Baseline Survey – Hoima

0000007

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EXECUTIVE SUMMARY

This base line survey was commissioned by Uganda Society for Disabled Children (USDC) so as to determined the incidence of disability in Hoima district, examine the problems facing children with disabilities, identify the programmes, services and opportunities in place that could benefit people with disabilities. It was also intended to assess the network of support to people with disabilities at different levels from the village to the district level.

This effort was meant to capture a pre-programme position to serve as a benchmark against which to measure the rate of performance once the programme is launched on the ground. The baseline survey covered eight sub-counties of Kiziranfumbi, Kitoba, Buseruka, Kigorobya, Kyabigambire, Kyangwali, Kabwoya and Busiisi where Hoima town is located. The sampling of these places that extensively covered the far-flung places was guided by the uniquely harsh situation that the lake regions have, so that it can correctly depict their plight. They are almost cut off from the mainstream social infrastructure due to bad terrain created of the rift valley drop and because of this, government authority is hardly felt in these places.

The baseline survey used a wide range of methods including semi-structured interviews guides, face-to-face interviews and probing, flooding, appropriate participatory rural appraisal techniques, direct observation, records review, transect walks, photographing, information cropping and collation, folk literature analysis, and empathy conversations. The findings are reported in a manner that emphasises the status variables under observation as they are reported on by the study population. This approach was adopted because it emphasises the objectivity of the findings.

The incidence of the disability in Hoima cannot be ascertained in the current absolute lack of a comprehensive record of the people with disabilities. Recourse to inference is therefore inevitable basing on the few data pointers from the effort of the local organisations of people with disabilities and EARS programme in the district education office. Popular community opinion however holds that the estimated number of 2500 people (as indicated by Hoima Welfare Society For The Disabled) registered from the three sub-counties is still an under estimation. Whether this is subjective or not is still an indication of the urgent need to establish a reliable database about disabilities and people with disabilities in the district.

The district has a number of sitting strengths including infrastructure of service roads, 131 primary schools, and 48 health units which can act as a starting point for any intervention programme, for referral and rehabilitation purposes. Except for a few places, which are not well served with roads like in the rift valley places, the bigger part of the district has access to these services. (76% of the population has access to health services **(Source : DDP 1997-2001)**. The population is very receptive and willing to learn at every availed opportunity. The population therefore constitutes a potential ally in community based rehabilitation work that USDC may wish to begin. The biggest problem that militates against understanding and managing disability are the attitudes which are largely hostile. Many people still don't know the causes and management of disability. As a result, their level of knowledge influences their attitudes towards people with disabilities leading to passing of sentence against them as indeed a social inconvenience.

There is a commendable local effort at pulling PWDs together for a strong voice and this can be a good ground for further mobilisation. With the sensitisation of the host community and policy makers in the district on formulating and adopting concrete policy on disability, the existing resources in the area can be put to full use to the advantage of the people with disabilities and in its prevention. However, for this to work, the level of knowledge about and attitudes towards disability of both the community members and policy makers would need rehabilitation.

LIST OF ACRONYMS AND ABBREVIATIONS.

ARI	-	Acute Respiratory Infections.
AVSI	-	International Service Volunteers Association
BIRD	-	Buseruka Integrated Rural Development - Programme
CAO	-	Chief Administrative Officer
CBR	-	Community Based Rehabilitation
CDD	-	Control of Diarrhoea Diseases
CWDs	-	Children with Disabilities
DANIDA		Danish Development Agency
DDP	-	District Development Plan
DEO	-	District Education Officer
DIC	-	Development Initiative Consultants
DMO	-	District Medical Officer
DPWO	-	District Probation and Welfare Officer
EARS	-	Education Assessment and Resource Services
IGAs	-	Income Generating Activities
LC	-	Local Council
NGO	-	Non-Governmental Organisations
NIDs	-	National Immunisation Days
NUDIPU	-	National Union and Disabled Persons of Uganda
PLE	-	Primary Leaving Examinations
POLIO	-	Poliomyelitis
PWD	-	Person(s) with Disabilities
RDC	-	Resident District Commissioner
STI	-	Sexually Transmitted Infections
TBAs	-	Traditional Birth Attendants
UNEPI	-	United Nations Expanded Programme for Immunisation
UNHCR	-	United Nations High Commission for Refugees
UPE	-	Universal Primary Education
USDC	-	Uganda Society for the Disabled Children
WSD	-	Welfare Society for the Disabled
WV	-	World Vision

1. DISTRICT PROFILE

1.1 GEOGRAPHICAL FEATURES.

Hoima District lies in the mid-western side of Uganda. It borders with Masindi district in the north, Kiboga in the eastern side, Kibaale in the south and the Democratic Republic of Congo in the west, where they are united by Lake Albert as a natural boundary (as is shown on **Map 1**of political and administrative boundaries). It covers a total area of 5492 sq. km where about 2000 sq. km are covered by water bodies and over 3200 sq. km constitute arable land.

Hoima's topography is defined by a highland coverage, which takes up most of the eastern, northern, and southern areas and a rift valley drop in the western side. Because of this rift valley drop, it has an altitude range of between 621-1158m above sea level **(Source: DDP-1997-2001).** The district has a variety of vegetation types ranging from savannah grass lands to thick evergreen impenetrable, forests, the latter of which are mainly found along Lake Albert shores and big rivers like Kafu, Kabale and Nkusi. The three sub-counties of Kangwali, Kabwoya and to a less extent Kiziranfumbi have the majority of this forest cover. The forest reserves in district include Bugoma, Wambabya and Bujawe **(Refer to Vegetation Map 2)**. This vegetation is a sequel influenced by the rainfall pattern in the area which is as high as 700mm-1000mm per annum, with a mean annual temperature of 28°C except for the rift valley area which sometimes stretches up to 32°C. Hoima enjoys two peak rainfall seasons, and two dry seasons. The peak rainfall seasons are normal equinox March-May and September-November, while the two dry seasons occur in June-July, and December-January.

1.2 SOIL PRODUCTIVITY, FAUNA AND FLORA

The climatic patterns shown above have engendered the endowment of deep, well weathered, fine texture, well-drained soils which are usually red on the uplands. Most soils throughout the districts are loamy with ranging proportionate degrees of sandy and clay components. It is sited that soils of fairly high productivity are widespread in the subcounties of Buhimba, Busiisi, Kizirafumbi, Buseruka and Kitoba. These soils and their vegetation have provided a good habitat for a range of fauna. These include, baboons, monkeys, crocodiles, water bucks, hippopotami, fish, bush-bucks and pigs. The area also has a rich variety of bird species. The majority of wildlife and birds live in or around the lake, rivers and swamps.

1.3 CULTURE AND ETHNICAL COMPOSITION

Like many districts in Uganda, Hoima is inhabited by people of different ethnic origins, with varied traditions, cultures, and religions. The domestic ethnic groups are Banyoro who make up 66% of the total population of about 250,000, Bagungu (mainly in Kigorobya and Buseruka) but who also speak a dialect close to Runyoro) make up about 17%. There are also 7.2% of the total population who are the Bakiga from south western Uganda, the Luo who make up 3.9%, while Lugbara constitute about 3.0%.

Inspite of this ethnic mix, Hoima as part of the Bunyoro-Kitara Empire and itself the seat of the king (Rukira Basaija, Solomon, Agutamba Iguru II) has also benefited the area in the harness of unity and order, due to the centripetal influence of the kingship.

