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HOSPICE JINJA 1st ANNUAL REPORT

July 2005 – June 2006

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ADMINISTRATION AT HOSPICE JINJA

Introduction

Hospice Jinja is a registered Community Based Organisation (CBO). Hospice seeks to provide Palliative Care and Support services to terminally ill patients from all over the Busoga region (Jinja, Iganga, Kamuli, and Mayuge). We largely offer symptom and pain relief, counseling, spiritual and physical, psychosocial support, Health education, to the patients and their family. Dr. Amandua, a Commissioner from the ministry of Health who represented the Minister, officially launched Rays of Hope Hospice-Jinja on 8 August 2005.



Opening Hospice Jinja

Hospice Jinja is located in Jinja Municipality East and it is located on Kyagwe Avenue, Plot 11 in the District Directorate of Health Services (DDHS) Premises. Jinja is located in the South Eastern Uganda. We are located in a relatively high population density of 643 per square km. The average household size is 4.5, the Average population growth rate is 2.4% (2% rural & 2.8% urban) with a youthful dependant population (50% of the population is under 15years of age.) male ratio is approximately 1:1 (96:100).

HOSPICE JINJA was founded by the Rev. Daniel Situka (a descendant of Busoga but presently resident in the United States of America) in partnership with palliative care of Uganda.

STAFF

Ms Elizabeth Nabirye, working with Hospice Africa Uganda, and hailing from Iganga Busoga, technically help us to implement the vision of hospice Jinja.

The Medical team: (4) This consists of two palliative care specialists who are attached to Jinja Regional Referral Hospital (DR. Namuyuga Miroce) and two on-site nurses (Ns. Betty Ntende and Sr. Maria Gorretti Nakombe, ESOM) who are full time volunteers with the Hospice Jinja Facility. They provided both day today care and home-based patient care services..

The community gets the above referenced through the media; local radio, newspapers and through volunteer's.

In their final agony, all patients need the presence of the priest who prays for them and tries to help them die peacefully. One is Rev Fr. Pitton John and Rev Fr. Silvester Dheyongera

Activities:

- Hospice staff with the coordinator (management meetings)
 - Hospice staff meetings held every Monday morning for the following purposes.
 - Reduce on the communication gaps.
 - Weekly meeting for planning and praying for our patients
1. The goal is to improve the quality of life of patients with their families facing with life threatening illness like cancer and HIV/AIDS, by using a holistic approach.

2. The objectives:
 - ❖ To establish and operate a hospice home based program.
 - ❖ To operate and conduct Conventions, Conferences, workshops for enhancing skills relating to palliative care education and end of life care symptoms management.
 - ❖ To establish, operate care facilities, and mobile Hospice clinics within Busoga Region.
 - ❖ To solicit, receive funding and acquire expert personnel, equipment and property both movable and immovable to enhance and promote palliative care to the community.

3. Our Core values is to
 - Pain/ Symptom assessment and control of our patients
 - Offer them out patient care
 - Home Care
 - Health Education
 - Counseling
 - Bereavement
 - Documentation (Record keeping and Report making)
 - Referral
 - Sensitization
 - Radio program and talk shows

Progress:

1. On 19 December- 2005 Hospice Jinja received visitors from the Himalayan Institute and VITAS. As they came to Jinja, Ms. Rose Kiwanuka and Dr. Ddungu Henry, all from Hospice Africa Uganda, accompanied them. The American Visitors were; Kristino Vaccaro, Pandirrit Rajmaui, Meaza Tiganant, Alat Tiyanai, Astrid Vaccaro, Kalpawa Mistry and Suelly. Dr Dungu Henry, Rose Kiwanuka. After meeting the patients, the visitors were so moved to see the plight of our patient. They gave the Hospice Jinja and patients Xamsa gifts, like bags, shirts and cheques worth US\$3500.



Hospice Jinja Staffs and the visitors from Himalayan Institutes and VITAS

2. On the 17th march-2006, we received a visitor from Netherlands who came to volunteer with us for three weeks. Ms. Rinty Plukklee a companied by Sylvia.



