COMBONI

HEALTH

PROGRAM

ANNUAL REPORT

2017

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
APDK	Association for the Physically Disabled of Kenya
ART	Anti-Retroviral Therapy
CBRP	Community Based Rehabilitation Program
CCC	Comprehensive Care Clinic
CD4	Cluster of Differentiation 4
CHAP	Christian Health Association of Kenya HIV AIDS Projects
CHP	Comboni Health Program
CHVs	Community Health Volunteers
EID	Early Infant Diagnosis
HEI	HIV Exposed Infants
HTS	HIV Testing Services
HIV	Human Immunodeficiency Virus
IPT	Isoniazide Preventive Therapy
NASCOP	National AIDS & STI Control Programme
PCR	Polymerase Chain Reaction
PMTCT	Prevention of Mother to Child Transmission
PNS	Partner Notification Services
RUNH	Ruaraka Uhai Neema Hospital
SEP	Special Educations Professionals
TAS	Treatment Adherence Support
TB	Tuberculosis
TPS	Treatment Preparation Support
UNICEF	United Nations Children's Fund

1. INTRODUCTION TO CHP

Comboni Health Program (CHP) is a Community Based Health Organization operating in the slums of Korogocho, Kariobangi and Huruma region within the vast Nairobi county. These regions are considered low-income regions, densely populated with most families living in single rooms of approximately 10 by 10 feet (3mts by 3mts) with average occupancy of 4 to 5 people per room. Majority live in extreme poverty conditions and are not able to afford the most basic daily needs of food, shelter and clothing. 99% of houses in Korogocho are semi permanent houses but Kariobangi and Huruma consist of both permanent apartment like and slum like dwellings with majority of the population still occupying single rooms. Water and sanitation is still a major concern in these regions despite the efforts made by several community initiative projects to improve them. Korogocho has no sewer systems and no proper measures of waste disposal whereas in Kariobangi and Huruma they exist up to a certain measure; they are overstretched with the population outburst in the region since the same have not been improved since. Water supply is a major problem in all the areas but

especially in Korogocho and the residents depend on water bought from water vendor points at a cost of sh. 5 per 20 litres (about $0,02)[1]. Toilets and bathrooms are communal, shared by an average of 10 households living in the same compound or flat, approximately 40 people. Very often, they have very poor hygienic conditions.

With the underlying tough living conditions, having a long term health condition or disability becomes a real challenge with majority of the people living in these regions not able to access proper medical health care. This is due to affordability and also because the already existing government facilities are overstretched. The poor road infrastructure and cost of frequent transportation for

[1] Most of these people live with less than 1,5 dollars a day.

hospital visits makes it even more challenging especially for clients who get very sick and more so people living with disabilities who especially experience a lot of challenges in using the public transport services. This makes long term health conditions such as HIV and disability management almost impossible since they require constant monitoring. CHP seeks to intervene through its projects and address these two concerns, by providing health care and support for people living with HIV& AIDS and children with disabilities.

The programme runs two projects that are right within the community, a ***Comprehensive Care Clinic (CCC***) for diagnosis and management of HIV and related complications and a ***Community Based Rehabilitation Project (CBRP)*** that offers therapy interventions for children with disabilities.

The programme ensures that their services are easily accessible to the community in terms of cost and infrastructure and the involvement and active participation of the community through the community health volunteers has ensured community acceptance of our activities among them. The programme also works with a team of 11 professional staff which include a clinical officer, nurses, counsellors, occupational therapist, assistant physiotherapist social worker and 5 support staff supported by the programme and a team of 20 community health volunteers, who offer their services for free and are our point of reference persons in the community. Through collaboration with partners, CHP has been able to include 7 professional who work as volunteers in our projects; they included physiotherapists, occupational therapists and a data collection person.

The programme runs two projects that are right within the community: a **Comprehensive Care Clinic (CCC)** for diagnosis and management of HIV and related complications and a **Community Based Rehabilitation Project (CBRP)** that offers therapy interventions for children with disabilities.

CHP advocates for prevention and early intervention as key in curbing various health concerns and does this by having forums for community sensitization on the importance of knowing their HIV status and early interventions for both HIV infection and disability cases. The programme also organises trainings for staff and individuals mostly done by our partners. We also work

closely with other health and social institutions within and outside our catchment region to ensure ease of referrals.

1.1 Our goal

Our overall goal as Comboni Health Program is to ensure early identification and intervention to care and management in order to improve the quality of life for people living with HIV and children with disabilities from poor families.

