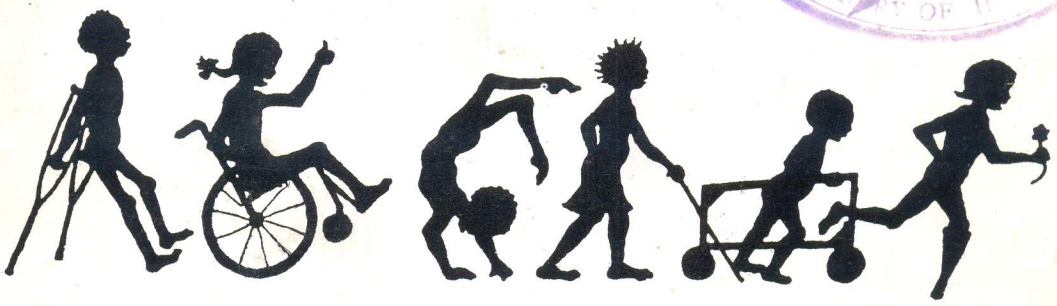
INTEGRATION OF CARE FOR AND WITH PERSONS WITH DISABILITIES AND EPILEPSY IN UGANDA

PROCEEDINGS OF A WORKSHOP HELD ON 27 AND 28 FEBRUARY AND 1 MARCH 1995 IN POPE PAUL VI MEMORIAL CENTRE, RUBAGA, KAMPALA.

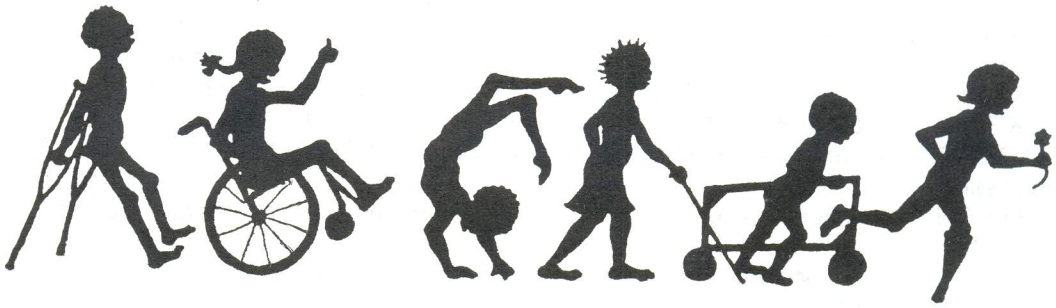


Summaries of papers compiled by: Florence Baingana, Magda McGregor-Schuerman, James Tumwine

Final Editing: Magda McGregor-Schuerman and James Tumwine.

INTEGRATION OF CARE FOR AND WITH PERSONS WITH DISABILITIES AND EPILEPSY IN UGANDA

PROCEEDINGS OF A WORKSHOP HELD ON 27 AND 28 FEBRUARY AND 1 MARCH 1995 IN POPE PAUL VI MEMORIAL CENTRE, RUBAGA, KAMPALA.



Summaries of papers compiled by Florence Baingana
Magda McGregor-Schuerman
James Tumwine

Final Editing: Magda McGregor-Schuerman and James Tumwine.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS AND LIST OF SPONSORS

This unique workshop was made possible through the financial support of five main sponsors. The organising committee extends its most sincere thanks to :

Royal Netherlands Embassy: Special Health Support Fund.

DANIDA / EARS / Ministry of Education and sports

Redd Barna: Save the children Norway

NAD / CBR / Ministry of Gender and Community Development.

USDC.: Ugandan Society for the Disabled Children.

The organising committee consists of the following members:

Chairperson:	Dr. Alice Baingana-Nganwa Department of Paediatrics and child health, Medical School, Makerere University
Secretary:	Dr. James Tumwine Department of Paediatrics and Child Health Medical School, Makerere University
Treasurer:	Dr. Magda McGregor-Schuerman Institute of Public Health, Room 223 Medical School, Makerere University
Member:	Dr. Kirsten Kristensen EARS Program, Ministry of Education and Sports.
Member:	Martin Omagor-Loican EARS Program, Ministry of Education and Sports.

We also wish to thank all the participants of this workshop whose contributions made this event a success and who have helped to formulate the recommendations which will be presented to the permanent secretaries of the relevant government ministries. We hope this workshop is the starting point for a much bigger effort that is needed to really care and integrate care for and with persons with disabilities in Uganda.

INTRODUCTION:

The idea of having a workshop on integrated care for and with persons with disabilities and epilepsy, looking at the role of community based rehabilitation programs and government departments at district and national level in Uganda today and tomorrow, was conceived by the Institute of Public Health and the Department of Paediatrics and Child Health of the Medical School, Makerere University in conjunction with the EARS program of the Ministry of Education and Sports

BACKGROUND:

As the UN decade for the disabled came to an end there was an outcry from organisations for and of the disabled to move from "Awareness to Action." In Uganda several N G O's and government departments heeded this call and put emphasis on the right for disabled people to optimally develop their abilities. This has taken form in the representation of the disabled people in the Constituent Assembly and in the clear acknowledgement of the rights of disabled children in the National Program of Action for Children, co-ordinated by the National Council for Children under the Ministry of Labour and Social Affairs.
Within the Ministry of Education and Sports there are special programs being developed for the education of children with special needs as part of a Danida aided project
To help disabled adults and children in Uganda achieve their full potential and attain self-reliance in society there are initiatives existing, mainly in the fields of social work and education. The Ministry of Gender and Community Development is co-ordinating community based activities for persons with disabilities.

NGOs and government departments in Uganda working in the field of disability all stress the importance of inter disciplinary and inter organisational co-operation. In practice however this collaboration is often lacking, leading to incomplete rehabilitation schemes and sub optimal utilisation of resources.
Taking all this into consideration it was justified to bring DMOs, DIS, DPWO's and DRO's together in a forum with educationalists and planners in the fields of health, education, social work and district development and with representatives of NGOs working in the field of rehabilitation and disabilities in a workshop of this kind.

PURPOSE OF THE WORKSHOP:

-To create awareness of the need for action plans at the national and district level for persons with disabilities and epilepsy.

-To equip field workers with tools for inter disciplinary collaboration and referral.

-To assess training needs for doctors, para medical personnel, teachers and social workers in disability related issues .

-To provide policy makers and planners with the necessary scientific information to support and plan for initiatives on integrated care for persons with disabilities and epilepsy.

-To develop guidelines for a national plan of action on disability and epilepsy in Uganda.

The workshop was held on 27 and 28 February and 1st March 1995 in the Pope Paul VI memorial Centre and brought together more than 150 interested participants to gather information and acquire knowledge in the complex field of integration of care for and with persons with disabilities and epilepsy in Uganda. The participants deliberated about the recommendations for plans of action for persons with disabilities at a national and district level

In this short publication we compiled the summaries of the papers, presented during the above workshop The complete text of the presentations will be published at a later stage in relevant professional journals..

