16th June in pictures

Inside: Interview with a Disabled Doctor, African Childs Day activities, Mother of 4 deaf children, Stephen the Special child, Nodding Disease and much more ....!
Dear reader,

Welcome to yet another edition of the SCOMER newsletter. We would like to take this platform to thank all our readers that have kept us moving this far. Whereas the going has not been simple, many things have been a success for FAMSA and SCOMER in particular.

This issue is being released after the celebration of the International Day of the African Child (DAC) which was on 16\textsuperscript{th} June, 2012 in several countries. The medical students too, took time off their busy schedule to share their love with the disabled children in their localities.

As students, we feel that the disabled children have been marginalized and discriminated in many areas of life; socially and economically. The statistics are alarming especially in Africa. For example, according to UNESCO, 90\% of children with disabilities in developing countries do not attend school.

Therefore, most of the content in this issue will be in line with the theme of the just concluded DAC which was ‘The Rights of Children with Disabilities: the duty to protect, respect, promote and fulfill.”

FAMSA would also like to thank the all individuals, companies, organizations and institutions that partnered with us to help make a difference in the lives of these children in Africa.

In conclusion, there is definitely no doubt that many countries are making impressive efforts to improve the social and economic well being of children, through, for example, universal or improved access to health and education. However, the lives of millions of Africa’s children especially the disabled remain hard, insecure and fragile.

And because of such, we would like to challenge our dear readers, to do something that will cause a difference in the life of a child.

Wishing you a pleasant reading

SCOMER TEAM
The International Day of the African child was first commemorated in 1991 in memory of over 700 children that where killed during the apartheid in Soweto South Africa in June, 1976. About 10,000 children marched along the streets of Soweto on 16th June, 1976 protesting the quality of education.

This day is celebrated annually to raise awareness and advocate for further action to address the physical and educational needs of children in Africa.

Led by SCOMER, Medical students in Kenya (led by Moi University) and their counterparts in Uganda (led by Kampala International University) commemorated this day this year.

Students, companies, institutions and organizations were involved in several activities to commemorate this day, as explained in the SCOMER-DAC report (that will be available on www.famsanet.org from 20th July, 2012);

The activities for that day across the two countries included;

Radio talk shows, marching for the children, games, drawing, exhibitions, eating, medical camps and donations.

In Uganda, money was also collected to pay school fees for six children in Bushenyi Primary School, a school for the disabled children in Western Uganda.

FAMSA also contributed by paying a year’s school fees in the same school for two deaf brothers from a family with four deaf children.

The event was organized by scomer in conjunction with SCOPE, both committees in FAMSA.

THE DECISION BY STUDENTS TO COMMEMORATE THE DAY WAS DERIVED FROM THE FACTS BELOW:

1. Africa has only 10% of the world’s population, but 40% of childhood deaths.

2. Almost 16 million African children have been orphaned by HIV/AIDS.

3. 4 out of 10 children in sub-Saharan Africa is a child-worker: the highest child labour rate in the world.

4. 1 in 8 children in sub-Saharan Africa will die before reaching their 5th birthday compared to 1 in 143 for developed regions.

5. 80% of persons with disabilities live in the developing world, according to UNDP.

6. 90% of children with disabilities in developing countries do not attend school, says UNESCO.

7. Violence against children with disabilities is at least 1.7 times greater than for their non-disabled counterparts.

8. In the decade where 100 countries slashed mortality rates for children under five by 20% or more, the rate for Africa declined by 3% overall. (UNICEF)

9. Over 90% of the world’s stunted children live in Africa and Asia; with Africa having the highest proportion in the world.

10. The gap between the survival rates, the education and development of Africa’s children and children from other continents is increasing

11. We can make a difference!
The Disabled Doctor- Mirror Image of a Protected, Respected and Fulfilled Child

One does not meet a disabled doctor everyday but I can honestly say that I have met the only disabled doctor in Korle-Bu Teaching Hospital and the only one I know. We have been friends for over 2 years during which he has tried severally to extol the virtues of his specialty—Internal medicine.

Q: Good evening, please tell me briefly about yourself.

A: My name is, Abubacarr Jagne, born on 6th March, 1979 in Brikamaba, a small farming province in the Gambia.

Q: When did you become disabled and how did your family handle it both in the long and short term?

