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REPORT ON:

THE SITUATION OF PERSONS WITH DISABILITIES IN MASAKA - UGANDA

@FOHO - UGANDA



2023

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A Study Commissioned by: FOHO UGANDA with Support from Viatores christi Ireland, Misean Cara Irelanda, VC Uganda office

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Acknowledgements

The situational analysis report on the situation of persons with disabilities describes and highlights Challenges and Opportunities facing Person Living with Disabilities in Masaka City and District. The research was a comprehensive process that involved reviewing literature, analysis of available national level data sets and undertaking key informant interviews with policy makers, programme implementers and most importantly interviews and focus groups with Children/ persons with disabilities and their care-givers.

FOHO UGANDA wishes to express its sincere thanks to all the stakeholders who participated in the research process that has resulted in this report on the

The process was spearheaded by Anthony Oleja Enyogu consultant alongside Florence Mahoro with guidance and support from organisations of persons with disabilities in Masaka District and City. We further acknowledge the technical support provided by the Dr Asiimwe John Bosco, Head of statistics Department of Makerere University for the development of the representative household survey on persons with disabilities in Masaka.

This would not have been possible without the support of the participating districts where the research was undertaken, namely; Masaka District Local Government and Masaka City. We are immensely grateful to the leadership, staff and residents of all these districts for their support and participation in the research.

We would also like to appreciate the help and support of the health workers, Masaka District Association of persons Living with HIV, Sign Health Uganda, Police, Deaf schools, political councilors, Masaka district Council for Persons with Disabilities and the Masaka Union of Persons with Disabilities in Uganda, as well as all the members of the Technical Working Group on disabilities, along with the many other non- governmental organizations who supported this research.

Finally, we wish to appreciate the financial and technical support provided towards the research by our development partners; Viatores christi Ireland, Misean Cara Irelanda, VC Uganda office

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Miiro Michael – *Chairperson Board*

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Contents

Acknowledgements ..... *i*
List of Tables ..... *iv*
List of Figures ..... *vi*
Acronyms ..... *vii*
Executive Summary ..... *viii*

SECTION ONE: INTRODUCTION AND BACKGROUND 1
1.1 Introduction 1
1.2 Global and Country Context on Disability 1
1.2.1 Disability Inclusive Development *5*
1.2.2 Policy and legislative framework *7*
1.3 Barriers to participation of Persons with Disabilities 8
1.4 FOHO UGANDA and her disability inclusion and support strategy 9
1.6 Purpose and Objectives of the study 10

SECTION TWO: METHODOLOGY AND APPROACH 12
2.1 Introduction 12
2.2 Technical approach 12
2.2.1 Review relevant literature *12*
2.2.2 Qualitative methods and sample size *12*
2.2.3 Quantitative methods *13*
2.3 Target population and sample size for the survey 13
2.3.1 Sample size estimation *14*
2.4 Data Collection and Analysis 15
2.5 Data management and statistical analysis 15
2.5.1 Quantitative data *15*
2.5.2 Qualitative data analysis *16*
2.6 Quality control 16
2.6.1 Quality Assurance *16*
2.6.2 Human Subjects consideration *16*
2.6.3 Confidentiality and privacy *16*
2.7 Study limitations 17

SECTION THREE: STUDY FINDINGS 18

CamScanner

3.1 Introduction 18
3.2 Situation analysis of Masaka 18
3.3 Demographics characteristics of the survey population 20
3.3.1 Sex, age and marital status of respondents 21
3.3.2 Cultures, tribes and religion 23
3.3.3 Household composition and parentage 25
3.4 Disability Awareness 25
3.4.1 Avenues of awareness creation 29
3.5 Service provision for persons with disabilities 30
3.6 Health and Rehabilitation 32
3.6.1 Surgeries and Therapies 33
3.6.2 Accessibility to health services 34
3.6.3 COVID-19 and Disability 35
3.6.4 State of living 36
3.6.5 Assistive Devices 37
3.6.6 Regimental and long-term treatments 39
3.7 Education and training 40
3.7.1 Usefulness of education and requirements for studying 42
3.8 Livelihoods employment and employability 43
3.8.1 The state of work 44
3.8.2 Difficulties faced at the places of work 45
3.8.3 Incomes 47
3.8.4 Donations and other sources of income 47
3.8.5 Access to Credit 49
3.9 Water, food and household assets 52
3.9.1 Water and food 52
3.9.2 Sources of light and energy for cooking 56
3.9.3 Toileting facilities and housing 58
3.10 Other social, political and cultural services 60
3.10.1 Common abuses 63
3.10.2 Common challenges faced 64

SECTION FOUR: CONCLUSIONS AND RECOMMENDATIONS 67
4.1 Introduction 67

CamScanner

4.2 Conclusions 67
4.2.1 Prevalence and impact of disabilities on families and communities 67
4.2.2 Barriers and challenges in accessing social services 68
4.2.3 Implementation of the legal and policy framework on disability in Masaka 68
4.2.4 Existing interventions and opportunities for persons with disabilities 69
4.2.5 Opportunities for strengthening the support systems and services 69
4.3 Recommendations 70
4.3.1 General recommendations 70
4.3.2 Implementational interventions for FOHO 71
4.3.3 Prevalence and impact of disabilities on families and communities 71
4.3.4 Barriers and challenges in accessing social services 72
4.3.5 Implementation of the legal and policy framework on disability in Masaka 72
4.3.6 Strengthening existent interventions for persons with disabilities 73
4.3.7 Opportunities for strengthening support systems and services 73
4.3.8 Recommendations for further research 74

Annex 1: Detailed samples per parish 75
References 76

List of Tables

Table 1: Disability statistics in Masaka (2014) 3
Table 2: FOHO UGANDA Outcome area 2: Increased economic and other opportunities for vulnerable youths 9
Table 3: Qualitative methods sample size 13
Table 4: Sample per location 14
Table 5: Sub Counties and the respective parishes where data was collected from 20
Table 6: Comparison of age bracket of respondents against their sex 21
Table 7: Comparison of age bracket, sex and household headship 22
Table 8: Tribes of respondents 23
Table 9: Languages commonly spoken by respondents 24
Table 10: Religious affiliations of respondents 25
Table 11: Knowledge of Children with disabilities 26
Table 12: Triangulation of having children and knowledge about Children with disabilities 27
Table 13: Difficulties faced by Persons with Disabilities (functional and ADL) 27

CamScanner

Table 14: Awareness of additional functional difficulties faced 28
Table 15: Services sought for persons with disabilities 30
Table 16: Where health and rehabilitation services were received from 32
Table 17: Reasons for not undergoing the surgery 33
Table 18: Means of transport to the nearest Health facility 34
Table 19: How COVID-19 affected the way health services were received 35
Table 20: How persons with disabilities felt in the past six months 36
Table 21: Assistive devices needed by Persons with Disabilities 37
Table 22: Sources of Assistive devices for Persons with Disabilities 38
Table 23: Duration of persons with disabilities on long-term therapies 39
Table 24: Sources long-term therapies 40
Table 25: Nature of education received by persons with disabilities 41
Table 26: Level of education reached by persons with disabilities 41
Table 27: Reasons for not receiving an education by persons with disabilities 42
Table 28: Requirements for continuing with education 43
Table 29: Nature of Income Generating Activities done by Persons with Disabilities 43
Table 30: Reasons as to why persons with disabilities were not working 44
Table 31: Difficulties encountered at the places of work by persons with disabilities 45
Table 32: Monthly incomed earned by persons with disabilities 47
Table 33: Sources of additional incomes for persons with disabilities 47
Table 34: Sources of household items for persons with disabilities 48
Table 35: Cross tabulation of age bracket and marital status of borrowers 50
Table 36: Cross tabulation of sources of credit and amount borrowed 50
Table 37: Cross tabulation of sources of credit and purpose 51
Table 38: Crosstabulation of sources of drinking water and setting 53
Table 39: Sources of food in the past three months 54
Table 40: Crosstabulation of land ownership and setting 54
Table 41: Crosstabulation of land size and setting 55
Table 42: Crosstabulation of sources of light and setting 56
Table 43: Crosstabulation of sources of energy for cooking and setting 57
Table 44: Crosstabulation of toileting facility and setting 58
Table 45: Crosstabulation of number of rooms in household and setting 59
Table 46: What is done when respondents give birth to Children with disabilities 60
Table 47: What showed that the respondent has a disability 62
Table 48: What the respondents do when they identify that the child has a disability? 62

CamScanner

List of Figures

Figure 1: Disability prevalence (by difficulty strand) for Masaka 3
Figure 2: The Map of Masaka indicating the population density (2014) 19
Figure 3: The Map of Masaka City (2023) 20
Figure 4: Marital status of respondents 23
Figure 5: Sources of information on Disability in Masaka 29
Figure 6: Satisfaction with service offered to person with disability 31
Figure 7: Health Services Available for Persons with Disabilities 34
Figure 8: Health experiences of persons with disabilities 37
Figure 9: Nature of items given to Persons with Disabilities 49
Figure 10: Loan repayment status 52
Figure 11: Food adequacy 56

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CBO	Community Based Organization
CBR	Community Based Rehabilitation
CLWHA	Children Living with HIV/AIDs
CRPD	Convection on the Rights of Persons with Disabilities
ECD	Early Child development
FGDs	Group Discussions
FOHO	Foundation of Hope
GPS	Global Positioning System
HIV	Human Immune Virus
IBM	International Business Machines Corporation
ICF	International Classification of Functioning, Health and Disability
KAP	Attitude and Practices
KII	Key Informants Interview
MGLSD	Ministry of Gender, Labour and Social Development
NGO	Non-Government Organization
ODK	Open Data Kit
OVC	Orphans and other Vulnerable Children
PLWHA	People Living with HIV/AIDs
PWDs	Persons with Disabilities
SDGs	Sustainable Development Goals
SPSS	Statistical Package for Social Sciences
UBOS	Uganda Bureau of Statistics
UNCRPD	United Nations Convection on the Rights of Persons with Disabilities
UNICEF	United Nations children Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

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Executive Summary

This report presents the results of a situation analysis study on persons with disabilities in Masaka (City and District). The study was undertaken in order to ascertain the challenges and opportunities that persons with disabilities face. The study was a precursor to developing disability inclusive programmes by FOHO Uganda not only in the study area but also country-wide where their services are offered. The study is unique and rightly responds to the global development agenda (Sustainable Development Goals) but equally highlights the current landscape, identify barriers, and explore avenues for promoting inclusivity and empowerment.

The global definition provided in the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (2006) states that, *'Persons with Disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis'* with others while Persons with special needs are defined/identified as those who need specific protection needs.

The situational analysis employed a multifaceted approach, combining quantitative data analysis, qualitative interviews, field observations, and an examination of existing reports and resources. The study encompassed various aspects of the lives of individuals with disabilities, including education, healthcare, employment, accessibility, and social inclusion.

Key Findings

The study reached 421 respondents. Of the 421 respondents, 27.6% (n=116) were male while 72.4% (n=304) were female. Majority (49%) of the households were headed by females aged between 25 and 64 years. This could be an indication of neglect, skipped generation, widowhood or even abandonment by the males who – in accordance with the predominant patriarchal arrangement are supposed to be the heads of the households. The situation could also be associated with the care roles that are ascribed to females in a patriarchal society like Buganda where Masaka lies. Similarly, majority of the respondents (41%) were married. However, the actual majority of respondents (59%) were living single lives due to: separation, being widowed, having divorced and other factors that drove them into such status. This is a common phenomenon with households that have children with disabilities.

The study established that the average number of persons in the household was 5.3 persons. This was higher than the Masaka average household size 0f 3.9 (UBOS, 2018) and the national average size of 4.7. The survey equally established that 91.7% (n=385) of the households had children aged 0-18 years. The households selected to participate in the survey were purposefully selected for having a person with a disability living in it. There were no significant differences in the households with children which were headed by females and marital status.

Disability Awareness

Of the nine district personnel reached, there was any who could barely define disability but rather related it to the common impairments while 4.7% (n=2) of the respondents in the

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survey understood the nature of impairment identified, cause and other notes. The understanding of functional limitation is imperative in designing programmes and services for persons with disabilities.

Information on disability was mainly passed on at the health centres, schools and community gatherings. Again, that the health centres were pivotal since that is where disability is first identified. However, the Health Unit In-charges sad that that lacked a Disability focal persons and knowledge of disability which limited them in their work.

Common functional difficulties faced

The common functional difficulties faced by persons with disabilities included: participation (33.3%), bathing (29.5%) and, hearing (27.1%). Other difficulties faced included: getting dressed, going to toilet, preparing meals for yourself, riding a bicycle, moving around, climbing stairs, learning and studying, cooking meals, carrying items such as water and food, caring for persons, cleaning, shopping, washing dishes, doing laundry and, feeding among others.

Service provision for persons with disabilities

Persons with disabilities enjoyed all services just like any other Ugandan and that there were specific services for persons with disabilities such as: a dedicated Vocational Training Institute (VTI) that offered hands-on skills training in vocational trades; a school/ unit for the Deaf and Blind learners and; the Special Grants Programme among others. There were also specialised services at Masaka Hospital although these were not adequate. 54% of the respondents were satisfied with the services provided.

Health and Rehabilitation

The respondents appreciate that most of the rehabilitative services are provided for at Health Centre IV and above (Hospitals). The visits to the allied health workers indicated knowledge of the cadre level that the caretakers of persons with disabilities visited. 14.5% (n=61) said that their person had ever required a surgery to correct or improve their condition. Of these, only 6.2% (n=26) underwent the surgery(ies) and; 4% (n=17) reported that the surgery actually improved their condition and yet 5.5% (n=23) said that they still needed to undergo the surgery but could not afford. The smaller percentage could be attributed to the cost of surgeries which is quite dear for most of the households with persons with disabilities. The survey established that 20.2% (n=85) said that the person had ever required to undergo therapy. However, only 12.1% (n=51) had undergone the therapy, 5.9% (n=25) said that the therapy improved their person's condition and; 6.4% (n=27) still needed to undergo the therapy but could not go for it.

The majority of households with persons with disabilities used motorcycles to the nearest health centre. This means that they either hire the services and fuel the motorcycle or pay a round cost for the distance covered. Only 10.5% (n=44) owned the means of transport used and; the average time taken from home to the health centre was 3.15 hours, the majority

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(48.2%) taking up-to 2 hours to reach a health centre. In the absence of outreach services, the distance and time covered to reach a health centre circumvents the efforts to receive health services and definitely tolling on the Universal Health Coverage (UHC) efforts.

Assistive Devices and regimental treatments

Only 44.9% (n=189) of the respondents stated that their household member with a disability needed an assistive device and; only 10.2% (n=43) of those in need had a functioning and/or fitting assistive device. Below is a table indicating the assistive devices need. The responses indicate that there are limited sources of assistive devices in the public sector amidst their expensive cost. On average an assistive device goes for 500,000/- (approximately USD 135.0).

40 of the respondents reported to be on long-term and regimental treatments. Majority of these (37.5%) had been on therapy for more than one year and the sources of such therapy were varied – the private sector being the biggest provider.

Education and training

Respondents were asked whether the person with disability in their household knew how to read and write. 45.4 (n=191) knew how to read and write while 53.9% (n=227) did not know how to read and write. This was way below the National literacy rate of 76.53%. Similarly, the survey established that, 53.6% (n=224) of the persons with disabilities had received formal education and training. The key reasons were related to impairments, discrimination and lack of scholastic materials. However, 83.8% (n=353) considered education to be useful to persons with disabilities while 15.4% (n=65) did not consider education to be useful to persons with disabilities. Again, respondents required school fees, assistive devices, scholastic materials, sign language interpreters and, addressing redicule in order for them to attend school.

Livelihoods employment and employability

Respondents to the survey stated that only 8.8% (n=37) of the persons with disabilities in their households undertook income generating activities. A bigger proportion (91.1%) were reported not to be engaged in any income generating activity. These included: farming, weaving, selling vegetables and merchandising among others. Participants were asked whether the person with disability in their household had ever worked. The results indicate that 7.4% (n=31) of the persons with disabilities had ever worked. However, 5.5% (n=23) were still working and; 3.3% (n=14) work on a daily. The respondents also said that only 5.2% (n=22) of the persons with disabilities in their households had work in the past twelve months. This indicates that a majority of persons with disabilities (96.7%) were not in work and this had a deleterious impact on overall incomes and the Gross Domestic Product (GDP). It increases income and care dependence whilst reducing on household savings and coupled with the high cost of care for persons with disabilities (over 39.2%), this perpetuates household poverty and precipitate of powerlessness.

Again, 54.6% of the persons with disabilities earned less than the average earnings. This has an implication on their welfare and living arrangements.

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Access to credit

The participants were asked whether they had taken any loan in the past five years. In this, 4.3% (n=18) had taken a loan while 95% (n=400) had not taken a loan in the past five years. Of these, majority (38.9%) of the participants had got the loans from Village Lending and Saving Associations (VLSAs), this was followed by SACCOs (22.2%), Friends (11.1%, Bank (11.1%), Emyoga – government facility (5.6%), a money lender (5.6%) and, a friend (5.6%). Of the 18 respondents who had taken loans, majority (72.2% - n=13) were female while 27.8%(n=5) were male. This could possibly be linked to the care role that is attached to the females as compared to the males. Again, majority (55.6%) of those who had taken the loans had attended primary education, 16.7% had no formal education while 27.8% had crossed to lower secondary school. This could be an indication of lack of formal employment.

When asked about the purposes of borrowing, majority borrowed for medical treatments and surgeries (33.3%). This was followed by those who intended to boost their business (27.8%), paying school fees (16.7%), business start-up (11.1%), treating animals (5.6%) and bribing for a job (5.6%). It should be noted that, treatment and fees are recurrent costs that most households with persons with disabilities have to continually meet. A cross tabulation below shows the sources of the credit and their purpose.

Water, food and household assets

The participants were asked to state their sources of water. Majority of the households (27.3%) fetched water from a public borehole. This was followed by public tap/standpipe (23.5%), borehole in yard/plot (11.9%), piped to yard/plot (5.9%), protected public well/spring (5.7%), river/ stream (5.5%), piped water into dwelling (4.3%), unprotected public well/spring (3.8%) and, lake (3.1%). The least used sources of water were: dam (0.5%), tanker truck (1.4%) and rain water (1.7%). The sources of water relate to cost and safety. Whereas one has to pay for user fees when using piped water and sometimes boreholes and protected springs, they are relatively safer in offering drinking water. The lakes, rivers, ponds and, unprotected wells offer less in terms of protection. Below is a cross tabulation of water sources and setting.

Growing and consuming own food (subsistence) can be linked to ownership of land. Respondents were asked whether they had land. In this regard, 13.8% (n=58) said that they owned land while 85.5%(n=360) said that they did not own any land.

