ANNUAL REPORT 2010/11

# Health Child

# HEALTH CHILD

## Annual Report
## 2010/11

# TABLE OF CONTENTS

# FOREWORD FROM THE EXECUTIVE DIRECTOR

I wish to take this opportunity to thank everyone who contributes to the work of Health Child; **CORDAID**, **International Institute of Communication and Development** and **Bernard van Leer Foundation** for the financial support during implementation, our National and Local Government partners in the districts of operation. We are who we are because of your collaboration. Thank you for opening your "doors" for us to come in.

Health Child continues to work with its community strengthening model that encourages inclusive approaches for all stakeholders. It is such approaches that acknowledge existing resources at all levels that can improve the quality of children and their caregivers.

The year 2010/11 has had tremendous achievements for Health Child. The development of the Strategic Plan 2011 - 2014 whose overall goal is to ***"Integrate all social service provisioning so that children and caregiver's wellbeing is enhanced through increased access to quality health, nutrition, education and livelihood services and their rights protected"***.

In addition 2010/11 was a year of successes. Through convenience snowball sampling method for reaching out to pregnant women, out of the targeted 450 pregnant women reached over a two year project, over 88 percent have given birth in health facilities under skilled care, 80 percent have visited health facilities over four times during pregnancy for antenatal sessions and over 70 percent of children born were weighed with 80 percent of these passing the 2.5 Kgs threshold. This achievement has been useful in planning for scaling up and out.

In 2010/11, Health Child started a pilot project of improving livelihoods for households with malnourished children. This saw the introduction of a scheme called **"SIGHA ENSIHGHO OKUNGULE"** translated to **"SOW A SEED TO REAP"** in this women are encouraged to save to start or boost their income generating projects. Plans are underway to develop a clear documented strategy for the scheme.

I also take this opportunity to thank Health Child staff and the Board of Directors who have been committed to our vision of ***"healthy, educated and protected children"***.

I do hope you enjoy reading this report.

Warm Regards

**Betty N. Walakira**
*Executive Director*, **Health Child**

# STATEMENT FROM A COMMUNITY REPRESENTATIVE

2010/11 has been a year of great achievements! I have particularly witnessed this on Kisima I Island in Jinja District where I serve as a Community Health Volunteer Worker in close association with Health Child.

Before Health Child interventions, deliveries in the health centre and generally health seeking behaviors of community members was very poor. Open defecation was rampant, washing in the lake and cases of child neglect and abuse common these all contributed to cases of maternal and infant deaths and generally life was unbearable. As I speak now, due to continuous sensitization by Health Child both in community and at the health centre, many mothers give birth in the health centre and attend antenatal care, immunization of infants and attendance of postnatal care service greatly improved. The uptake of family planning has also increased. The Island has registered improvement in the hygiene and sanitation levels, majority homes now have drying racks, open defecation stopped, washing in the lake stopped and now community members use pit latrines. With the support from Health Child, early childhood development centres (ECD) were established where children are kept safely and exposed to learning.

The time that I have been in close interaction with Health Child over the years, and 2011 particularly has greatly enhanced my skills as a Community Health Volunteer Worker. We have regular skills update trainings that we (Community Health Volunteer Worker) always have in the Health Child resource centre where we directly hold dialogues with Health Child project nurse and other project officers on a number of health and other community related issues. Health Child has also extended computer training community health volunteer workers which has helped me so much to access health information which I utilize during community sensitization activities

All in all, I am so much delighted and the same time privileged to share on behalf of other VHTs the great contribution made by Health Child towards improving our communities. We thank the organization for transforming our Communities!

**Musana Andrew**
*Community Health Volunteer Worker*

# ABOUT HEALTH CHILD

**Health Child** is an indigenous organization registered in 2005 under the Local Government provisions. In order to serve the interests of grassroots members better, Health Child is in the final stages of becoming a fully fledged Non-profit making Organization, to be registered under the Companies Act.

Health Child is committed to promoting the health of children aged 0 - 8 years through preventive activities against common childhood illnesses to reduce child morbidity and mortality.

Health Child in the past six years has been working in Eastern and Central Uganda in Jinja and Wakiso districts mainly reaching poor fishing communities.

In line with our new Strategic Plan 2010 to 2014, Health Child has expanded its coverage to Mayuge, Bugiri and Namutumba districts and has added one more region, Northern Uganda. Districts in Northern Uganda prioritized for intervention include Apac, Lira and Kitgum.