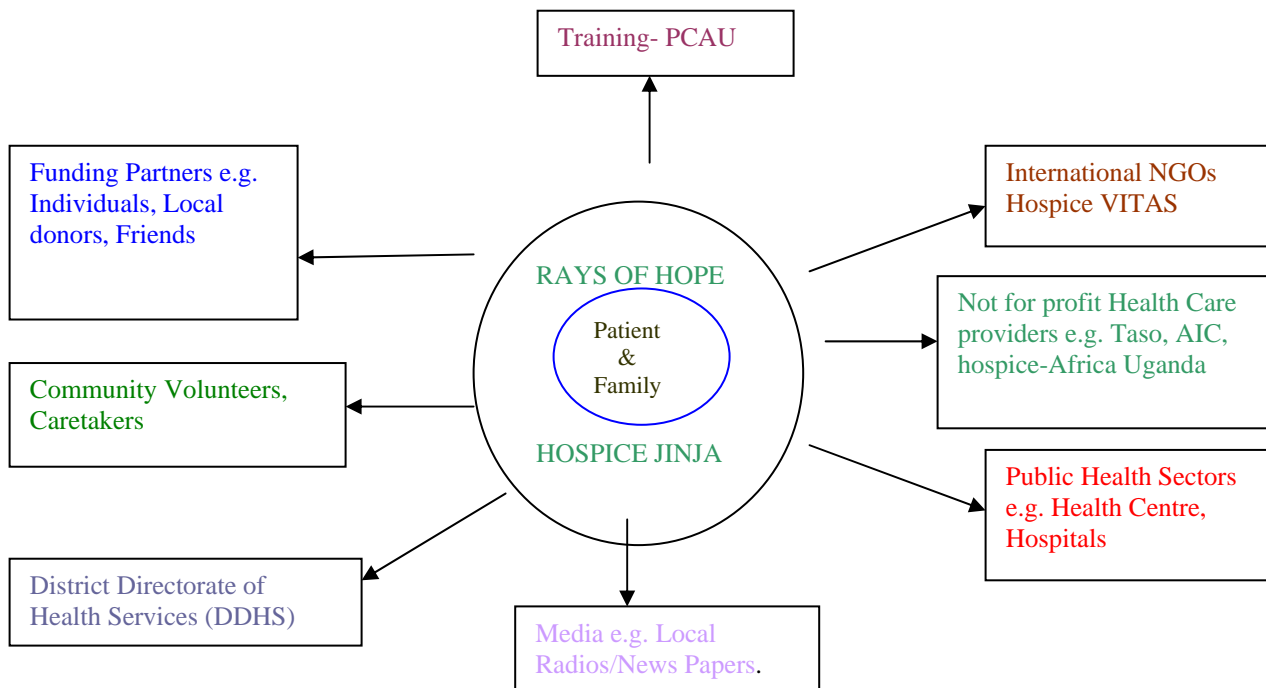
Ms.Rinty, Jackson, a hospice Jinja social worker in the field and one of our clients (widow) families

3. PCAU members at an update meeting organised by the PCAU Secretariat, Ms Rose Kiwanka On the 20th May 2006.
4. On the 16th June- 06 Ms. Kiwanuka from Palliative Association of Uganda accompanied Ms Daniela Aida Stevens, MA Advocacy Officer and technical Assistant Coordinator from the Foundation for Hospices in Sub-Saharan Africa.
5. Hospice Jinja participated in the Palliative care week. One talk show was conducted on local Radio Station Kiira FM. Because of the Palliative Care week, there was an increase in patient referrals and improved referral system by private clinics.

COLLABORATION AND NETWORKING

Hospice Jinja networks with Jinja Hospital/Hospice, Taso, AIC and some health centers within Jinja Municipal Council to provide support and care towards the terminally ill patients and their families. The programme to interact with other health organizations is still in progress.

The medical team works closely with the community volunteers, who sensitize their communities about palliative care services, identify patients that need the services and refer patients to Hospice Jinja. Most of our cancer and HIV/AIDS patients are at home at this time. We also encourage this because it is easy to manage patients in their homes with modern methods of pain and symptom control. However, in some cases we lose some of the patients due to our lack of transportation to visit them.



