Kawempe Home Care 2012 Annual Report

KHC Conference 2012

Palliative Home Based Care

OVC's end of year get together party

Walking against HIV in the community

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ABBREVIATIONS

AIC	AIDS Information Centre
AIDS	Acquired Immune-deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BFE	Beads for Education
CBO	Community Based Organization
CME	Continuous Medical Education
DNA	Deoxyribose Nucleic Acid
FORO	Friends of Reach Out
HAU	Hospice Africa Uganda
HBCT	Home Based Counselling and Testing
HCT	HIV Counselling and Testing
HES	Home Care Education Support
HIV	Human Immunodeficiency Virus
IDI	Infectious Diseases Institute
JCRC	Joint Clinic Research Centre
KHC	Kawempe Home Care
OI	Opportunistic Infection
PCAU	Palliative Care Association of Uganda
PCR	Polymerase Chain Reaction
PEPFAR	US Presidents Emergency Fund for AIDS Relief
PMTCT	Prevention of Mother-to-Child Transmission
TB	Tuberculosis
VCT	Voluntary Counselling and Testing
VICTASS	Volunteers in Care TB treatment and AIDS Support System
WHO	World Health Organization
CB-DOTS	Community Based Directly Observed Therapy
OVC	Orphans and Vulnerable Children

EXECUTIVE SUMMARY

Dear Friends and Partners,

Warm greetings to you all, since the inception of the organisation, we have cared for 2685 patients of who, 842 (31%) are male and 1843 (69%) are female. At the end of 2012, we had 1550 active patients of who 472 (30%) were male and 1078 (70%) female. A total of 3584 people were counselled and tested for HIV this year; 525 (15%) were tested positive and 3059 (85%) were negative. Active recruitment of patients was done through community HIV counselling and testing (HCT) outreaches. The enrolment of patients was scaled up this year with the support of the Infectious Diseases Institute with funding from the Centers for Disease Control/PEPFAR.

This year we have made some significant achievements in our development as an organisation. The highlight was the celebration of our fifth anniversary with an awareness walk through the community on July 27th 2012 and hosting a palliative care conference on August 17th 2012 that was attended by our partners in care, members of the palliative care fraternity, locally based donors and members of the board of directors. We are extremely grateful to IDI and HorizonT300 for funding these events. We also started up a livelihoods project for our clients who were supported by Hope for Children International and Innocent Foundation (UK). Our core activities of Home Based Care have also kept running with funding from Friends of Reach Out and the African Palliative Care Association. We have provided free school fees to 104 children and our OVC activities i.e. teens club and Kalimarimbas have continued to flourish with great support from Culture without borders (DK).

The growth of the organisation has also brought a number of challenges like lack of clinic space, competition for few resources available for patient care i.e. funds for medicines, home visits, staff welfare etc. A number of plans have been laid down to cater for these increasing needs i.e. buying land to build a new clinic, scale up on resource mobilisation and strengthening the income generating activities. We will also continue building the technical capacity of our staff in patient care, HIV programming and monitoring and evaluation, entrepreneurship etc.

I would like to thank our many private donors from UK, Australia, Denmark, USA, Norway, Austria and Iceland for the great support that they have given us over the years. The funds they send help us a great deal to cover critical areas of our budget that are not funded. Many thanks to our partner the Great Generation (UK) who continue to send us volunteers, the Soroptimist group (DK) for supporting our medical manager for the last three years and Samaritan Hospice (US) for supporting our Beads for Education project.

I would also like to thank the Chairman board of directors and all the members of the board for their great support, encouragement and advice. They have been very instrumental in the progress of KHC and we are indeed very grateful.

Dr. Samuel Guma
Executive Director

1.0 CLIENTS SERVED

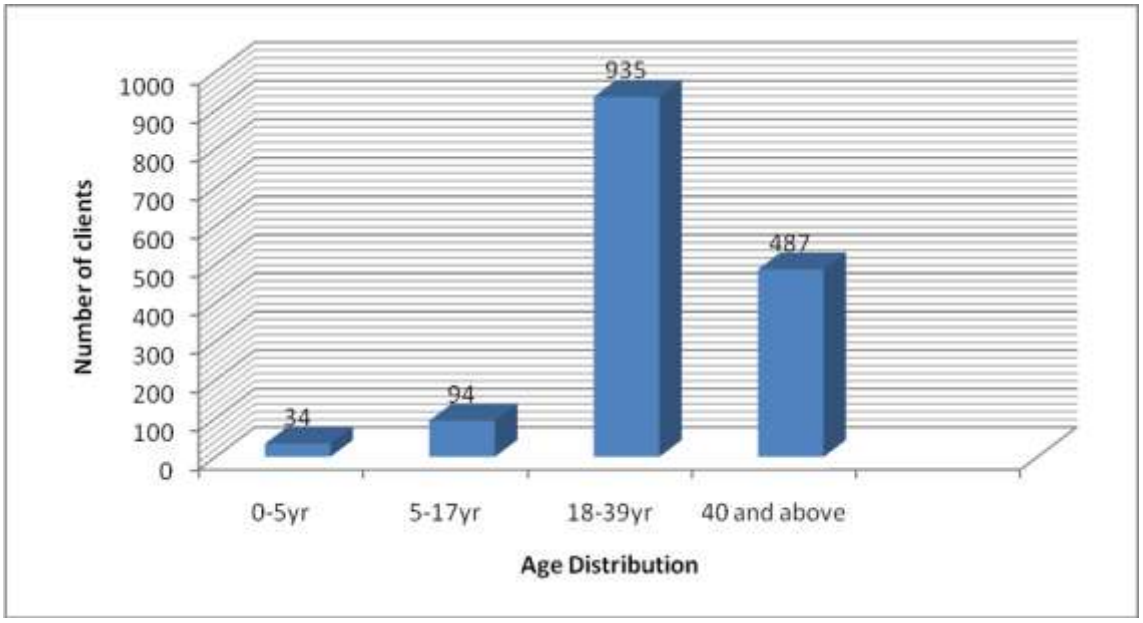
Kawempe Home Care has cared for a cumulative number of 2685 people living with HIV/AIDS, TB and cancer. Of these, 842 (31%) are male and 1843 (69%) are female. KHC continues to extend its services to more clients through community counselling and testing to identify HIV positive clients, then enrolling them into care. A total of 3584 people were counselled and tested for HIV this year; 525 (15%) were tested positive and 3059 (85%) were negative.

- 1550 clients are active on the program; 472 (30%) are male and 1078 (70%) female
- 47 are active on TB treatment
- 84 pregnant mothers are receiving PMTCT services
- 755 patients are active ART
- 25 cancer patients received treatment support

1.1 Age distribution

There are 34 clients between the ages of 0-5 years, 94 clients between 5-17 years, 935 between 18-39 years and 487 are above 40 years of age. The number of positive children has greatly decreased due to quality PMTCT services given to pregnant HIV positive mothers to prevent transmission to their children.

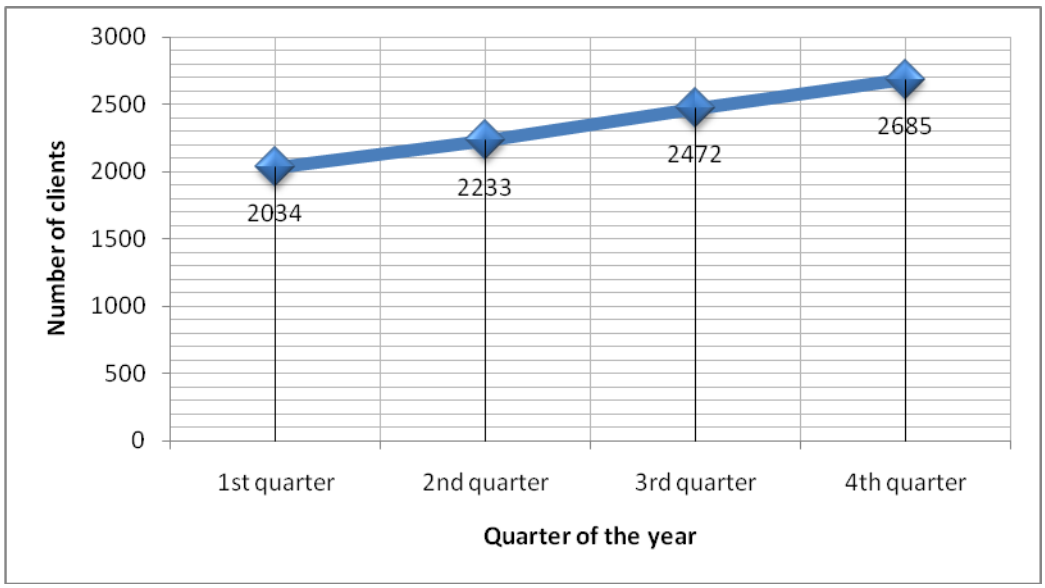
Graph 1: shows distribution of active clients by age



1.2 Client growth

The client numbers have steadily increased this year. This is attributed to community HIV counselling and testing that helps identify HIV patients who are then put into care and coordination with Kawempe Health Centre who refers clients who are in KHC catchment areas.