1.2 Objective

- To conduct outreach programs to increase HIV testing rate and ensure as many people as possible know their HIV status.
- To facilitate 100% linkages for all people who test HIV positive to care and treatment services.
- To ensure early identification and intervention for children with disabilities.
- To conduct awareness creation on management of disability and HIV prevention strategies.
- To undertake capacity building for caregivers and beneficiaries to ensure active involvement in their treatment plan.
- To offer quality and professional services to beneficiaries

1.3 Our Activities

1. Comprehensive Care Clinic
    - HIV Testing Services (HTS)
    - Treatment Adherence Support (TAS)
    - Enrolment to care and treatment
    - Patient monitoring
    - Early infant diagnosis
    - TB screening
    - Prevention of Mother to Child Transmission
    - Natural clinic

2. Community Based Rehabilitation Project
    - Physiotherapy and occupational therapy services

- Home therapy program
- Monthly follow up and review clinics
- Referrals

3. Social support
   - Counseling
   - Support groups
   - Follow up home visits
   - Food program

2. THE COMPREHENSIVE CARE CLINIC

Comboni Health Programme with the support of *Nazareth Hospital* and *Nangina Club Germany* operates a Comprehensive Care Clinic for people living with HIV & AIDS in the slums of Korogocho. The project had a cumulative total of 359 clients enrolled to care within the reporting period of 2017. HIV care and management still remains a major concern in the slums of Korogocho and this can be attributed to a number of factors related to or are common in areas of low income. They include: early and premature engagement into sexual life and early marriages, engagement in risky sexual behaviours, high prevalence of multiple sexual partners, low use of protection, drug use and abuse, lack of knowledge on sexual safety practices, poverty and despair in life, among many others. The objectives of our clinic are to address issues of HIV transmission and prevention, care and treatment of opportunistic infections and offering psychological and social support to clients to enhance treatment and adherence. These are done through the following activities planned throughout the year;

The project had a cumulative total of 359 clients enrolled to care within the reporting period of 2017.

2.1 HIV Testing Services (HTS)

The HIV Testing Service is a program that advocates for and encourages the community to know their HIV status and minimise the risky sexual behaviours mostly attributed with slum areas. The program does this by initiating HIV testing in the community through community outreach programs and availing a free testing centre at the facility. The community members are mobilised by the

community health volunteers and a counsellor goes out to test on scheduled days and venues. 1017 people (84.75 per month) have been counselled and tested both on site and on outreach program during this reporting period, 54 (5,3%) tested HIV positive and 44 were linked to care and treatment. 41 of those who tested HIV positive were linked within our clinic and 3 linked to other facilities as indicated in the table below.

2.1.1 Table showing testing targets and achievement

Testing target		1200 people
No. tested		1017
No. tested positive		54
LINKAGE TO CARE	No. linked within	41
	No. linked out	3
	No. on TPS	1
	No. on follow up	2
	Declined linkage	3
	Lost to follow up	4
	Percentage linkage	87%

Year 2017 saw a reduction in testing and linkages compared to the previous year, where 1077 people were tested and linkage achievement was at 98%. This slight decline was majorly attributed to the high risk and volatile political situation experienced in the year especially from the month of June. Our staff could not access certain areas to undertake the outreach programs and as a result of the political tension quite a number of people moved to their rural villages in fear of election violence.

Activities on site, though slow, continued as usual with our staff always present to offer service. One such activity was *Partner Notification Services (PNS)* introduced in the previous year. This is a service targeting partners of index clients already enrolled in our clinic supporting disclosure and encouraging index clients to bring their partners for HIV testing. The goal of PNS is to try and cut the spread of HIV by encouraging people to know their status and adopt safer sexual behaviours. Besides PNS, the HTS also provides enhanced family testing to follow up on families of index clients in the clinic to ensure all family members get to know their HIV status. Both family testing and PNS

are done on consent from index client. From our index clients, 99 partners and family members were identified for testing of which 86 had been tested by end of this reporting period. 4 tested HIV positive and were enrolled to care (4,65% of the tested).

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Our HTS also offers counselling support not just to clients enrolled in the clinic but also to the community and acts as a community support centre where information especially on HIV and other health concerns are shared. 129 people benefitted from this service, many people seeking information on HIV and other sexually transmitted infections with just about a handful asking about general health matters. Most cases that could not be handled on site were referred appropriately ensuring people in the community got the right health information and accessed the correct treatment in accredited facilities. Counselling needs for clients enrolled in our clinic however were more on issues affecting adherence to treatment which included lack of food, alcoholism and substance abuse, physical violence and challenges in disclosure of status.

