

THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF PUBLIC HEALTH

**SITUATIONAL ANALYSIS OF COMMUNICATION OF HIV
AND AIDS INFORMATION TO PERSONS WITH VISUAL
IMPAIRMENT: A CASE OF KANG'ONGA PRODUCTION
CENTRE IN NDOLA, ZAMBIA**

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ABSTRACT

Background

Despite and increase in health promotion and Education programmes on HIV and AIDS, there is still lack of information on HIV and AIDS and communication for persons with visual impairment. The underlying factors that create information communication gaps have not been explored in detail in Zambia. It is therefore important, that this study on communication of HIV and AIDS information to persons with visual impairment at Kang'onga Production Centre in Ndola district is explored.

Methods

A qualitative case study design was used to help in understanding perspectives of people involved. The study was conducted in the rural area of Ndola at Kang'onga Production Centre for the disabled. Sample size of the study comprised two focus group discussions, one for males and the other one for females, in order to allow full participation. Each focus discussion group comprised twelve participants. The study also included eight in-depth interviews with persons with visual impairments and five key informants. Participants included men and women with visual impairment who were sampled using maximum variation. Data was collected using In-depth interviews and focus group discussions by the use of semi-structured interview guides were used for the purpose of collecting data from different kinds of informants who were sampled using expert sampling. Data was analysed thematically after coding using the NVIVO 8 software. Ethical Clearance was sought from Excellency in Research Ethics and Science (ERES) and with reference number 2014-May-030.

Results

The study found that most visually impaired persons lacked knowledge on the cause, transmission and treatment and had misconceptions on HIV and AIDS. Research also revealed that health promoters and persons working with the visually impaired do not have specific HIV and AIDS information programs for visually impaired in Zambia. Study further revealed that ways such as Media, information education communication (IEC) and Health education were ways through which the visually impaired access HIV and AIDS information though not available to them. Further, many challenges such as discrimination/stigma, employment, funding

and poverty were revealed which the visually impaired face in accessing HIV and AIDS information. Furthermore, research pointed out the need for integration of the visually impaired in HIV and AIDS programs, increasing funding for economic empowerment and having health promotion were means of improving communication on HIV and AIDS information among visually impaired persons.

Conclusion

This study showed that the visually impaired persons in Zambia are not catered for in the dissemination of HIV/AIDS information. Further, available information is not user friendly as it is in unreadable formats increasing the potential for misinformation and limiting access even more. This calls for innovations in HIV information health promotion response to target these groups.

Key words: Situational Analysis, Communication, HIV and AIDS, Information, Visual Impairment

DECLARATION

I, **Grace Nsangwe Chintende** declare that the work presented in this dissertation entitled, **“Situational Analysis of Communication of HIV AND AIDS Information to Persons with Visual Impairment: A Case Study of Kang’onga Production Centre in Ndola District** is to the best of my knowledge and belief my own work and contains no material that has been submitted previously, in whole or in part for the award of any other academic degree to this university or any other. I have however acknowledged all other works.

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DEDICATION

This work is dedicated to my late father Mr M. Chintende, who always inspired me to make a difference in life. May his soul rest in eternal peace.

CERTIFICATE OF APPROVAL

We, the undersigned being examiners of the dissertation entitled, “**Situational Analysis of Communication of HIV and AIDS Information to Persons with Visual Impairment: A case study of Kang’onga Production Centre in Ndola District**”, have ascertained that in every respect the dissertation acceptably fulfils the requirements for the award of the degree of Master of Public Health by the University of Zambia.

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	-	Acquired Immuno-deficiency Syndrome
ARVs	-	Antiretroviral
CATIF	-	Community HIV and AIDS Task Force
CBOs	-	Community-Based Organisations
CSO	-	Central Statistical Office
DATIF	-	District HIV and AIDS Task Force
DPOs	-	Disabled People's Organisation
FBOs	-	Faith-Based Organisations
HIV	-	Human Immuno-deficiency Virus
IEC	-	Information Education Communication
IGA	-	Income Generation Activities
MCDSS	-	Ministry of Community Development and Social Services
NAC	-	National Aids Council
NSP	-	National Security Policy
NGOs	-	Non-Governmental Organisations
PWD	-	Persons with Disabilities
PWVI	-	Person with Visual Impairment
SANAC	-	South African National AIDS Council
UAC	-	Uganda AIDS Commission
UN	-	United Nations

UNAIDS	-	United Nations Programmeme on AIDS
UNICEF	-	United Nations Children’s Fund
VI	-	Visually Impaired
WHO	-	World Health Organisation
WPA	-	World Programmeme of Action
ZAPD	-	Zambia Agency for Persons with Disabilities
ZAFOD	-	Zambian Federation of Disability Organisations
ZNHLCC	-	Zambia National Household and Living Conditions Census

CHAPTER ONE

INTRODUCTION

1.0 Background

Blindness and vision impairment are major public health problems causing a substantial human and economic toll on individuals and society including significant suffering, disability, loss of productivity and diminished quality of life for millions of people. Vision impairment often affects people's ability to drive, read, learn, watch television or simply attend to common household or personal tasks (CDC, 2015). Reduced vision among mature adults has been shown to result in social isolation, increased risk of falling and resultant hip fractures, depression, family stress and ultimately a greater tendency to be disabled or to die prematurely. It has been commonly perceived that persons with sensory, physical, intellectual and developmental disabilities are not at risk of HIV, under the mistaken assumption that they are less likely to be sexually active, use drugs or engage in other risk behaviours (Groce et al., 2012). Moreover, the national HIV strategic plans, HIV-related services and HIV outreach efforts have tended to overlook persons with disabilities. Persons with disabilities are not reached by the general HIV prevention, care, support and treatment campaigns and services (Groce, 2004).

Additionally, because of the many barriers, persons with visual impairment often require an escort (e.g., family member or acquaintance) to access services. They may experience trouble finding one due to the escorts' fear of being associated with HIV and AIDS services or simply the inconvenience of the trip. Use of escorts also means that persons with visual impairment often do not have the basic confidentiality when learning their HIV status (CDC, 2015).

A marked increase in HIV AND AIDS programmes aimed at prevention, access, care and treatment and a combination of inequality, marginalisation, policy gaps and evidenced based data on HIV AND AIDS and disability prompted this study (Groce et al., 2012).

According to Global Health Policy (2014), in 2012 there were 35.3 million people living with HIV up from 29.4 million in 2001. While in the sub-Saharan Africa, the hardest hit region, is home to 71 per cent of the world's total population of people living with HIV,

yet it is only about 12 per cent of the world's total population. The latest Demographic and Health Survey (ZDHS) indicates an estimation of 1,106,400(12.7%) Zambians aged between 15 and 49 years old were living with HIV and AIDS. There were 30,300 AIDS-related deaths in 2013 and more than 630,000 children were considered orphans as a result of one or both of their parents dying from HIV and AIDS (ZDHS, 2013).The gradual development of HIV and AIDS research has been commendable in moving out of its initial conditioning with medical dimensions, with current interest pointing towards disaggregating the epidemic impacts on specific social categories within society. In the context of HIV and AIDS, persons with disability are at risk as any other including commercial sex workers and their clients, injecting drug users, homosexuals, orphans, women and prisoners (Groce, 2004).

According to the World Health Organisation (WHO) 650 million people or 10 per cent of the world's population have a disability. Four out of every five disabled persons live in developing countries (WHO, 2006; Jaggernath, J., (2014).Further, it has been estimated that 4-5 per cent of children who have lost one or both parents due to AIDS also have disability across the globe (Disability and HIV Policy Brief, 2009). In Zambia, about 2 million women and men or 15 per cent of the population have a disability (ILO, 2013). Disability sub-groups are generally identified as the deaf and hard-of-hearing, the blind and visually-impaired, people with physical disabilities and people with intellectual impairments (or "mental health users"), (NAC, 2006). A higher percentage of people with disabilities live in rural areas where access to basic services is limited, (ILO, 2013).Furthermore, an increase in people living with disabilities in many parts of Zambia has been reported (NAC, 2006a). This has been associated with various factors such as the increase in accidents, congenital disorders, diseases and malnutrition.

The global view on statistics indicates that, at present, little is known about HIV and AIDS and disability. Attempts to collect data on the disabled and HIV and AIDS are insufficient. Only a few studies in North America have estimated prevalence of 14 per cent to 15 per cent and no prevalence data exist for any populations from Europe, Asia, Central and South America, the Caribbean or sub-Saharan Africa (Kendi, 2010). Reports showed that, there was no data on the prevalence of HIV infection in any disabled

population in Africa. On the other hand, a growing number of disability advocates worldwide point to significant unreported rates of HIV and AIDS related infection, disease and death (Groce et al., 2012; UNAIDS, 2002; UNICEF, 1999).

Although HIV prevalence studies among persons with disabilities are still few in Africa, a study that was recently conducted in South Africa revealed a HIV prevalence of 12.5 per cent among sexually abused female adolescents with mental disabilities. Again, a 2008 South African national study showed a HIV prevalence of 14.1 per cent among persons with disabilities which is close to the national prevalence of 16.9 per cent among age group 15 to 49 years old. Similarly, among deaf populations in Yaoundé, Cameroon, the HIV prevalence was 4 per cent, which was similar to the prevalence of 4.7 per cent in the city and over a two-year period, 7 per cent HIV prevalence was documented in Kenya. These studies serve as proof that Africans living with disabilities are surely at the risk of HIV infection (Nokuphumla, 2013).

According to Nduta et al. (2009) “globally, programmes and campaigns to create awareness on how to prevent, manage and live positively with HIV and AIDS have rarely been made accessible to visually impaired persons”. A notable example that can be given is on factors influencing communication on HIV and AIDS information and related topics which are not available in Braille or large print, hence, inaccessible to visually impaired people.

It has been also argued that once infected with HIV and AIDS, people with visual impairment are likely to have reduced support due to various factors. These factors include limited access to health care, poor nutrition, social isolation and low levels of income and assets due to various factors influencing communication on HIV and AIDS (Eide & Loeb, 2006).

Despite the increase in Health Promotion and Education programmes on HIV and AIDS, there is still lack of information on HIV and AIDS and communication for persons with visual impairment. The underlying factors that create information and communication gaps have not been explored in detail in Zambia on HIV and AIDS (Nokuphumla, 2013). It was therefore, important that this study on communication of HIV and AIDS

information to persons with visual impairment at Kang'onga Production Centre in Ndola district was explored.

1.2 Statement of the Problem/Rationale

Despite the recognition and a wide spectrum of organisations getting committed to helping the visually impaired persons, challenges continue to encumber efforts to increase the dissemination of health promotion and prevention messages about HIV and AIDS to people living with visual impairment. Research in Zambia is yet to show that men and women with disabilities especially the visually impaired persons do or do not have challenges in accessing HIV and AIDS information (Simwaba, 2008). Recognising that men and women with visual impairment ought to be catered for in health, there are indeed specific ways to reach them. However, to date there is no empirical evidence in Zambia to show the various ways the Ministry of Health or other organisations are using in delivering or packaging information on HIV and AIDS to these men and women (Nokuphumla, 2013). It is hypothesized by some NGOs representing the disabled that the visually impaired have challenges. In the absence of empirical evidence, this hypothesis may not hold. There was an urgent need to establish what the state of affairs was. Given that the risk of HIV and AIDS increases with disability, it was essential that opportunities for enhanced provision of health promotion and prevention messages be fully explored and implemented.

1.3 Aim of the Study

This study was aimed at conducting a situational analysis on Communication of HIV and AIDS Information to Persons with Visual Impairment.

1.4 Research Questions

1. What do persons living with visual impairment know about HIV and AIDS?
2. In what ways is HIV and AIDS information accessed by the visually impaired persons?
3. What challenges do persons with visual impairment have in accessing HIV and AIDS information?

4. How can communication on HIV and AIDS information be promoted among the visually impaired?

1.5 Specific Objective

1. To find out what visually impaired persons know about HIV and AIDS
2. To establish ways in which HIV and AIDS information services is accessed by persons with visual impairment.
3. To explore challenges people with visual impairment encounter in accessing HIV and AIDS information services.
4. To determine how communication on HIV and AIDS information can be promoted among the visually impaired.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This section brings out studies that have been conducted on communication of HIV and AIDS information to persons with visual impairment across the globe, region and within Zambia. From the reviewed literature, it was evident that there was a gap on communication of HIV and AIDS information to persons with visual impairment. Furthermore, participatory research elsewhere has demonstrated positive results that when visually impaired have been involved in solving their own problem, success has been recorded. However, their involvement in solving problems on communication of HIV and AIDS information has been influenced by ways in which information is accessed and challenges the visually impaired persons face. Therefore, this section was guided by the following sub-headings: knowledge about HIV and AIDS, Ways in which the visually impaired access HIV and AIDS information; Challenges people with visual impairment encounter in accessing HIV and AIDS information; and Promotion of communication on HIV and AIDS information among the visually impaired.

2.1 Knowledge about HIV and AIDS

Studies globally have indicated that visually impaired persons lack information on HIV and AIDS-related issues and it is unclear how HIV and AIDS information target blind people in a sub-Saharan setting (Saulo et al., 2012). In line with this, another research conducted in South Africa on Needs, Barriers, and concerns regarding HIV prevention revealed that, HIV prevention programmes have been widely disseminated, but scant attention is given to the needs of people with visual impairments hence there is lack of information among the visually impaired persons (Singh, S., 2015; John Philander and Leslie Swartz, 2006).

In another study it was contended that, visually impaired people are vulnerable to HIV due to various factors such as information which is not provided in accessible formats like Braille or large print while demonstrations are presented visually using pamphlets, posters and other visual-oriented methods to distribute information to the general public.

A lack of such information means that visually impaired people do not receive knowledge of how to prevent themselves from contracting HIV, how to live with it or how to care for others with it (Nduta, 2007).

Furthermore, in another study conducted in Nigeria it was revealed that, there is inadequate documentations on HIV transmission and prevention knowledge for persons with visual impairment as well as risky sexual behaviours among persons with different impairments, with females' inclinding to possessing lower HIV knowledge than males (Aderemi T.J et al. 2013).

In the same study Aderemi, also documented another comparative study of HIV knowledge and accessibility to HIV information among the blind and sighted adolescents found out there was an association between blindness and low knowledge of HIV transmission, prevention and symptoms. The blind adolescents also reported that they had limited access to HIV information compared to their sighted peers (Chakuchichi et al., 2011).

2.2 Ways in which the Visually Impaired Access HIV and AIDS Information

Research conducted in Malawi on persons with disabilities on ' Effective HIV and AIDS and Reproductive Health Information to People with Disabilities' revealed that, people with visual impairment mostly communicated with others through speech because they were able to talk and hear. The research further demonstrated that radio; television, drama, Braille, large print and electronic media constituted some of the common ways of communicating HIV and AIDS messages to the visually impaired persons (Munthali et al., 2004).

Furthermore, in the same research it was established that, the radio was the most accessed medium of HIV and AIDS information as most of the respondents in the study with visual impairment first heard about HIV and AIDS through the radio and this was followed by health facilities where health workers play any important role in teaching seeking services about HIV and AIDS and friends. The other sources of information included teachers, peer groups, religious leaders and Non-governmental Organisationa

NS Community Based Organisations (NGOs/CBOs), Political leaders, religious church leaders, parents, HIV and AIDS resource centre and HIV and AIDS clubs. However, the study further revealed that, people who were visually impaired never heard about HIV and AIDS through the printed material (Munthali et al., 2004). Despite the radio being the most preferred source of information by the visually impaired, it is yet to be established if persons with visual impairment at Kang'onga blind centre also accessed HIV and AIDS information through the radio.

In another study on 'mitigating the impact of HIV and AIDS for people with disabilities through equitable information dissemination' participants with visual impairment preferred HIV and AIDS information conveyed in Braille alphabet or sound. They preferred radio programmes because these conveyed a complete image as opposed to television whose visual images they could not see (Chakuchichi et al., 2011). Braille accessibility required that one to have the ability to read and write just as it required the sighted on written information. However, the difference between the illiterate sighted and the visually impaired illiterate persons was that the latter able to see pictorial demonstrations and made sense out of the information, communication and education materials. While on the other hand, the visually impaired illiterate person was unable to see pictorial information, communication and education materials. Also, many persons with visual impairment could hardly read and write braille in many rural settings, hence the need to explore if persons with visual impairment at Kang'onga blind centre accessed HIV and AIDS information through Braille.

The other major way that was noted in which the visually impaired persons received information through community activities on HIV and AIDS education. It was established that the presence of HIV and AIDS education activities in the community were vital because these helped in the creation of awareness. They were also important in dispelling some of the misconceptions about HIV and AIDS that exist among people with disabilities. It further revealed that persons with disability were a major reason why visually impaired did not participate in these programmes (Saulo et al., 2012). Owing to this, it was therefore important that research was conducted to ascertain if persons with visual impairments at Kang'onga blind centre did access HIV and AIDS community

education activities. It was also imperative to hear their views about participation in community education activities.

