fire in me; a burning passion to make a difference," Sister Kate commented. "I have always had a keen interest in maternal mortality intervention, so I applied the lessons I'd learned to this. There is a way the fellowship training pushes you to start something—the approach, it was just different."

Shortly after the training, Sister Kate began full-time community outreach through Our Lady Comforter of the Afflicted, her community-based organization. Working in four different communities from 2009 to 2012, she led

several health-development interventions on sanitation; safe birth delivery; immunization; and HIV prevention, testing, and counseling, as well as prevention of mother-to-child transmission (PMTCT) of HIV. The training helped her identify an underutilization of primary health care centers by pregnant women and their preference for traditional birth attendants as obstacles to maternal health in Cross River State. She then designed an intervention to address each issue using the Challenge Model.

The Challenge Model is a simple learning tool teams use to address real challenges and achieve results in the workplace. Starting with a shared vision, the Challenge Model fosters team motivation and commitment to facing challenges and achieving results.

> "I have always had a keen interest in maternal mortality intervention, so I applied the lessons I'd learned to this."
>
> **—Sister Kate**

In partnership with the Cross River State Agency for the Control of AIDS, Sister Kate's community-based organization led the PMTCT component of a World Bank-funded project. In total, 143 traditional birth attendants in 4 communities were empowered to provide HIV prevention counseling and referral services (to primary health care facilities) toward a goal of zero maternal deaths and an HIV-free next generation. Ninety-seven male community members were also mobilized to encourage their partners to go for HIV testing and to support those found positive.

The project counts among its successes the fact that it has helped increase birth referrals by the attendants and decreased home deliveries in the community. Traditional birth attendant referrals in Boki community, for example, increased from 2 to 31 between February and May 2010, and the number of home deliveries decreased from 39 to 15 within the same period. ■

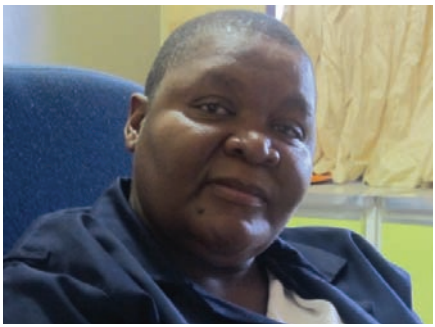
Adebisi Aderonke Arije is the director of communications for MSH Nigeria.

7 DETERMINED LEADERSHIP HELPS XHOSA CLINIC IMPROVE SERVICE DELIVERY TO THE COMMUNITY

—By Tinah Molatlhegi and Naume Kupe

A journey of many miles begins with a single step. Xhosa Clinic has taken many determined steps in the journey to improve the quality of care to the community, thanks to the leadership of Kgakololo James, the nurse-in-charge at the clinic.

N. Kupe / MSH



Nurse Kgakololo James in her office at the Xhosa Clinic.

Xhosa Clinic in Mahalape, a small town in the Central District of Botswana on the edge of the Kalahari Desert, is one of 11 health facilities enrolled in the Quality Improvement Leadership (QIL) program. QIL is a Botswana Ministry of Health pilot program to improve service delivery through international accreditation of health facilities. The MSH-led Building Local Capacity (BLC) for Delivery of HIV Services in Southern Africa Project coordinates the QIL with funding from PEPFAR.

Results of the 2009 baseline survey conducted by the Council for Health Service Accreditation of Southern Africa, the BLC partner in the QIL program, identified all the 11 service elements as partially compliant or noncompliant. "It was tough," recalled Nurse James. "We did not know where to start. We were not compliant in more than 50 percent of service elements, and some were critical criteria. BLC then conducted workshops on leadership development and showed us how to use tools to help us identify and address the many challenges we had."

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Walking around the compact clinic yard, Nurse James proudly points out the improvements that have come through implementing the QIL. "Our latest acquisition is these metal scraps," she says. "Next time you come here, they will have been transformed into cages to house our gas cylinders. I personally went to the old hospital to get these discarded materials," Nurse James reports with a laugh, adding that she is always scanning her environment for materials to improve her clinic.

At the back of the clinic are two sets of large, sturdy plastic bins, the red containing clinical waste and the black containing nonclinical waste. They are sheltered by a makeshift tin roof and enclosed in a fence. "Now we have two sets of bins to separate the rubbish," Nurse James explains. "Previously we had the bins under a tree where the dogs could scavenge. Now we can close the gate to manage the waste, and we control the spread of infections."

Nurse James emphasizes that patients' welfare is at the core of the work she and her staff do to improve the clinic. "This program has taught us to be more open to assessment. We regularly ask the patients to rate our services, and we work hard to improve the weak areas," she asserts.

