1st Global Conference on Patient Centered Care

Theme
Patient Centered Care: Training and Delivery of Universal Healthcare

29th September – 2nd October, 2015

Kenyatta University Amphitheatre

Nairobi, Kenya

FINAL PROGRAMME AND BOOK OF ABSTRACTS
Kenyatta University

This is the 2nd biggest university in Kenya and 40th in Africa. It is 2,426 in the World ranking. It is the home of the Young African Leaders Initiative (YALI), a Project started by the President of the United States. Just recently, Kenyatta University was honored to receive the President of the United States (POTUS), Barrack Hussein Obama, who is a son of Kenya and Africa and the First sitting President of the United States to have visited Kenya.

The university is located along the Thika Superhighway. The coordinates of Kenyatta University main campus are: 1°10'59.0"S; 36°55'34.0"E (Latitude:-1.183056; Longitude: 36.926111). It is 20 kilometers from Kenya’s Capital, Nairobi.

Welcome
PARTNERING ORGANIZATIONS

- KENYATTA UNIVERSITY
- 1st Global Conference on Patient Centered Care
- FUNZO Kenya
- Health Kenya
- St John Ambulance
- USAID
- KMA Medical Association
- INFA-MED
- Morris Moses Foundation
- German Cooperation
THE 1ST KENYATTA UNIVERSITY GLOBAL CONFERENCE ON PATIENT CENTERED CARE

Main Venue

*Kenyatta University Amphitheatre*
WELCOME ADDRESS FROM THE VICE CHANCELLOR, KENYATTA UNIVERSITY

I would like to welcome you all to Kenyatta University and to the 1st Global Conference on Patient Centered Care.

The sub-Saharan African region for sometime now has been grappling with a number of health-related challenges that require new approaches and strategies. It is encouraging to note that governments in the region are serious about putting in place efforts aimed at solving these challenges.

A key aspect of care that is very often forgotten by many stakeholders in health is the patient. The process of humanizing care that would provide client and provider satisfaction has never been adequately interrogated. Neither have budgets or investments been made specifically to address issues of care to patients and their families. Patient centered approach establishes a partnership or an alliance between health care workers, patients and their families, all geared to ensure that decisions made respect patient wants, needs and preferences. This concept involves a multidimensional approach that engage both health and non-health workers who are indirectly involved in care. This conference addresses these issues.

Kenyatta University driven by a desire to see more evidence based care and fully sensitive to its mandate as a teaching and research based institution is privileged to offer a platform where this critical gap in patient care can be addressed.

I hope that you will find Kenyatta University a place to learn, network and engage with various players on the important subject of health care. I wish you successful deliberations throughout the conference.

Prof. Olive M. Mugenda, PhD, MBA, EBS, CBS
Vice Chancellor
Kenyatta University
WELCOME ADDRESS FOR THE DEAN, SCHOOL OF MEDICINE, KENYATTA UNIVERSITY

Welcome to Kenyatta University.

The School of Medicine is delighted to have been given the opportunity to lead the organization of this 1st Global Conference on Patient Centered Care (PCC) at Kenyatta University.

The School is a centre of excellence in Medical Training, Health Research, Capacity Building and Product Development.

This Mandate is the basis of organizing this conference that is going to recommend research based re-alignment of healthcare that will focus more on patients’ needs, preferences and involvement of all stakeholders such as family members, friends, healthcare workers and even employers.

Generally, the School is committed in ensuring that health research undertaken is innovative so as to address emerging global challenges in the health sector.

Kenyatta University is developing a medical hub which will consist of Adult, Children and Gender referral hospitals, some institutes which will be used to propagate Patient Centered Care in the future.

Once more, welcome as I wish you fruitful deliberations during this conference.

I look forward to your dissemination and implementation of the knowledge, skills and values that will be generated.

Prof. B.M. Okello Agina, PhD
Dean, School of Medicine
Kenyatta University
WELCOME ADDRESS FROM THE CONVENER, 1ST GLOBAL CONFERENCE ON PATIENT CENTERED CARE, KENYATTA UNIVERSITY

We are delighted to welcome you to the 1st Global Conference on Patient Centered Care. The theme of this conference is “Patient Centered Care: Training and Delivery of Universal Health Care”

Patient Centered Care is a concept that we all know as one that encompasses qualities of compassion, empathy, and responsiveness to the needs, values and expressed preferences of the individual patient. The approach includes viewing the patient as a unique person, rather than focusing strictly on the illness, building a therapeutic alliance based on the patient's and the provider's perspectives. Patient-centered care is supported by good provider-patient communication so that patients' needs and wants are understood and addressed and patients understand and participate in their own care.

Unfortunately, many barriers exist to good communication and also health care providers differ in communication proficiency, including varied listening skills and different views from their patients' of symptoms and treatment effectiveness. Many other factors also influence patient centeredness and provider-patient communication namely language barriers, effects of disabilities on patients' health care experiences and providers' cultural competency just to mention a few. There is therefore a need to establish a therapeutic relationship, which will change focus from disease to the patient and take care of both body and mind. The main purpose of this conference is to interrogate patient centered care culture and to share evidence of success or failure in clinical outcomes.

A diversity of professionals from all sectors have been invited to attend this conference. Some who are directly involved in care while others provide secondary though critical aspect in patient care. As a center of excellence and a teaching and research based academic institution, Kenyatta University is interested in leading the implementation of best practices in patient care.

We look forward to enlightening and stimulating presentations from academia, clinical practice settings, international organizations such as World Health Organization, World Organization of Family Doctors, patients and patient based organizations, politicians, technocrats among others. I encourage all of you who are visiting Kenya for the first time to spare some time to visit the real Kenya; the hot bed of culture and champions. Welcome to our national parks, our museums, our farmlands and villages. In so doing you will be in a position to learn more about the people of Kenya and perhaps experience Kenyan hospitality firsthand.

Once again please feel most welcome to the 1st Global Conference on Patient Centered Care and I wish you all happy and fruitful deliberations during the course of the conference. May the conference afford you opportunities for networking and forging life long bonds of friendship, and may God bless you all.

Sincerely,

Dr. Titus Muhu Kahiga
Conference Convener
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Ms. Edith Kabure - Institute of Family Medicine, Kenya
GENERAL INFORMATION ABOUT KENYA

Kenya is an economic hub of East Africa. It is the leading economy on the East Africa Community block.

The Republic of Kenya has a Population of about 44 million people in an area of 582,646 square km (224,961 sq miles) – 47th largest country in the World. The Major languages are Swahili and English. The Major religion is Christianity and the Monetary unit is Kenya Shilling (1 Dollar = 100 Kshs.)

Weather

The Equator bisects Kenya almost at mid-point and thus Kenya experiences the equatorial climate. However, the unique feature about it is that it has a snow-capped mountain called Mount Kenya.

Kenya’s Capital

is Nairobi City. The only city in the World with a National Park within the city often referred to as “The Green City under the Sun”. Nairobi has an altitude that makes the weather cool. Temperatures go down to 10 degrees in June/July and a high of 29 degrees on a very sunny day.

Nairobi National Park.

The Nairobi National Park lies within the Capital City of Kenya. The large National game reserve is known for breeding endangered black rhinos and is the home of the Big Five wild animals – The Lion, Elephant, Buffalo, Leopard and the Rhino. Giraffes, Zebras Antelopes are in plenty too at the park. Next to it is a well-garded elephant orphanage.

Food

There is no singular dish that represents all of Kenya. Different communities have their own native foods. Staples are maize and other cereals depending on the region, including millet and sorghum eaten with various meats and vegetables. The foods that are universally eaten in Kenya are ugali, sukuma wiki (green vegetables), githeri (maize and beans) and nyamachoma (roasted meat). Continental Sea food worldwide cuisine is also available.

Safety

Register with your embassy as soon as you arrive. Knowing your embassy’s contact details is highly recommended.
Emergency contacts

999 is the local police hotline. Other emergency lines can be found at [http://www.infohub.co.ke/2013/09/what-are-kenya-police-telephone-numbers.html](http://www.infohub.co.ke/2013/09/what-are-kenya-police-telephone-numbers.html)

Communication

Kenya has two major telecommunication service providers. Safaricom and Airtel. Mobile phone subscribers can purchase sim cards for use with their mobile phones. Kenyatta University however has wonderful internet connectivity of 100mbps and one can comfortably enjoy the services.

Transport

The resident hotel can organize transport to and from the conference venue on request. Travel by public means is also available but advise is given that one shouldn’t go unaccompanied to avoid getting lost since Nairobi is quite a large city.

Electricity

A three pin plug socket is used. Electricity supply is between 220 -240 volts AC. Plug in to get in “Type G” British BS-1363 type sockets.
GUEST SPEAKER

H.E. Governor Peter Munya  
Chairperson, Council of Governors Republic of Kenya
KEYNOTE SPEAKERS

Professor Michael Kidd
The President of WONCA
(The World Body of Family Physicians)

Dr. Susan Frampton
The President of Plane tree Inc.

Dr. Matie Obazee
President WONCA (Africa Region)

Dr. Ronen Rozenblum, PhD, MPH
Harvard Medical School

Prof. James Kiarie
Coordinator, Human Reproduction Team (W.H.O)

Prof. Robert F. Woollard, MD, CCFP, FCFP
University of British Columbia, Canada

Dr. Bruce Dahlman
Kabarak University, Kenya
Dr. Matie Obazee, President, WONCA, African Region

**Building Capacity for Achieving Sustainable Development Goals for the Health of Africa**

It is becoming increasingly clear to all countries around the world that primary care and family medicine offers the most cost-effective way to ensure universal access to health care and equitable health outcomes. As the world considers the new Sustainable Development Goals, many nations are examining how models of Family practice can contribute to a more effective, coordinated and cost-effective approach to universal health coverage of their citizens.

The evidence is clear that the most cost-effective way to decrease morbidity and mortality and increase positive health outcomes in a population is through a well-developed system of primary care services that ensure accessible, comprehensive, coordinated and people-centred care.

Dr. Susan B. Frampton - Planetree International

**Creating Healthcare Cultures that Support Patient-Centered Care**

Many patients and families have experienced a system of patriarchal healthcare that has created passivity, and in some cases fear of retribution for being labeled “difficult” patients. Deep culture change efforts are necessary to address environmental factors –both physical and emotional - in which care is delivered. In a recent editorial in the New England Journal of Medicine, the authors summarized the global challenge very well in their statement: “Despite broad consensus that patient-centered care is important, patients’ actual experience often falls far short of the ideal. When people are not treated with basic dignity and respect by providers, they are likely to avoid future interactions with those providers. Thus, even if care is safe, effective and widely available, it is of little use if patients choose not to use it.” (NEJM 371;1 July 3, 2014)

In order to deliver better and more compassionate care and improve outcomes, we must first create healthcare organizations that support professionalism and empathy on the part of leadership and staff members. This presentation will describe the necessary elements and activities for implementing and sustaining an organizational culture that supports the human and individual needs of patients, their families, and the professionals that care for them.

Dr. Ronen Rozenblum, Brigham and Woman’s Hospital and Harvard Medical School, US

**Transforming Healthcare Organizations towards Patient-Centered Care and Improved Patient Experience**

Patient-Centered Care is considered a key dimension of healthcare quality. This session will provide information on the terms and concepts of Patient-Centered Care and patient experience and engagement; the importance of these dimensions of quality of care; the main determinants of patient experience and satisfaction; the evidence around the impact of these dimensions on health and healthcare outcomes; the current situation, existing needs, challenges and opportunities for improvement; the role of clinicians in Patient-Centered Care and patient engagement; and patient experience measurements and other patient-
reported outcomes. The session will conclude with a discussion on the fundamental principles needed to shift healthcare organizations towards a culture of Patient-Centered Care, including evidence-based practical initiatives, structured programs and patient-facing health information technology tools that were developed to enhance Patient-Centered Care, patient experience and engagement.

Dr. Bruce Dahlman – Head, Department of Family Medicine and Community Care Kabarak University, Kenya.

"Holistic Healing: Therapeutic Relationship in a Technological Age"

“The promise of what diagnostic and therapeutic technology can deliver is now expanding in Africa from the top-end private health care for the privileged to lay its claim to wananchi being served across both Ministry of Health and faith-based public health systems. The pressures are unrelenting. Once available, more advanced laboratory, imaging and especially surgical interventions are among other modalities that, on the one hand can provide life-saving intervention; but can be just as easily utilised inappropriately, further impoverishing the patient and their family unnecessarily. Use of technology without evidence is a cost African cannot afford.

What does ‘modern’ medical care really have to offer? The dualistic models that have been imposed from the West are insufficient to give full answers to the illness experience and need to be challenged. Of all places in the world, Africans understand the need for a wholistic approach to life and care. But if costly technology is all we can offer as our improvement in health care delivery, our patients might be even more likely to delay or avoid presenting for care, knowing it will impoverish them further. Instead, we must develop the primary care providers in the health system to be facilitative and interested in all aspects of patient support – physical, emotional, social and spiritual. But how can these caregivers engage when they are already overwhelmed, what with queues, stock-outs and now increasingly, stresses of devolution? What can our health education systems embrace to thoroughly indigenize our curriculae to tap the intrinsic strength of African, relational life? How can these cadres learn to engage and work with the already existing community supports that their service groups and faith communities provide? Can Africa provide an example to the world of an integrated, seamless approach for care of the whole “person-in-community” - physical, emotional, social and spiritual?”
Program

TUESDAY, 29th SEPTEMBER 2015

PRE-CONFERENCE

From 09:30 am  Continuous Registration of delegates
10:30-1:30 pm  Meetings of Special Interest Groups & Working Parties –
                    KPA, EAFMI, etc.
2:30-5:00 pm  Committee Meetings
6:30-9:00 pm  Cocktail

CONFERENCE

WEDNESDAY, 30th SEPTEMBER 2015

8:30-11:00 am  Opening Ceremony
11:00-11:30 am  Health Break/Exhibitions
11:30-12:15 pm  Plenary 1
12:15 – 1:00 pm  Plenary 2
1:00-2:00 pm  Lunch/Poster Viewing & Exhibitions
2:00-3:00 pm  Oral Presentations
3:00- 3:45 pm  Plenary 3
3:45 – 5:00 pm  Patients Experiences/Discussions
5:00 – 6:00 pm  Exhibitions
THURSDAY, 1st OCTOBER 2015

8:30- 9:15 am   Plenary 4
9:15 -10:00 am   Plenary 5
10:00 – 11:00 am Oral Presentations
11:00 – 11:30 am Health Break/Exhibitions
11:30 - 12:15 am Patients Experiences
12:15 -1:00 pm   Plenary/Discussions
1:00-2:00 pm     Lunch/Poster Viewing & Exhibitions
2:00-3:00 pm     Oral Presentations
3:00- 3:45pm     Plenary 6
3:45- 5:30 pm    Exhibitions/Meetings of Special Interest Groups & Working Parties –, KPA, EAFMI, etc.
7:00-10:00 pm    Gala Dinner

FRIDAY, 2nd OCTOBER 2015

8:00-9:00 am     Oral presentations
9:00-09:45 am     Plenary 7
9:45 – 10:30 am   Way Forward/Plenary Discussion
10:30-11:00 am    Health Break/Exhibitions
11:00 – 1:00 pm   Closing Ceremony
1:00-2:00 pm      Lunch/Exhibitions
2:00 pm-          Departures/ Tours
## DETAILED PROGRAMME

### TUESDAY 29TH SEPTEMBER, 2015

<table>
<thead>
<tr>
<th>DAY/TIME</th>
<th>ACTIVITY</th>
<th>PRESENTER</th>
<th>FACILITATOR</th>
<th>RAPPORTEUR</th>
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<tbody>
<tr>
<td>09:30 am</td>
<td>Continuous Registration</td>
<td>Edith Kabure</td>
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<tr>
<td>10:30 - 1:30 pm</td>
<td>Meetings of Special Interest Groups &amp; Working Parties – KPA, EAFMI etc.</td>
<td>Joseph Thigiti</td>
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<tr>
<td>2:30 - 5:00 pm</td>
<td>Committee Meetings</td>
<td>Secretariat</td>
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<tr>
<td>6:30 - 9:00 pm</td>
<td>Cocktail</td>
<td>Regina Kamuhu</td>
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### MAIN CONFERENCE

### WEDNESDAY 30TH SEPTEMBER 2015

| 8:30 - 11:00 am | Opening Ceremony                                                        | Francisca Ongecha                             |               |            |
| 11:00 - 11:30 am| Health Break/Exhibitions                                                | Aaron Musili                                  |               |            |
| 11:30 - 12:15 pm| Plenary 1: Transforming Healthcare Organizations towards Patient-Centered Care and Improved Patient Experience. | Prof. Ronen Rozenblum Harvard University     |               |            |
| 12:15 - 1:00 pm | Plenary 2: Creating Healthcare Cultures that Support Patient-Centered Care | Dr. Susan Frampton The President of Plane tree Inc. |               |            |
| 1:00 - 2:00 pm  | Lunch & Posters viewing/Exhibitions                                     | Larry Kimani                                   |               |            |
| 2:00 - 3:00 pm  | Oral Presentations                                                      | Margaret Muturi                               |               |            |

### TRACK 1: ACCESS AND COVERAGE IN HEALTH CARE

**Oral Presentation: Session1: Room 14 Akiruga Amisi**

1. Impact of the Integration of Supply and Demand-Side Interventions on Maternal Health Service Use
   - Chrispin Owaga

2. Tracking and caring of HIV positive pregnant mothers and exposed accelerating towards beyond zero infection. (Nyahururu county hospital-Laikipia county, Kenya.)
   - Charles Kabuga
<table>
<thead>
<tr>
<th>Title</th>
<th>Author(s)</th>
<th>Session/Room</th>
<th>Location</th>
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</thead>
<tbody>
<tr>
<td>4. Patient Centered Care and Family Medicine in Sub-Saharan Africa.</td>
<td>Thigiti J. M.</td>
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<tr>
<td><strong>Oral Presentation: Session2: Room 12</strong> S. Muthui</td>
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<tr>
<td>2. The Influence of Social Support on the Utilization of Health Care Services by Patients with Chronic <em>Lymphatic Filariasis</em> in Goshi location, Malindi Sub-County, Kenya</td>
<td>Muriithi David</td>
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<td>3. Effect of peanut supplementation on cardiovascular disease markers in HIV-infected adults with hyperlipidemia attending Nyeri Level- 5 -Hospital, Kenya</td>
<td>Regina Kamuhu</td>
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<tr>
<td>4. Establishing a community-based, primary-care-oriented breast and cervical cancer care program in Tajikistan</td>
<td>Zohray Talib</td>
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<tr>
<td><strong>Oral Presentation: Session 3: Room 149</strong> James Mwanzia</td>
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<tr>
<td>2. The case of mobile phone short text message service to enhance cervical cancer screening at Thika L5 hospital.</td>
<td>Wanyoro, A.K</td>
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<tr>
<td>Session 4: Room 152</td>
<td>Rosemary Sang</td>
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<tr>
<td>1. Community Screening and Assessment of Dietary Intake for Food Supplementation among Malnourished Children Aged 6-36 Months in Thika Urban Slums, Kenya</td>
<td>Juliana Kiio</td>
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<tr>
<td>2. Use of health information technology and home care for improved chronic disease management in U.S.A.; Lessons for Kenya.</td>
<td>Okiru Amoding Beverlyne</td>
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<tr>
<td>3. Application of GIS technology to health management systems for improved Patient Admission in Major Hospitals: Case of Kenyatta National Hospital.</td>
<td>Prof. Simon M. Onywere/Mugambi Kelvin Mwenda</td>
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<tr>
<td>4. Traditional and complementary medicine in Patient Centered Care and Integrative medicine.</td>
<td>Julius W. Mwangi</td>
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**Oral Presentation: Session 5: Amphitheatre**

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<thead>
<tr>
<th>Dr. Mathenge</th>
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<tbody>
<tr>
<td>1. Patient-Centered Pharmacy Services - Ethiopian Experience</td>
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<tr>
<td>3. GIS application in Patient Centered Healthcare in Kenya</td>
</tr>
<tr>
<td><strong>Oral Presentation: Session 6: Room 273</strong></td>
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<tr>
<td>1. Focusing on Nursing leadership as a Driver to Patient Centered Care</td>
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<tr>
<td>2. Differences observed after implementing various HIV testing strategies in a rural Kiambu Town and Kiambaa sub-counties in Kiambu County, Kenya.</td>
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<tr>
<td>3. Determinants of Isoniazid Prophylaxis Failure as a child Tuberculosis Prevention Strategy in Informal Settlements in Nairobi, Kenya.</td>
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<tr>
<td>4. A perspective on strengthening health systems for Patient-Centered Care.</td>
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</tbody>
</table>

**Workshop Presentation: Session 7: Room 280**

| Telemedicine | **Muiruri King’ang’a** |

**3:00 — 3:45 PM**

| **Plenary 3: Research and Patient Centered Care** | **Prof. James Kiarie**  
Coordinator, Human Reproduction Team-WHO, Geneva, Switzerland |

**3:45 — 5:00 PM**

| **Patient's Experiences/Discussions**  
**Patient Stories** | **Morris Moses**  
Foundation |
| Mr. Devgun | **Ms. Alice Mwongera** |