2.2 Treatment Adherence Support (TAS)

Most patients before initiation to ART and through their ART treatment go through support treatment adherence. This is an ongoing support process that begins on enrolment and all through treatment. It is done to ensure clients enrolled at the clinic understand and are ready for the lifelong treatment and are willing to work with the health care providers towards their treatment goals. The trainings are based on information-motivation and behavioral skills or adaptations to ensure clients adopt a healthy lifestyle and works towards a 100% viral suppression. It includes brief pill taking practice and a performance driven dose regulation systems that would ensure clients are actively involved in their treatment and take a front line in deciding on their treatment and encouraged to identify a treatment partner. All the 41 clients enrolled for treatment in the year did go through the initial TAS with continuous support given to those clients already in the clinic

Of the 359 clients seen in the clinic 49 have not been consistent in taking their ART as required needing a lot of follow up and adherence support.

but experiencing adherence issues. Of the 359 clients seen in the clinic 49 have not been consistent in taking their ART as required needing a lot of follow up and adherence support. These were mostly due to underlying social and psychological issues with poverty and alcoholism being the major causes.

2.3 Enrolment to Care and Treatment

People who test HIV positive and successfully go through treatment preparation and adherence support and show readiness to start treatment are started on ART but this is sometimes a challenge due to the inconsistency of some clients in this treatment initiation process that leads to delay in start of ART. These clients do not show a willingness or commitment to start treatment. Of the 54 people tested positive at our site, 41 were started on ART within the reporting period with 35 having been linked from our HTS and 6 referred in from other facilities. 3 clients from our facility were linked to care in other health facilities, 3 had not been started on care by end of this reporting period and were on follow up and another 3 declined treatment.

Several factors hinder our client enrolments, the most common one being clients poor attendance of treatment adherence support classes to initiate ART. Out of the 41 started on treatment, test and treat was only effective with 22 clients, 19 other clients had their treatments delayed, with some up to 4 months delay before initiating treatment.

2.3.1 Table showing enrolment to care and treatment

Set enrolment target	84
Tested positive	54
Enrolled to care	44
Started on ART within our facility	35
Successfully linked to other facilities	3
Referred in from other facilities	6
Declined treatment	3

2.4 Patient Monitoring Tests

All patients on ART undergo routine monitoring laboratory examinations. These are done to each client in the CCC, some are done on presentation of need but others like viral load and liver function

tests are done routinely to monitor treatment success. Most clients in our clinic are not able to pay for these tests hence the project together with other partners have collaborated to ensure these tests are done routinely as required. Other tests that the project supports include, X-rays and scans, full haemogram, haemoglobin tests, random blood sugar, fasting blood sugar, and renal function tests. 326 patients benefited from this medical support services. CHP not having its own laboratory, all the medical examinations were done in collaboration with other health institutions. TB screening is also done to all patients on each return visit to the clinic and those suspected of TB have to take a Gene X-pert test to confirm TB, this test is done for free at the government facilities. 11 people were diagnosed and treated for TB at our clinic, 6 successfully completed their treatments and cured while 3 were still on treatment at the end of this reporting period. 1 TB patient was lost to follow up and reported to the sub-county TB and infectious disease control department, 1 died. 7 out of the 11 people diagnosed with TB were also HIV positive.

2.4.1 Table showing number of patients and routine laboratory tests done

Laboratory tests done	**No. done**	**Target**
Viral load tests	326	328
EID	10	10
PCR	10	10
TB GENE X-PERT	11	11
X-RAY & SCANS	40	On need
Other laboratory examinations	43	On need

Other monitoring and follow ups done at the clinic include: *Prevention of Mother to Child Transmission* (PMTCT) where expectant mothers are closely monitored to follow up their antenatal clinics for safe delivery. 10 expectant mothers were enrolled for follow up, 5 newly diagnosed with HIV and 5 known HIV positive. *Early Infant Diagnosis* (EID) is another test done for HIV Exposed Infants (HEI) or babies born to women who are HIV positive. In the year we registered 10 HEI and all tested HIV negative at PCR done within ages 0 to 18 months. 1 HEI was discharged at 18 months with negative result this is a big success regarding the harsh poverty conditions that most of these babies are born. A lot of support is normally required from the project to ensure the mothers follow

all the preventive clinical advice given and many times to encourage exclusive breast feeding the mothers are given food support for at least the six months of breast feeding.

MOTHER TO CHILD TRANSMITED IRRADICATED – BIG SUCCESS

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2.5 Natural Therapy Clinic

This is an alternative therapy clinic for people living with HIV designed for patients who present with adherence challenges and are not ready for start of ART. Most of them are alcoholics but also people who are not ready or willing to start ART. The natural clinic, although having proven to be very effective in HIV management at our clinic, has not got new clients exclusively enrolled in it. This is because of the new "test and treat" directive from NASCOP[2], who has made it not possible to exclusively enrol new clients to the clinic. However, most clients already in the clinic opted to continue with the therapy together with their ART. Since the supplements are purely natural foods, there are no side effects experienced and the treatment works well with ART. The natural treatment therapy works on strengthen or boosting the body's own immunity system to be able to fight or suppress the HIV virus and it has been observed at the clinic that clients on natural therapy treatment rarely come down with opportunistic infections as compared to those not on this treatment. A total of 18 clients are enrolled in this with only 9 purely on natural therapy treatment. The other 9 are also on ART.