At the last sampled validation in June 2012, Xhosa Clinic's overall score stood at 77 out of a minimum of 80 points required for accreditation. The Ministry of Health is addressing the outstanding infrastructural challenges to ensure accreditation in 2013.

In Botswana, the USAID-funded BLC project provides targeted technical assistance to the Ministry of Health and 11 health facilities to overcome the challenges to improve their service delivery and advance toward becoming internationally accredited. Although not yet accredited, Xhosa Clinic is one of two facilities showing the most improvement. BLC is also implementing the QIL in two hospitals in Namibia. ■

Tinah Molatlhegi is the capacity building advisor and Naume Kupe is the communications specialist for the BLC Project.

8 LEADERSHIP PROGRAM STRATEGIES HELP HOME-BASED CARE TEAM IMPROVE CLIENT RECRUITMENT

—By Shameza David

Since 2004, the PEPFAR-funded, USAID-implemented Guyana HIV/AIDS Reduction and Prevention project (GHARP I and II) has trained 235 staff and health workers of non-governmental organizations from seven regions in Guyana using the Leadership Development Program (LDP). Designed by MSH, which leads GHARP II (2009–2013), the LDP provides health care teams with tools and skills to improve leadership and management systems and address workplace challenges.

Loretta Angel works for Family Awareness Consciousness Togetherness (FACT), one of the NGOs that receives technical support from GHARP II. Loretta completed GHARP I's LDP training in 2006 and is still using the leadership and management skills she gained through the course. In 2010, when FACT was struggling to enroll new HIV-positive patients into its home-based care program, Loretta began facilitating weekly LDP sessions with the entire home-based care team.

The program's root cause analysis revealed that staff members were not motivated to recruit new clients and most viewed their jobs as an obligation, rather than something they were passionate about. As a result, the team had enrolled only 98 new clients over seven months, though the annual target was 200. "I felt as though the LDP was our only hope for reaching our [home-based care] targets, since our backs seemed to be against the wall," Loretta said.

To address this issue, Loretta helped the team develop an

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action plan to improve staff morale and inspire a greater commitment to home-based care outreach. First, the team broke down the annual target into monthly targets, which immediately seemed more achievable. Loretta also used LDP tools to explain the difference between commitment and compliance and the benefits of working in cohesive teams where all members are dedicated to quality performance. As staff recognized the important roles they played in helping HIV-positive people access needed care, they began actively conducting outreach in their communities. FACT also started working closer with the local care and treatment center to strengthen referrals for the new clients. Four months after Loretta initiated the LDP training, FACT had enrolled 203 new people into the home-based care program, thereby surpassing its annual target with one month remaining in the year.

V. Hinds, USAID/GHARP II

Loretta Angel leading the LDP priority matrix exercises to help her colleagues select activities most essential for improving home-based care.

Looking back, Loretta attributes this accomplishment to the LDP's team-building and problem-solving strategies. "After we started using the different LDP tools, everyone took his or her responsibility more seriously and began to work as part of the team," she said.

To sustain the success of the LDP in Guyana, GHARP II has developed an LDP alumni network and a "core group" of 25 course graduates who help to lead the LDP expansion efforts. These alumni groups meet regularly to plan and conduct new LDP sessions and facilitator trainings. Several of the LDP graduates are also working with the Ministry of Health's Director of Health Sciences Education to incorporate LDP content into the national nursing school curriculum. In 2011, GHARP II's survey among LDP alumni showed that 74 percent of LDP alumni continue to use one or more of the LDP tools in their daily work. ■

Shameza David is a program officer for GHARP II in Guyana.

9 QUICKER MALARIA DIAGNOSIS LEADS TO FASTER TREATMENT

—by Yvonne Otieno

Around 11 in the morning, mothers begin streaming into a Western Kenyan health facility. Baby Victor's mother has brought him today for a routine immunization, but she's also concerned about his lack of appetite and high fever. The nurses recommend that one-year-old Victor be tested for malaria.

Y. Otieno/MSH

Baby Victor and his mother

Thanks to a malaria rapid diagnostic test (RDT) kit, Victor's test results come back in just half an hour. He is positive for malaria and is started immediately on first-line treatment.

Three months ago, Victor's mother would have had to wait hours to receive those results and treatment.

Mbale Provincial Rural Health Training Centre in Western Kenya receives about 120 outpatient cases, such as baby Victor's, per day; typically about 41 percent of them are treated for malaria. Although the Centre provides various medical services at a subsidized rate, malaria treatment is free.

According to Dr. Jacob Odipo, who is in charge of the facility, all children under five also receive free mosquito nets. Still, malaria infection in children remains high, most likely because of mosquito bites the children receive before going to bed.

"Previously, we relied on microscopy for malaria testing, and with the limited number of lab technicians, patients would have to wait for three to four hours for their results. Some left

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before receiving test results because of the long distances they would have to travel back home," explains Dr. Odipo. "We suspect, too, that an unknown number were self-medicating for malaria to avoid the long lines."