PROGRAMME

Time	Topic	Speaker
	February 27th, Morning Session	
08.00-09.00	Registration	
09.00-09.30	Welcome. Introduction to and Objectives of the Conference/Workshop	Organising Committee
09.30-10.00	Keynote Address	Prof. G. Bukenya, Dean of the Faculty of Medicine
10.00-10.30	Opening of the Conference	The Guest of Honour
10.30-11.00	**TEA BREAK**	
11.00-11.15	Community -based care for children with disability: the role of national, local and donor institutions	Maria Bawukya-Ssenkezi; UNICEF
11.45-12.00	CBR: What is happening in the field? The Bwaise experience	Maria Kangere, COMBRA
12.00-13.00	**Questions and discussion**	
13.00-14.00	**LUNCH BREAK**	
	February 27th, Afternoon Session	
14.00-14.15	The Educational Assessment & Resource Services (EARS) Programme, a national programme. The Ministry of Education and Sports' response to children with special needs in Uganda	Veronica Mpagi, EARS
14.15-14.30	Integration of disabled children into the mainstream education	Dr. Kurt Kristensen, UNISE
14.30-15.00	EARS in action	Video, Dr Kirsten Kristensen, EARS
15.00-16.00	**Questions and discussion**	
16.00-16.15	**TEA BREAK**	
16.15-16.30	The rights of disabled children. The village perception	P.T. Kakama
16.30-16.45	Disability and inequality	Hon. Mazima, NUDIPU
16.45-17.00	Disability in present-day Uganda	Dr J. Tumwine
17.00-17.30	**Questions and discussion**	

Time	Topic	Speaker
	February 28th, Morning Session	
08.30-08.45	**Report on recommendations**	
08.45-09.15	Care for disabled persons, need for a national policy	Dr. Hans Wullfsberg
09.15-09.30	Social work and community-based interventions, the "systems approach	Prof. J. Muzaale
09.30-09.45	An example of integrated care for disabled persons. The Masaka District experience	B. Kandyomunda, USDC Masaka
09.45-10.15	**Questions and discussion**	
10.15-10 45	The Districts at present. District Team discussions and poster presentation: "Which services exist for persons with disabilities in our district?"	
10.45-11.15	**TEA BREAK**	
11.15-11.45	Epilepsy: the Kenya experience	Dr. Osman Miyangi, KAWE
11.45-12.00	Community perceptions of epilepsy. The Nyimbwa and Kasana experience	S. Nanjobe, USDC Luwero
12.00-12.30	Causes of disability in Mulago Hospital, a review of clinical findings	Dr. A. Baingana-Nganwa
12.30-12.45	Testimony of an epileptic child	Video
12.45-13.00	**Questions and discussion**	
13.00-14.00	**LUNCH BREAK**	
	February 28th, Afternoon Session	
14.00-14.30	Introduction and aims of the group discussions	Organising Committee
14.30-16.00	Group Discussions	
16.00-16.30	**TEA BREAK**	
16.30-17.30	Continuation of group discussions	
17.30-17.45	Report of workshop on "Integration of care for persons with disabilities, the field workers' view"	H. Asamo, SDG

Time	Topic	Speaker
	March 1st, Morning Session	
08.00-09.30	**Presentation of yesterday's group deliberations**	One reporter from each group
09.30-09.45	Hearing impairment. How to improve liaison between professionals?	H. Barber, VSO, UNISE
09.45-10.00	Visual impairment. The problems we face	Mr. Kinubi, UNAB
10.00-10.15	The child with learning disabilities. What can be done in Uganda?	C. Okecho, UNISE
10.15-10.30	Community base rehabilitation (CBR) Uganda's commitment to persons with disabilities	J. Mirembe, CBR, Min. of Gender and Community Development
10.30-11.00	**TEA BREAK**	
11.00-11.15	Behavioural problems, field experience and community based approach	J. Wilson
11.15-11.30	Community based mental health care, the Butabika experience	Dr. F. Baingana
11.30-12.00	**Questions and discussion**	
12.00-12.15	Protection of the rights of the disabled child	Mr. Wadri
12.15-12.45	Support supervision, a possible way to meet our goals. Presentation and panel discussion	Dr. G. Paryo, P. Katende, E. Karuhije
12.45 13.30	**LUNCH BREAK**	
	March 1st, Afternoon Session	
13.30-15.00	**Group Discussions**	Organising Committee
15.00-16.00	Report back by groups and plenary discussions	
16.00-16.30	**TEA BREAK**	
16.30-17.00	Report on recommendations and guidelines for a national plan of action on disability in Uganda	
17.00-17.15	**Official closure of the Conference/Workshop**	Mr. E.L. Ssendaula, Permanent Secretary, MOE&S

"Activities on behalf of disabled persons are subject to no political controversy. They are supported by East and West, North and South. It is a field of endeavour in which the world community can truly work together, and in doing so, perhaps, establish a degree of understanding and confidence that can be a point of union-of united effort both nationally and internationally for the very real enhancement of the human condition"

Javier Perez De Cuellar, former Secretary General of the U.N.

cited by Basil Kandyomunda in his presentation during the workshop.

SUMMARY OF PAPERS

PROF. G. BUKENYA, Keynote Address

Dean elect, Faculty of Medicine

In the context of the conference, disability was defined as `any restriction or lack of ability to perform an activity in the manner or within the range considered normal for a person.'

Disability is a major global problem with 450 million disabled people in the world, of whom 70-80% live in the developing countries.

There is a lack of reliable data on disability but according to WHO, developing countries have and average disability rate of 10%, putting the number of disabled people in Uganda at 1.8m. Mental handicap and epilepsy are the most frequent disabilities.

There was need for the outcome of the workshop to be action-oriented in line with the recommendation of the end of the decade for the disabled - `move from awareness to action'.

The causes of disability need to be addressed so as to formulate intervention strategies. All infectious causes of disability are preventable using simple appropriate and easily available tools. Interventions should have an integrated approach including improvement of Maternal and child health, nutritional interventions and addressing the problem of teenage pregnancies, 80% of which occur in developing countries.

Cheap, and effective drugs, especially for epilepsy, should be included on the essential drugs list.

Training should be tailored to preventing disability and meeting the special needs of the disabled ranging from training of TBAs, special education teachers, to sensitisation of health personnel. There is also a need to strengthen research into the causes, the extent of the problem and into suitable interventions.

The need to maximise the abilities of the disabled, ensuring access to equal opportunities and providing them with an environment for social integration, was emphasised.

(Full text will be published in the journal of the Paediatric Association)

Speech by the Guest of Honour

The speech by H.E. the Vice President and Minister of Gender and Community development, hon. dr. Kazibwe was presented by H.E. the Minister of Labour and Social Affairs, hon. dr. Chebrot.

Many disabling conditions have "visible" features but it is commendable that "invisible" disabilities like epilepsy will be discussed in this workshop. The U.N. population statistics for 1990 indicate a global prevalence of moderate and severe disability of 5.2%. But in spite of the magnitude of the problem, only 25% of those persons in need are actually availed services. This led to a government of Uganda policy of promoting community involvement and financial review for social service delivery

There has been a re-orientation from institutional rehabilitation services to CBR. However, institutional services will continue to have a role to play, especially in providing referral services, assisting in staff development and providing mobile consultations and special services. Therefore it is suggested to develop a matrix which is a healthy and progressive combination of the two approaches building on their respective strengths. The key is inter-disciplinary collaboration in service delivery in order to practice integrated care for P.W.D.

There are still a lot of problems in the existing services and there is need for donors to seek joint solutions, pool funds and work with governments and communities in a co-ordinated way.

The Vice President than thanked the organisers and the sponsors of the conference and declared it open.