The foods used for this therapy include; cabbage, brazil nuts, isabgol or pesylium husks, whole lemon, chillies or hot pepper and olive oil. All these ingredients have different functions in the body and aid different organs to function well, improving the body's own natural defence. The mode of action includes detoxification, increase appetite, facilitate digestion and also act as antioxidants for the immune system. This therapy is, however, recommended only to those people who test HIV positive but have CD4 counts of above 800 copies. This is because it is a long-term slow action

[2] National AIDS & STI Control Programme (Kenya) - http://www.nascop.or.ke.

mode of treatment and may not be very effective for someone with AIDS. This treatment can be self-administered and regulated, and the client can also prepare it at home when given basic knowledge. Clients' weights are monitored monthly with other monitoring laboratory tests done twice a year to check on CD4 count and full haemogram.

3. COMMUNITY BASED REHABILITATION PROJECT (CBRP)

Comboni Health Programme also runs a Community Based Rehabilitation Project that targets children with disabilities up to the age of 10 years, from poor families. The project has availed two therapy gyms within Korogocho slum and in Kariobangi area, managed by qualified therapists. Therapy programs extend to the homes where home therapy programs are monitored by our social worker and occupational therapist. Besides offering therapy services, the project, in collaboration with Special Education Professionals (SEP), also seeks to address the social and cultural stigma issues attached to disability by organizing trainings for beneficiaries and sensitization talks for the community. The project also collaborates with World Friends in cases of referral that cannot be handled at our centers and World Friends, through Ruaraka Uhai Neema Hospital, has supported several medical and surgical cases from our project. The CBRP also offers counseling services and social support to our beneficiaries and in 2017 reporting year the project supported a total of 126 children through therapy interventions and other services.

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3.1 Therapy services

Our CBRP was able to help 95 children with disabilities by offering physiotherapy and occupational therapy sessions at the two rehabilitation centers in Kariobangi and Korogocho. Children were given individualized treatment during therapy sessions that are discussed with the parents and caregivers in order to develop a better understanding of their children's condition and actively participate in the therapy intervention. This approach contributed to a number of positive results that included: better management of the conditions, especially at home, preventing deformities and creating more functional movement enabling the children to achieve their full potential.

3.1.1 Table I: shows the no. of beneficiaries reached and sessions conducted during therapy sessions

Therapy centre	***No. sessions done***	***Number of children seen***		
		Male	Female	**Total**
St. Joseph Kariobangi	1109	35	38	**73**
St. John Korogocho	329	10	12	**22**
TOTAL	**1438**	**45**	**50**	**95**

6 children were discharged from therapy after gaining the required milestones appropriate for age ; 11 children developed a milestone or two and 24 have shown slight improvement in their abilities compared to when they started therapy. A major concern through the therapy process has, however, remained concerning the inconsistency of therapy attendance, slowing the progress.

3.2 Home Therapy Program

During therapy sessions at the centers parents and caregivers are trained on basic therapy skills to practice with their children at home. This is to enable continuity of therapy beyond the centers and also actively involve caregivers in their children therapy process. The therapy processes are followed up by the project social worker and occupational therapist who monitor the activities at home, advising and also supporting in home adaptations and improvising, using assistive devices. 379 follow up visits were made within the reporting year, 12 families were able to improvise simple toys and basic assistive devices like bucket seats, rollers and toys in the home with the help of our staff.

3.3 Monthly Follow Up and Review Clinics

The CBRP has two monthly clinics, the anticonvulsant drugs clinic where children with convulsive disorders are issued with anticonvulsant medication on prescription. 21 children were reviewed and issued with anticonvulsant drugs in the reporting year. 3 children were given transport and consultation fee to attend their clinics and four got transport to hospital. Association for the Physically Disabled of Kenya also conducts a monthly mobile clinic in partnership with us at our centre where children with disabilities are reviewed and both therapists and caregivers advised on management. They also fit special appliances and issue, at a subsidized cost, a support of the children in our projects. 87 children were seen during these clinics and 8 were fitted with assistive devices

which were paid for by another collaborator and partner called Light and Hope project. 4 surgical cases were identified for review during the clinics and referred to Ruaraka Uhai Neema Hospital.