A: It happened when I was three years old. My mother told me I had been taken to a children’s clinic the day before and had woken up the following day with a febrile illness and inability to walk. My father consulted every ‘marabout’ in the country and beyond after the hospital failed to give us a diagnosis.

Q: How did people around, relate to you and your family?

A: In the Gambian and Muslim cultures, the disabled child and his family are entitled to
alms from people who want to fulfill their religious obligations. My father would always quarrel with anyone who brought alms to our house, telling them he could more than provide for his home.

Q: How coloured were your educational life experiences by your disability?
A: School was so much fun for me. I had the honour of going through primary, secondary and tertiary education on academic scholarship.

Q: Please tell me briefly about your life as a married man and a father.
A: (laughs) The million dollar question. I met my wife through her brother who was a couple of years ahead of me in high school at the time. Dating was sketchy for us as most of the court ing was done over the phone because I was busy and far away in medical school.

Our son, Suleiman came along in the first year of our marriage just four days before I had to leave Gambia for post-graduate studies in Taipei.

Q: Would you have done anything differently if you didn’t have this disability?
A: (shakes head frantically) No, I don’t think so.

Q: Do you have a motto?
A: Not really!

Q: Has religion played any role in helping you deal with challenges in life?
A: I commit important life issues to God. In addition to my five daily prayers as a Muslim, I wake up at night to talk to God especially when I have a pressing need and it works.

Q: Do you think disabled people should be given special opportunities like affirmative action?
A: Not really! A disabled child needs to be empowered by education.

Q: Do you belong to a support group for disabled people?
A: Not in Ghana but I used to be a member of the Association of the Disabled in The Gambia. I was also a member of the Disabled-Friendly Gambia, advising the government on ways to make our country more disabled-friendly for Gambians and visitors as well.

Q: Do you sometimes think about receiving a miracle and walking?
A: (quite emphatically) Why do I need one? I really do not care. My wife will probably leave me because she loves ‘the man in the wheel chair’ (laughs).

Q: Any final words for disabled children in Africa?
A: No pampering! Disability is not inability.

Thank you for your time.

The interviewee is Doctor Abubacarr Jagne, currently a Junior Resident in Internal Medicine at the Korle-Bu Teaching Hospital Accra, Ghana.

Chiamaka N. Ilechukwu is a final year medical student of the University of Ghana Medical School in Accra, Ghana as well.

CHIAMAKA N. ILECHUKWU
UGMS
FAMSA-SCOMER
COUNTRY REPRESENTATIVE
GHANA.
The threats of malnutrition, inadequate sanitation, malaria, maternal, and neonatal mortality loom large but it is a time when mental health and illness have to be taken seriously as well.

The pictures were taken in November 2011 when I joined a parade through Gulu town centre marking Global Mental Health Day. In the heat of the tropical sun, I walked behind people whose tee-shirts bore the slogan “Mental Health Day 2011, the Great Push – investing in Mental Health”. Many of the people marching were in pairs – a mother with her tiny baby strapped to her back with a cloth; the baby’s head just visible, headlined by this bold statement. Many of the marchers were current or ex-patients of the Mental Health Unit at Gulu Referral Hospital. Through taking part in this march they were potentially making themselves vulnerable: mental health disorders still invoke many fears and myths, stigmatising its sufferers. Their personal statements were perhaps even bolder than the slogan. These were brave people. They deserve our admiration and support.

Mental health and illness services are being developed but it will be a long march. It is a major challenge simply to ensure support for those staff already working with minimal resources and in extraordinarily complicated conditions. Supporting these staff to teach and train future clinicians is imperative. To begin to learn about this and to contribute is humbling and enriching. Continuing to learn and hence to ensure future mental health practitioners is a shared responsibility: it is only through learning that we can become teachers. We may ourselves need these practitioners – a medical training does not immunise us against mental illness.

Dr Adrian Sutton
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http://www.uhsm.nhs.uk/academy/Pages/TheGuluLink.aspx

BUSHENYI PRIMARY SCHOOL, RUHANDAGAZI

Bushenyi Primary School is a mixed day and boarding primary school located off Kasese Road in the western part of Uganda in a district called Bushenyi. The school, the only one of its kind in the district, caters for the disabled persons of various categories including physical and mental disabilities. The school is unique in that they enrol both the disabled and their normal counterparts.

