ANNUAL REPORT
2008

ST. CAMILLUS DALA KIYE
CHILDREN WELFARE HOME

A Compassionate Response to
HIV/AIDS Impacts on Children

January – December 2008

PROGRAM PROFILE

ORGANIZATION:	ST. CAMILLUS DALA KIYE CHILDREN WELFARE HOME
PROGRAM NAME:	DALA KIYE PROGRAM
PROGRAMMING AREAS:	ORPHANS & VULNERABLE CHILDREN (OVC) & HIV[1]/AIDS[2]
TOTAL TARGET CLIENT:	2500 OVC & OVER 10,000 COMMUNITY MEMBERS IN NYATIKE & GWASSI COMMUNITIES
PROGRAM LOCATION:	KARUNGU DIVISION IN MIGORI DISTRICT
REPORTING PERIOD:	JANUARY 2008 - DECEMBER 2008
REPORTING PERSON:	FR. EMILIO BALLIANA
DESIGNATION:	THE PROGRAM DIRECTOR

[1] Human Immunodeficiency Virus
[2] Acquired immune Deficiency Syndrome

Introduction

HIV/AIDS is the single most devastating catastrophe that has one of the most negative and long lasting impacts on almost all social and economic aspects of life in Kenya. It has perpetuated poverty, chronic infections and deaths, food insecurity, gender disparity and has overwhelmed traditional social support systems.

Although the national HIV/AIDS prevalence has declined significantly from a peak of about 14% in 2000 to the current 6.1% (Dec, 2005) the cumulative AIDS deaths continue to rise and the impact on society is becoming increasingly severe. Unfortunately, with each person infected with HIV, a family is forever affected particularly the most dependent members, the youngest and the older generations. This explains why AIDS is breeding a generation of orphaned and vulnerable children who continue to face the unfair challenges of unmet basic needs during their critical time of development.

The OVC situation in Kenya is a massive, growing and long-term crisis. According to CBS 2005, there are about 1.8m OVC in Kenya and 1.1 million of them are orphaned by AIDS. Nyanza province leads with 650,000 OVC in Kenya while Migori and Suba districts lead closely with 143,152 and 125, 250 OVC respectively in Nyanza province.

St. Camillus Dala Kiye Children Welfare Home is a leading organization in working with and for Orphans and Vulnerable Children in South West Kenya. The organization uses community-focused interventions to respond to the needs of OVC living with their extended family members within their community settings. It addresses the specific needs of children living with AIDS; especially food & nutrition, medical, psychosocial and education support. The program follows a foster care family model which not only provides compassionate care and support, but also creates a drug-adhering culture for the children on antiretroviral (ARV) medication.

During this reporting period, the organization reached and impacted the lives of 2648 OVC with direct support. Core areas of program intervention included care and support services in Food & Nutrition, Health Care, Education & Vocational Training, Psychosocial Support, Shelter Care and Protection in Nyatike and Gwassi communities.

Vision and Mission

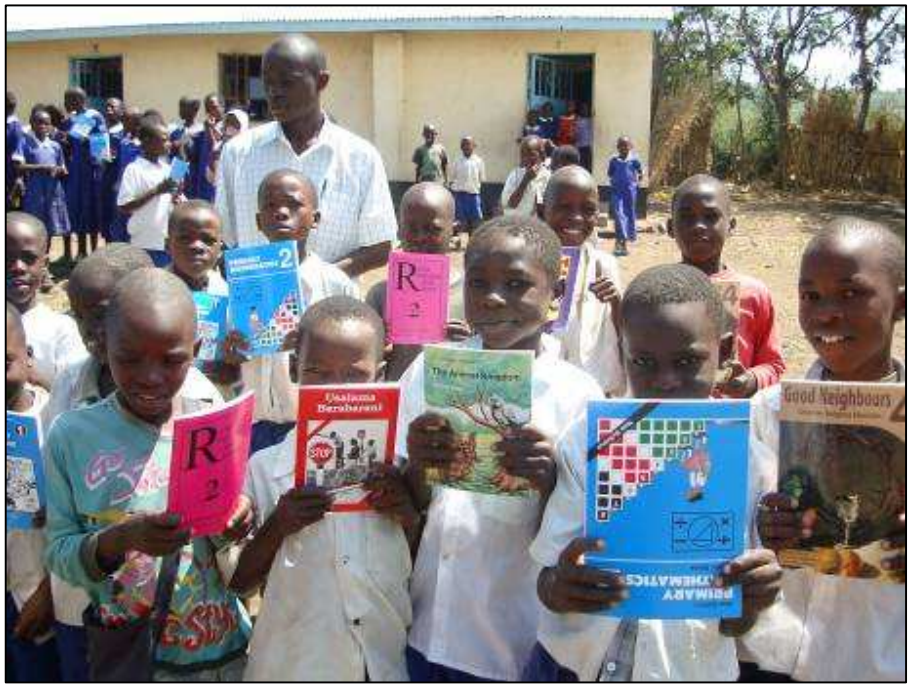
Vision
Dala Kiye envisions empowered children, fully integrated into the community, exploring their potentials and contributing to their own future progress.

