"HIV/AIDS AND DISABILITY" NUDIPU'S EXPERIENCE

A paper presented by Murangira Ambrose, Member National Youth Council and National Youth Committee of the National Union of Disabled Persons of Uganda (NUDIPU), at the Round table discussions in Washington DC.

November 2004

1.0 Background on NUDIPU and HIV/AIDS

The National Union of Disabled Persons of Uganda (NUDIPU) was formed on the 14th November 1987 to create a unified voice of PWDs to promote equalization of opportunities and active participation of PWDs in mainstream development processes.

NUDIPU's vision is "dignity for every person with disability."

NUDIPU's core business is advocacy where focus is on the right to be heard, policy influence, disability mainstreaming and equalization of opportunities for disabled children, youth men and women.

NUDIPU also builds the capacity of disability leaders (Youths, women and men) to be able to participate in the mainstream development processes. NUDIPU's capacity building package includes mobilization of PWDs for development, disability awareness, reproductive health, HIV/AIDS awareness, legal education, provision of appliances to PWDs at subsidized rates.

NUDIPU's interest in HIV/AIDS is because PWDs are also affected by this epidemic. NUDIPU therefore feels obliged to come up and ensure that her members are protected by enabling them to access information on transmission routes, guiding them regarding where they can go for voluntary counseling and testing (VCT).

In the proceeding paragraphs we shall find a worrying trend, itself exacerbated by the realisation that the world's marginalized are the least targeted by intervention mechanisms to stop the spread of the virus and to reduce its effect on those already infected[1]. Furthermore, there has been a growing concern from several organisations of and for PWDs and PWDs themselves about the marginalisation of PWDs by the current HIV/AIDS interventions locally and internationally. Several studies have been carried out that confirm this, but service providers and other stakeholders seem to be paying little attention to this concern.

Following this concern, NUDIPU, with financial and technical support from Swedish Organisations of Disabled Persons International Aid Association (SHIA)

[1] According to *The New York Times* (28 March 2004), experts, advocacy groups and health officials agree that the delays in coming up with appropriate mechanisms for prevention and treatment, compounded by inadequate medical facilities and training in very poor countries, are likely to persist, citing WHO's ambitious plan to have 3 million people in treatment by 2005 (announced on World AIDS Day in 2003) that was already collapsing from lack of money.

and the Centre for International Child Health (CICH) respectively commissioned a study to assess the level of knowledge of HIV/AIDS, HIV/AIDS service access and vulnerabilities among young people with disabilities[2]. In the same vein, NUDIPU together with Ministry of Health and with the support of Uganda HIV/AIDS Control Project commissioned another study to determine the level of awareness and access to HIV/AIDS information by the community of PWDs[3].

NUDIPU also wished to identify service providers in HIV/AIDS and how effectively they can respond to the needs of disabled children, adolescents and adults.

NUDIPU carried out three studies namely;

(a) A situational analysis on the Community of People with disabilities in the districts of Kaberamaido (Eastern Uganda), Rukungiri (Western Uganda), Mubende (Central Uganda) and Arua (Northern Uganda) This was jointly done with the Ministry of Health funded by Uganda AIDS Commission in 2003.

(b) A study to assess the Level of Knowledge of HIV/AIDS, Access to HIV/AIDS Service and Vulnerability of Young People with Disabilities, funded by the Swedish Organisations of Disabled Persons International Aid Association (SHIA), Stockholm, Sweden.

This study was carried out in the districts of Mbarara (in western Uganda), in Kampala (city area), Iganga (Eastern Uganda) and Lira (Northern Uganda). In all districts except Kampala, we mixed both the rural and the urban.

(c) A desk study on the level of knowledge and access to HIV/AIDS information and services by people with disabilities in Uganda. (A study of various research reports by other researchers from other organisations on different aspects of HIV/AIDS and how it relates to people with disabilities in Uganda and elsewhere to identify gaps, reconcile documented information and repackage it for easy access by stakeholders and enable them develop appropriate intervention mechanisms) – funded by SHIA.