M. BAWUBYA-SSENKEZI, Community Based Care of Children with Disability: The Role of Community and other Agencies.

Project officer, Children in Especially Difficult Circumstances, UNICEF.

UNICEF associates itself with the workshop, which is addressing a topical issue concerning one category of vulnerable children in Uganda.

The ratification of the convention of the rights of the child, adopted in 1990 in the UN General Assembly and the subsequent development of a National Program of Action for Children to guide the development of social services to as many children as possible, including community care of children in need of help, are two main factors that created a more supportive environment for children with disabilities in Uganda. The World Programme of Action concerning Disabled Persons, an off-shoot of the UN Decade for Disabled Persons which ended in 1992, aimed at promoting effective measures of prevention of disability, rehabilitation and the realisation of the goals of full participation of persons with disability in social development and equality.

As critical decisions concerning children with disability are primarily taken at the community level and the local environment determines the effect of an impairment or a disability on a child's daily life and development, the above forces provided a springboard for Community Based Care of children with disabilities.

It is important to understand what, why and by whom decisions on children with disabilities are made, which resources are available, how they are mobilised and managed. The critical challenge to the CBR approach is to enable parents, guardians and communities assess, analyse and take action, to care for children with disabilities. Sustainability of CBR is dependent on the response from within the community as well as availability of support from outside the community.

There is need to establish information systems, to strengthen professional support services, to train and support personnel within the relevant ministries at all levels. It is important to include children and adolescents with disabilities in the design, planning and execution of activities and they should be mainstreamed in all community development programmes.

(Full text will be published in "Tropical Health")

H. WULFFSBERG, The Concept of Rehabilitation, the Role of Referral Systems: An Integrated Approach.

M.D., Facilitator, DANIDA

Hans is a public health professional and father of a wonderful nine year old son with multiple disabilities. This together with his work with organisations of disabled people in Denmark has given him `a lot of food for thought' and insight into disability.

Several observations on disability and development in Uganda can be made. Firstly, Uganda is the second country in Africa to have an EARS program, which is government owned. So sustainability and commitment of financial resources are assured.

Secondly, the EARS program has nation-wide coverage with the potential to serve as the backbone from which disabled people in Uganda can be reached within their communities.

Thirdly there is a national NGO supported CBR program, and a unique focus on the education sector as the entry point for a national service programme for the disabled. Establishment of strong links and referral amongst the different sectors is crucial.

There are two key international documents on disability: the World Program of Action on Disability and the Standard Rules on the Equalisation of Opportunities for Persons with Disabilities.

The paper discusses referral mechanisms, rehabilitation and equalisation, reflecting on what the world governments have agreed should be the minimum standards in every country.

It ends with a big challenge to the health sector especially the lack of a policy statement on epilepsy. There is a need for MOH to establish task forces to produce strategies and program initiatives for ENT, orthopaedics, paediatrics, epilepsy, mental health and for assistive devices.

The role of the health sector in supporting EARS and CBR programmes at all levels is crucial. The MOH has the know how but needs concrete and committed action. Donors might be willing to support initiatives in this area.

(Full text will be published in "EARS")

M. KANGERE, CBR: What is Happening in the Field? The Bwaise Experience.

Programme Manager COMBRA

In Uganda CBR was pioneered by indigenous organisations in the late 80s. The government joined in the CBR challenge in the early 90s.

Some of the challenges of NGOs working in the field of CBR are: working in isolation. overwhelming numbers of clients at outreach clinics, lack of referral services at the district level and lack of government commitment.. Some of the disabilities are marginalised. i.e. mental retardation. behaviuoral problems. severe and multiple handicaps. There is also the problem of lack of technical know-how to deal with these disabilities

COMBRA (Community Based Rehabilitation Alliance) started running a CBR programme in Bwaise in 1991. The focus of COMBRA activities has been awareness on community mobilisation, training CBR volunteers. identification, assessment and intervention. referrals, and follow-up. exchange visits and income generating activities.

All involved in rehabilitation are urged to demonstrate a spirit of commitment to find a way of working together to improve rehabilitation services rendered. There is need to find a forum for sharing experiences. achievements and failures. Certain activities could be shared such as training and evaluation in order to avoid duplication and maintain high standards There is also a need to develop and strengthen inter-sectoral co-operation and collaboration if the CBR goal is to be achieved.

(Full text to be published in the journal of the Paediatric Association)

HON E. MAZIMA, Disability and Inequality

CA Delegate - NUDIPU

According to the American People with Disabilities Act of 1990 disability is defined as: A physical. mental or sensory impairment that substantially limits one or more of the major life activities of an individual. For P.W.D.s inequality in daily life happens because of lack of access to equal opportunities. available services. resources or facilities. The root causes for this inequality lie in the individual who may lack knowledge of his/her rights or may lack self determination. and in the society which has negative attitudes and traditional beliefs and practices that lead to inequality.

Inequality faced by P.W.D. in Uganda can be at the family level where a child may be hidden and is not encouraged to learn from practice. At the community level this child may then grow up as a social misfit. The state may not view P.W.D. as a priority and may not have policy guidelines affecting P.W.D and this limits the NGO sectors formulating and implementing intervention strategies. As a result. P.W.Ds have less developed or dormant potential. they loose hope. develop self pity and permanent dependency .

To overcome this situation one should aim at developing the full potential of the P.W.D by providing equal opportunities. enabling active participation. facilitating independent living and economic self sufficiency and protecting and promoting the rights of persons with disabilities through appropriate policies and laws.

(Full text will be published in "Tropical Health")

DISCUSSION

The main point of discussion after these first papers was the question: "To whom belong children with disabilities?". Do they fall under the responsibility of the district rehabilitation officer under the probation and welfare officer, the EARS programme or the district health team? It was felt that children with disabilities are first and foremost children and they therefore need access to the same services as their able bodied peers. Each ministry is therefore responsible for expanding its activities to persons with disabilities. Dr. Wulffsberg made here the remark that each ministry should develop its own budget line for activities for and with persons with disabilities and there should never be one central budget for the disabled.

On the question with which ministry lies the final responsibility for children with disability Dr. Wulffsberg suggested the following: It is obvious that there is a lot of supervision and leadership required if one wants to achieve the goal of "integrated care for and with persons with disabilities." The only office that would be in a position to do this is the Prime Minister's office if a "disability and epilepsy "-desk could be established there. The office of the Prime Minister has the authority to co-ordinate and supervise activities of other ministries in the field of disabilities and epilepsy.

V. MPAGI, The EARS Program

MoE&S: In-Charge - EARS

The Educational Assessment and Resource Services (EARS) programme is a Uganda Government national programme currently supported by the Government of Denmark through Danida It is based in the Ministry of Education Inspectorate as the Special Education Section of the Department

This paper gives an overview of the historical development of educational services for persons with disability which were partially supported by the Ministry of Education from 1963 It also highlights the goals. activities. progress and future plans of the EARS programme.

in 1989. the Education Policy Review Commission Report called for government commitment to provision of special education to children with disabilities. This resulted in UNISE- a programme for the training of teachers specialised in varied fields of disability. and the EARS program.

The EARS programme activities started in 1992. The goal of EARS is to ensure the education of children at risk targeting those from age zero to eighteen. Activities include prevention of disability. identification of cases of disability. assessment. referral and follow up. counselling and guidance of parents. and collaborative co-ordination of varied services.

EARS has reached reasonable converge in 18 districts and one of the selection criteria was availability of specialised teachers of children with disabilities. By 1996 most of the districts will be covered.