<p>| Naomi Ng'ang'a |</p>
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Presenter(s)</th>
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<tbody>
<tr>
<td>5:00—6:00 PM</td>
<td>Exhibitions</td>
<td>Larry Kimani</td>
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<tr>
<td><strong>THURSDAY 1ST OCTOBER 2015</strong></td>
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<tr>
<td>8:30—9:15 AM</td>
<td><strong>Plenary 4:</strong> Standardizing and accrediting a Patient Centered Care Approach by health providers in the Health Sector.</td>
<td>Prof. Robert F. Woollard, MD, CCFP, FCFP University of British Columbia.</td>
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<td></td>
<td><strong>Plenary 5:</strong> Wholistic Healing: Therapeutic Relationship in a Technological Age.</td>
<td>Dr. Bruce Dahlman Kabarak University, Kenya.</td>
</tr>
<tr>
<td>9:15--10:00 AM</td>
<td><strong>Plenary 5:</strong> Wholistic Healing: Therapeutic Relationship in a Technological Age.</td>
<td>Dr. Bruce Dahlman Kabarak University, Kenya.</td>
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<tr>
<td></td>
<td><strong>TRACK 2: QUALITY OF HEALTH CARE AND SERVICE DELIVERY</strong></td>
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<tr>
<td>10:00—11:00 am</td>
<td><strong>Oral Presentation Session 8:</strong> Room 14</td>
<td>Njeri Nyanja</td>
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<tr>
<td></td>
<td>1. Smart Phone-Based, Point-of-Care Clinical Decision Support Resources Relevant for Facilitating Learner-Centered Education in Africa</td>
<td>Bruce Dahlman</td>
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<td></td>
<td>2. The Knowledge and Perceptions regarding the Role of Family Physicians among Patients in Primary Care settings in Nairobi, Kenya.</td>
<td>Glnaz Mohamoud</td>
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<td>3. Universal Emergency Care For Kenya.</td>
<td>Benjamin W. Wachira</td>
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<td>4. Do Health Providers in Kenya use Patient-Centered Care model for treatment of childhood diarrhea</td>
<td>Ochola S</td>
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<td><strong>Oral Presentation Session 9:</strong> Room 12</td>
<td>Ramana – World Bank Group - Kenya</td>
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<td></td>
<td>1. The effect of Music Therapy as Complementary Medicine for Drug</td>
<td>Oketch T.V</td>
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<tr>
<td>Oral Presentation Session 10: Room 149</td>
<td>Raj Jutley</td>
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<tr>
<td>1. Diagnosis and Biographical Outcomes: A Phenomenology of Life with HIV in Western Kenya.</td>
<td>Owino George Evans</td>
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<tr>
<td>2. Determining Laboratory Test Turnaround Time and the Patients' Reaction in Kiambu Sub-county Hospital</td>
<td>Martin Wahogo</td>
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<td>3.</td>
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<td>4. Patient Satisfaction - statistical comparison between Integrated and Non-integrated care Models</td>
<td>Carol Mwendwa</td>
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<thead>
<tr>
<th>Oral Presentation Session 11: Room 152</th>
<th>Cathy Mwangi</th>
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<tbody>
<tr>
<td>1. Achieving high quality care for all: developing ethical guidelines for patient centered care in Kenya</td>
<td>Mariam Macharia</td>
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<td>Oral Presentation Session 12: Room 280</td>
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<tr>
<td>1.</td>
<td>Effect of exposure to clinical setting in Kiambu District Hospital on the preference for clinical pharmacy as a career choice among pharmacy students in Kenyatta University</td>
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<td>Susan Mageto</td>
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<td>2.</td>
<td>The Role of Counseling psychology in Patient Centered Care.</td>
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<td>Beatrice Kathungu</td>
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<td>3.</td>
<td>Assessing palliative care needs in a county referral hospital in Kenya</td>
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<td>Triza Ireri/Natalie Webber</td>
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<td>Robert Kei</td>
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<th>Oral Presentation Session 13: Room 273</th>
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<tbody>
<tr>
<td>1.</td>
<td>Providing comprehensive and continuous Patient-Centered Care at the Machakos Palliative Care Unit - A resident's elective term experience.</td>
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<tr>
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<td>J.M. Nthusi Nthula</td>
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<td>2.</td>
<td>Assessment of Patient and Family Centered Care in the Medical Ward at Thika Level 5 Hospital.</td>
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<td>Eunita Irene Akim A</td>
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<td>3.</td>
<td>Living healthy with diabetes</td>
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<td>Cyrus Tutu</td>
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<td>11:00 - 11:30 am</td>
<td>Health Break/Exhibitions</td>
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<tr>
<td>11:30 - 12:15 pm</td>
<td>Patients Stories</td>
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<tr>
<td>12:15 - 1:00 pm</td>
<td>Plenary/Discussions</td>
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<tr>
<td>1:00 - 2:00 PM</td>
<td>Lunch &amp; Poster Viewing, Exhibitions</td>
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<td>2:00 - 3:00 PM</td>
<td>Oral Presentation Session 15: Room 14</td>
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<td></td>
<td>1. Assessing The Impact Of Patient-Centered Nursing Care On Outcomes</td>
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<td>2. Communication: corner stone of patient centered care</td>
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<td>3. Making implicit community oriented primary care in patient centered care explicit.</td>
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<td>4. Learning from Jesus the teacher</td>
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<tr>
<th>Time</th>
<th>Session</th>
<th>Speaker</th>
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<tbody>
<tr>
<td>11:00 - 11:30 am</td>
<td>Oral Presentation Session 14: Room 280 Telemedicine</td>
<td>Muiruri King’ang’a</td>
</tr>
<tr>
<td>11:30 - 12:15 pm</td>
<td>Patients Experiences</td>
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<tr>
<td>12:15 - 1:00 pm</td>
<td>Plenary/Discussions</td>
<td>Felix Olale</td>
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<tr>
<td>1:00 - 2:00 PM</td>
<td>Lunch &amp; Poster Viewing, Exhibitions</td>
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<tr>
<td>2:00 - 3:00 PM</td>
<td>Oral Presentation Session 15: Room 14</td>
<td>Cathy Mwangi</td>
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<td>1. Assessing The Impact Of Patient-Centered Nursing Care On Outcomes</td>
<td>Mercy Mwangi</td>
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<td>2. Communication: corner stone of patient centered care</td>
<td>Nyirahabimana Christine</td>
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<td>3. Making implicit community oriented primary care in patient centered care explicit.</td>
<td>Thigiti J.M.</td>
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<td>4. Learning from Jesus the teacher</td>
<td>Kizito Shisanya</td>
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<th>Time</th>
<th>Session</th>
<th>Speaker</th>
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<tbody>
<tr>
<td>11:00 - 11:30 am</td>
<td>Oral Presentation Session 16: Room 12</td>
<td>Judith Karia</td>
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<tr>
<td>11:30 - 12:15 pm</td>
<td>Patients Experiences</td>
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<tr>
<td>12:15 - 1:00 pm</td>
<td>Plenary/Discussions</td>
<td>Felix Olale</td>
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<tr>
<td>1:00 - 2:00 PM</td>
<td>Lunch &amp; Poster Viewing, Exhibitions</td>
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<tr>
<td>2:00 - 3:00 PM</td>
<td>Oral Presentation Session 16: Room 12</td>
<td>Judith Karia</td>
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<td>1. Value of Pharmaceutical Industry in enhancing Patient Safety</td>
<td>Jayesh Pandit</td>
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<td>4. Implementation of Standard Treatment Guidelines Leads to small improvements in Prescribing</td>
<td>Sifiso Sithole/Sara Padidar</td>
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4. Factors affecting the utilization of family planning services in Malindi/Magarini Subcounty

Fredrick Majiwa
<table>
<thead>
<tr>
<th>Oral Presentations Session 17: Room 149</th>
<th>Kamau Boro</th>
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<tbody>
<tr>
<td>2. Family as a hidden patient in Palliative Care: Considerations for Care.</td>
<td>Muchiri Karega</td>
</tr>
<tr>
<td>3. Association of Self-rated Health with hypertension Among Urban Poor in Nairobi, Kenya.</td>
<td>Imesidayo Omua</td>
</tr>
<tr>
<td>4. Health seeking delay in PTB patients and the associated factors in Kibwezi Sub-county, Kenya.</td>
<td>Redempta Mutisya</td>
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<thead>
<tr>
<th>Oral Presentations Session 18: Room 152</th>
<th>Mwachari</th>
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</thead>
<tbody>
<tr>
<td>1. Advancing medical professionalism to improve healthcare in Kenya</td>
<td>Wala Elizabeth</td>
</tr>
<tr>
<td>2. Low consumer Awareness on Substandard, Spurious, Falsified, Falsely-labeled and/or Counterfeit Medical Products is a grim reality- A cross-sectional study of students of Kenyatta University.</td>
<td>Manyega K.M</td>
</tr>
<tr>
<td>3. Patient Centered Care: Assessing the Legal Exposure of Medical Practitioners.</td>
<td>Nelly Kamunde - Aquino</td>
</tr>
<tr>
<td>4. A Qualitative Exploratory Study of the Feasibility and best practices of Community Oriented Primary Care Curricula in Family Medicine Post-Graduate Programs in Kenya</td>
<td>Jacob Shundi Shabani</td>
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<tr>
<td>Oral Presentations Session 19: Room 255</td>
<td>Gulnaz</td>
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<tr>
<td>3. Patient Centered Care and Transformative Medical Education.</td>
<td>Thigiti J. M.</td>
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<tr>
<th>Oral Presentations Session 20: Room 273</th>
<th>Ravi Sharma</th>
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<tr>
<td>2.</td>
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<tr>
<td>3. Strengthening Clinical Practicum as a strategy for improving Patient-Centric Health care</td>
<td>Stephen Okeyo</td>
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<tr>
<td>4. Barriers to adherence on preventive iron and folic acid supplementation(IFAS) for pregnant women in Kenya-2013</td>
<td>Elizabeth Nafula Kuria</td>
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</table>

**Workshop Session 21: Room 280**

| Telemedicine | Muiruri King'ang'a |

**3:00-- 3:15 PM**

**Plenary 6: Driving Quality of Care in the Health Sector**

<p>| Charles Kandie - Ministry of Health (Kenya) |</p>
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<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Presenter/Details</th>
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<tbody>
<tr>
<td>3:15 – 3:30 PM</td>
<td>Translation and Cultural Adaptation of the Communication Assessment Tool (CAT) in Rwanda</td>
<td>Vincent Cubaka – University of Rwanda</td>
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<tr>
<td>3:30 – 3:45 PM</td>
<td>Meetings of Special Interest Groups &amp; Working Parties – KPA, EAFMI, etc./Exhibitions</td>
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<td>3:45 – 5:30 PM</td>
<td>Gala Dinner</td>
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<td>7:00 – 10:00 pm</td>
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<td>TRACK 4: PATIENT SAFETY</td>
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<td>8:00 – 9:00 am</td>
<td>Oral Presentation Session 22: Room 14</td>
<td>Joy Mugambi, David Scott</td>
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<td>1. Knowledge of correct use among Hormonal Contraceptive Users in a Kenyan Referral Hospital</td>
<td>Nancy G. Nkonge</td>
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<td>2. Evaluation of analgesic properties and phytochemical screening of <em>Tithonia diversifolia</em> Leaf Extract</td>
<td>Gladys Mokua/Diana Ogutu</td>
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<td>3. Utilization of Herbal Medicine among children under 5 years of age in Mwimbi division, Maara district, TharakaNithi County, Kenya</td>
<td>Nzuki D. M</td>
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<td>4. Evaluation of Patient Safety in Medication Administration at M.P Shah Hospital Critical Care Unit</td>
<td>Phoebe Amesa Assanga</td>
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<td><strong>Oral Presentation Session 23: Room 12</strong></td>
<td>Julius Wanjohi Mwangi</td>
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<td>1. Economic cost of diabetic care in urban area of belgaum- a community based study</td>
<td>Kassam O.V</td>
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<td>2. Patient Safety as a Patient Centered Care Concern.</td>
<td>Jane Wanjiru Maina</td>
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<td>Oral Presentation Session 24: Room 149</td>
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<tr>
<td>1. The Level of Awareness of Patient Centered Care among Medical Students in Kenyatta University, Kenya.</td>
<td>Daniel Baraka</td>
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<td>2. Anesthesia: The Role in Patient Centered Care.</td>
<td>Zipporah Gathuya</td>
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<td>4. Experience of Patient Centered Care at Karatina District Hospital</td>
<td>Mayaka Wesley</td>
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<td>1. Nutraceuticals based on amaranth grain for management of nutritional disorders</td>
<td>Nicholas K. Gikonyo</td>
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<td>2. The impact of Health Education on the prevalence of faecal-orally transmitted parasitic infections among school children in a rural community in Cameroon</td>
<td>Fouamno Kamga</td>
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<td>3. A Patient Centered Approach: Using Data to Drive Clinical Research.</td>
<td>Faith Muigai</td>
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<td>4. Whole Person Care: Health Beliefs and Compliance; Tree and Root Model.</td>
<td>Kizito A Shisanya</td>
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<td><strong>Oral Presentations Session 26: Room 273</strong></td>
<td>Kennedy Auma</td>
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<td>1. Assessment of laboratory practitioners competence enabling them provide Patient-Centered Care</td>
<td>Gathigia Njoroge Wacuka</td>
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<td>2. Patient-Centered care: A case of Kenyatta National Hospital</td>
<td>Anthony Wainaina</td>
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<td>3. Evaluation of pre cervical cancer signs screening and management in PGH (Nakuru county)</td>
<td>Esther Muiita</td>
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<td>4. Assessment of Hypertensive patients’ illness-experience using Patient-Centered consultation among patients seen at the family medicine clinic of the university of Calabar Teaching Hospital Calabar, Nigeria.</td>
<td>Ndifreke Udonwa</td>
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**Workshops Session 28: Room 280**

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<td>Impact of FUNZOKenya in Health and the use of Training Institution in Capacity Development in Counties</td>
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<td>9:15 – 10:00 AM</td>
<td><strong>Plenary 7</strong></td>
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<td>10:00-10:30 AM</td>
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<td>10:30-11:00 AM</td>
<td>Health Break/Exhibitions</td>
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<td>11:00—1:00 PM</td>
<td>Closing Ceremony</td>
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## POSTER PRESENTATIONS

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<td>Patients' virtual journeys during care</td>
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<td>PP.02</td>
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<td>PP.03</td>
<td>Patients' journeys during care</td>
<td>Penda Health</td>
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<td>PP.04</td>
<td>“Angels” Heart Empowerment Programme (ANHEP)</td>
<td>Angela Oruko</td>
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<td>Design of Patient Centric Service Delivery in Health Care - A Wholistic Approach</td>
<td>Mwaniki Wa-Gichia</td>
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<td>Case study on the role of a family physician in transforming Maragua Health Centre to a patient centered Comprehensive Care Sub-County Facility</td>
<td>Stephen Ngigi</td>
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<td>PP.07</td>
<td>Patient-Centred infertility Health Care: Comparison between Slovakia and the Netherlands</td>
<td>Slavica Karajicic</td>
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ABSTRACTS
TRACK 1: ACCESS AND COVERAGE IN HEALTH CARE
A 001 IMPACT OF THE INTEGRATION OF SUPPLY AND DEMAND-SIDE INTERVENTIONS ON MATERNAL HEALTH SERVICE USE

Chrispin Owaga1, Jill Luoto4, Richard Omore5, Peter Ouma3, David Levine6, Alie Eleveld1, Reid Harvey2, Benjamin Nygren2, Jamae Morris7, Tracy Ayers7, Aloyce Odhiambo1, Jared Oremo1, Sitnah Faith1, Joel O Omondi8, and Robert Quick2

1Safe Water and AIDS Project, Kisumu County, Kenya
2Waterborne Diseases Prevention Branch, CDC, Atlanta, USA
3Malaria Branch, Kenya Medical Research Institute/CDC, Kisumu County, Kenya
4RAND Corporation, Santa Monica, CA, USA
5International Emerging Infections Program, Kenya Medical Research Institute/CDC, Kisumu County, Kenya
6University of California Berkeley, CA, USA
7Division of Foodborne, Waterborne, and Environmental Diseases, CDC, Atlanta, USA
8Ministry of Health, Nyanza Province, Kenya.

In Kenya, underutilization of reproductive health services contributes to high maternal and neonatal mortality rates. Although >90% of pregnant women have at least one antenatal clinic (ANC) visit, a much lower percentage have >4 ANC visits (ANC4) and health facility deliveries. Increased ANC visits and health facility deliveries can decrease maternal and neonatal mortality rates. To increase the percentage of women with ANC4 and health facility deliveries, we integrated supply-side (nurse training and clinic supplies) and demand-side interventions (health product vouchers, group ANC visits, SMS messages) with ANC visits and deliveries in Kisumu County. During the same period, a different program offered Output-Based Aid (OBA) cards for ksh.100 in Kisumu County that paid for private hospital deliveries. SWAP selected a group of 10 public health facilities in Kisumu County to receive the intervention and 10 additional health facilities in Homa Bay County as a control group. We abstracted data on total ANC visits, ANC4 visits, and health facility deliveries from monthly ANC registers from intervention and control clinics during the pre-intervention period (November 2012–October 2013) and compared the results to the intervention period (November 2013–October 2014). We also abstracted health facility delivery data from 9 private hospital registries in Kisumu County (intervention area), comparing pre-intervention to post-intervention totals. Difference of differences analysis comparing post-intervention to pre-intervention service use showed statistically significant increases in total ANC visits and ANC4 visits of 22% and 50%, respectively, in intervention vs. control health facilities and a similar, but non-significant 12% increase in deliveries in intervention vs. control health facilities. Deliveries in private health facilities increased by 130% from the pre-intervention to the post-intervention period. In conclusion, the supply/demand side intervention appeared to motivate increased use of ANC services while the OBA Card program likely increased deliveries in private health facilities.

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A 002 TRACKING AND CARING OF HIV POSITIVE PREGNANT MOTHERS AND EXPOSED INFANTS THUS KEEPING THEM ALIVE AND ACCELERATING TOWARD BEYOND ZERO INFECTION. (NYAHURURU COUNTY HOSPITAL-LAIKIPIA COUNTY-KENYA

Charles Kabuga1,3, Martha Rukwaro1, Alice Wangui2, Rachael Kariuki2

1Ministry of Health,
2CHS (center for health solution) - mentor mother,
3Mount Kenya university-BSCN-student (nursing)

WHO guidelines recommend that HIV positive pregnant women be initiated on HAART as soon possible. This can reduce HIV transmission to the babies by more than 95% and reduce HIV related maternal death by 50%. Nyahururu hospital started PMTCT in 2005 but data management, integration of care, Patient /family centered approach and follow up were below average. The objective of this study was to assess and evaluate the progress and benefit of integrated, patient-centered eMTCT Programme (care) at Nyahururu hospital. Integrated Care-Patient Centered Approach, was started at the MCH/FP clinic, care under one roof, family centered psychosocial support group, focused mentor mothers and proper documentation. We conducted HEI cohort analysis for mother and infant enrolled during July 2012 to December 2013, with focus to total enrolment, infant tested HIV positive, total tested HIV negative at 18 months and discharged, any child or maternal death related to HIV. The results indicate that of the total infants enrolled-63, total babies tested HIV positive at 6 weeks-3 (4.8%), lost to follow-0 (retention rate-100%) Total babies tested HIV negative and discharged at 18 month-60 (95.2%), children and maternal death related to HIV-zero. In conclusion 95.2% babies tested HIV negative at 18 months and discharged. 4.8% tested HIV positive at 6 weeks and linked to CCC. Retention rate 100% and no mortality related to HIV. Those tested HIV positive at 6 weeks, were home delivery enrolled at 2 weeks, and no maternal intervention during ANC, intrapatum and immediate infant prophylaxis. This study recommends that good integration of care, patient centered approach, option B+ approach, adhere to the 4 - Prongs and 4-pillars of eMTCT should be followed. Proper documentation, stakeholder partnership and monitoring and evaluation, will reduce transmission to less than 5% and reduce HIV related maternal death by more than 50%. and finally beyond zero transmission.

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A 003 FAMILY MEDICINE RESIDENTS EXPERIENCE AT A LEVEL 3 HEALTH CARE FACILITY IN CENTRAL KENYA

Margarita Mwai1, Samuel Mucheru2, Catherine Gathu3, Jacob Shabani4, Lynda Koech5

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2 Resident Aga Khan University, Family Medicine– samuel.mucheru@aku.edu
3 Resident Aga Khan University, Family Medicine– catherine.gathu@aku.edu
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5 Instructor, Aga Khan University, Family Medicine – lynda2koech@aku.edu
Family medicine is a relatively new field within the Kenyan health system. A family physician is a doctor able to provide comprehensive, competent, continuous, cost-effective and coordinated care over a wide range of clinical conditions. He is not limited by age, gender, disease-entity or organ system. A family physician was acknowledged in the MOH family medicine policy August 2007, as the most appropriate person to respond to the challenges of the Kenyan health service delivery system. To describe the experience and role of 3 AKU part two family medicine residents in a level 3 health care facility in central Kenya were enrolled in the study. Practice of full-spectrum rural-based family medicine is part of the AKU family medicine curriculum. This experience is to enable acquisition of basic knowledge, attitude and essential surgical skills to manage common surgical and obstetrical emergencies under minimal supervision in a rural setting. In addition, it facilitates gaining of desired knowledge and skills to practice community oriented primary care. Accordingly, part two family medicine residents are assigned to clinical rotations in level 3 and 4 health care facilities in central Kenya. We have had the opportunity to see a wide range of conditions, diagnose some unique conditions (Duchene’s muscular dystrophy, cerebellar ataxia etc.), institute evidence based management of chronic disease like hypertension, diabetes and asthma, perform VIA screening for cervical cancer and treat suspicious lesions using cryotherapy, and train the health staff at the facility on various procedures. In conclusion, in keeping with the MOH family medicine policy, a family physician is best placed to provide for the primary health care needs of patients and communities. In order to provide competent, comprehensive and cost-effective care to the underserved Kenyan population, the health care system needs to appreciate the role of the family physician.

A 004 PATIENT CENTRED CARE AND FAMILY MEDICINE IN SUB-SAHARAN AFRICA

Thigiti JM

Kenyatta University

The 2nd African Regional WONCA (World Organization of Family Doctors) Conference held in Rustenburg, South Africa in October 2009, engaged participants in the development of a consensus statement on the definition of Family Medicine in sub-Saharan Africa. Among the eight identified key principles; Comprehensiveness, Person centered, Family Orientated, Integrated, Community orientated, Co-ordination of Care, Continuity of Care and First Contact, only the last one (First contact) was found to be missing in action. The need for patient-centeredness has become an important global issue, having been identified as one of six attributes of health care quality, the others being safety, timeliness, effectiveness, efficiency and equity. The main objective of this review is to describe the place for implementation of patient centered care in the practice of Family Medicine in sub-Saharan Africa. Person centeredness is a principle in family medicine. Both patient-centered and person-focused cares are important, but they are different. In contrast to patient-centered care, person-focused care is based on accumulated knowledge of people, which provides the basis for better recognition of health problems and needs over time and facilitates appropriate care for these needs in the context of other needs. That is, it specifically focuses on the whole person. The severe human resource shortage in the health sector globally and more so in sub-Saharan Africa places substantial challenge in the family physicians knowing individuals well before they are unwell. Patient centered clinical practice is a holistic concept in which the clinical, individual, and their context
components interact and unite in a unique way in each patient-doctor encounter. It (a) explores the patients' main reason for the visit, concerns, and need for information; (b) seeks an integrated understanding of the patients' world—that is, their whole person, emotional needs, and life issues; (c) finds common ground on what the problem is and mutually agrees on management; (d) enhances prevention and health promotion; and (e) enhances the continuing relationship between the patient and the doctor. The core value of health care is the health and well-being of all people and therefore before people become patients, they need to be informed and empowered in promoting and protecting their own health. This entails a more holistic people-centered approach to health care, and a balanced consideration of the rights and needs as well as the responsibilities and capacities of all health constituents and stakeholders. Patient centeredness clinical encounters allows for the potential creation of a continuum between the hospital, clinic and community. In conclusion, having defined community units with each unit co-ordinated by a Primary care team skilled in Person-Patient– family and people- centered care led by a family Physician, allows for the hospital-clinic-community continuum in sub-Saharan Africa. Health systems will need to carefully consider a combination of measures which are mutually reinforcing for their context in order to bring the desired goal and vision in the health sector.

A 005 THE IMPACT OF HEALTH EDUCATION ON THE PREVALENCE OF FAECAL-ORALLY TRANSMITTED PARASITIC INFECTIONS AMONG SCHOOL CHILDREN IN A RURAL COMMUNITY IN CAMEROON

Henri Lucien Fouamno Kamga\textsuperscript{1}, Dickson Shey Nsagha\textsuperscript{2}, Mary Bi Suh Atanga\textsuperscript{1}, Anna Longdoh Njunda\textsuperscript{2}, Jules Clement Nguedia Assob\textsuperscript{2}

\textsuperscript{1}Faculty of Health Sciences, University of Bamenda, Cameroon
\textsuperscript{2}Faculty of Health Sciences, University of Buea, Cameroon

Faecal-orally transmitted parasites are those parasites which are spread through faecal contamination of food and drinks. Infections with these parasites are among the most common in the world being responsible for considerable morbidity and mortality, especially in children.

