Kudvumisa Clinic

Maphiveni Community Clinic and Education Centre

a continuation of the Children's HIV Intervention Programme in Swaziland (CHIPS) outreach in eastern Swaziland

KUDVUMISA is 'to praise' in siSwati. Kudvumisa Clinic will be a place where the people of Maphiveni and Vuvulane can receive hope, healing, and health in Christ's name.

Executive Summary

Swaziland holds the dubious and sad distinction of the country with the highest HIV infection rate in the world. Compounded with sub-Saharan Africa's typical poor allocation of services and funds, the isolated and impoverished communities in this country have no way to access the even nominal health care available in the city centres.

In 2008, an outreach was initiated to make the available care accessible to one community in eastern Swaziland. Proactively targeting the HIV infected population of children and their caregivers, the Programme reached capacity in three short years. By providing transport services to the closest functional health centre and pushing as much of the medical services into the local communities as possible, CHIPS (for Children's HIV Intervention Programme in Swaziland) has made it possible for hundreds of children and caregivers to access lifesaving anti-retroviral treatment (ART) for HIV and many of the other opportunistic diseases associated with HIV.

Once patients on ART have begun to stabilize, many other health issues begin to manifest that must also be treated or managed. CHIPS client's access to the health system continues even when they have become stable thru ART.

There are still thousands in the communities CHIPS operates in that cannot be helped.

The government of Swaziland is pushing for decentralization of health services. Unfortunately, it has neither the capacity nor financial ability to do this on a significant scale. We propose developing a clinic in Maphiveni that can provide most of the services now only available in the closest health centre; pushing more services into the local community. Developed incrementally, the local clinic would ultimately provide comprehensive health services to the entire population of this area.

The most important question to ask is: "How is this clinic/community centre sustainable?" Any project that relies solely on donor funding to operate is doomed to collapse at some point. We have the opportunity through the purchase of a property in Maphiveni to both house the clinic and develop commercial lease income that will be dedicated for the long term operational costs of the clinic/community centre.

The purchase price of the property (including transfer fees) is E3 190 000 ($319 000 USD[1]). An additional E1 000 000 ($100 000 USD) is being sought for renovation for the commercial development.

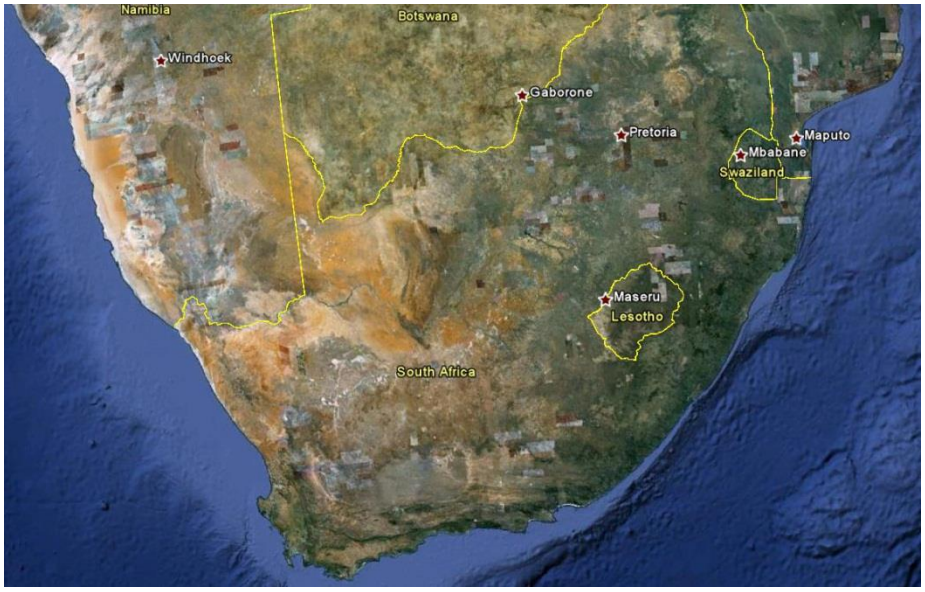
[1] Using an exchange rate of 10:1

Contents

Background

Swaziland[2]

Autonomy for the Swazis of southern Africa was guaranteed by the British in the late 19th century; independence was granted in 1968. Student and labour unrest during the 1990s pressured King MSWATI III, the world's last absolute monarch, to grudgingly allow political reform and greater democracy. A constitution came into effect in 2006. Talks over the constitution broke down between the government and progressive groups in 2007.



Swaziland is land locked, surrounded completely by South Africa on the west, north and south and Mozambique on the east. It is slightly smaller than the U.S. state of New Jersey at 17364 sq km (6704 sq miles). The climate varies from temperate in the mountainous high veld to tropical in the sloping plains of the low veld.

Swaziland is made up of a single tribal group. The 2011 estimated population is almost 1.4 million with the median age at 20.3 years. Infant mortality stands at 6.309% and life expectancy at birth is 48.66 years. Swaziland recently surpassed Botswana as the country with the world's highest known HIV/AIDS prevalence rate with an adult HIV prevalence rate of 25.9% and an estimated 180000 people living with HIV/AIDS. 31% of the population do not have access to improved water sources and 45% of the population do not have access to improved sanitation facilities. 79% of the population live in the rural areas of the country. 40% of the population would be considered 'Zionist' which is a blend of Christianity and indigenous ancestral worship.

Subsistence agriculture occupies approximately 70% of the population. The manufacturing sector has diversified since the mid-1980s. Sugar and wood pulp were major foreign exchange earners; however, the wood pulp producer closed in January 2010, and sugar is now the main export earner. In 2007, the sugar industry increased efficiency through mechanization (with resulting large scale furloughs) and

[2] https://cia.gov/library/publications/the-world-factbook/geos/wz.html

diversification efforts, in response to a 17% decline in EU sugar prices. Mining has declined in importance in recent years with only coal and quarry stone mines remaining active. Swaziland is heavily dependent on South Africa from which it receives more than 90% of its imports and to which it sends 60% of its exports. Swaziland's currency is pegged to the South African rand, subsuming Swaziland's monetary policy to South Africa. The government is heavily dependent on customs duties from the Southern African Customs Union (SACU), and worker remittances from South Africa substantially supplement domestically earned income. The government has also legislated that 30% of local pension funds need to be invested in Swaziland, boosting demand for government bonds. Customs revenues plummeted due to the global economic crisis and a drop in South African imports. The resulting decline in revenue has pushed the country into a fiscal crisis. The government has requested assistance from the IMF and from the African Development Bank. With an estimated 40% unemployment rate, Swaziland's need to increase the number and size of small and medium enterprises and attract foreign direct investment is acute. Overgrazing, soil depletion, drought, and floods persist as problems for the future. More than one-fourth of the population needed emergency food aid in 2006-07 because of drought.

Maphiveni

Located in the low veld on the north-eastern side of Swaziland, approximately 20km (12.5 miles) from the Lomahasha border with Mozambique, the population of Maphiveni is approximately 4000.

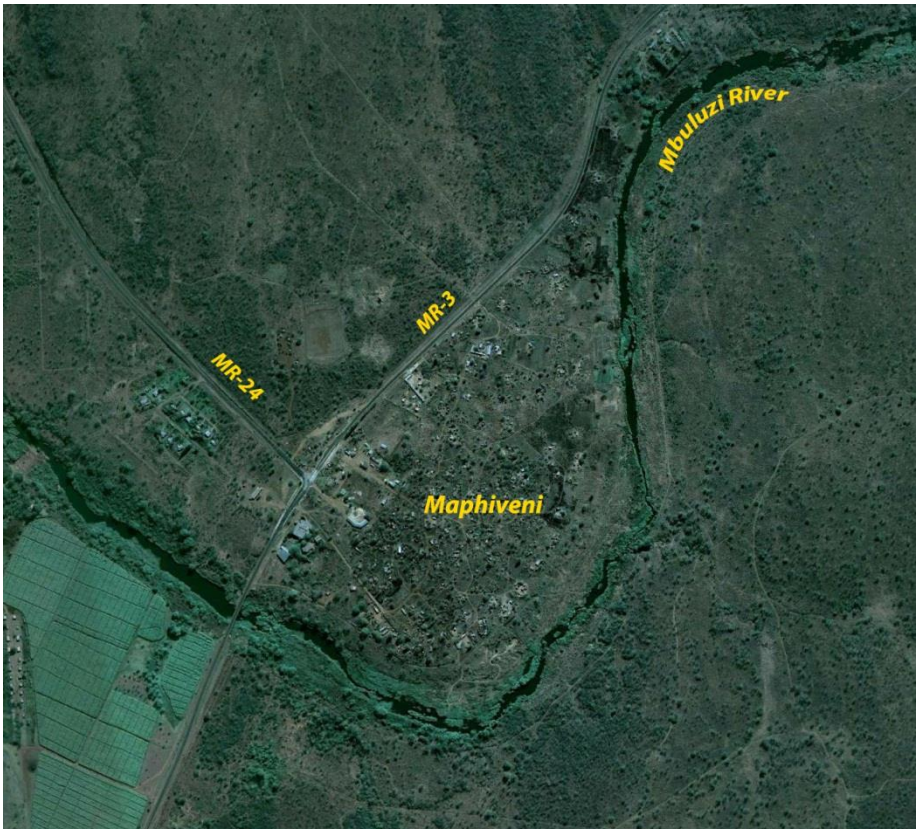
With its proximity to Mozambique and located just outside several sugar plantations, the population is made of a combination of displaced cane workers or their families and displaced Mozambicans (Mozambique fought a civil war that was concluded in 1992). While employed in the cane fields, housing is provided on the plantations (including the family). However, if someone is no longer employed (death, sickness,

redundancy (layoffs), etc.) the ex-employee and family have to leave the plantation. Many with nowhere else to go settled in Maphiveni. The large scale furloughs in 2007 also contributed to the population in Maphiveni as many of the workers and their families had nowhere else to go.

In typical rural Swaziland, each homestead is allocated enough land for subsistence farming. The Maphiveni area is bounded on the east by the Mbuluzi River and on the west by the main road to the border. There is a much higher than typical population density here with homesteads set aside with very little space even for a small garden.

Maphiveni

Background



Maphiveni is situated along the main road to the Mozambican border and the intersection of the main roads between the various sugar cane plantations. Unemployment is very high as there is very little work locally. Some enterprising residents cater to the thru traffic by selling fruits and snacks. There is an army checkpoint on the main road here that all traffic coming from the east must stop, disembark and be searched.

Poverty is rampant here and visible in the condition of houses, clothing, and general health. Prostitution is also common here because of the high volume of truck traffic associated with the sugar cane plantations and trade between Mozambique. There are few other opportunities for employment. A woman who chooses to become a 'sex worker' here can make more in a day that most people here will see all month. The lack of choices leading to the final decision to sell yourself to be able to afford basic necessities like food and shelter speaks volumes of the general condition of this area.

