'OURS'

ANNUAL REPORT

1998

OURS

for people with disabilities

East Ankole Diocese

A Community Based Rehabilitation (CBR) Programme

By : Liz Moulton
Programme Manager

'OURS' Annual Report - 1998.

1. Introduction.

I can say that 1998 has been a hectic one and writing this Annual Report seems a daunting task to me since there is so much to report. It has been an exciting, if not tiring year! This 3rd Annual Report attempts to summarise the activities for the year. Let me hope that the report is a true reflection of the work done.

2. Expansion - Mbarara Municipality.

We are pleased to inform that the programme has expanded its' work into Mbarara Municipality. This was agreed through the relevant District authorities and they have very much welcomed the work. 2 new Community Rehabilitation Worker's (CRW's) were recruited in June 1998. The house-to-house survey began in August 1998 after the CRW's had had a period of familiarisation and basic training on how to conduct the survey.

It was decided that the interventions would begin immediately after identification - hence the survey is slow. It has not been an easy exercise since the urban community is often either too busy, absent or continually migrating to be sure an accurate survey is being done. Mbarara Municipality is split into 3 divisions and has a total population of ~ 42,000 (1991 survey). We have started off in Kakoba Division (population 13,122). In 4 months, **1,105 homes** have been visited and, **4,336 people** (**33%** of Kakoba Division) have been screened. **148** people with disabilities have been identified (**3.4% prevalence**). The results up to now have been interesting *(see appendix 1)*. Especially we were surprised to find a few cataracts in the town despite Ruharo Eye Centre. Also we were surprised to find people with epilepsy who have not undergone medical intervention despite a well run Epilepsy Clinic found at Mbarara Hospital. Untreated osteomyelitis, club feet and other physical disabilities has also made us realise that there is a lot of sensitisation/awareness to be done in the town, not just in the villages.

3. Training.

i) Revision Workshop - Epilepsy.

A 3 day revision workshop was held in May 1998 *(Time-table : Appendix 2i)*. It was attended by 14 CRW's and by 18 Health Worker's. Collaboration with the Health Worker's is essential to the success of this work. The workshop encouraged open discussion on the collaboration. Each Health Unit presented its successes/problems and suggestions were put forward for improvements. The working guidelines were updated (modifications were few). The District Medical Officer, Mbarara District joined us for part of the workshop. The workshop closed with some good singing and dancing and all left with a positive motivation.

ii) Physical Impairment - all aspects.

The training was split into three blocks. Two blocks of 2 weeks and for the final block of one week the CRW's came as half groups (5 weeks in total) . All CRW's, 'OURS' field staff plus two others (other CBR programmes) attended the training's. All topics related to Physical Disabilities were included *(Time-tables : Appendix 2ii)*. Cerebral Palsy shall be tackled in yet more detail during 1999 training's. The

training's were organised by our Voluntary Service Overseas Physiotherapist, Joan Mullen's for which we are very grateful. Special thanks also go to the 2 CBM Physiotherapist's from the Cheshire Homes who have also contributed greatly to the training's either by advice or facilitation. These training's gave a sound basis for good follow-up and management of the people with physical disabilities. Certificates of successful participation were given to all but 3 of those attending the training. It is hoped that with some more 'on job' training the 3 who failed the examinations shall be rewarded a certificate - after all, the *real* training will now be as seen 'on job', putting the theory into practice.

iii) Traditional Healers Workshop - Eye Health.

Nine Traditional Healers attended this 3 day workshop which was organised in conjunction with Ruharo Eye Centre. Funding came via British High Commission to 'OURS'. *(Time-table : Appendix 2iii).* Despite some initial disappointment at the attendance number, the workshop went extremely well. REC and 'OURS' staff also attended making on average 17 participants at any one time. This was enough! Programme Manager, 'OURS' and Administrative Head, REC together led the sessions. Traditional Healers freely shared their knowledge which was very encouraging. Future ideas on collaboration were shared. The workshop concluded that Eye Workers best know how to treat cataract and Traditional Healers shall in future refer them to REC (Traditional Healers all had opportunity to see cataract surgery and to talk to the patients pre and post-surgery.) It further concluded that Traditional Practices should be tried by REC and combined rural clinics should be encouraged. It was agreed that we should meet in February 1999 to discuss further collaborations and each Traditional Healer shall invite along a colleague of his/her choice.

*(this meeting went ahead on 10th February 1999 & **26** Traditional Healers attended it, a pleasant surprise!!)*

iv) Sensitisation/awareness to Community Leaders.

One day sensitisation/awareness sessions were held in June/July 1998 in each of the 6 Sub-Counties in which 'OURS' programme works. The Local Government Councils had recently changed and it was an appropriate time to inform them of 'OURS' activities. Local Councillors, religious leaders, teachers, community workers, traditional birth attendants and healers were all invited. On average, **~ 85 important persons** attended each session. The history and work of 'OURS' was shared with the groups. Intra-ocular lenses were shown to the participants - they approved of them, much to my surprise! Interesting questions were addressed. All in all, the sessions went well although on each occasion the community expected free services and this issue had to be tackled with some tact since the dependency syndrome had already reached Mbarara before 'OURS' did! The CRW's appreciated the input from the office which further helped their credibility. This exercise needs to be repeated as an annual event *(photographs attached as Appendix 3).*

v) Income Generating Activities (IGA) - Evaluation.

In January 1998 an external evaluation was conducted by the trainer whom the CRW's had spent a week with in 1997. The evaluation concluded that CRW's are not putting much effort into their IGA's. Reasons given by the CRW's include not enough time to devote to the IGA, difficulty convincing relatives that the modern techniques are better, lack of resources eg. best seeds, breeding pigs etc. Programme Manager has decided not to put much more emphasis in motivating for

IGA's at present. CRW's seem to be expectant of loans, more training etc and Programme Manager wants to see more interest from CRW's first.
Most CRW's are active in 2 or three IGA's. Listed below are the first two priority IGA's for the CRW's:-

IGA	No. of CRW's with activity.
Banana Plantation	5
Bee Keeping	4
Piggery	3
Goat Keeping	3
Horticulture	2
Poultry	2
Rabbit Keeping	1

vi) Office staff training.

We were happy that our driver/field assistant underwent two training's of one week duration each to attain the level as 'Orthopaedic Technician Assistant'. The training was organised through Cheshire Homes. This training has already shown its value - **6 appliances** have been made and **4 repairs** have been done during 1998. More is expected from him during 1999, especially since his job title has changed to Orthopaedic technician/field assistant!

vii) Appropriate Vegetable Gardens.

Two office staff spent 3 days with a school farm learning modern techniques for appropriate vegetable gardens eg. Mandala garden(consists of double dug and raised beds, semi-circular) and sunken beds etc. Already, the clients are reaping the rewards of the first harvest eg. carrots, onions, cabbages, eggplants, tomatoes, spinach, green peppers. A piece of land has also now been secured - we are grateful to the Diocese for it - and the land shall be prepared during 1999, again using modern methods with the hope that we can grow most of our own food rather than have to buy it The attendant's have shown an interest in the method's - so we could also say that the client's and attendant's go home with more knowledge and have had training - they will be expected to maintain the gardens.

3. Field Visits/supportive follow-up.

i) Office staff visits to the field.

a) Time - the office spent **97 days** in the field (working area) during1998. **22** of these days were unannounced field supervision days. Taking into account training's and meetings of CRW's, this means that ~ 60% of the time was spent in the field.

Assessment clinics - Epilepsy - 57
- Physical - 41
- Visual - 16

(some of these were *combined* clinics.)

A further **18 days** were spent in the field conducting the school teaching programme for visual impairment.

Kampala trips to take patients for surgery tended to be done during week-ends. On average, 1 trip per month.

b) Km - a total of **34,321Km** has been covered in the field in the project vehicle - 401 UDM. The total number of Km covered in the year is **39,508Km** *(An increase of 8,422 Km cf. 1997)*. This means that **87%** of the vehicle usage has been devoted to field work. The second vehicle (Toyota Pick-up UPN 035) which was purchased in June 1998 has done **6,436Km**. Approx. **85%** of its usage has been for visits to the orthopaedic workshop in town, collecting firewood and other materials etc. Programme Manager has also used it for her journeys to & from office and for little personal milage ~ 15%. The office motorbikes have both been based at office during 1998. Usage has been for field supervisions and some local travel. It was felt that the *General Supervisors* were abusing the bikes and that 1998 they would be used for field supervisions from office only. Still, many trips have been announced assessment clinics rather than unannounced, hence the milage on the bikes for 1998 remains low. Unfortunately, despite several attempts to repair the speedometer of one, we have failed. Hence it is difficult to know exact Km done for one of the bikes. The other bike has travelled **3,126Km**.

c) Difficulties - Since it made sense to combine Epilepsy assessment days with Physical assessment days (using the vehicle) and these have been many, the amount of unannounced supervision days has been less than we would have hoped. It remains my concern that supervisions have been low. 1999 should show an increase since planned assessment days should be reduced.

On the whole, road networks have improved during the year. Rainy season has been confused by 'El Nino' , hence making planning for the training's at office less clear (try to plan around rainy seasons). Clients continue to migrate and expectations remain high (dependency syndrome). A loan scheme has been introduced and many clients are seeing the value of it and are responding to it. The hard work remains to convince the CRW's of the need to get contributions! Either financial or materials in kind are accepted to offset against the loan. For example, we hope to recover UgShs 65,000/- for a surgical intervention (physical).

The CRW's remain to be *very hard work for office staff to supervise.* It seems that they are becoming more and more complacent with time and their supervision and monitoring becomes harder rather than easier!

ii) **Bimonthly Meeting of Field Staff.**
During 1998, most meetings have been combined with the end of a training. This has helped reduce on added expense for travel & accommodation. These meetings have allowed for planning/discussions for time-tabling, surgery dates etc.

During the most part of 1998, Programme Manager had introduced the concept of 'reward scheme' as a positive motivation. CRW's would be issued *stars* for extra initiative/good work done etc. Every 5

stars deserved a reward eg. blanket, bed sheets, paraffin lamp etc. Stars would be rewarded at the bimonthly meetings. Unfortunately, CRW's did not show extra efforts to deserve the stars and the positive reinforcement failed as a motivation. It was with some disappointment that Programme Manager had to address this during the later months of the year, and it was agreed by all that penalties (negative motivation) needed to be re-introduced. A shame.

4. Achievements.

During 1998, a total of **6785** home visits were carried out by the 13 CRW's in the working area. **873 new homes** were visited **(~13%)**. *(see Appendix 4).*

The *measurable* results of their interventions are given below but it should be remembered that there is a lot of work which is difficult to measure/evaluate.

i) Visual Impairment.

a) In 'OURS' working area.
During 1998, **53** new clients with visual impairment were identified. **64** clients had eye surgery (see table below for type of surgery), **4** children were introduced to special education and **27** have benefited from home-based rehabilitation (8 completed rehab. in 1998). A further **87** referrals made by the CRW's presented to Ruharo Eye Centre for treatment, spectacles etc.

