Kawempe Home Care Initiative

P.O.Box 337 Kampala, Uganda

Providing Comprehensive Holistic Care to TB, HIV/AIDS and or Cancer Clients

KHCI Volunteers cut a cake to celebrate their 1st anniversary in July 2008

ANNUAL REPORT 2008

Dr. Samuel Guma
Executive Director
+256-712-691105
sguma@gmail.com

Mr. Chris Hodun
Operations Director
+256-712- 099178
br.chris@yahoo.it

Executive Summary

Dear Friends and Partners,
It is with great pleasure that we present to you the 2008 Annual report. KHCI has now been in operation for 18 months and it has managed to attain a number of achievements in this short period of time. In June 2008, Dr. Samuel Guma was appointed as the new Executive director after Ms. Anni Fjord the founding director left for Denmark and Mr. Chris Hodun joined the program as the director of operations. KHCI now has a Board of Directors who are the ultimate authority for the administration of the organisation.

In 2008, KHCI provided Voluntary Counseling and HIV testing to 1802 members of our community of whom 679 (37.7%) were positive and 1123 (62.3%) were negative. We currently have 653 active patients of whom 196 (30%) are males and 457 (70%) females and of which 78 (12%) are children less than 18 years old. We have 247 clients on ART of whom 30 (12%) are less than 18 years. We have provided care to a total of 848 clients of whom and 43 (5%) of them have passed away during this period.

We are especially extremely grateful to our partners the Joint Clinical Research Center (JCRC) who have provided us free antiretroviral drugs since June 2008 under the TREAT program. The AIDS Information Center (AIC) who has provided us with HIV testing kits, laboratory and counseling training. The TB Control Assistance Program (TB CAP) who have supported us in scaling up our Community Based DOTS program for care of the TB patients. The Ministry of health, National TB and Leprosy program (NTLP) has also been very helpful in providing us TB medication and technical assistance.

The activities carried out at KHCI have been designed to cater for our clients holistic needs. The report will provide details of the achievements and challenges of the medical program and the community and social support program. It will also give an insight in the management and administration achievements, challenges and future plans including resource mobilisation strategies, strategic planning, task shifting, program sustainability and capacity building of our multidisplinary team.

In 2008, KHCI received financial support from Friends of Reach Out (FORO) USA, the US Embassy, the TB control assistance program, the family of the late Uwe Prien, Esther's fund and many private donors. Your support gave us a total income of Uganda shillings **184,234,857** (US$ **102,732**) and Uganda Shillings **178,640,711 (US$ 111,650.44)** of which 80.5% were operational costs, 14% administrative costs and 5.5% Capital costs. Thank you so much for your support.

On behalf of all the volunteers and clients of KHCI, I would like to thank the almighty God for seeing us through the last year and you, our friends and partners for your great support and encouragement. Wishing you all a happy and prosperous 2009.

Dr. Samuel Guma
Executive/Medical Director

List of Abbreviations

AIC	AIDS Information Centre
AIDC	Adult Infectious Disease Clinic
AIDS	Acquired Immune Deficiency Syndrome
ARROW	Antiretroviral Research fOr Watoto
ART	Antiretroviral Therapy
ARV	Antiretroviral
CATTS	Community Antiretroviral and Tuberculosis Treatment Supporters
CBO	Community Based Organisation
CME	Continuous Medical Education
FORO	Friends Of Reach Out
HAU	Hospice Africa Uganda
HBCT	Home Based Counselling and Testing
HIV	Human Immunodeficiency Virus
JCRC	Joint Clinical Research Centre
KCC	Kampala City Council
KHCI	Kawempe Home Care Initiative
OI	Opportunistic Infection
PCAU	Palliative Care Association of Uganda
PCP	Pneumocystic Carinii Pneumonia
PCR	Polymerase Chain Reaction
PMTCT	Prevention of Mother-to-Child Transmission
TB	Tuberculosis
TREAT	The Regional Expansion of Antiretroviral Therapy
VCT	Voluntary Counselling and Testing

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1.0 THE CLIENTS SERVED IN 2008

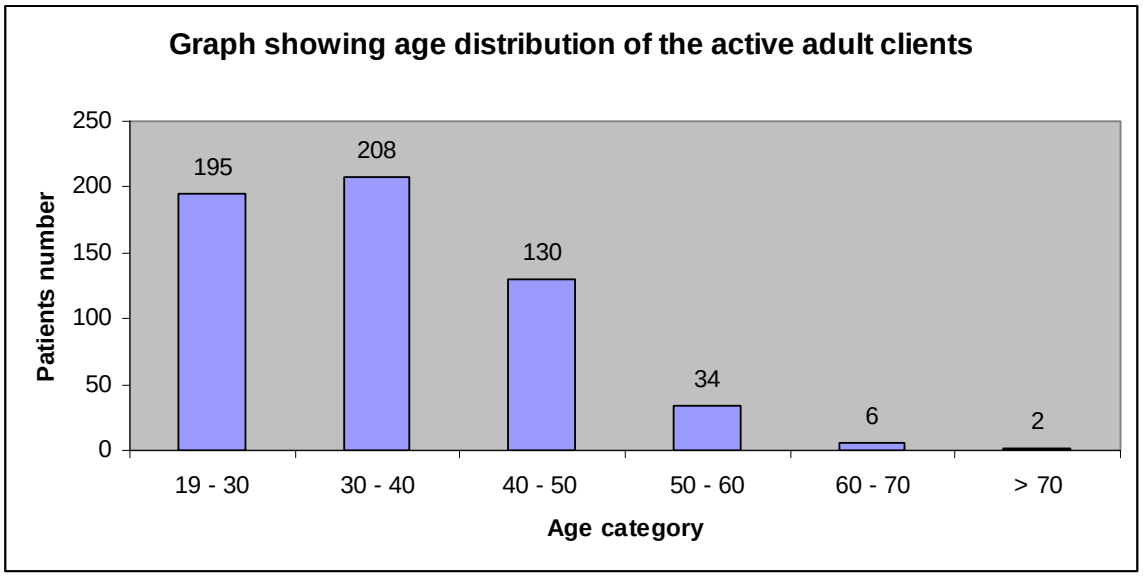
KHCI provides care and support to members of the community who are diagnosed as being HIV positive after Voluntary Counselling and testing. We also care for people diagnosed with both HIV and Non-HIV associated cancers. KHCI also caters for people with Tuberculosis who are diagnosed from the current HIV positive patients on the program and through patients transferred from Mulago hospital TB unit some of whom are co-infected for the Directly Observed Therapy (DOTS) service.

The program had cared for a cumulative total of 848 patients of who 653 patients were active on the HIV care and support program. Of these 196 (30%) were males and 457 (70%) females and 78 (12%) were children aged less than 18 years old. 11 patients had HIV related cancer and 2 patients had non-HIV related cancers. The CB DOTS program had a cumulative total of 161 Tuberculosis patients of whom 121(75%) were coinfected and by the end of the year 78 were still active and on treatment. A total of 43 patients passed away in 2008 to advanced AIDS and HIV associated Cancer.

The program has a total of 247 patients on antiretroviral therapy of whom 65 (26.3%) are male and 182 (72.7%) females and 30 (12%) children below 18 years. 152 patients access the ART from KHCI through the JCRC treat program and the rest were enrolled on the program while on ART from other care providers. The KHCI clinical team provides palliative home care for those patients getting ART form other programs and we urge them to continue getting ART from their respective organisations.

1.1.1 Age Distribution

Graph 1: Graph showing Age distribution of active adult clients



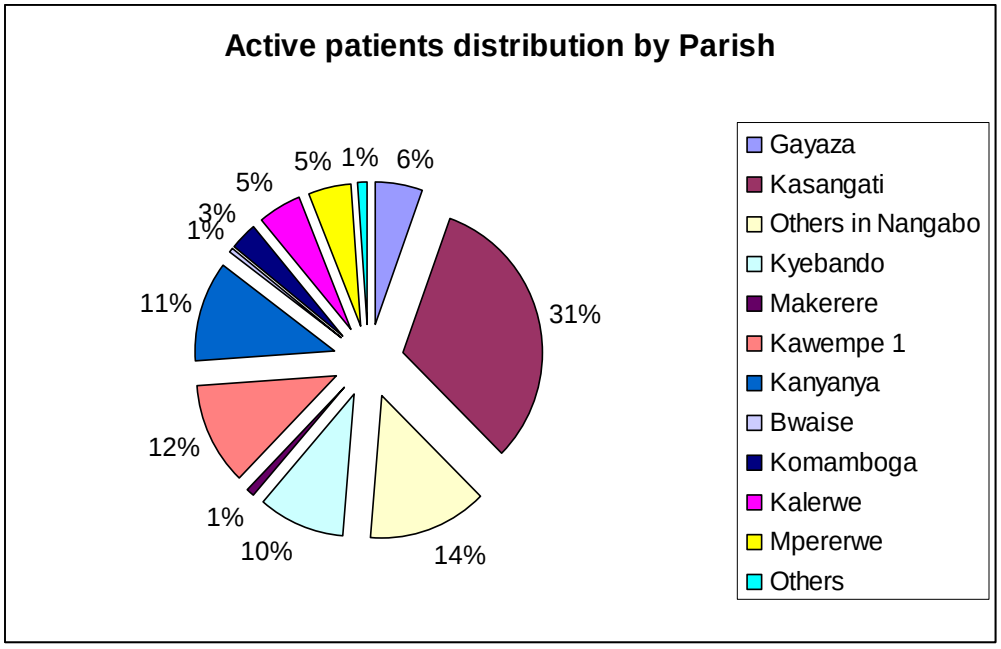
The graph above shows the age distribution of the active adult patients on the program. Significantly the majority of the patients were between the age groups of 19 – 30 and 30

– 40. The minority of them were in the age groups of 60 – 70 and above 70. This picture further illustrates the burden of the of the disease among the young productive age groups, hence leading to unemployment, reduced Gross domestic product (GDP) and a multitude of socioeconomic problems.

1.1.2 Client's Residence

KHCI provided comprehensive holistic care to the clients residing in Kawempe division. During the initial phases of the project, the operations were restricted to 5 parishes but with the introduction of the CB-DOTS program, more parishes like Bwaise 1, Makerere 3 and Mulago Parishes. In the Kasangati, Wakiso district weekly out reach clinic, more new clients were registered from the Gayaza and Kabanyoro Parishes. The chart below shows the distribution of the patients by residence.