## Our Vision:

Healthy, educated and protected children.

## Our Mission:

To create a safe and secure healthy environment for children and caregivers so that children both girls and boys can experience a safe and fruitful childhood to grow and become responsible and productive persons in their communities.

## Our Strategic Objectives

1. To reduce child mortality in Uganda.
2. To reduce maternal mortality in Uganda
3. To increase community participation in early childhood education and development.
4. Promoting active child participation in demanding and advocating for their rights and protection.
5. To increase opportunities of income for women in the communities.
6. To collaborate with state and non state actors to promote child growth and stimulation.
7. To promote active participation of communities to promote hygiene and sanitation at household and community levels.
8. To promote integration of Information and Communication Technology in achieving the broader goal of; ***"Integrate all social service provisioning so that children and caregiver's wellbeing is enhanced through increased access to quality health, nutrition, education and livelihood services and their rights protected"***.

# MATERNAL AND CHILD HEALTH

## 1.1 Building Capacity of the Community to Implement and Monitor Child Health Programmes

Community ownership of a project is very critical for it determines its success or failure. Health child uses a community based approach to implement all its activities; from planning, implementing and monitoring. This is because we recognize the abilities and strengths communities possess; which has proved to be both efficient and effective. We work with Village Health Teams. These are selected members of the community who command respect and have basic health training. 26 Village Health Team members were trained on; Early childhood education, child protection, nutrition, sanitation and hygiene maternal and child health. They have been very instrumental in implementing and monitoring programs at the community level.

## 1.2 Community Sensitization about Prevention and Management of Childhood Illnesses

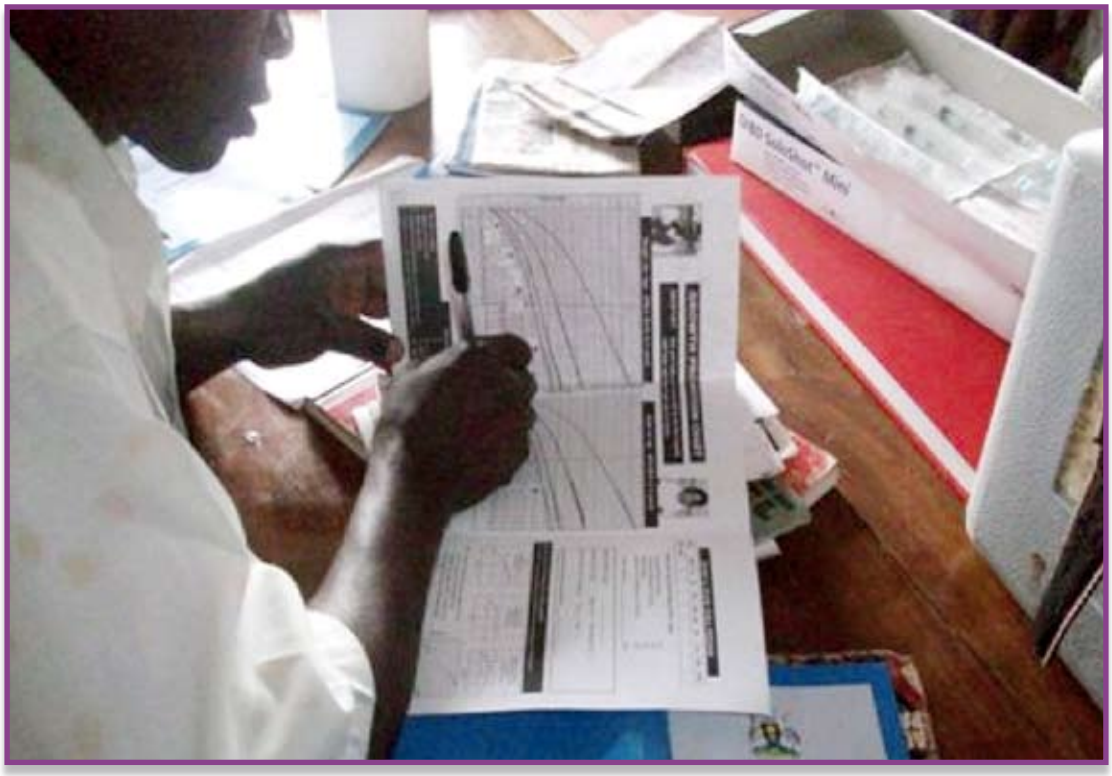
Most diseases that children suffer from are preventable. Prevention has been proved to be less costly compared to treatment. Diseases such as malaria, typhoid, diarrhea and Respiratory track diseases such as pneumonia are all preventable. Prevention is very effective at a household level. But if the disease occurs, its management draws the line between life and death. It is on this ground that caregivers were sensitized about childhood diseases and how to prevent and manage them.