The school was started by an individual, Mr. Ayesigye Stuart as a school purely for the disabled in 1990, and was taken over by the government in 1994. The school boasts of good
The school comprises of fifteen teaching and three non-teaching staffs and was established with a goal of upbringing children to fit in the community.

The school currently has an enrollment of 106 of which 54 are special needs children while 52 are ordinary children. There are 20 deaf pupils, 2 with visual impairment and 27 with mental disabilities.

As a school, our main challenge is with the parents that tend discriminate against the disabled ones and thereby denying them their rights and privileges including support in school.

We therefore, urge the parents and the community at large, to help the disabled children in their domestic life work and help create an environment that favours their growth so as to reduce their vulnerability and also meet their basic needs.

SCHOOL MOTTO: Disability is not inability
SCHOOL MISSION: Up-bring children to fit in the community
School objectives:
 a) To instill good behaviour, in and after school in our community
 b) To promote self reliance among people with disabilities so that they live happily.

NATURAL SUGGESTIONS

Children are often very vulnerable for infections and fever. The immune system is a very complex network of tissues, organs, cells, and chemicals that protects the body from infection and illness. A powerful immune system is the best natural fighter against any kind of infections.

**Mannose**: It inhibits viruses, parasites, bacteria and fungus. Best sources of them are cranberries, soybeans, beans, greens, tomatoes, eggplants, white cabbages, aloe vera gel and sunflower leaves.

**Arabinogalactan**: It promotes the growth of probiotic bacteria like lactobacillus and bifido. You can find it in tomatoes, carrots, pears, coconut, leek, onion, spinach, broccoli, avocado, eggplant, mango, apples, apricot, banana, radish, wheat, turmeric.

**Xylose**: It has anti-bacterial and anti-fungal effects. Rich in this compound is pear, guava, raspberry, broccoli, spinach, eggplant, green peas, green beans, cabbage, okra, corn, aloe gel.

**FOS**: It stands for fructooligosaccharide and this stuff activates the immune system and is a great fibre for the intestinal flora. FOS prevents cold, flu and general virus related conditions. Best sources are onion, garlic and Jerusalem artichoke.

**Papain**: It works well against shingles and herpes infections. This protease enzyme from papaya kills an overproduction of the yeast Candida and supports the immune system. In case of bacterial or viral infections a smoothie made from papaya,
Fresh lemongrass and lemon juice promotes the process of healing.

**Bromelain:** It is the natural enzyme found in pineapple and it can kill some viruses and bacteria. Useful to treat bronchitis, pneumonia, and urinary tract infections.

**Naturally Fever Reducers**

The yellow Sunflower leaves are beneficial to reduce high fever. You can prepare a tea made from fresh or dried leaves or you mix 3 to 4 tea spoonful (tsp.) finely chopped sunflower leaves in a cup cold juice of choice. Reduces high fever fast and effective in 20 to 30 minutes. Once, the fever is reduced use 3 to 4 tsp. again. Or mix a small amount of sunflower extract in a cup liquid. Also Lemon grass is a natural fever reducer, you can enjoy it made as tea or raw finely chopped and mixed in smoothies and juices. I prefer the last form, because in fresh lemongrass the content of essential oil is higher and the effectiveness in reducing of fever is stronger. Alternatively you can use 50 mg direct in the fever situation or 3 to 5 drops of a 100 % pure lemongrass oil mixed with one teaspoon cold-pressed oil e.g. coconut oil. For kids the dosage should be not more than 1 to 2 drops, because essential oil is very concentrated.

Cold-pressed coconut oil is rich of MCFA, called medium chain fatty acids. They work against fever and kill lots bacteria, viruses, fungi’s (yeast infections), parasites and protozoa. Also it works against the virus H5N1 and is useful in the situation of HIV.

All readers, students and doctors, who are interested to go a natural way, are welcome. The author offers more suggestions per email for free of charge.

By Dipl.-qualified NC., Mirko Albrecht

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**HEAD NODDING SYNDROME IN NORTHERN UGANDA**

**Introduction**

I am glad to share with you my experience from my community clerkship about head nodding syndrome (HNS). I was placed in Atanga health center III in Pader district in Northern Uganda. I was there for 6 weeks during the month of April and part of May. This health centre was chosen and launched as the treatment centre for HNS in the whole of Pader district in early March 2012. The health centre is located on the highway to Kitgum. Pader district has one of the highest prevalence of HNS followed by Kitgum and Lamwo districts.

