CHAK TIMES
"For the healing of the nation"
A publication of the Christian Health Association of Kenya
Issue No 51: January-April 2017

Maternal child health

Role of Church health facilities

Contents

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Published by:

Christian Health Association of Kenya

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Strides have been made in MNCH in Kenya but challenges still abound

Kenya has made steady progress in improving reproductive, maternal and child health outcomes in the last decade.

Child mortality has declined by over 20 percent since 2008 and the country achieved a total fertility rate of less than four. Stunting, which remained stubbornly high over the past two decades, has started to decline. Six out of ten pregnant women now receive skilled care at childbirth and over half receive postnatal care.

However, despite this progress, Kenya could not achieve maternal and child health Millennium Development Goals (MDGs). In Kenya today, many women, neonates, children, and adolescents continue to experience morbidity or die from preventable conditions that have proven and cost effective interventions.

Access to quality Reproductive Maternal Newborn Child and Adolescent Health (RMNCAH) services remains a challenge across all levels of care, and inequities continue to persist among population subgroups, and between rich and the poor.

Recent surveys show major supply and demand side gaps and challenges in coverage of health services that result in continued disparities between counties, urban and rural residents and different population groups.

The key supply side challenges include sub optimal functioning of the health system with uneven distribution of the health workforce as well as constraints in competency and motivation of the health care providers to provide quality care; insufficient financing and weak supply chain management resulting in missing critical inputs required for service delivery, especially essential commodities; and poor quality and utilization of routine data for evidence-based decision making.

Access to quality Reproductive Maternal Newborn Child and Adolescent Health (RMNCAH) services remains a challenge across all levels of care, and inequities continue to persist among population subgroups, and between rich and the poor.

Sociocultural and economic barriers and constraints in physical access to health services continue to limit demand.

Improving coverage for RMNCAH services is a priority for the Government of Kenya as is reflected in its Vision 2030, the Constitution of 2010 and the Health Sector Strategic and Investment Plan 2014-18.

The Government has introduced new policies as well as initiatives such as Free Maternity Services, Elimination of User Fee for Primary Care and the Beyond Zero campaign to address the critical barriers.

Globally, there is also a renewed momentum and support for RMNCAH as part of the Sustainable Development Goals (SDGs) and the updated Global Strategy for Women's Children's and Adolescent's Health (2016-2030) which aims to achieve the highest attainable standard of health for all women, children and adolescents, and ensures that every newborn, mother and child not only survives, but thrives.

The Global Financing Facility creates a new platform for collective action at the country level and is one of the main funding streams for the Every Woman Every Child movement.

Such growing national and international commitments provide an opportune time to enhance both domestic and external support for RMNCAH in Kenya to ensure smart, scaled-up, and sustained financing.

Source: Kenya Reproductive, Maternal, Newborn, Child And Adolescent Health (RMNCAH) Investment Framework, Ministry of Health, Government of Kenya, January 31, 2016

CHAK to review membership charges to bridge funding gap

CHAK member health units will also be required to contribute towards technical support services

Membership subscription and Annual Health Conference charges

CHAK EXCO has proposed review of membership subscription and Annual Health Conference registration charges.

This will help to bridge the funding gap for the new CHAK Strategic Plan 2017-2022.

To meet the funding gap, CHAK is seeking to raise funds from domestic as well as donor sources.

The CHAK Executive Committee (Board) met on April 6, 2017, discussed and approved charges to be levied to MHUs as a contribution towards the services provided.

These will be presented to the May 2017 AGM and the new rates effected from January 1, 2018.

Charges for technical support services

CHAK has the capacity to offer some technical services that can generate revenue by introducing a fee since these are only used by members who request for them on demand.

These include HCTS/medical equipment repair services, Hospital Management Software and Architectural services.

The charges on the opposite page will be applied where such services are not donor funded through CHAK.

Revised rates for CHAK membership registration and annual subscription

MEMBERSHIP ITEM	CURRENT FEE (KSH)	PROPOSED NEW FEE (KSH)
Application fee	500	2,000
Annual Subscription fee for Hospitals level 5	15,000	20,000
Annual Subscription fee for Hospitals level 4	10,000	15,000
Annual Subscription fee for Health Centre	3,000	5,000
Annual Subscription fee for Dispensary	1,500	3,000
Annual Subscription fee for Churches	1,500	3,000
Annual Subscription fee for MTCs	1,500	3,000
Annual Subscription fee for Community Based Health Care (CBHC) Organizations	1,500	3,000

Revised rates for CHAK Annual Health Conference registration

MEMBER CATEGORY	CURRENT	NEW
Hospitals	3,000	5,000
Health Centres	1,500	3,000
MTCs	1,500	3,000
Dispensaries, Churches & CBHC	1,000	2,000
Non Members	12,000	15,000

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CHAK reviews membership charges

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Proposed contribution of CHAK members for technical services

ITEM	FEES STRUCTURE	REMARKS
1. Medical Equipment maintenance (HCTS)	Cost recovery on spares, equipment, labour and travel costs	Target to ensure costing is sustainable and competitive. Charges are already being applied for HCTS services
2. CHAK Hospital Management Software (CHMS)	a) Installation and training monthly fees of Ksh 50,000 for Hospitals b) Ksh 30,000 for other Health facilities	It is estimated that the complete training and networking of all hospital departments will take 12 months
	a) Annual maintenance monthly fees of Ksh 30,000 for Hospitals and Ksh 15,000 for other MHUs ***OR*** *b) Request MHUs to take care of programmers travel cost when they requestl for onsite support*	To support trouble shooting, system enhancement & new reporting needs
3. Architectural technical support services	To include Architectural professional fees in project proposals that MHUs submit to Donors for payment to CHAK using the normal criteria for professional fees	Where projects are not funded, CHAK will require the MHUs requesting Architectural support services to meet CHAK costs of travel and staff per-diem

CHAK begins implementing five-year CHAP Uzima project

Overview

CHAP Uzima is a CDC-funded five-year follow on project to the CHAK HIV/AIDS Project (CHAP) that ended on March 31, 2017. The new award (CHAP Uzima), commenced on April 1, 2017, and will run until March 31, 2022.

Scope

While the CHAK HIV/AIDS Project predominantly supported HIV services to about 42,000 patients as per the treatment cascade in supported faith-based and affiliated health facilities. i.e. HIV Prevention, HIV testing and linkage services, care and treatment and retention into care interventions, CHAP Uzima will support an increased scope of services.

These include HIV care and treatment services to over 46,000 patients on care, about 1,500 of whom will be supported through Community Health Partners (CHP) in Narok County. The increased scope will include Orphans and Vulnerable Children (OVC) services and Gender Based Violence (GBV) services.

The GBV services will be supported for all the health facilities, while OVC services will be supported for about 6,000 orphans and vulnerable children and over 1,000 households in

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Numbers show improvements in maternal child health in Kenya

Excerpts from the Kenya Health and Demographic Survey 2014

Childhood mortality rates and trends

Childhood mortality continues to decline in Kenya. According to the 2014 KDHS, infant mortality is 39 deaths per 1,000 live births and under-five mortality is 52 deaths per 1,000 live births. This means that 1 in 20 children dies before their fifth birthday.

This is less than half the under-five mortality rate published in the 2003 KDHS when more than 2 in 20 children did not survive until their fifth birthday (115 deaths per 1,000 live births).

Neonatal mortality and infant mortality have also declined since 2003.

Under-five mortality is virtually the same in urban and rural areas of Kenya. It is lowest in Central region (42 deaths per 1,000 live births for the 10 years before the survey) and highest in Nyanza (82 deaths per 1,000 live births).

There is not a strong pattern between childhood mortality and mother's education, as the under-five mortality rate is exactly the same among children whose mothers have no education and those whose mothers have secondary or higher education. Under-five mortality appears to decrease slightly with household wealth.

Spacing children at least 36 months apart reduces the risk of infant death. In Kenya, the median birth interval is 36.3 months.

Antenatal care

Almost all women (96 per cent) age 15-49 who had a live birth in the five years before the survey received any antenatal care (ANC) from a skilled provider (doctor, nurse, or midwife).

The timing and quality of prenatal care are also important. Almost six in 10 women received four or more ANC visits, but only 20 per cent had their first ANC visit in the first trimester, as recommended.

The quality of ANC care is inconsistent. Sixty-nine percent of women 15-49 with live birth in last five years took iron tablets or syrup, and among women who received ANC, almost all had their blood pressure measured, a blood sample taken, and were weighed during ANC.

However, only 58 per cent were informed of signs of pregnancy complications. Three-quarters of women's most recent births were protected against neonatal tetanus.

- **Delivery in a health facility has improved dramatically since 2008-09, from only 43 per cent of births in 2008-09 to 61 per cent in 2014**
- **Three in five (61 per cent) children under six months in Kenya are exclusively breastfed**
- **There is no evidence that the maternal mortality ratio has declined in recent years in Kenya**

Delivery and postnatal care

Six in ten live births were delivered in a health facility, 46 per cent in the public sector and 15 per cent in the private sector.

Still more than one-third of births (37 per cent) were delivered at home.

Delivery in a health facility increases with a woman's education and wealth. Only one-quarter of births to women with no education were delivered in a health facility compared to 84 per cent of births to women with secondary or higher education.

Health facility births are most common in urban areas (82 per cent).

More than 90 per cent of births in Kirinyaga and Kiambu counties are delivered in a health facility, while Wajir has the lowest rate of facility deliveries at 18 per cent.

Just over 60 per cent of births are delivered with the assistance of a skilled provider—36 per cent by midwives and 26 per cent by doctors. Five percent of live births were delivered alone.

Postnatal care helps prevent complications after childbirth. Just over half (53 per cent) of women age 15-49 with a live birth in last two years received postnatal checkup within two days of delivery. More than 2 in 5 women received no postnatal care at all.

Newborns are less likely than women to receive a postnatal checkup: only 36 per cent of births had a postnatal checkup in the first two

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Maternal child health improving

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days after birth, and 62 per cent had no postnatal checkup at all.

Overall, maternal health indicators are improving in Kenya. Delivery in a health facility has improved dramatically since 2008-09, from only 43 per cent of births in 2008-09 to 61 per cent in 2014. Assistance at delivery has increased as well.

Maternal Mortality

The 2014 KDHS asked women about deaths of their sisters associated with pregnancy and childbearing to determine maternal mortality.

The 2014 KDHS reports that the maternal mortality for the seven year period before the survey (2007-2014) is 362 deaths per 100,000 live births, with a confidence interval of 254-471. While this is lower than the maternal mortality rate reported in the 2008-09 KDHS (520, with a confidence interval of 343-696), the decrease is not statistically significant due to the overlapping confidence intervals.

There is no evidence that the maternal mortality ratio has declined in recent years in Kenya.

Child health

Vaccination coverage

Almost 8 in 10 children (79 per cent) age 12-23 months have received all basic vaccinations (BCG, measles, and three doses each of DPT and polio vaccine, excluding polio vaccine given at birth).

- **Almost 8 in 10 children (79 per cent) age 12-23 months have received all basic vaccinations**

- **Almost six in 10 women received four or more ANC visits, but only 20 per cent had their first ANC visit in the first trimester, as recommended**

- **In Kenya, just over one-quarter of children under five are stunted, or too short for their age. This is a sign of chronic undernutrition.**

Two percent of children have received no vaccines.

Basic vaccination has improved only slightly since 2008-09 when 77 per cent of children had received all of these basic vaccines.

Basic vaccination coverage is slightly higher in urban than rural areas (83 per cent versus 77 per cent). There is tremendous variation by county, from 36 per cent coverage in West Pokot to over 95 per cent coverage in Nyamira, Nandi, Kiambu, Kirinyaga, and Tharaka-Nithi.

