BASELINE SURVEY ON PROMOTION

OF A DISABILITY PERSPECTIVE INTO UGANDA'S NATIONAL HIV/AIDS RESPONSE

NUDIPU

REPORT FEBRUARY 2007

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PROMOTION OF A DISABILITY PERSPECTIVE INTO UGANDA'S NATIONAL HIV/AIDS RESPONSE

BASELINE SURVEY REPORT

SUBMTTED TO

NATIONAL UNION OF DISABLED PERSONS OF UGANDA

(NUDIPU)

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LIST OF ABBREVIATIONS

ABC	Abstinence, Being faithful and Condom Use
ANC	Antenatal Care
AIDS	Acquired Immune Deficiency Syndrome
AIC	AIDS Information Centre
ARVs	Anti-revirol Drugs
AVIS	Association of Voluntary Services Internationa
CBO	Community Based Organisation
CHAI	Community HIV/AIDS Initiatives
CHWs	Community Health Workers
FGDs	Focus Group Discussions
FP	Family Planning
HIV	Human Immune Virus
IEC	Information, Education, Communication
IDPs	Internally Displaced Peoples Camps
KI	Key Informant Interview
LCs	Local Councils
LGs	Local Governments
MTCT	Mother to Child Transmission
MOH	Ministry of Health
NGOs	Non-governmental Organisations
NUDIPU	National Union of Disabled Persons in Uganda
PLWHAs	Persons Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
PWDs	Persons with Disabilities
SRH	Sexual Reproductive Health
STIs	Sexually Transmitted Infections
TASO	The AIDS Support Organisation
UDHS	Uganda Demographic Household Survey
UNFPA	United Nations Fund for Population Activities
USDC	Uganda Society for Disabled Children
VCT	Voluntary Counselling and Testing

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EXECUTIVE SUMMARY

This report presents findings of a baseline survey on Knowledge, Attitudes and Behavioural Practices regarding Sexual and Reproductive Health/HIV/AIDS among PWDs. The overall objective of the survey was to provide baseline information that will be used to measure progress and achievements of the NUDIPU Sexual Reproductive Health/ HIV/AIDS project and to refine the targets of the project. The specific objectives were to assess knowledge and attitudes of PWDs on SRH and HIV/AIDS, document SRH behaviour, practices and experiences, knowledge and utilisation of available SRH/HIV/AIDS services. In addition, the survey aimed at assessing knowledge and attitudes of SRH/HIV/AIDS service providers concerning disability issues, concerns and requirements and finally to examine accessibility and inclusiveness of existing HIV/AIDS/SRH services.

The study was conducted between September and October 2006 in the Districts of Masaka, Soroti and Gulu where the SRH/HIV/AIDS project will be implemented. It adopted both quantitative and qualitative methods of data collection namely- the survey questionnaire, Focus Group Discussions (FGDs), Key Informant Interviews and review of Programme documents. Altogether, 596 respondents participated in the survey (26 Key Informants, 462 PWDs survey questionnaire and 9 FGDs covering 127 PWDs.

Key Findings

Socio-demographic characteristics

Most of the respondents (74%) had physical disability followed by blind/partial (10%), deaf/partially deaf (9%), epilepsy (8%) and mental disorder (7%). Respondents who fell in other categories of deaf/blind, learning difficulties, leprosy accounted for less than 3%. A proportionately high number of PWDs were in the age range 24-39 accounting for 41% followed by 14-18 and 45-49 age groups 30%. Eighty four percent of PWDs had formal education and could therefore read or write. The main source of livelihood was crop agriculture (39%) and petty trade (22%). A high number (30%) of PWDs were dependants with Gulu having the highest percentage (45%). Only 1% earned a living through begging. The majority of PWDs were in a form of sexual relationship either as married, cohabiting or were dating (46%). An equally high number of PWDs were not married (41%).

Knowledge and utilization of SRH Services

Overall, awareness of SRH services in all the districts was high (76%) and among female and male PWDs (77%). Strikingly, 24% of PWDs had never heard of these services with Gulu having the highest of 41%. The high level of dependency among PWDs in this district could have led to these low levels of awareness. Key SRH services reported were immunisation (53%), FP (52%) and ANC (51%) and HIV testing services 26%. However, awareness of PNC was low (11%).

Knowledge of FP as SRH service was high (83%) but utilisation was relatively low (62%). District data showed that Soroti had the highest awareness level (96%), followed by Masaka (86%) and Gulu (77%). Reasons for non use of FP included fear of health side effects, spousal refusal, societal attitudes that portray PWDs as not having sexual desires, belief that FP is for only married people, rumours and misconceptions surrounding FP usage. Another cause of non-use of FP could be that a big percentage of PWDs were not married and have no regular sex yet have a desire to have children of their own.

Regarding knowledge of STIs among PWD, 89% knew about the problem of STIs and there were no major variations in districts and among both male and female PWDs. Soroti was at 94%, Masaka (88%) and Gulu (88%) awareness level. Among those who were aware of STIs, a relatively high percentage (35% males and 29 % females) of respondents had ever suffered from STIs. Soroti District had the highest percentage of PWDs who had ever suffered from STIs (45%) among male and female PWDs (35%) and lowest in Gulu. A majority of the PWDs (59%) got treatment from hospitals and health centres (22%), traditional healers (20%) and drug shops (11%).

Sexual behaviour, HIV/STIs Risk and condom use

Age at first sexual encounter: 47% of PWDS had their first sexual encounter below the age of 18 years. More females 51% than males 44% had their first sexual intercourse before the age of 18 years. This shows that PWDs display the normal sex pattern like non-disabled persons (average age for first sex in Uganda is 16.7 years). Most PWDs had their first sexual intercourse out of mutual relationships mainly as boyfriend/ girlfriend 60% and with spouse at 18% implying that they were virgins at marriage. Others were casual sex (10%), strangers and cohabiting at (5%) and relatives and commercial sex less than 2%. Circumstances for first the sexual encounter were curiosity (56%), marriage (21%), peer pressure (8%) and forced/ raped (6%).

Sex with non-regular partner and condom use: Out of the 362 PWDs (78%) who had ever engaged in sex, 23% had engaged in sex with a non-regular partner in the last 12 months. More female PWDs (27%) had engaged in sex with a non-regular partner than male PWDs (23%). Only 14% used a condom with a non-regular partner.

Number of sexual partners: One in every two PWDs in marriage reported additional sex partner portraying high-risk sex behaviour. Out of the 83 PWDs who reported having sex with a person other than their spouses, 46 (55%) had one additional sexual partner. The proportions of male and female PWDs who reported additional sex partners were 54% and 62% respectively. Twenty four percent of the respondents had 2 additional sexual partners and 27% of these were males and 20% females. The survey revealed that female PWDs tended to have only up to two additional partners whereas male PWDs went up to six although with very low percentages.

Awareness and utilisation of Condoms: The level of awareness about condoms was very high (89%). However, despite the current information dissemination on condoms, 11% had never heard of them. The probable reasons for the gap in knowledge among this category could be the weak conventional information dissemination mechanisms that do not address disability specific communication needs. The other is that the main sources of information for some categories of PWDs like friends and family members may have their limitations in discussing with openness issues of sexuality. On the other hand, utilisation was low as only (31%) had ever used condoms. Within districts, use of condoms was higher in Masaka (43%), followed by Gulu (29%) and lowest in Soroti (22%).

Main reasons for condom use were avoiding HIV (65%), pregnancy (56%) and STIs (45%). In Masaka, more female PWDs (77%) reported using condoms to avoid pregnancy than to protect against HIV (52%) and other STIs (20%) while in Soroti, male PWDs reported avoiding pregnancy (75%). Regarding non-use of condoms, being married (45%), lack of knowledge on proper use of condoms (39%), refusal by partner and not knowing how to use condoms (35%) were the main reasons why male PWDs would not use a condom. There were also a number of misconceptions about condom use such as bursting and remaining inside the woman, permeable, association with promiscuity and conditions of disability, which make access to sex very rare. These constrain PWDs ability to negotiate safe sex when the chance comes.

Ever heard of HIV/AIDS: The majority of PWDs in all the districts had ever heard about HIV/AIDS, (100% in Soroti, 96% in Masaka and 93% in Gulu. Although Uganda has run aggressive sensitisation activities on HIV/ AIDS since 1987, some PWDs in Masaka (8%) and Gulu (12%) had never heard of the epidemic. These fell in the category of physical disability, the deaf and those with speech problems. They were also young below 18 years, had no formal education and were not married. This highlights the need for targeting disability types in HIV/AIDS programming. The majority of PWDs (53%) mentioned unprotected sexual intercourse, 54% reported sexual intercourse, 48% use of unsterilized instruments and 34% having sex with an infected person. On the ways of HIV transmission, findings also showed some misconceptions like transmission of HIV through sharing utensils and staying close to an infected person and downplaying of some risk factors,

like sex with multiple partners, prostitutes and Mother to Child to Child Transmission (MTCT). Sharing utensils with an infected person was reported highly among the female PWDs in Soroti.

HIV/AIDS services: The most known services were ARVs supplies, food supplements, HIV counselling and testing. Prevention activities namely HIV sensitisation and education, condom distribution and PMTCT were the least known in all the districts. Overall analysis of data by gender revealed similar levels of awareness of HIV/AIDS services. But for specific services namely HIV counselling and condom distribution, the percentages of female PWDs was lower compared to that of males.

SRH Rights: Awareness on these rights was relatively high among adult male and female PWDs and lower among young female and male PWDs in all the districts as revealed by FGDs and KIs. The rights mentioned included right to sex, marry, medical care and child bearing. Key informants added access to ARVs, PMTCT, counselling and the right to information. Individuals within the organisations visited had high awareness of these rights by virtue of their education but weak at institutional level as evidenced by lack of formal procedures for handling PWDs issues within these organisations.

There was general recognition that PWDs should equally enjoy these rights like all persons as enshrined in the law. But in reality, PWDs do not enjoy these rights because of social, economic factors and non-institutionalisation of PWDs issues in SRH service delivery. For example, imposing a choice of a spouse or demanding for higher dowry, family planning (injection) is considered shameful, normal persons were reported to shun open relationships with PWDs preferring either a one off indulgence or very secretive. The nature of disability also contributed to non-enjoyment of SRH rights. For example, use of community meetings and conventional IEC materials, which do not necessarily address unique characteristics of PWDs. Most IEC materials were reportedly visual and to a limited extent audio.

Main and preferred sources of HIV/AIDS Information: The main sources of information mentioned were radios accounting for 79%, friends (49%) and health workers (31%). Others were parents (18%), community meetings (15%), sensitization workshops (14%), burial ceremonies and newspapers (12%) and schools (10%). It is important to note that while there are structures created to represent the interests of PWDs at all Local Government levels, PWDs could not cite them as main sources of information. The majority of PWDs preferred radio as a main source of information (50%) and the health workers (16%). Other preferred sources were sensitization workshops (7%), friends (6%) and schools (3%).

HIV risk factors: Unsafe sex (35%), mistrust of the partner (30%) and spouse having multiple partners (15%) emerged as key risk factors. There were also some district specific risk factors particularly reported by female PWDs like being unable to refuse sexual advance (14%) in Gulu and selling sex in Masaka (2%). Mistrust of partners was relatively high among the female PWDs in Gulu (42%) compared to males (27%). Whereas having multiple partners had a lower percentage on average, it was significantly recognized by female PWDs in Soroti (31%)

Problems encountered while seeking SRH/HIV/AIDS services: 48% reported encountering problems while seeking those services and desegregated data by gender showed an equal spread of 46% and 48% among female and male PWDs respectively. There were however, big variations at district level with Gulu recording 83%, Soroti 50% and Masaka having the lowest of 30%. The common problems encountered were negative attitudes of health staff, stigma and discrimination, limited information and lack of mobility aides, drugs and having to pay for some services.

Inclusiveness: The NSF in realising its goals identifies special categories namely youth, orphans, vulnerable children and IDPs. PWDs are however, conspicuously missing in these special interest groups. Omission of disability in defining special categories limits opportunities for development of national activities that target

their uniqueness in respect to HIV/AIDS. Consequently, the National Monitoring and Evaluation Framework developed purposely to measure and evaluate progress and provide information for decision making has no indicators on PWDs and HIV/AIDS. However, a review of progress of the NSF in 2004 acknowledged this omission and recognises PWDs among emerging concerns that need to be captured in the NSF.

The MoGLSD has a Department of Disability and Elderly whose role is to empower persons with disability, the elderly and the non-literate with skills and knowledge to enable them participate in the economic growth and development process.
This Department has a number of programmes focusing on empowerment of PWDs namely the Institutional Rehabilitation Programme where PWDs are trained on life skills and Functional Adult Literacy programme (FAL) which focuses on enhancing the literacy, numeracy and acquisition of functional skills relevant to life in a community. In delivering these services, the Department works through local governments and partner NGOs and HIV/AIDS issues are integrated in service delivery as a matter of policy.
However, one of the key document, FAL Curriculum developed with the support of Uganda AIDS Commission (UAC) did not demonstrate how HIV/AIDS and Disability issues should be addressed. For example, topics therein do not explicitly address disability and elderly yet disability poses unique challenges in HIV/AIDS service delivery.

At the district level, there was also an effort in targeting all members of the community with well-identified special interest groups. However, like at the national level, PWDs were missing in the special interest groups. This gap was particularly evident in all government health programmes and most NGOs. Consequently, there is likelihood that HIV/AIDS related concerns among PWDS may remain not well addressed. Regarding participation, in all the districts visited, there was virtually no evidence of participation of PWDs in planning process and district HIV/AIDS strategic plans and programmes that were availed to team were silent on HIV/AIDS and PWDs. There were a few NGOs that specifically targeted PWDs with HIV/AIDS programmes. In Gulu, MildMay Centre had a programme targeting pregnant mothers with counselling services while Association of Voluntary Services International (AVIS) targeted information giving to the deaf. In Masaka, Uganda Society for Disabled Children (USDC) has a programme for children with disabilities.

Recommendations

National and district level: It is important that PWDs are explicitly recognised as a special interest group in the NSF. This will provide a basis for programmatic inclusions of disability specific concerns in HIV/AIDS response. This should apply to the districts as well. To guide this process, NUDIPU should share some of the unique challenges PWDs face and compromise access and utilisation of SRH/HIV/AIDS services. This should be used as an advocacy tool for inclusion of PWDs in national programmes.

MoGLSD as mandated to formulate and review relevant guidelines, programmes and policies for the well being disability and elderly persons should establish a clear functional relationship with NUDIPU for purposes of strengthening the SRH/HIV/AIDS activities. For example, participation of NUDIPU in the review of the FAL Curriculum would have contributed to inclusion of disability specific issues on SRH/HIV/AIDS.

Service delivery

- Health workers and administrators should be targeted with sensitisation workshops on SRH rights of PWDs and training in basic communication skills. This should help in addressing stereotypes, marginalization and negative attitudes that were reported to be common in health units and were contributory barriers for low utilization of SRH/HIV/AIDS services by PWDs.
- The service delivery systems should be improved to take care of disability specific needs. Where lining in a Health Unit is required to access a health worker, PWDs should be given special consideration.
- There is need to improve coordination between PWD Unions at districts and lower levels on one hand and government and other service providers in planning and mainstreaming PWD concerns

in development activities/intervention and in areas where specialised skills are needed like communication. This would also help in scaling up the visibility of these Unions among SRH/HIV/AIDS providers and improve their role in advocacy for PWDs. Government through MOH in particular runs many SRH/HIV/AIDS programmes under safe motherhood, child survival, management of STIs/AIDs that are well spread in the communities and only need to specifically mainstream disability issues in them. The MoGLSD through the Department of Disability and the Elderly too has programmes specifically aimed at empowering these categories. SRH/HIV/AIDS activities would benefit from these existing programmes and structures if only they can be mainstreamed.

