Lwala September 2008 Update

The summer months saw many welcome additions to the Ochieng' Memorial Lwala Community Health Center: two new clinical officers were hired; a new staff house was completed; an improved rain water catchment system is supplying the clinic with clean, running water; a more fruitful partnership with nearby Tabaka Mission Hospital was forged; and a revamped village oversight committee was created. Each of these accomplishments has contributed not only to the quality of care offered by the clinic but also to its likelihood for long term sustainability.

An infusion of $20k, part of a grant received by RMF from World Children's Fund went partly toward the emergency ambulance. The other part is intended for the salary of the clinical officer, surgery for one woman who had a massive hernia, electricity for the clinic, laptop, digital camera for the clinical officer, salary raise for the clinical officer and more.

With the departure of clinical officer Peter Ochieng' last spring, a deficit in trained clinical staff was felt at the clinic. As RMF had been funding the salary of Peter Ochieng', it was agreed that any new CO hired would be paid out of RMF funding as well. The search for a new CO was, thankfully, a relatively short one, and resulted in the hiring of two COs, John Badia and Penina. John, whose salary will be provided by RMF, is from the nearby city of Kisumu, and completed his training there, first at Kenya Medical Training College (KMTC), and then through an internship at Nyanza Provincial Hospital. Afterwards he worked at the Patient Support Center, a special clinic for people with HIV/AIDS run by the CDC and PEPFAR in Kisumu. A clinical officer (CO) has a level of training roughly equivalent to that of a physician's assistant. In Africa they train COs because nearly all of the doctors they train leave for greener pastures. COs are trained in symptomatic management, which means they're trained to identify clusters of symptoms and apply decision making guidelines based on those symptoms. They do not have the extensive scientific background that physicians do, but in resource limited settings a CO can be a cost effective way of getting a lot of people treated for basic diseases. The standardization of treatments assures that the most common diseases are treated effectively, even if some of the more rare diseases are missed. In Kenya only the big city hospitals have doctors, and even there they're in short supply. In the smaller towns and rural centers, COs are the highest level of clinical staff.

The construction of a new staff house provides the clinic with much needed support for its incredible staff members. One of the problems in retaining clinical staff in the past was the inability to comfortably house staff members and their families. This often meant staff would spend

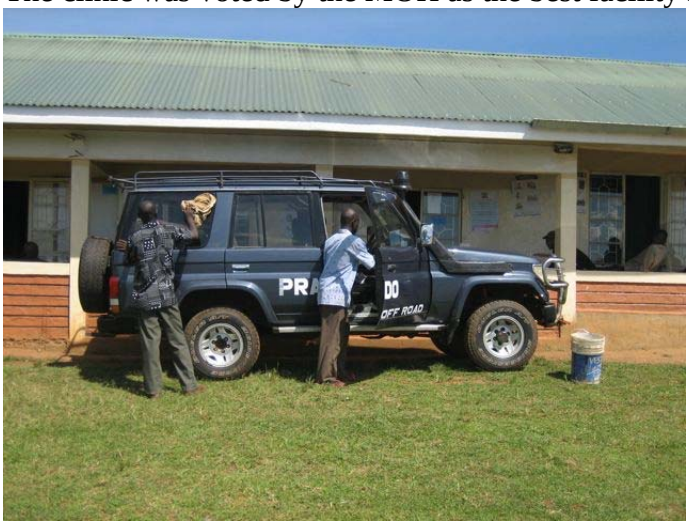
the weekdays in Lwala and return home to their families on the weekends. Such isolation from family inhibited the emotional connection between employee and clinic necessary for promoting a workforce that is dedicated to the health and prosperity of the community. Two additional staff houses are already under construction.

The clinic was built with running water in mind, so all the piping was in place from the beginning. All that was needed was a sufficient source of water and a pump to get the water into an elevated tank to provide pressure. However, getting a good source has been a major challenge. After consultation with Blood:Water Mission and several site visits to other clinics and hospitals in the region, the decision was made to install a large rainwater catchment system with enough capacity to see the clinic through the dry seasons. The entire clinic has been guttered, a 24,000L below ground storage tank has been installed, and an elevated tank was installed. Water now flows from the gutters into the below ground tank, then is pumped to the elevated tank using a bike pump, and then flows from the elevated tank into the clinic. Clean running water flowing from the clinic's sinks means that crucial sanitary practices (e.g. handwashing) are now part of the clinician's protocol. Additionally, the successful implementation of this rainwater catchment technology at the clinic provides a model for similar projects at local facilities like schools and churches.

There is a larger mission hospital called the St. Camillus Tabaka Mission Hospital approximately 20km from Lwala. This is a tertiary care hospital providing quality service, but it charges fees prohibitive for almost all people in Lwala. Complicated or emergent cases that come to the Lwala clinic are referred to the St. Camillus Tabaka Mission Hospital. The Lwala Health Center and the Tabaka Mission Hospital have a memorandum of understanding regarding how these cases are admitted, paid and followed-up. Both the District Hospital and the Tabaka Mission Hospital have ambulances which can be called by the Lwala Health Center, but they are not capable of reaching Lwala during rainy weather due to the poor road. The recent evolution of this partnership has produced weekly visits from Tabaka Hospital staff providing VCT and HAART to the community.

The Lwala Village Development Committee (LVDC) has been in place since 2005 to organize the construction and operation of the clinic. The 21 members were picked by their clans as representatives. As the clinic began operating, and the size and complexity of the project increased, the needs for community oversight and leadership changed. To keep pace with these changes a smaller, more skills-based LVDC was created to meet these needs. The new committee will meet monthly to evaluate financial and operational reports from the clinic manager and accountant, and to provide assistance as needed to the clinic staff. The new committee is comprised of 11 members, including representation from men, women, youth, people living with AIDS, the Church, and each of the 7 clans in the area. It includes people with management experience, financial expertise, and other critical skills. This updated committee will be able to more effectively provide leadership, assist the staff, and ensure financial accountability.

RMF's financial support of the clinic has been greatly appreciated by the clinic and the community. The community is very pleased with the services; everyone feels they have access because the service is free for most patients and nearly free for the rest. The clinic was voted by the MOH as the best facility in the district, and has been



designated a level two facility (basically a sub-district hospital).RMF's purchase and maintenance of the 4x4 ambulance as well as the continued clinical officer salary funding has improved the clinic's ability to handle the monthly patient load of 2000+ people as well as offer more effective emergency care. A recent success story highlighting the impact of RMF's contributions was reported by clinic co-founder Fred Ochieng':

> A 16 year old girl was in labor for many hours at her home. Village people brought her to the clinic at 3 AM and awakened the staff. A Clinical Officer concluded after 2 hours that the labor was obstructed. She was placed in the clinic's new 4 wheel drive ambulance at 5 AM and driven to Tabaka Mission Hospital. The doctors agreed with the CO's dystocia diagnosis and performed a cesarean section. The mother and baby are OK. Obstructed labor is a leading cause of maternal deaths in the developing world. The Lwala Clinic fortunately has skilled clinicians to make the diagnosis, a method to transport a sick patient, and a place that can provide emergency care. Real Medicine provided the ambulance and supports a clinical officer in Lwala. Asante.