Sources of light and energy for cooking

The survey established that electricity (40.6%) was most used by respondents as a source of light. This was followed by solar energy (34.9%), kerosene (20.7%) and others (2.1%) such as torches, candles and, phone. Whereas there are high costs of installation of electricity and limited electricity connectivity in rural areas, the forms such as kerosene and candle are potential risks especially where there are slum dwellers and persons with disabilities with mental and neurological impairments such as epilepsy. Below is a cross tabulation of sources of lights by setting.

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Toileting facilities and housing

Participants were asked the kind of toilet facility that the household had. Majority of the respondents (33.7%) used covered Pit latrine, with slab. This was followed by: VIP latrines (19.2%), uncovered pit latrine with no slab (16.2%), covered pit latrine with no slab (15.9%), uncovered pit latrine with slab (5.5%), latrine (4.5%) and, the bush (3.1%). The least used were: flush toilets (0.2%), none (0.5%) and, composting toilet (0.5%).

Common challenges faced

Persons with disabilities in Masaka still face several challenges which have remained unattended for quite sometimes with no proper mechanism to curb them. These challenges include lack of universal access in the structural buildings, persons with disabilities living under extreme poverty, the high unemployment rate among persons with disabilities and poor provisions of education and health services. Worse enough, universal access that calls for the enabling facilitating movement to persons with disabilities in the country is still a problem.

Recommendations

The key recommendations are: support education services through sponsorship and provision of assistive devices; provision of transportation to social service points such as health centres and schools for persons with disabilities; enhance income generation through trainings and guided mentorship; improve disability awareness across the board; provide psychosocial support to persons with disabilities and their caretakers; work towards disability prevention and management by supporting Immunisation drives, accident prevention and provision of assistive devices; provide basic and essential needs to the ultra-poor households with persons with disabilities; support trainings on legal and policy provisions for persons with disabilities; undertake sensitisation on legal and policy framework on disability; collaborate with local authorities and institutions; print and distribute key documents relating to disability and; engage with the media on disability awareness and advocacy.

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SECTION ONE: INTRODUCTION AND BACKGROUND

1.1 Introduction

Persons with disabilities constitute a significant minority in many societies, including Masaka District and City, Uganda. Disability is a multidimensional issue that affects respondents, families, and communities. A situational analysis study on persons with disabilities in Masaka District and City aimed at providing a comprehensive understanding of the situation of persons with disabilities, their needs, challenges, and opportunities for intervention. The study identified the current state of affairs, gaps, and potential solutions for addressing their needs in this location. The report provides FOHO Uganda with evidence for starter interventions for care, support and promotion of persons with disabilities – particularly the most vulnerable such as children, women and those living on the street among others.

Disability is part of the human condition. Almost everyone will be temporarily or permanently impaired at some point in life, and those who survive to old age will experience increasing difficulties in functioning. Most extended families have a a person with disability, and many non-disabled people take responsibility for supporting and caring for their relatives and friends with disabilities.

On the other hand, Disability is complex, dynamic, multidimensional, and contested. The transition from an individual, medical perspective to a structural, social perspective has been described as the shift from a "medical model" to a "social model" in which people are viewed as being disabled by society rather than by their bodies .The medical model and the social model are often presented as dichotomous, but disability should be viewed neither as purely medical nor as purely social: persons with disabilities can often experience problems arising from their health condition (WHO and WB report on disability 2011)

This report is organized into four sections as follows:

- Section 1 is the introduction and background;
- Section 2 methodology;
- Section 3 presents the assessment findings and;
- Section 4 presents the conclusions and recommendations.

We have equally included the study tools and key tables relating to the study.

1.2 Global and Country Context on Disability

The definition and understanding of disability are in most cases taken using a connotative approach. This is mainly because there is usually a cultural and emotional association or attachment to the meaning of disability. The ability of a given culture to associate a given condition to disability usually domains the very body disability.

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Even when taken that way, in the new era of globalization[12], there has to be some form of harmony in defining and describing disability and this harmony is rightly given by the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) (2006) which states that,

> *"Persons with Disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others." (UNCRPD, 2006; page 4)*

The Persons with Disabilities Act 2020[3] defines disability as a permanent substantial functional limitation of daily life activities caused by physical, mental, sensory, impairment, and environment barriers resulting in limited participation. Categorization of disabilities is in schedule 3 of the Persons with Disabilities Act 2020.

The CRPD definition appreciates the earlier terminology postulated by the International Classification of Functioning, Disability and Health (ICF) which considers disability as an umbrella term for impairments, activity limitations and participation restrictions. ICF also lists environmental factors that interact with all these components to cause and/or perpetuate disability[4]. Disability is thus not just a health problem. It is a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which he or she lives (WHO 2016)

Globally, it is estimated that 15% of the world population are Persons with Disabilities (World Health Organisation and World Bank, 2011). In Uganda, the disability prevalence rate for the population aged 2 years and above was 12.4 percent (Uganda Bureau of Statistics, 2016). Of these, 49.26% and 50.74% are males and females. In Masaka district[5], 9.8% (n=26,264) of the population aged 2 years and above have a disability as shown Table 1 below.

---

[1] A programming approach which takes cognizance of both the local and global situation

[2] Khondker, H. H. (2005). Globalisation to Glocalisation: A Conceptual Exploration. *Intellectual Discourse*, *13*(2). Retrieved from http://journals.iium.edu.my/intdiscourse/index.php/islam/article/view/109 (retrieved on 23rd February 2019)

[3] Laws of Uganda

[4] World Health Organisation (WHO) (2002) Towards a Common Language for Functioning, Disability and Health – ICF. World Health Organization, Geneva.

[5] It should be noted that the UBOS 2016 National Population and Housing Census report has statistics of both Masaka District and City. Therefore, the statistics and information that make mention of Masaka are inclusive of the City and the District unless separated in the statement

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Table 1: Disability statistics in Masaka (2014)

Persons with a Disability	Number	Percent
Persons aged 2 years and above with a disability	26,264	9.8
Persons 2 years and above with a seeing disability	13,791	5.2
Persons 2 years and above with a hearing disability	6,049	2.3
Persons 2 years and above with a walking disability	11,439	4.3
Persons 2 years and above with a remembering disability	10,462	3.9
Persons 2 years and above with multiple disabilities	8,287	33.3
Children 2-17 years with a disability	4,701	3.6
Youth 18-30 years with a disability	3,794	5.8
Older persons 60 years and above with a disability	7,936	62.0

***SOURCE**: UBOS (2014) - NPHC 2014: Area Specific Profiles – Masaka*

Besides the information provided in the table above, the summary statistics of all persons with Disabilities (by District Count-off) stood at 14.4% (n=42,849) This is presented herein below.

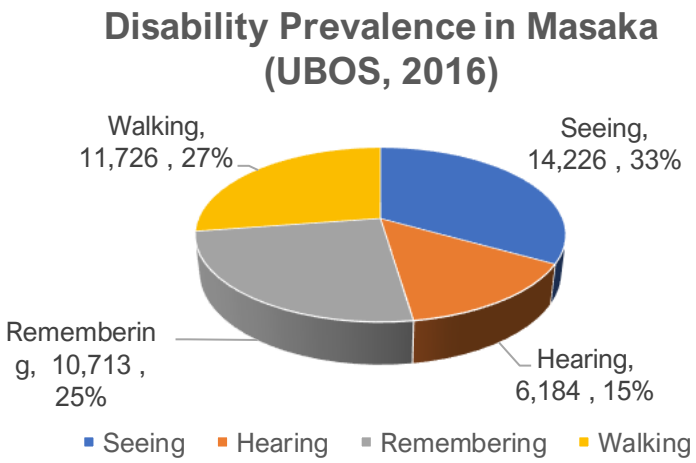


Figure 1: Disability prevalence (by difficulty strand) for Masaka

Source: UBOS 2016 Page 80

Masaka disability statistics are reflective of the entire country's disability distribution by impairment/ difficulty strands where, seeing and remembering difficulties dominate others owing to the unmet public health (education and management) needs

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especially in rural settings and; the close relationship between ageing and disability among others. Similarly, disability statistics tend to increase with age as a result of unattended to disabling conditions, knowledge, attitudes and practices towards prevention and management of disabling conditions and, the unmet habilitation and rehabilitation[6] needs of Children with Disabilities which graduate to complex, severe and/or secondary disabilities and ultimately exclusion.

Disability presents and/or results in a plethora of dismal conditions that require individualized and collective agenda of support. Although, there are quite a number of initiatives implemented by NGOs/DPOs to improve the above situation, the reach is always so limited that a bigger section of Persons with Disabilities still remains left out. A number of international treaties (including the UNCRPD) front holistic inclusion of Persons with Disabilities at all levels by all actors as the most viable approach of addressing the diverse aspirations and needs of Persons with Disabilities.

In Uganda, as elsewhere in many of the African societies, childhood disability and disability in general is conceived with negative connotations. The Research Study on the Situation of children with disabilities in Uganda (2014) revealed that society perceives disability as a curse and families that bear such children are probably being punished for misdeeds they would have committed. Such negative societal perceptions have led to stigmatization which in turn limits access to services. Families with Children with Disabilities at times hide them to limit the stigmatization that they are likely to face (UNICEF 2014).

Uganda faces obstacles to adequately supporting persons with disabilities and addressing the many barriers to participation that they continue to face. This challenge is magnified for refugees, whom we found to be generally poorer and more socially isolated than their local counterparts. Those in the refugee settlements were also geographically remote from many important services, such as inclusive education and rehabilitation centers. The physical layout of refugee settlements and even urban areas presents an obstacle to many refugees with disabilities, affecting their mobility. A lack of suitable transport and assistive devices exacerbates this. Such obstacles have an impact on many areas of life, including access to employment, education, health care, protection, food, water and social participation. (Crock & Smith-Khan, 2013).

It is important to programme for disability exclusively in all settings because:

[6] According to the World Health Organisation (WHO)/ World Bank World report on disability (2011), Rehabilitation is a set of measures a set of measures that assist respondents, who experience or are likely to experience disability, to achieve and maintain optimum functioning in interaction with their environments

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- persons with disabilities are often invisible and excluded from accessing emergency support and essential services such as food security and livelihoods, health and medical care, shelter and water, sanitation and hygiene (WASH) facilities;

- information on disaster preparedness is often not in accessible formats so persons with disabilities are less aware and prepared for a disaster;

- Environmental, social and attitudinal barriers result in requirements of the 15% of the world's population with a disability not being met within disaster management responses. It is therefore crucial that disability inclusion in all phases of disaster management occurs so as to ensure the full and equal fulfilment of human rights of Persons with disabilities;

- Disability inclusion in emergency management reduces morbidity and mortality. The rate of disability increases during an emergency due to direct trauma, illness from poor living conditions, the breakdown of health services and lack of rehabilitation and an increase in psychological stress and;

The CRPD requires that all responses and services are inclusive of, and accessible to, persons with disabilities. It should be noted that Uganda and its development partners are including Disability in their programmes most especially through setting strategies for including disability and provision of affirmative Action to refugees with Disabilities.

1.2.1 Disability Inclusive Development

Globally, the year 2023 marked the 17th anniversary of the adoption of CRPD which continues to play a critical role in promoting the inclusion of persons with disabilities and their perspectives in the global agenda.

Government is mandated to promote and protect the rights of Persons with disabilities and the Constitution of the Republic of Uganda (1995) stipulates the need to empower and provide equal opportunities to all including Persons with disabilities (Article 32). Government has focused on provision of health services, Community Based Rehabilitation (CBR), vocational training, universal primary and secondary education and holistic representation as some of the key measures to empower Persons with disabilities.

Persons with disabilities have the same rights as all other people as indicated in the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and as such, they should therefore benefit from all development programmes and activities on an equal basis. However, Persons with disabilities and the programming thereof are hardly prioritized in society. They receive less education, skills training and medical attention, which reduces their employment opportunities and may result in

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secondary disabilities and sometimes early death. Consequently, this discrimination and neglect increases their vulnerability to perpetual poverty, erodes their self-esteem and ability to articulate their needs[7].

Chambers (1983) outlines what he calls the 'deprivation trap' in which five 'clusters of disadvantages' interact with each other to trap people in a situation of disadvantage. One of the five clusters is poverty and it is used in the narrow sense of lack of assets. The others are powerlessness, physical weakness, isolation and vulnerability, which are the wider dimensions of poverty. The deprivation trap is a reality in the situation of Persons with disabilities. With poverty, Persons with disabilities are deprived of normal social, physical and cognitive development; the lack of rehabilitation, assistive devices and the necessary environmental modifications lead to exclusion in education, health, and employment intensify poverty, worsen vulnerability (WHO 2011, Sæbønes, 2015) and; exclusion and marginalization reduces the opportunities for Persons with disabilities to productively contribute to the household and community development, which increase the risk of falling into poverty (Elwan, 1999).

The most prominent needs of the persons with disabilities are; rehabilitation, provision of assistive devices, skills training (to maximize use of remnant abilities) and elimination of barriers among which are attitudes (both from them and the people they interact with), architectural challenges (steps, narrow entrances and lack of squatting rails/frames) communication (lack of Braille, sign language and communication charts) among others. Inclusion of Persons with disabilities can only be attained with empowerment and elimination of such barriers (WHO, 2016). However, in understanding the situation of persons with disabilities, it is better to first appreciate the demographic heterogeneity. In this therefore, analysis of gender (men and women with disabilities), age (children, young and older persons with disabilities), living arrangements and the development context. These are presented herein below.

Inclusion of disability issues in the 2030 Agenda for Sustainable Development was a result of the efforts of the international community, including successful multi-stakeholder partnerships between Governments, UN agencies and civil society. Disability and persons with disabilities are referred to 11 times in Agenda2030. The CRPD should be translated into concrete actions and measures for accessible social development policies and practices. The Convention also helps to advance the rights of marginalised persons with disabilities. Envision 2030*, a* campaign launched in March 2016, aims to engage all stakeholders in considering how the 17 SDGs can be achieved for persons with disabilities by 2030. It promotes the mainstreaming of disability in the implementation of Agenda 2030 throughout its 15-year lifespan.

Disability is referenced in multiple parts of the SDGs, specifically in the parts related to education, growth and employment, inequality, accessibility of human settlements,

[7] https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html (retrieved on 5th March 2019)

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as well as data collection and the monitoring of the SDGs. Although, the word "disability" is not cited directly in all goals, the goals are indeed relevant to ensure the inclusion and development of persons with disabilities.

Today, sustainable development is considered to be growth which is both inclusive and environmentally sound to reduce poverty and build shared prosperity for today's population and to continue meeting the needs of future generations (World Bank,2013). The thinking greatly influenced the development of Sustainable Development Goals (SDGs).

Some of the emerging issues in disability in Uganda during the reporting period relate to:

- Non -inclusion of certain persons such as: persons living with vitiligo, persons with mental and psychosocial conditions and nodding syndrome among others.

- The emergence and on-going scientific research on nodding disease/ syndrome has not included the social sector players and hence the failure to document the social and economic aspects of the situation leaves a lot to be desired in addressing the needs of persons suffering from nodding disease.

Disability is a changing phenomenon that needs to be looked at with the current development trends. In all these processes, government of uganda and her partners are taking a centre stage in ensuring that there is inclusion of persons with disabilities in development and in all programmes.

1.2.2 Policy and legislative framework

Uganda signed and ratified the CRPD in 2008 and its optional protocol without reservation and has demonstrated its commitment to serving Persons with Disabilities through enactment of a number of legislations. The constitution of the republic of Uganda, the Persons with Disabilities Act 2020, the Local Government Act 1997/2001, the Equal Opportunities Act 2008, The National Policy on Disability in Uganda 2006 (with a recent revision 2023), to mention but a few, make mention of disability and diversity. By nature, disability issues are cross cutting and all sectors in government ought to contribute to the development, protection and promotion of the rights of Persons with Disabilities.

A study conducted on the situation of Children with Disabilities in Uganda by UNICEF and Ministry of Gender, Labour and Social Development (MGLSD) in 2014 and the situational analysis study on persons with disabilities in Uganda 2020 indicated that, although the Uganda regulatory framework mostly domesticates the CRPD and CRC, there is need to clarify the measures to be taken and the responsibility of government institutions to realize the rights of all persons with disabilities. The protection mechanism of the rights of persons with Disabilities is also weak and

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existing laws and policies are not enforced to their full potential. Lack of coordination between national and local government institutions and gaps in knowledge, understanding and capacities of the organizations of the Disability and child movement have partly led to the fragmentation of the programmatic approach in answering the needs of Persons with Disabilities.

> *Throughout the course of the study, one of the clearest findings was the on-going presence of stigmatizing attitudes which led to rejection, neglect and denial of access to basic services, abuse and marginalization of Persons with Disabilities. This pattern of behavior based on misconceptions and stigmatization is associated with disabilities and development on what communities traditionally think of Persons with Disabilities.* (UNICEF, 2014 page 15)

1.3 Barriers to participation of Persons with Disabilities

The key barriers to participation of persons with disabilities among others include: the poor implementation of the regulatory and protection framework (policies, guidelines and laws relating to disability); a lack of coordination between national and local Government Institutions and gaps in knowledge, understanding and capacities of the organizations of the Disability and Child movement have partly lead to a fragmentation of the programmatic approach answering the needs of persons with disabilities; lack of reliable data; presence of stigmatizing attitudes which lead to rejection, neglect, denial of access to basic services, abuse and marginalization of persons and Persons with Disabilities and; denial and lack of access to basic services. Specifically, these barriers have been most felt in child protection and response in terms of:

- Health and rehabilitation provision and support;
- Lack of birth registration and support;
- Access and utilisation of education services and lifelong learning;
- Entitlements to property rights and inheritance;
- Neglect (by institutions and family)
- Discrimination from services (particularly schools and health facilities);
- Demeaning and hazardous child labour
- Trafficking in persons, child labour and other forms of exploitation;
- Non-representation/ non-consultation on Persons with Disabilities at the various child-rights for as and;
- Early marriages among others.

The barriers have been perpetuated by some Persons with Disabilities and their caregivers themselves through self-denial and the vulnerability thereof; care and service institutions, communities and government among others.

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1.4 FOHO UGANDA and her disability inclusion and support strategy

FOHO Uganda started in 2008 as A Foundation of Hope, a Community Based Organization (CBO) and has been elevated to an indigenous company limited by Guarantee, focusing on child protection, the health and wellbeing of people living HIV/AIDS (PLWHA) and economic empowerment of vulnerable youth including children on the street and those with disabilities. FOHO Uganda's vision is to transformed lives and wellbeing of vulnerable children, People Living with HIV/AIDS (PLWHA), Persons with Disabilities and the youth while her mission is to support and promote the welfare and rights of vulnerable children, PLWHA, Persons with disabilities and enable the youth into socio-economic development for better livelihoods.