- Improve access to information on SRH/HIV/AIDS through targeting PWDs in general but also specific disabilities. This should include support to service providers in developing disability sensitive communication materials and translating the existing ones to cater for the blind. In addition, information should be brailed and proof read before it is disseminated to the blind. It should also target building the capacity of LGs and LCs at the grassroots in promoting PWD rights and mainstreaming PWD specific concerns into the local SRH/HIV/AIDS programmes.
- NUDIPU should spearhead remodelling sessions in the target districts involving all SRH/HIV/AIDS service providers.
- Support PWD Unions in promoting peer support approaches on HIV/AIDS prevention/control. These groups should as much as possible be integrated with other groups to avoid stigmatization but also encourage sharing of experiences and challenges.
- PWD user-friendly structures especially for people with physical disability should be encouraged at all SRH/HIV/AIDS service centres. This may involve increasing the number of wheel chairs for internal movements, beds that are adjustable and putting in place special/separate toilets for PWDs among other things.

Sensitisation of PWDs

- Special programmes need to be developed for sensitizing PWDs, parents and guardians on HIV/AIDS emphasising ABC as the survey revealed that PWDs equally engage in risky sexual behaviour and yet receive minimal attention in the current sensitisation programmes.
- Area specific modals for realising access to condoms should be worked out with the active involvement of the target population, as the household survey revealed the common method of having them the shops or health units was not enough to their guarantee access by PWDs.
- SRH/HIV/AIDS services such as PNC, FP and condom use as conventional approaches have not realised high levels of usage of these services.
- Family planning should focus more on encouraging usage of the methods. At the rural areas, the use of community based distributors could be considered as is the case on malaria programmes.

HIV testing and counselling

- Design strategies to include PWDs in the ongoing HIV/AIDS testing and counselling services.

Monitoring and evaluation

- Districts Unions should be supported to develop comprehensive monitoring systems with clear indicators on HIV/AIDS and disability. This information will be useful in tracking progress and informing policy.

CHAPTER ONE: INTRODUCTION

1.1 Background

The National Union of Disabled Persons of Uganda (NUDIPU) is in process of implementing a Sexual and Reproductive Health /HIV/AIDS project titled *"Promotion of a Disability Perspective into Uganda's National HIV/AIDS Response,"* which will attempt to involve and target PWDs in prevention, care and treatment services. The project timeframe is three years and will be implemented in the districts of Gulu, Soroti and Masaka.

The project was initiated in order to address the vulnerabilities PWDs face in relation to HIV/AIDS. There is strong evidence to suggest that persons with disabilities (PWDs) are more vulnerable in the face of HIV infection and HIV/AIDS related mortality than the average Ugandan. The level of illiteracy, poverty and unemployment is significantly higher among disabled people than among the general population. Furthermore, PWDs often face discrimination and stigmatization as well as communication challenges, which prohibit them from taking part in public life as well as taking advantage of existing services in such areas as health and education.

World Health Organisation (WHO) defines Persons with Disability (PWDs) as individuals with physical, sensory, intellectual or mental health impairments that have a significant and long-lasting effect on the individual's daily life and activities. PWDs make up one person in every ten. According to the WHO estimate there are thus approximately 2.5 million disabled people in Uganda. Uganda Bureau of Statistics (UBOS) 2002 household survey figures estimate PWDs as 4 % of the population in Uganda. Human rights are universal, and disabled people thus have the same right to information, health and development as any other person in line with the UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities. However, Uganda's current multi-sectoral response to HIV/AIDS continues to be silent on issues related to disability. It appears that few HIV/AIDS/SRH service providers consider PWDs as a high-risk group of persons viz –a-viz HIV/AIDS and few policies, programs and interventions are in place to ensure inclusion and/or consideration of individuals with disability.

1.2. Project Aim

The project's development aim is to reduce the vulnerability of PWDs to HIV infection and to mitigate the effects of HIV/AIDS among PWDs living with HIV/AIDS in Uganda.

1.3. Implementation Strategy

The project will follow a two-pronged partnership strategy. The first element includes the involvement of eight other disabled Peoples Organisations (DPOs) in project implementation. The second element of the partnership strategy aims at building and consolidating strategic partnerships between the disability movement and relevant HIV/AIDS/SRH service providers, which are considered necessary to ensure the sustainability of the project. As part of the inception phase of this project a baseline survey was conducted in the Districts of Soroti, Masaka and Gulu.

1.4 Objectives of the Baseline Survey

The overall objective of the survey was to provide baseline information against which progress and achievements of the NUDIPU HIV/AIDS project would be measured at the end of the project period. The information generated by the survey will also be used to refine the targets of the project. Specifically, survey was commissioned to;

- Establish the background characteristics of PWDs.
- Assess the knowledge and attitudes of PWDs on SRH and HIV/AIDS.
- Document the sexual and reproductive health behaviour, practices and experiences of PWDs.
- Assess knowledge and utilisation of available HIV/AIDS prevention, treatment and care services as well as SRH services by PWDs.
- Assess knowledge and attitudes of SRH/HIV/AIDS service providers concerning disability issues, concerns and requirements.
- Examine accessibility and inclusiveness of existing HIV/AIDS/SRH services.

CHAPTER TWO: METHODOLOGY

2.1 Study area and Population

The survey was carried out in the districts of Gulu, Masaka and Soroti. The study population was PWDs in the reproductive age group (14-49 years).

2.2 Data Collection Methods and Tools

The survey employed both qualitative and quantitative methods of data collection. A number of tools namely; structured survey questionnaire, FGD guide, Key Informant Guide and secondary data checklist were used to gather data according to the objectives of the survey.

Questionnaire: This was structured and administered to PWDs. I focused on four major areas outlined below;

1. Background characteristics of PWDs which included type of disability, age, gender, place of residence, educational attainment, marital status and source of livelihood.

2. Knowledge, attitudes and beliefs of PWDs on SRH and HIV/AIDS namely knowledge of Family Planning methods, HIV transmission and prevention, attitudes and beliefs regarding FP and HIV/AIDS.

3. Sexual and reproductive health behaviour, practices and experiences of PWDs; use of condom during sexual intercourse with a non-regular partner, age at first penetrative sex, number of non-regular partners, age difference between respondent and his/her last sexual partner, relationship to first/last sexual partner, engaged in sex for gain, coerced into sex and subject of sexual abuse and current use of contraception and type.

4. Knowledge and utilisation of available SRH services/HIV/AIDS prevention, treatment and care services by PWDs: knowledge of available and utilisation of preventive services such as Voluntary Counselling Testing (VCT), prevention of Mother to child Transmission (PMTCT), condoms, contraceptives, Antenatal Care (ANC),information, Education, communication (IEC); distance to service centres and affordability of the services; care and treatment services; care for Persons Having AIDS (PHAS) antiretroviral (ARVs), Sexually transmitted Infections (STIs), and other opportunistic infections and, constraints in utilisation of these services.

Key Informant Interview Guide: This was used to conduct interviews with NUDIPU staff, representatives of PWDs at district and other lower levels, Special Needs Coordinators, District Union Representatives and providers of SRH/HIV/AIDS services to PWDs in the three districts. Others included policy makers at district level to gauge knowledge and attitudes in relation to disability issues, concerns and requirements and, inclusiveness of PWDs issues in existing HIV/AIDS/SRH services.

Focus Group Discussion guide: This tool guided discussions with PWDs groups and community members. These groups were homogeneous in terms of the nature of disability, gender and age. The discussions

focused on aspects of knowledge, perceptions, availability of SRH/HIV/AIDS and level of satisfaction with the services, equity in access among others.

Document review: This involved review relevant documents, which included the National Strategic Framework, the National M&E framework, District HIV/AIDS strategic plans and programme documents. Others included the Constitution of Republic of Uganda 1995, the Disability Policy and Disability Act 2006.

2.3 Procedure for data collection

The following steps were followed during data collection as outlined below;

2.3.1 Planning Phase

The following tasks were undertaken during this phase

- Review of relevant documents to the study (including all project documents).
- Design of survey instruments (questionnaire, FGD and KI guides).
- Recruitment and training of research assistants.
- Pre-testing of survey instruments in Wakiso District and making appropriate adjustments.
- Translation of final survey instruments into relevant local languages.
- Mobilisation of PWDs and conducting the actual survey.

2.3.2 Sampling procedure

The survey team used stratified random sampling method for quantitative data. The study area was stratified on the basis of sub-county such that each sub-county formed a stratum. In each stratum, villages were taken to be clusters whereby four villages were selected randomly from each stratum. A sampling frame for households with at least one PWD was compiled using a comprehensive resident village list with the assistance of PWD village executive. Using the compiled sampling frame, the required number of individual PWDs was selected using purposive sampling method. In Masaka, the sampling method did not apply as PWDs were scattered and thus the required number had to be sought outside the predetermined clusters.

For qualitative data, participants in the FGDs were purposively selected with the help of Local Council I Chairperson and a PWD representative. A total of 3 FGDs were held in each district according to gender and age. In case of young PWDs, a separate FGD with parents/caretakers/guardians of disabled young people was conducted. Each of the FGDs on average was composed of 12 participants. This gave a total of 9 FGDs covering approximately 127 PWDs. Twenty six KIIs were held (24 in each district and 2 at the national level). District KIIs were drawn from the AIDS Support Organisation (TASO) Masaka and Soroti, AIDS Information Centre (AIC), Family Planning Association of Uganda Soroti Branch, Teso AIDS Project (TAP), Association of Voluntary Services International (AVIS), District Director of Health Services, Uganda Society for Disabled Children (USDC), Community Development Office, District HIV/AIDS Committee and Councillors at the district and sub county levels. At the national level, interviews were held with Uganda AIDS Commission and Ministry of Gender, Labour and Social Development (MoGLSD).

2.3 3. Sample size

In this survey, the proportion (p) of PWDs who had adequate knowledge on HIV/ADS issues was not known, the formula given below was therefore used to estimate the sample size. The formula uses the optimum value of p with a desired variance (d) at (1-α) 100% confidence. Therefore, the sample size (n) is

$$n = \frac{0.25 z_{\alpha/2}^2}{d^2}$$

Where d is the desired variance (error)

1-α is the level of confidence

z is the number of standard errors away from the mean

If α=0.05 and the desired variance (d)=0.045, then n= 474. The calculated sample size was therefore 474 individual PWDs.

Since the study was conducted in 3 districts with PWDs population of sizes N_1, N_2, N_3, the selected samples were of sizes n_1, n_2, n_3. Thus, the number of PWDs that were interviewed from each district was determined using this formula;

$$n_h = (N_h / N)n \qquad \text{for h=1, 2, 3}$$

Where n was the total size of the stratified random sample

N_h is the number of PWDs in district h

N is the number of PWDS in the study area (3 districts), which was 68,575.

The number of PWDs in each of the three districts (N_h) was established at the beginning of the survey.

Selection of sub counties and villages

Two sub counties (one rural and one urban) were selected randomly using lottery method. A list of all sub counties in the district was compiled using the lists in the 2002 Census report and the names were written on small pieces of paper, rolled and put in two separate bowels for rural and urban. One piece of paper was picked randomly from each bowel. The same procedure was repeated to select villages. Table 1 gives the names of the selected sub counties. For Gulu district, one particular county (7 sub counties) were excluded because of insecurity. The rural sub county of Odek has an internally displaced Peoples (IDP) camp where the occupants are not yet resettled.

Table 1 Names and Sample sizes for Sub counties

Name of district	Names of sub counties	Total No of PWDS in the sub counties	No of PWDs in each S/C	No. PWDs to be selected from @ S/C
Masaka	Kyanamukaka	2320	1821	162
	Nyendo / Ssenyange		499	45
Soroti	Alio	1428	944	60
	Eastern Divison		484	31
Gulu	Odek	3734	1647	78
	Bar-Dege		2087	98

The selection of PWDs in each district and sub counties was based on the data obtained from the 2002 Population census results.

2.4 Data Management, Analysis and report writing

Quantitative data was checked for completeness, consistency and accuracy immediately after it was collected. Data entry screens for quantitative data were developed with all the necessary validation tools to eliminate error that could be introduced at the stage of data entry. Besides, double data entry system was employed to ensure a high degree of accuracy. Data was then entered into the pre-prepared computer databases using EPIINFO 2002 and SPSS software. Data cleaning was done by double entry of the data in the same file. Statistical characteristics of the PWDs were obtained and cross tabulations done in order to interpret the findings, which have been presented in tables, graphs and text. Qualitative data analysis was done on a master sheet following the thematic approach. The survey team interpreted the data according to the objectives of the survey. A summary of results was used to formulate conclusions and make relevant recommendations.

2.5 Quality control

Six experienced research assistants were recruited and trained in data collection methods (selection of the participants, how to handle respondents and administering the questionnaire). All the study instruments were pre-tested in Wakiso district before actual data collection to check for flow and completeness of questions. The research assistants edited questionnaires on a daily basis to check for completeness of the answers. In addition, the core team members assisted the research assistants to fill in gaps as they were discovered. The core team monitored the research assistants throughout the entire period of data collection to ensure completeness of information and to avoid forging of data.

2.6 Ethical considerations

Verbal Consent was sought from the respondents before the interview. Explanations about the purpose of the study and the expected benefits were made before each interview. Questionnaires remained anonymous to ensure confidentiality.

2.7 Team Composition

The core team was composed of 3 members with expertise in social research, HIV/AIDS and community development. These were supported by 9 research assistants and a statistician.

2.8 Limitations of the survey

It was hoped that within the sampling frame, a required number of respondents would be attained. However, in Masaka the team had to traverse many villages to realise the required sample size as PWDs were scattered across many villages. This had implications on time and transport costs as the team had to hire additional transport.

CHAPTER THREE: BASELINE SURVEY FINDINGS

3.1 Background Characteristics of PWDs

This section gives the background characteristics of the respondents by gender, type of disability, marital status, age, residence, religion, education and source of livelihood. The findings are shown in the table 2 below.

Table 2 Socio-Demographic Characteristics of PWDs by District

Characteristics		Soroti (N=91)		Masaka (N=197)		Gulu (N=174		Overall	
		Freq	%	Freq	%	Freq	%	Freq	%
Gender	Male	54	61	113	57.1	84	48.2	251	54.5
	Female	37	39	84	42.9	90	51.8	211	45.5
Type of disability	Physical	67	73.6	169	85.8	105	60.3	341	73.8
	Deaf/partial	9	9.9	11	5.6	17	9.8	37	8.0
	Blind/partial	18	19.8	7	3.6	22	12.6	47	10.2
	Speech problem	7	7.7	24	12.2	10	5.7	41	8.9
	Mental disorder	3	3.3	18	9.1	12	6.9	33	7.1
	Deaf/blind	-	-	1	0.6	1	0.6	2	0.4
	Learning difficulties	-	-	8	4.1	2	1.1	10	2.2
	Epilepsy	3	3.3	2	1.0	31	17.8	36	7.8
	Leprosy	6	6.6	-	-	5	2.9	11	2.4
	Others	3	3.3	8	4.1	1	0.6	12	2.6
Age group	<18	7	8.6	31	15.7	40	23.4	78	17.4
	18-23	9	11.1	28	14.2	21	12.3	58	12.9
	24-29	10	12.3	34	17.3	29	17.0	73	16.3
	30-34	11	13.6	25	12.7	21	12.3	57	12.7
	35-39	5	6.2	25	12.7	18	10.5	48	10.7
	40-44	11	13.6	24	12.2	23	13.5	58	12.9
	45-49	28	34.6	30	15.2	19	11.1	57	17.1
Place of residence	Rural	59	66.3	151	77.4	96	55.2	306	66.8
	Urban	30	33.7	44	26.6	78	44.8	152	33.2
Religion	Catholic	29	32.6	139	70.9	116	68.6	284	62.6
	Anglican/protestant	27	30.3	19	9.7	40	23.7	86	18.9
	Seventh Day Adventist	1	1.1	4	2.0	1	0.6	6	1.3
	Moslem	6	6.7	17	8.7	1	0.6	24	5.3
	Pentecostal	25	28.1	17	8.7	11	6.5	53	11.7
	Traditional	1	1.1	0	0	0	0	1	0.2

Source of livelihood: Overall, the main sources of livelihood among PWDs were crop agriculture accounting for 39% and petty trade at 22%. A large number of PWDs were dependants 30% with Gulu having the highest number at 45 %. Two percent were in civil service and only 1% of PWDs were begging with Soroti having a high number of 5.5%. The lower numbers of beggars among the disabled could be attributed to strong social systems that still take care of the weak and vulnerable. Table 3 has details about sources of livelihood for PWDs

Table 3 Sources of livelihood among PWDs by District (%)

Source of livelihood	Soroti		Masaka		Gulu		Overall	
	Freq	%	Freq	%	Freq	%	Freq	%
Crop agriculture	43	47.3	70	35.5	67	38.5	180	39.1
Cattle and cattle products	6	6.6	3	1.5	0	0	9	9.9
Brewing	2	2.2	4	2.0	3	1.7	9	1.9
Petty trade	23	25.3	41	20.5	37	21.3	101	21.9
Civil service	3	3.3	2	1.0	7	4.0	12	2.7
Charcoal /firewood	1	1.1	0	0	5	2.9	6	1.3
Casual labour	8	8.8	23	11.7	10	5.7	41	8.9
Begging	5	5.5	0	0	1	0.6	6	1.3
Being looked after	16	17.6	46	23.4	78	43.7	138	29.9
Others	11	12.1	37	18.8	18	10.3	66	14.3

Marital status: A relatively high number of PWDs were in a form of sexual relationship either as married, cohabiting or dating as shown by 46.1%. Of these, 30% were in monogamous marriage. An equally high number 40.7% of PWDs had never married. This finding has implications for HIV transmission because the level of sex exposure for people in relationships is higher.