Furthermore, although, information, education and communication (IEC) have been spelt out as the most effective tools in preventing the spread of HIV and AIDS and other STDs, frustrating factors that were not in conformity with IEC strategies such as formats that were readable by the visually impaired persons and therefore making the visually impaired persons more susceptible to the diseases (Kend et al., 2008).

Similar studies on ways of accessing HIV and AIDS information conducted in Kenya, Malawi and Zimbabwe have established that armed with information, the visually impaired persons would be able to access and utilise HIV and AIDS services. Inaccessibility to information, Education and communication (IEC) for the visually impaired persons. However, this meant that they have limited knowledge on how to live positively with HIV and AIDS or how to care for others who were either infected or affected. Traditional methods used to disseminate HIV and AIDS information were not visually impairment-friendly. For instance, the lack of brailled information and/or talking books and large print materials prevented people with visual challenges from accessing HIV and AIDS information. Further, traditional methods which included textbooks in print, diagrams, billboards, video shows, newspapers, magazines and television adverts did not make much sense to the persons with visual impairment (Kend et al., 2008; Chakuchichi et al., 2011 and Munthali et al., 2004).

In the same study it was also noted that, Information, Education and Communication (IEC) interventions used to alert the general public about the risk of HIV and AIDS were based on the assumption that HIV and AIDS knowledge would cause people's sexual behaviour to change from risky sexual behaviour to non-risky behaviour or safer sexual practices. HIV and AIDS education on transmission and preventive measures however did not particularly target the visually impaired (Kendi et al., 2008). Despite information being the most important and powerful human rights weapon, many persons with visual impairment in rural areas have hardly benefitted from Information, Education and Communication (Groce et al., 2012). Therefore, there was need to explore the

accessibility of Information, Education and Communication at Kang'onga Production Centre.

2.3 Challenges People with Visual Impairment Encounter in Accessing HIV and AIDS Information

There are many challenges person with visual impairment face across the globe. These challenges are relative depending on the region and nation. Information on HIV is not always easily accessible, especially in rural communities of Zambia (Simwaba, 2008). This can lead to special challenges for people with visual impairment in accessing HIV and AIDS information who live in rural areas.

Many studies conducted on information accessibility for persons with visual impairments have shown that their inability to access HIV and AIDS information was due to formats in which this information was supplied (Kendi et al., 2008 and Nokuphumla, 2013). The most common medium for providing information about HIV and AIDS in sub-Saharan Africa was through radio campaigns. Radios are more accessible to people living in rural areas and are more affordable than televisions (Groce, 2004; Regis et al., 2010). Unfortunately, many people with visual impairment are unable to afford radios as such radio campaigns on HIV and AIDS information cannot reach them (Groce, 2004; Munthali et al., 2004; Yousafzi and Edwards, 2004; Mulindwa, 2003).

Furthermore, the Federation of the Disabled (ZAFOD) also advanced that most persons living with disability, especially the visually impaired, did not have access to information through the radio, television and newspapers and other literature. This was caused mainly by the discriminatory funding and understaffing for effective HIV and AIDS communication programmes for persons living with visual impairments (Exchange Magazine Disability Issue, 2009 and Bcek-massey, 1999). This kind of discriminatory funding and understaffing reflected the marginalisation of the visually impaired in Zambian society (Rule et al., 2008 and Simwamba, 2008).

Furthermore, another identified challenge was the vicious cycle created by reduced employment opportunities leading to poverty, which increased vulnerability for persons with visual impairment (DFID, 2000). The problem of reduced employment opportunities

could be due to unsuitable workplaces and traditional job roles often assigned to the persons with visual impairment. Places of work are often unnecessarily inaccessible and people with impairments are often paid less than people without impairment in most sub-Saharan African countries which include Zambia. Further, it was advanced that, persons with visual impairment had less access to testing and treatment because transport and medication was unaffordable, clinics were not be not accessible, voluntary counselling and testing were not disability specific or counselling which violated basic requirements of confidentiality (Jill, 2009).

It has been argued that HIV and AIDS-related stigma and discrimination was another major challenge because it affected the individual, the family and the society at large (Yousafzi and Karen, 2004). Discrimination and stigma took many forms and can be defined as rejecting, isolating, blaming and or shaming (Groce et al., 2012). Globally, people living with disabilities in general who became HIV positive could doubly be stigmatised (Sullivan and Knutson, 2000). Double stigmatisation in this respect implied that a person would be discriminated on the account of being both disabled and HIV and AIDS positive. HIV and AIDS communication is affected to persons with visual impairments because stigma and discrimination lead to identity crisis, isolation, loneliness, low self-esteem and lack of interest in containing HIV and AIDS (Valdiserri cited in Onah, 2012).

People with visual impairment suffer from emotional stress such as anxiety and depression. They also suffer from guilt and shame; and are seen as people without a future or hope. They are looked upon with disdain. Stigma can also discourage individuals from knowing their HIV and AIDS status and when positive, complying with treatment for fear of discrimination (Groce, 2005). It can lead to denial, the continued adoption of a lifestyle that put others at risk, continued under-reporting of the epidemic and a resistance to the use of voluntary confidential counselling and testing services (Nwanna, 2005).

Research studies have shown that there is a common misperception that persons with visual impairments are sexually inactive and are unlikely to use drugs or alcohol and therefore, have often been left out of prevention campaigns and the development of

programmes (Action on Disability and Development, 2005). Discrimination and stigma severely limits the ability of persons with visual impairments to obtain effective information about safe sex and HIV prevention and to develop capacities to negotiate for safer sexual behaviours (Action on Disability and Development, 2005). Further studies conducted in Africa on young people with disabilities revealed that people with disabilities are as sexually active as the general population, yet sexuality is still not addressed. For instance, studies in South Africa, Uganda, Senegal and Zimbabwe reported that visually impaired youngsters have many mistaken ideas about HIV and AIDS and sexuality because they have less access to information on HIV and AIDS and sexuality than do their non-handicapped peers (Groce, 2003; IRIN and Plusnews, 2008; Kudzai, 2003).

Research findings from case studies conducted in several countries such as Ethiopia, Kenya, South Africa, Mozambique, Rwanda and Uganda, have shown that many health practitioners lack the necessary skills for adequately responding to the needs of persons with visual impairments (Kendi et al., 2008). This makes the visually impaired to face a multitude of challenges when accessing HIV and AIDS information on prevention and support.

Therefore, there was need for a research to explore the views of the visually impaired persons at Kang'onga blind centre if radio accessibility is a challenge. Also it is imperative to hear the feelings of the visually impaired at Kang'onga blind on the accessibility of clinics, treatment, voluntary counselling and testing and confidentiality in HIV and AIDS counselling. Further, in the study one will also find out the views from the point of view of the visually impaired persons at Kang'onga if stigma and discrimination also prevented people living with HIV from disclosing their HIV and AIDS status, even to family members and sexual partners. Furthermore, there was need for a research that will explore the views of the health providers if they have the skilled labour to handle communication on HIV and AIDS information for persons with visual impairments.

2.4 Promotion of Communication on HIV and AIDS Information among the Visually Impaired

According to Groce, the HIV and AIDS crisis cannot be effectively eradicated without the participation of persons with visual impairment. Groce's assertion was consistent with the findings of the study conducted by Chakuchichi (2011: 22) that persons with visual impairment would like to be involved in deciding the best information dissemination modalities compatible with the nature of their disabilities. For instance the use of Braille alphabet was cited as critical in HIV and AIDS information dissemination for people with visual impairment respectively. Therefore, it is inevitable to find out the views of the visually impaired persons on how they can effectively participate in deciding the best information dissemination modalities compatible with the nature of their disabilities at Kang'onga Production Centre.

It can be argued that negative perceptions and practices in society about persons with visual impairments can be changed if they are accorded equal participation in HIV and AIDS mainstream intervention initiatives through the provision of brailled information and inclusion in community and national workshops. Southern Africa Regional Universities Association (SARUA, 2008), state that through Information, Education, Communication (IEC) strategies, HIV and AIDS awareness of basic facts and intervention information was disseminated to society. According to (SARUA, 2008), IEC strategies could include mass campaigns, messaging, advertising, distribution of brailled pamphlets and other resources such as DVDs and large print literature. Routine information presentations on HIV and AIDS policies, programmes, stigma and discrimination are done. Peer education programmes, which help to mobilise one person at a time or in groups. These strategies were quite ideal for persons with visual impairments and as such, they should be included in all programmes while taking care of their information receptive modalities. Owing to such its necessary to understand the feelings of both the visually impaired persons and the HIV and AIDS information providers how Information, Education, Communication (IEC) strategies can be promoted at Kang'onga blind Centre.

There have been attempts in other areas to ensure the welfare of PWD have information. The following are notable works.

As a response to the increased awareness of linkages between disability and vulnerability to HIV, a number of ground breaking programmeming initiatives have emerged throughout the developing world. This document focuses on programmemes found on the African continent as well as some that have been established across some parts of Asia. Some programmemes have modified existing resources and programmeming for PWDs to address HIV while others have adopted new resources and toolkits to create innovative programmeming (Africa Campaign on Disability and HIV and AIDS, 2007).

In Africa, the official launch of “The Africa Campaign on Disability and HIV and AIDS” in January 2007 was a further step towards the integration of PWDs into the international HIV and AIDS response. A collection of organisations advocating for the rights of PWDs, organisations of people living with HIV and AIDS, non-governmental organisations, AIDS services organisations, researchers, activists and other citizens, the Africa campaign was initiated to fulfil a variety of objectives. Members agreed to address issues of equal access to HIV information and services and to coordinate a response to achieve inclusive national HIV and AIDS policies and programmemes (AIDS map, 2002; Africa Campaign on Disability and HIV and AIDS, 2008).

African Union of the Blind (AFUB Pan-Africa), through funding from the Canadian International Development Agency (CIDA) and the Canadian National Institute for the Blind (CNIB) launched the “HIV and AIDS Awareness and Training project for the blind and partially sighted persons in Africa” in 2005. Seven African countries (Cameroon, Ghana, Kenya, Malawi, Rwanda and Tanzania) were tasked with the following objectives: mainstreaming HIV awareness in their programming; establishing national lobby committees to advocate for greater access to programmes and raise awareness; developing specially formatted training and resource materials; and ensuring the participation of blind or partially sighted women as advocates, educators and beneficiaries. Peer counsellors were trained on various topics related to HIV including transmission methods, counselling and testing, where and how to obtain health services,

life skills, antiretroviral therapy, sexually transmitted infections and home-based care (Banda, 2005; Yousafski and Edwards, 2004).

Norwegian Church Aid (NCA) and National Council of Churches in Kenya (NCCCK) initiated programming to address HIV education for PWDs and prioritised the development of materials and messages in sign language, Braille and audio formats to meet the needs of individuals with disabilities. In the belief that self-sustainability contributed to the decrease of stigma and the ability to protect oneself against sexually-transmitted infections, NCCCK also supported income-generating activities including tailoring, shoe-making, beadwork, art and crafts, carpentry and vegetable and fruit vending by PWDs. Teams involved with community health education from Handicap International (HI) in Morocco, Kenya, Mozambique and Burundi included HIV prevention messages through a variety of means in their programming.

The recent assignment of an HIV and AIDS Medical Advisor to the East Africa Region resulted in the training of numerous health care workers on disability issues. Hearing impairment was in the process of launching a project that will enable access to legal and health services for sexually abused victims with disabilities. The HI programme in Togo will introduce HIV prevention information into pre-existing rehabilitation projects with the ultimate aim of reducing vulnerability and stigma against individuals with disabilities and are HIV positive (Banda, 2005; Yousafski and Edwards, 2004).

Family AIDS Caring Trust (FACT), Harare (Zimbabwe) did wonders in addressing information needs for the blind. FACT, an organisation dedicated to mitigating the impact of HIV in Zimbabwe, began training members with disabilities on the “Stepping Stones” programme, in order to address the ongoing lack of information and communication. “Stepping Stones” is a life skills behaviour change communication training methodology on HIV and AIDS, promoting gender equity, intergenerational respect and solidarity with people who are HIV positive (AIDS map, 2002; Campaign on Disability and HIV and AIDS , 2007).

In Asia, the Ho Chi Minh City Deaf Club, (southern Vietnam) did remarkable work. This project, “STI and HIV Prevention for Deaf and Hearing Impaired Young Persons of

HCM Deaf Club”, focussed on Club members (30 youths and 4 adults), advisors and other allies from orphanages and special schools for deaf children.

Peer education was employed by facilitators to create more self-sufficiency and self-reliance in HIV programming and information dissemination within the deaf community. The goal of the project was to increase the percentage of HCMC Deaf Club youth members who practiced and promoted STI and HIV prevention and consequently improve deaf and hearing-impaired youths’ knowledge on the subject.

In India, Nethrajothi, Chennai (Southern India) has been working on HIV programming for visually impaired people since 1992 and is cited as the earliest known example of disability and HIV and AIDS programming in India. Nethrajothi began by translating HIV prevention information into Braille and working closely with HIV and AIDS organisations. Currently, the organisation conducts awareness programmes in schools for the blind while continuing to maintain peer support programmes. Due to funding issues, Nethrajothi has only been able to work inconsistently and irregularly. The most significant lesson to take from this example is the importance of using a range of techniques (Braille, audio-cassette, talks and presentations, engagement with other sectors, both disability and HIV and AIDS focussed, the use of a peer support system to reach visually impaired people in the community at large) to achieve greater inclusion.

Deaf Way, Delhi (Northern India) and Hyderabad another organisation in southern India, founded in 2002 is renowned for its work. The primary focus of this organisation is to deliver workshops covering all aspects of sexual and reproductive health. Workshops last four days and are conducted in Indian Sign Language (IES). The organisation holds an average of three workshops per year in response to requests from other organisations for PWDs. To date, Deaf Way has conducted fifteen workshops, training and educating 350 deaf people. Facilitators use a fullrange of techniques, including IES, local gestures, captioning, mime, role played etc. As with Nethrajothi, this diversity was shown to promote greater inclusion.

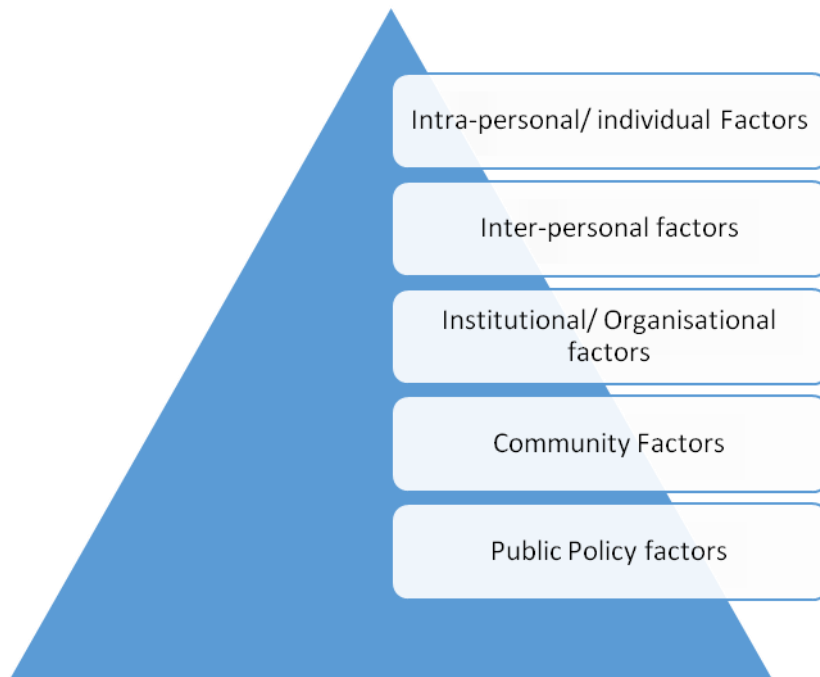
The Mumbai District AIDS Control Society (MDACS) and the Association for Blindness and Low Vision, Mumbai (Western India) has its own share as well. This collaboration

began in January 2005 when the Association approached the MDACS (a state-run organisation) requesting that they translate their HIV information into Braille and large print. These materials were then sent to all schools for the blind and all known organisations for PWDs in the area. This initiative demonstrated both the importance of an effective distribution and dissemination strategy as well as the value of engaging with existing state structures.