FOHO Uganda has developed her 5-year strategic plan (2023 – 2027) which focuses on interventions in the programme areas of Health, Human Rights, Sustainable Livelihoods and Organizational Development. under each programme area, gender and disability is considered core cross-cutting. The strategic plan acknowledges that, persons with disabilities are vulnerable by virtue of their impairments and negative societal attitudes arising from fear, ignorance, superstitions, neglect and lack of awareness. Those persons with disabilities especially those with severe disabilities are stigmatized and often deprived of productive resources even within their own families. FOHO UGANDA therefore pledges to undertake disability inclusive programming to empower and support persons with disabilities. FOHO Uganda's second outcome area (Increased economic and opportunities for the vulnerable youth including teenage mothers and youth with disability) will particularly take into account the needs and aspirations of persons with disabilities.

Table 2: FOHO UGANDA Outcome area 2: Increased economic and other opportunities for vulnerable youths

Focus Area	Areas of Interventions	
Sustainable agriculture and food security	• Food security and household income enhancement • Post-harvest handling and promotion agribusiness and value addition • Maize/Cereal milling and processing plants	• Vulnerable households (households with PLWHA, CLWHA, Persons with disabilities, CWDs, OVCs)
	•	•
Youth Economic strengthening	• Startup capital grant to sustainable income generating projects • Economic strengthening • Vocational education, apprenticeship and skilling	• Vulnerable youths • Youth with disabilities • Adolescent street children

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	• Finance literacy and enterprise development	
Teenage Mothers empowerment and Economic strengthening	• Rehabilitation and Psychosocial support • Start-up capital grant to sustainable income generating projects • Economic strengthening • Vocational education, apprenticeship and skilling • Finance literacy and enterprise development • Community awareness raising and support systems	• Teenage mothers • Adolescent girls and young women • Female youth living with disability • Adolescent female sex workers

Source: *FOHO UGANDA Strategic Plan 2023 – 2027, page 20*

In order to understand the actual situation and set clear targets for inclusion, FOHO Uganda undertook a situation analysis study on persons with disabilities in Masaka. The study particularly assessed the prevailing situation regarding the rights of Persons with Disabilities – including in ECD; extent of inclusion in rights, budgets, products and services and; therefore, establishes measurable parameters for inclusion of Persons with Disabilities at all levels in the programme area. The consideration of households with Persons with Disabilities to generate information on the knowledge, attitude and practices in relation to prevention, early detection and rehabilitation.

1.6 Purpose and Objectives of the study

The purpose of the study was to assess the prevailing situation on the inclusion and rights of Persons with Disabilities in Masaka. The study was intended to generate strategic and operational information on the extent, characteristics and service provision for Persons with Disabilities and; generate workable recommendations (in terms of actions, evidence-based and tested regional and global approaches) towards inclusion of Persons with Disabilities in Masaka

The study was specifically undertaken in order to;

1. To assess the prevalence and types of disabilities in the region and their impact on respondents, families, and communities;

2. To identify the barriers and challenges faced by persons with disabilities in accessing and utilising social services;

3. To examine the extent of implementation of the legal and policy framework on disability in Masaka;

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4. To identify the existing interventions and initiatives/opportunities supporting persons with disabilities and;

5. To explore the opportunities for strengthening the support systems and services for persons with disabilities in Masaka.

The study was undertaken in March 2023 upon preparation using the methodology presented in the next section.

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SECTION TWO: METHODOLOGY AND APPROACH

2.1 Introduction

This section gives the approach that was used in the study. The study methodology involved gathering and analyzing data to understand the current situation, identify trends, challenges, and opportunities in a regard to rights and services for persons with disabilities. The study team as much as possible followed agreeable practices in undertaking assessments. A mixed method (qualitative and quantitative) approach was used for collection and analysis of data regarding persons with disabilities and their situation in Masaka. This was done since an assessment of this nature requires participatory approaches owing to the number of stakeholders that were involved and the nature of information that was required.

2.2 Technical approach

The study used a mixed method approach involving quantitative and qualitative methods. This was intended to generate sufficient information on the knowledge, attitude and practices towards inclusion of Persons with Disabilities. In addition, the consultants conducted extensive literature review of international and national reports and publications to understand the study strategy and programme context.

2.2.1 Review relevant literature

A literature review checklist was designed to facilitate the review of relevant documents (reports, journals and other publications related to the subject matter) to extract information to answer the stated objectives. The review also provided a deeper understanding of the study thereby enabling the appropriate sampling of persons and organizations to consult and also feed directly into the design of data collection instruments.

2.2.2 Qualitative methods and sample size

The qualitative methods included Focus Group Discussions (FGDs), key informant interviews and observations and; quantitative data was collected through a survey. These were used to bring out the knowledge, attitude and practices of the community and family members towards Persons with Disabilities. The participatory sessions with Persons with Disabilities helped to triangulate information on the study generated from the local leaders, family members and community members on persons with disabilities.

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Table 3: Qualitative methods sample size

No	Category	Targeted Sample	Reached sample	Percentage reached
1	FGDs	8	7	87.5%
2	Participatory sessions with children	4	4	100%
3	Key Informant Interviews (KIIs)*	16	8	50%

The observation was conducted during the survey at household and institutional level. The household survey tool contained a section on observation which was administered to households with Persons with Disabilities. The observation checklist focused on adaptations made in the home to take care of Persons with Disabilities, nutrition status, physical appearance, rehabilitation and assistive devices. In addition to household observation, institutions, schools, health facilities and offices were also assessment to establish provisions for Persons with Disabilities.

2.2.3 Quantitative methods

As earlier stated, a household survey was conducted to collect quantitative data. The survey used a structured questionnaire with questions designed specifically to measure the KAP on disability and the inclusion thereof in relation to:

- Knowledge, Attitude and Practices of communities and service providers in regard to disability;
- Access (availability, affordability, efficacy and quality) and utilisation of services by Persons with Disabilities in Masaka;
- Coping strategies for emerging conditions and;
- Existing communication interventions, strategies, formats and source of information on disability and their interventions.

A survey questionnaire was developed addressing the components listed above. The survey questionnaire was administered to caregivers of all children (including Persons with Disabilities) in households that had at least one child below the age of eight (8 years) selected into the study sample.

2.3 Target population and sample size for the survey

The target population included all caretakers of persons with disabilities in the enumerated areas. The sample for the survey was designed to provide estimates of the community's levels of knowledge, attitude and practices (KAP) on the inclusion of Persons with Disabilities in social services in Masaka for the urban and rural areas separately.

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2.3.1 Sample size estimation

There was no clear source of a sampling frame. The team therefore agreed to use UBOS (2016) population of persons with disabilities in Masaka (42,849) and then subjected it to the estimated growth by UBOS for 2023 (56,397). Based on this therefore, a sample of 382 was obtained for survey household using the formular below;

$$\text{Sample size} = \frac{Z^2 * (p) * (1-p)}{c^2}$$

Where:

Z = Z value (e.g. 1.96 for 95% confidence level)

p = percentage picking a choice, expressed as decimal

(.5 used for sample size needed)

c = confidence interval, expressed as decimal (e.g., .04 = ±4)

In this, the sample sizes related to the krejcie & Morgan (1970) sampling tables. Therefore, the confidence level was at 95%, Confidence interval of 5 and a 50% percentage and; this gave us the following samples.

The samples were further divided into the Nyendo-Mukungwe Urban Division and, Bukakata Sub County (to represent rural Masaka). All these were based on the percentages allocated to every impairment and villages covered. This is presented below

Table 4: Sample per location

Sub County/City Division	Parish	# of villages	Total
Bukakata	Bukibonga	12	32
	Sunga	8	21
	Makonzi	5	13
Nnyendo – Mukungwe	Katwe	11	29
	Butego	8	21
	Nyendo	15	40
	Ssenyange	5	13
	Bugabira	8	21

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	Kalagala	13	34
	Bulayi	8	21
	Samalia	10	26
	Katwade	7	19
	Matanga	8	21
	Bulando	6	16
	Kitengesa	8	21
	Kasanje	6	16
	Kibisi	7	18
TOTAL		**145**	**382**

2.4 Data Collection and Analysis

Data collection tools were jointly designed prior to data collection and a one-day orientation for enumerators was arranged. The questionnaire was designed using KoBo Toolbox (mainly the survey questionnaire) and programmed on mobile phones.

Data was therefore collected using smart phones with Open Data Kit (ODK) software as the enabler. A team of two people collected group level data required for the qualitative assessment and thereafter collected survey-based data at household level within the community, with the help of interpreters in cases where there were linguistic differentials.

A data analysis plan was developed based on the assessment objectives. Survey data was uploaded from form-hub web application in Excel format and exported to IMB SPSS ver23.0 for analysis. Recordings from focus group discussions and key informant interviews were immediately transcribed, organized and analyzed using thematic and content analysis framework.

2.5 Data management and statistical analysis

2.5.1 Quantitative data

The quantitative data collected was downloaded from the server and run on cleaning scripts designed in STATA version 15 to check for errors of completeness, accuracy and consistently. Cleaned data was backed up on CDs and locked in secure locked cabins. Data was then analysed using Stata 15. Results for key outcomes is reported at district and by Sub County level by study domains (district, and urban/rural). Statistical analyses comprised the generation of descriptive information summarizing the study population, its characteristics and specific analyses related to the objectives. Frequency tables were generated, and comparison of variables done using chi-square tests for categorical variables and t-tests or ANOVA for continuous variables. The

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report presents results disaggregated by socio-demographic factors such as gender and age group. Adjustments for clustering were done by applying the sampling weights during data analysis. The P-values <0.05 in the report indicates statistical significance.

2.5.2 Qualitative data analysis

The qualitative data from Focus Group Discussions and Key Informant Interviews was transcribed then organized and analyzed to draw conclusions on the objectives of the study. The analysis was done using a deductive method. The Consultants basing on the objectives of the KAP survey generated themes and sub themes from the qualitative data. This was followed by grouping all the data along the identified themes and sub themes. Anecdotes were also captured to provide additional evidence on quantitative and qualitative findings.

2.6 Quality control

Experienced Research assistants were recruited and trained in conducting interviews and administering the study questionnaire. During the training, mock interviews were conducted, and various scenarios acted to ensure that the trainees are up to the task. The tools were pretested in a field (Kyanamukaka) prior to actual data collection.

2.6.1 Quality Assurance

Quality assurance started with orientation of enumerators on the assessment objectives and methodology. The smartphones used for data collection were GPS enabled to ensure that interviewers conducted the interviews in the actual sampling points. Additionally, the team lead visited Beneficiaries in their households to make sure that the right Beneficiaries were interviewed. During the processes of exporting data from excels to SPSS, it was further subjected to forensic checks and data cleaning to ensure validity and reliability.

2.6.2 Human Subjects consideration

All study participants were given information about the study and consent sought. Each participant was given a copy of the consent/assent form translated in local language used in the communities (Luganda) and a Research Assistant read the form to each respondent. Participants were given a chance to ask questions during and after reading of the consent form to ensure that they understood and consented to participate in the survey.

2.6.3 Confidentiality and privacy

All the study data was kept strictly confidential and password protected computers and database files. The data records were kept with only household identification numbers and any identification information such as names were removed and kept separately from the data. No names of individual identifiers were used in any reports or publications.

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2.7 Study limitations

Small sample size of families with Persons with Disabilities: The mapping of the households yielded a few households with Persons with Disabilities. This was attributed to inadequate knowledge of the family members especially for non-visible functional difficulties. However, the qualitative interviews involving caregivers of Persons with Disabilities, family members and Participatory sessions with Persons with Disabilities generated plausible information on the knowledge, attitudes and practices of the family and community members towards Persons with Disabilities.

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SECTION THREE: STUDY FINDINGS

3.1 Introduction

This section presents findings from both secondary (generated from the review of the relevant literature) and primary data. The section begins with the situational analysis of the study area (Masaka City and Masaka District) to provide a broader picture on a number of social, economic and political variables that contribute (positively or negatively) on the inclusion of persons with disabilities in social services and realisation of their rights. The second component focuses on the findings from the primary data collected during the household survey.

3.2 Situation analysis of Masaka

Masaka City and District until July 2020 was one district. Masaka District is a district located in the Central Region of Uganda. It is bordered by Rakai District to the south, Kalungu District to the west, Kalangala District to the east, and Lwengo District to the north. The district is further divided into several sub-counties and town councils. Masaka City, on the other hand, is a municipality and administrative center within Masaka District. It was elevated to city status in 2020, becoming one of the major urban centers in Uganda. Masaka City is located approximately 135 kilometers southwest of the capital city, Kampala.

Both Masaka District and Masaka City are significant hubs for economic activities, trade, and administration in the region. They are home to a diverse population, including persons with disabilities, who face various challenges and opportunities in accessing healthcare, education, employment, and social services. Conducting a situational analysis specifically in Masaka District and City would help identify the specific needs, gaps, and potential interventions required to support persons with disabilities in these areas.

Masaka District is primarily rural with with most of the population dependent on agriculture. The granting of City status of part of the old Masaka district has increased the number people living in urban areas in the two districts.

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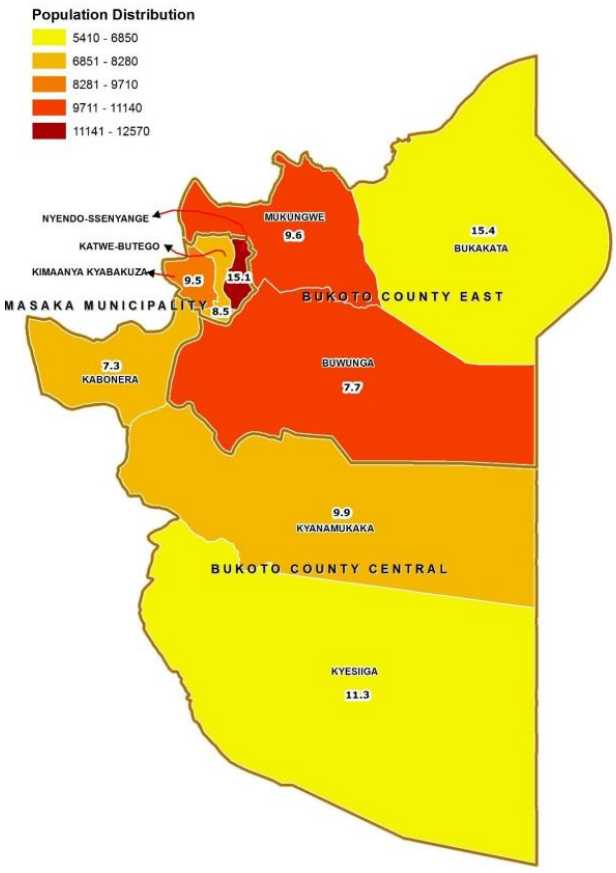


Figure 2: The Map of Masaka indicating the population density (2014)



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Figure 3: The Map of Masaka City (2023)

The UBOS National Population and Housing Census report 2016 indicated that Masaka had a population of 297,004 persons and, the UBOS population projections for the same area for 2023 is at 390,913. The Masaka District Budget framework papers for FY 2022/2023 indicated that the general social economic situation for the area is characterized by high infant mortality rate, low safe water coverage, high dropout rate at both primary and secondary. To address the above situation, the Financial Year 2022/2023 budget put emphasis on operationalizing, strengthening and improving existing infrastructure so as to improve accessibility to health services, education services, public markets and bridges. This situation is similar to Masaka City.

3.3 Demographics characteristics of the survey population

The survey had planned to reach a sample of 382 households. This target was surpassed and the team reached 420 respondents in households. Below are some of the social demographic characteristics of the respondents. The 420 respondents came from 7 sub counties/ Divisions and data was collected from 22 parishes as presented below:

Table 5: Sub Counties and the respective parishes where data was collected from

Sub County/Division	No	Parish/Ward	Respondents
Bukakata (134)	1	Bilinzi	4
	2	Bukakata	5
	3	Bukibonga	57
	4	Kibonga	5
	5	Makonzi	4
	6	Ssunga	59
Butego (18)	7	Butego	16
	8	Katwe	1
	9	Kigamba	1
Kyanamukaka (01)	10	Kalagala	1
Nyendo - Mukungwe	11	Binyonyi B	1
	12	Bugabira	32
	13	Bulando	19
	14	Butego	9
	15	Kalagala	92
	16	Katwadde	6
	17	Katwe	9

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	18	Kigamba	0
	19	Kitenga	1
	20	Kitengesa	25
	21	Kyabakuza	1
	22	Misaali	1
	23	Mukungwe	2
	24	Nyendo	28
	25	Samaliya	13
	26	Ssenyange	28
TOTAL			**420**

3.3.1 Sex, age and marital status of respondents

Of the 420 respondents, 27.6% (n=116) were male while 72.4% (n=304) were female. All respondents were adults aged between 18 and 99 years old. Below is a comparison of sex of respondents against their age.

Table 6: Comparison of age bracket of respondents against their sex

Age Bracket (in years)	Male	Female	Total
18-19	7	6	13
20-24	4	7	11
25-29	4	27	31
30-34	6	30	36
35-39	12	83	95
40-44	12	39	51
45-49	18	36	54
50-54	17	16	33
55-59	10	21	31
60-64	12	20	32
65-69	7	2	9
70-74	3	6	9
75-79	1	4	5
80-84	3	4	7
85-89	0	1	1
90-94	0	1	1

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95-99	0	1	1
TOTAL	116	304	**420**

The table above indicates that majority of the respondents (51.2%) reached were females aged between 25 and 49 years. In order to draw a clear justification, there is need to compare the sex of respondents against their being household heads. In this regard, the respondents were asked whether they were the household heads. 78.1% (n=328) said that they were household heads while 21.9% (n=92) were not the household heads.

Table 7: Comparison of age bracket, sex and household headship

Age Bracket (in years)	**Household Heads**			**Not Household Heads**			**Total**		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
18-19	2	3	5	5	3	8	7	6	13
20-24	3	4	7	1	3	4	4	7	11
25-29	3	17	20	1	10	11	4	27	31
30-34	6	19	25	0	11	11	6	30	36
35-39	10	66	76	2	17	19	12	83	95
40-44	8	36	44	4	3	7	12	39	51
45-49	16	21	37	2	15	17	18	36	54
50-54	16	14	30	1	2	3	17	16	33
55-59	10	17	27	0	4	4	10	21	31
60-64	12	16	28	0	4	4	12	20	32
65-69	7	2	9	0	0	0	7	2	9
70-74	3	6	9	0	0	0	3	6	9
75-79	1	4	5	0	0	0	1	4	5
80-84	1	2	3	2	2	4	3	4	7
85-89	0	1	1	0	0	0	0	1	1
90-94	0	1	1	0	0	0	0	1	1
95-99	0	1	1	0	0	0	0	1	1
TOTAL	98	230	**328**	18	74	**92**	116	304	**420**

A gendered comparison of household headship was made and this indicated that majority (49%) of the households were headed by females aged between 25 and 64

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years. This could be an indication of neglect, skipped generation, widowhood or even abandonment by the males who – in accordance with the predominant patriarchal arrangement are supposed to be the heads of the households. The situation could also be associated with the care roles that are ascribed to females in a patriarchal society like Buganda where Masaka lies.