Many shades of religion are represented, although the majority of people are Christians, followed by Moslems. Traditional African religions are also practised. Some followers of Christianity and Islam revert to traditional religious practices whenever spiritual solace is not adduced in the two former religions.

1.4 ADMINISTRATIVE UNITS AND POPULATION

1.4.1 General

Hoima District is divided into two counties, namely Buhaguzi and Bugahya. It has 11 subcounties, 44 parishes and 319 villages.

Although the districts' population is still relatively small, it has been growing at high rates over the last census periods. Available data shows that the population increased from 112,709 in 1969 to 142,247 in 1980 to 197,851 by 1991 and is estimated at 250,000 by 1997, registering an average growth rate of 2.8% between 1969-1997, and of 3.0% between 1981 and 1991. According to the District Population office, it is projected that the population will be 275,300 by the year 2000. This makes the district the eighth smallest district nationally, constituting 1.2% of the country's total population.

Table 1: Projected Population by Sex and Population Densities 1997-2000

Year	*Male*	*Females*	*Total*	*Popn. Per sq.km.*
1997	128,000	122,000	**250,000**	69
1998	132,600	125,800	**258,400**	72
1999	137,300	129600	**266,900**	74
2000	141,900	133,400	**275,300**	76

Source: Analytical report, Hoima District volume 1 Table A.7:21

1.4.2 Age-Sex Structure

Like many other districts with high fertility rate, Hoima too has 54.8% of its population as children under 18 years. This situation, arising from persistently high fertility rate (5.4%), has serious socio-economic repercussions. The available resources and infrastructual facilities like increasing educational, health, nutritional, housing, and other needs of this predominantly young population does not seem to grow at the same rate as population. This is shown in the table 2 below, where about 55% (148.652) is non productive-youth of this total population. The most populous sub counties are Kigorobya (38.095 persons), Kitoba (30,477 persons), Buhimba (29,299 persons). The smallest sub-counties in terms of population size are Kabwoya with (12,050) and Buseruka (15,791).

Table 2: Mid-year Population Projection by Age and Sex, July 1997

AGE RANGE	MALE	FEMALE	**TOTAL**
0-4	24,776	23,804	**48,580**
5-9	19,598	18,433	**38,030**
10-14	16,525	16,060	**32,585**
15-19	15,093	13,454	**28,541**
20-24	11,433	10,333	**21,766**
25-29	8,662	7,940	**16,602**
30-34	6,529	6,559	**13,088**
35-39	5,136	5,035	**10,171**
40-44	4,706	4,520	**9,227**
45-49	4,031	3,452	**7,483**
50-54	3,446	3,210	**6,657**
55-59	2,518	2,335	**4,853**
60-64	2,058	2,174	**4,233**
65-69	1,444	1,535	**2,978**
70-74	1,060	1,539	**2,599**
75-79	545	898	**1,443**
80+	441	719	**1,161**
Total	**128,001**	**122,000**	**250,001**

Source: District Population Survey July 1997.

1.4.3 HOIMA DISTRICT FACT SHEET

Percent of Household populations

a)	**Socio-economic indicators:**	Aged 10 and above who are economically active:	
		Male:	65.8%
		Female	53.5%
		Total Average:	59.7%
b)	**Working and aged 10 and above who are peasant farmers:**		
		Male:	44.7%
		Female:	70.3%
		Total average:	57.5%
c)	**Housing**:	Total number of households (July 1997)	50,000
		Mean household size	5
		Mean number of persons per room	1.5
d)	**Percent of households that:**		
		are female headed	1.2%
		are in urban areas	2.9%
		are headed by children	0.8%
		have only one member	27.2%
		depend on subsistence family as a livelihood	62.8%
e)	**Orphaned children who are household heads or spouses:**		
		Male	3.6%
		Female	7.8%
		Total average	5.7%
f)	**Percent Households which have:**		
		access to electricity for lighting	0.2%
		non-wood fuel for cooking	0.6%
		access to safe water	28.0%
		access to toilet facilities	27.6%
		no kitchen	37.0%
		no bathing facilities	82.0%
g)	**Percent of dwelling units which are:**		
		made of temporary materials	60.5%
		less than 5 years old	41.2%
		owner occupied	89.4%
h)	**Nutrition Indicators:**		
	Percent of children under five years who are:		
		stunted	26.8%
		underweight	18.4%
		wasted	7.7%

i) **Percent of Primary school children that have iodine deficiency disorders (goitre):**

Males	4.2%
Females	33.3%
Total average	27.9%

Source: Hoima District Population Office – 1997

1.5 ECONOMY

The economy of Hoima is one of the staggering kind, and a number of factors contribute to its dismal performance. According to the treasury report - 1995/96, the District sited as one reason the limited capacity to plan and collect revenue. However, the revenue base is also narrow. Revenue sums for Hoima Local Government includes:

Table: 3 Revenue Collection Indicators

Graduated Tax	20%
Licence fees and permits	3.2%
Rent, Rates and Interest	0.03%
Reimbursements	0.5%
Miscellaneous subventions	0.91%
Economic Revenue	0.12%
Central Government transfers	62.2%
Donor funds	7.74%

Source: Budgetary Estimates 1996/97 Fiscal Year

There is excessive over-dependence on central government transfers, and other donors. The prospects for revenue base from graduated tax are reflected in the 62.8% of the population which depends on subsistence farming for their livelihood; while 54.8% of the total population are children, with a general dependency ratio of 105.7. This should be seen against the source of revenue, and general production practices and production amounts.

There is therefore marked variance between budgeted and actual revenue collected leaving a huge funding gap, whose solution is not prescribed yet. This is attributed to inefficient assessment, small working populations, and inaccessibility of some of the places. The other complaint is that the **Local Government Act of 1996**, that stipulates 65% of the revenue collected to remain at source, leaves the district with little money to implement its priority programmes.

1.6 AGRICULTURE

Although about 3200sq.kms. of land is available for agricultural use, much of the land is still unutilised. According to the 1996 estimates, about 275 sq. kms.(109,947 acres) are utilised in crop production in proportionate acreage indicated below for the major crop production engagements .

The district main food crops include beans, sweet potatoes, bananas, maize, cassava, soya bean, rice, finger millet, and groundnuts, pigeon peas, simsim, yams and irish potatoes. The cash crops

include coffee, tea (in Bugambe subcounty), tobacco and cotton. The fruits and vegetables include onions, cabbages, tomatoes, pineapples and passion fruits.

Table 4: Agricultural Performance Indicators

Type of Crop	Acreage
Food crops	
Sweet potatoes	21,489
Cassava	16,055
Groundnuts	13,585
Maize	7,410
Cash crops	
Coffee	7,410
Tobacco	7,000
Cotton	1,853
Total	**74,802**

Source: District Extension Co-ordinator's Office, Hoima

Milk production is estimated at 315,000 litres per month. Due to the prevalence of tsetse flies mainly in the subcounties of Buhanika, Kiziranfumbi, Kabwoya, and the other lake regions, the propensity of animal husbandry still remains threatened.

Table 5: Live-stock Indicative Production Figures

Type of Animal / Bird	Total Number Reared
Local Chicken	586,000
Goats	75,000
Cattle	45,000
Sheep	21,000
Apiary	
Local hives	23,055
Modern hives	840
Pigs	343

Source: District Extension Co-ordinator's Office, Hoima

Fishing is also done on Lake Albert and the district has 62 fishponds. The district has taken impressive studies in making a five-year development plan 1997-2001, which is being implemented.

