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- Better Storage Practices for Improved Access to Medication
Dr. S.K Sharif, Director of Public Health and Sanitation, launching Malaria Rapid Diagnostic Test (RDT) Kits in Kenya. See full story on page 6
Word from the Chief of Party

September, 2012 marked one and half years since the launch of the Health Commodities and Services Management program in Kenya. The same September, 2012 also marked the end of the work plan year 1 for the program and presented a time for reflection by the project.

At inception, the Health Commodities and Services Management (HCSM) program had the clear mandate to collaboratively work with the Ministry of Health in strengthening commodity management, strengthening pharmaceutical services, and laboratory services.

This Newsletter - HCSM Recap, as the name suggests, presents a succinct snapshot of the activities undertaken with focus on both national and regional activities to support Tuberculosis treatment, Malaria diagnosis, Reproductive Health, HIV mitigation, better pharmaceutical and laboratory services. The ultimate aim is to ensure robust systems are put in place to assure the country of sustained availability of high quality medicines for all Kenyans. A summary of programme achievements and focus of work plan year 2 are detailed in the newsletter.

At health facility level, the programs and regional staff together with the members of the provincial and district Health Committees, have shown great commitment in ensuring commodity security through transfer of skills to health facilities on proper commodity management practices (determining the quantities required products, ordering, receiving, appropriate storage and issuing of the products to the users). This is highlighted in the article from Kabichbich health centre which shows how Better storage practices can improve access to medication. Esther on the other hand, a TB Nurse from Kabichbich Health Centre will help readers see the importance of correct record keeping in ensuring availability of correct medicine to the public. Read her story – A calling to care for sick and weak.

While availability of quality medication is key in the delivery of quality services to the population, reporting on adverse reactions or resistance to medication is just as important in the management of Tuberculosis. Pharmacy and Poisons Board (PPB) is creating awareness on pharmacovigilance for Multidrug resistant TB.

The last October signaled a key milestone for the Division of Malaria Control with how the launch and roll out of malaria rapid diagnostic kits nationally. What does the launch mean to the ordinary Kenyans? Mama Victor featured on page 14 will help us better understand the importance of the malaria rapid diagnostic kits while we can get the healthcare workers views on the experience during a training on use of the rapid diagnostics kits.

As a new addition to this team; I am optimistic that collaboratively working with Ministry of health, HCSM will continue supporting and informing policies and laws as well as strengthen systems for better pharmaceutical and laboratory services and commodity management. This need is greater especially as the country transitions to the devolved system of government. Together we can achieve Kenyans’ constitutional right to access to quality healthcare.

Happy Reading to all,

John Chimumbwa

Chief of Party,

Health Commodities and Services Management (HCSM) Program

Disclaimer: The information provided in this Newsletter is not official U.S Government information and does not represent the views or position of the U.S Agency for International Development or the U.S Government."
Kabichich is a Level 3 health Centre based in West Pokot County. The hospital receives about 1000 outpatients a month. The common ailments treated at Kabichich are Malaria, URTs and Skin diseases.

Mr. Mabele is one the participants at an orientation training organized by United States Agency for International Development financed Health Commodities and Services Management program.

His work involves screening outpatients, reviewing lab results, prescribing medication and lab follow up. He also assists in HIV and TB follow up. Andrew does not work alone but together with Sister Lillian Chebon who he helps in dispensing the Antiretroviral (ARVs) and Tuberculosis (TB).

In March 2012, the District Health Management Team conducted a supervisory visit at Kabichich among other facilities in West Pokot. “Our store had not been arranged for the past ten years,” says Andrew Mabele who joined the team in early January 2012.

“The arrangement of drugs in the store was disorderly, we had empty boxes and limited storage space. We could not access cupboards. The store did not have any pallets; commodities were kept on the floor presenting a risk of contamination. We also had some expired medication which we learnt about only after rearranging the stores.”

“I know that medicine is poisonous, if it is contaminated, it will poison my clients and they will keep returning to the facility. To prevent contamination of the medicine we receive, our facility has invested in proper storage,” says Andrew Mabele a clinical officer who working in Kabichich Health Centre area in West Pokot.
Every month, helps in monitoring the consumption and informs the planning and procurement of commodities at a national level. Wrong calculations from the facility can lead to over or under procurement leading to expiries or shortages.

“The quantities of commodities available on site did not correspond with those captured in monthly commodity reports I received. Additionally, laboratory commodities such as HIV test kits and malaria rapid diagnostic test kits (RDTs) were stored at the dispensing pharmacy instead of the laboratory thus contributing to space constraints,” Dr. Nyakundi explains. “Although the facility had stock cards and bin cards they were hardly used due to lack of skills on how to use the tools,” he adds.

“We were using exercise books as stock cards, and stock cards for dispensing medication to patients,” says Mabele.

According to Dr. Enock Nyakundi, West Pokot, District Pharmacist for four years in the area, the poor arrangement of the stores led to inaccurate physical count of commodities this resulted in frequent adjustments of data in monthly reports. The monthly reports from facilities are useful in determining the quantities of commodities required by each facility every month, helps in monitoring the consumption and informs the planning and procurement of commodities at a national level. Wrong calculations from the facility can lead to over or under procurement leading to expiries or shortages.

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Kenya Launches Malaria Rapid Diagnostic Test Kits

By Alex Muturi, Robert Kimbui and Yvonne Otieno

Malaria continues to be a leading cause of morbidity and mortality in many countries, especially in Sub Saharan Africa. In Kenya, malaria alone accounts for 30% of outpatient admittance and up to 5% of inpatient deaths while 170 million working days are lost annually because of it.

In 2004, Kenya changed its malaria treatment policy opting for the use of artemisinin based combination therapy (ACT) as first-line therapy for uncomplicated malaria. This led to a more effective treatment regimen yet it was noted that improvement of malaria case management requires not only the correct use of effective medicines but also ensuring that patients are accurately diagnosed and appropriately managed.

On October 4, 2012 malaria rapid diagnostic test kits (RDT) were nationally launched, marking another milestone in the fight against malaria. The launch is expected to scale up the diagnosis of malaria using RDTs nationally and promote appropriate use of anti-malarial medicines.

The USAID funded, MSH implemented, Health Commodities and Services Management (HCSM) program provided support to the Kenyan Division of Malaria Control (DOMC) for the development of the RDT roll out plan, including roll-out processes and procedures and an emphasis on quality management and monitoring and evaluation.

Speaking during the launch, Dr. S.K Sharif, Director of Public Health and Sanitation, said that evidence showed that Kenya has made significant strides in the fight against malaria in the past ten years and that the launch of the RDTs would see the country go to the next level in the fight against malaria.

“The 2010 malaria indicator survey points out that the malaria prevalence in the country is dropping from 40% to lower than 20% across the country with low transmission areas having prevalence of below 1%. However significant proportions of the population in the lake region still bear a high prevalence and it is no longer appropriate to equate fever with malaria, thus the need for a parasitological confirmation of every suspected case of malaria before giving appropriate treatment,” said Dr. Sharif.

