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# Health Report

## Namwendwa Parish

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## ABBREVIATIONS

**ARV** Antiretroviral

**CHAI** Community HIV AIDS Initiative

**HIV** Human immunodeficiency virus

**NGO** Non-Government Organisation

**TASO** The AIDS support Organisation

**ACT** Artemisinin-based combination therapy

**IPT** Intermittent preventative treatment

**IRS** Indoor residential spraying

**ITN** Insecticide-treated nets

**LLIN** Long lasting insecticidal net

**WHO** The World Health Organisation



## INTRODUCTION

### *The purpose of health research in Namwendwa*

At the beginning of 2009, I travelled to a rural village in Uganda called Namwendwa. While I was there I was interested to see what the most common health problems were and how accessible health care was. In order to do this I volunteered at The Namwendwa Health Clinic for two-weeks and conducted community surveys about general health access, HIV and malaria. The first thing I noticed about the clinic was the dispirited nursing staff, who did not seem to care about the line of approximately fifty sick women, children and men who were waiting for treatment. This shocked me because I imagined health clinics in all parts of the world to be driven by people who were passionate about the wellbeing of others. However, after spending more time at the clinic I realised that the staff were not heartless, but rather disheartened by their inability to make changes to improve their delivery of care. Due to constant shortages of essential medicines, the nurses who run the clinic have the job of continually turning away people whose lives depend on the medications that are supposed to be available for them at the clinic.

One of the most confronting experiences I had occurred when I visited a house of a woman who had HIV. I walked into the dark smoky house unaware that there was a lady in her thirties curled up on a blanket on the floor. She could barely move, but used all of her energy to sit up and shake my hand. As I got closer I could smell that she had soiled her blankets, but this did not seem to bother her or anybody else. I was later to discover that this woman came from a poor family. They could not afford to buy her every meal, so she ate a small serve of sweet potato or maize flour once a day. She was too weak to travel, so she could not go to a neighbouring town to access medication, because it



was out of stock at the Namwendwa Health Clinic. I realised that this frail woman without a voice was destined to slowly die, just because she could not access medication that every human being has the right to.

The following report was created to keep a record of current issues relating to health in Namwendwa. The first part evaluates the health clinic the second focuses on people living with HIV/AIDS and the services that are available for them, the third looks at the prevalence and treatment provided for people with malaria and the final part evaluates the community's attitude to people who have a disability.

## **EVALUATION AND REPORT ON NAMWENDWA HEALTH CLINIC**

### **1.1. Overview of the Namwendwa Health Clinic**

The Namwendwa Health Clinic has an outpatient clinic that is open Monday to Friday from 9 to 3. This clinic has two medical officers, two enrolled nurses, one registered nurse and two laboratory technicians. The registered nurse and medical officer assess and diagnose patients, the enrolled nurses dispense medications and the laboratory technicians perform serology testing on patients who require them. Nursing staff also have the responsibility of opening the clinic, weighing, treating and educating every patient about their illness.

For patients who are acutely ill and require intravenous medication there is an inpatient ward that has six female and six male beds. Directly across from the health clinic is a maternity hospital that is staffed with one registered midwife.

The Ugandan government provides all health services for free at government hospitals and health clinics.



## 1.2. Population of responsibility

The Namwendwa Health Clinic serves a population of 30 320 people, and is responsible for providing services for the following parishes<sup>1</sup>; Namwendwa, Kidiki, Bulogo, Isingo, Kyeya and Bugondha.

## 1.3. Health access for the community

Forty-people from Namwendwa Parish<sup>2</sup> were randomly selected from different areas and asked to give their view of the Namwendwa Health Clinic and health access. Below are the most common views about health access at Health Clinic.

Seventy-one percent of people surveyed believed that health services were not easily accessible. Forty-eight percent of these people felt this way as a result of the long waiting time. Many of the respondents commented on the 'lazy' attitude that the nursing staff have because they are always late to work and seem like they do not care about the patients. Most people who need to be seen by a nurse or medical officer must wait up to five hours; this is a major reason why many people are reluctant to utilise the government health services. A small percentage of people (13%) considered distance as being the main issue; majority of the people who were surveyed do not own a motor vehicle or motor-bike, so they must walk or ride their bicycle to the clinic.

