Kawempe Home Care Initiative

P.O.Box 337 Kampala, Uganda

'Moved by Love'

Providing Comprehensive Holistic Care to HIV/AIDS and or Cancer clients

Graduation of our first 8 CATTS Dec 2007

Home Care Team returning from the field

Annual Report 2007
July – December 2007

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EXECUTIVE SUMMARY

Kawempe Home Care (KHC) Initiative was founded on the 26th of July 2007 by a group of devoted health professionals who originally worked and trained at Reach Out Mbuya HIV/AIDS Initiative[1] in Mbuya Parish, Kampala. Our main objective is to provide holistic care to people living with HIV/AIDS and or Cancer, and to prevent further spread of HIV in our community.

Our services include free HIV counseling, testing, care and support, HIV-TB integrated care, palliative care, prevention of mother to child transmission, Paediatric care, community based antiretroviral and tuberculosis drug adherence support, HIV prevention strategies and social economic support.

The first 5 months of the project have been very busy with remarkable increase in the activities of all the services we are providing. Most remarkable is the gradual increase in the clientele from 5 in July to 195 by the end of the year. We tested a total of 505 people (38% were positive) of whom 195 clients were enrolled (194 HIV positive, 3 with related cancer and one HIV negative with intra-abdominal cancer). In the past five months eight of our clients died. At the end of the year we had 187 active clients.

We have been providing care for all age groups using a family based approach. Seventy-five percent of our clients are female and twenty-five percent are male. Nineteen of our clients are children below the age of 18. We have a total of 11 clients on Tuberculosis treatment and 39 clients on Antiretroviral Therapy (ART). We refer our ART eligible clients to other services providers including JCRC, TASO and AIDC. We then focus on the community based treatment support, treatment of adverse effects, opportunistic infections and provide psychosocial, spiritual and emotional support. We also visit homes of those who have lost family members.

Our social support system includes referral transportation, school fee and food support to clients and their families. We are searching for funders for a small grant and school fee support system.

Our committed group of volunteers has grown from sixteen to twenty-four by the end of the year. Our staff is comprised of one doctor (project coordinator), three nurses (one is project director), one laboratory technologist, three counselors, one community coordinator, three youth volunteers (Angels), one pharmacy aide, nine Community ARV and TB Treatment Supporters (CATTS) one cashier, one cook/cleaner. Out of the 24, 11 are also clients of the project. We see this as a major force for the success of the project. In December we had our first 10 day training for 8 CATTS from our respective communities.

We have received great support from friends in the support of grants and donations totaling 25,504,000 UgShs (US $15,002.40) with one donation of 7,500 US dollars from Friends of Reach Out. Our total expenditure was US $12,043.90 with operational cost covering 84,6 % , administrative cost 6.88% and capital expenditure 8.53%.

We look forward to expanding our services and serving our clients in 2008.

[1] Reach Out Mbuya Parish HIV/AIDS Initiative is a faith based non-governmental organisation started in May 2001 providing medical, social, spiritual and emotional support to poor people in Mbuya Parish, Kampala living with HIV/AIDS www.reachoutmbuya.org

TABLE OF CONTENTS

LIST OF ABBREVIATIONS

AIC	AIDS Information Centre
AIDS	Acquired Immune Deficiency Syndrome
AIDC	Adult Infectious Disease Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
CATTS	Community Antiretroviral and Tuberculosis Treatment Supporters
HAU	Hospice Africa Uganda
HCT	Home Counselling and Testing
HIV	Human Immunodeficiency Virus
JCRC	Joint Clinical Research Centre
KHC	Kawempe Home Care
OI	Opportunistic Infection
PCAU	Palliative Care Association of Uganda
PMTCT	Prevention of Mother-to-Child Transmission
TASO	The AIDS Support organisation
TB	Tuberculosis
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
PCP	Pneumocystic Carinii Pneumonia
PCR	Polymerase Chain Reaction