The Centre has only one lab technician performing an average of 200 lab tests per day. "Malaria RDT kits have helped ease congestion in the labs and help patients receive treatment faster—plus now, only those who test positive for malaria receive malaria medication," Dr. Odipo pointed out.

A much-needed intervention, rapid diagnostic tests reap benefits across all areas of the health care delivery system, including costs. Faster and correct diagnosis saves, for example, 80 percent in unnecessary treatment expenses for a negative result. The kit costs 1 USD; the unsubsidized retail cost for the medication used to treat malaria—artemisinin/lumefantrine (AL) 24s—is approximately 5 USD.

> "Malaria RDT kits have helped ease congestion in the labs and help patients receive treatment faster."
>
> **—Dr. Jacob Odipo**

Before now, the management of malaria has been based on the clinical symptoms of a patient under age five in malaria endemic zones, but the Kenyan government recently adopted a universal diagnostic policy to successfully provide universal malaria treatment. This led to the procurement of approximately 80 million rapid diagnostic tests for distribution and use in 2012 through the help of development partners.

Through funding from the President's Malaria Initiative (PMI), the USAID-funded, MSH-led Health Commodities and Services Management (HCSM) Program in collaboration with the Kenyan Division of Malaria Control (DOMC) currently provides assistance to ensure that the procured rapid diagnostic tests and other malaria commodities are managed appropriately. HCSM and DOMC are training 3,200 frontline health workers on the use of rapid diagnostic tests in lower-level facilities countrywide. ■

Yvonne Otieno is a communications specialist for MSH Kenya (HCSM).

10 ELECTRONIC PHARMACEUTICAL MANAGEMENT IMPROVES ANTIRETROVIRAL THERAPY SERVICE

—By Kekeletso Ntoi

Lesotho's pharmaceutical sector faced two formidable challenges: the unreliable supply of essential medicines and the unknown quality of medicines circulating in the country. Inefficiencies within the supply chain system were at the root of both problems, specifically weak information management systems that did not support decision-making in the supply chain. This resulted in the Global Fund to Fight AIDS, TB & Malaria (Global Fund), setting a condition precedent that had to be addressed for the country to qualify for further disbursement of a round of funds: the establishment of a robust and functional management information system for the antiretroviral therapy (ART) program.

MSH/Lesotho

Mr. Sello Lechesa, a pharmacy technician and RxSolution user in the ART pharmacy at Maluti Adventist Hospital.

The Ministry of Health established the Pharmaceutical Management Information System (PMIS) to provide information to drug supply management staff through scheduled and on-demand reports for management control and to facilitate informed decision-making and strategic planning.

The RxSolution, an electronic pharmaceutical management system developed by the USAID-funded Strengthening Pharmaceutical Systems, helps the Ministry of Health implement PMIS. Data from this electronic tool are used to meet all the reporting requirements for PMIS. The World Health Organization (WHO) early warning indicators can also be tracked using the system at antiretroviral therapy sites.

The Global Fund supply chain specialist from Geneva, along with SIAPS, visited Maluti Adventist Hospital, where RxSolution is used for antiretroviral therapy pharmaceutical management, and conducted data

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quality checks. The pharmacy technician in charge of the antiretroviral therapy pharmacy, Mr. Sello Lechesa, reported that since implementing RxSolution, the hospital has been able to calculate average monthly consumption for adults on antiretroviral therapy. The hospital uses that information, in turn, to accurately determine the number of people currently on antiretroviral therapy during the reporting period.

"All RxSolution needs is for you to understand how it works," Mr. Lechesa explained. "Use it, and it will work for you and for your ART clinical management solutions."

The RxSolution intervention has improved the quality of data generated from sites. Errors—especially transcription errors—have been minimized. The visiting team confirmed that RxSolution is a remarkably helpful tool to measure consistency and accuracy between the recorded data and reported information. Ninety-two percent of information from sites using RxSolution is accurate compared to 78 percent before RxSolution's introduction. Such high-quality data dimensions help ensure accurate quantification of needs and procurement of anti-retrovirals in the country.

> "All RxSolution needs is for you to understand how it works."
>
> **—Sello Lechesa**

So far, RxSolution has been implemented in 11 hospitals as the scale-up of the system continues. Ongoing on-the-job trainings during supportive supervision and mentoring visits ensure that the system is sustainable not only in maintenance but also as a continued effort to build capacity among health care workers.

Ultimately, the goal is better health outcomes—and that goal is at the core of the SIAPS program's work in support of the Ministry of Health. Data generated from sites will feed robust and comprehensive information up the chain to complete the pharmaceutical management framework, ultimately curbing the countrywide inefficiencies that once plagued Lesotho's pharmaceutical sector. ■

Kekeletso Ntoi is the monitoring and evaluation advisor for MSH Lesotho (SIAPS).