Benefits of RDTs

The RDTs represent benefits across all areas of the healthcare delivery system; specifically patients are diagnosed and treated correctly while in health facilities. With improved diagnosis, healthcare managers can forecast accuracy on medicines needed to treat malaria cases, saving a lot of money on a surplus of medicines.

For example, a malaria rapid test kit costs $1 USD while the unsubsidized retail cost for Artemisinin/ Lumeafantrine (AL) 24s – used for malaria treatment – costs approximately $5 USD. Correct diagnosis saves the government or the patient $4 USD in unnecessary treatment costs for malaria negative cases.

Additionally, the threat of parasites becoming resistant to medicines is reduced if diagnosis-based treatment is used. This subsequently increases the useful therapeutic life of the available medicines and reduces the chances of changing treatment guidelines to more expensive and ineffective medicines.

“These RDT kits will complement the efforts made by the ministry in strengthening malaria diagnosis,” he added.

The launch was attended by various development partners including USAID, Presidential Malaria Initiative (PMI), UKAID, UNICEF and WHO, all who congratulated the Ministry for achieving such a milestone. Partners holding the Implementation plan for RDTs

Test, Treat and Track

The management of malaria has previously been based on the clinical symptoms of a patient under five in malaria endemic zones. It became necessary to embrace a universal diagnostic policy for all age groups and all zones regardless of the endemicity to successfully provide universal malaria treatment.

Based on global recommendations, the Kenyan government adopted a policy of universal diagnosis of malaria for all ages and across all areas in the country. Any and all suspected malaria cases would be tested and those found to be positive would be treated with the recommended anti-malarial medicines and therapy.

In a bid to strengthen malaria diagnosis and implement the policy, the ministries of health with support from various development partners procured approximately eight million RDTs for distribution and use in 2012 and a further eleven million are targeted for 2013.

The deployment of diagnostics has in the past been reserved for hospitals and large health facilities with microscopy services and with formally trained laboratory technicians and technologists. However, procured RDTs kits will be distributed to all public and faith based healthcare facilities across the country with priority given to facilities which currently do not provide other diagnostic services for malaria. The deployment of RDTs by DOMC will expand diagnostic coverage all the way down to the dispensaries (Level 2 facilities) with a target to roll them out to the community health workers in 2013.

In the last three months, The Department of Malaria Control in Collaboration with the MoMs , MoPHS and HCSM have trained 3200 health workers from lower level facilities on the use of RDTs. (See page 20 for participants experience on RDT training.)
The availability of good-quality health commodities and their safe and appropriate use are important prerequisites for the provision of quality health services. Therefore, in addition to ensuring access, it is important to address issues related to quality assurance of these products and implement programs that will support health care workers and consumers in using these commodities rationally, minimizing side effects while deriving the required therapeutic outcomes.

Reaching these goals requires a wholesome approach to address commodity management, including selection, procurement, distribution, and use. These processes must be supported by an enabling policies and laws and proper management support, including adequate financing, appropriate human resources, and functional information management systems for evidence-based decision making.

Health Commodities and Services Management (HCSM) program in collaboration with the Ministry of Health has been working to improve health outcomes and impact through, supporting systems that deliver essential health commodities and services for the country’s health sector. The focus has been on key public health priorities, i.e., HIV/AIDS, malaria, TB, and reproductive health.

For the past year, the program has been focusing on improving commodity management and strengthening pharmaceutical services, and laboratory services.

Since inception in 2011 April, HCSM has been working collaboratively with both Ministry of Medical Services and the Ministry of Public Health and Sanitation, as well as other stakeholders, to address the ministry’s priorities and through joint planning and implementation. To achieve this, the program adapted a two-pronged approach, which involved working with Ministry of Health at the central (national) level and the peripheral (regional) level in implementing activities.

At the central level, the program worked closely with the ministries of health to strengthen structures and systems for commodity security, appropriate use, and medicine safety, and also supported initiatives to review and develop an appropriate policy and legal framework to guide and facilitate commodity management and service delivery at all levels of the health system.

Specifically, the program has provided technical leadership to national-level commodity Interagency Coordinating Committees (ICCs) and Technical Working Groups (TWGs) for improved commodity security. A key activity has been support for forecasting and quantification exercises across all programs to inform commodity procurement and supply planning. In addition, HCSM has supported compilation of national monthly stock-status reports for the priority health programs, which have been used to inform decision making.

Also at the national level, HCSM has supported the Ministry of Health in the development, finalization, dissemination, and implementation of policy guidelines and clinical governance tools, including the National Clinical Management and Referral Guidelines and program-specific treatment guidelines. In addition, the program contributed to health sector policy reviews to support the implementation of the 2010 constitution of Kenya.

The program has also supported the Pharmacy and Poisons Board in promoting patient safety through better documentation and reporting of poor-quality medicinal products and adverse drug reactions, and improved use of pharmacovigilance data for decision making. Specific decisions taken by the Poisons and Pharmacy Board have included medicine withdrawals, recalls, label changes, and closure of pharmaceutical manufacturing companies.

Recognizing that provision of quality and appropriate health care requires functional laboratory services, the program also worked with the ministries of health, the National Public Health Laboratory Service (NPHLS), and other stakeholders to strengthen laboratory systems at both the central and peripheral levels. The focus has been on ensuring an uninterrupted flow of laboratory commodities and their appropriate management and use; this has included development and implementation of laboratory commodity management curricula to improve inventory management and commodity usage reporting.

At the peripheral level, the program focused on providing technical support to regional health management teams and facilities in establishing and strengthening oversight structures for commodity management and use, including the establishment of provincial and district health commodity security committees and the strengthening of Medicines and Therapeutics Committees at hospitals. Eight provincial and more than 50 district commodity security committees have been operationalized, with the mandate to improve commodity management, accountability, and usage reporting. Working with these committees, HCSM has implemented a package of targeted interventions, including orientation on commodity management for district managers and facility staff; on-the-job training and mentorship on the use of various commodity management tools and approaches; and supportive supervision in the program’s priority districts.

The past 18 months saw the rollout of the ARV Dispensing Tool - an electronic dispensing tool for antiretrovirals (ARVs), which helps facilities to better manage these medicines, report usage, and follow up patients. Medicines and Therapeutics Committees have been formed or reactivated in more than 50 level 4-5 hospitals, with HCSM supporting capacity building for these committees as well as implementation of activities and interventions to improve medicine use, quality of service delivery, and ultimately, health outcomes.

The program learned a number of key lessons in the first 18 months of implementation, including the importance of leveraging with other partners and the need for tailored, region-specific interventions as well as greater Ministry of Health engagement for enhanced sustainability of interventions.

