COUNTRY REPORT ON COMMUNITY BASED REHABILITATION IN UGANDA

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INTRODUCTION:

The traditional concept of CBR was introduced by WHO and is being implemented in parts of Uganda. The new concept of ICBR has been introduced in some refugee affected areas (on a pilot project basis). MOLG and MGCD are the two lead Ministries in the programme and in collaboration with various NGO's, play an integral role in the design and implementation of CBR in East Moyo District (pilot area).

The origin of the ICBR programme came from the identified danger that vulnerable groups in Refugee Affected areas were not getting comprehensive assistance, and that the refugee population was receiving privileged services in comparison to the indigenous population of the area. ICBR in the refugee context integrates both the needs of refugees and nationals. Refugees have benefitted from the government allocation of land,which is the most important national resource to facilitate their settlement. This has been further enhanced by UNHCR which has assisted in developing infrastructure, health, education and social services in an integrated manner for both refugees and nationals.

Initial planning and assessment for the pilot project included an inter-agency mission from Programme Technical Support Section (PTSS) Geneva, WHO, and NAD, during September 1994. This was followed by a feasibility study led by NAD/MGCD, ACORD and UNHCR. Two sensitization workshops on CBR were held in 1995; one at National level for major actors and one at District level, for implementors in the District where CBR Programme would take place. During these workshops it was agreed that there was a need for a more embracing programme, taking both refugees and nationals into consideration, since nearly all refugees and many nationals are vulnerable in one way or another.

BACKGROUND:

The refugee population in Uganda consists of the mainly Sudanese population in the Northern districts of the country, including Arua, Moyo, Kitgum and Masindi district, Rwandan population in Mbarara district and Zairian population in Kabarole/Kisoro districts. The urban caseload consists of mainly Somali population, Ethiopian, Kenyan, Burundian, and Liberian refugees and other nationalities who are usually transferred to the camps if not registered as vulnerables or security cases. For the total number of refugees and the different settlements/transit camps, I refer to annex 1 and 2.

Many agencies and organizations are involved in providing assistance and services to the disabled and other vulnerable groups. Although the emphasis in this paper is on the refugee affected areas in Moyo District, the services provided in other Districts, and the needs of the vulnerable groups will be discussed as well. The input and policy of both MOLG and MGCD is also reflected in this paper, and statistic information on the local population of Uganda is attached (annex 3).

REHABILITATION SERVICES FOR PEOPLE WITH DISABILITIES (PWDS) IN UGANDA:

The Country Data:

The population of Uganda is estimated at approximately 17.2 m. Growing at a rate of 2,9% per annum. The population is predominately rural with over 90% living in the countryside. The GNP/Capital is US$ 260 and there is no detailed information on income distribution. The data available suggests that there is a very large group of urban and rural poor, a rather broad, not very rich class of civil servants, traders and farmers. There is a very small, very wealthy elite who have accumulated wealth from trade due to favorable conditions brought about by the National Resistance Movement (NRM) Government for the last 10 years. The infant mortality rate is 100/1000 while child mortality rate is 126. The fertility rate is 7.

There is still a great need in the field of provision of services to disabled persons especially in the field of prevention, early detention, early identification, early stimulation and in the whole range of managing secondary impairments.

In 1977 a WHO expert Dr. Burbrry estimated that 7-10% of every population is disabled and this was supported by recent sample surveys from India and Indonesia.The 1991 Uganda Census revealed the same result. In 1987 studies done in Canada, China, Great Britain and Africa (Einar Helander-Publication No.E.93-111-B-3 UNDP showed a downward trend from 5.2-5.8%.

This downward trend was caused by:

a) Protein-Caloric malnutrition is no longer considered to cause chronic disability but is seen as reversible impairment.

b) Estimates included slightly disabled people e.g loss of one finger but the 1987 studies confined to identifying the moderately and severely disabled who required rehabilitation.

For the purposes of this paper, we shall confine out planning to 944,777 disabled persons represented by 5.8% (Einar Helander: E93-111-B.3 UNDP) "Prejudice and Dignity".

Apart from the total coverage we shall go further and categorize functional limitations among the population in Uganda as follows:-

Type of Limitation	Prevalence %	No. of Disabled
Moving difficulty	2.0 - 2.5	407,733
Seeing difficulty	0.5 - 0.8	130,475
Hearing/Speech difficulty	0.5 - 0.8	130, 475
Learning difficulty	0.2 - 0.4	65,237
Chronic fits	0.3 - 0.6	97,237
Behavioral problems	0.1 - 0.2	32,618
Feeling difficulty (in hands or feet)	0.1 - 0.2	32,618
Combinations of the above	0.2 - 0.3	48,928
TOTAL	**4% - 5%**	**945,938**

As can be noted above, four categories stand out to challenge our efforts in provision of services to moving , seeing, hearing/speech and learning limitations not forgetting other limitations through equitable distribution of resources and drawing all pairs together in spirit of collaboration and cooperation.