Basic vaccination coverage increases with mother's education and household wealth. Only 57 per cent of children age 12-23 months whose mothers have no education have received all basic vaccinations compared to 87 per cent of children whose mothers have secondary or higher education.

Childhood illnesses

Nine percent of children under age five had symptoms of acute respiratory infections (ARI) in the two weeks before the survey. Among these children, two-thirds received advice or treatment from a health provider and half received antibiotics.

Fifteen percent of children under age five had diarrhoea in the two weeks before the survey. Diarrhoea is most common among children age 6-11 months (27 per cent). Almost 6 in 10 (58 per cent) children with diarrhoea were taken to a health facility or provider. Children with diarrhoea should drink more fluids, particularly through oral rehydration therapy (ORT). Eighty-two percent of children under age five with diarrhoea received ORT or increased fluids, while 11 per cent received no treatment.

Feeding practices

Almost all children in Kenya are ever breastfed (99 per cent). Just over 60 per cent were breastfed in the first hour of life, and 91 per cent were breastfed during the first day of life.

Sixteen percent of children received a prelacteal feed, that is, something other than breast milk during the first three days of life, contrary to recommendations. WHO recommends that children receive nothing but breastmilk (exclusive breastfeeding) for the first six months of life.

Three in five (61 per cent) children under six months in Kenya are exclusively breastfed. Exclusive breastfeeding has increased from 32 per cent in 2008-09.

On average, Kenyan children are breastfed for 21 months and exclusively breastfed for 4.3 months.

Complementary foods should be introduced when a child is six months old to reduce the risk of malnutrition. Just over 80 per cent of children age 6-9 months receive complementary foods.

Equipping health care workers to handle obstetric emergencies

Advanced Life Support in Obstetrics (ALSO) is a practical evidence based two-day interactive program designed to equip health professionals with skills and knowledge required in handling obstetric emergencies.

The procedures and approaches covered in the ALSO course are reasonable, consistent and evidence-based and enable everyone to not only identify those at risk of obstetric emergencies but also to manage them when they arise.

The safe motherhood and childbirth concerns addressed in the ALSO curriculum can be used to inform midwifery, post and undergraduate obstetric emergencies training.

The ALSO course was introduced in 1991 by two medical doctors, James Damos and John Beasley, from the University of Wisconsin in the United States. They proposed that the training could bridge knowledge gaps and increase skills among maternal health care providers to improve emergency obstetrical care management.

The teaching methodology used during the training emphasizes an inter-professional team approach which makes understanding easier.

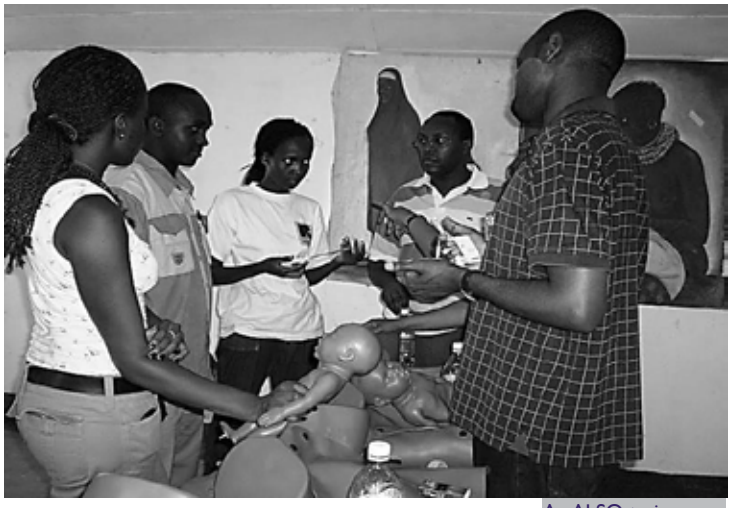
Provider course

A two-day provider course is targeted at all physicians, midwives, registered nurses and other clinicians. The programme utilizes the widely acclaimed humanistic training approach to enhance knowledge and skills acquisition when attending to a patient. This is achieved through the use of case studies, mnemonics and mannequins.

This session is open to all health care providers; nurses and midwives, medical interns, medical officers, clinical officers, clinical nurse instructors, OB-GYN consultants and OB-GYN registrars and nurses from private practice.

Instructor course

A two-day instructor course focuses on specific teaching skills required for adult principals. The course is based on a teach-the-teacher model, where students are trained to become future instructors.



An ALSO training session at the Kakuma Refugee Camp.

Some of the key areas covered include:

- First trimester complications
- Medical complications of pregnancy
- Vaginal bleeding in late pregnancy
- Intrapartum fetal surveillance
- Labour dystocia
- Malpresentations
- Shoulder dystocia
- Post-partum haemorrhage
- Forceps and vacuum delivery
- Neonatal resuscitation
- Repair of perineal laceration
- Maternal resuscitation
- Pre-term labour and premature rapture of membranes

Qualifications for the course

For a candidate to qualify for the instructors' course he or she should:

i) Have worked or be already working in a maternity set-up for more than a year post internship

ii) Be an obstetrician/gynecologist or family medicine registrar

iii) Be a midwife or nurse who is actively in-

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Training for quality maternity care

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volved in a maternity setting

iv) Have been actively involved/interested in teaching of obstetrics or midwifery

Course objectives

- To discuss methods of managing pregnancy and birth emergencies which may help standardize the skills of practicing maternity care providers.
- Demonstrate content and skills acquisition needed to effectively manage the emergencies

The use humanistic training approach, i.e. mnemonics and mannequins to enhance competency of participants and maternity care givers in selected critical areas of obstetrics and gynecological skills is achieved by itemizing the tasks to be performed and the sequence in which they follow.

The approach also equips participants with the best practical, evidence based skills and knowledge for implementation in their day-to-day services

Teaching faculty

The overall strategy of the ALSO program is to expand its efforts to provide quality and relevant educational materials.

The teaching faculty is drawn from various health facilities including Aga Khan University Hospital, University of Nairobi, consultant obstetrician/gynaecologists from government hospitals, faith-based hospitals, registered nurses/midwives and neo-natal consultants.

Assessment

At the beginning of the training session, a pre-assessment exam whose objective is to assess participant preparedness for the training, is conducted. This evaluation is usually carried out immediately after registration and before commencement of the lectures.

At the end of the course, participants are evaluated through a written exam and skills assessment (practical examination). Essentially, this is to equip participants with both skills and knowledge.

A work station in the ALSO Cameroon training.

Those who pass are awarded a certificate from the Institute of Family Medicine (INFAMED) which is authorized by the American Academy of Family Physicians (AAFP). The course curriculum is revised often.

Achievements

So far, 45 training sessions have been conducted in Kenya, reaching a total of 1,045 medical personnel and a pool of 53 approved instructors. The trainings have also been conducted in Rwanda, Puntland and Cameroon.

The ALSO Program has been accredited by the Medical Practitioners and Dentists Board (MP&DB) as a CPD Program. Physicians who attend the training therefore earn their CPD points.

The program falls under Level 2 of skills-based training.

The course has continued to attract participants from national referral and county facilities, faith-based hospitals, privately entities and institutions of higher learning. Regular training sessions are conducted in June and October in Nairobi. On-site training sessions have been conducted in:

i. Kakuma Refugee Camp (2008 & 2010)
ii. AIC Kijabe Hospital (2009 & 2010)
iii. Univ. Of Nairobi – Department of Obs/

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Solar fridges to ease storage of vaccines in rural health facilities

Project background

Refrigeration or cooling is a big challenge in rural and even urban areas of African countries. Most refrigerators run on kerosene, diesel or gas – causing high emissions. However, environmentally friendly concepts have been developed over the last 10 years. Alternative energy sources such as solar, wind and hydro are largely available in Kenya.

The SolarChill project being implemented country-wide is aimed at improving refrigeration in rural and remote health facilities. Under the project, each health facility will receive a solar fridge at no cost to the facility.

The target is the rural remote areas that do not have electricity or experience frequent blackouts and power flactuations. Some of these health facilities are sharing fridges or do not have fridges at all.

All the health facilities that will benefit from the fridges are offering immunization. Among the stakeholders in the project are the Ministry of Health – Kenya Expanded Immunisation Programme (KEPI), CHAK and SUPKEM.

The SolarChill project is a partnership between nine international organizations and CHAK. These international organisations are:

- Global Environment Facility
- Green Peace
- Programme for Appropriate Technology in Health
- UNICEF
- Danish Technological Institute
- Swiss Resource Centre and Consultancies for Development
- GIZ
- WHO
- HEAT

SolarChill A Project – Pilot phase	SolarChill B Project – Pilot phase
• Vaccine fridges	• Commercial fridges
• For health facilities	• For commercial areas/business
• Up to 66 to be distributed in Kenya	• Up to 15 to be distributed in Kenya
• Passing of WHO standard	• Passing of WHO standard

The project will be implemented in two phases - A and B as spelt out in the chart above.

It incorporates Greenfreeze technology developed by Greenpeace and is free of harmful chemicals (no use of HCFC - Hydrochlorofluorocarbon). The technology is publicly and freely available.

SolarChill demonstration and technology transfer pilot projects are taking place in Kenya, Colombia and Swaziland and involve production of solar fridges. The project is scheduled to end in December 2018 and is being under-

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ALSO Training for quality maternity care

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Gynae (2010)

iv. Aga Khan Uni. Hosp (2011)

v. M. P. Shah Hosp. (2013)

vi Kenyatta National Hosp – Department of Obs/Gynae (2010 & 2014)

vii. The Nairobi Hospital (2014)

viii. Aga Khan Hosp. - Mombasa (May 2015)

ix. Narok County (June 2015)

xi. Embu Provincial Hospital (November 2015)

xii. Aga Khan University Hospital (December 2015)

xiii. Kenyatta National Hospital – Department of Obs/Gynae (March 2016)

xiv. M. P. Shah Hospital (May 2016)

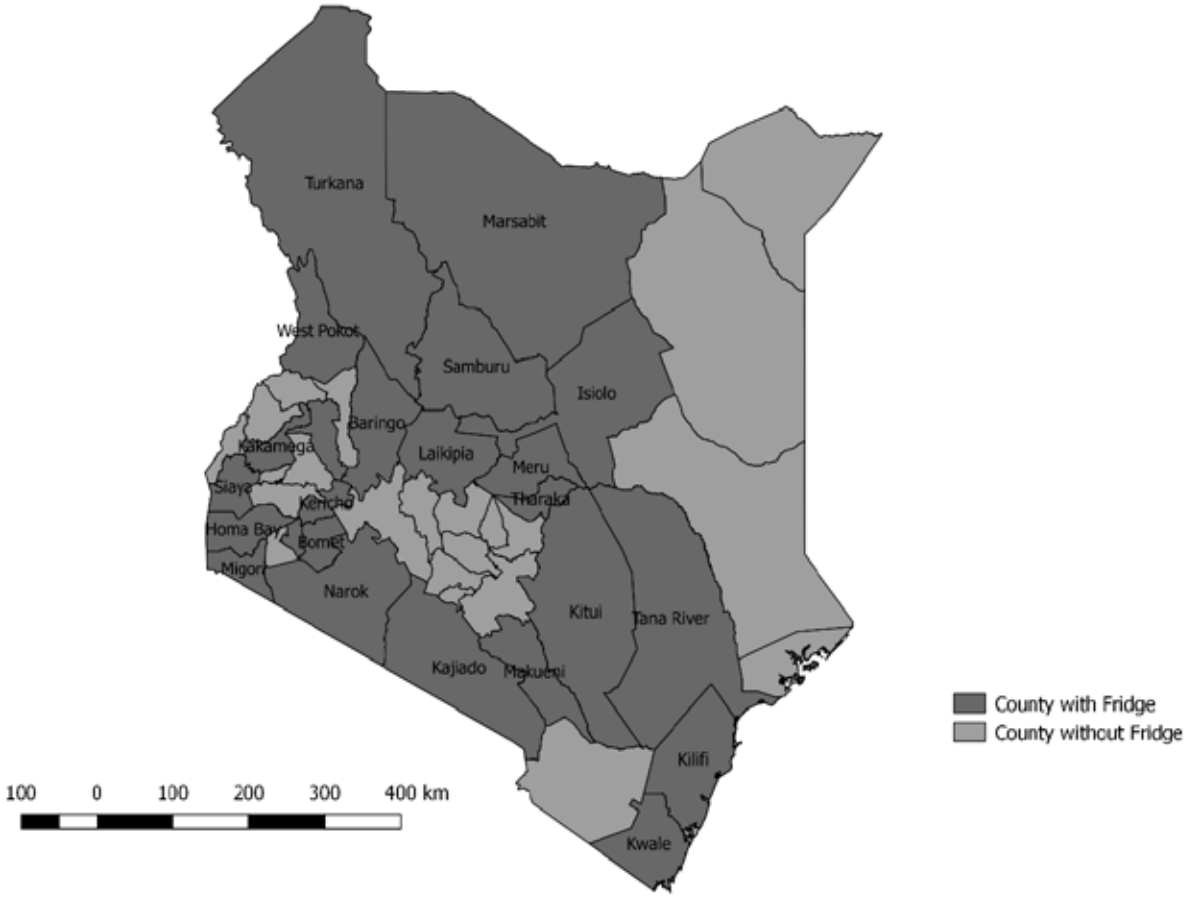
xv. The Karen Hospital (May 2016)

xvi. University of Nairobi – Department of Obs/Gynae (September 2016)

xvii. The Mater Hospital (September 2016)