The winter is the dry season in Swaziland. There is typically no (or inconsequential amounts) of rain from April through September each year. Since this area is in the low veld, planting could continue year round. But as most residents here lack the resources to irrigate from the nearby Mbuluzi River, even that opportunity is lost.

Drinking water is sourced from the river. Even gathering water from the river is dangerous as crocodiles are present and periodically do take people collecting water. The water is at times obviously polluted from the sugar mills upstream, but is always polluted from run off from the fields and animal and human faecal matter. Water borne illnesses are common here. Simple purification methods are financially out of the reach of most residents: bleach or extra firewood for boiling water are commodities beyond the financial reach of most.

While there is government mandated free primary education through grade 3, there are no primary schools in or close to Maphiveni. The closest functional public health centre is in Siteki (Good Shepherd Hospital) approximately 50 km (31 miles) distant.

Maphiveni is isolated and marginalized: there are very few services offered (infrequently) by either government or NGO's.

HIV + Poverty = Hopelessness

There are cultural and social factors that contribute to the high HIV prevalence in Swaziland. Many millions of dollars have been spent studying this issue and implementing fixes: most have failed. An education programme begun years ago ensures almost every Swazi is aware of HIV and how it is transmitted. But behaviour has not changed. In Maphiveni, this is compounded by a hopelessness and fatalism magnified by isolation, poverty, and marginalisation. Untreated HIV typically progresses from infection to death in 5 to 10 years.

The ability to work, even at low wage general labour and small scale farming ensure that a family can survive under typical circumstances. However, the ability of an infected person to work decreases as an HIV infection progresses to AIDS. The body becomes progressively weaker as multiple and recurring illnesses (such as TB, bacterial pneumonia, etc.) take their effect. As a provider loses the ability to work for even minimal wages or labour for food, they lose the ability to buy or grow what food they could before. Malnutrition decreases the ability to work even more. Malnutrition in entire households becomes common.

In children born with HIV, the prognosis is even worse. Without comprehensive intervention and support, the morbidity and mortality rates of HIV+ children are dire. Current statistics[3] indicate that 66% of children will not receive the anti-retroviral medications and support they need. As a result they will die. The mortality rate of children born with HIV who remain untreated is 85% by 10 years of age.

Because of the high cost of obtaining transport to and from the closest functional health centres most people living outside the catchments of the main government hospitals are in effect excluded from accessing the services available there. The paucity of both rural clinics and motivated staff at these clinics provides no relief. Up to 6 trips to the health centre may be required before a patient is initiated on ART.

[3] 4 August 2008, "Introduction to Paediatric HIV Care" Baylor College of Medicine and the Baylor International Paediatric AIDS Initiative

These trips are necessary for drawing blood (for CD4 and liver function), HIV counselling (how to live with HIV), adherence counselling (why it is critical to take your drugs as scheduled and never miss a dose), and chest x-rays (checking for TB is standard practice). Each trip may cost E50 (about $5 USD[4]) using public transport. In 2006, over two thirds (69%) of the population of Swaziland were considered to be living beneath the International Poverty Line (set at $1.25USD per day). These six trips would wipe out the entire budget for a family for over a month. The financial, physical, and emotional burden on a caregiver is beyond what most can afford.

The nationwide mantra has been "Test, test, test; everyone must test; know your status." However, of the countless organizations that provide testing services, none actually provide a way for an impoverished person living in an isolated area to access these health care services required to manage HIV.

Alan Whiteside, a leading HIV researcher in southern Africa, made the following comment in response to the worsening economic climate in Swaziland in 2010:

> *"I think it means that we'll start rationing - it'll be a subtle form of rationing where we'll say we'll provide treatment in Siteki and if you live 30km away you won't get treatment because you won't be able to get there; or, you used to have to wait four hours to see a doctor, now you have to wait 12 and some of you die in the queue,"*
>
> *"We don't have the courage to ration in an explicit manner, so we will do it in an implicit manner.[5]"*

Unfortunately, this has been the reality in Maphiveni for the last ten years.

CHIPS

Caregivers and by default their children living in rural Swaziland do not have the resources to access HIV/AIDS related interventions. These resources include transportation, the knowledge to know why, when and where to go for testing and treatment, symptoms that require immediate interventions, importance of drug adherence, nutritional requirements, and drug storage.

In 2008, CHIPS was organized to identify children in need of testing and to begin the process of counselling with their caregivers to bring the children to testing, then to provide transport to and from health facilities for actual testing, counselling, and treatment for the child and their caregiver. CHIPS would provide long term health care management for the child to ensure adherence and ability to obtain ART Refills.

Initially focused solely on HIV+ children, CHIPS was expanded within its first six months to accommodate HIV+ caregivers regardless of the status of the children in their care.

[4] Exchange rate of 10:1 is used in all calculations in this paper
[5] http://www.plusnews.org/Report.aspx?ReportId=91103

CHIPS 2008-2013

Initial training was performed in the Maphiveni community to teach community health volunteers and teachers to identify children who, based on medical and family histories, may be candidates for HIV testing. In the first year, **232** children were tested for the first time. Of these, **18** were HIV+ and began the process of starting ART. However, in the first year, **217** caregivers were also tested. Of these, **104** were HIV+. **7.8%** vs. **47.9%**. This huge disparity prompted the decision to include caregivers in the CHIPS program. Unaided caregivers would simply mean more orphans in the future.

CHIPS is proactive about ensuring clients adhere to ART and about tracking individual clients' health and appointments. This often translates to searching for a client who is in default of drug adherence or has failed to make appointments. CHIPS transport has also become the *de facto* emergency medical transport from the serviced communities to Good Shepherd Hospital (GSH) in Siteki.

When CHIPS first started operating in Maphiveni, all HIV and health services were sourced from GSH. This required a trip to GSH for each person for every appointment (testing, initial counselling, blood work, adherence counselling, sick, TB tests, drug Refills, etc.). The transport capacity of CHIPS soon reached capacity as the number of CHIPS clients expanded. In addition, the transport burden increased even more as CHIPS expanded coverage into surrounding communities.

To alleviate the transport burden, HIV services that could be pushed back into the community were moved. This included all initial and adherence counselling sessions.

Many of the CHIPS clients who started ART the previous year were now stable. Once a client's health had stabilized and improved to the point where a doctor's intervention was not necessary on a regular basis, the client could be referred to a local clinic for continued adherence checking and ARV Refills. However, the continued lack of motivated government nursing staff at the nearer clinics still proved a road block to pursuing this strategy to reduce the trips necessary to GSH. The staff at GSH and ICAP (Columbia University's International Center for AIDS Care and Treatment Programs in Swaziland) both recognized this problem and moved to help capacitate the nearer clinics. One of their primary motivations was to help facilitate the transfer of CHIPS clients from GSH to these nearer clinics. However, the government nursing staff has still proved unwilling to take on any new or expanded responsibility.

While CHIPS continued to expand into new communities, additional HIV services were also pushed back into the communities. This process of service decentralization allowed CHIPS to expand further into several communities not originally targeted.

While continuing counselling services, HIV testing and drawing of blood for CD4 counts was introduced at the community level.

Even in the confines of the current communities, CHIPS had reached capacity. Based on CHIPS service delivery model and available funding and equipment CHIPS was already operating at near full capacity. There are few open patient seats available for transport to GSH and many patients require appointment changes or alternative transport to accommodate their schedules. CHIPS no longer had the ability to take on new patients or move into new areas.

Claypotts Trust funded CHIPS during this period with a generous grant.

2013-

CHIPS was chosen to receive a grant from USAID/PEPFAR in 2013. Additional staff were hired to implement an expanded version of CHIPS in the original and surrounding communities. Even more services were pushed back into the target communities.

- A nurse hired through the grant provides ARV refills to stable patients in their home community. Prophylactic antibiotics are dispensed to patients who have not yet been initiated on ART.
- The Clinton Health Access Initiative (CHAI) assigned a Point of Care CD4 machine to CHIPS so that CD4 counts can be obtained in the field with CHIPS staff.
- Additional counselling and testing staff were hired to increase the number of people who could be accommodated daily at each field site. With the additional staff, CHIPS was able to open its services to all people in the community regardless of child or caregiver status.

A Memorandum of Understanding (MoU) was signed between Kudvumisa Foundation and the Swaziland Ministry of Health (MoH). The MoU provides the mechanism for CHIPS to become an outreach of the MoH and work as an outreach of Good Shepherd Hospital in Siteki. As well, the MoH is evaluating the CHIPS service delivery model for effectiveness and possible role out in other rural areas.

A new patient transport vehicle was donated by Rotary to replace the aging and decrepit van that was being used. An in-vehicle educational video system is installed to provide educational and motivational messages to the patients as they are being transported between their various communities and Good Shepherd Hospital for services CHIPS is not providing yet.

A mobile clinic was donated by Divinity Lutheran Church in the USA. This mobile unit will be used as the nurse's station for seeing patients.

The Future

Maphiveni and the immediately surrounding communities are unique in that individual homesteads are situated much closer to each other than in typical rural Swaziland. Without extensive investment in additional staff and equipment, this

limits the extent to which the CHIPS service model could be replicated or expanded beyond the these communities.

How, then, to best impact the communities for improved and expanded HIV and general health care? As clients become stable on ART and the immediate crisis of unmanaged HIV has been addressed, longer term health issues surface. These might be hypertension, diabetes, various cancers, STD's, etc. Some of these may be directly related to HIV, some may not. But all must be addressed to attain improved health for rural Swazis.

CHIPS could continue to cover the existing service areas by becoming a general medical transport to GSH. However, costs associated with transport continue to escalate. And as many donor funded programs are learning now, those funds are *not* guaranteed forever. Additionally, the main government hospitals (and clinics) have been overwhelmed by the number of patients seeking treatment for advanced diseases associated with HIV/AIDS as well as the new diseases and chronic conditions of a longer living and stable HIV population. Consequently, effective/compassionate service delivery has become rare. Adding additional burden to an already overstretched health delivery system will compound the problem and continue to stress both the system and patients.

Community Clinic & Education Centre

CHIPS future goals then are twofold:

- to provide quality and compassionate local long term care to a stable HIV population, and
- ultimately to provide quality and compassionate local health care to the entire population regardless of HIV status.

A third goal closely linked to battling HIV and malnutrition is to provide education and economic training to enable the impoverished people of this area to develop profitable businesses and skills.

A local clinic in Maphiveni would reduce the number of patient trips required to GSH, helping relieve the HIV health care delivery bottleneck at GSH. As Maphiveni is on the main road between the sugar plantations and the border, this local clinic could easily serve the isolated communities and homesteads located between the border and the sugar plantations.