GOVERNMENT POLICY ON REHABILITATION SERVICES:

The Uganda Government's main efforts in the social sector has undergone a lot of changes including the following:-

* Ensuring the security of persons and their property especially in the Northern area of Uganda. Peace has been singled out as a pre-requisite for any sustainable development to take place.
* Promotion of community involvement and participation in development schemes and initiating a Community Based maintenance system to sustain the social sector especially in health education, community development and human rights. It is pleasant to note that budgets of these sectors have been greatly revised. In Health emphasis has been placed on Primary Health Care, Immunization, Hygiene and Nutrition.
* *In* Education, emphasis will be placed in the field of Functional Adult Literacy and on every four (4) children per family to receive free primary education as the first step towards free and compulsory Primary Education. In the area of Community Development, all efforts will be directed towards alleviation and to be precise elimination of poverty. The guiding principal will be increasing household incomes to create "living income".
* Affirmative Policy: This policy will uplift the standard of vulnerable groups (i.e women, youth and disabled people) in sectors of advocacy, social, economic and political nature. To this end the Uganda Constitution Assembly included provisions in Uganda Constitution in recognition and Protection of rights of people with disabilities, as well as arrangements for provision of appropriate services.

Against this background, the Government of Uganda started Rehabilitation services for People with Disabilities in 1966. This was after a survey conducted in 1965 which revealed that there were 650,000 disabled persons in the country. The policy adopted by Government to institute measures against Disability sought to address the technical needs of disabled persons. It was believed that disabled persons were marginalized and desperate in the community because they lacked skills which they could utilize to earn a living. A Vocational Rehabilitation Programme was introduced to include facilities for identification, recruitment, training, resettlement and follow-up of disabled persons.

The facilities include:-

- An administration section under the Department of Community Development.
- An Industrial Rehabilitation Center at Kireka.
- Seven rural Vocational Rehabilitation Center at Lweza, Ruti, Bwama, Ocoko, Ogur, Nagongera and Mpumudde.
- Four Sheltered workshops at Masaka, Kireka, Jinja and Mbale.
- Two resettlement homes at Buyanga in Mbale and Onyakidi in Lira.
- A mobile unit for disabled women residing in rural areas.
- A retail shop in Kampala to market the goods form the centers and workshops.

Ever since the programme started in 1966, 12,000 disabled persons have benefited from the training programme in Rehabilitation Centers. 195 of them have been gainfully employed in Sheltered workshops, 480 have secured employment with Government organizations and Agencies, 375 have established production workshops on individual basis.
Like any other social sector programmes, the economic and political deterioration of the seventies and early eighties adversely affected the programme.
In 1988 the Government decided to re-orient Rehabilitation services for disabled persons from the institutional model to Community Based Rehabilitation (CBR) programme largely because it encourages community participation and public awareness.
The CBR programme has been implemented through joint efforts by the Norwegian Association of the disabled (NAD), Uganda Society for Disabled children (USDC) and the Uganda Government. So far it covers the Districts of Kabale, Ntungamo, Mbarara, Busheyi, Masaka, Luwero, Masindi, Arua, Moyo, Nebbi, Mbale, Tororo and Iganga and there is a Plan of Action in place to cover also the remaining districts by 1999.
The overall objective of CBR programme in Uganda is to achieve social integration of disabled persons through training of staff, disabled persons, their families, parents and the communities.

Presently the following has been achieved in respect to the above objective:-

- A total of 7338 disabled persons and parents of disabled persons has been trained in managing disability.
- 270 Community Development Assistants in the districts of Mbarara, Bushenyi, Kabale, Iganga, Tororo and Mbale have been trained in managing disabilities;
- 515 Disabled persons are receiving Rehabilitation Services at home by trained social workers under CBR programme;
- 109 Disabled youth have been integrated in normal schools in the community;
- 184 Children with simple disabilities have been surgically corrected;
- 583 Appliances have been supplied to people with disabilities who needed them. Appliances given include 124 wheel chairs, 224 crutches, 40 calipers, 35 pairs of spectacles, 56 artificial limbs and 104 surgical boots.
- 1,078 appropriate aids in the management of disabilities have been produced, these include standing frames, corner seats and parallel bars;

- 93 CBR committees to guide CBR activities have been established at Local Council 3 in the districts of Mbarara, Bushenyi and Kabale.
- 88 Cultural groups have been formed by people with disabilities and perform in public places like; schools, trading centers and local theaters for purpose of public awareness campaigns;
- 93 Groups of PWDs have been helped to start generating activities for their own welfare.
- Sensitization seminars on the need to plan and include Rehabilitation programmes in the district Plans of Action are going on country-wide with remarkable success as measured from the present level of public awareness on disability issues;

However, the present challenges to the integration of PWDs in Community Activities include the development of programmes which will reduce to a minimum all physical and social barriers as stipulated in Standard Rules for Equalization of Opportunities for disabled persons e.g attitudes, education, empowerment information, accessibility, etc.