A total of **52** were assessed in the field. There remain **91** who have not yet been assessed. This is because many refuse to come to meeting points and home visit assessments take time. Also, Programme Manager has less time these days for field work. It is hoped that Ruharo Eye Centre staff will be able to assist in 1999 to clear the back-log of assessments.

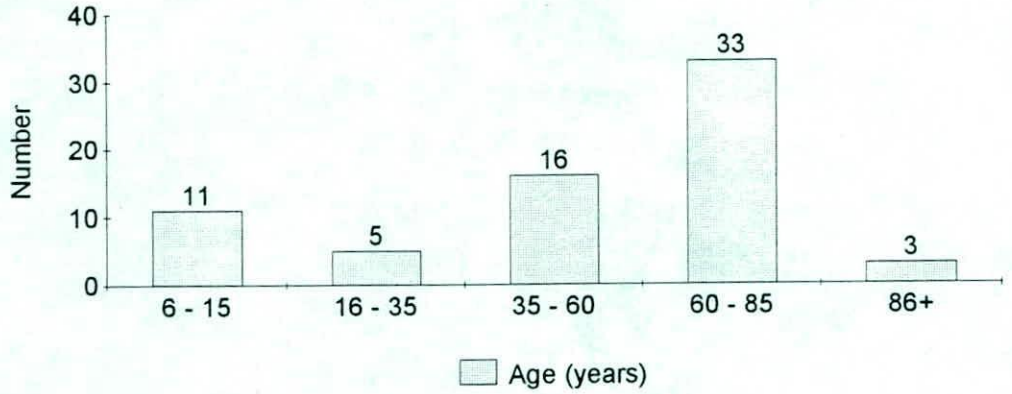
Type of Eye Surgery	No. of patients.
Cataract ICCE +10	3
Cataract ECCE +IOL (unilateral)	13
Cataract ECCE +IOL (bilateral)	18
Glaucoma	3
TLR (trachoma)	5
Evisceration	4
Enucleation	1
Conj. lump excision	3
Other	14

With the introduction of ECCE +IOL with visions of 6/60 or less (one eye) this allows for a greater number of patients to be assisted. During the original survey of 1995, only visions of <3/60 both eyes were identified. In November 1998, CRW's were informed to complete identification forms for visions of 6/60 or less in either eye. It will be interesting to see how much surgery will be done in 1999 now that referral criteria has dramatically changed.

As can be seen from the graph (next page), most surgical cases are for the aged, due to the majority being cataract surgeries.

Age Distribution 1998

Eye Surgeries



During 1998, **12** visually impaired clients have died.

b) School Programme.

This programme was started off in 1997 and was then funded by CBM. To summarise the programme, school children were taught the test *'Count Fingers at 3 Metres'* and they were also taught what a *cataract* looks like. Their job was to assess the vision and eye pupils of their families and neighbours. Early 1998 involved a return visit to Kagongi Sub-County where the children had been taught in 1997. This was for the eye workers ('OURS' Programme Manager & staff from Ruharo Eye Centre) to assess those that they had found.

A total of **14** bilateral blind (VA<3/60 Both eyes) were identified out of the **266** that the children sent to us. Of these, **35** were cataracts of one form or another but only **5** of them resulted in bilateral blindness. Kagongi has a population of ~ 30,000. The number we found was disappointing (suggests a prevalence of 0.057%). A further visit was made to the Sub-County Health Unit (using general announcement methods). No more bilateral blind were found on this visit but rather it was itchy eyes etc.

The table below gives an analysis of the causes of unilateral & bilateral blindness in Kagongi Sub-County.

Eye Disease	Bilateral Blindness	Unilateral Blindness
Uveitis	3	5
Cataract - senile	5	8
Cataract - congenital	1	0
Corneal Scar	1	10
Retina/Optic Nerve	1	3
Trachoma	0	2
Glaucoma	3	1
Other	0	1
Total	**14**	**30**

The same exercise has been fully completed in Kazo Sub-County (funded by British High Commission. **2,559** children were taught the same lesson. Their eyes were also screened on this day. Results are as follows :-

Just **7** bilateral blind (VA<3/60 Both eyes) were identified out of the **215** that the children sent to us. Of these, **43** were cataracts of one form or another but only **3** of them resulted in bilateral blindness! Even more disappointing a result, or perhaps we should be pleased that maybe blindness is not as high in South Western Uganda as Africa statistics would have us to believe? Quite a good number of unilateral blind were found - **37**.

Analysis of causes of blindness are given below:-

Eye Disease	Bilateral Blindness	Unilateral Blindness
Uveitis	0	4
Cataract - senile	2	7
Cataract - traumatic	0	5
Cataract - congenital	1	0
Corneal Scar	0	5
Retina/Optic Nerve	1	4
Trachoma	1	0
Glaucoma	1	1
Other	1	11*
Total	**7**	**37**

* 4 from penetrating trauma (lots of acacia here), 2 post-op ICCE +10D, 2 other type of cataract, 1 orbital disease, 1 corneal ulcer, 1 amblyopia.
So, quite a lot of unilateral blindness but little bilateral blindness.

The programme is still going on in Sanga & Kanyanyeru Sub-Counties. **1,813** children have been taught there (also screened). We are waiting for the schools to re-open to carry out assessments. It will be of interest to know if the trend remains similar. If so, then the future of this programme is in question. A lot of effort is put into the school teaching. It involves bringing in the CRW's, plus lots of field days. The outcome does not appear to warrant the efforts. But then, will we ever be able to measure if the child we taught will remember in 50 years from now that he/she may have cataract as the cause of his/her poor vision in old age? Or if his Mother goes blind in 5 years time that presentation to the eye clinic was because of our efforts. Certainly school teaching sensitises and creates awareness - the outcomes that we just cannot measure! outcomes!

On a separate note, CRW's are school teaching in their own working area on blindness, epilepsy and physical disabilities on average half a day every 2 weeks.

c) Low Vision.

With all honesty, *very little* has been done in this activity. Visits to the nearby School Units of St Helen's & Hornby Schools do show some improvement. Nationally, however, 'OURS' has had no impact. An attempt was made by sending an interested and able participant of the training done in Tororo in 1996 to visit the schools. However, after his first trip it was decided best that future trips be aborted since there were too many key players involved with differing interests. Low vision work in Uganda will not succeed until parties unite together. 'OURS' has tried towards collaboration but given up for now!

ii) **Epilepsy.** - *see Appendix 5a) & 5b)*

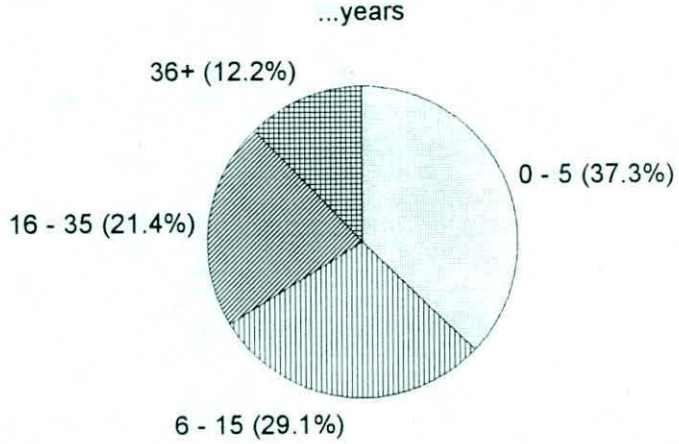
Statistics for epilepsy rely upon accurate recordings by the CRW's and Health Workers'. It should be realised that there are some questions as to the accuracy of these statistics which shall be evaluated during 1999.

a) Identified.
At the end of 1998, **907** people with epilepsy had been identified. Of these, we have survey forms for **801** of them. Many of the others are from 'outside the working area' but have learnt of the programme activities. Others have self presented and the CRW's have just not had time to complete survey forms for them.

This compares with 692 in 1997 **(31% increase).**

Age distribution is as shown on the graph below :-

Age Distribution - Epilepsy 1998



Age distribution shows that **two-thirds** of the people with epilepsy are less than 15 years of age.

b) Assessed.
Of the **907** identified, **748** have been assessed (**82%**).

c) Diagnosis.
Of the 748 assessed, **737** (99%) have got epilepsy of one form or another. During 1998, just **9** people have been taken off the drugs.

d) Management.

- Estimates re: compliance have been made according to Sub-County and range from 20% compliance to 79% compliance. Health workers have been encouraged to ensure people with epilepsy receive their medication monthly. Further, they are expected to record the patients in the 'OURS' follow-up notes so that we can evaluate compliance carefully. Unfortunately, some Health Workers do not see the importance of this on-going evaluation and are not always adopting the paperwork that we have tried to introduce. This makes it difficult for us to know how accurate our data is. In March 1999, we will be calling for another revision workshop and we will try once again to encourage

good collaborations. Therefore, little importance can be given to this statistic at present.

- ***32*** (4%) of the 907 people identified with epilepsy have **died** during 1998.

- Visits to the Health Units by the Mental Health Co-ordinators is now done **bimonthly** except for Ntungamo Health Unit, which is visited monthly. During these visits, new cases of epilepsy attend and also those having difficulties. The routine repeat prescriptions are left to the Health Worker's to manage. We have, however, decided to call **all** people with epilepsy to the next few clinics in the New Year (we are concerned if the quality of the work is falling because we are no longer seeing the routine patients ourselves to motivate them). This will allow us to check in their exercise books to evaluate the number of home visits they receive by the CRW, & to see if the Health Worker's are recording dates when prescriptions are issued - this may allow us to have a better idea of compliance and also a way of checking if CRW's are following their time-tables. A questionnaire has been prepared to ask all the patients.

- A total of **152,899** tablets (Appendix 5a) of anti-epileptic drugs have been supplied through the 'OURS' programme to supplement on the drugs supplied by the District Medical Offices. Despite efforts to encourage better supply via Government, no improvement has been made so far.