Based on the above findings NUDIPU was to draw concrete and/or practical recommendations as well as develop a practical plan of intervention geared

[2] Assessment of the Level of Knowledge of HIV/AIDS, HIV/AIDS Service Access and Vulnerabilities for Young People with Disabilities (NUDIPU, 2003).

[3] See Muhumuza and Senoga (2003): Report on Findings of an HIV/AIDS Situation Analysis Carried Out on the Community of People With Disabilities in Kaberamaido, Rukungiri, Mubende and Arua. NUDIPU, Kampala.

towards addressing the gaps identified to cause a positive change in the lives of PWDs.

2.0 The extent of the problem of HIV/AIDS among PWDs in Uganda

2.1 Introduction:

According to the Uganda Aids Commission report of 2003, it is over twenty years since the first clinical evidence of Acquired Immune Deficiency Syndrome (AIDS). Furthermore, it is now three years since the United Nations declared a world-wide offensive against AIDS and it is sometime now since President Bush of the United States promised US$15 billion for AIDS treatment in poor countries, but shortages of money and battles over patents have kept antiretroviral drugs (ARVs) from reaching over 90% of the poor who need them (*The New York Times*, edition of 28 March 2004). As a result, only about 300,000 people in the world's poorest nations are getting the drugs, of the 6 million who need them.

Of the over 60 million people estimated by UNAIDS (2002) and WHO (2001) to have been infected with the virus since the epidemic began, the majority thereof live in the Third World. Among the people severely affected by the scourge are the poverty stricken masses, various marginalized and socially excluded groups. This report, however, focuses on HIV/AIDS and its prevalence and effect among people with disabilities (PWDs). The World Health Organisation (WHO) estimates that PWDs make up 10% of any population (Nangendo, 2002; WHO in Owako, 2003)[4]. The incidence of HIV/AIDS amongst this group is also alarming as is revealed in this report.

2.2 Incidence of HIV/AIDS – A Global Perspective

UNAIDS and WHO estimate that over 60 million people have been infected with the HIV virus worldwide since the early 1980s and that about 40 million are living with HIV/AIDS (UAC, 2003). The majority of new infections occur among young adults, with women most vulnerable. It is also estimated that about one-third of the HIV infected are aged 15 – 24 years, most of whom live in developing countries (UNAIDS, 2002).

Sub-Saharan Africa is the region most severely affected by HIV/AIDS, with more than 80% of the global figure of people living with HIV (UNAIDS, 2002). Southern Africa is the worst affected area in this region with Swaziland leading

[4] With Uganda's population at 24 million, this means that about 2.4 million Ugandans suffer from one form of disability or another.

the infection rate whereby 4 out of every 10 people are HIV positive[5]. In Uganda, from only two cases in 1982, the epidemic has grown to a cumulative 2 million HIV infections by the end of 2000, about half of whom have now died (UNAIDS, 2002). Nearly 80% of those infected with HIV are between the ages of 15-45 years of age and the most common means of transmission is unprotected sex (84%) with an infected person. While Uganda AIDS Commission (UAC, 2003) is reporting a decline in HIV prevalence, the infection rates are still high. There is therefore a need, as UAC (2003) points out, for more concerted efforts to further reduce the prevalence and incidence rates and improve on existing HIV prevention and control strategies with more innovations.

2.1.2 Context of HIV/AIDS in Uganda

Uganda has a population of 24.5 million people. Of these 12.5 million are females while 12 million are males.

People with disabilities are 10% of Uganda's population.

Uganda's strategy in the fight against HIV/AIDS has been that of a multi-sectoral approach where there are ten self co-ordinating entities namely Parliament, Ministries of Government, UN and Bilaterals, International NGOs, National NGOs, Private Sector, Faith Based Organisations, People Having Aids Networks, Decentralised response and Research, Academia and Science.

This approach has contributed tremendously to reduction of the prevalence of HIV/AIDS over the last two decades from 16% to an estimated 4.1%. Right now in Uganda, a National Survey is being undertaken a more accurate prevalence will be confirmed.