When asked about the availability of medication at The Health Clinic 53% of the respondents said that many different medications are often

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<sup>2</sup>a parish is what people call their local town within a sub-county. One Village works in Namwendwa Parish



out of stock. A lack of medication means that patients wait to be assessed and then go home with no treatment for their illness. As mentioned earlier, government Health Clinics supply medication to all Ugandans for free. However, the reality is that the majority of the time health clinics are not supplied with the medication that they order from higher up in the government. This shortage of medication creates major issues for people who cannot afford transport to Kamuli (the closest town with health services).

## Conclusion

Overall the community did not have a positive view of The Namwendwa Health Clinic. The poor attitude that many people observed from the nursing staff became a major reason why many people avoid going to the clinic. To make matters worse the shortage of staff at the clinic means that health professionals do not have the time to provide education for their patients, and the services that are provided are delivered very slowly.

## 2. HIV/AIDS in Namwendwa

### Introduction:

When the founder of One Village (Nikki Lovell) visited Namwendwa in 2005, she was horrified to hear the type of stigma surrounding people who were living with HIV. An example of this stigma is the belief that people with HIV are possessed by the devil. In an attempt to eradicate such thoughts, Nikki and the Ugandan committee held a HIV/AIDS Awareness Day that was open to everybody in the community. This day offered HIV screening, counselling, and organised people living with AIDS to speak publicly about their journey.



One Village hosted a similar HIV/AIDS awareness day in Namwendwa in 2007.

The following survey was conducted in January 2009 to find out how commonly people in Namwendwa are affected by HIV/AIDS, the greatest challenges they face within the community and the services that they have available to them.

## **2.1 survey results**

### **2.1.1 Does anybody in your family live positively with HIV?**

22.5% of the people surveyed either have or have had somebody in their family with AIDS. ( *refer to appendix 1* )

### **2.1.2 What services do HIV positive people in your family use?**

Respondents who answered 'yes' to having somebody in their family who have or have had AIDS use or have used a variety of services. Some, if they were able to afford transport, (approximately 2,500US\$ or AUS\$1.80 by bus), travelled to the Kamuli Hospital to collect medication. Overall respondents found this expensive and the really poor or bedridden did not have the money or energy to make regular trips to Kamuli. One respondent was travelling to Kamuli to access HIV counselling. However, because the counselling sessions are not government services he was unable to pay for all of the sessions and therefore could no longer attend the group.



One lady who was interviewed relied on ARVs from Namwendwa Health Clinic. However, the clinic has been out of stock since September 2008, so she has had no medication since that date. She was too poor and weak to attend the HIV positive support group 'Balida Bene'<sup>3</sup> in Namwendwa (you have not mentioned the support groups in Nam yet – maybe a footnote with an explanation of this group – how it started, who runs it etc would makes things clearer. Sorry, I now see that you go on to talk about this in the next paragraph but still just specify which group you mean here)), or seek help from larger organisations like TASO. This lack of support means that she is now bedridden, malnourished and relies on family and neighbours to provide her with food.

Four NGOs are working or have worked in Namwendwa to supply people with HIV medication, nutrition and mental support. These organisations include Self-Help Africa, CHAI, TASO and International AIDS Alliance. Out of these NGOs, TASO and International AIDS Alliance are the only groups that continue to work in Namwendwa. TASO provides people living positively with HIV ARVs and other medication, but none of the people surveyed were registered with TASO. International AIDS Alliance has two community councillors who are HIV positive and work at the health centre every Tuesday and Thursday. While Self-Help Africa was in Namwendwa they offered outreach community screening, nutritional support and started a HIV positive group called 'Balida Bene'. This group meets on the 15<sup>th</sup> and 30<sup>th</sup> of each month to discuss how they are coping with HIV and plan where they are going to plant vegetable seeds that were given to them by Self-Help Africa. Balida Bene is hosted by two HIV positive volunteers from International AIDS Alliance to ensure that members

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<sup>3</sup> Balida Bene was established by the organisation Self-Help Africa. It consists of women and men who are determined to live a positive life with HIV.



know how important a nutritious diet is, whilst motivating them to maintain a positive outlook on life.

*2.1.3 How do HIV positive people in your family access medication? Is the medication accessible and how expensive is it?*

All of the people surveyed could not access medication from the Namwendwa Health Clinic, so the majority of them did not take any. Two people travelled to the Kamuli public hospital, which costs approximately AUS\$3.60 in travelling costs. Medication is neither accessible nor affordable for people in Namwendwa who are too ill and poor to travel. Many people who relied on ARVs from the health clinic have not been taking anything since September 2008.