The program implementation is continuing and as in line with the programs approach of country led, country owned sustainable initiatives.
In November and December 2012 the Division of Malaria Control under the Ministry of Public Health and Sanitation in collaboration with USAID funded Health Commodities and Services Management Program has been undertaking training of 3,200 health care workers on the use of Malaria Rapid Diagnostic test Kits. Trainees from Nyeri county share their experiences on the training below.

**Joseph Muriuki Ngochi**  
*District Clinical Officer – Kerugoya District Hospital*

We have 352 trainees from level 2 and 3 facilities i.e the Dispensaries and Health Centres. These facilities do not have 24 hour laboratories. This means that after 5pm the lab staff have left. These facilities, especially those built with Community Development Funding, have no labs.

The training is meant to empower the facilities that do not have normal laboratory services, to treat and test patients, these may also include patients who visit after normal working hours and over the weekend. We also have the 5 District Health Management Team members from each district in the training as they are required to supervise the facilities. These include the District Medical Officer of Health, District Clinical Officer, District public health nurse, District Medical Lab Technician and District Pharmaceutical Facilitator and District Malaria Control Coordinator.

The goal of the training is to update health workers on the current malaria situation and current guidelines on management and prevention, and to equip them with the Knowledge and skills on the rapid diagnostic kits soon to be rolled out to the facilities.

My observation is that most of the participants had not been updated on the latest guidelines as demonstrated on the pretest where the average scores are very low. Most had been recruited through the economic stimulus program and didn’t have the opportunity to be trained.

The uptake of the information is good and they have a positive attitude towards adoption of the new guidelines on malaria case management which includes the testing and use of RDTs. Their only concern is sustainability of the supply, quality assurance and control of the same. However, they have been assured that enough RDTs have been purchased, the kits have been pretested by World Health Organization and our national reference lab. The District Health Management Team will assist with quality control during support supervision.

**Irene Thiongo**  
*North Kinangop Catholic Mission Hospital*

I work in a mission hospital and there only the lab people get to see the RDTs. But now I am happy at least I know how to use one. It will help in identification of Malaria cases, and appropriate treatment.

**Dr. John Ngugi**  
*Provincial Malaria Control Coordinator, Central Province*

RDTs offer a good alternative to Microscopy in cases where microscopy is not present. Though microscopy remains the gold standard as RTDs cant tell the intensity of Parasitimia. The skills required for use in RDT can be used by all health care workers at all levels and require only one day training. Issues of quality assurance were addressed as the RDTs are WHO approved.

**Yvonne Kianduma**  
*Medical Officer*  
*North Kinangop Catholic Mission Hospital.*

Atleast I now know how to use the malaria test kits. We had been using them before but our skills have been improved. One thing that was totally new for me was the recording of malaria commodities usage in real time and that is something that I will definitely apply.
A testing kit must be sensitive and specific on what it wants to test. From 368 positive slides, 367 were found to be positive with RDTs. Which gives a sensitivity of 99.7%. From 200 slides which were negative, 199 were negative with RDT which gives a specificity of 99.4%. This means that its detection rate is high.

Nancy Njambi Muneno  
Sharon Dispensary, Nyandarua Central

I learnt about the case management of uncomplicated malaria, RDT testing, recording, monitoring and evaluation. The test was a new thing for me, it is helpful in that I will be able to confirm the malaria test, I won't be treating clinical malaria without testing.

Brian Momanyi  
Medical Officer  
North Kinangop

I have learnt the specificity and sensitivity of the test and how to use it. I have also learnt epidemiology of malaria the do's and dont's of treatments. I am enlightened because previously the World Health Organization guideline was every fever must be treated for malaria unless proven otherwise, but now I know guidelines is test, treat and track.

Jane Wakio Mureithi  
Sagara Health Centre Nursing Office

I learnt how to use stock cards, daily records and accurate feeling of the monthly summaries. Previously I used to rely on the Pharmacist for general commodity management issues but now at least I can verify and validate. I am also convinced and confident the use of maalaria RDTs.

James Kariuki  
Provincial Medical Lab Technologist (PMLT) Nyeri

I have been training healthcare workers from 11 districts on malaria rapid diagnostic kits.

This training aims to build the confidence of healthcare workers on the reliability of malaria rapid test kits and to improve the skills and treatment of malaria. One of things that helped improve attitudes was the section on validation of the kits, the specificity and sensitivity of the kit.

Cassette has an in built control for quality assurance. Additionally since our region has less that 0.1% prevalence of malaria any positive test with RDTs will be referred for Microscopy for quality assurance. For example out of 352 tests conducted by trainees only one was found positive and she was in coast for some time.

The reception by those trained has been positive. Most appreciated the practical and hands on training. Since most are not trained lab people so involving them in testing boosted their morale.

From the assessment of pre and post test performance. We can see that the participants have learnt something during the training.

Table showing pre and post test results during malaria rapid diagnostic kits training in Nyeri
Local solutions to local problems

By Patrick Boruett and Yvonne

“The first thing we did after identifying the gaps in our facility together with the DHMT was rearranging the stores so we could see what drugs were available. While arranging the stores we found some expired Amitryptiline tablets. Some had short expiries and so they were redistributed.

The second challenge addressed was getting pallets,” says Mabele. “There were no pallets in the stores. When it rained, water leaked into the store. We improvised and used some door mats in place of pallets. This was better than having the boxes on the floor, but the mats still sipped in water. An opportunity to solve this presented itself later when the facility was constructing a kitchen to cater for the maternity ward. We asked whether we could use the left over wood to make pallets, and the committee approved. We now have pallets in the stores,” Mabele explains.

“We received on the job training on proper storage, calculation of commodities required quarterly, use of reporting tools and proper dispensing of medication. This has led to improvement in the quality of service to our patients,” says Mabele.

Dr. Nyakundi confirms this “We went to the facility two months after the supervisory visit and there was a difference. Besides an organized store, the facilities now makes use of the stock control cards which are displayed routinely updated. That helps in submitting better reports. We were smiling.”

This change has not only occurred in this facility but in other facilities that have received training and supportive supervision within the District. The supervision and on the job training at facility level is facilitated through collaborative effort of Ministry of Health and USAID funded Health Commodities and Service Management program.

“There is increased availability of commodities in hospitals. Earlier, some facilities had surplus medication leading to expiries while some facilities were experiencing stock outs. This was caused by poor quantification and inaccurate data.”

“We now have improved reporting rates for health commodities, for example for laboratory reports the reporting rate has improved from 48% in October 2011 to 92% in August 2012 interventions included provision of tools and regular feedback to the facilities,” says Chris Kipkulei, District Medical Lab Technologist in the area.

Mabele credits the improvement in his facility to the leadership of Mr. Fredrick Chebet the facility in-charge, support from District Health Management Team, teamwork and shared responsibility among his colleagues. “Everyone took ownership to improve practices in our facility,” says Mabele.