2.5 Theoretical Framework

This research employed a qualitative approach guided by the multi-level, interactive approach which is also known as the ecological model. This model allowed the researcher to understand the meaning people attached to what they did and what they say (National Cancer Institute et al., 2012). However, this model includes not only educational activities but also advocacy, organisational change efforts, policy development, economic supports, environmental change, and multi-method programmes. This highlights the importance of approaching public health problems at multiple levels and stressing the interaction and integration of factors within and across levels (National Cancer Institute, 2012). The concept on communication of HIV and AIDS information for the visually impaired persons is anchored on the levels of influence for health-related behaviours and conditions which are intrapersonal or individual factors; interpersonal factors; institutional or organisational factors; community factors; and public policy factors. Therefore, a multi-level, participatory approach was used because it helped the researcher to explore participants' views on how they accessed information, challenges they face and how communication on HIV and AIDS information can be promoted.

Pyramid Showing the Summary of Aspects of the Framework



This framework shows the individual characteristics that influence behaviour such as knowledge, attitudes, beliefs and personality traits; interpersonal processes and primary groups including family, friends and peers that provide social identity, support and role definition; institutional factors such as rules, regulations, policies, and informal structures which may constrain or promote recommended behaviours; community factors such as social networks and norms, or standards which exist as formal or informal among individuals, groups and organisations; and public policies and laws that regulate or support healthy actions and practices for disease prevention, early detection, control and management (National Cancer Institute, 2012).

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This Chapter comprises the research design, study site and population, sampling and sample size, data collection methods, data management and analysis plan; it also includes a section on ethical consideration and limitations of the study.

3.1 Research Design

The study adopted a case study in qualitative methods. A case study was employed so that, the researcher was able to describe accurately as much as possible the phenomenon and remain true to the facts. In this study, the cases of study were persons with visual impairments living at Kang'onga Production Centre. The research approach was helpful in getting a detailed insight of persons with visual impairments on their views through description of variations, explaining relationships and describing individual experiences. Also, this design helped in understanding the perspectives of people involved. A situational analysis was used; this was a new approach to qualitative research. Its key analytical goal is to understand the situation and relation of action and interaction in the phenomenon of interest or the case being studied (Clarke, 2010). In-depth interviews and focus group discussions with the use of semi-structured interview guides was used for the purpose of collecting data from different kinds of informants which is a form of triangulation 'data triangulation' to contrast the data and 'validate' the data if it yields similar findings (Arksey and Knight, 1999; Bloor, 1997; Holloway, 1997).

3.2 Study Site

The study was conducted in Ndola rural at Kang'onga Production Centre for the disabled. The Centre is about 22km away from the central town of Ndola and is in the south-west direction, turning to the right off Kabwe road at Indeni Oil refinery. Kang'onga Production Centre for the disabled is a public employment centre for persons with disabilities, an institution of Zambia Agency for Persons with Disabilities (ZAPD) which is a quansi government organisation. The centre was founded in 1964 as Kang'onga

Resentment Centre for the blind and was later changed to Kang'onga Production Centre for persons with disability. It was at this time that it accommodated other types of disabilities though up to date the visually impaired are still the majority. The centre manufacture brushes, rattan (cane) furniture, rattan baskets and trays. The aim of the centre is to improve the socio-economic status of persons with disabilities of all categories in both sexes by providing to them on-the-job training and employment opportunities. The other aim of the centre is to ensure self sustainability among persons with disabilities through human resource development and training in livelihood skills. It was purposively selected for the study because it has a reproductive population of the visually impaired persons and it is the only production centre for the visually impaired in the country. Besides, the researcher was interested in persons with characteristic of visual impairment.

3.3 Study Participants

Only persons who were above 18 years and comprised the visually impaired residing at the blind Centre, individuals working with persons with visual impairment, health education and promotion staff at the DMO and staff at the National AIDS Council in charge of health information as well as the staff at Zambia Library for persons with visual impairment in charge of information and the manager at Kang'onga Production Centre were eligible to participate in this study. On the other hand, those that did not meet the above criterion were excluded from the study.

3.4 Sampling and Sample Size

There are “no hard and fast rules about numbers, however, qualitative research used experiential cell sample sizes from 1 to 100 with clustering around 30” (Rubinstein, 1994: 80). Others writing on this same area suggest ‘twelve to twenty respondents when looking for disconfirming evidence or trying to achieve maximum variation’ (Baum, 2002: 176). From this presentation, it is evident that there are no closely defined rules for sample size in qualitative research (Baum, 2002; Patton, 2002). Sampling in qualitative research usually relies on small numbers with an aim to study in depth and detail (Miles and Huberman, 1994; Patton 2002). Seeking a richness of data about a particular

phenomenon, the sample is derived purposefully rather than randomly (Reed et al., 1996; Mays and Pope 1995; Ezzy, 2002).

Looking at the sampling units as summarised in the research design below (Table 3.4.1), it was not possible to sample towards saturation for the key informants because expert availability sampling was used. This sampling was used to enlist key informants or individuals working with persons with visual impairment at Zambia Agency for Persons with Disabilities (ZAPD), health education and promotion staff at the DMO and staff at the National AIDS Council in charge of health information, staff at Zambia library for persons with visual impairments and the manager at Kang'onga Production Centre. Expert availability sampling strategy is particularly useful in the context of a situational and policy analysis. This sampling strategy involved identification of who the major stakeholders were and involved in designing, giving, receiving or administering the programme or service and who otherwise would affect it or be affected by it.

The second sampling method used was the maximum variation sampling until optimal theoretical saturation was reached for the visually impaired persons. This type of sampling involved searching for cases or individuals who met a certain criterion and in this case it was those who were visually impaired and stayed at Kang'onga Production Centre. It also involved equal numbers of both men and women representation. To ensure that there were differences in age, gender, marital status and education; groups were represented in four categories. Groups comprised those above 50 years old and below 50 years old to appreciate experience in the study. Therefore, the sample size of the study comprised two focus group discussions. One for males and the other for females each with twelve respondents in order to allow full participation, eight in-depth interviews were included with persons with visual impairments and five key informants.

3.4.1 Summary of Participants, Methods and Analysis

Research Question	Population and sampling	Data Collection method	Analysis of particular data
What do persons living with visual impairment know about HIV and AIDS?	The visually impaired. Sampling was done using maximum variation sampling	Focus group discussions, indepth interviews and Key informant interviews	Thematic analysis
In what ways is HIV and AIDS information accessed by the visually impaired persons?	The visually impaired, Individuals working with persons with visual impairment, Health education and promotion staff at the DMO. Staff at the National AIDS Council in charge of Health Information and staff at Zambia Library for persons with VI. Sampling was done using expert sampling(stakeholder sampling)		
What challenges do persons with visual impairment have in accessing HIV and AIDS information?	The visually impaired, Individuals working with persons with visual impairment,		
How can effective communication on HIV and AIDS information be promoted among the visually impaired?	Individuals working with persons with visual impairment, Health education and promotion staff at the DMO, Staff at the National AIDS Council in charge of Health Information and staff at Zambia Library for persons with VI.		

3.5 Data Collection

Data was collected using Key Informant interviews, in-depth interviews and Focus group discussions. Key informant interviews were conducted with people who know what goes on and who were involved in programming or developing interventions for the visually impaired which included the following in the study: Individuals working with persons with visual impairment at Zambia Agency for Persons with Disabilities (ZAPD); health education and promotion staff at the DMO; staff at the National AIDS Council in charge

of Health Information; staff in charge of information at Zambia library for persons with visual impairment and the manager at Kang'onga Production Centre.

It is evident from the list above that key informants were selected for their specialised knowledge and unique perspectives on the topic at hand.

The purpose of key informant interviews was to collect information from a wide range of people who had firsthand knowledge about the community. These people or experts with their particular knowledge and understanding could provide insight on the nature of problems and give recommendations for solutions.

Key informant interviews were semi-structured, relying on a list of issues discussed based on the research questions as primary themes. The researcher allowed a free flow of ideas and information. She framed questions spontaneously, probed for information and took notes which were elaborated on later.

Key informant interviews were specifically selected in this study because the researcher desired to obtain qualitative descriptive information which was sufficient for decision-making; understanding challenges, behaviour, and perspectives of respondents and how they can provide the how and why of what happens.

3.5.1 In-Depth Interviews

Eight in-depth interviews (IDIs) with the visually impaired persons were conducted under four characteristics of gender, marital status, education and age. These characteristics were used in order to give an in-depth understanding if they had any effects on communication of HIV and AIDS information on the visually impaired as well as helping in triangulation of data. An interview schedule was prepared and used during the interviews. The interviews were conducted at a place that was conducive to the respondent. A digital recorder was used to record the interview with permission from the participants. Furthermore, observations and note-taking were made during the interviews and throughout the period of data collection.

3.5.2 Focus group Discussions FGDs)

A maximum of two focus group discussions for persons with visual impairments were held. One was with women and the other with men. Each focus group discussion had twelve participants and was conducted by two facilitators. One facilitating and the other taking down notes and recording. This was audio recorded. Two audio recorders were used at each focus group discussion to provide backup recordings. The facilitator ensured smooth flow of the discussion and coverage of the topic. Key informant interviews were conducted by the researcher.

Focus Group Discussion Procedure

Before starting the focus group discussion, the facilitators got background information about the participants such as age, marital status and number of years they had lived at the Centre and other relevant information. Upon establishing the bio data in the following steps: brief introductions there after the purpose of the discussion was stated; participants introduced themselves and giving their brief backgrounds; the discussion was structured around key objectives using the probing questions prepared in advance; during the discussion all participants were given equal opportunity to give their views; a trained rapporteur took notes in the discussion and non-verbal expressions of participants. A digit recorder was used as an additional tool; various facilitating tactics were used to ensure full participation which included stimulation of participants to freely talk to each other and not necessarily to the moderator. Shy participants were encouraged to contribute by frequently engaging them into the discussion; use of in-depth probing without pre-empting the participants; close attention was paid to what was being discussed and encouraged other participants to give their views; and dominant participants were controlled through verbal and non-verbal cues like calling for other participants to say something, taking advantage of a pause to suggest that the subject were discussed in a different session. Prior to the discussion day, logistics such as, invitation of participants was done two to one

week in advance with reminders sent two days before the actual day through the letters and caretaker.

3.6 Data Processing and Analysis

Qualitative data which was derived from FGDs, in-depth interviews and key informants was analysed through the content analysis which considered word count or the number of times a concept occurred in the narrative. Responses from the audio tape recorder were also transcribed and analysed using content analysis (Ryan and Bernard, 2000). Emerging major themes from the study were identified and all units of data on particular issues were coded thematically (identify common themes, use CUT and PASTE themes together). The qualitative data analysis software programme NVIVO 8 software was used to facilitate coding and retrieve text.

Data processing and organisation was done immediately after each interview. This was to ensure that the interviews, notes and participants were properly labeled for easy management. Also audio files were marked with codes together with all notes made during the interviews. Names were not included to avoid linking them to any respondent. A verbatim transcription was done on the collected data. Interviews done in local languages were translated into the English language. Then the researcher read through the transcribed scripts several times to gain an understanding of the collected data. In the next stage, the researcher identified the thematic framework through initial coding of the collected data. This was done using NVIVO 8 software to code and the Table below shows the listed of all identified codes which participants brought out. Finally, in the mapping and interpretation stage, patterns, associations, concepts and explanations were searched in the data.

Table 3.6.1 below shows the sub-themes, categories and themes that were used in the generation of analysis of the collected data.

3.6.1 Selected Sub-themes, Categories and Themes

Sub-themes	Categories	Themes
Misperception of cause	Cause	Knowledge on HIV and AIDS
Unprotected sexual intercourse, sharp instruments, use of traditional herbs	Transmission	
Protected sex through the correct use of condoms, abstinence, being faithful to your partner.	Prevention	
Radio, television, Public announcement systems, drama,	Media	Ways through which the VI access information
Charts, braille books, HIV and AIDS Education, Pamphlets	IEC materials	
Peer education	Health education	
Health centres visits, specialised staff, disability specific, Community home based care and Anti-natal.		
Workshops, Counselling, health education.		
Asexual claims by the sighted, difficult people to teach		
Double discrimination, cultural barrier and acceptance	Discrimination/Stigma	Challenges the VI face in accessing HIV and AIDS information
Illiteracy among the VI, Lack of IEC's materials, No Programmes specifically for VI.	Education	
No Access to radio, easily taken advantage, distance		
Structures do not integrate the VI, Challenge in isolating and Mobilising special groups, Not accommodated in decision making,	Poverty Integration	
Few VI in employment	Employment	
Poor funding, discriminatory funding, low staffing		
	Funding	

Government to stop neglecting persons with VI, to be involved in planning,	Integrate	Promotion of communication of HIV and AIDS information for persons with VI
equal participation in HIV and AIDS mainstream interventions		
Representation of the VI in all structures		
government to Increase funding and source solar radios, initiate economic empowerment programmes,	Funding	
Increase awareness, train health professions on the needs of the VI.	health promotion	
Translation of HIV and AIDS information in readable and local languages, audio recordings ,		
entertainment for the VI collaboration between line ministries and other agencies		

3.7 Results Dissemination Plan

Results from the study were shared through presentations at graduate forum, department of Public Health, Kang’onga Production Centre, and Ndola district health office, Ministry of Community Development, Mother and Child and also the report will be published.

3.8 Ethical Considerations

Researching among the visually impaired brings about a variety of ethical, moral, legal, professional, and even personal issues which emerge within the context of working with HIV and AIDS and disability (Lynda, 1999). Many ethical issues are complex and challenging. Some of the ethical dilemmas could arise when establishing a positive and productive environment for all participants, strategies, activities and technologies used for promoting participant’s ability to use their vision effectively in functional contexts (AEPA, 2005). Other dilemmas could emerge when developing a conceptual understanding required for meaningful communication and observation to non-verbal skill such as facial expression and body language. Also when determining boundaries in HIV and disability work when the participant is isolated, experiencing discrimination or

confronting disability (ibid). Hence, forth a clearance was sort from Excellency in Research Ethics and Science (ERES). Written Permission was requested from relevant authorities atKang’onga Production Centre in Ndola where the study was conducted to be given a go ahead. The study was cleared by ERES CONVERGE and the reference number is 2014-May-030.

Informed Consent

Furthermore, participates were issued with both oral and written consent in Braille or large print in order to allow them exercise their autonomy to freely consent to participate in the study or not. The respondents were availed with information explaining the purpose, nature, benefits and risks and how the information was utilised while assuring them that the information was to be held in confidence. The signing of consent forms was done after all questions and possible doubts from participants were cleared. Only those that agreed to participate in the study signed the forms but even after signing, they were free to leave the study at any time if they so wished without any consequences. Those that could not emboss endorsed the consent form using their right thumb prints in the presence of a witness.

Confidentiality

Participants were assured of anonymity since their names were not to be written on the FGD interview guide and key informants were interviewed individually and privately in their homes and offices. Permission to use the tape recorder was sought from the respondent and assurance on issues of confidentiality was given and that no harm would come to them. The information collected was to be stored safely and disposed of immediately after saving its purpose. Only serial numbers appeared on the interview guides and all data was confidential. No other person apart from the research team was allowed to have access to the research data that collected. Participants were assured that the data collected was to used only for academic purposes as well as to provide information for the improvement of HIV and AIDS communication.

Risks and Benefits

Benefits were incurred though these could not be attained immediately because data collected would help to inform policy makers and to better their accessibility to information on HIV and AIDS. Participants were assured that no physical harm was anticipated in the study. The psychological issues arising during data collection were taken care because the researcher is a qualified counselor.

CHAPTER FOUR

FINDINGS OF THE STUDY

4.0 Introduction

The findings of this study are structured under the themes derived from the research questions. The four research themes are as follows: Knowledge on HIV and AIDS, Ways in which visually impaired persons access HIV and AIDS information, Challenges visually impaired persons face in accessing information on HIV and AIDS and Promotion of HIV and AIDS information among the visually impaired persons.

4.1 Socio-demographic Characteristics

Thirty seven (37) participants that took part in the study were aged between 18 and 60 years old out of which thirty two (32) were persons with visual impairment and the remaining five (5) were key informants working with the visually (ZAPD) impaired and health promoters. The majority of them were aged between 30 and 42 years old.

4.1.1 Attributes of Persons with Visual Impairments

In this study, the visually impaired participants had varying attributes among them. The attributes were grouped in categories of age (young and old), being an indigenous (living at the Kang'onga Production Centre) education (ability to read braille and not able to read). The other attribute was gender because both sexes (males and females) were included the other attribute was marital status for both married and single.

4.2 Knowledge on HIV and AIDS

Participants were asked to explain what they knew about HIV and AIDS. Their responses revealed that there was a variation among them regarding knowledge. Some were aware while others had limited awareness in the following critical domains in the subject such as cause, transmission, prevention and some had misconceptions. On the other hand, the respondents showed having some knowledge on treatment. Below are results of what the visually impaired persons know about HIV and AIDS and their experiences were sub-themalised under the critical domains.

Perceived Causes and Transmission of HIV and AIDS

The findings on the perceived cause of HIV and AIDS included some perceptions that, HIV and AIDS come from urine, wounds, coughing, diarrhea, tuberculosis and from the laboratory to kill the black race. This was testified by Participant: BM, 32 FGD for men: “*HIV and AIDS was made in the laboratory to kill black race*”.