Objective: This study was carried out to determine the impact of health education on the prevalence of faecal-orally transmitted parasitic infections among primary school children in a typical African rural community in Cameroon. An intervention study was conducted in two villages in the South-West Region of Cameroon. A total of 370 volunteer pupils aged between 5-15 years were enrolled in the study out of which 208 were from Kake II (experimental arm) and 162 from Barombi-Kang (control arm). The research was conducted in two phases. In phase 1, stool samples were collected from all participants and analyzed using the formol-ether concentration technique and health education was given to the pupils in the experimental village but not in the control village. Phase 2 was conducted six months later during which only stool samples were collected and analyzed from both villages. The results indicate that before health education intervention (phase1) faecal-orally transmitted parasites were present in 106 (50.9\%) stool specimens collected in Kake II and in 84 (51.5\%) of those collected in Barombi-kang. The difference in prevalence between these two villages was not significant (P>0.05). After health education intervention (phase2), 56 (26.9\%) stool specimens were positive for faecal-oral parasite in Kake II and 92 (54.7\%) in Barombi-kang, and the difference in prevalence between
these two villages was statistically significant (P<0.001). There was no significant difference between the prevalence of faecal-orally transmitted parasites and the ages of infected pupils (P>0.05). The change in the prevalence of infection was significant in Kake II (50.9% vs. 26.9%, P<0.001) but not in Barombi-Kang (51.5% vs. 54.7, P>0.05). There was a drop in the prevalence among pupils infected with *Ascaris lumbricoides* (24.9% vs. 3.4%, P<0.001), *Entamoeba coli* (12.9% vs. 6.5%, P<0.001) and *Trichuris trichiura* (22.4% vs. 12.5%, P=0.004). In conclusion, health education applied in the experimental village was responsible for the drop in the prevalence observed. We recommended that health education through the framework of schools be used as a strategy for the control of faecal-orally transmitted parasitic infections among children in African rural communities.

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**A 006 THE INFLUENCE OF SOCIAL SUPPORT ON THE UTILIZATION OF HEALTH CARE SERVICES BY PATIENTS WITH CHRONIC LYMPHATIC FILARIASIS IN GOSHI LOCATION, MALINDI SUB-COUNTY, KENYA**

**Murithi David**¹, Ng'ang'a Zipporah¹, Mukoko Dunstan², Njomo Doris W³

¹Jomo Kenyatta University of Agriculture and Technology,  
²Ministry of Health, Division of Vector Borne Diseases, Kenya  
³Kenya Medical Research Institute (KEMRI),

*Lymphatic filariasis* (LF) caused by filarial worms and transmitted by mosquitoes is ranked as the second largest cause of disability in the world. The disease causes considerable morbidity to affected individuals with consequent loss of income and social and psychological stress. The objective of the study was to assess the influence of social support on utilization of health care services among patients with chronic *Lymphatic filariasis* in Goshi location, Malindi Sub-County, Kilifi County, Kenya. A total of 220 patients with chronic (LF) were purposively selected and interviewer-based questionnaires administered to them for quantitative data. The quantitative data was analyzed by SPSS version 16 and the qualitative data manually by study themes. The results indicate that encouragement received by patients from family and friends was significantly associated with health care services utilization (P<0.001). Receiving encouragement from other patients with chronic LF was significantly associated with frequency of visiting health care facilities (P<0.001). Being affiliated to a support group was also significantly associated with utilization of health care services (P<0.001). In conclusion patients with chronic LF require encouragement from community members and fellow patients to remove the feeling of rejection and to seek health care services. Being a member of a support groups is an important contributor of increased health care services utilization and authorities should support patients to form such groups.

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A 007 EFFECT OF PEANUT SUPPLEMENTATION ON CARDIOVASCULAR DISEASE MARKERS IN HIV-INFECTED ADULTS WITH HYPERLIPIDEMIA ATTENDING NYERI LEVEL- 5 -HOSPITAL, KENYA.

Regina Wangui Kamuhu¹, Prof Judith Kimiywe (PhD)², Prof Eliud NM Njagi (PhD)³
Dr. Beatrice Mugendi (PhD)⁴

¹School of Applied Human Sciences, Kenyatta University
²Department of Foods, Nutrition and Dietetics, Kenyatta University
³Department of Biochemistry & Biotechnology, Kenyatta University
⁴Department of Foods Science & Technology, Dedan Kimathi University of Science & Technology

Cardiovascular diseases is currently the second most frequent cause of death (after cancer) among HIV-positive subjects in areas of the world where Highly active anti-retroviral therapy is widely available. Dyslipidemia is a major modifiable cardiovascular risk factor that is a common clinical feature of HIV-infected patients in the current era of HAART. Peanuts are a rich source of magnesium, Folate, fiber, α- tocopherols, copper, arginine and resveratrol. These compounds have been shown to reduce the CVD risk by improving the lipid profile. Roasted peanut is a cheap food product for patients especially because lipid lowering drugs are expensive and are of concern given their toxicity, intolerance and potential interactions with antiretroviral agents.

The purpose of this study was to investigate the effect of peanut supplementation on cardiovascular disease markers in HIV-infected adults with normal and hyperlipidemia.

The study design was a randomized cross-over clinical trial. Samples of 85 eligible participants were randomly assigned to a two arm study. In treatment I, the participants consumed their regular diet supplemented with 80g of peanuts and then crossed over to treatment II after six weeks wash out where the participants were counselled on healthy diet and supplemented it with 80g of peanut for eight weeks each. The primary outcomes are total cholesterol, LDL-C, HDL-C and BMI.

There was a significant increase in intake of total fat, PUFA, Vitamin E and MUFA while carbohydrate intake decreased between baseline and the two treatments. There was no significant change in weight, BMI, waist, hip circumference, body composition, blood pressure and fasting blood glucose after the two treatments. There was a significant reduction in total cholesterol, triglycerides and low density lipoproteins in both treatments while high density lipoproteins increased significantly. There was a significant reduction in the 10-year risk of coronary heart disease between baseline and end of study.

Peanut consumption has been found to lower cardiovascular risk significantly due to reduction in total cholesterol, triglyceride and LDL-C.

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A 008 ESTABLISHING A COMMUNITY-BASED, PRIMARY-CARE-ORIENTED BREAST AND CERVICAL CANCER CARE PROGRAM IN TAJIKISTAN
Breast and cervical cancer are the most common cancers and cause of mortality in females in Tajikistan yet awareness is minimal and cancer screening is not part of routine care. The main objective was to develop a community-oriented breast and cervical cancer program in a resource-constrained environment through a public-private partnership. The project included didactic training of family doctors, breast / cervical cancer screening and intervention, as well as, systematic collection of demographic and risk factor data. The program was conducted in Khorog, Tajikistan. Phase I of the project focused on clinical breast exam (CBE) training, and involved screening over 400 women for breast cancer. Phase II included refresher CBE training and introducing the Visual Inspection with Acetic Acid (VIA) method for cervical cancer screening. All patients provided Informed Consent and data was collected on all subjects using an online module. The results show that in Phase I, twenty-four family doctors received CBE training and ten master trainers were identified. Of the 441 women examined, 74 (17%) had abnormal CBE and underwent additional diagnostic procedures based upon a pre-defined algorithm. Six patients (1.4%) were diagnosed with breast cancer (all locally advanced) and 2 women had benign fibroadenomas. All received appropriate surgical management. Five of 6 subjects with cancer were previously aware of their breast lump and three had recently seen a family doctor. At seven months follow-up, the trained family doctors had independently conducted CBE on 1500 additional patients. Phase II verified the CBE skills of six master trainers (60 women examined) and introduced pelvic examination and VIA (183 women examined). In conclusion, this program successfully integrated breast and cervical cancer screening into routine care provided by family doctors and in the process revealed valuable information regarding disease burden, risk factors and potential barriers to care. Our program demonstrates how a community-based program for primary care providers conducted through a public-private-partnership can achieve sustained and ongoing improvements in cancer care in a low-resource environment.

A 009 CERVICAL CANCER SCREENING IN A RURAL HEALTH CARE FACILITY IN CENTRAL KENYA

Margarita Mwai, Samuel Mucheru, Catherine Gathu, Patricia Muthaura, Jacob Shabani, Lynda Koech

Aga Khan University

Cervical cancer is ranked second as the cause of female cancer in Kenya, but the most common cause of cancer deaths. Approximately 2,454 new cases are diagnosed annually, while the annual number of deaths is 1,676 in Kenya. Highest incidence rates are amongst women aged 15 – 44 years. In Kenya, it is estimated that only 3.2% of women, aged 18 -69 years, have been screened.
To determine the incidence of abnormal cervical lesions, during a cervical cancer screening camp, at a rural health centre in central Kenya, using Visual Inspection with Acetic Acid (VIA). Women in the reproductive age group were informed to avail themselves to a cervical cancer screening camp. 52 women attended the camp and received education regarding cervical cancer prior to screening. Screening was later done by three family medicine residents supervised by a gynecology consultant. For those found to have suspicious lesions, cryotherapy was done. They were then asked to come back for a review in three months. The results indicate that 10 women with suspicious lesions underwent cryotherapy. 7 out of the 10 women came back for a follow up review after three months, of which 2 underwent repeat cryotherapy. In conclusion, despite a small sample, approximately 20% of women screened had suspicious lesions. There’s need to create cervical cancer screening awareness among women of reproductive age in Kenya. Health care workers at level 2 and 3 facilities in Kenya need to be empowered to screen for cervical cancer and treat suspicious lesions. This is in keeping with the Ministry’s recommendation to give women complete care in one visit.

A 010 THE USE OF MOBILE PHONE SHORT TEXT MESSAGE SERVICE TO ENHANCE CERVICAL CANCER SCREENING AT THIKA HOSPITAL, KIAMBU COUNTY, KENYA

Wanyoro Anthony Karanja

Kenyatta University

Cervical cancer is a major public health problem among adult women especially in developing countries and its control is of paramount importance. Organized screening programs have led to a large decline in cervical cancer incidence and mortality in developed countries but the scourge remains largely uncontrolled in many developing countries like Kenya. In Kenya there exists no effective recall mechanism to enhance scheduled screening. The short text message service (SMS) may be used as a recall tool to enhancing cervical cancer screening in developing countries like Kenya where other communication means may not be easily available. The study aimed to determine the influence of using SMS in enhancing adherence to scheduled repeat screening for cervical. This was blinded RCT where after baseline screening of women who had never been screened before, eligible participants were randomly allocated to an intervention arm using 4 SMS reminders and a control (no SMS) group. Data was collected using interview guide analyzed using STATA. The results indicate that most of the participants were either below 29 years or above 45 years, married and of low social economic status. Only 20% of women attending the general outpatient’s clinic had ever been screened before and 7.5% had abnormal cytological smears. 67.1% of those sent an SMS and 20.3% of those who were not reminded re-attending as scheduled respectively. The odds ratio for re-attendance among the intervention group was 8 (P< 0.001). Age 30-34 years, husband being employed and using public means of transport were significantly associated with return to scheduled screening after sending SMS reminders (OR 2.24 P<0.005, OR 2.2 P<0.05, and OR3.29 P< 0.005) respectively. In conclusion sending SMS reminders to women reminding them of the next scheduled screening increases adherence to scheduled screening 8 times compared to those not reminded. The study
recommends SMS reminders should form part of the reminder system to enhance adherence to screening.

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A 011 ADOPTING STRATEGIES FOR TRANSFORMING PRIMARY CARE PRACTICES TO IMPROVE QUALITY OF HEALTH CARE IN KENYA: AN ANALYSIS OF PERFORMANCE OF HEI SERVICES AND KQMH MODEL

Maxmiller M. Gitamo, Vincent M. Andaya

More health institutions are recognizing the importance of quality models for improved health care delivery and health care outcomes. However, they are still facing a challenge on choosing and adopting a clear strategy in their pursuit. It is against this background that the authors sought to examine the performance at selected facilities of HIV Exposed Infants (HEI) services after Implementing Kenya Quality Model for health (KQMH). This study examined the effects of Implementing Kenya Quality Model for health (KQMH) on HIV Exposed Infants (HEI) outcomes at exit. A comparison was done through HEI cohort analysis for cohorts prior to implementation of KQMH and cohorts after implementation of KQMH. Two county referral hospitals, serving approximately 450 HIV exposed infants in Kiambu and Nakuru Counties were studied. A cross-sectional design was used to determine performance of HIV Exposed infants ‘services prior to implementation of KQMH and after implementation of KQMH at the Postnatal PMTCT clinic. HEI registers for years 2011 to 2014 were reviewed. The results indicated that Implementation of KQMH in the management of HIV exposed infants generated more favorable performance such as increased coverage in prophylaxis uptake, scheduled follow up visits, PRC and anti-body tests and linkage to care and treatment. Prior to the implementation of KQMH, there were more undesirable performance such as died, high defaulter rates, lower prophylaxis uptake and Lost to follow up. In conclusion, KQMH is a national model that has worked well in improving the quality of health care delivery. Indicators identified, and monitored showed remarkable improvement in performance. This led to improved outcome of health care. KQMH enables health facilities to Improve work for the health care provider while at the same time improve the quality of care offered to the clients. With this in mind, the study recommends adoption of quality models in health care service provision. Facilities can use the national model as a template to come up with a model that works well for them. There is also need for capacity building with regard to quality modeling.

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A 012 EVALUATING THE RELEVANCE OF COMPETENCIES IN COMMUNITY ORIENTED PRIMARY CARE OF POPULATION HEALTH GRADUATES, KENYATTA UNIVERSITY

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As an integral part of training, graduates of Population Health are trained in Community Oriented Primary Care (COPC) and undertake fieldwork and placement as part of preparedness. The major goal of the study was to assess the relevance of competencies in community oriented primary care (COPC) practice among Population Health graduates in Kenyatta University. The study specific objectives were: to determine aspects of training in population health on COPC; to relate the training to practical experiences and to identify gaps in training in readiness for COPC.

The methodology of data collection entailed a review of the BSc Population Health training curriculum and administration of structured questionnaires to BSc Population Health forth year undergraduates. Thirty six (36) students were approached. The study found that the students have knowledge and understanding on COPC and are well trained. This is because they were exposed to relevant field practicums that are related to COPC and that the curriculum covered all aspects of COPC. However, a few respondents felt that the practicums should cover a longer period of time (preferably 2 weeks instead of 1 week) and should also involve more than one community to expose the students to diverse contexts with different health inequalities. In conclusion the study therefore concluded that the population health graduates from Kenyatta University are competent and have relevant knowledge on COPC. The following recommendations were drawn from the study: the government of Kenya through the Ministry of Health should create adequate capacity to absorb these students into community based strategies in order to utilize these competencies; there is need for further studies to be conducted in order to ascertain the relevance of competencies in community oriented primary care practice in other health related courses in all universities.

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A 013 COMMUNITY SCREENING AND ASSESSMENT OF DIETARY INTAKE FOR FOOD SUPPLEMENTATION AMONG MALNOURISHED CHILDREN AGED 6-36 MONTHS IN THIKA URBAN SLUMS, KENYA

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Globally, undernutrition accounts for half of deaths among children aged below five years. Although malnutrition trends in Kenya have been decreasing, the Millennium Development Goals have not been achieved. Current efforts in community screening for malnutrition have not
been effective. The aim of this study was to screen for malnourished children, establish the adequacy of nutrient intake by the children and to establish feeding centres for targeted food supplementation. Moderately malnourished children aged 6-36 months were identified through door-to-door screening and active case finding. Children enrolled to other food supplementation programmes were excluded. Chronically sick, severely wasted and severely anaemic children were referred to Thika Level 5 Hospital. Dietary intake was assessed using a 24-hour recall questionnaire. Feeding centres were established considering the accessibility to mothers and availability of clean water and environment. A total of 377 children were identified, 363(96.3%) were moderately wasted, severely wasted (2.1%) and severely anaemic (1.6%). Over 86.7% of the children met their protein requirements with daily intakes ranging from 21.7 to 28.6g in the age categories 6-8 months, 9-11 months, 12-23 months and 24-36 months. Caloric intake was adequate for over 61.5% of children in the 6-8 month age category and less than 54.6% of the children aged above 9 months met the RDA for energy intake. The mean daily intake of iron ranged from 5.5-8.2 mg and was inadequate for over 92.1% of the children in the age categories. The mean daily intake of zinc ranged from 1.1-1.5 mg with over 93.2% of the children not meeting the RDA. A total of 16 feeding centres were established. Presence of aggravating factors for malnutrition such as poverty, food insecurity and poor sanitation calls for frequent screening of children in slum populations. Due to sub-optimal nutrient intake among malnourished children, food supplementation is recommended.

A 014 USE OF HEALTH INFORMATION TECHNOLOGY AND HOME CARE FOR IMPROVED CHRONIC DISEASE MANAGEMENT IN USA; LESSONS FOR KENYA

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Chronic diseases like cardiovascular diseases, cancer and diabetes are placing a growing burden on not only Kenya's health care system but also other nation’s health care system. There is need for health care organization to institute chronic disease management program to reduce incidence of preventable hospitalization and adverse health events by more effectively and comprehensively managing the health of patients with chronic conditions. Information technology has been applied in remote patient monitoring and management by maintaining patient contact, assessing needs, provide education and counsel caregivers. The US health care management system have adopted technology in medication management, care giver and patient communication, in-home remote patient management by use of mobile phones and wearable or planted monitors(health) and lastly social networking among patients, caregivers and health workers. Health information exchange has been made possible by highly interoperable and communicating systems. All the above is unlike in Kenya where chronic diseases are only monitored through hospital visits during scheduled clinics. Health information technology whose adoption requires significant investment of time and resources has positive impact on management (improved adherence) and delivery of care to individuals with chronic diseases and requires user trust for its successful implementation. Usability and system design are factors which drive the use of health information systems to improve chronic disease management. Donors and the Ministry of Health should encourage the use of innovative health Information technology in providing care to individuals with chronic diseases through home-based care by
health care institutions by allocation of funds on health information projects and ensuring sustainability by funders and lastly setting up regional information organization that facilitate health information exchange through computerized disease registers to enhance care coordination among providers electronically which can only be achieved through interoperability and communication between software and hardware in health information technology.

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A 015 APPLICATION OF GIS TECHNOLOGY TO HEALTH MANAGEMENT SYSTEMS FOR IMPROVED PATIENT ADMISSION IN MAJOR HOSPITALS: CASE OF KENYATTA NATIONAL HOSPITAL

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The identification of management systems to improve on patient admissions with the increasing populations has become a major area that has been and is still given a lot of attention by many scholars and researchers. The hospital beds demand in KNH occasionally exceeds capacity, thus leading to frequent delays and at times cancellation of admission. The hospital has a bed capacity of 1,800 yet the average number of patients hosted in the hospital wards each day ranges between 2,500 and 3,000 patients (KNH management records-Kenya National Audit Office as per 12 Nov 2012). The objective of this study was to assess the efficiency level of the current bed allocation management system at KNH. Kenyatta National Hospital is located in Nairobi County in Kenya along the Hospital Road (off Ngong Road). Quota sampling process was used to decide on the ward of research interest and the following was done using ArcGIS; creation of a modified Pending Discharge function which captures workflow tracking elements for effective bed management and patient tracking with a management report to be used by Admitting and Nursing Administration, integration of GIS system with the Hospital’s ADTIS to provide real time information on patient admission, bed transfer and discharge status and integration of GIS system with the Hospital’s Health information system and billing system to give a complete information of the admitted patient. The results indicate that ability of all emergencies’ to be promptly admitted, all elective surgery having available beds, short and effective call-ins to minimize delays in inpatient admissions, minimization on cancellations of surgical procedures and ability to facilitate timely patient discharge and housekeeping services. In conclusion, the study therefore evidently shows the need for GIS technology in hospital management system in addressing the multifaceted patient admission processes with varied aspects of bed allocations that are faced by hospital.
A 016 TRADITIONAL AND COMPLEMENTARY MEDICINE IN PATIENT CENTERED CARE AND INTEGRATIVE MEDICINE

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A few years ago it was realized that in spite of high technology and general success in modern treatment, patient medical care especially for chronic diseases was not being completely addressed. At present there is deliberate shift to patient centered care and integrative medicine in a number of medical institutions and facilities worldwide. Traditional and Complementary (Alternative) has been incorporated as part of integrative medicine and patient centered care. Integrative medicine is healing-oriented medicine that takes account of the whole person (body, mind, and spirit), including all aspects of lifestyle. Traditional and Complementary (Alternative) is one of the fastest growing areas of medical treatment and prevention. It is a holistic form of medical practice where diagnosis and treatment takes into account the individual physical, mental, emotional and even lifestyle aspects of the patient. This paper discusses the role of Traditional and Complementary in patient centered and integrative medicine. Types of traditional and complementary medicine will be highlighted showing why this type of medicine is gaining popularity especially in developed world. Diagnoses and treatment in a typical traditional and traditional medicine setting will be mentioned to indicate its relationship with the patient centered medicine and need for medical doctors to enquire about the use/concurrent use of with conventional medicine. The role of Traditional and Complementary medicine in patient care and integrative medicine including the importance of prevention of disease will also be discussed. That traditional and complementary medicine is an important element in patient centered care and should be embraced. In conclusion, going by the current trends in health care, and in order to consider the total person health, we can no longer ignore traditional and complementary medicine as part of health care.

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A 017 PATIENT-CENTERED PHARMACY SERVICES: ETHIOPIAN EXPERIENCE

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Up to 2010, pharmacists in Ethiopia were not involved in direct patient care. That year, the Ministry of Health issued a guideline necessitating pharmacists’ involvement in clinical pharmacy services. To help implement the guideline, a training curriculum was developed and in-service training provided to 200 pharmacists from 65 hospitals. The training participants then received onsite support and were provided with recording and reporting tools. The objective of this study was to assess the immediate outcomes of the in-service clinical pharmacy training and follow-up on patient care at selected public hospitals. This was a retrospective study based on monthly clinical pharmacy reports generated from 38 hospitals from August 2012 to December 2014. Reports that fulfilled criteria for accuracy and consistency were selected for analysis. Out of the 65 hospitals involved in the training, 60 (92.3%) started providing clinical pharmacy services. Forty-seven (72.3%) hospitals included the service in their annual plans. Pharmacists monitor patients from admission to discharge and participate in multidisciplinary rounds (89.2%) and morning sessions (72.3%). In 24 (37%) hospitals, pharmacists provide pharmaceutical care to patients with chronic diseases. A total of 38,184 patients benefitted from the services and 43% of these were documented. A drug therapy problem (DTP) was identified and documented for 4,800 patients (29.2%). The major DTPs included a need for additional drug therapy (29%), unnecessary drug therapy (18.8%), and noncompliance (14%). Interventions were recommended for 91% of the DTPs. Prescribing doctors fully accepted 83% of the recommendations. In conclusion, the initiative has created a paradigm shift in pharmacy practice in Ethiopia. Clinical pharmacy is now becoming an integral part of hospital services, but continuing support is required to consolidate the service. Clinical and economic outcomes should be studied for guidance in making informed decisions regarding the future of the practice.

A 018 HEALTH EDUCATION IN PATIENT CARE AT RWAMBURI DISPENSARY

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A descriptive study on health education in patient care at Rwamburi dispensary was carried out. Rwamburi dispensary is located in Ndeiya ward, Limuru sub-county, Kiambu County in Kenya. This study is a descriptive research on health education in patient care; it describes the integration of health education in patient care. The study was done at Rwamburi dispensary. The study population is the community living in Rwamburi, Ndiuni and Tiekunu villages in Ndeiya ward that make up the majority of the catchment population for Rwamburi dispensary. Data collection was by way of review of records, self administered questioners and face to face interviews. Analysis was done through pie charts, bar charts and histograms.