Figure 1: Chart showing clients distribution by address



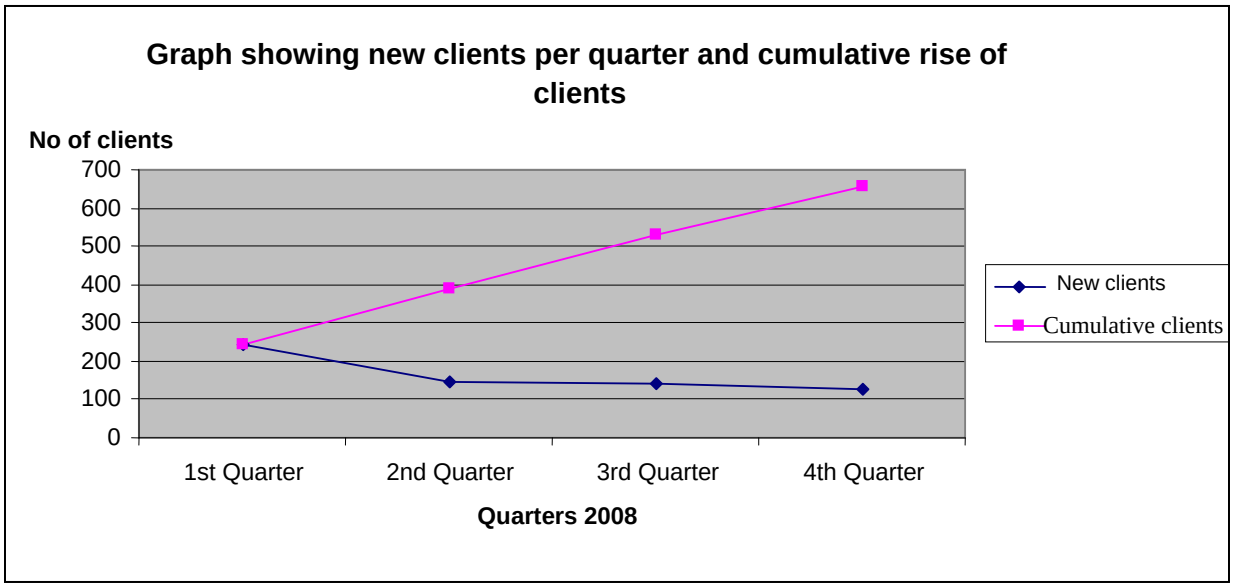
The chart shows the distribution of our clients by residence in the 11 Parishes in Kawempe division and Nangabo Sub County in Wakiso district. As clearly shown above, most of our clients (31%) reside in Kasangati and 14% in Nangabo town. We identify and enroll the clients through our weekly outreach program in Kasangati at the home of one of our community volunteers. This part of our catchement area has very limited medical services and most clients have to travel more than ten kilometers to access medical services in the city center.

1.1.3 Client Growth

At the end of 2007, KHCI had a cumulative total of 195 clients. By the end of 2008, the number of new patients had risen to 563 giving a cumulative total of 848 clients. The TB program received a total of 90 transferred from Mulago hospital TB unit for DOTS hence a total of 938 clients were registered and cared for in 2008.

The resources to provide care for the patients is still a major challenge to the program and as such a decision was made to scale down on enrollment of new patients after the first quarter of 2008. The community sensitisation programs informing the community about our services were stopped and we currently receive people who have been told by our services by the current clients. A reducing number of new clients was registered starting from the second quarter till the fourth quarter. The cumulative numbers of patients however kept on rising. We hope to secure sufficient funding in 2009, to cater for mobile clinics, more community outreaches and the ability to recruit more medical personnel, social workers and community volunteers to cater for the great demand for our services in the community.

Graph 2: Number of new clients per Quarter in 2008



The graph above shows the steady rate of recruitment of clients from within our community. Despite the decrease in the number of newly enrolled patients per quarter, we still have a steep rise in the numbers of cumulative patients.

2.0 MEDICAL PROGRAMME

Under our medical programme we operate four sections:
1. Voluntary Counseling and Testing (VCT)
2. Clinical services (medical consultations)
3. Laboratory
4. Pharmacy

2.1.0 Voluntary Counseling and Testing

KHCI counseling team counseled and tested a total number of 1802 clients and they all received their results. Among those who tested, 1153 (64%) were females both women and girls while 649 (26%) were males both men and boys.
Out of 1802 community members who tested and received results**,** 679 (37.7%) tested HIV positive among which 582 (85.7%) were adults of 18 years and above and 97

(14.3%) were children of 18 years and below. 473 of the positive clients were females while 206 were males.

Table 1; VCT results per quarter of 2008.

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
Positive	262	147	145	125	679
Negative	325	234	311	253	1123
Total	587	381	456	378	1802

This high prevalence of 37.7% can be explained by the fact we were actively seeking people who were chronically ill with in the community through community network and the neediest sought our help.

KHCI has a team of five counselors who provided pre and post test HIV counseling, on going, positive prevention, disclosure, bereavement, spiritual, social and supportive counseling. Through collaborations with Kyambogo University and The AIDS Support Organisation (TASO), Young Men's Christian Association (YMCA) and Uganda Christian University (UCU), we have had a number of trainees and students coming for placement at our center. These students have been actively participating in the counseling activities and on top of gaining knowledge they have also provided us with extra human resources.

In an effort to improve the confidentiality of the counseling section, screens were procured in the second quarter through support from the family of late Prien c/o Fredric Ebert Stiftung Uganda. These screens have enabled us to improve confidentiality during individual counseling sessions.

2.1.1 Home Based Counseling and Testing (HBCT)

The Home Based Counseling and Testing program was started in 2007 especially for those who were very sick or bed ridden. The activities were however scaled down in the 1st Quarter of 2008 due to the resource limitations like finances and personnel to run this program. This service was then provided for a few bedridden patients who were suspected to be HIV positive. This service also gave us an opportunity for HIV testing counseling to other family members including the children.

Table 2: Shows the distribution of VCT clinic and HBCT based sessions.

	1st quarter	2nd quarter	3rd quarter	4th Quarter	Total
Clinic VCT	585	377	456	378	1418
HBCT	2	4	00	00	06
Total	587	381	456	378	1424

The above table shows that there was no HBCT done in the 3rd and 4th quarters. This was attributed to lack of finances for the services. However, we hope to recommence HBCT when we get more funding in 2009

2.1.2 Couple voluntary counseling and testing

Throughout the year, 59 couples were counseled, tested and given results together during individual couple sessions.

Table 3: Test results of couples.

Couple category	1st quarter	2nd quarter	3rd quarter	4th quarter	Total
Concordant positive	4	8	11	0	23
Concordant negative	4	8	3	5	20
Discordant	4	5	3	4	16
total	12	21	17	9	59

The discordant couples were encouraged to use condoms, seek treatment for all sexually transmitted diseases and the negative partners were encouraged to be screened every 3months to confirm their sero status. The positive partners were counseled on positive living and positive prevention.

2.1.2.1 Discordant Couple Intervention.

The counseling section started a discordant couple club in the 4th quarter of 2008, as a way of sensitization and prevention of sero conversion among the negative partner. The club has 15 active pairs of couples which is a total of 30 people.

The members have monthly meetings where by they are given information on a number of health promotion topics which include;

- Understanding discordance and how it occurs
- Communication among discordant couples
- Reproductive health
- Risk reduction methods
- Alcoholism in relation to discordance relationship and life long medication.

The above interventions acted as an eye opener to many couples and those seeking services at KHCI. This cleared the myths of having resistant blood to HIV among others.

The counselors hope to strengthen this club in the first quarter of 2009 and elect an executive committee of the club, which will be managed by the clients themselves.

2.1.3 On Going Counseling

This is a follow up counseling offered to clients with TB, HIV/AIDS and or Cancer as away of offering psychosocial support in terms of dealing with adverse feelings/reactions after confirming their status. In 2008 a total of 772 clients were reached in relation to on going counseling activities. This was done at clinic visits, out reach visits and during home visits.

The table below shows the distribution of clients who received the on going counseling services and their respective age categories in 2008. Clients counseled presented different as stipulated in the table below; Adults received a total of 770 counseling sessions, the children below 18 years received a total of 52 counseling sessions.

Table 4: Number of on going counseling sessions per age group

	Children			Adults			
AGE CATEGORY	**17< yrs**		**Total**	**18> yrs**		**Total**	**KHCI Total**
GENDER	**M**	**F**		**M**	**F**		
Adherence	2	7	9	47	91	138	147
ART Education	3	2	5	32	65	97	102
Behavioral change	1	2	3	10	26	36	39
Disclosure	2	3	5	12	14	26	31
Nutritional counseling	2	2	4	13	20	33	37
Positive prevention	0	6	6	24	33	57	63
Positive living	6	11	17	30	63	93	110
PMTCT	0	0	0	0	16	16	16
Supportive counseling	0	0	0	19	52	71	71
Social support	0	2	2	19	62	81	83
Selective prevention	0	1	1	20	30	50	51
Spiritual counseling	0	0	0	2	2	4	4
Couple counseling	0	0	0	5	8	13	13
Bereavement	0	0	0	2	3	5	5
Total	**16**	**36**	**52**	**235**	**485**	**720**	**772**

The table above shows the different categories of on going counseling which are done at KHCI, the most common ones being Positive living, adherence counseling, ART education, supportive counseling and social support counseling. Also very importantly bereavement counseling is done for the families who have lost their loved ones.