960 caregivers met in their respective Family Health Support Groups to discuss factors affecting child growth and maternal health. These groups discussed proper feeding practices for young children, food preparation and preservation, child stimulation and protection. The sessions highly draw upon locally available knowledge and foods.

## 1.3 Immunizing, Deworming and Provision of Vitamin A Supplement

We collaborated with 9 public health centres in the areas where we operate. Through this collaboration, mobile clinics and outreaches were arranged where 4,078 children (1,886B and 2,192G) received immunization and treatment. This was coupled with deworming and provision of Vitamin A supplements based on the age of a child. These services are very vital in prevention of the immunizeable illnesses. Mothers received education about how to monitor growth of their children using the immunization card and advised about the importance of keeping their babies immunization cards safely.

**A child being immunized against polio**



**A health worker filling information in the child's health card**

## 1.4 Home Visits to Monitor Child Health and Welfare

960 caregivers were reached with messages of child illnesses, male involvement in child and maternal health, nutrition, family planning and sexual reproductive health. The CHVWs and local leaders also monitored child wellbeing, growth and development and household hygiene and sanitation.

300 households were visited to ensure high standards of hygiene and sanitation. Hygiene and sanitation indicators include; pit latrine, hand washing facilities, bathing shelter, drainage, drying rack and rubbish disposal. 3 communities formulated sanitation and hygiene by-laws which are monitored by the local leaders.

## 1.5 Increasing ANC Attendance and Delivery in Health Centers

450 pregnant women were systematically followed up until their postnatal period within last year. This was informed by Ministry of Health strategy to reduce maternal mortality by all pregnant women accessing ANC a minimum of 4 times during the pregnancy. This has so far resulted into 80 percent of them visiting the health centers either four or more times during pregnancy higher than the national average of 47 percent (UDHS, 2006). Of 217 who have so far given birth, 88 percent gave birth in health centers under skilled care. Of the 191 deliveries registered 95.8 percent got postnatal care within 24 hours of giving birth.

Health child highly utilized ICT tools such as phones to remind women to go to the health centres to receive ANC. While at the health centre they receive health education on nutrition, danger sings in pregnancy and delivery, HIV and early infant diagnosis, requirements during delivery, family planning and male involvement. This has drastically increased the number of women giving birth under skilled personnel.

**Mothers attending a session at Walukuba health centre**


**Some of the posters developed by Health Child hanged up at the Health Centre**

# EARLY CHILDHOOD EDUCATION

## 2.1 Harnessing Community Support for Running ECDs

Meetings were held with 6 communities to rally them behind Early Learning. Community members identified structures and spaces that were transformed into community based ECD centres. They further selected management teams to ensure the smooth running of these centres as per the ECD policy also expected to result into sustainability of these centers. Health Child has also created partnerships with 11 privately owned nursery schools with a purpose of improving the quality of learning and care for young children.

## 2.2 Refurbishing community structures to serve as ECD Centres

10 new ECD centres were refurbished and made operational this financial year increasing the number of Health child supported ECD centre to 22 existing in Jinja and Wakiso Districts with a total enrolment of 1,066 (587Girls & 479 Boys) children. 13 of these centres are community owned and 8 are privately owned. The centers have been instrumental in improving learning of young children and freeing up their caregivers such that they can get involved in economically viable projects. The centres were supported with learning materials, text books, stationary, furniture, continuous support supervision and continuous capacity building of the teachers and management committees. Learning within the centers is highly facilitated by locally available resources mainly used to develop learning and play aids such as toys, charts and flash cards.


**One of the classrooms that was refurbished for Masese community**

## 2.3 Training of Teachers and Support Caregivers in Indigenous Pedagogical Practice

Five (5) Health Child staff received training in basic early childhood education skills from the National Curriculum Development Centre. The skills and knowledge obtained through the training have been transferred to 48 ECD teachers and caregivers; the trainings conducted are expected to ultimately bring about quality early childhood education experience for the children who will attend the centres. The teachers and support caregivers are now knowledgeable and experienced in; usage of the learning framework, development of schemes of work, lesson plans, lesson development, daily routines, report generation, observation record management, standards and requirements for ECD center establishment.