Clinic – Phase 1 (Year 1-2)

The clinic would be open to the entire HIV+ population in the surrounding communities providing nurse-led ART initiation and refills.

Current CHIPS staff would continue providing proactive counselling and testing services in the community and providing transport where necessary to the local clinic or for clients requiring doctor attention to GSH. Additionally, they would assist in clinic functions such as drug adherence checking and counselling. A qualified nurse will staff the clinic.

Estimated 200 in-clinic client contacts per month.

Clinic – Phase 2 (Year 2-3)

A major issue with service delivery strain will occur as the HIV population stabilizes and begins to require care for diseases and chronic conditions that may not be related to the HIV infection. Beyond direct HIV care, the clinic would provide holistic health care to the HIV+ population.

Staff would be added to facilitate finding clients who fail to show for scheduled ART refills or appointments, performing home visits, continue in proactive community counselling and testing, clinic help and providing transport.

Estimated 500 in-clinic client contacts per month.

Clinic – Phase 3 (Year 4)

The final stage in the clinic development is to open the clinic services to the entire community regardless of client HIV status.

Additional nursing staff and a doctor would be added to the clinic.

Estimated 700 in-clinic client contacts per month.

Education Centre

The outreach facility would serve as a focal point for individual empowerment by offering, *inter alia*, adult literacy classes, support groups, training for income generation projects, and nutrition, health, and water and food security education. An outreach facility is critical for two reasons. First, for the people of these communities to take control of their lives, the causes of endemic poverty must be addressed. Secondly, long term health is related to nutrition, and nutrition is related to a person's ability to obtain sufficient and proper food for a balanced diet. Opportunity here would help these communities improve their baseline nutrition status (and thereby health) and help move towards self-sufficiency.

A sewing project has already been initiated where local women will be sewing women's hand and shoulder bags which will be marketed to the U.S.

Developing the Centre

The immediate questions concerning a community outreach such as this are the long term sustainability and viability.

Swazi Nation Land

One option in Swaziland is to approach the local Chief and request that land be set aside land specifically for a clinic and community outreach. Land allocated from the Chief (in this case from Shewula) is essentially free (traditionally the transaction is sealed by giving a cow to the Chief). Land set aside by a Chief is never owned in the sense of holding a title-deed to a piece of property. Conceivably, the land and any improvements could be confiscated at a later date at the Chief's discretion. Navigating the politics and agendas of the competing communities in the Chiefdom can also be problematic.

Financially, significant initial funding would be required to develop the infrastructure (buildings, equipment and supplies). Finances for buildings and supplies are easier to source. However, the major long term challenge is developing the required monthly operating budget. Very few people or organizations are willing to provide the long term operational budget.

From a pure sustainability standpoint, a standalone centre is <u>never</u> sustainable. Sourcing operating and maintenance funds will be a constant challenge and will depend on the availability of donor money continuously.

As was recently reported in Swaziland, even large organizations cannot guarantee operational funds forever: the Red Cross in Swaziland announced that their major donor (the Swiss Red Cross) was cutting back most funding to Swaziland and that most of the Red Cross clinics would have to be shuttered. However, if a source of income could be developed that was not dependent on donor's ability to continuously fund a project, than a project may actually be sustainable. A unique opportunity in Maphiveni may facilitate this.

Brown's Estate

Brown's Estate is a 1.7 hectare (4.2 acre) site situated at the juncture of the Simunye-Lomahasha and Mhlume roads in Maphiveni. There are three main structures on the property.

The entire property was valued at E3 000 000 ($300 000 USD) by an independent valuation firm in 2011. One building is approximately 750 sq m (8073 sq ft), the second 1700 sq m (18299 sq ft) and the third 342 sq m (3681 sq ft). The first building would be developed into the clinic and education centre. The second would be developed commercially with the intent to attract businesses to lease space. The third would be renovated to house visiting medical mission teams.

Use of the existing infrastructure would allow for a complete community clinic and education centre to be incorporated immediately.

The goal of operating from a commercial centre is to ensure the long term viability and sustainability of the project. Once the bond is retired, the income stream will ensure the monthly operating costs of the community health centre are met and services can be expanded.

Property Valuation

A property valuation was commissioned in March 2011 for Brown's Estate which arrived at a market value of E3 000 000 ($455 000USD). The replacement costs shown in the table were obtained from real-estate/development professionals in Swaziland.

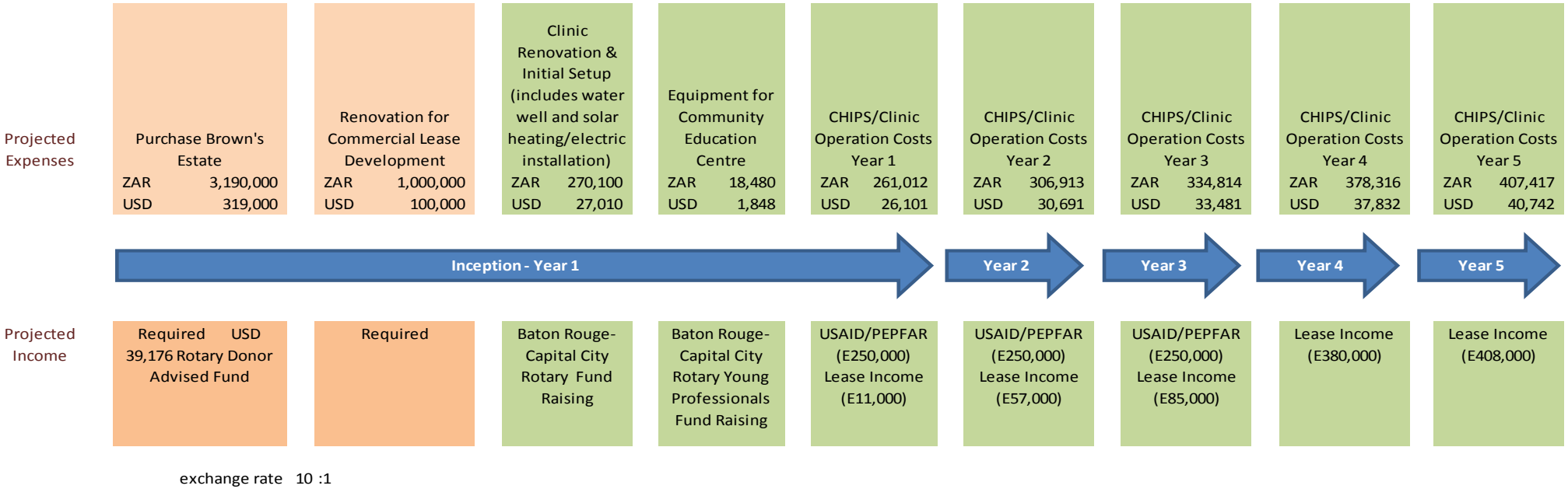
	Area (approx)	Replacement Cost (E)	Total (E)	USD
Land	1.7 hectares	20000 per ha.	34,000	$3,400
Commercial Bldg.	1700 sq. meters	3000 per sq. m.	5,100,000	$510,000
Clinic Bldg	750 sq. meters	3000 per sq. m.	2,250,000	$225,000
Residence	342 sq. meters	3000 per sq. m.	1,026,000	$102,600
			8,410,000	$841,000

exchange rate 10 :1

Although of little consequence in the total, the land value was chosen from the low end of a range of values for small property holdings. The building replacement value represents a cost for constructing bare bone/shell *warehouse* buildings. The cost to build similar sized building shells on a similar piece of land exceeds the Brown's Estate sale price by over five million Emalangeni ($500 000 USD).

Financial Plan/Time Line

The goal in purchasing and developing Brown's Estate is to begin operation of the clinic and expand the existing commercial use for lease income as soon as feasible. The following cost breakdown is based on raising the entire purchase price and commercial renovation costs. The property is currently generating E5200 ($520 USD) per month with only a small portion of the buildings and property actually in use. There has been significant interest generated in leasing out portions of the buildings and property for shops, warehouse and packing space, and a petrol station. In three years, lease income would be projected to completely cover operating costs. Surpluses would be invested to cover future possible shortfalls and unforeseen expenses.



exchange rate 10 :1

Financial Viability

Claypotts Trust[6] has funded CHIPS 2008-2013. CHIPS is currently operating under a USAID/PEPFAR grant. A Rotary Foundation Donor Advised Fund was established with The Baton Rouge-Capital City Rotary Club to be able to fund renovating and setting up the clinic as well as grants to help with empowering the local community to develop profitable and sustainable income generation projects.

The most obvious financial risk is that lease income does not match expenditures for operational costs. An advertisement was run in the local paper inviting expressions of interest in leasing the building designated for commercial use. There was a large turn out with several parties serious in taking up space in the building.

If the entire purchase price and commercial renovation funds are not raised, than a bond through a local bank would be necessary. This would place significant pressure on quickly leasing out the space reserved for commercial use to cover the bond. It would also retard the ability of rolling out clinic services as the lease income would have to be first dedicated to repaying the bond versus funding clinic operation. As the budget below indicates, the bond should be able to be serviced given the expected lease income, but after the funds from Claypotts expire, there would be little available for clinic operation.

	Emalangeni	USD (6.6:1)
Initial Investment		
Refurbishment/Modification	205000	$20,500
Initial Fixtures and Supplies	56000	$5,600
Medical Equipment	5500	$550
Initial Drug Stock	3600	$360
	270100	$27,010
Capital City Rotary (USA)	350000	$35,000
Monthly Budget		
Salaries	13834	$1,383
Transport/Vehicles	4917	$492
Drug Restock	1000	$100
Maintenance	2000	$200
Bond (15 year @ 9.75%, E3.175M)	33642	$3,364
	55393	$5,539
Monthly Income		
Claypotts Trust Grant (through 2014)	23009	$2,301
Commercial Rental Income	37550	$3,755
	60559	$6,056
exchange rate	10 :1	

Refurbishment/Modification: E50 000 modification/repairs, E55 000 Borehole (hydrographic geophysical) survey, drilling, and finished installation (given a

[6] www.claypotts.org

successful well)), E100 000 Estimate on solar installation for heating water and electric generation.

Initial Fixtures and Supplies, Medical Equipment, and Initial Drug Stock: quotes from local Swazi companies SwaziPharm, Woodmasters, and Lesco Engineering.

Capital City Rotary: Baton Rouge Louisiana club designating 2011 Peace One Day proceeds with projected matching grants and contributions from the local District and partners Mbabane and Mbuluzi Rotary Clubs.

Monthly Budget- Salaries: Annual salaries (year 1) for CHIPS/Centre Staff: E25 000 x 2, Nurse: E96 000, Security: E20 000.

Monthly Budget- Transport/Vehicles: Based on expected reduction in trips to Good Shepherd Hospital in Siteki. This figure includes insurance, maintenance and petrol.