The other strategy that Uganda has used is the (ABC) approach - Abstinence, Be faithful, Use of Condoms. This has also contributed to the reduction of HIV/AIDS prevalence.

There has been a high level political commitment in the fight against HIV/AIDS. The President has spearheaded the campaigns against HIV/AIDS and has taken it upon himself to always mention something about the virus in almost all his speeches.

[5] According to CNN International, Swaziland is the country with the highest HIV incidence in the world (*Diplomatic License*, broadcast on 3 April 2004, 04 – 05 GMT).

2.3 Incidence of HIV/AIDS among PWDs in Uganda

There is not much literature on the incidence of HIV/AIDS among people with disabilities in Uganda. This is mainly because those who have been charged with HIV/AIDS control have not yet considered HIV/AIDS and how it affects people with disability. What is known however,(basing on information derived from those working and interacting with PWDs), is that the incidence is high and that little has been done to put in place mechanisms to avoid its prevalence and incidence among this section of the population. Commonly noted in all reports reviewed was that there is a degree of awareness on the existence of HIV/AIDS among PWDs- though there is need for more emphasis on behaviour change programmes and strategies specifically targeting PWDs.

The following sections explore the factors that are responsible for the prevalence and incidence of HIV/AIDS among PWDs, their level of knowledge and access to relevant information and services as well as other factors that make PWDs more susceptible to infection by HIV/AIDS.

3.0 Methodology used

During the situational analysis on the Community of People with disabilities in the four districts, and in the study to assess the Level of Knowledge of HIV/AIDS, access to HIV/AIDS Service and Vulnerability of Young People with Disabilities NUDIPU used focus group discussions to get information from respondents both PWDs and service providers while in the desk study the researchers reviewed secured reports, studied them in terms of the stated aims and objectives and identified critical issues of concern. The analysis focused, among other things, on interpreting information and identifying gaps, finally making recommendations as is reported on later in this report.

On the whole, NUDIPU used a qualitative methodology and not a quantitative one.

4.0 The following issues were found out in the studies:

All the study reports that were accessed by the researchers have one commonality – that PWDs are in a vulnerable situation regarding HIV/AIDS infection and prevention. This is mostly because they are usually inflicted with poverty, discrimination and are generally stigmatised by the general public. They face many socio-economic problems that further exacerbate their plight. The following categories of findings may be discerned from the different reports.

The following factors were reported as being responsible for Vulnerability of PWDs to HIV/AIDS (Risks)

4.1 Poverty

People with disabilities met in the focus group discussions pointed out that most PWDs in Uganda are poverty stricken due to unemployment. Many of them are unemployed because of lack of employable skills. Lack of unemployable skills is because most of them have either no formal education at all or have very low levels of education.

The low level of education stems from discrimination starting from family level where parents do not give PWDs the same opportunity like the able bodied children. This scenario continues even to community level. When PWDs go to seek for employment, they are not given opportunity. The high level of poverty makes PWDs especially the women very vulnerable to sexual manipulation in order to earn a living.

The poverty situation in the family has a negative implication on the livelihood of a child with disability. Young people with disabilities (in particular girls) who are born in very poor families are more vulnerable and some confessed to knowing friends who had been lured into sex encounters in the name of satisfying their material needs.

Poverty has complicated access to information in that most PWDs cannot even afford radios and televisions leave alone newspapers where most information on HIV/AIDS is disseminated.

4.2 Low levels of literacy

Many PWDs are unable to read and write. This means that they are not able to access the abundant literature on various aspects of HIV/AIDS, including reproductive health and other critical areas of development, (which, unfortunately is in English and normal print. This increases their vulnerability.

4.3 The extent of disability

In cases of rape, PWDs pointed out that they have sometimes had to face rape as a result of inability to fight rapists due to the severe physical disability. Other cases have been where the victim is either deaf and dumb such that even when over powered, cannot raise an alarm to seek help or cases when the victim is both deaf and blind.