**Health Child staff during training in ECD**


**Support supervision to ECD teachers by a Project Officer**

## 2.4 Providing Nutritious Meals to Children Attending ECD Centres

In a quest to offer holistic service to children, Health Child supports a nutrition program in the community based ECD centers we support. We provided maize and soya flour for preparation of porridge for 1,066 young children. Parents and caregivers of the children also supported this program by making both cash contributions and in kind contributions which have been in form of nutritious supplements to mix with the porridge, packing bites for breakfast, collecting firewood and water to prepare the meals. This program has been highly instrumental to enhancing learning because children concentrate better when satisfied. To ensure sustainability of this programme, the ECD centre management committees have taken charge of its management.

## 2.5 Play Materials for Enhanced Learning

Playing not only promotes relaxation in children but also learning. Health Child promoted play for young children by encouraging usage of locally available materials to make playing materials for young children. We adopted a new model where older siblings to the children in ECDs were creatively engaged in making of play and learning materials for their young ones such as dolls, ropes, balls from locally available materials such as old clothes, banana fibers and polythene bags. The program also directly targeted the older siblings by equipping them with life skills such as baking, weaving, basketry, modeling, cooking, knitting and painting and education on preventing early pregnancies and child rights.

## 2.6 Early Stimulation and Development Activities for Children Below 3 Years

Health Child promoted learning for children aged 0 - 3 years by facilitating dialogues with caregivers having children within this age bracket. The dialogues were instrumental in sharing of indigenous knowledge and skills on age appropriate stimulation activities they could adopt to bring about cognitive, social and physical growth of their children.

Again in this regard, Health Child supported VHTs during home visits to monitor growth and development of these children including referring caregivers with children identified to have negative growth indicators to health centers.

## 2.7 Refurbishing Resource Centres

Three (3) Community Resource Centers were established and annexed to ECD centres mainly for propagation of community knowledge products on child development. The resource centers were equipped with text books, story books, manuals, storage facilities and play and learning materials for utilisation by children and parents who visit the centres.

The resource centre activities include reading, making of learning and play materials by older children, caregiver dialogue on a number of issues which include among others parenting, promoting child safety and promoting stimulating environments in the home. We now have a total of six established community resource centers being utilized by community members under the program.

**Older siblings making play and learning materials for ECD children**

# NUTRITION AND INCOME GENERATING ACTIVITIES

## 3.1 Strengthening Households to Enhance Child Nutrition

198 households with severely malnourished children were provided with seeds of vegetables and genetically modified passion fruit tree seedlings to increase consumption of vegetables and fruits in their homes.

A protected micro garden

A VHT sensitizing caregivers about proper feeding

## 3.2 Sensitization of Caregivers on Proper Feeding

Health Child worked with 85 grandmothers and 9 health centres in the area of intervention to implement activities that involved transferring knowledge and skills to caregivers in the communities and health centre about the importance of consuming balanced meals. The grandmothers organized practical sessions to demonstrate ways of preparing nutritious and delicious meals with minimal resources, integrated within the open and closing days of the ECD centres. The dialogues have been successfully conducted in 14 ECD centres attended by 663 caregivers in the communities of implementation.

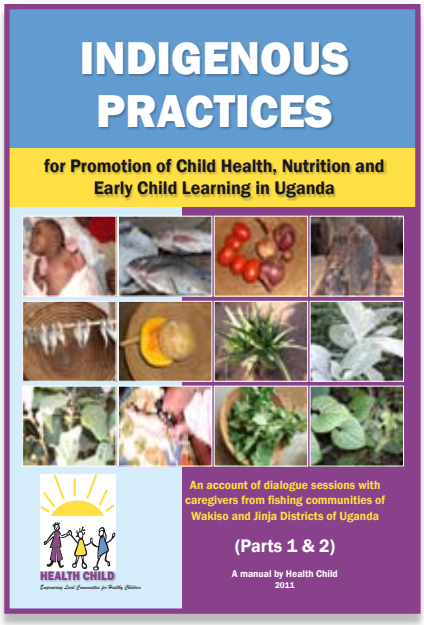
Nutrition has further been included in the Local Council (LC) meetings at village level where grandmothers and health workers provide information during the meetings to caregivers on importance of good feeding for children and options for cheaper yet nutritious feeding. 5 Local Council (LC)s have successfully made part nutrition for children as part of their village meeting agendas.