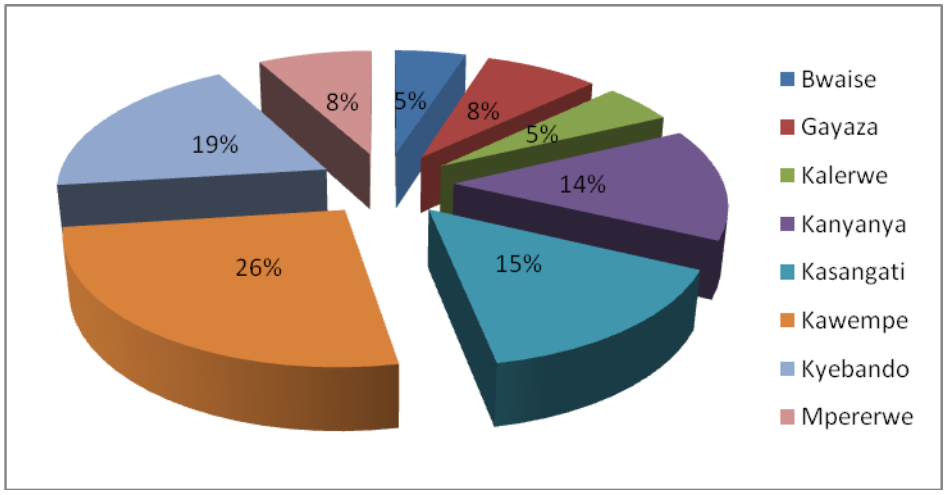
Graph 2: Shows clients' cumulative growth



1.3 Patients' residence

KHC serves patients that reside in parishes of Kawempe, Bwaise, Gayaza, Kalerwe, Kanyanya, Kasangati, Kawempe, Kyebando, Mpererwe and Nangabo subcounty.

Chart 1: shows clients' by residence



2.0 MEDICAL SERVICES PROGRAM

Kawempe Home Care (KHC) offers comprehensive holistic care to people living with HIV/AIDS, Cancer and Tuberculosis. By the end of 2012, KHC had reached a cumulative number of 2686 clients, 1550 of whom are active on our program.

The medical department is comprised of 4 sections: the clinic; counselling; pharmacy and laboratory. All these sections work hand in hand to ensure clients get all the services they need to assist them to improve their quality of life. The medical department routinely carries out Continuous Medical Education (CME) every Tuesday to equip department staff with knowledge relevant to their field of work and discuss challenging patients' conditions and their management in a case conference every Thursday.

A number of activities were conducted throughout the year and some of the most important ones are highlighted below.

The medical department's training team was privileged to carry out an external training course –"The OVC Caregivers Training"- held at the IDI training Hub. KHC trained a number of IDI caregivers from around Kampala district and this was one of the greatest achievements for the organisation.

Picture 1: Shows trainees and trainers at IDI

Secondly, the medical department in collaboration with the community department successfully carried out a 5 day training refresher course for community volunteers in Home Based Care of the patients. This has improved the skills and knowledge of the community volunteers in the management of the patients in the community by enabling them to identify the patients and refer them to the clinic for care.

In the last quarter of the year, we embarked on yet another internal training course targeting all staff of KHC - “Training of Trainers (TOT)”- aimed at equipping the staff with training skills. All participants who attended 90% of the sessions and presented a teach back will be awarded certificates.

Finally, we completed the training in comprehensive HIV care and management for the clinicians and now they are competent to manage the patients efficiently.

2.1 Counselling Services

At KHC we have been doing HIV counselling and testing (HCT) both at the centres and in the community including; couples HIV counselling and testing; HCT for Post Exposure Prophylaxis; and ongoing counselling services to address psychosocial issues clients face as they take their medication both at the centres and at home.

Health education on condom use is another service offered to sexually active clients to try to prevent the spread of HIV/AIDS as well as assisting them with family planning. According to the Counselling Coordinator Alice Tusiime, HCT in the community Outreach is in great demand because people think that they have been exposed. We are grateful to CDC and the Infectious Diseases Institute for supporting the HIV prevention program at KHC.

Picture 2: KHC staff carrying out Community HCT in Kyebando Parish

2.1.1 HIV Counselling and Testing (HCT)

Throughout this year, we counselled and tested 3586 clients both at the centres and in the community through community sensitization. 3059 (85.3%) clients were HIV negative and 527 (14.7%) tested HIV positive and were enrolled on the program for HIV care.

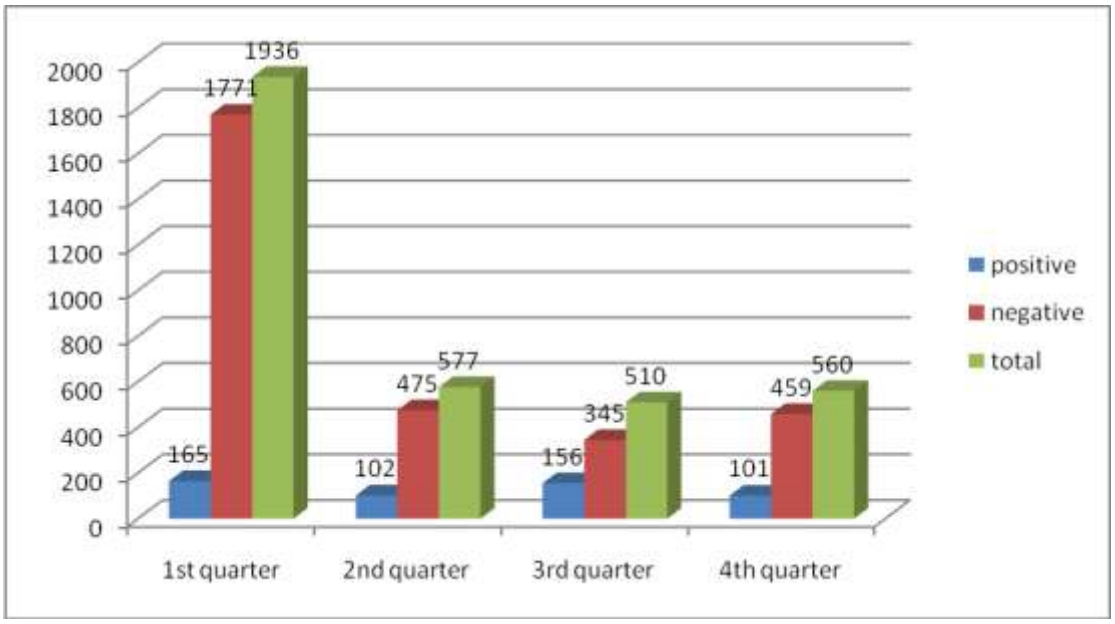
There has been massive sensitization of the people in the community through creating awareness of HIV; promoting the prevention of HIV infections; and early detection of the HIV infection.

KHC entered collaboration with Kawempe Health Centre this year; one counsellor does HCT from Kawempe Health Centre and those with HIV are enrolled into KHC care.

"I was very shocked when I got my results. I remember walking to KHC clinic thinking to myself it's going to be negative. I was counselled and I decided to deal with it. I made sure my family and close friends knew what was going on in my life. HIV is not something people neither can nor should go through alone. You need people to win this fight." Teopista, a client at KHC.

KHC emphasises couple counselling because it helps in disclosure, better adherence, HIV awareness and positive prevention by encouraging the use of condoms. During clinic consultations, clients that have spouses with unknown HIV status are encouraged to bring them to the clinic for testing.

Graph 3: shows the number of patients counselled and tested in 2012



2.1.2 Ongoing counselling

The follow up on the clients is done at the clinic during clinic visits and in the client's homes during home visits. Ongoing counselling is to help the clients and their care takers cope with the situation at hand.