- **Family Support Groups** (FSG's) for people with epilepsy were started in 1997. A total of **14** FSG's have been established and a total of **186** people have been involved in a group (average 13 members per group) but numbers of attendance at each meeting has continued to dwindle during the year. It was the hope that these FSG's would encourage compliance and self-funding to pay cost-sharing fees at the Health Units. IGA's would be introduced into the FSG's once established and showing an interest in helping each other. Unfortunately, these groups have not proved very successful to date. The groups have other motivations eg. money for themselves (not the child with epilepsy!). Sharing experiences was the other main objective of the groups, but they seem to think they have exhausted their discussions already! This has been disappointing. We wonder where we have gone wrong and how can the CBR concepts really be valued when communities continue to have a kind of lethargy to self-initiative. It seems that many families find it an easier alternative to deal with their child during the fit than to have to get drugs monthly, ensure that they are swallowed and to find the cost-sharing fee which is equivalent to the cost of half a bottle of soda. On a more encouraging note, there are some families/clients who are very appreciative of the service. The University Teaching Hospital in Mbarara has an active Epilepsy clinic and is successful with its support group. During 1999, it is my hope that we can work closely together and try to *start afresh*. Perhaps their input may help? The Epilepsy Revision Workshop in March 1999 will be a good starting point for this.

e) Awareness/Sensitisation.

The CRW's continue to visit the schools and give lessons on epilepsy. Posters are used with 3 main messages :-

- Epilepsy is not infectious - Help Me when I have a fit.
- People with epilepsy can lead an active life.
- Controlling epilepsy with drugs.

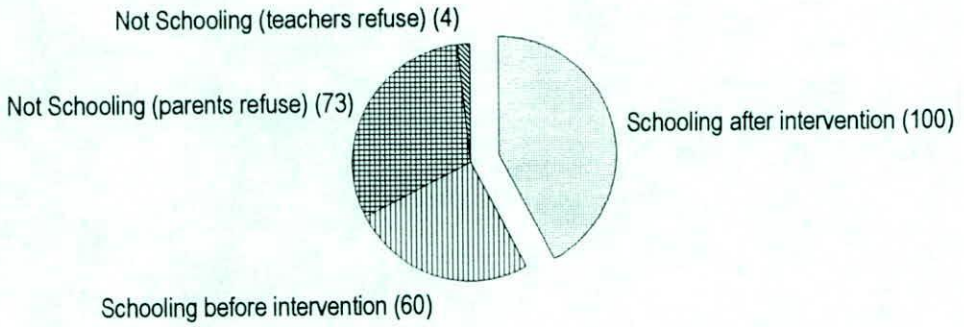
Attitudes in the community have changed. No longer do people with epilepsy hide or are hidden by the families. The number identified and coming forward to the health unit speaks for itself that the disease is very openly considered.

f) Schooling.

In July 1998, we analysed the statistics for children of school going age to find out if they are/are not going to school. The result are shown below:-

Schooling - children with epilepsy.

July 1998



The chart shows that, by July 1998, we had successfully introduced **100 children** into their local school who were **not attending** before the programme. There are still 73 children not attending school because their parents refuse them. Uganda now has Primary Education for all. How many of these children are not attending because of their epilepsy or other reasons is difficult to know eg. would not have gone anyway. Interestingly, only 4 children are not at school because the teachers have refused. This is much improvement since we started. Many teachers refused the children because they thought epilepsy was infectious - this myth seems to be getting dispelled.

3. Physical Impairment.

a) Rehabilitation/Training Unit. *(Photographs - Appendix 6).*

In June 1998, the rehabilitation/training unit was completed and handed over to us for its use. The unit was officially opened on 25th September 1999 by LC5, Mbarara District. The unit has 20 beds for use by the clients and also the CRW's when on training. We are all very pleased with the unit and it has created interest 'on the hill'. It also allows us to have something 'to show' for our work since with it being a community-based programme, potential local donors had not, until now had something to see nearby! Hopefully, this will help us with local fund-raising. It has also relieved Katalemwa of our clients since after 2 or 3 weeks post-op. the clients are returned to us for their rehabilitation.

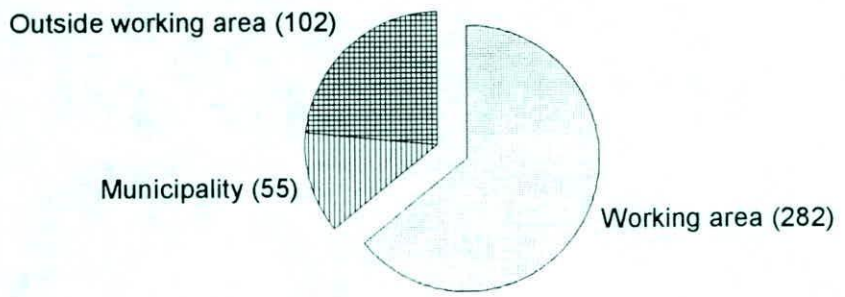
By end of 1998, **176 clients**(98 male & 78 female) & **154 attendants** (54 male & 100 female) had passed through the building in the first 6 months of it being opened.

b) Identified.

A total of **439** new clients with Physical impairments were identified during 1998 in the working area. Of the 439 identified, **282** are from the 'OURS' working area, **55** are from Mbarara Municipality survey and **102** are from outside the working area ie. people who have learnt about the programmes activities and are volunteering themselves. This is very encouraging and makes us wonder what the workload will be like in the future as our reputation grows.

Newly Identified - 1998

Physical Impairment



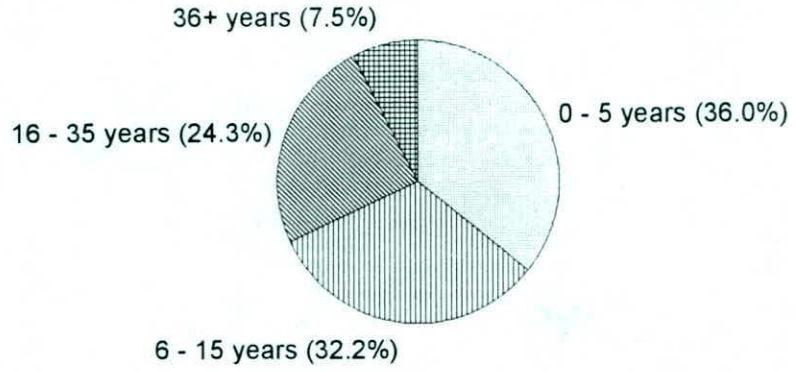
c) Assessments.

During 1998, most assessments were done either at the health units in the working area or at the Rehabilitation/Training Unit. A total of **582** new assessments were carried out in 1998. Of the 582 assessments done, **480** of them were done in the field, the remaining 102 were seen at the rehabilitation/training unit since they were outside the working area (self-referrals).

A further **66** clients have been seen for follow-up assessments eg. post-operatively, following fitting of appliance etc.

Age distributions are as shown on the graph below. Over two-thirds of the patients attended to were less than 15 years of age.

Age Distribution 1998 - Physical (%)



d) Diagnosis.

See appendix 7 for information on diagnosis.

Comments on diagnosis would be as follows :-

- many polio cases are 'old' polio meaning there is little that can be done in the way of a surgical intervention.
- many cases of club feet have been diagnosed. Most of these are young cases where surgical intervention is possible.
- there are many congenital abnormalities of one kind or another. In fact, there were so many 'others' but to classify them would have created a huge list!
- a large number of physical disabilities are a result of trauma. Sciatic nerve injury following injection is particularly worrying.
- cleft lip/palate continues to be high. These are new cases since we try each year to intervene with surgery. They will continue to be born...

e) Interventions.

i) **Surgery** *(see Appendix 8)*
27 Orthopaedic surgeries and **14** Plastic surgeries were done in 1998. There are many clients on lists waiting for surgery. We had hoped to carry out more surgeries but we were limited according to surgical dates available to us. We are able to send 6 clients per month for Orthopaedic surgery by CBM Orthopaedic surgeon based in Kampala. In 1998 we had a **fixed** date per month and this caused us some difficulties since we would have to book the clients in advance and circumstances would often mean that they could not attend on a fixed date eg. rain (no transport), burials, sickness in family etc. Normally, we have to refer 15 in order to hope to receive 6! Sometimes, we haven't even managed that. As the programme gains its reputation, we hope that this will improve since it makes planning difficult.

In 1999, we hope to be more flexible with the opening of Mengo Unit. This should help a lot to ensure attendance.

ii) **Appliances** *(see Appendix 9)*
A total of **101** appliance were fitted during 1998. A further **12** were measured for but not yet fitted. More than three quarters of the appliances provided were either callipers, crutches, shoes or splints.

Mbarara Orthopaedic Workshop sometimes has difficulties producing appliances and can cause delays at times, meaning clients have to stay long in the Rehabilitation Unit. The quality of their work is, however, good.

iii) **Other Interventions** *(see Appendix 10)*

233 other interventions were provided during 1998. **90** clients received training on physiotherapy (***26*** to exercise by self, and ***64*** to exercise with the assistance of the CRW and family).

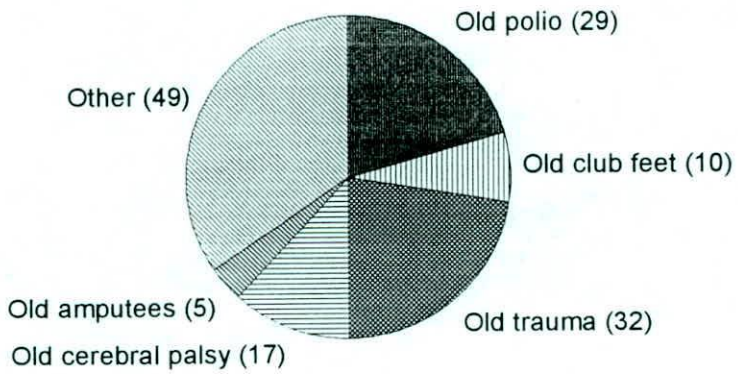
25 clients received plastering (ie. did not need surgery). Especially, this was for babies with club feet and polio cases.

Advice was given to **102** clients, the majority of these were advised to return for follow-up to monitor their progress.

A total of **142** clients assessed received **no** intervention ie. there was nothing to be done for the client that would reduce their disability by surgery or other intervention. CRW's have some training on encouraging vocational skills, social integration etc. but not a lot of emphasis has been put on this up to now. It is hoped, however, that CRW's are encouraging clients on self-reliance and empowerment etc. The graph below summarises those clients in which there no little intervention.

No Intervention (Physical) - 1998

-By diagnosis.



iii) **Referrals**

54 clients were referred to other institutions/departments/doctors. The table shown on the next page gives details on the referrals made.

Type of Referral	Number referred
EARS* office	4
Dermatology	3
Paediatrics	10
Medical Clinic	2
General Surgery	7
Urology	2
Dental Clinic	1
Mulago Hospital, Kampala	7
Gynaecology	2
TB Clinic	3
Hospice Uganda	1
Visiting Orthopaedic** surgeons	8
General Doctor	4
Total	**54**

* Educational Assessment & Resource Services.
** For *older* cases not suitable for CBM Orthopaedic surgeon.

