CHAK TIMES
"FOR THE HEALING OF THE NATION"
A PUBLICATION OF THE CHRISTIAN HEALTH ASSOCIATION OF KENYA

CHAK: 1946 - 2016
Celebrating 70 years
of quality health care

Focus on

CHAK Annual Health Conference (AHC) 2016

In this issue...

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CHAK annual conference reflects on way forward to achieve SDGs

At the United Nations General Assembly held in September 2015, World Leaders including the President of Kenya, adopted the Sustainable Development Goals (SDGs), marking a transition from the former Mellinium Development Goals (MDGs).

The SDGs will guide the global development and social services agenda for the next 15 years. The SDGs have identified 17 priority goals (focus areas) each with a set of priority targets. Health is covered in Goal number 3 - Health and Wellbeing for All.

Each country is expected to adopt the SDGs, identify country level targets and align plans, policies and investment towards attainment of the SDG country targets.

Kenya would need to align both National and County plans to deliver on the SDG targets. Development Partners will also prioritize technical support, capacity building and financial support to these goals. All stakeholders in the relevant sectors are mobilized and encouraged to align their programmes and services to the country plans and to report their performance as a contribution to the national SDG targets.

Church Health Services remain key stakeholders in the promotion and provision of quality health care services and medical/nursing education with particular focus on the remote rural areas and the urban slums in Kenya.

Their services are aligned to the country health policies and plans and they contribute towards meeting the national and county health needs.

It is therefore important for Church Health Services to understand the new Global Development Agenda, the country level implications and opportunities for alignment and partnerships for scale up and greater impact.

Partnerships have been part and parcel of health sector engagement because health requires multiple funding sources. The national legal, health policy framework and strategic plans promote partnerships. Technology, innovation and research are best sourced from the private sector.

While partnering with academic institutions will support research, medical education and sharing of knowledge, media is key in public education, mobilization, advocacy and service monitoring.

Among the partnership opportunities for FBO Health services are:

- The Church and Faith Based Organizations
- Mission Partners
- Communities
- County governments
- MOH and the national health Institutions
- Private sector including financing institutions
- Development partners
- NGOs and CBOs
- Private Foundations and societies
- Academic and research institutions

The CHAK network therefore needs to reflect on the opportunities, best practices and strategies towards building strategic partnerships to achieve the SDGs health agenda.

The purpose of the CHAK Annual Health Conference 2016 was therefore to sensitize CHAK members and partners on the new SDGs and discuss their implication to Kenya and Church Health Services. The conference also explored the contribution of Church Health Services to the SDGs at county and national levels and discussed opportunities for scale up through partnerships.

The conference objectives were:

1. Share information on the new Global Sustainable Development Goals (SDGs)
2. Discuss implication of SDGs to health policy, plans and programmes in Kenya and impact on the FBO health sector
3. Explore opportunities for partnerships in capacity building, health systems strengthening and financing of faith based health services towards achieving scale up and improving quality
4. Discuss opportunities for partnership in medical education
5. Share lessons and best practices from CHAK and member health facilities in addressing communicable and non-communicable diseases
6. Create space for networking and experiences exchange

This issue of CHAK Times focuses on the discussions of the CHAK Annual Health Conference 2016, best practices, experiences and government actions and policies shared.

It is our hope that the reflections of the conference will provide vital lessons on the way forward towards achieving the SDGs.

CHAK – Kabarak University project to transform healthcare in Kenya

CHAK has developed a strategic partnership with Kabarak University which is motivated by shared Christian values and mutual interest of developing high quality Christian Health Services with a functional referral network and expansion of medical education.

The GE team led by Paul Morton, with CHAK GS Dr Samuel Mwenda, Philemon Kimutai from KABU, Friends Lugulu Hospital Board Chairman and members, Hospital Director and Management Team during the fact finding visit by GE and EGMF Team. Kabarak provided an helicopter to facilitate GE team visit to seven mission hospitals.

Medical education

Kabarak University has established a medical school with nursing, clinical medicine, laboratory sciences and pharmacy undergraduate programmes as well as a Family Medicine post graduate programme.

Following an MoU that was signed in 2014, a Family Medicine residency training programme was launched in September 2015 at Kabarak University.

Six doctors have joined the training programme that is being delivered in partnership with AIC Kijabe, Tenwek and PCEA Chogoria hospitals.

KABU School of Medicine is interested in expanding this training programme to include other CHAK hospitals and discussion has already been initiated with Maua Methodist Hospital, AIC Litein Hospital, AIC Kapsowar Hospital and PCEA Tumutumu Hospital.

CHAK has recommended its 23 member hospitals for consideration for this support towards infrastructure, referral and medical training development

A scholarship fund is available through INFAMED which is hosted by CHAK to support Family Medicine residents. CHAK is encouraging doctors in its member hospitals to take advantage of this opportunity to join the Family Medicine programme.

In addition, KABU Medical School has an interest in partnering with several CHAK Hospitals in clinical placements and training in other nursing and medical programmes.

CHAK considers this an opportunity to expand and diversify the nursing and medical training programmes being provided by member hospitals.

We are cognizant of the fact that some of our Churches that sponsor member hospitals have universities with ambitions to develop or expand medical and nursing programmes.

CHAK would therefore facilitate partnership engagement to discuss potential collaboration among all Church universities and Church health facilities in the training of health workers for Kenya and the region.

Infrastructure development and refferal system: Kenya Mission Hospitals Improvement Project" (KeMHIP)

'Towards transforming healthcare and medical education in Kenya through infrastructure development in mission hospitals and establishment of a service delivery referral and medical training network'

Project background

His Excellency the 2nd President of Kenya, Daniel Arap Moi who is also the Chancellor of Kabarak University has had the vision to develop a fully fledged Medical School for Kabarak University including a Teaching and Referral Mission Hospital.

Construction of the medical school complex is complete and several medical and nursing programmes have been launched including the post graduate Family Medicine specialization training.

His Excellency has donated 100

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CHAK – Kabarak University project

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acres of land for the development of an ultra modern 500-bed teaching and referral hospital in Nakuru and elaborate designs are complete.

In the fund raising process for the new modern teaching and referral Hospital, H.E. Daniel Moi has graciously allowed for extension of some of the funds raised from donors in the US to support infrastructure transformation of mission hospitals .

These mission hospitals will then be linked with the new AIC Church-affiliated Kabarak Teaching, Research and Referral Mission Hospital (KTRRMH) for referral and training.

CHAK recommended 23-member hospitals for consideration for this support. The complete project will also have two other KTRRMH satellite hospitals in Eldoret and Nairobi with a 250-bed capacity.

CHAK has been invited to join the partnership to represent the 23 member mission hospitals and has been integrated in the project development process and negotiations with the key project partners and donor representatives.

Project funding

The Ronda Project (as the initiative is referred to by development partners), is pursuing funding from global humanitarian donors in the US through support by mission partners in the US and General Electrics Hospital and Healthcare Solutions. The Kenya Government has also expressed its support.

Project goal

Transform mission hospitals capacity, infrastructure, systems and performance in delivering comprehensive, sustainable quality health care and medical education in Kenya

Philemon Kimutai, the project's coordinator and key liaison for KABU makes a presentation at the CHAK Annual Health Conference 2016. CHAK MHUs expressed their gratitude for the much needed assistance that is anticipated to come from the Kenya Mission Hospitals Improvement Project" (KeMHIP)

Project objectives

1. Develop a 500-bed capacity high-end teaching and referral mission hospital in Kabarak together with all support facilities including housing for students and staff and research centre
2. Develop two satellite 250-bed Hospitals in Eldoret and Nairobi
3. Expand, develop, improve and equip infrastructure in 23 CHAK member Hospitals
4. Develop or improve medical education facilities including faculty and student housing
5. Create functional and effective referral linkages between CHAK hospitals and Kabarak Teaching and Referral Mission Hospital
6. Build partnerships for medical education, clinical placements and research between CHAK hospitals and Kabarak Teaching and Referral Mission Hospital

The five-year project is expected to accomplish the following outputs by the completion.

1. Infrastructure development and or refurbishment including medical gases, electrical, water and sewer upgrading or installation
2. Equipment improvement through installation of new modern equipment
3. Management systems improvement including ICT infrastructure and systems

Key project structures

1. KABU and CHAK are project recipients and are responsible for providing project design briefs, Government approvals, tax exemption processing and ensuring necessary political support
2. General Electrics will be responsible for project leadership and technical leadership and provide all medical equipment and technology
3. An EPC contractor will be engaged

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CHAK General Secretary receives international health award

On June 19, 2016, CHAK General Secretary Dr Samuel Mwenda became the third recipient of the Christian Inrernational Health Championship Award.

The award honors an individual who has dedicated his/her life to global health from a Christian perspective and has made significant contributions to the field and to Christian Connections for International Health.

Dr Mwenda received the award at the CCIH Annual Conference held at Johns Hopkins University, Baltimore, Maryland, USA.

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Dr Mwenda holding the Christian International Health Champion Award with Prof Henry Mosley of Johns Hopkins University who presented the Award, Jane Kishoyian and Wanjiru, a conference participant.

CHAK – Kabarak University project

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to design, build and equip the approved project infrastructure to acceptable international standards

4. Project funding and financial management will be provided by CPA (Audit Firm) to be appointed by the donors
5. A Project Steering Committee will be established to guide the partnership and steer the project. Membership will be drawn from CHAK, KABU, GE, EPC Contractor and Project Managers.
6. The Chairman of CHAK will lead key linkages with the political leadership in Kenya and the vision leader
7. CHAK General Secretary is leading partners engagement and will be closely coordinating with Philemon Kimutai, former Administrator of AIC Kapsowar Hospital, who is serving as the project coordinator and key liaison for KABU, CHAK and the project partners.
8. Patrick Kundu will lead design work for infrastructure improvements for CHAK member hospitals in collaboration with the KABU design consultancy team.

Project phasing

Due to its magnitude, discussions are underway to undertake the project in a phased approach.

Phase 1: KTRRMH and three CHAK hospitals which have an ongoing medical education MoU with KABU (Tenwek, Kijabe and Chogoria)

Phase 2: The two new KTRRMH satellite hospitals in Nairobi and Eldoret and possibly four other mission hospitals already in discussion on training partnership with KABU – AIC Litein, AIC Kapsowar, Maua Methodist Hospital and PCEA Tumutumu Hospital

Phase 3: Will include the other mission hospitals and any works for the other hospitals which are deferred to this final phase

Medical equipment support could however be provided at any phase of the project based on GE technical guidance and upon donors'

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CHAK GS receives international award

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"Dr. Mwenda has been a transformational leader for faith-based organizations (FBOs) in Kenya and the African region," said Dr. Rick Santos, president and CEO of IMA World Health, who nominated Dr. Mwenda for the award.

"He has used his skills and passion to build the capacity of emerging health leaders and to advocate for the significant role of FBOs in delivering quality health services to the most vulnerable populations in Africa."

Under Dr. Mwenda's leadership, CHAK has made significant contributions to the national fight against AIDS with support from various programs funded by the US government and the Global Fund to Fight AIDS, TB and Malaria.

CHAK now supports over 41,000 clients with antiretroviral therapy, representing about nine percent of the total number of patients nationally. Kenya now has the second largest treatment program in Africa (after South Africa), with nearly 900,000 people on treatment at the end of 2015.

CHAK has now turned its attention to the new pandemic of NCDs, working on hypertension and diabetes.