The deaf, blind and those with multiple disabilities are common victims in this regard. Some PWDs have mental or physical handicaps that limit their ability to fend off the attack. Too often, those that are expected to provide assistance to

them are the same people that sexually abuse them. Sadly, those who acquire HIV/AIDS out of such circumstances lack knowledge on the existence of VCT services.

4.4 Failure by parents to provide sex education to their children

The Young people with disabilities during their FGDs said that although parents are expected to provide sex education, to their children, they tend to shy away from this responsibility and avoid discussing issues of sexuality[6]. Sometimes parents think that their children are too young to be told about HIV/AIDS. Instead of making them understand the dangers of the epidemic, they only give open-ended instructions: 'don't do this', 'don't do that' As a result of this, adolescents do not get correct, appropriate and reliable information. In some other instances, some parents are not able to communicate and/or talk to their children because of lack of modes of communication (do not know sign language, for example).

4.5 Misconceptions on HIV/AIDS

4.5.1 Belief in witchcraft

Uganda is one of the least urbanised countries in Africa, with over 80% of the population living in rural areas. Even those living in urban areas still have strong belief in witch craft. In the rural districts of Rukungiri and Kaberamaido the focus group discussions revealed that most people with disabilities visit witch doctors first when they are sick.

There is a general misconception among some sections of PWDs that HIV/AIDS is caused by witchcraft. This is a big constraint to efforts that are meant to sensitise PWDs on the nature and threat of HIV/AIDS. Instead of seeking medical care, a person having HIV/AIDS or disability would prefer to visit a witch doctor. There are many chances of PWDs acquiring HIV/AIDS through practices of witchcraft either through sexual abuse by the witchdoctors or sharing of sharp instruments/equipment and performance of cultural rituals.

In many rural areas where most PWDs live, pregnant mothers with disabilities deliver in unhygienic environments with the assistance of unqualified personnel. This increases the likelihood of infection by HIV/AIDS.

4.5.2 The misconception that PWDs do not engage in sex

[6] In many communities in Uganda, culture dictates that it is taboo to discuss matters sexual with young people, let alone children. This is a big constraint in the fight against HIV/AIDS.

Most focus group discussions pointed out that there is a general attitude that PWDs are not sexually active and therefore are HIV/AIDS free. This results in some people approaching them for sex with a view that they might be free. Teachers were among the people cited in the FGDs as some of the people who sexually abuse the disabled girls that manage to go to school. Some of the offenders in these cases may already be infected.

4.5.3 Dangerous beliefs

In the FDGs it was revealed that there has been a belief that when an infected person has sex with a person with disability, he / she can be healed. It has made people with disabilities especially girls and women vulnerable to defilement, rape and sexual abuse.

4.5.4 PWDs are spread out and not easy to reach with awareness messages

Although there has been a high level of awareness on HIV/AIDS among the general public in Uganda, some categories of disabilities especially the Blind and the Deaf have not been educated on the deadly disease, which has left them very vulnerable. The females have been more vulnerable in these categories.

Service providers when contacted said that PWDs are generally geographically scattered in urban and rural areas (no large concentrations). It is not easy to reach them and collect them in groups for sensitisation and service provision purposes. This makes them generally inaccessible (this is mostly true in the case of those that live deep in the villages or rural areas where service providers do not reach.). They cannot, for example, access educational and health services and facilities[7]. This affects their level of awareness in matters pertaining to HIV/AIDS.

Others said that they were not able to talk to the Deaf because they do not know sign language, so they could not reach them.

Other factors to illustrate the apathy of the general public to the plight of PWDs are summarised below:

- Unfriendliness of service providers. Women with disabilities complain of health workers who rudely question why they get pregnant yet they know that they have disabilities. This discourages them from going to

[7] Developing countries like Uganda tend to have inadequate educational, health and other facilities even for able-bodied people. The few that exist are generally inaccessible (in terms of location/distance – ease of access- and money) to PWDs.

health workers who could give them useful information about HIV/AIDS.

