STUDY ON REPRODUCTIVE HEALTH AND HIV/AIDS AMONG PERSONS WITH DISABILITIES IN KAMPALA, KATAKWI AND RAKAI DISTRICTS

(Knowledge, Attitudes and Practices)

By

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Commissioned by Disabled Women's Network and Resource Organisation (DWNRO) with Support from Action Aid Uganda.

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ACRONYMS

FP	Family Planning
IEC	Information, education and communication
IGAs	Income generating activities
MWDs	Men with disabilities
PWDs	Persons with disabilities
RH	Reproductive health
RHS	Reproductive health services
STI	Sexually transmitted infections
TBAs	Traditional birth attendants
WWDs	Women with disabilities
UPE	Universal Primary Education

EXECUTIVE SUMMARY

The study on reproductive health and HIV/AIDS among disabled persons was commissioned by Disabled Women's Network and Resource Organisation (DWNRO), with support from Action Aid Uganda. The study was conducted in Kampala, Katakwi and Rakai Districts in order to:

- ③ Investigate the reproductive health and HIV/AIDS knowledge base of persons with disabilities.
- ③ Establish the beliefs, perceptions and reproductive health practices of persons with disabilities.
- ③ Identify constraints faced by persons with disabilities in their bid to seek reproductive health services.
- ③ Suggest possible strategies through which reproductive health service delivery could be improved among persons with disabilities.

The study adopted quantitative and qualitative research methods. A three-stage sampling criteria was used to select 3 sub-counties per district, 3 parishes per sub-county and 3 villages per parish. Respondents were then selected randomly from each village cluster. The procedure yielded 371 respondents (174 men and 197 women). These were men and women with disabilities, who were in the reproductive age groups of 15-49 for women and 15-54 for men. In addition, focus group discussions were conducted in each of the study districts targeting youth with disabilities, adults of either sex with disabilities, care providers of youth with disabilities and disabled parents of youth. All in all, 16 focus groups were conducted in the three districts. Thirty-one (31) in-depth interviews with key-players at the district and sub-county level were also conducted and these included councillors of persons with disabilities at district and sub-county levels, technical staff working on reproductive health and HIV/AIDS projects in the survey districts, reproductive health service providers, medical personnel from the District Directorate of Health Services including the District HIV/AIDS Coordinators.

The results indicate that 37% and 31% of the women and men in the sample were youth (15-24), while the age groups 25-34 and 35-44 constituted a quarter of the female sample each. Fifty-two (52%) of the women and 42% of the men were rural residents. The highest proportion of either

sex had attained primary school education (56% men and 48%). About 55% were Catholics and over 30% of the total sample thrives on agriculture.

Poverty, discrimination, and stigma, are the major socio-economic problems faced by persons with disabilities. The reproductive health problems faced by women with disabilities include sexual exploitation, unwanted pregnancy and complications during childbirth. Exclusion from the reproductive health sensitisation and awareness raising programmes was cited as a major problem by either sex.

In relation to sexual behaviour, about 80% of the respondents in the sample had ever engaged in sex and the estimated median age at first sexual activity is 16 years for women and 18 years for men. Noteworthy is that 22% of the women in Kampala and Rakai Districts were reported to have been raped in their first sexual encounter. More men (22%) than women (16%) have ever engaged in sex for gain. Awareness about condoms is over 90% for either sex and ever use of condoms is 44% among men compared to 27% of the women. Current use of condoms is only 24% and 10% of men and women respectively.

Awareness about sexually transmitted infections is over 91% for either sex. Incidence of STIs (proportion ever contracted sexually transmitted diseases) is however, very high (38% of women and 35% of men). Results also show that the incidence of sexually transmitted infections is higher among women in urban areas (41%) and those with primary education (42%). Awareness about HIV/AIDS is almost universal. However, only 6% of either sex reported testing for HIV as a means of knowing one's HIV status. Most persons with disabilities are aware that HIV is transmitted through sexual intercourse with an infected party. Vertical transmission of HIV is the least known mode of transmission (7% males and 10% females). Over half (55%) of the women with disabilities consider themselves at risk of contracting HIV/AIDS either because they regularly involve in unsafe sex or they have multiple sexual partners. About 87% are willing to take an HIV test. Poverty, rape, non-use of condoms, lack of awareness about reproductive health issues, polygamy and wife sharing were cited as pre-disposing factors to HIV among persons with disabilities.

The results on pregnancy indicate that 77% of women had ever been pregnant. The median age at first pregnancy is 18 years and the mean number of children ever born is 4. The danger signs of pregnancy are however, not well known. The proportion ever heard of contraception is 85% of either sex. Ever use of modern methods is 33% among women and 35% among men. Current use of modern methods is 21% of men and 30% of women.

Considering reproductive health service utilisation, three quarters of the women (75%) had ever utilised reproductive health services compared to 51% of the men. Majority however, feel they are not accessible to persons with disabilities. This was attributed to geographical inaccessibility of health facilities, unfriendliness of the service providers, poverty, lack of awareness on reproductive health issues and lack of confidentiality. Radios and friends are the major providers of reproductive health and HIV/AIDS information.

The findings call for design and implementation of reproductive health interventions which are specifically tailored to the needs of persons with disabilities; improvement in the poverty situation of persons with disabilities in order to improve their reproductive health status; provision of information, education and communication on reproductive health and HIV/AIDS to persons with disabilities; and sensitisation of parents/guardians, family members and the entire community about the plight of persons with disabilities particularly women, in order to curb stigma and discrimination.

CHAPTER ONE

BACKGROUND TO THE STUDY

1.1 Introduction

This report presents findings of the study on reproductive health and HIV/AIDS among disabled persons in Kampala, Katakwi and Rakai Districts. The study was commissioned by Disabled Women's Network and Resource Organisation (DWNRO), and supported by Action Aid Uganda.

1.2 Objectives and Rationale for the Study

The general objective of the study was to establish the reproductive health needs of disabled persons in a bid to facilitate the design and implementation of reproductive health programs and strategies among persons with disabilities in the DWNRO implementation districts. Based on data generated from Kampala, Katakwi and Rakai Districts, the study specifically went out to:

a. Investigate the knowledge base of persons with disabilities in relation to reproductive health issues including HIV/AIDS.
b. Identify the beliefs, perceptions and reproductive health practices of persons with disabilities.
c. Identify constraints faced by disabled persons in their bid to seek reproductive health services.
d. Suggest possible strategies through which the reproductive health service delivery could be improved among persons with disabilities.

The findings of the study will enable informed design and implementation of policies, programs and strategies that address the reproductive health needs including HIV/AIDS, of persons with disabilities. In specific terms, the findings will guide DWNRO to design specific interventions for the reproductive health and HIV/AIDS program in the districts of operation.

1.3 Scope of the Study

In light of the above-mentioned objectives, the study focused on the following themes and indicators, which were also presented to stakeholders for approval in a workshop held on 1st March 2003, at Shine Hotel in Kasanga - Kampala.

③ Demographic and socio-economic

i. Age, sex, form of disability, date of birth, marital status, educational attainment, childhood residence, religious affiliation, source of livelihood
ii. Media access
iii. Asset base of household

③ Sexual behaviour

i. Age at first sexual debut
ii. Age of first sexual partner
iii. Circumstances at first sexual experience
iv. Knowledge, ever use, current use, future use of condoms and circumstances surrounding condom use

③ STI/STDs including HIV/AIDS

i. Knowledge and incidence of STIs
ii. Knowledge of HIV/AIDS
iii. HIV testing
iv. Management of STIs
v. HIV/AIDS and STI risk perception
vi. Sources of HIV/AIDS information

③ Pregnancy and reproduction

i. Incidence of pregnancy
ii. Age at first pregnancy
iii. Pregnancy termination
iv. Incidence of childbirth

v. No. of live births
vi. Health seeking practices (ante-natal care, delivery care, etc.)
vii. Knowledge of danger signs of pregnancy

③ Contraception
i. Knowledge about contraception
ii. Ever use and current use of contraception
iii. Non-use of contraception
iv. Future use of contraception

③ Reproductive health services
i. Knowledge of RH services
ii. Sources of RH services
iii. RH service utilization
iv. Interaction on RH issues
v. Perceived quality of services
vi. Accessibility to RH services
vii. Sources of RH information

③ Qualitative issues
i. Problems faced by disabled persons (socio-economic and RH)
ii. Pre-disposing factors
iii. Constraints to RH service delivery and utilization
iv. RH information access and utilization
v. Harmful community practices
vi. Existing initiatives for disabled persons
vii. RH information dissemination
viii. Role of political leadership in the enhancement of quality reproductive lives
ix. Recommendations for policy and program action

1.4 Report Outline

The report is constituted by eight chapters, of which chapter one is introductory. Chapter two presents the methodological issues for the study including problems encountered. Chapter three presents socio-demographic characteristics of the respondents while chapter four highlights indicators on the sexual behaviour and condom use of PWDs, socio-economic and reproductive health problems faced by PWDs. Chapter five presents the findings on the status of PWDs in relation to sexually transmitted infections (STIs) and HIV/AIDS, and predisposing factors to STIs and HIV among PWDs. Chapter six focuses on pregnancy and contraception. Knowledge and utilization of reproductive health services among PWDs are explored in chapter seven, while the last chapter presents a summary of the major findings and emerging issues for policy and program action.

CHAPTER TWO

STUDY METHODOLOGY

2.1 Introduction

Presented in this chapter is the methodology used for the study. This includes the study design and sampling procedures, survey methods and survey administration and management.

2.2 Study Design

While the basic principle governing the selection of a representative sample in any scientific study is that the process must be random (so as to minimise sampling errors), the selection of Kampala, Katakwi and Rakai Districts as study districts was purposively determined. The criterion for selecting these districts was based on the principle that these are the districts where the Disabled Women's Network and Resource Organisation (DWNRO) is operating in relation to reproductive health and HIV/AIDS.

2.2.1 Sampling Procedures

The study adopted a three-stage selection criterion together with random procedures to select eligible respondents within the three study districts.

Stage I: Three (3) sub-counties were purposively selected in each of the three districts. While the whole of Kampala is urban, Rakai and Katakwi Districts are predominantly rural in nature. Nevertheless, one of the three sub-counties in these districts had to be Rakai and Katakwi Town Councils, to capture some aspects of urbanism in the two districts. The other two sub-counties were selected purposively, with the guidance of the disabled representatives to the district councils. These had to be sub-counties which had a comparatively large concentration of disabled persons as indicated on the lists available at the District Disabled Union Offices.

Stage II: Three parishes per sub-county were purposively selected - going by the concentration criteria as mentioned above, which made it 9 study parishes per district.

Stage III: The same criteria was used to select 3 village clusters for the disabled persons. Respondents were then randomly selected from the village cluster listing and interviews were conducted with all the selected respondents. These had to be disabled persons in the age group (15-49) for women and (15-54) for the men.

In arriving at the sample size for the study, it was important to recognise that the Ugandan society is still very patriarchal and discriminatory in nature in which disabled women are women first, then disabled and thus a double exclusion in society. It was therefore the intention of this study to have more than 60% of the respondents women and 40% men. In the selection of respondents therefore, 5 respondents were selected from each village cluster of whom 3 were meant to be female. The procedure yielded 371 respondents of whom 174 were men and 197 women.

2.3 Survey Methods

For better understanding of reproductive health issues among the disabled persons, quantitative and qualitative survey methods were adopted in this study.

2.3.1 Quantitative Survey

In order to generate data on the status of PWDs regarding RH and HIV/AIDS as also stipulated under study scope in the previous chapter, it was necessary to conduct a one to one quantitative study to foster effective strategy design by DWNRO in its bid to fight HIV and enhance reproductive well being among the disabled persons, particularly women.

The selected PWDs as per the above-mentioned procedures were thus probed through a quantitative survey instrument/questionnaire, which was designed by the Principal Investigator and administered to the respondents by enumerators/interviewers (see Appendix I). The instrument investigated the following individual/personal aspects:

③ Personal socio-demographic attributes assumed to be associated with one's knowledge, beliefs, attitudes and practices regarding RH issues.

③ Knowledge and awareness of HIV/AIDS including risk assessment to HIV. ③ Sexual practices - age at first sex, circumstances surrounding on-set of sexual activity among disabled persons, condom use, etc.

③ Reproductive health practices and service utilisation including contraception, STD incidence and management, etc.

③ RH service delivery factors and constraints to service utilisation.

2.3.2 Qualitative Survey

There was need to get qualitative views on a number of aspects governing RH issues among disabled persons, for better understanding of the perceptions, belief system, environment and entire context within which these persons operate. Focus-group Discussions (FGDs) and in-depth interviews with key informants were conducted in the study districts as follows:

2.3.2.1 Focus Group Discussions (FGDs)

Six (6) FGDs per district were conducted as follows:

③ 1 for female disabled youth (15-24)

③ 1 for male disabled youth (15-25)

③ 1 for adult disabled females (25-49)

③ 1 for adult disabled males (25-54)

③ 1 for care providers/parents/guardians of the particularly disabled youth

③ 1 for disabled parents/guardians of particularly adolescents

The Principal Investigator developed an FGD guide (see Appendix II), which was also tabled in the stakeholder's meeting for discussion and additional input before it was finalised. The purpose of this instrument was to guide the focus group discussants in the course of discussions on the general issues affecting persons with disabilities (youths, adults, parents/guardians) and how best these can be overcome.

2.3.2.2 In-depth Interviews with Key-informants

In-depth interviews were conducted in each district and these targeted the following persons:

- ③ Project personnel working with disabled in the district or selected subcounties
- ③ PWDs Councillors (1 at the district and 1 in each of the 3 selected subcounties.
- ③ Members of PWDs District Union
- ③ RH service providers (1 at the district level - DDHS' office and 1 at the subcounty health facility and 1 HIV/AIDS District Coordinator)
- ③ Secretary for women or health at the district.

The Principal Investigator also developed a key-informant interview guide (see Appendix III). The areas of focus investigated through this instrument were: problems faced by persons with disabilities, programs in place, constraints to their access and utilization of reproductive health services and how best this can be improved

2.4 Pre-testing and Translation of the Survey Instruments

The instruments were pre-tested for validity and consistency before being used for data collection. The one-day pre-testing exercise was conducted by a team of 6 researchers, who were also later recruited as part of the data collection team as explained in the subsequent sections. The exercise later provided information, which was used in the finalisation of the survey instruments.

The final of the instruments were translated in the two major language groups of the survey districts namely; Ateso (Katakwi District) and Luganda (Rakai and Kampala Districts). This helps in the standardization of probes and thus likely responses, which are fundamental to quality outputs.

2.5 Survey Administration and Management

The overall management of the survey was the responsibility of the Principal Investigator, who was working in close collaboration with the Executive Director, DWNRO and the SFA Team Leader, Actionaid - Kampala. For effective execution of the exercise, the following were undertaken:

③ Recruitment of three (3) District Supervisors to manage survey operations in each of the study districts on behalf the Principal Investigator. These were persons with long-standing experience in community survey operations. They were primarily charged with: making initial contacts with the survey districts (these were conducted between 3rd-5th March, 2003); selection of study sites as per the laid down study design with the guidance of the district officials particularly those working with disability persons; liasing with Local Council officials during the data collection exercise to ensure proper respondent selection; handling administrative issues related to the survey in the respective districts

③ Recruitment of six (6) Research Assistants (2 per district - 1 male and 1 female) to facilitate collection of FGD and Key-informant interview data. These were persons with expertise in conducting qualitative surveys through semi-structure dialogue. They also had proficiency in the local languages of the study districts. These were charged with conducting the 6 FGDs in each study district; conducting the in-depth interviews with key-informants and translating and transcribing the FGD tapes.

③ Recruitment of twelve (12) enumerators (4 per district - 2 males and 2 female) were recruited and trained to facilitate data collection in the districts. These were responsible for administering the individual questionnaires to the selected disabled respondents. Since some of the RH issues are sensitive, female enumerators interviewed female respondents, while males also interviewed male respondents.

2.5.1 Training of the Researchers

The entire field team (Supervisors, Research Assistants and Enumerators) were centrally recruited and trained for 3 days for standardisation and quality assurance purposes. The exercise was conducted from 7th to 9th March 2003, by the Principal Investigator. The training focused on the study objectives, highlights on reproductive health issues and HIV/AIDS, working with persons with disabilities and the various forms of disability, survey design and methods for this study, the individual study instruments, translations, and many other aspects. The last day of training also

involved a field trials to enable the researchers get acquainted with the actual experience on the study tools.

2.6 Data Collection

The research teams were deployed to the districts as soon as the training exercise was concluded and the data collection exercise was conducted between 10th and 17th March 2003.

The selected subcounties in the districts were:

- Kampala District: Central Division, Makindye and Kawempe Divisions
- Katakwi District: Katakwi Town Council, Kapujan and Acowa Camp.
- Rakai District: Lyantonde Town Council, Dwaniro Subcounty and Kyebe Subcounty.

All in all, the exercise yielded 371 respondents (174 males and 197 females), 31 key informants and 16 focus group discussions.

2.7 Summary

The field exercise yielded robust data that have been used to generate estimates on RH and HIV/AIDS among persons with disabilities. It was also observed that among persons with disabilities, there are relatively fewer females than males. Reasons for this observed pattern are likely to be two.

a. Probably the death rate among females with disabilities in the reproductive ages is higher than that of males.
b. In the towns, like Kampala and Lyantonde, the selectivity of the migration process- as is the case elsewhere, favours males more than females.

Nevertheless, the data set would be adequate to meet the objectives set out in the study.

CHAPTER THREE

BACKGROUND CHARACTERISTICS OF RESPONDENTS

3.1 Introduction

This chapter presents the socio-demographic characteristics of respondents. The variables considered include; form of disability and age of respondents, current and childhood place of residence, educational attainment, marital status and religious affiliation, sources of livelihood, household possessions and access to media.