1.0 ACTIVITIES OF KAWEMPE HOME CARE (KHC) INITIATIVE

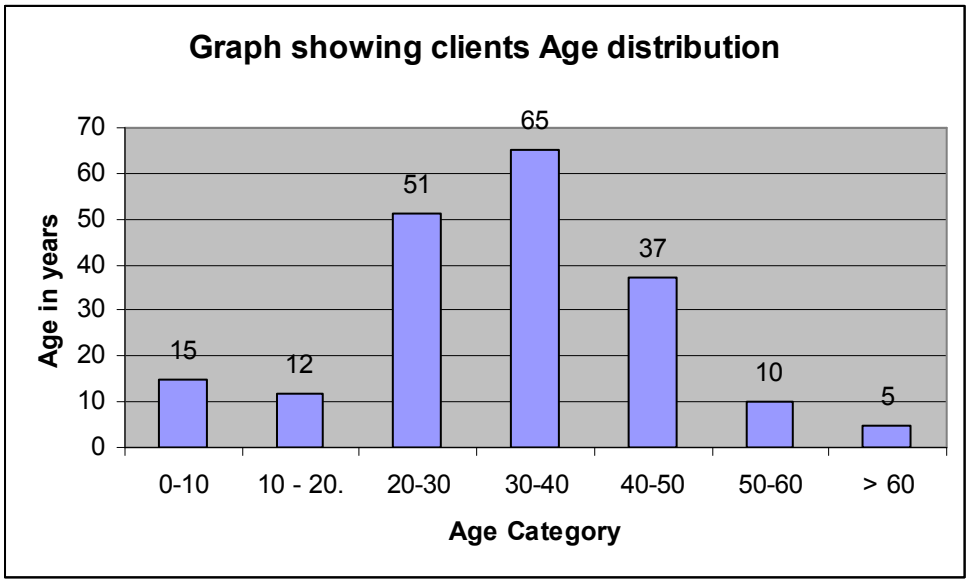
1.1 The Clients we serve

The year came to a close with an increase in the number of clients who were enrolled on our home care program. We enrolled 195 clients, 194 clients were found HIV positive (3 had HIV related Cancer) and 1 had advanced Intra-abdominal Cancer.

- Seventy five % (147) of our clients are women. During the year we have seen an increase in the percentage of men; from 18% in the first quarter to 25% (48) in the last. We follow the trend of more women seeking care than men as is commonly reported by other HIV/AIDS centred organisations.
- Nine % (19)) of our clients are children below 18. Five are on ART.
- Out of the 505 community people who were tested 39% were found positive.
- We have a total of 39 adult clients on ART.

Age Distribution

Figure 1: Distribution of Client Age



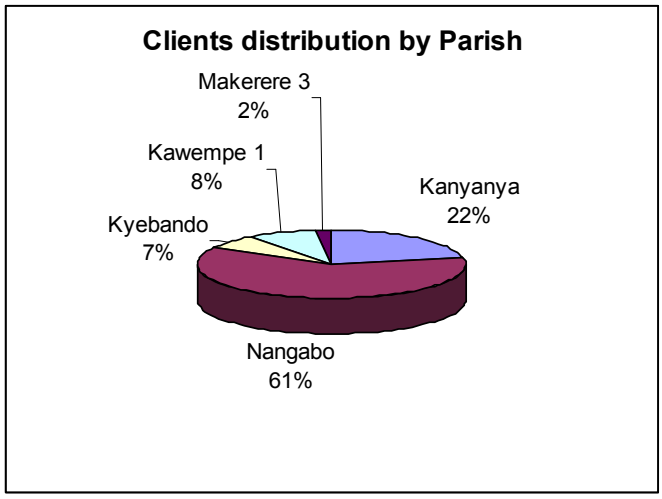
The chart above shows that the majority of our clients are in the economically productive age group between 20 – 50 years 153 (78.5%), those below 20 years comprise of infants, school going children and adolescents make up 27 (13.8%) and 15 clients are above 60 years(7.7%).

This age distribution of the clients shows the burden that the disease has on the house hold. The loss of employment or productivity leads to numerous psychosocial and economic challenges such as loss food security and lack of school fees.

Clients by Parish

During the last year we continued to provide comprehensive holistic care to our clients in Kawempe Division and 15 km along Gayaza road. Our clients live in Kanyanya, Kyebando, Kawempe 1, Makerere parishes in Kawempe division. We hold a weekly outreach clinic at Nangabo Parish in Wakiso district.

Figure 1: Distribution of Clients by Parish

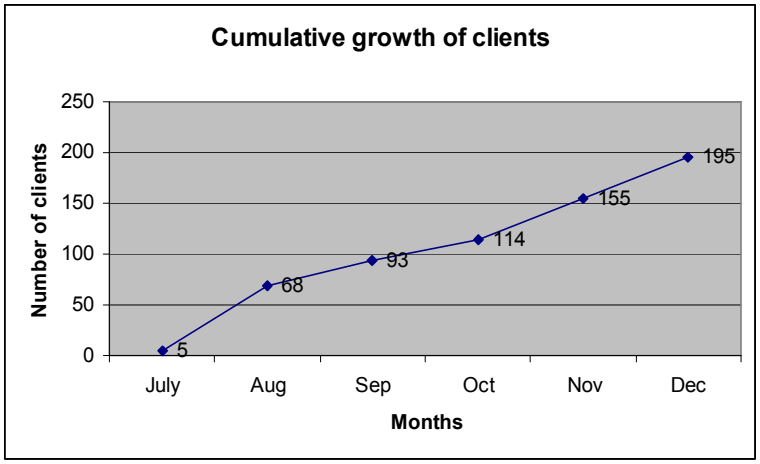


The majority of our clients (61%) are from Nangabo Parish in Wakiso District approximately 20km from the city center where the main source of livelihood is subsistence farming.