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A 019 GIS APPLICATION IN PATIENT CENTRED HEALTHCARE IN KENYA

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At the core of national and local efforts to improve the quality of healthcare is the concept of patient- and family-centered care. A key element for reducing health care costs and improving
community health is increased access to primary care and preventative health services. Geographic information systems (GIS) have the potential to assess, harness, integrate and visualize spatial patterns of health care utilization and community-level attributes to identify geographic regions most in need of primary care access. GIS provide us with a powerful tool for deepening that knowledge, explaining it to others, and using it to design interventions that improve the health of the communities we serve. GIS plays a critical role in determining where and when to intervene, improving the quality of care, increasing accessibility of service, finding more cost-effective delivery modes, and preserving patient confidentiality while satisfying the needs of the research community. The objective was to map the distribution of healthcare facilities in Kenya to identify geographic regions most in need of primary care and accessibility of quality patient centered care in cost-effective delivery modes. GIS, analytical hierarchy process, and multi-attribute assessment and evaluation techniques will be used to examine attributes describing primary care need and identify areas that would benefit from increased access to primary care services. Attributes will be identified and maps created based on socioeconomic status, population density. Maps identified areas in our community with the greatest need for increased access to primary care services. In conclusion, applying GIS to commonly available community- and patient-level data can rapidly identify areas most in need of increased access to primary care services. This model can be used to plan health services delivery as well as to target and evaluate interventions designed to improve health care access.

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A 020 UNIVERSAL EMERGENCY CARE FOR KENYA

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Emergency medicine is not a specialty in Kenya. Most of the emergency departments (ED) are run by clinical officers who work independently or alongside medical officers with no additional training on principles of triage and emergency patient management. This review aimed to evaluate the case mix of patients and the current clinical practices in ED across the country and some of the major incidents in Kenya with the hope of highlighting the importance of developing an integrated and well-trained emergency care system appropriate for the local health care system. We reviewed the data from two recent studies which highlighted the state of emergency care in Kenya. One was an observational study over 24 h, of patients who presented to two national referral hospitals, five secondary level hospitals and eight primary level hospitals across Kenya was conducted during a 3-month period. The second paper reviewed some of the major incidents in Kenya over a 12 year period. Data on 1887 patient presentations were described. Adults (≥ 13 years) accounted for the majority (70%) of patients. Two peak age groups, 0-9 and 20-29 years accounted for 27% and 25% of patients, respectively. In conclusion, emergency care in Kenya remains largely underdeveloped and ill prepared. Specific emergency medicine training of clinical officers and doctors working in the ED can reduce the morbidity and mortality of patients presenting with acute illness and injury. Training and development of Emergency Medical Services based on recent major incidents, along with the development of integrated
Command and Control structures, will greatly enhance the country’s preparedness and response to mass casualty incidents.

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A 021 DIFFERENCES OBSERVED AFTER IMPLEMENTING VARIOUS HIV TESTING STRATEGIES IN A RURAL KIAMBU TOWN AND KIAMBAA SUB-COUNTIES IN KIAMBU COUNTY

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Kiambu and Kiambaa Sub-Counties have a joint population of 280,093 with approximately 30% living below the poverty line. This abstract shows the experience in the Kiambu town and Kiambaa sub-counties after implementing various HIV testing strategies in the public sector over a period of two years. Increasing HIV testing coverage in sub-Saharan Africa remains a major challenge towards the rapid scaling up of Anti-Retroviral Therapy (ART) programs despite free medications and care services. Current HIV prevalence is estimated through Kenya demographic health surveys and Kenya AIDS indicator surveys. This abstract demonstrates how HIV Testing & Counseling (HTC) can scale up access to care and treatment. Three HIV testing strategies are currently used throughout the sub-counties. Voluntary counseling and testing (VCT) is done since January 2013 on a daily basis in our testing sites including 1 sub county referral hospital, 2 sub-county hospitals and 2 health centers and various dispensaries and private/ Faith Based Organizations (FBO) facilities. Prevention of mother to child HIV testing and counseling (PMTCT) is offered routinely in antenatal care clinics in 24 health facilities since January 2013. Provider initiated testing and counseling (PITC) is available in outpatient departments, tuberculosis clinics, inpatient department and clinics since January 2013. VCT is client initiated testing approaches (opt in) while PITC and routine HIV testing in ANC are health care provider initiated (opt out). All HIV tests offered free of charge. Kiambu 91582 clients were tested using the various strategies. 3552 clients tested positive over a period of two (2) years (prevalence 3.4 %). 16562 pregnant women tested in same period 462 tested positive (prevalence 2.8%) 43965 clients were tested using PITC approach. 2791 tested positive (prevalence rate 6.3 %). 31045 clients were tested in VCT, 1259 tested positive (prevalence rate 4.1 %). All clients testing for HIV positive were offered free comprehensive care services including: HAART, laboratory, clinical and psychosocial care. Since January 2013 to December 2014, 4512 clients were started on chronic HIV care and 2773 were started on Anti-retroviral Drugs. In conclusion, the three testing strategies employed in Kiambu and Kiambaa sub counties demonstrate significant differences in HIV prevalence. VCT has been recognized as a valid entry point for ARV care however needs to be complemented with other testing strategies. PITC is the most effective strategy to identify symptomatic HIV positive clients and potential Highly Active Anti-Retroviral Therapy (HAART) beneficiaries. Routine HIV testing of pregnant women has a very
high uptake. There is low testing in PITC due Human resource constraint but high positivity. Scaling up all strategies will significantly increase the access of the ART.

A 022 MAKING IMPLICIT COMMUNITY ORIENTED PRIMARY CARE IN PATIENT CENTRED CARE EXPLICIT

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In universal health there is widespread agreement on the need to extend access to health care to all individuals and populations. The implicit integration of public health responsibility of health prevention and promotion with individual-based clinical management of patients in patient centered care forms the cornerstone of community oriented primary care (COPC) approach. Demonstrate patient centered care partnerships role in explicit community oriented primary care. The Institute of Medicine (IOM) defines Patient Centered Care as “Health Care that establishes a partnership among practitioners, patients and their families(when appropriate) to ensure that decisions respect patients wants, needs and preferences and that patients have the education, and support they need to make decisions and participate in their care”. Partnerships are a key principle in patient centered care. Patient centered clinical practice is a holistic concept in which the clinical, individual, and their context components interact and unite in a unique way in each patient-doctor encounter. It (a) explores the patients' main reason for the visit, concerns, and need for information; (b) seeks an integrated understanding of the patients' world—that is, their whole person, emotional needs, and life issues; (c) finds common ground on what the problem is and mutually agrees on management; (d) enhances prevention and health promotion; and (e) enhances the continuing relationship between the patient and the doctor. Explicit COPC essentially takes the individual provider patient encounter as a starting point and combines individual and practice data with public health data at the community level, leading to a "community diagnosis", intervention and evaluation. Involvement of the community in all phases of the process is mandatory. This move goes beyond narrowly focused disease-specific interventions and addresses some of the root causes of community morbidity and mortality. This allows for the shift of the emphasis in medicine from reactive to proactive care. In conclusion, Community-oriented Primary Care (COPC) creates an opportunity to improve the coordination of health service delivery through partnerships-as envisioned in patient centered care- among families, communities, health service providers, policy makers, health professionals and academic institutions.
TRACK 2: QUALITY OF HEALTH CARE AND SERVICE DELIVERY
A 023 SMART PHONE-BASED, POINT-OF-CARE CLINICAL DECISION SUPPORT RESOURCES RELEVANT FOR FACILITATING LEARNER-CENTERED EDUCATION IN AFRICA

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Primary care providers in Africa do not often have access to current and reliable clinical decision support information. What is available is often in old textbooks or pirated software on practitioners’ computers that are left at home for fear of them “finding legs”. The initial 2009 Kenya pilot of 8 Kenyan family medicine residents using PDA-based Oxford Handbooks, BNF and integrated database (DynaMed) showed that answers to patient-prompted questions at the point of care increased from 6% with print/computer/internet to 43% with the handheld resource. Over 4% of patients were self-reported to have improved outcomes because of the new information that was gained from it being immediately available. The recently launched Digital African Health Library is an integrated, smart phone-based, point-of-care decision support resource offered by the Institute of Family Medicine (Nairobi) and the University of Nairobi to provide evidence-based, locally relevant decision support and health information. 150 final year medical students, residents and qualified doctors in Kenya, Rwanda, Somaliland, South Sudan and Botswana were enrolled in the study. Post intervention Likert-scale user survey of resource utility and impact was used. Survey administration is currently in concluding with results expected by September 2015. In conclusion, the expected results will inform the choice of additional components to the Digital Library to make it increasingly useful and relevant to all cadres of primary care diagnosticians (nurses, clinical and medical officers) in sub-Saharan Africa, focusing our expansion where Family Medicine is an emerging specialty. Ongoing development and continued broader dissemination to other African countries will continue with assistance from and the Swedish International Development Agency.

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A 024 PATIENT-CENTERED INFERTILITY HEALTH CARE: COMPARISON BETWEEN SLOVAKIA AND THE NETHERLANDS

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Despite the fact that PCC definition does not exist, in practice this concept includes patients' experience in health care. The aim of this study was to examine patients' (women and their partners) experiences in infertility care in Slovak clinics and to compare with results from Radboud University from the Netherlands. With permission from Radboud University, we used standardized patient-centeredness questionnaire-infertility (PCQ infertility), translated and adapted for Slovak context. Questionnaire covers eight domains (46 indicators): Accessibility;
Information and explanation; Staff’s communication skills; Patient involvement; Respect of patient’s values; Continuity and transition; Staff’s competence, and Care organization. Score range was between 0-3, where higher scores presented higher level of patient-centeredness. The questionnaire was completed by 190 infertile couples from four Slovak infertility hospitals. We found that Slovakia had high level of patient-centeredness in almost all domains. In comparison with Netherlands, Slovakia had the lowest score in Staff’s communications domain. Furthermore, in this domain was found the lowest indicator score in the research for question “How often did you have the impression that staff was talking “about” you instead of talking to you” (0.39). The highest indicator score had question “Did the physician(s) seem competent” (2.90) (Staff’s competences domain). The highest score gap between countries was found in the indicator concerning “Waiting time to make an appointment with the physician” (Accessibility domain), while the lowest was in question concerning “How often staff worked disorderly” (Information and explanations domain). Although overall patients’ satisfaction with total fertility care was high, we recommended caregivers in Slovakia to be more emphatic, clear about expectations from the fertility care, comprehensive when they provide investigations’ and treatment’s information as well as to have assigned one staff member for each patient for contact any time.

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A 025 THE KNOWLEDGE AND PERCEPTIONS REGARDING THE ROLE OF FAMILY PHYSICIANS AMONG PATIENTS IN PRIMARY CARE SETTINGS IN NAIROBI

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Family Medicine is a relatively new specialty in Kenya. It involves the care of the entire individual and the family and integrates biological, clinical and behavioural sciences. Understanding the current perception of Family Medicine in Kenya, while the specialty is in its nascent stage, is a crucial step in promoting, marketing and planning the delivery of family medicine services. The objectives of the study were to identify gaps in patients’ knowledge about the role of family physicians and to formulate programs to bridge those gaps and create more awareness on the role of the family physicians. A questionnaire based cross-sectional survey of patients visiting selected primary care clinics in Nairobi. Convenience sampling was used. Representative sample size was 162 participants. Consenting English-speaking adult patients were included in the study. Ethical approval obtained as necessary. Excel spreadsheet used for the data entry and analysis. A pilot survey conducted at a primary care clinic to assess acceptability and feasibility during May, 2013. The results indicate that majority were between the ages of 18 and 45 years, 54% female, 61.3% employed, 83.8% university graduates, 69.1% had children, 65.4% resided in Nairobi and 34.6% were from the periphery. General awareness: 68.5% had heard about family physicians. Treatment of children (1 to 12 years), 82.1% of participants thought diarrhoea can be treated, 64.8% believed in asthma treatment, and 58.7% in skin disease treatment. Treatment of adolescents (13 to 17 years), 28.6% were unsure about TB treatment, yet 65.8% confirmed that family physicians can treat sexually transmitted diseases. 40.2% of participants felt teenagers couldn’t be treated for cancer, and 35% of participants thought that adults couldn’t be treated for cancer. In discussing family doctor services, 45.1% of participants were unsure that family doctors could provide antenatal care, Pap smear tests, family planning services and circumcision. The survey captured perceived characteristics and roles of family physicians. While the majority of participants thought the family doctor can treat small babies and young children, some variance was noted. The majority also thought FP can treat common adult and childhood illnesses.

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A 026 BASELINE MENTAL HEALTH OUTCOMES AMONG PARENTS/GUARDIANS OF CHILD RAPE VICTIMS: A COMMUNITY BASED INTERVENTIONAL STUDY IN KENYA

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The study assessed the baseline mental health outcomes among parents/guardians of child rape survivors immediately following the rape. The objective was to assess the baseline similarities and differences in mental health outcomes between parents/guardians of child rape survivors presenting in Thika and Naivasha public health hospitals. 84 parents /guardians of sexually violated children were prospectively recruited consecutively in the two study sites from April 2012 to February 2013. 18 (21.42\%) parents/guardians were recruited in intervention site where Intense Community Lay Rape Trauma Counseling (ICLRTC) intervention was given by Community Health Workers, while 66 (78.57\%) in control site where survivors received standard post rape care. Trauma Counsellors explained the parents/guardians about the study and informed consents were obtained. Trauma Counsellors administered baseline questionnaires to parents/guardians on first contact to collect information on psychosocial pathological reactions and negative mental health outcomes. Measures were on basic demographic information and on dependent variables depression, secondary traumatic stress, self blame and shame. The data was analyzed using SPSS version 17.0. Persons’ chi square, odds ratio and P value were used to measure for similarity or differences at baseline. There were statistical significant differences between the intervention and control groups at baseline in symptoms ‘easily startled’ (p=0.001), ‘difficulty concentrating’ (p=0.007), ‘preoccupied with thoughts of incident’ (p=0.007), ‘people are unkind to you’ (p=0.002), and symptom ‘intense helplessness’ (p=0.017). In conclusion, there were significant differences between the two study groups in five symptoms of negative mental health outcomes at baseline.

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A 027 DO HEALTH PROVIDERS IN KENYA USE PATIENT-CENTRED CARE MODEL FOR TREATMENT OF CHILDHOOD DIARRHOEA

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Oral rehydration solution (ORS) and zinc supplementation is a cost-effective treatment for diarrhea, and standard treatment protocol in Kenya for diarrhoea yet it remains one of the major causes of childhood morbidity and mortality. Patient-centered care improves clinical outcomes yet this model has been underutilized in the management of diseases in Kenya. The objective of this study was to investigate the caregivers’ empowerment in terms of knowledge, attitudes and practices in the use of ORS and zinc for treatment of diarrhoea. A national Large Country Lot Quality Assurance Survey conducted in 98 randomly selected sub-locations from 161 randomly selected sub-counties. The respondents were 1862 randomly selected caregivers of children 0-59 months old and 574 frontline health workers interviewed to solicit their knowledge, attitudes and practices on ORS and zinc utilization for treatment of diarrhoea. The results indicate that 10.9% (95% CI: 8.6-13.2) of the caregivers knew the benefits of ORS and zinc for treatment of diarrhea and 95.7% (95% CI: 93.6-97.8) knew where to get the commodities. 8.7% (95% CI: 4.6-12.7) correctly described how to treat a child with ORS and zinc. 10.2% (95% CI: 7.7-12.6) expressed the intention to treat diarrhoea with these commodities. 14.9% (95% CI: 9.9-19.8) treated the most recent diarrhea episode with these commodities. 64.1% health workers knew the benefits of ORS and zinc and only 51.3% correctly described how to treat diarrhea with these commodities despite 91.7% reporting using ORS and zinc for treatment of diarrhoea. In conclusion, caregivers’ knowledge on the use of zinc and ORS is low and their attitudes towards the utilization of these commodities not positive. These findings probably indicate that the health providers do not use patient-centred model in the treatment of diarrhoea. Health care providers should be trained in and encouraged to use the patient-centred model to enable clients make informed decisions about their health care.

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A 028 THE EFFECT OF MUSIC THERAPY AS COMPLEMENTARY MEDICINE FOR DRUG INDUCED PSYCHOSIS MANAGEMENT AT KISUMU COUNTY HOSPITAL, KENYA

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Department of Pharmacy and Complementary/Alternative Medicine, Kenyatta University Music therapy is a form of Complementary and Alternative Medicine that uses music to address physical, emotional, cognitive and social needs of an individual. It has been used for treatment since ancient times and recent studies have demonstrated the potential of its use in psychiatric disorders. In the absence of clear policy direction, the sector has suffered from lack of both human and physical resources. The purpose of the study was to investigate the effect of music therapy as complementary medicine for the drug induced psychotic patients at Kisumu County Hospital. The study was done using Kisumu County Hospital data from the psychiatric patients’ files and informal conversations. The research design used was descriptive cross-sectional and the target population was the drug induced psychotic patient under the Occupational Therapy Department. The results showed that at least in short term treatment patients moods and blunt affect symptoms improved by random chance regardless of the number of music session attended. No symptom was associated with particular gender and the patients who had severe symptoms of hallucinations, disorganized speech and poor working memory at the end of the follow up were more likely to have attended more sessions than those with mild symptoms. The results of this study could provide information about music therapy as complementary medicine that can be utilized in health care sector and policy makers when planning and carrying out health care services for psychiatric patients. Incorporating music therapy into regular therapy programs for psychiatric disorders can help speed recovery and also help make therapy a more positive experience. We recommend that music sessions should be conducted by a music therapist with a proficiency in playing an instrument, varying levels of skills in assessment, documentation and other counseling& health care skills.

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A 029 STUDY ON DIETARY PRACTICES OF AUTISM SPECTRUM DISORDERED CHILDREN AGED 3-11 YEARS AT MATHARE TEACHING AND REFERRAL HOSPITAL

Koka Elizabeth

Autism is a Neuro-developmental problem from birth and alters a child’s ability to communicate. Food selectivity is quite common and also certain foods evasion due to hyper-sensitivity and hypo-sensitivity cases. This influences their dietary practices on meal consumption. The main objective of this study will be to establish a relationship between nutritional status of autism children and dietary practices, thus no significant difference between nutritional status of autism children and their dietary practices. This study will be conducted in Mathare teaching and
referral hospital as it capacitates for all autism related conditions in Kenya. Study will adapt a cross-sectional analytical method. Data from sample size will be obtained through comprehensive sampling. Sample size will comprise of (nf = 192), total. Questionnaires, 24hr recall sheet and KII interview schedule will be used to collect data. Results will be computed in statistical package for social sciences (SPSS), Nutri-survey and Enafor Smart program. Apart from descriptive analysis, inferential analysis will be used to establish a relationship between nutritional status and dietary practices of autism spectrum disordered children, by use of Pearson product moment correlation, coefficient. Data presentation will use bar graphs, and frequency tables. Thus need to establish nutritional standards for management of autism related diet by clinical nutritionists.

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A 030 ADHERENCE TO ANTI RETROVIRAL THERAPY AND ITS DETERMINANTS IN HIV POSITIVE CHILDREN ATTENDING THE AIC KIJABE HOSPITAL, KENYA

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Adherence is the essence of a successful antiretroviral program. Ensuring optimal adherence to antiretroviral drugs in children requires more than 95% adherence rate. Loss of the first line antiretroviral drugs to resistance due to non-adherence can be catastrophic. The objective of the study was to assess proportion and determinants of adherence among HIV positive children on anti-retroviral therapy at AIC Kijabe hospital. Across-sectional study conducted at AIDS Relief Program Clinic at the AIC Kijabe Hospital. We sampled 214 caretakers of HIV positive children on antiretroviral therapy for a minimum of three months: recruitment was by random sampling. A validated modified Paediatric AIDS Clinical Trial Group (PACTG) adherence questionnaire was used. Statistical procedures employed in the analysis included chi-square, Fisher’s exact test and logistic regression. P-values less than 0.05 were considered significant. In the study 109 (55.6%) were male out of 214 sampled. Majority of the caretakers 180(84.1%) were females, 87(40.7%) attained secondary level of education. Ninety one 91(42.5%) had unskilled occupation. Their mean age (years) was 41.6 (SD 12.7). Majority 128(59.8%) were biological parents of the child. A total of 87.4% caretakers attained more than 95% optimal adherence rate. Caretakers age (t=2.231, p<0.001), education level (χ2=11.335, p<0.001), occupation (χ2=10.024, p<0.001) were associated with child’s adherence to medication. Most cited deterrents to adherence were forgetting 87%, interference with caretaker’s schedule 76%, multiple caretakers 54.5% and stigma 47%. In conclusion, adherence to antiretroviral drugs in AIC Kijabe hospital was high compared to other developing countries. Increase in caretaker’s age leads to non-adherence. Caretakers with lower levels of education and those with skilled occupation were more likely to be non-adherent to antiretroviral therapy. Most non-adherent caregivers cited forgetting. Attention is needed for older care takers, those with lower levels of
education and skilled occupation. Innovative and indigenous ways to alleviate forgetting are needed.

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A 031 ASSESSMENT OF HYPERTENSIVE PATIENTS’ ILLNESS-EXPERIENCE USING PATIENT-CENTRED CONSULTATION AMONG PATIENTS SEEN AT THE FAMILY MEDICINE CLINIC OF THE UNIVERSITY OF CALABAR TEACHING HOSPITAL CALABAR, NIGERIA

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Hypertension is a widespread problem of major economic importance affecting people of all age groups, culture, sexes and socioeconomic classes. Therefore efforts towards its early detection and management, including adherence to antihypertensive therapy and understanding the illness experience, are justified. The study aimed at determining the hypertensive patients’ illness experience, using the patient-centred consultation approach, to form a better partnership with the patients. The patients’ fears about hypertension, ideas about its cause, associated functional loss and expectations were explored. The cross-sectional hospital-based study involved 268 hypertensive patients, using a semi-structured questionnaire. The response was based on a Likert scale ranging from strongly agrees to strongly disagree. Blood pressure, height and weight were measured and BMI calculated. The data was analysed with the SPSS software version 15. There were more females than males in a ratio of 1.6:1. Pre-obese and obese patients formed more than 75% of the study participants with severe form of obesity seen in the females. The patients expressed fear regarding every aspect of hypertension and its management with the highest frequency when they feared death. Most (74.7%) agreed that hypertension could be caused by stress. Others gave different non-biomedical views of the aetiology of hypertension, and 37.3% attributing it to spiritual forces. The ability of the patients to carry out their duties to their families and trade/official duties were affected (44.8% and 42.5% respectively). Most, 85.1% expected their medications to lower their blood pressure. Strikingly 70.5% of the patients expected a cure for their hypertension. In conclusion, the study supports the fact that hypertensive patients have varying illness experiences that can be explored using the patient-centred consultation style and recommends that doctors should tailor the management of individual patients to suit the patients’ unique experience.