Mission

This vision is strategically attainable through our commitment to roll out empowering, need-based and compassionate caring responses to HIV/AIDS impacts on children and their communities. The program therefore mobilizes and engages community responses that empower households with children for improved quality of life, decrease their chances of HIV infection and become healthy and productive members of the Karungu area community.

Program Interventions

Model 1: *School-based Care & Support for OVC*
This model recognizes that the majority of children have an alternative caregiver (grannies, uncles, aunties, siblings or sympathizers) within the community to provide care and support to school going OVC. The focal point of this model is the school, while the program interventions compliment the responses of the caring community members to maintain and provide care and support to 2575 OVC within their community settings.



Pupils of Obondi Primary School receiving essential scholastic materials

Model 2: *Foster Family Care and Protection for OVC in the Community*

This model provides alternative families within the community where the children are reintegrated. This intervention was developed upon learning that some children were living under difficult circumstances which threatened to paralyze their future. This model recognizes the fact that a number of children suffer abuse at the hands of their caregivers while others are victims of child trafficking making them become even more vulnerable. Such children are common among the heterogeneous beach communities, disjointed families and exposed children in need of protection. The program is currently reaching 32 children in 2 foster families situated within Rabour-Karungu.

Some members of Bethlehem Family outside their foster home in the community

Model 3: *Foster Family Care and Protection for OVC with Special Needs*

This project provides alternative families which responds to the substantial needs of children living with AIDS. This model is compassionately designed to care and support children living with AIDS. A majority of the children in this category are already enrolled on ART and are under the care of aged or chronically sick caregivers. All such children are referred from ART points of service presenting with high incidences of malnutrition, non-adherence to drugs, opportunistic infections, demonstrating lower resilience and with poor health seeking behavior. The program is reaching 60 children living with HIV/AIDS in 6 foster families.

Goal and Strategic Objectives

Goal
The program strives to improve the quality of life for Orphans and Vulnerable Children and their household members in Nyatike and Gwassi communities.

Objectives
This goal is being pursued through the following strategic objectives:

A. Strengthened capacity of community members to address the needs of OVC and their household members.
The program facilitates processes in the community aimed at positively reinforcing community strengths and imparting life skills to optimize care and protection for OVC and their household members.

Strategic Interventions:
a.) Community Strengthening
Care and support for OVC is the responsibility of respective communities yet the available social structures are already overburdened as their numbers increase unabatedly. OVC lose their family identity and inheritance rights as they move to other families of relatives when they become emotionally vulnerable and economically deprived. Community incomes and saving capacities get reduced when young parents die and leave behind young unproductive, fully dependant children.

Planned Activities

1. Develop supportive community functional structures to increase community participation, contribution and involvement in the program activities and to identify, prioritize and address OVC needs in the community.
2. Improve knowledge and skills of community members in OVC care and support to provide improved quality of community care and support services to the OVC.
3. Increase staff capacity in project facilitation processes and be able to provide improved quality of services to OVC households
4. Establish effective collaboration and networking linkages with other OVC actors Nyatike and Gwassi communities.
5. Increase the awareness of the community members on behavioral health issues (HIV/AIDS/STI, drug and substance abuse) and impart prevention skills and reduction risky behavior practices in the community.

b.) Shelter and Care

OVC are exposed to complex socio-economic and cultural conditions that push them out of their original parental homes. As they seek for alternative family and shelter for care and support from relatives and sympathizers, they are instead abused, exploited and discriminated against. In some cases OVC live in poor state of shelter or dilapidated houses which are in poor condition of sanitation and unhygienic state in the community. It is evidenced that some OVC even become homeless when their parents die.