“I got interested in the pharmacy and stores during the support supervision. What I have learnt assures me that I can provide better services to my patients,” He adds.

Improved record keeping and proper storage practices in facilities like Kaibichich (See on page 21), help avert potential wastages in public resources (e.g. expired medication). Improved documentation at facilities also helps enhance accountability of commodities in public hospitals who receive procured commodities.

This helps Kenyans move towards achievement of the Millennium Development Goals and enjoy their constitutional right of access to quality health care.
Creating Awareness on Pharmacovigilance for Anti-TB Medicines

By Janet Kimeu

Kenya has made significant achievements in the fight against tuberculosis. Notably, Kenya has achieved the World Health Organization targets of a treatment success and case detection rates of greater than 75% and 85% respectively. However, the emergence of drug resistant tuberculosis in the country has become a growing concern. Each month 15 cases are diagnosed through the central reference laboratory and at the regions by use of the new diagnostic Gene Expert equipment. All the patients are started on treatment with the use of second line anti-TB medicines which often result in side effects and adverse drug reactions (ADRs).

Several subjective reports of patients developing ADRs exist. Some of the ADRs have resulted in permanent harm/disability to the patients. In May 2012, out of nine (9) patients who were started on treatment at the Moi Teaching and Referral Hospital, five (5) of these patients developed acute hearing loss and some patients developed other second line anti-TB medicine related complications.

The Division of Leprosy, Tuberculosis and Lung Diseases (DLTLD) and the Pharmacy and Poisons Board (PPB) found that there is little documentation and reporting of severe side effects in peripheral facilities, despite subjective evidence showing many patients are suffering from these reactions at the treatment sites. By the end of October 2012, 1% of the suspected ADR reports at Poisons and Pharmacy Board were attributed to first line anti-TB medicines. There were no reports on the second line anti-TB medicines.

In November and December 2012, Division of Leprosy, Tuberculosis and Lung Diseases, Poisons and Pharmacy Board and the USAID funded Health Commodities program collaborated in the training of 324 healthcare providers, working in drug resistant TB treatment sites and comprehensive care centres all over the country, on pharmacovigilance. The training was received well with the healthcare providers committing to implement the principles learnt on the prevention, detection, management and reporting of ADRs to the second line anti-TB medicines.

“We have seen patients on anti-TB medication develop side effects and adverse drug reactions. However we did not know where to forward the information neither did we realize that it would enhance patient safety in the country. We are glad that there is a national pharmacovigilance system to capture this information and provide evidence to support policy and development of treatment guidelines” RCO, Lamu District Hospital

“The pharmacovigilance training was really timely for me because I have just joined the TB program. In last few days I saw patients who had experienced adverse drug reactions and I did not know what to do. I feel better equipped to handle adverse drug reactions when they occur.” District TB and Leprosy Coordinator Lunga Lunga

It is expected that the national database of suspected ADRs resulting from second line anti-TB medicines will grow and the information will be used to inform policy decisions on the management of Drug resistant TB in Kenya.
Towards Improved Supply Chain Efficiency at National and Peripheral Levels

By James Riungu

There were 23 regional workshops across all the regions in the country. The orientation workshops held between April 2012 and 21st September, 2012 were meant to shift reporting of TB and Reproductive Health commodities from the district TB and Leprosy coordinators (DTLCs) and District reproductive health coordinators (DRHCs) to the district pharmaceutical facilitators (DPFs). The shift was meant to help improve service delivery, commodity management and reporting for Malaria, TB and RH programs as the respective coordinators would focus on service provision while the pharmacist would focus on supply chain aspects.

Health cadres trained:

<table>
<thead>
<tr>
<th>Health cadres</th>
<th>Number</th>
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<tbody>
<tr>
<td>Reproductive health coordinators and officers</td>
<td>106</td>
</tr>
<tr>
<td>TB and Leprosy coordinators</td>
<td>170</td>
</tr>
<tr>
<td>Malaria coordinators</td>
<td>112</td>
</tr>
<tr>
<td>Pharmacists and Pharmaceutical facilitators</td>
<td>182</td>
</tr>
<tr>
<td>Other cadres drawn from the health facilities*</td>
<td>203</td>
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* Other cadres include nurses, DPHNs, nutritionists, DASCOs, PDPHS, MOHs, laboratory technicians among others

To ensure that all the provinces were covered the program used a phased and integrated approach for implementation. The roll-out plan entailed 3-day workshops in the regions with each workshop providing for a half day dissemination of Malaria quality of Care Survey 3 report and a discussion on all the programs reporting rates on day one. Days two and three were dedicated to TB and RH program specific orientations.

At the end of each workshop the district teams developed action plans to improve on the shortcomings identified.

Following the workshops, programs came up with the following recommendations to ensure sustained improvement in commodities management and reporting:

- Conduct an evaluation to assess the extent to which DPFs have taken up the new roles
- Promote on-job training of new DPFs by the provincial pharmaceutical facilitators (PPFs) to ensure they take up the role of commodity management and reporting at the district level.
- Promote integration of reporting tools and harmonization of reporting cycles for all programs with that of EMMS
- Repeat the orientation workshops at least every 2 years
- Clarify the new roles of DPFs in their revised job description

At the national level, HCSM also trained 30 senior MoH officers on quantification and supply planning and pipeline monitoring during the first 18 months of the program. This is expected to continue every year until all senior program officers at priority health programs and MoH gain adequate skills to independently undertake quantification and supply planning as well as pipeline monitoring for their respective health commodities.

Supply chain information flow greatly influences products flow behavior. However, in the past, management of health commodities in the health facilities and at district level was in the hands of district pharmacists while reporting was done by the program coordinators. Consequently, the reporting on consumption and management of inventory was done by two different entities with varying understanding of the expectations resulting in low reporting rates and poor inventory management at the district level as observed during HCSM Baseline survey, 2012. Inappropriate inventory management practices are associated with wastage of health commodities through expiries. On the other hand, poor reporting rates affect planning at national level (forecasting and supply planning).

To address these gaps, HCSM designed an orientation package to equip the district pharmacists with the necessary skills to take up the responsibility of inventory management and reporting at the health facilities.

Following the circulars from both directors of Public Health and Sanitation and Medical Services directing that TB, Reproductive Health and Malaria commodities be managed by the District Pharmacist, Health Commodities and Services Management (MSH/HCSM) program in collaboration with the Division of Reproductive Health (DRH), Division of Leprosy TB and Lung Diseases (DTLT) and Division of Malaria Control (DOMC) conducted district orientation workshops on the change of commodity management to prepare the district teams (Pharmacists and program coordinators) for smooth transitioning of the commodity management and reporting roles.