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A 032 DIAGNOSIS AND BIOGRAPHICAL OUTCOMES: A PHENOMENOLOGY OF LIFE WITH HIV IN WESTERN KENYA

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Knowing one's HIV status is acknowledged as a crucial step to entry into HIV treatment, care and support. However, not much work has been done to document the diagnostic experiences of people living with HIV (PLHIV) in Kenya. The main objective was to explore the circumstances of being diagnosed HIV positive, the diagnostic experiences and the coping outcomes of PLHIV receiving care and treatment at a rural-based health facility in western Kenya. We conducted 25 semi-structured, in-depth interviews which were personally transcribed, and thematically coded and analyzed. Ethical approval was granted by Kenyatta University Ethical Review Committee. Diagnosis with HIV mostly occurred in the context of illness and subsequent admission to hospital. Others sought diagnosis for unexplained, recurrent symptoms and episodes of illness. Nearly every respondent reacted to the diagnosis with shock, fear, worry and thoughts of imminent death. However, positive experiences with treatment care and support has made most of the respondents realize shifts in their prognosis. In conclusion, enrolment into anti-retroviral therapy has led to improved and stabilized health status, and boosted the social worth of people diagnosed HIV positive but who have disclosed their status. They have experienced significant attitudinal and behavioral transformations regarding their nutrition, health, sexual behaviours and social responsibilities. Since early diagnosis is crucial in realizing optimum health outcomes for PLHIV, programmes and interventions to ensure that increasingly greater proportions of the population are diagnosed early enough should be initiated and scaled-up.

A 033 DETERMINING LABORATORY TEST TURNAROUND TIME AND THE PATIENTS’ REACTION IN KIAMBU SUB-COUNTY HOSPITAL

*Martin Wahogo, Matelong Chepchumba, Mary Mutwii, Gloria Masitsa, Godwin Osiba, Kibiwott Boniface, Beatrice Kageha*

Laboratory turnaround time (TAT) is considered an important indicator of clinical laboratory effectiveness towards patient care. There have been complaints by patients regarding the long time taken for sample analysis. This study aimed to establish the turnaround time of routine tests for the outpatients and the patients’ reaction to it. The study was a single institutional study carried out in Kiambu sub-county hospital on 27th February and 4th March 2015. A total of 50 patients were chosen randomly based on the requested tests and data was collected using questionnaires. TAT was calculated from time of sample reception to dispatch of results. Data on laboratory TAT was also obtained from the laboratory records. The data was analyzed using the Epi Info statistical software. The average TAT of the various tests included: Malaria microscopy, 55 minutes; pregnancy test, 28 minutes; full haemogram 1 hour 47 minutes; urinalysis, 59 minutes and stool microscopy, 1 hour 25 minutes. The TAT data collected from the laboratory records was: Malaria microscopy, 28 minutes; pregnancy test, 32 minutes; full
haemogram, 47 minutes; urinalysis 34 minutes and stool microscopy, 37 minutes. 56% of the patients were dissatisfied by the time taken for analysis and dispatch of the results. 62% would complain to the Laboratory technologists in case of a delay while 36% would consider it normal and keep quiet. 46% of the patients believed that laziness of laboratory technologist was the primary cause of this delay. In conclusion, the discrepancy between the TAT in the laboratory records and the one collected from the patients may be due to post-analytical delays in the dispatch of results. We recommend that further studies be done to identify the pre-analytical and post-analytical factors that contribute to the long TAT.

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A 034 PATIENT SATISFACTION–STATISTICAL COMPARISON BETWEEN INTEGRATED AND NON-INTEGRATED CARE MODELS

Carol Mwendwa

The purpose of this study was to assess satisfaction with specific aspects of care for acute/subacute back pain and explore the relationship between satisfaction with care, back pain, and overall satisfaction. Comparison is made between the local (Kenyan) non-integrated health care model and studies done in the developed world where the integrated health care model is utilized. Analysis of patient responses was through the validated General Practice Assessment Questionnaire (GPAQ) (modified slightly for local context). Differences in satisfaction with specific aspects of care were analyzed using a linear mixed model. Respondents were divided into three groups: those who received a) Chiropractic Adjustment (CHI)) delivered by doctors of chiropractic; b) physiotherapy and home exercise advice (PHY) delivered by physiotherapists, and c) medication (MED) prescribed by medical doctors for acute/subacute back pain. The relationship between specific aspects of care and (1) change in back pain, and (2) global satisfaction were assessed using Pearson's correlation and multiple linear regression. Comparison is made to randomized clinical trials done in the United States of America and Canada (secondary analyses).Secondary analyses of random clinical trials in integrated care settings revealed satisfaction with general care (r = -0.75 to -0.77; R2 = 0.55-0.56) had a stronger relationship with global satisfaction compared with satisfaction with information provided (r = -0.65 to 0.67; R2 = 0.39-0.46). The relationship between satisfaction with care and back pain was weak (r = 0.17-0.38; R2 = 0.08-0.21). Analysis of Kenyan patients surveyed will be compared to these results (due for completion March 31, 2015). In conclusion, individuals in integrated care settings with acute/subacute back pain were more satisfied with specific aspects of care received during chiropractic and physiotherapy interventions compared to receiving medication alone. The relationship between back pain and satisfaction with care was weak.

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A 035 ACHIEVING HIGH QUALITY CARE FOR ALL: DEVELOPING ETHICAL GUIDELINES FOR PATIENT CENTERED CARE IN KENYA

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*KEMRI Scientific and Ethics Review Committee*

With the onset of the 21st century, medical systems are changing to becoming more responsive, sustainable and patient oriented. With these new systems, ethical guidelines must be put in place to avoid patient exploitation by medical personnel, respect for patients is maintained, consent is sought and confidentiality is maintained and that patients understand their rights to information and quality healthcare. Ethics is guided by the ‘Belmont report’ 1979 which states three major principles of “Justice, Benevolence and respect of persons” these principles if applied in patient centered care will go a long way to achieving the Kenyan vision 2030. Research findings will help guide researchers, patients, families, medical practitioners, policy makers on provision of patient centered care. The objective of this study was to develop ethical guidelines to guide patient centered care in Kenya and sensitize the masses on the new phenomena. Several focus group discussions will be held with the KEMRI Ethics Review Committee and the three sub committees. A questionnaire will be developed and interviews held with various stakeholders and people living within Nairobi County. This study will have several expected applications. First, develop ethical guidelines to guide patient centered care, advocacy, create safe medical systems and greater patient involvement.

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A 036 ASSESSMENT OF LABORATORY DESIGN SPECIFICATIONS THAT ADDRESS THE HEALTH CARE NEEDS OF PATIENTS

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Healthcare system ought to be designed to address the healthcare needs and preferences of patients. One of the widely accepted dimensions of patient centered care is physical comfort that is ensured by acceptable standards of the physical design specifications. There are a set of standards for practice structure in terms of space and basic amenities of laboratory developed by the KMLTTB based on WHO standards but Kenya has still very little concrete and reliable information on the actual levels of standard adaptation. The objective of this study was to address the gap in the knowledge pertaining to the level of compliance to practice standards. This is important because the quality of the employee’s workplace environment most impacts on their level of motivation and subsequent performance, which reflects on good service delivery to the customer. The study was an observational and descriptive study using a cross sectional design. Purposeful sampling was used to select the laboratories. When each laboratory was sampled a
check list of the standard expected structural design characteristics that take into account patients subdued by their varying disease conditions, physically challenged patients and the aged was used as a research tool. The work space was also evaluated to ensure it met safety standards and whether there was adequate space and room for service delivery. The overall assessment was that the highest level of rating of compliance to practice quality was found in private high class laboratories. Half of the private low class laboratories had no waiting bay. Burglar proofing was found covering most windows. Government laboratories met most specifications by KMLTTB, but were too congested with equipments due to expansion of services without addition of working space. From the study it is recommended that there is need to develop a model of laboratory services tailor made for consumers of all income levels including low income earning Kenyans.

A 037 THE ROLE OF NURSES IN PROMOTION OF COMMUNITY ORIENTED PRIMARY CARE: A CASE IN INFECTION PREVENTION AND CONTROL (IPC)

Ann N. Wanyoike

AKUHN

Nurses play an important role in health promotion. In infection prevention and control practices their role as promoters of health is more complex, since they have multi-disciplinary knowledge and experience of health promotion within their nursing practice. The role of nurses has included clinical nursing practices, consultation, follow-up treatment, patient/family education, safe practice and illness prevention. This paper aims to collate the findings of previous studies on the role of the health promotion in Infection Prevention and Control and their impact in community involvement in primary health care. To achieve the goal of infection prevention and control practices, clinical walkabouts, spot checks, audits and infection control are the key aspects to ensure that infection control practices are observed and maintained throughout the hospital. To maintain and sustain the practice of Infection Control and prevention, health promotion activities include sharing information with visitors and clients on safe practices (hand hygiene, waste management, and use of personal protective equipment (PPE). Infection control quiz with general questions to be attempted by the multi-disciplinary team as a way of sharing IPC knowledge. All the visitors involved were incorporated in these activities to promote awareness and to enhance knowledge. Continuous review of policies, procedures and protocols as per the institution’s standards and incorporation of the recent trend in evidence based practices are very essential. In conclusion health promotion is an important element in Infection Prevention and Control. This has led to policy review, Knowledge sharing amongst Multi-disciplinary team, community involvement and it has encouraged open communication among all stakeholders.
A 038 ASSESSING BARRIERS TO IMPLEMENTATION OF NURSING PROCESS AMONG NURSES WORKING AT MACHAKOS LEVEL 5 HOSPITAL

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Nursing process is a systematic problem solving approach used to identify, prevent and treat actual or potential health problems and promote wellness. It has five steps which include assessment, nursing diagnosis, planning, implementation and evaluation. Nursing Process is a global concept which forms a foundation of nursing as a profession and framework for patient centered care. Despite its importance, nursing process implementation still is lagging behind in most of health facilities. Lack of its implementation can affect the quality of nursing care given to patients in our health institutions. The study will be assessing barriers to implementation of nursing process which is a framework to delivery of quality patient centered nursing care. Quantitative and qualitative cross sectional study was undertaken at Machakos Level 5 Hospital. The study population was composed of 134 nurses and data was subjected to SPSS analysis. The results of the study will be expected to inform hospital administrators and policy makers to address gaps and come up with strategies which will enable nurses to implement nursing process as a frame work for patient centered nursing care.

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A 039 EFFECT OF EXPOSURE TO CLINICAL SETTING IN KIAMBU DISTRICT HOSPITAL ON THE PREFERENCE FOR CLINICAL PHARMACY AS A CAREER CHOICE AMONG PHARMACY STUDENTS IN KENYATTA UNIVERSITY

Manyega K M, Okova D, Githinji P K, Odhiambo VO, Mageto S N, Odhiambo M A, Wachira T

The growing demand for clinical pharmacy services necessitates a careful look on the training of pharmacists to understand their motivations and challenges towards or against a clinical pharmacy career. Exposure to a clinical setting is an integral part of pharmacy training and it may play a major role in attracting or repelling students away from this line of practice. This study investigates the effect of exposure to clinical setting on the preference for clinical pharmacy as a career choice among pharmacy students in Kenyatta University. Short and Long-term career intentions and factors that influence these were also under investigation. A longitudinal cohort design was used. The study focused on 49 Pharmacy students in their third of study at Kenyatta University. A preliminary survey was carried out in July 2015 (prior to respondents’ exposure to clinical setting). Data analysis was done by computing frequencies, percentages and means using Epi Info Version 3.5. A final survey will be carried out later in the year, a few months into exposure. The response rate was 48/49 (98%). The most popular short term career intentions were hospital/clinical Pharmacy 24/52 (46.2%) and industrial pharmacy 14/52 (26.9%). Academia and research was the least popular short term career goal with only 4/52 (7.7%) positive responses followed by community/retail pharmacy 5/52 (9.6%). Industrial pharmacy was the most popular long-term career intention 14/46 (30.4) followed closely by
hospital/clinical pharmacy 11/46 (23.9%). Career fulfillment, work environment, flexible work schedule and financial rewards were the most important factors considered in determining choice of a future career. 46/48 (95.8%) respondents either agreed or strongly agreed that clinical ward rounds will improve their pharmacy course experience. In conclusion, hospital/clinical pharmacy is the most popular career intention for pharmacy students. Students have positive expectations towards an oncoming compulsory course in clinical pharmacy. Findings from a final survey should determine the effect of exposure to a clinical setting to the preference of a clinical pharmacy career among respondents.

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A 040 "DIFFICULT CONVERSATIONS: A WORKSHOP ON TEACHING DOCTOR-PATIENT COMMUNICATION"

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Multiple studies illustrate the critical importance of empathic communication in the delivery of health care. In countries where communication across cultures is a frequent occurrence, these skills become especially important. Communications skills are traditionally taught in the first few years of medical school. We have observed that students, who are further along in their medical school training, and registrars, can benefit enormously from workshops that focus on the management of particular "difficult conversations." We believe that these learners have sufficient life experience in the health care arena to appreciate the importance of communication, and are able to recognize the situations which are especially difficult for them. In a typical workshop, we ask participants to name and describe the patient encounters that they have found most difficult. After a brief didactic session that focuses on specific empathic communication skills, the learners are given the opportunity to "re-do" the very encounters that they originally described, while working with a simulated patient. After each role play, feedback is provided. Our post-workshop surveys indicate learners respond to this exercise in a positive manner, and, when queried a month later, the majorities have been able to make at least one significant change in the way they interact with patients and their families. Those who enroll in this workshop will have a chance to participate in a simulated "difficult conversations" seminar, which will have a particular focus on cross-cultural communication in the African context. Participants will also be specifically trained in how to create similar learning experiences in their own educational settings.

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A 041 THE ROLE OF COUNSELLING PSYCHOLOGY IN PATIENT CENTRED CARE

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In recent decades a bio-psychosocial understanding of health has predominated the health care settings. Patient care has therefore ceased to be just a physician’s job to incorporate other stakeholders such as psychologists, nutritionists and social workers. This paper seeks to present scholarly evidence on the role psychology plays in the provision of holistic patient centered care. Studies reveal that psychosocial factors often act as predisposing, precipitating, maintaining and even sufficient causes of illness. For instance stress has been found to be a major trigger or accelerator of several diseases. In addition, there is evidence to show that chronic illnesses like diabetes may cause significant psychological distress that if not well managed may aggravate the condition. Similarly, patients are generally known to suffer a degree of anxiety that may become debilitating, either from the symptoms of an illness, or the investigative or treatment procedures. Such may complicate the illness and impair the recovery process. Further, there is evidence to show that hospitalization may result in significant adjustment challenges that may lead to stress which may further complicate recovery. It has also been observed that some medical conditions such as those resulting from attempted suicide are often accompanied by underlying psychological issues that require to be addressed in addition to the physical treatment. Integrating psychological treatment with medical treatment will therefore reduce the stigma associated with referring the patient to the psychologist outside the medical treatment setting. In addition patient cares such as families and nurses may require regular psychological debriefing to reduce the risk of compassion fatigue and burnout especially when caring for patients with chronic or life threatening illnesses. In conclusion, it is evident that psychologists with their enormous knowledge and experience in addressing psychosocial issues need to be an integral part of the integrated patient centered care team.

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A 042 ASSESSING PALLIATIVE CARE NEEDS IN A COUNTY REFERRAL HOSPITAL IN KENYA

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Palliative care is the right of every adult and child with a life-limiting illness. In Kenya, as in many other resource limited countries, the need for palliative care is not currently being met. The demand for equitable access to palliative care is expected to only increase with ageing populations, the growing burden from non-communicable diseases, and the on-going HIV/AIDS epidemic. We conducted a situational analysis to evaluate and better understand the palliative care needs at Msambweni County Referral Hospital. From January 2014 to August 2015, 107
adult and pediatric patients with an admission diagnosis of cancer were identified for inclusion in this situational analysis. Data was collected retrospectively. An in-depth analysis was performed for the 53 patients for whom medical notes were traced. The results indicate that prostate cancer amongst male patients (n=21, 42 %), and cervical (n=25, 44 %) and breast cancer amongst female patients (n=20, 35%) were the most frequent diagnoses. The majority had a confirmed diagnosis of cancer (70%). Median duration of in-patient admission was 7 days [Interquartile range (IQR) 3.5-10 days]. Median cost of in-patient admission was 3,850 KSh [IQR 2,325-5,000 KSh]. Pain was the predominant symptom reported (79% of admissions). There was significant underreporting of other symptoms, and no evidence of assessment of psychosocial needs. Appropriate treatment was given to patients reporting symptoms in 65% of cases. Co-prescribing of 2 drugs for pain management was common (n=19, 45%). 20% of analgesia prescriptions were unsafe. Documentation of discussions with patients and relatives regarding diagnosis, treatment options or prognosis were identified in less than 12% of medical records. No evidence of advanced care planning was found. 7 patients were referred to palliative care services. In conclusion, using oncology patients as an indicator of palliative care needs, we identified a clear and urgent need for formal palliative care services in Msambweni County Referral Hospital, to ensure that all patients with a life-limiting illness are afforded access to safe, holistic and patient-centered care. Care which is focused on achieving not just symptom control but also addresses the psychological, social and spiritual needs of the patient. Areas for staff training and education have also been recognized.
A 043 “SINGING THE SAME SONG: A GLOBAL APPROACH TO PROVIDER-PATIENT COMMUNICATION”

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For the past five years, (based on many years of teaching communication skills at Duke University Medical Center), I have worked on developing a series of health care communication research courses for medical students in Gondar, Ethiopia and Durban, South Africa. The overall focus has been on methods of bridging the “life world” of the patient with the “medical world” of physicians and other care givers, while honoring the culture and language of each country. The result has been the development of new techniques that enhance empathic communication, and lead, in the long run, to a therapeutic partnership between doctor and patient. In this lecture, I will discuss the attitudes and techniques that enable health care providers and patients to “sit on the same side of the table looking at the problem together,” and pose questions about the relevance of different methods in a variety of cultures. I will also focus on the key question of encouraging curiosity among students, and helping them to confront their own unconscious biases about the patients for whom they are caring.

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A 044 CLIENT SATISFACTION WITH COMMUNICATION SKILLS OF HEALTH CARE PROVIDERS

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Quality face to face communication between health providers and clients lead to information transfer that affects compliance, adherence, clinical outcomes and satisfaction. Safe motherhood plus emotional and psychological support may be enhanced through effective communication during ante-natal care. Halls (1996) suggests that addressing issues of satisfaction may influence client’s willingness to reduce high risk behavior during pregnancy. The main objective was to determine extent of clients’ satisfaction with communication skills of health care providers. This was a descriptive cross-sectional study design which utilized interviewer administered questionnaires and observation checklist to collect data through systematic sampling of the clients. A total of 384 clients were interviewed at ante-natal clinic of Moi Teaching and Referral Hospital, Eldoret, Kenya. Data analysis was done using Excel and SPSS computer packages. The study found that 70% of the clients were satisfied with the existing communication skills except 30% who were dissatisfied due to various reasons. Giving clients enough time to express themselves, greeting and introducing oneself to the clients by name were statistically significant. The client socio – economic factors were, however, statistically insignificant to satisfaction for all cadres of healthcare workers. Engagement, Educational and Empathic skills were statistically significant except Facilitation skills. It may be concluded that majority of the clients (70%) were
satisfied with communication skills of the health care providers, however, a significant number (30%) were not satisfied due to various reasons. It is recommended that the Hospital should plan and implement continuing education seminars to improve communication skills of health care providers in ante-natal clinics. Further research should be done to determine the extent of the problem in other hospitals.

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A 045 PROVIDING COMPREHENSIVE AND CONTINUOUS PATIENT-CENTERED CARE AT THE MACHAKOS PALLIATIVE CARE UNIT - A RESIDENT’S ELECTIVE TERM EXPERIENCE

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Patients with chronic and life-threatening illnesses often have unique and complex symptoms and needs. They would benefit from a multidisciplinary team approach to guarantee a comprehensive, competent and continuous care model that addresses their biological, psychological and social needs. The main objective was to familiarize with and participate in the process of providing competent and continued comprehensive care at the facility well as the home environment of the patients seeking palliative care and their families. A six week elective term was undertaken in the Machakos palliative care unit. The learning experiences included assessment and enrolment of patients for palliative care follow up, review of patients at the facility as well as in their homes, conducting follow up home visits, family conferences and patient open days, bereavement support to relatives and creation of awareness of palliative care services to fellow staff. The elective term was completed successfully and objectives of the placement were adequately met. With the patient at the centre, all health service providers and the community have a role in addressing the various needs brought about by a life threatening illnesses. The family physician plays a linking role between the patient, the facility and the community in provision of quality patient-centered care. We recommend that independent service provision centers such as Machakos Palliative care unit be set up in several facilities of the country to showcase the biopsychosocial model of health care provision and act as mentorship centers for health care providers with interest in improving competence in palliative care provision.

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A 046 ASSESSMENT OF PATIENT AND FAMILY CENTRED CARE IN THE MEDICAL WARD AT THIKA LEVEL 5 HOSPITAL

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Patient and family centered refers to the integration of both the patient and family in healthcare by working in collaboration with them and ensuring provision of compassionate, culturally responsive and respectful care that meets their values and preferences. Involvement of patient in healthcare is highly recognized as a main component in the reshaping of the healthcare process for improved patients’ outcomes. Very minimal attention has been accredited to the role played by patients and families in healthcare. Despite the efforts of policy makers to cater for this aspect, a lot still needs to be done to enable the patients and family to take up an active role in care. Majority of studies have looked at patient and family centered care from the healthcare providers’ perspectives as opposed to the consumers’ perspectives. The main objective of this study was to investigate patient and family centered care practices among patients and their families. This will be a cross-sectional study in Thika level 5 hospital. A sample of 102 patients will be selected by use of convenience sampling. The data will be collected using semi-structured questionnaires. Ethical approval will be obtained from Kenyatta University. Data will be cleaned, tabulated and analyzed using SPSS. Descriptive data will be presented using tables, charts and histograms.

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A 047 LIVING HEALTHY WITH DIABETES

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775,200 cases of diabetes were recorded in Kenya in 2014. Personnel and resources needed to manage diabetes are expensive and limited (IDF). 67.9% of Kenyans with diabetes have limited or no knowledge about etiology of diabetes with poor attitudes and practices against the disease. There is limited availability of self-management education in Kenya (United Nations Summit of 2011), with the existing ones being incoherent. Patient education is the cornerstone of care for patients with diabetes. Efficient management of diabetes includes patient’s understanding his or her disease and using such knowledge for an effective self-care. The objective of this study was to provide a patient-oriented guide supplying clear algorithms of management and prevention of diabetes disease. This shall facilitate informed decision-making and improved self-care behaviors of diabetics. A descriptive transversal observational study among previously and newly diagnosed patients with diabetes attending the Kenyatta University Diabetes Outpatient Health Unit Department was conducted from June, 2014 to November, 2014. Outreach assessment in the same facility was conducted on November 14th, 2014. The guide also sought
Evidence from the Kenya Ministry of Public Health and Sanitation [MOPHS], 2010. Overall mean knowledge score of the subjects was 39.5 % ±16.7 % range. No statistically significant difference in knowledge scores with respect to family history of diabetes, age and sex, p > 0.05. Patient characteristics such as illiteracy and denial are main challenges facing Kenyans with diabetes. In conclusion patients with diabetes have the right of access to diabetes education at the right time (IDF). There is little or no knowledge of its risk factors, prevention and management (20%). Increased awareness is highly recommended (IDF).