1.7 SOCIAL SERVICES STRUCTURE AND PERFORMANCE.

1.7.1. Education.

The education sector in Hoima still needs a big boost, which their development plan 1997-2001 exhibits. The comparatively comprehensive record used is for 1996 calendar year. At the moment the total number of primary schools are 131, and they held 41,825 pupils before the UPE effort. Compared with the potential 5 - 14 years primary school going children, this represents 59% enrolment rate.

The average class size in Hoima district before UPE was 39 pupils, where the number of female pupils enrolled was 48% of the total primary school enrolment. The dropout rate as at the close of 1996, was 9%, while the repeater rate stood at 22%. In face of the immense manpower needs, this is a high rate of both human and financial resources wastage. This dropout and repeater wastage will be reflected in human resources shortfalls several years from now. Although their effects are not easily noticeable, they remain latent and can be very costly to redress, since it may imply hiring labour from outside the district in the long run. This situation is not helped by high teacher turn-over rate of 11%, where only 24% of its teaching force is trained and qualified.

On performance, the passing rates of the last 2 academic years are far from being proud of. In 1995, only 5.9% of the total 2032 pupils, who sat P.L.E., passed in grade one. While in 1996, only 2.2% of the total 2127 pupils who sat P.L.E passed in grade one. (Source: District Education Office).

With high teacher turn-over rate, and no motivational justification for them to the cope up with the situation, and coupled with the great pupil numbers attracted by UPE, one can only wait for a year to end to assess the demands of the situation and design a correct interventionist policy.

1.7.2. Health

Hoima District has a total of 48 Health Units, 29 of which are government owned and categorised as follows.

Table 6: Health Units in Hoima District

Type	Government	NGO	Total
Hospitals	1	0	1
Health Centre	2	1	3
Dispensaries	18	1	19
DMUs	8	0	8
Private Maternity Homes	-	17	17
Total	**29**	**19**	**48**

Source: Hoima District Medical Office

Although the number of health units looks impressive, their distribution is inequitable and the average distance to the health unit is 20 kms. For example places like Kihomboza in Busiisi sub-county, Bulyango in Kitoba subcounty, Waki in Kigorobya, Kicompyo in Kiziranfumbi, Kyohana in Buhanika, Nyawaiga in Kabwoya, Buhuka and Nsozi in Kyangwali sub-county are earmarked by the District medical office as places which are still not well served. In terms of human resources,

the ratio of doctors to the inhabitants is estimated at one per 24,400, and per nurse at around 5,360 persons.

Looking at nutrition, it is estimated that between 20% and 30% of the pre-school age children are chronically malnourished and only 20% of the population can go through the year with sufficient food security.

According to the District Medical Office, the percentage of district population that is accessible to health service is 76%. The common health problems in the district include, upper respiratory infections, malaria, diarrhoea diseases, AIDS, Eye diseases, malnutrition, skin diseases, trauma, intestinal worms, dental diseases bilharzia and onchocerciasis along the lake regions.
The health sector is helped by the Family Planning Association of Uganda (Home Branch) who offer a wide range of services. As to whether the target population actually utilises them, or knows of their presence is still a matter to study.
Before the National Immunisation Days (NIDs) launched this year, the immunisation coverage of the district by 1995 stood at:

Table 7: Immunisable Diseases Coverage, 1995

BCG	70%
DPT_2	60%
Polio	89%
Measles	61%
TT_2	54%
with corresponding drop-out rates as indicated:	
DPT_1 Measles	21%
DPT_1 DPT_3	13%

Source: DMO's office - Hoima, July 1995.

2. GENERAL INFORMATION ON DISABILITY

2.1 INCIDENCE OF DISABILITY

There is no comprehensive database on disability in Hoima district from which one can extract up to-date information regarding the incidence of disability. Asked about the incidence of disability, the NUPIDU Regional Development Worker hazarded a guess of the usual 10% of the population, - the World Health Organisation estimate.

According to the 1995 NUDIPU study into the living conditions of disabled people in Uganda, done by Wilbert Schouten, the number of the people with disabilities in Uganda was estimated to be about 654,152 people of moderate and severe disabilities, which represented about 3.5 % of the total population. One should however use these figures with caution bearing in mind the low level of sensitisation of the census enumerators and the respondents about the problem of disability.

EARS and Hoima Welfare Society for Disabled people have started collecting data on people with disabilities in the district as indicated in table 8 below. However each of these groups has its own intentions and therefore their data cannot provide a basis for calculating accurate incidence of disability. There are however a few pointers to the magnitude of the problem. Much as they are not comprehensive, but given the nature of the hostile attitudes towards and knowledge about disability that the people still exhibit, these numbers should be treated as only a pointer to a deeper and perhaps more grievous problem.

Table 8: People With Disabilities Identified and Registered by Household per sub-county and Kyangwali Refugee Camp, 1996 - 1997

Subcounty	*Total Population. 1996/97*	*PWDs identified & Registered*	*Percent*
Kigolobya	28,095	55	0.19
Kitoba	30,479	67	0.2
Buseruka	15,791	33	0.2
Buhanika	18473	24	0.13
Busiisi	19939	29	0.15
Kyabigambire	27,443	69	0.25
Kyangwali Refuge camp	2000	45	2.3
Total	**142,220**	**292**	**0.2**

On the other hand, the EARS programme since 1993 to-date, has identified and assessed 533 children. Records also indicate that a total of 572 children with disabilities have been enrolled in various schools, since the start of this year alone, though not yet assessed by the relevant professionals. **(Source: EARS office, Hoima).**

However, on close observation from the countryside trips made to the sub-counties and through participatory research methods used, the incidence of disability is high most especially given the prominent likely causes as discussed in the next sub-topic. This view was supported by the local communities and PWDs interviewed who felt these figures were a gross underestimation.

Table 9: Prevalence of Disability in Children of School-going age in Hoima District.

Type of Disability	1993	1994	1995	1996	1997	Total
Hearing impairment	8	20	37	54	10	129
Visual impairment	6	27	46	33	2	114
Mental retardation &	8	17	65	58	8	156
Hearing impairment	4	11	55	55	9	134
Physical handicap						
Total	**26**	**75**	**203**	**200**	**29**	**533**

Source: EARS office, Hoima

EARS assessment is more skewed towards children in need of special education and quite often children with physical handicaps. Children with mild and moderate disabilities do not ordinarily come out for assessment. Therefore, the number for the physically handicapped may not be representative.

In the year 1997, Hoima lost its EARS staff (teachers) through transfers to other districts. The assessment drive slackened as a result. Therefore, these numbers do not reflect a full year's total staff effort, so as to be a representative guide to a comprehensive picture.

2.2 POSSIBLE CAUSES OF DISABILITY IN HOIMA

According to the District medical Office, the major causes of disability in Hoima district are mainly: -

i) Communicable and non-communicable diseases.
ii) Malnutrition
iii) Trauma
iv) Congenital causes

2.2.1 Diseases

a) The major communicable diseases that are responsible for causing disability include: -

i) Malaria, like in many other parts of Uganda, is still the leading killer disease and largely the cause of disability most especially in children.
ii) Diarrhoea diseases
iii) Child Immunisable diseases
iv) Upper respiratory tract infection
v) Lower tract infections
vi) AIDS/HIV and other STDs
vii) Eye diseases
viii) Intestinal worms
ix) Bilharzia; along the lake regions

Onchocerciasis along lake regions
Ear infections (otitis media).
There are also reported cases of epilepsy in most of the areas visited.

2.2.2 Malnutrition

According to the district nutritional study (1993), malnutrition is still one of the major problems in the district. The study revealed that among children: -

30% are stunted
18% are underweight and
7% are wasted.

