

HIV/AIDS AND ADOLESCENTS WITH DISABILITY

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**A dissertation submitted to the University of Zambia in partial fulfilment of
the requirements for the award of Masters of Education
in Special Education**



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DEDICATION

I dedicate this work to my late mother Ms. Beatrice Malikana Kamuneke and my late father Mr. Harry Muyunda Njekwa for educating me and for their love towards all of us, their children. May their souls rest in peace.

DECLARATION

I Margaret M. Simbyakula do declare that this dissertation is my own work, which has not been submitted for a degree at the University of Zambia or any other University.

Signature:.....

Date:30/06/09.....

APPROVAL

This dissertation by Margaret., M. Simbyakula is approved as a partial fulfilment of the requirements for the award of the Master of Education in Special Education of the University of Zambia.

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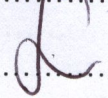
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ABSTRACT

The main objective of the dissertation was to find out whether adolescents with disability were catered for in educational and preventive outreach programmes in the fight against HIV and AIDS. The study specifically tried to find out if adolescents with disability are sexually active and if they do indulge in unprotected sex, among other things. It is at adolescent stage were individuals want to explore their identity, become adventurous, become sexually active and so on.

The study utilized a combination of quantitative and qualitative paradigms. Random sampling technique was used to select participants to ensure that all had an equal chance to participate in the study. They were drawn from Munali High School Special Unit in Lusaka Province which has a population of 238 pupils. The total sample size comprised of 104 pupils. A trained sign language expert was used as a research assistant to interpret certain concepts in sign language. The researcher conducted personal interviews to blind respondents since the questionnaire was not written in Braille.

The study revealed that knowledge of HIV and AIDS among adolescents with disability is still limited and the possibility of them being infected with HIV and AIDS is a reality because 35 percent of respondents in the study admitted that they were sexually active. Medium of communication suitable for specific disabilities if not used will forever exclude adolescent with disability from

acquiring information on HIV and AIDS. 42 percent of the respondents had no knowledge of HIV and AIDS.

The study made several recommendations. Among them, a national wide research should be undertaken by the Central Statistics Office to yield valid statistics on HIV and AIDS and Adolescents with Disability at national level, mode of communication about HIV and AIDS preventive and health care outreach programmes should be written in Braille and interpreted in sign language in order to reach adolescents with the hearing and visual impairments.

AIDS is real and it is affecting all categories of persons. HIV and AIDS reduction, prevention or eradication can only be achieved when HIV and AIDS advocates reach out to all categories of persons. Adolescents with disability should always be considered by all stakeholders in the preventive, education and health care outreach programmes.

ACRONYMS

ABC	Abstinence, Being faithful or Condom use
AIDS	Acquired Immune Deficiency Syndrome
ANASO	Angola Network of AIDS Service Organisation
CSO	Central Statistical Office
DFID	Department for International Development
DPSA	Disabled People of South Africa
FEDOMA	Federation of Disability Organization in Malawi
HIV	Human Immunodeficiency Virus
MCDSS	Ministry of Community Development and Social Services
MoE	Ministry of Education
MoH	Ministry of Health
NAC	National AIDS Council
NASC	National AIDS Surveillance
NAPCP	National AIDS Preventive and Control Programme
NFPDN	National Federation of People with Disabilities in Namibia
NGOs	Non Governmental Organisations
ILO	International Labour Organisation
RAISA	Regional Aids Initiative of South Africa
SAFOD	South Africa Federation of the Disabled

SADC	Southern African Developing Countries
SANAC	South African National AIDS Council
SHARES	Stop HIV and AIDS Reach Every Student
SIDA	Swedish International Development Agency
SPSS	Statistical Package for Social Sciences
STI	Sexually Transmitted Infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
UNZA	University of Zambia
VCT	Voluntary Counselling & Testing
VSO	Voluntary Service Overseas
WHO	World Health Organization
ZAFOD	Zambia Federation of the Disabled
ZAPD	Zambia Agency for Persons with Disability

CHAPTER ONE

INTRODUCTION

This chapter outlines a brief history of HIV and AIDS and adolescents with disability in the global context and Zambia in particular. It also discusses the importance of including adolescents with disability in the fight against HIV and AIDS. The chapter also presents the statement of the problem, purpose of the study, objectives, research questions, significance of the study, definitions of key words and conceptual framework.