Further, despite other participants’ revelation of the mode of transmission of HIV and AIDS, in the research some participants in the interviews attested that HIV and AIDS came through some diseases such as coughing and fever as can be seen below:

HIV and AIDS comes through coughing, fever, when one has these symptoms can see the doctors because HIV and AIDS come through this (IDI-UNEDU-55).

In terms of their knowledge on the transmission of HIV, most participants who participated mentioned that one can get infected through sexual intercourse. Some participants also stressed that, HIV transmission occurred when one engaged in unprotected sexual intercourse.

HIV and AIDS come through having unprotected sexual intercourse with a person who is positive and using razor blades (IDI-EDUC-41).

Information from in-depth interviews also revealed other ways perceived by the visually impaired persons on how HIV was transmitted such as use of razor blades, during child deliveries and injections. Some participants also indicated that women used traditional medicines to make their virgins dry in order to increase sexual pleasure for the man. This caused bruises during sexual encounter and friction leading to HIV transmission.

Even through injections that we get from the hospitals if they inject one who is HIV positive. Nurses when they are delivering during labour if treatment is not favourable that person assisting if he or she has no gloves for protection can be infected (Participant M aged 40).

If someone is not following instructions we are given when having sex such as the use of condom and women not to be

using herbs for dry sex. Because dry sex make people to have bruises during sex (IDI- married aged 40).

Treatment and Prevention

Relating to treatment and prevention, participants reported that there was no cure for HIV and AIDS but rather medicines to prolong life were available. Here is how one participant put it.

We know that when you are found HIV positive, you can be given medicines to prolong your life (Participant: GM, Male, aged 32)

... I was told, you cannot be healed, you can just be helped how to live long with the disease (Participant: AT, aged 28).

In terms of prevention, most participants indicated that one would also know that there was no cure for HIV and AIDS and as such they mentioned that one would prevent HIV and AIDS by being faithful to their partners, using of condoms, abstinence and not sharing blades. However, among some female participants in the in-depth interviews they argued that, they would not trust a condom because they were unable to see if it was being used correctly or if a partner had put a hole into it.

Using and trusting a condom is a challenge because one cannot know if your partner is using it correctly or has ripped it and besides we hear that a condom is not safe (IDI-FEM-39).

However, some male participants argued that, even if they were visually impaired they were able to use a condom correctly because they were also human beings as testified below:

Even if we cannot see, we also know how to use the condom correctly just like those who can see (IDI-SINGLE-40).

Overall, the visually impaired persons showed a variation on HIV and AIDS knowledge as participants had different responses on its cause, transmission, treatment and prevention.

4.3 Ways in which Visually Impaired Persons Access HIV and AIDS Information

The participants indicated a number of ways through which persons with visual impairments became aware of HIV and AIDS. These included media, information, education, communication materials (IECs) and health education.

Media

Information from both the in-depth interviews and focus group discussions indicated that most participants had common ways through which they accessed information on HIV and AIDS. These included listening to the radio, television, public announcement systems and drama (sketches).

Television and radio were among the common and most preferred modes of information through which persons with visual impairments accessed HIV and AIDS information.

We gain HIV and AIDS information by listening from those who teach about HIV and AIDS and Listening to the radio and television because they also teach about HIV and AIDS (IDI-AGE F-32).

In an interview with one of the key informants, it was also observed that, local radio stations and television (Muvi T.V.) are ways that health promoters use to reach out on HIV and AIDS information. However, these local television and radio programmes talk about different health issues and that health promoters have no say over programming.

Sometimes we have opportunities like with local radio stations around that feature and talk about different health issues. Actually, it is on Muvi TV where we usually feature and it is according to their schedule it is not a schedule coming from us. In short, we have no control over that schedule it is them who find the time, health education can be broadcasted (Key Informant from DMO).

Drama as an expressive art is another key way people send information. This mode is also being used to communicate information on HIV and AIDS to the visually impaired persons. Drama was cited by most participants in interviews and focused discussion as another preferred way of accessing information on HIV and AIDS. One participant from the female focus group aged 42 years old argued that, “*even through sketches that teach on how one can take ARVs and how HIV and AIDS is transmitted from one person to the other would be used to access HIV and AIDS information*”.

Further, some key informants in health promotion interviewed revealed that when mobilising people for HIV and AIDS programme they use the Public Address system (PA).

Currently we are having the PA system (Public Address), were you use big speakers and then you go round to give announcements on health to the public (Key Informant from DMO).

Information, Education and Communication (IEC) Materials

The other ways the visually impaired receive information noted from the responses especially from those able to read the braille were through books transcribed into braille. However, the participants noted that braille can hardly be accessed. The following quote illustrates the importance of braille:

Through health education on HIV and AIDS, braille books though not available (IDI-MALE-55).

... the best way to educate us on HIV and AIDS information is through books in braille (IDI-FEM-37).

During the in-depth interviews it was also observed that most of the visually impaired that were unable to read the braille had other views on how they access information on HIV and AIDS. A female participant narrated that they heard about HIV and AIDS from their children. This is attested to by the quotation below:

There were musicians who came to play music in our community at a local drinking place and when they left, they left behind a sign post on the door with the message reading, "we have left HIV and AIDS behind" I heard about this from my son who was able to read. So I heard from my son about HIV and AIDS for the first time (IDI-FEM-55).

Pamphlets are sources of written information for persons with visual impairment and in this study it was advanced by visually impaired as one of the ways HIV and AIDS information is accessed.

Even through books, we have pamphlets and braille which talk about HIV and AIDS (Participant from Male Focus Group Discussion aged 44).

It was also learnt from key informants or health promoters that charts were among the ways information is given to persons with visual impairments though not specifically designed for them. These charts have HIV and AIDS messages and other health concerns which can be of help to both the sighted and the visually impaired.

We have the charts on key different messages that we need to communicate but the health education we are giving is the same whether you are visually impaired persons or you are able person (Key Informant from DMO).

Health Education

Most participants revealed that one of the major ways they access HIV and AIDS information was through health education. The common ways cited by the visually impaired persons through whom they receive information under health education was through visiting health centres, trainings, peer education, workshops; community home based care and counselling.

Health Centres

However, it was also observed that the visually impaired persons don't usually visit health centres specifically for HIV and AIDS but for other health ailments. It is at such visits that sometimes they coincidentally access HIV and AIDS information. This is one of the statements which attested to that:

By listening to those who teach about HIV and AIDS, Listening to the radio and television because they also teach about HIV and AIDS and Visiting clinics and hospitals, because each time we go there they sometimes teach us on HIV and AIDS. I also escorted my friend to a clinic and was taught about HIV and AIDS (IDI-AGE F-23).

Even at the hospital they teach on HIV and AIDS (Male Participant aged 31 in the Focus Group Discussion).

Peer Education

Findings from the study also suggested that health education should also be given to the persons with visual impairments through peer teachings and trainings. They advanced that through different discussions HIV and AIDS and other health concerns were also covered.

We learn through education and from the sighted they tell us (Female Participant aged 39 in the Focus Group Discussion).

Besides we also learn from friends who are knowledge able about HIV and AIDS (Male Pparticipant aged 36 in the Focus Group Discussion).

Workshops

The other way female participants accessed HIV and AIDS information was through workshops, counselling and antenatal visits. Participants argued that it was during such programmes that they received HIV and AIDS information and shared information with each another. However, despite these methods being used, the visually impaired persons mentioned that they were rarely

invited to attend these programmes. Hence most participants argued that the best way of communicating HIV and AIDS information to the visually impaired persons was through one-on-one teaching and demonstrations. below are two sentiments that reflect this argument:

Through workshops and antenatal they hear about HIV and AIDS and counselling from the clinic, though not specifically but the general one (Female Participant aged 42 from Focus Group Discussion).

Sometimes we are invited for workshops on HIV and AIDS but the best way of teaching us about HIV and AIDS is through one on one because you can ask questions were you do not understand unlike the radio were you cannot ask a question. The other way is through community home-based care though we are not given any role to perform as a caregiver. The other way, I strongly feel is the best is through demonstration from experienced persons because we are visually impaired (IDI-single-40).

Community Home-based care

The sentiments on one-to-one teachings, community home based care and through demonstrations as the best methods of accessing information by the visually impaired persons were echoed by other participants and key informants. Below are some quotations:

In communities there is what they call home based cares, care counsellors all these are within the communities they are also a way we can access information on HIV and AIDS that's why they are there they go round the communities teaching on HIV and AIDS (Participants from Female Focus Group Discussion aged 40).

To date we usually have community meetings were we meet with our people in various centres (Key Informants from ZAPD).

The best way to reach out to them is through one to one because they will be able to ask questions (IDI-MANAGER).

Therefore, participants in the study indicated a number of ways through which persons with visual impairments received HIV and AIDS information. They revealed such ways as the media, information, education, communication materials (IEC) and health education.

4.3.1 Challenges Faced by the Visually Impaired Persons in Accessing HIV and AIDS Information

When asked on the challenges that persons with visual impairments faced in accessing HIV and AIDS information, participants highlighted a number of challenges which included discrimination or stigma, education, poverty, integration, employment and funding.

Discrimination or Stigma

Discrimination and stigma seemed to be a big challenge among the visually impaired persons. Discrimination and stigma was at personal (micro), interpersonal, community (meso) and public policy level (macro). Some of the participants felt discriminated because information on HIV and AIDS rarely reached them and as such the visually impaired persons assumed that they were considered less compared to their sighted counterparts. While on the other hand, others assumed that people thought of the visually impaired did not fall sick hence the little consideration in information dissemination. One of the participants in the in-depth interview advanced that double discrimination was also a challenge as those who were found HIV and AIDS positive were neglected by even their own families. These challenges were attested in the statements below:

Most people involved in disseminating HIV and AIDS information did not come to us regularly on HIV and AIDS; they don't come to us mostly because they think us we don't get sick. They should know that we also get sick. They consider us less when giving us information. If we can see the people we can learn from them (IDI Man 52 years).

When I was found to be HIV positive, my sighted husband left me and my family chased me from home and I went to stay with friends. They told me am going to die and that they did not have money to buy a coffin (IDI-YOUNG female living with HIV and AIDS-23).

Education

The level of education was identified to have a bearing effect on HIV and AIDS information dissemination to persons with visual impairments. For example, in this study most of the persons with visual impairments were unable to read and write braille. The participants reported that most HIV and AIDS programmes were done in English which they did not understand. According to the visually impaired persons interviewed, they argued that, they were not cared for because much of the concentration and care was on the people with sight. The study revealed that they had challenges with the escorts (people to take them from one place to the other), hence they found it difficult to visit health centres. Even when they managed to visit clinics, they remained unattended for too long a time. One participant stated that:

Most HIV and AIDS programmes were in English but most of us do not know English and we are not cared for because we are visually impaired. They concentrate on those that can see while we are not frequently given a chance to visit clinics, because people who take us at times refused to do so. Also at clinics they also discriminated against us, you can remain at the clinics unattended for a long time since we cannot see (IDI-OLD-52).

This study also found out that, the visually impaired persons had no HIV and AIDS designed specific programmes to meet their communication needs. The Key Informants working with persons with visual impairment confirmed through the interviews that they did not have programmes tailored to meet the diverse needs for the visually impaired persons. Some of the Key Informants had this to say:

We have not designed something specifically for the visually impaired persons (Key Informant from DMO).

Yes information is not prepared specifically for the visually impaired persons and we do not have much braille information (Key Informant from ZAPD).

Lack of IEC materials is another challenge that was mentioned by the participants. They argued that there were no IEC materials to specifically inform the visually impaired persons on HIV and AIDS. Lack of braille materials and tape recordings on HIV and AIDS was also cited as a challenge. It was further revealed that, most IEC materials were in English language which was hardly read by all. Here are some quotes from both the visually impaired and key informants are indicated below:

There are no IEC materials for visual impairment and they only write in the formats readable to the sighted and us the visually impaired have no access to HIV and AIDS information (Female Participant aged 29 years old from Focus Group Discussion).

I have not seen any IEC materials for the visually impaired persons in the district (Male Participant aged 32 years old from Focus Group Discussion).

Other languages should be used because not everyone knows English language (Female Participant aged 29 years old from Focus Group Discussion).

Yes actually we are very hungry for things like braille materials, tapes and radio programmes for us to reach out to them in terms of HIV and AIDS information (Participant from DMO).

Illiteracy among the visually impaired persons was mentioned as one of the greatest challenges in the dissemination and accessing of HIV and AIDS information. For example, most participants argued that they were very few visually impaired persons that

could read braille or large print as such only few could access information available in braille literature.

Of course illiteracy is one of the problem ... low levels of literacy in this country like in many other countries in Africa it is written then it becomes a challenge to those who may be literate (Key Informant participant from NAC).

Poverty and Unemployment

Besides discrimination, stigma and education, poverty and unemployment are key challenges persons with visually impairments face in accessing HIV and AIDS information. It was noted that most persons with visual impairment lived in poverty. As such, majority of them could not access health centres due to lack of money for transport because they had to pay for the escort and themselves. It was also noted that despite the radio being the most preferred way of accessing information, few hardly afforded a radio due to poverty. Below is how it came out in the interviews with participants and key informants.

Me I have a radio but some of my friends do not have, even though I have this radio I can not always afford to buy cells so some times I do not even play the radio and hence I miss most of the information (Participant from Focus Group Discussion aged 34).

Some of the visually impaired persons are able to afford radios while most are not (Key Informant from DMO).

Our salaries are poor, so most of the disabled people cannot afford radios. If not employed and HIV and AIDS positive you can die fast because of depression caused by thinking too much. Most of us, the visually impaired are not educated due to lack of finances in families we come from (IDI-MARRIED-55).

Further, some female participates in the interviews reported that one could protect themselves from HIV and AIDS by going for Voluntary Counselling and Testing (VCT).

In the same interviews participants argued that,they were more vulnerable to HIV and AIDS infection because they have little or no say on whom to have sex with and how to had it and as such it was difficult for one to prevent HIV and AIDS. The following statement below shows how one female participant narated:

We have no say on whom to have sex with because we do not have employment and yet we need to feed so any man offering to help we cannot stop him, and we also depend on others to see for us and tell us that he is a good a man and that is how we end up with HIV positive men (IDI-FEMALE-32).

Funding and Logistical Challenges

Some key informants interviewed also mentioned that distance was a challenge for them to reach out to persons with visual impairments on HIV and AIDS information. This was not the only challenge for the health promoters to reach to the visually impaired persons but to the general population in rural areas. The contributing factor to this was lack of a utility vehicle for them.

We as a regional office we do not have a utility vehicle. So even if they say can we meet at Kang'onga today, it will need me to write a letter to the provincial cabinet that I need to do this and I am asking for a vehicle and driverand will pay for fuel and lunch for the driver. It is a challenge to manage a province without a utility vehicle (Key Informant from ZAPD).

We have transport challenges because we have to counsel these people in their homes (Key Informant from LIB VI).

Integration

Integration is the inclusion and mainstreaming of persons with visual impairments into programmes that foster HIV and AIDS communication by adapting accessible readable formats. Integration also involves modifying and adaptation of the environment and

equipment to make it accessible to the visually impaired persons in terms of movement and easy access to readable materials for the visually impaired persons. Through the focus group discussion for both male and female, integration was cited by the majority that it was another challenge that they face in accessing HIV and AIDS information. They said that, some infrastructures had no lifts or elevators, wide doors and or lamps thus inhibiting them from accessing HIV and AIDS information as most they did not accommodate persons with visual impairments. This made them to fail to access health services on HIV and AIDS especially in hospitals where they were referred to.

Other structures do not integrate the visually impaired in activities despite it being documented in the national Act for persons with disabilities, and it is not fully implemented (Participant: ZAPD).

The other participants mentioned decision making as the component where they felt they were not integrated. As one participant argued that the visually impaired persons or disabled in general did not sit on decision making boards to give advice on HIV and AIDS or integrate the visually impaired persons in HIV and AIDS plans.

Acts actually requires that, whatever you do or plan must integrate people with disability. Even if it's a national HIV and AIDS plan, or anything to do with building or vaccines one needs to consult on how to integrate disables but mostly these guidelines are not followed (Participant: ZAPD).

Health promoters mentioned that the other challenge they faced was the issue of isolating and mobilising special groups in disseminating HIV and AIDS information among the visually impaired persons. This was because there were no specialists to help in isolating special groups such as the visually impaired persons to plan specific communication programmes for them on HIV and AIDS.

We usually have a challenge when it comes to isolating these special groups as per say ... we have no qualified health promoters, even me am not qualified but am in charge of

health promotion in this district. In my time at work as health promotion candidate I have not had an encounter of meeting the visually impaired (Key Informant from DMO).