## 3.3 Home Visits to Ensure Child Wellbeing

The purpose of this activity is to extend nutritional and other health related support to caregivers at a personal level. The indicators that the activity seeks to improve are reduced levels of malnutrition among children, improved feeding behaviors for children by caregivers, increased consumption of liquids, improved waste management by households, consumption of drinking water including having a clean container for drinking water, having a bath shelter, clean toilet facility and hand washing facility for individual households. This is also done to track progress on above indicators.

## 3.4 Exploiting Traditional Knowledge

We are proud to contribute to the propagation of the indigenous knowledge base on child upbringing in Uganda. We released a manual **"Indigenous Practices for Promotion of Child health, Nutrition and Early Child Learning in Uganda"** this Financial Year. This manual contains a list of locally available foods, ways of preparation and preservation. It also outlines other issues such as common childhood illnesses, herbs, traditional games played by children and aspects of child stimulation. Grandmothers are using this manual to conduct Monthly sensitization of mothers in their respective FSGs.



## 3.5 Formation of Saving and Credit Schemes

As an outcome of a survey conducted by Health Child in its program area, households that mainly depend on markets for household food were found to be more likely to have malnourished children. Also from our program experience, Health Child discovered that group income generating projects are not sustainable and that the culture of handouts to vulnerable households to start income generating activities is also not sustainable.

Health Child therefore decided to target households with malnourished children for income generating activities by initiating a savings and credit scheme called **"SIGHA ENSIGO OKUNGULE"** loosely translated to mean **"SOW A SEED TO REAP"**. Caregivers under the scheme make individual savings to the scheme but are required to come together once a week to save part of their weekly income. Caregivers are also encouraged to come up with business ideas which they will start when they start borrowing from the scheme. Successful business persons in the forms of trade of interest to the caregivers have been engaged in inspirational talks to share with the caregivers their life journey, successes, failures and the cost implication of investing in any preferred business. It is hoped that this will lead to reflection on the side of caregivers and further inspire them into starting their small income generating projects with vision 88 members have been enrolled to the scheme.