Clientele Growth

The program registered a gradual increase in the number of clients over the months with the majority of clients 66 (33.8%) enrolled in August 2007 and the least 5 enrolled on July 2007 at the start of the project.

Figure 2: Cumulative number of clients July-December 2007



This year eight clients died due to the following causes: advanced intra-abdominal cancer, Cryptococcal Meningitis, Tuberculosis and Kaposi's Sarcoma. These clients were enrolled at a late stage of their disease. Our community volunteers will reduce this number by encouraging people to come to the clinic as early as possible.

1.2 Medical Programme

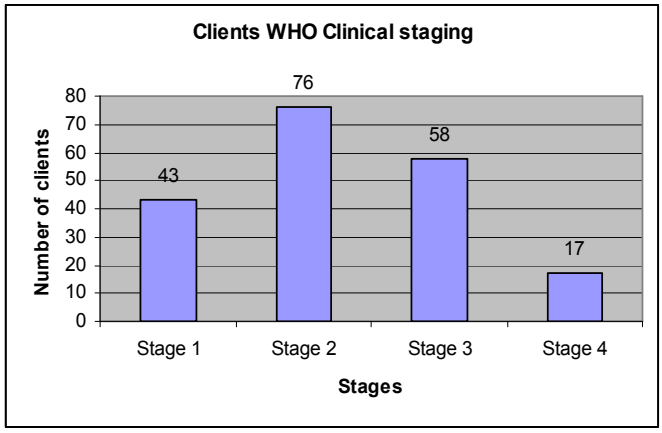
Clinical Status

At enrollment the clients are all assessed and their physical state is scored using the WHO clinical staging[2]. Below is a figure showing the various clinical stages of the clients at enrollment.

[2] World Health Organisation (2002) has developed a four-phase clinical staging system to describe HIV progression in adults and adolescents:

1) Asymptomatic or persistent generalized lymphadenopathy
2) Symptomatic with infections such as herpes zoster, minor skin problems and slight weight loss, but no impairment of activity
3) Symptomatic with opportunistic infections severe enough to keep the person in bed up to half the day during the previous month
4) AIDS with wasting, chronic diarrhea and fever, Pneumocystic Carinii Pneumonia (PCP) and other life – threatening conditions such as above, keeping the person in bed more than half the day over the last month

Figure 3: WHO clinical stages of our clients



Seventy six clients (38.9%) were found to be in clinical stage 2 and the minority, 17 (8.7%) in stage 4.

In the last quarter, we enrolled a total of 12 bedridden clients of whom 4 (33.3%) were in clinical stage 3 and 8 (66.7) in stage 4. In comparison to 6 bedridden clients in the 3rd quarter of 2007, hence a 50% increase.

Medical Consultations

During 2007 we had a total of 674 consultations. Of these, 91 (13.5%) were home visits, providing for acutely ill, bed ridden clients. We had 556 (82.5%) clinic visits and 27 (4%) hospital visits for the clients admitted with severe illness.

Figure 4: Number by Type of Consultation

Visit Type	**Total**
Clinic	556
Home	91
Hospital	27
Total	**674**

For the critical home care service we scheduled two days a week for the routine home visits and emergency visits on a daily basis as the need arises. During the home visits we also do home based HIV testing for the client and other family members. We also bleed clients for any clinical investigations e.g. screening for Cryptococcal Meningitis and CD4 bleeding to aid in management and work them up for antiretroviral therapy.

1.3 The clinical services

The clinical services comprise of home based care, out patient clinic visits and hospital admission care. Our team of clinicians comprises of 1 Doctor, 1 Clinical officer, 3 nurses and 1 laboratory technician. The team works together to ensure that all clients are attended to and receive quality service. The services provided include;

Voluntary Counseling and Testing

Over the last year we counseled and tested a total of 505 members of the community of whom 197 (39%) were HIV positive and 308 (59%) were HIV negative. Two of those who tested positive were not residing in our catchment area and were referred to other centers for further care. The high prevalence of 39% can be explained by the fact that we were looking out for people who were chronically ill within the community.

The counseling is done by **three counselors** who do the pre and post test HIV counseling, ongoing counseling, positive living, disclosure counseling and bereavement support.

Figure 5: Details of VCT Results

	3rd Quarter	4th Quarter	Total
Positive	87	110	197
Negative	98	210	308
Total Tested	185	320	505

Those found negative received education on modes of transmission of the infection, risk factors and the ABC strategy for prevention. They were also advised to repeat the test after 3 months.

Home Counseling and Testing (HCT)

We also embarked on a home counseling and testing program especially for those who were very sick or bed ridden. We also use this opportunity to do group counseling and HCT for the other family members, including children. The table below shows the distribution of HCT and the clinic based session.