Planned Activities:

1. Provide children living with HIV/AIDS with stable shelter in facility foster families and other children in the community with community foster families that are adequate, dry, and safe and lives like other children in their families.
2. Provide alternative families with at least one female adult who consistently guides, shows love and support in all aspects of parental responsibilities to children living with HIV/AIDS and other children in the community within foster families.
3. Provide OVC living with HIV/AIDS in foster families and OVC in community foster families with foster care services and household materials for daily use such as food, clothing/bedding, fuels, detergents etc

c.) Security and Protection

Inheritance rights of OVC have been disregarded over the years. The community social safety nets for OVC care and protection are broken down and child-headed households are common as OVC assume the roles of their dead parents. Under the guise of discipline, OVC have been assaulted, ill treated, abandoned and exposed to unnecessary suffering and injuries.

Planned Activities:

1. Facilitate child rights activities in the community that raise the awareness and enhance child safety from abuse, neglect and exploitation in the community.

2. Promote networking and collaboration through the Area Advisory Council to enhance legal protection of children and increase access to legal support when needed.

Program staff displaying their certificates after one of the in-house trainings

B. Enhanced social support services to OVC and their household members.

The program provides a package of social support services to address the immediate and long-term needs of OVC and their household members.

Strategic Interventions:

a.) Food and Nutrition Support

OVC and their household members are inherently more susceptible to malnutrition and stunted growth as they consume less food due to scarcity or limited access. Also, a majority of the OVC households have diminishing capacities to grow or buy nutritious food thereby making them more prone to malnutrition and infections.

Planned Activities:

1. Provide OVC with 2 hot meals a day for 5 days a week through school-based feeding programme in 6 primary and 1 secondary public schools.
2. Provide OVC households with ratios of maize and beans every month as supplementary food support.
3. Facilitate Nutrition Education sessions to representatives of OVC households every month during supplementary food distribution.

4. Measure the nutritional status of all OVC enrolled in school-based feeding programme every quarter

b.) Education and Vocational Training
OVC are often withdrawn from schools, vocational training centers and even colleges when their parents and/or care givers die owing to little or lack of resources to keep let them continue. OVC are frequently absent from school and a number of them eventual dropout to work and earn a living. Poor academic performance among OVC owes a lot to chronic depressions and distractions.

Planned Activities:

1. Provide OVC with school levies support, school uniforms and scholastic/educational materials to regularly attend primary schools and improve in academic performance.
2. Provide OVC with secondary school levies support to regularly attend school and improve in academic performance.
3. Support OVC with vocational training levies to increase retention in the vocational training centers and improve in academic performance.
4. Support OVC girls with school levies in boarding primary school to increase school retention and improve in academic performance.
5. Support OVC who are physically handicapped in special schools with school levies to increase school retention and gain basic literacy and survival skills

C. Improved health care services to OVC and their household members.

The interventions extend access to quality health care services to OVC and make provision for nursing and clinical care support to OVC care givers.

Strategic Interventions:

a.) Health care
A majority of OVC household members live in poor environmental conditions that promote transmission of communicable diseases such as TB and other URTI. Some of the OVC are exposed to bad weather and insects bites such as mosquitoes that cause malaria while at the same time they lack access to competent health care services. This contributes greatly to increasing numbers OVC falling sick. Increasing expenditures on medical/health services are often unaffordable to a majority of sick children and their care givers. It has become apparent that appropriate knowledge by caregivers on HIV/AIDS and reproductive health is also lacking and leads to more health issues in the OVC households.

Foster children enjoying a meal in the dining hall

Planned Activities:

1. Provide OVC with nursing and clinical health care services
2. Facilitate preventive care services and health promotion messages (health education) to OVC and their care givers

b) Psychosocial Support

As can be imagined, many OVC suffer quietly from emotional duress which subjects them to low-self esteem, insecurity and hopelessness. Caregivers and OVC undergo distress from the loss of dear ones, social isolation and regressive cultural experiences that lead to shame, irritation, fear and rejection in the community. Stigmatization and discrimination of OVC is common in the community. OVC inevitably suffer under burdensome domestic responsibilities assigned to them by caregivers who treat them with little respect. OVC caring for the sick/aged inevitably experience reverse roles and are exposed to myriad of mental distress leading to maladjustments in the future. OVC are subjected to psychological trauma, as they watch their dying parents become frailer, endure severe pain and suffer stigmatization and rejection.