Overall, the participants in this study revealed many challenges that persons with visual impairments faced in accessing HIV and AIDS information. The challenges highlighted were in the following themes; discrimination, stigma, education, poverty, integration, employment and funding.

4.5 Improving of Communication of HIV and AIDS Information Among the Visually Impaired Persons

In view of the challenges indicated by participants in this study, they suggested a number of interventions on how communication on HIV and AIDS information to and among the visually impaired persons can be improved and enhanced. These included improving integration, funding and awareness and sensitisation.

Integration

There is need for integration on how communication on HIV and AIDS can be promoted among the visually impaired persons because it was observed that a lot of things needed to be put in place. The participants in the study revealed that paramount to them in accessing HIV and AIDS was through integration of the visually impaired persons into HIV and AIDS programmes and programming. The participants also indicated that discrimination on account of them being asexual should be stopped. This can be attested below:

The abled persons should consider us persons with sexual feelings and not discriminate us from HIV and AIDS programmes and we should also be taken to radio stations to teach others on HIV and AIDS. They should integrate us (IDI-YOUNG-23).

Participants cited trainings, workshops and mainstreaming to be instruments in the promotion of communication on HIV and AIDS information. They said that training the visually impaired persons would enable them to become peer educators. Involvement in

programmes such as HIV and AIDS programming and workshops would enhance their HIV and AIDS information accessibility. Readable formats for the visually impaired persons should be available to those who were able to read because they would become a mouthpiece for other visually impaired persons who are unable to read. This is as attested to below:

They should be training us so that we can also teach others on HIV and AIDS and we should be encouraged to teach other. Also we should be integrated in workshops, trainings and planning (IDI-EDU-52).

Braille books should be made available to us who can read and write (IDI-MARRIED-40).

Funding

Prominent in the recommendations was the need for the government to stop neglecting the visually impaired persons in funding. Participants argued that most funding on HIV and AIDS went to programmes that benefited the people with sight which was wrong because visually impaired persons were also affected and infected by HIV and AIDS. They argued that funds should be made available for programmes that benefited persons with visual impairments in accessing HIV and AIDS information as mentioned by some participants below:

Us who have challenges with sight, the key people to promote or overcome these challenges that we face is the government to stop neglecting us and also to include the blind in HIV funds because mostly government releases funds for HIV and AIDS (Participant: AM aged 34).

It emerged in the findings that funding should also be available for economic empowerment programmes for persons with visual impairments. Economic empowerment programmes can help the visually impaired to set up businesses that can better their economic status. This will lead to self-reliance and control over their lives as this will prevent them from being involved in casual sex in exchange for food and other

needs which make them vulnerable to HIV and AIDS. This came up from participants who felt vulnerable to HIV and AIDS because they were unemployed as stated below:

Government seriously needs to help us with capital because we used to make shining brushes and baskets as this will help us avoid engaging in casual sex in exchange for food
(Participant from Female Focus Group Discussion aged 32).

It is very easy for the visually impaired persons to have capital and engage in the selling business. We try our level best as visually impaired persons in this country but we lack support
(Participant from Male Focus Group Discussion aged 42).

Awareness and Sensitisation

Training is one of the areas in which health promotion of HIV and AIDS programmes among the visually impaired persons can be enhanced. This training can be made through awareness and sensitisation campaigns such as community mobilisation, drama on HIV and AIDS, radio programmes and through readable formats for the visually impaired. From the key informants interviews with health promoters and persons working with the visually impaired persons it was stressed that Ministry of Health was a key player in providing some form of training to cater for the visually impaired persons as well as health practitioners. This would help to improve their abilities in attending to the needs of the visually impaired because it would prevent stigmatisation or discrimination. The participants indicated that:

Training must be made to specifically cater for the visually impaired persons as well as a way of empowering them in being aware of information concerning HIV and AIDS. There should also be mobilisations through drama and community activities which are tailored to meet the information needs for the visually impaired persons (Participant: LIB Visually Impaired Persons).

This was confirmed in focus group discussions and interviews where the participants revealed that they were not given training because people thought that the visually impaired persons are difficult people to teach or train. They argued that they were also human beings just like the sighted ones and that they also needed training to know more on HIV and AIDS. In this respect, they recommended that training should be inclusive of the persons with visual impairments.

Sighted people think we are difficult to teach, we are also human beings (IDI-female-36).

Entertainment was also stressed as one key area that needed to be taken care of if the information of HIV and AIDS was to be prioritised among the visually impaired persons. This was revealed by a key informant that drama in form of sketches and plays should be enhanced especially for those who cannot read or afford a radio to learn something on HIV and AIDS. In the same line, participants also indicated the need to be included in sporting activities because they lacked such social amenities. As noted in the interviews with persons working with visual impairments that persons with visual impairments viewed sexual intercourse to be the greatest entertainment. Below are some quotes from two participants as they emphasised some of the points above:

Not that we are trying to make a story sweet but it is a fact they do not have any other entertainment that's why the biggest entertainment they have is sexual intercourse so why not create awareness (LIB for Visually Impaired Person).

We have few activities and we are not considered in terms of entertainment, so they need to include us even in sports activities (Male Participant aged 42 from Focus Group Discussion).

During the interviews and discussion with the visually impaired persons, participants also revealed that language was a critical barrier in their accessibility to HIV and AIDS information, therefore, they recommended that the use of local language in HIV and

AIDS information should be encouraged and this was testified by male participants from focus group discussions aged 41 and key informant from National AIDS Council (NAC) when they stated that:

Production of audio tapes and braille books help in the promotion of HIV and AIDS information so long as this information is done in various languages so that everyone can have something to learn about. There are visually impaired persons out there who do not know English language but maybe knows local languages (Participant from Focus Group Discussion aged 41).

We will strive by all means to include all in terms of language and the visually impaired persons are not an exception (Key Informant from NAC).

Collaboration between ministries and other agencies was also mentioned. In order to serve the visually impaired persons better in terms of communication of HIV and AIDS information, participants argued that there was need for collaboration between ministries and other agencies as stated that:

These collaborations can create awareness among the stakeholders and promoters on how to attend to the visually impaired persons (Key Informant from District Medical Office).

While at the same time line ministries and others NGO organisations must make better use of us Zambia agency for persons with Disability (Key Informant from ZAPD)

Ministries have to come together like old days and meet the people where you give them hand-outs', we can design a programme for that. So that even in churches they can be reached though not as a majority but as a fraction for we know that visually impaired persons are everywhere (Key Informant from DMO).

The other challenge which needed to be worked on in the promotion of accessing information by the visually impaired person was the issue of the child guide (escort) and yet had to go to school meaning the visually impaired person would have no one to escort them and cannot access information or treatment at the health facility. So it was

suggested among the female group discussion that it would be better for the hospital to find a way of helping the visually impaired persons. Since they know the dates on which they conduct antiretro therapy (ART treatment) they can send care givers to pick up the visually impaired person and take them to the hospital. If they went to the hospital without an escort, they stated that they were probed why they went alone with no one to lead them.

Ministry of Health can help us by sending care givers to come and be our escorts especially on dates for ART clinics so that our children can attend school as well (Female Participant aged, 41, married from Focus Group Discussion).

Therefore prominent among the challenges indicated by participants in the study were to enhance improved integration, funding, awareness and sensitisation of HIV and AIDS information on persons with visual impairments.

In concluding this Chapter on findings, different responses were revealed by participants, the focus group discussion, in-depth interviews and key informants. It was indicated that the visually impaired persons showed a variation on HIV and AIDS knowledge because participants had different responses on its cause, transmission, treatment and prevention. Also participants in the study indicated a number of ways in which visually impaired persons received HIV and AIDS information. They revealed ways such as the media, information education, communication materials (IECs) and health education. Further, the participants highlighted many challenges that persons with visual impairments faced in accessing HIV and AIDS information. The challenges highlighted were discrimination, stigma, education, poverty, integration, employment and funding. Furthermore, prominent to the challenges indicated by participants in the study were to enhance improved integration, funding, awareness and sensitisation of HIV and AIDS information on persons with visual impairments.

CHAPTER FIVE

DISCUSSION OF THE FINDINGS

5.0 Introduction

The study aimed at understanding the communication of HIV and AIDS information for persons with visual impairments. Therefore, this Chapter generally provides an overview and discussion of results in comparison and contrast with other studies on the four research questions. Also the chapter gave limitation of the study.

5.1 Summary of Results

It was evident from this research that there was a variation in terms of knowledge on HIV and AIDS among persons with visual impairment in all the critical domains of the cause, transmission, treatment and prevention of HIV and AIDS. This study also found out that there were a number of ways in which persons with visual impairment accessed information on HIV and AIDS. These included the radio, television, public announcement systems and theatre. The visually impaired persons also accessed HIV information through brailled materials, pamphlets, charts, health centres, trainings, peer education, workshops, community home-based care, demonstrations, counselling and antenatal visits. In terms of the challenges in accessing HIV and AIDS information the study found out that the visually impaired persons faced discrimination and stigma as well as literacy challenges. The other challenges included inadequate IEC materials, lack of information programmes specific for the disabled, limited specialists to mainstream planning specific communication programmes on HIV and AIDS for the disabled, poor integration of the visually impaired persons in decision making and logical and funding difficulties to implement programmes for the disabled people. Poverty was also cited as another challenge among the visually impaired persons alongside unemployment, long distances and lack of money for transport to get to health centres where information on HIV was usually disseminated. Following these challenges, participants and key informants in this study recommended increased integration of the visually impaired persons into HIV and AIDS programmes and programming. They also recommended ways of promoting access of information programmes on HIV and AIDS through trainings, workshops as well as develop readable formats. Further, the participants and

key informants appealed for increased funding to programmes that did not only economically empower the visually impaired persons but increased capacity for programme managers to develop awareness and sensitisation programmes on HIV and AIDS in appropriate formats and language for the visually impaired. Lastly, the key informants recommended for improved collaboration between ministries and other sectors that work to improve the welfare of the visually impaired persons.

5.2 Comparing and Contrasting with Other Studies

The following paragraphs discuss how the findings from this study compare and contrast with similar studies conducted in other settings. The discussion is based on the broader themes: knowledge on HIV and AIDS, ways through which the visually impaired persons accessed information on HIV and AIDS, challenges in accessing HIV and AIDS information and the promotion of information and communication on HIV and AIDS to the visually impaired persons.

5.3 Knowledge on HIV and AIDS

This study established that, there was a knowledge gap on HIV and AIDS among the visually impaired persons. This knowledge gap on HIV and AIDS information was in different critical domains of its cause, transmission, treatment and prevention. Majority of the participants showed little knowledge on the causes of HIV and AIDS, as most of them advanced that it came through other diseases. On the mode of HIV and AIDS transmission, the participants showed an understanding, as the majority mentioned two modes, through unprotected sexual intercourse and the use of sharp instruments. Also this study found out that some participants knew of HIV and AIDS treatment and prevention while some did not have any information. Majority of the participants highlighted that HIV and AIDS had no cure and that one can prevent it through the use of condoms during sexual intercourse, abstinence and being faithful to one partner. Generally, the results of the study showed a variation of understanding on HIV and AIDS as participants had different views. These findings were not in isolation from previous studies (Saulo et al., 2012 and John H. Philander et al., 2006) conducted in other sub-Saharan African countries which indicated that the visually impaired persons lacked information on HIV and AIDS-related issues and it was unclear how HIV and AIDS information target blind

people in a Sub-Saharan setting. Also Groce et al., 2012; Action on Disability and Development, 2005 and Regis et al., 2010, have clearly established the fact that the level of HIV knowledge for people with disabilities is low. This was in comparison with the findings of this study as some participants exhibited lack of knowledge on HIV and AIDS. From the current study, this knowledge gap on HIV and AIDS information can be attributed to the level of education though not always. The literate participants showed more understanding of HIV and AIDS on its transmission, prevention and treatment. On the other hand, participants with low literacy levels had little or no knowledge at all of HIV and AIDS on its cause, transmission, prevention and treatment.

5.4 Ways in which the Visually Impaired Access HIV and AIDS Information

Our study revealed that there were many ways in which persons with visual impairment accessed HIV and AIDS information and the following were established from the research; Media, Information, Education and Communication (IEC) materials and health education. The participants indicated the media as a major source of HIV and AIDS knowledge. Media included listening to the radio, television, public announcement systems and drama (sketches). Also majority participants highlighted IEC materials as another way through which they receive HIV and AIDS information. These IEC materials mostly used by the visually impaired persons were noted to be braille materials and pamphlets, charts. Participants further, mentioned health education as another way the visually impaired persons through which HIV and AIDS information was accessed. This was reported by participants that they received HIV and AIDS information through visiting health centres, training, peer education, workshops and community home-based care, demonstrations, counseling and antenatal visits.

These ways in which the visually impaired persons accessed information were also in collaboration with many findings established in other studies conducted across sub-Saharan countries. For example, a research conducted in Malawi on persons with disabilities on ‘Effective HIV and AIDS and Reproductive Health Information to People with Disabilities’, revealed that people with visual impairments mostly communicated with others through speech because they were able to talk and hear. The research further demonstrated that the radio, television, drama, Braille, large print and electronic media

constituted some of the common ways of communicating HIV and AIDS messages to the visually impaired persons (Munthali et al., 2004). Although antenatal clinics were cited in the discussion as one of the ways through which they accessed information on HIV and AIDS, other studies contrast that, females with disabilities faced numerous physical and attitudinal barriers to accessing fertility and antenatal care (Groce et al., 2012). These barriers on the other hand made resulted in a few females with visual impairments to be able to attend antenatal and as such the majority still did not have access to information on reproductive health and HIV and AIDS.

Therefore, findings clearly indicated that despite the many ways through which persons with visual impairments accessed HIV and AIDS information, many of these ways were not available to them. Generally, it was found out that agencies that disseminate HIV and AIDS information to the general population had no designed programme or material in formats accessible by the visually impaired person as they do not have trained staff. The study revealed that there are no trained staffs or experts to attend to communication needs for the visually impaired persons on HIV and AIDS in organisations and health institutions. This was the reason why most ways were not utilised by health promoters to disseminate HIV and AIDS information to persons with visual impairments.

5.5 Challenges People with Visual Impairment Encountered in Accessing HIV and AIDS Information

The participants in this study also suggested that, despite the many identified ways through which the visually impaired persons accessed HIV and AIDS information, there were many challenges faced. Among the challenges revealed in this study was discrimination and stigma. It was established that the visually impaired persons are discriminated and stigmatised in accessing information on account of being visually impaired as there were hardly any accessible formats on HIV and AIDS information. In relation to the findings, a study on “Perceptions of the availability and effectiveness of HIV and AIDS awareness and intervention programmes by people with disabilities in Uganda” also found out that the visually impaired persons felt discriminated against on HIV and AIDS issues because had difficulties in accessing HIV and AIDS services because of mainly communication problems (Regis et al., 2010). This study further

found that, some of the visually impaired who were HIV and AIDS positive faced double discrimination, for being HIV and AIDS positive and visually impaired, this was indicated in the study that, families and health practitioners discriminate them. Similar findings were also reported by other researchers, that HIV and AIDS-related stigma and discrimination is another major challenge for persons with visual impairments as it affects the individual, the family and the society at large (Yousafzi and Karen, 2004).

The level of education attainment for persons with visual impairment was another challenge that was discovered in their accessing of HIV and AIDS information. This can be related to the ecological model which advance that an individual's education level, understanding and affluence may dictate what information he or she receives and processes and through which medium. This was evident because many participants in the study were illiterate and had misconceptions on the cause, transmission and prevention of HIV and AIDS. In addition, most of the messages are in English and this denied the majority of the visually impaired persons who had low education attainment from accessing HIV and AIDS information. These findings were in line with the Federation of the Disabled (ZAFOD) which advanced that, most persons living with disability, especially the visually impaired, did not have access to information through the radio, television and newspaper and other literature due to high levels of illiteracy. This was caused mainly by discriminatory funding and understaffed to carry out effective HIV and AIDS communication programmes for persons living with visual impairment (Exchange Magazine Disability Issue, 2009; Bcek-massey, 1999).

Further in the research, it was shown that there were no Information, Education and Communication (IEC) materials for persons with visual impairments in delivering HIV and AIDS information. The participants revealed that people who designed materials on HIV and AIDS mainly think that persons with visual impairments cannot engage in risk sexual behaviours. It was further, revealed that there were no braille materials, large print, chart or pamphlets for persons with visual impairments on HIV and AIDS information. These findings were in affirmation with similar studies which noted that, Information, education and communication (IEC) interventions which have been used to alert the general public about the risk of HIV and AIDS were based on the assumption

that HIV and AIDS knowledge would cause change in people's sexual behaviour from risky sexual behaviour to non-risky behaviour or safer sexual practices. HIV and AIDS education on transmission and preventive measures however was not particularly targeted at the visually impaired (Kendi et al., 2008).