Table 1: shows the number of clients who received ongoing counselling

Indicator being addressed	MALES			FEMALES			
	Under 5 years	**5>17 years**	**Above 18 years**	**Under 5 Years**	**5>17 Years**	**Above 18 years**	**Total**
Adherence counselling	1	1	99	2	3	137	243
ART counselling	4	0	99	3	1	155	262
Behavioural change	0	4	52	3	5	87	151
Disclosure	0	1	3	0	2	7	13
Nutritional counselling	0	0	0	0	0	0	0
Positive prevention	0	3	56	0	4	92	155
Positive living	0	1	14	0	4	95	114
PMTCT counselling	0	0	0	0	2	0	2
Supportive counselling	0	0	35	0	2	56	93
Social support counselling	0	1	5	0	0	5	11
Spiritual counselling	0	0	00	0	0	2	2
Bereavement counselling	0	0	0	0	0	0	0
Couples counselling	0	0	2	0	0	3	5
Stress management	0	0	3	0	0	19	22
Home visit	0	0	14	0	0	39	53

Picture 3: shows ongoing counselling at the clinic on a clinic visit

KAGULLILE STEVEN SUCCESS STORY

"My name is Kagullile Steven from Nabweru, I am 54 years old, married with 4 children. I came to KHC in 2008 for voluntary counselling and testing after having several illnesses for a long time. I was received by the counsellor and counselled on various information related to HIV/AIDS transmission and methods of prevention. I was tested and results came back positive, the counsellor discussed about positive living, which included disclosure, condom use, stress management, and adherence as a way of promoting quality life. I was enrolled on the program to begin taking the treatment and I was encouraged to disclose to my wife.

With the support from the counsellor I managed to bring my wife in to be tested together without disclosing the HIV status initially but we were both positive which stressed us deeply.

Picture 4: Steven (right) talking to the counsellor

Despite the situation, the counsellor addressed all the worries and at the end of the session, we managed to agree on the action plan that is; being faithful, using condoms, coming back for ongoing counselling as a couple. Counselling imparted a lot of courage on us, which became an asset in our life. Knowing together and taking the drugs together has helped us to strengthen the good adherence

strategy. I was started on ART with CD4 198 but with support from the counsellor and my wife, I managed to implement proper adherence, which helped me to increase my CD4 to 500.
I am grateful for the service of the counsellor which has helped to improve the quality my life, physically, I am able to sustain my family financially, I am faithful to my spouse, I am free to talk about all my concerns with a counsellor emotionally and I feel normal."

2.2 Clinical Services

We offer a number of services to our clients including; HIV counselling and testing (HCT), Home Based Palliative Care, Anti-Retroviral Therapy (ART), PMTCT, TB care, laboratory services among others, and all these services are rendered free of charge.

For other diagnostic tests that we do not offer (e.g. x-rays, biopsies, ultra-sound scan), the organisation may fully pay for, or contribute a portion of the charge fee depending on the cost of the test because it is out sourced from Mulago hospital.

The above services are offered to the clients in their homes or at the clinic depending on the condition of the client and at times the patient may be referred to Mulago hospital for hospitalization if he/she is very sick and needs close observation and monitoring.

2.2.1 Medical Consultations

These are consultations made by the clinicians on their routine clinic and home visits or on emergency call. This year we had 12,663 consultations of which 393 were home visits and 12,270 were clinic consultations.

These clinic consultations are made on appointment but at times, some patients come earlier than the appointment date as they fall sick and need access to treatment.

Table 2: Show consultations made during the year.

INDICATOR	1ST quarter	2ND quarter	3RD quarter	4TH quarter	TOTAL
CLINIC	2382	2856	3643	3389	12270
HOME VISITS	95	116	94	88	393
TOTAL	2477	2972	3737	3477	12663

2.2.2. Clients on ART

KHC had accumulative number of 1040 clients on ART, 755 clients were active on the program and in 2012, 306 were initiated on ART.

We have continuously provided free ARV's to the clients and through the good partnership with MOH and IDI we had enough stocks of ARV's for both adults and children and this has helped to improve our clients' lives. Our clients have had to face very few opportunistic infections due to the continuous refill of the ARV's and their good adherence we must mention.

The clients on ARVs are closely monitored though immunological tests (CD4 test) every six months. Clients with treatment failure are put on second line ART; we had 18 clients on second line ART in 2012. These clients had poor adherence because of stigma, non-disclosure and poverty (some clients have no food so they stop taking medicine because they claim the medicine cannot be taken on an empty stomach).

Picture 5: Clinician examines the patient on a clinic visit.

The good adherence is attributed to good counselling and a group of community workers who closely monitor clients' adherence by visiting them at home and doing pill counting to determine whether the client is taking their medicine well. KHC proposes appointment call strategy that aims to call a client and remind them of their clinic appointment three days before the appointment day.

Table 3: shows number of patients on ART

Indicator	**1st quarter**	**2nd quarter**	**3rd quarter**	**4th quarter**	**TOTAL**
Number of adults and children enrolled in the quarter	51	114	54	87	306
Number of pregnant mothers enrolled on ART	2	3	4	3	12
Number of cumulative Active patients on ART	483	572	637	755	755
Number of patients enrolled on ART cohort 12 months before this period	15	7	203	165	390
Number of patients known to be alive and on treatment 12 months after ART initiation	13	7	190	190	310
Percentage of adults and children known to be alive and on treatment 12 months after ART initiation	87%	100%	93%	91%	Average 92%
Cumulative number of adults and children with advanced infection ever started on ART at the centre.	691	810	927	1040	1040

2.2.3. TB /HIV Integrated Care

By the end of the year, we managed to screen **1550** clients of which **225 (14.5%)** were suspects.

84 (37.3%) of the suspects were confirmed to have active TB through sputum analysis and radiology (abdominal scan and x-rays). **23** clients were sputum positive. **7** of the active clients have extra pulmonary TB and 40 have pulmonary TB. 38 of the active clients are TB /HIV co-infected and 30 are

on ARV'S. 9 have TB only. 3 of the active clients are children below 12yrs, 2 of the children are TB/HIV co-infected and 1 child has TB only.

By the end of the year, 50 clients managed to complete their treatment successfully and were awarded certificates, unfortunately in the 3rd quarter of this year we got 1 MDR client and she was referred to Mulago hospital for treatment and is now doing well.

Table 4: shows the number of patients on TB treatment.

Indicators	**1st quarter**	**2rd quarter**	**3rd quarter**	**4th quarter**	**TOTAL**
No. of TB patients who had an HIV test result recorded in the TB register	24	18	22	20	84
No. of new smear positive	4	2	8	9	23
No. of TB patients that completed TB treatment.	9	14	13	14	50
No. of HIV positive patients that received TB treatment.	32	38	39	38	38
No. of TB/HIV co–infected	32	38	39	38	38
No. of active clients on TB treatment	41	46	47	47	47

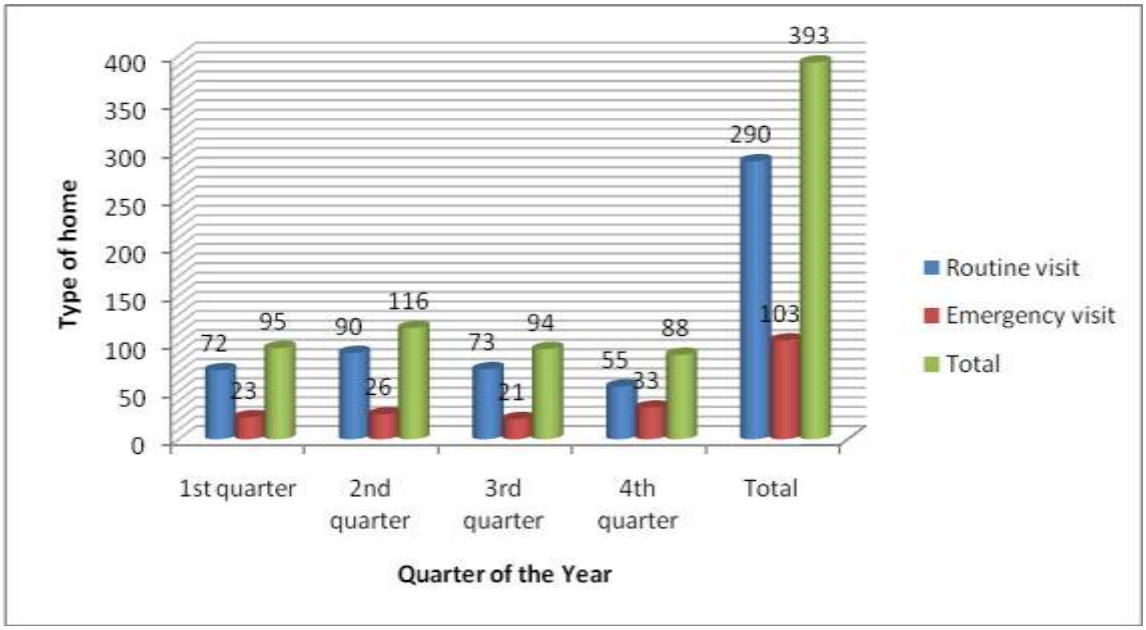
2.2.4. Home Based Palliative Care

One of the core services offered by Kawempe Home Care is Home Based Palliative Care, which is provided to all our patients through the community volunteers and the medical team. This is done through visiting the patients in their homes and care is provided because of their general poor conditions, being bed ridden or handicapped.