Future Plans.
Rehabilitation Centers will be equipped and strengthened to start production for sale as a way of sustaining the programme.

The main thrust of CBR strategies 1997-2007 will be to develop a CBR programme that will have a coordinated strategy, that will encourage collaboration between Government and NGO's working with vulnerable groups. The emphasis should be put on the following aspects:

a) Public awareness through mobilization and sensitization.
b) Training programmes to parents, beneficiaries and the community;
c) Referral services, to Medical, Education, Vocational and Social services;
d) Production of appropriate appliances, procurement and distribution of those appliances;
e) Joint venture in provision of income-generating programmes to mature (organized) groups or associations of the disabled on merit;
f) Collection of statistics while providing services to beneficiaries;
g) Joint venture in supervision of CBR programme;
h) Identification and Documentation of all CBR resources in Uganda;

How does the government link up with the situation of vulnerable refugees in Uganda:
The Government of Uganda as a signatory to the 1951 refugee convention, the protocol of 1967 and 1969 OAU convention has kept hosting the ever increasing population of refugees. The initial aim of CBR in Refugee Affected Areas in Uganda was to have a programme which would have an integrated approach towards identifying needs and sharing services with and for people with disabilities as agreed during the 1994 Programme Technical Support Section. (PTSS) mission.

Subsequently the emphasis has been put on vulnerable groups in general, and more effort is geared to integration of refugee concerns into national activities and programmes in order to rehabilitate the refugees into self-sufficiency and to facilitate integration into economic and social life of the local community. The disabled and other vulnerable groups are targeted through the community, relying on local skills and resources, aiming at empowerment of both the refugees and the nationals. the aim of this integration process is co-existence of nationals and refugees living side by side with the local population instead of being settled separately and isolated from the local population.

The local population within the refugee affected areas are also beneficiaries of programme activities. Government structures are also involved in ICBR. Before community development workers are going to the field, meetings should take place in which representatives from Refugee Welfare Committees and Local Councils participate and discuss how to assess the needs and services provided. Currently this happens on a small scale, we still need to focus more on integration of the refugee and the local communities.

MOLG is responsible for formulation of local government policies, to promote and enhance performance of local authorities in the socio-economic effort henceforth ensuring a better quality of life for all people at the grassroots. The local council system of local government plays an important role as an agency of popular participation. The refugee population gets the opportunity to share this popular participation through the Refugee Welfare Council system. MOLG, Directorate of Refugees, acts on behalf of GOU and provides a framework for addressing problems and strategies for integrating refugee concerns into the national socio-economic planning and development process.

ICBR IN REFUGEE AFFECTED AREAS IN MOYO DISTRICT

Community Based Rehabilitation started in East Moyo, the pilot area, with ACORD as the main agency involved in initiating the CBR programme in the refugee affected areas, including both refugee and local communities. This initiative culminated in the setting of an interagency CBR assessment mission in September 1994 conducted in several refugee affected areas in Uganda and carried out by representatives from UNHCR, WHO, AIFO, NAD and ACORD. East Moyo is located in Moyo district in Northern Uganda bordering Sudan and has a long history of refugee presence since the 1950's. In 1954, the District received refugees from the Anyanya I War in Sudan. In 1979, the post-Idi Amin wars forced over 300,000 people, mainly Lugbara, Madi and Kakwa, to flee to Sudan and Zaire. From 1986 onwards, after NRM came to power, Ugandans living in Zaire and sudan were repatriated. At the same time the civil war in Sudan between the SPLA and the Sudanese Government intensified and forced many Sudanese to enter Uganda.

East Moyo district is lagging behind in the provision of social services. There is a lot of willingness from the Ugandan Government to assist the vulnerable groups, but lack of economic resources makes it impossible. There is actually little left to assist the community in general without even focusing on vulnerable groups in particular. Originally, the vulnerable and disabled people in Uganda were taken care of by their relatives (extended family). This situation has changed due to economic transformation of the African society.
Social structures are broken down to smaller units, which leads to social disintegration. In a refugee society a similar situation exists, but to be forced out of your country makes it even more complicated. Disabled refugees often experienced most difficulties in war situation, not being able to flee with their relatives.

Situation analysis:

As a result of a survey done in 19 refugee settlements in East Moyo, (1995) 824 people identified themselves as being disabled for the following reasons:

Polio	93
Amputees	12
Totally or partially blind	128
Old Age	232
Mental problems	28
Leprosy	14
Lame-paralysis, difficulty in movement	155
TB, Asthma, epilepsy, sleeping sickness	162

Double count Old & Partially blind

For other statistic information concerning vulnerable groups in the refugee communities (including unaccompanied minors, single females, single headed household, elderly and physically disabled persons), I refer to annex 4.