Each EARS centre in the district is placed under the care of the District Development committee. right from the beginning. as a strategy for ensuring sustainability when Danida leaves.

EARS future plans include consolidation of the activities of the centres. development of a sophisticated comprehensive computerised statistical base for reliable reference and promotion of inter sectoral collaboration.

(Full text will be published in "Tropical Health")

DR. KIRSTEN. KRISTENSEN Co-ordination and Organisation of National Multipurpose Services for Disabled Children and other Children at Risk through the Educational Assessment and Resource services (EARS) Special Education Program.

Clinical Psychologist, Program Co-ordinator, EARS., MoE&S, DANIDA

A Description of the development of the EARS programme.

In Kenya, the EARS program started in 1984 and in Uganda in 1992. The main objective of this programme is to assist disabled children between 0-18 years and children with special learning needs , together with their parents, by integrating as many as possible of these children into the community and ordinary schools.

The EARS programme/Special Education is an integrated part of the Ministry of Education. However, it carries out wide multipurpose services for disabled children in conjunction with community based rehabilitation workers, staff from the ministry of health, and national as well as external NGO's. The interdisciplinary EARS team should co-ordinate, monitor and organise all services for disabled and other children at risk in the district..

The decentralised service should be co-ordinated from national level.

The multi-disciplinary services cover prevention, education, health care, production, maintenance and distribution of training, teaching and other aids for disabled people including hearing aids, training of teachers, local leaders and others working with disabled people and spreading of information to the public about disability. The EARS Programme should be a national programme, under the Ministry of Education with the conjunction of other Ministries and NGO's. At district level it should be the responsibility of all local leaders, of the community and of the disabled people themselves.

(Full text will be published in the journal of the Uganda Paediatric Association)

DR. Kurt. KRISTENSEN, Summary of Integration of Disabled Children into the Mainstream Education

Programme Co-ordinator, UNISE, MoE&S, DANIDA

The more disabled persons are given access to training in a society, the more the rest of the population will learn to respect all disabled persons. This, in turn , will enhance the possibilities for education and training of still more disabled individuals. It is these educated and trained disabled people who, in favourable circumstances, will be able to contribute to the development of their countries. Those favourable circumstances are a general acceptance and attitudes that disabled people are part of their countries' total growth potential. Whenever possible children with disabilities should be integrated into ordinary schools near to the child's home.

Integration of disabled children into mainstream education is closely linked to the training of teachers at the Uganda National Institute of Special Education (UNISE). Many disabled children can be integrated into mainstream education without any specialised support, but many of them will need Special Education attention. UNISE will provide teachers trained at all levels in Special Education to the whole country. UNISE is being built next to ITEK and is going to have academic links to ITEK and Makerere University

(Full text will be published in "Tropical Health")

Video: EARS in Action

This video was made in 1992 by the EARS programme in Kenya, ten years after the start of the project in that country. It explains and shows the different activities that take place in the EARS Centres:
-Assessment of children with handicaps. carried out by a multi-disciplinary team consisting of specially trained teachers and social workers as well as staff of the Ministries of Health.
-Setting up home programmes for young children or children with severe and multiple disabilities and guidance of the parents of these children.
-Integration of disabled children in mainstream classes in normal schools. and in special units in ordinary schools as well as the establishment of small homes for disabled children close to their school.
-Activities in resource rooms, where children with visual impairment are given individual help and attention to be able to attend ordinary classes for the rest of their time at school.
-Activities in the community to prevent as many handicaps as possible.
-Courses, seminars and training courses for teachers.

P. KAKAMA The Rights of Disabled Children: Village Perceptions

Ministry of Labour and Social Affairs, Social Worker

Article 23 from the Convention on the Rights of the Child and Article XIII of the African Charter on the Rights and Welfare of the Child both recognise the rights of the disabled child to special care.. Uganda has ratified both the convention and the charter but these provisions are yet to be incorporated into national legislation and policies.

In November 1993, a child rights study was carried out to assess the prevailing attitudes and level of awareness of the rights of the child at village level. Some of the findings which were very negative. The perceptions on child rights and consequent actions violate the disabled child's right to enjoy a full and decent life and undermine their self worth and dignity. These negative perceptions also undermine the child's right to protection from any form of discrimination.

Some of the factors affecting integration include absence or lack of special facilities for children with disabilities and ignorance about what could be done.

More positive was the fact that communities recognise the potential and the talents of children with disabilities which need to be developed.

The commitment of the GoU to the rights of children with disabilities is laid down in the Uganda National Plan of Action for Children (UNPAC) At the district level there are the District Plans of Action for Children (DPAC) and at sub county level, the sub County Plans of Action for Children (SPAC).

Securing the Rights of the child and particularly the rights of the disabled child needs a positive change of attitude. Government and NGO's must take up the challenge of creating awareness of the community to the rights. needs and potentials of children with disabilities.

(Full text will be published in "EARS")

DR J. TUMWINE Disability in Present -day Uganda

Department of Paediatrics and Child Health. Makerere University.

This paper reviews current trends in child disability and epilepsy in Uganda. and makes recommendations for practical plans of action.

Apart from the 1991 Uganda Population and Housing census there is very little information about the prevalence of child disability although there has been some attempt to establish distribution by type of disability.

Of the 190 453 people reporting their disability during the census. 28.4% were children in the 0-14 age group. Whereas 93.5% of the disabled live in the rural areas, only 30% of organisations dealing with disability issues are based in the rural areas.

The main causes of disability are "lame"(55%), mental retardation (19.8%). epilepsy (7.3%) and others (17.9%).

Similar information shows mental disability responsible for 25% of all forms of disability in West Nile, Luwero, Masaka and Masindi.

Physical disability (36%) followed by blindness(20%), hearing impairment (17%), mental retardation (14%) and epilepsy (12%) were the commonest type of disability known to the respondents who were themselves not disabled, in a recent study in eight districts of Uganda.

Cerebral palsy (37.5%) and epilepsy (27.3%) predominate the conditions seen at Mulago hospital paediatric neurology clinic.

Epilepsy is a very important condition yet anti epilepsy drugs like phenobarbitone are not easily available.

Although local political and development organs are supposed to play a key role in championing the rights of PWDs, a recent study found that 83% of respondents in 8 districts did not see any significant role of the RCs towards issues of people with disabilities.

Communicable diseases accounted for 50% of all causes of disability in children in Mityana, Uganda. These diseases which include malaria, measles, poliomyelitis, and meningitis, are either preventable or amenable to treatment.

Recommendations for practical plans of action for prevention and working with disabled children are made.

(Full text will be published in the Journal of ths Uganda Paediatric Association)

DISCUSSION

After a brief elaboration on the non availability of anti epileptic drugs in most districts in Uganda, the need for making these drugs available to up to 1% of the Ugandan population was emphasised. The situation has been as follows: The essential drug programme provides 5 rectal vials of Valium in each essential drug kit at the health centre level. On the essential drug list Phenobarbitone is foreseen but this anti epileptic drug has not been available in the central medical stores for the last 5 years. It is only recently that a stock of this drug has arrived at C.M.S. As very few District Health Teams perceive epilepsy as a problem in their district, anti epileptic drugs are not requested by the D.M.O.s. And there the viscous circle starts. Where there are no drugs for treatment patients will not come with a complaint like fits to the health Centre.