Throughout 2012, **393** home visits were conducted. Among these, **290** were routine home visits, which are carried out on every Tuesday and Wednesday and **103** were emergency home visits, which are carried out when the need arises, excluding Sundays.

Picture 6: shows a clinician examining a patient during a home care visit

Graph 4: shows the number of routine and emergency home visits conducted during 2012



2.2.5. Palliative Care for Cancer Patients

We cared for a total number of **24** cancer clients, and by the end of the year, **16** were active in care. **22** were HIV/ Cancer co-infected and **2** had cancer only. Of the HIV/ Cancer co-infected clients, **21** were on HAART while **1** is due for HAART and is soon starting after being prepared. **1** client was lost to follow up and regrettably **7** of our cancer clients condition deteriorated and eventually they passed on.

9 clients were on oral morphine for management of severe pain, **5** clients received radiotherapy and completed and **7** received chemotherapy.

2.2.6 Paediatric Adolescent Care

In 2012 we cared for a total number of 130 children and by the end of the year 127 children were active on the program. We had 43 enrolments; 37 of these tested positive through HCT, 2 were transferred-in from other centres and 4 were exposed infants who didn't go through a full PMTCT program and unfortunately had their DNA-PCR tests turn positive- all these infants were initiated on ARVs as per Ministry of Health guidelines regarding all children less than 2 years of age.

The total number of children on ART is 56, this increased from 40 children in the previous year. All these children are stable on their ART regimens.

This year we lost 2 children in the 2nd quarter. One had just been enrolled on the program and died hardly a month after enrolment. The other death was a child, who had been on the program for 3 years but died suddenly before our team could intervene following a febrile illness that he suffered. One child was transferred out.

Table 5: shows children in paediatric-adolescent care

Indicator	**1st quarter**	**2nd quarter**	**3rd quarter**	**4th quarter**	**Total**
Newly enrolled	13	11	8	11	43
Active on program	93	108	116	127	127
Active on ART	46	49	54	56	56

2.2.7 Prevention of Mother to Child Transmission

We had **88** active clients on PMCT program of which **59** clients were newly enrolled. Of which **27** were assessed for ART initiation by CD4 and WHO clinical staging and were initiated on ARVs leading to a total of **84** clients on ART. **30** clients successfully delivered their babies and all the babies were given NVP syrup to reduce the risk of HIV infection.

3 infants were referred from the community who needed NVP syrups making a total number of **33** infants on NVP syrups. **64** infants received HIV test by DNA/PCR, **60** infants tested negative and **4** tested positive, **1** child tested HIV positive by Rapid test at 18 months. The mothers of these positive infants never received any PMTCT intervention and knew their HIV status after delivery.

In 2012, we cared for a total of 115 mothers and only 1 (0.87%) were lost to follow up. We also cared for a total of 75 exposed children and only 1 (1.3%) were lost to follow up. This illustrates the strength of our community network of care in preventing loss to follow up in PMTCT.

Picture 7: shows a clinician on a PMTCT follow up visit in the community

Table 6: shows number of clients who received PMTCT services.

INDICATOR	**1st quarter**	**2nd quarter**	**3rd quarter**	**4th quarter**	**Total**
No. of active mothers on PMTCT	75	68	75	88	88
No. of new mothers on PMTCT	14	16	7	22	59
No. of clients assessed for ART eligibility thru CD4 testing or WHO staging	6	8	0	13	27
No. of clients receiving ARVs to reduce the risk of MTCT	74	67	74	84	84
No. of deliveries from PMTCT	4	13	10	3	30
No. of babies who died at birth	0	0	0	0	0
No. of infants born to HIV positive women who were given ARVs to reduce the risk of MTCT	3	13	10	7	33
No. of babies born who received an HIV test within 12 months of birth and tested negative	14	15	16	15	60
No. of babies born who received an HIV test within 12 months of birth and tested positive	0	1	2	1	4

2.3 Laboratory

In the year, we registered 7,595 laboratory tests (as shown in the graph below) of which 72% were completed on site while 28% were outsourced. In 2013 we would love to have less than 10% of the tests outsourced.

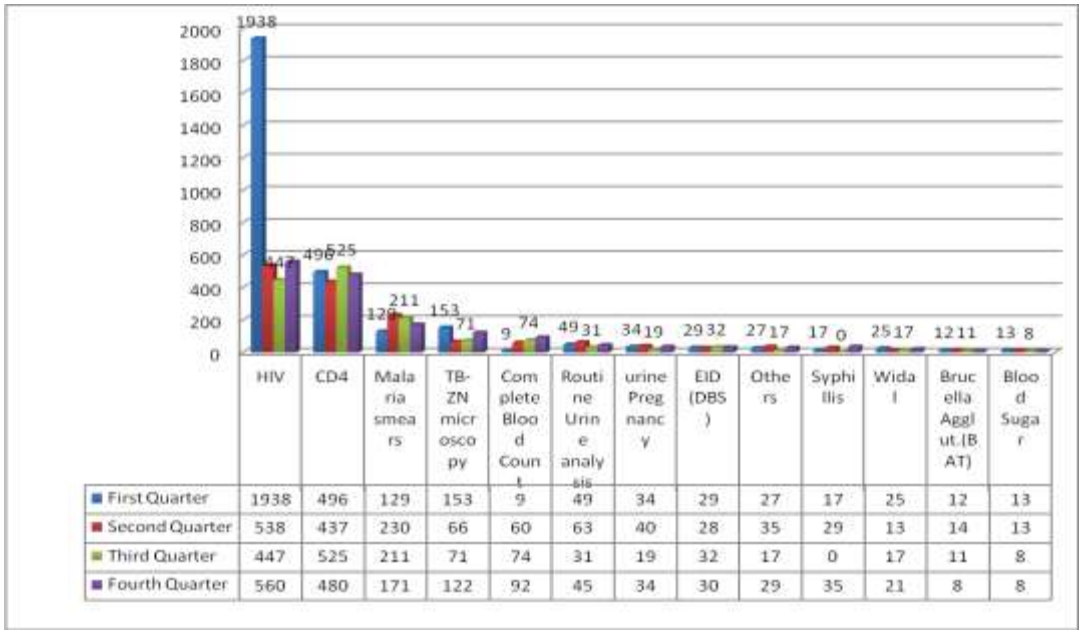
Majority of the outsourced tests were CD4, Viral load, liver function and renal function tests. The tests are required to monitor HIV patients before ARV initiation and during the course of treatment.

Other routine monitoring tests include complete blood count for diagnosing anaemia, while pregnancy test is done for all females of child bearing age since some of the drugs used is HIV treatment are contraindicated in pregnancy and syphilis for all pregnant mothers.

Picture 8: Bleeding a client for HIV testing

Picture 9: Laboratory technologist arranges TB smears for external quality assessment (EQA)

Graph 5: Laboratory tests done in the year



3.0 COMMUNITY AND SOCIAL SUPPORT PROGRAMS

The community department is composed of: Community Network of Care; Orphans and Vulnerable Children; Social support and Social entrepreneurism section, which includes the new projects such as mushroom growing and the piggery project, with the aim of making the KHC comprehensive program financially sustainable in the near future.

3.1 Community Network of Care

This section links the clinic to the community. It is comprised of 23 community volunteers of which 3 are supervisors. The community volunteers received a refresher course and also trained in Home Based Palliative Care. They were equipped with basic knowledge on how to provide quality services to bedridden patients during home visits. 95% of our community volunteers are living with HIV and they use their testimonies to empower and help the patients adhere well to their medication and live positively with HIV. They have been involved in cooking, washing clothes for destitute clients, and pill counting amongst other activities.