Figure 6: Distribution of HCT vs. VCT Tests

	3rd Quarter	4th Quarter	Total
Clinic VCT	153	282	435
HCT	32	38	70
Total Tested	185	320	505

Couple VCT

During the last year we had a total of 6 couples tested and of these we found 3 discordant couples, 1 both positive and 2 were both negative. Those found discordant were advised to use condoms, seek treatment for all sexually transmitted infections and the negative partner was advised to be screened every 3 months.

Laboratory

Since the start of the program, we have been able to do basic laboratory tests including malaria smears, sputum testing for Tuberculosis, pregnancy testing and urinalysis. We outsource more sophisticated test such as CD4.

During the last year we carried out a total of 92 laboratory tests (excluding HIV and sputum for TB), of these 55 (58.8%) were done in our lab and 37 (40.2%) were outsourced to other specialized laboratories. The outsourced tests include CRAG and LFTS are done in preparation of clients with a CD4 count of less than 100 cells/ml for antiretroviral therapy. This is done in anticipation of severe opportunistic infections (Immune reconstitution syndrome) after starting therapy. Those who are found positive during the screening are treated for 2 weeks before starting the ART. The pregnancy tests are also done on suspicion of pregnancy and also for all ladies of reproductive age before they start ART. The other tests Blood slide for malaria and urinalysis are done routine to aid the clinical management of the clients.

We tested a total of 49 clients for tuberculosis using ZN staining for AAFB's. A total of 7 smears were positive and 42 smears were negative (more in HIV/TB integrated care section).

Prevention of Mother to Child Transmission (PMTCT)

During the last quarter of the year we continued to use our community network to identify pregnant mothers and offer them VCT. We screened a total of 22 mothers and found 3 positive and 19 negative. The positive clients were enrolled and referred to Mulago Hospital PMTCT clinic for Antenatal care services and PMTCT. We then continue the community follow up of the selected ART option and ensure that the mother adheres to the treatment until after delivery. After delivery our community volunteers follow up the mother to ensure that they adhere to the selected feeding option and avoid mixed feeding.

Figure 7: VCT for Pregnant Mothers

Mother Address	Positive	Negative	Total screened
Kawempe	1	3	4
Nangabo	2	16	18
Total	3	19	22

We follow up the exposed children until they are confirmed HIV negative, by DNA PCR testing 6 weeks after cessation of breast feeding and by rapid testing at 18 months of age. Those found positive are then enrolled on our Paediatric program.

Paediatric – Adolescent Care

In total, 98 children below the age of 18 years have been tested. 19 (9.7% of all clients) were found positive and enrolled in our programme. Of these 9 are males and 10 females. All children enrolled have their CD4 counts done and those found eligible for ART are referred to appropriate centers for treatment. We currently have 5 children on ART at JCRC and TASO Kanyanya.

We encourage clients to bring along their spouses and children for testing. Families with more than one client are always given the same review date and are seen by the same clinician to save time, transport costs and address the family's social problems holistically.

The chart below shows the outcomes of the infants/children < 18 years screened by DNA PCR and rapid tests during 2007.

Figure 8: HIV Screening Children < 18 years

Test type	Positive	Negative	Total
DNA PCR	1	3	4
Rapid test	18	76	94
Total	19	79	98

HIV/TB Integrated Care

In view of the WHO estimation that 50% or more clients with Tuberculosis have HIV, we have been intensively screening all our clients for Tuberculosis using sputum analysis and Chest x–rays. During the last year we screened at total of **49 clients** with sputum tests and found **7 positive** and **42 negative**. The x-rays were positive in **6 clients** and negative in **2**. Sputum screening is done for all clients with productive cough for greater than 2 weeks plus or minus other symptoms. By the end of the year we had a total of 14 clients who received treatment for Tuberculosis. We have 3 clients with abdominal TB, 11 with Pulmonary (Lung) TB. The table

below shows the different phases of treatment that the active clients are in. We however **lost 3 clients** to AIDS and currently have 11 on treatment.

Figure 9: Description of Clients on Tuberculosis Treatment

	Below 18		Above 18		
	Male	**Female**	**Male**	**Female**	**Total**
Initial phase	0	2	1	2	5
Continuation	0	0	2	4	6
Defaulted	0	0	0	0	0
Completed	0	0	0	0	0
On Treatment	0	2	3	5	11

We also keenly follow up our clients on treatment and do repeat sputum tests to ensure identifying those responding and those failing on treatment. These tests are done every 2nd, 5th and 8th month of treatment. Our community ARV and TB treatment supporters (CATTS) also keenly follow up their adherence to TB drugs using DOTS.