Services provided:
Most of the disabled and vulnerables in the refugee community are relying on the assistance provided by the implementing agencies, mainly because of lack of knowledge and skills, and as such they are unable to know the nature of disabilities and unable to engage in income generating activities for themselves. Most of the services provided in the refugee affected areas are aimed at the population in general, including the vulnerable people. Many NGO's however provide some services targeting specifically the disabled and other vulnerable groups, like income generating services for women, mobilization of women groups, improvement of cooking facilities (grass burning stove), skill training, etc.

AAH in Palorinya settlement is currently mobilizing the community in order to sensitize and motivate them to assist the vulnerables in constructing their tukuls. The tukuls are built by the refugees themselves who receive an incentive for their services.

ACORD is planning to assist these vulnerable people in cultivating/clearing their plots. A census has been carried out to identify vulnerable groups, to assess their needs and investigate the ways to assist them.Other ongoing activities for the disabled are fishnet/hook making and weaving. Services for the blind people in the community are still very few. ACORD has plans to train the blind in making grass burning stoves, and teach them how to use these (as an income generating activity). ACORD has trained many people in blacksmith and provides tools for them to use in the community.

IPSER provides psycho-social counselling services for both mentally handicapped and traumatized people. Health services for these vulnerable groups are carried out by several NGO's.

The services provided for unaccompanied minors are rather specific. It is difficult to establish the total number of unaccompanied minors, because there has not been a systematic method of identifying these children. In '94/'95 it was estimated that there were about 300 unaccompanied minors located in the Adjumani orphanage, Biyaya and Agojo-South settlement. 39% of these children seem to have relatives or even parents in the camps. The policy of both the Government of Uganda and UNHCR is against institutionalizing and in favor of (re)integration of these children (back) in the community. Assistance should be aimed at tracing of parents/searching for foster families, sensitization of the community on how to take care for these children, and follow up on caretakers. Specific guidelines on how to assist parents/relatives in taking care of these children have to be developed and discussed. The services currently provided to the children in the institutions are food and supplementary feeding, non-food items, counselling services, education, introduction to some income generating activities, poultry, provision of tools, cooking fuel, and transport. Various religious organizations provide the accommodation for these children. The community also contributed (with earnings from income generating activities) to the accommodation for unaccompanied children.

Involvement of the vulnerable groups in the planning and delivery of services:
The vulnerables are involved in many ways:
* through RWC's and LC's, which still serve mainly as communication channels. Vulnerable groups are rarely involved in these committees as such, but more emphasis has been put to encourage this.
* through training of community development workers of both the refugee and the local community
* disabled and vulnerable groups are represented through several committees in the community. There is a committee for women and children, for the disabled, etc. These committees create at the same time possibilities for the vulnerables to express their needs.

Other ways to express their needs:
* through community development workers (out reach services) and trained facilitators
* group meetings
* discussions
* interviews
* Participatory Rural Appraisal (PRA)
* welfare community meetings
* traditional mechanisms for communication like songs, dance, drama and other cultural traditions

SITUATION OF THE VULNERABLE GROUPS AMONG THE URBAN CASELOAD:

Among the Urban caseload, 94 vulnerable cases are identified, including the mentally ill (18), the blind (4), tuberculosis (14), epileptic (2), physically disabled (11), elderly (11), and others (34). These included refugees suffering from ailments such as asthma, peptic ulcers, high blood pressure, etc. For these groups treatment, counseling and caretakers services are provided.

Regarding the other vulnerable groups several services are provided:

1) Medical health care, treatment and counselling for the mentally ill. So far four have recovered and entered vocational training courses.
2) Caretakers are provided for the blind people.
3) TB patients receive treatment and counselling services. A medical consultant for TB and Leprosy visits them once a week.
4) Epileptic people also receive treatment and caretakers are available to them.
5) Regarding the physically disabled wheel chairs have been provided to 3 refugees, calliper and clutches have been given to 4 refugees. Surgical operations have been conducted on 2 refugees and 2 others are assisted by caretakers.
6) Caretakers are available for the elderly.

Involvement in the planning and delivery of services:

Discussions and meetings are held together with the refugees in which decisions are made regarding the services provided and the possibilities to assist them. Through these discussions and through seminars, the refugees have possibilities to express their needs.

Problems faced by the vulnerables:

In most of the cases the type of accommodation provided is not suitable for their needs and physical condition. The allowances they receive is very little to meet their basic needs. Due to their handicap, mobility is a problem and there is a lack of transport to move them to hospitals and health clinics.

What has been done to assist the vulnerables?

Interaid, the implementing agency for the Urban Refugees set up a clinic at their offices. A nurse accompanies the individuals to the hospital and counsellors conduct home visits. An English training programme is available to improve their communication skills. Interaid also assists the disabled in searching for appropriate accommodation. Children are assisted through the provision of scholastic material and school fees are paid for 3 children per family. Some vocational training is taken place like tailoring, driving, and catering.