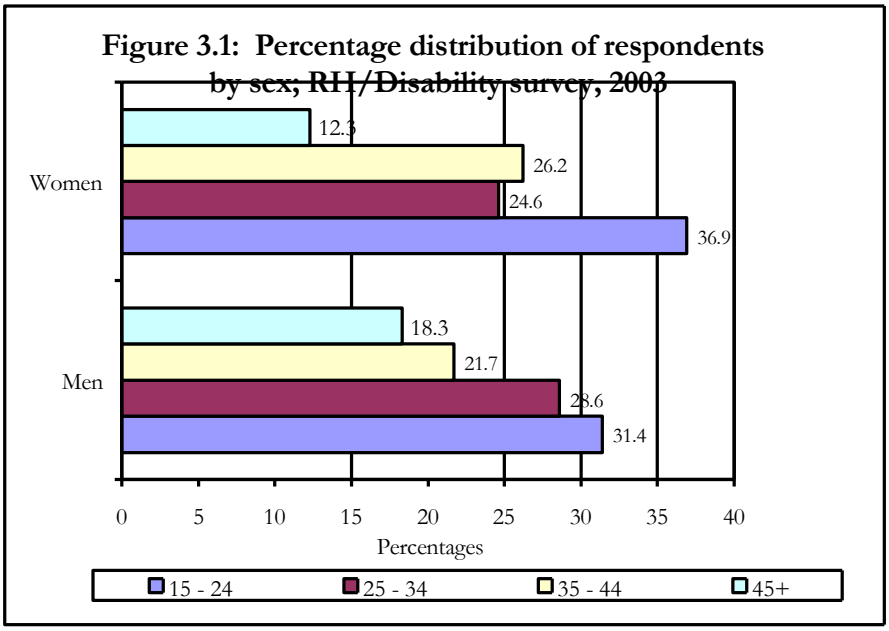
3.2 Age Distribution and Form of Disability

Table and Figure 3.1 show the age-distribution of respondents by sex and district. The data show that 37% of the female respondents were youth (15-24), while the 25-34 and 35-44 age groups constituted a quarter of the female sample (25%) each. Only 12% of the WWDs were 45 years and above. For the men, 31% were youth, 29% and 22% were in the 25-34 and 35-44 age groups respectively and the 45+ constituted only 18% of the male sample.

Table 3.1 also provides data on the various forms of disability that respondents had. In all the three districts, respondents mostly had physical handicaps and more so for the lower limb(s). In Kampala District, the proportion of respondents with such a handicap was 61% of males and 79% of females. A similar pattern applies to Rakai District except that the percentage of females was much higher (70%) compared to 36% among males. In Katakwi District however, male respondents with a handicap in the lower limbs were more (57%) than females (48%). A substantial proportion in the three districts had handicaps of the upper limb(s).

Table 3.1: Percent distribution of respondents by form of disability and age group; RH/Disability Survey, 2003

	Kampala		Katakwi		Rakai		All	
	Male	Female	Male	Female	Male	Female	Male	Female
Age group								
15-24	32.3	31.9	24.1	33.3	38.2	46.6	31.4	36.9
25-34	37.1	29.8	15.5	22.2	32.7	24.1	28.6	24.6
35-44	17.7	27.7	37.2	27.8	10.9	22.4	21.7	26.2
45+	12.9	10.6	24.1	16.7	18.2	6.9	18.3	12.3
N	62	47	58	90	55	58	175	195
Form of disability								
Deaf	1.6	2.1	6.9	5.6	7.3	1.8	5.1	3.6
Blind	3.2	4.3	15.5	14.4	16.4	5.3	11.4	9.3
Handicap-upper limb	12.9	8.5	13.8	18.9	21.8	10.5	16.0	13.9
Handicap-lower limb	61.3	78.7	56.9	47.8	36.4	70.2	52.0	61.9
Handicap-both limbs	17.7	4.3	6.9	12.2	9.1	7.0	11.4	8.8
Mental disorder	0.0	2.1	0.0	0.0	5.5	5.3	1.7	2.1
Others	3.2	0.0	0.0	1.1	3.6	0.0	2.3	0.5



3.3 Current and Childhood Place of Residence

Table 3.2 and Figure 3.2 show data on the distribution of respondents by current place of residence. Of importance to note is that Kampala District is all urban and hence the 100% for males and females. Considering Katakwi and Rakai Districts, about 3 out of every 5 respondents were rural residents. The proportion urban was approximately 30% in each of these districts. The results on childhood residence also reveal that 4 in every 5 respondents in Katakwi and Rakai Districts lived in rural areas during their childhood. Nevertheless, 65% and 70% of the respondents in Kampala District had a rural upbringing, which is not surprising in light of the fact that over 80% of the Ugandan population is rural based.

Figure 3.2: Distribution of respondents by Residence and Sex; RH/Disability Survey, 2003

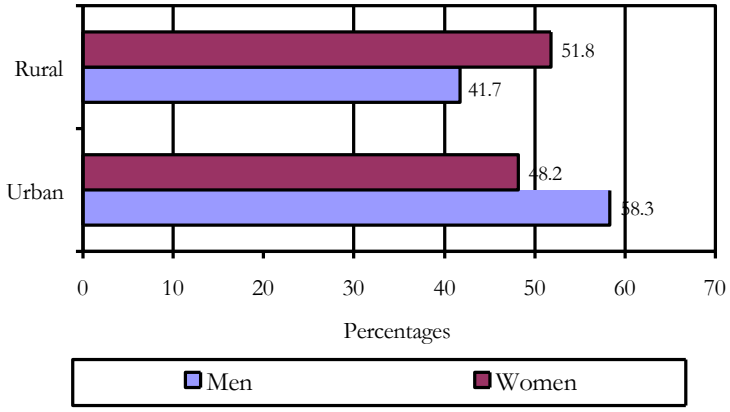


Table 3.2: Percent distribution of respondents by current and childhood place of residence; RH/Disability Survey, 2003

	Kampala		Katakwi		Rakai		All	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Current residence								
Urban	100	100	34.5	31.1	36.4	32.8	58.3	48.2
Rural	-	-	65.5	68.9	63.6	67.2	41.7	51.8
Childhood residence								
Urban	35.5	29.8	15.5	10.1	9.1	10.3	20.6	14.9
Rural	64.5	70.2	84.5	89.9	90.9	89.7	79.4	85.1
N	62	47	58	88	55	58	175	195

3.4 Educational Attainment

Education affects many aspects of one's life including individual demographic and health behaviour. Educational level is strongly associated with one's knowledge and perceptions about reproductive health aspects like contraception, fertility, reproductive health service utilisation to mention but a few. In addition, formal schooling enhances one's ability to manipulate and explore opportunities available for improved welfare. Educational attainment of the respondents was thus probed by asking whether they ever attended school, and if so, to specify the highest educational level attained. The results in Table 3.3 show that close to 88% of the respondents in Kampala District had ever attended school and the percentage for males and females is the same. The results from Katakwi District show that the proportion ever attended school was only 49% among female respondents compared to 88% of the male respondents. Rakai District presents a similar pattern only that the gender differential is not as wide as that of Katakwi District (67% females versus 80% males).

Of those who had ever attended school, the inquiry established the highest educational level they had attained (see Table 3.3 and Figure 3.3). The majority of female respondents had attained only primary school education, with the highest proportion reported by respondents in Katakwi (82%) and Rakai (80%) Districts, compared to 63% in Kampala District. The proportion with secondary education among women was 32% in Kampala District compared to 15% and 14% in Rakai and Katakwi Districts respectively.

Table 3.3: Percent distribution of respondents by educational attainment; RH/Disability Survey, 2003

	Kampala		Katakwi		Rakai		All	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Ever attended school								
Yes	88.7	87.2	87.9	48.9	80.0	67.2	85.7	63.7
No	11.3	12.8	12.1	51.1	20.0	32.8	14.3	36.3
N	62	47	58	88	55	58	175	193
Highest educational level attained								
None	11.3	12.8	12.1	50.6	20.0	32.8	14.3	36.1
Primary	41.9	55.3	58.6	40.4	69.1	53.4	56.0	47.9
Secondary	32.3	27.7	25.9	6.7	9.1	10.3	22.9	12.9
Post-secondary	14.5	4.3	3.4	2.2	1.8	3.4	6.9	3.1
N	62	47	58	88	55	58	175	194

Table 3.4 presents data on the educational attainment of respondents by age-group and sex. The results show that the proportion ever attended school across the four age-groups is higher among males than female. For example, 95% of the male youths (15-24) had ever attended school compared to 76% of their female counterparts. Similarly, 90% of the males in the 35-44 age group had ever attended school compared to only 49% of the women in the same age group. Noteworthy is that a half of the females (about 50%) in the age group 35-44 and 46% of women 45 years and above had never attended school. The proportion of females with post-secondary education is 4% for the three age groups, with the exception of the 25-34 age group, where none was reported.

Figure 3.3: Percent distribution of respondents by educational attainment; RH/Disability Survey, 2003

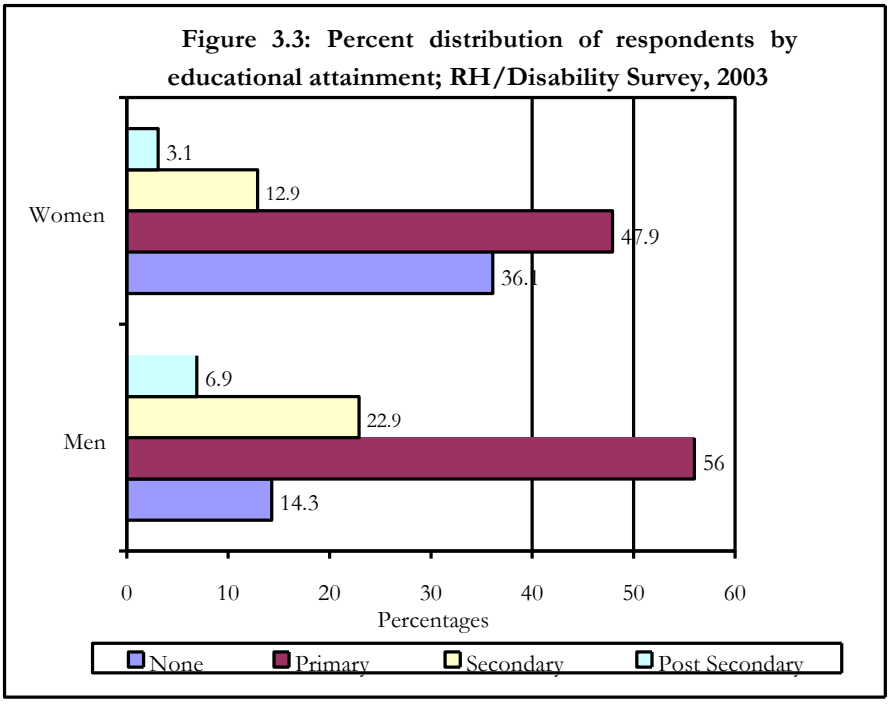


Table 3.4: Proportion ever attended school by age group and sex; RH/Disability Survey, 2003

	Male				Female			
	15-24	25-34	35-44	45+	15-24	25-34	35-44	45+
Ever attended school								
Yes	94.5	78.0	89.5	78.1	75.7	66.7	49.0	54.2
No	5.5	22.0	10.5	21.9	24.3	33.3	51.0	45.8
N	55	50	38	32	70	48	51	24
Highest level of education								
None	5.5	22.0	10.5	21.9	23.9	33.3	51.0	45.8
Primary	61.8	44.0	65.8	53.1	50.7	60.4	35.3	41.7
Secondary	29.1	22.0	15.8	21.9	21.1	6.3	9.8	8.3
Post-secondary	3.6	12.0	7.9	3.1	4.2	0.0	3.9	4.2
N	55	50	38	32	71	48	51	24

3.5 Marital status and Religious Affiliation

The findings on marital status and religious affiliation of respondents are presented in Table 3.5. Among females, the proportion married is 44% in Katakwi District, 36% in Rakai District and only 23% in Kampala District. As for the males, the percentage married is 60% in Katakwi District, 49% in Rakai District and 44% in Kampala District. The type of marriage was also probed and monogamous marriages seem to be the norm in all districts. However, substantial proportions of women also reported to be involved in polygamous unions. The percentages are 39, 24 and 22 in Rakai, Katakwi and Kampala Districts respectively.

Majority of the respondents in Katakwi and Rakai Districts were Roman Catholics. The Anglicans constituted a substantial share of the sample in Kampala and Rakai Districts. About 27% of the sample from Kampala District was Anglican.

Table 3.5: Percent distribution of respondents by marital status and religious affiliation; RH/Disability Survey, 2003

	Kampala		Katakwi		Rakai		All	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Marital status								
Never married	50.0	57.4	37.9	37.1	43.6	50.0	44.0	45.9
Married	43.5	23.4	60.3	43.8	49.1	36.2	50.9	36.6
eparated/Widowed	6.5	19.1	1.7	19.1	7.3	13.8	5.1	17.5
N	62	47	58	89	55	58	175	195
Type of marriage								
Monogamous	89.3	77.8	88.6	75.8	92.6	61.5	90.0	71.4
Polygamous	10.7	22.2	11.4	24.2	7.4	38.5	10.0	28.6
N	28	18	35	33	27	26	90	77
Religious affiliation								
Catholic	40.3	36.2	79.3	74.2	58.2	50.0	58.9	57.7
Anglican	25.8	27.7	10.3	15.7	21.8	31.0	19.4	23.2
Pentecostal	4.8	8.5	8.6	5.6	9.1	12.1	7.4	8.2
Muslims	27.4	27.7	0.0	3.4	10.9	6.9	13.1	10.3
SDAs	1.6	0.0	1.7	1.1	0.0	0.0	1.1	0.5
N	62	47	58	89	55	58	175	194

3.6 Socio-economic Status of Respondents

Proxies of socio-economic status include sources of livelihood and household possessions (see Table 3.6). There are variations in the sources of livelihood by sex and district of respondents. Kampala being urban, 43% and 39% of male and female respondents were traders. Noteworthy is that 20% of the female respondents in Kampala District had no source of livelihood. In Katakwi and Rakai Districts, highest proportions were earning their livelihoods from agriculture although female percentages are lower than those of males. In addition, the proportion of male respondents who thrive on agriculture is 60% in Katakwi compared to only half of this (31%) in Rakai District.

The household possessions probed were; electricity, radio, bicycle, motorcycle, and a car. Considering electricity, none of the respondents in Katakwi District and less than 10% of those in Rakai District lived in houses that had electricity. The proportion with electricity was 48% and 38% of males and females in Kampala District respectively.

Access to radio enhances information dissemination in a population. It is impressive to not that 86% of the male respondents and 70% of the female respondents in Kampala District live in

households that have radios. In Rakai District, slightly more female (62%) than male respondents (58%) have access to radio in their households. Only 19% of women and 40% of men in Katakwi District live in households that have radios.

Bicycles, motorcycles and cars ease mobility to various forms of service centres. The proportion of females that live in households with bicycles is 30% in Katakwi District, 26% in Rakai district and 11% in Kampala Distirct. Over a half of the males in Katakwi District live in households that have bicycles (53%) compared to 36% and 10% of their counterparts in Rakai and Kampala Districts respectively. Of importance to note is that none of the respondents in the districts of Katakwi and Rakai lived in a household with motorcycles and cars. The percentages for Kampala District are also very low.

Table 3.6 Distribution of respondents by major sources of livelihood and household possessions; RH/Disability Survey, 2003

	Kampala		Katakwi		Rakai		All	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Source of livelihood								
Farmer	1.6	2.2	59.7	30.6	38.2	29.3	32.3	23.4
Trader	42.6	39.1	1.8	10.2	5.5	15.5	17.3	18.8
Public officer	0.0	2.2	3.5	1.1	5.5	0.0	2.9	1.0
Casual labourer	1.6	6.5	7.0	11.4	10.9	1.7	6.4	7.3
Housewife	0.0	0.0	0.0	9.1	0.0	6.9	0.6	6.3
Fisherman	0.0	0.0	0.0	0.0	10.9	0.0	3.5	0.0
Craftsman	4.9	0.0	7.0	0.0	1.8	8.6	4.6	4.2
Domestic servant	0.0	2.2	1.8	1.1	0.0	0.0	0.6	1.0
Student	11.5	6.5	3.5	4.5	9.1	10.3	8.1	6.8
Others	27.9	15.2	5.3	22.7	18.2	22.5	17.3	20.8
None	9.8	19.6	8.8	9.1	0.0	5.2	6.4	10.4
N	61	46	57	88	55	58	173	192
Household possessions								
Electricity:								
Yes	48.4	38.3	0.0	0.0	9.1	6.9	20.0	11.4
No	51.6	61.7	100.0	100.0	90.9	93.1	80.0	88.6
No	62	47	58	88	55	58	175	193
Radio:								
Yes	85.5	70.2	39.7	19.1	58.2	62.1	61.7	44.3
No	14.5	29.8	60.3	80.9	41.8	37.9	38.3	55.7
N	62	47	58	89	55	58	175	194
Any household member with bicycle								
Yes	9.7	10.6	53.4	30.2	36.4	25.9	32.6	24.1
No	90.3	89.4	46.6	69.8	63.6	74.1	67.4	75.9
N	62	47	58	86	55	58	175	191
Any household member with motorcycle								
Yes	4.8	4.3	0.0	0.0	0.0	0.0	1.7	1.1
No	95.2	95.7	100.0	100.0	100.0	100.0	98.3	98.9
N	62	47	58	83	55	58	175	188
Any household member with car								
Yes	1.6	2.1	0.0	0.0	0.0	0.0	0.6	0.5
No	98.4	97.9	100.0	100.0	100.0	100.0	99.4	99.5
N	62	47	58	83	55	58	175	188

3.7 Media Access

Media access is essential in increasing people's awareness and knowledge of what is taking place around them, which may eventually affect their perceptions and behaviour. Access to media was established by asking whether respondents listen to radio and read newspapers. Table 3.7 shows that 70% of the female respondents in Kampala District listen to the radio daily compared to 86% of the male respondents. In Rakai District, the proportion that listens to radio is 58% of females compared to 67% of males. Daily radio listenership is only 16% among females in Katakwi compared to 41% of the male respondents. Noteworthy is that 35% of females in Katakwi District never listen to the radio.

Over a half of the respondents in Katakwi and Rakai Districts never read newspapers. The percentages for women are higher than those of males in both districts. Of the respondents that read newspapers, Table 3.7 indicates that a good number of them in all the three districts do it occasionally. Regular newspaper readership among women was higher in Rakai District (47%) followed by 21% in Kampala District and only 13% in Katakwi District.