4. Fund raising.

It has come as a surprise how much interest the new building has created locally. As stated earlier in the report, there is now something to show for our work within the town. This has given opportunity to start fund raising locally. Most donations to date have been from well-wishers from overseas but a few local contributions of milk, food have been made. Programme Manager conducts an aerobics class two evenings a week at the local hotel and many people attend - on average 15 per session. Participants know that the money raised goes towards the programme. A fund-raising account has been opened. 70 Christmas cards were sent to the local milk factories, hotels, businesses and important persons in town with the view to follow it up with visits in the New Year.

5. Collaboration with other programmes working with disability.

Not much progress has been made here despite efforts from the office to keep contacts. For 9 months, the District Rehabilitation Officer was away on a course in Kampala. Other organisations working with disability tend to want to *keep to themselves* and it has meant a lot of time wasted travelling to offices for appointments that get postponed. Those meetings that do go ahead involve a lot of words and theory, but unfortunately not a lot of action. Programme Manager has been just too busy to want to spend unproductive time during 1998.

Good collaboration is made with Departments of Mbarara University Teaching Hospital, especially now that many clients with physical disabilities are referred there for assessments. However, appointments get delayed or postponed which causes much *time-wasting*.

In 1999, we plan to have an 'open day' for Doctors to sensitise them better about our work.

6. Conclusion.

The report concludes by thanking all 'OURS' staff for their very hard work during 1998. We are fortunate to have an excellent team of people who work tirelessly with warmth and open hearts towards the people with disabilities. I was surprised one day when a friend commented *'I like your staff - they will look me straight in the eye!'*. I wondered if that was due to the fact we are often busy assessing eyes, but I think that is not the reason! I put it down to their sheer determination to want to succeed. I would like to thank the chief donor, CBM and I would like CBM to know just how determined we are here. I would also like to thank Voluntary Services Overseas (VSO) for supporting us with our Physiotherapist, who has done an excellent job in the short time she has so far been with us.

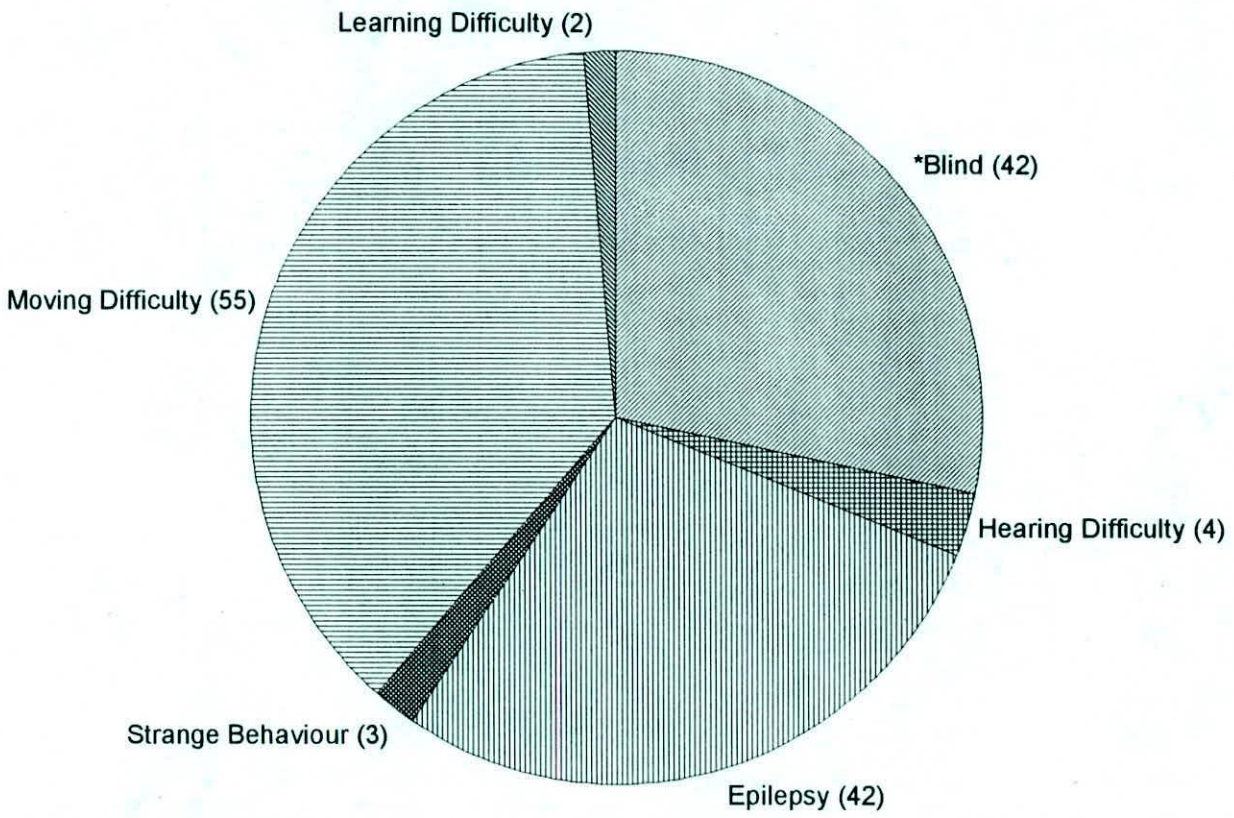
We feel proud of what we have achieved in a short time and with support and understanding who knows what 1999 may bring?

Prepared by : **Liz Moulton.**
'OURS' Programme Manager.

Dated : 20th February 1999.

1998 SURVEY RESULTS (so far) - MBARARA MUNICIPALITY.

*The pie chart indicates the **number** of people **identified** since the house-to-house survey started in August 1998 up to end of 1998. At this point, 4336 people had been screened. Some, but not all have been assessed to confirm diagnosis.*



* Blind : Best Corrected vision < 6/60 **either** eye

SECOND EPILEPSY REVISION WORKSHOP.
Continued Collaborations
'OURS' <> MENTAL HEALTH, MOH.

Date	Period 1 9am 11am Tea	Period 2 11.30am 1pm Lunch	Period 3 2pm 3.30pm Soda	Period 4 4pm 5pm	Evening Activity.
Mon 25th May	<-------Health Workers arrive---------->		- Welcoming address. - Introductions. - Assessment to date. <---------**Group Work**----------> - *'Collaborations to date.'*		
Tues 26th May	**Presentations.** Each Health Unit	Conclusions drawn.	**H/W's** 'Questions on Epilepsy' **CRW's** Family Support Groups	Sharing Information.	
Wed 27th May	- working guidelines. - have they been achieved? - suggestions for ammend - ments / inclusion.	**Open Discussions.**	What to do now?		

Supper shall be provided in the restaurant between **7pm - 7.30pm.**
The time-table is flexible and subject to change.
Please kindly observe the Diocesan codes of conduct and enjoy your stay with us!

Appendix 2i)
Time-Table - Epilepsy Revision Workshop - 1997.

TIME TABLE - TRAINING OF CRWS - 1ST SESSION PHYSICAL IMPAIRMENT 11TH - 15TH MAY 1998

	MONDAY 11TH	TUESDAY 12TH	WED 13TH	THURSDAY 14TH	FRIDAY 15TH
9 - 11am	CRWs arriving	Definition	Demonstration	Communication and Behaviour	Test 9-9:30
11-11:30am			BREAK		
11:30 - 1pm		Normal	Experimentation Development	Early stimulation with children	Decide upon us of appliances
1 - 2pm			LUNCH		
2 - 3.30pm	Introductions	Demonstration	Summary	Appropriate referrals	Disability/function problem
3.30 - 4pm			BREAK		
4 - 5pm	Discussion	Normal Development	Discussion	Continued	Continued

Sessions shall be strict to time. The training involves much group participation and discussion. Morning prayers should be organised by the participants and be conducted from 8.30 a.m to 9.00 a.m at your own discretion.
Please can you respect the Diocese during the time that you are here.

TIME TABLE - TRAINING OF CRWS - 1ST SESSION PHYSICAL IMPAIRMENT - 18TH MAY – 22ND MAY, 1998.

	MONDAY 18TH	TUESDAY 19TH	WEDNESDAY 20TH	THURSDAY 21ST	FRIDAY 22ND
9 - 11 a.m.	WATER & SANITATION (Mwebaze)	CHECKLIST FOR APPLIANCES (Joan)	CHILDHOOD IMMUNISATION (Dr Dobreva)	CLUBFEET (REVISION) Causes, prevention, treatment (Joan)	TEST CRUTCH WALKING (Joan)
11 - 11.30	B	R	E	A	K
11.30 - 1 p.m	NUTRITION, BREAST-FEEDING, WEANING & THE EARLY YEARS (Juliet)	PREPARATION BEFORE SURGERY eg. scabies, jiggers, coughs and colds (Dr Dobreva)	REVISION - EARLY STIMULATION & THE USE OF TOYS (Joan)	CLUBFEET (REVISION) Post-operative follow-up, splints, shoes & repair (Joan & William)	CRUTCH WALKING (Joan)
1 - 2 p.m	L	U	N	C	H
2 - 3.30 p.m	APPLIANCES MEASUREMENT OF AIDS (Joan)	POLIO (REVISION) Cause, prevention, treatment. (Joan)	MAKING TOYS APPROPRIATE TECHNOLOGY (Joan)	USE OF CASTING & STRETCHING Exercises. (Joan)	OPEN DISCUSSION & WHAT TO DO NOW (Joan & Liz)
3.30 - 4 p.m	B	R	E	A	K
4 - 5 p.m	APPLIANCES SELECTION & USE (Joan)	POLIO (REVISION) Post-operative follow-up, exercises, repairs etc. (Joan & William)	MAKING TOYS (Joan)	HEALTH UNITS FOR PLASTER CHANGES - is it practical? DISCUSSION (Joan & Liz)	WHAT TO DO NOW (Joan & Liz)

Sessions shall be **strict** to time. The training involves much group participation and discussion.

Morning prayers should be organised by the participants and be conducted from 8.30 a.m. - 9.00 a.m. at your own discretion.

Please can you respect the Diocese during the time that you are here.

Appendix 2ii)
Time-tables – Training, Physical Impairment.