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Adaptation of the national condom training manual

By Wambui Waithaka

The National AIDS and Sexually Transmitted Infections Control Program (NASCOP) manages and coordinates service delivery and commodity management for HIV prevention especially among Most-at-risk populations (MARPs). These commodities include condoms and syringes as well as commodities for use in Voluntary Medical Male Circumcision (VMMC). NASCOP is also involved in curriculum development for training of service providers. The program together with other partners and stakeholders involved in national condom programming such as the National AIDS Control Council (NACC), the Division of Reproductive Health (DRH), and United Nations Population Fund (UNFPA), NASCOP organized a workshop on adaptation of the condom (male and female) training manual which was held from 30th October to 1st November 2012.

The current national condom training curriculum was developed in South Africa and needed to be customized to fit local setting. The curriculum also focused heavily on service delivery and how to train service providers to counsel clients on condom use, but it had no section on how to manage the actual commodities.

The workshop served as an avenue to advocate for inclusion of commodity management in the curriculum. Once consensus was built, a module on best practices in inventory management, receipt and storage of the commodities was developed and incorporated into the training manual. Recording and reporting tools with instructions on how to complete them were also included. The addition of commodity management practices into the condom training curriculum will help in proper tracking of condoms from the national programmatic level down to regional level.

A gap on tracking of condoms for non-public health facilities was identified and NASCOP, with support from MSH/HCSM, will follow-up to develop/distribute tools and build capacity of service providers to fill them in.

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<th>FY2012/2013</th>
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<td>10,284,868</td>
<td>10,552,275</td>
<td>10,826,634</td>
</tr>
<tr>
<td>No. of female sex workers</td>
<td>140,000</td>
<td>143,640</td>
<td>147,354</td>
</tr>
</tbody>
</table>

Estimated population requiring male condoms

Capacity building of 6 officers from Division of Reproductive Health program officers on quantification concepts and tools

By Wambui Waithaka

Division of Reproductive Health, in collaboration with other Family Planning partners, carried out a 6 monthly forecasting and quantification review of FP commodities to meet the national needs for the next 3 years (2013 to 2015). This was scheduled for 2nd to 6th July 2012.

To prepare for this important review, training was organized for the DRH team from 27th to 29th June 2012 in Naivasha to help them acquire skills in forecasting and supply planning of family planning commodities, using current best practice computerized tools, Reality® and PipeLine®. The participants (6 in total) were taken through quantification concepts, the various forecasting methodologies and how to do effective data collection as well as build valid assumptions.

Participants learnt how to use Reality® for quantification, and Pipeline® for supply planning and pipeline monitoring.

This training was supported by the Health Commodities and Services Management program FP team, to build capacity of the Division of Reproductive Health and to promote a team approach when dealing with commodity management, bringing together the various skill-sets of the group (pharmacists, clinicians, Monitoring and evaluation officers and service delivery project officers).

The program will continue monitoring this team for monthly pipeline monitoring of national stocks for this team to enable monthly pipeline monitoring of national stocks and the ability to use this information for strategic decision making with various stakeholders. With time, this activity will be fully transitioned to DRH.
Lab in a pack: Improving Access to Malaria treatment in Kenya

By Yvonne Otieno

Vihiga County in western Kenya, 360 km from Nairobi the capital city of Kenya, is one of the counties with a high prevalence of Malaria. The facility receives about 120 outpatient cases per day and 41% of those are usually treated for Malaria. Dr. Jacob Odipo, facility in charge of Mbane Provincial Rural Health Training Centre, all children under five receive free mosquito nets and so the high rate of infection of Malaria in children can considerable be attributed to Mosquito bites received before children go to bed.

"Malaria RDT’s kits have helped ease congestion in the labs"

The culture in Vihiga is that people don’t come to hospital unless it is absolutely necessary. And even on the days that they come to hospital, they arrive at about 11am after ploughing their farms," says Mr. Odipo. The hospital provides various medical services at a subsidized rate; however Malaria treatment is free.

And true to his word, at around 11am, mothers start streaming into the hospital - some carrying children and others, while some have their siblings. Two of the mothers who have visited include Mama Victor.

Victor is one year old and Mama Victor has brought him to the hospital for routine examination but she also worried because Victor has a low appetite and is suffering from fever. After a quick examination, the nurses recommend that Victor gets a Malaria test. In half an hour’s time the Victor has received his test results and is receiving first line treatment for Malaria. However, three months ago, Victor’s mother would have had to wait three more hours to receive treatment.

"Previously we used to rely on microscopy for Malaria test and with the limited number of Lab technicians, patients would have to wait for three to four hours for their results. Some would leave before receiving the results because of the long distances they would have to travel back home. We suspect that an unknown number were self medicating for Malaria to avoid the long lines," explains Mr. Odipo.

The hospital only has one lab technician performing an average of 200 lab tests per day.

RDTs are a much needed intervention that represents benefits across all areas of the healthcare delivery system according to Mr. Odipo.

"Malaria RDT’s kits have helped ease congestion in the labs but has also helps to ensure that patients receive treatment faster and that only those who test positive for Malaria receive Malaria medication," say Dr. Odipo.

According to Dr. David Soti who heads the Division of Malaria Control (DOMC) in Kenya, receiving correct treatment translates to greater cost savings in procurement of RDTs nationwide - a Malaria rapid test kit costs 1 USD while the unsubsidized retail cost for Artemisinin/ Lumeefantrine (AL) 24s used for Malaria treatment costs approximately 5 USD. Correct diagnosis saves the government or the patient 4USD in unnecessary treatment costs for a malaria negative case.

The management of malaria has previously been based on the clinical symptoms of a patient under five in malaria endemic zones. It became necessary to embrace a universal diagnostic policy for all age groups and all zones regardless of the endemicity to successfully provide universal malaria treatment.

Based on global recommendations, the Kenyan government adopted a policy of universal diagnosis of malaria for all ages and across all areas in the country. Any and all suspected malaria cases would be tested and those found to be positive would be treated with the recommended anti-malarial medicines and therapy.

In a bid to strengthen malaria diagnosis and implement the policy, the ministries of health with support from various development partners procured approximately eight million RDTs for distribution and use in 2012 and a further eleven million are targeted for 2013.

USAID Kenya funded Health Commodes and Services Management (MSH/HCSM) program in collaboration with DOMC is currently involved in training 3,200 frontline health workers on the use of RDTs in lower level facilities countrywide as well as provision of technical assistance to ensure that the procured RDTs and other malaria commodities are managed appropriately at the facility level.

The deployment of diagnostics has in the past been reserved for hospitals and large health facilities with microscopy services and with formally trained laboratory technicians and technologists. However, procured RDTs kits will be distributed to all public and faith based healthcare facilities across the country with priority given to facilities which currently do not provide other diagnostic services for malaria. The deployment of RDTs by DOMC will expand diagnostic coverage all the way down to the dispensaries (Level 2 facilities) with a target to roll out to the community health workers in 2013.