Table 3.7: Percent distribution with access to mass media by district and sex; RH/Disability Survey, 2003

	Kampala		Katakwi		Rakai		All	
	Male	Female	Male	Female	Male	Female	Male	Female
Listen to radio								
Daily	85.5	70.2	41.4	15.9	67.3	58.2	65.1	41.6
Once a week	11.3	10.6	31.0	21.6	16.4	26.6	19.2	20.0
Once a month	0.0	2.1	17.2	27.3	3.8	1.8	7.0	13.7
Never	3.2	17.0	10.3	35.2	13.5	14.5	8.7	24.7
N	62	47	58	88	52	55	172	190
Read newspaper								
Yes	72.6	51.1	50.0	15.7	37.0	25.9	54.1	27.4
No	27.4	48.9	50.0	84.3	63.0	74.1	45.9	72.6
N	62	47	56	89	54	54	172	190
Frequency of newspaper readership								
Regularly	40.0	20.8	26.7	13.3	35.0	46.7	34.7	25.9
Occasionally	57.8	79.2	73.3	73.3	65.0	46.7	64.2	68.5
Never	2.2	0.0	0.0	13.3	0.0	6.7	1.1	5.6
N	45	24	30	15	20	15	95	54

3.8 Socio-economic Problems of Persons with Disabilities

The focus group discussions generated information on the major socio-economic problems faced by PWDs. Highlights of these may shed light on some of the observed patterns and levels regarding sexual and reproductive health aspects presented in this report. The findings show that all groups across the three districts cited poverty as the major socio-economic problem faced by PWDs. Contributors of poverty among PWDs that came up in the groups were inability to conduct agricultural activities, lack of formal education and skills and disability itself as a function of poverty.

③ Inability to engage in agricultural activities

In Rakai and Katakwi Districts, poverty is mainly attributed to inability of PWDs to engage in agricultural activities due to their physical body weaknesses. Because of their disabilities they can't cultivate large pieces of land and thus find it hard to earn a living from agriculture, which is the mainstay of the Ugandan economy. Some also added that they cannot even be hired for casual labour by agricultural employers because of the general belief among people that PWDs are too weak to conduct farm activities.

③ Lack of formal education and skills

It was mentioned that PWDs and particularly WWDs generally miss-out on opportunities of attaining formal schooling. Some groups attributed this to parental attitudes against disabled children while other participants felt that the un-friendliness of the Ugandan school system together with negative attitudes contributes to the PWDs failure to attain formal education. Sample quotations that bring out these sentiments are:

> *"Our parents feel we cannot perform well in school because we are disabled….they therefore, always say that they don't have money to waste on us" (Female youth, Katakwi District)*
>
> *"My parents wanted me to attend school but in all the schools I went, the teachers could not understand my problem (she is deaf)", another one adds "I could not climb the stairs of the schools they took me to and I stopped school after P2", (Male youths, Kampala District).*

"We don't have schools for the deaf and blind here and I don't see any hope for my child to get education and later on a job to sustain him" (Parent with disabled youth, Rakai District).

③ Disability as a function of poverty

The nature/form of disability was also mentioned as a key determinant of PWDs ability to escape poverty. Others also mentioned problems in mobility and communication, which are a result of the various forms of disability suffered by respective participants, which render them jobless and thus poor. Some responses to echo this were:

"Those who are crippled and weak cannot do anything to earn some money. Parents have to provide for them throughout their life and most parents are also poor", (Disabled parents, Katakwi District).

"The blind cannot count money as fast and transacting business is thus very hard for them. They are always cheated" (Adult males, Kampala District).

Other than poverty, PWDs also suffer discrimination and stigma from the entire community, which drains their esteem and capabilities.

"When we try to look for jobs, people tell us that our only job is to polish shoes"…all laugh (Male youths, Kampala District).

"Those who can perform drama on stage are always called last when the audience is tired", (Male Adults, Kampala District).

"It is difficult to take care of a disabled child and we suffer a lot raising them and yet we know they cannot contribute anything to the family wellbeing" (Parent of disabled youth, Katakwi District).

Geographical and social inaccessibility to particularly to socio-economic and health service centres also came up as a major problem faced by PWDs.

"Most of the health units are very far and we are physically handicapped. We cannot reach these places and public transport is very expensive", (Female adult, Rakai District).

"The jobs I could do are in the town and I can't move that far every day. Similarly, I have to send somebody to market my products for me because I find it hard to travel long distances", (Female youth, Katakwi District).

Lack of Aides to facilitate the life of the PWDs was strongly mentioned as a major socioeconomic problem faced by PWDs. Such Aides include:- wheel chairs, and hearing aides.

The discussants also raised some socio-economic problems which were however unique to certain areas and these are:

- The cattle raids by the Karamojong in Katakwi District, were identified as contributors to the wide-spread poverty in the area, not to mention the insecurity which has put their lives at great risk. In addition, those in the refugee camp in Katakwi District mentioned failure of the camp administrators to provide disaggregated services to the population in the camp. Responses that bring out these issues were:

  "The Karamojong raids have rendered us more helpless. We cannot do anything in our gardens. The oxen were all looted and the whole place is insecure", (Adult males, Katakwi District).

  "Able bodied people trample on us when we struggle for relief food and other forms of aid. This at times causes even more injury to our already disabled state", (Adult females, Katakwi District).

- The problem of single-headed female households and AIDS orphans in Rakai district strongly came up in the discussions that were held in the district. Female disabled parents in Rakai District mentioned that they are faced with a problem of caring for AIDS orphans left by their children who died of AIDS. Most of them stay alone without any form of spousal support. They lack sources of livelihood by virtue of their being disabled, lonely and some of them are now elderly. Caring for orphans in terms of health, education and other forms of wellbeing was mentioned to be a great strain.

- Failure to get sexual/marriage partners was also mentioned particularly among the male and female youth focus groups in Kampala and Rakai Districts.

  "It is hard for us to find faithful partners because we are disabled and men think we are not like able-bodied women". …all laugh. (Female youths, Katakwi District).

"Beautiful girls despise us and think we are not worth being taken as serious and capable partners, all agree", (Male youths, Kampala District).

3.9 Reproductive Health Problems of PWDs

The survey investigated the RH problems faced by PWDs through the qualitative methods (focus groups and key informant interviews). Findings indicate that PWDs are faced with a number of RH problems some of them rendering them more vulnerable to HIV/AIDS, while others exacerbate their already low socio-economic status in the community. The problems presented can be categorised into two broad areas namely; RH problems specific to women and youth and the problems that accrue from the RH service delivery.

3.9.1 Reproductive Health Problems Faced by WWDs

Females with disabilities cited a number of RH problems, which they are faced with and these include sexual exploitation, unwanted pregnancies and complications during pregnancy and childbirth.

③ Sexual exploitation

Female PWDs identified sexual exploitation by men as one of the major problems they are faced with. Some of this arises out of men's fear to identify themselves with girl friends who have disabilities. One of them actually echoed:

"Men only come to us for sex. None of them mentions marriage. They just use us", (Female youths, Kampala District).

Some participants also mentioned that sexual exploitation has led to risky and wreck-less behaviour among the WWDs themselves. A typical response was:

"Girls with disabilities offer themselves to men because they think that no man would ever approach them for true love. They lead wreck-less lives in a bid to have fulfilled sexual lives like their able-bodied counterparts", (MWDs, Rakai District).

③ Unwanted pregnancies

Almost all women groups mentioned that WWDs are abandoned by their partners when they get pregnant, while some others become pregnant after episodes of rape. This leads to unwanted pregnancies, with a resultant high incidence of single parenthood among WWDs. Some girls risk abortion with its complications including death. A sample response to echo this was:

> *"Young girls with disabilities are impregnated and abandoned without help because no man can mention to his family or friends that he has a child with a disabled women", (WWDs, Katakwi District).*

③ Complications during pregnancy and childbirth.

Qualitative findings show that there is a widely held belief that WWDs experience complications during pregnancy and delivery. It is however, not clear from the responses whether they are actual or perceived complications. Nevertheless, the complications include miscarriages, failure to carry the pregnancy to term and failure to have a normal delivery. Some WWDs actually said;

> *"Child delivery is always complicated and we normally deliver by caesarean section; (WWDs, Kampala District).*
>
> *"Women with handicaps in the lower limbs cannot carry a pregnancy to term", and then adds "Even those who are crawling. They give birth to premature babies, who are also a problem in life" (WWDs, Rakai District).*

While most discussants attributed these complications to the nature/form of disability, some relatively few discussants attributed it to failure of pregnant WWDs to attend antenatal care due to the fear they have for service providers, distances to the health facilities and lack of funds to facilitate their access to such health services.

3.9.2 Reproductive Health Problems Faced by MWDs

The two main RH problems that came up in the male discussion groups were failure to identify faithful sexual partners and failure to render effective RH spousal support.

③ Identification of faithful sexual partners.

MWDs singled out failure to identify faithful sexual partners and later on spouses as a major problem affecting their RH status. This exposes them to sexual exploitation by women and some also resort to commercial sex workers. Some citations, which bring out these sentiments are:

> *"Most of the beautiful girls we find feel ashamed to associate with us as sexual partners", all agree… "we only buy women for sex not love because it's the money they want from us not love" (MWDs, Kampala).*

> *"Our disabled children are detested by young girls and they have resorted to widows and some of these already have HIV", (Parents of youth with disabilities).*

③ Failure to render effective RH spousal support.

Male groups in Katakwi and Rakai Districts pointed out that the current trend is to encourage men to support their wives/partners with child rearing roles and also accompany them to seek some RH services. MWDs at times fail to accomplish these roles, which they mainly attributed to the various forms of disability suffered, thus making them and their partners lead unfulfilled lives. Sample quotations to back this up were:

> *"I can't help my wife with carrying the baby because I have no hands and she might not be happy with that. I have fear that other men will take her", (MWD, Katakwi District).*

> *"We understand that these days we have to go with our women for ante-natal care, but the hospital is vary far and many of us with handicaps of the legs cant move that far" (MWDs, Rakai District).*

3.9.3 Problems that Accrue from the RH Service Delivery

Exclusion of PWDs from the entire RH service delivery came up strongly as a major RH problem faced by PWDs. The exclusion stretches from the RH sensitisation and awareness raising programmes to the unfriendliness of the RH service delivery system to. Typical responses were:

> *" I would like to go for VCT but the providers don't know any basic sign language. I want my privacy and I hate going with a translator who is likely to spread rumours about my HIV status", (WWD, Kampala).*

> *"We are not invited to these RH workshops which are always held at the health centres"…. another interjects "In fact people think that we are not sexually active because we are disabled", (female youths, Rakai District).*

"The blind cannot see the charts that have been displayed everywhere on HIV/AIDS "…. "Even the deaf cannot hear the programmes on the various FM stations on HIV/AIDS or reproductive health issues. I have never heard of any workshop organised by the medical team for these people", (parents of youth with disabilities, Katakwi District).

3.10 Summary

This chapter presents the socio-demographic characteristics of respondents by district and sex.

The youth (15-24) constituted 37% and 31% of the female and male samples respectively. Most of the respondents had physical handicaps and more so for the lower limb(s) (52% women and 62% men). About 3 in every 5 respondents were from rural areas of Katakwi and Rakai Districts. Sixty-four (64%) percent of the female respondents had ever attended school compared to 86% of their male counterparts. Most of the respondents had attained only primary school education (56% men and 48% women). Noteworthy is that 36% of women had never attended school! 37% of the women were married compared to 51% of the males. Seventy-one (71%) and 90% of the married women and men were in monogamous unions. About 58% of either sex was Catholics. The highest proportion was farmers (32% men and 23% women). Daily access to radio was 65% of the men and 42% of women, while the proportion that has access to newspapers regularly was only 35% of men and 26% of women.

The main socio-economic problems faced by PWDs are poverty, discrimination and stigma together with inaccessibility to particularly socio-economic and health service centres. Others include the cattle raids by the Karimojong in Katakwi District and the problem of single-headed female households and AIDS orphans in Rakai District.

The reproductive health problems mainly faced by WWDs include sexual exploitation, unwanted pregnancies and complication during pregnancy and childbirth. Identification of faithful sexual

partners and failure to render RH spousal support were also raised by MWDs. Both men and women groups raised the issue of exclusion from the RH sensitization and awareness raising problems.

CHAPTER FOUR

SEXUAL BEHAVIOUR AND CONDOM USE

4.1 Introduction

This chapter examines the sexual behaviour of PWDs in a bid to come up with indicators that can be used to guide strategy design and implementation. The aspects investigated include; ever involvement in sexual activity, age at sexual debut and circumstances surrounding the first sexual experience. Knowledge and ever use of condoms among PWDs is also explored in this chapter.

4.2 Age at Sexual Debut

On set of sexual activity particularly in societies with low use of contraception and in light of the current scourge of HIV/AIDS signals a number of risks including pregnancy and STIs. Table 4.1 shows the proportion ever had sex and the median age at first sex by selected variables. The data show that 85% and 82% of female and male PWDs have ever engaged in sexual activity. The district specific data indicates that among WWDs, the highest percentage of those that have ever engaged in sex is recorded in Kampala (87%) and Katakwi (86%) districts, while Rakai District recorded 78%.

Women with disabilities (WWDs) have sex earlier (16 years) than their male counterparts (18 years). In Kampala District however, the median age at first sexual debut is almost the same for both male and female PWDs (17.5 males and 17.0 females). The pattern is however, different for other districts where the gender differential in age at sexual involvement is very distinct. In Katakwi District, WWDs start sexual activity 2 years earlier than MWDs (16 years versus 18 years), while in Rakai District, WWDs start engaging in sex 3 years earlier (17 years) than MWDs (20 years).

Table 4.1 also shows the median age at first sexual activity by age of respondents, residence, educational attainment and religion. The results by age of respondents don't seem to reflect any clear pattern, with the exception of females in Kampala District where the median age at first sex

increases with an increase in age. It is 16.0 years for the 15-24, around 17 years for the age groups (25-34 and 35-44) and 18 years for respondents 45 years and above.

Considering residence, rural WWDs have sex at 16 years while their urban counterparts start sexual involvement a year later (17 years). Noteworthy is that the WWDs in Katakwi District reported a much lower age at sexual involvement (15 years).

In relation to educational attainment, the pattern that seems to emerge from the data for WWDs in Kampala District is that the higher the educational attainment, the earlier the sexual involvement. Respondents who had no formal schooling had their first sexual activity at 18.5 years compared to 16 years and 16.5 years for those with secondary and post secondary education respectively. This pattern is however, negated by the results of WWDs in Katakwi district, whereby those who never attended school and those with primary education recorded median ages at first sex of 15.5 years and 15.0 years respectively, compared to 18.0 years among those with secondary education.

As for men, results for Katakwi District indicate that other educational categories registered a median age at first sex of 18 years compared to 23.4 years among those with post-secondary education. However, the men in Rakai District present another pattern, and the median age at first sexual activity decreases with an increase in formal schooling (from 23.5 years for those with no education, to 19.5 years among those with primary education and 18 years for those with secondary education).

Table 4.1: Proportion ever had sex and median age at sex by background variables; RH/Disability Survey 2003

	Kampala		Katakwi		Rakai		All	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Percentage ever had sex	83.9	87.2	82.8	85.6	80.0	77.6	82.3	85.1
N	52	41	48	77	44	45	144	163
Median age at sex	17.5	17.0	18.0	16.0	20.0	17.0	18.0	16.0
Age of respondents:								
15-24	16.0	16.0	13.5	16.0	18.0	17.0	16.5	16.0
25-34	18.0	17.5	20.0	15.0	20.0	18.0	19.0	17.0
35-44	18.0	17.0	18.0	16.0	20.0	16.5	18.0	16.0
45+	17.0	18.0	18.0	15.0	20.0	18.0	18.0	17.0
Current residence:								
Urban	17.5	17.0	17.0	16.0	20.0	17.0	18.0	17.0
Rural	-	-	18.0	15.0	18.0	17.0	18.0	16.0
Educational attainment								
None	16.0	18.5	18.0	15.5	23.5	17.0	18.5	16.0
Primary	18.0	17.0	18.0	15.0	19.5	17.0	18.0	17.0
Secondary	16.5	16.0	18.0	18.0	18.0	16.0	18.0	17.0
Post-secondary	17.5	16.5	23.5	16.5	-	16.0	19.0	16.5
Religion								
Catholics	18.0	18.0	18.0	16.0	19.0	17.0	18.0	17.2
Anglicans	17.5	16.0	16.0	16.0	20.0	18.0	19.0	17.0
Others	16.0	17.0	18.0	15.0	18.0	17.0	17.0	16.8

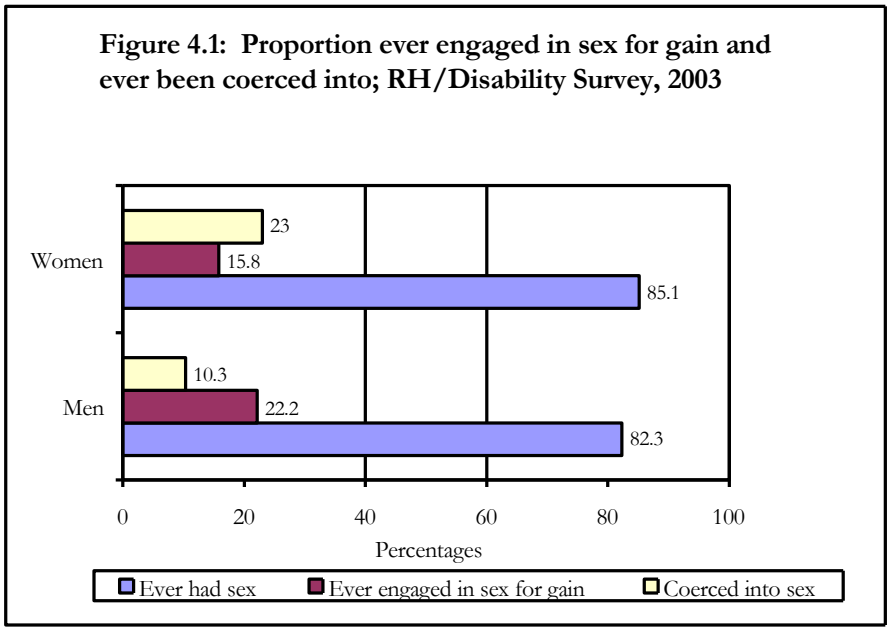
4.3 Type of Sexual Partner and Circumstances of First Sexual Activity

The survey probed for type of sexual partner with whom the respondents had sex for the first time and the circumstances under which the first sexual activity occurred. Table 4.2 shows that on the whole, 49% of WWDs and 57% of MWDs had their first sexual activity with their boy/girl friends. An equal proportion (22%) of both male and female respondents reported to have had their initial sexual activity with ordinary friends. The data also show that 22% of WWDs had their initial sexual involvement with their current husbands compared to 17% of their male counterparts.

The highest proportion of both male and female PWDs just desired to have sex at the time of their first sexual activity. The percentages are 79 and 59 respectively. However, 1 in 5 WWDs was a virgin at the time of marriage. The figures for Kampala and Rakai Districts also point to this pattern. It is of importance to note that around 22% of WWDs in Kampala and Rakai were raped at their first sexual encounter.