Respondents were asked about their marital status. The responses are presented in the chart below

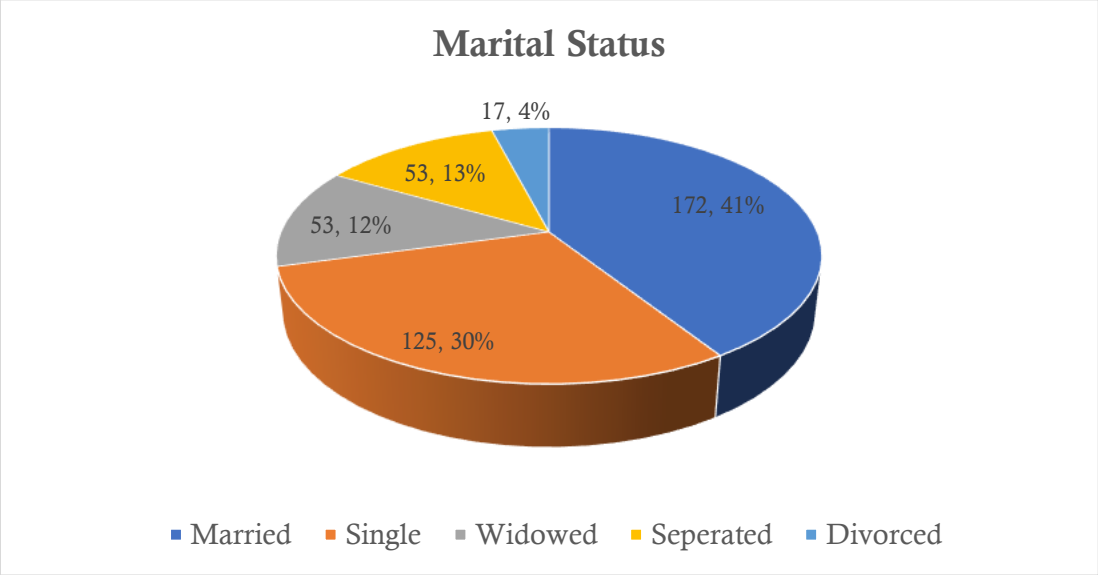


Figure 4: Marital status of respondents

The figure above indicates that majority of the respondents (41%) were married. However, the actual majority of respondents (59%) were living single lives due to: separation, being widowed, having divorced and other factors that drove them into such status. This is a common phenomenon with households that have children with disabilities.

3.3.2 Cultures, tribes and religion

The survey established that majority of the respondents were Baganda and mainly spoke Luganda at home. Below is the presentation of findings on cultures, tribes and religion.

Table 8: Tribes of respondents

Tribe	Frequency	Percent
Muganda	340	81.0
Munyarwanda	22	5.2

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Munyankole	21	5.0
Mukiga	7	1.7
Mukooki	6	1.4
Mufumbira	5	1.2
Munyoro	4	1.0
Mugungu	2	0.5
Musoga	2	0.5
Mwamba	2	0.5
Murundi	2	0.5
Tanzanian	2	0.5
Mukonzjo	1	0.2
Mutooro	1	0.2
Lugbara	1	0.2
Mugisu	1	0.2
Muhororo	1	0.2
TOTAL	420	100

Table 9: Languages commonly spoken by respondents

Language Spoken	Frequency	Percent
Luganda	383	91.2
Runyankole	9	2.1
Others: Sign language	6	1.4
Lukooki	3	0.7
Kinyarwanda	3	0.7
Rufumbira	3	0.7
Lugungu	3	0.7
Rukiga	3	0.7
Lukonzjo	1	0.2
Runyoro	1	0.2
Lusoga	1	0.2
Rutooro	1	0.2
Others: English	1	0.2

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Others: English and sign language	1	0.2
Others: Lumasaba	1	0.2
Total	420	100

Table 10: Religious affiliations of respondents

Religion	Frequency	Percent
Roman Catholic	243	57.9
Muslim	75	17.9
Anglican	55	13.1
Saved	38	9.0
Adventist	8	1.9
Orthodox	1	0.2
Total	420	100

3.3.3 Household composition and parentage

The study established that the average number of persons in the household was 5.3 persons. This was higher than the Masaka average household size 0f 3.9 (UBOS, 2018) and the national average size of 4.7. The survey equally established that 91.7% (n=385) of the households had children aged 0-18 years. The households selected to participate in the survey were purposefully selected for having a person with a disability living in it. There were no significant differences in the households with children which were headed by females and marital status.

3.4 Disability Awareness

Disability awareness starts from understanding and domaining the body disability. Most communities in the world domain disability around what they see or observe (impairment) and not the functional limitations inherent. The government leadership is mandated to spearhead in addressing leadership. A lack of awareness creates the worst forms of discrimination and stigma based on stereotyped interpretations of disability. In analysis of disability awareness therefore, the study engaged with the technical leadership and other respondents reached in order to understand whether they could describe disability, understand the core needs associated with specific impairments, the established legislative regime and programmes in regard to disability.

Of the nine district personnel reached, there was any who could barely define disability but rather related it to the common impairments. The understanding of functional limitation is imperative in designing programmes and services for persons with disabilities.

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"…They are the lame, the blind and those who do not hear. I do not know any other type, may be because they do not usually come here for health services" Health Worker at Bukakata Health Centre III

"How do I know that a learner has a problem with his head. In any case those who are mad should be sent to Butabika for treatment and not the school to learn because they will not learn anything and will end up stoning other children" Teacher in a mainstream school in Mukungwe

"We have two staff who have disabilities. One is blind and she is a Community Development Officer and another has a physical disability. We do not have special provisions for them but when they apply, we consider them and interview them. When they pass the interview, we employ them" Principal Human Resources Officer – Masaka District.

The survey asked respondents whether they knew anything about children with disabilities. Below is a table of the responses.

Table 11: Knowledge of Children with disabilities

Responses	Frequency	Percent
Yes	316	75.1
No	83	19.7
Don't Remember	5	1.2
I Don't Know	14	3.3
Total	**418**	**99.3**
Missing: System	3	.7
Total	**421**	**100.0**

From the table above, majority of the respondents (75.1%) said that they know something about children with disabilities. This was followed by those who did not know or remember anything about children with disabilities (24.2%). The results were compared with households that had a person with disability. Of the respondents who stated that they had children aged 0-18 years in their household, 79.8% of the respondents had a person with disability in their household while 11.8% did not have such a person. These responses directly related to the households that had children with disabilities and hence had some form of lived experience in terms of disability. Below is a triangulation of having children and knowing anything about children with disabilities

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Table 12: Triangulation of having children and knowledge about Children with disabilities

Have children aged 0 - 18 years?	Knowledge about Children with disabilities	
	Yes	No
Yes	291	77
No	25	6
Total	**316**	**83**

The table above indicates that 72.9% (n=291) of those who had children also knew about children with disabilities while 19.3% (n=77) did not know about children with disabilities. Similarly, 6.3% (n=25) of whose who did not have children knew about children with disabilities while 1.5% (n=6) neither had children nor knew about children with disabilities.

This however may not translate into understand the causes and responses in regard to disability. This is concretized by the observations that indicated that only 4.7% (n=2) of the respondents understood the nature of impairment identified, cause and other notes.

Of the 421 participants in the study, 86.9% (n=366) had a person with disability in their household while 11.9% (n=50) did not have a household member with a disability. In that regard, 85.7% of the respondents with persons with disabilities in their households could identify them by functional difficulty (could not see, hear, walk, speak among others). The table below indicates some of the difficulties that the persons faced (both functional limitations and activities of daily living).

Table 13: Difficulties faced by Persons with Disabilities (functional and ADL)

No	Activity	Responses	
		Freq.	Percent
1	Participate	140	33.3
2	Bathing	124	29.5
3	Hear	114	27.1
4	Getting dressed	110	26.1
5	Going to toilet	108	25.7
6	Preparing meals for yourself	107	25.4
7	Ride bicycle	99	23.5

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8	Moving around	93	22.1
9	Climb stairs.	88	20.9
10	Learn	86	20.4
11	Cooking meals for everyone	70	16.6
12	Work in the garden	71	16.9
13	Carry items such as water and food	71	16.9
14	Looking after your Persons	64	15.2
15	Sweeping, cleaning the house	62	14.7
16	Go to shop on your own	62	14.7
17	Washing dishes	60	14.3
18	Looking after elderly members	57	13.5
19	Doing the laundry	52	12.4
20	Eating or drinking	44	10.5
21	Any other (specified)	41	9.7

Additionally, the table below shows the respondents who could identify additional functional difficulties that their children with disabilities faced.

Table 14: Awareness of additional functional difficulties faced

No	Additional Difficulty experienced	Freq.	Percent
1	Make themselves understood	257	61.0
2	Understand what people say.	254	60.3
3	Learning new things easily.	221	52.5
4	Remember easily	218	51.8
5	Hear clearly when someone calls them	212	50.4
6	Finding way to express what you need	211	50.1
7	Talk easily to other people	206	48.9
8	Concentrating on more than one thing at a time.	200	47.5
9	Staying in one place	164	39.0
10	Going out of house because they are scared	125	29.7

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3.4.1 Avenues of awareness creation

The study established the sources of information on disability and persons with disabilities. The District Community Development Officer stated that, information on disability was mainly passed on at the health centres, schools and community gatherings. Again, that the health centres were pivotal since that is where disability is first identified. However, the Health Unit In-charges sad that that lacked a Disability focal persons and knowledge of disability which limited them in their work.

> *"…We have no information charts and so we do what we have learnt and interface with. Some of the conditions are complicated and we do not even know what to do other than discharging the patients."* Health Worker.

> *"…We work with the office of the Resident Distrct Commissioner and Resident City Commissioner to relay information on programmes for Persons with Disabilities on the radio. Other means seem to be so expensive for our department."* District Community Development Officer

Below is a figure indicating the sources on information on disability in the community.

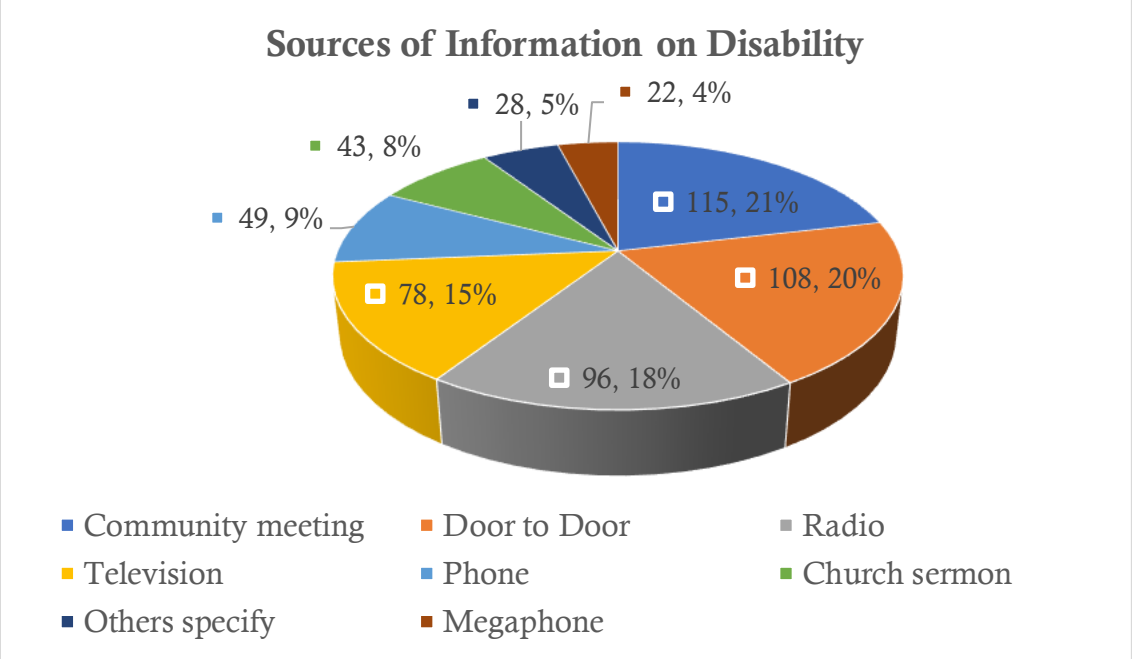


Figure 5: Sources of information on Disability in Masaka

From the figure above, the most common sources of information were: community meetings, door-to-door, radio and television. The phone and megaphone were the least used mediums. This indicates that, future advocacy interventions should target reaching the persons and households through either community or one-on-one meetings. However, the radio still provides an avenue for mass communication especially if such communication is routine.

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3.5 Service provision for persons with disabilities

The service delivery spectrum for persons with Disabilities is described in the Community Based Rehabilitation (CBR) matrix but most concretised in the Convention on the Rights of Persons with Disabilities (CRPD), the Persons with Disabilities Act 2020 as well as the Revised National Policy on Disability in Uganda 2023. These are further proclaimed in the specifics of the SDGs as well as the Global Disability Summit (GDS) Country commitments 2022. The study aimed at understanding the nature and quantity of services provided to persons with disabilities in Masaka. This focused on: health and rehabilitation, education, justice and, livelihoods and social protection among others.

When interviewed, the District Community Development Officer stated that, persons with disabilities enjoyed all services just like any other Ugandan and that there were specific services for persons with disabilities such as: a dedicated Vocational Training Institute (VTI) that offered hands-on skills training in vocational trades; a school/ unit for the Deaf and Blind learners and; the Special Grants Programme among others. There were also specialised services at Masaka Hospital although these were not adequate.

The respondents in the survey stated that there were a number of services that were provided for persons with disabilities in Masaka. Below is a list of such services

Table 15: Services sought for persons with disabilities

No	Service sought	Responses	
		Freq.	Percent
1	Provided with treatment	241	51.3%
2	Referral to hospital	69	14.7%
3	Nothing	44	9.4%
4	Referred to NGO/Organization working for children with disabilities	23	4.9%
5	provided with information	21	4.5%
6	Physiotherapy	21	4.5%
7	Counseling	17	3.6%
8	Prayers	8	1.7%
9	Collective surgery	7	1.5%
10	Took to home for children with disabilities	4	0.9%
11	provided with wheel chair	3	0.6%

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12	Other specify	12	2.6%
	Total	**470**	**100%**

The data shows that while some services are being provided to persons with disabilities, there is still a significant portion of respondents who have not received any services. This highlights the need for further efforts to ensure that all respondents with disabilities have access to appropriate and comprehensive support.

Some respondents received a combination of services. For example, one respondent received the following services: "Provided with treatment," "Referral to hospital," "Physiotherapy," "Provided with a wheelchair," "Referred to an NGO/Organization working for children with disabilities," "Took to home for children with disabilities," and "Counseling." Other services provided include "Collective surgery," "Counseling," "Referral to hospital," "Went for prayers," "Provided with information," and "Physiotherapy." A few respondents were referred to an NGO/Organization working for children with disabilities for additional support. The respondents were equally asked about their satisfaction with the services provided.

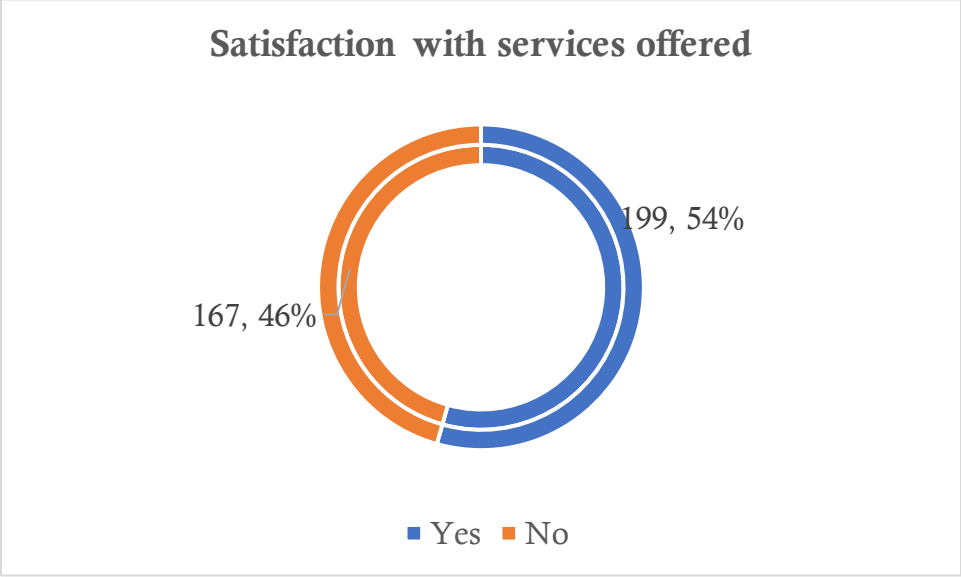


Figure 6: Satisfaction with service offered to person with disability

The figure shows the responses of child support to their expectations. Out of 366 valid responses, 199 children (54.4%) reported that their expectations were supported, while 167 children (45.6%) said their expectations were not supported. There are 55 missing responses (13.1%), which mean some respondents did not provide an answer to this question.

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Overall, more than half of the children felt their expectations were supported, but there is still a significant portion who felt their expectations were not met. This highlights the importance of understanding and addressing the needs and expectations of children to ensure their well-being and development. Further analysis and efforts may be required to identify the specific areas where support is lacking and implement measures to improve the support system for children in the community.

Improving access to services such as medical treatment, referrals, physiotherapy, and counseling is essential to enhance the well-being and quality of life for persons with disabilities. Additionally, addressing the gaps in service provision and expanding the range of services available can lead to better outcomes and inclusivity in the community.

Efforts should focus on promoting awareness, advocating for the rights of persons with disabilities, and strengthening the support systems to ensure that they can fully participate in society and enjoy equal opportunities. By addressing these issues, communities can work towards creating a more inclusive and supportive environment for persons with disabilities.

3.6 Health and Rehabilitation

Rehabilitation is a process aimed at helping persons with disabilities to regain, keep or improve skills and functioning for daily living. Rehabilitation is usually undertaken for development of functional skills that may have been lost or compromised as a result of acquiring a disability or due to a change in one's disability or circumstances. Rehabilitation takes on the form of surgeries, provision of therapies, regimental and long-term treatments, assistive devices and, disability prevention among others.

Most impairments acquired in childhood happen *after* birth, for example from endemic childhood diseases such as (cerebral) malaria, as well as vaccine-preventable diseases. This may include potentially avoidable conditions, which can worsen with limited access to healthcare and/or rehabilitation. The Interviews with health workers revealed that, they did not have capacity to undertake health rehabilitative services but rather referred these to hospitals.

> *"When you look at this environment, even when you give us a doctor, do you think that we can carry out surgery from here? Really? … we usually refer the cases that need surgeries due to accidents, post-natal and other congenital conditions to the hospital in Masaka"* Health worker in Mukungwe

Respondents in the survey were asked where they went in order to receive health services. Below is a table of responses.