A 048 EXPERIENCE OF PATIENT-CENTERED CARE (PCC) AT KARATINA DISTRICT HOSPITAL

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A patient-centered care is an approach which aims at providing high quality nursing care. Each patient is unique with unique needs and should be valued and respected as individuals. With PCC, the preferences and needs of patients have the potential to improve patients’ satisfaction with their care, as well as their clinical outcomes. Patient-centered care also helped to reduce both underuse and overuse of medical services. My Experience with PCC: During my hospital clinical placement experience in medical ward, I came across many medical conditions. Caring for all patients at random was a tiresome experience since not all needs of the patients were met thus made it difficult for me especially as junior students to understand all about patient care. It was not until the second month when our clinical instructor came and we shared our experience about patient care. I was almost giving up in nursing seeing how patients’ needs were not being met until we were introduced to patient-centered care (PCC). The whole concept of PCC was explained to us by the clinical instructor and I shared with my fellow students in the hospital. We organized for a continuous Professional Development (CPD) and the nurse manager in the hospital helped us implement PCC. Patient-centered care lessened a lot of work I was doing before. It made it very easy to understand individual patient needs and their concerns together with their families. One particular patient I cared for had been diagnosed with diabetes mellitus 3 years prior to admission. The patient had poor drug adherence and had been admitted on and off in hospital. The patient had had three admissions to hospital within a period of one and half months and his condition was deteriorated. When I implemented patient-centered care on this patient, I was able to identify his unique needs and helped him to meet them together with his family. On follow up, the patient had changed his lifestyle and had good drug compliance. What enabled me achieve patient-centered care included accepting the patient as a person, involving patient and family in planning and decision-making, listening actively to the patient and family, providing basic health care that supports and maintains normal body functions, respecting and acknowledging the family and friends’ support in patient care, involving patient and family in discharge planning and providing clear information and education on dangers signs to watch. In conclusion, for patient-centered care to achieve its full potential, the approach needs to be practiced by the entire nursing team.

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A 049 ASSESSING THE IMPACT OF PATIENT-CENTRED NURSING CARE ON OUTCOMES

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In the modern healthcare system, patient-centered care (PCC) is widely being used as a model within the nursing care. However, there is limited empirical evidence about the effective and impact of this system. The main objective of this study was to establish the impact of patient centered nursing care on outcomes among admitted patient. This was an observation cohort study involving 181 patients and 36 nurses saying they did not practice PCC (60.5 %). The main factor that influence the nurses performance of PCC was exposure to the established structure and support from hospital administration. Among the 36 nurses who practiced PCC, most of them did not practice it routinely (70%), nor did they have confident on the best approach to PCC (86.7 %). In conclusion, patient-centered practice was associated with improved health status and increased efficiency of care. Health services organization must recognize that efficiencies accrue from patient centered practice and encourage such practice through structure that enhance continuity of the patient-physician relationship and through meaningful education programs.

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A 050 COMMUNICATION: CORNER STONE OF PATIENT CENTERED CARE

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Professional nurses play several roles in health care settings and in community, where they intervene as care givers, communicators, teachers or educators, counselors, clients’ advocates, managers, and researchers. The role of nurse as communicator is with pivotal consideration in therapeutic process: frequently, clients and families do not communicate their concerns to physicians but to the nurses with whom a bond has been established. Good communication skills enable nurses to know the patients, to diagnose and to meet their overall health needs: physical, psychological, cognitive (intellectual), social, economical, cultural, religion or spiritual needs and so to provide holistic care to them. The aim of this presentation is to share different techniques to improve the communication skills, considered as the corner-stone of professional relationships between nurse & patient, nurse & nurse, and nurse & other health-team members who are involved in patient care. Techniques to improve listening skills: Sit when communicating with patient, and take sufficient time so that the patient feels respected, maintain eye contact, pay attention to what the patient is saying by using appropriate facial expressions and body gestures. Techniques to improve talking skills: be familiar with the subject of conversation, think before responding, control the tone of your voice, be clear and concise, stay on one subject at a time, be truthful, and be flexible.
In conclusion, nurses must listen and communicate the concerns of clients to other health care providers and they must record those concerns in Nursing care plan. Communication skills facilitate all Nursing actions: any nurse who wishes to be an effective caregiver must first learn how to be an effective communicator. Patient centered care requires leadership in going against the norm–leadership that will drive organizational culture change. It will also require commitment and support from the organization’s administrative leadership to give it momentum and sustain the gains achieved. Transformative education is a chance for a fresh start with a generation of health care workers willing to partner with patients in their care.

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DETERMINANTS OF EARLY INFANT DIAGNOSIS AND TREATMENT OF HIV AMONG EXPOSED INFANTS IN INFORMAL SETTLINGS, IN NAIROBI, KENYA

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Paediatric HIV infection is a growing health challenge, especially in sub-Saharan Africa. Most paediatric HIV infections are peri-natally transmitted. Early infant diagnosis (EID) and immediate initiation of treatment minimizes deaths. Though EID services are widely available, uptake remained low. The main objective was to evaluate determinants of EID and early treatment initiation among HIV exposed children from informal settlements in Nairobi, Kenya. A descriptive cross sectional study was done; where HIV infected mother-infant pair attending health care facilities were recruited. Consent was sought. Non-biological caretakers were excluded. Structured questionnaires were administered to obtain information on socio-demographics, knowledge and uptake of EID and prevention of mother to child transmission (PMTCT), and antiretroviral (ARV) therapy. A total of 238 mother-infant pairs were interviewed. Majority, 69.2% were aged below 30years, 71.4% were from poor social backgrounds, 75% had below secondary level of education, and 67.6% were married. Most (77.4%) had HIV diagnosis made 1 year before, 68.5% of them during pregnancy. Knowledge on importance of EID was poor and only 53.8% had knowledge of child PMTCT interventions. PMTCT care received was ARV prophylaxis (38.7%), and ARV therapy in 37.4%. Though, 63.5% had delivered in a health facility, only 56.7% had EID at 6 weeks, and 47(19.7%) infants tested positive. Only 10.6% of infected infants were started on treatment immediately. The main determinants of EID at 6 weeks were maternal delivery at a public health facility (p = 0.000, OR 0.171, CI 0.065 - 0.451), receiving of psychosocial support (p = 0.000, OR 0.173, CI 0.075-0.398), high maternal knowledge on PMTCT (p = 0.001), and mothers on ARV therapy (p = 0.017, OR 0.284, CI 0.101-0.795) and mother on ARV prophylaxis (p = 0.020, OR 0.306173, CI 0.113-0.830). Factors associated with early initiation of treatment were delivery in public health (p = 0.005) and receiving of psychosocial support ($X^2 = 64.195$, df =1, p =0.000). In conclusion, knowledge of on PMTCT and EID was low, and this lowered EID uptake. We recommend integration of PMTCT and pediatric HIV care services to MNCH setting.
A 052 LEARNING FROM JESUS THE TEACHER

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As learners and educators in the health profession we are usually aware of good examples of teachers from our training and clinical practice. We refer to them and consciously or unconsciously aim to emulate them. Sometimes teachers are so good at their work that we do not recognize their artistry. Jesus is one such teacher. He is the most known, talked and written about teacher and physician over time. Using the examples in his healing ministry and how he interacted with different kinds of patients/students and one of his parables, participants will explore the teaching principles Jesus employed to help his students and his audience discover important lessons. In small groups, participants will then be asked to relate these methods to their own teaching and learning contexts. In conclusion, Jesus is a well known teacher who utilizes many of the important means of involving the learner towards deep transformational learning. Studying and applying Jesus’ teaching methods can give us insight into better ways to engage our learners and help them become more holistic healers.

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A 053 PATIENT CENTERED CARE IN CANCER MANAGEMENT: PLANNING OF INDIVIDUALIZED CANCER CARE

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Cancer kills more people in low and middle income countries (LMIC) the HIV/AIDS, TB and malaria combined. Today 70% of all cancer deaths occur in LMICs, yet 1/3 of these cancers are preventable and an additional third can be detected and treated. Cancer knows no age, sex, ethnic background or place in society of an individual. The treatment of cancer is best within a multidisciplinary team comprising of surgeons, medical/radiation oncologists, specialized oncology nurses and psychosocial support teams among others. The diagnosis and treatments of cancer is shocking for the patient and everybody else around them, leave alone the side effects associated with chemotherapy and radiotherapy and the diversity of effects and outcomes for the same cancer in different patients receiving the same treatments. Therefore, cancer care right from diagnosis, plan of treatment and future follow-ups should be fully individualized and centered on that one patient only. Multidisciplinary tumor boards and patient/cancer survivors support group meetings before initiation of any cancer treatment have been shown to impact on the overall outcome of cancer treatment. Monthly support group meetings at the Aga Khan University (AKU) hospital oncology unit discussing different topics related to chemotherapy side effects and weekly multidisciplinary general/breast tumor boards aim to achieve this.

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A 054 MEDICAL LABORATORY SERVICE PROVISION: WHAT DO KENYAN PATIENTS WANT?

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There has been increasing interest to improve the quality laboratory service world-wide including in many resource poor countries where the quality of laboratory services have been unsystematic and are still questionable. A true measure of acceptable quality is customer satisfaction, which takes into account both the objective and subjective interpretations of the needs and expectations of the customer and stakeholders. The key dimensions of patient centered care are respect, physical comfort, information provision, involvement of family, and access to care in order to be responsive to patients needs. In tandem with the need for the provision of patient centered laboratory service, the objective of this study was to carry out a situational analysis to assess the patient’s perception of quality laboratory service delivery in Kenya. It was purposively limited to four counties namely; Nairobi, Mombasa, Kisumu and Nyeri. This study was both an observational and descriptive study using a cross sectional design. When each laboratory was sampled, a questionnaire was administered in order to determine patient’s views on the factors they consider important in the implementation of quality service. The consumer characteristics, practice characteristics and the assay process were evaluated. Participants placed different emphasis on the factors they considered important in order for them to perceive the laboratory practitioner as competent and the service user friendly. Patients in this study valued non-tangible practice characteristics like the laboratory visible hygiene, accessibility, affordability, and information. Affordable services rated the most important criterion by several patients, even higher than reliability of results. The practice standards set by the Ministry of Health (MOH)/ Kenya Medical Laboratory Technicians and Technologists Board (KMLTTB) should be set based on needs assessment considering all stakeholders including patient needs. There needs to be a relationship between quality, clinical laboratory service effectiveness and evidence - based quality indicators. The KMLTTB standards should have a customer focus and courtesy while delivering service came out as a strong expectation of patients from the practitioners. Patient-centered care is health care that is respectful of, and responsive to the needs of patients.

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A 055 PHYSICIAN-RELATED BARRIERS TO PATIENT-CENTRED COMMUNICATION AND DECISION MAKING AT THE END OF LIFE IN CRITICAL CARE

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Although many terminally ill people are admitted to an intensive care unit (ICU) at the end of life, their care is often inadequate because of poor communication by physicians and lack of patient- and family-centered care. The aim of this systematic literature review was to describe physician-related barriers to patient- and family-centered communication and decision making towards the end of life in ICU. We base our discussion and evaluation on the quality indicators for end of life care in the ICU developed by the Robert Wood Johnson Foundation Critical Care End-of-Life Peer Workgroup. Methods: Four electronic databases (Medline, EMBASE, CINAHL, PsycINFO) were searched for potentially relevant records published between 2003 and 2013. Studies were included if they reported on physician-related barriers to patient-centered communication and decision making. Study quality was assessed using design-specific tools. Evidence for barriers was graded according to the quantity and quality of studies. Results: Of 2191 potentially relevant records, 36 studies were withheld for data synthesis. We determined 90 barriers, of which 46 related to physician attitudes, 24 to physician knowledge and 20 to physician practice. Stronger evidence was found for physicians’ lack of communication training and skills, their attitudes towards death in the ICU, their focus on clinical parameters, and their lack of confidence in their own judgment of their patient’s true condition. Conclusion: We conclude that many physician-related barriers hinder adequate communication and shared decision making in ICUs. Better physician education and palliative care guidelines are needed to enhance knowledge, attitudes and practice regarding end-of-life care. Patient-, family- and health care system-related barriers need to be examined.

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A 056 IMPLEMENTATION OF STANDARD TREATMENT GUIDELINES LEADS TO SMALL IMPROVEMENTS IN PRESCRIBING PATTERNS

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In 2012, Swaziland launched its first standard treatment guidelines (STGs) to improve care and treatment outcomes of common conditions. The primary aim of this study is to measure the impact of the STGs on prescribing patterns. Simple prospective cross-sectional survey of out-patient prescriptions assessing prescribing patterns using WHO/INRUD prescribing indicators was carried out at 33 health facilities prior to launching the STGs in 2012. Twenty-four months after the launch of the STGs, a follow up study was carried out at the same facilities. Facilities were geographically conveniently selected from all 4 regions of Swaziland, reflective of facility type (e.g. hospitals and clinics) and sector (e.g. private and public). Prescriptions for STIs, HIV and immunizations were excluded in the analysis to reduce bias. Data was collected by nursing and pharmacy students, analyzed using Wilcoxon Signed Rank Test and Mann-Whitney U-Test using R. The average number of medicines per encounter improved from 3.33 to 3.19 medicines per encounter. Percentage of encounters with an antibiotic prescribed improved from 59% to 52%. However both of these remain undesirably above the WHO recommendations of 1.7 and 23% respectively. Percentage of facilities with STGs and other materials improved from 60% to 100%. Percentage of encounters with an injection prescribed improved from 19% to 15%, within WHO standards. Percentage of medicines prescribed by generic name significantly decreased from 53% to 34%, with public sector, clinics and hospitals experiencing the biggest reduction.

In conclusion, the implementation of the STG in Swaziland has had an overall positive impact on prescribing patterns, with small improvements in the extensive poly pharmacy and antimicrobial prescribing observed at pre-implementation. Patient education, training, supervision and mentorship on STG use and further studies into prescriber motivations and beliefs are recommended.

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A 057 FAMILY AS HIDDEN PATIENTS IN PALLIATIVE CARE CONTEXT

Muchiri Karega, John Samson Oteyo

The need for palliative care services in Kenya and Africa in general continues to rise, as a result of an increase in incidence of non-communicable diseases such as cancer. The primary goal of palliative care is to improve the quality of life (QOL) of the terminally ill by offering treatment, comfort and dignity in his or her last days. However, terminal illness has financial, emotional,
social and spiritual impacts on the family. In palliative context, family is unit of care who include not only the family members (related by blood or marriage) but also close friends, a large network of relatives and neighbors who are closest to the patient in knowledge, care and affection. The needs for these significant others are usually overlooked by the health professionals. This means that families with loved ones in palliative care may suffer silently and their needs may go unmet by palliative care facilities hence they are hidden patients. The family members who witness terminally ill’s distress may experience psychological anguish and guilty that they are unable to comfort the patient or obtain medical assistance to relieve the patient’s sufferings. As well, the burden of care giving adversely affects the members who may lack adequate resources or who are poorly prepared for care giving role. The family members are an important team in care giving and support of the terminally ill and therefore their wellbeing is important in ensuring comfort and dignity of terminally ill to die a good death. Factors such as communication with health professionals, hospital environment, and decision making related to patient care and management among others, have a bearing on how families cope with the illness of a loved one. The family members need to be assisted to cope with physical, health and social changes and pressures consequent of the terminal illness. This poster presentation aims to outline the importance of considering the unique needs of families with loved ones undergoing palliative care and to make a case for more comprehensive and systemic planning when developing and/or improving palliative care programs in Kenya.

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**A 058 VALUE OF PHARMACEUTICAL INDUSTRY IN ENHANCING PATIENT SAFETY**

Jayesh Pandit; Anastasia Nyalita; Helmut Oberender

Pharmacovigilance (PV) in the region has grown with patients being relatively better off in terms of preferred quality, safety and efficacy of the medicines they consume. Patients and Health Care Providers (HCP) have an opportunity to report Adverse Events and Poor Quality Medicines directly to their Regulatory Authorities; the Pharmaceutical Society of Kenya is encouraging their membership to live up to the oath we swore and the Regulator too supports and has stepped up the effort. The Pharma Industry can do better- not just to produce ‘good and safe’ medicines but to complement the existing efforts of enhancing patient centered care. Almost certainly, in the ‘last mile’, the Pharma Industry has fatigue or is a forgotten partner. Bayer Health Care has embarked on a number of initiatives to support these efforts. Through them, we have recognized the role we can further play. The results show that at all times, patient safety is enshrined in ALL our activities. What we know is complemented with what we learn and this goes back to build our knowledge- so that our patients receive the best in our medicines at all times. This is done not just for our human medicines but also for our Animal Health medicines. Ultimately, this helps all to realign to ensure there is value added care for the patient. In conclusion, pharmacovigilance is important to all of us at the industry. There are important roles that we can play given the chance. This way, we support the existing Regulatory and Societal activities and raise the standard of care that we as Health Care Providers can provide not just in Kenya but across the region.
A 059 COMPONENTS, PRACTICES AND BENEFITS OF HOME BASED CARE OF HIV AND AIDS PATIENTS IN KENYA: BUTULA LOCAL COMMUNITY’S PERSPECTIVE

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With the current diminishing global funding for the HIV/AIDS containment and dramatic increase in the reliance on Home Based Care (HBC) throughout Africa (Akintola, 2006) and other parts of the world, a rich understanding of the various components and benefits of Home Based Care (HBC) is indispensible. The main aim of this study was to examine the components, practices and benefits of HBC of HIV/AIDS patients (HAPs) with the reference to Butula Local Community in, Busia County, Kenya. The study employed a cross-sectional survey research design. The sample included three hundred and seventy seven respondents from Butula Division. Questionnaire method was used to collect data owing to its appropriateness in collecting data from a large sample. A statistical application, namely SPSS aided data analysis process. The study revealed that the key components of HBC were counseling (38%), nutrition (30%), social support systems (17%) and nursing (15%). The main practices of HBC included referral systems of HBC, medication and nursing of the HIV/Aids patients. Benefits of HBC were patients are nursed in familiar environment (41%), affordability (31%) and good support from family members (14%). Registered patients also benefited from free food rations and free medication. In order to realize the greater benefits of HBC, the study recommended integration of informal and formal referral systems, greater involvement and support of Ministry of Health in local community networks and initiatives for social protection.

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TRACK 3: EQUITABLE, ETHICAL, HUMAN RIGHTS BASED AND SUSTAINABLE HEALTH CARE APPROACH
MOKE’S FRAMEWORK FOR THE CONTEXTUALIZATION OF FAMILY-CENTRED CARE IN THE MANAGEMENT OF HOSPITALISED CHILDREN IN KENYA

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Appropriate management of hospitalised children is crucial to the recovery process. The philosophy and principles of Family-Centered Care (FCC) have made it to be identified as “best practice” in paediatric hospitals. The purpose of this paper is to present Moke’s framework for the contextualization of FCC in management of hospitalised children in Kenya. The framework was developed after analysis of data from a descriptive cross sectional study carried out in two phases at a national teaching and referral hospital and a private Children’s Hospital in Kenya. Data were obtained from healthcare providers and parents of hospitalized children by use of questionnaires and interview and focused group discussion guides. Quantitative data were analyzed by use of descriptive statistics. Significance testing was done by use of Chi Square and logistic regression at 95% significance level. Qualitative data were analysed using content analysis. About 54.6% of the parents were actively involved in decision making on the management of the hospitalised child. There was a statistically significant association between the healthcare providers’ knowledge of FCC and the level of parental involvement in decision making ($X^2 = 0.444, P<0.001$). The respondents defined partnership in care as a situation where the healthcare providers and the child’s family work together in planning, implementing and evaluating care for the hospitalised child. This is achieved through training and sensitization, review, establishment and documentation of childcare policies and implementation guidelines, improving of the work environment and attitude change amongst the stakeholders. These are the core tenets of Moke’s framework.

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A 061 FAMILY AS HIDDEN PATIENTS IN PALLIATIVE CARE CONTEXT

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The need for palliative care services in Kenya and Africa in general continues to rise, as a result of an increase in incidence of non-communicable diseases such as cancer. The primary goal of palliative care is to improve the quality of life (QOL) of the terminally ill by offering treatment, comfort and dignity in his or her last days. However, terminal illness has financial, emotional, social and spiritual impacts on the family. In palliative context, family is unit of care who include not only the family members (related by blood or marriage) but also close friends, a large network of relatives and neighbors who are closest to the patient in knowledge, care and affection. The needs for these significant others are usually overlooked by the health professionals. This means that families with loved ones in palliative care may suffer silently and their needs may go unmet by palliative care facilities hence they are hidden patients. The family members who witness terminally ill’s distress may experience psychological anguish and guilty that they are unable to comfort the patient or obtain medical assistance to relieve the patient’s sufferings. As well, the burden of care giving adversely affects the members who may lack adequate resources or who are poorly prepared for care giving role. The family members are an important team in care giving and support of the terminally ill and therefore their wellbeing is important in ensuring comfort and dignity of terminally ill to die a good death. Factors such as communication with health professionals, hospital environment, and decision making related to patient care and management among others, have a bearing on how families cope with the illness of a loved one. The family members need to be assisted to cope with physical, health and social changes and pressures consequent of the terminal illness. This poster presentation aims to outline the importance of considering the unique needs of families with loved ones undergoing palliative care and to make a case for more comprehensive and systemic planning when developing and/or improving palliative care programs in Kenya.

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A 062 ASSOCIATION OF SELF-RATED HEALTH WITH HYPERTENSION AMONG URBAN POOR IN NAIROBI

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Self-rated health is a simple, versatile, and critical component of patient-centered care; a model that is gaining traction in contemporary medical practice globally. Despite evidence of the utility of self-rated health in predicting disease outcomes, little is known of the association between patients' self-rated health and hypertension, an emerging "silent killer" in disadvantaged
communities in sub-Saharan Africa. The main objective was to determine the association between self-rated health and hypertension among the urban poor. The study involved a cross-sectional, population-based study in Korogocho, a Nairobi informal settlement involving consenting and representative adults aged 25 to 59 years. Data were collected with pretested and structured questionnaire. Self-rated health was the dependent variable and assessed through graded responses of the participants to the question: "How would you rate your current state of health"? Associations between variables were analyzed with odds ratio (OR) and logistic regression using SPSS v 20. Statistical significance was set at two-tailed $P < .05$. Out of 719 adults who participated in the study, 53 (7.4%) were aware that they were hypertensive (43 of 531 [8.1%] females; 10 of 188 [5.3%] males). One hundred and eighty nine (26.3%) had poor self-rated health (28.3% of females; 20.8% of males). Poor self-rated health was strongly associated with awareness of hypertension (OR, 2.97; 95% CI, 1.69-5.24; $P < .0002$) and in both genders (females, $P < .02$; males, $P < .001$). The association remained significant after controlling for age, marital status, religion, education, health insurance, and physical activity. It was concluded that the poor self-rated health is strongly associated with awareness of hypertension among the urban poor irrespective of gender and other socio-demographic factors. Self-rated health is a simple and valid outcome measure of hypertension that should be integrated into patient centered care to assess quality of life and effectiveness of care in disadvantaged communities in sub-Saharan Africa.

A 063 HEALTH SEEKING DELAY IN PTB PATIENTS AND THE ASSOCIATED FACTORS IN KIBWEZI SUB COUNTY

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Tuberculosis (TB) incidence in Kenya stands at 120 000 cases per year with 9 100 mortalities annually. TB control is still a major challenge for the Division of Leprosy TB and Lung Disease (DLTLD) and is exacerbated by HIV/AIDS and multi-drug resistant TB. Although TB diagnosis and treatment is free in Kenya, case identification is majorly passive and patient delay contributes significantly to the burden of undiagnosed TB. It is necessary to establish, from the patients perspective, the factors associated such delays in order to inform decisions on improvement of the quality of patient care and reduce the burden of TB in the population. The cross-sectional study sought to determine the duration from onset of symptoms to seeking appropriate TB treatment among pulmonary TB patients and the factors associated with patient delay in the high HIV prevalence Kibwezi Sub-County. PTB patients accessing treatment at five public health facilities in Kibwezi Sub-County formed the study population. Data on socio-demographic characteristics, knowledge and perception of TB disease, type of first health care provider consulted for TB symptoms, stigma and perception of quality of services in public health facilities was collected using semi-structured questionnaires. One hundred and thirty three (133) PTB patients were interviewed. The mean patient delay was 54 days and 65.4% of the patients reported delays of >30 days. Forty five (45%) preferred to visit a private clinic first. High TB knowledge scores did not translate to early care seeking. Delay in seeking the appropriate TB treatment among PTB patients was associated with poor perception of services in
public health facilities (OR = 4.91; CI: 1.6-15.3; p = 0.0061), visiting a private clinic (OR = 4.24; CI: 1.5-11.6; p = 0.0052) and stigma (OR = 2.46; CI: 1.9-12.2; p = 0.0178). Patients’ concerns of quality of care need to be actively addressed owing to their direct and indirect contribution to delay. Health care providers need to consider measures that can reduce/eliminate re-stigmatization of TB patients. These coupled with educational campaigns emphasizing embracing of positive attitudes to prevention of transmission through early diagnosis and treatments are vital in curbing the spread of TB.