Respondents were further asked if they had ever engaged in sex for any form of gain and the results in the table and Figure 4.1 reveal that more male than female PWDs have ever engaged in sex for gain (22% males versus 16% females). The district specific results indicate that this phenomenon is highest among the PWDs in Kampala District, where 44% of the males had ever engaged in sex for gain compared to 39% of the females.

Figure 4.1: Proportion ever engaged in sex for gain and ever been coerced into; RH/Disability Survey, 2003



Incidence of forced sex is also very high particularly among WWDs in Kampala District. Fortytwo (42%) percent reported to have ever been forced to have sex compared to 15% of the male PWDs. WWDs in Rakai District also recorded a substantial proportion (24%).

Table 4.2: Proportion of respondents who have ever engaged in sex by sexual behaviour; RH/Disability Survey, 2003

	Kampala		Katakwi		Rakai		All	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Type of 1st sexual partner:								
Spouse	7.7	19.5	14.6	17.7	31.8	28.9	17.4	21.2
Boy/Girl friend	71.1	36.6	68.8	65.8	27.3	31.1	56.9	49.1
Ordinary friend	15.4	26.8	16.6	12.7	36.4	33.3	22.2	21.8
Relative/Stranger	5.8	17.1	0.0	3.8	4.5	6.7	3.5	7.9
N	52	41	48	79	44	45	144	165
Circumstances of 1st sexual activity:								
Desired to have sex	84.6	50.0	75.0	68.4	75.0	51.1	78.5	59.1
Forced sex/rape	1.9	22.5	0.0	10.1	0.0	22.2	0.7	16.6
Marriage	9.6	20.0	14.6	17.7	20.5	24.4	14.6	20.1
Others	3.9	7.5	10.4	3.8	4.5	2.3	6.2	4.3
N	52	40	48	79	44	45	144	164
Ever engaged in sex for gain:								
Yes	44.2	39.0	0.0	2.5	20.5	17.8	22.2	15.8
No	55.8	61.0	100.0	97.5	79.5	82.2	77.8	84.2
N	52	41	48	79	44	45	144	165
Coerced into sex:								
Yes	15.4	41.5	4.2	12.7	11.1	24.4	10.3	23.0
No	84.6	58.5	95.8	87.3	88.9	75.6	89.7	77.0
N	52	41	48	79	45	45	145	165

4.4 Knowledge and Use of Condoms

Condom use is one of the programmatically emphasised approaches to avoiding STI infection not to mention its contraceptive effect. Therefore, knowledge of, access to, and use of condoms are essential and thus explored in this study. Results on the knowledge and use of condoms are presented in Table 4.3. All in all, a very high proportion of PWDS have ever heard of condoms (90% females and 94% males). Of the respondents who have ever heard of condoms, 78% and 84% of females and males have ever seen them. While all the male PWDs in Kampala District reported to have ever seen condoms, about three-quarters (75%) of their counterparts in Katakwi and Rakai Districts reported to have ever seen them. The WWDs in Katakwi District reported the lowest proportion ever seen condoms (61%). Rakai District recorded 88% and Kampala District registered a high proportion of 96%.

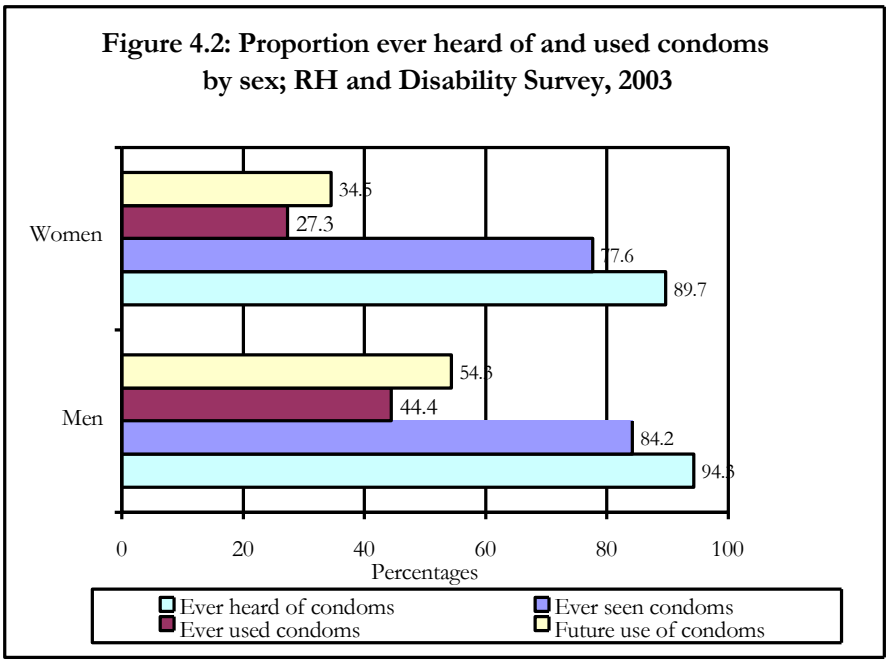
Respondents who had ever engaged in sex were asked whether they have ever used condoms and Table 4.3 shows that 44% of the MWDs have ever used condoms. The percentage for the WWDs is only 27%. About 70% of the male respondents in Kampala District had ever used condoms compared to 36% in Rakai and 25% in Katakwi District. Similarly, 54% of the WWDs in Kampala District have ever used condoms compared to 40% in Rakai District. The proportion ever used condoms among WWDs in Katakwi District is only 6%.

Use of condoms at first sexual experience together with use of condoms at last sexual activity before the survey were probed as also indicated in Table 4.3. Only 12% of the men and 7% of the women reported to have used condoms on their first sexual experience. District specific results show that about 15% of the MWDs in Kampala and Rakai Districts used condoms at their first sexual experience compared to only 6% in Katakwi District. Rakai District reported the highest proportion among females (13%) followed by Kampala District (10%). Only 1% of the women in Katakwi District reported to have done so. Use of condoms at last sexual experience before the survey is a proxy to current use of condoms and provides an indication on the current level of condom use. Current use of condoms among PWDs is 24% and 10% among men and women respectively. More men (54%) than women (34%) intend to use condoms in future, with a malefemale differential of 42 percentage points in Kampala District, 15.2 points in Katakwi District, and only 3.6 points in Rakai District.

Table 4.3: Distribution of respondents by condom knowledge and practice; RH/Disability Survey, 2003

	Kampala		Katakwi		Rakai		All	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Ever heard of condoms:								
Yes	95.2	97.9	89.7	87.6	98.1	86.2	94.3	89.7
N	62	47	58	89	54	58	174	194
Ever seen condoms:								
Yes	100.0	95.7	75.0	60.8	75.9	87.8	84.2	77.6
N	62	46	52	79	54	49	165	174
Ever used condoms:								
Yes	69.2	53.7	25.0	6.3	36.4	40.0	44.4	27.3
No	30.8	46.3	75.0	93.7	63.6	60.0	55.6	72.7
N	52	41	48	79	44	45	144	165
Used condoms at 1st sexual activity:								
Yes	15.4	9.8	6.3	1.3	15.9	13.3	12.5	6.7
No	84.6	90.2	93.8	98.7	84.1	86.7	87.5	93.3
N	52	41	48	79	44	45	144	165
Used condom at last sexual activity:								
Yes	34.6	24.4	16.7	1.3	18.2	13.3	23.6	10.3
No	65.4	75.6	83.3	98.7	81.8	86.7	76.4	89.7
N	52	41	48	79	44	45	144	165
Future condom use:								
Yes	73.0	31.0	45.5	30.3	47.8	44.2	54.3	34.5
No	18.9	48.3	47.7	53.9	34.8	44.2	34.6	50.0
Don't know	8.1	20.7	6.8	15.8	17.4	11.6	11.0	15.5
N	37	29	44	78	46	43	127	148

Figure 4.2: Proportion ever heard of and used condoms by sex; RH and Disability Survey, 2003



4.4.1 Differentials in ever use of condoms

Differentials in ever use of condoms by selected variables are presented in Table 4.4 by sex of respondents. The highest proportion of ever users of condoms was recorded among the 25-34 for both males and females (55% and 37% respectively). Considering residence, 47% of the urban males have ever used condoms compared to 27% of their rural counterparts. The females also present a similar pattern although the urban-rural gap in condom use is not as wide as that of males (29% urban versus 23% rural).

Table 4.4 also shows that condom use rises with education as one moves from the first three educational categories (none, primary and secondary). For example, only 14% of the males with no education have ever used condoms compared to 38% of those with primary education and 54% with secondary education. Considering the district specific results, the phenomenon is highest among PWDs in Kampala, where 44% of the males and 39% of females reported to have ever engaged in sex for gain. Similarly, 42% of WWDs have ever been forced to have sex. Rakai and Katakwi Districts reported 24% and 13% respectively.

Table 4.4: Proportion ever used condoms by selected variables; RH/Disability Survey, 2003

	Males			Females		
	Yes	No	N	Yes	No	N
Age of respondents:						
15 - 24	36.5	63.5	52	30.5	69.5	59
25 - 34	55.1	44.9	49	37.2	62.8	43
35 - 44	34.3	65.7	35	14.6	85.4	48
45+	20.7	79.3	29	16.7	83.3	24
Residence:						
Urban	47.4	52.6	97	29.1	70.9	86
Rural	26.5	73.5	68	22.7	77.3	88
Form of disability:						
Deaf	0.0	100.0	5	0.0	100.0	3
Blind	42.1	57.9	19	12.5	87.5	16
Handicap-upper limb	30.8	69.2	26	12.0	88.0	25
Handicap-lower limb	39.3	60.7	89	32.5	67.5	114
Handicap-both	47.4	52.6	19	23.1	76.9	13
Others	75.0	25.0	7	0.0	100.0	4
Educational attainment:						
None	13.6	86.4	22	8.8	91.2	57
Primary	38.0	62.0	92	33.7	66.3	86
Secondary	53.8	46.2	39	36.0	64.0	25
Post-secondary	41.7	58.3	12	33.3	66.7	6

4.5 Summary

This chapter highlights indicators of sexual activity. The data show that 85% and 82% of women and men in the sample have ever engaged in sex. WWDs have sex earlier (16 years) than the men (18 years). The median age at first sexual activity is 16 years for the rural PWDs compared to 17 years for their urban counterparts. Noteworthy is that rural WWDs in Katakwi District start sexual activity much earlier (15 years). The highest proportion (79% of men and 59% of women) start sexual activity just out of desire to have sex. However, 22% of WWDs in Kampala and Rakai Districts reported to have been raped on their first sexual encounter. Findings also show that more

MWDs (22%) than WWDs (16%) have ever engaged in sex for gain. District specific results reveal that this is much higher in Kampala District where 44% of men and 39% of women have ever engaged in sex for gain.

Awareness about condoms is over 90% for men and women. Ever use of condoms is 44% among MWDs compared to 27% of WWDs. Only 6% of WWDs in Katakwi District had ever used condoms. Current use of condoms is 24% among MWDs and only 10% among WWDs. More men than women intend to use condoms in future (54% men and 34% women).

CHAPTER FIVE

SEXUALLY TRANSMITTED INFECTIONS AND HIV/AIDS

5.1 Introduction

Sexually transmitted infections (STIs) have been identified as cofactors in HIV/AIDS transmission. Reduction of STIs by 25% by the year 2006, is one of the goals set out in the National Strategic Plan for HIV/AIDS prevention. It is therefore important for the population to know about STIs, their signs and symptoms, and treatment. This chapter presents findings on sexually transmitted infections (STIs) and HIV/AIDS. The issues investigated include knowledge about STIs, incidence and management of STIs, knowledge of HIV/AIDS and perception of risk to contracting HIV/AIDS.

5.2 Knowledge about STIs

Table 5.1 and Figure 5.1 show that almost all PWDs in the reproductive age brackets have ever heard of STIs. Females report a slightly higher percentage (96%) than the males (93%) and the pattern is similar in all the three districts.

In order to establish the magnitude of this knowledge, respondents were asked to state the specific STIs that they know. Results indicate that on the whole, 73% and 67% of WWDs have ever heard of syphilis and gonorrhoea respectively. As for the respective districts, three quarters of the women in Kampala have ever heard of syphilis and gonorrhoea, while in Katakwi, 76% have ever heard of syphilis and the proportion that have ever heard of gonorrhoea is 58%. The results also show that more females than males knew about syphilis, while the reverse is true for gonorrhoea with the exception of Rakai District.

Genital warts has ever been heard of by only 9% of the females and 5% of the males. Going by the district specific indicators, none of the males and 2% of the females in Katakwi District knew about genital warts. Only 2% of the males in Rakai District have ever heard of genital warts compared to 10% of the females. Kampala registered the highest proportion of respondents who had ever heard about genital warts (11% males and 19% females). Similarly, 18% of males in Kampala have ever heard of candidiasis compared to 13% of the females. The percentage ever heard of candidiasis is very low in Katakwi and Rakai, with the exception of the females in Rakai who registered 10%.

Knowledge about the signs of STIs was also investigated in the survey. Such signs include discharge in the private parts, painful urination, itching in the private parts, pain in the lower abdomen and sores. Table 5.1 shows that PWDs knowledge of the signs of STIs is very low. Only 38% of the females mentioned discharge in the private parts as a sign of STIs compared to 53% of the males. Kampala District registered the highest proportion of women who know this as a sign of STIs (53%) compared to 43% in Rakai District and only 27% in Katakwi District. Only a quarter (25%) of the WWDs know that painful urination would be a sign of STIs compared to 46% of the male PWDs. A third (33%) of the women know that itching in the private parts is a sign of STIs. However, 21% of the women didn't know any sign of STIs compared to 15% of the men.

Table 5.1: Proportion ever heard of STIs by sex and district; RH/Disability Survey, 2003

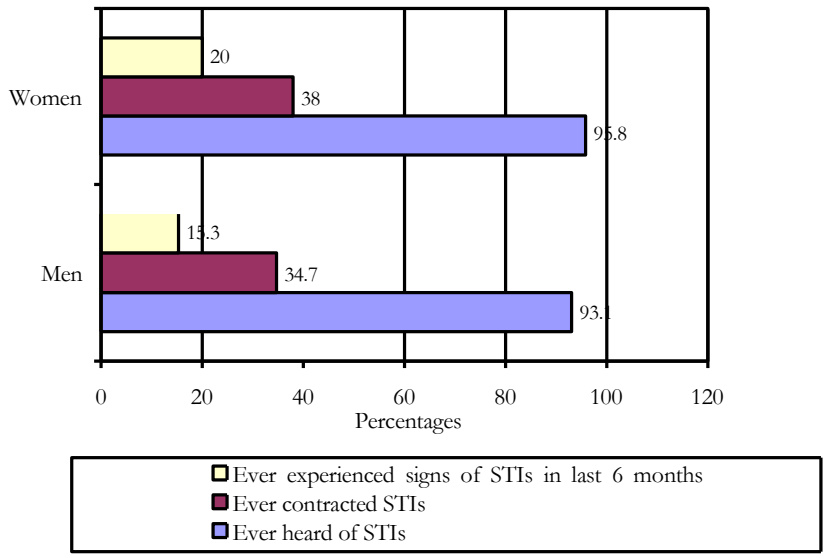
	Kampala		Katakwi		Rakai		All	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Ever heard of STIs:								
Yes	93.5	95.7	93.1	96.6	92.7	94.7	93.1	95.8
N	62	47	58	88	55	57	175	192
Ever heard of:								
Syphilis	67.7	74.5	75.9	75.6	61.8	67.2	68.6	72.8
Gonorrhoea	85.5	74.5	62.1	57.8	72.7	75.9	73.7	67.2
Genital warts	11.3	19.1	0.0	2.2	1.8	10.3	4.6	8.7
Candidiasis	17.7	12.8	5.2	1.1	0.0	3.4	8.0	4.6
Others	1.6	0.0	0.0	0.0	9.1	3.4	3.4	1.0
N	62	47	58	90	55	58	175	195
Signs of STIs:								
Discharge in private parts	67.7	53.2	41.4	26.7	47.3	43.1	52.6	37.9
Painful urination	56.5	27.7	29.3	23.3	50.9	25.9	45.7	25.1
Itching in private parts	61.3	55.3	17.2	27.8	23.6	24.1	34.9	33.3
Pain in lower abdomen	12.9	8.5	19.0	26.7	12.7	20.7	14.9	20.5
Sores	53.2	48.9	60.3	48.9	18.2	37.9	44.6	45.6
Don't know	9.7	17.0	15.5	22.2	20.0	25.9	14.9	22.1
N	62	47	58	90	55	58	175	195

5.3 Incidence and Management of STIs

In order to establish the incidence of STIs among PWDs, respondents were asked whether they have ever contracted any STIs. Table 5.2 and Figure 5.1 reveal that the incidence of STIs among PWD is very high (38% of females and 35% of males). Considering data for the districts, the WWDs in Kampala reported the highest incidence (45%), Rakai District reported 41% and Katakwi District had 33%. Among male PWDs, the highest incidence was reported in Katakwi District (42%). Kampala registered an incidence of 37% compared to 25% of the males in Rakai District.

Respondents were further asked whether they had experienced any of the earlier mentioned signs of STIs in the 6 months that preceded the survey (see also Figure 5.1 and Table 5.2). Thirty (30%) percent of the WWDs in Kampala District, 29% in Rakai and 10% in Katakwi District had experienced these signs in the 6 months period before the survey. The proportion among men was much lower (17% in Katakwi District, 16% in Kampala District and 13% in Rakai District).

Figure 5.1: Knowledge and Incidence of STIs by Sex; RH/Disability Survey, 2003



As to whether the respondents who had ever contracted STIs sought medical treatment, over 98% of the females and 94% of the males had received medical treatment. It is impressive to note that in Katakwi District, all the victims of STIs reported to have received medical treatment.

Effective management of STIs requires the victims to advise their partners to seek medical treatment, as this would control the spread of the STIs. Forty-five (45%) of the victims of STIs in Rakai District had not advised their partners to seek medical treatment, and 40% of the male victims in Kampala District also reported not to have done so. However, 86% of the males and 88% of the females in Katakwi District had advised their partners to seek medical treatment.