Also the ecological model can be used to analyse the timing of when information was received and identified the communication needs for visually impaired persons. This situation had an environmental influence that would be very far reaching to persons with visual impairments. The radio was identified as the key medium through which the visually impaired persons accessed HIV and AIDS information as it was able to benefit both those who can read and those who were unable to read braille. However, in contrast to this, it was also established that, many people with visual impairment were unable to afford radios and electricity bills or batteries. As such they had limited access to HIV and AIDS information. Besides, it was further evidently noted that, radio campaigns cannot reach many people with visual impairments in most cases because there were no programmes tailored to meet their communication needs. Worse still, the majority participants also cited reception of radio stations at Kang'onga area to be poor. These findings in the study were in contrast with other studies conducted across which showed that the most common medium for providing information about HIV and AIDS in sub-Saharan Africa was through radio campaigns. Radios were more accessible to some people living in rural areas and were more affordable than televisions (Groce et al., 2012; Yousafzi and Edwards, 2004; Mulindwa, 2003).

Health promoters in this research revealed that lack of disability specific programmes and specialists to isolate special groups on HIV and AIDS such as the visually impaired persons was a challenge in terms of planning and communication. These findings were in affirmation with other research findings conducted in several countries such as Ethiopia, Kenya, South Africa, Mozambique, Rwanda and Uganda which showed that many health practitioners lacked the necessary skills for adequately responding to the needs of persons with visual impairments. This made the visually impaired to face a multitude of challenges when accessing HIV and AIDS information on prevention and support (Chakuchichi et al., 2011; Kend et al., 2008; and Munthali et al., 2004).

Poverty and distance was another challenge that was noted by the participants. It was discovered that the majority of persons with visual impairments were in poverty. They were unable to afford basic necessities which included access to referral health centres due to transport challenges as they were supposed to pay for two people, the escort and themselves. These findings were not in isolation from other studies which also indicated that the majority of vision impaired individuals in developing countries failed to meet direct and indirect costs to finance their health care resulting in experiencing difficulties when paying for treatment, transportation and often they were unable to visit the health facilities where they could access health information (Mulindwa, 2003).

Lack of integration in decision making and equal distribution of HIV and AIDS funding was also a major challenge that affected the dissemination of HIV and AIDS information to persons with visual impairments. Poor funding or rather discriminatory funding and low staffing was described in this study as a challenge in accessing information on HIV and AIDS for persons with visual impairments. These findings were not new, as a similar study also revealed that, “This kind of discriminatory funding and understaffing reflected the marginalisation of the visually impaired in Zambian society in information provisions on HIV and AIDS” (Rule et al., 2008 and Simwamba, 2008).

Overall, the implication of these findings on the challenges indicated that most of them were as a result of lack of implementation on policy for equal accessibility of HIV and AIDS information mostly to the non-sighted. Despite information being the most important and powerful human rights weapon, many persons with visual impairment at Kang’onga Production Centre did not benefit from information, education and communication materials.

5.6 Improving of Communication on HIV and AIDS Information among the Visually Impaired

Participants advanced a number of interventions on how communication on HIV and AIDS information among the visually impaired persons can be promoted. These interventions reflected the ecological model as a framework and included mass media campaigns, social marketing, and skills development. The research revealed that the majority participants recommended the integration of persons with visual impairments

into HIV and AIDS programmes and programming to be prioritised. They further advanced that this would enable equal representation of persons with visual impairments and give them opportunities to be empowered with information on HIV and AIDS. These findings from the study were in line with the advance by the United Nations Report (2006) that, people with disabilities were in need of the same HIV and AIDS information, services and support as all other members of society. They can no longer be an afterthought as this corresponded with The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

In the same study, participants recommended that, peer education programmes should be enhanced among persons with visual impairments because it would help to mobilise one person at a time or in groups. These strategies were found to be quite ideal for persons with visual impairments, as other findings had also concluded that the visually impaired persons should be included in all programmes while taking care of their information receptive modalities (SARUA, 2008).

In order for integration to be fully implemented, it was noted from the majority of the participants, that more funding should be invested in awareness programmes that would help persons with visual impairments to have access to HIV and AIDS information. Ministry of Health on the other hand was to take keen interest in providing some form of training to cater for the visually impaired persons as well as information in readable formats especially in terms of HIV and AIDS. These findings were in line with the ecological model at meso level (community health promotion) in identifying high impact leverage points and intermediaries within organisations that can facilitate the successful implementation of health promoting interventions, combining person focused and environmentally-based components within comprehensive health promotion programmes on HIV and AIDS communication for persons with visual impairments, and monitoring the scope and sustainability of intervention outcomes over prolonged periods. This is the basis of intervention programmes to address issues such as HIV and AIDS communication for persons with visual impairments (National Cancer Institute, 2012).

The study further revealed that there were no social amenities for persons with visual impairments and as such it was advanced that they viewed sex as the only entertainment. Therefore, it was recommended that entertainment must be enhanced through drama as one of the most preferred way of accessing information according to the findings. Therefore, this would help the visually impaired persons not to only look at sexual intercourse as the source of entertainment. Participants mentioned further, that such programmes would lead to the creation and utilisation of Information-Education-Communication (IEC) strategies for disseminating HIV and AIDS information. These findings from the study were also consistent with findings by Southern Africa Regional Universities Association (SARUA, 2008), who advanced that, “negative perceptions and practices in society about persons with visual impairments could be changed if they were accorded equal participation in HIV and AIDS mainstream intervention initiatives through the provision of braille information and inclusion in community and social amenities.

It was further recommended that discrimination on account of them being asexual should be stopped, as this was found to have a negative bearing on persons with visual impairments in their accessibility to information. It was argued that persons with visual impairments were denied information on the basis of being perceived to be asexual. These recommendations were also noted in other research that advanced that "the stigma associated with disability led many in the disability community to avoid the issue of HIV and AIDS, fearing the double-stigmatisation of being associated with both disability and HIV and AIDS" (Groce, 2012).

Furthermore, the study established that, readable formats for persons with visual impairments must be availed to those who were able to read and not denied from accessing HIV and AIDS information. More funding should be invested in awareness and sensitisation on HIV and AIDS and communication needs should be encouraged among the visual impaired. There should be a translation of HIV and AIDS messages into local languages that can easily be accessed by the visually impaired persons. Also the use of audio tapes and braille books should be enhanced. For instance a study on “HIV issues and People with Disabilities” affirms that the use of Braille and alphabet was critical in

HIV and AIDS information dissemination for persons with visual impairment (Groce, 2012).

The study further revealed that, collaboration between ministries and agencies was vital and that it can increase awareness programme among stakeholders. Some participants also cited that there was need for concerned stakeholders to collaborate between ministries and agencies to mainstream the visually impaired persons to participate in all health related programmes. These findings were also in line with the findings of Groce (2004) who noted that HIV and AIDS crisis cannot be effectively eradicated without the participation of persons with visual impairment. Groce's assertion was consistent with the findings of another study conducted by Chakuchichi (2011: 22) that persons with visual impairment would like to be involved in deciding the best information dissemination modalities compatible with the nature of their disabilities.; promoters should be trained on how to attend to the visually impaired; and care givers to help visually impaired persons as escorts especially during ART clinic.

In communicating of HIV and AIDS information to persons with visual impairments, drawing upon the ecological model to address the health of a nation's population was viewed as critically important to the strategic alignment of policy and services across the continuum of population health needs, including the design of specific visually impaired tailored health promotion, HIV and AIDS prevention and control strategies (White et al., 2013). Hence, in the development of universal health care systems, it is inevitable to recognise health in policies at micro, meso and macro level for persons with visual impairments as the overarching policy framework, with public health, primary health care and community services as the cross-cutting framework for all health and health-related services operating across the spectrum from primary prevention to long term care and end-stage conditions. Although this perspective was both logical and well grounded, the reality was different for person with visual impairments in most settings and there wa need for improvement in all places (White, 2015).

5.7 Limitations and Strength of the Study

This study had strength and weakness. The first limitation was that of sampling as only one group of visually impaired was sampled based on purposive sampling which also

cannot be generalised. Nevertheless, in spite of the stated limitations and noting that this was a qualitative study. The lived experiences which were expressed through verbatim could not be captured by a survey questionnaire, and respondents in the study are hard to reach in the population. However, for such a study, this was the most appropriate methodology especially when the researcher wanted to transfer what is learnt to another setting. The use of maximum variation sampling had the value of representation which was seen in randomisation. In examining the researcher as an instrument of analysis in the qualitative research being a female; this could have affected male participants in revealing some of their lived experiences. However, being a specialist in special education and counsellor, the researcher was able to probe for in-depth information regarding the research study from both sexes.

5.8 Significance of the Study

The findings of this study filled in the gap in the body of knowledge in four domains which are knowledge, ways in which persons with visual impairment accessed HIV and AIDS information, challenges encountered in accessing HIV and AIDS information and promotion of HIV and AIDS information for the visually impaired persons.

The findings of this study may be useful to Zambia Agency for Persons with Disabilities (ZAPD), health education and promotion staff at the DMO and staff at the National AIDS Council in charge of Health Information, staff at Zambia Library for persons with visual impairments and the manager at Kang'onga Production Centre. This study is also particularly useful in the context of a situational and policy analysis. As it involved identification of who the major stakeholders were and involved in designing, giving, receiving, or administering the programme or service, and who might otherwise affect it or be affected by it.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.0 Conclusion

The findings suggested that, Visually Impaired persons in Zambia Were not adequately catered for in the dissemination of HIV and AIDS information. The available information was not user friendly because it was in unreadable formats. As such they were misinformed and faced a myriad of challenges in accessing information on HIV and AIDS.

The study also showed that, there was a variation regarding knowledge among persons with visual impairment. The study further showed that persons with visual impairment had no specific materials through which they accessed HIV and AIDS information. Health promoters and persons working with the visually impaired persons also faced challenges in delivering HIV and AIDS information to the visually impaired as they lacked funding and skilled manpower to reach out to the visually impaired persons in accessible formats. These findings emphasised the need for in-depth, context-specific understanding of the challenges so as to improve accessible HIV and AIDS formats for persons with visual impairments. Also was the need to implement the development of IEC's that were disability specific. This was because, HIV risks would continue to scale-up among the persons with visual impairment, and the lack of information may undermine the gains being scored in scaling-down of HIV and AIDS in Zambia.

6.1 Recommendations

Specific Information Strategies

There was a great need for health promoters to develop specific information dissemination strategies for persons with visual impairment. Failure to implement these strategies meant that persons with visual impairments would always be left behind and always put them at a very high risk.

Integration

The government must ensure that communication on HIV and AIDS to the persons with visual impairments should be promoted by integrating them in dissemination and designing of HIV and AIDS information. This was vital in the sense that, without the inclusion of the visually impaired persons then there would be no empowerment to take responsibility of the designed programmes and as such there would be no health promotion for them.

Funding

There was need for funding to be made available towards Information, Education and Communication materials (IEC) and the study therefore recommends that health promoters develop user friendly IECs that would also take into consideration the information needs for the visually impaired persons.

Mainstream

Health promoters must mainstream persons with visually impaired in HIV and AIDS programme so that they could also have representation and help in tailoring programmes that would suit the diversity information needs for the visually impaired. This collaborated with other studies that stated that, the lack of information on the needs of people with disabilities by HIV and AIDS service providers and policy makers created conditions for exclusion of people with disabilities from the principal mainstream interventions (Eide and Loeb, 2006).

Capacity Building

There was need for the government to build capacity for health workers so that they could know how to handle the visually impaired and help them not to feel discriminated or stigmatised on the basis of being disabled.

Qualified Health Promoters

There was need for government to have qualified health promoters in all structures, the district, provincial and national level with a bias in disabilities that they could fully

understand the information needs of special groups and be able to reach out to them in more appropriate and specific ways.

Further Studies

Need for more studies that cover all categories of disabilities because HIV and AIDS concerns everyone either abled or disabled and to fight it holistically there was a need to do a study that would give prevalence of HIV and AIDS for all categories of disability in Zambia. Because of the lack of statistics, always the visually impaired persons will be excluded. In relation to this Phillimon (2007), in his study mentioned that the national demographic statistics on disability were generalised but did not answer the crucial questions that related to the concerns of the disabled in areas of information accessibility. Moreover, statistics did not show the numbers of people with disabilities infected with HIV in Zambia.

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Appendices

APPENDIX ONE

INFORMATION SHEET

TITLE

Situational Analysis of Communication of HIV and AIDS information to Persons with Visual Impairment: A Case Study for Kang'onga Blind Centre in Ndola district of Zambia.

INTRODUCTION

Greetings!

My name is **Grace Nsangwe Chintende**. I am a student in the School of Medicine in the Department of Public Health at The University of Zambia. I am doing a Master's programme in Public Health. I am going to read to you a consent form that explains the research study you are being asked to join. Please, feel free to ask me any questions before you agree to join. You may also ask questions at any time after joining the study.

PURPOSE OF STUDY

In Zambia it has clearly been shown from the statistics that the rate of HIV and AIDS infection has scaled down from 14 per cent in 2007 to 12.7 per cent (ZDHS, 2013). This reduction was attributed to improved information accessibility by the general population which led to behavioural change. However, there is hardly any specific data on communication of HIV and AIDS information to persons with visual impairment. Therefore, the aim of the study is to explore ways in which communication of HIV and AIDS information is accessed by persons with visual impairment and challenges they face in receiving such information at Kang'onga blind centre in Ndola district of Zambia. As this will lead to promotion and improved HIV and AIDS communication on prevention, access care and treatment for persons with visual impairments. I believe that you can help us by giving your views on the subject.

PROCEDURES

You have been asked to join this study because we are looking for people who can provide us with information that will help in the evaluation of this project and you are one of them. If you agree to be in this study, you will be asked questions about yourself. The answering of these questions will take about one hour at the most. I will agree to do this in or at a place of your

choice. Your answers will be recorded because we want to be able to refer back to the interview for accurate information. If you agree, I will proceed with the recording but you can stop us at any point during the interview. Only the people on our research team will have access to the tape. At the end of our study, I will return here and share with you what we have found.

RISKS AND DISCOMFORTS

There are no physical risks involved in this study. However, you may feel uncomfortable answering some of the questions. You may refuse to answer any questions that you do not want to answer or questions that make you feel uncomfortable. You may stop the interview session at any time. Your responses or participation in this study will not affect you in any way or even your access to any clinic facilities belonging to MoH.

BENEFITS

Benefits will be incurred though may not be attained immediately, however, data collected will help inform policy and bettering the accessibility of information on HIV and AIDS by the visually impaired.

ALTERNATIVES TO PARTICIPATION

You can either choose to be in the study or choose not to be in the study. If you choose to be in the study you do not have to stay in the study until it ends. You can decide to leave the study at any time and this will not affect you or any other privileges that you enjoy now. If you choose not to be in the study, you will still get the same health care services from any MoH clinic or anywhere else and you will not be affected in any way.

CONFIDENTIALITY

We assure you that we will not share any information about you to anyone outside the research team. All the information that we shall collect from you will be kept private. You will be assigned a study number so that it will not be possible to identify you individually. Only the researchers who are in this study will be able to know your number and all information obtained will be locked up. We also ask you or others in the group not to talk to people outside the group about what is discussed during group discussion. Once we are finished with the study, all the audio tapes and other study information collected will be destroyed.

VOLUNTARINESS

Your taking part in this study is completely voluntary. You are free to withdraw at any time, for any reason. In the event that you decide to withdraw from the study, the information you have already provided will be kept in a confidential manner and will not be shared with anyone else to personally harm or affect you. This will not in any way affect you or your taking part in future or any other privileges.

RE-IMBURSEMENT

There is no financial re-imburement for participating in this study. However, transport refund and refreshments will be provided which will not exceed 30 ZMK.

CONTACT

If you want to talk to anyone about this study because you think you have not been fairly treated, or you have any other questions about the study, you should call the Principal Investigator of the study,

Miss Grace N. Chintende on or

The University of Zambia,

Department of Public Health,

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APPENDIX TWO

INFORMATION SHEET AND CONSENT FORM (ICHIBEMBA)

UMUTWE

Ukulashanya pabulwele bwa Ntanda bwanga (HIV and AIDS) ukulanda kubantu abashimona; Ukulashanya kwaliko ku Kang’onga iyaba nicende uko abanesu abashimona bekala ku Ndola muciputulwa ca migodi mu Zambia.

UKUILONDOLOLA

Mutende!

Ishina lyandi nine **Grace Nsangwe Chintende**. Ndimusambi mwisukulu lya miti muchiputulwa chabumi pa University of Zambia. Ndechita “Master’s programme” muchiputulwa chabumi. Nalamibelengelako ukufwayafwaya kwandi ukufuma mu cipepala chakusuminishyanya ukulondolola pesambilililo ili mwaipushiwa ukuikumikako. Mube abatungwa ukulandapo nangu ukwipusha ifipusho ifili fyonse apo tamulasumina ukuikumikako. Mulibatungwa ukwipusha ifipusho nalintufye mwaikumikako.