These activities are meant to ensure availability and appropriate use of antimalarial medicines at the facility level through increased access to diagnostic by use of RDTs in facilities with no laboratory services and therefore translating to the provision of quality care to patients like one year old Victor.
A calling to care for the sick and weak

By Yvonne Otieno

“Kwa dawa ya TB ni lazima utembee mpaka upate (You should never give up when searching for anti-TB medicines).”

This is the advice that Esther Wahome, a registered community health nurse in a Kenyan health facility, gives to her clients when they come to the tuberculosis (TB) clinic. Within a short time, Esther dispenses the drugs to the patient, provides health care advice and updates her records.

Esther’s TB clinic clients are usually referred to Kayole II sub-district hospital from Toto Bora and other smaller health care centers. Kayole II, located on the outskirts of Nairobi, provides free health services and receives nearly 300 outpatients each day.

During a routine supervisory visit conducted by the USAID-funded, MSH-led, Health Commodities and Services Management (HCSM) Program, Esther, a mother of two, spoke about her work at the Kayole II TB Clinic, which she has been running for the last three months.

“I like serving in the TB clinic because I get to see patients who are weak regain their strength. Sometimes the patients come in when they are so weak and close to skin and bones that at times I wonder where to inject them. Seeing patients thrive fulfills me and is my joy,” says a smiling Esther.

This is something that she hasn’t dealt with thanks to her keenness in record keeping. Esther explains that to manage her commodity supplies, she maintains a commodity tracking system which has monthly records with the beginning balance, closing balance, quantities ordered, positive and negative adjustments; and expiry dates of commodities.

For me the worst thing is to have patient come in and not get medication

“Sometimes our consumption may be more than our registered patients because of the transit patients. But our records help to ensure that there is no loss of TB drugs. Every time I get something from our stores, I record it in my bin card. It makes my work easier.”

Kayole II residents are happy that Esther pursued her dream of becoming a nurse.

Esther’s advice to those who wish to join her profession: to be a nurse you need to have a caring heart.
Earlier this year, several laboratories in Kenya experienced stock-outs of CD4 reagents, which are used to provide CD4 – or T-helper cells that help fight infection - counts and percentages to measure the stage of HIV or AIDS in a patient. The stock-outs were attributed to a lack of reporting on consumption, placement of supply orders, inability to quantify needs, and breakdown of CD4 testing equipment among other factors. The lack of reagents affects the proper monitoring of patients on antiretroviral therapy (ART) - an aspect that is necessary in ensuring evidence based patient care.

As of January 2012 approximately 500,000 patients were on ARV treatment and the stock-outs placed approximately 80% of them at risk of the issues related to empirical treatment. Recognizing the importance of the availability of reagents in ensuring patient care, Kenya National AIDS & STI Control Program (NASCOP), National Public Health Laboratories Services (NPHLS) and the USAID-funded HCSM program convened a consultative meeting on August 21st and 24th to map the way forward in addressing the ART laboratory supply chain issues.

Drawn from faith-based, private and public hospitals with labs that perform CD4 testing, 144 participants took part in the meeting. Also present were key suppliers of CD4 reagents’ equipment to address issues surrounding servicing and maintenance of CD4 testing equipment. During the meeting HCSM provided assistance through orientation of the participants on logistics and management information systems (LMIS), inventory management tools, provision of job aids and standard operating procedures on quantification and general laboratory commodity management aspects.

Part of HCSM’s mandate is to strengthen laboratory system and service delivery. In this area, HCSM works with key laboratory partners to strengthen policy implementation, leadership and governance. The program aims to improve and enhance efficiency of laboratory supply chains with a focus on HIV reagents. The program also supports expansion of lab networks, and control systems for increased to access to quality essential laboratory services at all levels of care.

To ensure all sites are included in order cycles, the list of functional ART lab sites were standardized, while consensus on commodity information flow and resolution of issues revolving around service and maintenance of CD4 equipment nationally were regularized.

It was also agreed that reporting of lab ART commodities would be a key performance indicator for laboratories. The stakeholders also agreed that issues of service, placement, and maintenance of equipment would be handled from the national level unlike before where individual facilities were dealing directly with suppliers. In addition, it was agreed that ART lab sites would be increased from 158 to 183.

Consensus and plans made during the meeting are key steps addressing the issues of stock-outs, expiries of ART lab commodities and other Lab commodity management related issues thus ensuring accessibility and provision of essential quality health services.
Streamlining reporting tools for better management of TB and TB/HIV Commodities

By Charles Njuguna

According to the Division of TB and Leprosy Diseases case finding report 2011, indicates that there are about 102,403 TB patients 39% of these are co-infected with HIV.

Management of TB patients requires that the correct medication is available and accessible. The regimen for treatment of co-infected TB/HIV patients and TB patients is different and thus ordering of co-infected TB/HIV patients and TB and none for knowledge, sometimes Pharmacist would due to lack of e.g. the same patient with TB can be increased work load when recording usage of drugs, neglecting some areas e.g. the previous tools had some obsolete medicines that needed to be removed while there were some new drugs that needed to be added to the tool.

To help streamline the processes there has been integration of management of TB and TB/HIV commodities. The process was of revising the data capture tools and simplify the process of recording orders and consumption of TB & TB/HIV medication. In addition, this prompted the need to integrate the tools and simplify the process of recording TB and HIV commodities was led by Division of Leprosy, TB and Lung, National AIDS and STI Control Program (NASCOP) and Kenya Medical Supplies Agency (KEMSA) and Health Commodities and Services Management (HCSM) program.

Integration means that the four tools have been merged to two. The removal of multiplicity of tools means that it will be easier to collect TB and TB/HIV data from the facility level thus improving efficiency. The improved tool – Daily Activity Drug Register (DADR) is used for recording TB and TB/HIV.

Printing of the revised tools has been facilitated by HCSM who are also supporting dissemination by developing an orientation package that will be used by District TB and Leprosy Coordinators (DTLC’s), District Pharmaceutical facilitators (DPF) for TB clinics.

These data is consolidated into the Facility Consumption Data Report and request (FCDRR) as one report and sent to the District level. Already 3000 copies of the tool have been printed and will be distributed to 2818 facilities in the first phase while 3000 more will be distributed in the second phase.
Key documents to help improve Kenya’s Laboratory Sector

By Yvonne Otieno

The majority of health laboratories in Kenya’s public sector encounter many challenges with more than half of the country’s laboratories plagued with rundown infrastructure, limited space to work efficiently, insufficient supplies and equipment and the absence of standard guidelines for many laboratory operations. Numerous efforts have been taken to improve the standards of the laboratory services with results achieved in some sections.

Four key documents were launched on November 22, 2012 adding to the efforts being undertaken in the improvement of Kenya’s laboratory sector at a colorful ceremony attended by over 80 laboratory stakeholders, development partners and directors from the Ministry of Medical Services (MOMS) and Ministry of Public Health and Sanitation (MOPHS). Key partners who attended the launch included training institutions, the National Public Health Laboratories Services (NPHLS), representatives from major regional and district public hospitals, Ministry of Health (MoH) departments from headquarters, representatives from private hospitals, laboratory regulation bodies and professional associations.