In a new project supported by Novartis Access, CHAK will offer a portfolio of products to treat cardiovascular disease, diabetes, respiratory illnesses and breast cancer at a very subsidized price. The program is currently in three counties of Kenya and is expected to be in all 47 counties by the end of 2017. It will be in a total of 30 countries by 2020.

"A key learning from HIV programs was that you cannot build awareness until there is treatment," said Mwenda. "It's the same with NCDs. It's access to treatment that gets individuals and families to learn about heart disease and diabetes and to come forward for diagnosis. When people see others in their communities living long, healthy and productive lives despite NCDs, it makes them more willing to invest their own time and resources in treatment."

"Africa is rapidly overcoming the challenges of infectious diseases," said Mwenda. "I'm proud to say that much of that is due to the commitment of faith-based organizations, that provide about half of all health care in the countries south of the Sahara. I believe that the same God-given mandate that we had to conquer polio and AIDS requires us to get serious about diabetes and cancer."

Christian Connections for International Health (CCIH) is a membership association founded in 1987 to promote international health and wholeness from a Christian perspective. The CCIH network includes more than 300 individuals and approximately 200 organizations based both in the US and abroad.

In his acceptance speech, Dr Mwenda expressed his belief that the award was not just a recognition of his passion, commitment and contribution to Church health work. Rather, it was also an expression of his conviction that there was hope and great future for the contribution of Church health services to the Global Health Agenda and the under-served communities of the world from a Christian perspective.

The award honors an individual who has dedicated their life to global health from a Christian perspective and has made significant contributions to the field and to CCIH

Further, the award was a result of relationships, partnerships and the collective work of all, including the entire CHAK family. Dr Mwenda pledged to forever cherish the recognition which he would share with the CHAK family.

He also thanked God for the grace and opportunity to serve, learn and grow in the Healing Ministry of the Church and make a contribution to the Great Commission (Mathew 28:19-20).

"I am grateful to God for the tremendous organizational growth that we have accomplished at CHAK over the years through partnerships and process of continuous learning and strategy improvement," said Dr Mwenda.

He pointed out that CHAK had grown from a small humble local organization to an internationally recognized faith based organization that was regionally and globally connected.

"CHAK provides leadership for the Faith Based Health Services Coordinating Committee (FBHSCC) in Kenya which provides a platform for the coordination and joint advocacy for the FBO health service providers in Kenya (Protestants, Catholics, Muslims and MEDS). I chair the FBHSCC which spearheaded the development of MoU between FBOs and Government of Kenya in 2009 in an elaborate process that involved an expansive situation analysis study," he added.

Some of the material for this article has been adapted from http://www.olson-globalcom.blogspot.com/

Opportunities for Public Private Partnerships in the counties

Introduction and background

CHAK has a well developed county engagement strategy that has continued to guide the Association in its collaboration with the devolved government system introduced in Kenya in 2013.

Face-to-face meetings with health officials from various counties have yielded tangible benefits for member health units in the form of staff secondments, drugs and medical supplies. The Faith Based Health Services Coordinating Committee, of which CHAK is a member, is engaging the Council of Governors through its health committee.

It is in the light of CHAK's county engagement efforts that the Annual Health Conference sought to learn on the potential areas of engagement in Public Private Partnerships within the devolved government system.

PRESENTATION BY DR. WILLIAM M. MURAAH, B. PHARM; MBA (U.O.N) - CEC MEMBER FOR HEALTH - MERU COUNTY; CHAIR OF HEALTH COMMODITIES AND TECHNOLOGIES COMMITTEE

Definition of PPP

The term "public–private partnership" (PPP) describes a range of relationships between state and non-state entities in the context of shared risk and benefits. A strong PPP allocates tasks, obligations, and risks among the public/state and private partners/non-state actors in an optimal way.

The public partners in a PPP are government entities, including ministries, departments, municipalities or state-owned enterprises.

The private/non-state partners are either the local or international for-profit-private sector organizations, faith-based organizations, non-governmental organizations, community-based organizations, among others.

Why Engage in PPPs?

- To Mobilize private capital: This frees up more government Resources for Infrastructure and other services
- A tool to elicit greater efficiency: task, time and motion are the key variables
- Catalyst for sector reforms: These include legal, service (quality) standards, financing, among other reforms.

There is need for Kenya to embrace PPP as a financing mechanism. There are national (and county) PPP laws but no clear national PPP guidelines. There is also no independent national PPP commission

The main health sector PPP nodes are the National Treasury and National MoH.

The PPP life cycle

- Phase 1: PPP project identification, screening and selection

A strong PPP allocates tasks, obligations, and risks among the public/ state and private partners/non-state actors in an optimal way

Dr Muraah, CEC for health, Meru County, making his presentation at the conference.

- Phase 2: Completing the PPP feasibility analysis and risk allocation structure
- Phase 3: Conducting the PPP tendering and procurement
- Phase 4: Final PPP contract signing and financial closure
- Phase 5: Monitoring and ensuring post-award PPP performance

Types of PPP arrangements

- Resource sharing agreements
- Service level contracts
- Placement arrangements
- Build, Operate and Transfer (BOT)
- Hire purchase agreements
- Lease agreements and residual value transfer

A number of opportunities exist for PPPs in the counties. These include:

- Resource sharing agreement which could involve land for infrastructure development, health commodities and Human Resources for Health

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Resource mobilization through marketing and partnerships

AIC Kijabe Hospital's experience

PRESENTATION BY DR. MARY MUCHENDU - CEO, AIC KIJABE HOSPITAL

Term definition

Resources mobilization is best defined as the process of acquiring resources (people, money, goods, and services) in a manner which meets organizational needs and satisfies the giver that resources have been wisely and effectively used.

Resource mobilization is not begging but a management process whose emphasis is on:

- Organizational strategic plan
- Resources in general
- Continuous and long-term process
- Internal and external sources
- Impact can be felt through the organization
- Outputs are both tangible and intangible

KRNA simulation training at AIC Kijabe through ImPact Africa grant.

Not-for-profit organizations

Income partners for not-for-profit organizations include:

1) Individuals and churches
2) Companies
3) Foundations and t rusts
4) Statutory or government funding
5) Earned income

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- Service level contracts involving regular equipment maintenance, service delivery, HRH skills development, catering and laundry services
- Placement agreements for lab equipment, imaging equipment and human resources
- Build, Operate and Transfer (BOT) to complete health facilities, build imaging and lab centres, cancer treatment centres, Medical Training Colleges and manufacturing facilities
- Hire purchase for land, equipment and infrastructure
- Lease agreements for land, equipment and infrastructure where the residual value remains with the providers. This is the most complicated PPP approach which is also very risky and expensive.

In Meru County, the following are potential areas of health investment:

- Equipment placement
- Building of private hospitals
- Building of a linear accelerator for radiotherapy
- Manufacturing of health commodities

AIC Kijabe Hospital case story

Mission

To glorify God through the provision of compassionate health care, excellent medical training, and spiritual ministry in Jesus Christ.

- Mission pillar 1: Target the most vulnerable hence the hospital offers services at subsidized rates, making resource mobilization a must.
- Mission Pillar 2: Train healthcare professionals to meet internal as well as Sub-Saharan Africa needs.
- Mission Pillar 3: Emphasis on the anchor-Jesus Christ - and launching pad of all of our undertakings. This is an ethical base that cuts

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Fund raising through partnerships

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across all the hospital does including resource mobilization.

Resource mobilization categories

1) Financial resources
2) Human resources
3) Organizational resources
4) Infrastructural resources: Current needs include the medical gases plant at Ksh90 million and development of Kijabe College of Health Sciences at over Ksh500 million.

Elements of resource mobilization

Organization management and development

- Identified roles for board, management and staff members
- Effective management of human, material and financial resources
- Designated positions and department for resource mobilization
- Strategic plan addressing stewarding of resources at hand
- Identification of future viable sources

Marketing: Communication and prospecting

The key words here are connecting and discerning.

- Connecting with 'potential donors in a manner and using a language they understand. This is finding a common ground for sharing values and interests. This is friendly-raising through key messaging.
- Discerning the right potential donor to approach and matching them with an appropriate resource mobilization strategy.

Social media, blogs, email, websites and newsletters are some of the platforms that can be used in marketing.

Relationship building

This is a three step process that involves:

- Initiating contact
- Growing 'depth'
- Long-term commitment

NOT-FOR-PROFIT ORGANIZATIONS
No goods sold but services/values to community

It would be prudent to move the masses from the bottom of the pyramid to the top and make them significant givers and partners.

It is also prudent to present different donation options.

AIC Kijabe Hospital success stories

- Partnerships in infrastructure projects have yielded several successes including water storage facilities and a water treatment plant.
- A Public-Private Partnership led to placement of a CT scan machine in the hospital.
- Mission agencies partnerships have yielded human resources including:

a) Long-term missionaries

b) In 2015, the hospital had help from 130 persons including 73 visiting short term consultant doctors, 43 visiting residents from UoN, Vanderbilt, UTMB, Cameroon, Australia and 31 medical students from Kenya and overseas.

c) There is also the KCHS-training Hub supported by FUNZO

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Fund raising through partnerships

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Kenya.

- Kenya Government Partnership has seen the hospital benefit from medical officer and clinical officer interns.
- There are also foundations and multi-agency partnerships.
- Watsi is a crowdfunding platform through which 17,898 people have funded healthcare for 7,572 patients in 23 countries including Kenya and in AIC Kijabe Hospital.

Water Storage

Wastewater Treatment Plant

Partnerships in infrastructure projects have yielded several successes.

- Friends of Kijabe Foundation-USA/Kenya: Through this platform, individual international donors have raised funds for infrastructure projects and needy patients. About Ksh25 million was raised in 2015.

Kenya Medical Laboratory Technicians and Technologists Board

Who is KMLTTB?

The Kenya Medical Laboratory Technicians and Technologists Board is established under Cap 253A of the Laws of Kenya.

Legal Notice 113 of 2011 gives the Board the mandate to regulate all in-vitro diagnostics to be used in the country. in addition, the Board also screens, validates, certifies and registers products to be used in laborotary science practice. It regulates the professional conduct of medical laboratory scientists, licenses and regulates business practices in medical laboratory science, inspects and approves institutions to train in medical laboratory science and registers medical laboratory technicians and technologists to practice.

The CHAK network has hundreds of laboratories and requisite professionals working in them. There are also institutions that train laboratory technicians and technologists within the CHAK network.

The CHAK Annual Health Conference was therefore delighted to hear from a representative of the Board who also sought to clarify several matters with regard to the member health facilities.

Role of KMLTTB in health service delivery

KMLTTB's Mandate

The KMLTTB has the mandate of general supervision and control over the training, business, practice and employment of laboratory technicians and technologists in Kenya (CAP 253 A). It also advises the Government in relation to all aspects of the above mandate.

Vision

An accountable, effective and efficient regulatory body promoting quality medical laboratory services for all

Mission

To protect the health of all Kenyans by ensuring compliance with standards for training, research, practice and business in medical laboratory services

KMLTTB policy documents

- CAP 253 A
- Strategic Plan 2012-2017
- CPD guidelines

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Kenya medical laboratory board

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Functions of KMLTTB

- Indexing
- Examinations
- Registration and renewals
- Laboratories
- Continuing Professional Development
- Validation

Achievements

- Registration of 11,630 medical laboratory professionals
- Retention of 4525 (39 per cent) professionals in 2016
- Registration of 1863 laboratories
- Retention of 486 (26 per cent) laboratories in 2016
- Registration of 10 universities to train degree MLS
- Registration of 30 colleges and technical institutions to offer DMLS
- Establishment of standards for infrastructure
- Approval of five institutions to provide continuous professional development (CPD)
- KMLTTB portal available in Kenya National Electronic Single Window System (KENESWS)
- Registered 156 vendors
- Successful review of MLS curricula for the three levels of training
- Harmonization of MLS curricula for EAC partner states-winding up certificate training
- Strengthened communication using various media

KMLTTB has the mandate of general supervision and control over the training, business, practice and employment of laboratory technicians and technologists in Kenya

The KMLTTB representative at the CHAK Annual Health Conference making his presentation.