Solar fridges to ease vaccine storage

Distribution of the solar fridges in the counties



Government	Christian	Muslim	Private
25	25	5	10

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taken in two phases:

- SolarChill A
- SolarChill B

The chart on the previous page gives more details on the two phases.

Solar fridges in Kenya

The solar fridges utilise a simple technology where 2-3 photovoltaic solar panels capture solar energy. The solar energy is then converted into direct current electricity (DC) which starts the compressor to run the actual refrigeration cycle.

Cool air is circulated by convection and cooling fan while a thermostat secures the desired temperature. Temperature monitoring and data collection is done through GPS (Satellite) or GSM (Global System for Mobile Communication). The fridges are battery free.

Distribution to relevant stakeholders

SolarChill A (health facilities)

The fridges will be distributed to stakeholders as per the table below according to the number of health facilities per stakeholder.

The table above shows the proposed distribution of the solar fridges in faith-based and government facilities.

SolarChill B (commercial)

It is yet to be decided where fridges under SolarChill B will be distributed.

The following counties are targeted to benefit from the fridges:

- Western and North Rift Region: Siaya, Kakamega, Turkana, West Pokot, Uasin Gishu, Elgeyo Marakwet, Baringo
- Eastern and North Eastern Re-

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CHAK awarded CHAP Uzima grant

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Machakos, Kajiado, Narok and Nairobi counties through four partners i.e. Africa Brotherhood Church (ABC), Adventist Centre for Care and Support (ACCS), Anglican Development Services – ACKNIDP, and Apostles of Jesus AIDS Ministries (AJAM).

The OVC package of support will include the following:

- Health – Support for HIV prevention, testing and linkage to care
- Education support to OVCs
- Household economic strengthening
- Food and nutrition support – Food distribution and OVC health nutrition education
- Psychosocial support including counselling, mentor sessions, home visits
- Protection and legal

The GBV services will be funded in all the supported health facilities and the package will include:

- GBV sensitization in health facilities and in the community
- Sensitization about availability of post-GBV services at facility level
- Capacity building for comprehensive post-GBV care services and reporting
- Support facilities to link with non-clinical services e.g. legal services, safe spaces

OVC sites supported in CHAP Uzima project

OVC partner	County Supported	No. of Sub counties supported	No. of OVC's supported	No of Households Supported
ABC	Machakos	2	1503	769
ACCS	Nairobi	2	1750	700 in Pamoja project and 498 in Timiza project
ACKNIDP	Narok	2	1236	499
AJAM	Kajiado	3	1472	660

Counties supported in CHAP Uzima follow-on project compared to CHAP

Counties supported in CHAP		Counties Supported in CHAP Uzima	
1	Nairobi	1	Nairobi
2	Mombasa	2	Mombasa
3	Kilifi	3	Kilifi
4	Taita-Taveta	4	Taita-Taveta
5	Kitui	5	Kitui
6	Kiambu	6	Kiambu
7	Muranga	7	Muranga
8	Kirinyaga	8	Kirinyaga
9	Nyeri	9	Nyeri
10	Nyahururu	10	Nyahururu
11	Laikipia	11	Laikipia
12	Nakuru	12	Nakuru
13	Embu	13	Embu
14	Tharaka - Nithi	14	Tharaka - Nithi
15	Meru	15	Meru
16	Kajiado	16	Kajiado
17	Marsabit	17	Narok
18	Isiolo	18	Makueni
		19	Machakos

Project coverage

There is increased coverage in the follow on award. Until March 31, 2017, CHAP supported 54 health facilities in 18 counties. The CHAP Uzima follow-on project is supporting 82 facilities in 19 counties.

Marsabit and Isiolo counties which were previously supported in CHAP will not be supported in CHAP Uzima.

However, in addition to the previously supported counties, CHAP Uzima will support care and treatment, GBV and Orphaned and vulnerable Children OVC services in faith-based and affiliated facilities in Narok, Makueni and Machakos counties.

AIC Cure reaching out to infants with orthopaedic conditions

"I thought it would correct on it's own..."

"I didn't think the condition could be changed by anyone, so we didn't even visit any hospitals... My relative had the same condition. He is old now and nothing was done to correct it, so we thought it was just another inherited disease. Hence, we never even bothered to seek medical help..."

Both of the above statements have been recorded from the parents or guardians of patients who have come to CURE seeking treatment in the advanced stages of their conditions. For a lot of patients, it has not been a matter of choice, but a lack of information that has kept them with their conditions.

In Kenya, there is still a huge number of mothers who give birth to their children in their homes with the help of traditional midwives. A lot of these midwives lack basic medical knowledge in regards to a lot of physical disabilities. In cases of congenital anomalies, instead of these mothers getting directed to specialists for help, they end up getting fed with myths and social stereotypes from day one.

Stories of communities which believe that disabilities are a result of witchcraft are common in our society. Communities getting rid of disabled children in our country are not tales of fiction.

In Kenya, some of the most common orthopedic conditions affecting children between the ages of zero and five years of age include clubfoot, bowed legs, knock knees, and developmental dislocation of the hip.

These affect the lower part of the body (hip, thigh, knee, leg, ankle and foot).

There are also conditions affecting the upper extremity such as: Polydactyly (extra finger digits) and syndactyly (webbed fingers). Scoliosis and kyphosis are spinal deformities which are characterized by an abnormal curvature of the spine. Arthrogryposis is a congenital condition characterized by multiple contractures in multiple joints. There are also other forms of acquired contractures, the most common of which being burn contractures.

The majority of these conditions are congenital with some having hereditary traits. Others are acquired as a result of trauma or an underlying pathology. Conditions like cerebral palsy, spina bifida, and other neurological conditions can lead to orthopedic conditions in children.

«« From

The most common of the above conditions is clubfoot, affecting one in every one thousand newborn babies in Kenya. The picture below shows pictorial representations of some of these conditions:

Pictorial representation of some common orthopedic conditions affecting children between the ages of zero and five years.

All of the above conditions have orthopedic procedures that can be used to correct them. For some of them, the management will be determined by the age of the patient at the time of intervention. The underlying pathology determines the management journey. These procedures span from surgical intervention to casting, physiotherapy, prosthetics, and orthotics.

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Reaching out to infants with disabilities

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AIC CURE International Hospital in Kijabe has specific management programs for identification and management of these conditions.

Taking an example of clubfoot, CURE has a clubfoot program that has clinics around the country. This program helps correct clubfoot for babies from zero to two years of age. The aim of the program is to have all babies born with clubfeet celebrate their second birthday with normal feet.

Under this program, we run clinics around the county in 25 locations to make sure that we reach as many communities in Kenya as possible. When clubfoot intervention is done to a baby below the age of two years, the Ponseti method (a corrective procedure using casting then braces) is used to correct the feet and in a majority of cases, a surgical procedure is not necessary.

For other orthopedic conditions, CURE runs mobile clinics across the country in more than 20 locations where a team from each hospital department travels to these locations and does sensitization, reviews patients with any orthopedic issues, does counseling for guardians with affected children, and follow up of patients who have already been treated at CURE hospital.

cleft lip

cleft palate

When babies are reviewed at the clinic, our team advises on a way forward for the patient. If a surgical procedure is needed, appointments are given for the patient to come to the hospital at Kijabe where all surgeries are done.

Our management procedures start at the clinic and then referrals are made as our team sees need. We also have a clinic in Nairobi situated in Westlands, Mpaka road, Westpoint Building, fourth floor. This clinic is always open to cater for the larger Nairobi population that cannot get to Kijabe.

CURE Kijabe has a special program where we work in collaboration with Smile Train, an NGO, to restore smiles to babies with cleft lip and palate conditions. CURE runs a one week camp at the hospital where we do surgical procedures free of charge for all kids with these conditions. The camps happen three times a year in March, July, and October.

Knowledge is power, and in matters health, knowledge is healing. We understand that at CURE and through different kinds of partnerships, we carry out awareness programs in schools, communities, and other public institutions to inform both parent and child about physical disabilities and their management.

As CURE, we do what we can, but we cannot help someone we haven't met yet. It's our prayer and request that every person in the community be duly informed regarding physical disabilities, the curative processes, and the facilities that cater for such. In that way, we can all be our brothers' and our sisters' keepers and point them in the right direction for help and healing.

An outreach in Mombasa County. CURE runs mobile clinics across the country in more than 20 locations where a team from each hospital department travels to these locations and does sensitization, reviews patients with any orthopedic issues, does counseling for guardians with affected children, and follow up of patients who have already been treated at CURE hospital.

WHO issues new guidelines on care of pregnant mothers

WHO's new antenatal care model increases the number of contacts a pregnant woman has with health providers throughout her pregnancy from four to eight. Recent evidence indicates that a higher frequency of antenatal contacts by women and adolescent girls with the health system is associated with a reduced likelihood of stillbirths. This is because of the increased opportunities to detect and manage potential problems. A minimum of eight contacts for antenatal care can reduce perinatal deaths by up to 8 per 1000 births when compared to a minimum of four visits.

The new model increases maternal and fetal assessments to detect problems, improves communication between health providers and pregnant women, and increases the likelihood of positive pregnancy outcomes. It recommends pregnant women to have their first contact in the first 12 weeks' gestation, with subsequent contacts taking place at 20, 26, 30, 34, 36, 38 and 40 weeks' gestation.

"More and better quality contacts between all women and their health providers throughout pregnancy will facilitate the uptake of preventive measures, timely detection of risks, reduces complications and addresses health inequalities," says Dr Anthony Costello, Director of Maternal, Newborn, Child and Adolescent Health, WHO. "Antenatal care for first time mothers is key. This will determine how they use antenatal care in future pregnancies."

The new guidelines contain 49 recommendations that outline what care pregnant women should receive at each of the contacts with the health system, including counselling on healthy diet and optimal nutrition, physical activity, tobacco and substance use; malaria and HIV prevention; blood tests and tetanus vaccination; fetal measurements including use of ultrasound; and advice for dealing with common physiological symptoms such as nausea, back pain and constipation.

"Counselling about healthy eating, optimal nutrition and what vitamins or minerals

The new guidelines contain 49 recommendations that outline what care pregnant women should receive at each of the contacts with the health system

women should take during pregnancy can go a long way in helping them and their developing babies stay healthy throughout pregnancy and beyond," says Dr Francesco Branca, Director Department on Nutrition for Health and Development, WHO.