The policy documents launched include - National Guidelines for Laboratory Specimen Referral Networks, National Guidelines for Medical Laboratory Equipment Management (2012), National Standard Guidelines for Medical Laboratory Physical Infrastructure (2012) and the Standard Laboratory Designs.

Speaking during the launch of the policy guidelines, Dr. Francis Kimani, the Director of Medical Services (MOMS) said that the launch of the documents was important in initiating steps to address these notable gaps in the laboratory sector.

“Quality has always been at the core of health services provision. In line with this, the Ministries of Health have supported implementation of the requirements of ISO 15189 Standard in laboratory services in order to attain international accreditation. These guidelines will be of great use for laboratories undergoing the accreditation process in addressing the facility design and safety requirements,” said Dr. Kimani.

He provided the example of the National Standard Guidelines for Medical Laboratory Physical Infrastructure in Kenya and the Standard Laboratory Designs which he said have come, “At a timely moment when the government investment focus on infrastructure is on establishment of model health centres.”

The guidelines were developed through a collaborative effort of the multidisciplinary and inter- ministerial team comprising personnel from the MoH (MOMS and MOPHS) and the CDC funded Strengthening Public Health Laboratory Systems Project (SPHLS). For the infrastructure guidelines the Ministry of Public Works was also involved.

“SPHLS staff provided technical assistance as well as facilitating stakeholder engagement in the development process of the guidelines while AMREF were key in the development of the Equipment Guidelines,” Jedida Wachira, SPHLS Project Director explained.

Dr. Kimani urged partners to adopt the same collaborative efforts in the dissemination of the guidelines to all who have a stake in ensuring delivery of quality laboratory services stating that the implementation of the guidelines would facilitate improved access to health care and high level laboratory services.

The guidelines are expected to direct laboratory managers and health facilities on what steps to follow when constructing or renovating laboratories, boost good laboratory practices, guarantee cost-effective spending of resources, ensure a safe working environment, and achieve fair and equal access to health care.

About the Guidelines

National Guidelines for Laboratory Specimen Referral Networks - This guide aims at increasing access to laboratory services to all Kenyans wherever they are. Specimen Referral Networks have been functional but with various challenges such as patients involved in the transferring of specimens from one laboratory to another, lack of uniformity in factors regarding quality and safety and lack of an integrated network supporting specimen referral for diseases of public health importance.

National Guidelines for Laboratory Specimen Referral Networks Equipment - This guide will help in making informed decisions on all procedures related to the management of medical laboratory equipment. It will complement many guidelines that were created recently with the purpose of enhancing the quality of laboratory services and health care in general.

National Standard Guidelines for Medical Laboratory Physical Infrastructure - This guide gives standardized and information on the key considerations regarding construction and maintenance of physical laboratory infrastructure. The improvement of laboratory infrastructure has been identified as crucial step in enhancing management of diseases and the safety of patients as well as healthcare workers.
Pharmacovigilance training, commodity management supportive supervision and distribution of commodity management tools are some of the activities undertaken by Health Commodities and Services Management program in Nairobi.

The pharmacovigilance (PV) training for Multi Drug Resistant MDR TB sites took place from 12th to 15th November 2012 Nairobi. Forty two staff from Multi Drug Resistant (MDR) TB sites in Nairobi attended the training. The team comprised pharmacists, pharmaceutical technologists, nurses, provincial and district TB & leprosy coordinators, clinical and medical Officers] from all the 9 districts in Nairobi.

This training was organized by the Pharmacy and Poisons Board (PPB) with support from the MSH-HCSM Program. The purpose of the training was to improve the capacity of the team in reporting and monitoring of adverse drug reactions and poor quality medicines for MDR TB.

Commodity management tools (inventory management & PV job aids, calculators, tablet counters and wall thermometers) were delivered to District Pharmaceutical Facilitators (DPFs) for Makadara, Njiru, Langata, Embakasi, Kamukunji and Kasarani districts for distribution to all the facilities that were represented in the two day commodity sensitization earlier in the year.

Commodity management supportive supervision is ongoing in Makadara, Njiru, Langata, Kamukunji and Kasarani districts.

Champions from Kamukunji and Kasarani districts accompanied by program staff visited facilities for commodity management supportive supervision. During these visits, the facility staff responsible for commodity management were mentored and received on the job training on various issues. They were provided with inventory management & pharmacovigilance job aids, calculators, tablet counters and wall thermometers.

Some of the facilities visited jointly by district champions and HCSM staff in Kamukunji include: Shauri Moyo clinic, Biafra Medical Centre, Biafra Lions Clinic, Mother and Child hospital, SOS Medical Centre, Family Life Promotion & Services dispensary, Mary Immaculate Sisters Dispensary and Bahati Health Centre. The facilities visited in Kasarani include: Baba Dogo HC, Comboni Sisters Dispensary, Mwangaza Ulio na Turmain Medical Centre, St Peter’s Clinic, Medipoint Dispensary and Sunton CFW Clinic.

The orientation brought together 33 participants from Ministry of Medical Services (MoMs) and Ministry of Public Health and Sanitation (MOPHS) in Mombasa county. The purpose of the course was providing the necessary knowledge, skills and attitude to enable regional level managers to function efficiently and effectively in the support of the management of health commodities. Participants were taken through the essentials of inventory management, good record keeping in health commodity management, quantification of laboratory commodities and facility medicine needs and storage of health commodities. They also learnt about Pharmacovigilance and reporting on adverse drug reactions, use of data for decision making, functions and operation of a Health Commodity Security Committee among other practices.

At the end of the meeting, participants developed work plans and put in place plans for the institutionalization of Health Commodity Security Committees for Mombasa District and Kilindini District.
James Kariuki demonstrates to a participant how to use the RDT test kit during the practical session.

Eunice and Judy learning how to test using RDTs kits day 2 of training.

Dr. Sharif shares the Malaria RDT roll out plan with UNICEF’s Mr Kanyankore Rudasingwa during the launch of Malaria RDTs.

Facility Incharge Mbale Hospital shares their experience using RDTs with USAID videography crew.