Challenges

- Some institutions are offering MLS courses without KMLTTB approval.
- There have been cases of people masquerading as laboratory professionals.
- Existence of unregistered medical diagnostic, research and teaching laboratories
- Failure of laboratories to comply with validation of their equipment, reagents and in-vitro diagnostic
- About 61 per cent of professionals and 74 per cent of laboratories registered do not renew their annual licenses.
- County governments are assuming the regulatory function.
- There are competing interests from other institutions on statutory mandate.

Looking forward

- Professional licenses will be renewed online once after three years.
- Promote partnerships and enhance advocacy for regulatory compliance
- The Act needs to be renewed in tandem with the Constitution.
- Renewal of licenses will be based on attainment of minimum CPD points.
- Establishment of regulatory liaison offices in different regions of the country
- Enhance ISO 15189 certification compliance

Promoting quality, patient safety and customer satisfaction

Introduction

Quality improvement in health care is currently a priority objective in Kenya. In 2012 the Department of Standards and Regulations under the Ministry of Health (MoH) launched the Kenyan Quality Model for Health (KQMH).

CHAK is not only a member of the Technical Working Group (TWG) that supports the Department of Standards and Regulations in sensitization and awareness creation on KQMH but also contributed to the development of the curriculum for Trainers of Trainers (ToTs) in quality model of health that will be used in health facilities throughout Kenya.

This program is supported by Bread for the World, with the assistance including one full time technical advisor.

The KQMH is currently under review, and CHAK is a key participant in the process, focusing on success and active implementation of the KQMH not only in the government health facilities but also in the private and faith based health facilities.

Quality management has the potential to increase CHAK's competitive edge, improve customer satisfaction and hence grow the market share of the CHAK network. It will assist CHAK health facilities to manage external factors more effectively, enhance communication and inculcate continuing improvement.

In addition, Health facilities are being audited by NHIF for accreditation purposes and to determine their rebates level.

The CHAK quality management programme will be implemented in the 20 largest CHAK hospitals as a start before rolling out to the smaller ones.

The objective of the project is to improve the overall quality of health care systems and services in CHAK member health facilities and also to contribute to the Kenya Quality Model for Health nationally.

Two implementing CHAK member units - PCEA Tumutumu Hospital and PCEA Chogoria Hospital shared their achievements in quality management during the CHAK Annual Health Conference as follows.

P.C.E.A Tumutumu Hospital

A Quality Improvement Team (QIT) and Work Improvement Teams were formed to perform the mandate of quality improvement in the hospital.

Mandate of the Quality Improvement Team (QIT)

- To align the current patient care in the hospital with the Kenya Quality Model for Health
- Focus its activities on improving patient care services in all departments in the hospital

Quality management has the potential to increase the competitive edge, improve customer satisfaction and hence grow the market share of the CHAK network

QIT activities

- All the current activities of the team are based on the KQMH.
- One of the main activities is promotion of the 5S in all departments so as to improve the working areas/environment.
- This is mainly accomplished by:
  - Formation of Work Improvement teams (WITs) covering all the departments
  - Strengthening and supporting the WITs in different departments
  - Conducting spot on assessments (by QIT) periodically

Achievements

Trainings

- All staff in the hospital have a knowledge base in KQMH.
- Heads of Departments have been trained in all four modules of KQMH in more detail.

Work Improvement Teams (WITS)

- The QIT has facilitated the formation of WITS in the following areas:
  a) Nursing
  b) CCC
  c) Clinical/OPD
  d) Finance
  e) Training college
  f) Administration

Guidelines for WITS

a) The WITs are to hold a minimum of one meeting every month. All such meeting should be documented and a copy of the minutes handed over to the secretary of QIT.

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Promoting quality assurance

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b) QIT would be holding quarterly meetings with the WIT leaders to check on the progress.

c) The QIT would be available to offer any support deemed necessary by the WITs

d) A major part of the role of WIT's is to implement the 5S.

e) WITs can co-opt any other staff that they feel to be helpful in executing their duties

Progress thus far by WITS

- Most of the WITs have shown some progress in conducting meetings and forwarding the minutes to the QIT. The best examples are CCC, training college, nursing and finance.
- Generally, all WITs need to be supported to carry out their mandate.

Questionnaires for continuous quality improvement

The Quality Improvement Team has developed several questionnaires that are used to collect data on the quality of care and on customer satisfaction which are later analysed.

Patient safety

Sub committee

The infection prevention and control committee (IPCC) was formed in October 2013. The team is chaired by the in-charge of laboratory department

Key issues to be delt with

• Continuous

Periodic assessment of quality of services in all departments

• Short term

a) Strengthening all WITs

b) Formulating questionnaires for other areas of assessment

• Medium term

a) Having a periodic way of carrying out the assessments

b) Finalising and implementing on the processes for all departments, through the WITS

• Long term

Management of documents for the institution

PCEA Chogoria Hospital

PCEA Chogoria Hospital is situated within the fast growing Chogoria township in Mwimbi Division, Tharaka-Nithi County of the former Eastern Province. It is about 200km north of Nairobi city along the Embu-Meru highway.

The Hospital was established in 1922 by Scottish missionaries and is owned by the Presbyterian Church of East Africa (PCEA). The Hospital has a 295 bed capacity and focuses on the provision of curative, preventive and promotive health care services in the region.

Chogoria Hospital is the largest non – govermental employer in the Meru South district (currently Tharaka – Nithi County)

Quality Journey 2015/2016

Where we are in 2016?

- Our culture is now more focussed on frontline service delivery.
- We are also focused on making changes and improvements that make a difference for our patients.
- Involvement of patients and staff in planning and execution of services has improved immensely

Quality assurance

The following has been achieved in quality assurance:

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CHAK TIMES issue 50

Call for Articles

The topic for the next issue of CHAK Times is "CHAK @ 70".
We invite articles, photographs, experiences and letters from our readers on this subject. CHAK member health units are also invited to send information about the services they offer, training activities, new projects, job vacancies and other developments that they wish to share with the rest of the network.

Send your articles to:
The Editor, CHAK Times
P.O. Box 30690 - 00100 GPO, Nairobi
Email: communications@chak.or.ke

To reach the editor by October 15, 2016

Promoting quality assurance

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- Appointment of an fulltime Quality Improvement Officer
- Performed 5s (Set – Sort – Shine – Standardize – Sustain) audits
- Documentation of quality management system in progress while working closely with quality health systems consultant from CHAK
- Formulated a Quality Policy Statement, Quality Manual, Control of Documents
- Reviewing procedures e.g. admission, transfer/referrals and discharge

Quality improvements

- Has introduced a quality role in the procurement process by appointing the Quality Improvement Officer to the procurement committee
- Key performance indicators (KPIs) in evaluating performance in service delivery to be reported in the financial year
- Conducts regular morbidity mortality review meetings
- Developed a form for items "In Use, Rarely in Use, Will Never be Used" and Auctioned the written off items to create space.

Patient safety

- Established Infection Prevention Control policy that conforms to Ministry of Health guidelines
- Strengthened the Medicines and Therapeutics Committee (MTC) to ensure pharmaco-vigilance (i.e. Adverse Drug Reaction, Irrational Drug Use) and drug management in the hospital
- Established Medication Error Reporting to collect data and make informed decision

Customer satisfaction

- Reviewed patient charters to conform to the MOH charter and displayed them at strategic places
- Patient surveys are done on a quarterly basis and feedback sent to management to act upon
- Increased number of suggestion boxes at all service points to allow suggestions, complements and complaints

Staff

- Staff opinion survey and feedback mechanism
- Focused on health and wellbeing e.g. through revised medical cover for staff - Akiba

5S Audit at PCEA Chogoria Hospital

Before

After

Reproductive, maternal and child health at Kima Mission Hospital

Presented by Susan Korir - Health Systems Manager, Kima Mission Hospital

Introduction

Kima mission hospital is a nonprofit making faith based organization started in 1936. The hospital is situated in Luanda Sub County, Vihiga County.

Initially, it was a missionary hospital until 1980. Later, it became a general public hospital sponsored by Church of God

The hospital caters for all patients who pay out of pocket and NHIF contributors.

Demographic profile

The catchment population of the area is 5040 while the number of women of child bearing age (15-49 years) is 1126. The number of children under one year (0-11 months) is 209 while the number of children under five years (0-59 months is 809. The estimated number of pregnant women is 420.

Mission

To promote and participate in the provision of integrated and high quality promotive, preventive, curative and rehabilitative health care services to all Kenyans.

Vision

An efficient and high quality healthcare system that is efficient and accessible to every Kenyan.

Core values

- Integrity
- Commitment to service
- Visionary
- Teamwork
- Accountability
- Empowerment

Services offered

- MCH/family planning services
- Outpatient services
- Laboratory services
- Comprehensive care services-HIV/AIDS care
- Maternity services
- Inpatient services
- Intergrated outreach services

Reproductive health

Introduction

Reproductive health is a state of physical, mental and social wellbeing in all matters relating to the reproductive system, at all stages of life.

Kima hospital respects this principle and offers services to people at all stages of life.

Services offered in RH/FP

- Focus Antenatal Care
- Delivery
- Post natal care
- Post abortion care
- CCC
- Family planing
- Cancer screening
- PMTCT

Antenatal care

Kima offers care to all pregnant women. Clients are encouraged to start clinic as early as 12 weeks and HIV testing and counseling is done.

The hospital also provides prevention of mother to child transmission services. Full HAART is started to those who turn positive according to the current guidelines.

The hospital also offers counsel on birth plans and family planning options. Other services offered are as follows:

- Nutritional counseling and monitoring
- IPT
- LLTN
- Tetanus toxoid

Cancer screening

This service is offered to all women of child bearing age who are sexually active. The total number of clients screened from January to March 2016 is 300

Clients who turn positive are referred for further investigation and management.

E2A family planning project

The hospital has been working hand

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Category	Baseline	Target	Achievement
CHVs trained	0	10	10
Religious leaders trained	0	10	10
HCWs	1	2	3
No of clients reached by religious leader and community health volunteers	0	10,000	15,910
New users	52	150	304
Revisits	211	450	633

E2A Family Planning project achievements at Kima Mission Hospital (March - December 2015)

Laboratory ISO certification process and impact on quality

PCEA Chogoria Hospital's experience

Presentation by Priscilla Ndung'u - PCEA Chogoria hospital

What is accreditation?

It is the process by which an authoritative body (accreditation body) gives formal recognition that an organization is competent to carry out specific tasks (tests).

Chogoria Hospital's journey towards accreditation started in 2012 with the support of Global Public Foundation. The CLSI/CDC came on board in 2012. A baseline assessment of the hospital lab was done in March 2014 and the lab obtained 2 stars. Mentorship then began on documentation of the QMS and training A midterm assessment was done in October 2014 and the laborotary received 3 stars.

A final assessment was done in April 2015 and the lab was awarded 4 stars. The hospital worked on non-conformities and submitted the documents for review to KENAS in September 2015.

An assessment was done in November 2015 and recomended the lab for accreditation subject to closure of identified non conformities within one month

The lab worked tirelessly to close the non conformities and an assessment was done in December 2015.