Monthly Budget- Drug Restock: This number is based on number of patient visits per month and estimated drug turnover, and is consistent with figures from the St. Philips Cabrini Ministries' clinic offering similar services to a similar community in the southern Lubombo Region.

Monthly Budget- Maintenance: Maintenance, grounds and repairs.

Bond: It is our goal and pledge to raise the funds necessary to purchase the property outright: without the need for a bond. The E3.175 Million is based on a purchase price of E2.9M less 25% deposit and an additional E1M for renovating the building to be used for commercial leases. The Swazi Building Societies' loan terms are prime plus 0.75% (prime is currently at 9%) and require a minimum 25% deposit. Other commercial banks require a minimum 40% deposit on commercial property loans.

Commercial Income: Income from existing tenants, new petrol station, new garage & shops.

Property Ownership

Kudvumisa Trust (a Trust registered in Swaziland) will hold title to the property. The Trust was formed in October 2008. The *Principal Objects* and beneficiaries of the Trust are:

> … to create a fund for assistance of orphaned and vulnerable children, women other persons affected or infected by HIV/Aids and for other societal needs as may be determined by the Trustees in consultation with the Founder from time to time in one or more of the following areas:
>
> – Kudvumisa Foundation
> – Provision of medical assistance.
> – Provide life, business and entrepreneurial skills training.
> – Any of the above together or separately.
> – Other assistance as may be determined by the trustees in consultation with the Founder.

The Trustees are Daran Rehmeyer (Founder) and Teresa Rehmeyer. Originally in Swaziland with Children's Cup International Relief (2005), they are currently independent missionaries under Kudvumisa Foundation USA Inc.[7]).

A separate non-profit company, Kudvumisa Foundation, is registered in Swaziland and will manage the financial aspects of the complex: property management for the lease holders and financial management of the community clinic and education centre. A Board constituted of professional and interested Swazi nationals is being assembled to ensure the project continues.

Community Impact

There are three areas that will be explicitly impacted by developing Brown's Estate. The first two are improved general and HIV health because of low cost access (transport and services) and increased opportunity for education advancement. The third is a benefit of the commercial development. As more shops and stores are opened, they will create employment opportunities for the local community. It is estimated that each person employed in Swaziland supports up to 12 other people!

[7] A registered 501c3 www.kudvumisafoundation.org

Appendices

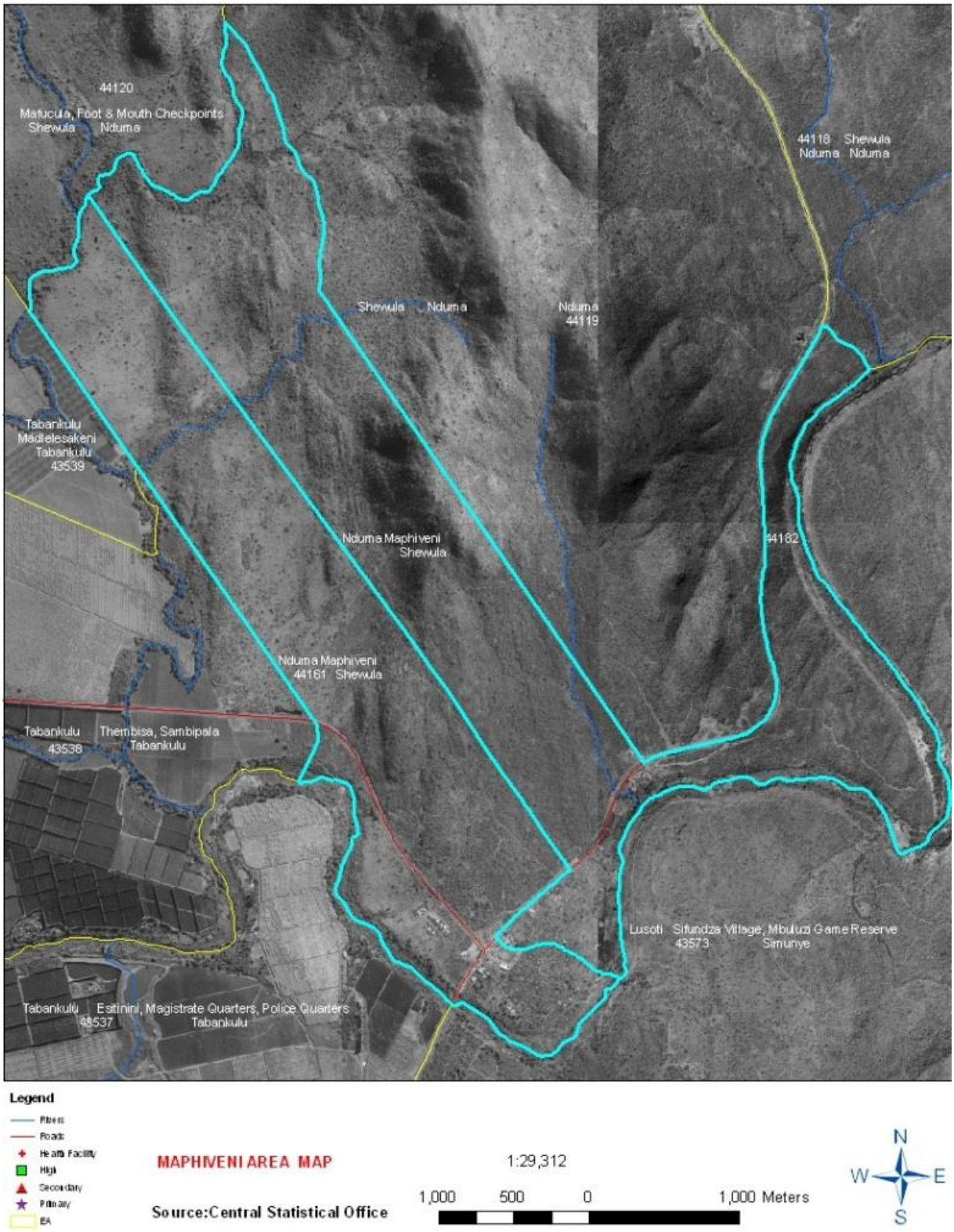
Demographics[8]

Maphiveni & Vuvulane Areas (Current CHIPS Service Areas)

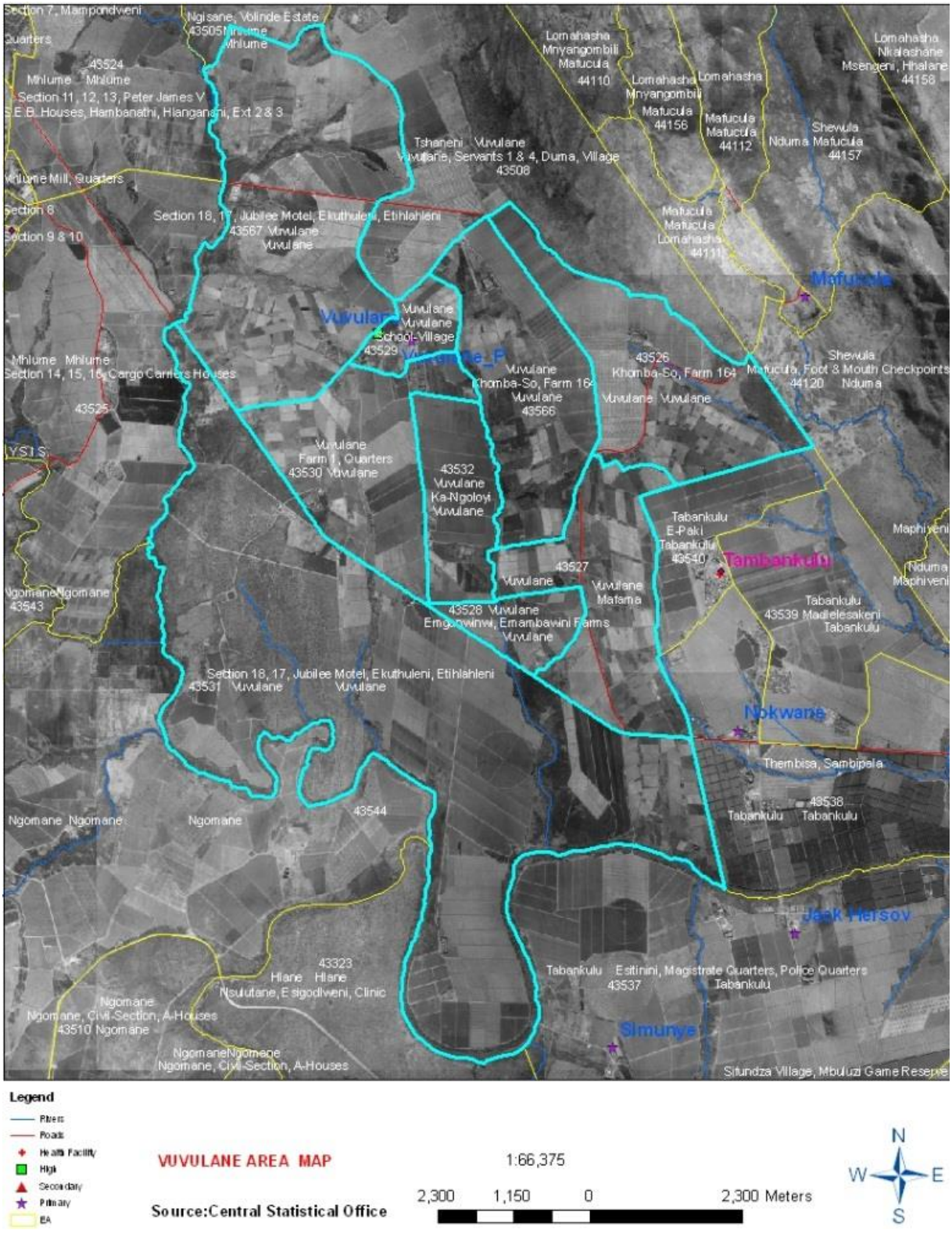
EA	Major Name	Sub Area	Minor Name	Homesteads	Households	Male	Female	Total Pop
43567	Vuvulane	Vuvulane	Section 18, 17, Jubilee Motel, Ekuthuleni, Etihlahleni	180	241	303	251	554
43566	Vuvulane	Vuvulane	Khomba-So, Farm 164	77	108	161	155	316
43526	Vuvulane	Vuvulane	Khomba-So, Farm 164	95	105	203	215	418
43527	Vuvulane	Vuvulane	Mafama	115	122	248	233	481
43528	Vuvulane	Vuvulane	Emganwinwi, Emambawini Farms	28	34	56	52	108
43529	Vuvulane	Vuvulane	School-Village	68	104	166	146	312
43530	Vuvulane	Vuvulane	Farm 1, Quarters	63	74	171	193	364
43531	Vuvulane	Vuvulane	Section 18, 17, Jubilee Motel, Ekuthuleni, Etihlahleni	46	54	105	73	178
43532	Vuvulane	Vuvulane	Ka-Ngoloyi	41	64	72	50	122
44161	Shewula	Nduma	Maphiveni	56	95	133	137	270
44182	Shewula	Nduma	Maphiveni	126	171	281	382	663
				895	**1172**	**1899**	**1887**	**3786**