By recommending an increase in the amount of contact a pregnant woman has with her health provider, WHO is seeking to improve the quality of antenatal care and reduce maternal and perinatal mortality among all populations, including adolescent girls and those in hard-to-reach areas or conflict settings.

WHO recommendations allow flexibility for countries to employ different options for the delivery of antenatal care based on their specific needs. This means, for example, care can be provided through midwives or other trained health personnel, delivered at health facilities or through community outreach services. A woman's 'contact' with her antenatal care provider should be more than a simple 'visit' but rather the provision of care and support throughout pregnancy.

Sample recommendations include:

- Antenatal care model with a minimum of eight contacts recommended to reduce perinatal mortality and improve women's experience of care.
- Counselling about healthy eating and keep-

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Contribution of the CHAK network to the health of Kenya's mothers and babies

CHAK is a key stakeholder in the delivery of maternal, neo-natal and child health services in Kenya. Among CHAK's key areas of contribution are:

1. Family planning and pre-pregnancy care to ensure that individuals and couples can plan their pregnancies.
2. Focused Antenatal Care to prevent complications where possible and ensure that complications of pregnancy are detected early and treated appropriately.
3. Essential Obstetric Care to ensure that essential care for high-risk pregnancies and complications is made available to all women who need it.
4. Essential Newborn Care to ensure that essential care is given to newborns from the time they are born up to 28 days in order to prevent complications that may arise after birth.
5. Targeted Postpartum Care to prevent any complication occurring after childbirth and ensure that both mother and baby are healthy and there is no transmission of infection from mother to child.
6. Post Abortion Care to provide clinical treatment to all women and girls seeking care for complications of incomplete abortion and miscarriage as well as counselling and contraceptives

CHAK health facilities performance in MNCH over the past year (2016) is shown in the tables below.

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ANC performance in CHAK facilities in 2016 (bottom)

Indicator	CHAK MHUs performance
ANC Breast exanimated	543,189
ANC Client Supplemented with Combined Iron and Folate	447,444
ANC Client given Iron	295,045
ANC Client given folate	206,494
ANC clients Syphilis +ve	3,500
ANC clients tested for syphilis	282,588
ANC given exercises	223,138
Adolescents (10-14 years) presenting with pregnancy	7,222
Children under 1Yrs distributed with LLITNs	65,021
Clients given IPT 1st Dose	95,845
Clients given IPT 2nd Dose	88,676
Clients with Hb <11g/dl	57,531
LLITNs distributed to ANC clients	244,646
Mother counselled on infant feeding options	232,998
New ANC clients	386,947
Pills Combined oral contraceptive	156,886
Pregnant women completing 4 ANC visits	201,610
Re-Visit ANC Clients	763,562
Adolescents (15-19 years) presenting with pregnancy	75,768

CHAK health facilities' contribution towards increasing skilled birth attendance and postnatal care in 2016 (right)

Indicator	CHAK MHUs performance
Adolescent (10-19yrs) Maternal deaths	407
Assisted vaginal delivery	2241
Babies discharge Alive	273455
Babies given tetracycline at birth	136281
Birth with deformities	379
Births with low APGAR score	4141
Breach delivery	2769
Caesarian sections	39175
Deliveries from HIV+ve Women	9110
Fresh still birth	3644
Infants initiated on breast feeding within 1 hour after birth	174221
Live birth	288352
Macerated still birth	2765
Maternal deaths audited	241
Maternity referrals From other health facility	9211
Neonatal deaths	3136
Normal deliveries	255825
Pre-term babies	8867
Total maternal deaths	302
Underweight babies <2500gms	14595

Contribution of CHAK to MNCH in Kenya

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CHAK health facilities inmmunization performance in 2016

Indicator	CHAK MHUs Data
Adverse Events Following Immunization(AEFI)	1475
BCG doses Administered	395558
DPT/Hep+HiB1 doses Administered	382883
DPT/Hep+HiB2 doses Administered	363978
DPT/Hep+HiB3 doses Administered	358247
Fully Immunized Child(FIC)above 2 years	2690
Fully Immunized Children(FIC) under 1 year	333686
IPV doses Administered	272354
IPV doses in stock at the beginning of the Month	605834
IPV doses received within the Month	291691
IPV doses remaining at the end Month	595460
Measles-Rubella 1 doses Administered	351007
Measles-Rubella 2 Dose Adm (at 1 1/2 - 2 years)	143893
Measles-Rubella 2 Dose Administered >2 yrs	15420
OPV Birth doses Administered	311455
OPV1 doses Administered	378087
OPV2 doses Administered	357717
OPV3 doses Administered	348745
Pneumococal 1 doses Administered	381807
Pneumococal 2 doses Administered	360783
Pneumococal 3 doses Administered	356795
Rotavirus 1 doses Administered	367816
Rotavirus 2 doses Administered	336547
Squint/White Eye reflection Under 1 year	6233
Tetanus Toxoid for Pregnant women	423398
Vitamin A 2 years to 5 years(200,000 IU)	870867
Vitamin A Supplemental Above1 Year(200,000IU)	25933
Vitamin A Supplemental Lactating Mothers (200,000IU)	252283
Vitamin A Supplemental under 1 Year(100,000IU)	12504
Vitamin A at 1 1/2 years(200,000 IU)	256319
Vitamin A at 1years (200,000IU)	287839
Vitamin A at 6 months(100,000 IU)	310679
Yellow fever doses Administered	4998

Solar fridges to ease vaccine storage

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gion: Meru, Tharaka Nithi, Isiolo, Kitui, Makueni, Marsabit, Samburu

- Nyanza and South Rift Region: Home Bay, Migori (Kuria), Nyamira, Kericho, Bomet
- Nairobi, Central, Coast and Ukambani Region: Kilifi, Kajiado, Narok, Laikipia, Tana River, Kwale

The fridges will be imported into Kenya from Swaziland. The procurement process will be undertaken with the help of MoH and UNICEF.

To ensure optimal utilisation of the equipment, two trainings have been planned:

a. Training on solar fridges for technical service personnel focusing on technology, maintenance and GPS/GSM. Among the groups targeted for this training are the CHAK team, biomedical engineers of selected counties (NVIP), SUPKEM engineers, private engineers and potential manufacturer technical team.

b. Training on solar fridges directly at the health facility to be done when installation takes place and will focus on the Standard Operating Procedure.

A common challenge in Kenya is equipment maintenance. Maintenance will be done by the trained technical service personnel.

Strengthening routine services through Malezi Bora initiative

Introduction

Malezi Bora are regular events organized bi-annually in May and November. The events consist of an integrated package of preventive, curative and rehabilitative services aimed at improving child and maternal health and nutrition. These health services accelerated and supported by advocacy activities.

Strategic objectives

- Promote early, exclusive, prolonged breastfeeding and complementary feeding
- Improve routine immunization of children
- Promote growth monitoring and promotion
- Increase Vitamin A supplementation for all children age 6 to 59 months
- To provide Integrated Case Management of Childhood Illnesses
- To improve service delivery to pregnant women and reduction of complications
- To enhance of the knowledge of mothers and other caregivers on new born care
- To Increase family planning uptake

2017 Malezi Bora activities

The 2017 Malezi Bora events are scheduled to

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New WHO antenatal guidelines

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ing physically active during pregnancy.

- Daily oral iron and folic acid supplementation with 30 mg to 60 mg of elemental iron and 400 µg (0.4 mg) folic acid for pregnant women to prevent maternal anaemia, puerperal sepsis, low birth weight, and preterm birth.
- Tetanus toxoid vaccination is recommended for all pregnant women, depending on previous tetanus vaccination exposure, to prevent neonatal mortality from tetanus.
- One ultrasound scan before 24 weeks' gestation (early ultrasound) is recommended for pregnant women to estimate gestational age, improve detection of fetal anomalies and multiple pregnancies, reduce induction of labour for post-term pregnancy, and improve a woman's pregnancy experience.
- Health-care providers should ask all pregnant women about their use of alcohol and other substances (past and present) as early as possible in the pregnancy and at every antenatal visit.

- **The guidelines include counselling on healthy diet and optimal nutrition, physical activity, tobacco and substance use, malaria and HIV prevention, blood tests and tetanus vaccination, fetal measurements including use of ultrasound and advice for dealing with common physiological symptoms such as nausea, back pain and constipation**

Strengthening health systems, including through improved access to qualified health providers, will be key if countries are to implement the guidelines. In September, the UN Commission on Health Employment and Economic Growth recently called for accelerated investment in the health workforce. In response to the Commission's request, the Vice-Chairs of the Commission from WHO, the International Labour Organization (ILO), and the Organizations for Economic Cooperation and Development (OECD) will convene all relevant stakeholders by the end of 2016 to develop a 5-year implementation plan for the 10 recommendations.

More information is available on https://www.ncbi.nlm.nih.gov/books/NBK409113/table/fm.s2.t1/?report=objectonly

Source: ***http://www.who.int/reproductivehealth/news/antenatal-care/en/***

Malezi Bora improves services uptake

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take place as follows:

• May 2 - 14, 2017

• October 15 - 27 2017

The national theme is ***'Afya ya Jamii, Ustawi wa Nchi'***. However, counties can come up with their own sub themes depending with health needs.

What is planned for 2017?

- Social Mobilization including launching the event
- Strengthened and integrated support supervision
- Enhance outreach services to hard to reach populations
- Disseminate 'Malezi Bora' Strategy 2017-2020
- Ensure supplies including drugs, vaccines, Vitamin A and family planning commodities
- Data tracking and reporting to strengthen M&E system
- Partners coordination and collaboration

Roles of County Health Management Teams

- Establish County/Sub-county 'Malezi Bora' Steering Committees for planning and coordination of activities
- Support advocacy and social mobilization including launching of the activity at county and sub-county levels
- Close supervision and monitoring of the event
- Manage logistics to ensure that essential medical supplies are available in the county
- Support outreach services targeting hard to reach areas and early childhood development centers

The 'Malezi Bora' package

Health facilities offer what they normally offer – Other interventions may be added according to need and capacity.

Achievements

Malezi Bora activities have been conducted successfully since 2007. Results shows increase in uptake of health services in health facilities and improved knowledge on maternal and child health through advocacy activities. Counties and sub-county use the Malezi Bora events to intensify supervision.

Key learning on Malezi Bora

- It is a good strategy to deliver integrated services to children and mothers.
- Social mobilization is key to success and sustainability of the strategy.
- Financial support to counties is key to sustainability.
- More community involvement in health care provision is needed.
- A functional M&E system is necessary to help capture the gains made.
- Outreach services to hard to reach population and early childhood development centres improve coverage.