Planned Activities:

1. Administer psychosocial support to OVC to address their emotional health and social behaviors.
2. Administer psychosocial support to care givers to address their emotional health ad social behaviors.

Program Performance During 2007

Through the 3 Program Interventions the program performance was as follows:

Objectives	Program Components	Program Interventions	Total Number of Children Reached With Specific Project Activities During 2007		

			Model 1	Model 2	Model 3
Strengthened capacity of community members to address the needs of OVC and their household members.	Community mobilization and sensitization	# community meetings held to identify and prioritize needs of OVC	13	4	2
	Institutional capacity building and development	# internal staff trainings # external staff trainings # staff trained	2 4 56	2 4 56	2 4 56
	Community capacity building and development	# community training/education sessions conducted # OVC identified, assessed & enrolled in the project # OVC identified, assessed and enrolled into family foster care systems # caregivers support group formed and functioning # caregivers support group sessions conducted # OVC being supported and integrated into family foster care systems # of OVC benefiting from household facilities and equipment support	13 1743 - 1 12 - -	4 2 2 0 1 32 32	2 12 12 0 2 57 57
	Monitoring and Evaluation	# program review meetings conducted	4	4	4
	Advocacy and Lobbying for OVC and their households	# OVC referred for legal assistance # supportive supervisory visits to home & school	- 89	32 25	57 25
	Collaboration and networking meetings	# networking meetings attended & participated in	12	12	12
	HIV/AIDS awareness and education	# OVC and caregivers reached with HIV/AIDS prevention and protection information # open education sessions with children on HIV/AIDS and related health issues in the community	2176 30	32 30	57 30
	Adolescent education on sexuality and Reproductive Health	# IEC materials distributed on HIV/AIDS & OVC	1000	32	57
	Life skills training	# life skills trainings conducted to children	78	10	8
	Guidance and counseling	# of sessions on Knowledge, Attitude, Practice & culture (KAPC) assessment among children and peer educators	12	12	12
	Sports and recreation	# Community open days on HIV/AIDS &OVC (World AIDS Day & The Day of the African Child)	3	3	3
Enhanced social support services to	Food and nutritional supplements to OVC households	# households provided with supplementary food assistance # OVC provided with supplementary food assistance	45 160	- -	- -
	School-based feeding	# schools supported to provide			

	programme	regular school-based feeding programme # of children enrolled on regular school-based feeding programme	7 2575	- 32	- 57
	Shelter support	# foster family houses established in the community to foster children # OVC identified, assessed & enrolled in the foster family care and protection system # OVC provided with legal fostering requirements # of OVC receiving support for shelter, security and continuity in social integration	- - - -	- 2 32 32	- 12 57 57
	Primary education support	# OVC with physical disabilities supported in various institutions to access quality primary education # OVC supported in boarding primary schools to access quality primary education # OVC provided with (scholastic materials) books and other essential stationeries # OVC enrolled in school and supported with official school uniforms # OVC retained in school for 80% of the school period # OVC supported and completed their primary education	10 39 1136 412 2247 54	- - 32 32 32 3	- 1 57 57 57 2
	Secondary education support	# OVC supported in various secondary schools to access quality secondary education	224	8	1
	Vocational training support	# OVC supported in Vocational training centers	21	-	-
	Post secondary education support	# OVC receiving support for post secondary education	-	-	-
	Clothing/bedding support	# OVC provided with clothing support	-	32	37
Improved health care services to OVC and their household members.	Nursing & Clinical Care	# cumulative continuous health assessments conducted to OVC at school and home # OVC treated as out-patients # OVC treated as in-patients # OVC treated & received medical services by the project nurses	696 574 110 1440	32 28 12 32	57 46 35 57
	Pediatric ART services	# individuals care plans developed for	-	-	60