Picture10:

Mr. Sentamu Joseph during sharing his community work experience with other VICTASS during network discussion meeting.

The volunteers throughout last year invested their energies in the patients' adherence and psychosocial support. Thanks to Friends of Reach Out USA, and the infectious Diseases Institute for making this possible.

Table 7: shows the number of clients visited during the year

Activity	1st quarter	2nd quarter	3rd quarter	4th quarter	Total
Home visits	3407	2222	2388	1820	9837
ART adherence visits	1691	1551	1696	1510	6448

3.1.1 Medication adherence support

Adherence support as been a core activity for the community volunteers and this is carried out through pill counting every time a community volunteer visits a patient at their home. **9837** home visits were done and an average of **1612** patients was visited this year.

3.1.2 Community Based DOTS

The second important activity by the volunteers is community based directly observed therapy for TB patients.

The TB patients are closely monitored throughout their treatment course.

A unique system for monitoring the TB patients by community volunteers was developed.

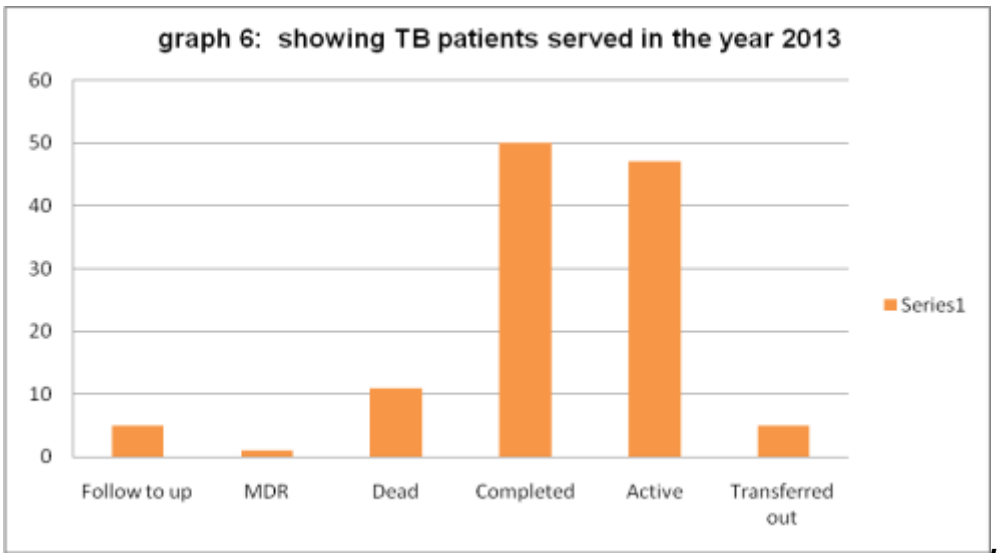
Picture11: shows a new client being helped to take medicine correctly.

Table 8: Shows the treatment system used by the community volunteers for TB clients

Phase	**No. of visits/week**
Initial extensive	3
5-7 months	2
Last month	1

This treatment system has helped us monitor the adherence, reduce lost to follow up and attain good treatment outcomes as shown in the chart below. In addition, our community volunteers are not over worked and they are able to see many patients with this schedule.

However, the mortality rate was high mainly because these patients came late in their advance stage of HIV/AIDS. This year we got the first MDR case in our TB care, this case was referred to Mulago TB ward.



3.1.3 Home Based Care

Home Base Care for the bedridden patients is a core activity for both clinicians and community volunteers. Every week, a team of clinicians, counsellor and community volunteer visit the patients in their homes where patients are given treatment for opportunistic infections, ART and TB medication, counselling for both patients and family members and community volunteers gave adherence support.

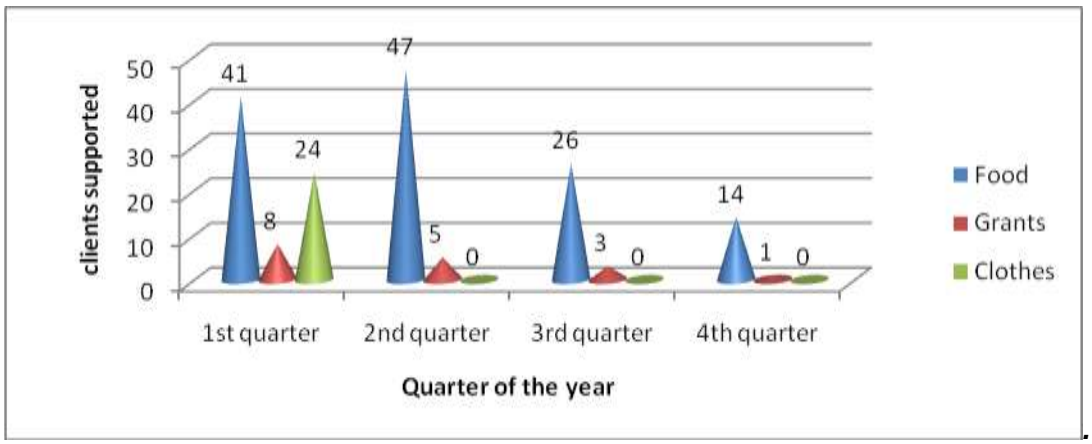
In addition, the community section assisted destitute patients that did not have any relatives so the community volunteers did home chores like washing, cooking food, turning patients on beds, giving medication and bathing the patients. This has not only improved their lives but also helped them to be happy and most of these clients are in better condition.

Picture 12: community workers in a training session for Home Based Care

3.2 Psychosocial Support.

This section takes care of the patients' psychosocial needs. In the year 2012, our patients benefited from small business grants, food support and clothes. 174 patients benefited from the psychosocial services and this was made possible by the support from Culture Without Boarder (CWB) snf friends of Reach out (FORO) USA.

Graph 7: shows number of patients who received psychosocial support



3.2.1 Food support for destitute patients

The demand for food especially from the patients on ART and receiving TB treatment, PMTCT mothers and children is high and at times, some of our clients cannot afford meals. Therefore, **152** patients were given food to foster good adherence to medication. The clients are on the food program for only three months, thereafter new clients are enrolled. This is because there are many clients in need and the resources are limited.

3.3 ENTREPRENEURSHIP SECTION

Kawempe Home Care focused on developing social enterprises for poor clients and for its own sustainability. A lot of emphasis was put on the expansion of the beads and piggery projects and mushrooms; with the help of the grant from the Innocent Foundation (UK), 50 people were each given pig seed for livestock farming (ie a meal and a female piglet) and were assisted to start mushroom growing.

112 patients are earning a living through either bead making, pig rearing or mushroom selling.

3.3.1 Beads for Education

The beads sales have enabled the OVC's attain education and the money from the beads has also helped run part of the organization operations especially Home Based Care.

The project currently has 12 beneficiaries who are living with HIV. We have managed sales locally and internationally through our friends and ambassadors. On Friday 14 December we combined the beaders Christmas party with a meeting where business ideas were shared especially on how to maintain the beads quality; making new designs; and to always fulfil their orders once given to them.

Picture 13: Sarah Nakimuli (Marketing assistant) at BfE shop

Our sincere appreciation goes to all those who have supported us by buying our beautiful beads and also to our ambassadors who work tirelessly to ensure that they sell our products

.

Picture 14: Elizabeth, Sabine with BfE supporters at KHC

3.3.2. Mushroom project

At the beginning of the year, we started a mushroom growing pilot project with 20 community workers. The project proved to be a financial success. This prompted the entrepreneurship team to start mushroom growing as a means of empowering poor clients improve food security and create a sustainable income for those people living with HIV.

This project has fifty beneficiaries funded through Innocent Foundation UK, who are all clients of KHC and the mushroom materials (cotton husks, spawns, drums, polythene bags, Jik, gunny bags, firewood, and toothpicks) were also given to the farmers. Transport for the materials to and from KHC office to the farmers' homes was given as liquid cash to the farmers.

Picture 15: Farmers with their mature mushroom gardens.