1.1 Brief History of HIV/AIDS and adolescents with disability in the global context and Zambia

The first recognized cases of AIDS occurred in the USA in the early 1980^s. A number of gay men in New York and California suddenly began to develop rare opportunistic infections and cancers that seemed stubbornly resistant to any treatment. At this time, AIDS did not yet have a name, but it quickly became obvious that all the men were suffering from a common syndrome. The discovery of HIV, the Human Immunodeficiency Virus, was made soon after (WHO, 2000).

In Zambia the first AIDS case was reported in 1984. Only one year later 17 percent of hospital patients in the capital city, Lusaka were found to be HIV-positive. Within two years of the first report of AIDS in the country the National

AIDS Surveillance Committee (NASC) and National AIDS Prevention and Control Programme (NAPCP) were established to coordinate HIV and AIDS-related activities (Post Newspaper, 1999).

In April 2004, the World Bank and Yale University published the report on HIV and AIDS and Disability entitled: "Capturing Hidden Voices". The survey revealed that individuals with HIV were also suffering from such vices as poverty, marginalization, stigmatization, lack of education, lack of information and resources to ensure safer sex, elevated risk of violence, rape, lack of legal protection, substance abuse and being orphaned or made vulnerable (Janssen, 2005).

Recent World Bank estimates suggest that individuals with disability may account for as many as one in five of the world's poorest (World Bank, 2004). Because of this, disability is now increasingly recognized as a key development issue and its importance in relation to social, human rights and the achievement of internationally agreed upon development goals is receiving mounting recognition.

The Demographic and Health Survey conducted in 2001-2002 confirms that the current infection rate in Zambia is 16 percent among adults of reproductive age (17.8 percent for women, 12.9 percent for men). At the end of 2001, more than 1.2 million people were living with HIV and AIDS (COS, 2001-2002).

Still in the midst of such an epidemic, it is important to remember that 84 percent of people aged 15-49 remain uninfected with HIV and have the opportunity to take measures to protect themselves and help stop the spread of the virus. This is why a strong response to the epidemic from all sectors of Zambian society is critically important (NAC, 2007).

The 2000 census found that there were 282,684 people with disabilities in Zambia, comprising 2.9 percent of the population. This figure is significantly lower than the WHO estimate of 7 to 10 per cent, according to which the population of disabled persons lies between 690,000 and 1 million (ZAFOD, 2003).

Apparently, persons with disability are frequently a forgotten minority in the national response to HIV and AIDS. Nevertheless persons with disability are an important stakeholder group that may be particularly vulnerable to infection and susceptible to its impact. The focus of the study is on adolescents with disability. Adolescents in all societies are expected to acquire skills, go through physical and psychological maturation, become sexually active and assume a social identity that will enable them to fully participate in their communities. What distinguishes this group is not their common needs, but the fact that these needs continue to go largely unmet.

Webb et al. (1996) categorizes adolescents in the range of 12 and 19 years old, while UNICEF ranges them between 10 and 18 years old and UN ranges them between 19 and 24 years old. This study captured those ranging from 13 to 21 years old. However, for persons with disabilities, who may be more susceptible to becoming infected and who then may feel the impact of HIV all that more greatly, the availability to medical treatment and sexual health knowledge is especially important (DFID, June 2007).

Too often, adolescents with disability have not been included in HIV prevention and AIDS outreach efforts because it is assumed that they are not sexually active and at little or no risk of HIV infection. The Global Survey on HIV and AIDS and Disability has proven this assumption wrong. Individuals with disability have equal or greater exposure to all known risk factors for HIV infection. Research has proved that adolescents and adults with disability are as likely as their non-disabled peers to be sexually active (Groce and Trasi, 2004).

The preliminary findings from the Yale and World Bank study strongly advocated that disabled people can—and should—be included in all HIV and AIDS outreach and service efforts. Much of this work can be done at little or no additional expense. Other programmes need only slight modification to be made significantly more inclusive. Disability-specific measures will also be needed to reach some subgroups within the larger population of persons with disability. These can be justified from the perspective of both development economics and

human rights. A three-stage intervention model is proposed by the study to ensure that individuals with disability are reached by HIV and AIDS outreach efforts. The need for expanded research and increased educational and clinical outreach was strongly urged by the study (World Bank and Yale University, 2004).

It has been a trend by HIV and AIDS and disability advocates not to include adolescents with disability in outreach programmes for disabled children, women, orphans, and so on. There is little literature known about how persons with disabilities can best be reached as part of the general HIV and AIDS outreach efforts or through disability-specific programmes. Currently, interventions that include individuals with disability are rare, most of them are short-term, and almost all lack monitoring or evaluation (Groce, 2004). Similarly, there are unique social, psychological, educational and economical needs addressed by programmes designed for their non-disabled age-mates.