Waswa's Story

Waswa is a 40 yr old man who was diagnosed with Pulmonary Tuberculosis and in clinical stage 4 with HIV wasting syndrome. He is a widower and previously worked as a trader in Kasangati Trading Center. He began falling ill in May 2007 with chronic productive cough, weight and appetite loss and frequent fevers. He started TB treatment in October 2007, two weeks later he showed some improvement but still had a productive cough and chest pain. It was then discovered after assessing his TB card that he was not taking his medication as prescribed. He was then assigned a CATTS who visited his home and found that he had very poor social support and lacked food. His CATTS then started supporting him to take his medication by direct observation daily. She also requested for basic food support i.e. Maize flour, beans and sugar. He improved tremendously after 2 weeks of resumption of treatment. He was also found to have a very low CD4 count of 1 cell/ml and is scheduled to start on antiretroviral therapy from JCRC in January 2008. He is now much better and looking forward to resuming his work as a local business man.

Palliative Care

As part of our on going medical care we provide palliative care services to all our clients with pain and distressing symptoms. This year we have had a total of 5 clients with Cancer, 3 of whom had HIV/AIDS related cancer (Squamous cell carcinoma of the conjuctiva and 2 with Kaposi's sarcoma). 2 of the Cancer clients have passed on since free of pain.

Figure 10: Cancer Clients

Cancer type	**Frequency**	**Other treatment**	**Outcome**
Squamous cell Carcinoma	1	Palliative Radiotherapy & Surgery, Oral Morphine	Mass debulked, Pain controlled
Advanced Intraabdominal Cancer	1	Oral Morphine, NSAIDS, Dexamethasone	Pain controlled died peacefully
Kaposi's Sarcoma	2	Oral morphine, Chemotherapy	1 died peacefully, other on treatment
Pulmonary Malignancy	1	Was Under investigation, NSAIDS	Died in peace, not in pain

Olivia's story
Olivia is a 43 years old mother of 2 sons. She developed a wound on her right eye lid in August 2005. She applied numerous ointments and saw many clinicians but the wound kept increasing in size. During the same month she was also diagnosed HIV positive at one of the clinics she visited. She went to Mulago hospital in April 2006 where she was diagnosed with Skin Cancer (Squamous cell carcinoma) on the right eye lid and surgery was performed to remove the cancer. She however didn't get better and the wound increased in size and began spreading to her right eye and was associated with a lot of pain. She sought help from a private eye physician in November 2006 who suggested extensive surgery but her relatives and friends discouraged her and they opted for herbal remedies. The swelling became worse and so did the pain until August 2007 when our home care team visited her. She was immediately started on oral morphine to relieve the pain and Flagyl powder to remove the dead decomposing tissue on her right eye. We then referred her to Mulago hospital for radiotherapy and surgery in October 2007. She got the radiotherapy and surgery to remove the whole tumor mass and her right eye which had been involved. She returned home after 3 months in better general condition and still on oral morphine for pain relief. We continued to manage her pain and the distressing symptoms like nausea, vomiting and oral sores which were adverse effects of the radiotherapy. Her quality of life has greatly improved, she is now pain and symptom free. Except for morphine and psychological support we are also support her with food as Olivia used to be the breadwinner of the family by sewing and selling clothes. From 2008 we will also be supporting the youngest son to go back to school. Due to the mothers illness he has not been able to attend school for the last year.

The other clients access our palliative care services through emergency and routine home visits, hospital and clinic visits. Below is a list of the common illnesses, distressing symptoms and the corresponding number of clients.

The other services provided to the clients and their families included ongoing counseling, spiritual counseling, emotional support, end of life counseling, bereavement support, legal aid, school fees, nutrition support and nursing care.

Figure 11: Number of clients who accessed the above services.

Palliative Care service	**Number of clients**	**Comments**
Ongoing Counseling	74	Positive living
Spiritual Counseling	3	
Bereavement Support	8	For all families who loose their patient
End of life Counseling	8	For terminally ill clients
Emotional Support	47	
School Fees	3	Orphans & Vulnerable children
Nutrition Support	3	Malnourished, socially & economically deprived
Nursing Care	24	Home based
VCT	178	Revealing diagnosis of HIV infection or Cancer

1.4 Pharmacy

Through out the last year we were able to provide all our clients with Septrin or Dapsone and Multivitamins as prophylactic treatment. We also provided all the other drugs for treatment of opportunistic infections, pain and symptom control. The clients diagnosed with Tuberculosis were referred to surrounding government health centers for anti- TB drugs. ARV's were accessed from the referral centers including Mulago hospital and JCRC.

The clients in severe pain accessed oral morphine through referral and collaboration with Hospice Africa Uganda. We hope to acquire oral morphine in January 2008 from the Ministry of Health through Mulago Hospital. This will enable us to provide pain relief to our clients in the shortest time possible.