- Lack of special programmes from Government and the private sector targeting people with disabilities on HIV/AIDS related issues. This is as a result of non-streamlined roles of potential partners in mainstreaming disability issues hence insensitive programmes to specific needs of PWDs**.**
- Lack of specially trained service providers/health care providers to help people with disabilities.
- Lack of involvement of PWDs in mainstream development issues.

4.5.6 Cases of unfaithfulness

Some PWDs confessed to being unfaithful to their partners. This also exposes them to HIV/AIDS infection.

4.5.7 Level of Knowledge and Access to HIV/AIDS Information and Services

The currently available services and resources as well as channels of disseminating HIV/AIDS information of any category (for example targeting prevention) do not specifically take into account people with disabilities. Communication barriers persist between the able-bodied and PWDs. These inappropriate methods of disseminating critical information leave certain categories of PWDs (with specific disabilities) isolated and excluded. This is elaborated upon below.

4.5.8 Inaccessible IEC materials

The nature /mode of information dissemination about HIV/AIDS is not user-friendly to PWDs (especially the deaf and the blind). The blind cannot read / see the posters generally used for disseminating such information on radio, TV or print media and therefore cannot easily benefit from what is currently available (the blind cannot see printed messages/materials, the deaf cannot hear verbally disseminated messages on HIV/AIDS).

Many such categories remain ignorant about their sero status and the available services and opportunities, for example, information on use of condoms as a preventive measure. This is underlined by the following situations (revolving around the use of condoms) that are a result of inadequacies in the awareness campaigns when it comes to reaching out to PWDs. PWDs have inadequate knowledge about the distribution centres of condoms, and are not even aware that these are distributed free of charge in designated health units. The few that manage to access the condoms do not use them (just keep them or use them

improperly), as they do not have the knowledge on how to use them or about their effectiveness.

Use of condoms by PWDs is not a prevalent practice. This primarily due to the following reasons:

- Many PWDs do not normally have the opportunity to engage in sex because of their general exclusion, but they too are human and sometimes desire sex although potential partners do not normally approach them. When an opportunity arises and the partner shuns condom use, the PWD is generally vulnerable and just accepts to engage in sex without a condom.

  Some PWDs doubt the effectiveness of a condom – the knowledge about the use of the condom and its effectiveness is limited. In some FGDs, in Nyakishenyi, in Rukungiri, some PWDs told the team that they feared using condoms because they had heard that they could get stark in women during intercourse.

  Blind people met pointed out the problem of inability to read expiry dates on condoms, yet they may not wish to ask any body whether the condoms they have are still valid for use or not.

- Where some PWDs could have used condoms, they find them expensive, yet they are not aware that free condoms exist at Government Health Centres.
- The Blind and the deaf people do not have adequate information about HIV/AIDS and the use of condoms as a protective measure. Sometimes interpreters are needed but interpretation services are scarce and costly – this may not be affordable by PWDs.

Apart from perceptions, behaviours, practices and attitudes that make PWDs vulnerable to HIV/AIDS infection, there are constraints summarised as follows:

- Lack of mobility appliances/assistive devices to enable PWDs reach health centres for services.
- Difficulty in comprehending information in the case of the mentally retarded people because of loss of some sensory functions.
- Some physically disabled persons confessed to having been denied access to VCT services because they were dirty. Health workers were not willing to touch them because of their appearance. They were quite dirty because they crawl on the ground.

4.5.9 Engagement in risky Behaviours

Several behavioral aspects also serve as catalysts for vulnerability. Alcoholism, for example, is yet another risky factor in the spread of HIV/AIDS. PWDs who have been caught by the alcohol abuse trap, for example, tend to be prone to the practice of engaging in casual sex and this increases the chances of contracting HIV/AIDS.

Some PWDs are unable to control their sexual desires even when alcohol is not a factor. Others are hyper sexually active. Others just lead an irresponsible life, which may lead them to engage in sex with their friends, relatives, strangers and/or casual friends. The engagement is either desired or forced. Like the "able-bodied" some of them no longer take HIV / AIDS as a serious issue but like any other disease. This is a risky situation that may not enable them to escape from the risk of infection.