Table 16: Where health and rehabilitation services were received from

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Sources of Health and Rehabilitation Services	Freq.	Percent
Hospital	227	54%
Health Centre	95	23%
Others (witch doctors, pharmacy etc)	62	15%
Orthopaedic Centre	23	5%
Medical Doctor	7	2%
Physiotherapist/ Allied health worker	7	2%
Total	**421**	**100%**

The results in the table above indicate that the respondents appreciate that most of the rehabilitative services are provided for at Health Centre IV and above (Hospitals). The visits to the allied health workers indicated knowledge of the cadre level that the caretakers of persons with disabilities visited.

3.6.1 Surgeries and Therapies

Respondents were asked whether their person with disability had ever been required to undergo any surgery to correct or improve their condition. 14.5% (n=61) said that their person had ever required a surgery to correct or improve their condition. Of these, only 6.2% (n=26) underwent the surgery(ies) and; 4% (n=17) reported that the surgery actually improved their condition and yet 5.5% (n=23) said that they still needed to undergo the surgery but could not afford. The smaller percentage could be attributed to the cost of surgeries which is quite dear for most of the households with persons with disabilities. This is presented in the table below

Table 17: Reasons for not undergoing the surgery

No	Reasons for not taking up surgery	Freq.	Percent
1	It is expensive	24	68.6%
2	I do not have funds for the surgery	5	14.3%
3	I fear the negative outcome	3	8.6%
4	I have been told to contribute	1	2.9%
5	I like myself the way I am	1	2.9%
6	Any other [There is nothing I can do now]	1	2.9%
	Total	**35**	**100%**

The respondents were also asked whether the person with disability in their household had ever been required to undergo any therapies to correct or improve their condition.

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20.2% (n=85) said that the person had ever required to undergo therapy. However, only 12.1% (n=51) had undergone the therapy, 5.9% (n=25) said that the therapy improved their person's condition and; 6.4% (n=27) still needed to undergo the therapy but could not go for it. The reasons are the same as those presented in table 16 above.

The respondents were asked the kind of health services available for the person with disability in their household. Below is a figure of the responses

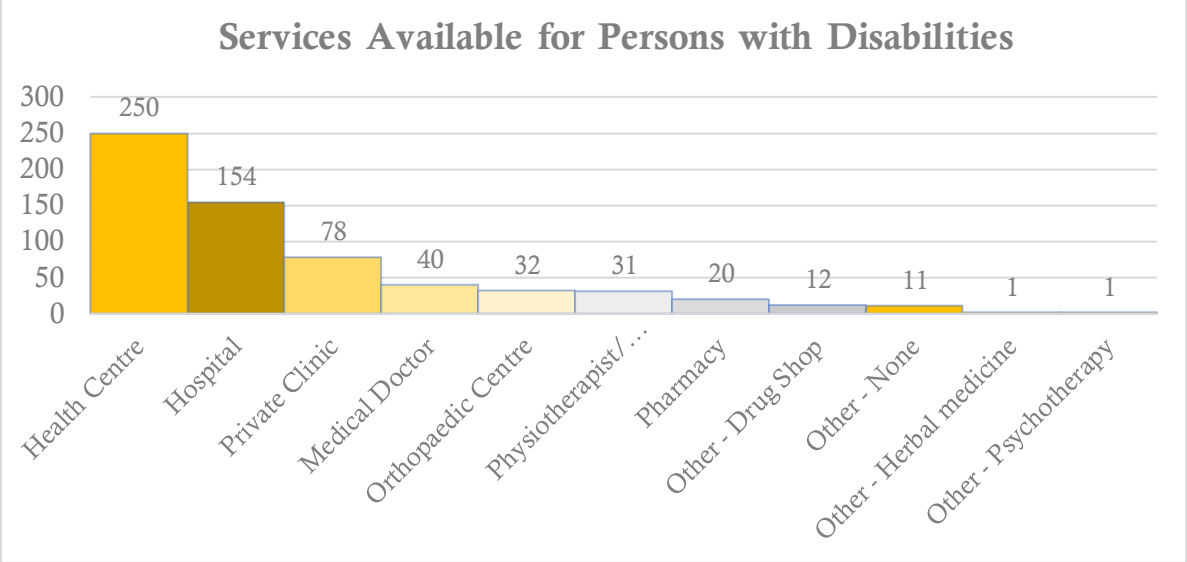


Figure 7: Health Services Available for Persons with Disabilities

From Figure 7, the common services available (59.4%) were the Health Centres which seldom offered habilitation and rehabilitation services for persons with disabilities. Again, psychotherapy, herbal medicine and none are the least mentioned (3%) which could be a pointer towards a limitation in awareness in regard to disability, impairments and associated health and rehabilitation needs.

3.6.2 Accessibility to health services

Respondents were asked how the person with disability in their household often got to the closest available health care facility.

Table 18: Means of transport to the nearest Health facility

No	Means to the Health Facility	Freq.	Percent
1	Motorcycle	314	74.6%
2	Foot/Limb	144	34.2%
3	Bicycle	37	8.8%
4	Other - Doesn't go	2	0.5%

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5	Other - Taxi	2	0.5%
6	Other - Foot/Near	2	0.5%
7	Other - Wheel Chair	2	0.5%
8	Animal (such as donkey)	1	0.2%
9	Other - Bring Health Worker Home	1	0.2%
10	Other - None	1	0.2%

The majority of households with persons with disabilities used motorcycles to the nearest health centre. This means that they either hire the services and fuel the motorcycle or pay a round cost for the distance covered. Only 10.5% (n=44) owned the means of transport used and; the average time taken from home to the health centre was 3.15 hours, the majority (48.2%) taking up-to 2 hours to reach a health centre. In the absence of outreach services, the distance and time covered to reach a health centre circumvents the efforts to receive health services and definitely tolling on the Universal Health Coverage (UHC) efforts.

Respondents were asked whether they had tried any traditional or religious cures for a health condition during the past year. 13.8% (n=58) had tried while 85.5% (n=360) had not tried any means.

3.6.3 COVID-19 and Disability

Respondents were asked whether the COVID-19 situation changed the way the person with disability in their household receives their usual treatment. 30.4% (n=128) of the respondents said that COVID-19 had affected the way the person with disability received their usual medicine while 68.9%(=n=290) said that COVID-19 did not affect they way they received treatment and health care. When asked about how COVID-19 had changed the way the person with disability in their household received their usual treatment, the responses were varied as presented in the table below.

Table 19: How COVID-19 affected the way health services were received

No	How COVID-19 affected them	Freq.	Percent
1	Transportation limitations	67	52.3%
2	No money to treatment and food	21	16.4%
3	Curfew laws limited movement	15	11.7%
4	No food	8	6.3%
5	Expensive to reach health Centres and medicines	6	4.7%
6	No medication	5	3.9%
7	Medicines increased	3	2.3%

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8	No service providers	2	1.6%
9	Lost right eye completely	1	0.8%
	Total	**128**	**100.0%**

Most of the respondents said that these conditions have ragged on even amidst the total lifting of the lock-down and associated restrictions. This calls for a social protection approach in order to enhance income security and, social care and support.

3.6.4 State of living

The respondents were asked how their persons with disabilities felt and lived. Below are the results.

Table 20: How persons with disabilities felt in the past six months

No	How Persons with Disabilities felt	Freq.	Percent
1	Have rapid changes of mood	196	46.6%
2	Feel afraid for no reason	181	43.0%
3	Feel very sad/cry without a specific reason	175	41.6%
4	Feel angry and resentful for no particular reason	175	41.6%
5	Sit for a long time and think	168	39.9%
6	Feel oppressed for no particular reason	168	39.9%
7	Not feel hungry for long periods of time	144	34.2%
8	Feel suffocated for no particular reason	140	33.3%
9	Want to live somewhere else, away from family	136	32.3%
10	Want to stay locked up inside the house	80	19.0%

The prevalence of the conditions above relate to long seated psycho-social conditions as a result of the conditions associated with primary impairments such as discrimination, failure to access given goods and services and, stigmatization. Similarly, the respondents stated that the persons with disabilities had experienced the following conditions in the past six months.

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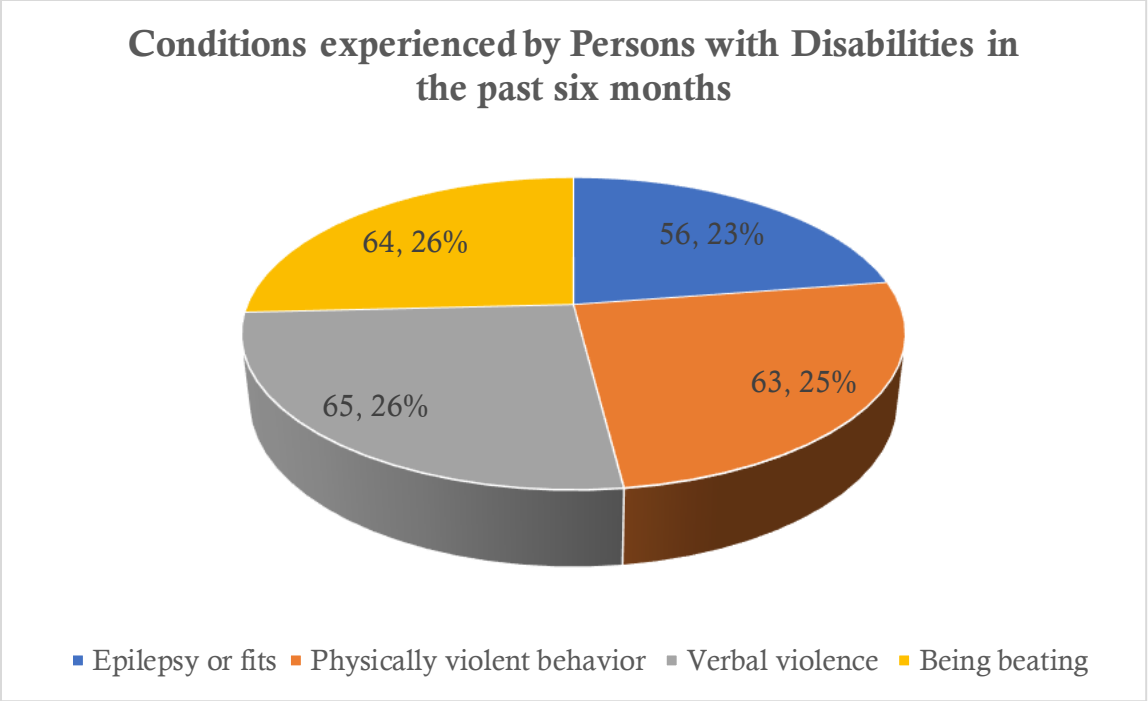


Figure 8: Health experiences of persons with disabilities

The figure above shows that majority of (30.2%) of the Persons with disabilities experienced physical violent behavior. This was sometimes retaliated by other persons hence causing more bodily harm.

3.6.5 Assistive Devices

Assistive devices are key in ensuring mobility and limiting physical barriers caused by a lack or limitations in access. The Revised National Policy on Disability in Uganda 2023 defines assistive devices as:

> *"All goods and services that support persons with disabilities to participate effectively in all aspects of life. These may include; wheelchairs, tri-cycles, calipers, crutches, white-canes, Orthopaedic appliances, qualified readers; taped texts, audios, visual and pictorial recordings; braille and tactile equipment or materials, large print and, enabling software and among others"*

There were no sources of assistive devices locally for persons with disabilities. The survey respondents were asked whether the person with disability in their household needed any assistive device to help them with their day-to-day work. 44.9% (n=189) of the respondents stated that their household member with a disability needed an assistive device and; only 10.2% (n=43) of those in need had a functioning and/or fitting assistive device. Below is a table indicating the assistive devices need.

Table 21: Assistive devices needed by Persons with Disabilities

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No	Assistive devices needed	Freq.	Percent
1	Tri-cycle/ Wheel chair	63	15.0%
2	AFOs	43	10.2%
3	Computer	43	10.2%
4	Spectacles	41	9.7%
5	Crutches	40	9.5%
6	Hearing aids/ molds	40	9.5%
7	White cane	40	9.5%
8	Walking frame	29	6.9%
9	Other - Lenses, glasses and magnifiers	3	0.7%
10	Others (unspecified)	3	0.7%
11	Other - *Kisipi*	2	0.5%
12	Other - Artificial legs	1	0.2%
13	Other - Hearing assertive	1	0.2%

The sources of the assistive devices are presented in the table below

Table 22: Sources of Assistive devices for Persons with Disabilities

No	Source of assistive device	Frequency	Percent
1	Bought it	14	32.6%
2	Charity/ organisation	8	18.6%
3	Government Hospital/ Health Centre	6	14.0%
4	Charity outreach	5	11.6%
5	Private Hospital/ Health Centre	4	9.3%
6	Well wisher	3	7.0%
7	Any other [Please specify]	3	7.0%
	Total	**43**	**100.0%**

The responses indicate that there are limited sources of assistive devices in the public sector amidst their expensive cost. On average an assistive device goes for 500,000/- (approximately USD 135.0).

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Overall, the data indicates a variety of sources from which respondents acquired their assistive devices, including government and private health centers, charitable organizations, personal purchases, and donations from well-wishers. The presence of missing responses highlights the need for more comprehensive data collection to understand the full landscape of assistive device procurement. It should be noted that Government of Uganda does not have an Assistive Products Priority List (APL) – a recommendation of the AT2030 agenda.

Respondents stated that thy had challenges with repairing assistive devices. In this, the sources of the assistive devices equally helped with their repairs and maintenance. However, there were reports (7%) that showed that the assistive devices were repaired from homes. The limitations in mechanisms for repair and maintenance of assistive devices led to unsustainability of AT interventions.

3.6.6 Regimental and long-term treatments

Regimental and long-term treatments are essential in the control of the deleterious impact of impairments on individuals. Indeed, the CRPD Committee responses on Uganda's maiden report in 2016 recommended that,

> *"State party repeal all laws and practices allowing or perpetuating forced treatment of persons with disabilities. It recommends that the State party develops alternative modes of medical treatment which respect the dignity, will and preferences of persons with disabilities in consultation with organizations of persons with disabilities. It also recommends that the State party criminalizes the practice of female genital mutilation"*
> CRPD, 2016

Indeed, regimental and long-term treatments are part of the rehabilitation agenda and it is sometimes combined with home-based therapies. 40 of the respondents reported to be on long-term and regimental treatments. Majority of these (37.5%) had been on therapy for more than one year as presented in the table below.

Table 23: Duration of persons with disabilities on long-term therapies

No	Duration on treatment	Freq.	Percent
1	Less than one year	7	17.5%
2	One year	4	10.0%
3	More than one year	15	37.5%
4	Less than three years	1	2.5%
5	Over three years	6	15.0%
6	Five years	2	5.0%
7	Over five years	5	12.5%
	Total	**40**	**100%**

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Overall, the data indicates that there is a diverse range of durations for respondents' regimental and long-term treatments, with a significant proportion having been on the treatment for more than one year. This suggests the need for ongoing support and monitoring for respondents with long-term treatment requirements.

Table 24: Sources long-term therapies

No	Source of therapy	Freq.	Percent
1	Government Hospital/ Health Centre	17	42.5%
2	I bought it	10	25.0%
3	Private Hospital/ Health Centre	4	10.0%
4	Charity outreach	4	10.0%
5	Charity/ organisation	4	10.0%
6	Church/ Religious organization	1	2.5%
	Total	**40**	**100.0%**

The data indicates that treatment is provided by a variety of sources, with government hospitals/health centers being the most common provider. Additionally, some respondents are purchasing the treatment themselves, indicating potential financial constraints in accessing healthcare services. The availability of treatment through charity organizations and religious organizations also plays a role in providing assistance to respondents.

3.7 Education and training

Education is a developmental right for persons with disabilities. Persons with disabilities require a quality and inclusive education in order to reach their fullest potential. Other developmental rights include: play and leisure, cultural activities, access to information, and freedom of thought, conscience and religion.

It is estimated that only 74% of children with disabilities aged between 5 and 18 years attend school) in Uganda[8]. The study established the challenges and opportunities in education in Masaka. Well as the District boosts of implementing inclusive education, having integrated and special needs units for learners with disabilities, these are concentrated in primary schools. This offers little in regard to education progression and completion for persons with disabilities.

Respondents were asked whether the person with disability in their household knew how to read and write. 45.4 (n=191) knew how to read and write while 53.9% (n=227)

[8] UNICEF (2014) Situational Analysis of Children with Disabilities in Uganda, Unicef and MGLSD, Kampala.

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did not know how to read and write. This was way below the National literacy rate of 76.53%. Similarly, the survey established that, 53.6% (n=224) of the persons with disabilities had received formal education and training. The following table shows the nature of education that was received by the person with disability in the household.

Table 25: Nature of education received by persons with disabilities

No	Nature of education	Freq.	Percent
1	Formal education	193	45.8%
2	Special Needs Education	19	4.5%
3	Inclusive education	12	2.9%
4	Sign language	11	2.6%
5	Mobility Orientation	8	1.9%
6	Other - Formal Primary	5	1.2%
7	Non-formal skills development	3	0.7%
8	Adult literacy	1	0.2%
9	Other - Guidance and Counselling	1	0.2%

Table 26: Level of education reached by persons with disabilities

No	Nature of education	Freq.	Percent
1	Completed a course	8	3.6%
2	Completed P7	54	24.1%
3	O Level class	16	7.1%
4	Completed O level	1	0.4%
5	A level Class	4	1.8%
6	Tertiary training	4	1.8%
7	Any other [still studying]	137	61.2%
	Total	**224**	**100%**

This table provides a summary of the highest level of education attained by respondents with disabilities in the surveyed households. The "Frequency" column represents the number of participants who provided each response, and the "Percent" column indicates the percentage of participants for each response out of the total surveyed (421 participants). The "Valid Percent" column shows the percentage

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excluding missing or invalid responses, and the "Cumulative Percent" column indicates the cumulative percentage up to each row.

The responses indicate various educational achievements, ranging from completing specific courses to reaching different levels of formal education, including primary (P7), O level, and A level. Additionally, some participants specified "Any other [Please specify]," suggesting that there are other diverse educational experiences or achievements not listed in the predefined response options. The table below shows reasons as to why persons with disabilities did not receive an education

Table 27: Reasons for not receiving an education by persons with disabilities

No	Reason	Freq.	Percent
1	I could not see	38	19.6%
2	I failed	25	12.9%
3	I could not hear	18	9.3%
4	The school was far	17	8.8%
5	My parents refused to take me to school	16	8.2%
6	There was no school fees	9	4.6%
7	I could not see well	8	4.1%
8	I did not have scholastic materials	7	3.6%
9	I did not have assistive devices	6	3.1%
10	I was told that I was 'stupid'	4	2.1%
11	I did not want	4	2.1%
12	I could not hear well	3	1.5%
13	The children/ learners used to belittle me	1	0.5%
14	My parents preferred taking other people who did not have disabilities	1	0.5%
15	Any other [Please specify]	37	19.1%
	Total	**194**	**100.0%**

3.7.1 Usefulness of education and requirements for studying

Respondents were asked whether they considered education useful to persons with disabilities. 83.8% (n=353) considered education to be useful to persons with disabilities while 15.4% (n=65) did not consider education to be useful to persons with disabilities. Again, respondents were asked about the requirements for persons with disabilities to attend school and training. These are presented in the table below.

