ASSOCIATION DES MEDECINS HAITIENS A L'ETRANGER (AMHE)
AMHE MEDICAL RELIEF MISSION
HUEH HIV PROGRAM ASSESSMENT

Report of June 16, 2006
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AMHE Medical Relief Mission had achieved his goal to implement an HIV program at HUEH. The program had been officially launched in December 2005. AMHE has been involved in the initiation, design, and execution of the proposal, supervision of programmatic activities and provision of expert technical assistance.
AMHE project director, Dr. Vladimir Berthaud was in Haiti, June 4-13, 2006 to evaluate program operations.

HUEH HIV PROGRAM OPERATIONS

Dr. Berthaud reviewed all activities sites and met with nearly all involved personnel, including hospital medical director, attendings and residents, nurses, pharmacists, laboratory technicians, HIV counselors, psychologists, social workers, field workers, educators, administrators, as well as HIV/AIDS patients. Everyone was very cooperative and gave him a warm welcome.

A. Internal Medicine

Strengths:

The department of internal medicine is the backbone of this program. It is responsible for the adult HIV continuity clinic, adult HIV inpatient hospitalizations and the adult HIV consultation service. Its leadership strongly supports the program at all levels. The department is privileged to have a chair that is very familiar with HIV/AIDS and

a highly-qualified full time infectious disease specialist. The Faculty understands that HIV/AIDS care is comprehensive and complex.

The department was fortunate to hire two very bright young and dynamic, HUEH-trained internists. Both received additional formation at GHESKIO that revealed to be extremely helpful. They have been providing HIV/AIDS inpatient care and identifying potential ambulatory patients. The nurses have been trained at GHESKIO as well and are satisfied of their formation. The department chair had assigned a team of nurses to the management of pharmaceuticals and HIV care and opened two very accessible VCT rooms near the service entrance.

The department is equipped with an endoscopy suite, a dialysis unit and a hematology-oncology ward, all of them led by an excellent and dedicated Faculty. These four divisions as well as those of endocrinology, neurology and cardiology can greatly enhance the care of HIV/AIDS patients presenting with advanced multi-organ disease, if they are provided with adequate support. The hemodialysis unit in particular, is indeed a national referral center, with an outpatient clinic on site. However, it is under funded and always short on essential dialysis supplies.

Deficiencies:

The continuity clinic lags behind schedule, due to abrupt interruption of funding. It dampens patient and clinician's enthusiasm and creates a huge gap in the continuity of care. To palliate this inconvenience, a general internist is seeing patients recently tested for HIV in the ambulatory clinic. But when the main problems fall under the competency of another specialty, patients have to be referred out and spend additional waiting hours. A process to identify HIV seropositive patients hospital wide is not in

place. When such identification does happen, it can generate confusion, anxiety and frustration. The laboratory technician leaves at 2:00 PM. The VCT office does not guarantee strict confidentiality and privacy.

The HIV inpatient service operates at full capacity creating a backlog in the emergency department. Construction of the infectious diseases unit is at a standstill. In the meantime, there is no isolation room. Patients on treatment for active pulmonary TB are coughing up among everyone else. Infection control procedures are lacking, protective gear and tap water are absent. Most AIDS patients admitted to the service are very sick and require acute medical intervention including rehydration, life-saving procedures for diagnosing and treating opportunistic infections, antibiotherapy and others. In this particular setting antiretrovirals are not critical. In fact, patients are admitted from GHESKIO because of failed or toxic antiretroviral therapy. Moreover, there is no coordination between physicians, nurses, psychologists, social workers and field workers. The multidisciplinary team does not exist. This raises serious concerns for adherence to antiretrovirals and follow-up. There are no meals for hospitalized patients, while many of them are malnourished and wasted.

The infectious diseases consultation unit is not ready to run due to a shortage of physicians. This is supposed to be a virtual unit made of a multidisciplinary team led by a full time attending physician, assisted by at least one resident, a medical extern, a psychologist, a social worker, a patient educator and a field worker. The team is responsible for ensuring continuity care to HIV/AIDS patients anywhere in the hospital. Policies and procedures will have to be worked out with the different

services. Rapid and clear communication cannot be overemphasized. A more efficient mechanism of referral and follow-up between OBGYN and internal medicine has to be worked out.

Data collection is unreliable since the electronic medical records system is not operating. This makes it more difficult to follow patients, coordinate care and avoid duplication. Needlessly to mention the importance of continuous power supply and current stabilization as illustrated by the unrepairable electrical damage of the echocardiography machine, the EKG machine and one desktop computer. We have to note that according to the staff, the EKG machine Kenz 108 or 110 seems well-suited to the service.

Medical residents have not attended a formal HIV/AIDS training. I-TECH is scheduling one in the coming months of September and October.

B. Pediatrics

Strengths:

In the department of pediatrics, leadership and the motivation are overwhelming. Five pediatric attendings, including the department chair, have attended HIV training abroad. All of them are assigned to the program. I-TECH had just completed a well attended and well organized two-week didactic training in the department of pediatrics. The presentations raised the level of excitement among the participants. VCT room is functioning and a temporary space is being renovated for the on-site pharmacy.

Deficiencies:

Many of the deficiencies encountered in the department of internal medicine also apply to the department of pediatrics. Yet, we would like to mention a few particularities.