In all the findings young people or children (below 18 years of age) are the most vulnerable and in many cases defenceless members of society. Yet the community generally ignores their plight.

According to WAC News (2003), children are not only infected but also affected, stigmatised, isolated and denied basic services of life, which negatively impacts on their growing process. These include those who are actually infected and are living with HIV/AIDS, those who are affected because members of their family (mainly parents) are living with HIV/AIDS and children as a whole. Children with disabilities are not exclusive of these categories.

Children who lose parents to AIDS suffer traumatic and psychological torture and are orphaned at an age when parental care and guidance is most needed. For children whose parents are bedridden or dead, the quality of care, education, nutrition and socialization is often poor. The rate of sexual abuse by adults who think that children are free from HIV/AIDS is also very high. The girl child with a disability is the worst affected.

Many women with disabilities in the focus group discussions pointed out that they rarely get an opportunity to have sex as most times, men consider able – bodied women first before approaching a disabled woman. What happens is that when a man approaches a woman with disability, she does not want to lose this opportunity because they do not know when it will come again.

5.0 ANALYSIS

The findings of NUDIPU's desk study which involved scrutiny and analysis of reports of already conducted studies on different aspects of HIV/AIDS was meant to establish how this scourge affects PWDs. It was meant to bring together, in a coherent manner, information that is scattered in various reports, identify gaps (if any) and fill them in and repackage the information for ease of access by stakeholders. It was envisaged that this would ultimately enable the development of appropriate intervention mechanisms for the benefit of PWDs.

While most of the reports that were studied by the researchers cover only certain aspects of HIV/AIDS or different categories of PWDs, this report now gives a holistic picture examining, for example, the different genders and age groups, as well as various aspects of HIV/AIDS.

HIV/AIDS is the greatest human challenge facing the development community today as it devastates the development progress. It has aggravated the poverty situation and has had a frustrating impact on the poor (World Vision strategy, 2002/04). Effects of HIV/AIDS have been faced in almost every household and in every part of the country and across all sectors of Uganda's economy.

Although Uganda as a country has been at the forefront in the fight against HIV/AIDS, some categories of people have not been targeted. PWDs have not been educated on this deadly disease and a good number has died of illnesses similar or incidental to HIV/AIDS. Because of their socio-economic situation, some PWDs cannot read or write and as a result cannot access available literature on HIV/AIDS. For those who are educated, there are still other limitations, for example the blind can only read Braille, the deaf/blind require interpreters to be able to benefit from audio programmes on radio, television, etc. These services are costly and hardly available.

The findings of this study reveal that the incidence of HIV/AIDS among PWDs in Uganda is high and that little has so far been done that specifically targets PWDs in this regard. The situation has not been made any easier by the attitudes, behaviours and practices of PWDs themselves and the generally apathetic attitude from the general public. Poverty and the generally low levels of literacy among PWDs are also crippling factors. There is therefore still need for behavioural change and appropriate strategies targeting PWDs.

Although Information, Education and Communication (IEC) and condom use have been spelt out as the most effective tools in preventing the spread of HIV/AIDS and other STDs, frustrating factors like negative attitudes and perceptions from the community (for example that PWDs are not sexually active and not expected to use condoms), the type of disability (this may restrict one from using a condom – as is the case with the blind who may not see and make a

choice of the type of condom to use, determine whether the condom is expired or not; or people with one arm/hand that may feel uneasy while putting on the condom)- are all factors that are not in conformity with IEC strategies and therefore making PWDs more susceptible to infection.