Table 4 Marital Status of PWDs by District (%)

Characteristic	Soroti		Masaka		Gulu		Overall	
	Freq	%	Freq	%	Freq	%	Freq	%
Married (monogamous)	35	38.9	60	30.6	51	29.3	146	31.7
Married (polygamous)	6	6.7	12	6.1	10	5.7	28	6.1
Never married	35	38.9	91	46.4	61	35.1	187	40.7
Divorced/separated	3	3.3	8	4.1	27	15.5	38	8.3
Co-habiting	4	4.4	16	8.2	13	7.5	33	7.2
Dating	1	1.1	1	0.5	3	1.7	5	1.1
Widow/widower	6	6.7	8	4.1	9	5.2	23	5.0

Education of PWDs: Out of the 462 respondents interviewed, 37% had completed primary education, 30% stopped at P.4, 16% had never gone to school. Those who had attained secondary education accounted for 17% of which 4 % had gone up to tertiary level as shown in Fig. 1

Figure 1 **Education Level of Respondents**

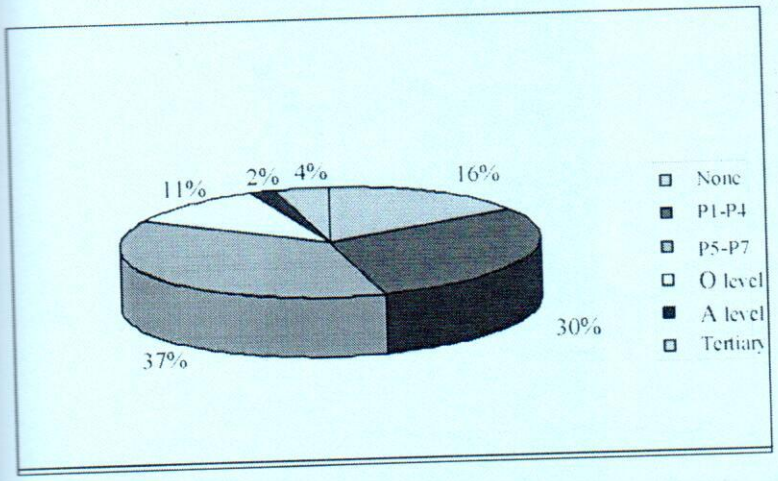


Table 5 **Education level by Gender by District (%)**

Education level	Soroti			Masaka			Gulu		
	Male	Female	Overall	Male	Female	Overall	Male	Female	Overall
None	13	17	**15**	18	26	**22**	15	27	**21**
P1-P4	28	20	**25**	23	26	**25**	23	38	**36**
P5-P7	28	46	**35**	42	31	**37**	40	33	**36**
O Level	17	17	**17**	12	13	**12**	9	1	**5**
A level	4	0	**2**	2	2	**2**	0	1	**1**
Tertiary	11	0	**7**	2	1	**2**	4	0	**2**

There were no big gender disparities in the level of education attained at primary and ordinary level except in Gulu where the percentage of males was higher at 9% compared to females (1%). The study also revealed that more male PWDs (9%) had attained tertiary education than females (0.3%) with Soroti having the highest level of tertiary education at 11%. Fewer PWDs in Gulu (5%) had attained lower secondary education than those of Soroti (17%) and Masaka (12%).

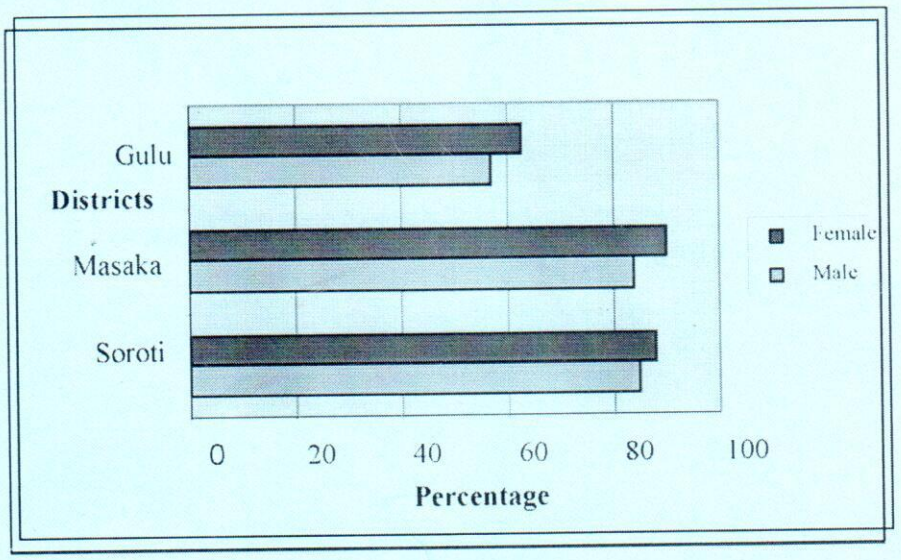
3.2 Knowledge of Sexual Reproductive Health

This section presents findings on the knowledge of SRH services in general, Family Planning and usage, knowledge of STIs and related services, sexual behaviour and condom use among the respondents.

3.2.1 Ever heard about sexual reproductive health services

According to the survey findings, overall awareness of SRH services was high (76%) and among both female and male PWDs (77%). However, there was a noticeable percentage (24.3) that had never heard of these services with Gulu having the highest of (41%). The high level of dependency among PWDs in this district could have led to these low levels of awareness. Details are shown in Fig.2

Figure 2 Awareness of SRH services by Gender by District



SRH services mentioned by PWDs

Survey findings revealed that immunisation (53%), FP (52%) and ANC (51%) were the most reported SRH services. The high level of awareness of ANC is not surprising as there is evidence that 94% of pregnant women attend ANC at least once (Uganda Demographic Household Survey 2001). Awareness of HIV testing services was also relatively high at 26%. Within districts, Soroti registered highest awareness in FP (71%), immunisation (68%) and HIV testing (43%). The high levels of awareness could be attributed to concerted mobilisation efforts by government and partners to scale up these activities. Examples include TASO, AIDS Information Centre (AIC), world Vision, **TAP,** Rakai Health Sciences programme, Kitovu Mobile and the District Director of Health Services among others. These were further augmented by numerous FM radios.

On the other hand awareness of PNC was low (11%). The low awareness of PNC is consistent with available literature that show that most women do not deliver in health facilities and those that do are likely not to seek PNC unless they develop complications. None the less, Gulu and Soroti districts showed comparatively higher awareness levels of PNC (17% and 13 % respectively) than Masaka (6%). This could have been influenced by high residence in camps where these services are emphasised and brought nearer to the population. Details about SRH services as mentioned by PWDs are in table 6

Table 6 SRH services mentioned by PWDs by District (%)

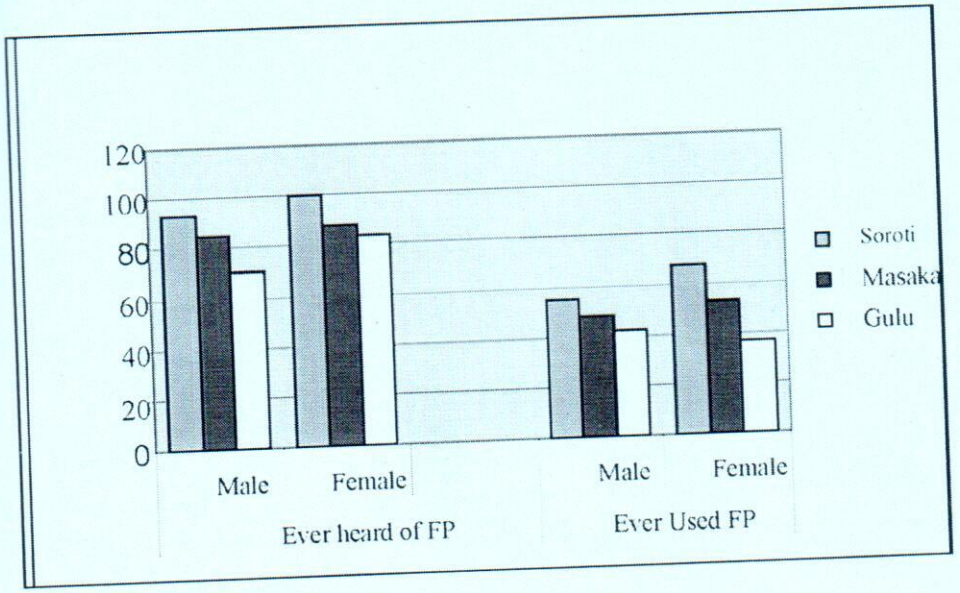
Type of SRH service	Soroti	Masaka	Gulu	Overall
STI diagnosis and treatment	47	23	10	27
ANC	46	48	60	51
PNC	13	6	18	12
Delivery care	3	21	11	12
Immunisation	68	65	25	53
FP	71	37	47	52
Treatment of infertility	1	1	2	1
Counselling	23	5	12	13
HIV testing	43	16	18	26

2.2.2 Knowledge and Usage of Family Planning Services

Family Planning (FP) is one of the reproductive health sub programmes within the health sector in the country aimed at contributing to improved maternal health. The multi-pronged approach has been adopted to promote FP through massive sensitization, support to FP clinics and inclusion of a wide range of service providers.

A specific question was asked on knowledge of FP as a reproductive health service. Findings revealed that high level of awareness of FP 86% among female and 79 % male PWDs in all the districts. It should be noted that in the earlier question about awareness of SRH services generated through spontaneous responses; only 52% mentioned FP among these services. District data showed that Soroti had the highest awareness level at 96%, followed by Masaka at 86% and Gulu at 77%. This implies that the concerted efforts in FP promotion are yielding results at least in terms general information access. However, understanding of the objectives of FP appeared to be associated to only stopping childbirth but not as a measure of child spacing and associated health and economic benefits.

Figure 3 Knowledge and Use of FP by Gender by District



While awareness of FP methods was high (85%), utilisation was significantly low among male and female PWDs (42%) and (52%) respectively. District specific data showed Soroti as leading in utilisation of FP (61%), followed by Masaka (50%) and the least being Gulu (40%). Important to note however is that FP utilisation levels were higher than the national average of 23% (UDHS 2001).

Sixty two percent (182/380) of those who had heard of FP methods were not using any. This should be a pointer that the current initiatives for FP promotion should focus more on encouraging adoption of the FP practices but also diversifying targeting. Reasons for non-use of FP were fear of health side effects, resistance from spouses, societal attitudes that portray PWDs as not having those sexual desires, belief that FP is for only married people and mobilisation methods that emphasize that both partners have to go for

FP sensitisation mentioned in Soroti. Other reasons included rumours and misconceptions surrounding FP usage and that a big percentage of PWDs were not married and had no regular sex yet have a desire to have children of their own.

FGDs expounded further the fears associated with FP and these included fear of negative health effects such as excessive bleeding, irregular menstrual cycles, excessive weight gain or loss, loss of appetite, nausea, blood pressure and fear to produce abnormal children.

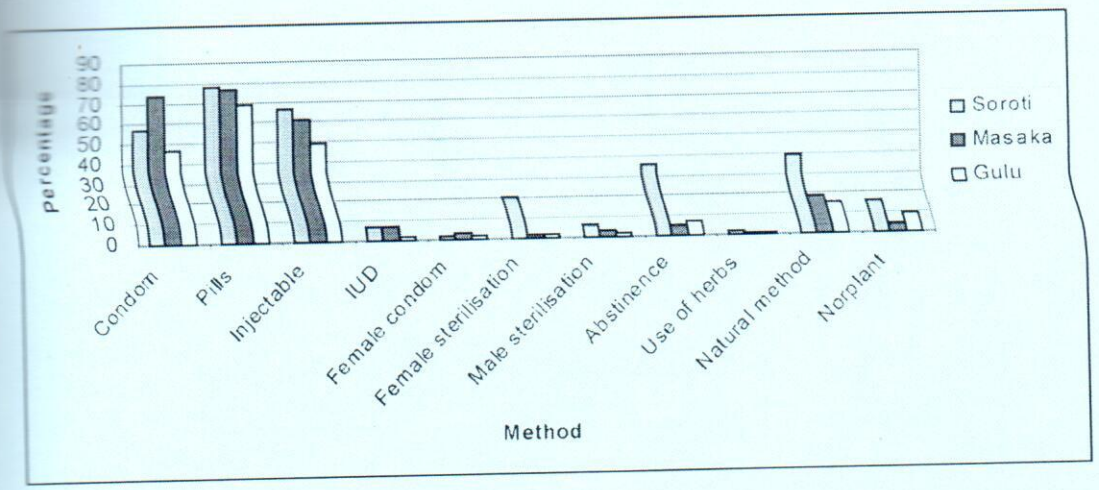
> *"My sister produced a child without ears because of those pills,"* male PWD.
> *"If you use pills the next time you want a child you can only deliver through caesarean,"* female PWD
>
> *"God said produce and fill the earth. When you use FP when will you ever fill the earth,"* male PWD
>
> *"Pills can cause cancer and can lead to producing abnormal children,"* female PWD
> *"Family planning is good but those who use them complain of many problems. There was a woman in our neighbourhood who got very heavy menstrual flow and almost died"* Female PWD

Family Planning Methods Reported by PWDs

The most reported FP methods were contraceptive pills accounting for 62%, condom (51%), injectable 49% and natural methods (18%). Others were abstinence (10%), Norplant (7%), female sterilisation and IUD at 5% as shown in the Fig 4. There were also other less reported methods namely male sterilization, use of herbs, diaphragm and female condom accounting for less than 3% of the respondents. Interestingly, 10% of PWDs who were aware of FP as a service could not cite any method.

District specific data showed similar trends regarding knowledge of common methods. There were however, some methods that were highly reported in Soroti compared to the other districts. These included abstinence (36%) compared to 7% and 5% in Gulu and Masaka respectively. The others were female sterilisation (20%) compared to Masaka and Gulu at 2% and natural method at 39% in Soroti while Masaka and Gulu were (19%) and 15% respectively. Details are shown in the Table7.

Figure 4 Known FP Methods by District



Gender specific data also manifested similar levels of knowledge regarding common methods of FP. However, abstinence was cited more by male respondents than females with Soroti males recording the highest (42%) compared to their counterparts in Gulu at (14%) and Masaka (7%) respectively.