2016 Activities- Some Results see tables

Recommendations

- Resource mobilization for Malezi Bora at national and county level is important to ensure all counties

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Expectant Women	Under- fives	Lactating Mothers/ WoRA
Weight monitoring & counseling	Growth monitoring & Promotion	Vitamin A
Palpation	Vitamin A	Family planning
De-worming	Immunization	Post-partum care
IPT (malaria)	De-worming	
Immunization (TT)	Integrated management of the sick child	
Iron and folic acid	Malaria control (ITN)	
PMTCT Facility delivery	Child health rights Immediate newborn care	

The Malezi Bora package

Malezi Bora improves services uptake

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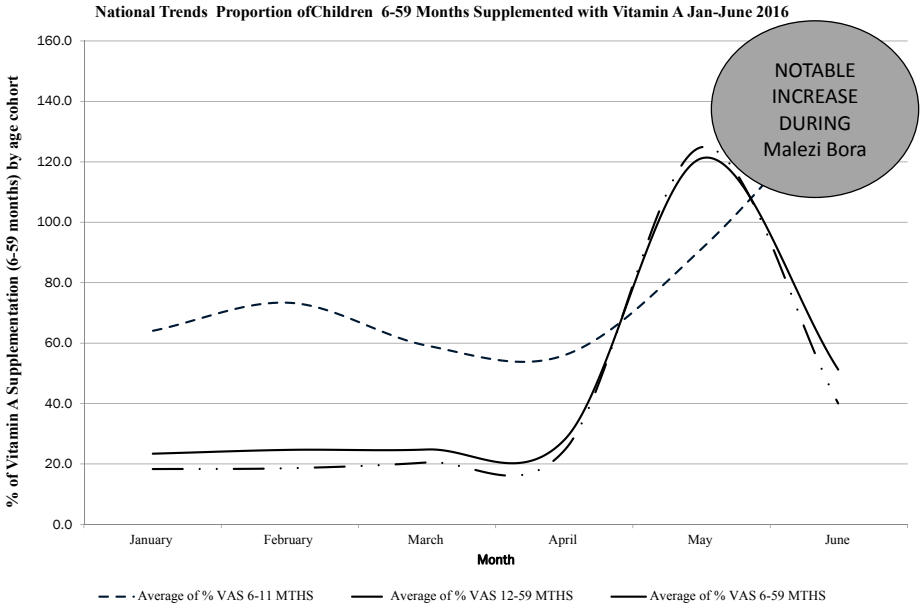
are supported to carry out the activities.

- There is need to improve logistical supplies. Vitamin A supplements can be integrated with distribution of vaccines.
- Strengthen monitoring and evaluation and use of DHIS-2 for all routine reporting.
- Strengthen outreach services and also target the early childhood development centres to improve coverage of the targeted interventions.



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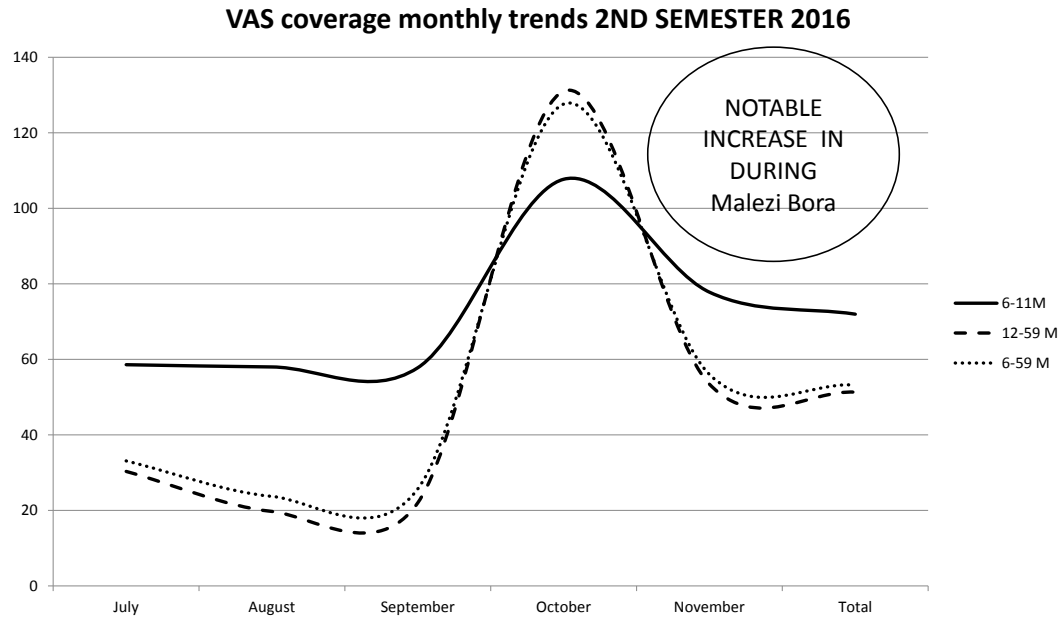

Innovating to improve maternal child health in Narok county

John Leposo from Ongata Nado in Narok North says deliveries have increased from an average of 4 to 12 per month in the facility.

Introduction

Narok County has some of the lowest performing indicators in maternal child health. As a key pointer, the number of health facility births stands at below 36 per cent while teenage child bearing is at 40 per cent according to the Kenya Health and Demographic Survey (KHDS) 2014.

The Maternal and Child Health project implemented in the county sought to address issues around the health of mothers and children.

Project objectives

The project aimed to address four main areas:

a) Increase uptake and utilisation of improved quality maternal child health services by 30 per cent in Narok County.

b) Reduce acute malnutrition among children by five per cent and increase micro-nutrient supplementation among pregnant women by 20 per cent in target communities

c) Increase access to reproductive health services by 30 per cent and increase knowledge, attittude and practice related to family planning by 45 per cent

d) Strengthen capacity of the county health management teams and two civil society organisations to lead, coordinate and supervise health services in Narok County

The four-year project was implemented from 2013 to 2016 with Christian Aid and the lead partner who supported ADS South Rift, Narok Integrated Development Project, Trans Mara Rural Development Programme and Community Health Partners.

Project strategies

The project utilised the following strategies:

- Training of community health workers
- Training of community health facility committees
- Re-orientation of traditional birth attendants to become mother companions to accompany pregnant mothers to deliver at the health facility. The mother companions received Ksh500 for every mother they accompanied to the health facility for delivery.
- Training mentor mothers who are in the reproductive age bracket to become maternal child health champions. These mentor mothers were required to have attended all ante-natal clinic visits during pregnancy and their children received all standard immunisation. The role models were tasked with encouraging other mothers to seek appropriate health services for themselves and their children. To bring the mentor mothers together, they were given seed money amounting to Ksh25,000 per group to begin table banking.
- The project also conducted mobile outreaches to raise awareness and encourage proper nutrition in the community. Nutritionists and health care workers screened children for malnutrition. Those who were not severely malnourished were managed at the site while those who were severely malnourished were admitted at the county referral hospital and treated at no cost until their recovery.
- Another strategy was equipping health

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Maternal child health in Narok County

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care facilities with basic emergency obstetric equipment such as resuscitors, delivery beds, delivery packs, sunction machines, among others.

- Men forums were useful in increasing uptake of family planning in the county. The project realised that there was a huge knowledge gap on family planning between men and women, with women being very well informed.

  However, the women required permission from their husbands to take up any family planning method.

  The project therefore brought men together in forums and educated them mainly on family planning as well as gender based violence among other issues.

The response from the men proved excellent. Uptake of family planning in the country increased from 18 per cent to 41 per cent by the end of the project.

To mobilise the men, the project went through Community Units each of which had a Community Health Worker. Each Community Health Worker was asked to come with at least 10 men from their village. During the meetings, a goat was slaughtered and eaten after the information had been passed to the men.

- The Maasai community does not plan for child birth as this is believed to be a bad omen. To ensure infants got a good start in life, mothers who delivered in the health facility were provided with a mother pack which included a baby shawl, basin and diapers at the facility after delivery.
- The project also employed the m-health strategy under which community health workers were provided with mobile phones into which a software to record indicators for house hold visits was installed. For the m-health pilot, a few indicators including immunisation and ANC visits were tried. The community health worker was required to register all mothers in their community units who were pregnant or had children requiring immunisation. The mobile phone would remind the community health worker of the impending appointment about one week before the actual event. The community health worker would then take the initiative to remind the mother to visit the health facility.

Once the mother visited the health facility, the nurse would record the patient's information and the community health worker would visit the health facility to confirm if the mother had honored the appointment.

- **Deliveries at Nturumeti Dispensary, for example, increased from between one and three in a month to 30**
- **Uptake of family planning in the country increased from 18 per cent to 41 per cent by the end of the project**
- **Health care facilities were equipped with basic emergency obstetrics equipment**

However, the m-health strategy did not pick well due to the high illeteracy rates in the region.

Under the project, deliveries at Nturumeti Dispensary, for example, increased from between one and three in a month to 30.

A key driver of the huge increase was the free maternity services offered by Government health facilities. Mothers were encouraged to take advantage of the free services and reap the benefits of proper care in maternal child health.

Additionally, the nurses at the health facility were encouraged to allow the mother companions to stay with the mother and offer the same comfort that they would have offered as traditional birth attendants. However, the mother companions were not allowed to deliver the baby or to be present during the birth.

Narok County has major infrastructure challenges, leading to low access to health services. Distances between health facilities are often quite large. Even when the patient manages to get to a health facility, attendance by a health worker is not guaranteed due a huge shortage of human resources for health. This has led to very low access to health services for the local community.

Innovative approaches to maternal child health bring changes in Narok

Anne Oyee and John Leposo, health workers in Narok County, speak of the changes in the community following innovative project

Ann Oyee was posted to Nturumenti Dispensary three months ago.

She was transferred from Entoto Dispensary in Narok East where the Maternal and Child Health project had not supported any interventions .

"There were no TBA trainings, no mother packs or training for mother groups. I had stayed six months without conducting any delivery and the facility has not had any referrals from the villages either," says Ann.

"I have seen such a big difference since i came to Nturumenti. I am very encouraged to see what the project has done especially in changing the attitudes and perception surrounding the TBAs."

Ann reports that the mother companions have encouraged more women to attend antenatal and post natal care clinics. Mothers in the comunity are demanding for family planning methods. Things are changing as mother companions encourage pregnant women to have some savings to cater or transport food and clothes.

"In fact, maternal deaths have significantly reduced", she said, adding, "I have not recorded any since I came here".

Despite the poor road network. the project should go to more areas to change poor health seeking behavior in this community, she advises further adding that a few roads have been constructed after intense advocacy efforts.

John Leposo - Ongata Nado Dispenary, Narok North.

"Despite the size of rooms we are working in, the greatest thing that I have seen recently has been the changed attitude by the community members in health seeking.

Although the fourth ANC attendance is still low in the facility's catchment community, new ANC has risen by over 100 per cent and immunization uptake is very good.

Ann Oyee a registered health Nurse recently posted to Nturumenti dispensary.

Deliveries have reached an average of 12 per month up from four. This has improved because of the TBAs (mother companions) who have been very active in bringing the mothers.

Although we trained 29 community health workers, 14 withdrew but 15 are actively coordinating with the mother companions.

Quality services have also contributed to more and more people seeking care. As a result, the county government has posted an additional nurse and has sent us the supplies we requested.

We have even seen new TB cases and the CHWS have been doing defaulter tracing. About three TB patients are on treatment.

Additional staff include one new nutritionist who was posted in July. A support staff to support in cleaning linen and the room has also been assigned to us.

We have also been facilitated with a motor bike to enable supervision of the community unit. I am very happy with the progress and responsiveness of the community."

Role of mother companions in Narok maternal child health project

An interview with Nalango Neikunyi, a mother companion in Nturumenti community unit

I started assisting pregnant mothers when I got my first born about 21 years ago. I am happy now because I got trained as a mother companion in August 2014 and my role has changed to referring mothers to give birth at our medical facility here in Nturumenti.

Before my training as a mother companion, I had conducted over 40 deliveries - actually I don't keep an account of how many. This is just an estimate considering that about two to four women came to seek my help every month over the last 10 years.

I faced many problems.

I recall about three mothers who bled excessively and yet I had no drugs or water (intravenous fluids) that we see the nurses giving under such conditions in the health facility. They bled and died.

Babies nostrils were blocked by mucus but I could not assist them. One premature child was born and she died due to lack of knowledge and skills. I could not offer the mother and baby any assistance. Yet, with the knowledge I have today, some of this cases could have been assisted.

She states that the training has helped her and other TBAs realise the importance of skilled hospital deliveries. Since September 2014 she has referred 13 mothers whose babies are healthy, have received all their vaccinations in time and their growth has been monitored by the health workers.

Nalango says that it is very wrong to keep mothers who are delivering at home.

"In case of complications they can be referred to the district hospital."