TIME TABLE - TRAINING OF CRWs - 2ND SESSION PHYSICAL IMPAIRMENT 7TH - 11TH AUGUST 1998

	Monday 7th	Tuesday 8th	Wednesday 9th	Thursday 10th	Friday 11th
9-11am		Anatomy of the spine	Osteomyelitis	Crutches forms	Test Swings
11 - 11.30 am			**BREAK**		
	Introduction Test/Game	Burns-Justus	Schooling & Vocational Training	Malaria & Prevention	Swings
1 - 2 pm			**LUNCH**		
2 - 3.30pm	Normal Development Revision	Hydrocephalus	Tuberculosis & TB Spine	Parallel Bars (A)	Hypertonial/Hypotonia - What's next?
3.30 - 4pm			**BREAK**		
4 - 5pm	Child History Forms - and their use	Spina Bifida	Loan Schemes	Parallel Bars (B)	Discussions

Weekly Timetable - Physical Impairment Training - 3rd Session -(14th - 18th September 1998)

Date	Period 1 9am - 11am	Tea	Period 2 11.30am - 1pm	Lunch	Period 3 2.pm - 3.30pm	Soda	Period 4 4pm - 5pm
Monday **14/9/98**	Review of Child normal development What is a C.P		Neurology		-Causes of C.P prevention		Description of different types of C.P
Tuesday **15/9/98**	Main Characteristics of C.P children 1 case 18 months 2 case 3 years		Video/discussion		Delayed development in C.P - Early signs		Attitudes and beliefs towards C.P in Uganda
Wednesday **16/9/98**	Communication Learning Behaviour Epilepsy and Eye problems		Some cases		Handling a c.p child at home		Video, learning "Learning together" Discussion
Thursday **17/9/98**	Contractures formities P.O.P's for c.p children		Some cases		Appliances for c.p one word		Aids for c.p children Occupational therapy
Friday **18/9/98**	Surgical Procedures for c.p children		Some cases		Multiple disabilities. Discussion with parents		Final test and final discussion

Appendix 2(ii)
Time-tables – Training, Physical Impairment.

WEEKLY TIMETABLE - PHYSICAL IMPAIRMENT TRAINING - 4TH SESSION (9TH - 13TH NOVEMBER 1998)

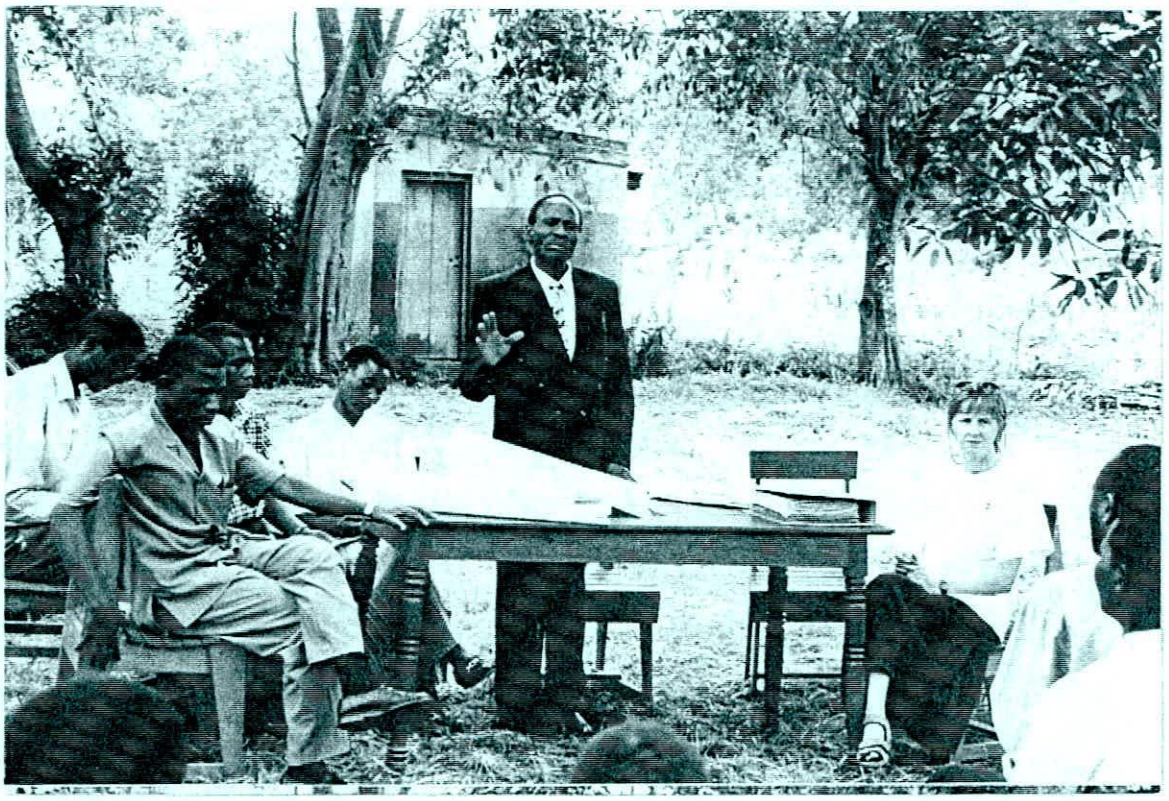
	Monday 9/11/98	Tuesday 10/11/98	Wednesday 11/11/98	Thursday 12/11/98	Friday 13/11/98
9-11am	CRWs arriving	Drinking eating, writing aids	Corner Seat A.P.T	Use of c.p & Assessment forms	Test, puzzles games, etc
11:00am - 11:30am		**BREAK**			
11-30am- 1.00pm	Revision Last Session	Standing frames	A.P.T	Hand/knee pads Transfer board, Hand blocks	A.P.T & Measurements
1 - 2.00pm		**LUNCH**			
2.00pm - 3.30pm	Anatomy + First Aid Justus	Introduction paper technology	Lesson plan	Cushions - bike tyre & Cardboard	Counselling Mary Moran
3.30 - 4.00pm		**BREAK**			
4.00PM 5.00pm	Review Stretching	Wheel Chair & Tricycle use & Maintenance	School teaching	A.P.T.	Discussion

WORKSHOP - TRADITIONAL HEALERS AND EYE WORKERS WORKING TOGETHER

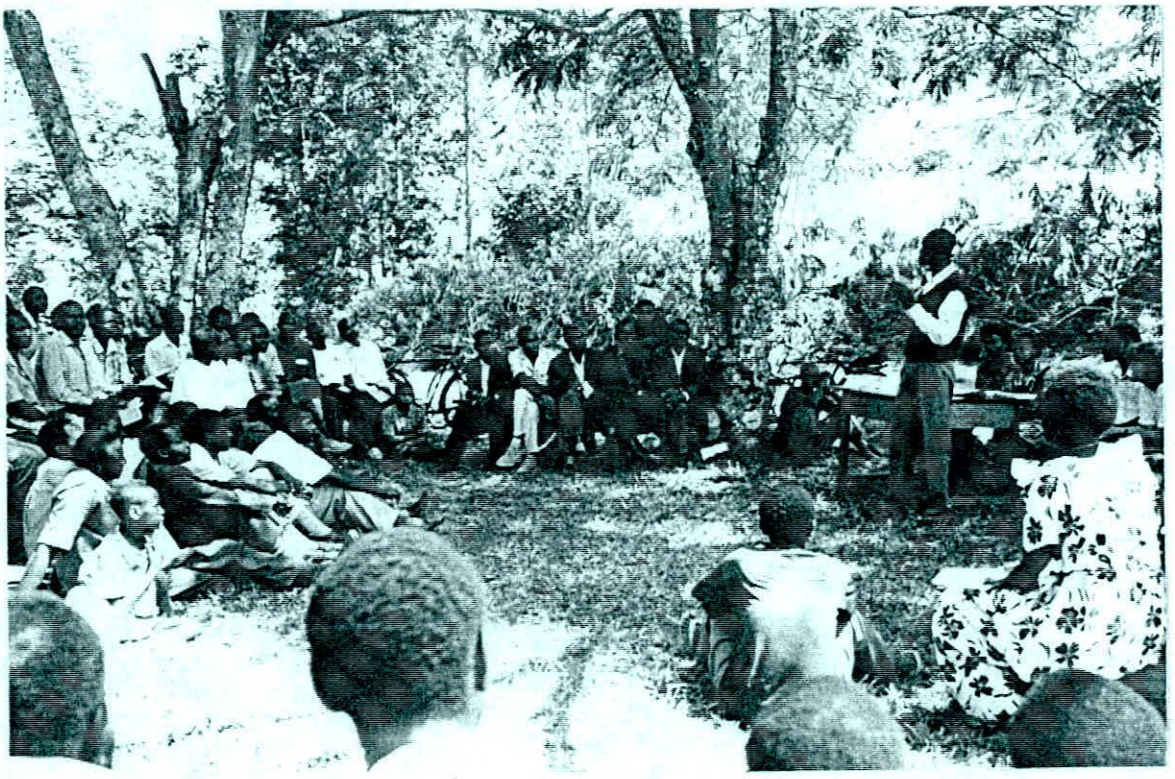
	9:00am - 10:30am		*11:00am-1:00pm*		*2:00pm-3:30pm*		*4:00pm 5:00pm*
Tuesday 8th Dec 98	Participants arrive & register	**T** **E** **A**	Introductions Expectations of Workshop (Formation of groups)	**L** **U**	Common Eye problems	**S** **O** **D** **A**	Experiences on Management - leave alone - medicine - surgery - spectacles - other
Wednesday 9th Dec 98	Groups X2 - Out-patients - Surgery 45 minutes each	**B** **R** **E**	Groups X 2 - Traditional Eye Practices - Western Eye Practices (1 hour each)	**N** **H**	Presentations by Group leaders (Common ideas)	**B** **R** **E** **A**	Discussion How can we work together? Ideas Groups - Traditional Healers - Eye Workers
Thursday 10th Dec 98	Ward round **(8:30am)** Presentations How can we work together? Guidelines for future collaboration	**A** **K**	12:30 Official closing	**C**	Participants departure	**K**	

- You shall be picked at 8:00am prompt from your place of accommodation.
- Breakfast shall be taken at 8:15am in the Community Centre building.

Appendix 2iii)
Time-Table - Traditional Healers Workshop.



Local Council Leader, Kikagati Sub-County praises the work of 'OURS' and encourages the people to support us however possible.



Henry Baguma, CRW in Bugamba Sub-County talks to the local leaders about his activities and answers questions that they have for him.

HOME VISITS* BY COMMUNITY REHABILITATION WORKERS - 1998

Data collection for home visits was introduced in March 1998. Therefore, the statistics below are for **10 months of the year. 2 of these months would have been spent having training/workshops & taking leave. Therefore, the results below can be considered for **8** working months in the field.*

CRW	New P	New E	New V	Total	Old P	Old E	Old V	Total
Twiine	34	20	6	**60**	208	133	147	**488**
Denis	32	30	4	**66**	284	294	44	**622**
Mary	50	47	1	**98**	273	212	37	**522**
Herbert	42	52	21	**115**	197	143	39	**379**
James	6	5	1	**12**	188	274	3	**465**
Elias	27	37	4	**68**	77	353	39	**469**
Stella	65	24	1	**91**	186	368	72	**626**
Henry	76	33	28	**118**	194	109	49	**352**
Agnes	43	37	12	**92**	179	237	60	**476**
Katusiime	4	26	4	**34**	152	361	96	**609**
Begumisa	16	17	1	**34**	218	173	42	**433**
Moses	25	57	3	**85**	114	351	6	**471**
Total	**420**	**385**	**86**	**873**	**2270**	**3008**	**634**	**5912**

'New' - indicates *first* home visit.
'Old' - indicates *follow-up* visit.