Accreditation

In April 2016, the hospital received a letter confirming that the PCEA Chogoria Hospital Laboratory was ISO 15189:2012 certified

Impact of accreditation

- Improvement in the management of laboratory services demonstrating high standards
- Improvement in areas such as supply chain, training, and equipment maintenance.
- Reduction of testing errors
- Timely reporting
- Proper documentation
- Dependable results
- Confidence in the lab leading to increased clients

Lessons learnt

- Involvement of and support by management is critical
- Staff involvement is also crucial
- Improvement is continuous
- Monitoring is needed

Reproductive health at Kima hospital

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in hand with CHAK- E2A (Evidence to Action) family planning project

The project started in March 2015 and will go up to March 2016.

A total of 10 religious leaders were trained on advocacy for demand creation and information while 10 CHVs were trained on community counselling and distribution of FP methods.

Achievements

- Increased number of clients using FP methods
- Male involvement in family planning has increased
- Improved skills of health care providers on contraceptives
- Value clarification and attitude transformation has been achieved especially with the religious leaders.
- Dissemination of FP messages has increased in the community.

Challenges

- Inadequate space for FP services
- High turnover of service providers due to poor motivation
- Inadequate FP commodities.
- Poor motivation of community health volunteers and religious leaders.

Recommendations

- CHAK to support improvement of infrastructure
- Enhance advocacy for improved supply of FP commodities
- Assist in equipping theatre to reduce referral
- More projects to be rolled out in Kima Mission Hospital
- Support with ambulance for prompt referrals
- More capacity building is needed for the staff due to high turnover.

AIC Litein records rise in number of patients under NHIF cover

PRESENTATION BY ERICK LANG'AT - AIC LITEIN HOSPITAL

Introduction

AIC Litein Hospital was registered as a fully-fledged hospital in 1990 and currently has a 200 - bed capacity. The newly completed hospital building is now in use. It operates as a level four hospital. The facility provides promotive, preventive and curative services to a population of about 600,000 people. The sections under curative include operating theatres, outpatient and inpatient and rehabilitative.

NHIF outpatient universal scheme

Background

The majority of Kenyans cannot access quality health care services due to high costs. It has become apparent that although health is a basic human right as enshrined in the 2010 Kenya constitution, only financially able individuals can access good health care.

Yet, for whatever reasons, ignoring the health problems of any nation can lead to needless suffering economically, socially and physically. The net effect of this neglect would be devastating complications in an individual's wellbeing with financial and social costs that significantly reduce quality of life. Consequently, this phenomenon produces an economically weak nation.

The National Hospital Insurance Fund (NHIF) is the primary provider of health insurance in Kenya, with a mandate to enable all Kenyans to access quality and affordable health services.

NHIF capitation numbers for AIC Litein Hospital

- July – September 2015 - 6,919 clients
- October – December 2016 – 21,469 clients
- January- April 2016 – 23,251 clients

Reasons for the rise in patient numbers

- Branding the hospital
- Door-to-door campaigns
- Introduced customer care desk
- Recruiting staff from different companies into NHIF with Litein Hospital as their preferred service provider
- Fast and quality service
- Drugs availability 24/7
- Introduced NHIF outpatient office
- Engaging county government to pay NHIF fee to the elderly, needy, vulnerable people

Challenges

- The system cannot account for children over 18 years and still under the custody of the parent.
- There has been movement of clients from hospital to hospital yet the capitation fee is issued quarterly. Some hospitals are serving patients who have not been paid for.
- NHIF blocked the module where it showed the number of clients subscribed to a facility. These hinders decision making and planning.
- Ksh100 per visit is not enough to serve a client fully.
- Connection down-time: The NHIF portal frequently crashes, making verification difficult.
- Fraud – This is a vice that is hard to

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AIC Litein Hospital NHIF home page.

Kendu hospital making a difference in high HIV prevalence zone

PRESENTATION BY GEORGE OPUNDO - CEO, KENDU ADVENTIST HOSPITAL

The Comprehensive Care Centre (CCC) at Kendu Adventist Hospital, though under AIDS Relief Kenya since its inception in 2005, is one of the sites in Nyanza and Western regions that were taken over by the Kenya AIDS Response Program, a constituent programme of Kenya Conference of Catholic Bishops in 2011.

Funding for the CCC comes from PEPFAR, through CDC to KCCB.

Over the years, the CCC has strived to provide quality and sustainable service to clients who are HIV positive in Rachuonyo-North, Rachuonyo-South sub counties and their environs in Homa-bay County.

Partnerships

Some of the key partners include:

- Community
- Community Health Workers
- Ministry of Health, Homa-bay County
- CDC
- KCCB/KARP
- CHAK

Key services offered

These are offered at the main site located at KAH and in the satellite at Wire.

- Pre test/post test counseling
- Enrolment into care and treatment
- Elimination of mother to child transmission
- Cervical cancer screening
- Defaulter tracing
- Home visits
- Linkage to support groups
- Community mobilization and outreach
- Follow ups
- TB care and treatment

The KAH CCC team

- 1 project coordinator
- 1 project accountant
- 7 clinical officers
- 8 nurses
- 4 pharmaceutical technologists
- 7 data managers
- 8 support staff
- 7 social workers
- 2 lab technologists
- 2 drivers
- 7 PITC counselors
- 2 peer educators

Other highlights

Homa-Bay County has the HIV highest prevalence rate in the country at 27.1 per cent (KAIS 2012).

KAH has therefore taken the following measures:

- Ensure 100 per cent and 80 per cent testing in IPD and OPD respectively as per national guidelines
- Initiation of rapid results/response initiative in testing
- Institutionalize early infant diagnosis and family/partner testing among others
- Ensure initiation of all HIV positive clients on HAART
- Harmonization of data from IQ care, DHIS,ANC, PMTCT and MOH registers for accuracy

Some achievements

- Improved quality of care
- Retention rate has gone up
- Prompt and effective investigative tests
- The required staffing is present
- Due-to-refill-concept patient wait-

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eradicate but it can be managed.

Recommendations

- There is need for the hospital to be given access rights on the capitation list module.
- There need to have photos of all clients and their ages to avoid fraud.
- Solutions or a back-up plan in case of downtime is urgent.
- Excess fees need to be paid within the quarter.
- NHIF should consider broadening the services to cover dental and optical.
- The monthly capitation per patient may have to be raised from Ksh100 to around Ksh200.

Kendu in high HIV prevalence area

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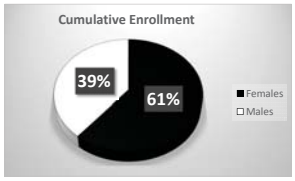
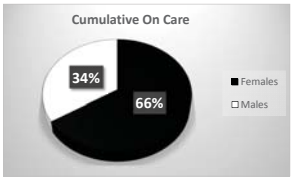
Statistics (as at March 31, 2016)





Cumulative Enrollment	
Females	7,486
Males	4,806
Total	12,292

* 7,703 clients currently on ART

Cumulative On Care	
Females	3,219
Males	1,665
Total	4,884

* 21% of the above are children

ing time has been reduced significantly.
- Positivity rate in PMTCT has declined.
- Integration of laboratory services with the hospital
- Linkage of HIV positive clients with other facilities is at 90 per cent.
- Children linkage and coverage is at 100 per cent.
- PMTCT coverage at Wire clinic is at 100 per cent.

Challenges
- Difficulty in following up the fishing community under MAPS, thus more defaulters
- Re-infection of clients
- Cultural beliefs
- Socio-economic challenges
- Delay in receiving viral load and PCR results
- Worn out/depreciating equipment
- Full integration of MCH/PMTCT and pharmacy yet to be realized
- Inadequate staff capacity building systems
- Lack of refresher courses for technical staff
- Mobilization

Non –communicable diseases in Kenya: What needs to be done?

BY DR. MARTIN MWANGI - DIVISION OF NON-COMMUNICABLE DISEASES

Introduction

The trend of non-communicable disease has changed in Kenya with a rapid increase over the years. This rapid increase has primarily been influenced by adoption of unhealthy lifestyles such as:
- Physical inactivity
- Unhealthy dietary habits
- Tobacco use
- Harmful use of alcohol
- Environmental exposures to harmful agents

Why focus on NCD care services?

1. The risk factors are becoming common. These risk factors include:

Lifestyle factors:
- Unhealthy diet
- Physical inactivity

Studies have shown a correlation between physical inactivity and the following outcomes:

a. Depression
b. Type 2 diabetes
c. Heart disease
d. Stroke
e. Hypertension
f. Colon cancer
g. Breast cancer
h. Osteoporosis
i. Obesity
j. Arthritis
k. Premature death
- Excessive alcohol consumption
- Smoking
- Physiological association including increasing age, overweight and

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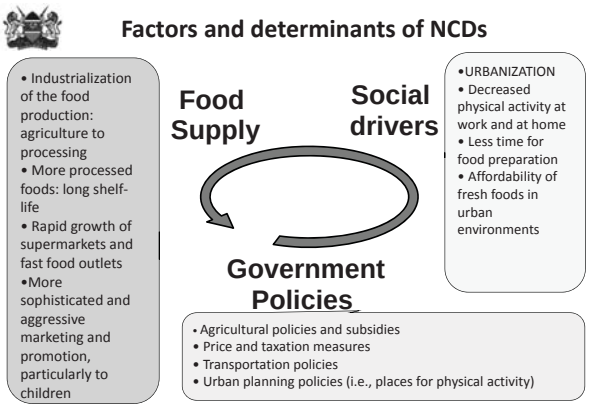

Nutrition transition: As incomes rise and populations become more urban, societies enter different stages of what has been called the nutrition transition.

Generally, diets high in complex carbohydrates and fiber give way to diets with a higher proportion of fats, saturated fats, and sugars. These shifts in diet structure accompany demographic shifts associated with higher life expectancy and reduced fertility rates.

An associated epidemiologic transition also takes place as patterns of disease shift away from infectious and nutrient deficiency diseases toward higher rates of obesity, coronary heart disease, non-insulin dependent diabetes and some types of cancer.

Government action on NCDs in Kenya

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obesity and stress

2. Numbers are increasing every year

It is estimated that the mortality due to CVD in Kenya ranges from 6.1 per cent (NHSSP) to 8 per cent (WHO NCD fact sheet 2014).

The prevalence of diabetes is about 4.7 per cent (2.7 per cent in the rural and 10.7 per cent in urban areas).

The annual incidence of cancer is close to 37,000 new cases with an annual mortality of over 28,000.

3. The current NCD care in Kenya needs to be organized because it is:

- Episodic than continuous
- Reactive rather than proactive
- Sporadic rather than planned
- Provider centred rather than patient centred
- Hospital based rather than community
- Not children and youth friendly

4. Low Public Awareness

There is low public awareness of NCDs, their risk factors and available treatment and prevention options. For example, only 27.2 per cent of the population has good knowledge of diabetes while only 41 per cent of the population have practices that promote diabetes prevention. (Maina et al., 2010)

5. No Elaborate screening programs

Screening of NCDs is not routine in clinical practice with 60 per cent of cases missed at presentation. Majority of patients present late often with irreversible complications, a direct result of poor health seeking behavior in the community.

Frontiers of the NCD war

- ***Economics vs accounting thinking in public health:***

Health is abnormal good that does not follow the demand supply curve. Resources for health care are limited. In economic thinking we look at the most efficient way of distributing these scarce resources through cost efficiency analysis. Accounting distributes resources without considering the scarcity.

- ***Poverty reduction:***

There is a clear link between social inequalities and ill health.