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Table 28: Requirements for continuing with education

No	Requirement(s)	Freq.	Percent
1	Payment of school fees	49	29.9%
2	An assistive device	29	17.7%
3	Scholastic materials	24	14.6%
4	Hearing aids	15	9.1%
5	Sign language teachers	14	8.5%
6	Go to a boarding school	12	7.3%
7	Braille materials	11	6.7%
8	Tell the school (*teachers and learners*) not to laugh at me	4	2.4%
9	Any other [Please specify]	6	3.7%
	Total	**164**	**100.0%**

The data provided reveals the specific requirements and needs mentioned by respondents to support the education and learning of persons with disabilities. The findings underscore the importance of addressing these requirements to ensure inclusive and accessible education for respondents with disabilities.

3.8 Livelihoods employment and employability

Issues of employment and livelihoods form part of the social development agenda in Uganda. As part of its overall commitments to the UNCRPD, in particular Article 27 ("the right of persons with disabilities to work, on an equal basis with others") and the SDGs (in particular SDG 8, *"to promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all"*, Uganda has acknowledged the rights of workers with disabilities. These rights are also acknowledged in its National Employment Policy (2011) and included in the Persons with Disabilities Act 2020. While some of the interventions to tackle unemployment, such as the Youth Empowerment Programme (YEP), are ostensibly inclusive, they do have some conditionalities attached, which are discussed below. Furthermore, it is difficult to determine whether any of these income generating opportunities have improved the livelihoods or wellbeing of youths generally, and youths with disabilities specifically.

Respondents to the survey stated that only 8.8% (n=37) of the persons with disabilities in their households undertook income generating activities. A bigger proportion (91.1%) were reported not to be engaged in any income generating activity. Below is a table on the nature of income generating activities engaged in by persons with disabilities

Table 29: Nature of Income Generating Activities done by Persons with Disabilities

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No	Income Generating Activity	Freq.	Percent
1	Any Other *[Farming]*	5	13.5%
2	Weaving	4	10.8%
3	Selling of vegetables	4	10.8%
4	Raring livestock	4	10.8%
5	Petty trade	3	8.1%
6	Any Other *[Teaching]*	3	8.1%
7	Any Other *[Hair Dressing]*	2	5.4%
8	Any Other *[Retail business]*	2	5.4%
9	Any Other *[Tailoring]*	2	5.4%
10	Brick making	1	2.7%
11	Any Other *[Boda boda rider]*	1	2.7%
12	Any Other *[Charcoal]*	1	2.7%
13	Any Other *[Laundry]*	1	2.7%
14	Any Other *[Shoe making]*	1	2.7%
15	Any Other *[Chapati and eatery]*	1	2.7%
16	Any Other *[Selling Fish]*	1	2.7%
17	Any Other *[Selling Kipooli - Groundnut paste]*	1	2.7%
	Total	**37**	**100%**

The table shows that the respondents are engaged in various livelihood activities, with a significant proportion engaging in Petty Trade, Weaving, Selling of Vegetables, and Raring Livestock. Additionally, the data highlights a considerable number of respondents engaging in other unspecified livelihood activities, indicating a diverse range of economic pursuits.

3.8.1 The state of work

Participants were asked whether the person with disability in their household had ever worked. The results indicate that 7.4% (n=31) of the persons with disabilities had ever worked. However, 5.5% (n=23) were still working and; 3.3% (n=14) work on a daily. The respondents also said that only 5.2% (n=22) of the persons with disabilities in their households had work in the past twelve months. Participants were asked the reasons as to why the persons with disabilities were not currently working and below is a table of the summarized responses

Table 30: Reasons as to why persons with disabilities were not working

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No	Reason	Frequency	Percent
1	Functional limitation	229	56.3%
2	Young	65	16.0%
3	Studying	54	13.3%
4	No work	40	9.8%
5	No Skills	6	1.5%
6	Young and Functional Limitation	6	1.5%
7	Lack of capital	4	1.0%
8	Discriminated	3	0.7%
	Total	**407**	**100%**

The reasons presented above indicated that the majority of persons with disabilities were out of employment due to functional limitations associated with their impairments and disabilities. The reasons given included: not being in position to see, hear, walk or do anything on their own. The lack of work and skills also significantly contributed to a lack of work and possibly incomes on the part of persons with disabilities. The study reveals that discrimination contributed to 20% of the loss of work to persons with disabilities.

This indicates that a majority of persons with disabilities (96.7%) were not in work and this had a deleterious impact on overall incomes and the Gross Domestic Product (GDP). It increases income and care dependence whilst reducing on household savings and coupled with the high cost of care for persons with disabilities (over 39.2%), this perpetuates household poverty and precipitate of powerlessness.

3.8.2 Difficulties faced at the places of work

Participants were asked about the difficulties that the person with a disability in their household faced at their work places. Below is a table of the difficulties highlighted at the places of work.

Table 31: Difficulties encountered at the places of work by persons with disabilities

No	Common challenges	Freq.	Percent
1	No job opportunity	33	35.5%
2	Functional limitation	27	29.0%
3	Discrimination	11	11.8%
4	Lack of capital	5	5.4%
5	Abuse	4	4.3%

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6	No/ little pay	4	4.3%
7	Poor accessibility of work places	4	4.3%
8	Failure to be paid	1	1.1%
9	High cost of transport	1	1.1%
10	Isolation	1	1.1%
11	New trends and fashions eg computers	1	1.1%
12	No Trust	1	1.1%
	Total	**93**	**100%**

The summarized responses above indicated that, a lack of job opportunities or decent work topped the list of challenges. The functional limitations equally affected the work of persons with disabilities and below are some of the responses relating to functional limitation.

> *"I was told to be cleaning the health centre but then, I could not do all that work with a stick"* Respondent in Mukungwe

> *"I as weak and could not see well"* Respondent in Misaali

> *"Difficulties in finding those grass because its risky she can be raped and also looking for market its very hard"* Respondent at Bukakata

Some of the responses relating to discrimination include:

> *"The boss does not allow me to go for treatment and yet I have to get more drugs"* Respondent in Ssenyange

> *"People do not believe that even persons with disabilities can work"* Respondent in Butego

> *"New trends and fashions such as computers are sometimes a challenge"*
> *"People don't want to employ us"*
> *"People ignore us and our work"*
> *"People think that they are unable to do good things"*
> *"Poor transport means to the places of work"*
> *"They don't trust us"*
> *"They under pay us"*

The challenges presented above are both individualised and institutionalized and require advocacy and enforcement measures in order to address them for the benefit

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of persons with disabilities. For example, the discrimination and functional limitation relate to limited education and skills for employment and, a lack of adequate incomes to afford assistive technologies and auxiliary support (such as guides and sign language interpreters)

3.8.3 Incomes

The question of livelihoods is not complete without incomes. Persons with Disabilities have a right to work, earn and benefit from their incomes. Participants were asked the monthly income from activities undertaken by persons with disabilities in their households. The responses reveal that, the average incomes were 110,909.1 /- (Approx. 29.98 USD). This is presented in the table below

Table 32: Monthly incomed earned by persons with disabilities

No	Incomes (Ugx)	Frequency	Percent
1	30,000	1	4.5%
2	40,000	1	4.5%
3	50,000	6	27.3%
4	60,000	3	13.6%
5	90,000	1	4.5%
6	100,000	4	18.2%
7	150,000	2	9.1%
8	200,000	2	9.1%
9	350,000	2	9.1%
	Total	**22**	**5.2%**
	System (missing)	399	94.8%
		421	100%

From the table above, 54.6% of the persons with disabilities earned less than the average earnings. This has an implication on their welfare and living arrangements.

3.8.4 Donations and other sources of income

The study explored other sources of income and support to households with persons with disabilities. Participants were asked whether some people (including family) had given the persons with disabilities I their household any money during the last one year. In responses indicate that 7.4% (n=31) of the respondents had received income support while 91.9% (n=387) had not received any income support.

Table 33: Sources of additional incomes for persons with disabilities

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No	Source of additional incomes	Frequency	Percent
1	Family	16	47.1%
2	Friends and well-wishers	6	17.6%
3	Employer	4	11.8%
4	Charity organisation	3	8.8%
5	Parent	3	8.8%
6	Government (National Special Grant)	1	2.9%
7	Men (*Suiters*)	1	2.9%
	Total	**34**	**8.1%**
8	None (missing)	387	91.9%
	Total	421	100%

Family made the biggest contribution (47.1%) of the incomes to households with disabilities. However, the concerns are that, some of the household might have been engaging in sexually risky behavior (suiters) in order to meet the household demands.

Participants were also asked whether some people (including your family) given them goods during last year. The survey reveals that, 7.8% (n=33) had received some goods while 91.4%(n=385) had not received any goods at all. The goods in this case related to household usable items such as soap and food items. Below is a table of the sources of such items.

Table 34: Sources of household items for persons with disabilities

No	Source of additional items	Freq.	Percent
1	Family	12	36.4%
2	Parents	11	33.3%
3	Friends and well-wishers	6	18.2%
4	Charity organisation	4	12.1%
	Total	**33**	**7.9%**
5	None (missing)	385	92.1%
	Total	**418**	**100.0%**

The findings revel that family and parents were the major sources of additional items (69.7%) while friends and charities contributed (30.3%). The findings also reveled that

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the items came in on support and for those with learners, the support was always at the beginning of the school term. Below is a figure on the nature of items provided.

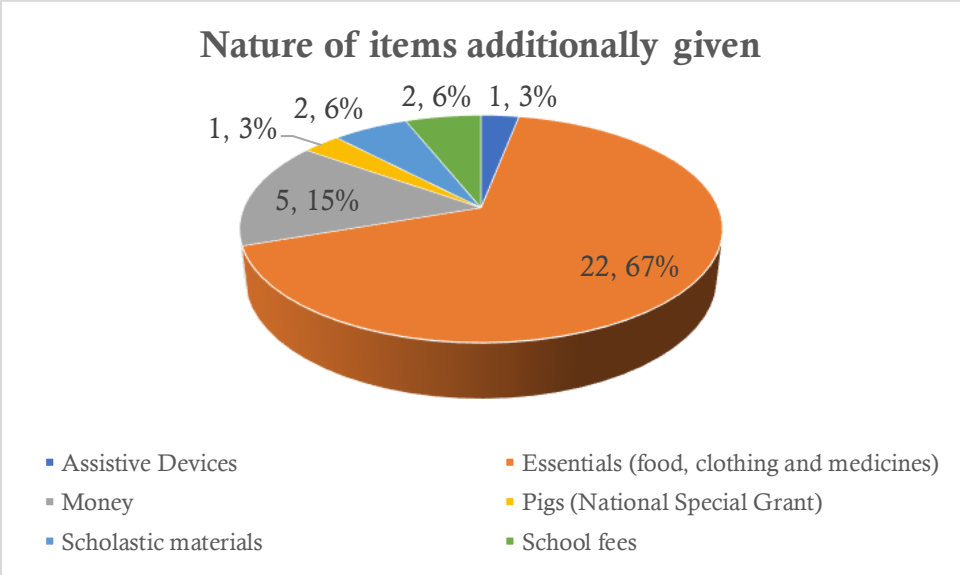


Figure 9: Nature of items given to Persons with Disabilities

The figure above indicates that the common additional items provided were mainly related to essential needs such as food, clothing and medicines (67%). The least provided were animals (such as pigs) and assistive devices. It is important that families of persons with disabilities receive some form of additional support in order to survive and thrive. In much developed economies, issuance of income security in-terms of cash transfers (Disability Benefits) is done although this is still farfetched in Uganda. This leaves the households with persons with disabilities in perpetual debt and poverty.

3.8.5 Access to Credit

The participants were asked whether they had taken any loan in the past five years. In this, 4.3% (n=18) had taken a loan while 95% (n=400) had not taken a loan in the past five years. Of these, majority (38.9%) of the participants had got the loans from Village Lending and Saving Associations (VLSAs), this was followed by SACCOs (22.2%), Friends (11.1%, Bank (11.1%), Emyoga – government facility (5.6%), a money lender (5.6%) and, a friend (5.6%).

Of the 18 respondents who had taken loans, majority (72.2% - n=13) were female while 27.8%(n=5) were male. This could possibly be linked to the care role that is attached to the females as compared to the males. Again, majority (55.6%) of those who had taken the loans had attended primary education, 16.7% had no formal education while 27.8% had crossed to lower secondary school. This could be an indication of lack of formal employment. Below is a cross tabulation of the age bracket of borrowers and their marital status.

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Table 35: Cross tabulation of age bracket and marital status of borrowers

No	Age Bracket	Marital Status of borrowers					Total	Percent
		Single	Married	Widowed	Divorced	Separated		
1	18-19			1			1	5.6%
2	20-24	2					2	11.1%
3	25-29		1				1	5.6%
4	30-34	1	1				2	11.1%
5	35-39	1	3				4	22.2%
6	40-44	3	1		1	1	6	33.3%
7	45-49							0.0%
8	50-54		1				1	5.6%
8	55-59							0.0%
9	60+			1			1	5.6%
Total		**7**	**7**	**2**	**1**	**1**	**18**	**100%**
Percent		38.9%	38.9%	11.1%	5.6%	5.6%	100%	

From the table, more single and married persons aged 20-44 years were more likely to borrow. This could be explained by the increase in the burden of care in those age brackets.

On average, the amount borrowed was 1,750,000/- (Approx. 475.0 USD) although 77.8% of the borrowers borrowed less than the average. Below is a cross tabulation of the amounts borrowed and the sources

Table 36: Cross tabulation of sources of credit and amount borrowed

No	Source	Amount borrowed				Total	Percent
		40,000 - 500,000	600,000 - 1,000,000	2,000,000	20,000,000		
1	Bank		1	1	1	3	16.7%
2	Friend	1	1			2	11.1%
3	Money lender	1				1	5.6%
4	Myoga		1			1	5.6%
5	SACCO	4				4	22.2%
	VLSA	5		2		7	38.9%

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Total	11	3	3	1	18	100%
Percent	61.1%	16.7%	16.7%	5.6%	100.0%	

The cross tabulation above indicated that those who borrowed one million shillings and less did not get the facility from a bank but mainly SACCOs and VSLA. This could possibly be because of the nearness and favorable repayment terms.

When asked about the purposes of borrowing, majority borrowed for medical treatments and surgeries (33.3%). This was followed by those who intended to boost their business (27.8%), paying school fees (16.7%), business start-up (11.1%), treating animals (5.6%) and bribing for a job (5.6%). It should be noted that, treatment and fees are recurrent costs that most households with persons with disabilities have to continually meet. A cross tabulation below shows the sources of the credit and their purpose.

Table 37: Cross tabulation of sources of credit and purpose

No	Source	Bribing for a job	Treating animals	Business Start-up	Paying fees	Boosting business	Medical treatment	Total	Percent
1	Bank			1			1	2	11.1%
2	Friend					1	2	3	16.7%
3	Money lender					1		1	5.6%
4	Myoga		1					1	5.6%
5	SACCO					2	3	5	27.8%
6	VLSA	1		1	3	1		6	33.3%
Total		1	1	2	3	5	6	18	100%
		5.6%	5.6%	11.1%	16.7%	27.8%	33.3%	100%	

The cross tabulation above indicates that the bank and VSLAs provided the biggest source of business investments – possibly through a nuanced claim on business boosting while the VLSAs cut across in all purposes of borrowing.

The survey established that 66.7% (n=12) of the borrowers had a repayment period of less than one year while 33.3% (n=6) had between one and two years to repay the loans. The capacity to repay the loans without defaulting, generating penalties and eventually losing their collaterals were not delved into but was likely. In order to understand this better, we asked the participants about the loan status – on whether it was paid or not. Below is a figure of the findings.

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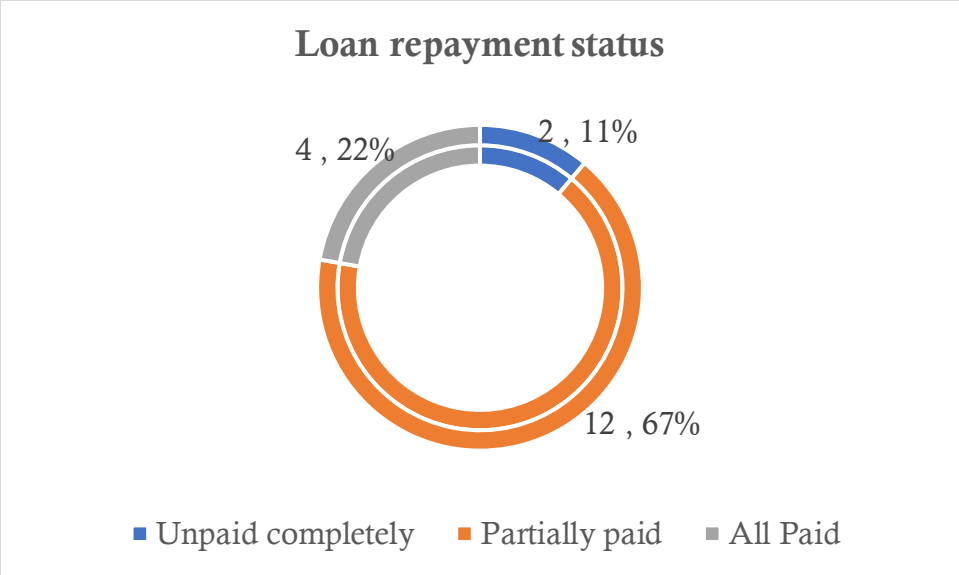


Figure 10: Loan repayment status

From the figure above, majority of the borrowers (67%) have only partially paid up, 11% have not paid up at all while, only 22% (n=4) have fully paid up. This puts the already collaterals at risk of being lost.

When asked about the purposes of borrowing, majority borrowed for medical treatments and surgeries (33.3%). This was followed by those who intended to boost their business (27.8%), paying school fees (16.7%), business start-up (11.1%), treating animals (5.6%) and bribing for a job (5.6%). It should be noted that, treatment and fees are recurrent costs that most households with persons with disabilities have to continually meet. A cross tabulation below shows the sources of the credit and their purpose.

3.9 Water, food and household assets

Food, water, housing and household assets are as imperative to households with persons with disabilities just like any other. The presence of these essential items promotes good health whilst reducing the severity of disability, burden and poverty in such households. The study established the extent to which households with persons with disabilities had these essential items.