One physician has been affected to coordinate PMTCT and pediatric care but this is still a work-in-progress.

Referrals from GHESKIO need to be formalized.

There is no transportation to assist the parents in picking up artificial milk and food supplement outside of HUEH.

The pediatric infectious disease unit lags behind schedule and there is no isolation room.

OBGYN

Strengths:

The chair of OBGYN is a strong supporter of the program and provides necessary guidance to his staff.

He includes HIV training into the residency curriculum.

The residents received formal training in PMTCT in May 2006.

The chair of OBGYN and the designated physician responsible for the program are both eminently qualified and advocates for progressive changes.

The program had done a self-evaluation and conducted a follow-up reassessment that showed a significant increase in acceptability of VCT. Average HIV seroprevalence rate is about 3%.

Deficiencies:

Faculty should be more involved and supportive.

The residents are still reticent to embrace the program in spite of open discussion with their chair and program chief.

The laboratory technician works from 8:00 AM to 2: PM; a second year resident is assigned to provide HIV counseling and testing during off hours but such coverage has been erratic.

Prenatal charts are frequently unavailable in the delivery room at night; only one person is in charge of medical records during that shift.

It is difficult to retrieve the charts of HIV seropositive women due to the absence of a coding system.

Designated personnel have not been trained in drug management.

Support group is not available.

The neo-natal unit is non-functional, necessitating the transfer of all newborn babies to the pediatric building.

The service lacks basic obstetrical material and supplies, including suture material, parenteral solutes, $MgSO_4$, hydralazine, blood products, antibiotics, oxytocin, dopamine, anesthetics, epidural trays, oxygen supply, propofol, ergotrate, sodium bicarbonate, methyldopa, nifedipine, suction machine etc.

This is a high-risk environment and more attention should be placed on infection control procedures.

The pharmacy space is not ready yet; the roof of the VCT office is leaking.

The actual number of deliveries is decreasing; the main reasons being rerouting of patients and a more pro-active role played by outside philanthropic health centers in peripartum services.

The program target number of VCTs and PMTCTs could be missed.

C. Laboratory

Strengths:

The personnel are motivated and trained.

Quality control is done routinely.

Rapid HIV tests results are timely.

CD4 lymphocytes are counted manually, while waiting for the flow cytometry.

A limited number of blood chemistries are done, while waiting for the Sismex machine.

Deficiencies:

Eight laboratory technicians have been reaffected to VCTs and have not been replaced.

Remaining technicians are the only persons doing the Mantoux test for the entire hospital. Patient transportation back and forth for testing and reading is problematic. Escort service is unavailable. Nursing staff can be rapidly trained to do the Mantoux test.

The technicians double as phlebotomists and laboratory technicians

The bacteriology laboratory is not functioning.

Interrupted supply of reagents and irregular equipment maintenance hamper laboratory performance.

HIV patients are allowed free care but the requisition process is not foolproof.

Important diagnostic tests like cryptococcal antigen, toxoplasma antibody, hepatitis B serology, urine for GC and chlamydia, quantitative non-treponemal tests and arterial oxygenation are not available.

The laboratory is not allowed to adopt a sliding fee schedule to partially compensate for maintenance.

D. Pharmacy

Strengths:

The pharmacy plays a central role in drug management. Haiti is only one out of 4 selected PEPFAR sites around the world to receive direct assistance from Supply Chain Management System (SCMS).

The pharmacy director feels satisfied of her formation at GHESKIO. Her staff is waiting for the three-part training that SCMS is planning to open later this month.

Deficiencies:

The pharmacy has been wired but it does not have any computers.

It does not have an electrical back-up system either.

The storage area assigned to the program needs major renovation, including a secured door.

The number of pharmacists cannot adjust to a 24/7 schedule.

Environmental conditions are substandard.

Medication supply is very limited.

E. Social services

Counseling is a one-time event instead of continuous and global.

Most of the social workers were trained at Cange, which is very different from the metropolitan environment.

F. Psychology

It is very difficult to counsel hospitalized patients, comfort them and preserve their privacy and confidentiality.

G. Field workers

The field workers are a group of enthusiastic individuals but they are not well integrated into the program. Given the security situation in Port-au-Prince, more attention should be paid to the daily risks they are taking.

H. Patient educators

The IEC (information, education, communication) group needs to receive HIV formation and education materials adapted to this patient population.

They need to have more access to the patients.

They are preparing a sponsored newsletter. The table of contents has already been drafted. A more widespread participation should be solicitated.

I. Administration

Strengths:

The Direction Médicale fully endorses the program.

It continues to provide a strong leadership in the strategic programmation.

Collaboration with funding agencies and NGOs has been reinvigorated.

The administration had demonstrated accountability.

Deficiencies:

The administrative infrastructure needs reinforcement.

Communication channels should be optimized to clarify the process and better define everybody's role and connections in the multidisciplinary teams.

No incentives are offered to win the support of non-program staff.

Program personnel do not receive their earnings on time.

Installation of the electronic medical record system is to be completed as soon as possible to allow enough time for staff training and field testing.

An electronic scheduling system is not available yet.

Patient feedback and participation of PLWHA has not been incorporated.

Funding is largely insufficient to meet the demands and expectations and ensure the success of this program.