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NCDs are a key part of SDG 3 on ensuring healthy lives and promoting well being at all ages.

Government action on NCDs in Kenya

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- ***Gender and youth agenda:***

The woman bears the greatest brunt of the NCD burden.

- ***Economic, social cultural, health system, geographical and religious barriers***
- ***Information***

1. Patient level: It is not what we know; it is how much it influences our behavior and choices

2. Health system level: Investment in HMIS and strengthening of vital registration systems

- ***Appropriate and bold legislation***
- ***Advocacy***

Proposed interventions to combat NCDs

- To create platforms for advocacy and awareness on NCD prevention and care across all sectors of the society
- Establishing an innovative chronic care model for NCD service delivery at the primary care level
- To build the capacity of primary health care workers to provide NCD care services
- To develop and update clinical guidelines and protocols
- To develop strategies geared towards strengthening screening, diagnosis and care of NCDs
- Ensuring availability of essential NCDs medicines and technology at the national and county levels.
- To strengthen platforms for public private partnership to address challenges posed by NCDs
- To strengthen NCDs data collection and reporting
- Engage relevant stakeholders to develop policies and legislation on NCDs prevention and care

SDG 3 on health deals extensively with NCDs

- **Target 3.a:** Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate
- **Target 3.b:** Support the research and development of vaccines and medicines for the communicable and NCDs that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all

Focus on NCDs by SDG 3 shows they are global health concern.

- **Target 3.4:** By 2030, reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and wellbeing
- **Target 3.5:** Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
- **Target 3.8:** Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for al

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Government action on NCDs in Kenya

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Analysis of policies – What the MOH is doing to address the determinants of NCDs

NO.	PROPOSED ACTION	CURRENT SITUATION
1.	Kenya National Strategy For The Prevention And Control Of Non-communicable Diseases, 2015 – 2020	Mainly focusing on the four major non-communicable diseases: Cardiovascular diseases, cancer, chronic respiratory diseases and diabetes Also focusing on their four shared behavioral risk factors—tobacco use and exposure, unhealthy diet, physical inactivity and harmful use of alcohol.
2.	Strategic plans	National diabetes strategic plan available 2010 - 2015 (Needs revision) Cancer strategic plan available
3.	Diet and physical activity policies	Healthy diets and physical activity guidelines finalised and awaiting printing National action plan on physical activity being developed
4.	Policies influencing food environment	Trans fats regulation almost finalised. To follow are salt and fat reduction standards

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Government action on NCDs in Kenya

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NO.	PROPOSED ACTION	CURRENT SITUATION
5.	Policies influencing marketing of unhealthy foods and non-alcoholic beverages to children	Not in place but there is an urgent need
6.	Policies influencing initiatives leading to consumption of fruits and vegetables	Incorporated in the guidelines for healthy diets and physical activity but not explicit.
7.	Social marketing campaigns/media campaigns	Mainly occurs during the UN recognized health days e.g. World Tobacco Day, World Diabetes day, World Cancer Day, e.t.c. Sometimes Ad hoc mainly media triggered
8.	Policies targeting reduction of tobacco use	Ratification of FCTC 2004 Tobacco control Act 2007 Tobacco National action plan due for review Tobacco control policy Signing of ITP (Protocol to eliminate illicit trade in tobacco products)
9.	Development of clinical guidelines	Cancer treatment guidelines available Diabetes treatment available Hypertension treatment protocol available (partner guided) CVD management guidelines being developed Training curriculum for health care providers on diabetes and hypertension available, needs update

Healthy Heart Africa project addressing hypertension burden

Overview

The Healthy Heart Africa (HHA) project was created by AstraZeneca to tackle hypertension in Africa.

The ultimate aspiration of the programme, launched in October 2014, is to reach 10 million hypertensive patients across Africa in the next ten years, supporting the WHO global hypertension target (25 per cent reduction by 2025).

Kenya is the first implementation country for HHA. In Kenya, the prevalence of raised blood pressure (BP) is estimated at 24 per cent, with the highest prevalence reported among those aged 60-69 years (53 per cent) [Kenya STEPwise SURVEY, 2015 Report].

In a study conducted in Nairobi, about 20 per cent of people were aware of their hypertension status and of this, about 20 per cent were able to control it (Van de Vijver et al., 2013).

Building on existing health systems, the initiative supports three pillars of activities.

Pillars of Activities

1. Education and awareness

This involves conducting prevention and disease awareness raising activities that will encourage people to live healthier lifestyles and seek screening and diagnosis when needed.

2. Provider training and guidelines

This involves:

- Training community health volunteers (CHVs) and religious leaders on creating awareness on hypertension
- Training CHVs on screening for hypertension
- Training health care workers to provide comprehensive and appropriate hypertension care, based on guidelines developed in collaboration with professional societies and the Kenyan Ministry of Health

3. Access and affordability

This involves strengthening the supply chain (from MEDS to the health facilities) and ensuring patients can access affordable, high-quality antihypertensive medication.

Project implementation

HHA being implemented for an initial period of 18 months after which successful components will be scaled up.

Partners in HHA are AstraZeneca, CHAK, AMPATH, AMREF Kenya, PSK, Jhpiego, Mission for Essential Drugs and Supplies (MEDS), Abt Associates and newly Kenya Conference of Catholic Bishops.

CHAK is implementing the

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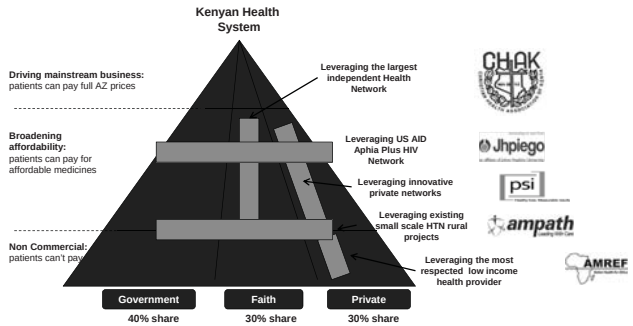

The implementation plan is to "learn by doing".The project is starting by running a number of demonstration projects in Kenya

Addressing the burden of hypertension

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project in 23 counties in 113 level 4, 3 and 2 facilities.

The CHAK project has trained 450 CHVs, 134 religious leaders and 329 HCWs.

Implementation strategies

• Community based strategies

1. Community mobilization and health education to raise awareness, prevention and treatment and control of hypertension by community health workers and religious leaders
2. Screening of high blood pressure for early diagnosis of hypertension at community level
3. Creating linkages between the community and health care facilities
4. Promoting health facility and community based support groups for hypertension patients in order to improve compliance with lifestyle changes and antihypertensive medication

• Health facility based strategies

1. Capacity building for health facility staff to ensure effective management of hypertension
2. Post-training onsite mentorship and On Job Training by the project technical team

• System based strategies

1. Capacity building of health care providers

One key reason why hypertension prevention and treatment services are not available in CHAK health centers and dispensaries is lack of skills and competencies among health care providers to manage hypertension.

Community screening through the Church.

As a result, nurses and clinical officers in lower level health care centers were discouraged from treating hypertension patients. This had a negative impact on access, screening, treatment and care services for hypertension patients in the peri-urban and rural areas.

The HHA project has collaborated with the Ministry of Health (MOH) to develop hypertension screening, treatment and care guidelines to support task shifting in order

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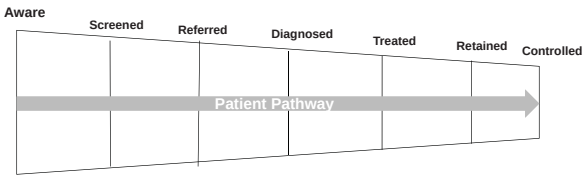
Patient Pathway



Addressing the burden of hypertension

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to increase access to these services.

2. Data

The HHA project targets to develop/ improve and roll out an effective MIS for NCDs and specifically hypertension to ensure that data is collected and the information used for decision making in prevention, care and treatment of hypertension. This will include the development of national data collection and reporting tools, mechanism to review the service level data for use in decision making by the service delivery points and for programmatic management.

• CHAK developed an electronic Hypertension Module which has been rolled out to facilities with electronic medical records systems either the CHAK-HMIS or independent facility HMIS. This upgrade is free for facilities and we encourage facilities to take this to improve data collection and quality.

3. Improved access to medication for hypertension

Establish an efficient and effective drugs and commodity logistic system to ensure uninterrupted and timely supply of high quality affordable antihypertensive medication to the patients.

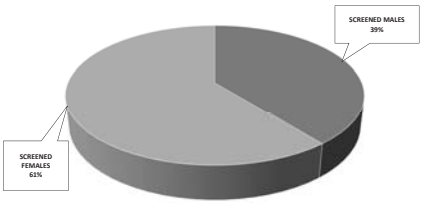
• AstraZeneca has now opened up the supply for HHA products to all CHAK facilities including the ones that are not HHA programme sites.

• The target price is pegged at an approximate markup of 33 per cent of the MEDS supply price. Facilities are encouraged to lower markups even further where possible to ensure that more patients benefit from low prices.

Successes

1. Created awareness and health education on hypertension and its risk factors to nearly two million Kenyans

Male Vs Female Screened



2. Screened over 850,000 persons for high blood pressure nearing the target of one million.
3. Establishment of community units around facilities, hence strengthening linkages between communities and health facilities.
4. A number of facilities have established functional support groups for hypertension and diabetes where patients share their experiences and ideas.
5. Capacity building for nurses and clinical officers who treat the bulk of the peri-urban and rural populations on hypertension management
6. Development of new hypertension management guidelines by HHA partners and MOH which are now in use in CHAK facilities implementing the project
7. Development of an electronic medical records system (Hypertension Module), the first of its kind to help collect relevant data for Hypertension and other NCDs such as diabetes.
8. Made it possible for patients in peri-urban and rural settings to access affordable, high-quality anti-hypertension medication. The project has received tremendous feedback from patients on their tolerance, friendly dosing and control of blood pressure.

Challenges

1. Lack of screening and treatment hypertension data. this is due to intermittent reporting or complete failure to report by the sites.
2. Little or no support from top management of facilities implementing the project affecting overall performance of facility.
3. High turnover of health care workers especially for level 2 and 3 facilities. Investment in training has to be done over and over again.
4. Rate of re-ordering drugs from MEDS is low or lacking, affecting patients' drug supply, hence control of hypertension due to non-compliance.

Way forward

- The project needs the support of facilities to be able to move forward.
- CHAK is committed to working closely with facilities to improve health systems at community and health facility levels.
- We have an opportunity of extending the programme for another 3 years with the support of AstraZeneca.

Meditec support with HbA1c for diabetes control evaluation

PRESENTATION BY CATHERINE WANJIRU - MEDITEC

Epidemiology of diabetes

Around 285 million people worldwide currently have diabetes and the numbers are predicted to nearly double to 439 million by 2030, affecting 7.7 per cent of the world's adult population.

An additional half a billion people are expected to be at high risk. The means by which diabetes is defined and, in particular, the utility of hemoglobin A1c (HbA1c) as a diagnostic tool are therefore major issues for discussion.

What is HbA1c?

The term HbA1c refers to glycated hemoglobin. Hemoglobin is a protein within red blood cells that carries oxygen throughout your body.

'Glycated' hemoglobin occurs when Hb joins with glucose in the blood. By measuring HbA1c, clinicians are able to get an overall picture of what our average blood sugar levels have been over a period of 2-3 months. The higher your blood sugar, the more sugar that sticks to your red cells and the higher your A1c.