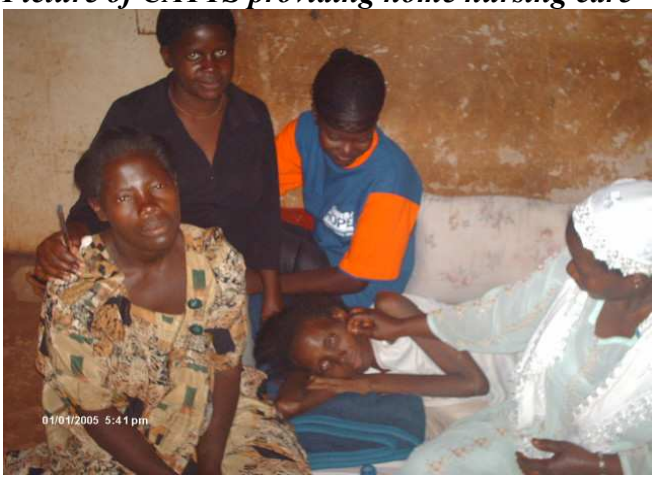
The dispensing of drugs, record keeping and logistics management is done by a nurse who is assisted by one of our community volunteers.

1.5 Home Based Care

Our multidisciplinary team comprising of clinicians, counselors and community care givers work together to provide Home Based Care services. Most of the community care givers are PLWHA . They provide a great deal of social support, drug adherence support and nursing care, especially for the terminally ill and bed ridden clients.

During the last quarter of the year we intensified our home care activities by training a group of 8 community care givers in the basics of home based care, Antiretroviral and Tuberculosis drug adherence support. The community volunteers have now been empowered to go into the community to identify, provide initial support and then refer those in need to the program.

Picture of CATTS providing home nursing care



1.6 Medical Training

Due to human resource and financial limitations, we intend to have a nurse led clinical team, with a supervising doctor and clinical officer. We have therefore embarked on an in house training program which will empower our nurses with the necessary skills and knowledge to provide quality care to our clients. Our routine training comprises of a weekly journal club on

HIV associated illnesses and case discussions on complicated clients seen during the week. We always emphasize our holistic care model.

2.0 NETWORKING/PUBLICITY

It is our priority to work closely with and utilize the existing services available from other, nearby organizations

AIDS Information Centre (AIC)[3]

We have been working closely with the AIDS Information Center (AIC) in relation to VCT. They have been providing us free testing kits since October 2007. Furthermore, they have provided training for two counselors and our lab technologist on how to fill in the AIC counseling cards and the best procedure for testing. AIC have promised to assist with supervision follow up in 2008.

Hospice Africa Uganda

Hospice Africa Uganda who provides palliative home care for people in severe pain has been very helpful in providing morphine for our clients in severe pain. A memorandum of understanding is in the pipeline for further collaboration. We are however targeting getting our own morphine supplies directly from the Ministry of Health in the coming year.

The Palliative Care Association of Uganda[4] *(PCAU)*

KHC has become a member of the PCAU, this will help us in palliative care training through regular update meetings. The membership led to an invitation by PCAU to hold a talk about palliative care on a local radio station in Kampala in October 2007

Joint Clinical Research Centre (JCRC)

We have also set up links for referral of our Adult and Paediatric clients to (JCRC) for investigation and consideration for ART. So far we have started 3 clients on ART through referral to JCRC. This collaboration will hopefully be expanded in 2008.

Kasangati Health Centre IV[5] *– Wakiso District*

Kasangati has continued to provide TB drugs for our needy clients. Furthermore that have given us and promised us a regular supply of Coartem (malaria treatment). We also refer our critically ill clients for admission on their medical wards and participate in their management while they are admitted.

The International School of Uganda (ISU)

We have established a close link with grade 7 at ISU, who are in the process of creating a logo for Kawempe Home Care. KHC went on a visit to the school both to create awareness of the project but also to discuss about HIV in general. The student were very touched by one of our Angel volunteers who gave her testimonial about how she discovered when 14 years old she was HIV positive. Grade 7 has donated money for school fees for one of our HIV positive children

[3] A local NGO established in 1990 to provide the public with voluntary and anonymous counselling and testing. AIC has grown to become on of the leading organizations in the struggle against HIV/AIDS and a model of excellence in provision of VCT services including training in Uganda and Sub-Saharan countries

[4] A national NGO formally established in 1999 to support and promote the development of palliative care and palliative care professionals in Uganda

[5] This is a Health Centre under the Ministry of Health. The HC is based in Kasangati where we run our weekly out reach programme

Reach Out Mbuya HIV/AIDS Initiative

We have been very grateful for all the moral support we have received from old colleagues of Reach Out. In December we had the honor of hosting a visit form the founding members of Reach Out, Father Joseph and Dr Margrethe Juncker

Reach Out has informally agreed to assist with hands on training of some of our nurses and counselors and hopefully one of our nurses will be able to attend the 6 months comprehensive HIV/AIDS training at Reach Out in 2008.