Compiled by Alistidia (Counseling Supervisor)

2.2 Clinical Services

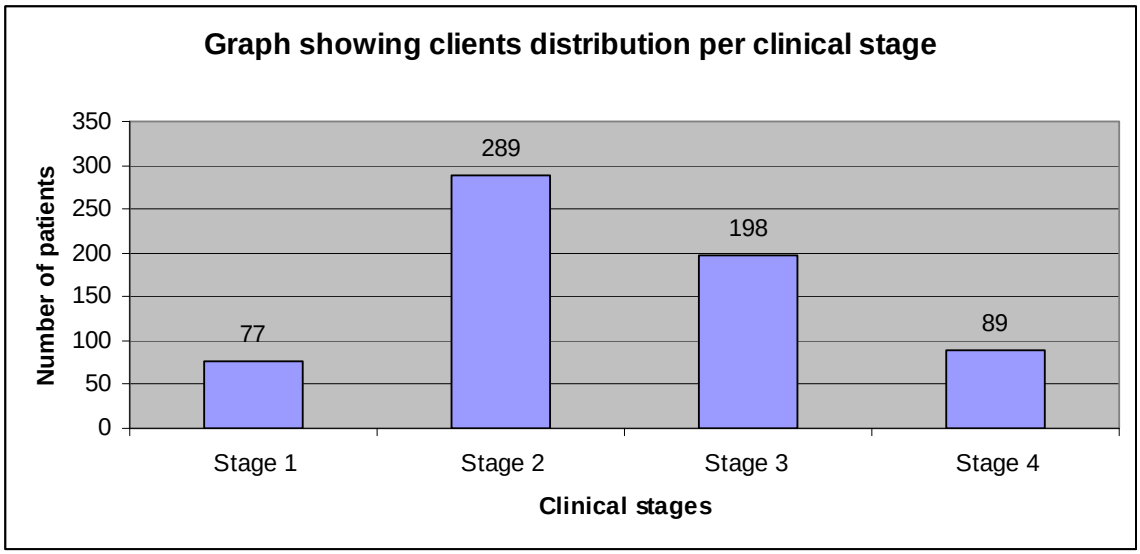
The KHCI clinical services have been greatly strengthened over the 2008 period. The current clinical team is comprised of one doctor, 2 clinical officers and four nurses who on going trainings and CME sessions have gained the necessary knowledge and skill to provide a quality service to the patients. The clinical services provided through out the year include out patient clinical care, home based HIV/AIDS care and support, provision of antiretroviral therapy and pain and symptom control.

The KHCI medical team strives to provide quality care to the clients and as such aims at keeping the mortality rate as low as possible. The team uses a number of strategies to achieve this; linking up with the community volunteers for emergency home visits, appropriate referrals and follow up of clients to hospital, routine home visits and clinic visits for those in a good general condition. The clinicians' are also keen in assessing the various psychosocial, emotional and spiritual needs of the clients and then address them appropriately through linking with the departments of the organisation.

2.2.1 Clients Status

The clinical status of our clients is an important indicator of their well being. The team therefore records their WHO clinical stage of all clients at enrollment and follows them up through the illness. The graph below shows the current WHO clinical staging distribution for the active clients.

Graph 3: Shows the distribution of the clients as per their WHO status



The majority of the clients 289 (44.3%) are in stage 2 and stage 198 (30.3%) in stage 3. Most of the clients who are enrolled in stage 4 are found very sick and bed ridden in the community. This quarter we enrolled 18 new bed ridden clients on to our chronic HIV care program.

2.2.2 Clients on ART

The KHCI care and treatment program received a major boost in May 2008 when a Memorandum of understanding was signed with the JCRC TREAT program for the free supply of HAART and laboratory services. This was a great boost to the program and helped build the clients' confidence in KHCI. It was also enabled us to cut on our operational costs like transportation of patients previously enrolled on the JCRC treatment program.

Table 5: Number of clients on ART/Quarter

Report Period	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**
No. starting ART/Quarter	103	36	54	54
Cumulative No. on ART	137	176	230	248

KHCI currently has a cumulative total of 247 clients on ART; of these 30 are children below 18 years. This increase in the number of clients on ART has been due to our

collaboration with the Joint Clinical Research Center (JCRC) who provides us with free antiretroviral drugs and laboratory services including CD4 testing and other tests. The drugs have been helpful in enabling us to improve the quality of life of our clients through the support of our community volunteers who provide adherence support for clients through the regular home visits.

Picture 1: Above shows a community volunteers providing CB-DOTS care

2.2.3 Medical Consultations

With the gradual increase in the number of new clients enrolled each quarter, the number of consultations done showed a gradual increase especially the out patient clinic consultations. The number of medical consultations done in 2008 was 6863, of which 410 (6%) were either routine or emergency home visits, 50 (0.7%) were hospital visits and the majority 6401 (93.3%) were out patient clinic visits.

Table 6: Below shows the number of medical consultations for the 3 quarters in 2008.

Consultation type	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**	**Total**
Home	45	97	172	96	410
Hospital	15	18	11	6	50
Clinic	1045	1316	2012	2028	6401
Total	1107	1431	2195	2130	6863

The trend shows a general increase in the number of clients over the last three quarters of 2008 and a slight decrease in the 4th quarter. The number of home visits also showed a gradual increase due to the intensified efforts by the clinical team to keep the death rate per month as low as possible.

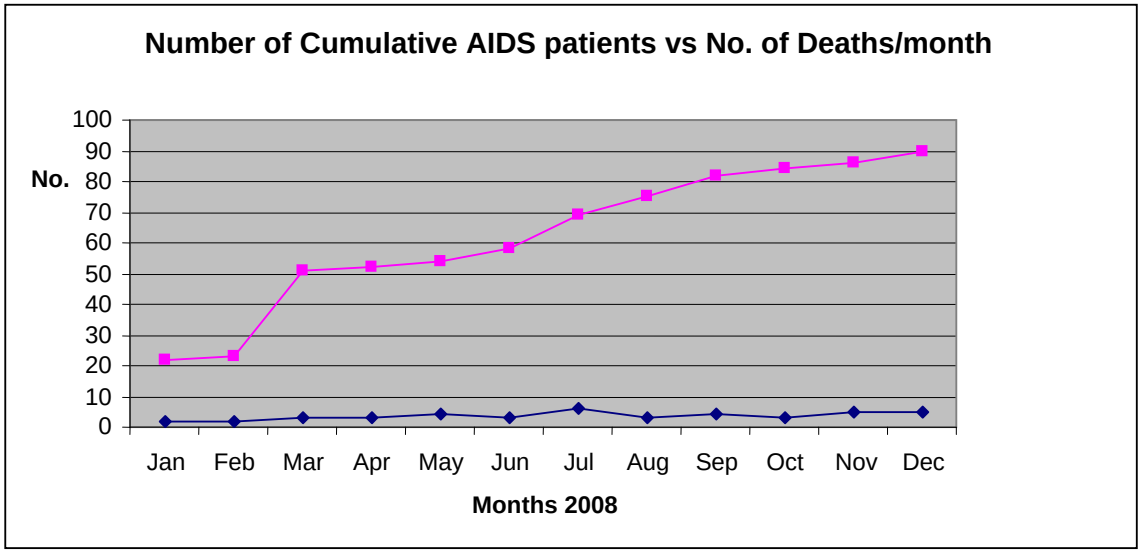
2.2.4 Home Based Palliative Care

The provision of quality home care services is one of the main objectives of the program. This strategy has helped us reach the most vulnerable people in the community to who we provide care and support and work to improving their quality of life. The following services are provided by the multidisplinary team: Palliative care (pain and symptom control), nursing care (for the complications of the illnesses), nutrition and hygiene support, ARV and TB adherence support, appropriate referral to hospitals for investigations and further management and on going counseling for the client and the family. The clients who are critically ill undergo intensive support to ensure that they take their medication and get enough food and fluids.

As a result of this remarkable intervention, we have maintained a very low incidence of death per month through out the entire year especially those with AIDS.

The graph below shows the cumulative number of clients enrolled on our program with AIDS and the corresponding incidence of deaths per month.

Graph 4: Cumulative number of AIDS clients versus deaths



The chart above clearly shows how the mortality rate has been kept low per month despite the continuously raising number of patients with WHO stage 4 disease. This has been made possible by the intensive holistic support given to the clients including regular clinician's visits, provision of Palliative care plus initiation of ART including adherence support, hospital referral for clinical investigations and further management for those with reversible conditions e.g. Cryptococcal meningitis and psychosocial support including nursing care by our community volunteers. Notably the mortality increased in the 3rd and the 4th quarter as some of the earlier recruited clients succumbed to the disease. The common cause of death was mainly from AIDS associated Cancer – Kaposi's sarcoma, disseminated TB and Cryptococcal meningitis.

The main goal of our home based palliative care service is to improve quality of life for our clients through the provision of a quality palliative care service. In so doing we realise many clients improve and live longer and for those with terminal AIDS we make them as comfortable as possible and ensure that they pass on, free of pain or distressing symptoms.

The provision of the home care service requires a multidisplinary team of community volunteers and health professionals to provide the holistic service. Through our weekly case conferences the team discusses patients who have got various problems e.g. psychosocial challenges like lack of food, household rent etc. The team then finds appropriate solutions for the client. Since most of our clients are very poor, we have many clients with various kinds of stressors. The team therefore has to prioritize the needs and provide within the resource limits.

Transportation remains to be a major challenge for the home care program. The clinical team has been using motorbikes (Boda Boda) and public taxis to access the patients' homes. We hope to improve the mode of transport used through acquisition of a vehicle for the home care program. This will help us reach more vulnerable patients in the catchement area and also help in transportation of patients in need of critical care to hospital. A group of friends in Italy are mobilizing funds for a vehicle and hopefully we will get one in the first quarter of 2008.

Picture 2 : Shows clinicians providing palliative home care to an AIDS patient

We have also continued to provide support for the non-physical problems for our clients and their families include ongoing counseling, spiritual counseling, the emotional support, end of life counseling, bereavement support, legal aid, school fees, nutrition support and nursing care. This has helped relieve their other stressors that have a negative impact on their illness. This care has also contributed to improved treatment outcomes for our clients.

2.2.5 Palliative Care for Cancer patients

KHCI has been providing care to patients with HIV associated Cancer and HIV negative patients with other types of Cancer. In 2008 a total of 13 (23%) Cancer patients were cared for of whom 3 were HIV negative. The care provided by KHCI includes pain and

symptom control, supportive home care i.e. feeding, end of life counseling for the terminally ill patients and the families and bereavement care for the families. A total of 5 Cancer patients died during the year.