Dr.Miyangi highlighted the same situation in Kenya, where KAWE is taking over the responsibility of making anti epileptic drugs available to the population in Kenya through the KAWE epilepsy clinics.

It was suggested to approach the Essential Drug Programme directly with the request to have anti epileptic drugs on the essential drug kit or to request The MoH to look into the problem.

PROF. P. MUZAALE, Social Work and Community Based Interventions: The Systems Approach.

Department of Social Work, Makerere University.

Social work is a helping profession whose mission is to help people as individuals or collectives, to resolve problems they have in their social functioning. The underlying philosophy is to facilitate a client to learn and solve his or her own problems and to be empowered for future problem solving without professional intervention.

The different models of social work practice are a result of the dominant theoretical orientation of the social workers who develop and use them. This paper further elaborates on the systems approach to social work.

A system is a whole a unit, composed of people and their interactions including their relationships. The systems the social workers work with include individuals, families, neighbourhoods, communities, community groups and organisations.

An understanding of the concepts of boundaries, feedback and role is essential to appreciate how the systems approach works. The most important goal of a system is survival.

In relating the systems approach to community based interventions on behalf of PWDs, the PWDs constitute the client system, while the community of this person is a social system with various sub-systems. The target system, the system whose behaviour needs to change if the social functioning of the PWDs is to be enhanced could be the family, friends, employer organisation or hospital.

Whereas in the past approaches tended to focus on PWDs as the person in whom the problem resides, the systems approach directs attention to the various systems with which the PWDs interacts and the problems which this interaction produces. They are the appropriate target for community based intervention.

(Full text will be published in "Tropical Health")

B. KANDYOMUNDA, An Example of Integrated Care for Disabled Persons: The Massaka District experiene.

Uganda Society for disabled children (USDC): field co-ordinator for Massaka District.

USDC is a NGO registered in the U.K., founded in 1985 with the main objective of "Providing resources and opportunities for children with disabilities in Uganda to develop their potential. USDC has been operating in Massaka district since 1988 but only started with a CBR approach since 1991. Since than USDC has been able to reach 1607 children with disabilities.

The two most frequently encountered disabilities are post poliomyelitis and Cerebral Palsy but also mental and sensory impairments and epilepsy are encountered.

To reach the ultimate goal of CBR: supporting children with disabilities to reach their full potential trough involvement of their families and the communities USDC Massaka collaborates with established programmes within Government and the NGO structures alike and finds its clients during community organised outreach clinics or home visits where parents and other family members are given on the spot training on the rehabilitation plans of their children.

Physical rehabilitation requirements can easily be delth with by the physiotherapist in Massaka but for impairments like speech, hearing, and behavioural problems they have to refer to relevant professionals in Mulago referral Hospital . Also corrective surgery has to take place in Kampala. Every year USDC Massaka supports more than 300 children to go to Kampala for these services. It is hoped that by the end of 1995 corrective surgery will be provided in Massaka Hospital.

To better reach children with epilepsy USDC collaborates with the DMO office to integrate the

care for such children in the day to day health service delivery system.

As much as possible USDC Massaka works on integration of children and adolescents with handicaps into mainstream education: primary and secondary education and vocational training

(Full text will be published in the journal of the Uganda paediatric association)

DR O. MIYANJI, Epilepsy: The Kenya Experience

Chairman. Kenya Association for the Welfare of Epileptics.

The Kenya Association for the Welfare of Epileptics (KAWE) was still mourning the tragic loss of Dr Dekker a renowned innovator in the field of epilepsy.

This paper gives a general overview of the KAWE experience in epilepsy in urban and rural communities in Kenya.

Regrettably there is a general lack of statistics on epilepsy in Africa but estimated rates are likely to be 2-3 times those of the developed world.

Epilepsy is a major health problem but it is not yet a priority. since many health services in the developing countries do not have the resources to establish single disease oriented health systems. It is also heavily stigmatised.

Such factors led to the formation of the Kenya Association for the Welfare of Epileptics in 1982 by Mrs Caroline Pickering. a mother of a child with epilepsy. She is presently the administrator and general co-ordinator of the organisation.

The main objectives of KAWE include provision of free medical services and drugs. educational programmes and social help and training of caretakers. KAWE runs three clinics in Nairobi and four outside of Nairobi. The organisation also has a support group started in 1987 and a youth group started in 1993.

KAWE has produced several education materials which include the award winning video *'It is not my choice'*. booklets and pamphlets.

The main sources of funding are both local and foreign donors as well as self supporting fund raising like annual walks. and cost sharing.

The KAWE experience shows that epilepsy can be treated effectively with easily available and cheap drugs. without resorting to expensive tests. Education and support of the patient. family and community are just as important to the well being and rehabilitation of people with epilepsy.

(Full text will be published in the journal of the Uganda Paediatric Association)

S. NANJOBE Community Perceptions of Epilepsy

USDC. field co-ordinator for Luwero District.

At Nyimbwa Health Centre in Luwero District the first Outreach Epilepsy Clinic has held by the Department of Paediatrics and Child Health. Paediatric Neurology. Mulago Hospital. This followed the identification of a number of Epileptic People around one parish. The clinic rapidly grew and people started coming from very far to this epilepsy clinic. Thus the birth of a second outreach epilepsy clinic in Kasana for people from the other side of Luwero. The clinic in Kasana started in 1994 and both clinics together have registered over 500 epileptic people so far.

Common believes in the community about epilepsy are: It is a "spiritual condition". often thought of as infectious. It is a disease of very high fevers. In the case of children it is thought of as "stubbornness". Causes of epilepsy are believed to be "witchcraft". "evil spirits". incest. alcohol abuse. beating. hereditary. Therefore treatment is often sought in witchcraft. An increasing number of people with epilepsy now believe they can be helped with medication. But there are still a number of popular believes remaining that make efficient treatment of epilepsy in the community difficult.

(Full text will be published in "EARS")

VIDEO "It is not my choice"

The Kenya Association for the Welfare of Epileptics has produced several education materials which include the award winning video *'It is not my choice'*,

In this video a young boy is followed after he has a first "grand mal" fit in class. The following believes are very well highlighted:
- Epilepsy is perceived as a highly contagious disease,
- Epilepsy is an hereditary disease,

Social taboos and eviction from school are illustrated.
The roles of educational, medical and social workers in the rehabilitation of a child with epilepsy is explained.

It is interesting to know that all the actors in this film are clients of KAWE themselves.

DR. A. BAINGANA-NGANWA, Trends in Disability: Implications for Serving Providers.

Department of Paediatrics and Child Health, Makerere University.

This paper highlights trends in disability world wide and focuses on specific countries in particular. It discusses the implication of these trends for national and local intervention strategies. A comparison of the data from more developed with that from the less developed countries in relation to the causes is made. In children, 3/4 of causes of childhood disabilities are largely due to preventable causes.

Prevalence data is also presented and this highlights the impact of war and the differences between urban and rural prevalence rates.

Cerebral Palsy is discussed. The prevalence in Uganda is not very different from that of the developing countries. There is a shift in the causes from post natal to prenatal and intra partum, in countries where prevention strategies are carried out. In Uganda there has been no change from 1972 to 1989, the post natal causes are still predominating.

The main implications of the data presented are that causes are so diverse between urban and rural and between different ethnic groups within the same district. The experience and trends in disability in the more developed countries can assist us to plan interventions.