1.PATIENTS' STATISTICS.

A total of 145 patients were registered at Hospice Jinja between the months of August 2005 – June 2006 These included Cancer, HIV/AIDS, Cancer + HIV/AIDS, and others. The distribution is as shown in Table I below.

TABLE 1: **SITE OF CARE**

| SITE OF CARE | NUMBER OF PATIENTS SEEN | | | | | | | | | | | |
|--------------|-------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN |
| HOSPICE | 0 | 8 | 21 | 16 | 9 | 22 | 11 | 20 | 21 | 16 | 36 | 23 |
| HOME | 0 | - | 1 | 2 | 5 | 13 | 0 | 2 | 8 | 7 | 2 | 10 |
| Hospital | 0 | 0 | 8 | 5 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL | 0 | 8 | 30 | 23 | 15 | 35 | 11 | 22 | 29 | 23 | 38 | 33 |

TABLE II: **DIAGNOSIS**

| DIAGNOSIS | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN |
|-------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| CANCER | 0 | 3 | 9 | 6 | 4 | 7 | 2 | 1 | 2 | 7 | 10 | 1 |
| HIV/AIDS | 0 | 2 | 8 | 12 | 8 | 22 | 6 | 2 | 21 | 2 | 12 | 0 |
| HIV/AIDS + CANCER | 0 | 1 | 2 | 2 | - | 4 | 0 | 0 | 0 | 1 | 1 | 0 |
| OTHERS | 0 | 2 | 11 | 3 | 3 | 3 | 3 | 17 | 6 | 13 | 13 | 32 |
| TOTAL | 0 | 8 | 30 | 23 | 15 | 35 | 11 | 22 | 29 | 23 | 36 | 1 |

NOTE: OTHERS; Includes Patients with unknown diagnosis and those with condition associated with severe pain or other distressing symptom

TABLE III: **ON ART AND NOT ON ART**

| ANTI-RETRO VIRAL THERAPY | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN |
|--------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| ON ART | 0 | 2 | 3 | 5 | 1 | 11 | 3 | 0 | 0 | 2 | 0 | 0 |
| NOT ON ART | 0 | 1 | 6 | 10 | 7 | 15 | 3 | 2 | 3 | 0 | 2 | 0 |
| TOTAL | 0 | 3 | 9 | 15 | 8 | 26 | 6 | 2 | 3 | 2 | 2 | 0 |

TABLE IV: **SEX DIFFERENCE**

| SEX | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN |
|--------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| FEMALE | 5 | 4 | 32 | 38 | 33 | 76 | 50 | 13 | 14 | 11 | 18 | 20 |
| MALE | 2 | 10 | 14 | 34 | 17 | 25 | 20 | 9 | 15 | 12 | 20 | 13 |
| TOTAL | 7 | 14 | 46 | 72 | 50 | 101 | 70 | 22 | 29 | 23 | 38 | 33 |

TABLE V: DEATHS

| SEX | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN |
|--------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| FEMALE | 0 | 0 | 0 | 2 | 1 | 3 | 1 | 1 | 1 | 2 | 0 | 0 |
| MALE | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 4 | 3 | 1 |
| TOTAL | 0 | 0 | 0 | 3 | 1 | 4 | 1 | 2 | 1 | 6 | 5 | 1 |

TABLE VI: NURSE TO PATIENT RATIO

| | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN |
|--------|-----|-----|------|------|------|------|------|------|------|------|------|------|
| NURSES | 1:4 | 1:7 | 1:23 | 1:36 | 1:25 | 1:51 | 1:35 | 1:11 | 1:15 | 1:12 | 1:16 | 1:17 |

PATIENT'S STORY:

DOREEN: aged 17 years was a total orphan born in Mbarara district, Western part of Uganda. She got married at the age of 14 in Busoga Jinja and had one child who was 2 years old by the time she became a client of Hospice Jinja.