Concern Worldwide Uganda[6]
On two occasions (World AIDS Day and the Family Christmas Party) our Angels group of four young women have been invited to the Concern Office to tell about their experiences in relation to being HIV positive. This visit led to an invitation to the Concern family Christmas party where they went to share their experiences.

3.0 COMMUNITY AND SOCIAL SUPPORT

3.1 Community Caregivers

The community support department trained 8 Community ART and TB Treatment Supporters (CATTS) in drug adherence support and monitoring, home based care, nutrition and hygiene. They have done 312 home visits; this has improved greatly on drug adherence and general well being of our clients. The CATTS also go out into the community and identify sick people suffering in their homes, suggest testing and enroll them if eligible. The community volunteers are assigned villages in which they will carry out their operations. All the community volunteers in each Parish are supervised by a central supervisor, whose role is to ensure that all CATTS are given psychological support and advised on how to support their respective clients.

The care giver group meets once a week to discuss progress and challenges

3.2 The 'Angels' Network

The 'Angels' network embarked on door to door sensitization which has increased the number of Voluntary Counseling and Testing sessions. Apart from working within Kawempe Home Care catchment area, they have also raised awareness about HIV/AIDS at the International School of Uganda, and fundraise school fees for orphans infected and affected by the epidemic. We have reached approximately 675 youth within our community.

4.0 SOCIAL SUPPORT PROGRAMME

Many of the clients we meet are poverty stricken due to failure to work for a living because of chronic illness. This is multiplied when the family bread winner falls sick and is unable to work. As a result of this we are faced with numerous challenges such as poor food security, drop out of children from school and eviction from rented homes. Our social support program is therefore tasked to find solutions to solve numerous domestic challenges.

[6] An International NGO with head office in Ireland

Nutrition Support
We created a nutrition support program where we give weekly rations of posho, beans, rice and sugar. Due to the resource limitations we follow strict criteria which includes; malnutrition, poor social support and household poverty as the main qualifiers for nutrition support. So far 4 clients have benefited from this programme.

Grants and Microfinance Loans
In 2007 gave out three grants, two to female clients and one to a grandmother taking care of an HIV positive grandchild. The grants helped them to re-establish their business in the nearby markets. If clients and/or caregivers have very little or no income, a loan would just fill the big hole and there would be no money to start up the business. The intention of the relatively small grant (30US$) is to help them get back on their feet and provide them with a small business loan to expand their business.

In 2008 we would like to give more attention to grandmothers who take care of their grandchildren, especially HIV positive grandchildren who need a lot of support.

School Fee Support
One of the major effects of the HIV/AIDS epidemic is the chronic ill health of bread-winners. This results in the lack of funds to pay school fees for their dependent children. This in turn results in a lot of psychosocial stress for the patient and their family. We therefore attempt to relieve the stress and suffering by providing school fee support for affected primary and secondary school children. The categories of children include those who are HIV infected, orphans and other vulnerable children who parents are chronically ill and unable to earn a living. In 2007 we supported three children with schools fees for the last term of the school year. Two of our volunteers are in the process of setting up "Operation School Fees", which is a programme dedicated to assisting families with school fee support. This programme involves clear criteria for enrollment, home visits, visiting and linking up with governments and private schools in our catchment area.
To initiate Operation School Fees in 2008 we received a donation from private donors in Ireland and the International School of Uganda.

Income Generating Projects

In an effort to make KHC self sustainable we have created plans to fundraising project activities, aiming to be a source of livelihood for our clients. The clients will be trained to professionally run the projects and will be accountable for outputs. We are currently carrying out small feasibility studies for a number of projects. These include a tailoring workshop, piggery unit, poultry farm, Motorcycle (Boda Boda) project and a beads and crafts unit. We will provide more details on the progress made in our first 2008 Quarterly Report.

5.0 FINANCIAL REPORT

	Ug. Shs	US$	Percentage
Total Income	**25,522,000**	**15012.90**	**100.0**
Total Expenditure	**20,474,700**	**12,043.94**	**80.2**
Operational Costs	17,320,850	10,188.70	84.6
Administrative Costs	1,408,350	828.40	6.9
Capital Expenditure	1,745,500	1,026.80	8.5
Balance	**5,047,300.00**	**2,968.96**	**19.8**

Kawempe Home Care has continued the struggle against HIV/AIDS, cancer and other opportunistic infections. In order to maintain the quality service for our clients, we have embarked on Good Financial Management practices. We have introduced coding of all our expenses and cherish values of honesty, and accountability.

