Tackling antimicrobial resistance
a story of health professionals playing their part

You too ... can take action!

I use my medical knowledge to try to improve the services in our hospital.

Dr J.

I try to stay on top of the newest developments in patient care.

I make infection control and availability of medicines top priority in our hospital.

I take initiative so that more essential medicines are available for my patients.

I make infection control and availability of medicines top priority in our hospital.

Nurse Waja

Medical director

Pharmacist
Antimicrobial treatment is a major lifesaving intervention for infectious diseases but Antimicrobial Resistance (AMR) is rapidly reducing the effectiveness of antimicrobials. As a result, many first line treatments for diseases such as malaria, TB and opportunistic infections of AIDS are no longer effective and the cost of care is inevitably increased.

Storylines: Donna Kusemererwa, Gelliann Omondi, Elisabeth Goffin, Anke Meiburg
Design and layout: Elisabeth Goffin
Illustrations: David Radoli

EPN wishes to thank its partners for supporting the development of these strips.

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Tackling antimicrobial resistance - Availability of antibiotics

Hello doctor. I am Dr J from the Good Samaritan Hospital.

Ah, it’s good to meet you. Our hospital is concerned about the increasing incidents of apparent MDR TB. But we don’t seem to be well informed about control and availability of treatments.

The Ministry is in the process of formulating a national response. I am here to help them with that. At national level, we are looking into strengthening the performance of the TB Programme. There seem to be a number of weaknesses, especially in diagnosis and treatment.

And for hospital level... what strategies are proposed?

Well, we are asking government to invest in building laboratory capacities, introduce new rapid diagnostic tests and assist hospitals in early case-finding and effective treatment using DOTS.

That is true. As you are aware, the Finance Department has been short of funds. As pharmacy, we have to prioritize what we buy based on the resources available. Expensive antibiotics are often not purchased.

My colleague in charge of pharmacy was also concerned about how to get second-line medicines.

I think government policy is to have all suspect cases referred to the national referral hospital. However once they are on treatment, any hospital should be able to manage the patient.

There is a representative of the programme responsible for commodities attending the meeting. I will introduce her to you.

Sorry Sir, I didn’t think there was anything that could be done.

That will be great, thanks. Catch you later.

There has to be! Availability of antibiotics is one of the indicators that is being used to determine how serious we are about containment of antimicrobial resistance.

Complaints have been reaching me from patients. It seems patients are continually being told to buy certain medicines outside the hospital.
The medical director, finance manager and pharmacist meet to discuss the availability of antibiotics.

Sir, the antibiotics that we are not buying are really expensive, for example a single vial of meropenem costs up to 40 USD. Buying four of such antibiotics would exhaust a big chunk of our medicines budget.

But if we bought only what we sell in say two weeks, we could help the patients without causing a burden to the hospital.

Exactly my concern! Patients are exploited when they buy from these pharmacies in town.

Question is where to get the money for the initial investment? My accounts are truly constrained.

Good idea. We could even treat it as a loan and pay back in round about 24 months. Might make it a better sell...

Let me think. Parliamentarians have funds to help their constituents, yes?

Maybe if I approached our MP, she might help...

In the mean time, I will ask the MTC to prioritize the medicines in our formulary that we are currently not stocking.

Excellent, that way we guarantee that any funds go to the most needed medicines.

That’s settled then! As our finance manager, please prepare a short note on this for management.

At the Good Samaritan Hospital monthly staff meeting

Over the coming weeks we are to start the process of developing an infection control policy and setting up an infection control committee for the hospital.

Why is this necessary? We don’t have a problem with hospital-acquired infections.

We have engaged an infection control specialist from the Ministry of Health who will be here in one week’s time to kick-start the process. Please give her your support.

The development of the policy will be through a consultative process in which you are all invited to give your input. We need to develop policies that we can implement collectively.

I hope this does not mean a whole lot of new do's and don'ts for us to comply with.

Oh no, we already have so many committees.

We, want to ensure that hospital acquired infections continues to be minimal and as you know, infection control is one of the pillars of containment of antimicrobial resistance.

So it fits well with the other containment actions we are undertaking.

When does the process actually start?
A week later, the infection control specialist arrives at the GSH.

Madam, this is Nurse Waja, she will be your right hand while you are here.

Thank you. It’s a pleasure to meet you.

Where would you like us to start?

My plan is to do an assessment of infection control in the different areas of the hospital. We could start with theatre.

Welcome. This is Toto Ward.

Well, I can see that waste management is being addressed and hand washing facilities are plentiful.

Great job! Do you have any infection control issues?

Some of the nurses have barely any knowledge on infection control and prevention. I wish a course would be organized for them.

What happens when you have a needle stick injury?

It is treated and if necessary PEP is given. However, we don’t have a protocol on this.

Are the injuries recorded?

Hmmm no. Should they be?

I will include that in my report. Infection prevention and control principles need to be understood by everyone working in the hospital. By the way, I have not seen many protocols or job aids on IPC.