There is need to strengthen information systems, prevention programmes, and to plan for the projected explosion in disability in the elderly. Development of an instrument for the assessment of disability at all levels is essential..

(Full text will be published in "EARS")

GROUP DISCUSSION

A first group activity was introduced:

Purpose: To identify the needs of Persons with disabilities during the various stages in their life cycle.
The following were the instructions given to the different groups:

1. Locate your "individual" in one of the household types listed below. Give the household a "story" in terms of both social and economic activities.

a) Low income urban household.
b) Low income rural household.
c) Middle income urban household.

2. Choose one of the situations listed below:

1) A person with severe disability (describe).
2) A person with a disabled parent.
3) The parents of a severely mentally handicapped person.
4) The family with a totally deaf person.
5) The family of a totally blind person.
6) A chronically ill person.
7) A person with severe epilepsy.

3. Follow this individual from birth to death, identifying his/her needs and possible problems over the life cycle. (L.C.)

4. Using the chart provided, plot the needs and possible problems over the L.C.

A second activity was presented as follows:

Purpose: To identify the resources available to Persons with disabilities:

a) in the family.
b) in the community.
c) at county level.
d) at the district level.
e) at the national level.

1. Which resources are available to your "subject".

2. Are these resources accessible to persons with disabilities?

3. Who is controlling these resources?

4. How can we maximise the use of available resources to meet the needs of the "individual" you are describing?

At the end of the day one Rapporteur per group presented the work of his/her group.
The discussions within the groups and those during and after the presentation of each group broadened the participants' understanding of the problems faced by persons with disabilities and epilepsy

H. ASAMO Report of workshop on "Integration of care for persons with disabilities, the field worker's view".

Representing NUDIPU, member of the Soroti Disabled Group, Raporteur for the field workers work shop.

On November 25th, 1994, a group of 30 field workers in "caring for and with persons with disabilities and epilepsy" came together in Cardinal Nsubuga Leadership Centre, to give their views on how care for P.W.D.s could be improved. This meeting was sponsored by OXFAM.

The following where their recommendations:

- There is need to look into accessibility of new buildings: schools, health facilities.

- There is need for training of teachers , field workers, local manpower, i.e. human resources at all levels.

- Data collection on disability and epilepsy is needed

- Revision of the curriculum for training of teachers and health workers is needed to include working with PWDs.

- Referral services are to be established for PWDs.

Emphasise mainstream education for children with disabilities.

There is need for enacting, evaluation, revision of government policies: i.e. remand homes, reformed schools, special schools for PWDs, mainstream education for PWDs, white paper on education, essential drug lists, etc.

In the decentralised districts there should be resource allocation to cover activities concerning PWDs.

Activities for PWDs should be co-ordinated by ONE government ministry, networking to achieve total rehabilitation. The various ministries and departments should keep their responsibilities for children and adults with disabilities.

There is need for positive discrimination of PWDs.

Services for children with disabilities should be free, i.e. education.

PWDs should be involved at all levels and be empowered to do so..

H. BARBER, Hearing Impairment. How to improve liaison between professionals.

VSO, Speech and Language Therapist.

Ms Heather Barber is a member of staff at ITEK, training teachers in Special Education and she is a therapist both at Mulago Hospital and at Mengo Hospital.

For the day's presentation, she concentrated on Hearing Impairment.

Identification and implementation of care starts with the individual and his/her family who identify the problem. They react by going for advice and treatment. Depending on the age of the child they may be referred to a pre-school programme within the community or to a school programme. Depending on the severity of the impairment different approaches may take form and Ms Barber elaborated on them.

The present problems being faced are lack of societal exposure to people who are deaf, lack of employment opportunities for them, lack of sign language and interpretation facilities. There are also difficulties in implementing multi-disciplinary care but there is a strong team of care givers including. NUDIPU, UNAD, ENT Department Mulago Hospital, EARS Programme, Head-teachers and UNISE.

They joined together, shared experiences and drew up a plan of action to tackle prevention, assessment, treatment, rehabilitation, education and social welfare.
FROM SMALL SEEDS TREES DO GROW.

(Full text will be published in "EARS")

MR KINIIBI Visual Impairment: The Problems We Face, Focusing on the Child.

Mr Kiniibi, UNAB

Mr. Kiniibi explained that he is going to review the main effects of blindness rather than its causes. This will be confined to the limitations that are a direct result of blindness and leave the indirect effects such as those on attitudes.

The limitations imposed by lack of sight can be described in relation to touch, such as inability to appreciate spatial relationships, colour, distance and the inability to appreciate certain conditions such as burning or boiling or moving. Other limitations include reading by sense of touch which is slower and limits the variety and quantity of reading material available.

Other limitations to the blind person can be addressed using the sense of hearing which is often the only available source of information for a blind person.

Limitations associated with mobility: even with the best skills and assistance, this limitation remains a severe one because it affects the blind person in his opportunities for experiences as well as in social relations.

Negative effects of cultural practices and beliefs towards the blind which can lead to negligence and isolation, emotional disorders, low self esteem and lack of trust of others.

The problems encountered in education and the discriminatory job market which often lead to the dependency syndrome. were addressed.

UNAB attempts to alleviate these negative effects are being tackled in a dual way. The first addresses the blind person and the second approach is sensitisation of the general public. As public awareness is stepped up, the blind child will go to school, acquire education, get employment and sustain his own living.

(Full text to be published in the journal of the Uganda Paediatric Association)

C. OKECHO, Children with Learning Disabilities

Asst. Lecturer, Mental Retardation., ITEK

A learning disability is different from mental retardation. Learning disabilities may affect one area of development or academic learning. e.g.: a reading disability. Mental retardation is slowness or delay in development and would usually affect general intellectual ability and social adaptation. Anyone can have a learning disability whatever their intelligence.

There are two categories of learning disabilities and these are developmental and academic. There are many types of specific learning difficulties

General interventions after diagnosis and identification include an individual approach, multi-sensory integration, over learning in a structured and systemic way and teaching from the child's strengths.

One can use some of the specific programmes such as skill training, ability process training, process task approach and behaviour analysis to further help or train children with learning disorders.

(Full text will be published in "Tropical Health")

J. MIREMBE, Community Based Rehabilitation: Uganda's Commitment to Persons with Disabilities.

MoG&CD, CBR Programme manager.

The paper reviews the development of rehabilitation services in Uganda which started in 1965 as institutional based services (IRS). There were several reasons why IRS was thought to be the best approach then. These included a limited number of professionals, focus on use of expensive equipment which had to be centralised for ease of maintenance and repair, provision of rehabilitation by a multi disciplinary team of professionals who could only be found in institutions, and PWDs needed training covering the whole day.

The strengths and weaknesses of IRS are discussed. The rational given to justify this focus was the need to `maintain standards' but to the 98% of families who are receiving no assistance, the argument concerning standards has no relevance.

Although there is no agreed definition of CBR, the paper attempts to define it, outlines the justification for starting a CBR programme, the achievements as well as the advantages. Does CBR work?

CBR empowers people with disability and their families, is cost effective, is a form of community development and is sustainable. One of the ways of showing that CBR works is to develop functional indicators.

Some of the limitations of CBR programmes include overwork, poverty, social tensions and sheer exhaustion which make parental involvement a challenge.

To be sustainable, CBR must operate at the community level, intermediate or district level and at the national level, with each level carrying out core functions which include decision making by community members, mobilisation of local resources, planning, implementation and evaluation.