11 LIFE LINE BRINGS BACK PATIENTS IN ETHIOPIA

—By Berhan Teklehaimanot

Tesfa Taye, a pharmacist and representative of the Pharmacy Case Team at Selam Health Center in Addis Ababa, Ethiopia, constantly reminds patients to come to the health center to collect their medicines at their scheduled appointments. He knows that doing so will improve his patients' adherence to treatment.

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Tesfa Taye, a pharmacist at Selam Health Center

In the past, Tesfa's efforts to keep in touch with his patients had been met with little success. "The health center had only one telephone line," he recalled, "and it was in the office of the medical director. We had to wait for our turn if we wanted to use it, and even then we could use it only for urgent and supply-related purposes."

In response to similar problems, the USAID-funded Systems for Improved Access to Pharmaceuticals and Services (SIAPS) Program installed telephone lines at more than 100 of the largest antiretroviral therapy pharmacies—including Tesfa's Selam Health Center—and paid a maximum of Birr 400 per month (22 USD) to settle telephone bills at each of the health facilities.

"Thanks to the support of USAID and SIAPS," Tesfa remarked, "we were able to establish contact with our patients at their homes or workplaces or through their relatives or friends. We are grateful for this support because it has allowed us to trace many lost-to-follow-up patients

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and bring them back to treatment."

More than 300 patients who had defaulted on their treatment have been tracked down. Thus far, 240 have been brought back to treatment—that's an impressive 80 percent of patients who had defaulted or stopped taking lifesaving HIV & AIDS medicines.

In addition, many of the health facilities have realized the importance of the service and are now paying the telephone bills themselves. ■

Berhan Teklehaimanot is a technical advisor for MSH Ethiopia (SIAPS).

"We were able to establish contact with our patients at their homes or workplaces or through their relatives or friends. We are grateful for this support because it has allowed us to trace many lost-to-follow-up patients and bring them back to treatment."

—Tesfa Taye

12 SUPERVISION TOOL IMPROVES HOSPITAL PHARMACY OPERATIONS

—By Julian Natukunda

In eastern Uganda, the staff at Kapchorwa Hospital had continuously searched for ways to improve their services. They conducted and attended continuing medical education training sessions where they discussed challenges and shared new ideas, and participated in other trainings held within the district. But they wanted more.

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Kyoko Yamada (left), a volunteer pharmacist, and other pharmacists use the new trays to count medicines to dispense to patients.

So in 2011, Shaban Cherop, head of the Kapchorwa Hospital pharmacy, took a two-week medicines management training course conducted by the USAID-funded and MSH-led Securing Ugandans' Right to Essential Medicines (SURE) program.

The program trained 146 medicines management supervisors to carry out regular supportive supervision and on-the-job training in public and private facilities. To monitor progress in medicines management, the supervisors assess performance during their visits to health facilities using a standard tool with indicators that measure storage and stock management, ordering, reporting, prescribing, and dispensing quality.

Shaban presented the performance assessment tool he acquired from the training to the Kapchorwa Hospital health staff who agreed to adopt the tool to improve medicines management.

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"After acquiring the supervision tool from the SURE program, we have been incredibly pleased to use it to standardize our practices," Shaban reported.

"Using the tool, we score ourselves, identify weak areas, and discuss, plan, and act on them before the supervision period approaches. We have now adopted the tool for training staff in our continuous medical education sessions," added Kyoko Yamada, a volunteer pharmacist from the Japan International Cooperation Agency working with the hospital.

Since the hospital started using the supervision tool and incorporating it into their continuous medical education curriculum, the pharmacy staff has noted increases of up to 67 percent in the correct use of stock cards, and from 27 to 100 percent on stock management indicator scores between June 2011 and January 2012.

"Using the tool, we score ourselves, identify weak areas, and discuss, plan, and act on them."

—Kyoko Yamada

Other key improvements at Kapchorwa Hospital pharmacy include the following:

- Medicine counting trays now replace the unhygienic use of bare hands for dispensing.
- A hand-washing facility for patients was installed along with a source of drinking water.
- The hospital has adopted the use of standard labels for dispensing envelopes.
- Store assistants have learned how to detect and correct stock discrepancies.
- Medicines are now categorized vital, essential, or necessary, which facilitates medicine use analysis. ■

Julian Natukunda is a communications associate for MSH Uganda (SURE).

TAO OF LEADERSHIP

Go to the people
Live with them
Love them
Learn from them
Start with what they have
Build on what they know.

But of the best leaders
When their task is accomplished
The work is done
The people will all remark
We have done it ourselves.

—Lao Tzu

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