**Definitions**

**Head Nodding Syndrome (HNS):** A condition which presents in any person (usually child or adolescent) with two or more episodes of recurrent head nodding that occur spontaneously or consequent to the sight of food or coldness in a child who was previously growing well.

**Head Nodding Syndrome plus:** Any person with HNS with other types of seizures/fits/neurological signs or regression in growth or mental retardation.

**Epilepsy:** Any person with recurrence of, at least
two epileptic seizures with or without positive response to treatment with any anti-epileptic drugs.

**Epidemiology and Aetiology**

The syndrome affects mainly children between 5-15 years though a few cases below five and a few above fifteen years have been reported. The etiology of HNS is not yet established but suggestions have been made by several scientists. One of them is the association of the condition with *Ochocerca volvulus*, a nematode which causes river blindness and skin lesions. *O. volvulus* is transmitted by a black fly which lays its eggs in fast flowing rivers. The 3 districts mainly affected by the syndrome are located between two fast flowing rivers Aswa and Pager in Pader and Kitgum districts respectively. CDC took samples from children in this region but results are not yet back. However, according to a study done by CDC in South Sudan, the researchers found that 22 of 25 children with nodding syndrome in one community had the parasitic infection compared to 11 of 25 healthy controls.

Parents to the children suffering from the syndrome and the rest of the community believe that it is due to the following:

- The spirits of those who died during the war between Lord’s Resistance Army and the national resistance army of Uganda.
- Others believe that they were just cursed by God.
- The chemicals from the weapons used during the war.
- Some say it is because of their poverty that they are suffering.

**Clinical Presentation**

- Head nodding on sight of food, coldness or spontaneously.
- Generalised seizures.
- Drooling of saliva
- Dumbness
- Wasting especially among those malnourished.
- Growth retardation

**Complications of Head Nodding Syndrome**

The complications can be categorized as physical, psychological and social.

**Physical**

- *Malnutrition*; From the definition, one of the triggering factors is sight of food. Parents say that since food is a triggering factor, they decide to keep it away predisposing them to malnutrition. It is also believed that the condition itself malnourishes.

- *Burns*; During a head nodding episode, it is very common that these children fall in fire, hot food or water which burn them.

- *Wounds from falls*; During episodes of attack, they tend to fall down. They can fall on anything so they are injured in the process.

- *Infections*; Because of malnutrition, their immunity is suppressed so microorganisms take advantage of them and cause infections such as pyomyositis, respiratory tract infections, skin diseases and others.

- *Speech difficulties*; Some find it hard to speak meaningful things while others completely fail to speak.

- *Growth retardation*; Depletion of the macro- and micronutrients retards the growth of these children.
Psychological
- *Mental retardation;* It’s not clear whether this is a complication or a sign of the syndrome.
- *Emotional disturbances;* Sometimes some of these children are abnormally excited but easily irritable.

Social
- *Neglect;* Some parents tend to neglect these children and deny them the basic needs like food, clothing and good shelter.
- *Restraint;* Sometimes these children are hard to control while at home, so parents decide to restrain them on ropes inside their huts or on trees.
- *Breakdown of families;* Husbands and wives have separated because of head nodding syndrome which makes children appear useless. A mother of three HNS children was interviewed and she said that the husband calls her children ghosts and therefore, got another wife and constructed for them a separate hut which was in poor condition.
- *Loss of time for working;* Parents lose a lot of time while taking care of these children at home, moving to the health centre.

**Interventions**

Interventions have been established at community, health centre, national and international levels.

**Community level**
- Parents are trying to bring their children who are affected to the health centre to seek for medical attention.
- Village health teams have been trained on how to identify these cases in community and then refer them to the health facility.
- Parents also try as much as possible to keep watching their children from injuries though it seems to be so hard for them.

**Health centre level**
- The health workers at the centre also try to go for community outreaches in order to sensitise them on how to identify the cases. On these outreaches new cases are identified and then brought to the health centre for better management.
- Screening for new cases, reviewing re-attendents and dispensing of drugs. The drugs being used currently are sodium valproate 200mg twice daily. Children who have been started on this drug show improvement. Other drugs given are haematinics, dewormers (albendazole or mebendazole), vitamin A.
- A separate ward has been set up for nodding syndrome only. Children are admitted in case they are getting repetitive attacks, severely malnourished and in case of wounds or burns.
- Counselling of parents on how to handle their children.