ARUA DISTRICT: SUDANESE REFUGEES

After an initial OXFAM survey, the Refugee Community now identifies and OXFAM reverify the vulnerable groups and the disadvantaged on basically the criteria of who has relatives in the community to take care for them, rather then only on the basis of being old, disabled, widow(er), or an unaccompanied minor. The re-verification exercise has been completed (including skill-survey) and initial figures of around 5000 vulnerable and disadvantaged people have dropped by 50%. Remarkably the refugee community had viewed the "welfare approach', i.e. an agency handing out assistance with the criticism of this undermining their own support structures. A workshop was held to review interventions with the following conclusions:

1) IGA support based on identified skills.
2) CBR training in Kampala, one per zone.
3) Distribution of second hand clothes for P1 children to improve school attendance and to meet the most needy.
4) OXFAM has involved Kuluva Hospital and Ocoko rehabilitation center for joint medical assessment for refugees needing appliances.
5) Monitoring on unaccompanied minors (normally fostered) regarding their access to entitlement.

Nearly half of the refugee population in Imvepi and Ikafe settlement are female. There have been cases of sexual harassments at night especially while women are queuing for water, since the planned quota of boreholes/persons is not yet achieved. Lack of resources for dowry leads to early breakdowns in temporary marriages and consequently female headed households are numerous.

Other services for vulnerable groups:
Community center construction will facilitate training and ceremonial functions. Drums have been purchased for cultural activities. Netballs, volleyballs, footballs and slashers have been purchased whose guardians are mostly identified by the youth groups.
Gender awareness training is planned to analyze reasons among men and women regarding equal representation in the existing structures and the services being provided.
Orphans and unaccompanied minors have being absorbed into families.
Appliances for disabled such as tricycles etc., have yet to be supplied.

URCS, the implementing partner in Koboko transit provides counselling services, surgery, medical health care and income generating activities for the vulnerable groups.

DED, implementing partner in Rhino camp they have, though newly introduced to multi-sectoral activities, identified vulnerable groups, but are still on the way to organize interventions. Services so far provided include extension work and organized workshops by a Community Development Officer.

Refugees are in several ways involved in the planning and delivery of services:

1) Communication with relatives, communities, and churches to increase their involvement.

2) Food for work as a last resort for those families not able to till their land; house construction will not be started in the new zones in favor of influencing the Point Chairman and churches to act.

KITGUM: SUDANESE REFUGEE POPULATION

AVSI, an Italian NGO is working in Acholi pii camps (Kitgum) where about 15725 Sudanees refugees are settled. For the statistic information on the vulnerable groups I refer to annex 4, information we obtained from a census conducted in 1995. Assistance for the disabled and vulnerable groups is integrated in the services provided for the refugee population in general. Sprecial services targeting the disabled are the following:

1) Tailoring school, skill training and Income Generating Activities to empower the disabled
2) A survey is still ongoing to identify cases of post-trauma stress disorders, especially among children.
3) Appliances are provided for the disabled, some wheelchairs and crutches, in collaboration with Mulago hospital Kampala.
4) Social counselling services are provided in the camps.
5) future plans are developed for training of teachers to enable them identifying post-war trauma's and stress disorders.
6) A survey has been developed for all the refugee camps, in order to identify the disabled. Social workers and physiotherapists are going to be trained to conduct this survey. Again due to security problems this has not yet been implemented.
7) An orthopedic workshop will be established in Gulu (in the Government hospital) to supply the disabled with appliances. This initiative will serve both the local and the refugee population.

KABAROLE DISTRICT: ZAIRIAN REFUGEES

In Kyaka II Resettlement Camp, where about 12,525 Zairian refugees live, is ARC the implementing partner, identifying and targeting vulnerable groups in order to understand their special needs and provide services. All members of vulnerable groups are scattered throughout the communities; most with the support and care of family members.

House-to-house survey, to locate the disabled and access their living conditions have been undertaken. 196 physically and mentally handicapped persons have been identified. A series of workshops on both individual and groups self-reliance targeted the disabled; as a result most have formed groups to support each other and to conduct group income generating projects, like growing groundnuts, poultry farming, mat weaving, embroidery, crocheting, and petty trade. ARC has also designed and promoted an Income Generating Activities Planning Tool (IGAPT) to assist in initial business planning. Services are provided to take care of individual disabilities, like appliances for the physically handicapped (wheel chairs, crutches, surgical boots, etc). Orthopedic personnel visited the camp to access the needs.
The Kyaka Association of the Handicapped and the District Union of the Disabled, two local grassroots NGO's, are in close touch with the disabled refugees of Kyaka II.
ARC runs a supplementary feeding center to counter malnutrition among children under five years of age. Adolescents and young adults are encouraged to form groups for the purpose of income generation, sports, drama, and dance.