2007 Census Information for Vuvulane and Maphiveni

[8] 2007 Census Data, Swaziland Central Statistics Office



Maphiveni EA Map



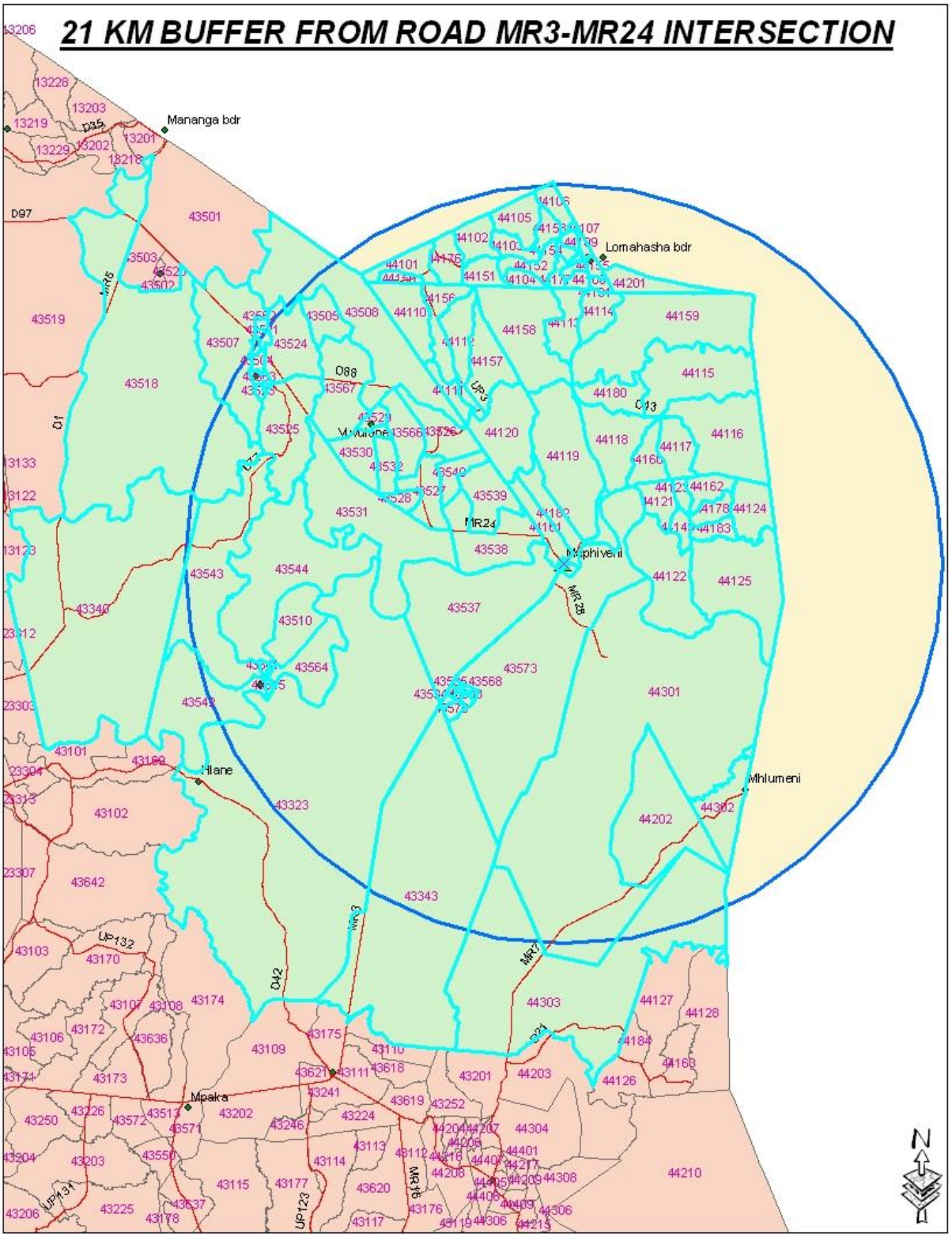
Vuvulane EA Map

Catchment for Services at Maphiveni Clinic and Commercial Development

EA	Inkhundla Name	Major Name	Sub Area	Minor Name	Homesteads	Households	Male	Female	Total Pop
43323	Hlane	Hlane	Hlane	Nsulutane, Esigodlweni, Clinic	22	72	90	67	157
43343	Hlane	Hlane	Hlane	Hlane Nature Reserve, Tibiyo Houses	39	48	106	86	192
44101	Lomahasha	Tsambokhulu	Macakula	Shoka	70	77	165	219	384
44102	Lomahasha	Lomahasha	Nkalashane	Mgazini, Teachers	77	90	236	229	465
44103	Lomahasha	Lomahasha	Nkalashane	Nkalashane	91	110	292	362	654
44104	Lomahasha	Lomahasha	Nkalashane	Nkalashane	27	31	67	76	143
44105	Lomahasha	Lomahasha	Matfuntini	Nhlambelo, Majaji, Nkalashane	73	86	227	231	458
44106	Lomahasha	Lomahasha	Matfuntini	Matfuntini	112	133	315	362	677
44107	Lomahasha	Lomahasha	Ngulubeni	Ngulubeni	74	96	225	275	500
44108	Lomahasha	Lomahasha	Lomahasha	Mbasheni, Mbokojweni	69	89	224	301	525
44109	Lomahasha	Lomahasha	Lomahasha	Lomahasha	82	107	198	189	387
44110	Lomahasha	Lomahasha	Mafucula	Mnyangombili	61	65	216	221	437
44111	Lomahasha	Lomahasha	Mafucula	Mafucula	72	78	219	210	429
44112	Lomahasha	Lomahasha	Mafucula	Mafucula	44	52	142	135	277
44113	Lomahasha	Lomahasha	Nkalashane	Mbokodvweni, Tigodzini	64	85	170	240	410
44114	Lomahasha	Lomahasha	Nkalashane	Ebuloyeni, Emkhangala, Mbokodvweni	75	92	211	242	453
44115	Lomahasha	Shewula	Nduma	Sifundza	67	85	223	281	504
44116	Lomahasha	Shewula	Shewula	Kuthuleni, Hhawalala	72	97	260	307	567
44117	Lomahasha	Shewula	Shewula	Ndzaweni, Mlakashane, KaMswati	77	108	265	283	548
44118	Lomahasha	Shewula	Nduma	Nduma	68	81	176	214	390
44119	Lomahasha	Shewula	Nduma	Nduma	70	87	231	267	498
44120	Lomahasha	Shewula	Nduma	Mafucula, Foot & Mouth	91	99	257	270	527
44121	Lomahasha	Shewula	Shewula	Shewula	58	77	233	244	477
44122	Lomahasha	Shewula	Nhlungwini	Nhlungwini	52	83	197	256	453
44123	Lomahasha	Shewula	Shewula	Ndzaweni, Sikhonkwane	72	127	295	355	650
44124	Lomahasha	Shewula	Shewula	Encumatsini	4	12	29	27	56
44125	Lomahasha	Shewula	Nhlungwini	Maphakama, Mangwenya	71	118	290	402	692
44146	Lomahasha	Shewula	Shewula	Shewula	62	84	197	231	428
44150	Lomahasha	Tsambokhulu	Macakula	Macakula	73	80	198	247	445
44151	Lomahasha	Lomahasha	Nkalashane	Tigodzini	81	93	176	245	421
44152	Lomahasha	Lomahasha	Nkalashane	Luhwayi	90	111	273	312	585
44153	Lomahasha	Lomahasha	Matfuntini	Majaji, Dzinwane, Matfuntini	70	74	109	160	269
44154	Lomahasha	Lomahasha	Ngulubeni	Ngulubeni	53	63	176	218	394
44155	Lomahasha	Lomahasha	Lomahasha	Border-Gate	74	99	204	254	458
44156	Lomahasha	Lomahasha	Mafucula	Mnyangombili	70	76	233	231	464
44157	Lomahasha	Shewula	Nduma	Mafucula	60	71	221	240	461
44158	Lomahasha	Lomahasha	Nkalashane	Msengeni, Hhalane	64	82	208	227	435
44159	Lomahasha	Lomahasha	Nkalashane	Msengeni, Ebhandeni,	68	89	255	333	588
44160	Lomahasha	Shewula	Shewula	Mbuluzi	72	83	173	223	396
44161	Lomahasha	Shewula	Nduma	Maphiveni	56	95	133	137	270
44162	Lomahasha	Shewula	Shewula	Ndzaweni, Mlangane	83	107	245	300	545
44176	Lomahasha	Tsambokhulu	Macakula	Shoka	55	68	193	188	381
44177	Lomahasha	Lomahasha	Ngulubeni	Embokodvweni, Ngulubeni	62	96	231	254	485
44178	Lomahasha	Shewula	Shewula	Mlangane	39	56	194	192	386
44179	Lomahasha	Lomahasha	Lomahasha	Mbasheni,Mbokojweni	59	85	185	198	383
44180	Lomahasha	Shewula	Nduma	Sifundza	86	108	269	312	581
44181	Lomahasha	Lomahasha	Lomahasha	Border-Gate	78	107	282	336	618
44182	Lomahasha	Shewula	Nduma	Maphiveni	126	171	281	382	663
44183	Lomahasha	Shewula	Shewula	Mlangane	48	73	251	274	525
44201	Lomahasha	Lomahasha	Lomahasha	Mafusini	77	95	228	269	497
44202	Lugongolweni	Siteki	Mhlumeni	Machibini, Mhlumeni Primary	82	87	227	227	454
44301	Lugongolweni	Mlawula	Siweni	Mlawula Nature Reserve, Siweni	59	102	126	50	176
44302	Lugongolweni	Siteki	Mhlumeni	Mlawula, Mhlumeni Bordergate	14	35	26	23	49
44303	Lugongolweni	Siteki	Mhlumeni	Grocpan	13	26	36	8	44
43567	Mhlume	Vuvulane	Vuvulane	Section 18, 17, Jubilee Motel, Ekuthuleni, Etihlahleni	180	241	303	251	554