The UN Committee on Economics, Social and Cultural Rights (2000), specifically noted the need for the right to equal access to health care for persons with disability as a major component in their general comment on The Right to the Highest Attainable Standard of Health. In light of this statement, the issue of the impact of the HIV and AIDS epidemic on adolescents with disability could not be more timely or more significant.

Therefore, this dissertation discusses HIV and AIDS and Adolescents with visual and hearing disability at Munali High School in Lusaka.

1.2 Statement of the Problem

The disabling effects of HIV and AIDS on previously healthy people have been the subject of attention by AIDS researchers. However, there is a striking absence of attention to the risk of HIV infections in individuals who have a physical, sensory, intellectual or mental health disability prior to acquiring the virus (Groce, 2004).

Schriner (2003) reported that the South African National Aids Council (SANAC) argued that people with disabilities must be involved in HIV and AIDS programmes to overcome the current focus on “normal” people. He is quoted as saying “We must acknowledge that our AIDS education had mainly been targeted at people who are considered ‘normal’ and people with disabilities have been left without any knowledge about HIV and AIDS and the protective measures needed to be taken to prevent the spread of disease or infection”. This is compounded by the fact that too often, it is incorrectly assumed that these adolescents are not or will not become sexually active or be victims of rape.

The medical, social and economical needs of adolescents with disability have often been placed last on a long list of competing social priorities. It is not unusual to have policy makers suggest that time, energy and resources should

first be devoted to non-disabled population, with the assumption that the benefits would trickle down to the disabled. This tradition has led to a striking absence or limited attention to the risk of HIV infection to adolescents with disability.

1.3 Purpose of the Study

The purpose of the study was to find out the impact of HIV and AIDS on adolescents with disability; outreach programmes for them; how accessible the information is and what can be done.

1.4 Objectives of the Study

The objectives of the study were to:

1. To establish how much information has been disseminated to adolescents with disability on HIV and AIDS.
2. To establish whether adolescents with disability are sexually active.
3. To establish whether there were preventive measures of HIV and AIDS directed at adolescents with disability.

1.5 Research Questions

The following questions guided the study:

1. How much knowledge do adolescents with disability have on HIV and AIDS?
2. Do adolescents with disability engage in sexual activities?

3. Are there preventive measures targeting towards adolescents with disability on HIV and AIDS?

1.6 Significance of the Study

The findings of the study will be of value to the Ministry of Education and National HIV and AIDS policy makers; teachers and NGOs who work with visual and hearing impairments and other stakeholders of HIV and AIDS and disability in the global effort to fight HIV and AIDS.

This study will also show why it is important to involve adolescents with disability in HIV and AIDS education and preventive programmes.

1.7 Definitions of Key Words in the Study

1. *Acquired Immune Deficiency Syndrome* - Disease due to infection with the human immuno deficiency virus (HIV).
2. *Human Immunodeficiency Virus* - Virus that destroys the immune system of the body to fight against infections.
3. *Adolescent* –stage of development between childhood and adulthood, between puberty and adulthood.
4. *Disability* – refers to loss or reduction of functional ability as a result of impairment. A person is said to be disabled when he/she finds it difficult to move, see, hear, feel, think, control oneself or do certain things.
5. *Visual impairment* – low vision or being blind.

6. *Hearing impairment* – difficulties in hearing sound or being deaf.
7. *High School* – an educational institution that offers academic subjects to pupils from grade 10 to grade 12.

1.8 Conceptual Framework

Zambia has been collecting disability data in all the four censuses of 1969, 1980, 1990 and 2000. In collecting information for the past four censuses, categories used the 2000 Census of population and housing. Data collected on disability included eight categories, but only five categories were captured. This was in recognition of the varying degrees of disability. The increase in the number of disability categories in the 2000 Census was also aimed at capturing more persons with disability who were left out in the previous censuses such as those who are partially sighted and hard of hearing.

Persons with disabilities have the same rights as other citizens to opportunities for self-actualization and participation in the economic and social development of this country. Information on persons with disabilities is important for addressing barriers that limit their enjoyment of these human rights and their integration into the mainstream of society, (CSO, 1969, 1980, 1990 and 2000).

Adolescents with disability have needs that are very similar to the needs of all other young people (UNICEF 2000). Since the study was on HIV/AIDS and adolescents with disability, the conceptual framework applied to this study is the

human rights perspective. It places human rights at the centre, recognizing every human being as a person and as a right holder. It supports mechanisms to ensure that entitlements are attained and safeguarded by rights holders (Kisson et al., 1998). This human rights based approach was relevant to this study because it helps to understand and explain the importance and significance of including adolescents with disability on HIV and AIDS preventive and health care outreach programmes as a basic human right and not a privilege.