*2.1.4 Are you involved with any of the support groups in Namwendwa that are living positively with HIV?*

None of the respondents were involved with Balida Bene

*2.1.5 Have you ever been tested for HIV?.*

Sixty-three percent of the survey respondents had been tested for HIV, twenty-nine percent of whom had been tested at the One Village Health Awareness Days. This shows that our educational events are effectively teaching people within the community whilst providing them with an easy opportunity to be screened for HIV. (see appendix 2)



*2.1.6 If yes, have you been tested in the last three months?*

87% of respondents who did not have HIV had not been tested for HIV in the past three months. The reasons for this varied. Some thought that it was not necessary, some were not aware of how frequently they should be tested and others did not have time to wait at the health clinic for a blood test. Due to polygamous marriages being common in Namwendwa it is important that people are aware of testing centres and how frequently they need to be tested.

*2.1.8 Are you aware of the HIV screening that occurs at the Health Clinic every Tuesday and Thursday?*

Every Tuesday and Thursday the Namwendwa Health Clinic has HIV screenings that is promoted for pregnant women, but open to everyone in the community. Only 18% of the respondents were aware of this service. During the surveys we raised awareness about this service. When people found out about the services some were eager to utilise them and others were reluctant, because they generally must wait up to a minimum of four hours before they are tested.<sup>4</sup> This waiting time is a serious issue for people in Namwendwa, as most families rely on subsistence farming for survival. When people must wait all day at the health clinic they cannot work on their land or prepare food for lunch and dinner.



## *2.1.9 What is the hardest thing that people living with HIV face in the Namwendwa community?*

The majority of respondents thought the most challenging thing for people with HIV/AIDS was poor access to nutrition and treatment. As mentioned earlier one lady who was HIV positive and receiving no medication, lived on a small serve of sweet potato and water for lunch and dinner, and had no other vegetables or beans for nutrition. Another concern was the lack of clean bedding. Often the blankets that are used by bedridden people are soiled and those who are ill have no money to replace them. This was seen with the bedridden woman: her bedding smelt of faeces, but her family could not afford to change the blankets.

## *2.1.10 How do you think programs and services for people living with HIV/AIDS could be improved?*

Most people suggested that grassroots organisations should come into the area to provide medication and help people living with HIV start income generating projects.<sup>5</sup> There was also the suggestion that NGO volunteers should help connect people living positively with HIV to TASO, so that they have greater access to free medication.

## **2. 2 Information from the health clinic:**

Between June 2007 and June 2008, 3622 people were tested for HIV at the Namwendwa Health Clinic. 145 of these tests were positive. (see *appendix 3*)

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The difficulty with this is that there is very little economic activity in Namwendwa so at this stage income generating projects are unlikely to be a viable option.



### 2.3 Information from TASO:

In Namwendwa parish 93 people who are HIV positive are registered with TASO, 35 of whom are men and 58 are women. Out of these people 15 women are receiving ARVs for TASO. (see appendix 4)

### Conclusion

Overall the greatest challenge for people living with AIDS in Namwendwa is their access to medication. This lack of medication decreases their ability to maintain a nutritious diet, because they become too weak to perform their activities of daily living, such as subsistence farming. AIDS education that is taking place at the Namwendwa Health Clinic, is a positive service that has the ability to erase much of the stigma surrounding HIV/AIDS whilst empowering people with AIDS to live a healthy life. Despite these positive developments, the quality of life for people infected with HIV will only be improved if they have a constant, reliable, and affordable source of medication.

## 3. Malaria in Namwendwa

### 3.1 What is malaria?

Malaria is a life threatening disease that is caused by parasites that are transmitted to people through the bites of infected female Anopheles Mosquitoes. There are four main types of parasites that can cause malaria these include: Plasmodium falciparum; Plasmodium vivax; Plasmodium malariae; Plasmodium ovale. (World Health Organization, Geneva, 2009)



### 3.2 Ugandan national malaria prevalence and treatment

Malaria transmission occurs in all areas of Uganda. In 2006, there was an estimated 10.6 million reported cases of malaria. (*The World Health Organisation, Geneva, 2006*) In the same year the government launched malaria control projects that were funded by the government, UN organisations, The Global Fund and other donors. The total expenditure for these programs exceeded US\$75 million. During these malaria programmes 1.9 million people were supplied with LLIN and IRS protected 470 000 people. National Surveys also revealed that 34% of households owned mosquito nets and only 10% of children slept under the net. (*The World Health Organisation, Geneva, 2008*)