3.9.1 Water and food

The participants were asked to state their sources of water. Majority of the households (27.3%) fetched water from a public borehole. This was followed by public tap/standpipe (23.5%), borehole in yard/plot (11.9%), piped to yard/plot (5.9%), protected public well/spring (5.7%), river/ stream (5.5%), piped water into dwelling (4.3%), unprotected public well/spring (3.8%) and, lake (3.1%). The least used sources of water were: dam (0.5%), tanker truck (1.4%) and rain water (1.7%). The sources of

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water relate to cost and safety. Whereas one has to pay for user fees when using piped water and sometimes boreholes and protected springs, they are relatively safer in offering drinking water. The lakes, rivers, ponds and, unprotected wells offer less in terms of protection. Below is a cross tabulation of water sources and setting.

Table 38: Crosstabulation of sources of drinking water and setting

No	Sources of Water	Setting			Total	Percent
		Urban	Rural	Slum		
1	Dam	1	1		2	0.5%
2	Tanker truck	2	4		6	1.4%
3	Rainwater	3	4		7	1.7%
4	Protected well/spring in yard/plot	7	2		9	2.1%
5	Unprotected well/spring in yard/plot	4	8		12	2.9%
6	Pond/lake	3	8	2	13	3.1%
7	Unprotected public well/spring	6	10		16	3.8%
8	Piped into dwelling	12	6		18	4.3%
9	Protected public well/spring	18	6		24	5.7%
10	River/stream	9	14		23	5.5%
11	Piped to yard/plot	8	17		25	5.9%
12	Borehole in yard/plot	13	37		50	11.9%
13	Public tap/standpipe	66	31	2	99	23.5%
14	Public borehole	43	70	2	115	27.3%
15	others *[Given by friends and neighbors]*		1		1	0.2%
	Total	**194**	**218**	**6**	**418**	**99.3%**
16	Missing	1	1	1	3	0.7%
	Total	**195**	**219**	**7**	**421**	**100%**
	Percent	**46.3%**	**52.0%**	**1.7%**	**100%**	

From the cross tabulation above, more households in rural areas got water from safer places than persons in urban areas. This data underscores the diversity of water sources people in the surveyed area utilize. It highlights both the availability of modern infrastructure like piped water and the reliance on traditional and communal sources like public boreholes and wells. The presence of unprotected sources also points to potential water safety concerns. The data could be used to inform policies and interventions aimed at improving water access and safety in the region.

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The respondents stated that, majority of them (52.3%) obtain their drinking water from sources located "Less than 200m (in compound)." Substantial proportion (37.5%) access water from sources "Less than 1km but outside compound." A smaller group (9.5%) relies on sources "More than 1km - far outside compound." The data emphasizes the distribution of drinking water sources based on varying distances for the given population.

The provided data outlines the sources of food for households over the past three months based on a survey.

Table 39: Sources of food in the past three months

Source of Food	Frequency	Percent
Own Garden	154	36.6
Market/buy	263	62.5
Others specify	1	0.2
Total	**418**	**99.3**
Missing	3	0.7
Total	**421**	**100**

This data offers insights into how households have been acquiring their food over the last three months, with a notable portion relying on their own gardens and a significant majority opting to purchase food from markets or stores.

Growing and consuming own food (subsistence) can be linked to ownership of land. Respondents were asked whether they had land. In this regard, 13.8% (n=58) said that they owned land while 85.5%(n=360) said that they did not own any land. Below is a comparison of land ownership by setting.

Table 40: Crosstabulation of land ownership and setting

No	Own land?	Settings			Total	Percent
		Urban	Rural	Slum		
1	Yes	28	30	0	58	13.8%
2	No	167	187	6	360	85.5%
	Total	195	217	6	418	99.3%
3	Missing	1	1	1	3	0.7%
	Total	**196**	**218**	**7**	**421**	**100%**

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Percent	**46.6%**	**51.8%**	**1.7%**	**100%**

From the cross tabulation, slightly more respondents in urban areas (14.4%) said that they had land as compared to their counterparts in rural areas (13.8%). The slum dwelling respondents said that they did not own any land at all. On average, the land owned by the 58 persons was 1.8 acres. However, the average land owned by rural persons was 1.13 acres while the urban respondents owned an average of 0.68 acres.

Table 41: Crosstabulation of land size and setting

No	Land (Quantity in Acres)	Settings		Total	Percent
		Urban	Rural		
1	0.5	3	1	4	6.9%
2	1	15	9	24	41.4%
3	1.5	0	1	1	1.7%
4	1.6	0	1	1	1.7%
5	2	7	9	16	27.6%
5	2.5	0	1	1	1.7%
6	3	3	4	7	12.1%
7	4	0	1	1	1.7%
8	5	0	2	2	3.4%
10	6	0	1	1	1.7%
Total		28	30	58	100.0%

This data provides insights into the distribution of land ownership among surveyed households. The majority of responses are missing; indicating that a large percentage of households do not cultivate land or have not disclosed the size of the land they cultivate. Among the accounted responses, there is a range of cultivated land sizes, from small plots to larger acreages. Availability of land is at the helm of prestige, food and income security especially in rural settings. Indeed, the participants were asked how much of the land was cultivatable and this reveled that 77 acres were cultivatable. This meant that on average each respondent had 1.33 acres. However, there were variations between the urban and rural land. The average cultivatable land in urban areas was 1.33 acres as compared to the rural area that had 1.47 acres.

Participants were asked how often they got enough food to eat. Below is a figure indicating the responses

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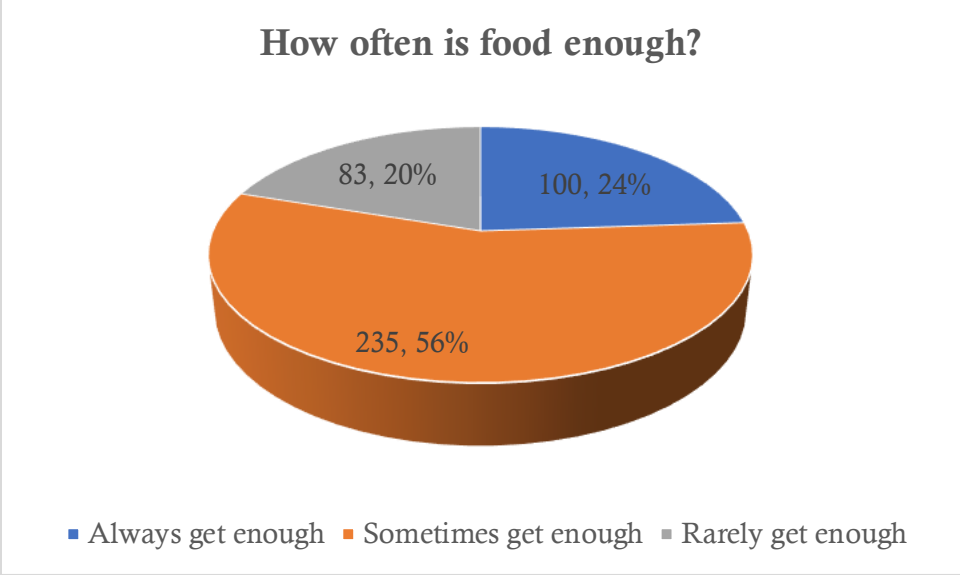


Figure 11: Food adequacy

This data sheds light on the diverse eating situations within surveyed households. While a significant number of households sometimes or always get enough food, a noteworthy portion faces challenges in accessing enough food on a regular basis.

This data offers insights into the varying levels of food availability among surveyed households. While a significant portion of households sometimes or always have enough food, there is also a notable percentage that rarely obtains enough food, highlighting potential food insecurity. It's important to address the needs of households facing food scarcity to ensure their well-being.

3.9.2 Sources of light and energy for cooking

The survey established that electricity (40.6%) was most used by respondents as a source of light. This was followed by solar energy (34.9%), kerosene (20.7%) and others (2.1%) such as torches, candles and, phone. Where as there are high costs of installation of electricity and limited electricity connectivity in rural areas, the forms such as kerosene and candle are potential risks especially where there are slum dwellers and persons with disabilities with mental and neurological impairments such as epilepsy. Below is a cross tabulation of sources of lights by setting.

Table 42: Crosstabulation of sources of light and setting

No	Sources of Light	Settings			Total	Percent
		Urban	Rural	Slum		
1	Electricity	89	81	1	171	40.6%
2	Solar	69	77	1	147	34.9%

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3	Kerosene/Paraffin	37	48	2	87	20.7%
4	Other *[Torch]*		6	1	6	1.4%
5	Other *[Candle]*		3	1	2	0.5%
6	Other *[Phone]*		2		1	0.2%
Total		**195**	**217**	**6**	**418**	**99.3%**
7	Missing	1	1	1	3	0.7%
Total		**196**	**218**	**7**	**421**	**100%**
Percent		**46.6%**	**51.8%**	**1.7%**	**100%**	

The crosstabulation above indicates that there was more use of electricity in urban areas as compared to rural areas although the use of solar energy for lighting was higher in rural areas.

The respondents were asked about the sources of energy for cooking. 64.4% (n=271) relied on wood, 31.1%(n=131) used charcoal, 2.1%(n=9) used electricity, 0.7%(n=2) used kerosene, 0.5%(n=2) used biogas and, 0.2%(n=1) used gas. Below is a cross tabulation of the sources of energy used for cooking and setting of respondents.

Table 43: Crosstabulation of sources of energy for cooking and setting

No	**Sources of Energy for cooking**	**Settings**			**Total**	**Percent**
		Urban	Rural	Slum		
1	Wood	103	164	4	271	64.4%
2	Charcoal	85	44	2	131	31.1%
3	Electricity	3	6	0	9	2.1%
4	Kerosene	3	0	0	3	0.7%
5	Biogas	0	2	0	2	0.5%
6	Gas	1	0	0	1	0.2%
7	No food Cooked in home	0	1	0	1	0.2%
	Total	**195**	**217**	**6**	**418**	**99.3%**
8	Missing	1	1	1	3	0.7%
	Total	**196**	**218**	**7**	**421**	**100%**
	Percent	**46.6%**	**51.8%**	**1.7%**	**100%**	

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The cross tabulation above indicates that, there was much use of firewood in the rural areas as compared to urban places although charcoal was much used in the urban areas. This can be explained by the existence of forests and woodlands in rural areas as compared to urban places. The dominance of traditional cooking fuels like wood and charcoal, suggesting that a majority of households in the survey rely on biomass for cooking. Modern fuels like electricity, gas, and biogas are used by a smaller proportion of households. The usage of kerosene and the absence of food cooked at home are relatively limited.

3.9.3 Toileting facilities and housing

Toileting is an activity of daily living that persons with disabilities are encouraged to undertake independently. The presence of better toileting and housing facilities contributes to hygiene and ultimately a reduced burden of health care on the part of the households.

Participants were asked the kind of toilet facility that the household had. Majority of the respondents (33.7%) used covered Pit latrine, with slab. This was followed by: VIP latrines (19.2%), uncovered pit latrine with no slab (16.2%), covered pit latrine with no slab (15.9%), uncovered pit latrine with slab (5.5%), latrine (4.5%) and, the bush (3.1%). The least used were: flush toilets (0.2%), none (0.5%) and, composting toilet (0.5%). Below is a cross tabulation of distribution of toileting facility and setting.

Table 44: Crosstabulation of toileting facility and setting

No	Toileting facility	Settings			Total	Percent
		Urban	Rural	Slum		
1	Covered Pit latrine, with slab	53	88	1	142	33.7%
2	VIP latrine	42	39	0	81	19.2%
3	Uncovered Pit latrine, no slab	46	21	1	68	16.2%
4	Covered Pit latrine, no slab	30	37	0	67	15.9%
5	Uncovered Pit latrine, with slab	18	5	0	23	5.5%
6	Other *[Public latrine]*		17	2	19	4.5%
7	Bush	5	6	2	13	3.1%
8	Composting toilet	1	1	0	2	0.5%
9	Other *[None]*		2		2	0.5%
10	Flush toilet	0	1	0	1	0.2%
	Total	**195**	**217**	**6**	**418**	**99.3%**
11	Missing	1	1	1	3	0.7%
	Total	**196**	**218**	**7**	**421**	**100%**

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Percent	**46.6%**	**51.8%**	**1.7%**	**100%**	

The cross tabulation indicates that there were better and safe toileting facilities in rural areas that slum areas. This data underscores the varied sanitation practices within the surveyed area, with a mixture of traditional and more advanced options. While the prevalence of covered pit latrines with slabs indicates progress in sanitation, there is still work to be done to improve access to modern facilities and promote better hygiene practices.

On average, every household had three rooms. The data equally indicated that: a minimal 0.2% of households have no rooms; the most common configuration is households with 1 room, accounting for 13.5%; households with 2 rooms constitute a notable portion at 25.9%. Similarly, those with 3 rooms also represent a significant proportion, making up 30.4%; households with 4 rooms account for 13.8%, followed by 5-room households at 7.4%. The distribution becomes more varied in larger households with 6 rooms (6.4%), 8 rooms (1%), 9 rooms (0.2%), 10 rooms (0.2%), and 12 rooms (0.2%). Below is a cross tabulation of number of rooms in the household and setting

Table 45: Crosstabulation of number of rooms in household and setting

No	# of rooms in HH	Settings			Total	Percent
		Urban	Rural	Slum		
1	0	0	1	0	1	0.2%
2	1	15	38	4	57	13.5%
3	2	60	48	1	109	25.9%
4	3	60	67	1	128	30.4%
5	4	30	28	0	58	13.8%
6	5	16	15	0	31	7.4%
7	6	8	19	0	27	6.4%
8	8	4	0	0	4	1.0%
9	9	1	0	0	1	0.2%
10	10	1	0	0	1	0.2%
11	12	0	1	0	1	0.2%
	Total	195	217	6	418	99.3%
12	Missing	1	1	1	3	0.7%
	Total	**196**	**218**	**7**	**421**	**100%**

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Percent	**46.6%**	**51.8%**	**1.7%**	**100%**

Where as the average number of rooms per household was 3, rural areas were likely to have more rooms than urban areas. The slums were the worst affected when it came to rooms for accommodation. This data paints a picture of the housing landscape, indicating a range of living conditions from smaller households with just one or two rooms to larger households with multiple rooms. The prevalence of households with 2 and 3 rooms underscores the middle ground, while variations in the distribution of larger households suggest diversity in housing arrangements.

Rooms for accommodation are imperative in ensuring hygiene, separation of houses for choices and specific roles such as cooking and raring animals respectively and, isolations in case of a contagious infection in the household.

3.10 Other social, political and cultural services

Cultural norms/beliefs that may affect adequate communication on issues related to having persons with disabilities in the household:

Believing in witchcraft and curses: Some respondents may attribute disabilities to witchcraft or curses, leading to fear, stigmatization, and reluctance to openly discuss the issue.

Empewo (Traditional beliefs): Traditional beliefs and practices may influence perceptions of disabilities, affecting open communication about persons with disabilities.

Family problems and spiritual beliefs: Some families may believe that disabilities are a result of family issues or punishment by ancestors, leading to hesitation in discussing the topic openly.

Twins, witchcraft, and Empewo: In some cultures, disabilities in twins may be associated with witchcraft or traditional beliefs, creating challenges in communication and understanding.

These cultural norms and beliefs can have a significant impact on how persons with disabilities are perceived and treated within the household and community, highlighting the importance of promoting awareness, education, and inclusive dialogue to break down barriers and foster understanding and support

Table 46: What is done when respondents give birth to Children with disabilities

No	Response	Freq.	Percent

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1	Take to health facility	245	34.7%
2	Hide in their homes	219	31.0%
3	Take for Prayers	109	15.4%
4	Inform community	60	8.5%
5	Inform friends and relatives	30	4.2%
6	Report to social workers	24	3.4%
7	Others specify	19	2.7%
	Total	**706**	**100%**

Table 46 shows the responses of what people do when they give birth to children with disabilities. The total number of responses exceeds the number of cases (706) because respondents were allowed to select multiple options.

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Table 47: What showed that the respondent has a disability

Responses	Responses	Percent
Cannot talk	140	23.70%
Cannot see	88	14.90%
Could not walk	168	28.50%
Avoiding normal social situations and gathering	26	4.40%
Difficulty focusing and remembering	64	10.80%
Behaving in an inappropriate way	30	5.10%
Hyper activity-attention deficit	11	1.90%
could not use any of his/her limbs	16	2.70%
Other specify	47	8.00%
Total	**590**	**100.00%**

These indicators mentioned in the table are essential for identifying children with disabilities and providing appropriate support and interventions. It's common for children with disabilities to exhibit a combination of these signs, and understanding them helps in early detection and ensuring that the necessary assistance and services are provided to support their development and well-being. Early identification and intervention can have a significant impact on improving the quality of life and outcomes for children with disabilities.

Table 48: What the respondents do when they identify that the child has a disability?

	Freq.	Percent
Informed the parent	79	17.60%
Took to health care for proper diagnosis	87	19.30%
Reported to the community development officer	6	1.30%
Visited the social worker in our community	16	3.60%
Took to hospital for care	183	40.70%
Nothing	46	10.20%
Took to NGO/DPO concerned with such children	16	3.60%
Went to the witch doctor	2	0.40%
Went to church	6	1.30%
Other specify	9	2.00%

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Total	**450**	**100.00%**

It's crucial to ensure that when a child with a disability is identified, appropriate and evidence-based steps are taken to provide them with the necessary support, care, and services to improve their well-being and quality of life. Seeking medical evaluation and care from healthcare professionals is essential for proper diagnosis and intervention planning. Additionally, engaging with community resources and organizations that specialize in supporting children with disabilities can be beneficial in providing comprehensive support.

3.10.1 Common abuses

These are the common kinds of manipulations PERSONS WITH DISABILITIES face:

Discrimination: Persons with disabilities often face discrimination in various aspects of life, such as education, employment, healthcare, and social interactions.

Physical Abuse: Some respondents with disabilities may experience physical violence or abuse from family members, caregivers, or others.

Emotional and Verbal Abuse: Verbal insults, belittling, and emotional abuse can be directed towards persons with disabilities, impacting their mental and emotional well-being.

Neglect: Some respondents with disabilities may experience neglect, where their basic needs for care, support, and attention are not adequately met.

Financial Exploitation: Persons with disabilities may be vulnerable to financial exploitation, where others take advantage of their disability to manipulate or misuse their finances.

Institutional Abuse: Abuse can occur in institutions such as residential care facilities or group homes, where the rights and well-being of persons with disabilities are not adequately protected.

Bullying: Children and adults with disabilities can be targets of bullying, leading to social isolation and psychological distress.

Harassment: Persons with disabilities may face harassment and ridicule in public spaces or online platforms due to their disability.

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Denial of Rights: Persons with disabilities may have their rights denied or restricted, including the right to education, healthcare, and participation in decision-making processes.

Lack of Accessibility: Inaccessible environments, transportation, and services can be a form of abuse, as they prevent persons with disabilities from fully participating in society.

Forced Sterilization or Medical Procedures: Some respondents with disabilities may face forced sterilization or medical procedures without their consent, violating their bodily autonomy.