A 064 ADVANCING MEDICAL PROFESSIONALISM TO IMPROVE HEALTHCARE IN KENYA

Wala Elizabeth

Kenya Medical Association

The Constitution of Kenya 2010 recognizes the right to access to healthcare services. The National Patients’ Rights Charter 2013 is meant to inform clients and patients of their rights and responsibilities thus empowering them to demand quality services from health care providers. To make this a reality, a high standard of professionalism must be put in place to regulate the services offered by the health care providers and to protect the rights of the patients/clients. The health care providers’ image of trust to society seems to be fast deteriorating. For many, medical professionalism is the "heart and soul of medicine." More than the adherence to a set of medical ethics, it is the daily expression of what originally attracted them to the field of medicine – a desire to help people and to help society as a whole by providing quality health care. But many physicians today experience profound obstacles to fulfilling the ideals of medical professionalism in practice. Medical Professionalism in the New Millennium: Physicians Charter 2002 written by the ABIM Foundation, the ACP Foundation and the European Federation of Internal Medicine. The fundamental principles are the primacy of patient welfare, patient autonomy and social justice. The Charter also articulates professional commitments of health care professionals, including: access to high-quality health care, a just and cost-effective distribution of finite resources and managing conflicts of interest. Many medical schools in the developed world have integrated medical professionalism within their curriculum or have introduced behavior into the clinical clerkships.

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A 065 LOW CONSUMER AWARENESS ON SUBSTANDARD, SPURIOUS, FALSIFIED, FALSELY-LABELED AND/OR COUNTERFEIT MEDICAL PRODUCTS IS A GRIM REALITY-A CROSS-SECTIONAL STUDY OF STUDENTS OF KENYATTA UNIVERSITY

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Substandard and counterfeit medicines/medical devices pose an inherent danger to public health. Lack of information among consumers allows SSFFCs to flourish. The main objective was to quantify the knowledge and explore opinions of Kenyatta University students on SSFFCs and by extension investigate the role of health education in fighting counterfeits. The study focused on students based in Kenyatta University main campus in Nairobi and was carried out between 10th and 20th January 2015. A cross-sectional descriptive design was employed. A structured questionnaire was used to collect data from 399 respondents using stratified sampling. Only 192/399 respondents (48%) were correctly informed on the prevalence of substandard, counterfeit medicines/medical devices in the Kenyan market. 119/399 respondents (30%) exhibited familiarity of characteristic features necessary to detect a possible SSFFC. 119/227 respondents (52%) did not know how to identify authorized pharmacies. 272/399 (68%) of respondents are willing to report suspected SSFFCs. 313/399 respondents (78%) were not aware of any electronic reporting or verification systems for fighting counterfeit or substandard products. In conclusion, consumer awareness on SSFFCs is low. Health education may add momentum to conventional strategies currently in use to fight SSFFCs. Increased involvement of healthcare providers in the education process may enhance reporting of counterfeits and enforce a culture of vigilance among consumers.

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A 066 PATIENT CENTERED CARE: ASSESSING THE LEGAL EXPOSURE OF MEDICAL PRACTITIONERS

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The Institute of Medicine (IOM) defines patient-centered care as one which is mindful of a patient’s preferences (whether values or needs), and ensuring that it is these preferences that guide clinical decisions, to a certain extent. Common law creates a responsibility for doctors on three aspects: the duty to decide whether to undertake the case, a duty of care in deciding what treatment to give and a duty of care in the administration of that treatment. The new approach to medicine creates opportunities to commendably enhance patient specific care, while at the same time diminishing the exercise of discretion on the part of the physician, doctor or other medical professional. There is need to assess the extent of exposure that the patient care approach fashions and how a balance can be struck between the patient’s preferences and the legal safety of the medical professional. In law, the assessment of responsibility of medical professionals is based on a standard test of what is accepted as proper by a responsible body of medical professionals. The novelty of patient centered care brings in an aspect of what will be the accepted standard, that is allowed by medical practitioners, which is not going to expose them to legal responsibility in case of negative consequences occasioned as a result of allowing those patient’s choices.

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A 067 A QUALITATIVE EXPLORATORY STUDY OF THE FEASIBILITY AND BEST PRACTICES OF COMMUNITY ORIENTED PRIMARY CARE CURRICULA IN FAMILY MEDICINE POST-GRADUATE PROGRAMS IN KENYA

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The growing recognition of the value of the COPC process in family medicine training has prompted several training programs in Kenya to create COPC curricula. Moi University (MU) implemented COPC projects as part of the family medicine post-graduate curriculum. Aga Khan University East Africa (AKU) Family Medicine Program in Nairobi is the second family medicine post-graduate program developed in Kenya, and conducted a qualitative study to inform development and implementation of its COPC curriculum. Family medicine post-graduate students and faculty at MU and AKU were invited to participate in the qualitative study involving focus group discussions (FGDs) and one-on-one interviews. Interview tool was designed to explore the best practices in COPC curriculum design and implementation, current experience with community engagement at the institution, challenges and barriers to implementing COPC, and training needs to carry out COPC, and skills learned by carrying out a COPC project. Recordings were transcribed and qualitatively analyzed using theme analysis. Two FGDs of family medicine post-graduate students (one from MU and one from AKU) and five interviews of faculty (three MU and two AKU faculty members) were conducted. Six themes arose from the interviews: (1) Making a community diagnosis is important to guide project development; (2) Empowerment of community fosters ownership and sustainability of a project; (3) Training should provide research skills, proposal writing skills, and personal and peer experiences with COPC; (4) Community health workers (CHWs) should be embraced to facilitate linkage to the community; (5) Financial constraints threaten sustainability and include the cost of transport and payments expected by CHWs and community members; (6) Through COPC projects, students expect to learn social determinants of health. In conclusion, the findings from this study will inform the development of AKU’s COPC curriculum. A public-private partnership has been developed with Gatundu district health management. AKU family medicine residents have a weekly clinic at a primary health care facility in the district. The community diagnosis is made in that clinic’s catchment community through interdisciplinary collaboration with public health practitioners, community leaders, community health workers, community members, and health professionals. Community health workers are enlisted as team members to develop and implement the COPC project to increase sustainability.

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A 068 PATIENT CENTRED CARE AND TRANSFORMATIVE MEDICAL EDUCATION

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After 1910 and spurred on by the famous Flexner (1910) report the scientific process of breaking down everything into its smallest component parts in order to understand the whole has had a profound and lasting effect today in health professions education and practice. This approach which is ideally suited to scientific investigation has created an inappropriately dichotomous situation with regard to the patients. In 1995, the World Health Assembly adopted resolution WHA 48.8 which urged the World Health Organization and its Member States to undertake a reorientation of medical education worldwide to better serve the future health needs of individuals and communities. The objective was to illustrate the “Five Star Doctor” in transformative medical education and patient centered care. Patient centered clinical practice is a holistic concept in which the clinical, individual, and their context components interact and unite in a unique way in each patient-doctor encounter. It (a) explores the patient's main reason for the visit, concerns, and need for information; (b) seeks an integrated understanding of the patient's world—that is, their whole person, emotional needs, and life issues; (c) finds common ground on what the problem is and mutually agrees on management; (d) enhances prevention and health promotion; and (e) enhances the continuing relationship between the patient and the doctor. Treating each patient as a unique human being who has an individual history, education level, behavioural style, cultural heritage, health belief system and sets of vulnerabilities; who lives in a particular community and who presents with multiple problems can present a formidable challenge. It is not a challenge that traditional medical education has prepared the practitioners to meet. Based on the concept of social responsiveness and on basic educational strategies, schools should foster programmes that create an “ideal” doctor (i.e. the WHO “five star doctor”): The five-star doctor who is a care provider, who considers the patient holistically as an individual and as an integral part of a family and the community and provides high-quality, comprehensive, continuous and personalized care within a long-term relationship based on trust; decision-maker, who chooses which technologies to apply ethically and cost effectively while enhancing the care he or she provides; communicator, who is able to promote healthy lifestyles by effective explanation and advocacy, thereby empowering individuals and groups to enhance and protect their health; community leader, who, having won the trust of the people among whom he or she works, can reconcile individual and community health requirements and initiate action on behalf of the community; manager, who can work harmoniously with individuals and organizations inside and outside the health care system to meet the needs of patients and communities, making appropriate use of available health data. In conclusion, there should be a process to ensure that all educational endeavors by the schools: basic, clinical and continuing education — should clearly contribute to the acquisition by all learners of the essential aptitudes as outlined in the ideal doctor profile. Particular attention should be paid to issues related to quality of care (patient-centeredness is one of six attributes of health care quality, the others being safety, timeliness, effectiveness, efficiency and equity), humanism, social justice, empathy and respect of the person.
A 069 “KARIBU KWETU”- HEALTH SYSTEM STRENGTHENING IN KENYA THROUGH A PATIENT CENTERED CARE TRAINING PROTOCOL FOR FRONT LINE SERVICE DELIVERY

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The release of the 2010 “Frenk Report” in The Lancet calling for global transformative health systems was a critical impetus for defining an African Patient Centered Care (PCC) model. The concept was endorsed by key stakeholders of ECSA region in 2012 and motivated the development of the African Patient Centered Care Initiative (APCCI), defining core components for quality of care indicators in human development, quality, safety, health care access and growth of services. With devolution in Kenya providing the opportunity to strengthen health care delivery on the county level, a protocol is needed to equip health care facilities to be centers of excellence in the delivery of PCC. Before the PCC training protocol is offered at a health care facility, top management (stakeholders) must first embrace the need for PCC delivery at their health care facility and facilitate the two-day training. Top management would then invite leaders from pre-defined front-line service areas, both clinical and non-clinical, to attend the training delivered by trained facilitators of Karibu Kwetu. Phase I of the training protocol involves two days of curriculum around PCC. Day 1 covers five essential pillars of PCC derived from the definition: “Patient-centered care is quality health care achieved through a partnership between informed and respected patients and their families and a coordinated health care team.”

Modules are offered in each of the five areas: Patient-Provider Communication, Evidence-based Practice, Whole Person Care, Patient Safety and Coordinated Health Care Team. Teaching methodologies on Day 1 include interactive small group and individual activities, guided imagery exercises, videos and role-playing. On day 2, participants score their healthcare facility based on an international readiness tool aligned with the 11 core components of the APCCI. Each service area assesses their strengths, weaknesses and measurable performance indicators to be implemented for quality improvement. Phase II of the PCC training is the implementation process and institutional alignment to established performance indicators. A baseline of measurement outcomes per service area will be determined within the first week after training. Phase III will determine outcomes of dissemination of the PCC training to all staff on stated performance indicators at 3, 6 and 12 months after training is completed. To ensure sustainability, top management of healthcare facilities should then conduct quarterly reviews of the PCC performance indicators and refine on-boarding process of newly hired staff to include delivery of PCC. To date, the training protocol will be piloted in September 2015 in a MA level course in Family Medicine at Kabarak University, “Physicianship/ The Art of Family Medicine.” Departments of Nursing, Clinical Medicine and Pharmacy will also be invited to participate in the pilot. Pre and post-course surveys will assess effectiveness of the protocol to describe and plan for delivery of PCC from the perspective of diverse health professionals. A revised training protocol informed by participant feedback can then be used for clinical trials in healthcare facilities. Health facilities that utilize the training protocol can then determine the resulting impact on patient satisfaction, staff awareness and endorsement of PCC and other facility-defined outcomes.
A 070 RE-ALIGNING HEALTHCARE TO PEOPLE'S NEEDS: PHARMACY AT THE HEART OF PATIENT-CENTRED CARE

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In recent times there has been much discussion over the changing role of pharmacy practice. Indeed, the world has seen a trend for pharmacy practice to move away from its original focus on medicine supply towards a more inclusive focus on patient care. Patient-centered care is a model of health care delivery that facilitates comprehensive and coordinated care. The model supports active involvement of patients and their families in decision-making about individual options for treatment. As the third largest professional group in national health systems, the pharmacy profession has a significant and unique role to play in the healthcare of the people of a nation and in re-engineering healthcare services to deliver more patient-centered care. The contributions of pharmacists to the inter-professional team-based care in areas such as: collaborative drug therapy management; health information technology; personalized medicine; and the integration of advocacy and community-engagement into the profession are essential toward improving the quality of care, cost-effectiveness, and the patient experience. These activities support and strengthen the patient-centered care model. Medicines are one of the most common interventions today, used in all care settings and in all manner of ways to control pain, fight infection, manage disease, and prevent illness. It is essential for patients that their medicines and pharmaceutical needs are overseen and coordinated at all points of the health and social care pathway to ensure they can benefit from their medicines and suffer no harm. Patients must be able to benefit from wider access to the pharmacy team, with the pharmacy profession taking greater responsibility for the outcomes of medication and working in partnership with patients to coach them to achieve their health goals at all points of their care journey. Given that the role of the pharmacist has evolved from that of a compounder and supplier of pharmaceutical products towards that of a provider of services and information and ultimately that of a provider of patient care; it is imperative that pharmacists become patient-centered and collaborative towards re-aligning pharmaceutical practice to meet people's needs.

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A 071 STRENGTHENING CLINICAL PRACTICUM AS A STRATEGY FOR IMPROVING PATIENT-CENTRIC HEALTH CARE

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Clinical practicum has been documented as an area of weakness in health system, with direct adverse implication for quality of care and the achievement of national health and development goals. This is the basis of a USAID Sponsored Kenya National Training Mechanism (NTM) that included clinical placement, faculty development and mentorship as a strategic focus. The project used information from clinical facilities and literature review to develop and piloted an
integrated clinical placement and mentorship model. The project, including strategic focus in clinical practicum, is being implemented at a time of significant policy transition which influences the implementation processes. The policy changes and other contextual variables need to be carefully considered in scaling up the intervention. The objective of this study was to describe what worked, what did not work and the impacts of these on the overall achievement of the strategy. This report describes the lessons learnt, and draws lessons useful in scaling of clinical placement reforms in the devolved Governance system. Interpretation and recommendations have been made in alignment with available regulatory quality standards and seeks to ensure effective acquisition of clinical skills in medical education and training.

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A 072 BARRIERS TO ADHERENCE ON PREVENTIVE IRON AND FOLIC ACID SUPPLEMENTATION (IFAS) FOR PREGNANT WOMEN IN KENYA-2013

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In Kenya barriers on the use of iron and folic acid supplementation (IFAS) was minimally documented in 2013. These data is useful in accelerating the nutrition interventions towards the country’s achievement of the Millennium Development Goals. Quantitative information was obtained from 2667 pregnant women and 987 postpartum women, 298 community health workers and health workers from 12 counties. Qualitative data was obtained from 24 pregnant women and 48 community members. The main barriers of compliance are the lack of sustained availability of IFAS in the health facilities. Many health care workers do not entirely comply with the policy on preventive IFAS for pregnant women and gave dosages that lasted for short periods of time. Lack of follow-up mechanisms on the clients to establish whether they took the supplements or not affected adherence. Women who did not attend ANC clinics were not reachable. In addition women started attending ANC late in their 2nd or third trimester. There was limited counseling on IFAS. Women did not complete the recommended dosage due to the fear and experience of side effects and discouragement from influencers. ANC attendance is hampered by long distances to the facilities, lack of knowledge on the importance of ANC attendance and limited resources which affects IFAS. Religious beliefs on medication were a barrier to the uptake of IFAS. In conclusion, barriers to taking IFAS by pregnant women are related to the supply of IFAS, health workers knowledge, attitudes and practices on IFAS and barriers related to pregnant women and their influencers. There is need to ensure adequate supplies of IFAS both for curative and preventive purposes in all health facilities. CHWs should be involved in distribution of IFAS through the community strategy. The authors wish to acknowledge Micronutrient Initiative, Ministry of Health Kenya and participants in this research.

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TRACK 4: PATIENT SAFETY
A 073 KNOWLEDGE OF CORRECT USE AMONG HORMONAL CONTRACEPTIVE USERS IN A KENYAN REFERRAL HOSPITAL

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Contraception is the intentional use of temporary, long-term or permanent methods to prevent pregnancy. The consistent and correct use of contraceptives ensures that unintended pregnancies and pregnancy-related health risks are prevented. The main objective was to assess the prevalence, types and level of knowledge on the correct use of hormonal contraceptives among women of reproductive age at Kenyatta National Hospital. A cross-sectional study was carried out targeting 400 women in their reproductive age at Kenyatta National Hospital, Nairobi, Kenya. Data was collected using an interviewer administered questionnaire and analyzed using SPSS version 20 into descriptive and inferential statistics. The prevalence of contraceptive use was 42.8%. Contraceptive use was associated with number of children [OR 1.7 (1.3-2.1)] p<0.001. 56.1% of contraceptive users were on hormonal contraceptives. Injectable contraceptives were the most preferred followed by implants and pills. The choice of contraceptive methods was associated with age [OR 2.003 (1.330-3.017)] p=0.001 and level of education [OR 1.697 (1.135-2.539)] p=0.010. The level of knowledge on the correct use of hormonal contraceptive use was limited and was associated with the level of education [OR 1.389 (1.144-2.051)] p=0.000. In conclusion, contraceptive use is low compared to knowledge of contraceptives. Injectable contraceptives are the most preferred hormonal contraceptives. The level of knowledge on the correct use of hormonal contraceptive is low.

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A 074 EVALUATION OF ANALGESIC PROPERTIES AND PHYTOCHEMICAL SCREENING OF TITHONIA DIVERSIFOLIA LEAF EXTRACT

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The leaves of *Tithonia diversifolia* have been used for a long period of time as an analgesic agent. Recent studies have proved that it possesses analgesic activity. The study set out to investigate the analgesic activity of dried methanol and aqueous leaf extracts of *T. diversifolia*. The extracts obtained were separately injected through the intraperitoneal route to mice and analgesic effect examined using tail-flick analgesiometer, at different currents and similar time intervals. Three known conventional drugs; Tramadol, Paracetamol and Diclofenac sodium, were also injected in the same manner and results obtained used to make comparisons. Phytochemical screening of the extracts was undertaken using standard methods. Both methanol and aqueous extracts exhibited dose-related analgesic activity. Paracetamol had a longer response time at the current of 2 amperes compared to the two extracts. Lofnac could withstand the 3 ampere current much longer, though the methanolic extract also had a better profile at this current compared to the aqueous extract. The aqueous extract had a faster analgesic profile, which similarly washed waned much faster compared to the methanolic one. Tramadol’s profile showed that it had a prolonged effect with increase in time after exposure to the drug. Both extracts contained the phytochemicals tested, albeit in varying amounts. It was concluded that methanol and aqueous leaf extracts of *T. diversifolia* exhibit analgesic activity however clinical applications of these findings must wait for further studies to isolate the active constituents. The mechanism of action should also be that focus of another

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A 075 UTILIZATION OF HERBAL MEDICINE AMONG CHILDREN UNDER 5 YEARS OF AGE IN MWIMBI DIVISION, MAARA DISTRICT, THARAKA NITHI COUNTY, KENYA

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Herbal medicine use is increasing globally. In Kenya herbal medicine is widely used, with 70% of the population having been reported to be dependent on it for primary health care. The World Health Organization (WHO) warns that growing use of traditional medicine, both in developed and developing nations, has been mirrored by an increasing number of child mortality reports due herbal medicine use and concomitant use among under-five years of age. This study examined the utilization of herbal medicine among under-five years of age in Maara division,
Tharaka Nithi County. A descriptive cross sectional was administered. Multistage Cluster sampling was used to randomly pick the 350 parents and guardians of under-five years of age children. Data was collected using a semi-structured researcher administered questionnaire. Focus Group Discussions and key informants in-depth interviews were used to collect qualitative data. Data was analyzed using Statistical Package for Social Sciences (SPSS) version 17.0 software. Results indicate that herbal medicine use among under five years children is high (89.4%) in the county. Education level, location of residence, monthly income, and occupation influenced herbal medicine use (p<0.05). Herbal medicine was most used in the treatment of gastrointestinal (26.2%) and respiratory disorder (19.2%). Most commonly used herbs were *Erythrina abyssinica* (35.1%) and *Amaranthus hybridus* (32.9%). Concomitant use of herbal medicines with conventional medication was reported by 50.2%. Apart from treating illnesses, the need for supplement, growth improvement, and appetite improvement were other conditions contributing to use of herbal medicines. The study recommends for traditional medical practitioners training on conservation of herbs, complete documentation of the herbs, processing and commercialization of the herbal medicine. Traditional medical practitioners should be linked with researchers so as to come up with evidence based alternative medicine. Finally indigenous knowledge on health care using herbs needs to be conserved.

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**A 076 EVALUATION OF PATIENT SAFETY IN MEDICATION ADMINISTRATION AT M.P SHAH HOSPITAL CRITICAL CARE UNIT**

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Drugs are substances intended for use in diagnosis, cure or prevention of disease. Medications are among the most frequently used interventions to improve patient health. The complexity of medication use and management process in in-patient setting creates a significant risk for hospitalized patients. Medication errors are preventable events that may cause or lead to inappropriate medication use or patient harm. Common errors result from wrong dose, drug or route of administration. 98,000 people die per year due to preventable medical errors and they cost loss of lives, carry functional burdens and can diminish trust and satisfaction in the healthcare system and professionals. Preventing medical errors and promoting patient safety and quality is important. Patient safety is a global issue affecting healthcare and is concerned with interventions needed to decrease medication errors and improve patient safety through medication administration. Nurses play a major role in reducing medication errors since they frequently administer medication. The main objective was to evaluate patient safety in drug administration and prevention of medication errors. Cross sectional survey. Purposive sampling of 10 nurses was used. A check list was used to collect data which was analyzed using Statistical Packages of Social Sciences. Permission was obtained from the unit manager. The findings indicated that 100% of the nurses counterchecked physician orders, established allergies, followed rights of medication administration and entered legible initials on the treatment sheets. 60% signed treatment sheets immediately. 80 % educated patients regarding medication side
effects. 100% of the nurses left un-administered medications at the patients’ bedside. In conclusion, there is need for assessment of medication administration for routine monitoring of safety of medication administration since patient safety is a global priority. There is need to train the nurses on importance of ensuring patient safety in medication administration to avoid medication errors and adverse drug effects. Those medications that are un-administered should not be at the patients’ bedside unless they are in a locked area.