### 3.3 National treatment:

The plasmodium species in Uganda include falciparum and vivax. The first line treatment for unconfirmed and confirmed P.falciparum malaria is the ACT, artemether-lumefantrine. When this treatment fails quinine is used, it is also used to treat severe malaria. (*The World Health Organisation, Geneva, 2006*) ACTs are highly subsidised by the government and supplied to all affected people for free. An antimalarial called chloroquine was once the most effective treatment. However, because of Chloroquine's extensive use in Sub-Saharan Africa, P.falciparum has now acquired resistance to this antimalarial so it is no longer an effective treatment in Uganda.

All people must have parasitological confirmation to be diagnosed with malaria and receive treatment. (*The World Health Organisation, Geneva, 2008*) The Namwendwa Health Clinic uses blood smears to identify if there are parasites present in blood samples.



### 3.4 Diagnosis in Namwendwa

At the Namwendwa Health clinic 14 318 people were diagnosed with malaria in 2007/2008. Out of these people only 3 528 people had a blood smears and 57% of the blood smears were positive, meaning that a diagnosis without a blood smear is often inaccurate. With 68% of patients not having blood tests, it is likely that over half of all patients diagnosed at the clinic with malaria are not housing plasmodium parasites. According to the WHO guidelines, all patients in high-risk regions who are over 5 years old must have a blood test before commencement of medication. (*The World Health Organisation, Geneva, 2006*) If these guidelines are not followed, the parasites sensitivity to the drug is jeopardised and the health care system spends more than needed. The only people exempt from this rule are children under 5 years because they are more vulnerable to severe malaria, so the benefits of immediate treatment outweigh the complications listed above.

### 3.5 Medication at the Namwendwa Health clinic

The Ugandan government supplies the Namwendwa Health Clinic with ACTs for uncomplicated and complicated malaria and quinine for severe malaria. Cortem is the chosen ACT, it is a combination of artemether and lumefantrine. This combination is one of the most effective antimalarials because it can treat chloroquine sensitive/resistant *P.falciparum* Malaria. In addition to this, it interrupts the asexual process of *P.vivax*, which deactivates the parasite. (*Bryant & Knights, Australia, 2007*) For adults, eight cortem tablets must be taken per day for three days, children must take four per day for three days and infants are given three tablets per day for three days.



When symptoms of malaria arise, 68.4% of respondents to community surveys attended the Namwendwa Health Centre. 28.9% went to the pharmacy, and 2.7% went to health clinics in surrounding districts.

Corteum and paracetamol are supplied to all patients at the Namwendwa Health clinic who present with uncomplicated malaria. Quinine is given intravenously to those presenting with severe malaria. At pharmacies in Namwendwa people can purchase a different form of ACT, chloroquine and paracetamol. Both *P.falciparum* and *P.vivax* parasites have acquired a resistance to chloroquine; making it no longer an effective form of treatment. However, pharmacies in Namwendwa are continuing to sell chloroquine. Pharmacies also do not employ trained health professionals, therefore customers do not have parasitological confirmation to identify the type of the parasite they have and the appropriate treatment for the parasite. However, as a result of the long waiting time at the health clinic, many people prefer to use pharmacies because it saves them time and they can always access medication.

### **3.6 Community knowledge**

When community members were asked 'how do people get malaria' 55.3% of respondents knew that it was the anopheles mosquito, 39.4% could not answer the question and 5.3% had a very vague idea. Out of the 55.3% of people who did know the cause, the people with the best understanding were two teachers and one lawyer.<sup>6</sup>

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Ideally raising awareness should be a priority of Namwendwa Health Clinic but as they are already understaffed there is no one available to coordinate such awareness programs.



### 3.7 Environmental Conditions

In order to decrease the prevalence of malaria in Namwendwa and eliminate malarial parasites, the community must design an environmental strategy that will decrease the presence of the anopheles mosquito in the region. The WHO has made general recommendations about how organisations and governments can minimise malaria transmission in high-risk populations (see appendix 1).