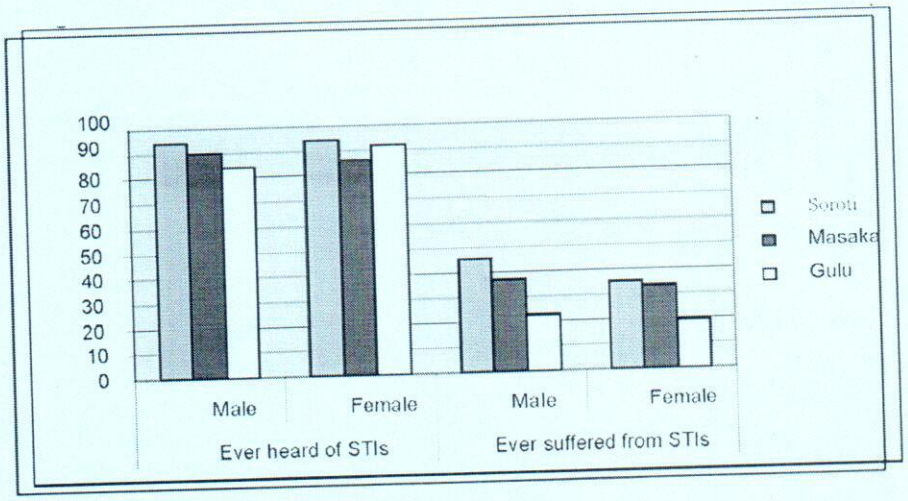
Table 7 Known FP Methods by Gender by District (%)

Method	Soroti			Masaka			Gulu		
	Male	Female	Overall	Male	Female	Overall	Male	Female	Overall
Condom	56	59	57	77	70	74	66	32	47
Pills	74	83	78	75	78	76	68	70	69
Injectable	52	89	66	55	69	61	41	55	49
IUD	4	12	7	3	12	7	2	3	2
Female condom	2	3	2	3	3	3	4	1	2
Female sterilisation	18	24	20	1	4	2	4	1	2
Male sterilisation	8	3	6	3	3	3	4	0	2
Abstinence	42	27	36	7	3	5	14	1	7
Use of herbs	2	3	2	1	1	1	2	0	1
Natural method	38	41	39	24	14	19	14	16	15
Norplant	16	15	16	3	5	4	5	13	9

3.3.3 Knowledge of STIs and Related Services

Overall, awareness of STIs among PWDs was high (89%). There were no major variations in awareness by district. Soroti was at 94%, Masaka (88%) and Gulu stood at (88%) awareness level as shown in Fig 5. Findings showed similarities in awareness among male and female PWDs.

Figure 5 Ever heard and Ever Suffered from STIs by Gender by District



PWDs who were aware of STIs were asked whether they had ever suffered from any, and a relatively high percentage (35 males and 29 female PWDs) of respondents had indeed ever suffered from STIs. Soroti District had the highest percentage of PWDs who had ever suffered from STIs (45%) among male and female PWDs (35%) and lowest in Gulu.

The study also sought to establish treatment-seeking behaviour for STIs among PWDs. Respondents were therefore asked where they obtained treatment for STIs. A majority of the PWDs (59%) got treatment from hospitals and health centres (22%). A considerable number also used the services of traditional healers (20%) with a few using drug shops (11%) as shown in the Table 8. The use of traditional healers could be as a result of being easily accessible to PWDs since most of them live within communities. This is an opportunity government could exploit to empower these traditional healers with knowledge and skills so that they are able to provide quality services.

Table 8 Source of STI treatment by Gender by District (%)

Source	Soroti			Masaka			Gulu		
	Male	Female	Overall	Male	Female	Overall	Male	Female	Overall
Health centre	30	33	**31**	38	15	**30**	13	25	**19**
Hospital	48	56	**50**	22	35	**26**	60	58	**59**
Drug shop	9	0	**6**	22	25	**23**	20	0	**11**
Traditional healer	13	0	**9.4**	3	20	**8.8**	7	25	**15**

STIs Reported by PWDs

The respondents were asked to mention the STIs they knew. Findings revealed that the highly reported STIs in all the districts were syphilis (80%), HIV (69%) and gonorrhea (60%) and were no variations in reporting among male and female PWDs. Within districts, gonorrhea was mostly reported in Masaka (81%) and

Candida 13% which was very low in other districts. These findings are consistent with available information from the general population especially on syphilis. Details of the STIs reported are shown in table 9

Table 9 Reported STIs by Gender by District (%)

Known STIs	Soroti			Masaka			Gulu		
	Male	Female	Overall	Male	Female	Overall	Male	Female	Overall
Syphilis	88	94	**91**	78	72	**76**	75	74	**74**
HIV	92	88	**91**	48	38	**44**	66	75	**71**
Gonorrhoea	50	45	**48**	83	78	**81**	54	48	**51**
Candida	2	3	**3**	13	14	**13**	2	9	**5**
Pubic lice	6	0	**4**	2	4	**3**	3	4	**3**
Genital Herpes	4	7	**5**	7	6	**6**	2	0	**1**
Genital warts	2	3	**2**	10	8	**9**	0	3	**1**
Chlamydia	2	0	**1**	3	3	**4**	0	0	**0**

Reported Symptoms of STIs

Most symptoms of STIs reported by PWDs were skin rash (57%), sores (48%), discharge from private parts (43%), pain while urinating (27%), itching (25%) and pain in the lower abdomen (23%). High awareness of the symptoms could imply that PWDs would be able to seek medical advice once they suspect to have sexually transmitted infections.

Table 10 Reported symptoms of STIs by Gender by District (%)

Reported STIs	Soroti			Masaka			Gulu		
	Male	Female	**Overall**	Male	Female	**Overall**	Male	Female	**Overall**
Skin rush	82	81	**82**	44	35	**40**	53	48	**50**
Sores	63	76	**68**	47	38	**43**	31	36	**34**
Discharge from private parts	35	19	**28**	53	47	**51**	49	49	**49**
Pain while urinating	31	19	**26**	35	29	**33**	29	18	**23**
Pain in lower abdomen	16	13	**15**	17	21	**19**	19	28	**34**
Itching	30	16	**25**	28	31	**31**	21	18	**19**
Pain having sex	4	0	**3**	8	7	**8**	7	5	**6**
Others	55	48	**52**	16	21	**18**	21	18	**19**

3.4 Sexual Behaviour, STI/HIV Risk and Condom use

Sexual behaviour is a key predisposing factor and or increases the risk of acquiring HIV. Examples of sexual behaviour practices investigated in this survey included age at first sexual encounter and circumstances, sex with non-regular partner and condom use, number of sexual partners.

3.4.1 Age at first sexual encounter

Out of the 462 PWDs interviewed 362(78%) had ever had sex. 47% had their first sexual encounter below the age of 18 years. The average age for first sex in Uganda is 16.7 years (Ministry of Health 2005). This shows that PWDs display the normal sex pattern like non-disabled persons. Desegregation of data by gender showed that more females (51%) than males (44%) had their first sexual intercourse when they are still minors that are below the age of 18 years. Early engagement of PWDs in sexual intercourse exposes them to the risks of acquiring STIs including HIV/AIDS and unplanned pregnancies.

Table 11 Age of first sex by Gender and District (%)

Age group	Soroti			Masaka			Gulu			Overall	
	Male	Female	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
4-13	9	15	11	4	7	5	5	2	4	1	1
14-17	24	29	26	51	52	51	38	46	42	38	36
18-23	46	32	40	34	26	31	35	48	42	40	36
24-29	4	6	1	5	2	4	5	2	3	6	3
30-34	0	1	1	2	1	3	4	0	4	6	2
35-39	0	0	0	1	0	1	0	0	0	1	0
40-44	0	0	0	0	0	0	0	0	0	0	0
45-49	1	0	1	0	0	0	0	0	0	1	0
DK	7	5	12	2	6	8	6	2	8	15	13

Note: DK-Do not know

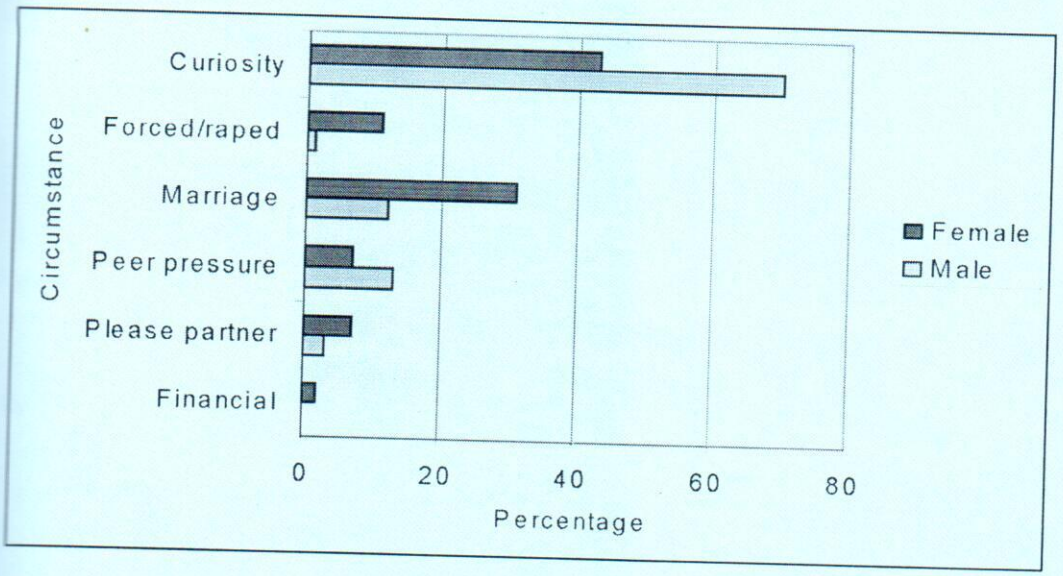
3.4.2 Relationship with the first sexual partner

When asked about the relationship with the person PWDs had the first sexual encounter, findings showed that most of them had their first sexual intercourse out of mutual relationships mainly with boyfriend/ girlfriend 60% and with spouse at 18% implying that they were virgins at marriage. Others were casual sex accounting for 10%, strangers and cohabiting at (5%) and relatives and commercial sex less than 2%.

3.4.3 Circumstances that forced PWDS to engage in first sex

Regarding circumstances for the first sexual encounter, most PWDs engaged in first sex out of curiosity (56%) marriage (21%), peer pressure (8%) and forced/ raped (6%) as shown in Fig.6. While there were high numbers of PWDs engaged in the first sexual encounter out of mutual consent, findings by gender revealed that some female PWDs had the first sexual encounter through force/rape, commercial gain or to please a partner. Districts data showed that female PWDs whose first sexual encounter was through force/rape were higher in Masaka (18%) and Gulu 6%. This portrays a level of vulnerability of female PWDs to STIs and unwanted pregnancies. Four percent of the PWDs in Masaka and 3% in Soroti engaged in first sex for commercial gain. Although, this was a small percentage, it is indicative of a form of survival mechanism among female PWDs. In Masaka district, engagement in commercial sex was reported at the fish landing sites in the FGDs. This raises an important issue that the current HIV/ AIDS programmes should include PWDs among other vulnerable groups. *"In the current situation in Uganda, women just want money. In one of our lake shores, women including PWDs go in bars to look for money by selling themselves,"* female FGD.

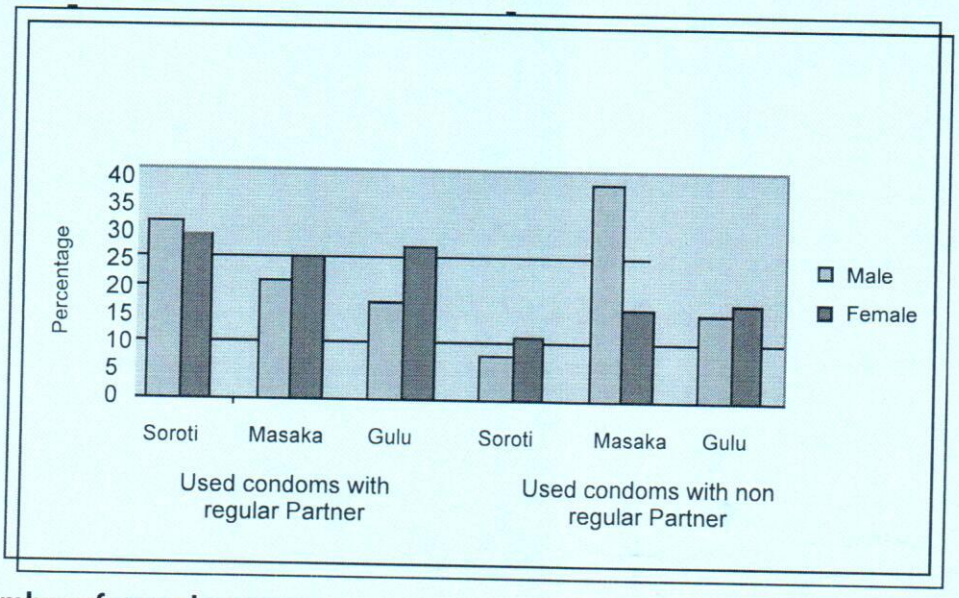
Figure 6 **Circumstances for First Sexual Encounter**



3.4.4 Sex with a non-regular Partner and Condom Use

Out of the 362 PWDs who had ever engaged in sex, 83(23 %) had sexual intercourse with non-regular partners in the last 12 months. Findings showed that more female PWDs (27%) had engaged in sex with a non-regular partner than male PWDs (23%). Overall, use of condoms with a non-regular partner was generally low (14%). That is (20%) and (15%) among males and females respectively as shown in the Fig 7.

Figure 7 **Had sex with Non-Regular Partner and Used Condom**



3.4.5 Number of sexual partners

One in every two PWDs in marriage reported additional sex partner portraying high-risk sex behaviour. Out of the 83 PWDs who reported having sex with a person other than their spouses, 46 (55%) had one additional sexual partner. The proportions of male and female PWDs who reported additional sex partners were 54% and 62% respectively. Twenty four percent of the respondents had 2 additional sexual partners

and 27% of these were males and 20% females. The survey revealed that female PWDs tended to have only up to two additional partners whereas male PWDs went up to six although with very low percentages (8% with 3 partners, 7 % had four while 2% had 5 and 6 respectively). Details are shown in Table 12.

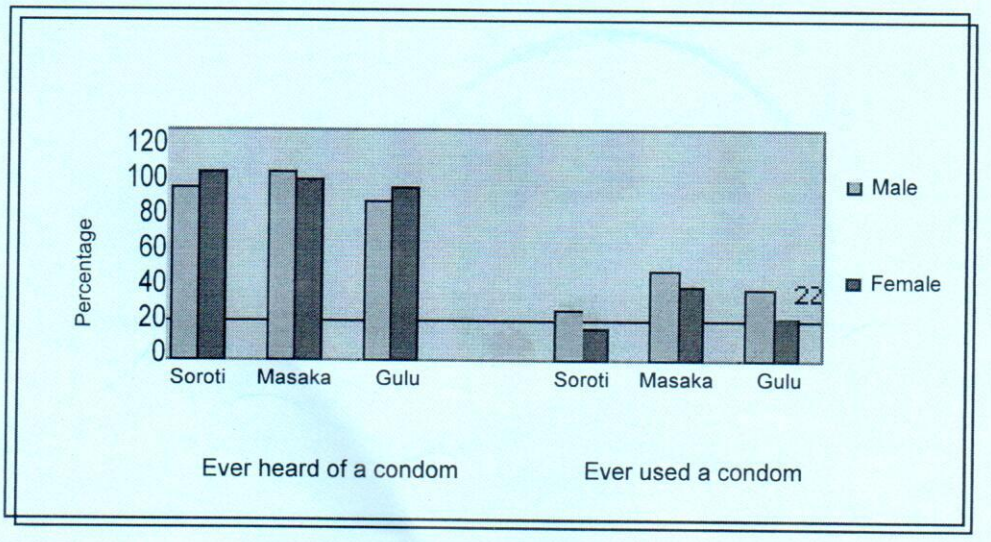
Table 12 Number of Sexual Partners by Gender by District (%)

No. of partners	Soroti			Masaka			Gulu		
	Male	Female	Overall	Male	Female	Overall	Male	Female	Overall
1	80	67	**73**	37	42	**39**	46	77	**64**
2	10	33	**23**	26	42	**23**	46	24	**32**
3	0	0	**0**	16	0	**10**	9	0	**4**
4	10	0	**5**	11	0	**7**	0	0	**0**
5	0	0	**0**	5	17	**10**	0	0	**0**
6	0	0	**0**	5	0	**3**	0	0	**0**

3.4.6 Condom Awareness and Use

The level awareness about condoms was very high as represented by 410 /462 (89%) of the respondents as shown in Fig.8. As already mentioned, there has been a rigorous campaign to promote condoms yet within PWDs, 11% had not heard of them. The probable reasons for the gap in knowledge among this category of PWDs could be the weaknesses of the conventional information dissemination mechanisms that do not address disability specific communication needs. The other is that the main sources of information for some categories of PWDs like friends and family members may have their limitations in discussing with openness issues of sexuality and condom use.