The patients with HIV/AIDS associated Kaposi's sarcoma get extra support in form of clinical investigations, pain and symptom control, antiretroviral therapy and Chemotherapy when indicated. This is because this type of cancer can go into remission when treated aggressively hence leading to improved treatment outcomes and a better quality of life. The table below shows the different types of Cancers the patients have, how they were managed and the outcomes.

Table 7: Below is a table summary of the clients with Cancer on our program and their current status

Cancer type	**clients**	**Other treatment**	**Outcome**
Kaposi's Sarcoma	8	Oral morphine, NSAIDS Chemotherapy, HAART	2 died in 2008, pain and symptoms controlled
Squamous cell carcinoma Oral cavity	2	Oral morphine, NSAIDS	1 died, pain controlled in other patient
Breast Cancer	1	Palliative radiotherapy, pain and symptom control	Alive in fair condition, No distress
Oesophageal Cancer	1	Oral Morphine, HAART	Died free of pain
Cervical Cancer	1	Palliative Radiotherapy and chemotherapy, NSAIDS	Symptoms resolved and is pain free

2.2.6 Prevention of Mother to Child Transmission (PMTCT)

As a major intervention to the reduction of the prevalence of HIV in our community, we have been providing PMTCT services to mothers who test positive and all current clients who become pregnant. The services KHCI provides for PMTCT include; Voluntary Counseling and testing, nutrition education, treatment for malaria and other illnesses, provision of antimalarial prophylaxis, provision of appropriate antiretroviral medication and referral for antenatal care. The clients are referred to Mulago hospital for delivery and provision of ART for the new born children.

Table 8: Shows the numbers of mothers and children of different HIV status.

Category	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**
No of new Preg mothers on PMTCT	10	7	8	6
No. of Active mothers on PMTCT	10	11	8	6
No. of deliveries	0	7	1	7
No. of mothers who died giving birth	0	1	0	0
No. of alive children	10	10	0	08
No. of dead children	0	1	0	0
No of twin deliveries	0	0	0	1
No. of Babies tested positive	1	1	0	0
No. of babies tested negative	6	4	3	0
No. of babies tested	7	5	3	0

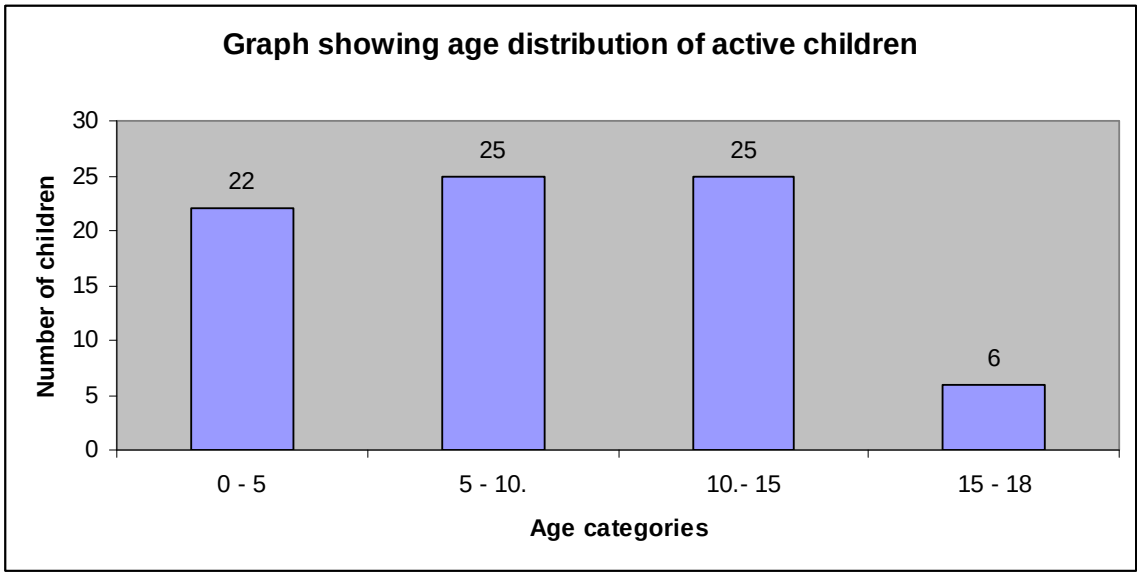
The table above shows a total of 31 mothers who were enrolled for PMTCT care in 2008, of these 15 had delivered by the end of the year. One mother died after giving birth due to excessive bleeding and the child later died from severe pneumonia. A total of 15 babies were tested after cessation of breast feeding and 13(87%) were HIV negative and 2 (13%) turned out HIV positive.

In 2009, the community volunteers will be trained to provide to provide support to the pregnant mothers on the HIV program, to ensure that they adhere to the education given e.g. breast feeding practices, nutrition education and ensuring adherence to HAART regimen selected by the clinicians. We hope this will enable us to decrease the number of children who become positive.

2.2.7 Paediatric – Adolescent Care

The program has continued to provide care for children less than 18 years, we provide them with the whole range of holistic care but refer them to JCRC for evaluation and enrolment in the ARROW Study for Paediatric – Adolescents. We also provide them with Palliative home care, social, emotional, spiritual support and the community follow up for ARV and TB adherence and link up with the JCRC clinicians in case of any medical urgency. The chart below shows the Age distribution of the under 18 year old clients enrolled in our care.

Graph 5: Age distribution of active children on the program

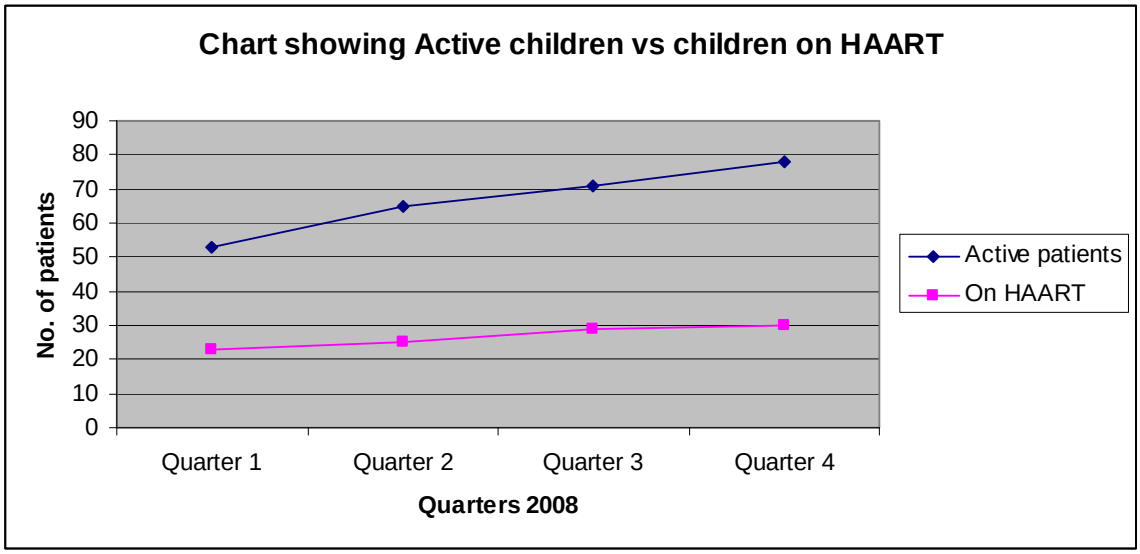


Through out the year a number of children have been enrolled on the program and at the end of December 2008, we had 78 active children of whom 30 (38.5%) were on HAART.

Table 9: Shows the changes in children numbers and those of HAART.

Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
New enrolled in care	36	13	13	10
On HAART	23	25	29	30
Active on Program	53	65	71	78

Graph 6: the cumulative number of children enrolled per month compared to those on ARV.



The graph above shows the increasing trends in the number of children enrolled on the program and those started on HAART. The clinic provides a family based service and as such the clients are encouraged 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. We have also set up a Saturdays' teen's club for the children to meet, learn, play and share their experiences. We also provide them with the other social services that the program offers.

DNA PCR testing is done for children below 18 months, who have been exposed to HIV during delivery and breast feeding. All these children were referred to JCRC for the DNA PCR testing. In 2009 our laboratory is however looking into taking dry blood spots from the clients and taking them to JCRC for analysis.

Picture 3 above shows a HIV positive mother and child who have benefited from the KHCI services and are now healthy and happy

2.2.8 HIV/TB Integrated Care

Kawempe division has a high TB case detection rate of 7.1 per 1,000 persons.The control of the spread of Tuberculosis within our community is therefore high on our agenda since we started operation. In view of the WHO estimation that 50% or more clients with Tuberculosis have HIV and that TB is responsible for at least 30% of all AIDS associated deaths, KHCI laid a number of strategies in 2008 that would help reduce the burden of TB in Kawempe division. These include;

Scaling up the CB-DOTS program in the community through support of the TB Control Assistance Program (TB CAP). In June 2008, we began a daily follow up program of our clients on therapy and we recorded significant successes in the outcomes and the follow up of clients on treatment. This methodology was evaluated after 4 months and a new schedule of patients visits was designed i.e. 3 visits a week in initial phase of TB treatment, 2 visits a week for next five months and 1 visit per week for the next month. The DOTS is done by a group of community volunteers 87% of who are also clients on the HIV/TB program. A collaboration was established with the ***Mulago hospital TB unit***, who identifies and refers to us newly diagnosed TB clients who live in our catchement area.

Intensified TB case finding is also being routinely done among the HIV patients on the program through screening at every clinic or home visit. A standardized screening tool is used to identify and screen suspects.

The community volunteers have also been empowered to educate members of their communities about TB and also help identify TB suspects from the community and then bring them for screening. In order to facilitate the community supporters, we provided them with mobile phones and weekly airtime so that they can communicate with their clients and the clinicians. They have also been given bicycles to enable them move through the community with ease. These two commodities have enabled them to be very effective in implementing the DOTS. We also provide the community volunteers with a small stipend that helps them supplement their other sources of income.

In addition to the DOTS and the ART adherence support, we also provide on going palliative care for the clients i.e. treatment of opportunistic infections, pain management, management of TB and or ART side effects and other distressing symptoms etc. Emergency food support is also given to the poor and destitute patients. The table below shows the numbers of patients cared for in 2008 by quarter.