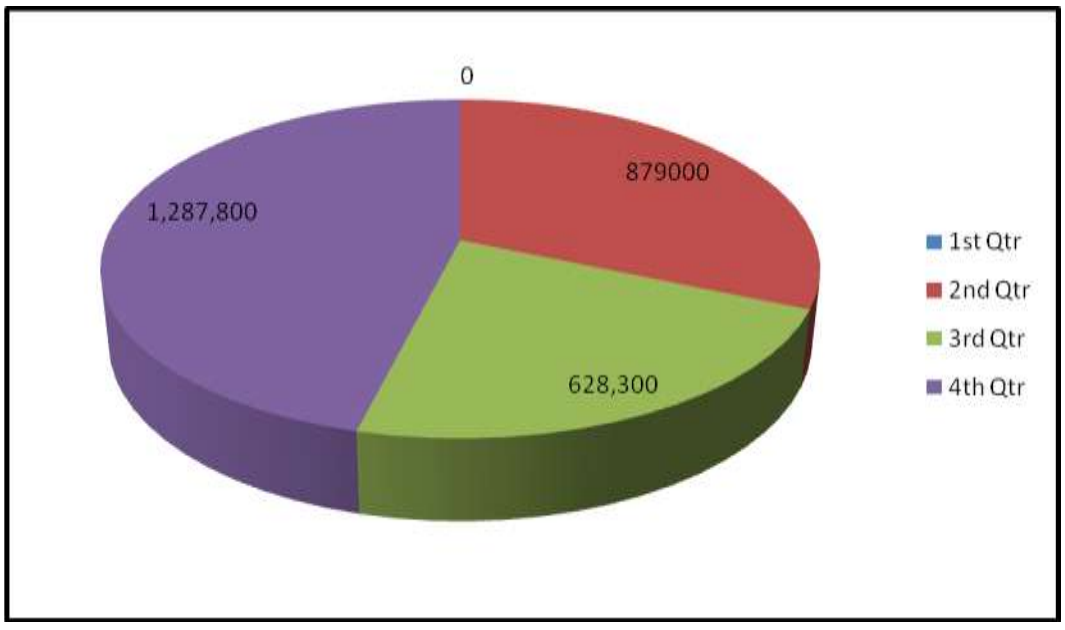
1.2.1. Mushroom selling and market.

The mushroom farmers have already started harvesting the mushrooms and they are selling to KHC. Below are some of the mushrooms we have bought from the farmers.

Picture 16: shows fresh mushrooms **Picture 17: Packed dry mushrooms**

At KHC, the mushrooms are packed primarily for our patients, supermarkets, health centres and KHC staff. The mushrooms are either sold fresh or dried and the farmers are paid on a monthly basis. We buy fresh mushrooms from the farmers at Ug Shs 3,000 a kilogram and sell for Ug Shs 4,000. Whilst 10gms are sold for 1000 shillings. We hope to increase production and sales next year.

Chart 2: shows the mushroom sales during the year



3.3.3 Piggery project.

Kawempe Home Care has been running this pilot project on a small scale for the last three years. However, in 2012 Innocent Foundation UK gave us a grant purposely to expand the project and enable 300 families to earn a living through pig raring. Currently 50 clients have been trained in rearing pigs for commercial purposes. At the end of the training each client was given a pig seed ie a meal and a female piglet. Next year more than 50 clients will benefit from this life-changing project. As a section, we have high hopes that our patients will benefit from the project and be able to earn a living from the sale of pigs and therefore their quality of life is expected to improve. However, this project is faced with one challenge of swine fever which killed most of the pigs of the first farmers and in addition this delayed the off set of new project.

The good news is that the fever is wiped out and we have started again and so far we have not had any hindrance as far as swine fever is concerned.

Picture 18: piggery beneficiaries receiving their pigs.

3.4 Orphans and Vulnerable Children

The Orphans and Vulnerable Children's (OVC) section has **59** children who are either infected or affected by HIV/AIDS. The section has four programs through which the organization intervenes to address the OVC issues. The programs are designed according to different ages to ensure that each child's unique needs are met. The programs are; Day Care with **33** children, Teens Club **87**, Kalimarimbas **43** and Home Care Education Support (HES) **104**.

The children participate in two or more of these programs. Many different activities have been conducted during the year in our programs. In December we had the children's

Christmas parties and among other things, spending time in a different place, participating in different activities gave the children a wonderful experience.


Pictures 19, 20: children enjoy the games and Staff cut the cake with children during the party.

3.4.1 Day Care

Day Care program has HIV positive children below the age of 5 years. We have 33 who meet every Wednesday at KHC centre to participate in the day care activities. These include playing, praying, writing, reading, telling and listening to stories, watching cartoons, singing, drawing, shading and painting, learning communication skills and having good meals (breakfast and lunch). The doctor sees each one every Wednesday.

3.1.3 Teens club

The program has been so essential in ensuring follow up on teenagers to check poor adherence. The results have been very good. All 78 of our children on the program are healthy and happy.

The program comprises of 87 teenagers who are living positively with HIV/AIDS. Teenagers meet at least twice each month to empower the youth with knowledge and skills for positive living. Topics discussed include; adherence, nutrition, positive living, infections, assertiveness. During the meeting, the teens have one on one discussion with the counsellor and a room to develop their skills through playing football and role plays.

3.1.4 Kalimarimbas

Kalimarimbas has 33 active members. There are both HIV positive and negative children in the group. Kalimarimbas is an entertainment group whose focus among others is to sensitize the community through its educative yet entertaining art pieces. Traditional dances as one of the activities on the groups curriculum, helps the children learn and appreciate their culture, this lesson is passed to all who watch them perform. The group helps the members to define and develop their talents. We had six performances both internal and external this year.

Picture 21 Kalimarimbas performing

3.4.4. Home Care Education Support.

HES program supports children who have been made most vulnerable by HIV/AIDS. Throughout 2012, the program has supported 104 children by paying their school fees and providing them with scholastic materials. We have had three parents meetings to emphasize and encourage the parents' role in their children's education; ensure the safety of their children.

This year we have two children who have joined institutions and are pursuing certificate courses. We have five candidates; two have sat UCE exams, 3 have sat for their PLE. Our achievements have been due to our sponsors; Samaritan Hospice, BfE Ambassadors and individual sponsors. Due to many children on the waiting list for school fees we have decided to have children on education program performing music in schools and parties to raise more funds for the children that do not have sponsors. We hope this will boast the program as we go forward.

Matovu William's success story

Picture 22: William leads Kalimarimbas male dancers during a performance

William is 18 years old. He was born and is living with HIV/AIDS. He lost his mother when he was still very young. His father re-married., unfortunately he also died years later leaving the boy under the care of his step-mother. He has older siblings but he and his step sister are the youngest children of his father. Williams step mother gave birth to a girl. As a boy he poses a threat to the step mother because she thinks that all the late husband's possessions will go to the son-William.

Later after his father's death, William observed that he was often falling sick. He was advised to go for an HIV test at Kasangati where Kawempe Home Care had just started and was operating in Nyakazze at Joyce's (one of the Kasangati Community volunteers) house. William's was tested positive 5 years ago and immediately put on treatment. At this difficult point in time, he had and has no support from his family except from Kawempe Home Care as far as his education is concerned.

His life at that age wasn't easy since he had to deal with a lot of issues; the maltreatment at home (among other reasons, his step mother never wanted him to go for the test for fear of suffering stigma and discrimination) , challenges of growing up, and also accepting the HIV results in order to live positively. But the VICTASS (Joyce Nakyaze) made sure he received treatment. William was enrolled in Teens Club meetings, Kalimalimbazi, and got a sponsor for his education. William has gained a lot from guidance and counselling, emotional support, sharing, and the feeling of belongingness. He is an active member (a very good dancer and teacher) of the Kalimarimba group. Home Care Education support program has helped him to adopt a positive attitude towards life. He is now pursuing a Certificate in Motor vehicle engineering. We look forward to his graduation after his course at the end of 2013.

Picture 23: OVC's participate in music dance and drama to help fellow children.

6.0 ADMINISTRATION DEPARTMENT

6.1.1 Resource mobilization

This section was introduced this year to mobilize the funds for our comprehensive holistic care program. The resource mobilization coordinator was recruited together with a technical advisor. HorizonT3000 supports the salary of the technical advisor. We thank you for supporting KHC HR needs. The section has been engaged in fundraising activities proposal writing, stakeholder management and networking.

Furthermore, the Kalimarimbas dance group was invited to a Christmas Bazaar organized by the International Women's Organization at Kampala International School where the group was hired to perform for the people and collected some funds for helping the OVC. We thank the internal women's organisation in Uganda for giving an opportunity to our children

We had a successful conference to mark 5 years of KHC existence. The theme of the conference was "Palliative Care in the Era of ART" all stakeholders attended it from palliative care fraternity. We greatly commend them for the support to network as well as KHC.