EA	Inkhundla Name	Major Name	Sub Area	Minor Name	Homesteads	Households	Male	Female	Total Pop
43568	Mhlume	Simunye	Lusoti	Gosh Szocolay Stadium	124	187	267	201	468
43569	Mhlume	Simunye	Lusoti	Lusoti	173	178	299	277	576
43570	Mhlume	Simunye	Lusoti	Lusoti	73	73	112	129	241
43573	Mhlume	Simunye	Lusoti	Sifundza Village, Mbuluzi Game Reserve	4	21	25	6	31
43574	Mhlume	Simunye	Lusoti	Lusoti	122	222	275	293	568
43562	Mhlume	Mhlume	Mhlume	Section 7, Mampondweni	51	94	114	156	270
43563	Mhlume	Mhlume	Mhlume	Mhlume Mill, Quarters	200	259	466	441	907
43564	Mhlume	Ngomane	Ngomane	Ngomane, Civil-Section, A-Houses	120	156	213	178	391
43565	Mhlume	Mhlume	Mhlume	Quarters	58	69	152	154	306
43566	Mhlume	Vuvulane	Vuvulane	Khomba-So, Farm 164	77	108	161	155	316
43340	Mhlume	Dvokolwako	Impala-Ranch	Impala-Ranch	29	38	38	10	48
43504	Mhlume	Mhlume	Mhlume	S.E.B. Houses, Hambanathi, Hlanganani, Ext 2 & 3	141	151	292	269	561
43505	Mhlume	Mhlume	Mhlume	Ngisane, Volinde Estate	13	23	27	26	53
43506	Mhlume	Mhlume	Mhlume	Section 8	73	131	296	125	421
43507	Mhlume	Mhlume	Mhlume	Section One, R.S.P. Quarters, Section 1, 3, 4 & 5	76	116	155	133	288
43508	Mhlume	Tshaneni	Vuvulane	Vuvulane, Servants 1 & 4, Duma, Village	88	128	154	125	279
43509	Mhlume	Simunye	Lusoti	Gosh Szocolay Stadium	149	233	321	264	585
43510	Mhlume	Ngomane	Ngomane	Ngomane, Civil-Section, A-Houses	88	94	167	163	330
43518	Mhlume	Tshaneni	Tshaneni	I.Y.S.I.S.	36	71	95	91	186
43521	Mhlume	Mhlume	Mhlume	Quarters	73	110	194	187	381
43523	Mhlume	Mhlume	Mhlume	Section 9 & 10	30	63	78	41	119
43524	Mhlume	Mhlume	Mhlume	Section 11, 12, 13, Peter James V	42	86	115	52	167
43525	Mhlume	Mhlume	Mhlume	Section 14, 15, 16, Cargo Carriers Houses	74	187	190	142	332
43526	Mhlume	Vuvulane	Vuvulane	Khomba-So, Farm 164	95	105	203	215	418
43527	Mhlume	Vuvulane	Vuvulane	Mafama	115	122	248	233	481
43528	Mhlume	Vuvulane	Vuvulane	Emganwinwi, Emambawini Farms	28	34	56	52	108
43529	Mhlume	Vuvulane	Vuvulane	School-Village	68	104	166	146	312
43530	Mhlume	Vuvulane	Vuvulane	Farm 1, Quarters	63	74	171	193	364
43531	Mhlume	Vuvulane	Vuvulane	Section 18, 17, Jubilee Motel, Ekuthuleni, Etihlahleni	46	54	105	73	178
43532	Mhlume	Vuvulane	Vuvulane	Ka-Ngoloyi	41	64	72	50	122
43533	Mhlume	Simunye	Lusoti	Lusoti	97	97	146	104	250
43534	Mhlume	Simunye	Lusoti	Lusoti	86	106	184	198	382
43535	Mhlume	Simunye	Lusoti	Lusoti	151	155	277	232	509
43536	Mhlume	Simunye	Lusoti	Lusoti	102	149	224	180	404
43537	Mhlume	Tabankulu	Tabankulu	Esitinini, Magistrate Quarters, Police Quarters	74	76	140	92	232
43538	Mhlume	Tabankulu	Tabankulu	Thembisa, Sambipala	167	232	332	189	521
43539	Mhlume	Tabankulu	Tabankulu	Madlelesakeni	82	123	219	111	330
43540	Mhlume	Tabankulu	Tabankulu	E-Paki	95	156	225	190	415
43541	Mhlume	Ngomane	Ngomane	B1, B2	108	125	223	175	398
43542	Mhlume	Ngomane	Ngomane	Section A	121	143	201	179	380
43543	Mhlume	Ngomane	Ngomane	Ngomane	66	77	142	142	284
43544	Mhlume	Ngomane	Ngomane	Ngomane	41	44	84	77	161
43545	Mhlume	Ngomane	Ngomane	Ngomane	51	60	90	84	174
					7319	**9740**	**18906**	**19206**	**38112**

2007 Census Information for 21 km (13 miles) Radius from Maphiveni



21 km Radius Potential Maphiveni Service Area

CHIPS Stories

Simphiwe Maseko - 10 years old

Simphiwe has been on ARV's for 18 months. Her health has always been frail. In August 2010 she suffered a right stroke and was transported by CHIPS in a critical condition to Good Shepherd Hospital in Siteki. She was in a coma for two weeks and spent an additional six weeks slowly recovering. She is now able to walk and talk but it has left her with some deficits in learning and mobility.

CHIPS sustains Simphiwe through providing transport to the hospital for her ART Refills and doctors' visits to GSH. She has recently had a hearing screen because it was noted she was very hard of hearing; perhaps due to ART.

The long term future for her is uncertain as she is unable to attend government primary school: it is a long distance to walk and she tires easily, she has fallen far behind the other children of her age. Her hearing problems also make it difficult to attend school. Her family are looking into the possibility of placing her in a special residential school here in Swaziland.

CHIPS makes regular visits to the homestead to encourage the family to continue the physiotherapy and to assess any new problems while offering encouragement and praying with them.

There are nine other children living at the homestead. The father works as a casual labourer for the sugar corporation.

CHIPS History

Visit Date	Site Name	Service Offered
20-Jul-09	Good Shepherd ART Clinic	HIV Test
30-Jul-09	Good Shepherd ART Clinic	Chemistry
19-Aug-09	Good Shepherd ART Clinic	ART Initiation
25-Aug-09	Good Shepherd ART Clinic	ART Initiation
09-Sep-09	Good Shepherd ART Clinic	ART Refill
23-Sep-09	Good Shepherd ART Clinic	ART Refill
21-Oct-09	Good Shepherd ART Clinic	ART Refill
18-Nov-09	Good Shepherd ART Clinic	ART Refill
16-Dec-09	Good Shepherd ART Clinic	ART Refill, CD4
10-Feb-10	Good Shepherd ART Clinic	ART Refill
07-Apr-10	Good Shepherd ART Clinic	ART Refill
05-May-10	Good Shepherd ART Clinic	ART Refill
30-Jun-10	Good Shepherd ART Clinic	ART Refill
12-Aug-10	Good Shepherd ART Clinic	CD4

25-Aug-10	Good Shepherd ART Clinic	ART Refill
20-Oct-10	Good Shepherd ART Clinic	ART Refill
13-Dec-10	Good Shepherd ART Clinic	ART Refill
12-Jan-11	Good Shepherd ART Clinic	CD4
09-Feb-11	Good Shepherd ART Clinic	ART Refill
10-Feb-11	Good Shepherd ART Clinic	ART Refill
10-Mar-11	Good Shepherd ART Clinic	ART Refill
07-Apr-11	Good Shepherd ART Clinic	ART Refill
04-May-11	Good Shepherd ART Clinic	ART Refill

Vusile Dlamini - 4 years old

Vusile has mental and physical challenges. He is unable to walk and stand unaided and since the age of 3 months has a right shoulder dislocation. He receives poor stimulation in his home situation but he does respond to when he is spoken to and recognizes people. He has some speech can say good bye etc.

CHIPS sustains Vusile by providing transport to the local government clinic in Vuvulane for his ART Refills. When his physical condition deteriorates due to neglect and malnutrition he is taken by CHIPS transport to GSH for either out-patient care or admission to the hospital. CHIPS pays his inpatient and outpatient bills.

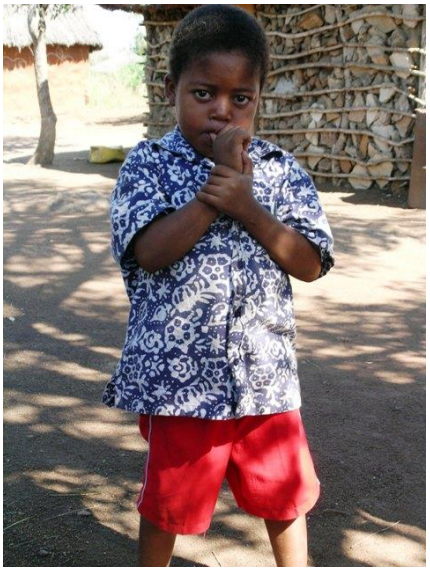
The homestead is an unstable environment. Vusile's father is also a CHIPS client on ART. He is about 75 years old. The long term future for Vusile is uncertain. Options of placement in a children's home have not been possible. CHIPS staff visits the homestead on a regular basis to monitor Vusile's condition and offer any support including bathing him and playing with him to provide stimulation. CHIPS staff meets regularly with his father to assess any new needs and concerns.