### 3.8 Uganda's Implementation of WHO policies:

In 2002 the Ugandan government implemented activities that would safe guard the population and in turn decrease the prevalence of malaria. This was done by supplying free or subsidised LLINs to communities. By 2006 the government had supplied 1365 919 LLINs covering 12.8% of the population. IRS was also implemented, but to a lesser degree. 104 000 houses have been sprayed, protecting 470 000 or 1.8% of the population. (*The World Health Organization, Geneva, 2008*)

### 3.9 Mosquito net ownership in Namwendwa

In Namwendwa the most common reason for why 50% of recipients did not own one mosquito net and 40% only owned one for some members of the family, was the expense. Of the 40% of people who did own a net, only 5% had IRNs. In Uganda an untreated mosquito net is approximately 5000 USH (AUS\$ 3.60) and a treated net is 12 000 USH (AUS\$ 8.60). Due to large family sizes some people may need 60 000 USH (AUS\$42.60) to provide their families with the right protection. This amount may seem small, so to put it to perspective, full-time teachers in



Namwendwa cannot afford to buy a bottle of water at the price of USH2000 (AUS\$1.40).

On Feb 25<sup>th</sup> 2009, Softpower Health went to Namwendwa to sell long LLTNs at a subsidised price of 3000 USH. LLTNs were bought by one-hundred and fifty people in the Namwendwa sub county. This organisation will return to Namwendwa in six months to investigate how well these people have been using their nets.

Despite, an increase in mosquito net ownership, people in Namwendwa are usually still active when the Anopheles Mosquito (the mosquito species that houses the parasite) begins to pray (approximately 10pm). This means that people with nets are still at a high risk of being infected. The only way to reduce this risk is if people start going to bed earlier, cover all water sources that are around the household during the evening or implement IRS. However, IRS is expensive and unsustainable.

### **Conclusion:**

Due to the high prevalence of malaria in Namwendwa it is clear that treatment regimes and protection measures must be improved. The Namwendwa Health clinic needs to improve their services, by making serology testing for people over five a prerequisite for the distribution of Antimalarial medication. When patients are diagnosed, nurses must be more informative as to how the patient got malaria and how they can reduce the risk of getting it again. Education about protection methods must also be conducted in more isolated parts of Namwendwa. The implementation of the correct malarial practices, increased community knowledge and access to cheaper LLITNs, will decrease the risk of



resistance to ACTs and help to lower the prevalence of Malaria in Namwendwa parish.

#### 4. Disability in Namwendwa

##### Introduction

When Nikki Lovell visited Namwendwa in 2005, she was shocked to see the lack of dignity that people living with a disability were forced to accept. For six months she was living directly across from a fourteen-year-old girl who was both intellectually and physically disabled. Due to the community's lack of understanding about disabilities the young girl's family hid her inside their hut all day. This treatment stripped her of the right to grow and participate in everyday activities. In the same year The World Health Assembly approved resolutions that would strengthen The United Nations *Standard Rules on the Equalisation of Opportunities for Persons with Disabilities* (see appendix 2). The resolutions were made to ensure that all United Nations member states,

*"...promote the rights and dignity of people with disabilities to ensure their full inclusion in society; promote and strengthen community-based rehabilitation programs; and include a disability component in their health policies and programs." (World Health organisation Disability and Rehabilitation Team, 2006, pp.2)*

In order to raise awareness about disabilities One Village held a Disability Awareness Day in 2007 which was open to the entire community. However in order to make lasting change the community



and government must work together to create accessible support services that are available to all people in Namwendwa.

In order to evaluate the knowledge that the community has about disabilities, One Village asked people how they view disabilities and if they are aware of any disability support services.

#### ***4.1.1 What is your understanding of a disability?***

Due to the lack of education surrounding disabilities, much of the community did not understand this question. One man said 'my teeth have been removed' and considered this to be a disability. People who could answer the question generally knew somebody who had a disability. Some common responses included:

" I do not understand what a disability is"

" Somebody with reduced activities"

"Unable to undertake full activities"

As part of this survey process, we explained to each community member surveyed what it means to have a disability, and gave a brief explanation of the different types of disability, such as intellectual or physical.

#### ***4.1.2 Do you have any family members living with a disability?***



The majority of people surveyed either had a family member with a disability or knew somebody in the area who was living with a disability.

***4.1.3 If you know someone with a disability what kind of disability do they have and was it congenital or did they get it after birth?***

People who did not have a family member with a disability were unsure of when and why the person developed the disability. Those who did have a family member with a disability could be more specific about when it developed and what sort of disability it was.

Both physical and intellectual disabilities were seen in the village. The more prominent of the two were physical disabilities that occurred after birth. The causes include polio; cerebral malaria; strokes; cataracts and other undiagnosed eye pathologies, which lead to blindness.