1.9 Summary

The statement of the problem, purpose, significance and the research questions raised in this chapter justifies the need to carry out a study on HIV and AIDS and adolescents with disability.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter explores relevant literature on HIV and AIDS and Adolescents with disability in the global context, Southern African countries and Zambia in particular.

2.2 The Global Context

Globally, there are roughly one billion adolescents in the world with roughly 100 million adolescents with disability in the Developing world (UN Statistics, 1990). One in ten people or as many as 600 million people worldwide – live with a physical, sensory (deafness, blindness), intellectual, or mental health impairment significant enough to make a difference in their daily lives (UN 1993). Eighty percent (80%) of these live in the developing world (Helander, 1999).

Despite growing numbers and their striking needs, adolescents with disability have historically fallen through the cracks. General programmes that are intended for adolescents and young adults rarely include those with disabilities. Programmes for disabled populations, where they do exist are, unfortunately no more inclusive. Particularly, outside the Developed World, programmes for those with disability are generally either intended to provide services and general

advocacy for all disabled members of a society or fall decisively into one of the two categories – programmes for disabled children or for adults with disability (Wallace, 1990). It is important to note that adolescents with disability have needs very similar to the needs of all other young people, as clearly stated in Article 23 of the United Nations' Convention on the Rights of the Child (UNICEF, 2004).

Of equal concern, although too often overlooked is the increased risk for adolescents with disability to be infected by the HIV and AIDS virus. This is compounded by the fact that society incorrectly assumes that they are not or will not become sexually active (Groce: 2003). Even the call made by UNICEF (1999) on adolescents for more research on the wide array of issues that influence the lives of adolescents with disability has remained largely unanswered.

Groce (2004) also noted that, AIDS is a looming problem for adolescents with disability worldwide – a problem that is still largely unrecognized by both the AIDS and the disability advocacy communities.

Furthermore, Murphy and Young (2005), observed that adolescents with disability seem to be participating in sexual relationships without adequate knowledge and skills to keep them healthy, safe, and satisfied. Although their sexual development may be hindered both by functional limitations and by

intentional or unintentional societal barriers, the formal and informal opportunities for adolescents with disability to develop into sexually expressive and fulfilled persons do exist.

Adolescents and young adults with disability are often grouped together and discussed jointly because they share common characteristics: they are often bypassed both by the programmes and policies designed for disabled children and they are left out of advocacy initiatives, social and employment schemes designated for adults with disability.

SIDA, (1995) observed that globally, social, economic and educational issues are far more pressing for many adolescents with disability than are medical issues (such as HIV and AIDS). However, the availability of rehabilitative care, prosthetic devices and age appropriate health care need to be singled out. This is because of a significant lack of such services and because all too often, socio-economic discussions about adolescents with disability are side tracked by the presumed medical or rehabilitative needs of the population.

UNICEF (1993) stated that activities that help adolescents develop self-esteem and thus make them less likely to engage in risky behaviour also rarely receive adequate attention. Nor do adolescents have access to counselling or health services that help them deal with sexuality, reproduction and HIV and AIDS. Furthermore, the UN (2004) report revealed that cases of HIV and AIDS among

adolescents are due to unsafe sexual relations, lack of appropriate sex education and ignorance of means of protection. Worldwide, less than one in five people at risk of becoming infected with HIV has access to basic prevention services (UNAIDS, 2004).

Sex education empowers adolescents with disability to enjoy personal sexual fulfilment and to protect themselves from abuse, unplanned pregnancies and HIV and AIDS. It also becomes easier to initiate and continue conversation on sexuality when they are discussed openly and routinely among adolescents (Murphy and Young, 2003) but Coleman and Hendry, (1999) argue that even in schools where sex education is taught, adolescents still feel unprepared for the changes of puberty, suggesting that these important topics are not being dealt with in ways that are most useful to them.

However, education has a key role to play both in the prevention of HIV and AIDS and in mitigating its effects on individuals, families, communities and society, but what is taught and how, has a major bearing on the specific target group (Janssen, 2005).

The effects of HIV and AIDS among adolescents and young adults between the ages 13-24 years in the United States, has continued to be an increasing concern. The average duration from HIV infection to development of AIDS is 10 years. Most adults with AIDS were likely infected as adolescents or young adults.