IPC is an issue that has only recently become topical. Probably the starting point was to provide the basic facilities.

Facilities alone are not enough. You would be surprised how much people need to be supported to make the most of them.

What about disposal of sharps?

We have been provided with containers which are incinerated once they are full.

Now, let me take you to the children’s ward. You will see it looks quite smart. The in-charge is on top of things. She is able to get a lot done through her personal initiative.

Here we are in the hospital kitchen. Chef, madam here is from MOH. She’s helping us set up an infection control committee and policy.

Can I see your schedules for pest control please? Any reports of cultures from the kitchen?

Pest control is routinely done. The schedule is on the wall in my office. But I don’t recall any swabs ever being taken. Sorry.

Nurse Waja, I am done. My report should be ready in a week.

I thought the hospital was doing so well on IPC. Working with you today has really opened my eyes. There is still a lot to do.
Tackling antimicrobial resistance - Neonatal sepsis
At the Good Samaritan Hospital Board meeting

Benefits of bacteriology lab
- More effective treatment of infections
- More efficient patient management
- Shorter hospital stays
- Lower mortality
- Lower costs

Hold on now, we barely meet running costs. How can we dream of investing in such a venture?

Yes Madam Chair, but this investment should help us reduce running costs in the long term.

And help reduce the spread of resistant organisms!

We hear that the Danish Government is equipping hospitals. We would like to submit the proposal to them.

One minute, I don’t see anything about the financing.

Please see page 5, for the 3-year financial projections.

Why would they give the money to GSH when government hospitals are in such a sad state?

Many donors are increasingly aware that faith-based providers are critical for achievement of national health goals.

I am convinced. I think it makes sense.

I don’t hear objections, therefore we can adopt the proposal on a new bacteriology lab for GSH.

Just wish they would leave us alone. We went to school to learn to practice medicine.

What for? A witch hunt?

Why?

Do you know that we are qualified practitioners?

These pharmacists, they should stick to dispensing.

Well then, if there are no other questions, we can move on to the next item on our agenda.

Thank you for your support and cooperation. We hope to present the study report to you in 3 months.

At the hospital fortnightly clinicians meeting

GSH

CLINICANS MEETING AGENDA
1. Ward reports
2. Antibiotic prescribing
3. Update on H1N1 flu

The findings of the survey will help us tackle inappropriate use of antibiotics, saving both our patients and the hospital a lot: better outcomes, shorter hospital stays and lower cost.

Thank you for the initiative. The hospital has a number of standard protocols on management of various conditions. It will be interesting to see how compliant we are.
A few months later, the study results are presented.

We reviewed 100 prescriptions or cases in each of these areas. We are doing well in generic prescribing and management of pneumonia but...

The protocols for antibiotic use in surgical prophylaxis are not followed! Shame!

I think fear of infection drives prescription of antibiotics more than anything.

But our wards are quite clean and the nurses do their best to keep wounds clean. Isn’t the risk low?

I should be. That is why we agreed on that pre-op protocol.

I wish we had data on the rate of post-op infections with different protocols.

Aaah scientists. So you can’t move without local evidence!

These studies have been done elsewhere, even in our country. Use of antibiotics for prophylaxis pre-op is effective.

Think of the benefits: savings due to lower antibiotics usage, less nursing time, less consumables required and lower risk to patients.

We need to conclude. In both areas where we are doing badly we have measures in place: the hospital formulary and the protocols.

After the meeting

It looks like I need to ask the Heads of Department to hold meetings about these measures. The appeal I made here may not work on its own.

Thank you sir. I will also inform everyone about the next assessment in good time.

Something else... 30% of our prescriptions have non-formulary antibiotics?

Our hospital formulary is quite limited. There are a lot of new antibiotics out there.

And our patients need them.

I vaguely recall, did it mean our prescribing was limited to what was on that list?

Yes, of course. Why would you have a formulary otherwise!

But we stock representatives of literally each class of antibiotics recommended in the current national treatment guidelines.

How current are those guidelines? Do we have them?
30 years of strengthening pharmaceutical services in church health systems

Professionalism and good governance
Institutional strengthening through capacity building and distribution of tools to impact governance
Training on pharmacy for health facility staff as well as provision of guidelines and standards to strengthen pharmacy practice

Access to medicines
Addressing supply systems, medicine use, quality of medicines, pharmaceutical care and affordability

Campaign against antimicrobial resistance
Activities on rational use of antibiotics and implementation of hospital-based infection control interventions reached more than 500 health professionals in 9 countries in 2010.

HIV and AIDS
Treatment Literacy Guide for Church Leaders available in English and French.
EPN also offers Treatment Literacy Courses for Church Leaders on invitation from any church or other group.

Ecumenical Pharmaceutical Network
4th Floor Rosami Court, Muringa Road, Kilimani, Nairobi, Kenya. P.O. Box 749 - 00606 Nairobi, Kenya
Tel: +254 572 522702 | 724 301755 E: info@epnetwork.org
EPN – Ecumenical Pharmaceutical Network EPNNetwork

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