Doreen developed the cancer of the left leg and due to the conditions i.e. much swelling, huge wound and offensive smell accompanied by pain, the husband abandoned her.

Her friend who became the main career for her plus the child of two years who already had signs of Kwashiorkor took Doreen. The friend took her to Jinja Regional Referral Hospital where they stayed for one month. They left the hospital after seeing that there was no change for all that period. They went home at Mpumudde Jinja where the friend was residing. Doreen and the friend had no more hope since the conditions worsened everyday. This was until one of our community volunteers identified her and referred them to Hospice Jinja on 5th December 2005.

The hospice received Doreen on her first visit with love and care though the smell chased some of the people who were at the premises that time and others even vomited.

Hospice managed to control pain, smell and handled even other psychosocial problems she had. We visited her weekly because she needed constant medication, dressings of the wound, counseling and monitoring.

In a period of two weeks, there was an improvement because the pain and smell had subsided and people could at least sit near her as you can see below



Doreen's quality of life was generally improved after handling all her physical, emotional, spiritual and psychosocial problems. She was now comfortable and smiling.

However, the careers when they saw that there was an improvement took her back to the husband where unfortunately she stayed for two weeks and died. That was in early April 2006. May her soul rest in peace

A Patient,

I praise God that I am still alive. For sure, this is a result of efforts of Hospice Jinja because they met me in critical condition and I had lost hope. It was in 1998 when I started getting multiple boils and lesions all over the body. In 1999, I went for HIV/Aids test and the results came out positive. I was advised to go to Taso Jinja for medical care.

In 2005, I developed a dry cough and evening fevers, which made me weak. I went for TB test and it was positive. Immediately I was also advised to go for CD4 cell count test, which was very low. Therefore, I was put on TB treatment and eventually put on ARVs. Their effects made the situation worse than even before because I had poor diet yet the drugs were very strong. I developed swelling of the lower limbs burning feet and constant headache. I could some times buy ice block and put on my feet because of burning but could not help.

On addition to that, I had many thoughts, which increased my pain day and night. I was worried of my young children who were soon becoming total orphans, the friends who had abandoned me and the sources of income, which were cut off. Yet my two children are very young, one is 14 years and another is 8 years old. This was until the community volunteer introduced me to Hospice Jinja team who showed me mother love and care. The team of (Nurses and a social worker) came to me at home, assessed my pain and other needs I had. They gave me drugs and counseling. They left me that day when at least I was a bit relieved as most of my needs were addressed. They then started to visit me weekly. They enabled me to complete the TB treatment and supported me to continue with ARVs. The lesions subsided and now I have a smooth and beautiful skin. Any problem I get I just call them and they respond. Now I feel comfortable and I have started doing some simple work to support my family.

Sincerely I look at Hospice team as people who picked me from the coffin.

May God bless Hospice Jinja team for the good work?

2. Experience /Challenges

- i. There are many patients in need of palliative care services in and outside the catchments area.
- ii. Our means to help the patients is very limited. We cannot reach them because of lack of transport. We serve only those who can reach HOSPICE or those living in walk able distances.
- iii. Cancer and end-stage AIDS patients are very poor as they have drained resources on treatment therefore many of them cannot afford the cost sharing of 5,000/= Ugshs, and our funding limits us to offer support and comfort.
- iv. Resources for patients care and comfort like - food, clothing is not there. Most of our patients live in very poor conditions some without shelter and relatives to support them.
- v. It is very distressing to the family and the medical team when a patient dies and bereavement is not carried out.
- vi. Day care programmes have not been initiated due to financial constraints yet this is a programme, which pulls patient together and share experiences / ideas to encourage one another.

3. Impact of having no medicine

- i. Once one's pain is considered controlled with regular medicine, the policy of palliative care does not allow the patient to go back to pain. Therefore, when the drugs for pain control run-out of stock, patients go back to their previous pain or even worse pain, which is very difficult to manage and control again. This becomes very distressing to the patients and their families as well as the medical team.
- ii. Quality of life of these patients and their families are at stake e.g. some drugs to control other symptoms apart from pain killers are also essential like drugs for infections if not available; some patients having nasty symptoms remain with them affecting their quality of life.
- iii. Lack of drugs is a very distressing issue to both the patients and the nurses.