By the end of December 2008, a cumulative total of 161 TB patients had been enrolled for DOTS of whom 121(75%) were HIV co-infected and on Cotrimoxazole and 52(43%) of them are on HAART. 137(85%) were treated as new cases and 24(15%) were re treatment cases of who 5(20.8%) were defaulters. 60 patients were expected to complete treatment by 31st December 2008, of these 52 (86.7%) patients completed and were declared cured. 2 (3.3%) were lost to follow up and 6 (10%) died while on treatment due to advanced AIDS. The program therefore retained 58 (96.7%) of the 60 patients and had a cure rate of 87%.

Table 10: Below shows the numbers of patients cared for in 2008 by quarter

Patient Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
No. Active patients	21	31	83	86
New pts enrolled	5	9	37	41
Transferred out	0	1	2	2
Lost to follow up	2	2	3	1
Died	3	1	6	5
Completed treatment	2	6	15	9
HIV/TB Coinfected	21	9	62	28
Referred from Mulago	0	3	74	13
Diagnosed at KHCI	5	11	11	29

The clinicians work with the community volunteers in provision of emergency home care services and follow up the clients on treatment for sputum testing to ensure that we identify those responding and failing treatment. These tests are done every 2nd, 5th and 8th month of treatment. The community supporters are given the task to ensure that they collect the samples from the clients during the stipulated months.

Compiled by (Dr. Samuel Guma and Sarah Komugisha)

2.3 Laboratory

In the year 2008 we performed a total of 3420 laboratory investigations. This includes those investigations performed at the site and the outsourced ones representing 32.3% and 52.7% respectively. The outsourced investigations were all performed at the Joint Clinical Research Centre (JCRC) and they included but not limited to Viral Load,CD4, Liver Function Tests, etc and the delivery of samples is done twice a week by the assigned laboratory personnel.

Table 11: Shows summary of the investigations done in 2008

Test		Positive/Abnormal	pos %	Negative	Total
Sputum	S	14	4.9	214	228
	F	2	2.4	81	83
B/s		5	7.4	63	68
URINALYSIS		9	42.9	12	21
CRAG		3	5.1	56	59
HB		18	52.9	16	34
CD4			0.0		564
VL			0.0		65
HIV		683	37.9	1119	1802
CBC		12	7.0	159	171
RFT		1	1.3	74	75
LFT		10	11.8	75	85

TOXO		16	32.0	34	50
HCG		8	19.5	33	41
VDRL		7	10.1	62	69
HBSA		0	0.0	2	2
ESR		0	0.0	3	3
Total					3420

Majority of these outsourced tests especially VL, CD4, LFT, CRAG, TOXOPLASMA are done in preparation of clients for antiretroviral therapy and/or routine monitoring of clients. This is done in anticipation of severe opportunistic infections (Immune Reconstitution Syndrome) after starting therapy and those who are found positive during the screening process are treated for 2 weeks before initiating the ART.

The pregnancy tests are also done on suspicion of pregnancy and also for all women of reproductive age before they start ART. Blood slides for malaria and urinalysis are done routinely to aid the clinical management of the clients and haemoglobin levels are estimated to rule out anemia.

Tuberculosis sputum testing for screening purposes and follow up while on treatment is one of the major tests done in the laboratory and it accounts for 9% of all tests done in 2008. Significantly 4.9% of all the smears done for TB screening were found positive. This is slightly higher than the expected average of 3% positives for laboratories doing work for TB/HIV patients.

Compiled by John Apuuli (Laboratory manager)

2.4. Pharmacy

KHCI provides free drugs to all its clients including medication for opportunistic infections, pain and symptom control, anti Tuberculous drugs and antiretroviral drugs. We occasional raise funds and procure drugs for chemotherapy for AIDS related Kaposi's sarcoma (Cancer). We are still following up oral morphine from the ministry of health. We are however still referring our clients who are in severe pain for the morphine at Hospice Africa Uganda or to the Cancer Institute in Mulago hospital.

Our collaboration with the national TB and Leprosy program has enabled us to get anti TB drugs in our pharmacy and dispense to the community supporters who are doing the DOTS. A US based charity organisation Direct Relief International (DRI) has been helpful in providing KHCI with some drugs including antibiotics, pain killers etc. The JCRC also provides us with some antibiotics and Septrin for prophylaxis.

Table 12, below shows the number of clients on the different types of prophylactic treatment and the opoids for pain relief.

Drug	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
1. Fluconazole	34	6	5	6
2. Septrin	532	359	516	649
3. Dapsone	26	17	8	4
4.Multi-vitamins	558	278	207	245
5.Oral Morphine	3	4	0	2
6.Codein phosphate	15	2	2	4

Picture 4: Shows a nurse and a volunteer dispensing and packing drugs at the Kasangati out reach clinic

Compiled by Nelima Harriet (Pharmacy Supervisor)

3.0 COMMUNITY AND SOCIAL SUPPORT DEPARTMENT

3.1 Volunteers in Care of TB treatment & AIDS Support System (VICTASS)

KHCI recruited a total of 18 volunteers who were trained in drug adherence support and monitoring, home based care, TB control, HIV/AIDS prevention, nutrition and hygiene. Their knowledge and skills in providing the above has greatly improved over the year. A major strength they have is their ability to share their experiences as having ever been on TB treatment or are still on antiretroviral therapy. Their experiences/testimonies to the very sick/ill patients provides encouragement and hope hence leading to improved adherence and better treatment outcomes.

In 2008 the VICTASS went out on a total of 9834 home visits for TB DOTS, ARV adherence support and psychosocial support etc. These visits have ensured good adherence to TB/ARV medicines, low number of loss of follow ups and low mortality.

The VICTASS also go out into the community and identify sick people suffering in their homes, they then bring the patients for testing or if they are bed ridden home based VCT is done.

Picture 5: Shows community volunteers leaving a clients home in one the slums

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 VICTASS 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 the clients go through; and also report the bedridden clients. As a result we have recorded a huge improvement among all our clients both on ARV's and TB medication.

Below: Nassiwa one of the client shares her ordeal and how KHCI came to her aid.

Nassiwa is crouched on the floor of her home while she recounts her story. She talks with a shy and humble voice always glancing down at the edge of her garment. She is a widow and has to provide for her children and the rent of her house. Her husband died five years ago in the same small room where she lives with her kids. When Nassiwa's husband fell sick he was taken to the hospital but refused to undergo the HIV test and also refused to take the drugs for the TB that doctors had diagnosed. "I was administering the drugs, unaware of the fact that he would just hide them and then throw them away. One day my kids told me to check in the pocket of daddy. As soon as I did it, I realized that he was not taking the medications." He eventually died and Nassiwa regrets that her husband could not benefit from the system used at the Kawempe Home Care.

"The volunteers from the KHC come everyday to supply me with the TB drugs. I think that if somebody could have provided it to him, my husband would still be alive," Nassiwa adds. Since the death of her husband, Nassiwa had to work in a small shop selling cassava chips. She was also washing people's cloths and with her income she managed to send her four children to school. Then, she started feeling weak and a fierce cough caused her to loose the job. "The people in the shop where I was working requested me to go away because they said that nobody would come and buy from somebody who is coughing," she says with a submissive and sad voice, while fraying the edge of her garment. "So - she continues - I lost my job and my kids were prevented to attend classes because we could not pay the school fees."

Nassiwa's health condition started to worsen at the beginning of the year 2008 and on April, 18 she was tested with both TB and HIV. She can clearly remember that day, but above all she can recall the sadness and the fear she felt when she was told the news: "I felt lost and scared. Only after being counselled I started feeling better." One of the KHC volunteers who is working as a nurse at the hospital, met Nassiwa and informed her about the KHC. "So far I have been to the clinic four times but I get my TB medications from a community worker. I think that the KHC is doing a great job," Nassiwa states, comparing the service she received at the hospital with the one from the KHC. "They take care of us, not only with the treatments, but also with the food."
**********.

The CB – DOTS program has presented some challenges to the community volunteers' e.g. occasional burn out due to big work load and insistence of TB clients transferred from Mulago hospital, who insist that they would like to enroll on the KHCI program after the 8 months of the support given for the TB program.

The daily DOTS schedule was too taxing and caused burn out for some volunteers. The schedule was however revisited and made more flexible hence leading to reduced work load and better efficiency for the volunteers.

3.2 Angels Youth Network

HIV prevention in the community is one of the main objectives of KHCI and the Angels Youth Network is a group of youth (counselors and social workers) who have been tasked with visiting schools and holding seminars in the community to provide HIV prevention education. The Angels have helped the community to appreciate the beauty of life by promoting healthier lifestyles through engaging them in educative activities and life skills debates in secondary and primary schools.

In the first two quarters of 2008, the sensitisation activities were limited to the clinic, out reach clinic and few schools. However with the support received from the US Embassy small grants project, the school and community interactions have increased.

Table 13: Shows the numbers of people met in the different quarters of 2008

Activities	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**	**Total**
No. Sensitised in community	328	365	591	672	1956
No. of students Sensitised	200	200	40	459	1198
No. of Pupils Sensitised	295	295	295	295	295
No. of schools visited	08	08	08	08	08
No. of community seminars	04	04	04	30	42

3.3 Teens club

This group is for young people from 6 – 19 years of age who were born with HIV. This new initiative is aimed at reducing stigma, creating more awareness, and preventing re-infection among the infected. The Teens Club meets every week (once or twice) for health talks about HIV/AIDS, talks about Positive Living which includes nutrition, drug adherence, disclosure, hygiene, counseling etc. They are also actively involved in games and sport activities. This year a total of 72 children benefited from these activities.

3.4 Golden Vessels

This is a drama and Music club, with children who are both HIV positive and negative between the ages of 8-20 years. It's based on the Christian principles of love and caring for the community. The main objective of this group is to sensitize the youth and community through music dance and drama. The activities compile:

- ✓ Training of traditional dances and songs
- ✓ Training in drama play and learning of songs about HIV/AIDS
- ✓ Performance in the schools and in the community
- ✓ Education about Life skills; these are tools which one can use to help reach one's goals and pursue ones purpose. They include self awareness, self confidence, coping with emotions that's to say stress and sadness, self discipline, effective

communication skills, identifying talents, literacy and providing domestic skills like: cooking, cleaning, and taking care of others.