This means that over 50% of the children are at risk of getting disability due to malnutrition.

2.2.3 Trauma

Trauma is also one of the causes of disability in the district. The main conditions reported in the district are due to fractures arising from traffic accidents, accidents at home, falls from mango trees mainly amongst children during the mango season, gunshots mainly from robbers, child abuse and birth complications.

2.2.4 Congenital Causes

The commonly reported cases of congenital disabilities in the district are: -

i) Cleft palate and cleft lip
ii) Club feet
iii) Mongolism
iv) Sickle cell anaemia

With all these likely causes of disability in the district coupled with virtually, lack of knowledge on disability by the affected people, it is no wonder that disabilities in all types including physical, mental and sensory disabilities can be this abundant in the district.

2.3 PREVENTION MEASURES

There are already some efforts towards prevention of conditions that cause disability. Some of these measures are already undertaken consciously by the district while others are actually indirect but their success definitely would boost the preventive measures. These measures include:

2.3.1 General Health Education

The district has a Health Educator who works hand in hand with all the health personnel based in the district to assist in preventive measures. The health personnel most especially employed in the Health units, scattered all over the district as well as the trained community based health workers, Traditional Birth Attendants (TBAs) and trained immunisers are all involved in preventive measures. All these are involved in educating the public about health care issues.

2.3.2 Onchocerciasis Control Programme

Sight Savers together with the department of Health in Hoima district are in concerted efforts to control the spread of Onchocerciasis in the district through public education and distribution of free preventive drugs to the population at risk. According to the programme manager, during this year alone, 59,859 tablets of Mectizen have been distributed, representing 76.5% coverage of the total population at risk.

2.3.3 UNEPI and NIDS Programmes

These programmes like in other districts of Uganda and elsewhere, target prevention of the 6 immunisable killer diseases especially in children below five years, including: -

i) Poliomyelitis
ii) Tuberculosis
iii) Measles
iv) Tetanus
v) Whooping cough
vi) Diphtheria

Reports from the DMO indicate the following successes in these programmes for the year 1996.

Table 10: Coverage of Immunisable Diseases EPI (1996).

Antigen	Coverage
BCG	90.6%
Polio 3	83%
DPT 3	85%
Measles	72%
TT2 (pregnant mothers)	12%

Source: DMO's office.

Although the statistics for NIDS were not accessed, it was also reported that the district response was well over 85%.

2.3.4 C.D.D/ARI/AM/Malaria Programmes

These programmes aim to: -

i) Control of diarrhoeal diseases
ii) Control of Acute Respiratory tract diseases
iii) Advising mothers at risk of pregnancy, and
iv) Control of malaria (which is still the leading cause of death in the district.)

2.3.5 STI Project

This project aims at addressing and controlling the spread of sexually transmitted infections and most especially HIV/AIDS. syphilis, gonorrhoea and others.

2.4 EXISTING REHABILITATION SERVICES FOR PWDS IN THE DISTRICT.

2.4.1 General

Services that are specifically established to provide rehabilitation services to PWDs per se are indeed in short supply in the district. The only rehabilitation services available at Hoima Hospital are physiotherapy and the occasional corrective surgery visitation programmes from Dr. Penny Norgrove from Canada who comes to assess and carry out corrective surgery on children from Masindi and Hoima. While St. Bernadette unit for the Blind is the only education rehabilitation service. However, in this age of integration the existing services and facilities in the district can be used profitably to augment rehabilitation efforts.

2.4.2 Medical Rehabilitation Services

a) General Healthcare Units

There are 48 health units in the district, which can be tapped to integrate disability prevention and rehabilitation services. Although the above mentioned number does appear in the District Development Plan, only 35 are reflected in the available records per subcounty as reflected in Table 6.

All these units are however not equitably distributed, for instance, Buhaguzi County has only 11 units, while Busiisi sub-county has none and Kyangwali sub-county, which is the farthest point of the district from the centre, about 80 kms. has only one, with a population of 15,630 people..

Kyangwali Health Centre Staff

TABLE: 11 Health Units by County and by Sub-County Locations - 1995

County	Sub-county	Health Units		Status
Bugahya	Town Council	1.	Hoima Hospital	Hospital
		2.	DMO clinic	Aid Post
		3.	Mobile Team	
		4.	Islamic (NGO)	Dispensary
		5.	Bujumbura	Dispensary
		6.	Bunyoro Kitara	Health Centre
	Kitoba	7.	Dwoli	S/Dispensary
		8.	Karongo	S/Dispensary
		9.	Kyabasengya	S/Dispensary
	Buseruka	10.	Buseruka	S/Dispensary
		11.	Kibale	S/Dispensary
		12.	Bonya	
		13.	Kigorobya	Health Centre
		14.	Kigorobya (NGO)	Dispensary
		15.	Kibiro	
		16.	Kitana	S/Dispensary
		17.	Kigorobya	Dispensary
				Leprosy Camp
	Buhanika	18.	Buhanika	Dispensary
		19.	Butema	Disp
		20.	Kyakapeya	S/Disp
		21.	Mparagasi	S/Dispensary DMU
		22.	Burabu	S/Disp
		23.	Kisabagwa	S/Disp
	Busiisi		-	
Buhaguzi	Buhimba	24.	Buhumba	S/Disp
		25.	Kinogogzi	S/Disp(NGO)
		26.	Bujalya	S/Disp
		27.	Kitoole	S/Disp
		28.	Muhwiju	S/Disp
	Kiziranfumbi	29.	Kikuube	Disp/DMU
		30.	Wambabya	S/Disp
		31.	Mukabara	S/Disp
		32.	Munteme (NGO)	Dispensary
	Kabwoya	33.	Kabwoya (NGO)	DMU
		34.	Kaseeta	S/Disp
	Kyangwali	35.	Kyangwali	Health Centre

Source: DMO'S OFFICE/HOIMA
Percentage of district population accessible to health unit - 76%.
Aware of the inequitable distribution of these health facilities, the following have been earmarked as places, which are very far away from Medical Units;

Kihomboza in Busiisi sub-county
Bulyango in Kitoba sub-county
Waki in Kigorobya sub-county
Kicompyo in Kiziranfumbi sub-county
Kyohairwe in Buhanika sub-county
Nyawaiga in Kabwoya sub-county
Buhuka and Nsozi in Kyangwali sub-county

b) Specialised Medical Rehabilitation Services
The only Medical Rehabilitation referral facility is Hoima hospital with 150 bed capacity, a consultant surgeon, dental surgeon, a gynaecologist, 4 medical officers and intern doctors. Besides the general medical treatment services, the hospital offers specialised services which include: -

i). Physiotherapy Services
There is a physiotherapy unit (read room) which has no equipment to talk about. The hospital has a physiotherapist on its payroll, Mr. Galimaka Fred who can be an opportunity for a CBR programme, that has medical rehabilitation component imbedded. However, he seriously needs some refresher training and support with equipment. According to Galimaka, the commonest problems he receives are fractures.

ii). Eye Care Services
The hospital for sometime has been hosting eye care camps that involves assessments, treatment and even surgery, such as removal of cataracts. The surgeons come from without but on a regular basis, once a year.

iii). Reconstructive Surgery
Of recent, on its programmes, Hoima hospital has added on reconstructive surgery with a visiting surgeon Dr. Penny Norgrove. He has already made some visits including one during the period of this study. There is however not yet enough awareness created about this service within the countryside.

iv). General Surgery
The hospital has a resident surgeon offering the general service in that respect. This one is already an opportunity to understudy Dr. Penny and to start handling the simple cases, thus freeing Dr. Penny for the most complicated ones.

v). Psychiatric Services
The entire of Hoima district has two qualified psychiatric nurses, both working at Hoima hospital. However, they are now posted on wards just like any other nurse. This means that cases that would benefit from their specialised knowledge are now missing out, or they are not aware of these

professionals' presence. A case in point is epilepsy, mental illness, and stress. Going through the exercise; these cases were cited not to be in short supply.

vi). General Workshop

At the hospital, though idle now, there is a general/multipurpose workshop, which was put up by AVSI and handed over to the district. This workshop could be useful in making rehabilitation devices such as crutches, callipers and other walking devices.