Figure 8 Ever Heard and Ever Used Condom



Information from FGDs was mostly in support of condom use as shown in these voices.
"Let us discuss condom use because it helps young people to protect against diseases. For us our days were good but now things are dangerous. Let the young people use them," elderly community member.

"For me a condom is good because it protects your life," female PWD.

"Condoms are good because they help in controlling unwanted pregnancy and HIV," female PWD.

While the awareness of condoms was very high, on the contrary utilisation was low as only 131/410 (31%) had ever used condoms. Within districts, use of condoms was higher in Masaka (43%), followed by Gulu (29%) and lowest in Soroti (22%). Further analysis by gender showed that condom use was relatively higher among male PWDs (36%) than female PWDs (26%). Female PWDs in Soroti had the least condom utilization levels.

Reasons for Condom use

Condom promotion is one of the three national strategies (ABC) for HIV prevention and control among the general population. It is also one of the main interventions for HIV prevention among People Living with HIV/AIDS (PLWAs). The study investigated the reasons why PWDs were using condoms. The results showed that overriding factors in condom use were avoiding HIV (65%), pregnancy (56%) and STIs (45%). In Masaka, more female PWDs (77%) reported using condoms to avoid pregnancy than to protect against HIV (52%) and STIs (20%). In Soroti, the driving force among the male PWDs was to avoid pregnancy (75%). The details are shown in the Table 13.

Table 13 Reasons for condom use by Gender by District (%)

Reason	Soroti			Masaka			Gulu			Overall	
	Male	Female	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
Avoid pregnancy	75	60	71	61	77	67	36	24	31	57	54
Avoid STI	58	40	40	37	20	30	56	59	57	50	40
Avoid HIV	58	80	80	69	52	63	64	41	55	64	65

Non-use of condoms

Non-use of condoms still remains one of the key challenges in STIs/ HIV prevention initiatives mainly arising from misconceptions surrounding condom use, inadequate access and the issue of individual decision-making among others. It was therefore important to find out why PWDs who were engaged in sex were not using condoms and the following were the findings.

Being in marriage (45%), lack of knowledge on proper use of condoms (39%), refusal by partner and not knowing how to use condoms (35%) were the main reasons why male PWDs would not use a condom. Other

factors influencing non-usage of condoms included not knowing where to get them, old age, religion and non-availability of condoms. The issue of religious influence featured highly in Gulu particularly among the male PWDs (39%). Use of condoms is still influenced by levels of decision making as seen by the number of female PWDs who cited partner refusal in its use (35%) as compared to males (15%). The role of culture seems to be weak in influencing condom use particularly among female PWDs (4%) compared to males (7%). The details are presented in the Table 14.

Table 14 Reasons for non-use of condom by Gender by District (%)

Reason	Soroti			Masaka			Gulu		
	Male	Female	Overall	Male	Female	Overall	Male	Female	Overall
Not available	7	9	8	25	13	20	9	24	19
Married	61	40	53	36	26	32	38	26	31
Does not know how to use it	28	50	4	33	33	33	56	22	39
Partner does not like it	7	36	21	22	29	25	17	39	32
Old	28	47	37	10	13	11	17	26	23
Does not know where to get it	20	10	16	14	13	14	25	11	17
Fear to break or get stuck	13	18	15	0	0	0	10	0	4
Religious influence	0	0	0	5	0	6	39	6	19
Cultural factors	7	0	4	14	0	8	0	11	7
Poor method of distribution	0	10	4	0	0	0	0	0	0
Does not make sex enjoyable	0	0	0	0	0	0	4	1	5

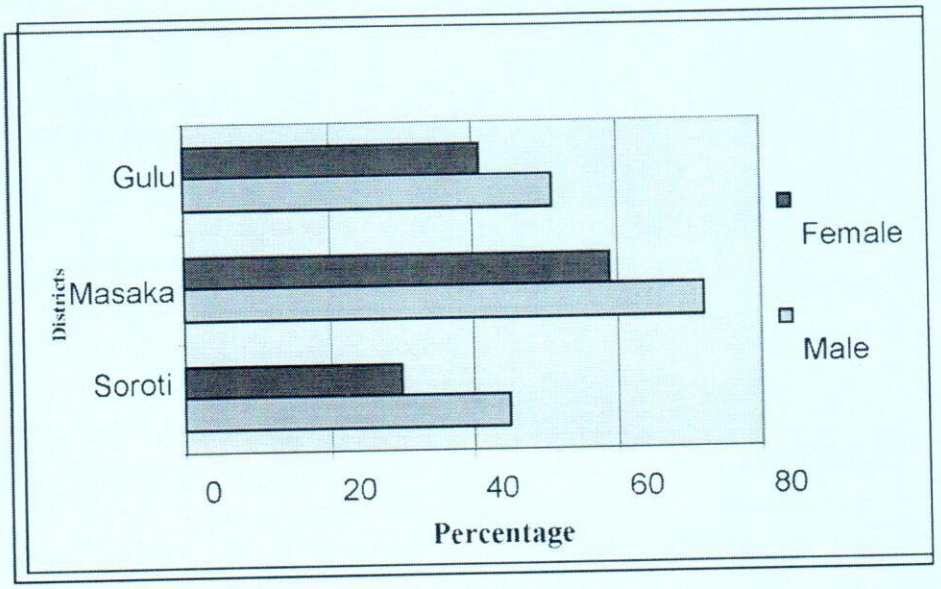
Qualitative data generally supported findings from the survey but also provided information on other dimensions regarding non -use of condoms. The issue of religion came out strongly in Soroti where use

of a condom was equated to abortion and unfaithfulness and therefore sin. *"If you know the truth of God, you cannot use a condom otherwise get a trusted partner,"* male youth PWD. Male youth PWDs also reported that most girls resist the use of condoms. There were also a number of misconnections about condoms such as bursting and reaming inside the partner, permeable and association with promiscuity. *"We did an experiment at school where we filled a condom with water and hanged it. After five minutes, it started leaking,"* youth PWDs. *We also hear in peer groups that a condom is not perfect*, male youth PWD.

Other dimensions of non-use of condoms were conditions of disability, which make access to sex very rare and hence constrain PWDs ability to negotiate safe sex when the chance comes. *"We do not ordinarily get sex so when you get a girl, you do not even think about using a condom,* male PWD. Others indicated that it is an opportunity to get pregnant hoping that the children you bear would look after you. The physical disability was also cited as another hindrance to condom use. *"If you are lame with one hand, you cannot put on a condom by yourself and have to rely on a partner who may be reluctant,"* male PWD.

The survey results showed that overall access to condoms was at 51% with the least reported in Soroti (39%), followed by Gulu (46%) and Masaka having the highest access of (67%). Overall access to condoms by female PWDs was lower in all the districts as shown in the Fig 9.

Figure 9 Access to Condoms by Gender by District



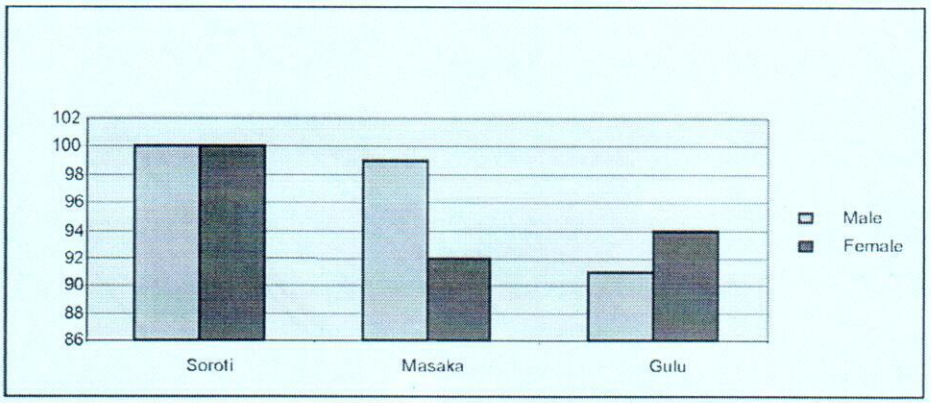
Non availability and not knowing where to get condoms that featured prominently in the survey were downplayed in the FGDs. Condoms were reported to be easily accessible in shops, clinics, health centres and with community peer educators. The latter being the case for Masaka. These findings revealed that having condoms in nearby localities as enumerated above does not necessarily guarantee physical access especially to the PWDs. Differences in levels of knowledge about availability of condoms between participants in the survey and those in the FGDs may also be a pointer to the gaps in information-giving mechanisms given the fact that most PWDs mobility is constrained.

3.5 Knowledge of HIV/AIDS and Related Services

3.5.1 Ever heard of HIV/AIDS

The level of awareness of HIV/AIDS was very high among PWDs in all the districts (100% in Soroti, 96% in Masaka and 93% in Gulu as shown in Fig 10. Although Uganda has run aggressive sensitisation activities on HIV/AIDS since 1987, some PWDs in Masaka (8%) and Gulu (12%) had never heard of the epidemic.

Figure 10 Level of HIV/AIDS Awareness by Gender by District



Further analysis revealed that PWDs who had never heard of HIV/AIDS fell in the category of physical disability, the deaf and those with speech problems. These persons were also young below 18 years, had no formal education and were not married. This highlights the need for targeting disability in defining special groups in HIV/AIDS programming.

3.5.2 Ways through which HIV is spread

As a way of gauging knowledge, PWDs were asked to name ways through which HIV is spread. There was a general understanding of the ways through which HIV is transmitted. The majority of PWDs (53%) mentioned unprotected sexual intercourse, 54% reported sexual intercourse, 48% use of unsterilized instruments and 34% having sex with an infected person. Findings also showed some misconceptions like transmission through sharing of HIV through sharing utensils and staying close to an infected person and downplaying of some risk factors, like sex with multiple partners, prostitutes and MTCT. Sharing utensils with an infected person was reported highly among the female PWDs in Soroti

Table 15 Ways of HIV transmission mentioned by PWDs (%)

Ways of prevention	Soroti			Masaka			Gulu			Overall	
	M	F	T	M	F	T	M	F	T	M	F
Unsterilized instruments	78	80	79	41	50	45	47	48	48	58	59
Sexual intercourse	69	60	65	49	57	53	43	55	49	54	57
Unprotected sexual intercourse	33	40	36	48	32	41	26	22	24	36	31
Sex with an infected person	15	14	15	18	27	22	26	17	21	36	31
Blood transfusion	30	17	25	37	24	31	32	28	30	33	27
Sex with multiple partners	7	9	8	3	5	4	6	14	10	5	9
Sharing other utensils	7	23	14	4	2	3	0	0	0	4	8
Staying close with infected people	2	3	2	0	1	1	1	1	1	1	2
MTCT	0	0	0	11	10	10	5	6	5	5	5
Sex with prostitutes	2	3	2	2	2	2	3	1	2	2	2
Kissing	4	0	2	5	1	3	1	1	1	3	0.6
Sharing toilet with an infected person	4	0	2	1	2	2	0	0	0	2	0.6
Witchcraft	0	0	0	0	0	0	0	0	0	**0**	**0**
Mosquito bites	0	0	0	0	1	1	1	0	1	0	0
Homo sexual contacts	2	0	1	1	1	1	0	0	0	1	0

3.5.3 Ways of HIV Prevention

The highest percentage of PWDs (63%) mentioned abstinence, condom use (42%), having one sexual partner (33%) as ways of HIV prevention. A significant percentage (14) put emphasis on correct use of condoms. District specific findings showed that emphasis on correct use of condoms was from Masaka District at 25%. The findings are in line with the Government of Uganda HIV/AIDS campaign that emphasises abstinence, being faithful and condom use (ABC).

Table 16 Listed ways of HIV prevention by Gender by District (%)

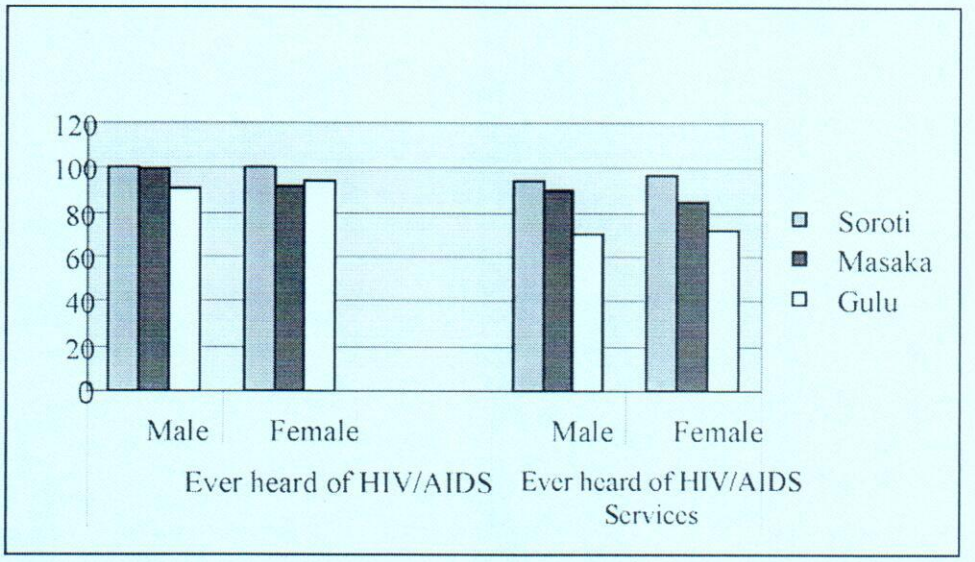
Ways of prevention	Soroti			Masaka			Gulu			Overall	
	M	F	T	M	F	T	M	F	T	M	F
Abstain from sex	72	69	71	77	73	75	44	45	45	64	62
Have one sexual partner	61	49	56	27	23	25	27	30	29	44	34
Use condoms	57	49	54	37	40	38	44	37	41	46	36
Correct use of condoms	4	6	5	28	20	25	10	6	8	14	11
Don't have sex with prostitutes	2	0	1	2	0	1	4	0	2	3	0
Do not inherit widows	2	0	1	0	1	1	3	2	4	2	1

3.5.4 Ever heard of HIV/AIDS services

Out of the 435(96%) PWDs who had ever heard of HIV/HAIDS, 374 (85%) were aware of the existence of HIV/AIDS services indicating a slight drop of 9% overall. Among the females it was 10% and 12% among the males. Results also showed equal awareness of HIV/AIDS services by gender (85%). Further analysis by

district revealed that Soroti had the highest levels of awareness at 95% followed by Masaka at 88% and Gulu having the lowest of 71%. Details are shown in Fig.11 below.

Figure 11 Awareness of HIV/AIDS and Services



3.5.5 HIV/AIDS Services Reported by PWDs

The known services cover the basic areas in HIV/AIDS prevention, care and support. The most known services were ARVs supplies, food supplements, HIV counselling and testing as shown in Fig.12. On the other hand, prevention activities namely HIV sensitisation and education, condom distribution and PMTCT were the least known in all the districts. Overall analysis of data by gender revealed similar levels of awareness of HIV/AIDS services. But for specific services namely HIV counselling and condom distribution, the percentages of female PWDs was lower compared to males.