To summarise :-

Total number of 'first' home visits = 873
Total number of 'follow-up' visits = 5912

Grand Total of number of visits done = **6785**

Epilepsy Summary Sheet - 1998

Anti-epileptic drugs supplied by 'OURS' programme.
- to supplement those supplied by Distict Medical Offices.

Health Unit	Phenobarbitone	Phenytoin	Total
Bugamba	7000	3000	10000
Ntungamo	15984	11165	27149
Kikagati (Main)	16000	4750	20750
Ruhaama	7000	8000	15000
Kikagati (Nshungezi)	7000	1000	8000
Kikagati (Kamubeizi)	5000	2000	7000
Kabuyanda	15000	13000	28000
Rukoni (Rwoho)	9000	2500	11500
Rukoni (Kyamwasha)	9000	3500	12500
Rukoni (Kitwe)	8000	5000	13000
Total	**98984**	**53915**	**152899**

Epilepsy Programme - 1998.

Analysis by Sub-County.

*** Compliance** - this is an approximation. Reliance is put on the Health Workers' to record in the follow-up notes kept in the Health Unit in order for us to be able to evaluate compliance. It is unfortunate that often the importance of monitoring is not realised by the Health Workers'. It is therefore difficult to know the exact compliance rate at present. An evaluation exercise is going on in 1999, which involves a questionnaire to be completed by the Mental Health Co-ordinators' in order to better establish the compliance.

** Lost - this refers to those persons with epilepsy who have been assessed but were not seen in the Health Unit even once during the whole of 1998. Follow-up by CRW's has been done but the clients are not known of.

Sub-County	No. Identified	No. Assessed	% Assessed	No. confirmed epilepsy (%)	~ % compliance *	Taken off drugs by Dr	Lost**	Died
Bugamba	74	64	86%	62 (97%)	78%	4	1	7
Kikagati	229	193	84%	191 (99%)	55%	1	14	6
Ntungamo	133	108	81%	106 (98%)	79%	1	1	2
Kabuyanda	173	132	76%	130 (98%)	35%	2	7	4
Ruhaaama	128	89	70%	87 (98%)	25%	1	6	7
Rukoni	170	162	95%	161 (99%)	20%	0	20	6
Total	**907**	**748**	**82%**	**737 (99%)**	**20% - 79%**	**9**	**49**	**32**

Rehabilitation/Training Unit.

Appendix 6.

And the children sing for us!

Appendix 7.

Diagnosis - Physical Assessments - 1998.

Diagnosis	Number
Polio (unilateral)	70
Polio (bilateral)	14
Club foot (unilateral)	37
Club feet (bilateral)	25
Osteomyelitis	23
Cerebral malaria	26
Valgus knee(s)	18
Varus knee(s)	3
Windswept knees	2
Tuberculosis	11
Cerebral Palsy	72
Septic Arthritis	9
Amputee	11
Trauma	64
Delayed milestones	8
Sciatic Nerve injury (Post injection)	19
Congenital others	56
Burns	14
Cleft lip	10
Cleft lip & palate	6
Scars	1
Others	83
Total	**582**

Physical Impairment Summary Sheet - 1998.

SURGICAL CASES.

Orthopaedic Surgeries.

Diagnosis	Surgery Done	Awaiting Surgery	Total
Polio (unilateral)	6	3	9
Polio (bilateral)	1	0	1
Club foot (unilateral)	2	9	11
Club feet (bilateral)	5	8	13
Osteomyelitis	5	5	10
Cerebral Palsy	2	1	3
Valgus Knees	2	4	6
Septic Arthritis	2	1	3
Other	2	1	3
Total	**27**	**32**	**59**

Other surgeries.

Diagnosis	Surgery Done	Awaiting Surgery	Total
Urinary	2	0	
Burns	6	6	12
Cleft lip	5	9	14
Cleft lip & palate	0	7	7
Other (plastics)	1	6	7
Other surgeries	0	4	4
Total	**14**	**32**	**46**

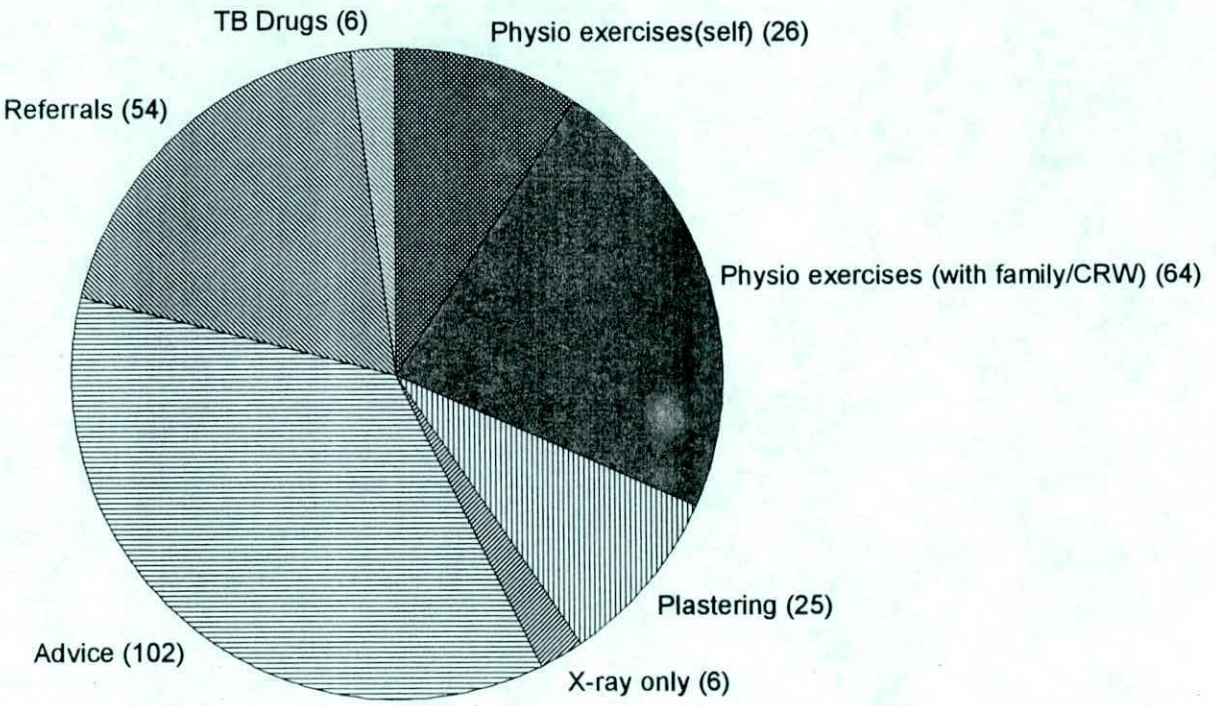
Physical Impairment Summary Sheet - 1998.

APPLIANCES.

Type of Appliance	Received 1998	Measured (but not yet received)	Total
Shoes/boots	12	2	14
Shoe Raise	8	5	13
Callipers	23	2	25
Crutches	20	0	20
Splints	22	1	23
Wheel chair	2	0	2
Tricycle	2	2	4
Standing Frame	2	0	2
Corner Seat	4	0	4
Prosthesis	2	0	2
Other	4	0	4
Total	**101**	**12**	**113**

Physical Impairment Summery Sheet - 1998.

OTHER INTERVENTIONS.



***Advice offered**	
- nutrition	1
- trauma	1
- cerebral malaria	1
- cerebral palsy	1
- other	1
- for follow-up	97

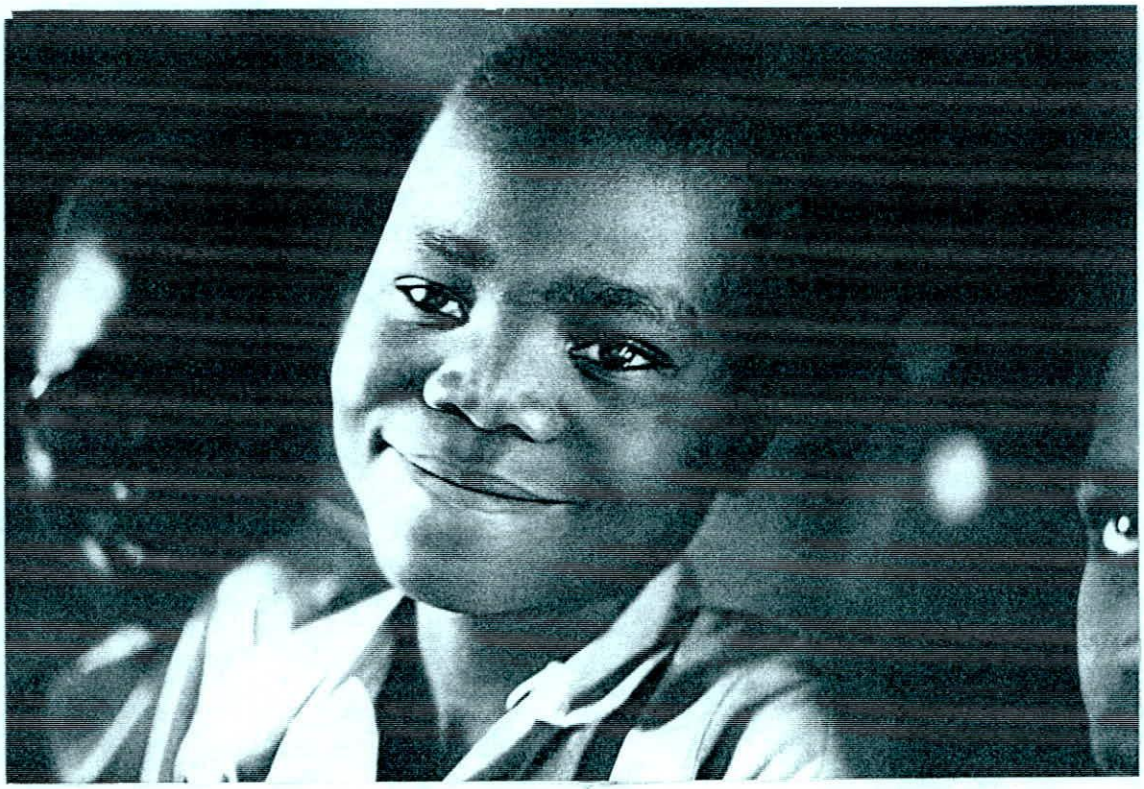
Plastering (diagnosis)	
Club foot (unilateral)	- 6
Club feet (bilateral)	- 6
Polio (unilateral)	- 8
Polio (bilateral)	- 1
Other abnormalities	- 4