We have also lost our counterparts through HIV infections. The risks are higher if a traditional birth attendant does not use gloves. They do not use gloves consistently, she explains.

The other TBAs are also fighting female genital mutilation practices. I have realised that those women who pass through FGM have scars that further complicate giving birth. Emergency deliveries on the way to the hospital sometimes occur. I remind the mothers to always have a pair of sterile gloves, threads and razors which come in useful in such circumstances. We ask the mothers to always be prepared due to the challenges we have in our villages."

I asked her where she got the confidence and knowledge she proudly boasts off.

"I was among the beneficiaries trained by the government some years back. We had been trained how to conduct deliveries. We were trained on how to remove a retained placenta. This how I knew how to tap and remove mucus from a new born.

For every mother I bring to the health facility, I have been getting Ksh500, while the mother goes home with a pack that contains a towel, cotton wool, sanitary pads, soap and a bathing basin. This has helped us to advocate to the husbands to release their wives for us to escort to the hospital.

Unfortunately, we no longer get the traditional gift of a goat's backbone meat that we used to get after conducting a delivery because customarily it was meant to cleanse the blood we touched while assisting with the birth.

Asked if she has lost her status in society as a traditional birth attendant and also her lively hood as a result of the project, she gives her view.

It is not a loss compared to the

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Tumutumu recognised for maternal child health services in doctors' strike

PCEA Tumutumu Hospital has signed an MOU with the Nyeri County Government following the high number of deliveries done by the health facility during the recent doctors' strike.

The MoU is expected to strengthen the hospital's partnership with the county Government with its framework guiding their relationship in the future.

The hospital whose partnership with the county government has greatly improved due to its role in mitigating the effects of the doctors' strike, also received supplies and commodities to enable it cope with increased patient numbers and emergency cases during the industrial action. The national doctors' strike began on December 5, 2016 and was called off on March 15, 2017. The strike lasted 100 days.

PCEA Tumutumu Hospital Finance manager Ms. Christine Kimotho at the facility's MCH clinic.

Hundreds of patients in Nyeri County who could not access services in Government health facilities found their way to PCEA Tumutumu where they were assured of quality health services, albeit at a greater cost.

A big percentage of these patients were pregnant mothers and clients of the MCH clinic.

With experienced gained from handling increased workload during previous strikes, the hospital's staff and management did not expect major difficulties with the latest industrial action.

Handling high patient numbers was not expected to put a big strain on PCEA Tumutumu. However, this perspective was to change as the strike period extended to over three months.

Resources started to run out and most drug companies closed their doors during the Christmas and New Year season.

Patient numbers multiplied by three to four times the normal average in MCH and maternity departments. The hospital received many emergency cases that had to be attended to, whether a bed was available or not.

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Narok mother companions making a difference in MCH

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value that has been added. Since no life of a mother or child has been lost, the new knowledge has transformed the community. In fact, the training given by the project has also improved our status in society and those who haven't got any training are no longer recognised.

The MCH project in Narok has been targeting Traditional Birth Attendants (TBAs) by reintegrating them into health service provision by redefining their roles to mother advisors.

The project seeks to actively involve them in health facilities to discourage them from conducting unsupervised home deliveries as well as attract mothers who have a strong preference for their services to the facilities to ensure supervised and skilled birth assistance.

Moreover, the TBAs work closely with the CHWs and mother groups to recruit, refer and follow up pregnant women for ANC and PNC services. The voucher system includes a provision for TBA incentives so that they will be rewarded per the number of women they refer to health facilities for delivery. This has increased the number of women who receive focussed antenatal services.

We wish to sincerly thank Mr. Wiry Asige, ADS South Rift, for providing us with the information used in these articles.

PCEA Tumutumu signs MOU with county

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Despite being low on resources, God saw us through and provided.

In a bid to cope with the increased patient numbers, more beds were added in the maternity ward and fitted into every available space. Further, mothers had to share beds with a maximum of four per bed.

Despite the increased workload and strain on resources, the hospital is proud that it did not report a single maternal death during the period of the strike. To God be all the Glory!

Strategic ways of handling the strike

1. Delaying staff leaves, recalling staff who were on leave in addition to employing staff on short term basis (locum).
2. Quick discharges to ensure shorter average length of stay and access to treatment by more patients.
3. Educating clients on waste management and cleanliness

Benefits/gains

1. Partnership with the county improved. The hospital got assistance from the County in terms of:

- Extra beds
- Commodities - mainly vaccines and BCG syringes

2. The county Government of Nyeri expressed its willingness to share its staff if the workload increased further.
3. Being a teaching institution, the Registered Nursing students were able to meet their Nursing Council requirements due to the high patient numbers. This also reduced the cost of external placements for the training college.
4. Exposure of our services to external clients especially the benefits of NHIF comprehensive coverage.

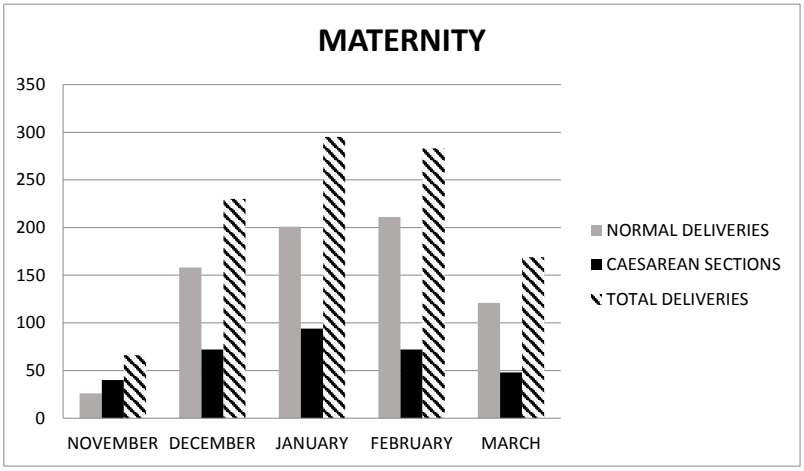
Challenges

- Heavy workload leading to staff being overwhelmed and experiencing burnout

Numbers in PCEA Tumutumu MCH department before and during the strike

CASE	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	TOTAL
ANTENATAL	170	232	242	243	232	1,119
FAMILY PLANNING	65	93	74	74	88	394
CHILD WELFARE CLINIC	289	529	472	489	452	2,231
PAP SMEAR	16	17	14	17	14	78
POST NATAL	26	26	28	32	28	140
TOTAL	**566**	**897**	**830**	**855**	**814**	**3,962**

Comparison in deliveries at PCEA Tumutumu Hospital before and during the doctors' strike



- Mothers had to share beds up to a maximum of four per bed . This had an effect on the patient attitude with some understanding the challenge while others did not.
- Shortage of supplies, mainly vaccines and BCG syringes. The hospital worked very closely with county officials who assisted by having the commodities delivered to the facility.
- Many poor patients could not afford to pay for services.
- Many under age maternity clients could not pay their bills and did not have insurance coverage from programmes such as Linda Mama.
- Poor hygiene and waste disposal by some clients

Though at the beginning of the strike the staff were not confident they would be able to handle the effects of the industrial action, the hospital learned a key lesson: Team work towards one common goal is key.

We wish to sincerly thank Ms. Christine Kimotho, Finance Manager, PCEA Tumutumu Hospital for providing us with the information used in these article.

Effects and complications associated with the practice of female genital mutilation

By Salome Kisang - Director, AIC Kapsowar Hospital

Female genital mutilation refers to all procedures involving partial or total removal of external genitalia or other injury to female genital organs for cultural or other non-medical reasons. It is widely practiced in some Kalenjin subtribes, commonly referred to as yatitaet/murwo.

The Community practices it for several reasons:

- Rite of passage from childhood to adulthood
- Believed to guarantee marriage for girls and increase the amount of dowry
- Believed to reduce sexual desire, hence curtailing promiscuity
- brings social/tribal cohesion and unity
- makes girls clean (i.e. non mutilated girls are believed to be dirty/smelly)
- brings honour to the family and the girl

Effects

FGM has serious implications for the sexual and reproductive health of the girls and women. The effects depend on:

- Type of FGM performed
- Expertise of the practitioner
- Hygiene conditions
- Amount of resistance
- General health conditions of the girl/woman undergoing the procedure

Complications occur in all types of FGM, but the type which most frequently causes major side effects is infibulation.

Immediate complications

These are complications that occur within the first 48 hours of the procedure. They include but are not limited to:

- Severe pain
- Shock, both hemorrhagic and neurogenic
- Haemorrhage is the most common complication. Several survivors have been admitted to AIC Kapsowar Hospital with this complication.
- Tetanus infection
- Urine retention
- Ulceration of genital region and injury to adjacent tissues
- Wound infection
- Urinary tract infections
- Fever and septicemia

Long term complications

- Complications during childbirth: The woman will have greater risk of caesarian section delivery, episiotomy, obstetric fistula, postpartum haemorrhage and child deaths during delivery as well as increased hospital stay.
- Formation of cysts and abscesses
- Keloid and hypertrophic scar formation
- Urethral damage resulting in urine incontinence
- Dyspareunia (painful sexual intercourse)
- Sexual dysfunction
- Hypersensitivity of genital area due to damage of neurovascular bundle
- Increased risk of HIV transmission
- Psychological effects. The survivors develop psychological stress, behavioral disturbances, anxiety and depression
- Marital conflicts and divorce due to sexual dysfunction
- Death which can be immediate or late

Economic implications

The community spends a lot of money in the surgical operations and ceremonies that accompany FGM. A lot of money is also spent on treatment of complications resulting from FGM.

Mitigation

1. Educating the community especially the male counterparts on the negative impact of FGM.
2. Educating the girl child of her rights so as to enable her make informed decisions
3. Sensitizing the authorities to take the appropriate action against FGM and those carrying out the deadly practice.
4. Educating the women who do the actual cutting in FGM.

- **The community spends a lot of money in the surgical operations and ceremonies that accompany FGM. A lot of money is also spent on treatment of complications resulting from FGM.**

Official opening of Tei Wa Yesu health centre eye clinic

Tei Wa Yesu Family Care Centre has opened a state-of-the-art eye care clinic to serve its catchment population. The eye clinic established with assistance from the Akamba Aid Fund, an independent charitable trust based in the United Kingdom, is fully equipped to provide the full range of eye care services. Akamba Aid Foundation is also supporting a health worker to ensure patients receive the proper care for all eye conditions. The clinic was officially opened on March 27, 2017, in a ceremony attended by partners of Tei wa Yesu, church representatives, representatives from CHAK and member facilities and Akamba Aid Foundation.

Left: Dr. Simon Franklin from the Akamba Aid Fund (UK) and Moderator of AEPC Rev. Daniel Kimanzi Bishop cut the tape to open the facility.

Right: Akamba Aid Fund's Dr Franklin hands over keys to the facility to Rev Kimanzi.

The Moderator is shown some of the high quality equipment which will be used in the clinic.

Eye wear at the Tei Wa Yesu Eye Clinic.

Church leaders discuss effects of doctors' strike on CHAK facilities

By Anne Kanyi, CHAK Secretariat

Throughout the health care crisis brought about by the doctors' strike in Kenya, health care workers in mission hospitals demonstrated their calling and dedication to serve the underprivileged. The dedication of health care workers in health facilities under the umbrella of Christian Health Association of Kenya (CHAK) was a testament that they were ready to make a positive difference in Kenya's health sector.

In the light of the crisis, CHAK brought together religious leaders drawn from churches supporting health facilities under its umbrella and the heads of these health facilities in a meeting to discuss the health sector crisis. The meeting held on February 9, 2017, was also aimed at coming up with an advocacy strategy for enhancing partnership and support for faith based health facilities in Kenya.

The meeting identified several key effects of the doctors' strike in CHAK health facilities.