Table 5.2: Percent of distribution of respondents by incidence and management of STIs; RH/Disability Survey, 2003

	Kampala		Katakwi		Rakai		All	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Ever contracted any STI:								
Yes	36.5	45.0	41.7	32.9	25.0	40.9	34.7	38.0
No	61.5	55.0	58.3	65.8	75.0	56.8	64.6	60.7
Don't know	1.9	0.0	0.0	1.3	0.0	2.3	0.7	1.2
N	52	40	48	79	44	44	144	163
Experienced any signs of STIs in last 6 months:								
Yes	15.7	30.0	17.0	10.4	12.8	28.9	15.3	20.0
No	84.3	70.0	83.0	89.6	87.2	71.1	84.7	80.0
N	51	40	47	77	39	38	137	155
Did you seek treatment for STI:								
Yes	90.5	100.0	100.0	100.0	90.9	94.1	94.0	98.4
No	9.5	0.0	0.0	0.0	9.1	5.9	6.0	1.6
N	21	18	22	26	11	17	50	61
Advised partner for treatment:								
Yes	60.0	73.7	86.4	88.5	54.5	55.0	70.6	76.2
No	40.0	26.3	13.6	11.5	45.5	45.0	29.4	23.8
N	20	19	22	26	11	20	51	63

5.3.1 Incidence and management of STIs by background variables

Table 5.3 shows the incidence of STIs by selected socio-demographic variables. Incidence of STIs increases with age particularly among WWDs. It is 18% for the 15-24, 38% for the 25-34, 40% for the 35-44 and 71% for the 45+. Urban PWDs reported a higher incidence of STIs than their rural counterparts. The differential is wider among WWDs where the urban reported 41% compared to 37% of the rural.

Considering educational attainment, the results for MWDs show that incidence of STIs in inversely related to educational attainment (50% for none, 34% for primary education and 30% for secondary and post secondary education). The pattern for the WWDs is however, slightly

different. The highest STI incidence (42%) was reported by females with primary education followed by those who had no formal schooling (36%). The lowest incidence (17%) was reported among women with post secondary education.

Table 5.3: Incidence of STIs by background characteristics; RH/Disability Survey, 2003

	Males			Females		
	Yes	No	N	Yes	No	N
Age group						
15-24	18.8	81.2	32	18.2	81.8	44
25-34	30.4	69.6	46	37.8	62.2	45
35-44	51.4	48.6	35	40.0	60.0	50
45+	38.7	61.3	31	70.8	29.2	24
Residence						
Urban	36.1	63.9	83	40.8	59.2	76
Rural	32.8	67.2	61	35.6	64.4	88
Educational attainment						
None	50.0	50.0	16	36.1	63.9	61
Primary	34.1	65.9	82	42.3	57.7	78
Secondary	30.6	69.4	36	33.3	66.7	18
Post-secondary	30.0	70.0	10	16.7	83.3	6

5.4 Awareness About HIV/AIDS

Results in Table 5.4 show that there is almost universal awareness about HIV/AIDS among PWDs. In order to ascertain the level of awareness, respondents were asked how they can tell that a person has HIV/AIDS, how HIV is spread and how to avoid HIV/AIDS. On the whole 68% of the women and 73% of the men reported that loss of weight is a sign that a person has HIV/AIDS. In addition, 68% of the men and 58% of the women also mentioned skin rash as a sign of HIV/AIDS. Other reported signs were frequent illness (46% of both men and women) and coughing for long, which was reported by 24% of the respondents of either sex. It is disappointing to note that only about 6% reported testing for HIV as a means through which people could know ones HIV status. District specific statistics is even much lower (approximately 1% in Katakwi and Rakai Districts), with the exception of Kampala District, which registered 19% for either sex citing HIV testing.

Considering how HIV is spread, there is a high level of knowledge that it is mostly spread through having sex with an infected person. However, the proportions that reported this were relatively low in Rakai - 63% of males compared to only 47% of females. Other modes of HIV transmission are however, not well known as can be seen from Table 5.4. For example, unsafe blood transfusion was mentioned by only 13% of males and 17% of the females in Rakai District; 14% and 22% of the women and men in Katakwi District respectively. Sharing of sharp objects as a means of HIV transmission is also moderately known. However, the percentage that mentioned this mode was much lower among females in Katakwi (38%) and Rakai (48%) Districts. Vertical transmission of HIV is the least known mode, and this was reported by only 7% of females and 10% of the males. None of the MWDs in Rakai and only 3% in Katakwi Districts know of this mode of HIV transmission.

People's awareness about how to avoid HIV enables effective execution of behaviour change programmes and strategies. In all the districts, more female than male PWDs are aware of abstinence as a major HIV prevention strategy. This differential is much wider in Katakwi where 74% of the female respondents cited abstinence as one of the ways of avoiding HIV compared to 62% of the male respondents. Use of condoms was highly reported in Kampala District (74% males and 60% of females). Noteworthy is that only 43% of females in Rakai District reported use of condoms as a means of avoiding HIV. Being faithful was also reported by a substantial proportion of respondents, with the highest percentage of 50% being reported by males in Katakwi District. Non-sharing of sharp objects was the least reported mode of avoiding HIV by PWDs in all the three districts.

Table 5.4 Distribution of respondents by knowledge of HIV/AIDS; RH/Disability Survey, 2003

	Kampala		Katakwi		Rakai		All	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Ever heard of AIDS:								
Yes	100.0	97.8	94.8	96.6	100.0	98.2	98.3	97.4
N	61	47	58	90	55	58	174	195
How to tell that a person has HIV/AIDS:								
Loss of weight	66.1	51.1	74.1	76.7	80.0	69.0	73.1	68.2
Skin rash	77.4	68.1	56.9	51.1	69.1	62.1	68.0	58.5
Frequent illness	51.6	53.2	44.8	45.6	43.6	41.4	46.9	46.2
Coughing for long	29.0	19.1	17.2	25.6	25.5	25.9	24.0	24.1
Testing HIV	17.7	19.1	0.0	2.2	1.8	1.7	6.9	6.2
Don't know	1.6	4.3	6.9	4.4	5.5	3.4	4.6	4.1
N	61	46	58	89	55	56	174	191
How HIV is spread:								
Sex with infected person	93.5	93.6	96.4	93.1	62.9	46.8	93.1	92.3
Blood transfusion	62.9	46.8	22.4	14.4	12.7	17.2	33.7	23.1
Sharing injections/ Sharp objects	66.1	59.6	50.0	37.8	61.8	48.3	59.4	46.2
At birth	16.1	10.6	3.4	7.8	0.0	12.1	6.9	9.7
N	61	46	58	90	55	58	174	194
How to avoid HIV:								
Abstinence	75.8	78.7	50.0	56.7	61.8	74.1	63.2	67.3
Being faithful	48.4	31.9	50.0	36.7	45.5	31.0	55.6	34.5
Use of condoms	74.2	59.6	53.4	51.1	54.5	43.1	66.0	52.1
Don't share sharp objects	25.8	23.4	22.4	13.3	14.5	19.0	23.6	18.2
Others	6.5	4.3	1.7	2.2	1.8	3.4	2.8	3.0

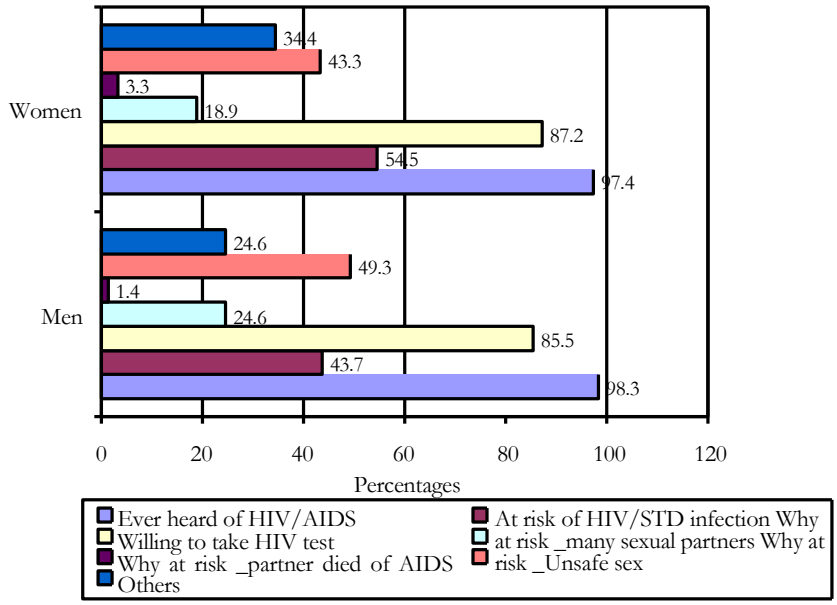
Note: These were multiple responses and thus don't add up to 100.

5.5 Risk perception to HIV among PWDs

Respondents were asked whether they consider themselves at risk of contracting HIV or any STIs. On the whole, 55% of the female respondents consider themselves at risk of contracting HIV compared to 44% of their male counterparts (see Table 5.3 and Figure 5.2). Considering the district specific data, respondents in Kampala District reported the highest percentage of those who consider themselves at risk of contracting HIV (72% males and 69% females). As to why

respondents consider themselves at risk of contracting HIV, approximately 50% of the men and 43% of the women attribute it to their being involved in unsafe sex. Substantial proportions (25% men and 19% women) also engage in sex with multiple sexual partners.

Figure 5.2: Knowledge about HIV/AIDS and HIV risk perception by sex; RH/Disability Survey 2003



The source of HIV/AIDS information was probed as can be observed from Table 5.5. Two-thirds of the female respondents cited radios as the major providers of HIV/AIDS information compared to three-quarters of the males. Friends are the second major sources of HIV/AIDS information and they were reported by 48% of females and 45% of the males. Around a third of the respondents reported community health workers as major providers of HIV/AIDS information. Noteworthy is that 51% and 41% of the males in Rakai and Katakwi Districts respectively cited community workers as some of their major sources of information on HIV/AIDS. Least mentioned sources of HIV/AIDS information particularly among females are civil society organisations, LC officials, schools, and magazines. Only 1% of males and 2% of females reported partners as major providers of HIV/AIDS information, which probably signals the minimal or non-existent spousal communication when it comes to issues related to HIV/AIDS.

Table 5.5: Percent at risk of HIV and source of information on HIV/AIDS; RH/Disability Survey, 2003

	Kampala		Katakwi		Rakai		All	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
At risk of HIV or STD infection:								
Yes	72.1	68.9	31.0	52.8	25.5	45.5	43.7	54.5
No	23.0	26.7	67.2	39.3	70.9	49.1	52.9	39.2
Don't know	4.9	4.4	1.7	7.9	3.6	5.5	3.4	6.3
N	61	45	58	89	55	55	174	189
Why do you consider your self at risk of HIV:								
Many sexual partners	27.5	17.2	20.0	14.3	21.4	31.6	24.6	18.9
Partner died of AIDS	2.5	0.0	0.0	7.1	0.0	0.0	1.4	3.3
Unsafe sex	50.0	37.9	60.0	45.2	35.7	47.4	49.3	43.3
Others	20.0	44.8	20.0	33.3	42.9	21.1	24.6	34.4
N	40	29	15	42	14	19	69	90
Source of HIV/AIDS information:								
Television	11.3	12.8	6.9	1.1	1.8	3.4	6.9	4.6
Radio	79.0	68.1	74.1	70.0	70.9	58.6	74.9	66.2
Friends	46.8	46.8	44.8	47.8	43.6	48.3	45.1	47.7
Partner	0.0	2.1	1.7	1.1	1.8	3.4	1.1	2.1
Community health worker	17.7	23.4	41.4	35.6	50.9	37.9	36.0	33.3
Civil society	16.1	2.1	6.9	4.4	9.1	5.2	10.9	4.1
LC official	17.7	8.5	10.3	3.3	5.5	1.7	11.4	4.1
Parents	12.9	8.5	1.7	6.7	7.3	10.3	7.4	8.2
School	11.3	8.5	13.8	3.3	5.5	6.9	10.3	5.6
Church	6.5	6.4	12.1	18.9	10.9	6.9	9.7	12.3
Magazines	19.4	10.6	13.8	5.6	5.5	1.7	13.1	5.6
Others	25.8	23.4	5.2	12.2	7.3	12.1	13.1	14.9

5.6 HIV Testing

Some indicators on HIV testing were also probed as shown in Table 5.6. Around 87% of both males and females in the sample are willing to take an HIV test (also see Figure 5.2). The data for Katakwi District even shows a much higher percentage (91% males and 93% females). As to where one could obtain an HIV testing service, 67% of the women and 63% of the men cited

hospitals as the major providers of HIV testing services. The AIDS Information Centre (AIC) was mentioned by 21% of the men and 16% of the women in Katakwi District.

Table 5.6: Proportion willing to take HIV Test; RH/Disability Survey, 2003

	Kampala		Katakwi		Rakai		All	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Willing to take HIV test								
Yes	82.3	80.0	90.9	93.0	83.6	84.2	85.5	87.2
No	17.7	20.0	9.1	7.0	16.4	15.8	14.5	12.8
N	62	45	55	86	55	57	172	188
Why not wiling to take HIV test								
Don't want to know status	75.0	25.0	33.3	40.0	44.4	44.4	55.0	36.4
Not sexually active	12.5	25.0	66.7	40.0	33.3	55.6	30.0	40.9
Faithful	12.5	25.0	0.0	20.0	11.1	0.0	10.0	13.6
Others	0.0	25.0	0.0	0.0	11.1	0.0	5.0	9.1
N	8	8	3	5	9	9	20	22
Where to obtain HIV test								
Hospital	53.2	56.8	61.5	68.2	74.5	71.9	62.7	66.7
Clinics	0.0	2.3	1.9	1.2	1.8	1.8	1.2	1.6
Health centres	6.5	2.3	21.2	16.5	7.3	8.8	11.2	10.8
AIC	30.6	25.0	9.6	0.0	3.6	5.3	15.4	7.5
Don't know	6.5	13.6	5.8	12.9	12.7	8.8	8.3	11.8
Others	3.2	0.0	0.0	1.2	0.0	3.5	1.2	1.6
N	62	44	52	85	55	57	169	186

5.7 Predisposing Factors to HIV/AIDS and STIs Among WWDs

A number of factors that predispose WWDs to HIV/AIDS came up in the focus group discussions and the most common factors were; poverty, rape, non-use of condoms and contraception.

③ Poverty

As already mentioned, PWDs are among the chronically poor groups of the population. The high levels of poverty pre-dispose them to HIV/AIDS in that women have to engage in sexual activities with multiple sexual partners in anticipation of financial and other forms of support. This exposes them to a higher risk of contracting HIV. Similarly, MWDs are also affected in a similar manner as also evidenced in the following responses:

"Many of our colleagues are in constant need for food, money and other necessities but don't have anybody to provide for them. They, therefore, resort to men who provide them with these basics in exchange for sex", (WWDs, Katakwi District).

"We want good things like all young girls but even our parents don't provide them because we are disabled. We have to find alternatives and these are mainly men who give us some little money and we buy what we want", (Female youth, Kampala District).

"Widows entice disabled men, who engage in sex in exchange for money and other forms of support", (MWDs, Rakai District).

③ Rape

Results indicate that the blind, and the deaf and dumb are very vulnerable to forced sex and rape. The former cannot identify the victims particularly strangers while the latter cannot effectively communicate and thus find it hard to obtain protection when faced with such situations. This pre-disposes them to a high risk of contracting HIV/AIDS and other STIs. Other persons with other forms of disability are also often raped because they are weak and cannot fight their assailants.

"Men often way-lay our friends and rape them since they can neither run nor fight to defend themselves", (Female youth, Rakai District).

Findings from the in-depth interviews with key informants also indicate that rape was the most harmful practice in the community in relation to RH and HIV/AIDS particularly among PWDs. 37% of the responses generated echoed this. As to why this is so, key informants attributed it to alcoholism among men in the community.

③ Non- use of condoms

Condom use among PWDs is very low and both women and men with disabilities mainly attributed this to dislike of condoms, lack of confidence to negotiate safe sex among WWDs, fear and stigma suffered in the process of securing a condom and reluctance of female partners to engage in sex with men who use condoms. Sample responses that highlight these views are:

"Young girls with disabilities feel honoured to sleep with a man and they dare not discuss condoms with their partners", (WWDs, Rakai District).

"Some of our girlfriends particularly fellow disabled, don't like condoms and we fear losing the. We just have to forget about condoms and live with the risk of contracting HIV" (male youths, Kampala District).

"When a disabled person goes to buy a condom, she/he laughed at" also adds "…providers and the entire community think we can only get women by witchcraft, we therefore fear to buy condoms" (male PWD, Rakai District).

③ Traditional/cultural practices.

Mention was made of traditional practices, which pre-dispose WWDs to a number of reproductive health problems. Such practices include visits to shrines, forced marriages, widow inheritance and sharing of wives among brothers. Key informants also cited tattooing as a cultural practice in some communities, which may render one vulnerable to HIV/AIDS. Some of the responses that echo these sentiments were:

"Many WWDs visit traditional healers and these at times abuse them sexually while others use the same materials (like razor blades) on a number of them and hence HIV and unwanted pregnancy", (WWDs, Kampala).

"It is hard for us to find marriage partners by ourselves and we are often forced to marry men who are often chosen by our parents and relatives. …"my friend was forced to marry a man only to find that his wife died of AIDS", (Female youths, Rakai District).

③ Reliance on traditional medicine

Female focus group discussions kept reflecting on the heavy reliance of WWDs on traditional medicine particularly during pregnancy and after childbirth. There is a general feeling that this medicine exposes them to some reproductive health problems including use of un-sterilised materials during delivery, reliance on untrained service providers with associated risks to the mother and child, heavy ingestion of traditional medicine by pregnant mothers, which could probably endanger the mother and probably worsen the complications at delivery. These factors were reiterated by a number of female key-informants who made mention of the fact that most child deliveries of WWDs occur either at home or TBAs. They also mentioned that many pregnant WWDs hide from members of the community and thus cannot seek modern means of medical care.

Other factors which pre-dispose PWDs to HIV/AIDS and other related problems include:

③ Lack of awareness and general information on RH among PWDs

As earlier mentioned, PWDs lack general awareness and information on RH mainly because they have been excluded from these programmes by both government and development partners. Information generated reflects on the lack of knowledge regarding protective measures like condom use, family planning/contraception and sexually transmitted infections. This makes PWDs highly vulnerable to RH problems. A sample of the responses is presented below;

> "Many youth with disabilities are ignorant about condoms. No one has ever invited us on a training about HIV/AIDS, condom use and other related issues", (Male youths, Katakwi District).

> *"We don't know where to go for family planning and we fear that some of the methods would compound our disabilities and we fail to get children", (WWDs, Rakai district).*

③ Polygamy and wife sharing

It was reported in a number of FGDs that when MWDs get money, they resort to alcoholism and acquiring more women. Such behaviour exposes them to greater risks of acquiring STIs including HIV. Key informants also mentioned widow inheritance and wife sharing as some of the harmful practices in the community and even among PWDs.