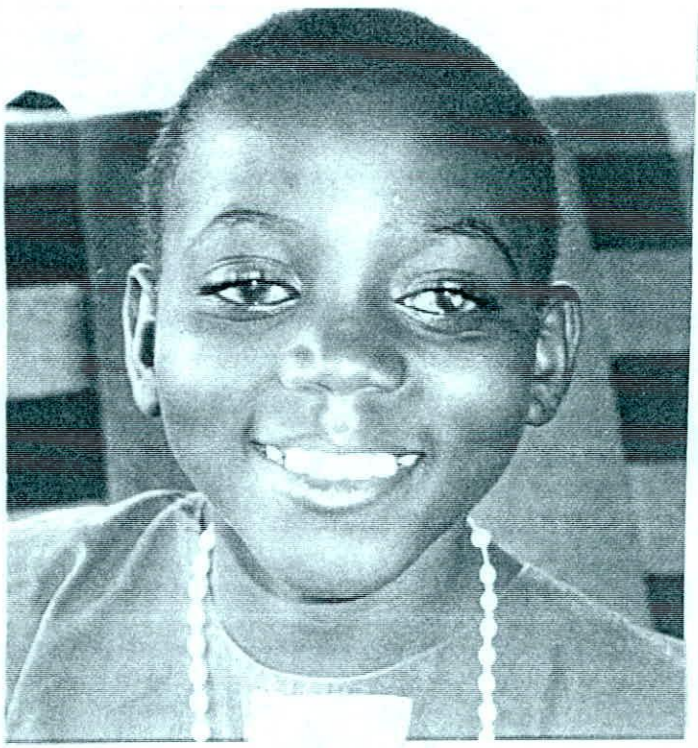
The work for the visually impaired still remains active.

For the **ELDERLY**, it is great to find the post-operative patients and to see they are still wearing their aphakic spectacles.....

It is also great to see those who have now had the inta-ocular lenses rather than +10 spectacles. Despite encouraging them to come back for check-up, it is sometimes necessary to find them in their homes. Most cases are doing very well.

The blind children are happy to be at school. We continue to keep in touch with them.

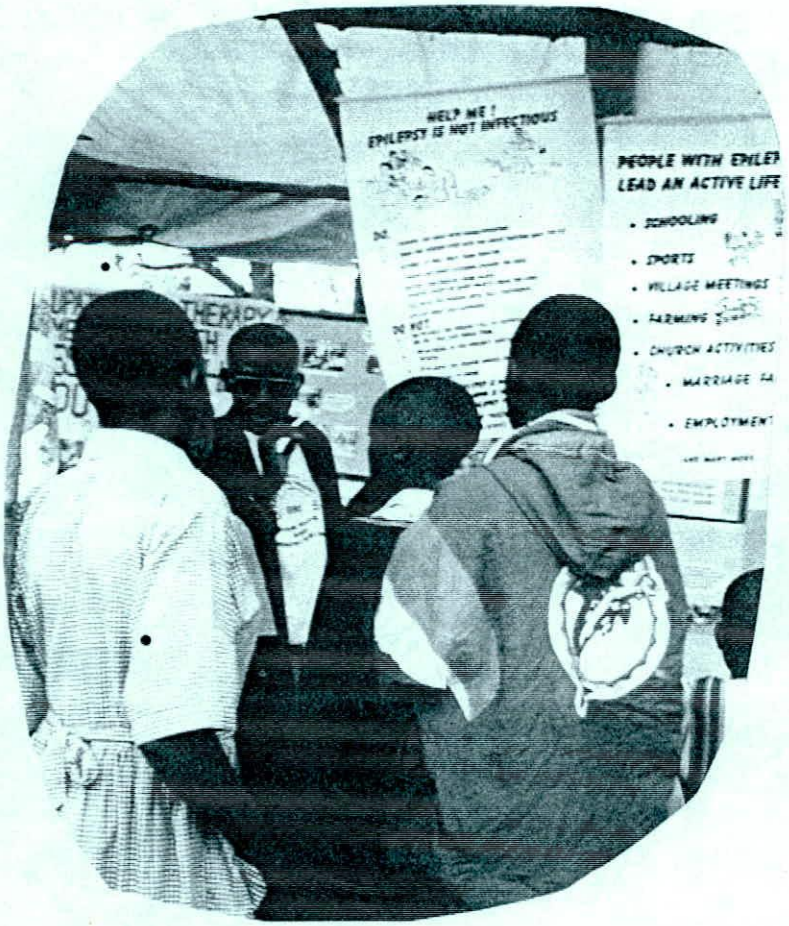


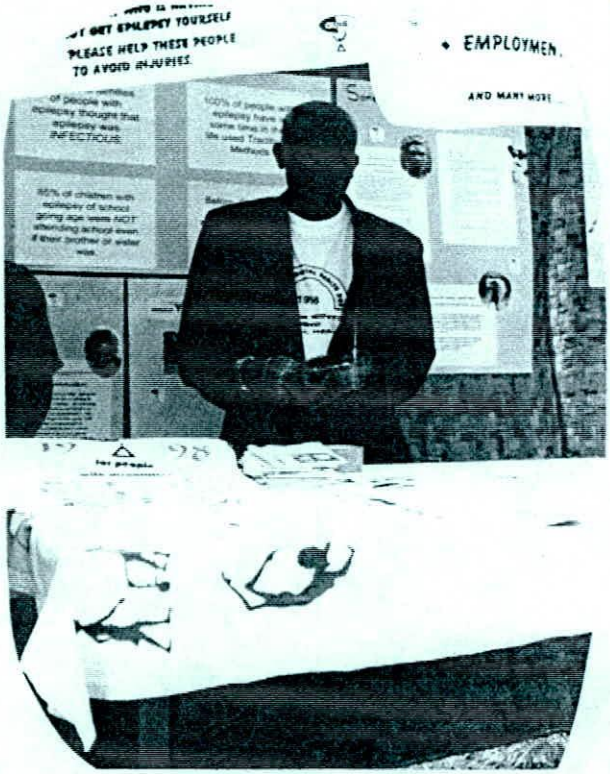


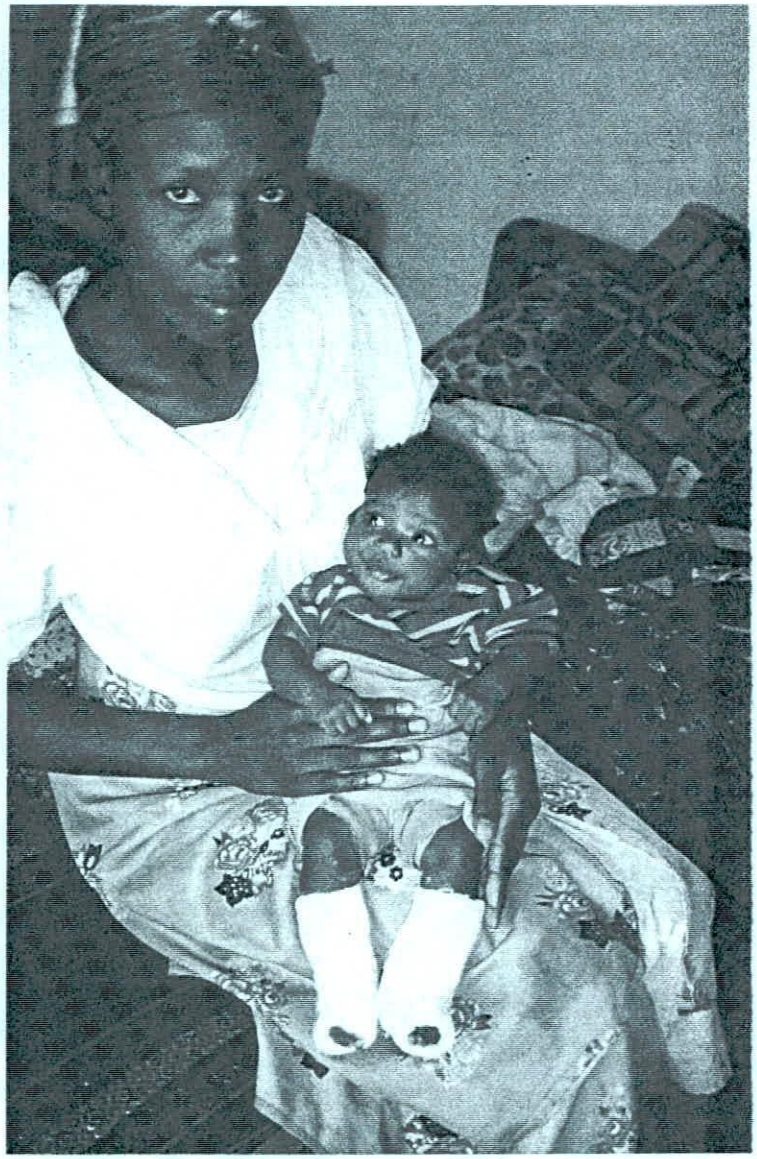
Photographs.

Epilepsy - sensitisation.

Mental Health Day (10th November 1998) was celebrated in Mbarara. This was a good opportunity to sensitise about epilepsy. A march through town and then a stall at the venue. People were surprised to be told that epilepsy is not infectious and can be controlled by drugs. They were also surprised to learn that 'OURS' is treating over 700 people with epilepsy in just a small part of Mbarara District.