UMULANDU UKULU WAILI SAMBILILLO

Muciputulwa cesu ichaZambia chalishinikishiwa ukufuma kubapendwa ukuti ukwambula kwabulwele bwantanda bwanda bwanga nangula HIV and AIDS kwalibwelelela panshi ukufuma pali 14 per cent ukwisa pa 12.7 per cent (ZDHS, 2013). Ukubwelela panshi kwalenga ukwilako pantashi kwamashiwi ayo ichintu bwingi chasanga ichaleta ukucija kwamibele .Nangula chakuti takwaba ayengi amashiwi ayalandwa palwa ubu bulwele bwantanda bwanga nangula HIV and AIDS kubantu abashimona. Eico ili sambililo liminine pakufwaya ishila ishakulashishyaninamo pamashiwi yabulwele bwantanda bwanga nangula HIV and AIDS efyo yengafika kubantu abashimona, nobwafya basanga pakupokelela amashiwi pa Kang’onga Blind Centre mumusumba wa Ndola mu Zambia. Pantu ici chatwala pamulu ubuyantashi bwakulandishanya pali HIV and AIDS pakutila ati kwaba ukucingilila, ukusanga ukusakamana nokuundapwa kubantu abashimona. Ndecetekela mwalatwafwilisha pakutupela amatontokanyo yenu pali ilisambililo.

IFYAKUKONKA

Mwaipushiwa ukuibimbapo kuli ilisambililo pamulandu tulefwaya abantu abengatupelako ifishinka ifikatwafwa ukubebeta palilisambililo elyo kabili muli bamo pabengi abasalwa. Ngamwasumina ukuba muli iliisambililo mukepushiwa amepusho palwa imwe. Ukwasuka kwa aya mepusho kukasenda isa imo. Nkasumina ukuchita ichi pachende iyo mukasala mwebene. Amasuko yenu yakalembwa pantu kuti twafwaya ukubwelela kufyo tukamwipusha.

Ngamwasumina, nkakonkanyapo ukulemba lelo kuti mwatulesha panshita ili yonse ilyo tulelashanya. Bantufye abo ebo tuli nabena mwisambililo ili ebakakwata isambu kumashiwi tukalalashanya pakupwa kwe sambililo, nkabwela kuno nokwisa mweba ifyo tukasanga.

IFYAKUTINA

Takuli ifingaleta ubusanso kumibili yesu muli ili sambililo. Nangula ifingabapo kuti limo mwaufwa ububi pakwasuka amepusho yamo. Kuti mwakana ukwasuka amepusho yamo-yamo ayo tamungafwaya ukwasuka nangula ayenga mufwisha ububi. Elyo nakabili kuti mwalesha ukulashanya pashinta ili yonse. Amasuko yenu nokwiimbamo muli ilisambililo tekuti mumpufyanishiwe mushila ili yonse nangula ukuya kwachipatala ichaputulwa ichabumi (MoH).

UBUNONSHI

Ubunonshi bukatumbukamo lelo tabwakese mukampampa, nangula ifishika ifikasendwa fikaafwilisha ukupanga amafunde kabili ayakawamya ukusanga kwama shiwi palwa pabulwele bwantanda bwanga nangula HIV and AIDS kubantu abashimona.

INSHILA MWINGAIBIMBILAMO

Kuti mwasala ukuba nangu ukukanaba mwisambililo. Ngachakutila mwasala ukuba mwisambililo, teti mwikalilile mwisambililo paka ukufika nakupela. Kuti mwasala ukufuma mwisambililo panshita iliyonse elyo tachakampufyanye imwe nangula isambu shimbi isho muleipakisha pali nomba. Ngamwakana ukuba mwisambililo nalyo line mukakonkanyapo ukupokelela imilimo yabumi ukufuma kuchipatala ichili conse icha MoH nangula ukuli conse elyo tamwakampufyanishiwe munshila ili yonse.

INKAMA

Tulemilaya ukweba ati tatwakebeko nangula bamo abo abashili naifwe pali imwe nangula pa amashiwi yonse ayo tukafumya kuli imwe tukasunga munkama. Mukapelwa inamba imwe

pakuti tachakabe ichayanguka ukumwishiba palwenu kanofye abo abalefwailisha ifishika abali naifwe ebakeshiba inambala yenu nafyonse eflyo mukalandapo tukafikomona. Tamufwile ukulanda kumuntu uli onse uwakunse yebumba palifyonse ifyo tukalashanya. Ngalyapwafye isambililo yonse amaseleti yakonaulwa.

UKUIPELESHA

Ukuisashamo kwenu muli uku kusambilila kwakuipeleshafye. Muli abakakulwa ukufumamo ishita ili yonse pamulandu uli onse. Panshita iyo mwalafuma mwisambililo ifishika mukatupela fikasangwa munkama kabili tafyakeshibikwe kumuntu uli onse eico ichingaleta ububi nangula ukumumimpufyanya. Ichitachakampufyanye ukusangwamo kwenu panshita yakuntashi nangu insambu shimbi.

AMALIPILO

Takuli ulupiya lwakulipila umuntu nangula umo pakusangwa muli ukukusambilila. Lelo kukabafye ukubapela ulupiya lwakwendela nolwa kunsita ifyakulya ulishifwile yachila pali 30 ZMK.

AKEYALA

Ngamulefwaya ukulanda kuli onse pali ili sambililo pamulandu wakutontonkanya ati tabamisakamane bwino nangula namukwata amepusho pali ili sambililo kuti mwaipusha umukalamba webumba muli ili sambililo.

Miss Grace N. Chintende nangula

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APPENDIX THREE

CONSENT FORM

If you sign this form, it means that the information sheet has been read and explained to you orally, or you have read the aims of this study and you have been given the chance to ask any questions now or at a later time. If you voluntarily agree to participate, confirm this below. By signing below, I agree to take part in the study.

Print name of participant:

Signature/Thumbprint of participant

Date

Or legally Authorized representative or guardian for under age

Signature of person obtaining consent

Date

Signature of Witness to Consent Process

Date

(Must not be a member of study team)

APPENDIX FOUR

CONSENT FORM (ICHIBEMBA)

AMASHIWI YAKUSUMINISHANYA (ICHIBEMBA)

Ngamwa saina uyu form, chilepilibula ukuti namubelenga amapepala yafishika nokumilondolwela nangula namubelenga apo ili sambililo liminine elyo mwalipelwa ishita iyakwipusha maepusho ayali yonse palinomba nangula kuntashi. Ngachakuti mwasumina mukuipelesha ukuibimbamo, suminisheni panshi mukusaina ukweba ati nasumina ukusendamo ulubali muli Ili sambililo.

Ishina abaleibimbamo:

Ukusaina/Ukufwatika

Ubushiku

Nangula abakwimininako nangula basunga abaice ukulingana nefunde

Ukusaina Kwa muntu ulepoka ukusuminishanya

Ubushiku

Ukusaina kwakwakambone mushita yakusuminishanya

Ubushiku

(Tafwile ukuba membara webumba lilechita isambilisho)

APPENDIX FIVE

FOCUS GROUP DISCUSSION

<p>Introduction Key Components:</p> <ul style="list-style-type: none"> • Thank participants • Name • Purpose • Benefits • Duration • How interview will be conducted • Confidentiality • Language • Place • Opportunity for questions • Signature of Consent 	<p>FOCUS GROUP DISCUSSION</p> <p>Part One: Introduction (10 minutes)</p> <p>I want to thank you for taking the time to meet with me today.</p> <p>My name is Chintende Nsangwe Grace.</p> <p>I would like us to discuss on communication of HIV and AIDS information for you.</p> <p>Benefits will be incurred though may not be attained immediately, however, data collected will help inform policy and bettering the accessibility of information on HIV and AIDS by the visually impaired.</p> <p>The interview will take between 45-50 minutes.</p> <p>I will be audio recording the session because I don't want to miss any of your comments. Although I will be taking some notes during the session, I cannot possibly write fast enough to get it all down. Because we are recording, please be sure to speak up so that we do not miss your comments.</p> <p>All responses will be kept confidential. This means that your interview responses will only be shared with research team members and we will ensure that any information will include in our report does not identify you as the respondent. Remember, you do not have to talk about anything you do not want to and you may end the interview at any time.</p> <p>Ichibemba (local language)</p> <p>Kang'onga Blind Centre in Ndola district</p> <p>Are there any questions about what I have just explained?</p> <p>Are you willing to participate in this interview?</p>
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	<hr/> Interviewee Witness Date
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Questions	<p>Part Two: Questions (45-50 minutes)</p> <p>Theme 1: Generic question.</p> <ul style="list-style-type: none"> • Describe for me what you know about HIV and AIDS? <p>Theme2: Ways HIV and AIDS information accessed by the visually impaired persons</p> <ul style="list-style-type: none"> • In what ways do you access HIV and AIDS information? <p>Probe for the following:</p> <ul style="list-style-type: none"> • communication with one another • Radio • What radio messages do you access on HIV and AIDS information • Television/drama • What about television and drama • Braille • Do you have access to braille messages • Large print and electronic media • Health facilities • Community activities on HIV and AIDS Education (participation) • IEC materials (strategies such as formats that are readable) • In your view which one among the discussed ways is the mostly preferred and easily accessed mode of communication?
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Theme 3: Challenges persons with visual impairment encounter accessing HIV and AIDS information.

- What challenges do you encounter in accessing HIV and AIDS information?

Probe for the following:

- Information on HIV is not always easily accessible
- Un able to afford radio
- campaigns cannot reach people with visual impairments
- discriminatory funding
- reduced employment opportunities
- Paid less than people without impairment
- less access to testing and treatment because transport and medication might be unaffordable
- clinics might not be not accessible,
- Voluntary counselling and testing might not be disability specific, or counselling may violate basic requirements of confidentiality.
- HIV and AIDS-related stigma and discrimination
- misperception that persons with visual impairments are sexually inactive, have often been left out of prevention campaigns and the development of programmes
- Health practitioners lack the necessary skills for adequately responding to the needs of persons with visual impairments.

Theme 4: Promotion of communication on HIV and AIDS information among the visually impaired.

- In your view what do you think can promote communication on HIV and AIDS information among the visually impaired?

Probe for the following:

- Participation of persons with VI.
- Involved in deciding the best information dissemination modalities compatible with the nature of their disabilities.
- accorded equal participation in HIV and AIDS mainstream intervention initiatives through the provision of:
 - Brailled information;
 - Inclusion in community and national workshops; and
 - Information-Education-Communication (IEC) strategies (Mass campaigns, messaging, advertising, distribution of brailled pamphlets and other resources such as DVDs and large print. Routine information presentation about HIV and AIDS policies, programmes, stigma and discrimination.)
- Peer education programmes;
- modified existing resources and programming for PWDs to address HIV;
- advocating for the rights of PWDs;

	<ul style="list-style-type: none"> • address issues of equal access to HIV information/services; • to coordinate a response to achieve inclusive national HIV and AIDS policies; • mainstreaming HIV awareness in their programming; • establishing national lobby committees to advocate for greater access to programmes and raise awareness; • developing specially formatted training and resource materials; • ensuring the participation of blind/partially sighted women as advocates, educators and beneficiaries; • Peer counsellors were trained on various topics related to HIV including transmission methods, counselling and testing, where and how to obtain health services, life skills, anti- retroviral therapy; • development of materials and messages in sign language, Braille and audio formats to meet the needs of individuals with disabilities; • Supported income-generating activities including tailoring, shoemaking, beadwork, art and crafts, carpentry and vegetable/fruit vending by PWDs. • training of numerous health care workers on disability issues; • access to legal and health services for victims of sexual abuse with disabilities;
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	<ul style="list-style-type: none"> • promoting gender equity, intergenerational respect and solidarity with people who are HIV positive; • Peer education; • translating HIV prevention information into Braille and working closely with HIV and AIDS organisations; • conducts awareness programmemes in schools for the blind while continuing to maintain peer support programmemes; and • Workshops covering all aspects of sexual and reproductive health. Including IEC, local gestures, captioning minirole play etc. <ul style="list-style-type: none"> • In your opinion what do you think should be done in addressing the challenges you face in accessing HIV and AIDS information?
<p>Closing Key Components</p> <ul style="list-style-type: none"> • Additional comments • Next steps 	<p>Is there anything more you would like to add?</p> <p>I'll be analysing the information you and others gave me and submitting a draft report to the organisation in one month. I'll be happy to send you a copy to review at that time, if you are interested.</p> <p>Thank you for your time.</p>

APPENDIX SIX

FOCUS GROUP DISCUSSION (ICHIBEMBA)

Umusapu	Ukulanshanya Kwe Bumba
Ifipande	Icipande cabumo (10 Bamineti)
Ukutotela abantu	Ndefwaya ukumitotela pakuti mu pose inshita yenu pakuti munkumanye ine leelo.
Ishina	Ishina lyandi nine Chintende Nsangwe Grace
Umulandu	Ndefwaya ukuti tulanshanye pa mulandu wa kumfwana pa fishinka fya bulwele bwa HIV na AIDS.
Ubunonshi	Ubunonshi emo buli leelo teapa peene iyoo. Leelo ifishinka twalasendapo fyalaafwilisha ukwafwa ubuteeko ukupanga amafunde no kwangusha inshila sha ku kwatilamo ifishinka pali HIV na AIDS ku bantu balya baba nobwafya bwa kumona.
Inshita	Ukulanshanya kwalaposa fye inshita 45 – 50 bamineti.
Ifyo ukulanshaya kwalaba	Ilyo twakulanshanya, nakulalemba. Nomba pantu teti nkwanishe ukulemba fyonse, nalabomfya iseleti ukusunga amashiwi yonse. namwishiba teeti nembe mulubilo ilyo mulelanda. Kanshi namilomba ukuti mulelandishako pakuti fyonse fyaumfwika.
Inkaama	Fyonse ifyo twalalaanda tulefisunga ni nkaama. Ici cilepilibula ukuti kulifye kaliibumba kalya fikumine e bakamona ukuti tamwishibikwe mwebo nde lanshyanya naimwe. Aikona ukulanda pa cintu ico mwebene mulemona ukuti tamulefwaya ukulandapo elyo kabili ukukulanshyanya kuti mwakupwisha inshita iili yonse mwatermwa.
Ululimi	Icibemba
Incende	Kang’onga Blind Centre ku Ndola
Ishuko lya kwipusha amepusho	Bushe namukwatapo amepusho pali ifi nalondolola?

Ifunde 3: Amafya abantu ababa no bwafya bwa kumona bapitamo pakuti bakwate ifishinka pali HIV na AIDS.

- Mafya nshi upitamo pakuti ukwate ifishinka pali HIV na AIDS?

Fwailikisha ifishinka pali ifi:

- Ifishinka pali HIV tafya anguka ukusangwa
- Ubwafya pa kusanga icilimba ca wailesi
- Ukulaima ukulaya ku mabumba ya bantu tacafwilisha balya ababa no bwafya bwa kumona.
- Umucisha cinani mu kupeela ulupiya lwa kubomfya kuli uyu mulimo.
- Ukuya kuceepa kwa kwa kubomba imilimo
- Ukulipilwa ulunono ukucila abashaba nobu ubwafya.
- Ukucepa kwa balepimwa no ukuundapwa pantu imyendele ne imiti teeti bakwanishe.
- Ifipatala limo bambi teeti bakwanishe ukufikako.
- Ukuimina ukuyafundwa na ukupimwa limo temulandu wa bwafya bwakumona iyoo, ukufundwa limo kuti kwalenga isambu ya kusunga inkaama bwino bwino.
- Umucisha – cinani no ukulasontwa iminwe ku mulandu wa HIV na AIDS.
- Ukumona kwati umuntu uwaba no ubwafya bwakumona teeti asangwe mu bulaalelaale, icilenga ukuti aba bantu balebasha ilyo lyonse kuli amalyashi ya kuicingilila ne milimo imbi iya buyantanshi.
- Abalolekesha pa bumi bwa bantu tabakwata kulya kucenjela kufwaikwa pakuti babombe bwino ifilefwaya abantu ababa no bwafya bwakumona.

Ifunde 4: Ukupakamisha ukumfwana bwino pa fishinka fyapali HIV na AIDS ku bantu baba no bwafya bwakumona.

- Mukumona kobe bushe finshi wingalabonfya ukupakamisha ukumfwana pali HIV na AIDS pa bantu balya baba no bwafya bwakumona?

Fwailikisha pali ifi:

- Ukuibimbamo abantu balya bonse baba nobwaya bwakumona.