**National level**
- The government has launched a treatment centre in the affected districts.
- They are also trying to ensure drug supplies plus other materials needed in the management of these children. The challenge is that sodium valproate is so expensive.
- Government has also tried to recruit and train staff on management of HNS.
- They have also given food (posho and beans) to
the health centre in order to cater for the feeding of the inpatients.

♦ Supervision of the staff at the health facility through the local government.

**International level**

♦ CDC came around and took samples from some of the children affected though results are not yet back.

♦ NGO’s have come in order to help the health facility to carry out community outreaches, provision of formula feeds though it was for a short time and they got finished.

**Challenges**

♦ Lack of transport both for referral and for outreaches.

♦ Drug stock-outs; This is because they are very expensive and every time they are over, they have to be ordered for from abroad.

♦ Lack of enough space for the inpatients.

♦ Lack of enough staff at the facility. The numbers of patients, especially when drugs arrive after a stock-out, are usually overwhelming.

♦ Lack of a lighting system to help the caretakers see well during night hours in case their children get attacks.

**In Conclusion,** as we commemorate the day of the African child think about the children in Northern Uganda who are suffering from this very disabling condition. Let us also pray that the cause will be established and that definitive treatment will be started.

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**LIVING WITH FOUR DEAF CHILDREN**

Mama Judith (as she is commonly known) is a 37 year old mother of seven living in Kakuba, Bushenyi District in Western Uganda. Her first born died at birth and four out of the remaining six children are deaf. She has nine dependants at home. Our first encounter with her children was during the African child day celebrations (DAC) at Bushenyi Primary School where three of her four deaf children study.

Just before our interactions with the family, we were warmly welcomed at the home (after about 2km walk through the banana plantations and crossing a swamp) with a great meal. The way we were received actually masks the pain and challenges the family has to deal with everyday. Her husband, who literally does not stay provide any kind of support to
the family is a chronic alcoholic and only comes once in three months.

Being the breadwinner, Mama Judith has to rise up very early daily to look for food for her family. Because she is illiterate, she says digging people in their gardens and selling banana leaves is nearly all she does for a living.

Despite her love for the family (especially the deaf kids), communication is not very easy. “I find it very hard to talk to my own children and I cannot even easily understand them,” she says. The stigma in the community adds insult to injury.

During our stay at the home, Mama Judith always asked herself, “Why me, oh God.”

In conclusion she thanked the medical students for thinking about her and offering to pay for her children fees for the whole year.

By David
KIU Western Campus

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When I was growing up, I used to picture that day when I would meet the man of my dreams – my prince charming get married and have children of my own and raise a wonderful family. Fast forward over several years and I have successfully completed my undergraduate university education with a degree and shortly after I am in a serious relationship bound for marriage. We talked about children... ten... a dozen...no!! ... three... as you can well imagine we never resolved that issue until marriage.

Marriage came by and I jumped into its wagon and four years later the Lord blessed us with a beautiful bouncing boy. We named him Stephen. Life with Stephen unfolded normally; he was on target with his developmental milestones until about the 14 month when there was an unexpected twist in his developmental progress. He wasn’t as bubbly as he used to be, he started to...
avoid eye contact with us or any other person he came into contact with. He seemed to have trouble hearing, was easily irritated especially when his routine was interfered with and more changes in his behavior were unveiled as the years went by.

At this point, every one who knew about Stephen was trying to be helpful by sharing with us their perspective on the condition. Some proposed witchcraft as the cause while others accused the devil for what was happening since we were actively involved in Christian work.

We eventually got a medical diagnosis that confirmed that Stephen was on the Autism spectrum. Personally, that was the most difficult news I had ever received in my life. It felt like I had been knocked down by a train moving at a very high speed. It took some time to come to terms with this information but we knew that we had a choice to either wallow in self pity or do something about our child's condition.

♦ First we had to painfully accept our child as a special gift to us and that he deserved to be loved unconditionally like any other child.
♦ Accept his condition even if it didn't make sense.
♦ Accept that his condition is a life long condition.
♦ Accept that it is neither our fault nor our child's fault that he had Autism.
♦ Educating ourselves about the condition was a paramount necessity and it was quite helpful that I had written a research paper earlier on children's disorders for my course module in the university. And with new information always being found about the condition we have been keeping abreast of current research on autism.