Isolation and Segregation: Persons with disabilities may be isolated or segregated from the rest of society, preventing them from fully engaging in community life.

3.10.2 Common challenges faced

Persons with disabilities in Masaka still face several challenges which have remained unattended for quite sometimes with no proper mechanism to curb them. These challenges include lack of universal access in the structural buildings, persons with disabilities living under extreme poverty, the high unemployment rate among persons with disabilities and poor provisions of education and health services. Worse enough, universal access that calls for the enabling facilitating movement to persons with disabilities in the country is still a problem.

The prevailing challenges faced by households with persons with disabilities (Persons with disabilities) are:

A Lot of Time to Care: Providing care and support for Persons with disabilities can be time-consuming, leading to potential challenges in balancing household responsibilities and other activities.

Augmented Household Expenditures: Households with Persons with disabilities may experience increased expenses related to medical care, assistive devices, and other disability-specific needs.

The survey indicates that there is gender imbalance of employment opportunities to Persons with disabilities as men with disabilities are more employed than that of their counterparts and that the working environment are not dependent and always wait to be helped. Lack of physical power, Persons with disabilities also lack physical energy to fight sex aggressors.

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Maintaining Sanitation of Persons with disabilities: Ensuring proper sanitation and hygiene for Persons with disabilities can be challenging, especially if their disability requires special facilities or accommodations.

Community Attitudes: Negative attitudes and misconceptions about disability in the community can lead to social stigmatization and limited opportunities for Persons with disabilities and their households.

Limited access to information, they are marginalized groups who are not easily reached by health information sites, for example many persons with disabilities to have the opportunity to access where HIV/AIDs discussion, blood screening and sensitization take place They deliberately have unprotected sex with them.

Wrong beliefs that women with disabilities are not HIV/AIDS infected. Some men tend to assume that women with disabilities are less likely to have HIV and so involve in sexual relations.

Current Livelihood Activities: The existing livelihood activities in the household may not be suitable for accommodating the needs and abilities of Persons with disabilities, affecting their economic participation.

Livelihood Support Required: Additional support, such as training, resources, or assistive technology, may be needed to enable Persons with disabilities to engage in income-generating activities.

Capacity of Persons with disabilities to Engage in Enterprise Development/Projects: Persons with disabilities may face challenges in accessing training and opportunities for enterprise development and projects.

Required Support to Make Animals More Profitable: If households engage in livestock farming, support may be needed to make the livestock enterprise more profitable and sustainable.

Required Support for Crop Production: For households involved in crop production, support may be needed to improve agricultural practices and increase productivity. Enablers for Persons with disabilities Participation in Community Developments: Identifying and implementing factors that enable Persons with disabilities' active involvement in community development initiatives is essential.

Barriers for Persons with disabilities Participation in Community Developments: Identifying and addressing barriers that hinder Persons with disabilities' participation in community development initiatives is crucial.

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Supply of Food Rations: Some households may require food rations or assistance due to the additional needs of Persons with disabilities.

Sanitation and Hygiene Requirements: Ensuring adequate sanitation and hygiene facilities that are accessible to Persons with disabilities is essential for their well-being.

Most Needed Sanitation and Hygiene Facilities: Identifying the specific sanitation and hygiene facilities that are most needed for Persons with disabilities can help in designing appropriate interventions.

Addressing these challenges and providing appropriate support and accommodations can contribute to improving the well-being and inclusivity of households with Persons with disabilities.

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SECTION FOUR: CONCLUSIONS AND RECOMMENDATIONS

4.1 Introduction

The section provides conclusions based on the study objectives whilst providing recommendations for actions to be undertaken by FOHO Uganda in as far as reaching persons with disabilities is concerned. From the data analysis, it is evident that caregivers, community members and leaders need more knowledge on disability. Most people associate disability to the visible impairments on an individual. A third of the respondents believed that disability is as a result of the curse or bad deeds of the parents especially where a family had more than one child with a disability. It was also noted that almost half (45.3%) of the respondents believed that Persons with disabilities in the community were not appropriately identified and assessed for interventions. The information from participatory sessions with children indicated that Persons with disabilities are subjects of jokes, negative comments and bullying. This is experienced at both family and community levels which affects their effective participation in family and community events and access to social services like health and education.

4.2 Conclusions

4.2.1 Prevalence and impact of disabilities on families and communities

In Masaka district, 9.8% (n=26,264) of the population aged 2 years and above have a disability. The district prevalence of disability stands as 14.4% overall. Those with seeing difficulties are the majority (33%) and followed by: walking (27%), remembering (25%) and hearing (15%). Disability presents and/or results in a plethora of dismal conditions that require individualized and collective agenda of support. Although, there are quite a number of initiatives implemented by NGOs/DPOs to improve the above situation, the reach is always so limited that a bigger section of Persons with Disabilities still remains left out. A number of international treaties (including the UNCRPD) front holistic inclusion of Persons with Disabilities at all levels by all actors as the most viable approach of addressing the diverse aspirations and needs of Persons with Disabilities.

The presentation and conception of disability with negative sentiments and connotations leads to stigma, limited support and interventions for persons with disabilities and, discrimination among others. A lack of suitable transport and assistive devices exacerbates this. Such obstacles have an impact on many areas of life, including access to employment, education, health care, protection, food, water and social participation.

The prevalence of the conditions above relate to long seated psycho-social conditions as a result of the conditions associated with primary impairments such as discrimination, failure to access given goods and services and, stigmatization. Similarly, the respondents stated that the persons with disabilities had experienced the following conditions in the past six months.

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4.2.2 Barriers and challenges in accessing social services

On access to health care services, long distances, inadequate health care services (e.g. physiotherapy, orthopaedic workshop and essential medicines) in most health centres coupled with low incomes of the caregivers affect timely access to health care services by persons with Disabilities. In terms of access to education services, the survey noted a number of barriers including inaccessible physical environment; lack of scholastic and learning materials; reference books and teaching aids and SNE teachers.

4.2.3 Implementation of the legal and policy framework on disability in Masaka

There exists a rich policy and legal framework in Uganda and this applies to Masaka as well. However, there are no localised/ bye-laws that relate to disability in the district. The localised laws could be associated with prevention, management and inclusion of persons with disabilities. The Persons with Disabilities Act 2020 and the Revised National Policy on Disability in Uganda 2023 are the latest legal and policy documents respectively that address concerns around rights, administration of justice relating to disability, discrimination and a standard of services to be provided to persons with disabilities. These however are not known at all and yet they are rich in policy and legislative guidance. In this regard, their implementation remains blurred in ignorance and unawareness.

The inability to define disability, separate impairment from disability and illness/ sickness by implementers perpetuates disability-based discrimination, makes it difficult for specific interventions to be identified and addressed and equally limits the service providers in as far as addressing such challenges at lower local governments (sub county and below). Indeed, one of the CRPS recommendations on Uganda's maiden report recommends the harmonisation of the definition of disability to include functional imitation and environmental barriers. The denotation of disability by visibility, inability and failure affects the quality and quantity of services that persons with disabilities receive.

Standards of accessibility, service delivery, special services for persons with disabilities – such as the National Special Grant (NSG) as well as government's policy on Inclusive Education are still far fetched amidst a growing number of persons with disabilities requiring these interventions in Masaka. The social service points, caretakers and persons with disabilities are not in the know of such standards and legislations which often jeopardises their efforts to access and utilise endowed goods, services and facilities. The standards should not just be known but also be seen in action or being done often. Similarly, the blanketing of persons with disabilities in 'other special interest groups' amidst separate governing laws and policies makes their recognition in policy, laws, practices and programmes impossible.

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4.2.4 Existing interventions and opportunities for persons with disabilities

Masaka also has a number of Special Schools which could integrate the training of vocational skills since evidence shows that 24.1% of persons with disabilities in Masaka complete Primary education.

The health services undertake outreach services however, these do not have targeted reach to persons with disabilities in the communities. This limits their reach as well as benefit from such interventions.

4.2.5 Opportunities for strengthening the support systems and services

Besides the affirmative action provided by government in terms of education, health and information and communication technologies, Masaka boosts of a Vocational Rehabilitation Centre (VRC) that trains specifically persons with disabilities in vocational skills such as tailoring, shoe making and carpentry. The question is the penetrative ability of such vocations in the labour market and, whether the commerce of these vocations is emphasised in the trainings. Similarly, there appears to be little relevance of some of the trades in the current market spaces and therefore may require modification and or improvement in the curricular in order to produce market competitive persons with disabilities.

The existence of traditional religious organisations – with a particular predominance of the catholic church in Masaka could be a force to recon with. The churches – could be pivotal in the establishment of learning and training centres, treatment, care and rehabilitation centres as well as other community outreach services that the government may not be in position to provide at the time. However, the onset of delivery of such services may take longer and hence affecting persons with disabilities the more and yet could benefit from them earlier than later.

Masaka boosts of a strong media presence with radios, television stations and other social media influencers who could be pivotal in addressing the disability awareness concerns, attitudes and responses relating to abuses meted on persons with disabilities in the communities and;

Masaka equally has numerous graduates in rehabilitation professions who may not be currently employed. These include graduates of Community Based Rehabilitation (CBR), physiotherapy and occupational therapy, orthopaedics, clinical medicine, mobility and orientation as we all audiology and sign languages among others. Their skills, expertise and experience could be tapped in by the district authorities as well as FOHO in order to deliver sets of required interventions to persons with disabilities.

The FOHO situational analysis on disability marks a significant step towards fostering a more inclusive and equitable society. By translating insights into action and working collaboratively with stakeholders, FOHO is well-positioned to create lasting positive

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change, ensuring that individuals with disabilities not only gain access to opportunities but also become empowered agents of change within their communities.

4.3 Recommendations

The insights gained from this situational analysis will serve as a blueprint for action. By capitalizing on the identified opportunities, addressing the highlighted challenges, and building on the organization's existing strengths, FOHO can pave the way for transformational change in the lives of individuals with disabilities. Below are the recommendations from the study

4.3.1 General recommendations

The respondents expressed the need for various services and support to promote the well-being and inclusion of persons with disabilities. The key themes and recommendations can be summarized as follows:

1. **Free Education Services:** The respondents emphasized the importance of providing free education services for Persons with disabilities to ensure their access to quality education. This should come from pre-school up-to tertiary levels and in order to do this well, a sponsorship programme that targets persons with disabilities can be started;

2. **Access to Health Services:** Ensuring Persons with disabilities have access to free medical services, assistive devices, and specialized health centres to cater to their specific needs. This can be achieved by working with organisations and associations of persons with disabilities, councils for persons with disabilities, the health unit management committees as well as strengthening the association of rehabilitation professionals;

3. **Income Generating Activities and vocational rehabilitation:** Supporting Persons with disabilities with income-generating activities and vocational training to enhance their economic independence. The IGAs as well as trainings should be market focused and led other than focusing on the traditional vocations that are becoming obsolete. Persons with disabilities should be trained in vocations that promote value addition in agriculture, manufacturing and, tourism among others.

4. **Awareness and Sensitization:** Creating awareness in communities and schools to promote inclusivity and change negative attitudes towards Persons with disabilities.

5. **Infrastructure and Accessibility**: Improving infrastructure, such as building more special schools and providing wheelchair accessibility, to enhance the participation of Persons with disabilities in society. This can be done by adhering to the accessibility standards of government in physical environment as well as implementing the existent legislative regime;

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6. **Psychosocial Support:** Providing psychosocial support and counselling to both Persons with disabilities and their families to address their emotional and mental well-being. The formation, working through and supporting Parents Support Groups (PSGs) can particularly improve the wellbeing of persons with severe impairments and disabilities;

7. **Advocacy and awareness creation on disability:** Advocating for the rights of Persons with disabilities and ensuring their inclusion in government programmes and policies. The use of free airtime on radios provided for government can be requested for and used to raise awareness on disability laws, policies, programmes, guidelines, prevention and management interventions as well as any other emerging issues around disability in the district. This will go a long way to address disability-based discrimination;

8. **Collaboration and Follow-ups:** Working with local authorities and conducting regular follow-ups to ensure sustained support and improvement of services for Persons with disabilities.

Overall, the respondents highlighted the need for a comprehensive approach that encompasses education, health, economic opportunities, and social inclusion to empower Persons with disabilities and improve their overall quality of life.

4.3.2 Implementational interventions for FOHO

By implementing these recommendations, FOHO Uganda can enhance its efforts in promoting inclusivity and improving the lives of persons with disabilities in the communities it serves. This can be done by direct implementation of interventions that government is not taking on; regular and joint monitoring of activities and interventions in order to track the progress of initiatives, assess their effectiveness, and adapt strategies as circumstances evolve. Based on the responses provided, the following are some recommendations for FOHO Uganda to include persons with disabilities in their programming:

4.3.3 Prevalence and impact of disabilities on families and communities

Improve interventions towards disability prevention and management through strengthening immunisation and vaccination interventions, accident prevention and, pre-conception screening. This can be done in collaboration with health institutions, rehabilitation professionals and government agencies working in the field of health. FOHO Uganda can take on a pivotal role in mobilising communities for such programmes, working with Village Health Teams (VHTs) as well as starting communications and meetings for rehabilitation professionals to discuss their work and individuals who need targeted interventions from them.

FOHO Uganda can advocate for the rights of persons with disabilities and promote their inclusion in various aspects of community development, education, and

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employment. This will surely relieve families from the bigger burden of care and support to persons with disabilities. This however requires concerted efforts of other partners and government.

4.3.4 Barriers and challenges in accessing social services

Providing transportation support: Given that persons with disabilities may face challenges with mobility, FOHO could consider providing transportation support for medical check-ups and other essential services.

Offering assistive devices and medical support: FOHO can facilitate access to assistive devices such as hearing aids, walking frames, and wheelchairs, as well as provide medical support and treatment for persons with disabilities.

Raising awareness and sensitization: FOHO could conduct awareness campaigns and sensitization programs in communities to challenge negative attitudes and stereotypes towards persons with disabilities.

Provision of basic necessities: FOHO can also consider providing support for basic necessities such as food, clothing, and bedding to families of persons with disabilities.

Provision of educational support: FOHO could support persons with disabilities in accessing education by providing school fees, scholastic materials, and educational subsidies. In addition, sponsorship programmes that target persons with disabilities can be undertaken.

4.3.5 Implementation of the legal and policy framework on disability in Masaka

The existence of the law is and its numerous regulations that seek to ensure Persons with disabilities are always given due recognition and equal right in accessing public facilities, but the most important thing is how the society perceives them and responds to their needs. This is about setting in process a turn-around in mindsets, so that the persons with disabilities do not feel left out or held down by their disabilities. The most important is that, the government should go beyond enactment of legislations on employment of Persons with disabilities through intensifying awareness raising efforts towards disability policies and legislations to public and private sector's employers as an attempt to encourage them employ persons with disabilities.

Persons with disabilities should be encouraged to apply for formal employment opportunities and that there should gender equality. All working barriers such as lack of lifts and ramps in office buildings, equipment's, and reliable transport to and from the office should be removed and companies should be sensitized to have disability policies and legislations in workplaces that oversee the employment of Persons with disabilities and penalties for those who do not comply with them must be formed.

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Media should be in a frontline on this. The society too should realize that Persons with disabilities are part of the society; they also can contribute the same or even more in the society development if given opportunity to education and empowered to work.

Sensitisation on legal and policy framework on disability: FOHO Uganda working with the Ministry of Gender, Labour and Social Development (MGLSD), the city and district authorities can undertake sensitisation on the legal and policy frameworks targeting implementers, government workers and, communities. This can be done through workshops and actions that address the specific needs of persons with disabilities. In these trainings, FOHO may produce posters to be placed on service points as well as distribute copies of the policies and laws to the implementers, government officials, teachers and health workers among others;

Collaboration with local authorities and institutions: FOHO Uganda could work closely with local authorities and institutions to ensure that persons with disabilities are included in various development projects and programmes. This can be particularly done in collaboration with the Councils for Persons with Disabilities whose mandate is clearly stated in Part V of the Persons with Disabilities Act 2020.

Publish and distribute key documents: FOHO Uganda may publish and distribute key legal, policy and guiding documents to government officials and other implementers. Key among these is: the Persons with Disabilities Act 2020, the Revised National Policy on Disability in Uganda 2023; the Building Control Act 203; the Building Control Regulations 2019 and, the Accessibility standards among others.

4.3.6 Strengthening existent interventions for persons with disabilities

Regular follow-ups and updates: FOHO should maintain regular follow-ups and updates on the progress of their programmes and initiatives, ensuring continuous support for persons with disabilities. This can be done by working with and placing learners with disabilities in the special schools, the Masaka Vocational Rehabilitation Centre and, supporting education and health sponsorship programmes among others.

4.3.7 Opportunities for strengthening support systems and services

Income Generation: FOHO Uganda could promote the establishment of businesses that are inclusive and accessible for persons with disabilities, providing them with opportunities for income generation and economic empowerment.

Provide marketable trainings: FOHO Uganda can work with Masaka VRC to identify marketable vocations and then work towards training persons with disabilities in such trades prior placing them for apprenticeship and providing a settlement package;

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Media engagements: Work with the existing media houses such as radios, television stations and social media influencers in order to raise disability awareness, improve attitudes and responses relating to abuses meted on persons with disabilities in the communities and;

Organise rehabilitation professionals into an association and facilitate their meetings and activities: Their skills, expertise and experience could be tapped in by the district authorities as well as FOHO in order to deliver sets of required interventions to persons with disabilities.

4.3.8 Recommendations for further research

Further research can be undertaken on: the cost of disabilities, drivers of abuse for persons with disabilities and barriers and enablers of success in employment and trade as well as education for persons with disabilities.

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Annex 1: Detailed samples per parish

Sub County/City Division	Parish	# of villages	Seeing	Hearing	Remembering	Walking	Self-care	Communication	Total
Bukakata	Bukibonga	12	10	4	8	8	1	1	32
	Sunga	8	7	3	5	5	1	0	21
	Makonzi	5	4	2	3	4	0	0	13
Nnyendo – Mukungwe	Katwe	11	9	3	7	8	1	1	29
	Butego	8	6	3	5	6	1	0	21
	Nyendo	15	13	5	10	10	1	1	40
	Ssenyange	5	4	2	3	3	1	0	13
	Bugabira	8	7	3	5	5	1	0	21
	Kalagala	13	11	5	7	9	1	1	34
	Bulayi	8	6	3	5	5	1	1	21
	Samalia	10	8	4	6	7	1	0	26
	Katwade	7	6	3	4	5	1	0	19
	Matanga	8	7	3	5	6	0	0	21
	Bulando	6	5	2	4	4	1	0	16
	Kitengesa	8	6	3	5	5	1	1	21
	Kasanje	6	5	2	4	4	0	1	16
	Kibisi	7	6	2	4	5	1	0	18
TOTAL		**145**	**120**	**52**	**90**	**99.0**	**14**	**7**	**382**

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