It involved a lot of research, information dissemination and networking between sister organisations. This conference was sponsored by IDI, APCA and HORIZONT3000. We thank you for supporting us and making that day memorable.

This year was blessed with many stakeholders visiting our clinic to see the HIV comprehensive holistic care program done in a resource limited environment. Below are some of the guests that visited different sites of our program.

Picture 24: Dr. Amandua Jacinto (right), Commissioner for clinical services in the Ministry of Health and country Director (second left) visit KHC

Picture 25: Dr. Alex Coutihno (centre), Director IDI paying a visit

Picture 26: Students from UK on their visit to exchange knowledge about mushrooms

These visitors were health professionals, palliative care practitioners, Volunteers, students on placements for knowledge exchange, ambassadors to the Beads project, and even those who came to learn more about Palliative Care in an organization. This enhances knowledge exchange between KHC, different organisations and individuals.

Finally, we thank all organisations and individuals that have supported in the last five years. The road has been tough but you kept holding our hands! May the lord bless you for touching and changing many lives in the community.

Samaritan hospice USA, Century bottling Company Uganda,

6.1.2 Human Resource

Kawempe Home Care had 30 permanent staff, 23 community volunteers, 5 local volunteers and 2 international volunteers who worked tirelessly in order to improve client's lives.
Without these vital human resources, we would not be able to make a difference. We are therefore grateful to every member for contributing to this noble cause. All staff had appraisals and received training and mentorship in different areas.

There are many people who work tirelessly in KHC and we like to promote and recognize excellence of individuals who have gone that extra mile. This year, the overall best performer for the "Moved By Love" award went to 'Mzee' Ssentamu, a self-motivated man with a passion for delivering good Home Based Care support to his patients.

Ssentamu Joseph is 70 years old. He joined KHC in 2007 as a client. In 2008, he was trained in Home Based Care where he has shown exceptional service, love, total dedication and care for patients. He visits more than 50 patients in a month. He is passionate about Home Based Care and carries other community workers on his motocycle to visit bedridden patients in the community. He is married and a father of. 10 children. Joseph stood out as an exemplary worker and won the '*Moved by Love' award.*The Chairman of the Board of Directors Mr Aloysius Byaruhanga thanked him and encouraged all the staff of KHC to emulate the example of Mr. Ssentamu Joseph.

Picture 27: Mzee Sentamu Joseph sharing experiences with KHC staff at Kasangati outreach clinic.

6.1.3 International Volunteers

KHC was blessed to have international volunteers with technical skills to assist us. We had Dr. Elora from UK who worked in the clinic for six months and a caring nurse Krisitna from Ireland who has been with us for the last three years. These good-hearted individuals have been filling a big gap in the medical department. We are extremely grateful for their contribution.

Picture 28: Kristina and her husband with KHC Management on her farewell day.

The following is a list of people who worked at KHC in the year 2012. Some worked for a whole year while others a few months, weeks, or even days but each made a unique contribution. We shall be forever grateful for your generosity.

6.1.4 List of Human resources

	Staff List
MEDICAL DEPARTMENT	**RESPONSIBILITY**
Komugisha Sarah	Manager Medical Services
Ursula Nanfuka	Clinician
Nanozi Aidah	Clinician
Bugingo Alex	Clinician
Wakuba Herbert	Clinical coordinator
Kristina	Clinician/Volunteer
Dr. Elora	Clinician/Volunteer
Counselling Section	
Tusiimemukama Alicitidia	Counselor
Jacinta Asingwire	Counselor
Selukuli Julius	Counselor
Laboratory	
John Apuuli	Lab Manager
Kayizi Shafiq	Lab officer
Pharmacy	
Sharifa Shariff	Incharge
Stella Nanyombi	Dispensing Assistant
Blitt Anderson.	Medical student/volunteer (USA)
Carolyn Mütsch	Medical student (volunteer from Germany)
COMMUNITY & SOCIAL SUPPORT DEPT.	
Namirimu Oliver	Manager Community and Social Support Dept.
Ninsiima Amelia	OVC coordinator
Musiimenta Ruth	Entrepreneurship coordinator
Nakimuli Sarah	Marketing Assistant/ Volunteer
Birungi Julet	Social Support/ Volunteers
Community Volunteers (VICTASS)	**Kasangati**
Nakyazze Joyce	Kasangati Supervisor
Sekasi Allen	Kasangati
Nalwoga Christine	Kasangati
Ssentamu Joseph	Kasangati
Mugambe Rona	Kabanyoro
Lukwaya Mukwaya	Kasangati
Nakivumbi Teddy	Kasangati
Matovu Charles	Kasangati
Kigongo Prossy	Kasangati
Bukirwa Esther	Kasangati
Ntabadde Rebecca	Kasangati
Naigaga Getrude	Kasangati

Kawempe Community	
Nankya Maria Assumpta	Patient recruitment supervisor
Namulinda Zaina	Mulago.
Hadija Kibuuka	Kyebando Central
Sanyu Nagita	Kanyanya
Namuddu Joyce	Mperegwe
Naiga Stella	Kitala/Komamboga
Benard Nterehe	Kalerwe
Namboze Jalia	Kawempe1/Kakungulu
Namazzi sarah	Kagoma/Maganjo/ Kawepe ku Taano
Nanyazi margrett	Tula /Kilokore
Mamulinda Zainah/	Mulago.
Naiga	Bwaise
Kagoro B	Bwaise
ADMINISTRATION DEPARTMENT	
Dr. Samuel Guma	Executive Director
Gerever Niwagaba	Program Manager
Kebirungi Henrieta	Resource Mobilization Coordinator
Tumwine Elias	Accountant
Patiance Orishaba	Admin Assistant
Nabisbo Mary	Stores Manager
Turinawe Joseph	Security Head Office
Elisabeth Unterberge	Technical Advisor
Support staff	
Turinawe Joseph	Head of Security
Baguma Godfrey	Driver
Siminyu Patrick	Security Officer
Mukasa Constante	Cleaner
Sofia Nakasi	Cook
Monitoring & Evaluation	
Mwije Justus	Data Management Officer
Namulwa Claire	Data Management Officer
Mpakibi Mary	Receptionist/Data Clerk
Miria Kahiza	M&E Coordinator
Kakuru Mugarura	IT Consultant

6.2 Finance report

The finance section is under the Administration department and is responsible for planning and budgeting, accounting and controlling of expenditure, data entry, analysing, advising, auditing internal and external as well as reporting to both the organisation and donors. This has been possible because of good financial systems and software (*QuickBooks*) that were put in place by the management. The Finance report is divided into the traditional categories of Income and Expenditure. The income category is further divided into Grants and donations, in-kind donations and Income Generating Activities with the expenditure category divided into Administrative Costs, Operational Costs and Capital Costs.

Table 9: shows income and expenditure for 2012

Category	AMOUNT Ug. Shs.	US Dollars	Percentages
Grants and Donations	**462,665,523**	192,777	82
Income Generating Activities	**92,628,329**	38,595	17
In-Kind Donations	**5,975,000**	2,490	1
Total	**561,268,852**	233,862	100
Administrative Costs	**48,333,470**	20,139	11
Operational Costs	**384,234,176**	160,098	86
Capital Costs	**14,472,800**	6,030	3
Total	**447,040,446**	186,267	100

6.2.1 Total Income

In the year 2012, our total income came to **Ug Shs 561,268,852 (US$ 233,862).** These funds came from the generous donations provided by our friends the donors and our own income and In-Kind Donations that are converted into cash.

6.2.2. Grants and Donations

These funds are contributions from all over the world given by different agencies and individuals that support HIV/AIDS organizations. This year we received a total of **UGX 462,665,523** from Infectious Disease Institute/Centers for Diseases Control, Friends Of Reach Out, Hope For Children, African Palliative Care Association/True colours trust (UK), Culture Without Boarders and The Great Generation. We are grateful for their continued support. We also received private donations from many friends all over the world i.e. Australia, US, UK, Denmark, Austria and Norway.

6.2.3. Income Generating Activities

The funds under this category came from Kawempe Home Care incoming generating projects that provide clients in the projects with an income so that they can sustain their families. Also KHC receives

funds which go to paying school fees and other operational costs. The projects are: Beads project is jewellery made by clients from recycled paper and they are sold to KHC which then resells them to the international markets through our Beads Ambassadors. We are grateful to our ambassadors for developing the international markets in countries like Denmark, Norway, Scotland, England, Iceland, Australia, and the USA. We also are grateful to those who have helped solicit markets in Uganda.