CHIPS History

Visit Date	Site Name	Service Offered
10-Nov-09	Good Shepherd ART Clinic	Chemistry
17-Nov-09	Good Shepherd ART Clinic	ART Initiation
25-Nov-09	Good Shepherd ART Clinic	DR Exam
30-Nov-09	Good Shepherd ART Clinic	DR Exam
03-Dec-09	Good Shepherd ART Clinic	ART Refill
31-Dec-09	Good Shepherd ART Clinic	ART Refill
28-Jan-10	Good Shepherd ART Clinic	ART Refill
18-Feb-10	Good Shepherd ART Clinic	Sick
26-Feb-10	Good Shepherd ART Clinic	Sick
04-Mar-10	Good Shepherd ART Clinic	Sick

12-Mar-10	Good Shepherd ART Clinic	Sick
22-Mar-10	Good Shepherd ART Clinic	ART Refill
01-Apr-10	Good Shepherd ART Clinic	Sick
13-Apr-10	Good Shepherd ART Clinic	Sick
21-Apr-10	Good Shepherd ART Clinic	ART Refill
17-Jun-10	Good Shepherd ART Clinic	TB Refill
27-Jul-10	Good Shepherd ART Clinic	ART Refill
24-Aug-10	Good Shepherd ART Clinic	ART Refill
21-Sep-10	Good Shepherd ART Clinic	ART Refill
30-Sep-10	Mbabane Gov	Sick
19-Oct-10	Good Shepherd ART Clinic	ART Refill
22-Dec-10	Good Shepherd ART Clinic	ART Refill
25-Jan-11	Good Shepherd ART Clinic	ART Refill
09-Feb-11	Good Shepherd ART Clinic	ART Refill
10-Mar-11	Good Shepherd ART Clinic	ART Refill
21-Mar-11	Home visit	Pill count
07-Apr-11	Good Shepherd ART Clinic	ART Refill
20-Apr-11	Home visit	Routine Check-up
04-May-11	Good Shepherd ART Clinic	ART Refill
11-May-11	Home visit	Pill count
23-May-11	Good Shepherd ART Clinic	Sick
01-Jun-11	Good Shepherd ART Clinic	ART Refill
22-Jun-11	Vuvulane Clinic	ART Refill

Sikhumbuzo Mlotsa – 24 November 2002 – 24 June 2010



Sikhumbuzo is a little boy who was a part of CHIPS. He was 7 years old and very sick when he joined CHIPS. He was born with HIV: his mother is also HIV+. He had been treated for TB in the past, but we were never sure whether he completed the treatment. He was started on ART in 2009 while he was hospitalized. The first time we saw him, his stomach was very swollen and his breathing was very rapid. He was a very sick little boy. Each time we saw him he would seem a little stronger! We saw him in church after he was discharged from the hospital that first time. When he saw us, he gave me a big smile, which melted our hearts. CHIPS visited him at his homestead often. He frequently had a runny nose and cough, and maintained sores around his mouth that may have been herpes. CHIPS kept a close watch on him. Sikhumbuzo started back to school but still had frequent bouts with pneumonia. In June 2010, Sikhumbuzo was admitted to the hospital one last time. It looked like his lungs had finally given out. CHIPS visited him in the hospital often during his final days there. It was hard to

watch him fight and struggle for every breath, even with oxygen. CHIPS paid for Sikhumbuzo's hospital fees as his mother and family could not afford the fees.

CHIPS History

Visit Date	Site Name	Service Offered
15-Jan-09	Good Shepherd ART Clinic	Chemistry, TB Refill
23-Jan-09	Good Shepherd ART Clinic	ART Initiation
02-Feb-09	Good Shepherd ART Clinic	ART Initiation
17-Feb-09	Good Shepherd ART Clinic	ART Initiation
24-Feb-09	Good Shepherd ART Clinic	Chemistry
03-Mar-09	Good Shepherd ART Clinic	ART Initiation
11-Mar-09	Good Shepherd ART Clinic	DR Exam
17-Mar-09	Good Shepherd ART Clinic	ART Initiation
14-Apr-09	Good Shepherd ART Clinic	ART Initiation
21-Apr-09	Good Shepherd ART Clinic	DR Exam
12-May-09	Good Shepherd ART Clinic	ART Refill, DR Exam
27-May-09	Good Shepherd ART Clinic	ART Refill
03-Jun-09	Good Shepherd ART Clinic	DR Exam
08-Jun-09	Good Shepherd ART Clinic	TB screening
16-Jun-09	Good Shepherd ART Clinic	DR Exam
23-Jun-09	Good Shepherd ART Clinic	DR Exam
16-Jul-09	Good Shepherd ART Clinic	ART Refill
20-Jul-09	Good Shepherd ART Clinic	CD4
11-Aug-09	Good Shepherd ART Clinic	ART Refill
12-Aug-09	Good Shepherd ART Clinic	ART Refill
24-Aug-09	Good Shepherd ART Clinic	DR Exam
26-Aug-09	Good Shepherd ART Clinic	DR Exam
14-Sep-09	Good Shepherd ART Clinic	DR Exam
07-Oct-09	Good Shepherd ART Clinic	ART Refill
26-Oct-09	Good Shepherd ART Clinic	DR Exam
04-Nov-09	Good Shepherd ART Clinic	ART Refill
03-Dec-09	Good Shepherd ART Clinic	ART Refill
30-Dec-09	Good Shepherd ART Clinic	ART Refill
24-Feb-10	Good Shepherd ART Clinic	ART Refill
21-Apr-10	Good Shepherd ART Clinic	ART Refill
27-Apr-10	Good Shepherd ART Clinic	CD4
01-Jun-10	Good Shepherd ART Clinic	ART Refill
14-Jun-10	Good Shepherd ART Clinic	DR Exam
16-Jun-10	Good Shepherd ART Clinic	ART Refill
24-Jun-10	Good Shepherd ART Clinic	**Death**, DR Exam

Shandu Sithole - 55 years old

Shandu had hip surgery 18 months ago and has limited mobility. He has been in the CHIPS program since 2009. CHIPS staff makes frequent visits to his homestead just to check that he has food, wood, water, to share prayer and the Word of God with him.

CHIPS provides transport for him to obtain his ART Refills from the government clinic in Vuvulane. He is unable to work, read or write so he relies on the CHIPS staff to inform him of his next clinic visits and to supply batteries for his alarm clock so he knows when it is time to take his medication.

CHIPS History

Visit Date	Site Name	Service Offered
03-Nov-09	Good Shepherd ART Clinic	ART Refill
05-Nov-09	Good Shepherd ART Clinic	ART Refill
06-Nov-09	Good Shepherd ART Clinic	DR Exam
07-Dec-09	Good Shepherd ART Clinic	ART Refill
04-Jan-10	Good Shepherd ART Clinic	ART Refill
01-Mar-10	Good Shepherd ART Clinic	ART Refill
06-Apr-10	Good Shepherd ART Clinic	ART Refill
04-May-10	Good Shepherd ART Clinic	ART Refill
01-Jun-10	Home visit	ART Refill
05-Jul-10	Good Shepherd ART Clinic	CD4
27-Jul-10	Good Shepherd ART Clinic	ART Refill
15-Sep-10	Good Shepherd ART Clinic	ART Refill
10-Nov-10	Vuvulane Clinic	ART Refill
08-Dec-10	Good Shepherd ART Clinic	ART Refill
02-Feb-11	Good Shepherd ART Clinic	ART Refill
21-Feb-11	Home visit	Pill count
02-Mar-11	Vuvulane Clinic	ART Refill
17-Mar-11	Good Shepherd ART Clinic	CD4
30-Mar-11	Vuvulane Clinic	ART Refill
20-Apr-11	Home visit	Routine Check-up
27-Apr-11	Good Shepherd ART Clinic	ART Refill
25-May-11	Vuvulane Clinic	ART Refill
22-Jun-11	Vuvulane Clinic	ART Refill

Commercial Centre Renovation Quote

Lihlandze Projects (Pty) Ltd

Project Managers, Building and Civil Engineering Contractors

Estimate

P.O. Box 27
Tshaneni
L308

Telephone Cell: 7602 5255
w/h: 2323 2460
E-Mail: greg@swazigreen.co.za

Date.	25/Jun/2011
Quotation No.	Q 2001/740

To: Daran Rehmeyer
Kudvumisa Trust
P O Box 131
Eveni, Mbabane

Brown's Garage Renovation Proposal

Our estimate to complete the works is as follows:

Existing Shop Area adjacent to Filling Station

Building Works	**45,442.00**
Floor Tiling Allowance	**21,000.00**
Shop Front Allowance - over 3m High	**60,000.00**
Shop Front Allowance - less than 3m High	**16,150.00**
Double Doors to Shop Fronts - 3 off	**17,700.00**
Plumbing Allowance	**10,000.00**
Electrical Allowance	**15,000.00**
Water and Electrical Supply?? - poss already available	**0.00**
Roofing Painting	**4,600.00**
Sub Tot	**189,892.00**
P&G	**37,978.40**
Total	**227,870.40**

New Shop Area

Building Works	**163,100.00**
Floor Tiling Allowance	**37,800.00**
Suspended Ceiling Allowance	**56,700.00**
Shop Front Allowance - over 3m High	**37,500.00**
Shop Front Allowance - less than 3m High	**28,500.00**
Double Doors to Shop Fronts - 4 off	**23,600.00**
Plumbing Allowance	**0.00**
Electrical Allowance	**50,000.00**
Water and Electrical Supply?? - poss already available	**0.00**
Roofing Including Structural Work	**116,830.00**
Sub Tot	**514,030.00**
P&G	**102,806.00**
Total	**616,836.00**

Work Shop Area

Building Works	**0.00**
Sliding Door with Rails to Main Entrance	**15,000.00**
Service/repair existing roller door	**5,000.00**
Plumbing Allowance	**0.00**
Electrical Allowance	**10,000.00**
Roofing Including Minor Structural Work	**122,725.00**
Sub Tot	**152,725.00**
P&G	**30,545.00**
Total	**183,270.00**

General Notes

Rates used for Suspended Ceilings, Shop Fronts and Tiling are current rates used in the industry. The reason for the increased rate on the higher shopfronts is due to a heavier/stronger profile aluminium being required due to the higher wind loadings. We have measured the existing openings and made allowances accordingly based on m2.
Allowances for electrical and plumbing are purely thumb suck as we are not sure what is actually required and likewise we have no idea of what existing infrastructure is still complete.
We have also made the assumption that water and Electricity supply to the building is already in place and therefore there is no reason for additional allowances for an SEC or Water connection.
Should you feel a certain item is not required, perhaps floor tiling or ceilings for example then please feel free to remove them from the estimates above.
Below is a short explanation of what has been allowed for the building and structural/roofing work in each area.

Existing Shop Area adjacent to Filling Station

Strip out redundant windows and close up openings.
Patch walls and replaster in areas where necessary.
Patch and replace floor screeds where necessary.
Install doors and frames internally where necessary - allowed 3 off.
Patch existing ceilings where damaged - current ceiling is uneven but will remain as is.
Painting internally as well as externally.
Patch wall tiling.
Replace upstairs 3 x window frames complete with glazing.
Repair gutters and sand and paint roof which is still sound but rusting.

New Shop Area

Demolish existing beams and blockwork to the front area, recast beams at 2.1m hight and build blockwork full heigh
Existing beams, columns and suspended floor slab to remain as is.
Close up high level openings in walls.
Construct dividing walls to split front shops into 3, we have allowed to construct walls to 3.5m high as full height will push the costs up substantially, this does however pose a problem for security between shops as access can be obtained through the ceiling void, possible close off with weld mesh and razor wire as a cheaper option.
Painting of walls internally and externally.
We have allowed to lay a floor screed to the entire area.
We have allowed to do minor landscaping externally in the front to lower the existing ground level.
We have allowed to retain the 3 openings down the side of the building and install shop fronts in this area with one double door entrance, this is the area with the shopfronts exceeding 3m, the height here being 4.2m.
We have allowed to strip the roofing structure and start from scratch, utilising the existing material as well as new.
We have allowed to retain the roofing profile down the side including the installation of proper columns etc., this is perhaps an area of some cost saving as currently this additional covered area serves no purpose.
We have allowed for the installation of 0.58mm galvanised IBR roof sheeting as well as the installation of Sisalation.