The communities are mobilized to build houses for those unable to do so for themselves. Referrals are given to the Ministry of Local Government project for needed items outside ARC's scope of services, for example agricultural implements for widowed or deserted women.

Involvement of the vulnerable groups and possibilities to express their needs:
Workshops conducted resulted in the disabled forming groups. Each disabled person is represented by a committee, chosen by all group members, to monitor and report problems occurring within the group. regular meetings provide a forum for extensive discussion of member concerns. Communication takes place through welfare committees and through committee leaders.

MBARARA DISTRICT: RWANDESE REFUGEE POPULATION IN NAKIVALE AND ORUCHINGA CAMPS:

Special attention is given to the most vulnerable; unaccompanied minors, physically handicapped, mentally handicapped, orphans, unaccompanied elderly, single parent households, widows/widowers, chronically ill, AIDS patients, refugee women and children.

Unaccompanied minors	12
Disabled	34
Elderly persons	70
psycho-social problems	30
orphans	10
Chronic illness	20
widows	85

The services provided include the following: income generating activities, such as poultry, skill training in handicrafts (tailoring and cookery), counselling, provision of mobility aides, special medical care, special diet for malnourished children, elderly, sickly, nursing and pregnant mothers, foster care for unaccompanied minors and orphans, tracing for family reunification. The 12 Unaccompanied Minors are settled within the refugee community and a caretaker looks after them. The major problems the disabled and other vulnerable groups face is that their needs are not adequately met and some are unable to carry out the day to day activities and therefore can't take part in community activities. Sometimes they are not recognized in the community, which leads to an inferiority complex.

Refugees are involved in the planning of these services:
Planning is based on need and problem assessment. The disabled and vulnerable groups express their needs during home visits by Red Cross staff and community workers. On regular times meetings are held with the vulnerable groups in which they can express their needs.

The problems identified and the future planning for services:

1) Early diagnosis and assessment of a refugee population is needed, in order to provide appropriate services.

2) Mobility is still a big problem for the disabled. There is a need for more crutches, wheel-chairs, Recently ACORD in conjunction with NAD is supporting Adjumani hospital to establish the orthopedic department. An orthopedic technician is assisting in the training of people on how to make orthopedic appliances and maintenance of the material. .

3) There is a lack of basic needs, and thus a need for IGA, to improve the economic resources. More different income generating activities needs to be developed like: blacksmithing, carpentry, shoemaking, leatherwork, beekeeping, pottery, etc. More emphasis should be put to develop Income Generating Activities for women in general.

4) More skill training is needed, so that people are able to get employment and to earn a living. Employment will also lead to more self confidence amongst the vulnerables and appreciation by the community. It will eliminate the negative attitude from the community towards the disabled and from the disabled people themselves.

5) When we talk about IGA we should also create a market for these products. Currently there is a lack of markets and hardly access to raw materials. (Again mainly due to security problems).

6) More survey and research is needed on the needs and assistance for vulnerable groups. For example, AVSI, implementing partner in Kitgum proposed to conduct several surveys to identify the disabled, traumatized children, etc. Due to security problems in the North of the country, they were not able to implement their services completely.

7) Families of the disabled should be trained in how to assist them

8) Need for scholarships for vocational training for disabled people, especially for the blind people.

9) There is a need for sensitization and awareness raising on the situation and the needs of the disabled and other vulnerable groups (in the community).

10)Participatiuon of vulnerable groups in RWC's and LC's has to be encouraged..

FINAL COMMENTARY:

In general the major problems are caused due to poverty and lack of resources. Lack of resources is also one of the major constraints for the NGO's to implement their services and assist the vulnerable groups in an appropriate way. In Northern Uganda the situation is even more difficult due to security problems caused by rebel activities. A need for leadership skill training to enhance participation of the different vulnerable and disadvantaged groups in the community through training, seminars and workshops is recognized. Also the need for more income generating activities, vocational/skill training, and experts who can conduct the training, has been expressed.
Government institutions, UN agencies and implementing organisations should collaborate through training seminars, networking, and skill training, in order to acquire full integration of disabled and other vulnerable groups. A monitoring and evaluation system, capable in measuring the impact of programme implementation in the field of ICBR, has to be developed.

There are other organisations (not mentioned) which complement or substitute the Government efforts by providing special assistance to disadvantaged and vulnerable groups, like Uganda Society for Disabled Children (USDC), which aims at improving the quality of life of children and young people with disabilities in Uganda. Their work follows a community based approach; using local and appropriate resources and they transfer rehabilitation skills and knowledge on disability to children with disabilities, their families and other community ,members. USDC collaborates with the Government of Uganda and other partners to strengthen service provision through professional, technical and material support. Other organizations like Education Assessment and Resource Services Uganda (EARS), National Union for Disabled People in Uganda (NUDIPU), Religious institutions and many other indigenous organization of and for people with disabilities provide services as well. Their experience and the commitment of their staff has played significant contribution to ICBR in Uganda and are invaluable resources for the future development of activities and services.