4. Impact of NOT having our own transport

- i. Not all patients live by the roadside; one has to foot 4-5km to reach the patient's home after using the public transport.

- ii. The staff comes back late to the unit when other patients have waited and become tired.
- iii. Re-assessment is impossible in cases where long journeys are involved.
The medical team fails to go back.
- iv. Some patients are in conditions that cannot enable them to use public means to Hospice yet they need the services.
- v. It is very expensive to hire a taxi or boda-boda for either half or one day.
- vi. It is hard to serve well those patients coming from far away.

Here is the means of transport being used to reach our clients



Ruth a widow, 60 years old with a huge malignant tumor, which is septic and offensive. Ruth needed dressing twice a day because of the septic wounds, which oozes pus. Rays of hope Hospice Jinja is facing a big challenge to visit her daily since it has no transport.



5. Examples of critical cases handled.

Such patients are primarily found in villages in much pain without being diagnosed, no access to drugs, Radiotherapy or chemotherapy.



Moses 29 ,a years old a refuge from Rwanda. He was referred to Hospice from Jinja Regional Referral Hospital with a diagnosis of cancer of the liver. By the time he came to Hospice, Moses had a paracentesis abdominis and severe pain.

Moses was in hospital with no career, relatives, and even had no money to purchase the medicine that was prescribed for him in the hospital.

Hospice Jinja provided him with the drugs as prescribed relieved the pain and Fr. Piton John volunteered to cater for his cost sharing, welfare and his transport for abdominal tapping every week.

Here is Moses and a palliative care nurse of Hospice Jinja smiling and very appreciative.



These show a need for an in-patient unit. Many of these patient are send home to dies but some do not make it, they dies in the grounds of the hospital in the hands of helpless family members.

The emotional, spiritual and psychosocial needs are also accessed and addressed by the palliative care social worker as seen.



This picture shows home based care being administered to patients in their own homes by the palliative care team.

She is an HIV/AIDS patient with KS, in poor state, cannot afford buying food and drugs. She is under palliative care by Rays of Hope Hospice Jinja. The little girl you see is the main career.



Challenge of the children's need

Hospice also helps identify organizations and sponsors for the orphans/Vulnerable Children of our clients. Below are Hospice Jinja social workers in the field following up some of the enrolled children in their homes and at school. This helps to find out more of a child's problems and to give them the psychosocial support to help them cope up with the situation that as be fallen them at that tender age.



Bena and Jackson in the field

FINANCIAL REPORT: JULY 2005 TO JUNE 2006

For one year of our existence, the total income is 10,135,336 having 9% from local contributions and 91% from international contributions.

Local contributions are the contributions made by the individuals, the community, well wishes, and friends here locally at home. So far, we have the following as our local contributors.

- The community: The District Directorate of Health has rendered part of its premises to Hospice Jinja with all its utilities, i.e. Electricity, water, with non-rental fee that Hospice at present is occupying.
- Volunteers did the day-to-day running and maintenance.
- Hospice Africa Uganda: Through Dr. Anne, Hospice Africa acts as our over seers because whenever there is any need, they call in very fast to help. For instance, Drugs were supplied to Hospice Jinja on credit, the Setting of Hospice Jinja; one staff was sent from Hospice Africa to work with the volunteer staff, the advocacy, through radio programs was sponsored by Hospice Africa, and still more help from Hospice Africa is rendered to us to mention but a few.
- The volunteer staffs; work directly in patient care without allowances.
- Individual contributions from friends and well wishes contribute both material and spiritual support to these patients.
- We also received contributions from the patient towards users' charge. Patients who come to Hospice Jinja are expected to contribute a fee of Ushs. 5,000 towards their treatment and maintenance, But because of some other factors as seen below this contribution is poorly made.