Work Shop Area

We have allowed to replace the rotten and missing roof sheeting in this area with 0.58mm galvanised IBR sheeting.
We have allowed to replace the missing vertical sheeting on the existing shop side as well as replacing the gutter.
We have allowed for the installation of a sliding door to the main entrance instead of a roller shutter as the latter will be considerably more expensive.
We have made an allowance for repairs/servicing to the existing grid roller shutter on the oposite side but do not know the extent of possible damage at this stage.

Unfortunately when doing a proposal like this we can only price what we see and what we think might be adequate so we hope we have interpreted your requirements correctly.
I would suggest an allowance be made by yourself for contingencies over and above this for unforseen items/issues.

I trust this meets with your approval, should you have any queries please do not hesitate to contact me.

Regards

Greg Green

Management CV's

Daran L. Rehmeyer, PE, CDT

Education

Louisiana State University, Baton Rouge, Louisiana: M.S.E.E. and Post Graduate studies, Thesis titled "A Data Acquisition and Processing System for High Speed Repetitive Waveforms." 1990.

Johns Hopkins University, Baltimore, Maryland: Geology 101, 102. 1983

Virginia Tech, Blacksburg, Virginia: B.S.E.E. 1982.

Professional Experience

2008 – pres Independent Missionaries. Developed and implemented program in an impoverished and isolated area of Lubombo Region of Swaziland for managing care of HIV+ children and their caregivers (CHIPS). Developed and implemented youth life skills/entrepreneurial program currently taught at Hawane Lighthouse TCMI program.

2005 – 2008 Children's Cup International Relief, Swaziland Director. FBO working with children impacted by HIV in Swaziland. Oversaw urban and peri-urban Neighborhood Care Point (NCP) operation and development in Swaziland. NCP's provide a safe place for the children to come to for a daily meal, basic health care, informal education, and life skills training.

1998 – 2005 GeoSpec, LLC, Baton Rouge, Louisiana. Principal and Manager, Geophysical Operations: Established GeoSpec to provide the highest quality and most cost effective engineering and environmental geophysical surveys available. Types of services included Subsurface Utility Engineering, Ground Penetrating Radar, EM, 2D resistivity profiles, magnetometer, gradiometer, and borehole geophysics.

1996 – 1998 WaveTech, Inc., Baton Rouge, Louisiana. Manager, Geophysical Operations: Developed near surface geophysics program for Subsurface Utility Engineering, Structural Evaluation, and general Nondestructive Subsurface Investigations (UST's, etc.). Coordinated automated software analysis development for ground penetrating radar signal interpretation specifically for air-coupled GPR pavement analysis. Responsible for survey design, technique selection, reporting, managing fieldwork, and marketing development.

1987 – 1996 Quaternary Resource Investigations, Inc., Baton Rouge, Louisiana. Project Manager: Developed an ultra low frequency GPR system for mapping shallow stratigraphy. Developed transducer for coupling the transmitted signal into the ground and the antennae for recording the subsurface response. Designed computer control and data acquisition system for the transmitter and receiver. Developed post processing interpretation software, implementing neural net and wavelet based analysis. Managed field program design and implementation. Responsible for reporting, presentation, and market development.

1992 – 1993 Forte and Tablada, Inc., Baton Rouge, Louisiana. Senior Programmer

1984 – 1987 Schlumberger Offshore Services, Morgan City, Louisiana. Senior Field Engineer: Open hole wireline geophysical logging. Used induction, nuclear, sonic, and other geophysical tools including dipmeters, and core guns for open hole, exploration well logging.

Papers/Presentations

Rehmeyer, D. L. and Lindfors, F., “A New Technique for Stratigraphic Evaluations with Applications to Industrial Site Evaluation,” Association of Engineering Geologists section meeting. Baton Rouge, Louisiana, May 1988.

Rehmeyer, D. L., and Aravena, J. L., “A 1 GHz Data Acquisition System for Repetitive Waveforms,” IEEE Southeast Conference. New Orleans, Louisiana, April 1990.

Rehmeyer, D. L. and Aravena, J. L., “Wavelets and Neural Nets for Stratigraphic Analysis,” IEEE International Geoscience and Remote Sensing Symposium. Pasadena, California, August 1994.

Rehmeyer, D. L. and Aravena, J. L., “Multiresolution Filter Banks: Application to Stratigraphy,” Society for Industrial and Applied Mathematics Third Annual SIAM Conference on Mathematical and Computational Issues in the Geosciences. San Antonio, Texas, February 1995.

Rehmeyer, D. L., “Pulser: A Subsurface Radar Survey System,” Baton Rouge Section of the IEEE. Baton Rouge, Louisiana, February 1995.

Rehmeyer, D. L., “Completing the Ground-Water Model: We Need More Data,” Environmental and Engineering Geoscience, Vol. I, No. 3, Fall 1995, pp. 353-358.

Rehmeyer, D. L., “Subsurface Utility Engineering,” Annual Meeting of the Deep South Section of the Institute of Transportation Engineers. Vicksburg, Mississippi, October 1997.

Rehmeyer, D. L., “Applications and Limitations of Ground Penetrating Radar in Coastal and Wetland Environments,” 14th Annual Louisiana Remote Sensing and GIS Workshop. Lafayette, Louisiana, April 1998.

Davidson, J. E. and Rehmeyer, D. L., "Infrared Imaging and Ground Penetrating Radar as QA/QC Procedures," The Construction Specifier, December 2000, pp. 39-44.

Professional Affiliations/Licensure

President Rotary Club of Mbabane 2013-2014
CSI Certified Construction Document Technologist;
Licensed Professional Engineer in Environmental Engineering (Louisiana 29074)

Other

Co-author of ASTM Standard D-4748-98, “Standard Test Method for Determining the Thickness of Bound Pavement Layers Using Short-Pulse Radar.”

OSHA 40 Hour HAZWOPER Training

Teresa A. Rehmeyer

PROFESSIONAL EXPERIENCE:

- Medical Director for Kudvumisa Foundation: managing medical outreach of CHIPS in the Lubombo Region of Swaziland
- Chair of the Swaziland Breast and Cervical Cancer Network: bringing diagnosis and treatment services to Swaziland for these diseases.
- Developed medical program for Children's Cup International Relief to provide basic medical care to the children attending the Children's Cup CarePoints in Swaziland.
  - Developed program of care and follow up
  - Developed HIV response and intervention strategies for children and caregivers associated with the CarePoints.
- Instructed nursing students in the clinical area.
- Assisted in developing the Outpatient Oncology Department at the BRGMC.
  - Designed forms for follow up, discharge, admit, and recurrent visits.
  - Visited doctor's offices - instructed staff on use of outpatient services.
  - Conducted audits for quality assurance.
  - Assisted in writing and reviewing policies and procedures.
- Participated in patient/family teaching regarding cancer and chemotherapy. Taught a portion of the chemotherapy course, acted as a preceptor to new RN's learning to give chemotherapy at BRGMC.
- Member of the Policy and Procedure Committee and the Quality Assurance Committee for Outpatient Oncology at OLOL Regional Medical Center.
  - Reviewed policies and procedures.
  - Reviewed and audited charts.
  - Compiled data for QA report.
- Worked with Data Managers in Oncology clinical trials.
  - Obtaining informed consent.
  - Assessing patients for inclusion in clinical trials.
  - Assisted in teaching and patient follow-up.
- Data Manager for Navelbine Venous Irritation Study at Ochsner Cancer Institute, New Orleans, LA.
  - collected data for study through retrospective chart audits.
  - compiled and categorized data.
- Oncology Clinical Research Coordinator- Baton Rouge General Regional Cancer Center
  - collect and manage data for Oncology Intergroup Clinical Trials (ECOG, SWOG, NSABP RTOG, ACOS)
  - Coordinate and manage Pharmaceutical based Oncology Clinical Trials (AstraZeneca, Cell Pathways, Genentech, GlaxoWellcome, SmithKline Beechum, Bristol Myers Squibb Oncology, Schering)
  - write and revise consent forms for protocols
  - update and send protocols to IRB for approval
  - teach patients about protocols
  - assist in the informed consent process
  - follow up with patients on protocol
  - assess patients for protocol eligibility

EMPLOYMENT HISTORY:

9/08 – present Independent Missionaries. Began the Children's HIV Intervention Program in Swaziland (CHIPS) in the eastern Lubombo Region. This program is a pediatric (and caregiver) HIV care management program implemented for a population who has restricted access to the available HIV care because of poverty and distance from

health facilities. Volunteered with the Swaziland Breast Cancer Network to design and implement a breast and cervical cancer treatment program for Swaziland while overseeing current breast cancer clinics for screening and counseling.

9/05 – 8/08 Children's Cup International Relief, Volunteer. Developed medical program for children attending Children's Cup CarePoints and developed HIV response in coordination with Baylor-Bristol-Myers Squibb Children's Clinical Center of Excellence – Swaziland.

6/94 – 8/05 Baton Rouge General Medical Center/Regional Cancer Center; Oncology Clinical Research Coordinator.

8/92 - 5/94 Our Lady of the Lake College of Nursing & Allied Health, Baton Rouge, Louisiana; Clinical Instructor.

2/92 - 10/92 Our Lady of the Lake Regional Medical Center, Baton Rouge, Louisiana; Outpatient Oncology/Same Day Surgery.

6/86 - 2/92 Baton Rouge General Medical Center; General Medicine for one year, Oncology for the remaining five years.

EDUCATION:

9/92 - 2/94 MN, Louisiana State University Medical Center, School of Nursing, New Orleans, LA.

9/88 - 8/90 Louisiana State University, Baton Rouge, LA. Courses toward MN.

9/83 - 5/86 BSN, Southeastern Louisiana University, School of Nursing, Hammond, LA.

9/82 - 5/83 Lee College, Cleveland, TN. Pre-Med Curriculum.

REGISTRATION

Registered Nurse – State of Louisiana
Nurse - Swaziland

PROFESSIONAL AFFILIATION:

Oncology Nursing Society (thru 2005)

CERTIFICATION:

Oncology Certified Nurse (thru 2006)

PAPERS:

Carruth A.K., Steele S., Moffett, B., Rehmeyer, T., Cooper, C., & Burroughs, R. (1999) "The impact of primary and modular nursing delivery systems on perceptions of caring behaviors." Oncology Nursing Forum, 26(1), 95-100.

Rittenberg, C.N., Gralla, R.J., & Rehmeyer, T.A. (1995) "Assessing and managing venous irritation associated with Vinorelbine Tartrate (Navelbine)." Oncology Nursing Form, 22(4), 707-710.

Reducing Venous Irritation in Chemotherapy Administration: "An Investigation During the New Agent Testing of Navelbine with Development of an Appropriate Recording Instrument" presented at the Oncology Nursing Society 19th Annual Congress, May 1994.