> *"We can't get our own women because girls fear to be seen with us. Most male PWDs have relationships with wives of their brothers, and this has exposed them to HIV", (MWDs, Rakai District).*

5.8 Problems Faced by PWDs in an Attempt to Lead Quality Reproductive Lives

The survey probed for the problems faced by PWDs in their attempt to lead quality reproductive lives. Negative societal attitudes and stigma, poverty, failure to fulfil sexual obligations and failure to get a partner of choice, came up in the most of the focus groups.

③ Stigma and discrimination

PWDs are highly stigmatized by the community and this greatly affects their effective integration into the society. Some of the sentiments expressed in regard to stigma are:

"People in our community don't expect us to move with handsome and normal men because we are disabled. They always ask where and how you got him and start calling you or your partner names" (Female youths, Katakwi District). Similar sentiments were expressed in other focus groups in all districts including male groups.

"Parents keep disabled children indoors or at the back of the house because they don't want to associate with them. This is where men find them and rape them" (Parents of disabled children, Rakai District).

③ Material poverty

The poverty situation of most PWDs denies them an opportunity of leading quality reproductive lives. They lack money to access good health services or even provide good health care and other needs to their dependants. Some even hinted on failure to marry due to poverty.

"We are poor and cannot raise enough money to pay the bride price and hence acquire wives like other men", another adds" even when you manage to marry a wife, time comes when you cannot fulfill all the requirements of your family members and you loose even your wife (Adult males, Rakai District).

"The poverty situation of most PWDs denies them an opportunity to enjoy steady marriages and relationships", (Females, Katakwi District).

③ Failure to fulfil sexual obligations

Participants in the FGDs echoed failure of PWDs to fulfil their sexual obligations as one of the factors that undermines their ability to enjoy quality reproductive lives.

"Some forms of disability impact on one's sexual performance and it means if you are a man, you can't satisfy a woman sexually", all laugh, and another adds "your wife keeps getting other men and probably also HIV", (Adult males, Kampala District).

③ Failure to get a partner of choice

PWDs kept mentioning their failure to get the partners they truly love as a hindrance to their enjoying quality reproductive lives. It was reported that many PWDs experience some form of "forced marriages", which keeps them longing and experimenting with other men and women and hence running a risk of contracting HIV or even total failure to be happy with their spouses.

"Men marry us after making us pregnant and only when our parents pressure them to do so but not for true love like other women. They thus mistreat us in marriage and keep

getting other women". Another interjects "a man can even keep telling you that they forced him to marry you which is so disheartening", (WWD, Katakwi District).

"Most of our marriages are 'forced' either because the girl is already pregnant or she is wanted by your parents", (MWDs, Rakai District).

"A disabled women cannot refuse someone who offers to marry her even if she does not truly love that person". Another adds "this means you have to live in a loveless marriage, which at times leads to unfaithfulness and related problems", (Females, Kampala District).

5.9 Summary

This chapter highlights findings on knowledge and awareness of STIs and HIV/AIDS among PWDs. Incidence and management of STIs was also presented. Ninety-six (96%) and 93% of women and men with disabilities have ever heard of STIs respectively; and more specifically syphilis (73% women and 69% men) and gonorrhoea (74% men and 67% women).

The proportion ever contracted STis is 38% of women and 35% of men. Over 90% of these reported to have sought medical treatment and over 70% also informed their partners. Incidence of STIs was reported to be higher among females in the urban areas (41%), those with primary school education (42%) and those in the age groups 35-44 (40%) and 45+ (70%). The later is expected because of the much longer experience and hence exposure to sexual activity than the younger respondents.

Awareness about HIV/IADS is almost universal. Most reported signs of HIV/AIDS include loss of weight, skin rash and frequent illness. Only 6% of either sex reported testing for HIV as a means of knowing one's HIV status. Most PWDs are aware that HIV is transmitted through

sexual intercourse with an infected party. However, only 47% of females and 63% of men in Rakai District reported this. Vertical transmission of HIV is the least known mode of HIV transmission (7% of females and 10% of men). Most WWDs reported abstinence (67%) as a means of avoiding HIV and 52% cited use of condoms. Being faithful as an HIV prevention strategy was mentioned by 34% of the women. Over a half (55%) of the WWDs consider themselves at risk of contracting HIV, either because they are involved in unsafe sex and with multiple sexual partners. About 87% of either sex is willing to take an HIV test.

Predisposing factors to HIV/AIDS and STIs among WWDs include poverty, rape, non-use of condoms, traditional practices and reliance on traditional medicine, lack of awareness on RH, polygamy and wife sharing. Failure to get a partner of choice, material poverty, failure to fulfil sexual obligations and, discrimination and stigma are hindrances to quality RH lives.

CHAPTER SIX

REPRODUCTION

6.1 Introduction

Reproductive aspects considered in this chapter include pregnancy and related aspects, children ever born and contraception. The sections that follow provide data on these aspects for particularly female respondents with the exception of contraception.

6.2 Pregnancy

The survey sought information from female respondents regarding pregnancy. The probes focused on whether or not female respondents had ever been pregnant, the age at which they conceived for the first time, whether or not the first and last pregnancies were wanted, and whether they had ever had an induced abortion. Table 6.1 provides data on these aspects by district. On the whole, 77% of the women in the sample had ever been pregnant by the time of the survey. The percentage is even higher for Katakwi (83%) and Kampala (80%) Districts.

It was of interest to establish whether the pregnancies were wanted and more specifically the first and last pregnancies. Approximately 3 in every 5 first pregnancies among WWDs are wanted. Results by district show that 70% of the first pregnancies among WWDs in Rakai were wanted compared to 62% of those in Kampala District and 51% in Katakwi District. Noteworthy is that close to a half of the first pregnancies in Katakwi District (49%) are not wanted. The percentages for Kampala and Rakai Districts are 38% and 30% respectively. Substantially high proportions of women also reported not to have planned their last pregnancies (around 30% in the three districts). The table also shows that 22% of the WWDs in Rakai District were pregnant at the time of interview compared to 8% in Katakwi District and 3% in Kampala District.

Incidence of abortion among WWDs is low and only 3% of the women had ever had an abortion. The proportion in Kampala is 5%. Figures on abortion are however subject to mis-reporting because abortion in Uganda is illegal and it's thus difficult to obtain statistics through self-reporting.

Table 6.1: Proportion ever been pregnant and circumstances of the pregnancy among female respondents; RH/Disability survey, 2003

	Kampala		Katakwi		Rakai		All	
	%	n	%	n	%	n	%	n
Ever been pregnant:								
Yes	80.4	37	83.0	73	63.8	37	76.6	147
No	19.6	9	17.0	15	36.2	21	22.9	44
N		46		88		58		192
Did you want 1st pregnancy:								
Yes	62.2	23	51.4	38	70.3	26	58.5	87
No	37.8	14	48.6	36	29.7	11	41.2	61
N		37		74		37		148
Was last pregnancy planned:								
Yes	67.6	25	68.1	49	72.2	26	69.0	100
No	32.4	12	31.9	23	27.8	10	31.0	45
N		37		72		36		145
Incidence of abortion:								
Yes	5.4	2	2.8	2	2.7	1	3.4	5
No	94.6	35	97.2	70	97.3	36	96.6	141
N		37		72		37		146
Pregnant now:								
Yes	2.7	1	8.1	6	21.6	8	10.1	15
No	94.6	35	90.5	67	73.0	27	87.2	129
Don't know	2.7	1	1.4	1	5.4	2	2.7	4
N		37		74		37		148

6.3 Age at First Pregnancy and Number of Live Births

The age at which childbearing commences is an important determinant of the overall level of fertility as well as the health and welfare of both mother and the child. In light of this, the survey asked women who had ever been pregnant the age at which they had their first pregnancy. Table 6.2 shows the median age at fist pregnancy by background characteristics of respondents. Childbearing starts at age 18 among WWDs in Katakwi and Rakai Districts, while in Kampala District, the median age at first pregnancy is 19 years.

Results by background variables indicate slight differentials by age, education and religious affiliation in the three districts. In Kampala District, respondents in the 35-44 age group recorded a median age at first pregnancy of 20 years compared to around 18 years for other age groups. In Katakwi District, the median age at pregnancy increases with age. The median age at first pregnancy among youth is 16 years compared to 18 years for the 25-34 and 35-44, while those 45+ registered a median of 20 years. Urban women in Katakwi District get their first pregnancies one year earlier (17years) than their rural counterparts (18 years). The results by education don't show any clear pattern. While PWDs with post-secondary education in Katakwi registered a median age at first pregnancy of 16.5 years, their counterparts in Rakai registered a median age at first pregnancy of 23 years. In actual terms, the results for Katakwi negate the general theory about education and pregnancy.

Considering religious affiliation, the Anglicans and Pentecostal in Kampala District registered a median age at first pregnancy of 18 years compared to 19 years for the Catholics and Muslims. For Katakwi District, the Muslim WWDs have their first pregnancy a year later (18 years) than the Catholics and Anglicans (17.0 and 17.5 years respectively), while the Pentecostal in Rakai District registered a much earlier age at first pregnancy (16 years). Similarly, the Pentecostal in Rakai have their first pregnancy a year before the rest (17 years) as compared to 18 years for the other religious groups. The mean number of children ever born by respondents is 4 children. Cross tabulations by other variables never generated significant differentials and hence not presented in the report.

Table 6.2: Median age at 1st pregnancy and mean number of live births; RH/Disability Survey 2003

	Kampala	Katakwi	Rakai	All
Median age at 1st pregnancy:	19.0	18.0	18.0	18.0
Age group:				
15 - 14	18.0	16.0	18.0	18.0
25 - 34	18.5	18.0	18.0	18.0
35 - 44	20.0	18.0	18.0	18.0
45+	18.0	20.0	18.5	18.5
Residence:				
Urban	19.0	17.0	18.0	18.0
Rural	-	18.0	18.0	18.0
Educational attainment:				
None	18.5	18.0	18.0	18.0
Primary	20.0	17.0	18.0	18.0
Secondary	18.0	20.5	18.0	18.0
Post-secondary	-	16.5	23.0	17.0
Religious affiliation:				
Catholics	19.0	17.0	18.0	18.0
Anglicans	18.0	17.5	18.0	18.0
Pentecostal	18.0	16.0	17.0	17.5
Muslims	19.0	18.0	18.0	19.0
Mean no. of live births	4.3	3.8	3.8	4.0

6.4 Utilisation of ANC and Knowledge about Safety of Pregnancy

Respondents were asked whether they received antenatal care during their last pregnancy before the survey. It is impressive to note that around 80% of the respondents in all districts reported to have received antenatal care during their last pregnancy. Awareness about safe pregnancy was established by asking women's knowledge about the danger signs of pregnancy.

On the whole, Table 6.3 shows that knowledge about the danger signs of pregnancy is very low. Forty-four (44%) percent of WWDs are aware that abdominal pain, while pregnant is a sign that the pregnancy is not progressing well. The proportion that knows this is even higher among WWDs in Katakwi District (54%). Fatigue as an indicator of danger during pregnancy, was also reported by 40% and 46% of the women in Kampala and Katakwi Districts respectively, compared to 22% in Rakai District. Vaginal bleeding is most known in Rakai District (26%) compared to 19% in Kampala District and only 8% in Katakwi District. Persistent headaches were mostly

reported in Katakwi District (29%), while Rakai and Kampala Districts recorded 17% and 15% respectively.

Table 6.3: Proportion received antenatal care and danger signs of pregnancy; RH/Disability, 2003

	Kampala		Katakwi		Rakai		All	
	%	N	%	n	%	n	%	n
Received ANC on last pregnancy:								
Yes	80.6	29	80.6	58	83.3	30	81.3	117
No	19.4	7	19.4	14	16.7	6	18.8	27
N		36		72		36		144
Danger signs of pregnancy:								
Swollen feet	23.4	47	7.8	90	10.3	58	12.3	195
Abdominal pain	25.5	47	54.4	90	41.4	58	43.6	195
Vaginal bleeding	19.1	47	7.8	90	25.9	58	15.9	195
Headaches	14.	47	28.9	90	17.2	58	22.1	195
Fits	0.0	47	1.1	90	1.7	58	1.0	195
Fatigue	40.4	47	45.	90	22.	58	37.4	195
None	6.4	47	10.0	90	6.9	58	8.2	195

6.5 Contraception

Indicators of contraception include knowledge, ever-use and current use of contraception. Although critical focus is on women, men play an important role in the realisation of reproductive goals and hence data on men are also presented in this section.

6.5.1 Knowledge About Contraception

Knowledge about contraception was established by probing whether respondents had ever heard of any methods of delaying or preventing pregnancy and if so, what the specific methods were. Table 6.4 shows that a very high proportion of respondents have ever heard of contraception (91% female and 88% male). The pill is the most known method of contraception (74% female and 72% male), and it is more known among PWDs in Kampala (90% male and 85% female) compared to other districts. Injectables are the second known methods of contraception and they

were reported by 68% of the women compared to 55% of the men. Katakwi males however, reported a low level of knowledge in relation to injectables (43%).

Despite the dual protection offered by condoms, only 31% of the WWDs know about its contraceptive role compared to 56% of the MWDs. These percentages are even much lower amongst PWDs in Katakwi with only 16% of the women and 38% of men reporting to have ever heard of condoms as means of delaying or avoiding pregnancy. However, three-quarters of the MWDs in Kampala reported to have ever heard of condoms as a means of contraception. The proportion ever heard of implants is around 24% in Kampala and Rakai Districts compared to only 6% in Katakwi Districts. Only 8% of MWDs know of male sterilisation and only 11% of the women have ever heard of female sterilisation. Among the traditional methods (withdrawal, rhythm, abstinence and breastfeeding), abstinence is the most known traditional method of birth control, and it was reported by only 14% of the males and 12% of females.

Table 6.4: Proportion ever heard of contraception; RH/Disability, 2003

	Kampala		Katakwi		Rakai		All	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Ever heard	95.1	91.3	81.0	87.6	87.3	94.7	87.9	90.6
N	61	46	58	89	55	57	174	192
Contraceptive methods:								
Pill	90.3	85.1	62.1	65.6	61.8	79.3	72.0	74.4
IUD	6.5	10.6	1.7	2.2	9.1	17.2	5.7	8.7
Injectables	69.4	72.3	43.1	68.9	52.7	63.8	55.4	68.2
Implants	21.0	23.4	1.7	5.6	10.9	24.1	11.4	15.4
Diaphragm	4.8	8.5	1.7	0.0	1.8	1.7	2.9	2.6
Condoms	75.8	46.8	37.9	15.6	52.7	43.1	56.0	31.3
Foam	0.0	4.3	0.0	0.0	0.0	0.0	0.0	1.0
Male sterilisation	11.3	2.1	3.4	1.1	9.1	3.4	8.0	2.1
Female sterilisation	9.7	12.8	17.2	10.0	12.7	10.3	13.1	10.8
Withdrawal	3.2	4.3	0.0	0.0	7.3	1.7	3.4	1.5
Rhythm	1.6	2.1	3.4	2.2	7.3	0.0	4.0	1.5
Abstinence	9.7	8.5	24.1	17.8	9.1	5.2	14.3	11.8
Breastfeeding	4.8	4.3	3.4	2.2	0.0	3.4	2.9	3.1
Others	4.8	4.3	1.7	7.8	3.6	5.2	3.4	6.2
None	1.6	0.0	0.0	1.1	5.5	3.4	2.3	1.5

6.5.2 Ever Use and Current Use of Contraception

Table 6.5 shows the percentage that has ever used the various methods of contraception by sex. The data have been aggregated due to the smallness of cases for some response categories. The data reveal that among male PWDs, the condom is the most ever used method and it was reported by 26% of the respondents. For the female PWDs, 14% of them reported to have ever used condoms and injectables, while 12% have ever used pills. Ever use of abstinence was reported by an almost equal percentage of male and female PWDs (6%).

Table 6.5: Percent ever used contraception; RH/Disability Survey, 2003

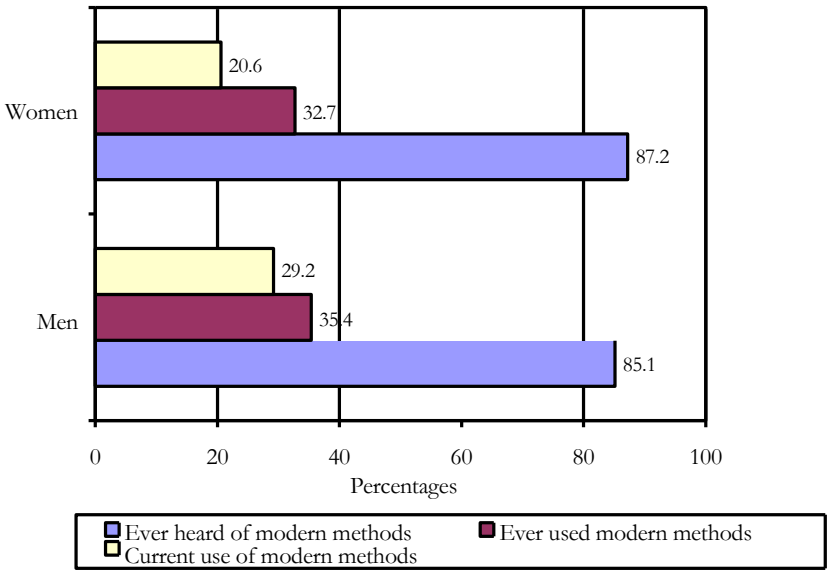
% Ever used	Male (%)			Female (%)		
	Yes	No	N	Yes	No	N
Pill	5.6	94.4	144	11.5	88.5	165
IUD	0.0	100.0	144	0.0	100.0	165
Injectables	5.6	94.4	144	13.9	86.1	165
Implants	2.1	97.9	144	0.6	99.4	165
Diaphragm	0.0	100.0	144	1.2	98.8	165
Condom	25.7	74.3	144	13.9	86.1	165
Foam	1.4	98.6	144	0.0	100.0	165
Male sterilisation	0.0	100.0	144	0.0	100.0	165
Female sterilisation	1.4	98.6	144	3.0	97.0	165
Withdrawal	1.4	98.6	144	0.0	100.0	165
Rhythm	1.4	98.6	144	0.6	99.4	165
Abstinence	6.3	93.8	144	6.7	93.3	165
Breastfeeding	0.0	100.0	144	2.4	97.6	165
Others	36.1	63.9	144	29.7	70.3	165

Table 6.6 and Figure 6.1 present data on knowledge, ever use and current use of modern and traditional methods of contraception by respondents. Modern methods include: the pill, intra-uterine device (IUD), injectables, implants, diaphragm, condom, foam, male and female sterilisation. Traditional methods include: withdrawal, rhythm, abstinence and breastfeeding. The table reveals that much as knowledge about modern methods of contraception is high, ever use is 35% and 33% for males and females respectively, while current use is only 30% and 21% among males and females respectively. The male percentage is highly contributed by condom use as can also be seen from the previous table (Table 6.5). As expected, current use of modern methods is highest among women in Kampala District (39%). Rakai and Katakwi Districts record 22% and 10% respectively.