**Caregivers meeting for saving scheme "SIGHA ENSIGO OKUNGULE"**

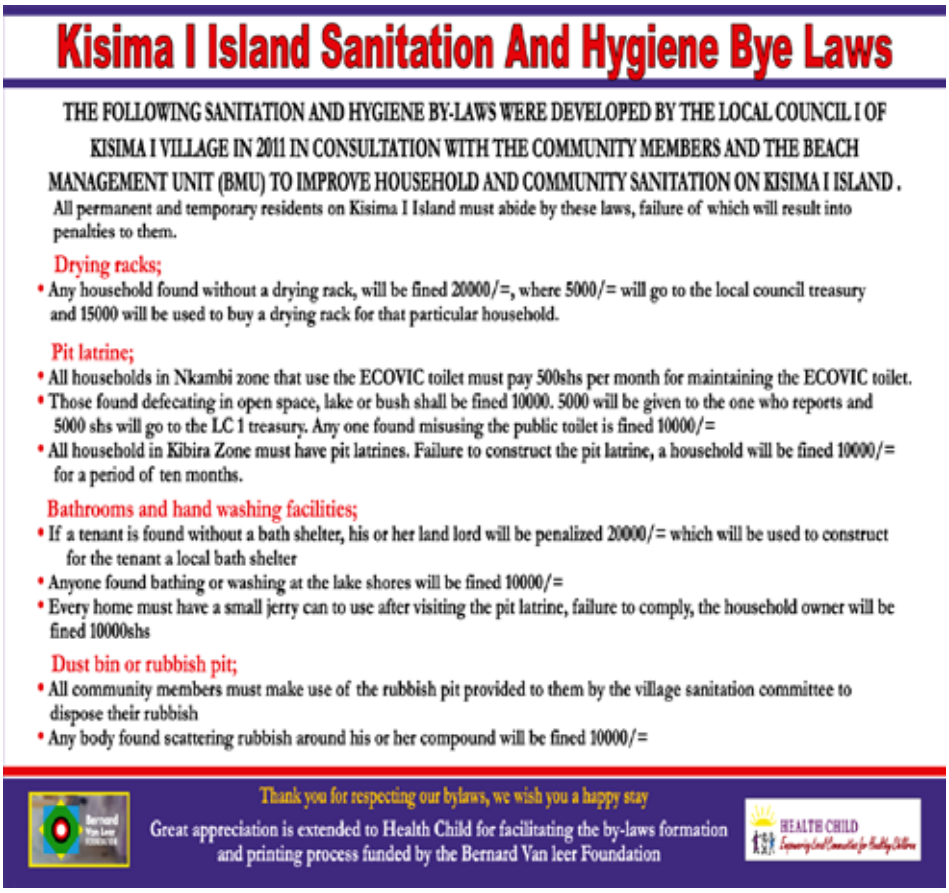
# SANITATION AND HYGIENE

## 4.1 Home Visits to Ensure Improved Sanitation and Hygiene

300 households were followed up by VHTs with an objective of improving key sanitation indicators which include: waste management, consumption of safe drinking water, proper water storage, drainage, having a bath shelter, ventilation, pit latrine and hand washing facility for individual households. This has led to improvement of sanitation standards especially in the 3 communities with operational bye-laws.

## 4.2 Formation of Sanitation and Hygiene By-laws

In a bid to improve sanitation standards in our catchment area, we offered technical support to communities to form sanitation by-laws. 3 communities have so far generated and operationalised these by-laws. The by-laws focus on availability and cleanliness of key sanitation facilities and penalties or fines.



**Kisima I Island Sanitation And Hygiene Bye Laws**

THE FOLLOWING SANITATION AND HYGIENE BY-LAWS WERE DEVELOPED BY THE LOCAL COUNCIL I OF KISIMA I VILLAGE IN 2011 IN CONSULTATION WITH THE COMMUNITY MEMBERS AND THE BEACH MANAGEMENT UNIT (BMU) TO IMPROVE HOUSEHOLD AND COMMUNITY SANITATION ON KISIMA I ISLAND.

All permanent and temporary residents on Kisima I Island must abide by these laws, failure of which will result into penalties to them.

Drying racks;

- Any household found without a drying rack, will be fined 20000/=, where 5000/= will go to the local council treasury and 15000 will be used to buy a drying rack for that particular household.

Pit latrine;

- All households in Nkambi zone that use the ECOVIC toilet must pay 500shs per month for maintaining the ECOVIC toilet.
- Those found defecating in open space, lake or bush shall be fined 10000. 5000 will be given to the one who reports and 5000 shs will go to the LC 1 treasury. Any one found misusing the public toilet is fined 10000/=
- All household in Kibira Zone must have pit latrines. Failure to construct the pit latrine, a household will be fined 10000/= for a period of ten months.

Bathrooms and hand washing facilities;

- If a tenant is found without a bath shelter, his or her land lord will be penalized 20000/= which will be used to construct for the tenant a local bath shelter
- Anyone found bathing or washing at the lake shores will be fined 10000/=
- Every home must have a small jerry can to use after visiting the pit latrine, failure to comply, the household owner will be fined 10000shs

Dust bin or rubbish pit;

- All community members must make use of the rubbish pit provided to them by the village sanitation committee to dispose their rubbish
- Any body found scattering rubbish around his or her compound will be fined 10000/=

Thank you for respecting our bylaws, we wish you a happy stay

Great appreciation is extended to Health Child for facilitating the by-laws formation and printing process funded by the Bernard Van leer Foundation

HEALTH CHILD

**Sample of Sanitation and Hygiene Bye-Laws**

# CHILD PROTECTION

## 5.1 Fostering Community Sensitization on Child Rights through Dram and Debates

Health Child has meaningfully worked with youth in the communities it serves to initiate a youth troupe called **"BASOGA BAIHNO"**. The troupe has been engaged in community sensitization on child rights using music dance and drama. The troupe has successfully organized 2 community performances under the theme **"STOP CHILD LABOR IN SUGAR CANE PLANTATIONS"**. Health Child has also harnessed school debates so far in 5 primary schools in Jinja District to promote discussions and awareness by children on their rights. A total of 940 children (493G/ 447B) and 213 adults have been reached through these initiatives.