3.4 Referrals

Being a Community Based Organization, quite a number of cases cannot be handled at our facilities at community level. Thus, CHP works in collaboration with other partners to ensure ease of referral and access to services. Our main collaborators with referrals have been Ruaraka Uhai Neema Hospital and the government health centres within our catchment area. 18 referrals were made during this reporting period, 6 medical health cases and 4 surgical sent to Ruaraka Uhai Neema Hospital with 1 child having corrective surgery done. All these services were offered for free from our partners. 8 children with rickets and malnutrition were referred to Baraka Health Centre for nutrition support and feeding programme and treatment of rickets.

18 referrals were made during this reporting period, 6 medical health cases and 4 surgical sent to Ruaraka Uhai Neema Hospital with 1 child having corrective surgery done.

4. SOCIAL SUPPORT

CHP social support program assists clients and programme beneficiaries in meeting those social and psychological issues that may hinder their treatment processes. This is done through counselling support, medical financial support, food support and even material support in terms of clothing and others. 212 beneficiaries of the projects received counselling support through both individual and group counselling sessions. This year our CCC youth support group participated in a youth forum event at Nazareth hospital where there were games and project presentations and our team got second position in the football game out of 8 teams and third position in youth clinic presentation. These programs help expose our youth in interactions with others, building their esteem and allow then experience other environments and opportunities outside Korogocho. Together with SEP the programme organized sibling support group workshops for siblings of children with disabilities, the workshops were attended by 34 siblings of children with disabilities. The goal of these workshops was to encourage the siblings to understand disabilities and get more involved in the care of their brothers and sisters with disabilities.

On other support activity, 130 families in the programme received food, 351 had their medical examinations paid for by the programme with 10 receiving transport to hospital. 6 families were issued with clothing, blankets and mattress through the social service support. CHP has received a lot of support from individuals and groups who have donated food, clothing and in some instances supported patients directly with finances towards hospital transport and consultation fees. Kariobangi Catholic Parish and Nazareth Hospital have played a key role in supplying the programme with food supplies throughout the year. CHP also in the year supported 4 children to school, 2 in special schools supported by CHP and 2 in high school paid for by UNICEF.

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5. COMMUNITY HEALTH VOLUNTEERS (CHVs)

CHP works with a team of 20 CHVs who volunteer their time to support the clinic in reaching patients in the village and also helping the patients at home. They undertake quite a number of activities from helping out at home when a client is very sick, linking the patients to services, taking regular pill counts and advising the clinic on patients adherence and even following up on clients clinic appointments to ensure they keep their appointment dates.

The CHVs undergo continuous basic health trainings and updates done both by internal and external facilitators to ensure they are up to date with current management skills. All the CHVs are community members derived from our catchment area each representing small regions and are always neighbours or living close by to our clients making follow up easy and manageable. Being community members the CHVs are also a form of security to our staff when they go on home visits and make it easier for our team to reach even the areas in the slum that are considered to be very risky.

6. TRAININGS

CHP, together with partners, organized and conducted a total of 25 workshops and trainings for both staff and beneficiaries. The goal of these trainings was to build knowledge in beneficiaries both

parents and caregivers, including staff members by providing information on specific topics and health issues related to various needs. 302 people went through the various capacity building programs; 292 being projects beneficiaries and 10 staff members.

Staff trainings		
Training title	***Training facilitator***	***Number trained***
Pediatric TB training	Ruaraka sub county	1 clinician
ARV optimization training	Ruaraka sub county	1 clinician 1 pharm-tech
Data and reporting regional training	CHAP-UZIMA	1 clinician
NGO & FBO revised CARP reporting tool	NAAC	1 nurse
Differentiated care training	Ruaraka sub county	1 nurse
TB reporting tools	Ruaraka sub county	1 nurse
Integrated TB curriculum training	Ruaraka sub county	1 nurse
Partner notification services	CHAP-UZIMA	1 HTS counselor
Sexual and gender based violence	CHAP-UZIMA	1 clinician 1 HTS counselor
New HIV reporting tools and registers	Ruaraka sub county	1 clinician
Continuous quality improvement	Ruaraka sub county	1 programme coordinator
How to improvise and use assistive devices in the home	World friends	1 therapy assistant
Club foot & cerebral palsy management	World friends	1 occupational therapist 1 therapy assistant

Note: 10 staff members attended various trainings as indicated in the table above.

Projects beneficiaries Workshops		
Training title	***Training facilitator***	***Number trained***
First aid	SEP	16 caregivers
Toy making	SEP	28 caregivers

Epilepsy awareness	CHP	14 caregivers
Communication	SEP	33 caregivers
Acceptance	SEP	13 caregivers
Nutrition	SEP	28 caregivers
Chest Therapy	SEP	25 caregivers
How to improvise and use assistive devices in the home	WF	10 caregivers
Patients sensitization training	CHP	88 clients
Adherence training and partner notification	CHP	22 clients
Adherence and importance of natural supplements	CHP	5 clients
New updates on HIV management	CHP	10 CHVs

Note: Total no. of beneficiaries trained were 292

7. OUR PARTNERS

CHP has in the 12 months maintained a stable working relationship with several partners ensuring proper care and management of children with disability within our catchment areas. These partnerships enable us to put together several resources locally in order to deliver the results presented in this report.