**A 077 ECONOMIC COST OF DIABETIC CARE IN URBA AREA OF BELGAUM–A COMMUNITY BASED STUDY**

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Diabetes mellitus is an emerging health problem in globally. Estimated show that 50.8 million people living with diabetes globally and India has the world's largest diabetes population. The objective of the study was to estimate the direct and indirect costs incurred by diabetics and understand interplay between the various demographic and disease characteristics with the cost of care among known diabetics in Khasbag, Belgaum. This study was a community based cross sectional study for a period of 12 months (i.e. from Feb 2011- Jan 2012). A pretested self administered questionnaire was used for data collection with a follow up of three months for each participant from the date of recruitment. All the known diabetics above 40 years residing in Khasbag, were listed in a sampling frame through a baseline study. SPSS Version 16.0 software was employed for statistical procedures. A total of 192 individuals participated. The average monthly total direct cost was Rs.1,360,855.39 (US$ 28,954.37). The mean total direct cost for each person with diabetes were estimated to be Rs. 12,319.17 (US$ 262.11±155.61). Costs of surgery accounted for the largest share of direct costs. However there was significance between the number of complications and duration of the disease with the burden of cost of care (p < 0.05).

In conclusion, adequate and appropriate management can prevent, delay or arrest the development of complications of diabetes. Growing evidence suggests that this can be achieved through improved large scale and cost-effective prevention programs so as to maximize health gains and to reverse the advance of this epidemic.
A 078 PATIENT SAFETY AS A PATIENT CENTERED CARE CONCERN

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Patient safety is an attribute of healthcare systems that is of outmost concern in the provision of Patient Centered Care. It focuses on ways to minimize the incidence and impacts of unintended harm to patient while undergoing healthcare management. There is evidence that significant numbers of patients are harmed from their healthcare resulting in temporary or permanent damage, increased length of hospital stay or death. The rate of harm also known as Adverse Events in the Developing or Transitioning Countries is about 8.2%. This paper will focus on P.R.O.A.C.T.I.V.E Quality Healthcare Improvement Strategies to enhance Patient Safety which is a crucial factor in Patient Centered Care. The strategies look at proactive interventions to reduce harm and reactive measures when the harm has occurred to avoid its reoccurrence.

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A 079 STRESS MANAGEMENT IN PATIENT CENTERED NURSING CARE

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Professional nurses have four main responsibilities: to promote health, to prevent illnesses, to restore health, and to alleviate suffering. In the past, the system was “duty oriented” where all activities were based on duties and responsibilities, but, in our days, all clients’ needs (all dimensions of life) should be considered while taking care: physical, psychological, and cognitive (intellectual), social, economical, cultural, religion or spiritual needs. The above approach requests us to work as team members and be free from stress. The aim of this presentation is to share different strategies for stress prevention and stress management. Stress is a state or situation considered as challenge or problem, and damages the person’s balance or equilibrium. Causes of stress are many, including health problems, employment, school activities, family problems, poverty. Specifically, for health professionals, stress may be due to high responsibilities, poor client outcomes, risk of making an error, unfamiliar situations, excessive workload, etc. Common stress symptoms are: fatigue, irritability, hopelessness. Some may be withdrawn and isolated. Other physiological indicators of stress are: backache, change in appetite, nausea, constipation or diarrhoea, headache, increased pulse, blood pressure, and respirations, sleep disturbances (insomnia), weight gain or loss and decreased sex drive. There are many ways to reduce stress, including time management, physical exercises, and activities involving others, balanced diet, avoiding alcohol and tobacco and sharing feelings. In conclusion, since health care professionals are prone to stressors, it is advisable to apply stress management measures to reduce the risks. Nurses can contribute to the overall welfare of their clients and this request them to enter in Stress Free Zone.
A 080 USE OF CULTURALLY ACCEPTABLE FOOD PRODUCT TO BRIDGE MICRONUTRIENT INTAKE GAP AMONG PASTORALISTS CHILDREN IN KENYA

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Children under five years are more vulnerable to deficiencies of vitamin A, iron and zinc with a prevalence of 84%, 74% and 50%, respectively in Kenya. For success in interventions addressing micronutrient deficiencies, affected communities need to be involved. Minimal information exists on how community based approaches, like use of micronutrient dense dried vegetables incorporated into cereal flours would translate to micronutrient status. The study aimed to use a culturally acceptable dried amaranth leaves (DAL) based product to bridge the vitamin A, iron and zinc intake gaps among pastoralists in Kajiado, Kenya. A pre-test–post-test control group design was adopted. A comprehensive sample of 42 children aged 24-48 months for experimental group and 46 for control group from two selected villages was used. A maize-dried amaranth leaves blend porridge (85:15%), tested for acceptability, and was used among the experimental group while pure fermented maize flour was used among the control group for six months. Serum levels for β-carotene, retinol, ferritin and zinc were done at baseline and after six months. Serum level analysis was done by use of AAS (Mini Vidas) for ferritin and Shimadzu AA-680 for zinc levels. High performance liquid chromatography (HPLC) was used to analyze serum β – carotene and retinol. Data were analyzed using SPSS software. Results show that majority of the children from both groups had low mean serum levels for retinol, β -carotene, ferritin and zinc at baseline showing deficiency. This significantly increased (p<0.05) by the sixth month. The change among the control group was not significant (p>0.05). This suggests the role of DAL in improving micronutrients. In conclusion, use of DAL incorporated into cereals can significantly increase micronutrients intake. This study recommends the use of DAL as part of diet for children.

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TRACK 5: EFFICIENCY AND COST EFFECTIVENESS IN HEALTH CARE
A 081 THE LEVEL OF AWARENESS OF PATIENT CENTERED CARE AMONG MEDICAL STUDENTS IN KENYATTA UNIVERSITY

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Patient Centered care is a way to improve healthcare while at the same time, cutting costs. It is being embraced by many physicians. However, there is currently no initiative in Kenyatta University to formally teach or examine medical students on patient centered care. Therefore, the knowledge and attitude of the medical students towards patient centered care remains unknown. The objective of this study was to investigate the level of awareness of patient centered care among the medical students of Kenyatta University. A total of 250 Kenyatta University medical students were invited to participate, from third year through sixth year. We used electronic surveys which were distributed through class emails. All duly completed forms were taken into account. Knowledge on the topic scored a point, partial knowledge scored half a point, and total ignorance on the topic scored a zero. Study results were based on a weighted data for 150 medical students. There were 100 abstentions. From the results, a total of 150 students participated. This was a response rate of 60%. 65% of the students were unaware of the basic concepts of patient centered care. 10% of the students had partial knowledge on the basic concepts. The remaining 25% portrayed significant knowledge on the basic concepts. 49% of the students cited the absence of the topic in the curriculum as being the major reason for their ignorance. In conclusion, medical students of Kenyatta University appear to have limited knowledge on patient centered care. This will definitely affect their willingness to embrace it when they become physicians in future. This suggests the need to incorporate a comprehensive patient centered care curriculum into the medical school syllabus.

A 082 PERITONEAL DIALYSIS–A SUCCESSFUL HOME-BASED RENAL REPLACEMENT OPTION

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Peritoneal dialysis (PD) is the use of the capillary rich peritoneal membrane as a dialyzer (Porth, 2002). It differs from haemodialysis (HD) in that the blood is cleaned while still in the patient’s body (intracorporeal). Unlike HD, PD does not require a water treatment plant and can be used in the patient’s homes. There are few dialysis centers in Kenya with few options of renal replacement therapy (RRT) modalities, the main one being HD. PD has scarcely been used in Kenya despite the many advantages. Patients have had to travel for long distances to queue for HD machines leading to a delay in treatment and congestion in the few Government HD centers available. The main objective of the study was to examine the current availability of data for patients who were put on PD renal replacement therapy and followed up for optimal outcome.

Methodology: This was a case study. The study was carried out in Nairobi Kenya. Two patients who were trained to carry out continuous ambulatory peritoneal dialysis (CAPD) for themselves were followed up and proved to achieve the desired effects. Data was analyzed using SPSS.
Results: There was absence of uremic symptoms, Stable blood pressure and optimal fluid balance, Management of anemia, metabolic control, optimal nutritional status, and adequate patient comfort. No peritonitis episodes were recorded throughout the dialysis period. One of the patients was on PD for three and a half years before successfully undergoing a renal transplant. The other patient was on PD for three years. From the results, the researcher established that there was optimal nutritional status following PD renal replacement therapy. The patients showed absence of uremic symptoms, Stable blood pressure and optimal fluid balance, metabolic control and adequate patient comfort. In conclusion, results indicated that patients who are critically ill with changed renal function can become stable enough to continue with their daily activities at home while on PD. Patients should receive unbiased education regarding treatment options in a timely fashion. It is important to have a dedicated team to home therapy that will be willing to provide leadership and teaching to patients in the community.

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A 083 GRAIN AMARANTH AND TRADITIONAL HEALTHCARE SYSTEMS: PROVIDING NEW THINKING AND APPROACHES IN CHRONIC DISEASES CONTROL
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Non-Communicable Diseases (NCDs) represent a leading threat to human health and development. Many people are dying younger due to NCDs, often in their most productive years. At the household level these diseases contribute to poverty and reduction in GDP, (WHO, 2011). However, in most poor countries there exists no healthcare system for chronic diseases but a disease management system dependent on expensive drugs and invasive surgeries. Indeed, the existing flawed model of “care” for people with chronic illnesses is a leading cause of death and bankruptcy. Interest in traditional systems of medicine and, in particular, herbal medicines, has increased substantially in both developed and developing countries over the past two decades, (WHO, 2003). Therefore, this paper will demonstrate how Strategic Poverty Alleviation Systems-SPAS has been using organic grain amaranth-a non-grass cereal or pseudo-cereal which is also medicinal and traditional healthcare systems to control chronic diseases. Communities grow organic grain amaranth for food/nutrition and incomes and SPAS buys part of the surplus for making grain amaranth based nutraceuticals for chronic diseases. People with NCDs such as diabetes, cancers, hypertension, and cardiovascular diseases, for instance, have previously taken these nutraceuticals with extremely promising results. Within 14 days diabetics and hypertensive taking these nutraceuticals are off all medications, for instance. In qualitative terms, the quality of healthcare provision of people with chronic diseases has been greatly enhanced and at low cost resulting in a higher level of community participation and people with chronic diseases satisfaction. Indeed, a critical window of opportunity now beckons to move healthcare systems for chronic diseases off the current path of disease management and embark on a trajectory towards curative therapies for these illnesses based on grain amaranth and traditional healthcare systems.
A 084 WHOLE PERSON CARE: HEALTH BELIEFS AND COMPLIANCE: TREE AND ROOT MODEL

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The health belief model construct suggests what it is in a patient’s world that influences health seeking behavior. The Perceptions of susceptibility, seriousness of threat, barriers, benefits, modifying variables, attendant cues to action and self efficacy play varying roles in this process. It is in the interest of the medical world to explore deeply rooted aspects of the patient world, to reflect on, reinforce learning from and identify how this has helped in clinical practice. It is good practice to further understand the patient’s agenda and health beliefs. Using the example of a tree from its root to branches, participants will explore the disease presentation patterns. The symptom, sign and diagnosis will be discussed in small groups, participants will then be asked to relate these to their own practice, to teaching and learning contexts with examples of Whole Person Medicine. Trees are universally understood. The changes they exhibit from season to season give us unique lessons. The story of the fig tree Mark 11:10-25 and the withering out of sight exemplify pathophysiological processes that take place. In another dimension it reveals processes beyond the routinely investigated pathophysiology. They demand our keen interrogation of these dimensions if we have to offer appropriate means of cure. Appreciating that the concept of the withering signs appearing in the leaves reflect the processes in the unseen roots can transform the process of understanding disease. The attention to unseen spiritual and emotional causes of disease is necessary and important. These play a similar and significant role as do the biophysical causes. They enable mutual support and encouragement. Studying and applying these can give us insight into better ways to engage as practitioners, teachers and pass this on to our learners and help them become more holistic healers.

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ANAESTHESIA: THE ROLE IN PATIENT CENTRED CARE

Zipporah Gathuya

Patient-centered health care is a movement within modern medicine that aspires to tailor care to the needs, desires, and dynamics of each individual patient. Physician anesthesiologists are recognized across the health care landscape as leaders in patient safety. For improved healthcare in our generation, there is need to improve the individual experience of care, the health of populations, and reduce the per capita costs of care. Achieving this Triple Aim requires an “integrator” to optimize services on all 3 of its dimensions. This integrator is an entity that accepts responsibility for achieving all 3 components of the Triple Aim for a specified population. Recent data suggest that the Patient centered care improves outcomes and produces cost savings. These achievements are only possible with seamless team work between surgeons,
anesthesia, nursing and other players in the care of the patient. Surgical care accounts for more than half of all the costs of hospital admissions in the USA. Ways that have been suggested to reduce these costs include; standardization, removal of unnecessary preoperative tests, coordination and transitions, and value of care, throughout the perioperative continuum, including the post discharge phase. The emphasis on patient-centered care and shared decision-making are not simply capitulating to patients’ requests, giving them what they want, when they do not want it, regardless of cost or value, nor is it throwing information at them and leaving them to sort it out on their own. The care givers have to respect, listen to and honor patients’ choices, give them unbiased information and time to process this information and allow the patient and or their family to take part in the decision. Anaesthesia is a very core part of the continuum of surgical care with overlap in critical care and pain management. Pain management is especially important in measurement of patient satisfaction with the whole process of care. Blood transfusions preoperatively are also very common procedures where the anaesthesia role in terms of patient centered care is very important. Shared decision-making has been associated with better patient satisfaction and health outcomes. Anaesthesia easily fits as the physician who directs the patient centered care preoperatively to provide seamless continuity from preoperative evaluation to postoperative care. Fast track surgery aimed at early discharge from the hospital is also key in this regard. Fast-track surgery focuses on enhancing recovery and reducing morbidity by implementing existing and new evidence-based, best practices in surgery and anesthesia, including analgesia, reduction of surgical stress, fluid and blood management, nutrition, and ambulation.

A 085 PATIENT-CENTRED-CARE; A CASE OF KENYATTA NATIONALHOSPITAL, NAIROBI KENYA

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Kenyatta National Hospital is the largest teaching and referral hospital in East and Central Africa. The Hospital is mandated to serve as National Referral and Teaching Hospital, participate in national health planning and to provide medical research environment. The hospital offers quality specialized health care and a wide range of diagnostic services. The average bed occupancy is between 200% and 300%. On average the hospital caters for over 80,000 in-patients and over 500,000 out-patients annually. In the current Strategic Plan (2013–2018), the hospital has identified Patient Centeredness model as the model guiding its operations thus the vision “world class patient-centered specialized care hospital”. Both the hospital’s vision and mission are clear, well articulated and communicated to the members of staff and they do understand what is expected of them. The establishment of Patient Affairs Department is a major demonstration of the hospital management’s commitment towards Patient-Centered Care. It’s through coordination by Patient Affairs Department and other stakeholders that the hospital endeavors to improve patient experience. A number of initiatives to support and sustain Patient-Centered Care have been started at the hospital. These initiatives include: development of Patient-Centered Care Guidelines, Patient Charter, conducting Patient Safety Surveys,
Clinical Audits, establishment of Feedback Mechanisms, regular Patient and Family open days, establishment of worship areas for different faiths, assisting Patients start and maintain support groups as well as Customer Care training for all staff. Children have a play field among other amenities. The hospitals has also developed tools to guide and measure patients’ experience and include: Standard Operating Procedures (SOP) on complaints handling, SOP on Clinical Team Patient Communication, Credit policy, Standard Questionnaire to measure patients’ satisfaction and the Billin g policy. Feedback from clients is considered very important and as such the hospital has put in measures to ensure as much feedback is received, analyzed and suggestions for improvement considered. Feedback gathering starts with departments developing service delivery charters where they display the services they offer, cost for each service rendered, time it takes to render the service and channel for raising/registering compliments or complaints. Plans are underway to establish a communication centre from where patients will get comprehensive information regarding services within the hospital. Other avenues the hospital uses to get feedback from patients include daily reports by nursing team through the office of Deputy Director Nursing, conducting patient satisfaction surveys and auditing of the service delivery charters as well as clinical audits and patient safety surveys among others. Major complaints and concerns noted are credit approval request taking long, billing process queues usually very long, delays in providing various services especially theatre related, poor communication, multidisciplinary reviews get delayed, poor customer relations by some staff members and check bed for patients awaiting elective surgery. There has been an improvement on the customer satisfaction index since the emphasis on Patient-Centered Care was introduced.

A 086 FACTORS AFFECTING THE UTILIZATION OF FAMILY PLANNING SERVICES IN MALINDI/MAGARINI SUBCOUNTY

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The contraceptive prevalence rate in Africa at 31% still remains is lower than that of the world, 63%. The rate of maternal mortality in the developing world is high where a total of 529,000 women die at childbirth due to pregnancy related complications each year. This has been attributed to the low level of utilization of family planning (FP). We investigated factors influencing utilization of FP services in Malindi Sub County with an aim to establish the role of men in uptake of FP services. Using a cross-sectional study design married women and men of 18-45 years residing within 2km radius of the health facilities were interviewed. Data was collected by interviewer-administered questionnaires, key informant interviews and focused group discussions. The results show that the overall prevalence of utilization of FP services was 174(53.0%) in Malindi sub-county. While comparing utilization per type of marriage, this was highest at customary (51.5%) compared with religious (30.2%) and civil (4.3%). Of the total participants interviewed, 350 (95.6 %) were aware of FP services. Out of these, 326 (92.4 %) were aware of the modern FP methods for women. Type of marriage (p value=0.007) was found
to be a strong predictor of contraceptive use. Educational level at tertiary was also found to be significantly associated with utilization of FP services (OR=4.02(1.32-13.08) while age was not (p=0.134) At a spousal communication rate of 84.3%, a woman was 2.43 times more likely to use contraceptive than a woman whose husband is not involved (p= 0.003) The main available methods included pills, injectables, implants and male condoms. Conclusions: utilization of FP services is low in Malindi sub-country which was influenced by several factors including educational level at tertiary, customary type of marriage and religion. Male involvement in FP remains low and was strongly associated with increased FP use. There is need for increased promotion of family planning Services targeting men including creation of male friendly centers.

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A 087 EVALUATION OF PRE CERVICAL CANCER SIGNS SCREENING AND MANAGEMENT IN PGH (NAKURU COUNTY)

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Background Cervical health is ascertained through the prompt detection of pre-cancerous signs seen as lesions, detected in the cervix using highly sensitive, reliable and effective cervical screening tests. This survey conducted in Nakuru’s provincial general hospital assessed the algorithm in current practice, with the ultimate goal to review and improve the screening policy employed in the management of early cervical cancer sign detection. The objectives of the study included to categorise women age groups at risk of cervical cancer disease development, to establish the interval period between the preliminary and the confirmatory cervical cancer screen test and to establish the interval period between pre cancer diagnosis and the administered treatment. Methods Data was retrieved by means of consult records, ex post facto from the cancer registry. 52 women subject records who had visited the Reproductive Health Clinic in the period of October 2013 to October 2014 were considered. Both descriptive and inferential statistics were used for analysis and to establish associations between data variables. Results 75% of the subjects portrayed pre cancer signs. 59.6% had their signs confirmed above 31 days (over 1 month). 50 % took over 31 days for them to receive their relevant treatments from which there were individual cases (5.7%) that took an overwhelming 211 days (over 7 months).In conclusion the overall management of pre cervical cancer signs detection, diagnosis and relevant treatment intervention in the Rift Valley PGH is reasonably satisfactory, although a lot can be done to improve timeliness and service delivery quality in the circumvention of cervical cancer disease incidence and mortality amongst women.

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POSTERS
P 001 ANGELS’ HEART EMPOWERMENT PROGRAMME (AnHEP)

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In most slums, drug abuse of over-the-counter drugs is very rampant. This is because the low income of the slum dwellers limits them from accessing proper medical facilities. Thus poverty plays a role in barricading the necessary link between doctors and patients. Poor sanitation also contributes to the high intensity of diseases in slums. Among the medics, unrefined soft skills when interacting with patients, would make patients to incline more to one doctor, and not another, which should not be the case. AnHEP’s primary objective is to reinforce this vulnerable link between doctors and the urban poor by bring into the gap, university students taking health related courses. These students offer community oriented primary care, through free door-to-door medical services. They also empower the community with first aid skills. AnHEP ensures that medicines taken by the households involved are well prescribed and in good condition. At the end of the day, the students who enroll for the course benefit by nurturing their soft skills for better interactions with their future patients. We are currently biasing our services at Mathare slums and serve an estimate of 1000 residents. Apart from the door-to-door visits every Sunday afternoon, we hold medical camps and clean ups every semester. The students enroll for AnHEP as a volunteer course every semester, for free. They then receive training from our partnering health training facility in Kiambu and apply what they learn in class and from the trainings, to serve the society. We also run projects such as bio-toilet sale and management in an attempt to control disease transmission by poor excreta disposal. Through its three pillars: Education, Health and Sanitation, AnHEP has been able to drastically decrease the occurrence of the otherwise rampant communicable diseases in slums. Abuse of over-the-counter drugs has also decreased. The community has learnt much on maintaining good sanitation and on essential first aid skills. This programme will help avail health facilities to the urban poor through a win-win platform. It should thus be encouraged or emulated.

P 002 DESIGN OF PATIENT CENTRIC SERVICE DELIVERY IN HEALTH CARE- A WHOLISTIC APPROACH

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Hospital care needs to ensure that the patient (user of the services) is at the centre of any provision of care. Care is provided within hospital environments that are themselves built environments with physical spaces, that accommodate equipment, processes, technologies and that also create micro environments. These technologies, equipment, processes and environments all contribute to the quality of service that patients (end users of care) receive. Design of physical space requires a patient centered approach to providing appropriate hospital design that operationalises provision of care for optimum patient centered services. This calls for an
understanding of physical accommodation and associated elements required to facilitate appropriate patient centered service design in health care. At the heart of this understanding is the establishment of a set of benchmarks for services to be provided and a link or integration to spatial design that would enable or facilitate such benchmarks and also allow for the evolution or continual improvement of services. An evaluation of existing theory and practical applications to such service delivery within physical environments is made and lessons summarized from the body of work. The paper then recommends that an interdisciplinary approach is required for such provision of appropriate and holistic patient centric service design in health care.

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P 003 A CASE STUDY ON THE ROLE OF A FAMILY PHYSICIAN IN TRANSFORMING MARAGUA HEALTH CENTRE TO A PATIENT CENTERED COMPREHENSIVE CARE SUB-COUNTY FACILITY

S.K.Ngigi

Maragua Health Centre was elevated to a Level 4 facility in 2010 and a Family Physician assigned the role of a Medical Superintendent. Initial catchment population was 20,000. The hospital now has a population of over 400,000. The hospital has been expanding rapidly in the last five years to cater for this population. The main objectives were to re-organize the health facility infrastructure, staffing and equipment to meet the patients’ needs and expectations, to introduce a multi-disciplinary daily Family Medicine Clinic in Out-Patient to cater for all referrals, critically ill patients and to introduce community oriented outreach services that include health promotion, screening camps in the catchment area. The methodology included setting up a comprehensive hospital master plan and a five years investment plan, setting up a resource mobilization committee (HCDC), write up proposals, BQs (Bill of Quantities) and other priority projects, lobbying for funding from GOK, CDF, Donors (Vidha-Africa Digna Foundation) Spain and timely utilization of the resources allocated. The results indicate increased range of services in the hospital, (New Maternity Unit, Paediatric Unit, General Ward, Major Operating Theatres, and New Equipment) and increased patient attendance and utilization of the services. In conclusion family medicine leadership is needed at the grassroots; health centers level to transform these institutions to patient Centered Care Institutions.