	<ul style="list-style-type: none"> • Ukuibikapo pa kusuminishanya umusango uusuma uwakubomfya ukulingana namafya bapitamo abeene. • Ukupeela umulinganya ilyo baleibimba muli HIV na AIDS ilyo balesanga inshila iyineyine iyakwafwilisha ukucefyanya amafya ukupitila mu: <ul style="list-style-type: none"> • Mufilembelwa ababa no bwafya bwa kumona • Ukulabikamo ifya muncede bekala no kukumana no kulanshanya nga bekala calo bonse; elyo • Ifishinka – ukusanbilisha – no kumfwana inshila (ukupitila mu kulungama abantu abengi pa muku umo, ukusabankanya ilyashi, ukoongola, ukusalanganya ifyalembelwa ababa no bwafya bwakumona pamo nobunkolanya bwa ma DVD elyo nefya kulengalenga (ukupulinta). Libililibili ukulaibukisha abantu mu kubacinkula pali HIV na AIDS amafunde yalepangwa, ukutantika ifyakucita, ukusontwasontwa no mucisha – cinani) • Abantu abalingana mu micitile yafintu ukulafundana. • Ukulabomfya ifipe filipo no butantiko bwa bantu baba na mafya yamubili pakuti balelandapo napali HIV. • Ukulalandilako insambu shabantu ababa na mafya pamibili yabo. • Ukubombela pa mulandu wakuti bonse balekwata umulinganya pakukwata ifishinka pali HIV na AIDS elyo no kwakusanga ubu bwafwilisho • Ukulaumfwana bwino na bonse abo balingile pakuti kube ukubombela pamo icaalo conse pali HIV na AIDS • Ilyashi lya HIV ukulalitantika nalyo lyeka. • Ukupanga utubungwe twa caalo utwakulanda no kulomba ubwafwilisho pakuti kuleeba ukusangwako mu fipekanishiwe elyo nokuti kuleba ukwiluka. • Ukupanga inshila ishayibela no kutantikwa bwino pamo – pene nafyonse ifyakubomfya. • Ukumona ukuti balesangwako ababa no bwafya bwa kumona banamayo balya abakuti balamonako panono baba abantu abakulandilako, e balafunda no ukusekelamo. • Abakufunda abanabo balya ifimbusa basambilishiwa pa fintu ifingi ifikumine HIV na AIDS nge imisango akashishi kambukila, ifyakufunda ngembusa, ukupimwa, ukwakuya ne
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	<p>fya kwafwilishiwa pakuti kube ukusunga ubumi, elyo no muti wama ARVs ubomba.</p> <ul style="list-style-type: none"> • Ukupanga apali ifishinka fya HIV na AIDS elyo ne fishinka fili mu musango wa fishibilo, mu fyalembelwa ababa no bwafya bwa ku mona, mu musango wakuti abantu baleumfwakofye ukulingana no bufwayo bwa bantu baba namafya pa mibili yabo. • Ukubapeelako ukwakuti kulefuma akabukumu ifili nga ukubila ifyakufwala, insapato, ukupikula ubulungu, ukulenga na ukupikula no kubaasa, ukupala imbao, ukushitisha umusaalu nangu ifiseepo. • Ukusambilisha abengi abalolekesha pa bumi bwa bantu ukuti beshibilepo ifingi pa bantu baba no bwafya bwa kumona balebafwa bwino. • Ukwafwilishiwa nga baba ne milandu nangu balefwaya ukwafwilishiwa ifya bumi bwabo ku mulandu wakubalaala ku fipondo. • Ukupakamisha ifyakutwala mu ku pakamisha banamayo, umucinshi kuli bonse banamayo no kwi katana pamo bonse abasangwa na kashishi ka HIV. • Ukulanfundana ukulingana nefyo mulingene. • Ukupilibwila ifishinka fyakuitalusha fyapali HIV ukubika mu musango wafitabo balembela ababa nobwafya bwa kumona elyo nokubombela pamo notubungwe tulolekesha pali HIV na AIDS. • Ukulafunda muma sukulu ya bana baba no bwafya bwa kumona panshita imo ine ukukonkanya nabalya abafunda ukulingana nefyo balingene. • Ilyo bakumana mu kusambilila, kusambilila fyonse ukwambila fye ku kwampana pamo no ukusunga ubumi bwino. Kuti balembomfya ifya fishinka, ukufunda na ukumfwana, ukulangila kuminwe nangu umubili, ukupalanya umuntu nayimbi imisango. <ul style="list-style-type: none"> • Mu kutontonkanya kwenu, finshi muletontonkanya ifilingile ukucitwa pa mafya mule pitamo pakuti mukwate ifinshika pali HIV na AIDS?
<p>Ifikankala ifyakwisalila</p>	<p>Bushe pali na fimbi mwinga temwa ukulandapo?</p>

<p>ifipande Ukulundapo ifyakulanda</p> <p>Inshila shakonkapo</p>	<p>Nalapitulukamo mufyo twalanshanya na imwe nefyo bambi tulashenye nabo elyo nokutwala ifyo nalasanga no kulemba ku kabungwe pa mpela ya mweshi. Kuti natemwa namituminako ifyo nkalemba pakuti naimwe mwapitulukamo nga mulefwaya.</p> <p>Natotela ukumpeelako inshita yenu.</p>
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APPENDIX SEVEN

INTERVIEW GUIDE FOR KEY INFORMANT

Part One: Introduction-(10 minutes)

- Thank the participants for coming
- Explain the purpose of the study
- Ask for their consent to participate and explain that their participation is voluntary
- Date:.....
- Place:.....
- Language used during discussions:.....
- ID No:.....Interviewer:.....
- Profession of Interviewee:.....

Part Two: (45-50 minutes)

THEME 1: WAYS IN WHICH HIV AND AIDS INFORMATION ACCESSED BY THE VISUALLY IMPAIRED PERSONS

- You have been working with persons with visual impairment, in which ways do you facilitate their accessibility of HIV and AIDS information?

Probe for the following:

- communication with one another
- Radio

- What radio messages do you access on HIV and AIDS information
- Television/drama
- What about television and drama
- Braille
- Do you have access to braille messages
- Large print and electronic media
- Health facilities
- Community activities on HIV and AIDS Education (participation)
- IEC materials (strategies such as formats that are readable)
- Among the ways discussed, what would you consider to have been a key way to help with dissemination of information concerning HIV and AIDS to persons with visual impairments?
- Describe how people with visual impairment are mainstreamed/ integrated in community activities on HIV and AIDS Education?

THEME 2: Challenges persons with visual impairment encounter in accessing HIV and AIDS information.

- What challenges do you face in disseminating HIV and AIDS information to persons with visual impairment?

Probe for the following:

- Information on HIV is not always easily accessible
- Un able to afford radio
- campaigns cannot reach people with visual impairments

- discriminatory funding
- understaffed to carry out effective HIV and AIDS communication programmes
- less access to testing and treatment because transport and medication might be unaffordable
- clinics might not be not accessible,
- Voluntary counselling and testing might not be disability specific, or counselling may violate basic requirements of confidentiality.
- HIV and AIDS-related stigma and discrimination
- misperception that persons with visual impairments are sexually inactive, have often been left out of prevention campaigns and the development of programmes
- Health practitioners lack the necessary skills for adequately responding to the needs of persons with visual impairments.

THEME 3: Promotion of communication on HIV and AIDS information among the visually impaired.

- What kind of IEC materials do you have for the visually (strategies such as formats that are readable)?
- In your view do you think these IECs on HIV and AIDS are able to reach people that have visual impairment?
- Are there experts working with you in designing IEC materials on HIV and AIDS information materials for visually impaired?
- Is there anything more you would like to add?

Thank you for your cooperation

APPENDIX EIGHT

INTERVIEW GUIDE FOR KEY INFORMANTS (ICHIBEMBA)

Ichipandwa Cabumo: Ukulondolola -(10 minutes)

- Ukutetela abaleibimbamo pakwisa kwabo
- Ukulondolola umulandu wesambililo
- Ukwipusha nganabasumina ukuibimbamo nokulondolola ukweba ati ukuibimbamo kwaipelesha
- Ubushiku;.....
- Ichende;.....
- Ululimi lwalabofyeshiwa pashita yakulashanya
- Inamba yakwishibilwapo.....Uleipusha.....
- Ichito ibomba ulepusha.....

Ichapandwa Cabubili: (45-50 minutes)

IFIKOMO FYA MEPUSHO BALEISHI BISHIWA

IFUNDE 1: INSHILA SHIMO BESHIBILAMO PALI HIV NA AIDS KU BANTU BALYA ABASHIMONA

- Walebomba na bantu bakwata ubwafya bwakumona na menso, bushe ni munshila nshi wingabafwilishako ukwishiba ifishinka ba HIV na AIDS?

Fwailikisha ifishinka pali ifi:

- Ukumfwana cila umo na umo
- Umulabasa wa pa cilimba (waileshi)
- Bushe fishinka fya pacilimba fya musango shani iwe wingakwatatapo pali HIV na AIDS
- Ifitunshitunshi/ifisela

- Ifitabo filembelwa abakwata ubwafya bwa kumona.
 - Bushe walikwata ishuko lya kubelenga ifitabo fyalembelwa abakwata ubwafya bwa kumona?
 - Ifilangililo fyalengwa nangu ukulembwa nangu ukukopa na ukusabankanya ilyashi ukupitila muli ba komputa.
 - Ifyakubomfya mu kusunga ubumi
 - Ifyo abekala mushi baibimbamo pa kusabankanya ifishinka pali HIV na AIDS.
 - Umusango mupekanishishamo ifya kubelenga ifilepeela ifishinka, ukufunda no kumfwana.
- Munshila isha lekana lekana mulanshenye, ninshila nshi iikalamba mwinga sala iyingafwilisha ukusabankanya bwino ifishinka pali HIV na AIDS ku bantu balya ababa nobwafya bwakumona bwino na menso?
 - Londolola ifyo abantu balya baba no bwafya bwakumona balolekeshiwa ukulinga no bwafya bwabo nangu ifyo babombela pamo na bantu bambi bekala nabo mu mishi bekala mu kucita ifintu ifyalekanalekana pakufunda kwa HIV na AIDS.

Ifunde 2: Amafya Abantu ababa na mafya yakumona bapitamo mukuti bakwate ifishinka pali HIV na AIDS.

- Mafyanshi upitamo ilyo ulesabankanya ifishinka pali HIV na AIDS ku bantu baba nobwafya bwakumona?

Fwailikisha ifishinka pali ifi:

- Ifishinka pali HIV tafya anguka ukusanga
- Ubwafya bwakusanga icilimba ca mulabasa (waileshi)
- Ukulaima ukulaya ku mabumba ya bantu tacafwilisha balya abashimona bwino.
- Umucisha cinani mu kupeela ulupiya lwa kubomba uyu mulimo.
- Ukucepelwa kwa bantu bakubomba uyu mulimo bwino pakuti ilyashi lyapali HIV na AIDS lyumfwikishe bwino munshila ishalekana lekana.
- Ukucepelwa kwa bakuya mu kupimwa no ukundapwa ne miti ku mulandu wa bwafya bwa myendele elyo no kundapwa kwine bamo balafilwa ukukwanisha.
- Ifipatala limo kuti kwaba ukulafilwa ukufikako
- Ukuipelesha ukuyafundwa no kupimwa limo temulandu wabwafya bwakumona, ukufundwa limo kuti kwalenga isambu ya kusunga inkama ukukaana isunga bwino bwino.
- Kuba umucishacinani no ukusontwa iminwe ku mulandu wa HIV na AIDS.

- Ukumona kwati abantu baba no bwafya bwakumona teti basangwe mu bulaalelaale, icilenga ukuti aba bantu balebasha ilyo lyonse kuli amalyashi ya kuicingilila ne milimo imbi iya buyantanshi.
- Abalolekesha pa bumi bwa bantu tabakwata kulya kucenjela kufwaikwa pakuti babombele bwino ifilefwaya abantu ababa no bwafya bwakumona.

IFUNDE 3: Ukupakamisha ukumfwana bwino pa fishinka fyapali HIV na AIDS ku bantu baba no bwafya bwakumona.

- Bushe fintu nshi wingala bomfya ku baba nobwafya bwakumona ifyakuti nabo balebelenga?
- Mukumona koobe bushe uletontokanya ifi fintu ifya kubomfya pa kufunda pali HIV na AIDS ababa no bwafya bwa kumona kuti fyafika nangu ukubomba bwino ku bantu balya baba nobwafya bwakumona?
- Bushe kuli incenshi isho ulebomba nasho ilyo ulepekanya ifi fintu fyakubomfya pa kufunda HIV na AIDS ku bantu balya ababa nobwafya bwakumona?
Bushe paliko fimbi ifyo wingatemwa ukulundapo?

Impela

Twatotela pabwapano bwenu

APPENDIX NINE

IN-DEPTH INTERVIEW FOR THE VI

(Duration: 40 to 50 minutes)

Part One: Introduction-(10 minutes)

- Thank the participants for coming
- Explaining the purpose of the study
- Ask for their consent to participate and explain that their participation is voluntary
- Date:.....
- Place:.....
- Language used during discussions:.....
- ID No:.....Interviewer:.....
- Profession of Interviewee:.....

Part Two: Questions

Demographic characteristics and general information

1.Please, tell me about yourself

Probe for

- Age
- Sex
- Marital status
- Educational level
- Occupation

2. Theme One: Knowledge on HIV and AIDS.

Describe for me what you know about HIV and AIDS?

Probe for the following

- Cause
- Transmission
- Prevention

3. Theme2: Ways HIV and AIDS information accessed by the visually impaired persons

In what ways do you access HIV and AIDS information?

Probe for the following:

- Communication with one another
- Radio (What radio messages do you access on HIV and AIDS information)
- Television/drama (What about television and drama)
- Braille (Do you have access to braille messages)
- Large print and electronic media
- Health facilities
- Community activities on HIV and AIDS Education (participation)
- IEC materials (strategies such as formats that are readable)
- In your view which one among the discussed ways is the mostly preferred and easily accessed mode of communication?

4. Theme 3: Challenges persons with visual impairment encounter in accessing HIV and AIDS information.

What challenges do you encounter in accessing HIV and AIDS information?

Probe for the following:

- Information on HIV is not always easily accessible

- Un able to afford radio
 - campaigns cannot reach people with visual impairments
 - discriminatory funding
 - reduced employment opportunities
 - Paid less than people without impairment
 - less access to testing and treatment because transport and medication might be unaffordable
 - clinics might not be not accessible,
 - Voluntary counselling and testing might not be disability specific, or counselling may Violate basic requirements of confidentiality.
 - HIV and AIDS-related stigma and discrimination
 - misperception that persons with visual impairments are sexually inactive, have often been left out of prevention campaigns and the development of programmes
- Health practitioners lack the necessary skills for adequately responding to the needs of persons with visual impairments.

Theme 4: Promotion of communication on HIV and AIDS information among the visually impaired.

In your view what do you think can promote communication on HIV and AND AIDS information among the visually impaired?

Probe for the following:

- Participation of persons with VI.
- Involved in deciding the best information dissemination modalities compatible with the nature of their disabilities.

- accorded equal participation in HIV and AIDS mainstream intervention initiatives through the provision of:
- Brailled information;
- Inclusion in community and national workshops; and
- Information-Education-Communication (IEC) strategies (Mass campaigns, messaging, Advertising, distribution of brailled pamphlets and other resources such as DVDs and large Print. Routine information presentation about HIV and AIDS policies, programmes, stigma and discrimination.)
- Peer education programmes;
- modified existing resources and programming for PWDs to address HIV;
- advocating for the rights of PWDs;
- Address issues of equal access to HIV information/services;
- to coordinate a response to achieve inclusive national HIV and AIDS policies;
- mainstreaming HIV awareness in their programming;
- establishing national lobby committees to advocate for greater access to programmes and raise awareness;
- developing specially formatted training and resource materials;
- ensuring the participation of blind/partially sighted women as advocates, educators and beneficiaries;
- Peer counsellors were trained on various topics related to HIV including transmission methods, counselling and testing, where and how to obtain health services, life skills, anti- retroviral therapy;
- development of materials and messages in sign language, Braille and audio formats

- to meet the needs of individuals with disabilities;
- Supported income-generating activities including tailoring, shoemaking, beadwork, art and crafts, carpentry and vegetable/fruit vending by PWDs.
 - training of numerous health care workers on disability issues;
 - access to legal and health services for victims of sexual abuse with disabilities;
 - promoting gender equity, intergenerational respect and solidarity with people who are HIV positive;
 - Peer education;
 - translating HIV prevention information into Braille and working closely with HIV and AIDS organisations;
 - conducts awareness programmes in schools for the blind while continuing to maintain peer support programmes; and
 - Workshops covering all aspects of sexual and reproductive health. Including IEC, local gestures, captioning minirole play etc.
 - In your opinion what do you think should be done in addressing the challenges you face in accessing HIV and AIDS information?

Thank you