**Community Awareness Building on Child Protection**

**Performance by Basoga Bainno to raise Child Rights Awareness**

## 5.2 Building Capacities of Communities in Identification and Reporting of Cases of Violence to Justice Institutions

Five (5) trainings were conducted for 54 local leaders who included 20 religious leaders and 6 teachers. The purpose of this initiative was to strengthen participants' capacities to address cases of child rights in their communities and their jurisdictions. The workshops focused on the formation of the Local Council (LC) courts and their responsibilities, referral systems for the cases that cannot be handled by the Local Council (LC) courts, format of the monthly report for the Local Council (LC) court, proper planning and management, financial management, development process of child protection by-laws by the LCs/Courts, boundaries in which LC courts should set penalties. This was done in partnership with the District Probation and Social welfare Officer (DPSWO).

A positive outcome of these training has been the formation of 5 village Local Council (LC) courts. 3 of the Local Council (LC) courts have introduced registers of children aged 0 - 8 years for easy monitoring of child abuse cases where a total number of 1,229 children have been registered.

## 5.3 Supporting Local Council (LC) Courts

Three (3) Local Council (LC) Courts were facilitated to make child protection by-laws. This has enabled them effectively plan and also address key issues of child rights violation. The by-laws were formed basing on the child abuse cases in each area as reflected in the baseline project report. Areas that were covered in the by-laws include stopping child labor, child neglect, education of children, physical abuse and exploitation of children. In addition, Local Council (LC) courts have been facilitated to write reports for easy monitoring of child rights violation in their areas and also for sharing with other justice institutions.

## 5.4 Support to Survivors of Rights Violations

4 Primary schools were supported by Health Child to form platforms through which children would report cases of violation. This was done through head teachers and senior women and men. Action taken include acquiring of registers to document child rights violations that have been reported by children, organising of counselling sessions for children who have been violated, organising of debates and inter school quiz to allow the children talk for themselves in a program called **"I TOO HAVE A SAY" 'NANGE MUMPULIRIZE'**. This has encouraged children to open up and a total number of 63 children have been counselled by the external counsellors and so far 4 cases have been forwarded to the local courts for further follow up.

6.0

# ICT FOR DEVELOPMENT

We utilize ICT tools to enhance our work. We registered the following successes:-

- 9 IEC materials on maternal and child were developed and disseminated in the community. The developed materials include posters on immunisation, nutrition, breastfeeding, items a pregnant mother should prepare for delivery, videos on delivery items, family planning, cleaning the umbilical cord, PMTCT and a chart on breastfeeding.
- 24 text messages were sent to 348 pregnant women and new mothers reminding them about their ANC, PNC appointments. These messages also contained health information.
- 12 quiz messages were sent to 741 beneficiaries. These are health questions that are designed to measure community's knowledge on key health issues. We do this in collaboration with Text to Change.
- 216 community members were trained on basic computer applications from our resource centre
- 121 community members were sensitised using video about child protection, STDs and STIs, family planning, cleaning of a new baby's umbilical cord and responsible fatherhood.
- Upgrading the Health Child Website

  The website can be browsed on **http://www.healthchild.org.ug**

**Community members having computer training by Health Child**

7.0

# RESEARCH

We conducted 2 household surveys gathering data on specific indicators critical for measuring progress and impact of our 2 projects. Details on the outcomes of the surveys were featured in the project baseline reports. The first survey systematically collected data in the area of child growth, development and nutrition levels, income and household livelihood, sanitation and hygiene, early childhood learning, child abuse and neglect.

The second one was guided by key issues affecting child and maternal health such as; nutrition, ANC and PNC attendance, HIV testing for both mother and child, delivery in health centres, child immunization, Family planning use and malaria prevention.

Health Child further presented a paper at the International Conference on Family Planning held in Senegal titled, **"Community driven approach to increase uptake of Family Planning services and child health services in public health facilities"**:- a case of Health Child.

Programme implications discussed include; need for strengthened skills and capacity of CHVWs (VHTs) to deliver health messages to communities, need to increase public-private partnerships in implementation for cost reduction and wider coverage, delivery of integrated health services is useful for reducing costs of implementation and helps in tacking health problems at household and community level holistically and need for an existing source of information that acts as a referral point for women who use family planning to address issues of misconceptions and also the side effects that come as a result of using a method.

We continue to document good practices in the process of implementation.

8.0

# PARTNERSHIPS

Health child continues to collaborate with state and non state actors in the process of our project implementation. We established 4 new collaborative networks with an aim of increasing learning and sharing. We further strengthened our relationship with old state and non state actors.