Figure 12 Overall Awareness of HIV/AIDS Services by District

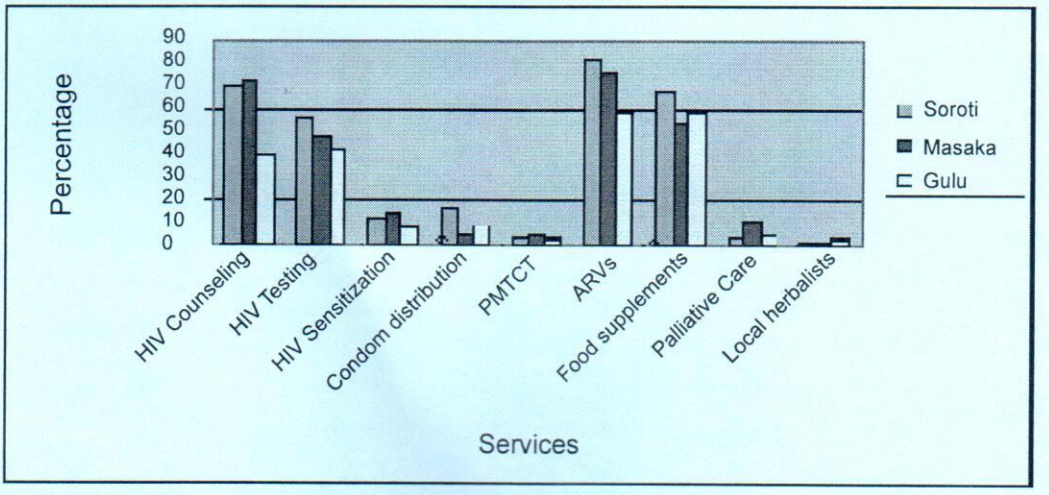


Table 17 Awareness on HIV/AIDS services by Gender by District (%)

Service known	Soroti			Masaka			Gulu		
	Male	Female	**Overall**	Male	Female	Overall	Male	Female	Overall
HIV counselling	75	66	**71**	62	35	73	40	40	40
HIV testing	59	53	**56**	56	37	48	46	38	42
HIV sensitisation	16	6	**12**	16	11	14	7	9	8
Condom distribution	20	9	**16**	7	3	5	13	5	9
PMTCT	6	0	**4**	5	5	5	0	5	3
ARVs	86	76	**82**	75	80	77	59	59	59
Food supplements	64	73	**68**	49	61	54	49	67	59
Palliative care	4	3	**4**	12	9	11	6	5	5
Local herbalists	2	0	**1**	0	1	1	6	2	3

3.6 Awareness and Views on SRH rights of PWDS

Information on awareness on SRH rights was obtained from key informants and FGDs. Findings revealed that awareness on these rights was relatively high among adult male and female PWDs and lower among female and male PWDs in all the districts. It was also limited in one rural and one urban community in Soroti District. *"This is one chance we have had to discuss SRH. NGOs go to villages and neglect us thinking that town people are well informed"* male FGD Soroti Urban. The rights mentioned included right to sex, marry, medical care and bear children. In addition, key informants added access to ARVs, PMTCT, counselling and the right to information. Among the key informants, it was observed that individuals within the organisations visited had high awareness of these rights by virtue of their education. But weak at institutional level as evidenced by lack of formal procedures for handling PWDs issues within these organisations. *"We have not had any sensitisation on PWDs and SRH issues. We treat all people as individuals,"* KI. *"We do not address issues of rights but only conduct health education and counselling,"* KI.

There was general recognition in all the FGDs and key informants that PWDs should equally enjoy these rights like all persons. This is line with the Constitution of Republic of Uganda 1995 provision, which states that all persons have equal rights in all the spheres of life. According to the Disability Act 2006, PWDs shall enjoy the same rights with other members of the public in all health institutions including general medical care. The Government shall ensure that sign language is introduced into the curriculum for medical personnel; interpreters are included in hospital organizational structure and labels on drugs are pre-brailed. The Government shall promote special health services required by PWDs including access to reproductive health services which are relevant to women with disabilities, enforcing user friendly hospital materials

and encouraging population based public health programmes relevant to PWDs. However, PWDs do not enjoy these rights because of social and economic factors and non-institutionalisation of PWDs issues in SRH service delivery.

Social factors: Societal stereotypes that negatively portray PWDs and family controls limit PWDs from enjoying their rights. These stereotypes and controls were mostly evident in the areas of relationships, marriage, child bearing, participation in economic activities, access to education and salaried employment. Consequently PWDs suffered from isolation and high poverty levels.

At family level, most PWDs were denied marriage and child-bearing rights by close relatives as a way of protecting them from challenges of child bearing or marriage in general. Where marriage was an option, it was reported that PWDs would be treated unfairly either by imposing a choice of a spouse on them or demanding for higher dowry. *"...if a PWD man wants to marry a normal woman, her family will try all ways to discourage you including doubling the dowry."* There was also a case of one PWD in Masaka who was raped and got pregnant. On delivery, the relatives put her family planning (injection) without her knowledge. In other instances, relationships or marriage to a PWD is considered shameful, so normal persons were reported to shun open relationships with PWDs preferring either a one off indulgence or very secretive affairs.

"Men fear to approach us lame people because they fear public opinion. They come to us at night," female PWD.

"Disabled persons have feelings like non-disabled. We would want to have beautiful wives who can give us children but some people shun us and emphasise our disability. They do not consider what is inside us but only judge us by the outward appearance. This is very hurting and we feel neglected and discriminated", male PWD.

Nature of disability: The nature of disability also contributes to non enjoyment of SRH rights. Information dissemination on SRH/HIV/AIDS tended to be limited to general community meetings, use of conventional IEC materials which do not necessarily address unique characteristics of PWDs. Most IEC materials were reportedly visual and to a limited extent audio.

"SRH messages are written on posters, which the blind cannot read," KI.

"We deaf people find it difficult to communicate to nurses because they do not know sign language," female PWD.

"Some of our clients become deaf as a result of HIV/AIDS and we get a challenge of communicating with them. This limits their access to information," KI.

3.7 PWDs Access to SRH and HIV/AIDS Information

The discussion on access to information on SRH/HIV/AIDS focused on the current sources of information and preferred methods as detailed below.

3.7.1 Source of information about SRH services

It is evident in the survey that PWDs received information about SRH from various channels. The most cited sources of information were radios (66.6%), friends (61%), health workers (52%), community meetings (15%) and sensitisation workshops (13%). Others included schools (7%), churches/mosque and NGOs (6%),

posters (4%). District data by gender revealed commonalities in the main sources of information as shown in Table 18.

Table 18 Sources of information about SRH services by Gender by District (%)

Source of SRH information	District									Overall	
	Soroti			Masaka			Gulu				
	M	F	O	M	F	O	M	F	O	M	F
Friends	46	60	51	81	43	38	67	67	67	65	57
Radio	85	74	81	71	62	67	67	53	59	71	63
Health workers	54	53	54	39	47	42	57	62	59	50	54
Community meetings	22	13	19	13	13	13	15	9	12	17	12
Sensitisation workshops	18	10	15	17	12	15	4	2	3	17	8
School	7	0	4	9	15	11	4	7	6	7	7
Churches/mosque	13	20	16	1	2	2	2	0	1	5	7
NGO	0	0	0	7	5	6	17	7	12	8	4
Newspaper/magazines	7	3	5	3	5	4	7	2	4	6	3
Posters	9	7	8	2	3	2	2	0	1	4	3
Fellow PWD	0	3	1	1	1	1	2	0	1	1	1
LCs	2	0	2	0	1	1	1	0	1	1	0

Note: M= Male, F=Female, O=overall percentage

Information from the FGDs also confirmed findings from the survey. In Soroti, the main sources information reported were FM radios (Voice of Teso, Veritas, Calvary), churches, NGOs (Soroti Catholic Diocese Integrated Development Organisation- SOCADIDO), school, drama. The blind mainly got information from the parents and friends. In the villages, funerals and local leaders featured prominently as a source of information. *"A burial attracts a large audience. Even us PWDs who do not attend public functions get an opportunity to attend,"* male PWD.

In Masaka, the sources mentioned included health workers in public health units, radios, friends/relatives and a few PWD representatives. In one of the parishes in Kyanamukaka, information was obtained from a project known as Rakai Health Sciences Programme. In Gulu, the main sources reported were radios, health workers friends, relatives and workshops.

3.7.2 Source of Information about HIV/AIDS

Overall, findings show that PWDs are exposed to numerous sources of information on HIV/AIDS. The main sources of information mentioned were radios accounting for 79%, friends (49%) and health workers (31%). Other significant sources included parents (18%), community meetings (15%), sensitisation workshops (14%), burial ceremonies and newspapers (12%) and schools (10%). While friends were among the second largest source of HIV/AIDS information among PWDS, analysis of district level data revealed that it was higher in Masaka and Soroti but quite low in Gulu. It is important to note that while there are structures created to represent the interests of PWDs at all Local Government levels, PWDs could not cite them as

main sources of information nor preferred avenues as shown in Fig. It was also notable that community meetings, which are commonly used as principle avenues for community sensitisation and general information dissemination were least reported by female PWDs. While the radio remained a preferred means of information, its dominance substantially drops in rating by 30% as shown in Fig. 13. This signifies a desire to by the respondents to have a mixture of other sources of information.

Table 19 Source of information about HIV/AIDS by Gender by District (%)

Source of HIV/AIDS	Soroti			Masaka			Gulu			Overall	
	M	F	O	M	F	O	M	F	O	M	F
Friends	72	66	70	62	47	56	20	28	24	51	47
Radio	89	77	84	72	74	73	77	83	80	79	78
Newspaper/magazines	26	14	22	10	10	10	7	2	5	14	9
Posters	2	0	1	6	4	5	1	1	1	3	2
Health workers	44	37	42	30	39	34	32	2	26	35	26
School	8	11	9	7	13	10	11	15	13	9	13
Sensitisation workshops	21	9	16	14	7	11	19	11	15	18	9
Community meeting	26	20	24	17	12	15	11	5	8	18	12
Church/mosque	19	23	21	2	3	2	1	0	1	7	9
Burial ceremony	17	9	14	12	9	11	14	10	12	14	9
Drama	2	0	1	4	8	5	5	5	5	5	4
Community leaders	17	3	11	10	8	9	3	2	3	10	4
Drinking place	4	0	2	1	0	1	3	2	3	3	1
Fellow PWDs	4	3	**3**	2	4	**3**	1	0	**1**	2	2
Parents	13	9	**11**	17	20	**18**	15	31	**33**	15	20

Note: M= Male, F=Female, O=overall percentage

3.7.3 Preferred sources of HIV/AIDS information

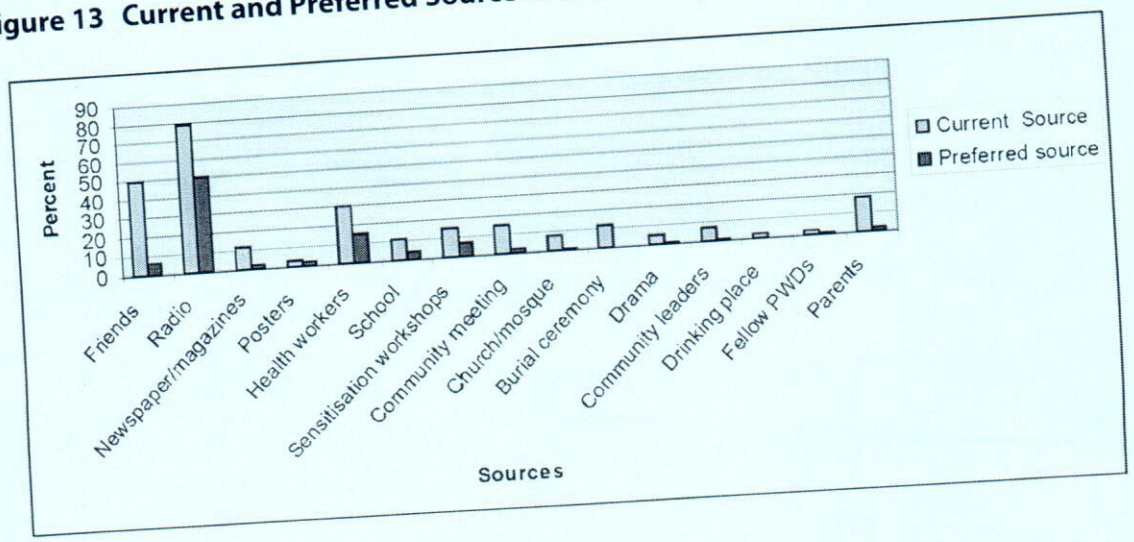
The majority of PWDs preferred radio as a main source of information (50%) and the health workers (16%). Other preferred sources were sensitisation workshops (7%), friends (6%) and schools (3%) as shown in Table 20 and Fig 13. Popularity of radios as a source of communication could be attributed to the advent of FM stations that broadcast in local languages. Given that most PWDs are constrained in terms of mobility and participation in public functions, radios therefore serve as a social equaliser in terms of bringing information closer to the PWDs. Whereas there were no significant variations on the preferred sources of information, there were cases where preferences were influenced by specific disabilities, as was the case with the deaf. This group tended to prefer friends and family as a source of information. *"We the deaf do not get information because many people do not know how to talk to us. So we rely on close relatives,"* youth PWD.

Table 20 Preferred sources of HIV/AIDS information by Gender by District (%)

Preferred source	Soroti			Masaka			Gulu			Overall	
	M	F	O	M	F	O	M	F	O	M	F
Radio	44	62	51	57	52	55	40	66	53	47	53
Health workers	26	12	21	5	10	7	26	16	21	18	13
Sensitisation workshop	7	3	6	7	15	10	4	2	3	6	7
Friends	9	9	9	5	1	3	8	1	4	7	4
School	0	3	1	5	6	5	3	2	3	3	4
Parents/family	2	0	1	1	3	2	3	2	3	2	2
News paper	4	3	3	3	0	3	0	0	0	2	1
Posters	0	0	0	7	3	5	3	1	2	3	1
Community meetings	4	0	2	6	3	5	1	1	1	3	1
Church/Mosque	0	3	1	2	1	2	0	0	0	1	1
Drama	0	0	0	0	1	1	3	1	2	1	1
Community leaders	2	0	1	0	0	0	3	0	1	2	0
Fellow PWDs	2	0	1	0	0	0	3	0	1	2	0

Note: M= Male, F=Female, O=overall percentage

Figure 13 Current and Preferred Source of Information



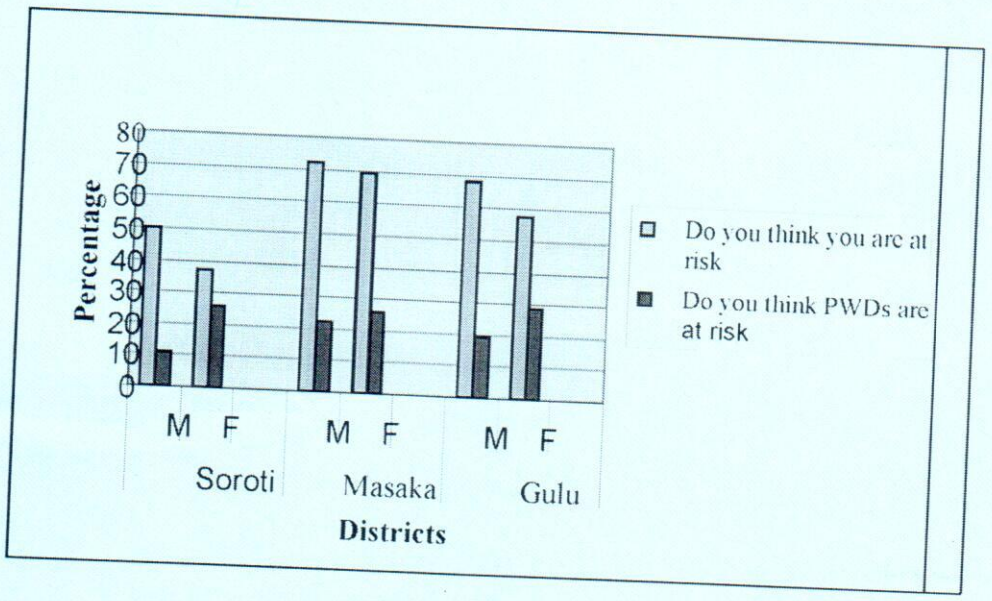
3.8 Attitudes, Beliefs and Perceptions

Understanding individual attitudes, beliefs and perceptions regarding HIV/AIDS is crucial in formulation of HIV prevention strategies, for example, design of appropriate communication messages that are tailored to addressing the gaps in information and those that target stigma and discrimination.