- ✓ Providing information about HIV/AIDS

A total of 46 children have benefited fro this program. The teen's club and Golden vessels activities have been supported by a grant from the American Embassy at the end of October, this has improved on our service delivery.

3.5 Piggery Project

A piggery project was set up in Kasangati as an income generating project for a group of 7 community volunteers. Ten pigs were bought in April 2008 with support from a group of ladies in Denmark. The group bought 5 male and 5 female piglets which are now fully grown. Four males will be sold when fully mature and the money used will be used to buy a fully grown male pig and the rest will be used to buy food for the other pigs. All the females will be kept until they produce piglets. These piglets will then be sold and a few will be kept and distributed among the volunteers. The female pigs will be kept for years and over time the piglets they produce will be sold and a few given out to other clients to start their own piggeries.

3.6 Beads for Education

This is a major source of income for the school fees program. The sales of beads in our overseas markets showed a gradual increase in the last two quarters of 2008. The KHCI former Director Ms. Anni Fjord has been extremely helpful in selling beads to friends and members of her community. Sinead Walsh from Ireland and Carol Menzies from Australia have also been extremely helpful in helping sell beads in their respective countries. The International School of Uganda and the Irish Society also gave us opportunities that enabled us to sell our beads in the 3rd quarter of 2008. In 2009, we hope to expand this project through training more clients in bead making and developing a marketing strategy for the expansion of beads sales.

3.7 Health Education (ARV & TB Education)

The counselors and the Angels team provide daily health education to the patients as they await HIV testing or waiting to see the clinicians. The education consists of HIV prevention messages, TB spread in health centers control, nutrition and hygiene. They also conduct bi weekly sessions on ARV and TB education as a strategy to give the patients more information about TB and HIV and hence explain why they need to take their medication daily. This has greatly helped improve the adherence to medication and hence produced better treatment outcomes.

4.0 SOCIAL SUPPORT

The social support section has different projects which include: Food /Nutritional support, Home Care Education Support and the Talent project income generating activities. These projects help our clients to start up again and those who are not able to provide for themselves can get some portions of food to support them during the time they are not able to work.

4.1 Home care Education Support

As a result of registered success in beads business we have been able to support 32 children both in primary and secondary school through our Home Care Education support. Apart from school fees we provided other scholastic materials such as books, pens, toilet paper, blooms, one ream and at times shoes and school uniforms. We give them also psychosocial support through counseling and our HES team managed to visit them both at school and at home at once every month. We also gave them carrier guidance and a get together party every term before going back to school and certificates of attendance were awarded. It is in this gathering that we pass on to them prevention messages through singing, playing and drama.

Pictures 6 & 7 above show class room of some primary school children being supported by KHCI and Mr. Tom Pinkey of Home Bush High school hands over a cheque for school fees support to Dr. Samuel Guma.

4.2 Nutritional Support

AIDS associated Poverty is very common among our clients most of whom earned a living through casual work. When they fall ill they cannot earn any income resulting in severe household poverty and loss of food security. KHCI therefore provides minimal food support to the poorest and most vulnerable patients especially those on TB treatment and those who have just started antiretroviral therapy. A total of 118 clients where supported with food in 2008.

Table 14: Below shows the trends of clients on food support by quarter.

Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
ARV Only	3	8	12	17	40
TB or TB/ARV	8	13	18	34	73
Malnourished	2	0	2	1	5
Total	13	21	32	52	118

The table above clearly shows the increasing trends in the number of clients given food support, the social support coordinators ensure that no client spends more than 3 months on food support. Friends of Reach Out (USA) and The Union - TB Control Assistance program have been provided funds that have enabled us to provide the weekly rations of 1kg of beans, rice, sugar and posho to the clients in need.

4.3 Talent Project (Grants and Loans)

The above name originates from the parables of Jesus in the scripture where people were given money to multiply it through business (Luke 25:15-17). With this inspiration Kawempe home care started loan scheme. The small loans are given for the clients to start up small businesses like market vending, selling second hand clothes and charcoal selling. Most of our clients in this section are widows or divorced due to HIV/AIDS and left alone without any family support. This has enabled them to start up and become self reliant. A total of 18 clients were given loans and 52 received grants through out 2008.

4.4 Challenges

The social support programme has faced a lot of challenges and the most pressing one being lack of enough money to support all the clients in need of food. We have many poor clients in our rural-urban area mostly unemployed. So you find that they are in need of food to accompany their ARV and TB drugs, school fees, and at times rent since they are sick, deformed and without strength to work. They have a great social need but due to limited resources we can not provide what they need. Another challenge is that we have many people waiting for loans and grants but since we don't have a stable income generating source we can not provide support to all of them.

5.0 TRAINING AND CONFERENCES

As much as possible we do on the job training meaning our more experienced staff/volunteers work along side and give advice to the less experienced.

- The Continuous Medical Education (CME) has been done according to plan on a weekly basis for staff members covering all aspects of HIV/AIDS and related illnesses. The teacher/facilitator has been on a rotary basis, a good learning experience for everyone to improve their teaching skills.
- The clinical team and counselors also hold weekly case conferences where patients with complicated conditions are discussed and solutions identified for their various challenges.
- Palliative Home Care training. On the Job training has continued with the more experienced staff i.e. medical doctor and clinical officer training the less experienced members of the clinical and counseling teams.
- Our lab technologist received a one day training at the National TB and Leprosy program (NTLP), on a new initiative of diagnosing Multidrug resistant TB (MDR-TB) through culture and sensitivity testing of smear positive patients with treatment failure.
- The KHCI team attended the National AIDS Conference in the first quarter where two posters were presented, one school fees support and the other about the HIV/AIDS home based care.
- The Executive Director was invited to attend a Kampala district TB stake holders meeting and make a presentation about the DOTS program.
- A team of experts in TB control from the Project Management Unit of TB CAP, visited the program in the 3rd quarter and got first hand experience of the DOTS program.

- Half day trainings on ART and TB were held for clients on ART and CATTS. The aim was to give more information on the drugs and enhance adherence. This training is done twice a month for clients who have recently started or about to start ARV's or TB medication.
- During the second quarter we held in house training for staff on communication, such as how to communicate effectively, face to face, presentation skills and time management.
- The clinic coordinator attended a one week course on the diagnosis and treatment of TB. They also taught techniques of monitoring and evaluating the TB program.
- Our clinical officer attended a two weeks training course in comprehensive HIV care at the Institute of Infectious diseases.

5.1 Team Building/Education Activities

During the year the KHCI team had a number of social gatherings that were aimed at building the team spirit and strengthening the interpersonal relationships of the volunteers.

5.1.1 Staff Day out

In June, all the volunteers of KHCI had a day out at the Nyanza Sailing Club in Kaazi. The main aim of the day out was for team building, designing program structure and planning how we can improve our services at departmental level.

The staff took a canoe boat ride from Speke Resort Munyonyo to the sailing club. They enjoyed a hearty breakfast, played games and danced then settled for the departmental brainstorming. Presentations were then made for every department and a way forward was agreed by the whole team.

5.1.2 Children's' Party

In the 3rd quarter, we had 2 parties for the children in the Home Care Education support program who reside in Kawempe and Kasangati. The parties where meant to encourage both the children and their parents/guardians to continue schooling and aim at high performance in their exams. The party's were sponsored by Carol Menzies and Tom Pinkey with Tom's school providing funds for the school fees for the children for their third term studies.

5.1.3 Clients Christmas Party

In December all patients on ARV's and TB medication were invited for a special session of adherence education at the outreach clinic in Kasangati. Lessons on the importance of adherence to medication, positive living, nutrition and sexuality were given. Being a festive season they were urged to desist from the temptations of alcoholism and casual sex which could put them at risk of missing the medicines and getting re infected or infecting others with HIV. After the session, they were given eats and soft drinks after which they sang songs of praise to God for the good things he had done for them in their life.

5.1.4 Staff/Volunteers Christmas Party

The staff Christmas party was held on Friday, December 19th 2008 at Sabrina's pub in Kampala. The staff turned up in formal party dresses with gifts that they had bought for their secret friend of the year. A raffle had been held and all staff/volunteers randomly picked a name of some one who they were expected to buy a present. The gifts were then handed over to the secret friends, award were given to the Volunteers who performed well in CB-DOTS, which was won by Maria Assumpta Nankya the supervisor from Kawempe and Ms. Nyakyazze Joyce the supervisor of Nangabo. The award of employee of the year was a draw for Zainah Namulinda the volunteers attached in Mulago hospital and Namirimu Oliver the coordinator of the community volunteers. The chief guest was the Chief of Party of the TB Control Assistance Program (TB CAP), who was represented by the deputy chief of Party. The staff/volunteers were then treated to a full course dinner and finally a dance crowned the evening.

5.2. International Volunteers

KHCI has been blessed with a number of good hearted volunteers since the organisation started in July 2007. Ms. Anni Fjord the founding director of the organisation had to leave Uganda and go back to Denmark with her entire family. It was a very sad time for all the volunteers and clients to see one of the founding members who had been extremely instrumental in the set up of the organisation leave just before our first anniversary celebrations. It was however a time to celebrate the remarkable achievements that KHCI had made during past months. Anni and her Husband Gerry invited all staff and volunteers of KHCI and their other friends to a party at their home in Kampala. It was a great farewell party with lots of food, drink, singing and dancing. The Golden Vessels presented a number of Christian and traditional folks songs. The KHCI team thanked Anni for all she had done and presented a number of gifts to her and the family. Since Anni left she has continued to support KHCI through fund raising from a small support group, selling beads made by the patients and through making presentations at various functions. Anni thank you so much for your love, continued devotion and support.

Picture 8 above shows volunteers dancing during the staff day out at Kaazi Sailing Club

Through out the year KHCI received a number of volunteers who helped out in various capacities; **Britt Anderson** a volunteer from Denmark who had just finished her high school volunteered with us for 6 months. During this time she helped us set up systems for monitoring and controlling the drugs and other logistics in the pharmacy. She also helped with other activities around the clinic.

Mayte Rimmer Lomelin joined KHCI in the first quarter as a volunteer fro the school fees program. She put in a great effort to set up the systems, guidelines or criteria of which children should benefit for the school fees support. She has supported the Home care Education support team and has also sourced some funds for the school fees.