Effects of the doctors' strike in CHAK health facilities

Partnerships

PCEA Tumutumu signed an MOU with Nyeri County which agreed to support the CHAK member health unit with staff, commodities and equipment.

This followed an increase in the maternity and delivery workload by over 500 per cent during the strike. The new development has opened up communication with the county government, which initiated the process of development of the MOU, and other health facilities in the area.

Medical Training Colleges are now sending students for rotations to the mission hospitals with these partnerships expected to continue into the long term. A good example of this is Kendu Adventist Hospital which has started receiving MTC students on rotation.

Group photo of participants at the meeting attended by church leaders and the heads of health facilities under the CHAK umbrella.

Upsurge in patient numbers

A key outcome of the industrial action was a general upsurge in the number of patients visiting mission hospitals, in both outpatient and inpatient departments, with numbers sometimes increasing by as much as 40 per cent.

Head of the Anglican Church Most Rev. Dr. Jackson Ole Sapit makes his contribution during the meeting.

Human Resources for health

The upsurge in patient numbers put immense pressure on health systems in the CHAK facilities, especially on health workers who had to work extra hard to serve every client professionally. The threat of burnout for health care workers in CHAK health facilities became real as even the pool of available locum staff was depleted.

When the work load became too heavy for health care workers in the mission hospi-

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Church leaders discuss doctors' strike

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tals, they could only plead with their colleagues in Government hospitals for reason, through every available channel, including social media.

"Doctors, nurses and all health care workers, I want to tell you that there comes a time when we must remember that we serve under oath," Edith Chege, a nurse at PCEA Kikuyu Hospital, wrote on her facebook page, probably out of frustration after seeing the suffering of so many Kenyans.

"The poor cannot afford private hospitals. Do they continue to die?" She posed.

Some of the health workers in the CHAK health facilities are unionisable and were sympathetic to their striking colleagues. Doctors and nurses were some of the cadres sympathetic to the strike.

Effects on the bottom line

Mission hospitals experienced an increased burden of staff allowances for work done overtime.

Medical supplies and commodities quickly dwindled due to increased patient numbers. The volume of medical supplies purchased went up, in some instances by as much as 35 per cent. Storage space for the increased quantities of medical supplies was a challenge.

The Constitution of Kenya guarantees the right to health care for every Kenyan. Some mission hospitals, as a policy, do not turn away patients who are unable to pay. Additionally, many patients affected by the strike paid minimal fees or nothing at all in government facilities and yet were forced to seek services in mission hospitals due to the strike. Mission hospitals ordinarily charge for services for their sustenance. These factors conspired to increase the level of bad debts incurred by CHAK hospitals during the strike.

Due to demand for surgical services, mission hospitals were focusing on emergency cases and postponing elective cases leading to unhappy clients. Some of the unhappy clients took to social media to air their grievances, compromising the reputation of the mission hospitals. The long queues also put off some of the loyal customers of mission hospitals. This may lead to reduced revenue once the strike is resolved.

CHAK Chairman Bishop Rev. Dr. Robert Langat makes his opening remarks during the meeting.

CHAK General Secretary Dr Mwenda makes his contribution at the meeting.

Referral

Referral proved quite a challenge. Many critical patients were getting to the health facility when it was too late to make an impact on their recovery.

Sammy Ikeny, a nursing officer at AIC Lokichoggio Health Centre in north-western Kenya, had to work extra hard during the strike.

The only Government hospital in the town partially shut down and the church health centre became the only source of medical care in the border town. Sammy and his team had to work very long hours to deal with the increased patient numbers while drugs and medical supplies ran out at unprecedented rates.

However, Sammy, who doubles as a health systems manager at the facility, says his greatest test was dealing with referrals. He gives the example of a HIV positive mother whose child

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Africa Christian Health Associations' biennial conference held in Lesotho

The 8th Africa Christian Health Associations' biennial conference was held in Maseru, Lesotho from February 27 to March 3, 2017. The conference' theme was 'Building partnerships for FBO health systems strengthening towards achieving the 2030 agenda (Sustainable Development Goals)'.

The conference created an opportunity for Christian health associations in Africa to reflect on their current contribution to health service delivery, the new global SDGs context, the challenges and opportunities to scale up their contribution through building effective partnerships for capacity development, resource mobilization and systems strengthening.

"Nothing we do could be done without partners," said Rick Santos, President and CEO of IMA World Health.

Moderating a panel about global health partnership opportunities for faith-based organizations, Santos noted that partnerships between faith-based organizations and secular, governmental and private donors must grow in order to reach the UN's Sustainable Development Goals.

The conference had the following objectives:

1. Understand the role of national faith stakeholders in supporting the realization of SDGs in collaboration with UN agencies, national and local governments, and academia
2. To take stock of the evidence based systems that CHAs have put in place to enhance accountability and decision making as well as advocate for partnerships with others
3. To review the existing partnership initiatives that CHAs have undertaken in the last two years to strengthen members capacity for service delivery with emphasis on children and women's health
4. To facilitate joint advocacy with and for the Christian Health Associations and Church Health Networks in Africa on matters of health systems strengthening
5. To review sustainable supply chain models that help achieve equity and support supply of essential medicines to the most at risk population groups
6. To enrich the knowledge base of Africa Christian Health Associations and Church Health Networks and participants on global perspectives of health financing facilities and requirements for partnerships from Health Financing partners.

The three-day conference was attended by 120 faith leaders and global health experts. The deliberations were summed up in a conference statement which made the following observations:

- Christian Health Associations provide a significant amount of health service and recognize the need for evidencing this contribution. The CHAs acknowledged the need for capacity building for both qualitative and quantitative evidence to verify their contribution to health care.
- The CHAs committed to work with partners towards achieving the SDGs and called for continued collaboration with international and national partners as well as within national health systems.
- There exist CHAs that find themselves in fragile states. The community of CHAs committed to supporting fragile states through sharing capacity and exchanging best practices among CHA networks. The CHAs also committed to be transparent and account for resources given to them.
- CHAs have traditionally had a pro-poor approach to health provision. They committed to align themselves to universal health care values of equitable access to healthcare.
- The CHAs called upon the United Nations, Africa Union, SADC and other development partners to collaborate more closely with Faith Based Organizations.
- They further stressed the need for data-driven service provision statistics and the need for continual engagement with the government in times of financial uncertainty.
- Collaborative partnership would strengthen international and regional initiatives towards the achievement of Sustainable Development Goals.

In Africa, at least half of all health care is provided by faith-based groups, according to the World Health Organization. The Africa Christian Health Associations Platform was formed 10 years ago to be a convening body for Christian Health Associations. CHAK hosts the platform in its offices.

Church leaders discuss doctors' strike

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was born with the intestines hanging out. Samy and his colleagues referred the child to the government hospital in Lodwar, over 200 kilometers away in scorching heat. However, due to the doctor's strike the child could not be treated as was taken back to AIC Lokichoggio Health Centre.

Sammy and his team then made arrangements for the child to be taken to AIC Kijabe Hospital in Kiambu County, Central Kenya. However, the child could also not be treated at the facility which was facing industrial action by its health workers.

"The baby was brought back to AIC Lokichoggio. We had to make alternative arrangements for the baby to be flown to Nairobi for treatment," said Sammy.

Moving forward, the meeting pledged to take steps to ensure CHAK health facilities were supported to deliver quality services at all times, given that they could not turn away people in desperate need of medical attention.

Way forward

Targeted advocacy

Targetted advocacy would ensure that the voice of CHAK health facilities was heard by the policy makers who were in a position to influence decisions. The first step would be for CHAK to identify the target for its advocacy efforts.

The national government would be a critical target as would be individual counties. The Council of Governors had established a committee to deal with health. County executives for health also had a council, a secretariat and an advisor on health and could thus be targeted through these structures.

There was also need to engage the President for buy-in at the highest level of government.

An MOU with the Council of Governors would be used to target individual counties. Already, St Lukes, PCEA Tumutumu and some health facilities in Turkana County were being supported from the county budgets.

Identifying teams towards these engagements would move the agenda forward. The meeting tasked CHAK Chairman and General Secretary to put together advocacy teams to target both the counties and national government through State House.

Role of Church leaders

The unity of the church needed to be identifiable to move forward the advocacy efforts. Through CHAK, the Church had a central and loud voice in health care. Church leaders needed to be facilitated and equipped with the right information. It was suggested that a forum for this purpose be set up and convened by CHAK.

Additionally, the clergy needed to feature in negotiations on the doctors' strike as they were a key moderating voice in times of crisis in the country.

The MOUs between FBOs and the Government and FBOs and the County Governments were identified as core in voicing the concerns of FBOs in health service delivery as well as the level of support they were seeking from the State.

Government support

CHAK member health units were sometimes identified as private hospitals, disqualifying them from assistance from the government. CHAK MHUs needed to carve a niche and market themselves separately from private hospitals. Additionally, there was need for self-evaluation on the role of corruption in the current crisis.

There was also need for advocacy on taxation imposed on drugs and supplies and medical equipment. Removing these taxes introduced over the past three years would bring down the cost of doing business for mission hospitals, hence reduce costs to patients.

CHAK was tasked with collecting data to make a case for government support for its member health units. This data would include an inventory on the resources and inventories in the mission hospitals.

The meeting further recommended that a legal and legislative think tank be established to support advocacy to government.

Conclusion

It is the duty of the Government to provide health care to its people. However, the State is not able to meet all the health care needs of the population, thus health service providers such as FBOs needed to be recognized for their role in health. Based on this scenario, the CHAK network was encouraged to come together to make a case for support from the Government.

The crisis led to honest self-evaluation by CHAK health facilities enabling them to clearly identify their strengths and weaknesses. It was also an opportunity for the facilities to market themselves.

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.

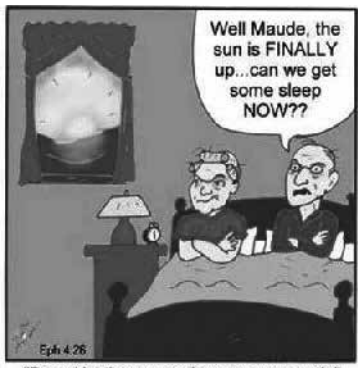
You could discuss a meals timetable together with your house help and your teenagers, and ensure they are reasonable and realistic as they plan. Additionally, have the teenagers prepare a meal which you can all enjoy. Let them prepare what they like eating once in a while.

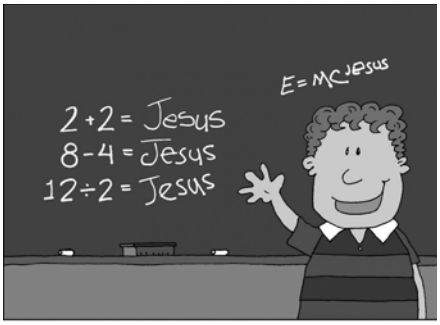
As for the one who is insisting on a transfer, you may have to find out what could be making him hate his current school. Is he being bullied by other students? May be he does not like the food in this school, or the school is far from home, What really make him hate this school?

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.

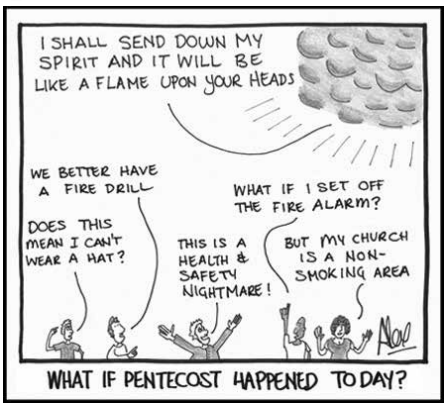
As a parent, do not allow your children to dictate what they want to eat, where they want to go, who should cook for them, which school they want to go, etc. You must stand firm and take the leadership position in your house.