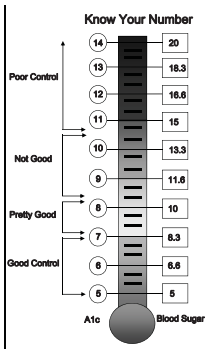
Monitoring diabetes: What does an A1c mean

An A1c measures how much sugar has been sticking to red blood cells over a three-month period. An A1c is a measure of long-term diabetes control.

When is HbA1c tested?

Your doctor will check your A1c every three to six months. Your doctor may check your A1c more often if:

- You have blood sugars above goal
- Your last A1c was high
- You have had symptoms of low blood sugar



The goal is A1c below 7.

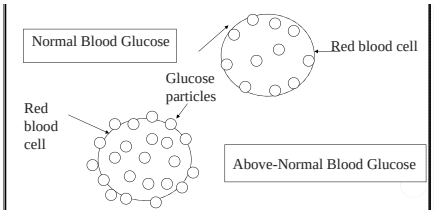


Diagramme showing glycated hemoglobin.

Individual blood glucose are great for deciding how a patient is doing at one particular point in time but they don't give the full picture. Readings can change a great deal even in an hour.

To deal with this variation, HbA1c is carried out and this gives the overall picture of the blood sugar over many days, weeks or even months. Moreover, there is no special treatment like consuming a special drink or fasting.

A simpler test like HbA1c, provided that it is calibrated to international standards may improve detection of diabetes.

A1C as a diagnostic tool for diabetes

In 2009, an international expert committee recommended the A1C test as one of the tests available to help diagnose type 2 diabetes and pre diabetes. It was later adopted by WHO and ADA.

Importance of testing HbA1c

Blood sugars and an A1c at or below goal (7 per cent or less) can reduce the chances of the following diseases:

- Heart and circulation problems
- Eye problems
- Kidney problems
- Nerve damage
- Feet problems e.g. ulcers

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Novo Nordisk-CHAK partnership addressing diabetes burden

PRESENTATION BY DOROTHY OWEGI - BOP PROJECT MANAGER

Sustainable Development Goals

For 15 years, Millennium Development Goals have shaped international priorities and activities. The MDGs were eight global time-bound goals with targets to focus development and end poverty. The MDGs came to an end in 2015, ushering in the Sustainable Development Goals (SDGs).

Sustainable Development Goals which were introduced in 2015 have NCD targets and provide a recognized position for private actors. Examples of these SGDs are as follows:

- 3.4: By 2030, reduce by one third premature mortality from non-communicable diseases
- 3.8: Achieve universal health coverage, including access to affordable essential medicine
- 3.c Substantially increase health financing and the recruitment (…) and training of the health workforce
- 17.17 Encourage and promote effective public, public-private and civil society partnerships

Novo Nordisk believes that health is essential to sustainable human development and is therefore committed to contributing to SDGs achievement.

Three key targets from the UN Sustainable Development Goals are important for Novo Nordisk:

- By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well being.
- Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all.
- Encourage and promote effective public, public-private and civil society partnerships, building on the experience and resourcing strategies of partnerships.

Why are the SGDs important for Novo Nordisk?

Health is our business

Novo Nordisk is a global healthcare company with over 90 years of experience in diabetes.

It is our responsibility to our patients

- 387 million people are living with diabetes
- We provide diabetes care products to over 24 million people
- We want to help all people with diabetes achieve a good quality of life

It makes business sense

- Increased priority and funding for NCDs
- Universal health coverage is likely to be included
- Goals will apply to all UN member countries
- It is a long-term advocacy platform for diabetes

Base of the Pyramid Diabetes Project in Kenya

The project seeks to make insulin affordable and available to diabetes patients at the base of the economic pyramid.

The BoP Project is a model Public Private Partnership initiative for diabetes management.

The present partnership combines many strengths

1. MoH for policy and capacity building guidance
2. FBOs i.e. CHAK and KCCB's partners representing a big part of the Kenyan health sector
3. Civil society represented by KDDA
4. Novo Nordisk with strong expertise in diabetes of over 90 years
5. Danish embassy with sector knowledge and strong ability to support
6. Phillips Healthcare Services (PHSL) for importing insulin
7. Mission for Essential Drugs and Supplies (MEDS) distributing insulin country wide

The BOP diabetes project seeks to make insulin affordable and available to diabetes patients at the base of the economic pyramid

Main objectives of BoP

The overall objective of the project is to improve diabetes care for diabetics in the low income bracket by:

- Bringing insulin and treatment physically closer to patients
- Lowering the price of insulin and

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Partnership addressing diabetes burden

Benefits of the project for people with diabetes

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increasing availability of insulin in health care facilities

- Building up specialized treatment capacity close to patients
- Increasing awareness of diabetes.

Are these objectives being met?

These objectives are being met as follows:

- Thousands of new patients identified/diagnosed with diabetes, registered at a health facility and receiving treatment
- Capacity to diagnose and treat diabetes patients at facility level has improved
- Supply of insulin has been strengthened with a penetration index of 98 per cent.
- Affordable price of insulin is still being adhered to in the country

Next steps in the diabetes war with reference to SDGs

- Make diabetes visible among NCDs so that programs targeting diabetes are funded and implemented within the SDG framework
- Communicate the burden of diabetes (incl. cost of complications) to drive improved reimbursement of diabetes treatment
- Advocate for very specific training on diabetes to be included in the curriculum of health care providers and funded by authorities
- Use the SDGs to birth new Public Private Partnerships with NGOs, governments and others

HbA1c for diabetes control evaluation

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DCA analyzer

The DCA Vantage Analyzer is a diabetes system that delivers clinically proven, clinically relevant HBA1C results. It helps to monitor and detect kidney disease earlier. It also manages to detect patients at high risk of developing pre-diabetes, helping the clinician to respond quickly.

Why DCA HbA1c test for diabetes testing?

- Simple to use
- Convenient for patient and healthcare professional
- Precise, lab-quality results
- Comprehensive patient consultation tools
- Testing compliance

Why choose the DCA vantage analyzer?

- Siemens has had a market presence with the DCA technology for over 20 years.
- This is the newest Analyzer and together with the DCA 2000, its predecessor, there are over 45,000 analyzers in use all over the world.
- This represents the largest number of POC HBA1C in use by any one company.
- It is the most widely used brand worldwide with over 45,000 analyzers shipped
- It has been highlighted in more than 140 clinical articles.
- It is used by three out of four physicians who perform HbA1c testing in the office.

Afya Jijini project to increase access to quality HIV and health services

BY ANNE MBUGUA - CHAK SECRETARIAT

The Afya Jijini project was launched at the Mama Lucy Kibaki Hospital in Nairobi on June 16, 2016.

CHAK is a consortium member in the USAID- funded project led by IMA World Health which is working in Nairobi County. Under the project, CHAK has been assigned to work in Dagoreti and Westlands sub-counties.

The project works to:

- Increase utilization and access to quality HIV services
- Increase access and utlisation of focused maternal, newborn and child health (MNCH), family planning (FP), water, sanitation and hygiene (WASH) and nutrition services

The launch was attended by the Nairobi County Health Team, project partners and other guests. Chief guest, Nairobi Governor Dr Evans Kidero was represented by the county CEC for Health Dr Bernard Muia.

Speaking at the forum, Nairobi County Secretary Dr Robert Ayisi revealed that health services consumed a big portion of the Kenyan capital city's budget, Ksh8 billion in 2016, to be specific. Among the pillars of health care in the county are MNCH services where the Afya Jijini project was helping the county government achieve its targets.

Dr Ayisi revealed that Afya Jijini had been adopted in the CEC and challenged the project leaders to make presentations to the council. The project had also been captured by the Council of Governors, hence enjoyed support from the county chiefs.

Nairobi County CEC for Health Dr Bernard Muia (right), who represented chief guest, Nairobi Governor Dr Evans Kidero and Nairobi County Secretary Dr Robert Ayisi (second right) visit an exhibition stand during the launch. Looking on is Afya Jijini Project Chief of Party Dr Ernest Nyamato (third right).

Nairobi CEC for Health Dr Muia challenged Afya Jijini to put in place effective M&E systems to ensure the project's impact was measurable. He also challenged the project to ensure the impact identified could be directly attributed to its efforts.

Deputy Mission Director, USAID, Kenya and East Africa Tina Dooley-Jones pointed out that despite the many gains made in the city's health care system with the support of the funding agency, there were still gaps occasioned by economic and social disadvantages experienced by some populations. Critical interventions were therefore required to address these persistent inequalities.

Afya Jijini would therefore support local health structures and unify the county around critical issues to ensure these inequalities were addressed. People centered service delivery would be key to the success of the project.

Project Chief of Party Dr Ernest Nyamato thanked the county health leadership for providing stewardship and support towards successful commencement and implementation of the project during the nine months it had been in operation.

Among the key project success in its initial implementation phase are:

MNCH, WASH, FP and nutrition services

- Life saving emergency obstetric and new born care (EmONC) equipment distributed to 52 maternities
- 131 sites supported to integrate management of acute malnutrition
- The programme initiated the 'We Men Care' services as a vehicle for meaningful engagement of male partners in health care.

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BethanyKids Centre holds opening and dedication ceremony

BY WILLIS OBUNGA AND MALCOLM ROBINSON - BETHANYKIDS

The opening and dedication of the BethanyKids Children's Centre at Kijabe Hospital on Friday April 22, 2016 was characterized by joy and celebration. It was all smiles as approximately 200 friends and supporters from various parts of the world including Norway, Belgium, Canada, the USA and Kenya gathered in the front yard of the 32,000 square foot building.

Several key people in BethanyKids brought greetings including former Executive Director and Board Chair Dr. Ivan Stewart, Founder Dr. Dick Bransford, and Clinical Director Dr. Dan Poenaru. A highlight was the testimonials by a staff nurse and a parent, both of whom have experienced what it was like in the "old" ward and now in the new Children's Centre.

The Presiding Bishop of the Africa Inland Church of Kenya, Rev. Silas Yego, offered a prayer of dedication, declared the Centre officially open and unveilled the dedication plaque mounted on a large rock in front of the building.

He thanked Dr. Bransford for his dedication and vision of caring for children with disabilities. He also acknowledged Mr. Njaal Lovik and his wife Aase from Norway for their generous support towards the construction of the BethanyKids Children's Centre.

The new building includes seven inpatient wards with eight beds per ward plus an eight-bed High Dependency Unit – a step down from an ICU, two isolation rooms and two private rooms with a total of 74 beds.

Bishop Silas Yego (left) and other key guests unveil the dedication plaque during the ceremony.

There are multiple treatment rooms, a physiotherapy room, a children's play room and a spacious outpatient clinic area. The generous space, abundance of natural lighting and child-friendly colors all contribute to the well-being of the patients, their families and clinicians.

Emily Chelang'at, a parent of an eight-old month baby who recently received care at the new centre emphasized the quality of the new facility.

"The new building is so spacious, has enough beds, more examination rooms, and parents are no longer asked to go back home with their children because of lack of space!"

"It is with tremendous gratitude that i see this new building, a true miracle especially for some of us who had the opportunity to be there at the very humble beginnings of the BethanyKids program," said Dr. Dan Poenaru, BethanyKids Clinical Director. "We celebrate those who went before us, the founders and the visionaries, and it is out of their dream that this vision has indeed happened."

AIC Kijabe Hospital's Executive Director, Dr. Mary Muchendu, also recognized those behind the celebration. "We are celebrating the success, and behind the success we have so many people who have gone through the hands of our doctors and surgeons at Kijabe."

Dr. Ivan Stewart, former BethanyKids' Executive Director and International Board Chair echoed Dr. Poenaru's sentiments.