Claudia Peters, a sociologist joined the organisation in the first quarter of 2008. She wrote up many stories which were used in the development of the website. She has also been extremely helpful in sourcing funds to support the program activities.

Carol Menzies a volunteer from Australia joined us in August and has been with us through out the quarter. She has been extremely helpful, i.e. helped us set up a web site at www.kawempehomecare.org with the help of grade 12 student from Homebush Boys' High School in Australia. Carol during her time with us has also been helpful in streamlining administrative processes and procedures, financial management, Human resource management and training in communication skills and Time management for all staff members.

Claudia Giampietri, an Italian journalist is also providing her services to KHCI. She has been helpful in visiting our clients in their homes and providing them with psychological support. She has also been helpful in compiling our client's stories that are useful for our publications and web site updates. Towards the end of the year she got involved in fundraising for a mobile clinic through a group of doctors and private donors in Italy

Tom Pinkey visited us for a week and helped out in the Home Care Education support program through visiting schools and interacting with their head teachers. He provided career guidance for the children at one of the children's parties. He also managed to raise funds for school fees from the students at his school, Homebush Boys' High School and the local Rotarians club members.

5.3 Capacity Building
One of the major objectives of the KHCI program is to become a center of excellence in the provision of comprehensive HIV/AIDS care and support. A major strategy we have set up is to build the technical and administrative capacity of the organisation and as such the employees are encouraged to pursue further studies, attend internal and external trainings.

In 2008 a number of our staff completed their studies in various disciplines. Our lab manager completed a degree course to become a laboratory technologist. The monitoring and evaluation coordinator got her bachelors of information technology and the counseling supervisor attained a bachelor's degree in counseling. A number of other staff are actively involved in studies e.g. one receptionist enrolled for a counseling course at YMCA and is currently doing her practicum studies and our administrative assistant is pursuing a Masters' in counseling and guidance. The Executive director completed his exams for Masters in Public health and is in the final phases of completing his research, he hopes to graduate in June 2009.

6.0 NETWORKING AND PUBLICITY

In 2008 we have, with joy, continued our close collaboration with various organizations

AIDS Information Centre (AIC)

AIC has continued to support us with free HIV testing kits. A memo of understanding has been signed for initially one year

Hospice Africa Uganda

Hospice Africa Uganda has continued to provide us with morphine for our clients in severe pain. We are also getting support in training our clinicians in Palliative medicine. To date three of our clinicians have attended this course.

African Palliative Care Association (APCA) (Based in Uganda)

APCA gave us the opportunity to submit a proposal for medicine and medical equipment to Direct Relief International (US based). We expect to receive the first batch of drugs and medical supplies in the next quarter. KHCI is also working through APCA to secure oral morphine from the Ministry of Health.

The Palliative Care Association of Uganda[1] *(PCAU)*

We are still working closely with PCAU to secure oral morphine for pain control from the Ministry of health. Meanwhile we are still referring our clients to Hospice for the drug and the Cancer Institute also provides the medication to our clients who are enrolled in their care.

Joint Clinical Research Centre (JCRC)

We are extremely happy to report that we have had a great support from the JCRC a renowned center of excellence for HIV/AIDS care and support. JCRC provides KHCI with free ARV's to dispense directly to our clients and access to their laboratory facilities where we run our advanced tests like CD4, Viral load and other advanced clinical investigations. This has greatly enabled us to reduce our costs our operational costs in the management of our clients. We are extremely grateful for their support

[1] A national NGO formally established in 1993 to support and promote the development of palliative care and palliative care professionals in Uganda

Kasangati Health Centre IV[2] *– Wakiso District*

The local government health center provides us with an occasional 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 National Cancer Institute, Mulago

We refer all our clients who have been confirmed to have Cancer to the Cancer Institute in Mulago where they receive curative or palliative chemotherapy for mainly Kaposi's Sarcoma. They also receive treatment for the management of the complications of the Cancer or the Chemotherapy including rehydration and blood transfusion.

Right to Play

They have continued to support our Angels Youth network with training in HIV/AIDS communication in communities, they also train our volunteers in the various games that help the AIDS orphans and vulnerable children to have a better life and improve their self esteem.

The International Union against Tuberculosis and Lung diseases (TB-CAP)

The Union has provided us with support that has enabled us to start up the CB-DOTS program as described in the HIV/TB integrated section. This has enabled us to do daily follow up and for TB clients in the community thereby reducing the number of TB defaulters.

7.0 ADMINISTRATION AND FINANCE

The fight against HIV/AIDS and Tuberculosis in the Communities of Kawempe and Nangabo continued through out the year 2008. Over this period we were witnessing miracles happened and this would have been impossible without our friends and donors. The success of our program cannot be measured in monetary terms or in time spent at the project but only in the smile of a client who regains his health, in the child who goes to school and in the loving hands of our volunteers.

Despite may challenges we persevere in providing free quality care to all our clients. The achievement of our program is an outcome of good team work, dedication and support of many friends around the world. During this year we develop new policies and procedures in our financial department as well as in the pharmacy; this facilitated our day to day work and ensured quality. In order to improve our work we set up monthly departmental and management meetings.

From the beginning of June Chris Hodun came on board as an Operations Director and is now in charge of financial and administrative part of our project and for coordination of numbers of activities throughout the program.

In the third quarter we redesign and up graded KHCI data base what improved our Monitoring and Evaluation, and helped immensely in generating reports.

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

As the number of clients and activities grown up administrative team scaled up on fund raising strategies, we also recruited new staff and community volunteers. With the help of friends from Australia we set up our web site (www.kawempehomecare.org) which made our program known by more people.

The year 2008 saw the move from using excel spreadsheets to QuickBooks accounting package in our organisation. This made reporting much easier and better for us. We also had renewed energies and focus on the fight against Tuberculosis with Support from the TB Union, where Kawempe emerged the best Health Unit in Central Uganda in the implementation of CB-DOTS.

We thank the Almighty God for giving us the strength to persevere in the times of financial turmoil.

7.1 Financial Report

Our financial report is divided into income and expenditure. The income refers to all funds we received in form of grants and donations from friends and well wishers. The expenditure is subdivided into our three traditional categories of Administrative Costs, Operational Costs and Capital Costs.

7.2 Total Income:

During the year 2008, we received a total of Uganda Shillings **184,234,857** (US$ **102,732**). These came in form of Grants and Donations from friends and Donor agencies and Income Generating Activities:

Kawempe Home Care income for 2008

INCOME	**First Quarter**	**Second Quarter**	**Third Quarter**	**Fourth Quarter**	**Annual Total UG SHS**	**Annual Total US$**
Donations and Grants	41,802,110	40,069,486	22,074,126	73,289,135	**177,234,857**	98,464
Income Generating Activities	228,000	1,624,500	2,002,200	3,828,296	**7,682,996**	4,268
Total Ug Shs	42,030,110	41,693,986	24,076,326	77,117,431	**184,917,853**	**102,732**

7.3 Grants and Donations

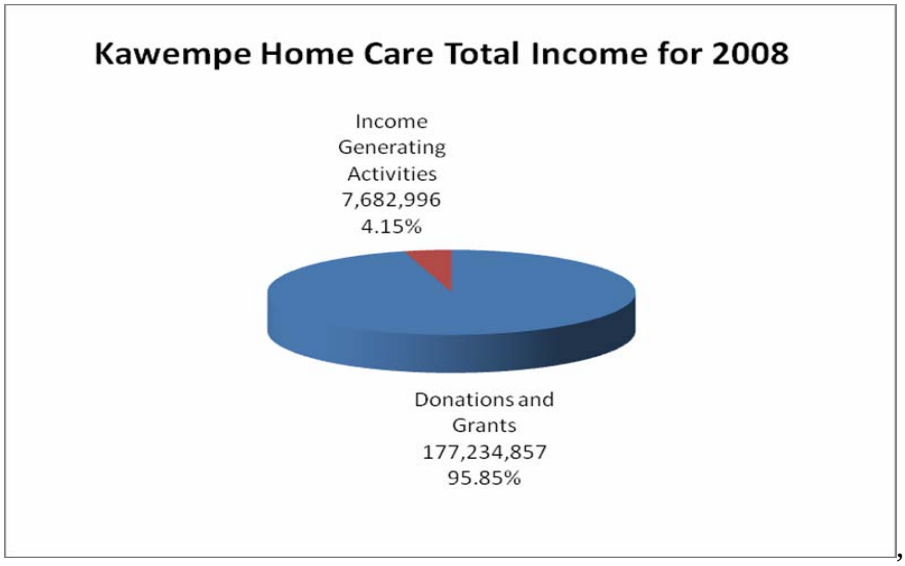
Grants and Donations constituted the biggest percentage of our income. They accounted for 95.85 percent of our total income. We are indebted to our dear friends: The US Embassy in Uganda, who gave us funding for the community programmes; The Union Uganda TB CAP, Friends of Reach Out (FORO) USA, The Irish Society, Esther's Foundation, the family of the late Uwe Prien of Germany, International school of

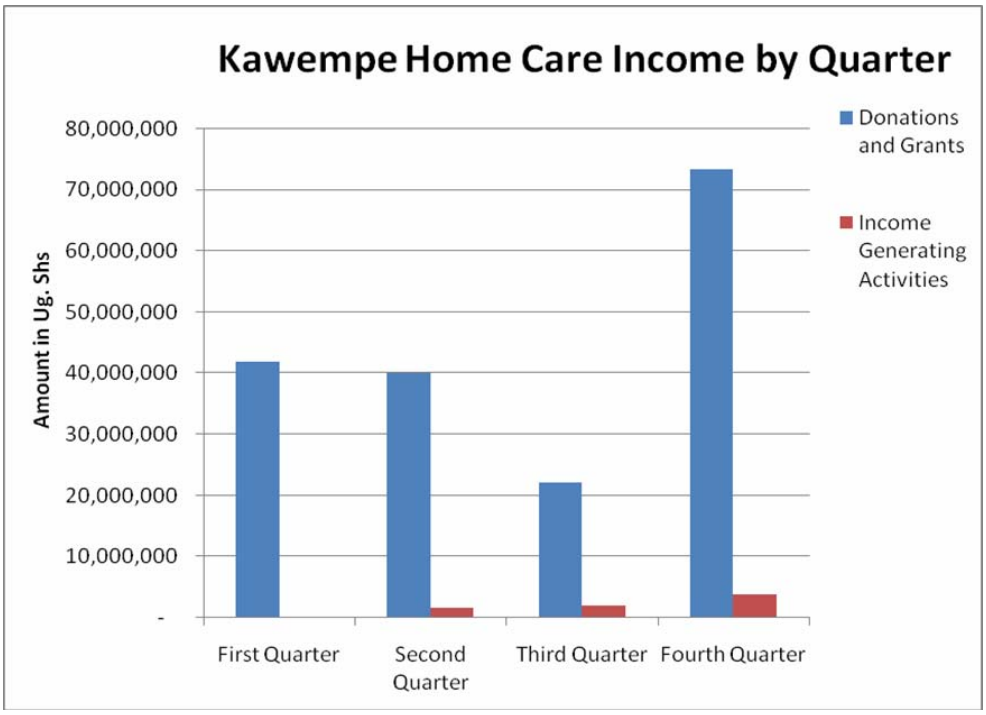
Uganda, Plan International, Home bush high school students and friends from support groups in Denmark, Australia and Ireland. KHCI also has many good hearted private donors, who send us various amounts of money that have helped us keep afloat over the last year.