2.4.3 Educational Rehabilitation Services.

a). General

The district has an apparent resource scarcity in this area. Children with disabilities hardly have any access to education, since the district lacks the requisite special units or the personnel to handle children with special education needs. There is however, an effort in these three places.

b). Educational Assessment and Resource Services (EARS) Programme

The EARS programme is directly under Ministry of Education mainly funded by DANIDA and the Government of Uganda. In Hoima district, the programme was introduced in 1992. The main objectives of the EARS Programme include:

i) Identification of assessment of children with disabilities (CWDs).
ii) Referral of the CWDs to different referral services in and outside the district.
iii) Placement of children with special education needs in schools where they can access education.
vi) Placement of children with special education needs in schools where they can access education.
General sensitisation of parents, and the general public.

viii) Organising of refresher training for ordinary teachers in simple methods of handling children with special education needs.
ix) Development of teaching materials for children with special education needs.

So far, during the last 5 years, EARS has identified and assessed 533 children with disabilities in Hoima district. The programme has put up its own premises near the Hoima Boma Grounds.

The building that houses EARS Centre - Hoima

The district has employed 2 specialist teachers at the rank of Assistant Inspector of schools to manage the programme. At the moment, the programme is involved in mobilisation and public education about disability and rehabilitation and it uses a variety of methods, which include:

i) Regular visits to schools.
ii) Public rallies
iii) Use of posters
iv) Workshops and seminars.

Although EARS has had its mobilisation done, the strategies are still fund trapped. At the moment, the centre operates a total monthly budget of about UShs 400,000/= where 50% is contributed by the District Administration and 50% by DANIDA. According to the Head of the programme, this

can only help them to operate at half capacity. This is therefore a big hindrance to their otherwise much wanted service delivery.

Other challenges to the programme include:

i) the negative social stigma attached to disability in general.
ii) low level of parental commitment to rehabilitation.
iii) lack of aids for children.
iv) lack of referral services and specialised rehabilitation personnel within and around Hoima district.

The long-term wish of EARS in Hoima district is to have a vocational rehabilitation centre to meet the current rehabilitation skills needs of the district. The programme also hopes to open more annexes to ordinary primary schools to augment efforts of accessibility of education to children with very severe disabilities, as well as training more teachers.

c). St. Bernadette Unit for the Blind.

Located at St. Bernadette Primary School next to Hoima Catholic Cathedral, the unit was established in the 1960s to access education to children with visual impairments. The unit currently has 8 pupils (2 non-residents and 6 boarders). Of the 8, 2 are girls and 6 boys. The 8 children are integrated in all the 7 classes, except class four. The unit has 2 qualified teachers, one of them currently an EARs assistant inspector, and the other who is on study leave in Denmark. The unit has identified one extra teacher to go to UNISE for special education.

Besides attending the ordinary classes, the visually impaired children attend special classes to sharpen their skills in use of Braille. The unit occasionally gets subvention from Ministry of Education and Sports, and the last tranche got was Ushs.150, 000/= for the entire year 1997. The school also gets assistance from some donors through Hoima Catholic Diocese at the request of the Bishop, Rt. Rev. Deogratias Byabazaire. The unit has also been receiving some equipment for the blind from USDC through Ministry of Education and Sports.

Nyakato (P.6) and Kusiima (P.3), the two girls at St. Bernadette Unit
Three of the six visually impaired boys at St.Bernadette Primary School Unit

d). Bulemwa Primary School.

Bulemwa Primary School, found in Kitoba subcounty, is an ordinary primary school also at the forefront of integration. Although it is not yet recognised as a special unit, it has 16 children with disabilities. Perhaps Bulemwa Primary School is an ideal form of integration. Any move to turn it into a special education unit would make some of the children lose their chance to education, depending on which type of disability it specialises in. The Headmistress, Mrs Kiiza Sarah, has had an exposure to a short course in special education. This lady can be a very useful contact for a Community Based Rehabilitation (CBR) programme.

PRA
session in Kitoba

Table 12: Categories of Children with Disabilities Integrated at Bulemwa P. School.

Physically handicapped	7
Mentally Retarded	4
Visually Impaired	1
Hearing/speech	4
Total	16

Source: Headmistress' Office – Bulemwa Primary School
Interesting to note of the 16 children, 14 are from Kiragura Parish. The effort to take these children to school is attributed to the constant encouragement and sensitisation about disability of Mrs. Kiiza Sarah and Mr. Byakagaba who hail from this same parish.

3.0 ATTITUDES AND KNOWLEDGE ABOUT DISABILITY

3.1 ATTITUDES

3.1.1 People with Disabilities (ref. Appendix ii)

Although there is an effort at top level to bring people with disabilities (PWDs) up for social recognition, participation, and entitlement, its impact is largely felt at the top levels by the organisers/leaders. Down below there is still a yearning need for the PWDs to have access to equal opportunities like their fellow non-disabled people. This remains a natural reminder, a scar of identity, which erodes their social confidence.

For that matter, PWDs feel:

i) Disadvantaged and marginalised, and
ii) Denigrated and humiliated.
iii) To most PWDs interviewed their tone exhibits:
iv) Denial and life sentence resignation nailed down by the sometimes hostile attitudes that society holds against these people.

Photo - Irumba Edward

According to "Irumba Edward"(in picture below) a young man whose legs were paralysed by polio he feels that society is "insensitive" to their conditions and needs.

According to Byabagambi Gerald, ***(in picture left)*** a disabled young man (27 years) married with one child, a dealer in pork, from Kitoba, to him his disability has not affected him much. "Even when I wanted to marry, my in-laws could not do much, because the dowry they wanted, I just paid" he stated with confidence.

According to Byarugaba Joseph a 21-year old senior six student of Hoima Academy, he sometimes feels "ignored" by his fellow students as if he "did not exist".

Byarugaba Joseph, a senior six student at Hoima Academy

According to Mr. Rwaswiri Yoramu, (***first from left in the picture***) a businessman, in Kigolobya Town Council, and treasurer LC1 Kikwanana village, to him disability can only curtail his agility but not his sales. Moreover, it does not discount his social status as a social service provider.

According to Mr. Kahwa Johnson (***in picture with a crutch***) the Chairman/Co-ordinator, Kakindo Welfare Association of the Disabled, social insecurity seems to plague the disabled people, which is the cause around which his association was formed. The main aim of the Association, therefore, is to fight the negative attitude that they experience daily from society and be able to cope with their situation. by pulling together their numbers.

3.1.2 Families of People with Disabilities (see appendix iii).

The general tendency is for parents of children with disabilities to be over protective so that they do not let their children with disabilities show up in society to evoke stigma against the family. Besides, these children with disabilities are over protected because, the parents feel that they cannot take control of themselves - they are looked at as total dependants. Such is the cause why **Nyakato Frida,** a mother, from Bulemwa, Kitoba could not take her son Wamani John (7 years) to school.