COMPUTATION OF PATEINT CONTRIBUTION

| Month | Amount | Number of Patients | No. of patients who paid | No. of Patients with non payment |
|----------------|----------------|--------------------|--------------------------|----------------------------------|
| July 2005 | - | 7 | - | 7(100%) |
| August 2005 | 25,000 | 14 | 05(36%) | 9(64%) |
| September 2005 | 55,000 | 46 | 12(26%) | 34(74%) |
| October 2005 | 62,500 | 72 | 15(21%) | 57(79%) |
| November 2005 | 64,000 | 50 | 16 (32%) | 34(68%) |
| December 2005 | 83,000 | 102 | 15(32%) | 87(85%) |
| January 2006 | 102,000 | 70 | 20(29%) | 50 (71%) |
| February 2006 | 72,000 | 22 | 14 (64%) | 8 (36%) |
| March 2006 | 54,000 | 29 | 11(38%) | 18(62%) |
| April 2006 | 106,000 | 23 | 21 (91%) | 2(9%) |
| May 2006 | 155,000 | 38 | 31 (81%) | 7(19%) |
| June 2006 | 179,500 | 33 | 33(100) | - |
| TOTAL: | 958,000 | 506 | 193(38%) | 313(61%) |

From the above figure shown, the total number of patients seen last year as regards to the contributions per visit is reflected and having 38% of patients who contribute and 61% who can not give patient contributions.

The following are the factors that affect the variation of patient contributions

1. Poverty: Generally, these patients are very poor to contribution because they are terminally ill that they can no longer do any job to earn a living since they are bed ridden. In addition, in most cases they are breadwinners in the family.
2. Nature of sickness: The ratio of cancer to HIV/AIDS patients in terms of payment is greater in that Cancer patients are much more willing to contribute than AIDS patients.
3. Distance: Most patients come from rural areas to hospice, which is located in urban area city of Jinja. Transport affects these patients in that some cannot afford to pay the transport fee to town, and others cannot manage to travel in the poor condition of means of transport or the bad roads because of their state of conditions.
4. Climatic Conditions; during rainy season, many diseases come up because of the runny water lodging breathing spaces for mosquitoes, which cause malaria, pneumonia and other diseases, and in mainly with HIV/AIDS patients this whether harbors the opportunistic infection.
5. International Contributions: About 91% of our income is from external donation from Friends and well-wishers from U.S.A through Rev. Situka Daniel together with his personal contributions. For instance the visiting team from Wings of Hope U.S.A. and the Coordinator for FHSSA Daniela Stevens.
6. Our sincerer gratitude to the above mentioned individual and all other people who contributed here. We hope that the community, well-wishes and friends of Hospice Jinja continue to join hands together to support this palliative care provider in this region through generous continuous contributions.

However, despite the fact, the organization is trying hard to minimize its expenditures to fit the available funds received from the above incoming resources, as we see here below in the Annual financial statement and the last Quarterly financial report.

**INCOME AND EXPENDITURE SUMMARY FOR THE
YEAR ENDED 31 JUNE 2006**

| Particulars | INCOME | EXPENDITURE |
|---|-------------------|--------------------|
| INCOME | | |
| Local loan | (9,914,600) | |
| Rev. Daniel Situka | 3,875,700 | |
| Users Charge | 958,500 | |
| Membership fee | 50,000 | |
| Hospice Jinja Friends USA Wings of Hope | 5,250,000 | |
| Hospice Africa-(Creditor) | (405,775) | |
| Bank Interest | 1,136 | |
| TOTAL | 20,455,711 | |
| EXPENSES | | |
| Patient care | | |
| Office | | 953,350 |
| Transport | | 4,985,650 |
| Drugs | | 847,190 |
| Staff costs | | 5,730,200 |
| Sub total | | 8,516,390 |
| Management & Administration | | |
| Assets | | 1,288,900 |
| Maintenance | | 648,100 |
| August conference (meetings) | | 994,500 |
| Electricity | | 416,000 |
| Renovation | | 1,015,000 |
| Membership fee | | 50,000 |
| Fundraising | | 3,130,980 |
| Loose on exchange/Bank charges | | 94,087 |
| Sub total | | 11,637,567 |
| TOTAL EXPENDITURE | | |
| Balance at hand and Bank as at 31st June,06 | | 287,769 |