We also changed his diet from cooked to raw food in order to boost his immunity and it has paid off for the last 16 months in keeping us away from the hospital.

We furthermore committed ourselves to identifying areas of need in his life and focusing on them through training. For example we realized he needed help being trained to use the toilet. We set small but achievable goals. After four months he had mastered proper toilet usage. The list here is still long but we encourage ourselves with the Chinese proverb that “a journey of a thousand miles begins with one step”... and thus we have made it this far.

He has strengths which we are trying to nurture. He loves music and we are working on teaching him how to play a musical instrument.

We try not to over protect him or give him extra attention at the expense of the other family relationships. He is a part of the class and is expected to do what is required of him whether to sit quietly or color his book.

Our main aim is to teach him to be independent like any ordinary person and less a liability to us and the rest of the family members.

Our next goal is to get started with school with a major focus on writing and reading.

Finally, I've learned that ordinary and motivated parents can overcome seemingly impossible hurdles and make an extraordinary difference in their children's lives. It is not what you experience that matters but it is what you choose to do with that life experience. I am committed to making Autism add value to Stephen's life and not otherwise.

Beatrice Langariti (blangariti@gmail.com)
Chairperson: Fellowship of Christian Unions (FOCUS) - Uganda
OPPORTUNITIES IN SCOMER

REPRESENT YOUR MEDICAL SCHOOL IN SCOMER

SCOMER invites medical students from MSAs (medical students Associations) across Africa that want to be representatives for SCOMER in their respective medical schools to submit their application to;

Coordinator SCOMER via email at scomer2012@gmail.com

REQUIREMENTS

Application letter
CV

NB: The applicant must be a medical student at any Medical School in Africa.

For more information don’t hesitate to contact us at scomer2012@gmail.com or scomer@famsanet.org

VACANCY IN THE NEWSLETTER

SCOMER newsletter takes this opportunity to invite any persons that are interested in being part of the newsletter team to contact the Editor by email at scomer2012@gmail.com

The newsletter needs

Columnists
Cartoonists
Other writers

NB: ANYBODY from anywhere around the world can apply for this

For more information don’t hesitate to contact us at scomer2012@gmail.com or scomer@famsanet.org

UPCOMING EVENTS

World Mental Health Day (10th October, 2012)

This day is commemorated annually and the theme for this year is “Depression, a global crisis.” Main celebrations for the African medical students will be led by the Ghana medical students.

All MSAs are encouraged to celebrate this day in their localities / countries. We welcome all ideas photos and clips concerning the day.

More information can be accessed from scomer2012@gmail.com or facebook pages (FAMSA-SCOMER, FAMSA)

World AIDS Day (1st December, 2012)

The world AIDS day is celebrated in many countries.

Plans for this day as students are still ongoing and we welcome all ideas on how best to commemorate it.

Contact us at scomer2012@gmail.com
Students across the continent organized the day for African child under the theme: The Rights of Children with Disabilities: the duty to protect, respect, promote and fulfill. The main cerebrations for SCOMER were at MOI University. This did not deter other medical schools including Kampala International University in Uganda from organize the same event.

SCOMER on behalf of FAMSA, takes this opportunity to thank the following for partnering with medical students in making the day colourful.

**Uganda**

1. Hunter Radio
2. Pride micro finance Ishaka branch
3. The Rotary club of Bushenyi
4. KIU-Anglican Chaplaincy
5. Red Cross; KIU-Link
6. Association of Medical students’ Kampala International University (AMSKIU)
7. Bushenyi Primary School
8. Contagious fellowship (KIU)
9. United faith chapel
10. KIU- SDA community
11. KIU catholic community
12. KIU - The Muslim community
13. Watoto church (Kampala)
15. Kampala International University Western Campus Students and Staff

**Kenya**

1. APHIA plus, rift valley
2. Handicap international, kitale
3. Safaricom
4. Hiv free generation
5. Family Health Options Kenya
6. Chanuka youth group
7. Khetias Supermarket:
8. Transmatt Supermarket:
9. Suam Supermarket:
10. Paul's bakery
11. Coca cola bottlers: rift valley
12. The faculty and staff of moi university