We also appreciate the tireless efforts of our fifty three volunteers both local and international; who give in their time and skills to ensure that the clients are home visited, given home care, having their beddings washed, looked after in the hospital, receive adequate and timely treatment and the children and orphans are sent to school. All these we cannot value in monetary terms

Kawempe Home Care would also like to recognise the in-kind donations from all our friends—Here we would like to acknowledge the US Embassy for the Grant for Motorcycles which will ease the movement for our community workers in the wide and inaccessible areas to public transport—all our friends who gave us Computers, clothes for our clients, to mention but a few—all these kept us afloat.

7.4 Income Generating Activities:
Though contributing only a small percentage **4.15** percent of our total income the Income Generating Activities which involve sale of recycled paper beads made by our clients, tailoring workshop and piggery give us a sense of pride and self reliance. We would like to acknowledge all our friends in Denmark, Australia, USA and different parts of the World—just know that every bead you buy is improving the life of atleast one family in Kawempe.





7.5 Total Expenditure
During the year 2008, our total expenditure came to a total of Uganda Shillings **178,640,711 (US$ 111,650.44).** These we spent on Administration costs, Operational Costs and Capital Costs.

Kawempe Home Care Expenditure for 2008

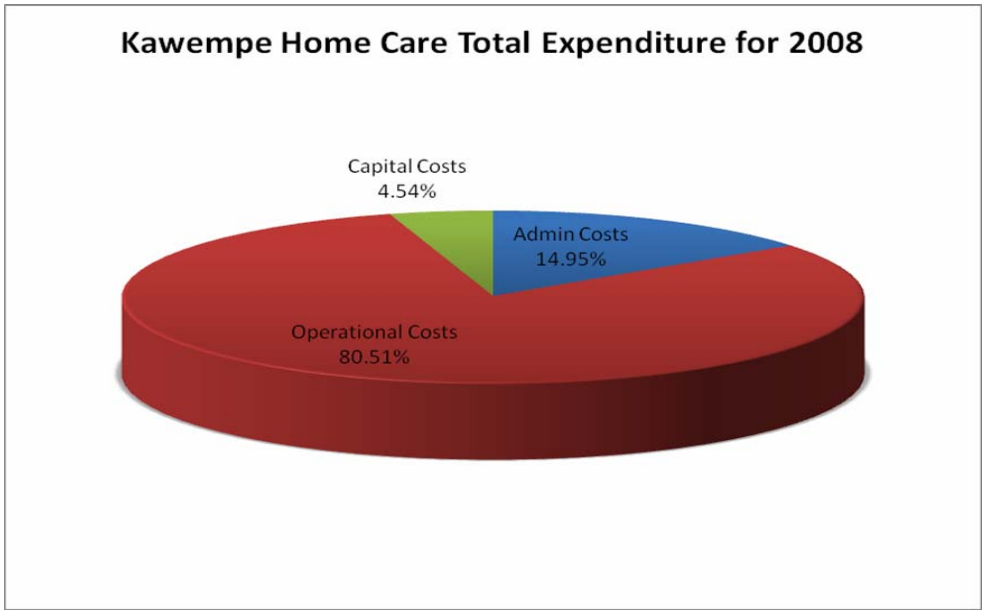
EXPENDITURE	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Annual Total	Amount US$
Admin Costs	4,204,820	6,357,560	5,642,580	10,503,950	**26,708,910**	**16,693.07**
Operational Costs	24,775,800	34,791,054	30,528,750	53,719,197	**143,814,801**	**89,884.25**
Capital Costs	3,063,600	4,446,900	280,000	326,500	**8,117,000**	**5,073.13**
Total Ug. Shs	32,044,220	45,595,514	36,451,330	64,549,647	**178,640,711**	**111,650.44**

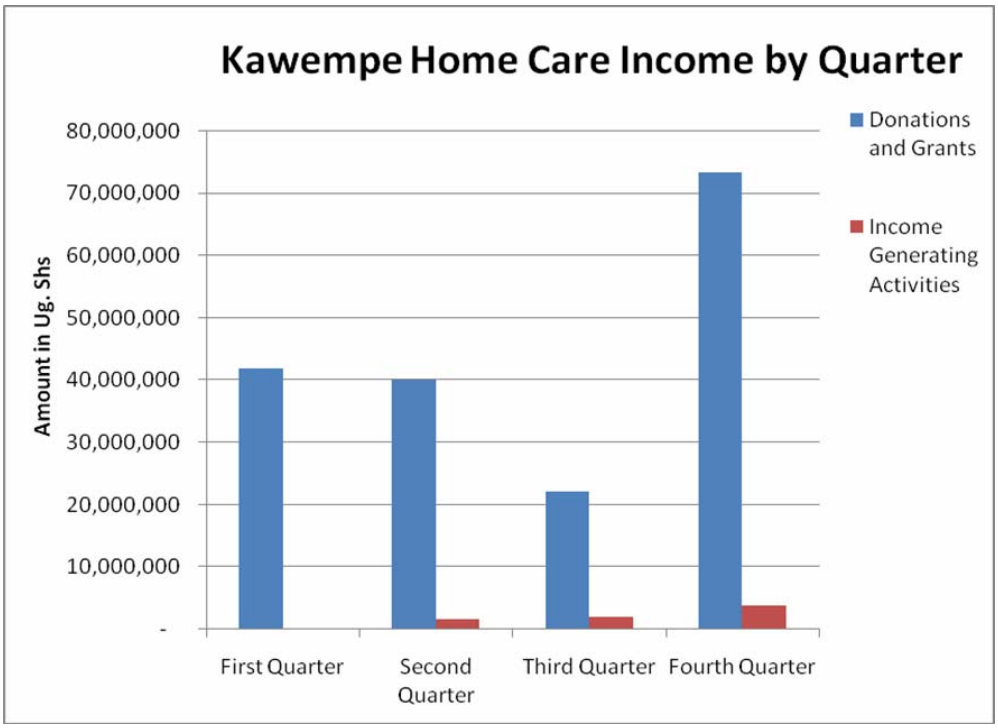
7.6 Administration Costs:
Our Administration costs came to a total of Ug. Shs **26,708,910 (US$ 16,693.07).** This represents **14.95** percent of our total expenditure. It is usually our policy to keep the costs of Administration low—below 15 percent—it is our preference to spend much of the money on costs that directly go to the clients.
The administration costs went into paying for utilities: water, electricity, internet, providing simple lunch for our volunteers as the clinic takes the whole day—this saves on

the time one would lose looking for lunch--stipends for our cashier, cook, cleaner as well as paying for paper based office supplies.

7.7 Operational Costs:
We spent Ug. Shs. **143,814,801 (US$ 89,884.25).** This represents **80.51** percent of our Total Expenditure. We spent these funds on: **Clinical investigation** (e.g. tests, X-rays, Scans, admission/referral, transport, salary/stipends for clinical staff); **Home Based Community Support (**e.g. travel cost, teen's club- children's right to play activities, stipends for VICTASS, Angels Net work. With the support of TB Union, we obtained bicycles for our community workers to ease transport; **Laboratory** (e.g. Lab supplies, stipends for lab. technologist); **Medicine** (e.g. all medicine for Opportunistic Infections and others); **Other Operational Costs** (membership fees, office rent, fund raising costs); **Social support to clients and families** (e.g. transport, School Feers for orphans, food for our bedridden clients to enable them take their medication, household support, loans to enable our clients start small income generating activities and grants to enable our clients who are bedridden meet their rent obligations); **Training** for staff and community volunteers**.** We also paid rent for our clinic and office space. In the at the end of the year, due to increase in the number of clients, we expanded the office and the clinic space.

7.8 Capital Costs:
In 2008 at Kawempe Home Care, we spent Ug. Shs **8,117,000 (US$ 5,073.13)** for the much needed Capital costs such as Computers—which enabled us keep accurate data and information as well as giving timely reports. We also managed to get examination screens, tables and chairs for the clinicians and counselors. We also acquired new printer as well as equipment repairs.





7.9 Challenges:

As our more and more HIV clients come to know about our services and with referral of TB clients living in Kawempe Division from Mulago Hospital; the number of our clients in the last one year rose to over 650 active clients. This has meant need for more community workers and bigger office space. Coupled with the above, most of these community workers are clients who have improved and give their time and energy to help their fellow friends---not forgetting that they are in need of basic living wage to feed themselves, pay house rent and school fees for their children, we call upon all people of good will to come and join the fight against HIV/AIDS, Cancer and Tuberculosis in Kawempe Division and Wakiso District.

Prepared by: Bruno Onzima, Chris Hodun and Elias Tumwine

8.0 Conclusions

The year 2008 has been a time of progress for Kawempe Home Care. It has been a time of growth and learning lessons and getting new friends. We thank the Almighty God for having enabled is sail through the year. In 2009, our target will be to build the professional capacity of all the staff and get a step closer to becoming experts in home based HIV/AIDS care and support.