ANNEX 1

Refugee Population in Uganda

Districts	Population		
	30/04/96	31/05/96	30/06/96
Sudanese Population *Arua District*			
Koboko	29,622	28,195	26,905*
Ikafe	43,622	59,235	45,299*
Rhino Camp	18,833	19,423	20,750*
Mvepi	9,305	9,305	9,321*
Moyo District			
Adjumani	73,843	74,025	74,293
Palorinya	19,648	19,813	20,331
Kitgum District	15,327	15,509	15,725
Masindi District			
Kiryandongo	9,290	9,358	9,404
Rwandan Population *(Mbarara District)*			
Oruchinga	5,716	5,759	5,834
Nakivale	1,323	1,493	1,346
Zairian Population *(Kabarole/Kisoro Districts)*			
Kyaka	12,517	12,697	12,525**
Kisoro	--	--	2,589
Somali Population & Urban Caseload (Ethiopian, Kenyan, Burundian, Liberian). All refugees registered as vulnerables or security cases.	461	452	458
Unassisted	***	***	***
Total Refugees in Uganda	**238,938**	**255,264**	**244,780**

* Figures are subject to the security situation which has caused many refugees to flee from their settlements and travel to other locations within the area, or back to Sudan. Therefore, the figure for Mvepi may actually be higher as some refugees from Ikafe South have moved to Mvepi. Also, Koboko has received some refugees from Ikafe, but some refugees originally in Koboko have left for other areas.

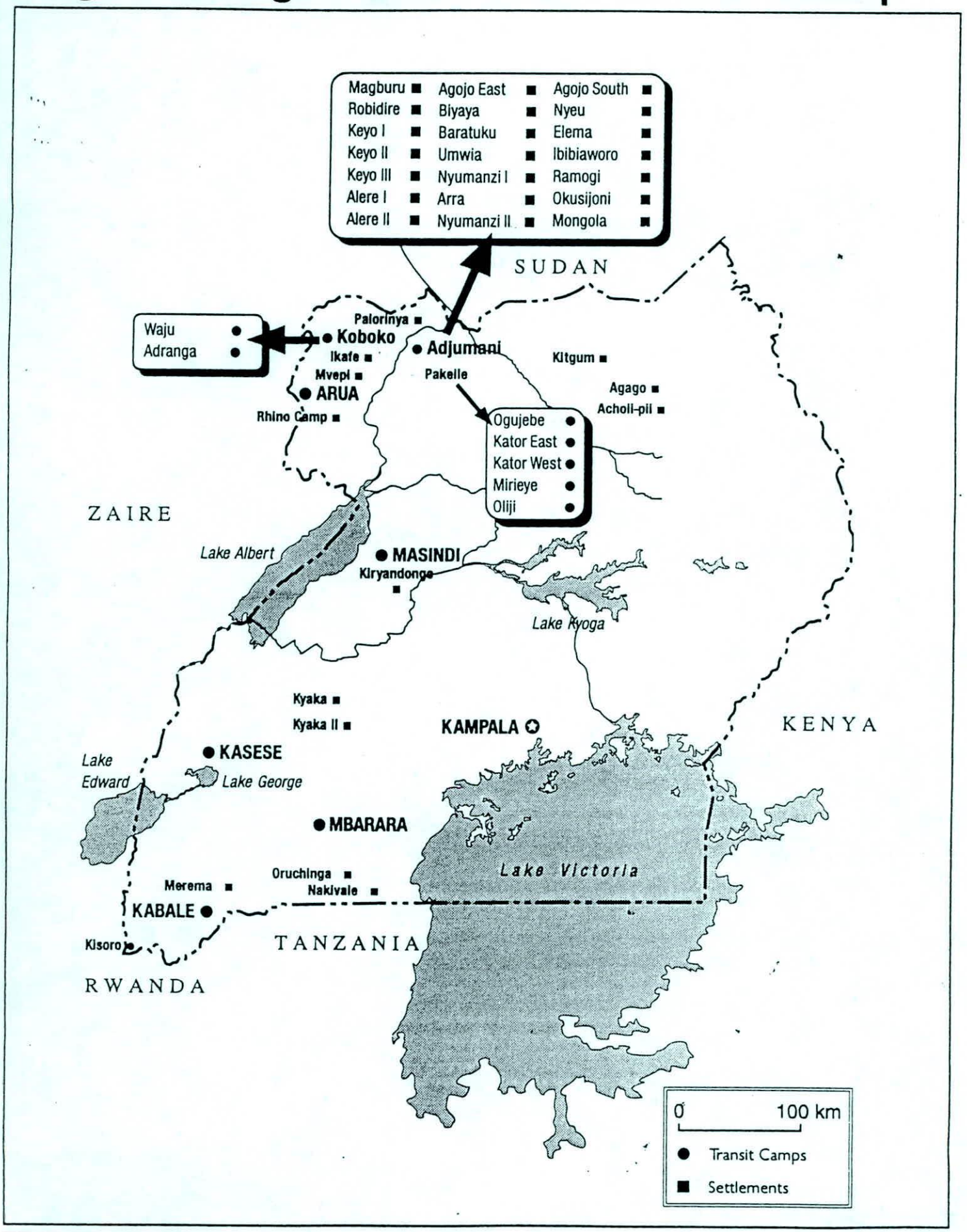
** Approximately 100 refugees may have spontaneously repatriated, accounting for the drop in numbers from the previous month.