"Dick's heart for disabled and marginalized children has inspired many of us. We've had the privilege of seeing thousands upon thousands of children receive surgery and care at BethanyKids, and had their lives rescued and changed unbelievably."

The opening and dedication of this Centre marks a major milestone in the short history of BethanyKids. We praise God and pray that we will use the new Centre well for His glory and for the good of children and their families needing healing and hope.

CHAK 70th anniversary celebrations begin at Annual Health Conference

By Anne Mbugua - CHAK Secretariat

A celebratory cake was cut to mark CHAK's 70th anniversary during the AHC/AGM 2016.

The CHAK Annual Health Confernce and Annual General Meeting 2016 was successfully held on April 26 – 28, 2016 at AACC Desmond Tutu Conference Centre. The event was attended by over 260 delegates comprising CHAK member health unit representatives, development partners, Ministry of Health representatives and representatives from various counties. Also in attendance were representatives of health sector regulatory bodies, among others.

Annual Health Conference

The Annual Health Conference theme was "Partnerships for sustainable quality health care in the context of the new Global Sustainable Development Goals".

The conference was structured in plenary sessions and two technical workshops focusing on:

- Health Systems Strengthening and Community Systems
- Health service delivery – covering communicable and non-communicable diseases

Presentations focused on the role of partnerships in delivering quality health services in CHAK programmes and member health facilities. The presentations were grounded in the United Nations Sustainable Development Goals that were launched in 2015 to act as a reference point for the international development agenda.

Exhibition

An exhibition with several exhibitors was held throughout the conference. CHAK HHA project, BoP Project and Partners provided free Blood Pressure and Blood Sugar screening to interested conference delegates for free throughout the conference. The exhibition also attracted partner organisations and member health facilities who sought to show case their work to conference delegates.

AGM

During the AGM held on April 28, Dr Mary Muchendu was re-elected Vice Chair while Mary Gitari was re-elected RCC chair for Eastern/North Eastern. Dr Oliver Mamati, MOIC, Friends Lugulu Mission Hospital, was elected the new chair for Western/North Rift Region to replace Samuel Jomo who retired on completing the maximum allowable term.

The AGM also approved a Constitutional amendment that would see CHAK assets distributed among MHUs which provide charitable health services in the event of its dissolution.

CHAK 70th anniversary celebrations

A dinner reception was held on Wednesday April 27, 2016, to celebrate CHAK 70th Anniversary and recognize retiring EXCO member (Samuel Jomo).

An informative and inspiring reflection on CHAK's journey of organizational development and the Church Health ministry in Kenya was given by Trustee, Rev. Dr George Wanjau.

Rev. Dr. Wanjau inspired and challenged those present to take the vision to greater heights by working towards expansion of specialized services and medical education. A special cake was shared to mark the celebrations.

CITAM Kiserian children's home rehabilitation efforts bear fruit

CITAM Children's Home, Kiserian, Director Janet Muhoro with CHAK Times Editorial Committee member Maurice Ikoti at the centre.

For the children at the CITAM Children's Home in Kiserian, life has changed dramatically, and for the better. The minors once roamed the streets of Nairobi and Kajiado, bitten by the chill or beaten by the hot sun, depending on the season. With a roof over their heads, food for their bellies and an education, life at the rehabilitation centre is definitely less bleak.

The centre, founded in 1995 by Rev. Dr. Dennis White and his wife, rehabilitates former street children, giving them a second chance and offering them an opportunity to pursue their education to the highest possible level.

According to the centre's director Janet Muhoro, Rev. White and his wife often gave street children clothes and food. However, the children would return to the streets, still lacking other basic necessities such as shelter and education.

In order to fully assist these children, the Whites decided to buy 56 acres of land in Kiserian to set up a rehabilitation centre.

About 70 per cent of the children are from the streets of Nairobi while 30 per cent are from the streets of Kajiado. The children come to the home through referrals or direct identification by the centre's social worker with the centre being mainly funded by CITAM.

The centre consists of:

• A dispensary

Some of the children come to the centre when they are sick, thus the need for the dispensary. Among the most common ailments are coughs and colds, flu, malaria, minor stomach infections and parasites, skin and other infections. However, some of the children may also have mild mental issues which require counseling. Currently, one child has hemophilia and requires constant monitoring and treatment.

The dispensary is run by a nurse as part of Government regulations which state that such a centre should have the capacity to administer first aid in case of emergency. The children also receive information on nutrition and hygiene from the nurse.

The dispensary comes in handy given that the nearest health facility

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Afya Jijini project launched

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HIV services

- 3,000 clients have benefitted from HIV psychosocial support in the health facilities
- Close to 13,000 clients have been screened for TB during active case finding initiatives
- Mapping for the DREAMS initiative has been done in over 18,000 households in the Mukuru Kwa Njenga area.

The DREAMS partnership aims to reduce HIV infections among adolescent girls and young women in 10 sub-Saharan countries.

The goal of DREAMS is to help girls develop into Determined, Resilient, Empowered, AIDS-free, Mentored and Safe women. Kenya is one of the countries in which the initiative is being implemented.

The initiative comes at a time when Kenya is grappling with social trends such as 'masponsor' and 'mafisi' phenomenons which are potentially disruptive to the lives of girls and young women.

- The project also supported the Nairobi City County to complete its HIV strategy.

CITAM Kiserian children's home

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is in Kiserian while the nearest Government hospital is Mbagathi. When necessary, the children are also taken to Kenyatta National Hospital for treatment.

• A farm

Towering maize plants are the first thing one notices on looking towards the edge of the centre's compound.

The maize plantation pans out several metres to the perimeter fence, and with each plant boasting a cob as its crowning glory, it is obvious the farming venture is going well.

On the right side of the compound, a crop of vegetables is watered using sprinklers while several dairy cows are visible from a shed a few metres away.

According to Janet, seven beehives are thriving in a forested area at the far edge of the huge compound with another eight being rehabilitated to increase honey production.

A few years ago, the centre also reared fish and poultry, ventures which the current management is trying to revive.

The centre's farm supplies food for the children while the surplus is sold in local markets and to CITAM congregations for a profit. Janet says the farm is very dear to the centre, given that Kiserian, which is the nearest town, is about 17km away and buying food regularly for the children from here would be a very expensive affair. Rongai, a bigger town where almost all of the foodstuff required would be available is about 25km away.

The centre's chapel.

A borehole, electricity and generator ensure there is water for irrigation and domestic use all year round. Drip irrigation equipment has been set up although there is need to replace some of the pipes that have broken down. Once this is done, the centre will be able to produce even more food for the children and for sale.

• A church

The church started as a chaplaincy to minister to the community. It is used by both the children and the local community. There are plans to relocate it to Rongai town since Government regulations do not permit a fully-fledged church inside a children's centre.

• Education sponsorship programme

The children at the centre come from very poor backgrounds. Although most of them know their parents and are living with them at the time of admission to the centre, their parents are extremely poor, a situation that pushes the children out to the streets to eke out a living.

The centre therefore takes up the responsibility to sponsor each child's education all the way to university. Education for the average child to tertiary level takes up to 15 years with the cost of maintaining each child differing according to their level of education. For example, according

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A workshop at the centre ensures the centre's school is well equipped.

CITAM Kiserian children's home

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to Janet, maintaining a child in secondary school costs about Ksh80, 000 per year while those in primary school may need up to Ksh65,000.

Currently, the centre has 59 children in secondary school, a number that will continue to rise as rescue efforts continue. The centre, with a capacity of 128 children, holds an annual intake, and is set to receive 35 more minors in 2016. In 2015, a double intake saw the children's home take in 57 minors.

Life at CITAM Kiserian Children's Centre

Life in the streets can be harsh and the children often pick up deviant behavior from peers and as a means of survival. However, upon arrival at the home, they soon realise that things have to change.

Discipline is paramount in the home and children who fail to adjust to the required routine risk being kicked out. In 2015, four children were expelled from the home.

According to Janet, it takes about six months for a child to adjust to the routine and leave street life behind. Children who have not adjusted after six months are given a grace period for rehabilitation until they can attend normal classes.

Dairy cows at the children's centre.

The key to seeing a complete turn-around in the children, however, is prayer, with the centre's staff constantly and continuously praying for their charges.

The centre works with the police and children's department to identify children in need of assistance, most of who know no other home except the slums which have been the abode for generations of their families. Also providing such information are the community and children's neighbours'. The centre's social worker is also actively involved in identifying the children to be assisted.

When a child in need is identified, the centre also finds out the number of siblings and their ages.

According to Janet, all siblings will more often than not be taken in as admitting one child may lead to peer pressure to return to the streets, especially during the holidays.

The centre has placed the age limit of beneficiaries at 12 years as it may be tricky for teenagers to adjust to the new environment. Another requirement is that the children must have been on the streets for not less than six months.

Once the required number of needy children have been identified, an assessment process involving two committees then follows.

The centre-based admission committee goes through each case and makes recommendations to the Deacon Committee which based on several factors makes the final decisions. By the first quarter of the year, the children are taken into the home. The annual target is 30 children with recruitment taking place from September to November.

The school goes up to standard six although there are plans to introduce classes seven and eight. Previously, it only went up to standard four, forcing older pupils to make a return journey of 10km on foot to the nearest local school.

There is also a pre-school section and rehab class for recently rescued children who are yet to adjust to the centre's routine.

Until 2004, the centre offered an informal education system. Regular

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the Samaritan

A good samaritan stopped to help a stranger. he took on the burden of caring for someone he did not know. If you have a burden that you cannot bear on your own, share it with the Samaritan. Send your questions to:

The Samaritan, CHAK Times, P.O. Box 30690 - 00100, Nairobi. Email: communications@chak.or.ke

Dear Samaritan,

I am a parent of two teenagers. My communication with them has been very poor. I tell them not to watch TV the whole day but this seems to be falling on deaf ears. Sometimes they refuse to eat food prepared by my house help. Recently the younger one who is in form one refused to go back to school at the beginning of the term and insisted on a tranfer. What can I do to improve communication between my children and i?

Concerned parent

Dear concerned parent,

You sound frustrated because you are not able to communicate with your teenagers effectively. For you to communicate with your teenagers you need to become good friends. Talk to them as opposed to talking at them and speak their language.

You also need to spend a lot of time with them. You can do some activities together, for example cooking, playing or walking. Have as much fun with them as possible.

In addition, try as much as possible to talk to them when both of you are calm to enable communication to take place. Practice good communication skills like active listening, observe non-verbal communication and encourage them to talk as much as possible.

There is a great need to appreciate even the small things that your child does. That way, you build their self- esteem and help them become more responsible.

When you tell them not to be glued to the TV the whole day, are you proposing some alternative activities that they could do to keep themselves busy? Teenagers have a lot of energy and if not directed in the in the right way, they may end up engaging in some unhealthy behavior.

You may have to teach them some life skills to ensure they understand how to deal with the challenges of life.

When you say that sometimes your children refuse to eat food prepared by your house help, what do you really mean? Is your house help a good or poor cook? Do you like the food prepared by her/him? Most teenagers usually like junk food and you as a parent should discourage this and offer a healthy diet. You also teach them why junk food is not healthy for them.

You could discuss a meals timetable together with your house help and your teenagers, and ensure they are reasonable and realistic as they plan. Additionally, have the teenagers prepare a meal which you can all enjoy. Let them prepare what they like eating once in a while.

As for the one who is insisting on a transfer, you may have to find out what could be making him hate his current school. Is he being bullied by other students? May be he does not like the food in this school, or the school is far from home, What really make him hate this school?