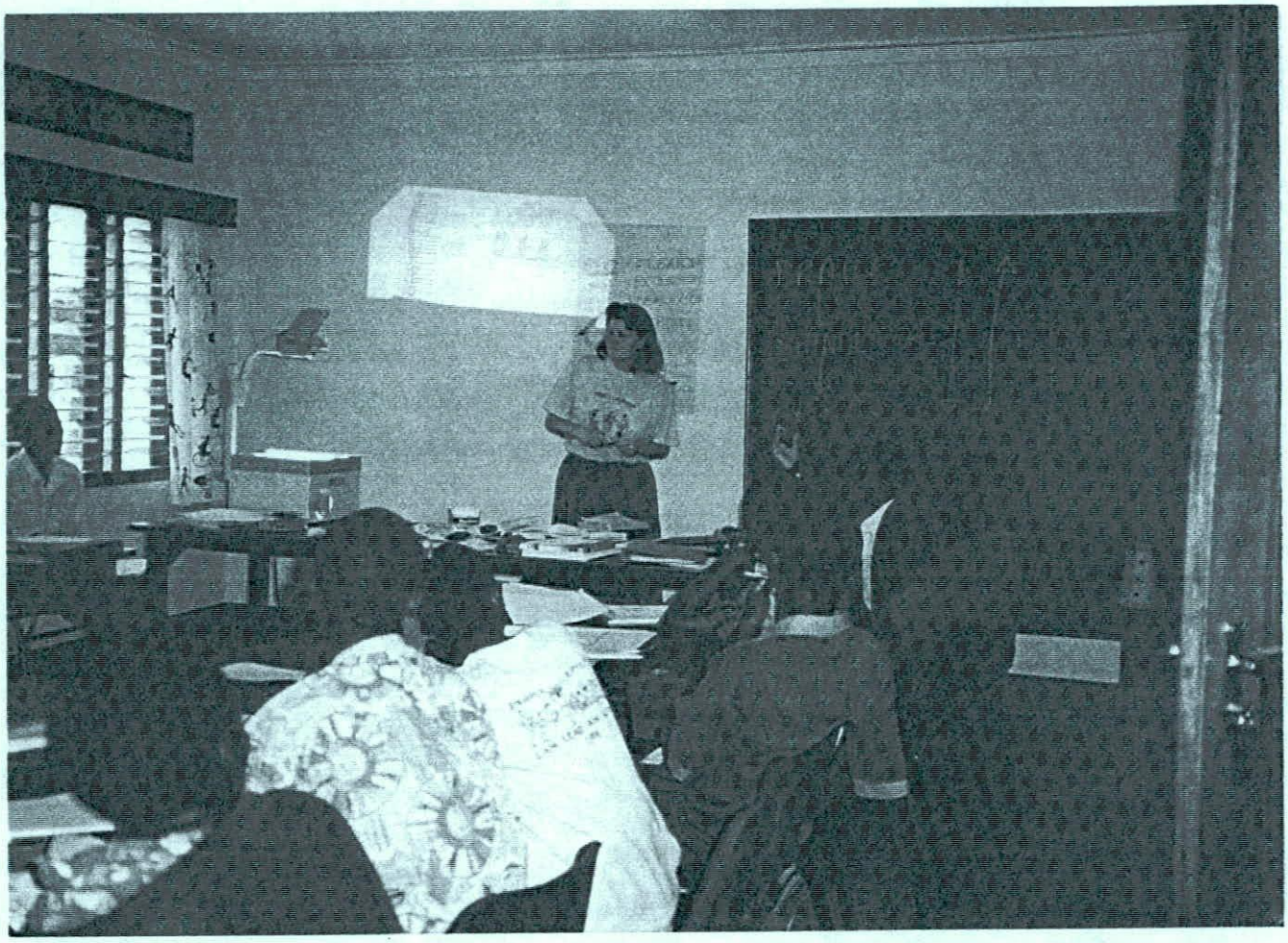
We are so happy when we find the babies with physical impairtments so soon after delivery. There is so much that can be done for them. *'The younger, the better!'*

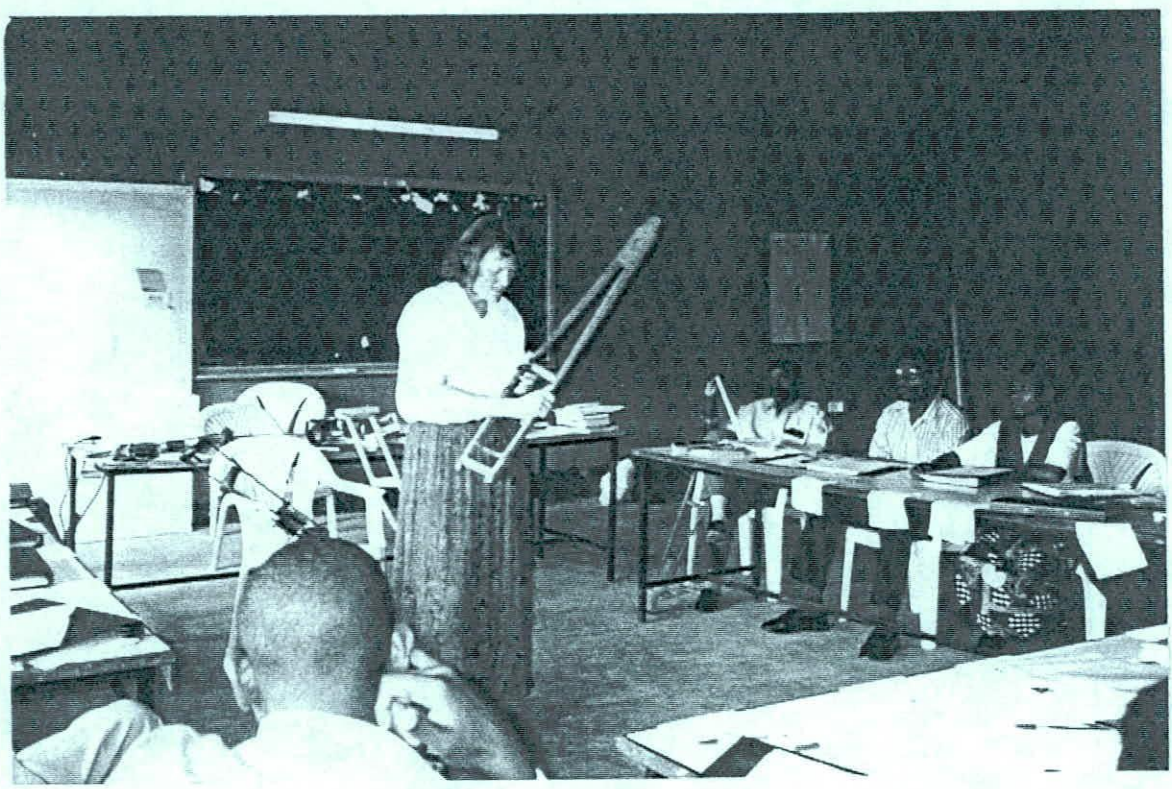
The sheer determination and willpower of the children makes for a humbling experience. It also makes the hard work all seem very worthwhile.

Training on Physical Impairment considered all aspects of management of the most common physical disabilities that are likely to be seen in Uganda.

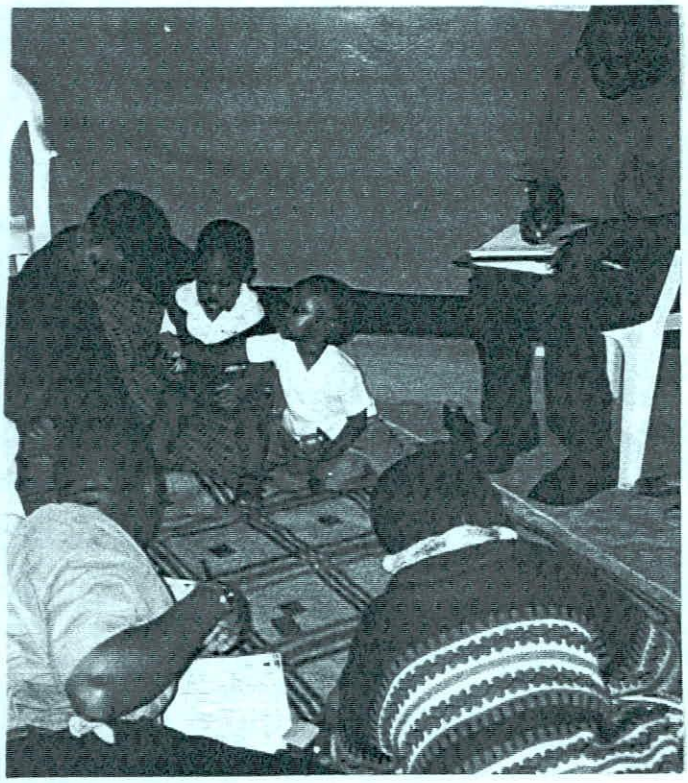
Training was both ....

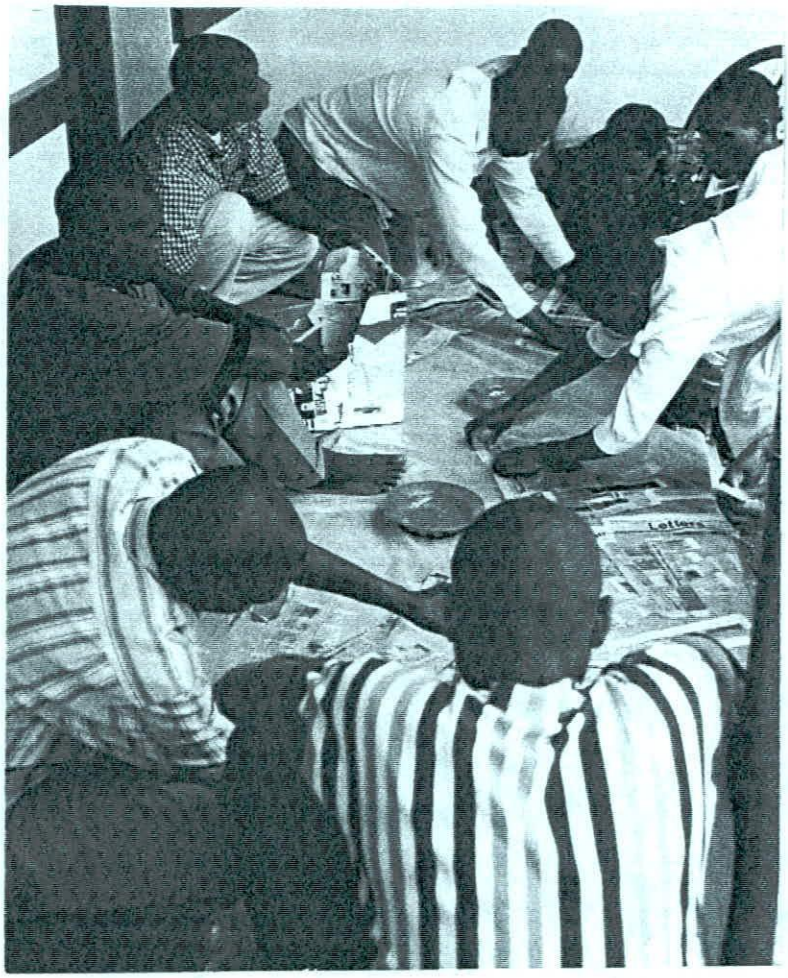
THEORY.....





and **PRACTICE.....**





Field work brings us surprises. We aim to come back with the vehicle full. Poor roads and unpredictable rains continue to make field work exhausting. Sometimes we are 3 days per week in the field. Only a few people can keep up this pace for long...

Sometimes, we are not always sure if we will get back at all!!

Photographs.
Field work.

Home visiting is very important by the office staff in order to support the work of the CRW.

Sometimes, we have no choice but to put up the tents and spend the night in the field. The furthest place we visit can be 2 hours from the office.