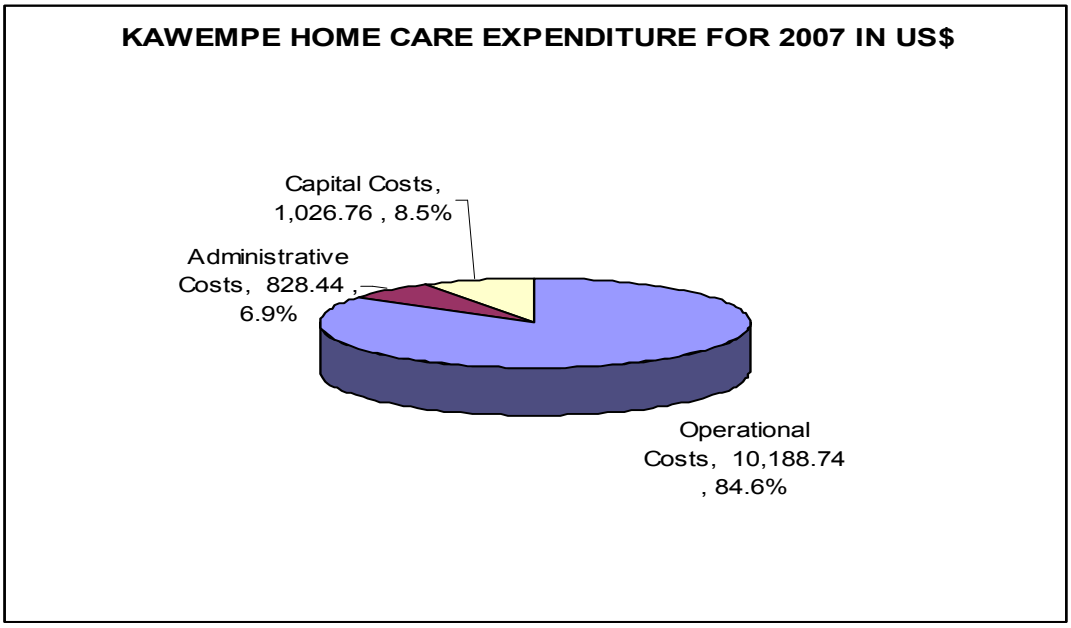
In 2007 we operated from August to December with the assistance of many friends. We also heavily relied on the invaluable support of our volunteers, who worked tirelessly to ensure that, Kawempe Home Care became a reality. These included volunteers at the clinic, in the community and abroad who have given us their moral and expert support to ensure that the KHC achieved what we have.

Total Income
During the year that ended, our total income came to **Ug Shillings 25,522,000 (US$ 15,012.90).** All our income came from grants and donations from friends in Uganda, the United States, Ireland, Denmark as well as the United Kingdom. We are very grateful to all our friends who kept us going.

In-kind Donations
We also received in-kind donations and logistical support for testing kits from the AIDS Information Centre and Bead for Life; Stationary support (client files) from JEMS Agencies LTD; Furniture from Concern Worldwide, Gerever Niwagaba, and Dr. Samuel Guma.

Total Expenditure
Kawempe Home Care's expenditures came to **Ug Shillings 20,474,700 (US $12,043.94).** The expenditure fell in three different categories: Operational Costs, Administrative Costs, as well as Capital Expenditure

Graph showing Expenditure by Categories



Operational Costs:

The operational costs came to a total of **Ug Shillings 17,320,850 (US$ 10,188.70).** This represents 84.6% of the total expenditure.

In this category we include costs of all medicine, Clinical tests and investigations, X-rays, laboratory supplies, Home Based Community support for our clients including food support to weak clients, holistic social support to the clients and costs for training our community volunteers. Also covered in this category are our transport costs to the community clinics, home visitation of the critically ill, transportation of clients to other treatment centers, as well as paying for materials, stipends for the medical team, community workers, community education and youth work.

Administrative Costs:

The costs for the administrative and support costs of the program activities of Kawempe Home Care came to **Ug Shillings 1,408,350 (US $ 828.40) or 6.88% %** of total costs.

In the year that ended, we kept the administrative costs as low as possible. We used the funds in this category for the stipends of our administrative team, office and computer supplies, telephone and postage.

Capital Expenditures

As the number of our clients grows, there is need for furniture, bed for examination, computers for proper record keeping as well as a security cash box. The total of our capital costs came to **Ug. Shs. 1,745,500 (US $ 1,026.8)** in the months of August-December 2007. Capital expenditures came **to 8. 53%** of our total budget.

2007 has been a very special year we will always remember. It was the year in which we got the vision to set up this home care service and provide the much needed home care for the socially and economically deprived AIDS and or Cancer clients of our community. We have been able to achieve so much, thanks to the team work and giving spirit that our volunteers have exhibited, without their loving care we would not have achieved this much. We have a lot of faith that the year 2008 will present us with many opportunities and successes in all aspects of our program. We thank the almighty God for the inspiration, perseverance and love he has given all our friends, partners, supporters, volunteers and the clients in ensuring the successes achieved in 2007.

May the lord bless you all. We wish you a happy and prosperous 2008.