Table 6.6: Percentage ever used and currently using contraception; RH/Disability Survey, 2003

	Kampala		Katakwi		Rakai		All	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Ever heard of modern contraception:	91.9	89.4	79.3	84.4	83.6	89.7	85.1	87.2
N	62	47	58	90	55	58	175	195
Ever heard of traditional methods:	16.1	14.9	29.3	21.1	21.8	10.3	22.3	16.4
N	62	47	58	90	55	58	175	195
Ever use of modern contraception:	55.8	56.1	22.9	17.7	25.0	37.8	35.4	32.7
N	52	41	48	79	44	45	144	165
Ever use of traditional methods:	5.8	0.0	18.8	15.2	2.3	6.7	9.0	9.1
N	52	41	48	79	44	45	144	165
Current use of modern methods:	50.0	39.0	16.7	10.1	20.5	22.2	29.9	20.6
N	52	41	52	79	44	45	144	165
Current use of traditional methods:	1.9	0.0	12.5	5.1	6.8	2.2	6.9	3.0
N	52	41	48	79	44	45	144	165

Figure 6.1: Contraceptive Knowledge and Practice by Sex



6.6 Summary

The results show that 77% of the women in the sample had ever been pregnant and 59% of these desired their first pregnancy. The proportion that never desired their pregnancy was however high (41%). In addition, 31% also never desired their last pregnancy. Incidence of abortion was only 3%. The median age at first pregnancy is 18 years and mean number of children ever born is 4. Noteworthy is that 81% of respondents received ante-natal care for their last pregnancy. However, danger signs of pregnancy are not known among PWDs.

Ever heard of contraception was about 85% of either sex. Ever use of modern methods is 33% of women and 35% of men. Current use of modern methods of contraception is 21% and 30% of women and men with disabilities.

CHAPTER SEVEN

REPRODUCTIVE HEALTH SERVICES

7.1 Introduction

This section provides information on indicators of reproductive health services (RHS). The areas explored include knowledge of reproductive health services and utilisation of reproductive health services. The chapter also provides constraints in utilisation of RHS among PWDs and also presents avenues through which access to RHS can be improved amongst this sub-group of the population.

7.2 Knowledge About RHS

Table 7.1 presents data on the respondents' knowledge about RHS. The aspects probed include ever heard of RHS, where they can be obtained, and knowledge about their availability in the community. The table indicates that 71% of the women and 74% of the men have ever heard of RHS. District specific results show that 78% and 74% of the WWDs in Rakai and Katakwi Districts have ever heard of RHS respectively. The percent ever heard of such services among their counterparts in Kampala District is 58%. Noteworthy is that a substantial proportion of respondents are not aware of any RHS - in Kampala District for example, 42% of the WWDs have never heard of any RHS.

The survey also probed for the various sources of RHS, and around 3 in every 5 PWDs stated that these services can be obtained from government health facilities. Seventy (70%) percent of the WWDs in Katakwi District know that these services can be obtained from Government health facilities compared to 57% and 51% of the WWDs in Rakai and Kampala Districts respectively. Only 6% of the women in Kampala District cited the availability of RHS in private health facilities compared to 20% of the women in Katakwi and Rakai Districts. All in all, approximately 7% of the WWDs cited the awareness of the provision of RHS by traditional birth attendants (TBAs).

Awareness about the availability of respective RHS was also probed as can be seen from Table 7.1. On the whole, the RHS most known of their availability in the community by WWDs are immunisation (96%), antenatal care (91%) and delivery care (86%). Around 80% of the women also cited the availability of contraceptive services in the community, while 71% are also aware of the availability of services meant for the diagnosis and management of STIs in their community. Post-abortion care and HIV testing are regarded as the least available services in the community (37% of the WWDs). Considering the district specific findings, the services mentioned to be least available in the communities of Rakai and Katakwi District are HIV testing and post-abortion care.

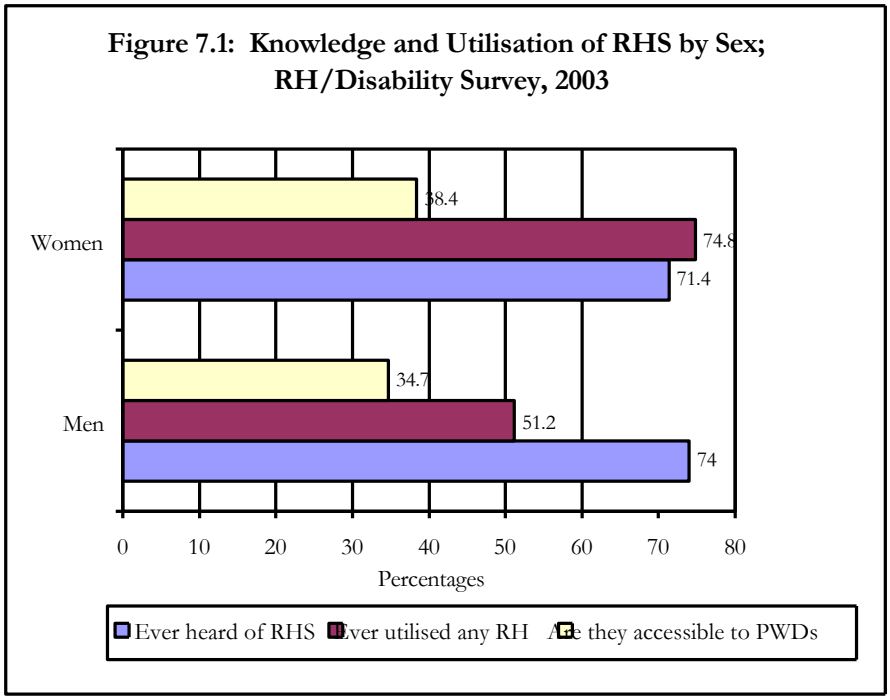
Table 7.1: Knowledge of reproductive health services; RH/Disability Survey, 2003

	Kampala		Katakwi		Rakai		All	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Ever heard of RHS:								
Yes	80.3	57.8	70.7	74.4	70.4	77.6	74.0	71.4
No	19.7	42.2	29.3	25.6	29.6	22.4	26.0	28.6
N	61	45	58	86	58	173	189	
Sources of RHS:								
Govt. health facilities	67.7	51.1	67.2	70.0	56.9	64.6	61.5	65.3
Private health facilities	19.4	6.4	22.4	20.0	10.9	20.7	17.7	16.9
Private clinics	8.1	4.3	10.3	3.3	1.8	8.6	6.9	5.1
Drug shops	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TBAs	3.2	2.1	5.2	10.0	1.8	5.2	3.4	6.7
Others	4.8	4.3	0.0	5.6	7.3	1.7	4.0	4.1
N	61	45	58	86	54	58	173	189
Available services in the community:								
Guidance and counselling	70.8	70.4	78.0	66.7	65.8	61.4	71.7	65.7
Management of STI	68.8	76.9	82.9	77.3	71.1	57.8	74.0	70.8
Contraceptives	87.2	76.2	75.6	83.3	68.4	75.6	77.8	79.6
Antenatal care	83.7	80.0	75.6	98.5	73.0	86.4	78.0	91.2
Delivery care	87.5	76.9	73.2	97.0	71.1	75.0	78.0	86.0
Post delivery care	70.8	72.0	65.9	81.8	40.5	37.2	60.3	65.7
Post abortion care	33.3	36.0	34.1	53.0	22.2	15.9	30.4	37.8
Immunisation	91.8	96.3	97.6	97.0	89.5	95.5	93.0	96.4
HIV testing	63.0	74.1	46.3	22.7	50.0	36.4	53.6	37.2
Others	27.3	14.3	0.0	1.5	2.7	2.4	4.5	2.6
N	61	45	58	86	54	58	173	189

7.3 Utilisation of RH Services

Utilisation of RH services was probed by asking whether respondents had ever used any of the RH services earlier mentioned. The analysis of the responses reveal that three-quarters (75%) of women with disabilities have ever used RH services compared to a half (51%) of the men with disabilities (See Figure 7.1 and Table 7.2). Katakwi District registered the highest proportion of female users (81%) followed by Kampala District (73%). Over a half of the men in Kampala and Rakai Districts have never sought RH services, which is not surprising since most services are female based and male participation in the RH issues is also a relatively new phenomenon in our setting.

Figure 7.1: Knowledge and Utilisation of RHS by Sex; RH/Disability Survey, 2003



As for the utilisation of the specific RH services, 80% and 60% of WWDs have ever utilised immunisation services and antenatal care services. The proportion that has ever sought delivery care services and counselling services is 53% and 49% respectively. Noteworthy is that 25% of the MWDs have ever utilised HIV testing services compared to 15% of the WWDs. This sex differential is even wider in Katakwi District, where 12% of the MWDs have ever utilised HIV testing services compared to 6% of their female counterparts. The data in the table further show

that 49% of the men have ever utilised management of STI services compared to 29% of the women. Much as the sex differential in percent ever utilised STI management services is wider in Rakai District (44% of men Vs 17% of women), the proportion ever sought these services is highest in Kampala District which registered 83% and 73% among men and women respectively.

Information was also obtained on the quality of RH services that had ever been utilised by respondents. On the whole, a quarter of the female and 64% of the male respondents mentioned that they were satisfied with the quality of services. Substantial proportions in all districts however, were not satisfied with the quality of RH services.

The enquiry also probed whether respondents feel RH services are accessible to PWDs as can also be seen from Table 7.2 and Figure 7.1. Around 57% of the females and 58% of the males feel the RH services are not easily accessible to PWDs. These sentiments were even stronger among males than females in the districts of Kampala and Katakwi. On the contrary only 26% of the male respondents in Rakai District felt these services were not accessible to PWDs compared to 58% of their female counterparts.

Table 7.2: Percent ever utilised reproductive health services by district and sex; RH/Disability Survey, 2003

	Kampala (%)		Katakwi (%)		Rakai (%)		All	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Ever utilised any RH services:								
Yes	48.9	73.1	57.9	81.3	47.4	66.7	51.2	74.8
No	51.1	26.6	42.1	18.8	52.6	33.3	48.8	25.2
N	45	26	38	64	38	45	121	135
Specific services:								
Guidance and counselling	76.2	75.0	52.0	44.4	23.5	41.4	52.4	48.5
N	21	16	25	54	17	29	63	99
STI management	83.3	73.3	28.0	22.6	44.4	17.2	49.2	28.9
N	18	15	25	53	18	29	61	97
Contraceptives	61.9	80.0	16.0	38.5	16.7	27.6	31.3	41.7
N	21	15	25	52	18	29	64	96
Antenatal care	60.0	75.0	4.0	59.3	33.3	51.7	30.2	59.6
N	20	16	25	54	18	29	63	99
Delivery care	50.0	75.0	8.0	56.6	33.3	33.3	28.6	52.5
N	20	16	25	53	18	30	63	99
Post delivery care	47.4	73.3	8.0	47.2	16.7	10.3	22.6	40.2
N	19	15	25	53	18	29	62	97
Post abortion care	16.7	10.0	0.0	24.5	0.0	7.1	5.0	17.6
N	18	10	24	53	18	28	60	91
Immunisation	81.8	100.0	64.0	83.0	44.4	60.7	64.6	79.6
N	22	17	25	53	18	28	65	98
HIV testing	40.0	38.5	12.0	5.7	27.8	20.0	25.4	14.6
N	20	13	25	53	18	30	63	96
Satisfied with quality of services:								
Yes	57.7	63.2	68.0	85.7	66.7	63.3	63.8	75.2
No	42.3	36.8	32.0	14.3	33.3	36.7	36.2	24.8
N	26	19	25	56	18	30	69	105
Are services available to disabled?								
Yes	21.7	37.0	27.5	36.4	57.9	42.2	34.7	38.4
No	76.1	55.6	67.5	56.1	26.3	57.8	58.1	56.5
Don't know	2.2	7.4	5.0	7.6	15.8	0.0	7.3	5.1
N	46	27	40	66	38	45	124	138

7.4 Constraints to Effective Utilization of RH Services

Information on constraints of effective utilization of RH services by PWDs was obtained through focus group discussions and in-depth interviews. This section presents highlights on those problems.

③ Inaccessibility of health centers

Most focus groups hinted on the geographical inaccessibility of the health units to particularly persons with impairments of the legs. Many again lack mobility aides to facilitate their travel to these centres for health care services. Some also said:

> *"Taxi drivers don't want to take us because we occupy more than one seat and only pay for one person", (Female youth, Kampala District).*

> *"Boda bodas (bicycles and motorcycles) are the main mode of transport here and we find it hard to sit on them because of our disabilities (of the limbs), yet there are no taxis to the health centre", (WWD, Rakai District).*

③ Poor quality of health services

Lack of drugs and trained personnel in most of the health facilities was cited as a major hindrance to PWD's utilization of health services. Other related responses hinted on the massive corruption at these health centers as another constraint to RH service utilisation.

> *"There is no visiting doctor at the nearby health unit and every time I go there, I am not given any medicine. I am just advised to go and buy (MWDs, Rakai District).*

③ Unfriendliness of health service providers towards PWDs

This came up in all the women's focus group discussions as a major deterrent to their utilization of reproductive health services.

> *"Nurses ridicule, laugh and abuse us when we emerge with reproductive health problems. They always insult us by asking questions like; how did you get this pregnancy you crippled women"(WWDs, Rakai District).*

> *"We are always made to line-up with able bodied persons and we are tossed around yet we are weak and cannot stand up for long periods" (MWDs, Katakwi District).*

"We find it hard to locate the places where we are referred to in the hospital because we are illiterate, and at times cannot even easily communicate (Female youths, Kampala District). Similar sentiments were also expressed in the male youth groups.

"Those who move by crawling are always dirty and health workers just push them away because of the dirt on their clothes and bodies" (WWDs, Kampala District).

"Some hospital facilities are not favourable for disabled persons e.g. stairs, high beds for pregnant women, high toilets, etc". (WWDs, Kampala District).

③ Fear and suspicion PWDs have for the health system

Some participants expressed that they fear accessing modern health services particularly after observing experiences of their colleagues. Such sentiments can be captured in the following responses:

"Why is it that all WWDs who deliver in hospitals get caesarian sections yet those who go to TBAs don't? We therefore fear to get complicated deliveries in hospitals", (WWDs, Kampala District).

"My friend received a tubaligation when she went to deliver her second child in the hospital. Doctors said she would die if she had another pregnancy and now she can't have babies anymore. Those who don't go to hospital can have as many children as they want" (WWDs, Katakwi District).

"Those with mental disabilities worsen when treated with modern medicine", (Parents with disabled youths, Rakai District).

"Some doctors give WWDs contraceptive methods which permanently prevent them from having children and we fear using them" (Female youths, Kampala District).

7.5 Improvements in the Delivery of RH Services Among PWDs

Effective service delivery and programme design should always draw views from the beneficiaries of the planned programmes. It was therefore important to seek respondents' views on how RH service delivery could be improved among PWDs. Table 7.3 shows that 44% of the female respondents feel a strong need for the establishment of more health units to increase the availability and accessibility of RH services. District specific results show that the highest proportion of respondents across the three districts cited the same strategy. Around 30% of the females also cited the need for increased sensitisation and awareness raising programmes on RH

issues as an avenue for improving the delivery of RH services. Twenty-six (26%) of the women also mentioned the need to provide transport aides in order to ease the geographical accessibility to RH service points among PWDs. Substantial proportions also mentioned support towards setting up income generating projects/self reliance projects in a bid to improve incomes and hence accessibility and affordability of RH services among PWDs.

Table 7.3: How to improve reproductive health service delivery; RH/Disability, 2003

	Kampala		Katakwi		Rakai		All	
	Male	Female	Male	Female	Male	Female	Male	Female
How to improve Reproductive Health Services among PWDs:								
Provide health units	54.8	55.3	36.2	37.8	47.3	43.1	46.3	43.6
Sensitization	32.3	31.9	27.6	27.8	36.4	31.0	32.0	29.7
Projects for self reliance	24.2	10.6	24.1	27.8	18.2	19.0	22.3	21.0
Provide transport	3.2	10.6	24.1	38.9	12.7	19.0	13.1	26.2
Free education	0.0	4.3	5.2	0.0	3.6	1.7	2.9	1.5
Others	11.3	10.6	6.9	5.6	7.3	5.2	8.6	6.7
N	62	47	58	90	55	58	175	195

7.6 Information on RH Issues

Availability and accessibility of information on reproductive health matters is central to informed decision making and thus safe and desirable behaviour. On this basis, respondents were asked about the various sources of RH information in their community and the summary of responses is presented in Table 7.4.

Radios are the major providers of RH information to PWDs and 53% of the females and 69% of the males reported them. Next to radios are the peers and friends who were reported by 43% of the women compared to 38% of the men. The data for Rakai District also conforms to the general pattern and 66% of the females and 60% of the males obtain RH information from the radios. Similarly, 43% and 35% of women and men obtain this information also from peers and friends. In Katakwi District, the highest proportion of WWDs (46%) obtain RH information from peers

and friends and 42% also gets this information from radios. Health facilities are the major providers of RH information to females in Kampala (75%) followed by radios (57%) and peers (38%). The print media were the least providers of RH information to PWDs. These include newspapers, pamphlets, and straight talk. This may be due to the fact that they are not really cost free - one needs to buy a newspaper to be able to access the information therein including straight talk.