7.1 CHAP-UZIMA

Nazareth Hospital partly funds CCC activities and also offers monitoring and evaluation of activities. They fully supply ARVs and partly drugs for opportunistic infection to our CCC. They also offer operational support to the clinic by seconding technical staff to work at the clinic; they also pay part of the staff costs and plan trainings related to HIV care and management for staff and community health volunteers. They also support the program with food for patients. Nazareth Hospital, in collaboration with CHAP-UZIMA, also monitors and evaluates CCC activities.

7.2 World Friend (WF)

WF has collaborated with Ruaraka Uhai Neema Hospital in supporting the CBRP. They support the salary of one therapist assistant. They have also offered medical treatment on charity to children with special needs enrolled in our projects and offered free surgical clinics and corrective surgeries to identified children and trainings to both staff and beneficiaries of the project.

7.3 Ruaraka Uhai Neema Hospital (RUNH)

RUNH has offered us credit services which have eased the referral of patients for laboratory services paid for by the programme.

7.4 Comboni Catholic Dispensary (CCD)

CCD offered laboratory services and treatment to our patients on credit.

7.5 Special Education Professionals (SEP)

SEP provided 6 technical staffs to our centres at no charges: 2 physiotherapists, 1 occupational therapist and 3 interns to work in the project. SEP also together with CHP organized and facilitated several workshops and continuous therapy training for beneficiaries.

7.6 Association for the Physically Disabled of Kenya (APDK)

APDK has continuously conducted monthly mobile clinics at our centres which are open to the community. Here there are reviews and fittings for special appliances done for already identified children in the project and issued at a very subsidized cost. The clinics were also open to the community, both children and adults. Information is also given concerning disability.

7.7 Light and Hope Project (LHP)

LHP paid the full cost of special appliances for 3 children in our project in collaboration with APDK.

7.8 Baraka Health Centre (BHC)

BHC offers nutritional support and treatment of rickets.

7.9 National County Government (NCG)

NCG supplies all HTS consumables and testing kits, trainings and monthly CCC support meetings.

8. CHALLENGES

One of the major challenges experienced by the programme in undertaking its activities in the slum region and non-formal settlements remains is the **high insecurity and crime rates**. Despite the CHP team making tremendous efforts to ensure our services reach and are felt in all our target areas, sometimes it becomes impossible to access some areas due to the high security risk. These areas are also considered to be volatile in terms of security and any slight provocation can turn into serious violence. The election period during most part of 2017 was particularly a very risky period for both staff and residents and some areas could not be accessed with some of the people moving to rural areas in fear of the elections violence.

The other major challenge is the **high levels of poverty**. Most clients in or projects are not able to afford a regular meal in a day which is very important when it comes to managing their health

Challenges

1. High insecurity and crime rates
2. High levels of poverty
3. Poor adherence to treatments
4. 'Client self-stigma' and 'community stigma.'
5. Client retention in both projects

conditions. In many instances, the programme had to support some families with regular food supplies and with the toughening economic situation in the country the number of people in need of food support keeps increasing. The number of people given food support within the reporting period went up to 130 families compared to the previous which was at 102.

Poor adherence to treatments and lack of commitment to treatment is also a concern hindering treatment interventions. Several clients, either due to ignorance or despair out of poverty, do not follow their treatment plans as advised. This is both at the CCC and CBRP leading to treatment failures due to the inconsistencies. Despite the social service support and the psychological support offered by the programme, adherence issues have remained to be a big challenge to the projects personnel.

Stigma is also a central part of treatment challenges, both **'client self-stigma' and 'community stigma.'** More than 40% of our clients living with HIV still find it very difficult to disclose their status to their families and hide their medication, taking them at irregular intervals. The project, through counselling and social service, support clients through disclosure especially to spouses or partners and eventually to family so that the clients can have support which would in turn reflect in treatment success. Some community members also do not like being associated with our clinic or seen to be coming to our centres due to the association with HIV and it is assumed that all people visiting our clinics are HIV positive. The community stigma is at times so extreme that some of our clients decline home visits as seeing our staff getting into their houses would imply that they are HIV positive. This calls for integration of other services in our CCC so that not only people living with HIV are seen at our centre.