Innocent Tumusiime (12 years) the son of Isingoma Joseph (***right in the picture below***) from Bulemwa village, cannot be let to support himself at school despite looking quite capable of being independent.

Innocent Tumusiime

Tumusiime Innocent (right) with Mental Retardation with his mother and brother

Some parents feel that, the case of their children is "God's will" - a preordained condition against which they are totally incapable of doing a redress - *"Ogu mwana wa Lubanga nikwo yakazairwe"*, as re-echoed by Nyakato Frida. For that matter, families regard their disabled members as "an extra time wasting burden", a kind of punishment from God which they have resigned themselves to.

3.1.3 Community Members (see appendix iv)

Communities having little to do about these members so they can not choose but "just have them". This is exhibited in the mixed feelings expressed by the different community members, without a specific individual effort in the crusade against disability.

Sarah Kiiza, Headmistress Bulemwa Primary School appeals that every possible help should be given in an effort to fight disability.

According to Kiiza Innocent, LC 1 Chairman, Kipapati village, Kitoba, disability is a matter for government to take action. This view was jointly shared by many community members interviewed.

According to Moses Businge, a community member from Kipapati, feels that disability is deadly and he grieves as anybody who is a victim. He feels the community should report cases of disability to the relevant organisations and government should launch an enthusiastic polio campaign accompanied by mass education on disability.

In general, communities regard people with disabilities with disdain and as useless people who cannot contribute positively to the welfare of the community. Therefore, society feels that they should be treated with contempt and harshness on one hand, or pity and sympathy on the other, as is exhibited in the following Runyoro proverbs:

- *"Oweibango bwotamuhemukira akuraza omurombe"* (If you kindly consider the condition of a hunchback when you share with him/her a bed, you will not cover yourself).
- *"Hali omugenge ali tomegeraho akaara"* (You do not break fingers where there is a leper - because/he has no fingers in the first place).
- *"Nyamwoha endema ngu ez'owaitu ziguruka"* (The tempter of the lame, will always say, that the lame people in his/her place can jump and fly).
- Or even a more harsh one *"Empitsi ekarya ow'eibango eti orufu rwamwitsire naruhikaho"* (A hyena mused while eating a hunchback that it had reached and discovered the cause for the hunch - because it found the hunch a soft delicacy).
- *"Enkuba akateera ow'eibango eti ti nakuteera nakutura omwetuniko"*. (Lightening struck a hunchback and justified its action by saying it was irritated by his proud profusion of hunch)

3.2 COMMUNITY PARTICIPATION IN REHABILITATION SERVICES.

3.2.1 Community Members (See appendix v)

Community members' participation is based on their level of attention and appreciation of disability as a problem. This is directly influenced by how much knowledge they have regarding causes, effects and attitudes towards disability.

This is explained in the phenomenon of some enlightened community members having started a Welfare Society for the Disabled (WSD) as late as 1992, which doesn't presuppose that disability had not been resident with the people. Even after it had been launched, WSD has only worked in 3 subcounties out of the 11 subcounties that make up Hoima district. Community participation is therefore still limited to the few fairly sensitised members and those who are directly affected by disability.

Inspite of this the WSD has helped in securing Ushs. 300,000/= from District Administration towards procurement of wheel chairs. So far, 10 wheel chairs have already been secured, and 25 are yet to be delivered from Mulago.

In terms of prevention not much has been done by WSD, much as it has not featured on its agenda for actions. Its efforts are wholly directed towards those who are already disabled, although they are overwhelmed by the immense need.

Technical departments, but mainly the health department has contributed to the effort by providing personnel to assist in assessing and referring the PWDs to relevant specialised

services. Otherwise, disability is still regarded as the problem of the individual and the affected family, where government has the largest role to play in terms of provision of rehabilitation services, leaving the crucial prevention stage barely attended to.

3.2.2 People with Disabilities.

Because of the prevalent laxity of care and knowledge of the community, the PWDs have not had enough opportunity to learn about causes, prevention, referral and rehabilitation of disability. They are resigned to fate. They see themselves as people who are completely unable to rise up to the disability and cope with it, unless government steps in. However, the district authorities do not seem to have either the money, nor even know the number of people with disabilities. This makes services provision to PWDs difficult, fragmented.

4.0 COORDINATION AND COLLABORATION

4.1 GENERAL

Hoima district has several organisations/groups of people with disabilities, NGOs engaged in development and relief work and government departments. Many of these are engaged in one way or the other in provision of services that are aimed at prevention of disability or rehabilitation work. Unfortunately, these efforts largely lack co-ordination. Each of these bodies seems to be working in isolation, including even the groups of PWDs.

However, it is important to note here that the main mission of the few groups of PWDs in Hoima district seem to be that of **empowering their members** to enable them participate in social, economic and political affairs of their society.

4.2 ORGANISATION OF PEOPLE WITH DISABILITIES.

4.2.1 National Union of Disabled Persons of Uganda (NUDIPU)

Contact person: Mr. Charles Kyamanywa. Regional Development Worker, Mid- Western.
Office location: EARS Offices.

Composition, Goals and Commitment

NUDIPU, in its bid for decentralisation of power and practice has recruited and posted Regional Development workers. Mr. Charles Kyamanywa is the Regional Development Worker responsible for Hoima, Masindi and Kabale districts.

The membership to NUDIPU is by affiliation of organisations of PWDs preferably of district level status.

Mr. Charles Kyamanywa, the Regional Development Worker, Mid- Western

The activities of NUPIDU include:

i) Having a Regional Development worker in place; full-time employee with an office at EARS centre (though not yet equipped).
ii) Sensitisation seminars going on in the 3 districts and seminars in Hoima so far with PWDs and civic leaders.

Mobilisation of PWDs for political recognition and representation at national and local levels.

Capacity to achieve their goals.

i) Few personnel in place (he is alone).

Because he scantily facilitated, he cannot cover 3 districts alone and without a vehicle, and no other office logistics. Communication by writing is difficult to administer through bureaus as he is doing at the moment.

Knowledge about Disability

As a representative of NUDIPU, Kyamanywa may not know the technical aspects of disability such as the causes, incidences and management, but he is well aware that disability is a very big problem.

Participation and Support to Rehabilitation Activities.

i) During sensitisation, PWDs, their families and community members are informed about the existing referral services and how to access them.

ii) NUDIPU assisted in procuring about 30 wheel chains for disabled people in Hoima district although the distribution was purportedly not very transparent. (NUDIPU had not yet posted the Regional Development Worker then).

iii) Though sensitisation programmes have going on in the district, the subject content is not yet systematically developed and be made available for reference.

4.2.2 Welfare Society for Disabled. Hoima

Contact Person: Mr. Amos Byakagaba - Co-ordinator

Composition and Goals

This group is not restricted to PWDs only. Its membership therefore constitutes PWDs, parents with children with disabilities, and other interested members.

It started as a demand - driven out-cry to co-ordinate effort on disability sensitisation and referral services. Mr. Byakagaba Amos and Mr. Israel Mirimo, who are the co-ordinator and General Secretary respectively, both, parents of children with disabilities are the founders.

Capacity to achieve their goals

WSD is still operating as a "satellite" organisation with no established office premises. So far, their scope of operation covers the sub-counties including; Kigorobya, Kitoba, Buseruka, Busiisi and Kyabigambire. The co-ordinator cited that WSD has identified about 2500 people with disabilities in 3 sub-counties of Kigorobya, Kitoba and Buseruka. Though there is no comprehensive record of these identified PWDs.