3.8.1 HIV Risk Perception among PWDs

HIV risk assessment focused on the extent to which individuals think they are at risk and their perception of PWDs vulnerability to HIV as a social category in general. At individual level, PWDs had a high conviction that it is possible for him/her to contract HIV/AIDS (63%) yet at the same time viewed PWDs as a social category to be at a low risk (22%) as shown in Fig 14. There was a small percentage 13 who could not tell whether PWDs were at risk or not.

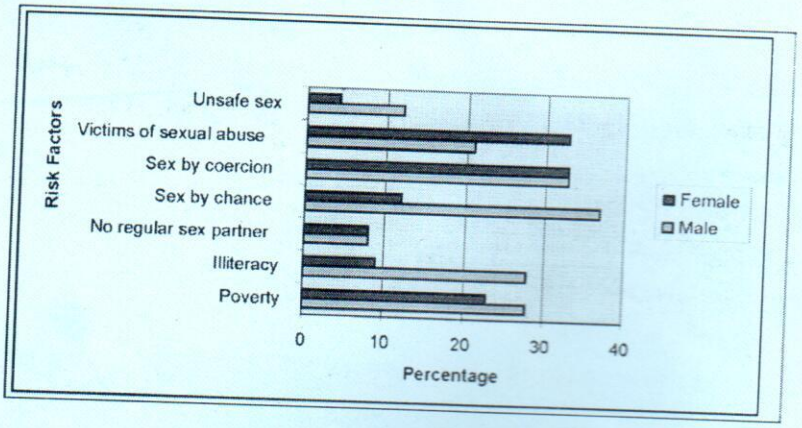
Fig 14: HIV Risk Perception by Gender by District



HIV risk factors: Respondents enumerated a number of factors that made them susceptible as individuals to contracting HIV. Unsafe sex emerged as the main risk factor mentioned (35%), mistrust of the partner (30%) and spouse having multiple partners (15%). There were also some district specific risk factors particularly reported by female PWDs like being unable to refuse sexual advance (14%) in Gulu and selling sex in Masaka (2%). Mistrust of partners was relatively high among the female PWDs in Gulu (42%) compared to males (27%). Whereas having multiple partners had a lower percentage on average, it was significantly recognised by female PWDs in Soroti (31%) compared to 4% by the males.

Respondents were asked of their opinions regarding HIV risk levels between PWDs and non-disabled persons. Most of the factors mentioned revolved around circumstances arising from disability and perpetrated by community stereotypes as already alluded to. They included sexual coercion, sexual abuse, having sex by chance and poverty as shown in the Fig 14.

Figure 15 Why PWDS are more at Risk



In the FGDs and key informants, those who thought PWDs were more at risk indicated that they have normal sexual feelings, are poor, physically weak due to nature of disability, have limited chances to negotiate safe sex and lack of knowledge on HIV/AIDS. Further discussion on the level of risk among the categories of PWDs revealed that female PWDs especially the physically disabled, mentally affected, the deaf and the blind were at a greater risk. They observed that they are exposed to sexual abuse, rape, get involved in coerced sexual relations and are poor and therefore unable to meet most of their basic needs. The deaf cannot shout or hear once assaulted. It was also reported that workshops, which are currently a common means of sensitization, were also common avenues exposing PWDs to HIV. Below are some of the voices:

"In our communities here it is usually the blind and physically disabled who mainly face sexual abuse. They just get you, throw you in a wheelbarrow and carry you to his house. You have no strength of fighting back" female FGD

"When we also try to socialize, like going to parties, then we are raped and you have no where to report because you will be asked, ""what were you also doing there"", female youth PWD

"There is a perception that PWDs are free from HIV as they do not look attractive so they are target of most men, KI.

"In workshops, high profile PWDs induce the PWDs at the lower levels yet they have many partners..."

"When you are blind, HIV infected persons may take advantage of you because you may not be able to see the symptoms," female PWD.

Those with speech problems may be raped as they may not be able to shout," female PWD.

"PWDs have sexual feelings like non –disabled," community FGD.

"Most of the PWDs have not even seen a condom, so they lack preventive measures," Community FGD.

"The greatest risk is poverty, PWDs can not fulfil most of their basic needs and this exposes them to easy temptations," Female PWD Councillor.

"PWDs tend to have multiple sexual partners, because many do not get stable offers in terms of relationships," KI.

Non-risk factors: Out of the 280 PWDs who believed they were not at risk of acquiring HIV, abstinence and old age were main factors reported at (36%) and (27%) respectively. The others were being faithful to one partner (15%), marriage (14%) and use of condoms (7%). Male PWDs in Soroti had confidence in marriage

(39%) but female PWDs in the same district as in others appeared to have little faith in marriage as a factor in protecting them against HIV (8%).

Supplementary information regarding HIV non- risk factors among PWDs was obtained from FGDs and key informant interviews. Findings from these groups revealed concerns of mobility, nature of disability and general community perception that PWDs do not have sexual feelings and therefore are not at risk of acquiring HIV like non-disabled persons.

> *"How can a PWD acquire HIV? A PWD cannot engage in promiscuous activities. For example, my son is 28 years but she has never engaged in sex with any one. There is no woman who can love him,"* parent of a mentally disabled person.
>
> *"PWDs are dirty and they are not sexually appealing because of crawling,"* member of the community FGD.
>
> *"For us lepers, we have many sores on the skin. So no one wants to sleep with us,"* female PWD.
>
> *"PWDs do not move a lot like normal people. So they do not get exposed to men,* member FGD.

3.8.2 Factual and Common Misconceptions about HIV/AIDS

Since its discovery, HIV/AIDS pandemic has had a number of mysteries and misconceptions among the general population. One of the aims of the sensitisation initiatives in Uganda is to provide factual information to the population about this pandemic so as to improve their understanding and hence be able participate in its control from an informed position. This study found it important to find out whether there were still any misconceptions in the communities about HIV/AIDS. Respondents were asked to state what they believed on a number of statements put to them. Table 21 below gives details about their responses to the commonly held misconceptions.

Findings showed that a majority of the respondents had the right facts on basic HIV/AIDS namely faithfulness (90%), that a healthy looking person can have HIV(87%), that HIV cannot be cured (82%) and a person can have HIV in the body for many years before falling sick (76%). However, there is still a knowledge gap on MTCT and discordance. There were also misconceptions namely HIV transmission through mosquito bites (34%) and sharing a meal and witchcraft (17%) as shown in Table 21. Although gender desegregated data showed little variations more females (22%) than males (12%) believed that HIV can be transmitted through witchcraft.

Table 21 Factual and Common Misconceptions about HIV/AIDS (%)

Category	Yes	No	Don't know
It is possible for a mother with HIV to produce an uninfected child?	**67**	25	8
A person can have HIV in the body for many years before falling sick	76	15	9
It is possible for a husband to have HIV but not his wife or vice versa.	57	35	8
A healthy looking person can have HIV	87	9	4
HIV can be transmitted from mother to child through breast feeding	69	22	9
A person can protect himself or herself from contracting HIV by having sex with only one faithful uninfected person.	90	6	4
A person can get HIV from mosquito bites	34	58	8
A person can get HIV from sharing a meal with someone infected	17	77	6
A person can get HIV through witchcraft	17	77	6
it is possible to cure HIV/AIDS	12	82	6

3.9 Access and Utilization of SRH and HIV/AIDS related services

This section examines the issue of access in relation to providers of SRH/HIV/AIDS services, distance to the nearest government health facilities, utilisation, quality of services and problems in utilisation of these services.

3.9.1 Providers of SRH services

The main providers of SRH services were government (86%), private providers (32%), NGOs (27%) and CHWs (20%). District specific information however, revealed significant variations regarding SRH service provision. In Soroti, participation of the private sector was very low at 5% but higher CHW and NGO role at 55% and 44% respectively. In Masaka the opposite was the case with high private sector participation at 40% and low NGO role at 17%. Overall, government remained the main provider of SRH services across the districts but with a significant participation of NGOs in conflict affected districts.

Table 22 Providers of SRH services by District (%)

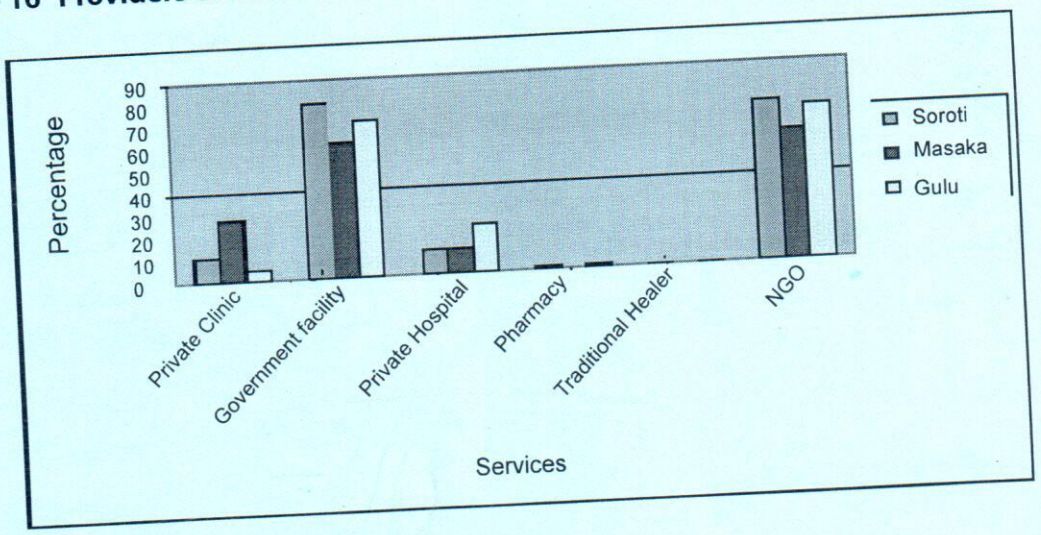
Provider	Soroti	Masaka	Gulu	Overall
Government facility	86%	88	84	86
Private facility	5	40	37	32
Drug shop	4	3	3	3
TBA	1	5	9	5
Traditional healer	1	3	-	2
NGO	44	17	31	27
Youth Centres	-	2	4	2
CHW	55	9	12	20

In Soroti, Action on Disability and Development (ADD) and National Union of Women with Disabilities (NAWODU) carried out sensitisation meetings on safe motherhood and HIV/AIDS for one day. There has been an initiative by TASO to capture disability parameters among their clients and create a disability friendly environment arising from NUDIPU's advocacy work to in Masaka.

3.9.2 Providers of HIV/AIDS services by District

Findings revealed that government hospitals and NGOs were the lead providers of HIV/AIDs services mentioned by PWDs accounting for 57% and NGOs (53%). Others included private facilities and clinics (13%), traditional healers (3%) and pharmacies (0.6%). District specific findings also revealed similar trends in HIV/AIDs service provision as shown in Fig 15.

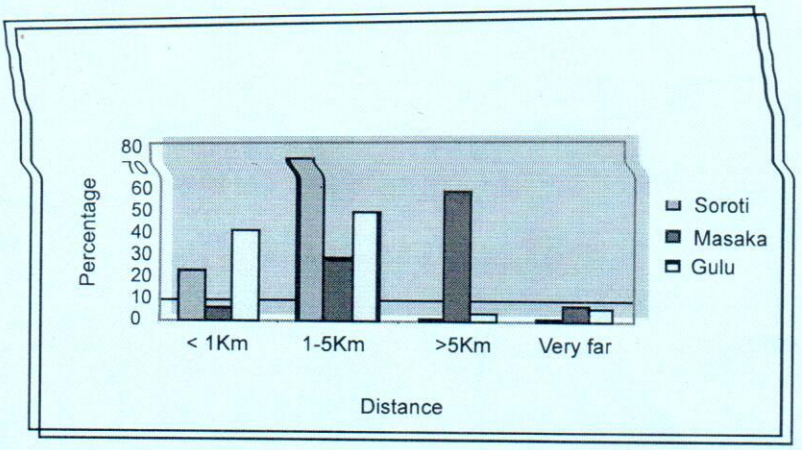
Figure 16 Providers of HIV/AIDS Services by District



3.9.3 Access to government health facilities

The current national physical access to services stands at 72 % (MOH 2005). The survey showed that the majority of PWDs lived within the recommended distance of 1-5 KMs (72.4%) as shown in Fig.19. This however, does not show improvements from the perspective of PWDs as constraints in access specific are not addressed. Analysis of district specific data showed that government health facilities for example in Masaka are still far way from the population. Only 34% live within the recommended government distance.

Figure 17 Distance to Government Health Facility by District



3.9.4 Access to Obstetric Care

From the survey results, 271 persons that reported having children, 59% of them were handled by trained health workers during delivery. The others used trained and untrained TBAs at (17% and 15% respectively. They were also relatively fewer persons either delivering with a help of a relative 5% or alone (3%). It should be noted that while the above health-seeking behaviour for ANC services was seemingly high, a significant number of PWDs 41% did not use trained health care providers. Information from the FGDs and KIs revealed that most PWDs did not use formal health care services due to negative attitude of some service providers, lack of disability sensitive structures and skills, lack of mobility aides, lack of transport and the distant health facilities. The details are discussed under constraints in utilisation of health services.

3.9.5 Utilization of SRH services

Overall, utilisation of SRH services was high at 68 % among both male and female PWDs in all the districts. Specific district data showed that Masaka had the highest utilisation levels (73%), Soroti (68%) and Gulu (65%). In terms of utilisation by gender, again Masaka had the highest (79%) among females followed by Soroti (64%). Findings also a showed high utilisation levels among males with Soroti having the highest (70%), Masaka (69%) and Gulu (66%).

The most highly utilized SRH services were ANC and immunisation at 63% and FP at 40%. Findings also revealed that male involvement in SRH was high especially in immunisation, ANC and FP including condom use. STI diagnosis and treatment was higher in Soroti compared to other districts and this was mainly among men. HIV testing was generally low at 10 % even within the low figures, men tended to seek this service more than women. Utilisation of PNC services was at 11% which was higher than the national average of 5% (UNFPA Country Programme 2001-2005). This could be attributed to susceptibility of most female PWDs to pregnancy related complications.

Table 23 Utilisation of SRH services by Gender by District (%)

SRH Service used	Soroti		Masaka		Gulu		Overall	
Type of service used	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
STI diagnosis and treatment	28	11	12	17	7	0	16	**9**
ANC	**61**	**71**	**27**	**50**	**48**	**69**	**45**	**63**
PNC	10	21	5	0	16	12	10	**11**
Delivery care	3	6	13	27	0	9	11	**14**
Immunization	79	**91**	64	60	31	38	58	**63**
FP(including condom use)	69	55	28	30	53	35	50	**40**
Infertility	0	0	2	0	3	3	2	1
Counselling	7	0	5	7	3	15	3	7
HIV testing	7	6	11	9	3	15	7	10

3.9.6 Utilization of HIV Counseling and Testing Services

A specific question was asked PWDs on whether they had ever utilised HIV Counselling and Testing Services. In order to avoid suspicion, respondents were assured that the team was not interested in knowing the results. Findings revealed that 81% of the respondents were aware of where to access these HCT services but only 25% had undertaken an HIV test.