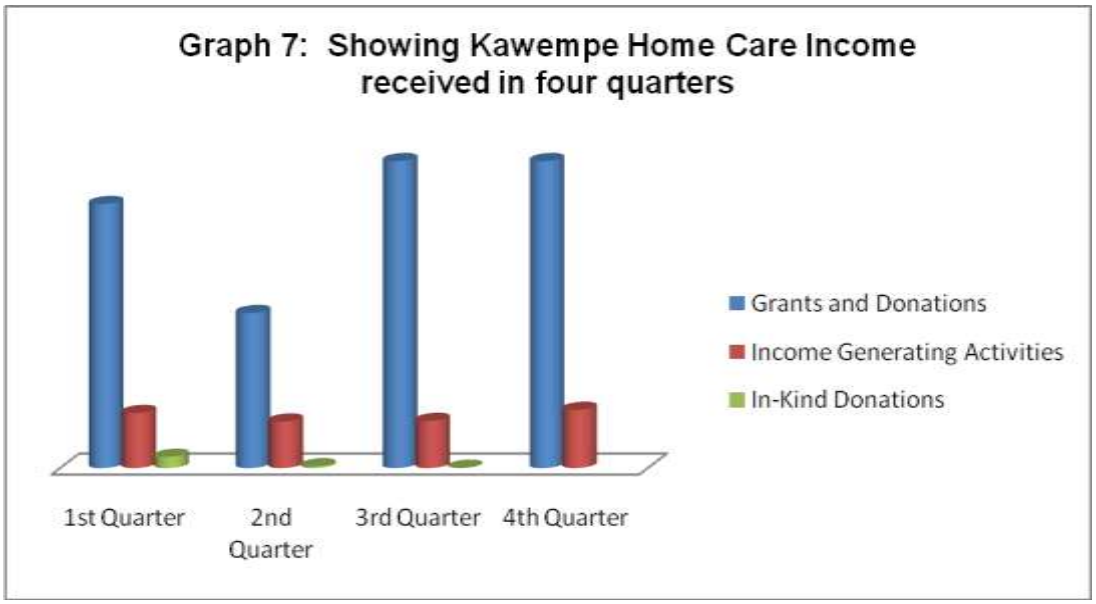
The Mushroom project also has become another source of income for both our client/growers and Kawempe Home Care, it is nutritious to both the old and young and many clients and staff buy them. We also have the Piggery project, which was started at the end of this year, and we hope that it will be financially viable for our clients. Thanks go to Innocent Foundation and Hope or Children for the funds that they contributed for these projects.

This year, income generated from these projects came to a total of **UGX 92,628,329** equal to **17%** of the total income.

6.2.4. In-Kind Donations

We are equally thankful to those who donated in-kind in particular we thank IDI and Ministry of Health for ARVs and TB drugs and Laboratory supplies, Training and workshops. Also, to friends in Uganda and abroad that donated clothes for our children TV, fridge, tables and chairs, textbooks for school children mention but a few. Thank you so much.

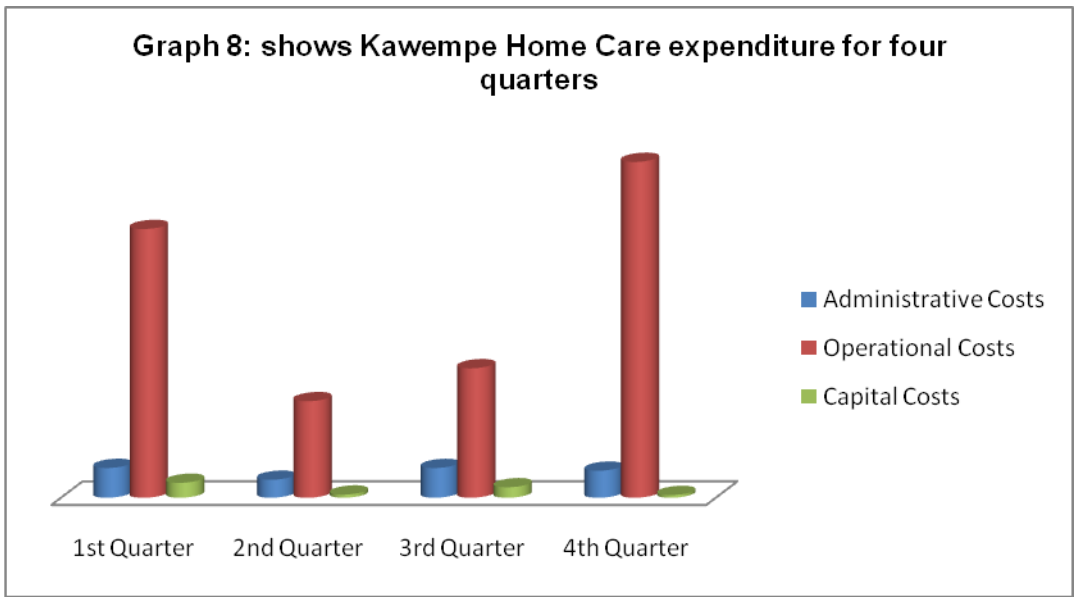
Graph 7; Shows income received in 2012.



6.2.5.Total Expenditure

Our total expenditure in 2012 came to **UGX 447,040,446 (US$186,267).** These were sub divided into Administration Costs, Operational Costs and Capital Costs.

Graph 8: Shows expenditure for 2012



6.2.6. Administration Costs

One important principle we value is to ensure the majority of the donor funds are for client based expenses for example medicines, laboratory tests, and emergency food support among others. We therefore keep our administration costs below 15% of the total expenditure. In the year 2012, our Administrative costs came to a total of **Shs 48,333,470 (US$20,139).** This represented **11%** of our total expenditure.

The administration costs went into paying for utilities: water, electricity, internet, providing simple lunch for our staff and volunteers at outreach clinic, stipend for support staff in administration assistant administrator, security guard, cook, and cleaner as well as paying for paper based office supplies.

6.2.7. Operational Costs

The Operational Costs came to **Shs 384, 234,176 (US$160,098).** This represents **86%** of the total expenditure. We spent these funds on: clinical investigation (tests, X-rays, scans, admission/referral, transport, salary/stipends for clinical staff); Home Based Community Support (travel costs to clients homes, teen's club, Kalimarimbas- drama group activities, stipends for VICTASS). Social support for clients and families - (transport, school fees for orphans, food for our bedridden clients to enable them take their medication, household support, Grants to enable our clients to start small income generating activities and receive an income); Training for staff and community volunteers; Laboratory (Laboratory supplies, stipends for lab, technologist); Medicine (all medicine for Opportunistic Infections and others.); Other Operational Costs (membership fees, Auditing fees, fund raising costs).

6.2.8 Capital Costs

In 2012, our Capital Costs stood at 3% of the total expenditure. We spent **Shs 14, 472,800 (US$ 6,030**)**.** The funds were spent on renovation of the clinic and painting to maintain the standards of the health centers, purchased a tent to protect our clients as they wait in the very hot sun especially in the community (***HCT),*** purchased new computers, and Flip chart stand for our meetings. Repairs and maintenance of the computers and printers was another expense.

6.3. Acknowledgements

We acknowledge the contribution of our Partners/Donors: Infectious Disease Institute (IDI); Friends of Reach Out (FORO); Hope for Children; Innocent Foundation (APCA) African Palliative Care Association; Culture Without Boarders; The Great Generation and HorizonT3000 for funding the KHC conference and the individual donors who have supported us and made us sail through 2012. We are also proud of and thankful to KHC Board of Directors and our Beads Ambassadors for distribution of our beads.

6.4. Challenges and way forward

The main challenge in 2012 was the domestic increase in prices of everything including but not limited to office rent, transport costs which was brought about by fluctuation in dollar rates; this led us into short falls in many areas of the budget.

6.5. Conclusion

Once again, we are very grateful to everyone who contributed in one way or another to KHC reaching 5 years. In particular HorizonT3000 and IDI who supported our anniversary celebrations and the Palliative care conference. We can never repay you for your tireless efforts and contributions. You have donated your time, your funds, your energy and your efforts to helping those who struggle with HIV/AIDS. Know that your love has helped so many have a second chance for life. Love is the only treasure that when divided grows not less, but, more and more.

"Moved by Love"