Most non-formal settlements being temporary residence to most people in the region, **client retention in both projects has remained a challenge** with some patients or beneficiaries moving out without communicating or even getting referrals to other health facilities for proper continuity

of treatment. Our client retention is also affected by duplication of services in the slum areas which is a very common occurrence with several projects coming up offering similar services. Most of these projects offer incentives to lure people with many of them closing up after short durations. Such programs interfere with patients' adherence and retention of clients both in the CCC and CBRP.

9. LESSONS LEARNED

The major lesson learned in dealing with our clients is that people need proper information to help them understand and deal with the various health issues they are undergoing and to participate actively in their treatment plan. CHP will continue facilitating learning among clients and community members on various health issues affecting them. Only through an open and welcoming attitude towards the situation of the clients we can easy and probably eradicate the stigma problem. It is proven in our dealings with the clients that an open non-judgmental, carrying and supporting attitude contributes to an easier and even more efficacious treatment.

10. CONCLUSION

HIV infection and disability still remains a concern among this community and CHP will continue its services to the community. Strategies are in place to strengthen a youth support group that was already started in the year of this report and to roll it out to include youths not registered in our clinic. Besides the ongoing programmes, more trainings targeting CHVs will be planned for 2018 for capacity building and also pastoral retreats to motivate and build their team spirit since they are the key persons in the community to reach clients. CHP also plans to start sustainability program by opening up a dispensing chemist for the community on prescription and not only to registered clients in the clinic. This is also to extend our services to the community and to ensure they are getting the right medication from qualified professionals.

CHP, with the support of partners, will continue to offer the described services to the target community and work in improving our service delivery through monitoring and evaluating our projects on intervals to ensure they still have the desired impact to the community. Despite the various challenges experienced by our team in rendering services, especially the challenge on security, CHP has remained one great united and assorted team determined to support and give service to the people with love, care and concern to humanity. Our strength is derived from the support from one another and support from the administration which organizes staff retreats and teambuilding activities that have motivated and encouraged staff members to work with devotion in

reaching not just to the physical aspect of the clients but give holistic care and also spiritual in fulfilling Christ ministry in service to the poor.

CHP ensures that all services rendered meet expected established standards by ensuring our staffs undergo continuous trainings throughout the year and CMEs to sharpen their skills. Work performance measures are also conducted each year to make sure that our staff are always working above standards and rendering the best services to the community

WORKING THAT NEVER ENDS...