> While all PWDs are at risk, the situation of the female gender is especially worrying as is the case with HIV/AIDS infection and prevalence among able-bodied people. Highly vulnerable as women are, society continues to mainly pay lip service to their plight. To many, unfortunately, this appears to be a non-issue and women remain an invisible group not worthy of consideration (Bylan in Nangendo, 2002). There is no better illustration of this than what happened on 8 March 2004 during celebration to mark the International Women's Day in Uganda, celebrations whose theme was "Women and AIDS: Challenges and the Way Forward". None of the honourable speakers said anything about the theme, not even women leaders present hinted on the theme (*Sunday Vision*, edition of 14 March 2004). Instead, virtually everyone who spoke was talking about the possibility (or lack thereof) of the Ugandan President's third term in office (commonly known as '*ekisanja*' in Ugandan speak). The situation of women with disabilities is worse to the extent that even in forums for women, women with disabilities are still a non-issue.
>
> Apart from women, young people or children with disabilities are also especially vulnerable. Because of cultural restrictions and other factors mentioned elsewhere in this report, young people are increasingly becoming more vulnerable. They are deprived of information on sex even when they are sexually active. Available health services are not attractive enough and do not promote their health seeking behaviour. Service providers are urged to recognize the sexual and reproductive rights and to accord them their dignity. Intervention strategies must be all inclusive of PWDs needs.
>
> A number of steps have been taken, mostly by government institutions, to come up with various interventions pertaining to HIV/AIDS in Uganda. These include a draft National AIDS Policy (UAC, 2003) developed jointly with organisations (both public and private) working in various areas of HIV/AIDS. The policy recognizes PWDs as a marginalized group that should be specifically targeted, stating that 'there is need to develop a comprehensive policy on protecting PWDs from HIV/AIDS and managing PWDs living with AIDS'. This is clearly grossly inadequate. One would have expected a national policy to come up with relevant interventions but in this case it appears to only lay some basis for the

formulation of yet another policy specifically targeting PWDs. This could be an indicator that PWDs did not take part in the policy-making process.

Apart from government interventions, attempts have also been made by other stakeholders, including various sectors, NGOs, HIV/AIDS organisations to put in place strategies for inclusion of PWDs in the HIV/AIDS mainstream programmes. However, a lot is still desired especially in terms of accessing information to PWDs in a friendly manner that promotes their participation.

Generally, a number of protection mechanisms/methods are in place (current HIV/AIDS intervention strategies). These include the following:

- Information Education and Communication (IEC)
- Counselling programmes
- Counselling and HIV/AIDS testing programmes
- Condom distribution
- STD control

The question that remains, however, is to what extent are PWDs benefiting from such interventions and what can be done for the benefit of PWDs? As it is, they mainly target able-bodied persons.

6.0. RECOMMENDATIONS

In light of the findings of these studies, NUDIPU recommends the following interventions with the hope and expectation that they will lead to the empowerment of PWDs as change agents in this era of HIV/AIDS:

There is need to:

- Adopt appropriate and disability sensitive channels of communication to disseminate HIV/AIDS messages/information to the community of PWDs.

- Lobby Government and other service providers to support Brailing and/or recording of messages/information on condoms, leaflets and other HIV/AIDS-related literature.

- Print HIV/AIDS posters with PWDs on them to attract the attention of the public and stir them into positive action and intervention.

- Lobby Government to promote and decentralize disability sensitive VCT services and health centres to all districts.

- Promote adult literacy programmes for PWDs to enable them to read, write and interpret disseminated HIV/AIDS messages.

- Organize and strengthen community outreach programmes targeting PWDs and their families.

- Train and counsel PWDs on positive living with HIV/AIDS and individual behavioural change.

- Sensitise PWDs about safer sex options with emphasis on abstinence.

- Ensure full participation of PWDs in HIV/AIDS control and sensitisation activities.

- Facilitate training of service providers in sign language so as to be able to reach out to the Deaf.

- Train reproductive health peer educators (leaders of disabled people) drawn from PWD communities/groups to assist in training PWDs in life planning skills.

- Train reproductive health and HIV/AIDS service providers for effective reach of PWDs.

- Provide gender sensitive counselling to PWDs including family planning services and contraception.

- Strengthen networking with other organizations working in the area of HIV/AIDS and human rights.

- Support PWDs drama groups to disseminate information on HIV/AIDS and reproductive health.

- Provide the PWDs with radios to subsidized prices to enable them access messages on HIV/AIDS and follow sensitisation programmes.