Table 7.4: Sources of RH information by sex and district; RH/Disability survey, 2003

	Kampala (%)		Katakwi (%)		Rakai (%)		All	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Sources of RH information:								
Radio	87.1	57.4	56.9	42.2	60.0	65.5	68.6	52.8
Newspaper	24.2	12.8	22.4	10.0	16.4	6.9	21.1	9.7
Pamphlets	14.5	6.4	3.4	0.0	0.0	1.7	6.3	2.1
Straight Talk	8.1	6.4	5.2	0.0	0.0	3.4	4.6	2.6
Meetings	19.4	19.1	20.7	27.8	7.3	8.6	16.0	20.0
Peers/Friends	40.3	38.3	37.9	45.6	34.5	43.1	37.7	43.1
TV programmes	19.4	8.5	5.2	1.1	1.8	0.0	9.1	2.6
Health facilities	6.5	74.5	20.7	25.6	18.2	17.2	14.9	23.1
Community health worker	6.5	6.4	25.9	22.2	23.6	25.9	18.3	19.5
Others	12.9	10.6	8.6	5.6	5.5	15.5	9.1	9.7
	62	47	58	90	55	58	175	195

Note: This was a multiple response question and percentages don't add up to 100.

Focus group discussions and in-depth interviews with key informants also probed the various sources of RH and HIV/AIDS information for PWDs. Radios and friends were cited in all groups and in-depth discussions as the most common sources of information on HIV/AIDS and RH for PWDs. Various NGOs were also mentioned to be providers of HIV/AIDS and RH information to disabled persons. Notable of these are: The AIDS Support Organisation (TASO) through their awareness raising activities in Katakwi District, Lutheran World Foundation (LWF) and Rakai Project through their mobile film van in Rakai District, Health Need Uganda (HNV) in Katakwi District and Straight Talk through its regular newsletter on reproductive health. PWDs in Kampala also cited charts and posters on HIV/AIDS, while those in Rakai and Katakwi District made mention of their LC councillors at the district and subcounties. Drama as a source of HIV/AIDS and RH information was only mentioned in Kampala District while the respondents in

Katakwi District also cited blood transfusion teams. Key-informants also mentioned out-reaches, health education talks together with interacting with friends and relatives as the other sources of information on HIV/AIDS among PWDs.

7.6.1 Improvements in HIV/AIDS and RH Information Dissemination Among PWDs

Participants in both the focus groups and in-depth interviews felt there is need to improve RH and HIV/AIDS information dissemination among disabled persons by:

a. Facilitating all PWD councillors with transport to enable them reach all the groups of PWDs in their areas of operation.

b. Organise RH seminars specifically targeting disabled persons given their unique problems with communication.

c. Support PWDs drama groups so that they disseminate RH and HIV/AIDS information among PWDs. Such support could include equipment and script development for uniformity of information.

d. Train disabled peer educators on RH and HV/AIDS.

Other general suggestions regarding IEC on RH and HIV/AIDS, which came up include:

a. The need to develop uniform messages to be translated in all local languages and aired at the same time on all radio stations in the country.

b. Adoption of the mobile van approach to community sensitization about RH and HIV/AIDS across the country.

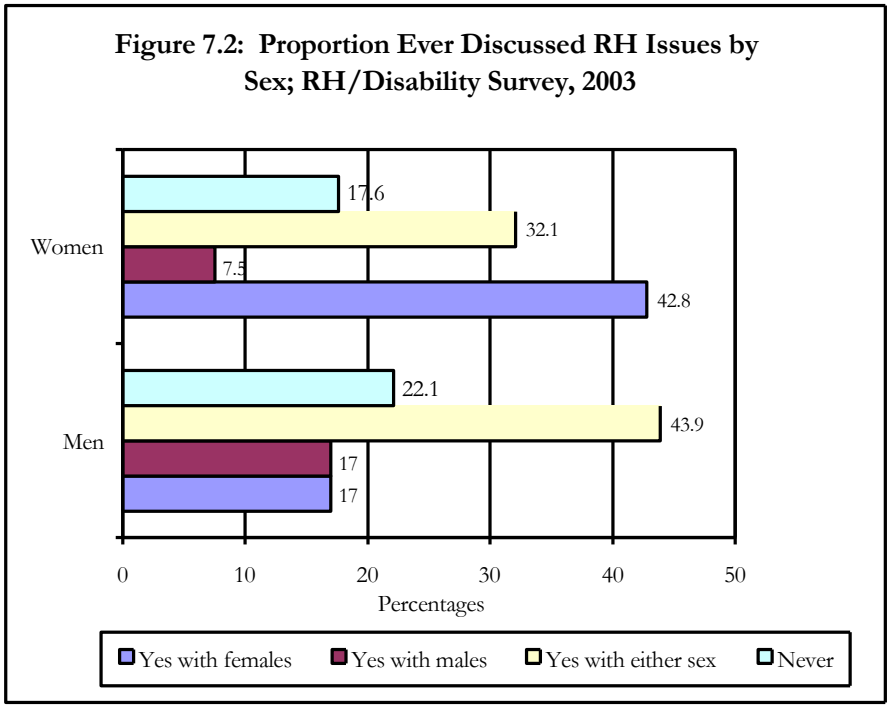
c. Messages on posters and charts should always be translated in all local languages and put at all conspicuous places in the communities other than putting them at health centers alone.

7.7 Discussions on Reproductive Health Issues

Respondents were asked whether they ever discuss RH issues with, either females, males, or both males and females. The findings of this analysis (see Table 7.5 and Figure 7.2) indicate that with whom PWDs discuss RH issues varies by sex. On the whole, the highest proportion of females (43%) discuss RH issues with only females and 32% discuss such issues with either sex. A similar pattern is observed among women in all the three (3) survey districts.

Data for the men indicate that while 44% discuss RH with either sex, 22% never discusses such issues with anybody. Only 17% discuss RH issues with fellow men, and an equal proportion also discusses RH issues with females. There are variations in the data by district as can also be observed from Table 7.5. In Kampala and Katakwi Districts, the highest proportion of males discuss RH issues with either sex. The percentage for Kampala District is 61% while that of Katakwi District is 40%. In Rakai District however, the highest proportion of males (35%) never discuss RH issues with anybody and only 29% discuss such issues with either sex.

Figure 7.2: Proportion Ever Discussed RH Issues by Sex; RH/Disability Survey, 2003



Considering the specific issues discussed, approximately 54% of males and females discuss about HIV/AIDS, and such discussions are important in guarding against infection. Fifty-six (56%) percent and 46% of men and women respectively, also reported that they discuss family planning issues; and another 53% of the women also discuss issues related to pregnancy compared to 30% of MWDs. A quarter of the women (25%) and 32% of the men discuss about sexually transmitted infections (STIs). Issues to do with antenatal care are the least discussed amongst PWDs.

Table 7.5: Percent ever discussed reproductive health issues by district and sex; RH/Disability Survey 2003

	Kampala		Katakwi		Rakai		All	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Discussed RH issues								
Yes with females	18.6	45.5	12.3	41.9	20.0	42.1	17.0	42.8
Yes with males	13.6	11.4	21.1	7.0	16.4	5.3	17.0	7.5
Yes with either sex	61.0	31.8	40.4	31.4	29.1	33.3	43.9	32.1
Never	6.8	11.4	26.3	19.8	34.5	19.3	22.1	17.6
N	59	44	57	86	55	57	171	187
Issues discussed								
Family planning	72.7	61.5	35.7	40.6	55.6	39.1	56.4	45.5
N	55	39	42	69	36	46	133	154
STDs	38.2	23.1	38.1	21.7	16.7	32.6	32.3	25.3
N	55	39	42	69	36	46	133	154
Pregnancy	49.1	66.7	14.3	43.5	19.4	54.3	30.1	52.6
N	55	39	42	69	36	46	133	154
Antenatal care	10.9	10.3	4.8	8.7	0.0	8.7	6.0	9.1
N	55	39	42	69	36	46	133	154
HIV/AIDS	43.6	33.3	71.4	58.0	52.8	60.9	54.9	52.6
N	55	39	42	69	36	46	133	154

7.8 Role of Political Leadership in Relation to Improvement of RH Situation of PWDs

In-depth interviews probed for the perceived role of the political leaders in the improvement of the RH status of PWDs. The perceived roles that came up were:

- ③ Sensitisation of PWDs on RH and HIV/AIDS issues
- ③ Encourage PWDs to seek voluntary counseling and testing services
- ③ Lobby for funds to undertake projects and programmes on RH among PWDs

③ Disseminate RH information to PWDs in seminars and community meetings

③ Ensure proper monitoring and coordination of RH programmes in their localities ③

Be role models in the fight against HIV/AIDS

③ Help PWDs access aides (wheel chairs, Braille, etc.) ③

Promote condom use in the communities.

7.9 Summary

The findings indicate that 71% of women and 74% of men have ever heard of RHs. About 60% are aware that RHs can be obtained from government health facilities. Three-quarters (75%) of WWDs have ever utilised at least one RH service compared to 51% of their male counterparts. However 71% and 74% of women and men feel they are not accessible to PWDs. Constraints to effective utilisation of RH services by PWDs include inaccessibility of health centres, poor quality of health services, unfriendliness of health service providers, fear and suspicion PWDs have for the health system.

Considering information on RH, radios and friends were cited as the major sources of such information. 43% of the WWDs discuss RH issues with women only and 32% discuss RH issues with either sex. On the contrary, only 17% of MWDs discuss RH issues with fellow men and another 44% discuss them with either sex. Twenty-two (22%) of the men and 18% of the women have never discussed RH issues with anyone.

CHAPTER EIGHT

SUMMARY OF MAJOR FINDINGS AND ISSUES FOR PROGRAM ACTION

8.1 Introduction

This section presents major findings of the study in relation to sexual behaviour, HIV/AIDS, reproductive health issues and reproductive health service utilization among PWDs. Issues that can be taken up for program action have also been highlighted.

8.2 Sexual Behaviour

The findings indicate that 88% of the females and 82% of the males in the sample have ever engaged in sex. However, females on average start sexual activity two years (16 years) than males (18 years). Female PWDs in Katakwi District start sexual activity as early as 15 years of age. There are also variations in age at first sexual debut by residence and educational attainment. While results on educational attainment reveal no distinct pattern, rural female PWDs have sex earlier (16 years) than their urban counterparts (17 years). Results also indicate that the majority starts having sex out of sheer desire (75% males and 59% females). However, 22% of female PWDs in both Kampala and Rakai Districts were raped at their first sexual encounter.

Having sex in anticipation for a reward is also prevalent among PWDs (22% males and 16% females). Considering the district specific findings, the phenomenon is higher among PWDs in Kampala, where 44% of the males and 39% of females reported to have ever engaged in sex for gain. Similarly, 42% of female PWDs have ever been forced to have sex. Rakai and Katakwi Districts reported 24% and 13% respectively.

Knowledge about condoms is almost universal for both male (94%) and female (90%) PWDs. Ever use of condoms is 39% and 26% among male and female PWDs respectively. However, only 6% of the females in Katakwi District have ever used condoms. Future condom use was estimated at 54% for males and 34% for females.

The socio-economic problems faced by PWDs include poverty, discrimination and stigma, lack of aids, together with geographical and social inaccessibility to service centers. Poverty was attributed to a number factors including inability to engage in agricultural activities among PWDs, lack of formal education and skills and various forms of disability. Area specific problems cited include the cattle raids in Katakwi District and the single-headed households and AIDS orphans in Rakai District.

Reproductive health problems faced by WWDs are sexual exploitation, unwanted pregnancies, and complications during child birth. MWDs are also faced with problems in identification of faithful sexual partners and they also find it hard to render effective RH support to their spouses. Many PWDs also hinted on the entire exclusion of PWDs in the RH service delivery system.

8.3 Sexually Transmitted Infections (STIs) and HIV/AIDS

Knowledge about STIs among PWDs is very high (96% females and 93% males). As for specific STIs, syphilis and gonorrhea were the most known STIs by both men and women. Genital warts and candidiasis are almost unknown by the PWDs. In addition, knowledge about the signs of STIs is very low. For example, only 38% and 25% of the female PWDs know that foul discharge in the private parts and painful urination are signs of STIs respectively. Noteworthy is that around 1 in every 5 female PWDs don't know any sign of STIs.

The incidence of STIs among PWDs is very high. The proportion ever contracted any STI is 38% females and 35% males. The district-specific data indicate that more females than males had ever contracted STIs in all the three survey districts. Women in Kampala reported the highest incidence (45%) followed by Rakai (41%) and Katakwi (33%). On a positive note, 98% and 94% of the females and males had received treatment for the STIs.

Awareness about HIV/AIDS is almost universal among PWDs. The signs of HIV/AIDS mostly reported by respondents include loss of weight (68% women and 73% men), skin rash (68% men and 58% women). Only 6% of both sexes cited HIV testing as a means through which people can know their HIV status. Regarding HIV spread; noteworthy is that only 47% of the female PWDs in Rakai District cited having sex with an HIV infected person as a mode of HIV transmission.

Unsafe blood transfusion, sharing sharp objects and vertical transmission of HIV were the least known modes of HIV transmission among PWDs.

Results also show that preventive mechanisms of HIV are not highly known among PWDs. Fiftyfive (55%) percent and 44% of females and males respectively, consider themselves at risk of contracting HIV either because they engage in unprotected sex or have multiple sexual partners. Major sources of HIV/AIDS information were identified as radios and friends.

Pre-disposing factors to STIs and HIV/AIDS among WWDs include poverty, rape, non-use of condoms, traditional and cultural practices (tattooing, forced marriages, visits to shrines, widow inheritance and wife sharing), reliance on traditional medicine, lack of awareness about RH and polygamy. Stigma and discrimination, material poverty, failure to get sexual and marriage partners of choice and failure to fulfill sexual obligations hinder PWDs from leading quality RH lives.

8.4 Reproduction

On the whole, 77% of the women in the sample had ever been pregnant and 3 in every 5 first pregnancies among PWDs are wanted. District-specific results however, reveal that almost half of the first pregnancies among females in Katakwi and about 38% in Rakai District are not wanted. Incidence of abortion was only 3%. The median age at first pregnancy is 18 years in Katakwi and Rakai Districts and 19 years in Kampala District. The mean number of children ever born among PWDs is 4.

Around 80% of the respondents in the three districts received antenatal care during their last pregnancy. However, knowledge about the danger signs of pregnancy is very poor. Contraceptive awareness is 91% and 88% among female and male PWDs. Going by the classification of contraception (modern and traditional), 87% and 85% of females and males had ever heard of modern contraception. Only 22% and 16% of males and females knew about traditional methods of contraception. The pill is the most commonly known method (74% female and 72% male) followed by injectables (68% female and 55% male). Only 31% of the women know the contraceptive role of condoms compared to 56% of the men. All in all, ever use of modern

contraceptives is 35% of males and 33% of females. Only 9% of both sexes had ever used traditional methods of contraception.

8.5 Reproductive Health Services (RHS)

On the whole, 70% of the men and women have ever heard of RHS. District analysis however, show that 42% of the female PWDs in Kampala District have ever heard of RHS. The percentage in other districts is around 25%. About 3 in every 5 PWDs are aware that these services can be obtained from government health facilities. HIV testing and post-abortion care was the least known RHS. As expected, more women (75%) than men (51%) have ever utilized RH services. The majority however, feels RHS aren't easily accessible to PWDs. The reasons cited in the qualitative data for this trend include geographical inaccessibility of the health facilities, unfriendliness of the service providers, poverty, lack of knowledge and lack of confidentiality as key hindrances to PWDs' access to RHS services.

As to whether PWDs discuss RH issues, 43% of the females mostly discuss with females and 32% discusses RH issues with either sex. Radios and friends are the major providers of RH information to PWDs.

8.6 Issues for Program Action

The findings from the study clearly indicate the need to promote sexual and reproductive health among PWDs as a right and to also respond to their sexual and reproductive health needs through various interventions. In light of this, the following are proposed for program action:

1. In order to effectively address the RH needs of PWDs, there is need to design and implement PWD-specific interventions. This is one of the critical steps that DWNRO and other organizations working with PWDs need to undertake in order to reverse the indicators realized in this study. The components of such a program would be:
    a. Training of RH and HIV/AIDS peer educators drawn from the PWD communities/groups. The peer educators would not only provide RH and HIV/AIDS training to PWDs but can also provide condoms (both male and female) and other IEC materials to PWDs.

b. Training of RH and HIV/AIDS service providers is central to effective reach of PWDs. The emerging training requirements include: change in attitudes towards PWDs so that they are also viewed as people with sexual and reproductive health needs some of which are general but others quite unique to their state and thus warrant recognition for healthy lives; training in sign language in order to guarantee confidentiality among the respective PWDs, which is the cornerstone of RH and HIV/AIDS service utilization. This might require advocacy targeting pre-service and in-service health training institutions so that the required training content is designed and eventually delivered to the trainees.

c. Since family planning (FP) remains at the core of sexual and reproductive health care, there is need for the RH program to also provide FP services to PWDs including FP counseling, information, education, communication and contraceptive supplies. Provision of gender-sensitive information, education and counseling on sexuality among PWDs needs to be done since results indicate that there variations in men and women's sexual needs and challenges.

2. The incidence of STIs among PWDs is extremely high and requires urgent and intensive program/project efforts. There is need to:

   a. Educate PWDs about HIV/AIDS and STI prevention and management including the dangers of unprotected sex particularly in light of the HIV/AIDS scourge. The training package could constitute the various forms and signs of STIs, the need for effective STI management including partner notification to avoid re-infection to mention but a few.

   b. Provide PWDs with life-skills training to improve their esteem and confidence for better RH outcomes.

These could be done through organized seminars facilitated by technical personnel in the field of STI control and management.

3. There is need to improve the poverty situation of PWDs in order to improve their reproductive health status. This could be done through a number of ways including:
    a. Setting up micro-credit scheme/s, which can be accessed by PWDs either in groups or individually.
    b. Provision of skills in income generating activities (IGAs) particularly to the youths. These skills could actually form basis for their access to the micro-credit facilities.
    c. Intensification of efforts to encourage parents and guardians enroll their disabled children in school and where possible, communities could be urged to devise ways of ensuring that PWDs attend school. The UPE program can be effectively utilized as a driver to this noble cause. It is through education that PWDs can acquire skills and thus lucrative employment in their adult lives.

4. Information, education and communication (IEC) on RH for PWDs also need to be developed with special focus not only on the messages but also special focus on the various forms of disability. DWNRO could take up development and production of IEC materials on RH and HIV/AIDS specifically targeting PWDs. These should be up to date and properly distributed with translated versions in the various local languages for effective reach.

5. Sexual abuse (violence) in form of rape and forced sex was noted to be high and this is a violation of reproductive rights of particularly female PWDs. Parents, guardians, family members and the entire community have to be sensitized about the need to provide a safe environment for PWDs. In addition, there are strong indications that PWDs require life skills to be able to know, live and appreciate the state of having a disability so that they eventually make informed decisions. The life skills building package could embrace: self awareness, self esteem, coping mechanisms, friendship formation, peer pressure resistance, negotiation, effective communication, decision making, creative thinking and problem solving.