***4.1.4 Are you aware of any services that are provided for people living with a disability?***

In Namwendwa parish there are no services for people living with a disability, so the person who has the disability often becomes a burden on the family. Adults who have a physical disability generally rely on their children or neighbours to provide them with food, because they are unable to cultivate their land or afford food from the trading centre. Children with a disability generally do not attend Namwendwa Primary. This is because the families are often ashamed of the children and the school does not have the facilities to provide special education for the children who need it.



One of the respondents who cares for her niece who is legally blind, sends her to 'Kiworlera School for the Blind'. Kiworlera School is a boarding school in Mbale District; its relatively expensive, so many families cannot afford to send their children there.

#### ***4.2 Research and development in Namwendwa***

Allen, the Vice President of One Village in Uganda, has recently produced a research paper about the integration of legally blind students into government primary schools in Namwendwa Sub-county. This paper is a positive movement because it evaluates why the school is not suitable for students who are blind whilst creating techniques that the school can adapt for the students integration.

#### ***Conclusion***

Overall, the lack of services that are available for people and families who are living with a disability mean that many disabled people are not able to access education, health services and assistive equipment. An increase in education about what a disability is and why all disabled people have the right to access services, will help to ensure that they are integrated into the community. Research about affordable education for children who are blind has started in Namwendwa. This is a positive development because it has the ability to change how people view those with a disability, and ensure that those who are blind are able to exercise their basic human rights.



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World Health Organisation, 'World Malaria Report 2008', Geneva, 2008



## Appendix

### 1. Table 2.1.1

Note: HH = Household

HH with a member infected with HIV	15%
HH with a member who has died from AIDS	7.5%
HH without family member with AIDS	77.5%

### 2. Table 2.1.5

Percent of people who have had a HIV test	63%
Percent of respondents tested at OV health day	29%
Percent of people who have not had a HIV test	37%

### 3. Table 2.2 a

<b>HIV/AIADS</b>	
Total diagnosis	145
Total serology tests	3622

### 4. Table 2.2 b

Registered with TASO Jinja	93
Male	35
Female	58
Receiving ARVs from TASO	15 (fem)

### 5.

#### ***The WHO recommendations for malaria reduction:***

- Both IRS and ITNs may be used in a range of epidemiological settings, from low to high transmission.*



2. *The distribution of ITNs should be either free of charge or highly subsidised. Mosquito nets are bulky, so special attention should be paid to procurement, storage and transport.*
3. *In order to protect a high proportion of people at risk, a minimum ratio of one ITN or LLIN per two persons at risk is recommended.*
4. *Several years of consecutive rounds of IRS are usually required to achieve and sustain the full potential of this intervention, so the adoption to of IRS requires medium to long term political and financial commitment by national programs and funding partners. Therefore, IRS would ideally not be planned unless the capacity for implementation, monitoring and evaluation is in place on national, provincial and district levels.*
5. *Timing is IRS operation is essential. Owing to the short duration of insecticide efficacy when sprayed on walls, spraying campaigns must be completed just before the onset of the transmission season. Because they are costly, it is not usually feasible to implement IRS continuously for long periods of time.*
6. *IRS is effective in reducing malaria parasite prevalence and incidence in areas of high transmission, but once these goals have been achieved, IRS may be supplemented or supplanted by other interventions, including LLINs.*
7. *IRS is the first line intervention for containing malaria epidemics, and earlier application is likely to be more effective. IRS may also be used to prevent transmission in epidemic-prone areas and in areas with low seasonal transmission.*
8. *IRS and LLINs may be jointly deployed in areas of high transmission to further enhance their impact through extended insecticide coverage in time and space. The combination can also maintain the efficacy of vector control through the management of insecticide resistance, and limit the application of IRS in situations where it cannot be properly implemented or might be interrupted.*  
*(The World Health Organisation, Geneva. 2008 pp.5)*



## 5.

Rule 1. (awareness-raising), Rule 2. (medical care), Rule 3. (rehabilitation), Rule 4. (support services as preconditions for equal participation) and Rule 19 (which addresses in part issues related to training of personnel providing health and rehabilitation services). (World Health Organisation, Disability and Rehabilitation Team, 2006, pp,5)

## 6. Table 4.2

Families who have a member with a disability	43.2%
Families without a member with a disability	29.8%
Families who know somebody in the area with a disability	27%