- Lobby Government and policy makers to incorporate disability issues into the mainstream poverty reduction (PEAP) and human rights programmes.

- Strengthen support to disabled people's organizations at lower levels to enable PWDs meet, exchange information and work towards improving access to health services.

- Use of media to increase awareness on the plight, abilities and reproductive health needs of PWDs including the dangers of unprotected sex in light of the HIV/AIDS scourge.

- Initiate a specially designed programme on HIV/AIDS targeting young people with disabilities purposely to counsel, guide, advise and equip them with basic quality information and education regarding health care and HIV/AIDS. This is because not much awareness has been previously been made to them.

As a consequence of the study, a plan of intervention that is geared towards addressing the identified gaps and causing a positive change in the lives of PWDs with regard to access to information and services on HIV/AIDS has been drawn up (see appended plan at the end of this report).

6. CONCLUSION

Overlooking the threat of HIV/AIDS to disabled persons is one of the most dramatic forms of exclusion they can face.

NUDIPU calls for mainstreaming of disability in all interventions to mitigate HIV/AIDS or else the entire population of disabled persons may be lost to HIV/AIDS.

SOURCES

Government of Uganda, 2000. The National Strategic Framework for HIV/AIDS Activities in Uganda: 200/1 – 2005/6. UAC, Kampala.

Government of Uganda, 2000. Draft HIV/AIDS Sectoral Plan: 2000/1 – 2005/6. Ministry of gender, labour and Social Development, Kampala.

Government of Uganda, 2000. Draft HIV/AIDS Plan for Ministry of Education and Sports (2000/1 – 2005/6). Ministry of Education and Sports, Kampala.

Government of Uganda, 2000. Draft HIV/AIDS Sectoral Plan: 2000/1 – 2005/6. Ministry of Agriculture, Animal Industry and Fisheries, Kampala.

Muhumuza, FK and Ssenoga, M. 2003. Report on Findings of an HIV/AIDS Situation Analysis Carried Out on the Community of People With Disabilities in Kaberamaido, Rukungiri, Mubende and Arua. National Union of Disabled persons of Uganda (NUDIPU), Kampala, Uganda.

Mulindwa, IN. 2003. Study on Reproductive Health and HIV/AIDS Among Persons With Disabilities in Kampala, Katakwi and Rakai Districts (Knowledge, Attitudes and Practices). Disabled Women's Network and Resource Organisation (DWNRO), Kampala, Uganda.

Owako, RO. 2003. People With Disabilities and HIV/AIDS – A rapid Assessment. Handicap International, Nairobi.

Nangendo, F. 2002. Awareness of reproductive Rights, HIV Prevention and Sexual Exploitation Among Women With Disabilities. A Research Report Submitted to the Community Based Rehabilitation Alliance (COMBRA), Kampala, Uganda.

NUDIPU, 2003. Assessment of the Level of Knowledge of HIV/AIDS, HIV/AIDS Service Access and Vulnerabilities for Young People with Disabilities. Report Submitted to Swedish Organisations of Disabled Persons International Aid Association (SHIA), Stockholm, Sweden.

The Sunday Vision Newspaper, edition of 14 March 2004.

The New York Times Newspaper, edition of 28 March 2004.

Uganda AIDS Commission, 2003. The HIV/AIDS Epidemic: Prevalence and Impact. UAC, Kampala, Uganda.

Uganda AIDS Commission, 2003. Draft National Aids Policy. UAC, Kampala, Uganda.

Uganda Youth Anti—AIDS Association – Organisation Profile, UYAAS, Kampala.

UNAIDS**,** 2002. Report on the Global HIV/AIDS Epidemic. UNAIDS, Geneva.

WHO, 2001. HIV/AIDS Strategy in the African Region – A Framework for Implementation. World Health Organisation, regional Office for Africa, Harare, Zimbabwe

World Vision, 2002. HIV/AIDS Strategy 2002/04.

WAC News 2003, A publication of Uganda AIDS Commission.