Their referral efforts have had impact with some beneficiaries functionally doing well for example **Alison Katwesigye** referred to Masindi centre now in P.7 at Kipaapi primary school, **Atuhairwe Justine**, Kiiza Salai and many others. The society too, has been soliciting support from other bodies such as USDC, and the two girls ***(in pictures left)*** were helped by USDC to get their surgical boots and crutches.

The society has been identifying, registering and referring PWDs to relevant referral facilities like Hoima Hospital, Mulago Hospital and Masindi Centre, for disability management and rehabilitation **(ref. Appendix VI).** The efforts of WSD are commendable but could be augmented to make their data more reliable, introduce more community-based rehabilitation for prevention and management of disability.

4.2.3 Kakindo Welfare Association for the Disabled

Contact Person: Mr. Johnson Kahwa Chairman/Co-ordinator ***(pictured below)***

Composition, Goal and Commitment

This organisation started in May 1996. Its membership is limited to only PWDs (cross disability) and, though it has more than 100 eligible members only 52 are paid up. Membership fee is 5000/=. 22 of these paid up members are women.

The purpose of the Association is to support the PWDs by garnering all the various talents, which can be welded into an economically self-supporting group.

The association is duly constituted and is recognised by the office of the District Probation and Welfare Officer. It is only limited to Kyabigambire subcounty.

Capacity to Achieve its Goals

The apparent strength of the association lies in the good amity and neighbourhood which has enabled easy integration of its members so as to provide market for their handicrafts. There is also, a lot of interpersonal advice, counselling and helping and this has helped the members to cope with their disability situation.

Knowledge about Disability

This group is oblivious of the actual causes of disability apart from the general symptomatic information. Only few members are knowledgeable about the sitting referral services in Hoima district while Mulago is a far off cry.

Participation and Support to Rehabilitation Activities

The only apparent rehabilitation that this association seems to work towards is economic empowerment and psychosocial counselling. This is in resonance with their desire to have a micro-financing scheme, skills training and general education. Among other needs, sensitisation and special education annexes for special cases were a big priority. The members still experience denigrating attitude associated with disability.

The association was also grateful to UPE for having enrolled 9 children with disabilities 4 of who are from Kibingo and 5 from Kibigubya village.

4.2.4 Kigolobya Group

Contact Persons: Mr. Rwaswiri Joram, Member, Mr. Solomon Arinaitwe, Member.

Mr. Rwaswiri (seated right, front) in front of his shop in Kigolobya Town Council

Composition/Goals and Commitment

The group, whose name is even not yet agreed upon by the members, is still in its infancy. Its goals are not yet clear to the members and hence their commitment is still shaky. Membership is open to PWDs and parents of children which disabilities.

Capacity to Achieve their Goals.

The will and commitment is there to pursue the goals, but the group requires alot of support to build its organisational capacity. The L.C.V Councillor Mr. Mwijjakubi Sendrach is supportive to the group, so is Rwaswiri, Arinaitwe and almost other sensitised members of the community.

Knowledge about Disability

The knowledge about disability is still very scanty, like for any other community member in the locality. The group is not even knowledgeable about rehabilitation services available in Hoima.

4.3 OTHER NGOS INVOLVED IN DISABILITY AND REHABILITATION WORK

4.3.1 International Service Volunteers Association (AVSI)

Contact person: Mr. Hind Steven, Co-ordinator, AVSI, Hoima

AVSI started its operations in Hoima way back in 1987, with a strong presence in the health sector which included renovation of Hoima Hospital, AIDS Control Programme, Acute Respiratory Infections Control. Expanded programme on immunisation, Maternal and Child Health Care, and Water and Sanitation programme. Their 5 years programme ended in 1992, and was extended for 3 years, which also expired in 1996.

Besides these programmes, AVSI put up a multipurpose workshop in Hoima Hospital, which was handed over to the district and is apparently idle due to disagreements on its management between the district authorities and the hospital.

The current mandate of AVSI is the management of Kyangwali Refugee Camp on behalf of UNHCR. They have already identified and assessed PWDs in the camp and are yet to decide on how to assist them. **(ref. appendix.III)**

AVSI is also interested in raising funds to develop health and social services with in and the areas around the camp that will be beneficial to the refugees and the population around Kyangwali. The services/programmes developed by AVSI provide the essential

infrastructure and skills that are beneficial to the prevention and management of disability in the district.

4.3.2 World Vision

Contact Person: Mr. James Kahwa, Project Manager, Kasenyi, Buseruka.

The purpose of World Vision is to build capacity for community advancement by offering training, promoting functional adult literacy, supporting community health mobilisation and facilitation, promoting evangelism, general environmental awareness, and small scale enterprise. The organisation also helps the community to develop infrastructure. It also supports micro financing through the "BIRD" programme.

World Vision has 250 children in the project that it is supporting in schools and assists some children with micro-credit.

Although the staff of the organisation have limited knowledge on disability, they mobilise for EARs staff to assess children with disabilities. They encourage mainstreaming of CWDs in schools, and have so far sponsored one Ojok Julius (15 years) who had a cleft lip to Mulago for corrective surgery.

4.3.3 Sight Savers

Contact Persons: Mr. Stephen Kasolo Onchocerciasis Co-ordinator, Hoima, Kibaale and Masindi districts.

Sight Savers works with the DMO's office to support the efforts of their staff, in the management of Onchocerciasis through training of health personnel and village support workers involved in the raising awareness about the prevention and management of Onchocerciasis in the programme districts. Sight Savers procures and distributes the drugs for the control of Onchocerciasis free of charge. According to the co-ordinator's report for April June 1997, so far, out of the 78,293 people targeted in 135 villages of concentration in the three districts 59,859 people have received this year's dose of Mectizen, which reflects a distribution of 96,288 tables living a balance of 56,496 tablets. This represents 76.5% coverage of this year's second allotment.

One of the major challenges Sight Savers has encountered is the bias with Banyoro people that Onchocerciasis is not a disease for Banyoro but for the Alur. Therefore, there is more reception with the Alur communities than Banyoro communities, which has kept the disease in cycle.

Besides, Sight Savers is also involved in the training of Ophthalmic Clinic Officers (OCO) at Jinja.

4.3.4 Kolping Society.

Contact Persons: Mr. Aloysius Mugasa, A., Executive Director.

The Uganda Kolping Society is basically an NGO with a mission to strengthen their members as a family with a strong economic and moral base. Membership is by committed and practising catholic families who believe in strong Christian morals. It is involved in vocational training/craftsmanship, leadership training and home activities/support and provision of restaurant and lodging services. The Society believes that a PWD can best be supported within the Kolping family structure, which is the organisation's mainstay.

4.3.5 Hoima Catholic Diocese

Hoima Diocese has been the main promoter and supporter of St. Bernadette Unit for the Blind. Besides occasional visits by the Bishop to the unit, real aid in terms of finances and other material support is extended to the unit.

The Diocese is also still a respectable force within the provision of education and health services through their founded institutions, and can therefore a conduit for awareness raising on disability among its members.

4.4 GOVERNMENT

4.4.1 General

A number of government department, bodies and offices were contacted, including;-

i) The Resident District Commissioner (RDC).
ii) LCV Councillors
The Chief Administrative Officer (CAO)
Members of the District Service Committee
Hon. Matayo Kyaligonza, MP, Buhaguzi county
The District Probation and Welfare Officer (DPWO)
The District Planner
The District Education Officer, (DEO)
The District Medical Officer, (DMO)

Persons from these offices and bodies were interviewed on a number of issues including, policy, commitment, and knowledge on disability.