Participants at a Commodity management & AMU training held in Mombasa in November 2012.
July 2012 - February 2013

MSH and AMREF representatives during the launch of Laboratory Policy guidelines

Janet Kimeu setting up the show and tell desk during HCSM work planning meeting that involved stakeholders

HCSM Workplanning Meeting Group Picture July 2012

USAID training on Family Planning compliance held in October 2012

The power of teamwork...it takes team effort and commitment to make a difference
Western Rift Valley Regional Updates Continued

Regional staff posted to Western province:

Health Commodities and Services Management (HCSM) program has deployed Dr. Patrick Boruett to support pharmacy and commodity management activities in Western Province. This has been necessitated by the need to have adequate support for commodity management activities in the vast Nyanza/Western zone and improve the program’s collaboration and coordination with other implementing partners in the region. He shall be based in Kakamega and co-located at the with AphiaPlus offices. Dr. Patrick Boruett is an experienced Pharmacist and Public Health Practitioner who before this assignment worked as the HCSM Regional Pharmacy and Commodity Management Specialist in the Rift Valley Zone. Prior to this, Patrick worked as the program’s liaison with NASCOP in Nairobi.

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Provincial health commodities technical working group held a successful meeting on 13th December 2012. The team came up with priorities for the coming year (priorities include capacity building on commodity management, formation of district based health commodities technical working groups (TWGs), redistribution of excess commodities, quarterly review meetings and targeted support supervision) and selected 5 additional priority districts for the HCSM project implementation. A total of 26 members participated led by the Provincial Director of Medical Services Dr. Godrick Onyango.

Rift Valley

By Joseph Mwangi

New regional staff posted to Rift Valley province:

The Health Commodities and Services Management (HCSM) program has deployed Dr. Joseph Mwangi to support pharmacy and commodity management activities in Rift Province. Joseph takes over from Dr. Patrick Boruett who has moved to Western province in the same capacity. Prior to this redeployment, Joseph worked as the HCSM program liaison for DRH in Nairobi.

His contact details are:

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• Tel: 0710 150766 (APHIA Plus Office Line)
GUIDELINES FOR PROPER STORAGE OF HEALTH COMMODITIES

1. Clean and disinfect the store regularly, and take precautions to discourage harmful insects and rodents from entering the storage area.

2. Store the health commodities in a dry, well-ventilated store and away from direct sunlight.

3. Protect the store from water penetration.

4. Keep fire safety equipment available, accessible and functional; and train the health facility staff on how to use it.

5. Store latex products away from electric motors and fluorescent lights.

6. Maintain cold storage, including a cold chain, for health commodities that require it.

7. Limit storage area access to authorized personnel and lock up controlled substances.

8. Stack cartons at least 10cm off the floor, 30cm away from the walls and not more than 2.5 meters high.

9. Arrange cartons with arrows pointing up (↑), and with identification labels, expiry dates and manufacturing dates clearly visible.

10. Store the health commodities to facilitate ease of application of “First-to-Expire, First-out” (FEFO) principle and stock management procedures.

11. Store the health commodities separately and away from insecticides, chemicals, flammable products, hazardous materials, old files, office supplies and equipment.

12. Keep narcotics and other controlled substances in a lockable cupboard/cabinet.

13. Separate damaged and expired health commodities from usable commodities, remove them from inventory immediately and dispose them off using established procedures.
Health Commodities and Services Management is a national level USAID-funded program with a 5 year Implementation period (April 1, 2011-March 31, 2016). The program is anchored on USAID Kenya’s objective of strengthening health systems for sustainable delivery of quality services and has three outcome areas - strengthened Ministry of Health commodity management, strengthened pharmaceutical services and strengthened laboratory services.

Upcoming Events

**Brain teasers**

**WORD SEARCH PUZZLE**
Find words that are related to better medicine storage practices. The first one has been done for you.

| A | S | C | S | T | E | N | I | B | A | C | N | H | R | Y | N | V | A |
| T | S | T | O | C | K | C | A | R | D | S | S | N | V | E | Z | F | D | C |
| P | M | A | O | I | M | G | N | N | R | G | F | N | A | D | N | P | C |
| M | L | B | Z | R | P | A | L | L | E | T | S | H | R | A | H | S | O |
| F | G | L | M | N | E | F | V | H | T | D | V | T | R | H | X | N | U |
| C | H | E | C | K | L | I | S | T | S | Y | S | D | A | T | N | O | N |
| O | V | T | Z | N | F | N | U | H | I | N | T | I | N | Z | S | I | T |
| N | F | C | V | Z | N | D | X | E | G | O | S | G | X | C | T | A |
| Y | R | O | T | N | E | V | N | I | E | I | C | P | I | C | I | N | B |
| M | I | U | M | X | D | A | F | N | R | T | K | E | N | F | R | E | I |
| H | G | N | F | T | G | C | U | H | Y | A | O | N | G | Z | I | V | L |
| F | N | T | V | C | T | F | O | N | L | N | U | S | V | N | P | R | I |
| N | H | E | B | D | A | X | H | T | I | I | T | I | F | G | X | E | T |
| D | T | R | A | I | N | I | N | G | A | M | S | N | C | P | E | T | Y |
| Y | N | S | T | K | X | V | D | F | D | A | H | G | F | F | C | N | H |
| F | A | S | D | R | A | C | N | I | B | T | G | F | C | Z | A | I | A |
| N | Z | O | K | S | L | O | O | T | G | N | I | T | R | O | P | E | R |
| M | O | N | T | H | L | Y | R | E | P | O | R | T | S | F | S | N | V |
| K | X | Q | U | A | N | T | I | F | I | C | A | T | I | O | N | X | F |

Words can be found horizontal, vertical or diagonal, spelled frontwards or backwards.

**THE SECOND NATIONAL BIENNIAL HIV AND AIDS CONFERENCE MAY 6-9, 2013**

It is now thirty one years since HIV and AIDS was first discovered in the world. In Kenya, the first case of HIV and AIDS was reported in 1984. Since then several achievements have been made in the fight against HIV and AIDS. The epidemic has stabilized with the prevalence rate having gone down from 14% (1990s) to 6.3% in 2009. HIV related deaths have reduced from 102,794 in 2000 to 57,000 in 2011. However, the new infections still remain high, estimated at 104,000 annually. It remains a major public health concern in Kenya. Similarly, the proportion of the HIV positive population accessing ARVs has increased to more than 540,000 people currently on treatment. Nonetheless, there still exist continuing and emerging challenges that need to be addressed for the country to achieve its national goals as articulated in KNASP III and go beyond the universal access targets of 2010. These challenges include: High new infection rates, low condom use at high risk sex, gaps in scientific evidence (research) to inform HIV programming. The cornerstone of KNASP III implementation hinges on evidence based programming. Thus, the 2nd Biennial HIV and AIDS conference provides a platform for dialogue among diverse stakeholders.

The second National Biennial HIV and AIDS Research Conference whose theme is ‘Accelerating Progress Towards Zero’ builds on the gains and lessons learnt from the first conference. The theme of the second conference has been informed by the current global trend and efforts towards elimination of new HIV Infections and further reductions of morbidity and mortality. Furthermore, the conference takes place during a time when there is concern and considerable debate regarding financial sustainability to maintain momentum of the gains made in the war against AIDS. For more information about the conference, visit the Conference website [http://conference.nacc.or.ke/](http://conference.nacc.or.ke/)