*** Since GOU designated a refugee camp for the Urban Population at end November 1994, most of the Somalis have refused to transfer. Many are reported to have departed spontaneously for Kenya or Somalia.

*** GOU estimates not included in the above statistics for unassisted refugees: 50,000.

ANNEX 2

Uganda Refugee Settlements and Transit Camps



ANNEX 3

(**Source:** "The state of the World's children 1991.") ?How? Based on?

Estimated figures of disability in Uganda.

(ESTIMATED FIGURES - 1991 POP.CENSUS)

District	Population	Total Pop. of Disabled Persons	Total Pop. of those in serious need of Rehabilitation services
1. Apac	453,207	45,321	26,286
2. Arua	633,254	63,325	36,728
3. Bundibugyo	166,092	11,609	6,733
4. Bushenyi	734713	73471	42613
5. Gulu	331,028	33,103	19,199
6. Hoima	197,080	19,708	11,431
7. Iganga	941,151	94,115	54,587
8. Jinja	286,958	28,696	16,644
9. Kabale	219,751	21,975	12,746
10. Kabarole	735,685	73,569	42,669
11. Kalangala	15,888	1,589	992
12. Kampala	730,189	73,019	42,351
13. Kamuli	482,634	48,263	27,993
14. Kapchorwa	115,860	11,586	6,719
15. Kasese	340,381	34,038	19,742
16. Kibale	291,751	21,975	12,746
17. Kiboga	140,820	14,082	8,168
18. Kisoro	186,222	18,622	10,800
19. Kitgum	354,022	35,402	20,533
20. Kotido	173,520	17,352	10,064
21. Kumi	234,954	23,495	13,627
22. Lira	498,912	49,891	28,937
23. Luwero	444,149	44,415	25,760
24. Masaka	843,359	834,436	48,392

25. Masindi	246,990	24,699	14,325
26. Mbale	706,946	70,695	41,003
27. Mbarara	922,408	92,241	53,499
28. Moroto	170,766	17,077	9,904
29. Moyo	173,431	17,343	10,058
30. Mpigi	908,655	90,866	57,701
31. Mubende	496,059	49,606	28,771
32. Mukono	821,059	82,106	47,621
33. Nebbi	314,531	31,453	18,242
34. Ntungamo	734,713	73,471	42,613
35. Pallisa	357,006	35,701	26,706
36. Rakai	382,053	38,205	22,159
37. Rukungiri	389,274	38,927	22,577
38. Soroti	426,276	42,628	24,724
39. Tororo	553,310	55,331	32,092
TOTAL	**16,309,344**	**1,628,935**	**944,777**

ANNEX 4

VULNERABLE REFUGEES

TYPE	PLACE	SEX	CTRY OF ORIGIN	NUMBER
Physically Disabled	ACHOLI PII	F	*SUDAN*	82
		M	*SUDAN*	90
	Arua	F	*SUDAN*	438
		M	*SUDAN*	582
	Pakelle	F	*SUDAN*	127
		M	*SUDAN*	123
	Palorinya	F	*SUDAN*	18
		M	*SUDAN*	18
Single Female	Acholi pii		*SUDAN*	424
	Arua		*SUDAN*	1,872
	Pakelle		*SUDAN*	1,041
	Palorinya		*SUDAN*	141
Single Parents	Acholi pii	F		638
		M		625
	Arua	F	*SUDAN*	3,228
		M	*SUDAN*	2,819
	Pakelle	F	*SUDAN*	7,396
		M	*SUDAN*	1,722
	Palorinya	F	*SUDAN*	781
		M	*SUDAN*	155
Unaccompanied elders	Acholipii	F	*SUDAN*	189
		M	*SUDAN*	214
	Arua	F	*SUDAN*	400
		M	*SUDAN*	367
	Pakelle	F	*SUDAN*	279
		M	*SUDAN*	274
	Palorinya	F	*SUDAN*	34
		M	*SUDAN*	28
Unaccompanied minors	Acholi pii	F	*SUDAN*	287
		M	*SUDAN*	539
	Arua	F	*SUDAN*	543
		M	*SUDAN*	956
	Pakelle	F	*SUDAN*	484
		M	*SUDAN*	1,313
	Palorinya	F	*SUDAN*	20
		M	*SUDAN*	11
TOTAL				28,258