Reasons for undertaking an HIV test ranged from wanting to know sero-status (21%), falling sick and being pregnant (2.4%) and having lost a partner, requested by a partner accounting for less than 1%. Virginity and being sexually inactive (15%), long distance (13%) were the main reasons why PWDs had not undertaken an HIV test. The others were cost, fear of results, having trust in a partner at (8%), lack of confidentiality 5% and fear of stigma and resistance from the partners both at 3%.

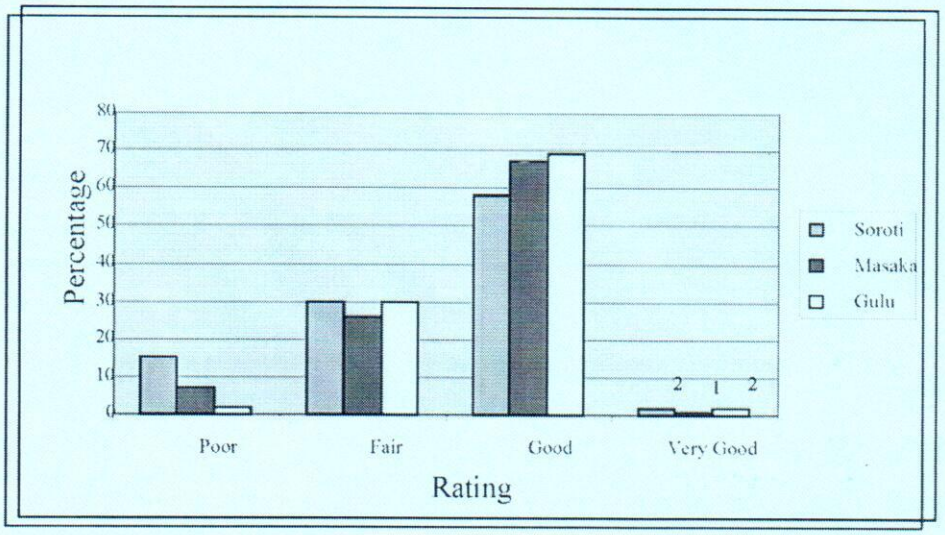
3.9.7 Quality of RH services

There was average satisfaction with the quality of services among PWDs who utilised the services in all the districts (63%). The rest of the PWDs` rated these services as fair or out rightly dissatisfied as shown in Fig 17.

Table 24 Rating of quality of services by PWDs by Gender by District (%)

Rating	Soroti			Masaka			Gulu		
	Male	Female	Overall	Male	Female	Overall	Male	Female	Overall
Poor	18	10	15	5	10	7	0	3	2
Fair	30	19	26	27	25	26	39	20	29
Good	49	71	57	67	66	66	61	74	68
Very Good	3	0	2	2	0	1	0	3	2

Figure 18 Rating of quality of RH services



3.9.8 Problems encountered while seeking RH services

Out of the 235 PWDs who had ever used SRH services, 113(48%) reported encountering problems while seeking those services and desegregated data by gender showed an equal spread of 46% and 48% among female and male PWDs respectively. There were however, big variations at district level with Gulu recording 83%, Soroti 50% and Masaka having the lowest of 30%. The common problems encountered were negative attitudes of health staff, stigma and discrimination, limited information and lack of mobility aides, drugs and having to pay for some services.

Table 25 Problems encountered by PWDs by Gender by District (%)

Nature of problem	Soroti		Masaka		Gulu		Overall	
	Male	Female	Male	Female	Male	Female	Male	Female
Providers do not know sign language	1	0	2	0	1	1	4	1
Limited access to information	0	1	6	2	15	10	21	13
Cannot read IEC materials	2	1	0	1	1	1	3	4
Negative staff attitude	8	3	5	4	5	7	18	14
Lack of mobility aides	2	2	6	1	6	13	14	17
Inaccessible buildings	0	1	2	0	1	0	3	1
Stigma and discrimination	10	4	3	8	2	2	15	14

While the problems were thinly spread among female and male PWDs, and therefore appear to be low in terms of percentage, the gravity of these problems as expressed during the FGDs and key informant interviews in all the districts showed that they had far reaching social consequences and contributed largely to non enjoyment SRH services by PWDs.

"When you go to the health unit, the providers are few, it is hot and you are crawling. It is challenging," youth PWD

"People believe that PWDs do not have HIV/AIDS so when you go wanting to know your status, counsellors get shocked on seeing you," youth PWD

There is intimidation and ridiculing of PWDs. The worst part is that you are subjected to too many questions that normal people are not asked. For example, they keep on saying..... You how did you get pregnant? female PWD.

Lack of mobility aides: Most of PWDs who are physically handicapped lack mobility aides and thus cannot move to access health services. "Some PWDs who are physically disabled cannot reach facilities because of lack of mobility aides. With this current problem of HIV, they cannot know their status," KI.

Lack of user-friendly health services: Information from FGDs and KIs, revealed that some disabled have a challenge in utilising some health services because of being not user friendly. Some of these services included inaccessible buildings, lack of disability friendly technologies, for example, raised toilets and beds,

poor hygiene and generic nature of IEC methods which largely benefit only those who can either see or read. "In hospital, there are few wheel chairs causing most PWDs with physical disabilities craw in dirty places including toilets, lining to get treatment," KI."

Stigma and discrimination: Stigma and discrimination was an attitudinal problem of health workers because of limited knowledge of rights of PWDs thereby contributing to low self esteem and a feeling of rejection among PWDs.

"There was a day I was in hospital and a pregnant physically disabled woman was brought to the ward. The nurse blamed her. ""You are disabled, why do you get involved in sex? Child bearing is not for you,"" She went ahead to humiliate her with many insulting words. She was not even aided to climb a hospital bed," male youth PWD.

We are always treated last because PWDs are usually slow and yet health workers have many people to attend to, so they accuse us of wasting their time," female PWD.

3.10 Inclusiveness of PWDs in the Current HIV/AIDS Response

This section discusses the extent to which PWDs HIV/AIDS concerns are mainstreamed in the national HIV/AIDS policies, national strategic framework and district plans. It also examines the extent to which PWDs participate in planning and implementation of HIV/AIDS initiatives.

3.10.1 National Policies and Strategic Framework

The Government of Uganda has put in place a national HIV/AIDS policy, National Strategic Framework and M&E framework that give guidance to stakeholders (government, NGOs and communities) in the delivery of HIV/AIDS programmes. The National HIV/AIDS policy recognises PWDs among the special interest groups.

The National HIV/AIDS Strategic Framework (NSF), which is an evolution from the National HIV/AIDS Policy, sets priorities for all stakeholders involved in HIV/AIDS response. It identifies three broad goals of reduction of HIV prevalence by 25%, mitigation of effects on HIV/AIDS and strengthening the national capacity to coordinate and manage the multi-sectoral response to the epidemic. The NSF in realising its goals identifies special categories namely youth, orphans, vulnerable children and IDPs. PWDs are conspicuously missing in these special interest groups. Omission of disability in defining special categories limits opportunities for development of national activities that target their uniqueness in respect to HIV/AIDS. Consequently, the National Monitoring and Evaluation Framework, developed purposely to measure and evaluate progress and provide information for decision making has no indicators on this and HIV/AIDS. However, a review of progress of the NSF in 2004 acknowledged this omission and recognises PWDs among emerging concerns that need to be captured in the NSF. This was confirmed in an interview with the national level officials that the previous HIV policies were not tailored to disability. This was attributed to lack of information about HIV and disability and the assumption that the lead agencies like NUDIPU and Ministry of Gender, Labour and Social Development (MoGLSD) would take care of these needs and would advance them for inclusion in the policy. "The policies were designed to offer HIV/AIDS services to every one irrespective of whether they are disabled or not."

The MoGLSD has a Department of Disability and Elderly whose role is to empower persons with disability, the elderly and the non-literate with skills and knowledge to enable them participate in the economic growth and development process.

This Department has a number of programmes focusing on empowerment of PWDs namely the Institutional Rehabilitation Programme where PWDs are trained on life skills and Functional Adult Literacy programme (FAL) which focuses on enhancing the literacy, numeracy and acquisition of functional skills relevant to life in a community. In delivering these services, the Department works through local governments and partner NGOs. In these programmes, HIV/AIDS issues are integrated in service delivery as a matter of policy. However, a review of one of the key document, FAL Curriculum developed with the support of Uganda AIDS Commission (UAC) did not demonstrate how HIV/AIDS and Disability issues should be addressed. For example, topics therein do not explicitly address disability and elderly yet disability poses unique challenges in HIV/AIDS service delivery.

3.10.2 District level

Under the Uganda HIV/AIDS response, all districts have HIV/AIDS Focal Point persons supervised by the Chief Administrative Officer whose role is to provide a forum through which multi-sectoral HIV/AIDS responses are coordinated. All the districts visited had established relatively well defined HIV/AIDS programmes that addressed prevention, care and impact mitigation. Networks and collaboration mechanisms for realising wider coverage and optimising resource use were also in place. There was also an effort in targeting all members of the community with well-identified special interest groups. Some of these interest groups were youth, traders, drivers, police, prisons, boda bodas, commercial sex workers and fishing communities. However, like at the national level, PWDs were missing in these special interest groups. This gap was particularly evident in all government health programmes and most NGOs. Consequently, there is likelihood that HIV/AIDS related concerns among PWDS will remain not well addressed. "Our programmes have been general but we plan to remodel them to address specific concerns of PWDs, KI. "We have been having a problem of focusing on PWDs. It is a big challenge. Interest groups are very many and we lost focus," KI.

In Masaka, partnerships were reported to be strong under the Uganda HIV/AIDS Control Project where HIV/AIDS activities were implemented under the Community HIV/AIDS initiative (CHAI) groups. Some of the community groups were formed by PWDS while others were chaired by PWDs, for example, in Bukulula under the CHAI. However, these groups were reportedly ineffective due to lack of funding. In 2002-2003, the Community Development Department in Masaka carried out few sensitisation activities on HIV/AIDS for PWDs.

Other than government supported programmes, there were also a few NGOs that specifically targeted PWDs with HIV/AIDS programmes. In Gulu, Mild May had a programme targeting pregnant mothers with counselling while AVIS targeted information giving to the deaf. In Masaka, USDC have a programme for children with disabilities.

3.10.3 Planning and implementation of SRH/HIV/AIDS Programmes

In all LGs, the planning process as advocated for by the government requires wider participation of the population and has mechanisms for participatory prioritisation of development needs into strategic or rolling plans. This planning mechanism is strengthened by the provision in the LG Act 1997 that establishes

LG Planning Units at parish, sub-county and districts levels with a representation of PWDS in each of them. Under this planning requirement, it is assumed that the PWDs/HIV/AIDS concerns would be identified, prioritised and mainstreamed into sector plans. This however, was not the case in all the districts visited as there was virtually no evidence of participation of PWDs in planning process and district HIV/AIDS strategic plans and programmes that were availed to team were silent on HIV/AIDS and PWDs.

In Masaka and Gulu, non inclusion of PWDs SRH/ HIV/AIDS concerns was attributed lack of capacity by the sub county to identify, prioritise and effecting a plan for these needs. As a result, PWD HIV/AIDS concerns are not mainstreamed in the district LG workplans. There have been initiatives by LG to involve a wide spectrum of NGOs is developing HIV/AIDS strategic plan. One of the key actors was USDC.

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CHAPTER FOUR: CONCLUSION AND RECOMMENDATIONS

From this study, it can be concluded that the SRH/HIV/AIDS response in the country has yielded high awareness levels in the population including PWDs. The government of Uganda has put in place comprehensive policy measures, implementation and monitoring arrangements to facilitate effective SRH/HIV/AIDS response in the country with active participation of all stakeholders. This has entailed promotion of IEC on SRH/HIV/AIDS, condom use and accessibility, expansion of VCT services among others.

However, PWDs were omitted in the NSF categorisation of special interest groups, thereby creating a gap in terms of development of specific activities and indicators targeting PWDs and HIV/AIDS. Consequently, there was a trickle down effect where at district and lower LG levels, PWDs were not identified as special interest groups in development of HIV/AIDS programmes. The generic nature of SRH/HIV/AIDS service delivery does not address the unique concerns of PWDs. The most affected were the deaf, some physically impaired, mentally impaired and the blind.

Recommendations

National and district levels

It is important that PWDs are explicitly recognised as a special interest group in the NSF. This will provide a basis for programmatic inclusions of disability specific concerns in HIV/AIDS response. This should apply to the districts as well. To guide this process, NUDIPU should document some of the unique challenges PWDs face and compromise access and utilisation of SRH/HIV/AIDS services. This should be used as an advocacy tool for inclusion of PWDs in national programmes. In light of this, an official at the national level had this to say, *"Disabled persons should be proactive so as to influence policy. They should select advocates to front their needs. They should not expect anybody to identify their needs."*

MoGLSD mandated to formulate and review relevant guidelines, programmes and policies for the well being disability and elderly persons should establish a clear functional relationship with NUDIPU for purposes of strengthening the SRH/HIV/AIDS activities. For example, participation of NUDIPU in the review of the FAL Curriculum would have contributed in highlighting disability specific issues on SRH/HIV/AIDS.

Service delivery

- Health workers and administrators should be targeted with sensitisation workshops on SRH rights of PWDs and training in basic communication skills. This should help in addressing stereotypes, marginalization and negative attitudes that were reported to be common in health units and were contributory barriers for low utilization of SRH/HIV/AIDS services by PWDs.
- The service delivery systems should be improved to take care of disability specific needs. Where lining in a Health Unit is required to access a health worker, PWDs should be given special consideration.
- There is need to improve coordination between PWD Unions at districts and lower levels on one hand and government and other service providers in planning and mainstreaming PWD concerns in development

activities/intervention and in areas where specialised skills are needed like communication. This would also help in scaling up the visibility of these Unions among SRH/HIV/AIDS providers and improve their role in advocacy for PWDs. Government in particular MoH runs many SRH/HIV/AIDS programmes under safe motherhood, child survival, management of STIs/AIDS that are well spread in the communities and only need to specifically mainstream disability issues in them. The MoGLSD through the Department of Disability and the Elderly too has programmes specifically aimed at empowering these categories. SRH/HIV/AIDS activities would benefit from these existing programmes and structures if only they can be mainstreamed.

- Improve access to information on SRH/HIV/AIDS through targeting PWDs in general but also specific disabilities. This should include support to service providers in developing disability sensitive communication materials and translating the existing ones to cater for the blind. This information should be brailed and proof read before they are published. It should also target building the capacity of LGs and LCs at the grassroots in promoting PWD rights and mainstreaming PWD specific concerns into the local SRH/HIV/AIDS programmes.
- NUDIPU should spearhead remodelling sessions in the target districts involving all SRH/HIV/AIDS service providers.
- Support PWD Unions in promoting peer support approaches on HIV/AIDS prevention/control. These groups should as much as possible be integrated with other groups to avoid stigmatization but also encourage sharing of experiences and challenges.
- PWD user-friendly structures especially for people with physical disability should be encouraged at all SRH/HIV/AIDS service centres. This may involve increasing the number of wheel chairs for internal movements, beds that are adjustable and putting in place special/separate toilets for PWDs among other things.

Sensitisation of PWDs

- Special programmes need to be developed for sensitizing PWDs on HIV/AIDS emphasising ABC as the survey revealed that PWDs equally engage in risky sexual behaviour and yet receive minimal attention in the current sensitisation programmes.
- Area specific models for realising access to condoms should be worked out with the active involvement of the target population, as the household survey revealed the common method of having them in shops or health units was not enough to their guarantee access by PWDs.
- SRH/HIV/AIDS services such as PNC, FP and condom use as conventional approaches have not realised high levels of usage of these services.
- Family planning should focus more on encouraging usage of the methods. In the rural areas, the use of community-based distributors could be considered, as is the case on malaria programmes.

HIV testing and counselling

- Design strategies to include PWDs in the ongoing HIV/AIDS testing and counselling servies.

Monitoring and evaluation

- Districts Unions should be supported to develop comprehensive monitoring systems with clear indicators on HIV/AIDS and disability. This information will be useful in tracking progress and informing policy.