31ST APRIL 2006 TO 31ST JUNE 2006

| Particulars | Apr-06 | May-06 | Jun-06 | Totals |
|--|------------------|------------------|----------------|------------------|
| INCOME: | | | | |
| Balance b/f : Cash at hand 31st March,2006 | 78,700 | | | |
| :Bank A/C No. 5204223019 | 1,009,976 | | | |
| Rev. Daniel Situka | - | 904,400 | - | 904,400 |
| Fr. Mubiru Peter | - | 900,000 | - | 900,000 |
| Patients contributions | 106,000 | 155,000 | 179,500 | 440,500 |
| Creditors - Drugs supplied by Hospice Africa | - | 405,775 | - | |
| Bank Interest | - | - | 463 | 463 |
| Total Income | 1,194,676 | 2,365,175 | 179,963 | 3,739,814 |
| EXPENSES: | | | | |
| Direct charitable Expenses | | | | |
| Patient care | | | | |
| Office | 2,000 | 9,500 | 21,200 | 32,700 |
| Transport | 36,900 | 62,200 | 8,100 | 107,200 |
| Staff Costs | 762,700 | 1,654,200 | 137,600 | 2,554,500 |
| Drugs | 18,500 | 405,775 | - | 424,275 |
| Management & Administration | | | | |
| Repairs - Hospice Premises | - | - | - | |
| Coordination and networking | 306,000 | | | 306,000 |
| Transport | - | - | - | |
| Bank deposit | 24,000 | | | 24,000 |
| Bank Charges | | 335 | 3,035 | 3,370 |
| Total expenditure | 1,150,100 | 2,132,010 | 169,935 | 3,452,045 |
| Cash on Hand and Bank as at 31st June 2006 | | | | |
| Allied Bank Jinja Branch A/C No. 5204223019 | | | 204,869 | 204,869 |
| Cash | | | 82,900 | 82,900 |
| Total | | | | 3,739,814 |

FUTURE PLANS FOR RAISING FUNDS FOR HOSPICE JINJA.

1. Our first plan is to develop a donor database from daily acquaintances, co. workers, church members and well-wishers.
2. We plan to have public education about the need through public awareness campaign like public speaking, radio shows, sell of T-Shirts, and hold a charity walk.
3. We plan to recruit volunteers from public and private institutions
4. We plan to have partnership with other sister organization within and in the developed countries.

Appreciation

The Hospice – Jinja team would like to express their sincere gratitude to the programme coordinator, Rev Daniel, PCAU National Office Hospice Africa Uganda and all well-wishers who are working day and night tirelessly so that Hospice Jinja continues to provide services of palliative care to those patients and their families facing life-threatening illness.

You are invited to apply to be a member of Hospice Jinja.

HOSPICE JINJA REGISTRATION (MEMBERSHIP) FORM

Qualities of Members:

1. Should have the aim and aspirations of Hospice Jinja at heart and want to support the total care of dying patients throughout Uganda.
2. **Membership Fee**
3. **One time gift**

| | |
|---------------------|---------------------------|
| Students | 5,000/= per annum (\$3) |
| Annual Ordinary fee | 10,000/= per annum (\$10) |
| Life membership | 1.700,000/= (\$1000) |
| | |

MEMBERS WILL RECEIVE:

1. A Membership card
2. Voting rights for the Board Members
3. Notification of events taking place at Hospice
4. Quarterly Newsletter

APPLICATION FORM: (tick relevant box)

- I wish to become a paid up Ordinary member of Hospice Jinja.
- I wish to become a Life Member
-

Name Address.....

Tel No Occupation

Previous exposure to Hospice:

- Through patient or Family:
- Through Volunteering:
- Through Training Course
- Other (please state):

Please give ideas about how you could help us (not a requirement of membership)

.....

.....

.....

Please return this form, with payment and two passport photos:

The Coordinator, Hospice Jinja, P.O.BOX 830 Jinja
 TEL: 043-4122-924, Email: hospicejinja@yahoo.co.uk

Signed: Date:.....