		OVC			
	Psychosocial Support	# households provided with counseling and guidance services # OVC receiving routine guidance & counseling at school and during home visits	858 2575	2 32	6 57
	Nutritional Care	# of children enrolled on comprehensive feeding programme under foster family care # caregivers receiving routine nutritional counseling # meals provided to foster family houses per day	- 45 -	32 - 4	57 - 5
	Health Education & Campaign	# OVC households visited by technical project staff # health education sessions conducted	240 26	2 26	6 10
	Referrals to other points of health care services for comprehensive responses	# OVC referred to other points of care # caregivers referred to other points of care	4 61	- -	2 -

Accomplishments

General:

1. The three programming models provide a comprehensive continuum of OVC care and support. The models expose and explore the gaps in the dilemma of placing a child under constrained community-care versus institutional care. At the program level the models impart better understanding of not only orphanhood but also the

circumstances, level of vulnerability and discernment of the needs of every individual child.

2. Through determination and demonstrated abilities together with the support of partners and collaborators(TROCAIRE, Diocese of Homa Bay, Save the Children-Canada & AED[3]/USAID[4],) the Dala Kiye program had the opportunity to present the programming models in Joint HIV/AIDS Program Review (JAPR) held at Las Jona Hotel Rongo.

Specific:

1. Health care services were provided to 1440 OVC and 105 care givers enrolled in Dala Kiye Program to improve their physical health status.
2. Psychosocial support services were administered to 2575 OVC and 1121 care givers enrolled in Dala Kiye Program to improve their mental health status.
3. 2 meals[5] a day were provided to 2575 OVC enrolled in school-based feeding program in 6 primary[6] schools and 1 secondary[7] school to improve their nutritional status, school attendance and academic performance.

4. At least 3 meals a day[8] provided to a total of 57 OVC living with AIDS enrolled in 6 foster families in Dala Kiye and 32 OVC enrolled in 2 foster families in Nyatike community to ensure that they received regular meals to improve their health and nutritional status.

5. A package of supplementary food support[9] was provided monthly to 45 households to increase their average number of daily meals from one to at least two.

6. School uniforms were provided to at least 412 OVC enrolled in 6 primary schools to keep them in school and improve their academic performance.
7. School fees support was provided to 224 OVC to ensure that they access secondary education, retain them in school and improve their academic performance.

8. 10 OVC who are physically handicapped were supported with school fees at special schools for the physically handicapped to access special education, retain them in school and gain basic literacy and survival skills.

[3] Academy for Educational Development
[4] United states Agency for International Development
[5] Breakfast between 7:00 – 8:00 am and Lunch between 1:00 – 2:00 pm
[6] B. L. Tezza Complex Primary School, Kopala, Rabuor, Kaduro, Obondi and God Oloo Primary schools
[7] B. L. Tezza Complex Secondary School
[8] Breakfast at 6:30– 8 am, Lunch at 1–2 pm, and Super between 6–7 pm (Snacks provided as necessary between meals)
[9] Ratios proportional to OVC household sizes: maize and beans.

9. 21 OVC were supported with vocational training fees and other vocational training expenses to attend technical training institutions, gain technical skills in various trades and contribute to their ability to improve their livelihoods.

10. Foster care services[10] were provided to a total of 89[11] OVC enrolled in foster family care to ensure that they are protected and able to access services for continuity in social reintegration within family settings in Dala Kiye and community settings in Nyatike community.

11. Life skills education was provided to 2575 OVC and 1121 care givers enrolled in Dala Kiye Program to enhance knowledge and skills for prevention and protection against HIV/AIDS infection among OVC and their caregivers.

95 school-going orphaned and vulnerable girls were provided with sanitary towels to address their sexual health needs.

Strategic Direction

1. Greater emphasis on the formation of care givers support groups to facilitate community care and support to OVC and elicit high level of community contribution, participation and involvement.
2. Learn and adopt best practices for replication in all programming areas.
3. Emphasize an intensive life skills training and health education for all children in and out of school.
4. Engage in aggressive resource mobilization to respond to the increasing immediate needs of OVC and their family members.

[10] Operationally refers to an alternative home and family members in a homely shelter where daily household needs are provided and a family set-up is instituted for care, growth, development and protection of a child

[11] 45 OVC (32m, 13f) living with AIDS enrolled in 6 foster families in Dala Kiye and 48 OVC (24m, 24f) enrolled in 4 foster families in Nyatike community