We are currently collaborating with; Ministry of Health Technical Working Groups for Child and Maternal Health, District Health Working Group, 8 Government health Centres, MoES, Forum for Education NGOs in Uganda (FENU), Health Communication Partners (HCP), Marie Stoppes, Text to Change, District Probation and Social Welfare Officer (DPSWO), Jinja Network for Marginalised Children, Jinja Network for AIDS Support Organizations, ANPPCAN, Jinja Vector Office, Police, Community Development Officer, Sub-County, VHTs and Local leaders.

9.0

# FINANCIALS

Health Child received funding for the period October 2010 - September 2011 from Cordaid, Benard Van Leer Foundation and IICD to implement the following projects:-

***Health Child income by Donor***

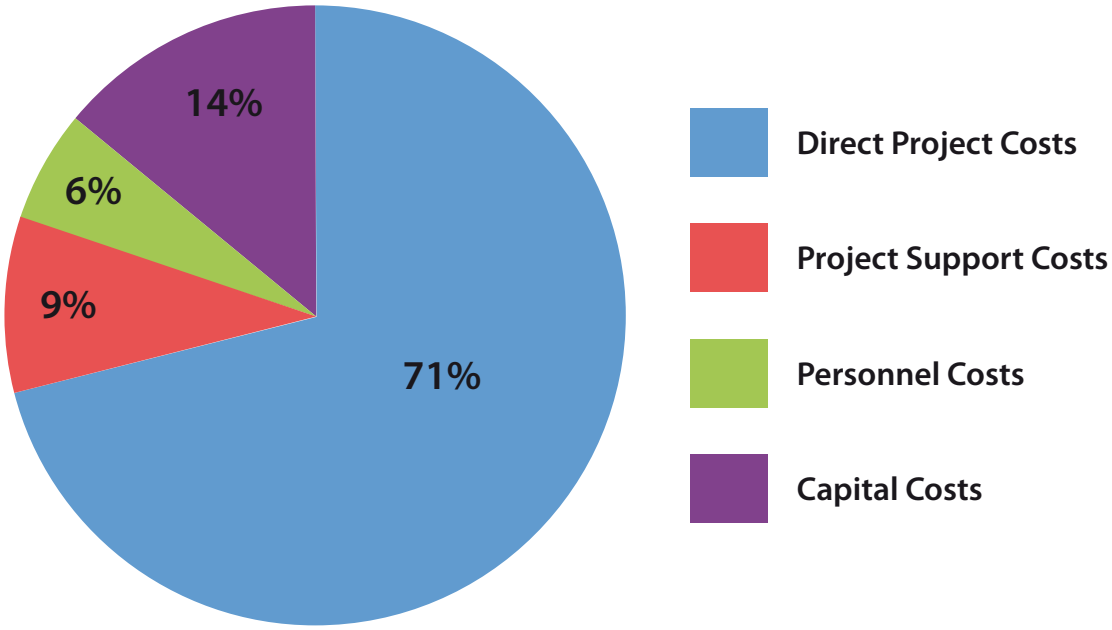
| Donor | Project Name | Funding October 2010 - Sept 2011 | Funding October 2009 - Sept 2010 |
|---|---|---|---|
| **Cordaid** | Accelerating uptake of postpartum care and child health including early infant HIV diagnosis | 149,106,973 | 123,616,226 |
| **Benard Van Leer Foundation** | Home grown resources for enhancing Child nutrition, Early childhood education and Child protection in poor fishing communities | 400,034,580 | 125,606,704 |
| **Institute for Communication and Development (IICD)** | Using ICT to Accelerate uptake of postpartum and child health including early infant HIV diagnosis | 169,267,140 | 0 |
| **MIVA Switzerland** | Purchase a double cabin | 37,000,000 | 0 |
| **Total** | | **755,408,693** | **249,222,930** |

***Expenditure by activity***

| Activity | Actual 2011 | % Performance | Actual 2010 | % performance |
|---|---|---|---|---|
| **Direct Program Costs** | 538,704,167 | 71% | 160,958,814 | 66% |
| **Project Support Costs** | 66,360,183 | 9% | 37,966,003 | 16% |
| **Personnel Costs** | 42,358,000 | 6% | 45,900,000 | 18% |
| **Capital Costs** | 108,049,343 | 14% | 0 | 0 |
| **Total** | **755,408,693** | **100%** | **244,824,817** | **100%** |

In 2011, we received more funds than the previous year. Benard Van Leer and Miva Switzerland contributed funds for the organisation vehicle.

***A Pie Chart showing Expenditures for the year 2011***



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