4.4.2 Policy on Disability and Rehabilitation

Although the district is conscious of the disability issues prevalent in the district, policy on its prevention, and management is not yet in sharp focus. Consequently, it does not rank as a high priority on the district expenditure budget.

According to the RDC, Hoima, the total number of PWDs with disabilities in the district is not yet quite ascertained, although he contends the incidence could be worryingly high. He said, in the 4 months he had spent in the district (May-September) he had seen "13 different mad faces" in Hoima Town Council alone. He requested that an effort should be made to do a formal count of disabled people district wide, so as to assess correctly the gravity of the situation.

Low effort provision to disability prevention and management. For instance during the last year, the department of Childcare and Protection was allocated only Ushs. 1 million, which represents less than 0.5% of the total budget, but only Ushs. 800,000 were received by the PWD to cover all the child service sector activities. Subcounty commitments to children's affairs and disability vary from subcounty to subcounty.

Table 13: Subcounty Budgetary Allocation to Children's and Disability Affairs - 1996/97

Subcounty	Budget Allocation
Buseruka	40,000/=
Kyangwali	500,000/=
Kabwoya	60,000/=
Kizirafumbi	300,000/=

This depicts the level of effort undertaken by the subcounties and implies how low children's and disability issues rank in some of these sub counties, and the district in general. This diversity in allocation is a pointer to how much out of focus children's issues are to some subcounties.

The District Service Committee has not yet taken serious strides towards having some PWDs on their payroll. This was exhibited in the shock expressed by the members when asked whether they remembered any PWD on their employment roll.

4.4.3 Knowledge about Disability and Commitment to Rehabilitation

There are few rehabilitation professionals in the district rehabilitation, as indicated in the table below:

Table 14: Rehabilitation Professionals in Hoima.

Type of Profession	Number of Personnel
Physiotherapist	1
Special Education teachers	4
General surgeon	1
Psychiatric nurses	2

With these limited numbers of professionals, little has been done to translate knowledge on disability and rehabilitation to benefit the people in their communities. This is reflected in the enormous lack of local capacity to prevent and manage disability.

Mr. Rugondo, Chairman, District Social Services Committee. He Believes disability is an original Condition for the Alur emigrants

The glaring unpleasant state of affairs was captured by Mr. Mukiga, Deputy Chief Administrative Officer (DCAO) through his acknowledgement of lack of basic information on some of these preventable disabilities.

He also decried the apathetic lethargy expressed by the communities towards disability. He observed that a big portion of the population take life in a matter-of-fact manner with little input which has caused slump in production of basic necessities like food. He observed that the district had embarked on improving participatory processes at local level by training two change-agents per parish. The role of these change-agents is to teach the population means by which they can live meaningfully.

Mr Mukiga, Deputy Chief Administrative Officer, Hoima

He pointed out micro financing and low-loan schemes as key steps the district has adopted in building local capacity. In addition, he noted that vocational skills are a priority for the population including production to be able to tap the abundant resources in the district.

According to the District Planning Officer, uncertainty of disability incidence and inadequate funding have relegated disability issues to low priority rank on district funding agenda. He was however, hopeful in creating Income generating Activities (IGAs), and training PWDs in IGAs and entrepreneur skills. The Planning and the Production Units, he promised, "could take it upon themselves to handle technical issues relating to the running of these IGAs".

4.4.4 Support to Prevention and Rehabilitation Activities.

The district provides support to the disability crusade mainly through 3 departments, namely:

i) Health
ii) Education
Community Development and Childcare and Protection.

a) Education

Sarah Ayesiga, Assistant Inspector of Schools, in charge of EARS and Special Education

The district supports EARS programme whose mandate includes:

i) Identification and assessment of children with disabilities with the bias on educational needs.
ii) Sensitisation of the public on disability issues on the needs of children with disabilities (appendix).
iii) It helps in developing training materials for use in teaching children with disabilities.
iv) It gives in-service refresher training to ordinary primary school teachers in handling CWDs.
v) It also supports the establishment of specially education units to cater for the severely handicapped children who can not benefit from the main stream schools.

b) Health:

Good effort has been made towards preventive measures against disabling conditions including:

i) The STI project aimed at preventing HIV/AIDS and other sexually transmitted infections.
ii) UNEPI programme and NIDS - aimed at preventing the 6 immunisable diseases in children below 5 years.
iii) The CDD/ARI/Malaria Control programmes.

The Onchocerciasis programme is aimed at controlling and management of the spread of the Onchocerciasis in the district.

Corrective surgery at Hoima Hospital by Dr. Penny Norgrove, a visiting surgeon funded by Uganda Society for Disabled Children. The availability of a physiotherapist at the hospital (despite their inadequacies due to lack of sufficient equipment) is also a big opportunity to the district.

Childcare and Protection Services

This is the office responsible for disability and rehabilitation activities. It has a total staff of 3 people who are expected to cover the whole district with one motor cycle.

The main activity of the department is raising awareness, advising on referral services and co-ordinating any ground effort that would ameliorate the disability incidence, childcare and protection.

The district to date has not employed a district Rehabilitation Officer to take care of responsibilities for disability and rehabilitation in the district.

5. WAY FORWARD

1. **Attitudinal Change and Increase of knowledge about causes, prevention, and Rehabilitation Services.**

It is clear from the report that disability has not had serious attention from both the communities and local government policy makers in Hoima. How much people know about disability affects their attitudes towards it. This has left the persons with disabilities alienated and condemned to their fate. This does not only dis-empower them but also makes society merely a community that is insensitive to their plight.

If anything is to be done in this field, mass education and sensitisation of the people in control at all levels, and the communities where the people with disabilities live should be considered a prerequisite. With no clear programme to lessening disability incidence, and increasing awareness, it would be beneficial to create this awareness, using participatory processes, which are all-persons inclusive, and demonstrates that disability is indeed not disability. Here, the locally trained community based mobilisers and rehabilitation staff need to see the relationship between their personal and community development and disability. This should chart a course of action (planning) that should reverse these trends in the long run.

2. **Making a Comprehensive record of People with Disabilities.**
A deliberate effort should be taken by the district authorities to create a comprehensive database on the people with disabilities and by category of disability and location.

This will be useful in depicting the incidence of disability and serve as a benchmark for performance measurement of any future effort. This would further strengthen the existing organisations of people with disabilities since they would not be let down by the inferiority of numbers, and the ideas being contributed will be as diverse as they will be genuine. Awareness that a strong voice is vital for them is a step ahead in restoring their confidence and shaping their purpose for life.

3. **Support to the district in developing capacity to handle and manage disability.**

The district still lacks capacity to handle disabilities. At the moment, no effort of managing disability in terms of rehabilitation is taking place at community level.
Therefore;

Training of personnel at different levels LC1 - LCV, should be taken as a first priority if community based rehabilitation is to be effected in Hoima district. With the availability of change agents (two per parish) in Hoima, these would be a good ground for extension of knowledge on disability. If these persons were given participatory and mobilisation, sensitisation and planning skills, making a truly community based rehabilitation programme should not be a problem.

Referral services both at community and district levels need to be supported to render services quickly to the resident communities.

4. **An elaborate Monitoring and Evaluation System.**
With any programme coming in place, elaborate monitoring and evaluation indicators should be developed. These will enable the programme to measure its impact over the agreed period.

5. The district could benefit from USDC's vision and outlook to disability by working closely with district authorities and networking with the existing local organisations for sustainability purposes. It should be seen as a partner and not as a donor agency that is prescriptive in solution seeking.