CBR is a learning process and requires flexibility taking into consideration the social, cultural economic situations, the circumstances of disabled persons, the country's existing services and personnel and its phase of development, priorities, and social service policies.

(Full text to be published in "Tropical Health")

J. WILSON, Behavioural Problems Field Experience and the Community Based Approach.

Occupational therapist, Lecturer School for occupational therapy, Mulago Hospital.

Ms Wilson presented Sanyu, a girl with mental retardation, to illustrate that what parents perceive as their major problems is not always seen as such by health care workers. The problems she normally encounters are mainly behavioural problems such as anti-social behaviour, toilet problems and self care, hyper-activity and self-injurious behaviour.

The causes of this behaviour may be due to pathological environmental factors.

The older the client, the more difficult the management so Ms Wilson stressed the importance of early intervention.

She then outlined the working method which involves assessment of the problem ,planning the approach and setting realistic goals, implementing the intervention and evaluation.

Occupational therapists are to be deployed through the district hospitals and will offer advice and training as well as clinical intervention.

(Full text will be published in the journal of the Uganda Paediatric Association)

DR F. BAINGANA Mental Health Services in Uganda: A Case for Community Based Mental Health Care.

Psychiatrist, Mulago Hospital.

Introduced the paper by giving a brief outline of the country the population, the economy and transportation.

She then went through the history of mental health services in Uganda from 1925 when an asylum was built in Masindi to the present day organisation of mental health services.

Those are on parallel systems:- the governmental mental health services, the non-governmental mental health services. Dr. Baingana elaborated on each system highlighting the various problems of each, a prominent problem being poor co-ordination by the M.O.H.

She then presented the case for community Based Mental Health Care, this being:- over centralisation of present services, poor catchment of New Mulago and Butabika Hospital, too expensive for patients to travel from up country.

Dr. Baingana then made some recommendations which include appointment of a Co-ordinator of Mental Health Services at M.O.H. Headquarters who will then streamline and co-ordinate activities of those working in the mental health field.

She also recommended that drugs essential to the treatment of the mentally sick should be included on the Essential Drugs List.

In conclusion. Dr. Baingana states that if the goal of 'Health for All by the year 2000' is to be achieved, government should review its priorities and make a commitment to improve the Mental Health Services of Uganda.

(Full text will be published in "Tropical Health")

K. WADRI, Protection of the Rights of the Disabled Child

MoL&SA, Senior Probation Officer.

This paper addresses the rights of disabled children through a conceptual framework that includes the definition of disability, causes, magnitude of the problem and consequences of disability.

Over 1.2 million children in Uganda have a disability and of these, one million live in the rural areas.

Children with disabilities have little or no access to education, health and recreational facilities and are disadvantaged by a society that discriminates against them. Cultural beliefs and practices lead to stigmatisation of disability and negligence of children with disability. Mothers are the main carers with little or no access to family resources so the child with disability often lacks the basic necessities of life.

The emphasis of the health services is on curative rather than physio therapeutic services which are badly needed.

The rights of a disabled child include provision of equal opportunities for protection, survival and development. This should be provided at the family, community and national levels.

The role of the promotion of effective measures for the prevention of disability which include immunisation, and accident prevention should be emphasised, in addition to mitigating the impact of disability.

The crucial role played by NGOs, religious institutions and government agencies in the protection of the rights of children with disability is commended..

(Full text will be published in "EARS")

DR. G. PARIYO Support Supervision as a Tool in Improved Care of the Epileptic/Disabled Person by the Health Worker.

IPH, Lecturer in Health Management and Primary Health Care.

The provision of mental health and the provision of rehabilitative services are components of Primary Health Care which is the guiding Principle in the delivery of health services in Uganda.

Many cultural practises and beliefs play in the lives of P.W.D. whereas health workers receive thorough and detailed training in carrying out technical procedures little or nothing is usually taught about supervision.

Important issues in support supervision are:

- Support Supervision I an instrument for continuous training.

- It needs technical, communication and conceptual skills.

- Clear guidelines and instructions are needed for both the supervised and the supervisor.

- Problems do not usually occur in isolation so solutions must be comprehensive.

- The supervisor needs authority and decision-making power.

- Support Supervision is an important tool in the identification of training needs of field staff.

- Support Supervision is a useful tool in identifying priorities for research.

- Support Supervision requires a good level of mutual confidence and respect.

(Full text will be published in the journal of the Uganda Paediatric association)

P. KATENDE, Supportive Supervision, a possible way to meet our goals.

MoG&CD. CBR Programme.

We should define supervision as " A way to ensure competence, effectiveness and efficiency through observation , discussion, support and guidance."

Supportive means:" To give encouragement or empathy to the lower cadres in their activities."

Factors that contribute to successful supportive supervision are:

- Well laid out plans with clear objectives, activities and methodologies of operation.

-..Proper communication channels,

- Guidelines on data collection

- Open discussions with both supervisor and supervisee willing to accept their mistakes.

- Good work should be appraised

- Supervision should be a learning experience

(Full text will be published in "Tropical Health")

E. KARUHIJE Support Supervision, Possible Ways to Meet the Goals.

MoE&S

Started with some quotations from the Bible to illustrate the historical perspective of compassion in dealing with the disabled. Followed this with quotations on education to illustrate possible ways to meet the goals of special education.

Mr Karuhije then gives the historical background of the start of special education and an outline of the challenges and the facilities/resources available to work with. The importance of the power of collaboration between the Parent/Teacher Associations and schools as well as parents being the right to choose the kind of education to be given to their children is stressed. There is a need for matching between the child's needs and the available resources.

In his concluding remarks, he made some recommendations for more teachers, increase in the number of open air schools, courses and programmes to enhance quality, access and equity. He recommends equitable distribution of finances and income generating activities for P.W.D. There is also an increased need for facilities to ease learning for sports for P.W.D. accessibility to buildings and transportation and toilet facilities.

The job market should be more open to P.W.D.

(Full text will be published in "EARS")

DISCUSSION 4

Purpose: 1.)To identify resource gaps for Persons with disabilities:

2.) To develop guidelines for a National Plan of Action for P.W.D.s

1. How well do resources meet the needs of persons with disabilities? List resource gaps.

2. How can these resource gaps be bridged? By who should the gaps be bridged?

3. Come up with some recommendations for a National Plan of Action for P.W.D.s.

4. Come up with some recommendations for District Plans of Action for P.W.D.s

The final result of this discussion is represented in the recommendations from the workshop participants as lined out below:

RECOMMENDATIONS

DISABILITY AND EPILEPSY IN UGANDA - THE WAY FORWARD

The first National Workshop on Integrated Care for and with persons with disabilities which brought together District Inspectors of Schools, District Medical Officers, District Community Development Officers, District Probation and Welfare Officers, NGOs and individuals working in the field of disability, was held at Pope Paul VI Memorial Centre Kampala, on 27th February to 1st March, 1995.

This historic meeting came up with the following recommendations for consideration by Government, Districts and NGOs:

RECOMMENDATIONS

1. When considering disability the following should be included:
   Physical, intellectual and sensory impairment; chronic medical conditions such as epilepsy, albinism, sickle cell anaemia, and mental illness.

2. An inter ministerial committee should be established through the Prime Minister's Office, to formulate and integrate policy concerning people with disabilities.