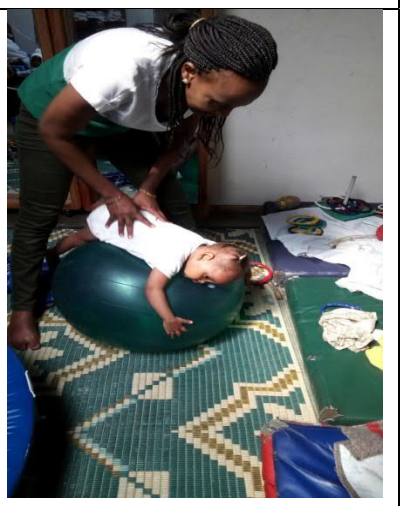
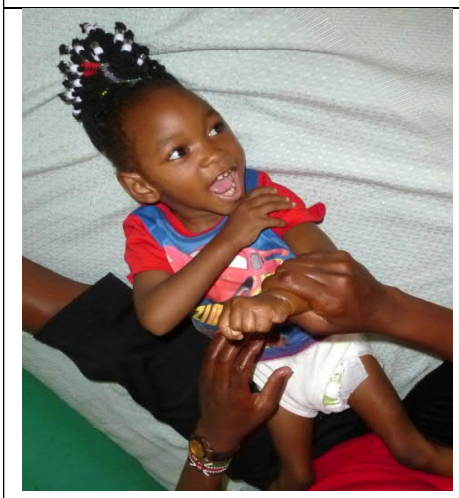
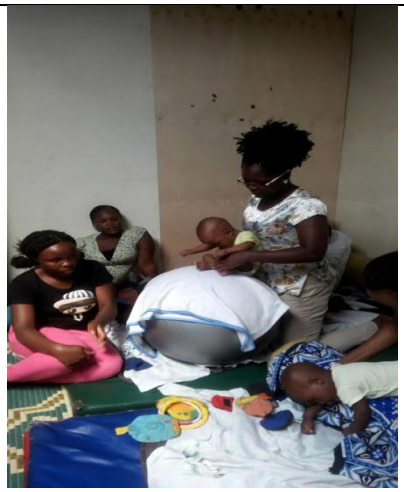
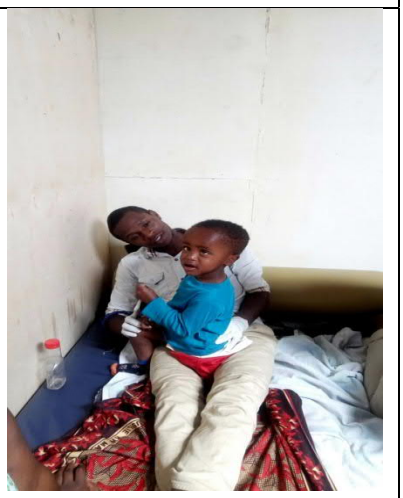
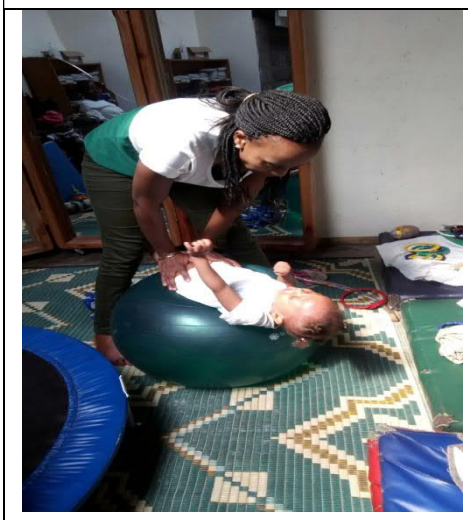
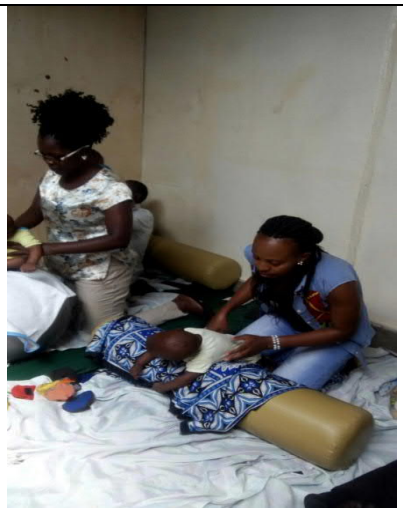
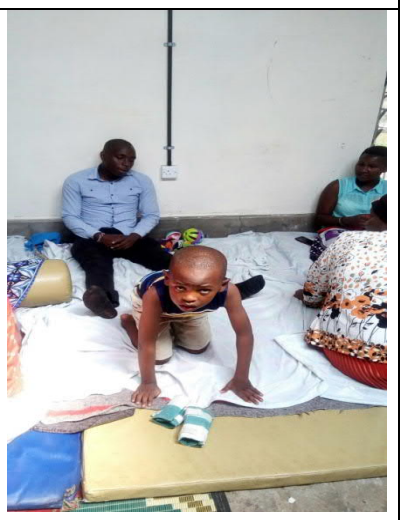
HIV infection and disability still remains a concern among this community and CHP will continue its services to the community.

Besides the ongoing programmes, more trainings targeting CHVs will be planned for 2018 for capacity building and also pastoral retreats to motivate and build their team spirit since they are the key persons in the community to reach clients.

11. PHOTOS GALLERY

Pictures of therapy sessions at our CBRP therapy centers



OUR CCC PHOTOS

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<tr><td>Our community CCC</td><td>Patients triaging room</td></tr>
<tr><td>  </td><td>  </td></tr>
<tr><td>Our staff receiving drug</td><td>On site testing at our VCT</td></tr>
<tr><td>  </td><td>  </td></tr>
<tr><td colspan="2">Picture of door to door community testing with our counselor</td></tr>
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TRAINGS

Pictures of beneficiaries training sessions at our center halls

Pictures of staff at a team building event

12. Financial Report

We present below the summary of the financial report for the year 2017. The conversion rate of the Kenyan Shilling to the Euro at the end of 2017 was around 120 Ksh per each 1 Euro.

With a quick look at the Income/Expenses report, we can realise that the amount of grants and donations received accounted only to 69% of the total expenses, meaning that we had to run 31% of the project in 2017 from the current assets of the previous year.

Concerning Incomes, 46% comes from oversees donors (Germany, Italy and Portugal), 38% from local donors and partners (CHAK and World Friends), 10% from local church Kariobangi Parish (including in kind such as rent, internet, water, electricity which are paid in bulk by the parish) and 6% from other income. An effort is also being put for 2 years now to increase cost sharing of the project, which in the reporting period amounts to 3% of the total income of the project.

Concerning the expenses, generally, they are as follows: Programme Expenses costs the project 79% of its total cost in 2017, while Administration accounts to 21%. As far as the programme expenses are concerned, Home Base Care DPTM (CCC) costs the project 71% of its total cost, Handicapped Department (CWD) costs the project 27%, while School Fees and Social Welfare and Insurance amount to 1% each.

12.1 Balance Sheet