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

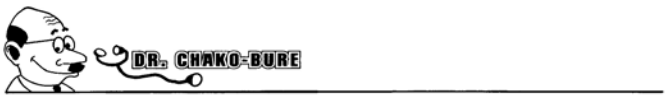




IN BIBLE CLASS WE LEARNED THAT JESUS IS THE ANSWER



Source: internet jokes



Mother and child in worship

BY JOSEPH OYONGO - CHAK SECRETARIAT

God is the source of life, good health and healer of all disease and infirmity. God's will is that we enjoy good physical, social and spiritual health.

The Bible tells us that "God created human beings in his own image, in the image of God he created them; male and female he created them. God blessed them and said to them,"Be fruitful and increase in number; fill the earth and subdue it. Adam made love to his wife Eve, and she became pregnant and gave birth to Cain. She said, "With the help of the LORD I have brought forth a man." Later she gave birth to his brother Abel'. (TNIV)

The role of pregnancy and childbirth was delegated to Eve, but parenting is a shared responsibility between the father and mother. The mother carries the pregnancy, delivers and then nurtures the neonate till maturity.

A mother plays a very important role in the life of a child which goes on as the child grows. She is a role model and guardian that is first recognized by the child. Thus, the mother must devote time to the baby in the initial years then continue being present in the life of child irrespective of age.

On maturity, a mother guides a child in their career choice. It is until the child moves and establishes their own home that the maternal care is gradually reduced.

The Bible in Proverbs 22:6 says: "Train up a child in the way he should go: and when he is old, he will not depart from it".

The mother is the best teacher and trainer of her child. The mother conducts toilet training and teaches the child how to express his needs. This should be extended to social and spiritual training.

King Lemuel was taught by his mother as follows in Proverbs 31.

1. What, my son? and what, the son of my womb? and what, the son of my vows?
2. Give not thy strength unto women, nor thy ways to that which destroyeth kings.
3. It is not for kings, O Lemuel, it is not for kings to drink wine; nor for princes strong drink
4. Lest they drink, and forget the law, and pervert the judgment of any of the afflicted
5. Give strong drink unto him that is ready to perish, and wine unto those that be of heavy hearts.
6. Let him drink, and forget his poverty, and remember his misery no more.

God has made us kings and priests and thus we should follow the instructions given by this concerned mother.

Prophet Jeremiah was chosen to be a prophet before his birth. The mother of Samson was told not to consume beer during pregnancy. Hannah the mother of Prophet Samuel was childless till she God heard her fervent prayer and gave her a son. She avoided beer during pregnancy and on delivery and weaning dedicated her child to God's service.

Can mothers today avoid beer during pregnancy and motherhood for the sake of their children?

Some of us do not have time for God in our lives. This leads to children who are ignorant of God. This can change if one person in the family commits time to pray for the rest of the family members and live by example.

The Bible tells on the foundation of Timothy's faith in God. It was first in his grandmother Lois and in his mother Eunice before he got converted to Christianity through Apostle Paul's evangelism. See the text taken from 2 Tim. 1:1-5 below and imitate it in your family:

1. Paul, an apostle of Jesus Christ by the will of God, according to the promise of life which is in Christ Jesus
2. To Timothy, my dearly beloved son: Grace, mercy, and peace, from God the Father and Christ Jesus our Lord.
3. I thank God, whom I serve from my forefathers with pure conscience, that without ceasing I have remembrance of thee in my prayers night and day;
4. Greatly desiring to see thee, being mindful of thy tears, that I may be filled with joy;
5. When I call to remembrance the unfeigned faith that is in thee, which dwelt first in thy grandmother Lois, and thy mother Eunice; and I am persuaded that in thee also.

DHAMINI AFYA YA MAMA NA MTOTO

MALEZI WAKATI WA UJA UZITO

1. Enda usajili katika kliniki wakati unapo tambua kuwa wewe ni mjamzito
2. Enda kliniki angalau mara nne wakati wa ujauzito wako
3. Unapo tambua kuwa wewe ni mjamzito anza kujitayarisha kwa mambo kama:
- Kuweka akiba ya dharura
- Kununua nguo na vitu vya mtoto
- Kuchagua rafiki unaye amini atakaye kusaidia
- Kuchagua hospitali utakayo enda kujifungulia ama wakati wa dharura
- Kupanga jinsi utakavyo fika hospitalini wakati wa kujifungua au dharura

UMUHIMU WA WANAUME KUJIHUSISHA WAKATI WA UJAUZITO

- Wanaume wanahimizwa kuandamana na wapenzi/bibi zao wakati wa kutembelea kliniki ya ujauzito, upangaji uzazi na hata wakati wa kujifungua
- Wanaume wanahimizwa kutembelea kituo cha VCT wakiandamana na wapenzi wao wakati wa ujauzito ili kujua hali yao ya virusi vya ukimwi
- Wanaume wanahimizwa kuwa waaminifu ama kutumia mipira ili kuzuia maambukizi ya ngono na virusi vya ukimwi
- Wanaume wanahimizwa kusaidia wake zao wakati wa ujauzito.

DALILI HATARI WAKATI WA UJAZITO

Ni muhimu kwa kila mama mjamzito kufahamu dalili hatari wakati wa ujauzito. Kila mjamzito anafaa kuenda katika kituo cha afya kilicho karibu naye mara tu anapo ona dalili zifuatazo:

- Kutokwa na damu katika sehemu ya siri
- Kutetema na kuanguka
- Joto jingi.
- Kizunguzungu
- Macho na mikono nyeupe
- Kupasuka kwa maji
- Kuchoka haraka
- Kufura uso na miguu

UMUHIMU WA KUJIFUNGULIA HOSPITALINI

- Hakikisha umejifungulia katika kituo cha afya chenye daktari aliyehitimu
- Kukuwa na daktari kutakuwa na usaidizi mwafaka wakiokoa maisha ya mama na mtoto

MALEZI BORA YA MTOTO

- Baada ya kujifungua kinga mtoto kutokana na baridi
- Usioshe mtoto siku moja baada ya kuzaliwa
- Mtoto anafaa anyoyeshwe kabla lisaa limoja kuisha anapozaliwa

DALILI HATARI ZA MTOTO

- Mtoto asiponyonya vizuri kama inavyofaa
- Shida ya kupumua au kupumua kwa haraka
- Mwili, macho na kijanja kubadilisha rangi na kuwa manjano
- Uvimbe kwenye utosi
- Mtoto kuzembea

UMUHIMU WA CHANJO

- Inazuia mtoto kupatwa na magonjwa
- Inapunguza gharama kwani husaidia kukinga afya ya mtoto
- Chanjo ni salama na haina hatari yoyote
- Chanjo zinapatikana bila malipo yoyote katika vituo vyote vya afya.
- Chanjo huokoa maisha kwani hukinga mtoto kutokana na magonjwa hatari kama vile Kupooza, kifua kikuu, kuhara, homa ya mapafu na magonjwa mengineo.
- Hakikisha mtoto wako anapelekwa chanjo hadi mwaka mmoja na nusu na vile vile kuendelea kupewa vitamini A ambayo hukinga mtoto kutokana na kupoteza uwezo wa macho kuona, mtoto pia hupewa dawa za minyoo ili kuzuia ukosefu wa damu mwilini, kilo za chini na magonjwa mengineo.

LISHE YA MTOTO

- Maziwa ya mama inatosha na ina madini yote mtoto anahitaji ili akue vizuri akiwa chini ya miezi sita.
- Mtoto anahitaji kunyoyeshwa pekee kila mara akihitaji bila kumupa chakula kingine chochote, maziwa na hata maji labda dawa ambayo anaweza kuwa amepewa hospitalini.
- Miezi sita hadi mwaka mmoja mtoto anahitaji kuendelea kunyoyeshwa na pia apewe chakula chenye lishe bora angalau mara tatu kwa siku.
- Mwaka mmoja hadi miaka mbili mtoto aendele kunyoyeshwa kila anapohitaji na pia kupewa chakula chenye lishe bora angalau mara tano kwa siku.
- Kwa mama mwenye virusi vya ukimwi aliyejifungua anahimizwa kunyoyesha mtoto wake kwa miezi sita bila kumpa chakula chochote au maji ili kupunguza hatari ya kusambaza virusi kwa mtoto.

UMUHIMU WA LISHE BORA

- Lishe bora husaidia afya ya mama na mtoto.
- Lishe bora ni mchanganyiko waVitamini, madini, kabohidrati,proteini, mafuta na maji
- **Kabohidrati** zinapea mwili nguvu ambayo husaidia mwili kufanya kazi vizuri, inapatikana kwa chakula kama ugali, mchele, chapati,viazi na zinginezo
- **Proteini** ni chakula inayo saidia katika kujenga mwili na hupatikana kwa chakula kama Maharagwe, nyama, ndegu, mayai na zinginezo
- **Vitamini** na madini inasaidia kuimarisha kinga ya mwili. Hupatikana kwa aina zote za mboga na matunda
- **Mafuta** inasaidia kupatia mwili nguvu. Hupatikana kwa mafuta ya kupika na ya kupaka mkate
- **Maji** inasaidia shughuli zote mwilini zifanyike vizuri
- Mtoto chini ya miaka mitano anahitaji lishe bora ili akue vizuri na kinga yake ya mwili iimarike.

KUIMARISHA MAJI, MAZIGARA SAFI NA USAFI

Kuharisha

1. Kuharisha ni moja wapo ya magonjwa hatari yanayo sababisha vifo vya watoto chini ya miaka mitano
2. Kuhara ni ugonjwa unao husishwa na mazingira, uchafu na maji chafu.

Tabia zinazo punguza na kuzuia magonjwa

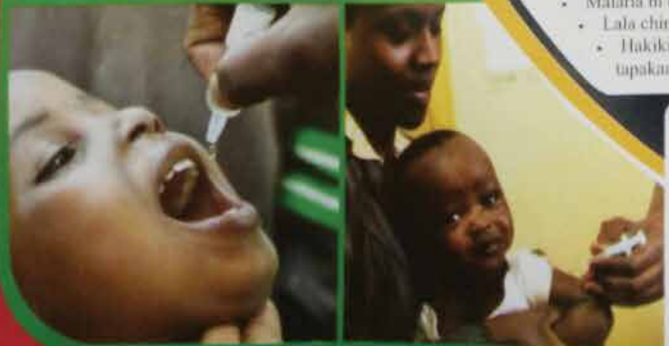
- Nawa mikono kutumia sabuni na maji yanao tiririka kila mara unapo badirisha mtoto ,tumia choo na kabla ya kutengeneza chakula
- Tumia dawa ya kutibu maji ama chemsha maji kabla ya kuyanywa
- Mwaga kinyesi ndani ya choo kila mara
- Tumia choo kila wakati unapo patwa na haja
- Weka mazingira safi ili kujikinga kutokana na maradhi.
- Funika chakula chako vizuri ili kuzuia uchafu unaoweza kusababisha maradhi
- Osha vyakula vyako vizuri kabla ya kuvipika na pia matunda kabla ya kuyala

KUZUIA MALARIA

- Malaria ni ugojwa hatari kwa mama na mtoto
- Lala chini ya neti iliyotibiwa
- Hakikisha hakuna nyasi ndefu na maji yaliyo tapakaa nyumbani ilikuzuia mbu kuzaana

PATA HABARI SAHIHI KUTOKA KWA WAHUDUMU WA AFYA

ACHANA NA TAMADUNI NA DESTURI HATARI!



January 2017

Sun	Mo	Tu	We	Th	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

February 2017

Sun	Mo	Tu	We	Th	Fri	Sat
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28				

March 2017

Sun	Mo	Tu	We	Th	Fri	Sat
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

April 2017

May 2017

June 2017

July 2017

August 2017

September 2017

October 2017

November 2017

December 2017

ST. JOHN'S COMMUNITY CENTRE

Child Rescue