3. An inter sectoral committee including NGOs should be established through the District Executive Secretary's Office to co-ordinate the implementation of policy concerning people with disabilities at district level.

4. A specific budget line on disability should be established in each relevant Ministry or Department at National, District, and Subcounty level.

5. Developmental programmes like "*entandikwa*" should target families with disabled children and people with severe disabilities.

6. Services for people with disabilities should be decentralised, supported and supervised by relevant ministries and departments.

7. Government should initiate legislation for the promotion and protection of the rights of people with disabilities including equalisation of opportunities in education, employment and access to information.

8. All training curricula for teachers, health workers, social workers, architects, builders and other relevant groups should include a component on disability issues.

9. Essential, affordable and effective drugs for treatment and prevention of epileptic fits should be made available at health centre level.

10. A database on disability to assist in policy review, planning and implementation should be established in each relevant ministry.

LIST OF PARTICIPANTS

PROBATION OFFICERS

NO.	NAME	DISTRICT
1.	Mwota Joe	Mityana
2.	Mugisa M.M.	Masindi
3.	Bananuka Patrick	Kiboga
4.	Mujjukirizu Daniel	Kampala
5.	Katusiime Grace	Masaka
6.	Odit Peter	Apac
7.	Ebong Kenneth	Tororo
8.	Kiwanuka J.B.	Entebbe
9.	Tabu Alex	Kabarole
10.	Hirya Grace	Pallisa
11.	Lwanga Samuel	Iganga
12.	Inzikuru Teddy	Arua
13.	Kisabagire Simon	Kamuli
14.	Bagarukayo A.	Rakai
15.	Ekule Yekonia	Nebbi
16.	Oselle K. Charles	Kotido
17.	Ngabirano Fred	Bushenyi
18.	Emuria Acaya Magaret	Soroti
19.	Okello Mike	Soroti
20.	Magall Moritz	Kumi
21.	Waako R. Joy	Rukungiri
22.	Tumwesigye E.	Kisoro
23.	Edonga Peter	URA
24.	Baihemuki B.S.	Kasese
25.	Okpwongo	Moyo
26.	Buin Simon	Moyo
27.	Ocan Marcelino	Kitghum
28.	Okiirwoth Richard	Gulu
29.	Kashungna Charles	Ntungamo
30.	Kiiza K. Alfred	Hoima
31.	Makombe G.W.	Katalemwa
32.	Kerujik Betty	Arua
33.	Kimuli S.	Rakai
34.	Bigirimana	CDO-Kisoro
35.	Nyakana Lawrence	Kabarole
36.	Ampaire Christine	Mukono
37.	Kayizzi-Wabbi	Luwero
38.	Ssemanda G.J.	Luwero
39.	Muhanguzi B.	Rukungiri
40.	Katungye F.I.	Mbarara
41.	Sande W.T.	Kampala
42.	Barekye A.	Ntungamo
43.	Kaggwa Florence	Kibaale
44.	Asamu H.G.	Soroti
45.	Odongo Alex B.	Kumi
46.	Nsubuga F.M.	Mubende
47.	Oleimo D.	Moroto
48.	Obongo C.C.	Apac
49.	Okumu B. L.	Kitgum
50.	Emorut B. E.	Kotido
51.	Oketch P. (Mrs)	Kapuchworwa
52.	Oketcho P. (Mr.)	Mukono
53.	Onyango-Opend	Pallisa

54.	Bengeyi Mathias	Bundibujjo
55.	Sabiiti Stephen	Hoima
56.	Aritua J.L.	Arua
57.	Masiga M.	Kampala
58.	Nyeko Bala Wilson	Kitgum
59.	Mari Samuel	Kamuli
60.	Okello Stephen	Lira
61.	Kujuna Cyprian	Jinja
62.	Kitamirike Stanley	Jinja
63.	Ojiambo Joseph	Mbale
64.	Ndaziboneye Ben	Kampala

DISTRICT INSPECTOR OF SCHOOLS

1.	Aroda J. Robinson.	Tororo
2.	Higenyi Agnes M.	Mpigi
3.	Munyole W. Patrick	Kibale
4.	Ssewanyana E.	Mukono
5.	Rugira Kahumuza Pardon	Kabarole
6.	Okol Charles	Pallisa
7.	Bongomin Anthony	Gulu
8.	Kyahurwa David	Ntungamo
9.	Baguma H. Antony	Bundibugyo
10.	Akol Amuge M.P.	Soroti
11.	Kasimaggwa Margaret	Kiboga
12.	Ejalu Chuck Stephen	Kamuli
13.	Masaba Charles W.	Kampala
14.	Bamwesigye Rutebarika	Bushenyi
15.	Kashobera J.	Kasese
16.	Tumwiragize	Kisoro
17.	Luswata A.G.N	Masaka
18.	Wamayi	Mbale
19.	Ochan Daniel	Kumi
20.	Apilli Madrama J.J.	Moyo
21.	Omara Enang Tamali	Lira
22.	Tembeiza Owen	Kalangala
23.	Bitambeki	Hoima
24.	Katarahweire H.	Rukungiri
25.	Okabo Opiyo J.W.	Apac
26.	Endriaku Robert	Nebbi
27.	Aboke Moses	Kitgum
28.	Okiror John Robert	Iganga
29.	Alori Lucy	Kotido
30.	Sabiiti K.B.	Kabale
31.	Ekwang M.	Masindi
32.	Magara Silver	Mbarara Munic.
33.	Nyero Dwe	Kitgum
34.	Mukasa M.T. (Mrs)	Kabale Munic.
35.	Mukasa K.E. (Mr.)	Rakai
36.	Ndahiro Samuel Peter (Rev)	Kampala Ed. Off.

DISTRICT MEDICAL OFFICERS

1.	Tibuhwe Agnes (Dr)	Kasese
2.	Namusoke Rose	Mpigi
3.	Ochora B.S. (Dr)	Nebbi
4.	Mubiru Wilson	Mubende
5.	Oonyu E. (Dr)	Kumi
6.	Munaba (Dr)	Pallisa
7.	Kitimbo D.W. (Dr)	Jinja

8.	Biginmawa E.Z.	Kisoro
9.	Mutabazi (Dr)	Hoima
10.	Odongo Getrude	Lira
11.	Wabulembo H. (Dr)	Masindi
12.	Kerunega F.	Kalangala
13.	Namusobya J.	Iganga

INVITED GUESTS

1.	Kanyesigye Dr.	MoH
2.	Ndugwa Prof.	Dept of Paed. Makerere
3.	Ssegwanyi Prossy	Pead. & Neuro.
4.	Peterson	
5.	Songa Peter	
6.	Atim Stella	
7.	Kurt (Dr)	
8.	Mpagi Veronica (Mrs)	
9.	Mazima (Hon)	NUDIPU
10.	Baranzi (Mr.)	
11.	Lakidi Eric (News reporter- Lira)	
12.	Hartley Sally (Mrs)	
13.	Nyeko Jolly	Mo Labour & Social Affairs
14.	Kangera Maria	COMBRA
15.	Bukenya Gilbert (Prof)	Makerere Medical School
16.	Bawubya Maria	UNICEF
17.	Otim (Mr)	Mo Labour & Social Affairs
18.	Kalinda N. (Mrs)	
19.	Katende Phoebe	Mo Gender & Communit Development
20.	Bulenzibuto James	ITEK