Young people usually experience peer pressure. He/she could be getting influenced by his age mate. He may want to be with his friends as opposed to being around strangers. Listen to him and try to help him cope as much as possible.

As a parent, do not allow your children to dictate what they want to eat, where they want to go, who should cook for them, which school they want to go, etc. You must stand firm and take the leadership position in your house.

MEDICAL QUIZ 49

Send your reponses to:
The Editor, CHAK Times, P.O. Box 30690 - 00100, Nairobi; Email: communications@chak.or.ke
The first five correct entries will receive a CHAK gift pack
Remember to include your name, health facility, mobile phone number and full postal address

1. Name and explain the types of Public Private Partnership arrangements (6 mks).

2. Explain three elements of resource mobilisation (9 mks)

3. Explain three government actions against Non Communicable Diseases (NCDs) (6 mks).

Answers to medical quiz 48

1. List six underlying characteristics of partnerships. (6 mks)

Any of the following earns you a mark:

If partnerships are to be successful, and have both clear mutually agreed upon objectives and risks, there are some underlying characteristics that must be in place. These are:

a) Clearly specified, realistic and shared goals
b) Clearly delineated and agreed roles and responsibilities
c) Distinct benefits for all parties
d) The perception of transparency
e) Active maintenance of the partnership
f) Equality of participation
g) Meeting agreed obligations

To have all these characteristics, a partnership needs to be very well negotiated with each partner recognising their strengths and weaknesses.

2. Explain four common birth complications that the CHAK-Bread for the World partnership on maternal child health is addressing. (8mks)

Among the common birth complications encountered in CHAK health facilities are:

- Anti-partum hemorrhage
- Post-partum hemorrhage
- Obstructed labour
- asphyxia
- Shoulder dystocia
- Post-abortion complications
- Breech presentation among others

3. Give six examples of partnerships for health in the CHAK network. (6mks)

Maua Methodist Hospital partnership with AON Insurance Company to provide medical services to teachers. Like many mission hospitals, Maua found the National Hospital Insurance Fund (NHIF) capitation rates too low and unsustainable. Partnering with AON Insurance Company has allowed the hospital to serve more clients and in the process also ensure its services remain sustainable.

Kendu Adventist Hospital partnership with NHIF for in-patient, civil servants and the national scheme covering out-patient services among others. The Hospital is keen on promoting NHIF to the community through sensitization and mobilization. KAH has also been recently selected as a facility of choice in the region by NHIF to offer services to senior civil servants in Job group M and above.

The Mombasa TB Active Case Finding project's main implementers were CHAK and KAPTLD. The project was funded by Global Fund through AMREF Kenya as the prime recipient and came to an end in December 2015.

CHAK implemented in public and FBO health facilities while KAPTLD implemented in the private sector.

Other important players in the project were Mombasa County Health Teams, sub-county health management teams, Community Health Volunteers (CHVs) and Community Health Extension Workers (CHEWs).

A partnership between CHAK and EED is seeking to improve maternal and child health in CHAK member facilities. The collaboration involves updating service providers from CHAK Health facilities on the most current life-saving skills for maternal and neo-natal health and Basic and Comprehensive emergency Obstetric care (BEmOC/CEmOC).

A partnership between AIC Kijabe Hospital and Jamu Imaging Centre Limited is providing CT scan services to Kijabe clients. The partnership was expected to mainly benefit residents of Nakuru, Narok, Nyandarua, Kiambu and Kajiado counties although the hospital's clientele is drawn from

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Answers to medical quiz 48

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all corners of the country as well as neighboring states.

Five months after the introduction of the machine, it has become clear that partnerships are critical to raising the standards of health care in the country.

A partnership between CHAK and DAK, a charity based in Australia, is providing radiology and other equipment to CHAK member health units and other medical facilities.

The partnership saw 23 CHAK member health units benefit from portable ultra sound machines designed for point of care services in 2015.

A partnership between AIC Cure Hospital and Safaricom Foundation is improving the lives of children with physical disability. Safaricom began by funding mobile clinics around the country. The partnership enabled Cure Kijabe to charter a helicopter to further destinations where a team of medical professionals would deliver services, identify new cases for treatment and follow up on surgical cases. Through this partnership, Cure was able to do a lot of work around the country.

And in a partnership for medical education, Kendu Adventist Hospital School of Medical Sciences has teamed up with Funzo Kenya to give loans and scholarships to students. Funzo Kenya has so far given loans and scholarships to about 30 students with more expected to benefit.

With other students getting assistance from other sponsors such as Springs of Hope International and ADRA Finland, the school is meeting its medical education goals through partnerships.

Jhpiego, an affiliate of Johns Hopkins University, in collaboration with CHAK, have done a great deal in sharpening the lecturers at Kendu Adventist Hospital School of Medical Sciences with effective teaching skills in areas such as principles of training, effective facilitation skills, developing competency, facilitating in the class room, formulating course objectives, formulating supporting objectives and student evaluation.

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CHAK facilitated due diligence visits by GE and EGMF teams to seven mission hospitals and collaborated with KABU in convening a meeting of all the targeted 23 mission hospitals, KABU and the visiting team from GE and EGMF that was held at KABU Guest House in Nakuru.

The feedback from the field visits was good and participants expressed their excitement and interest in being included in this transformative project.

CHAK Chairman will host a meeting of Religious Leaders from sponsoring churches of the targeted mission hospitals to brief them about the project and appeal for their prayers and support.

CHAK wishes to acknowledge and deeply appreciate HE Daniel Arap Moi for his vision, foresight and generosity and his personal commitment and leadership towards ensuring that this project is accomplished.

KeMHIP provides a springboard for major transformation of mission hospitals' capacity and services as they re-position themselves to make a substantial contribution to the SDGs health agenda.

We are pleased that KABU is mobilizing resources to support infrastructure development that will support expansion of quality health services, medical education and research at the Kabarak Teaching, Referral and Research Mission Hospital and 23 CHAK Member Hospitals through the Kenya Mission Hospitals Improvement Project (KeMHIP).

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success stories have been reported since.

The centre's administrator, for example, began with the rehab class and later proceeded to Kenyatta University for undergraduate classes. Four of the centre's beneficiaries have completed undergraduate courses while two are yet to graduate.

• Carpentry and tailoring workshops

All the sections work together to make the lives of the children as comfortable as possible during their stay at the centre.

For any assistance to the centre: Mpesa paybill number 933949

Jokes... jokes... jokes...

All time Christian

The light turned yellow, just in front of him. He did the right thing, stopping at the crosswalk, even though he could have beaten the red light by accelerating through the intersection.

The tailgating woman was furious and honked her horn, screaming in frustration, as she missed her chance to get through the intersection, dropping her cell phone and makeup.

As she was still in mid-rant, she heard a tap on her window and looked up into the face of a very serious police officer.

The officer ordered her to exit her car with her hands up. He took her to the police station where she was searched, fingerprinted, photographed, and placed in a holding cell.

After a couple of hours, a policeman approached the cell and opened the door. She was escorted back to the booking desk where the arresting officer was waiting with her personal effects.

He said, "I'm very sorry for this mistake. You see, I pulled up behind your car while you were blowing your horn, making lewd gestures to the guy in front of you and, cussing a blue streak at him. I noticed the 'What Would Jesus Do' bumper sticker, the 'Choose Life' license plate holder, the 'Follow Me to Sunday-School' bumper sticker, and the chrome-plated Christian fish emblem on the trunk, so naturally . . . I assumed you had stolen the car."

Ask yourself . . . Am I just a Sunday morning Christian? Do I set a good Christian example everyday? Think about it . . ..

Best poem in the world

I was shocked, confused, bewildered,
As I entered Heaven's door, Not by the beauty of it all, Nor the lights or its decor. But it was the folks in Heaven who made me sputter and gasp – The thieves, the liars, the sinners, The alcoholics and the trash.

There stood the kid from seventh grade Who swiped my lunch money! Twice. Next to him was my old neighbor, Who never said anything nice. Herb, who I always thought, Was rotting away in hell, Was sitting pretty on cloud nine, Looking incredibly well.

I nudged Jesus, 'What's the deal? Would love to hear Your take. How'd all these sinners get up here?

'Hush, child,' He said, 'they're all in shock. No one thought they'd be seeing you.' JUDGE NOT.

(internet sources)

Is it selfish to set boundaries?

Philippians 4:12-13 – "I know what it is to be in need, and I know what it is to have plenty. I have learned the secret of being content in any and every situation, whether well fed or hungry, whether living in plenty or in want. I can do everything through him who gives me strength."

"Now, wait a minute," Teresa said, shaking her head. "How can I set limits on those who need me? Isn't that living for me and not for God?"

Teresa was voicing one of the main objections to boundary setting for Christians: a deep-seated fear of being self-centered, interested only in one's own concerns and not those of others.

It is absolutely true that we are to be a loving people. Concerned for the welfare of others. In fact, the number-one hallmark of Christians is that we love others (John 13:35).

So don't boundaries turn us from other-centeredness to self-centeredness? The answer is no. Appropriate boundaries actually increase our ability to care about others. People with highly developed limits are the most caring people on earth. How can this be true?

First, let's make a distinction between selfishness and stewardship. Selfishness has to do with a fixation on our own wishes and desires, to the exclusion of our responsibility to love others.

Though having wishes and desires is a God-given trait (Proverbs 13:4), we are to keep them in line with healthy goals and responsibility.

For one thing, we may not want what we need. Mr. Insensitive may desperately need help with the fact that he's a terrible listener. But he may not want it. God is much more interested in meeting our needs than he is granting all our wishes. For example, he denied Paul's wish to heal his "thorn in the flesh" (2 Corinthians 12:7–10). At the same time, he met Paul's needs to the point that Paul felt content and full:

I know what it is to be in need, and I know what it is to have plenty. I have learned the secret of being content in any and every situation, whether well fed or hungry, whether living in plenty or in want. I can do everything through him who gives me strength. (Philippians 4:12–13)

It helps the Christian afraid of setting boundaries to know that God meets our needs. "God will meet all your needs according to his glorious riches in Christ Jesus" (Philippians 4:19). At the same time, God does not make our wishes and desires "all bad" either. He will meet many of them.

Our needs are our responsibility

Even with God's help, however, it is crucial to understand that meeting our own needs is basically our job. We can't wait passively for others to take care of us. Jesus told us to "Ask … seek … knock" (Matthew 7:7). We are to "work out [our] salvation with fear and trembling" (Philippians 2:12). Even knowing that "it is God who works in [us]" (Philippians 2:13), we are our own responsibility.

This is a very different picture than many of us are used to. Some individuals see their needs as bad, selfish, and at best, a luxury.

Others see them as something that God or others should do for them. But the biblical picture is clear: our lives are our responsibility.

At the end of our lives this truth becomes crystal clear. We will all "appear before the judgment seat of Christ, that each one may receive what is due him for the things done while in the body, whether good or bad" (2 Corinthians 5:10). A sobering thought.

The gift of stewardship

A helpful way to understand setting limits is that our lives are a gift from God. Just as a store manager takes good care of a shop for the owner, we are to do the same with our souls. If a lack of boundaries causes us to mismanage the store, the owner has a right to be upset with us.

We are to develop our lives, abilities, feelings, thoughts, and behaviors. Our spiritual and emotional growth is God's "interest" on his investment in us.

When we say no to people and activities that are hurtful to us, we are protecting God's investment.

As you can see, there's quite a difference between selfishness and stewardship. That's why boundaries make life better!

Adapted from Proverbs 31 ministries (proverbs31.org)

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