Most HIV-infected adolescents are exposed to the virus through sexual intercourse. Approximately 25 percent of sexually transmitted infections (STIs) reported in the United States each year are among adolescents. Adolescents tend to think they are invincible and, therefore, deny any risks. This belief may cause them to engage in risky behaviour, delay HIV testing, and if they test positive, delay or refuse treatment. The inability to link them to medical care can lead to increased transmission of HIV. Recruiting adolescents into clinical trials is important to ensure that research results will be applicable to therapy for that age group. Most clinical trials are open to adolescents, but in reality very few enrol (UNICEF, 1999).

Of people living with HIV, only one in ten had been tested and knows that he or she is infected. One group for whom no statistics are available, however, is people with disabilities. For instance, a small survey in the United States reported that the HIV infection rate among deaf individuals was twice that of the surrounding hearing population, but no such studies have been done in Southern Africa. This lack of information generally leads to an assumption that adolescents with disability are not at high risk of contracting HIV and AIDS. They are not targeted specifically in campaigns and in many cases are excluded from receiving information on HIV and AIDS (Janssen, 2005).

It must be mentioned, however, that, reaching adolescents with disability with HIV and AIDS messages, clinical care and reproductive health services presents

unique challenges. Even when AIDS messages do reach persons with disabilities, low literacy rates and limited educational levels complicate comprehension of these messages (UNICEF, 2004).

Furthermore, Janssen (2005) stated that messages to the general public often do not reach people with disabilities because radio campaigns do not reach the deaf, billboard messages do not reach the blind. Education has a key role to play both in preventing HIV and AIDS and in mitigating its effects on individuals, including: adolescents, families, communities and society at large.

For example, for the visually impaired and the blind – they have little or no access to printed material: there is a great need for audio tapes and Braille information for the literate, and for the hearing impaired and the deaf – sign language is not well- suited to explaining some issues surrounding HIV and AIDS and lack of deaf counsellors means that deaf people do not have any privacy when receiving counselling.

Individuals with disability usually suffer victimization, marginalization and stigmatization. More often than not, this group of people is highly vulnerable to sexual abuse. The idea that sex with a virgin can cure AIDS has fuelled some violence because disabled female adolescents are often assumed to be not sexually active and therefore virgins. They are systematically raped by people who are desperate to get rid of their infection (Groce, 2003).

Furthermore, Murphy and Young (2005), stated that adolescents with disability were more than twice likely to be sexually abused compared to adolescents without disability. This is more because of their daily dependence on others for intimate care, increased exposure to a large number of caregivers, inappropriate skills, poor judgment and inability to seek help or report abuse and lack of strategies to defend them against abuse.

From the global perspective, there is evidence that studies have been carried out by researchers in the area of HIV and AIDS and disability.

2.3 The Southern Africa Context

HIV prevalence rates are staggering in Southern Africa, with infection rates among adults as high as 38 percent in Swaziland, 23 percent in Namibia and 16 percent in Zambia; in some districts the rate even exceeds 50 percent. Prevalence is higher than average among most vulnerable groups, such as women, sex workers, substance users and men who have sex with men (Janseen, 2005).

The Southern African Federation of the Disabled (SAFOD) is the umbrella organization of the national disabled organizations of the SADC countries, Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, Swaziland, South Africa, Zambia and Zimbabwe. SAFOD is working on several Regional Development Programmes to lobby and advocate for the rights of disabled

people in the region (Musakanya, 2003). SAFOD main objectives are to; minimize and prevent HIV and AIDS among persons with disabilities, improve the quality of life for persons with disabilities through awareness on the effects of the consequences of HIV and AIDS and Improving the accessibility to information production, pertaining to HIV and AIDS through the production of Braille AIDS awareness materials and training of sign language interpreters in order to absorb the hard of hearing, the deaf and the visually impaired into the programmes.

Mozambique was among the first countries to launch the initiative in 2005. The global campaign is an urgent call for action to put care and protection of children and young people at the centre of the AIDS agenda and to scale up interventions for children infected and affected by AIDS. Two years into the campaign, significant progress has been achieved as a result of the joint work of the various partners in the four main priority areas: prevention of mother-to-child transmission of HIV; provision of paediatric treatment for children infected by HIV; prevention of new HIV infections among young people, and protection and support for children affected by HIV and AIDS.

However, an increasing proportion of Mozambicans are getting infected with HIV, with most new infections occurring in young people (adolescents). In 2000, the national HIV prevalence among adults in their prime years of life – between 15 and 49 years of age – was estimated to be 12.2 per cent and by 2006 it had risen to 16.2 per cent (UNICEF, 2007).

The HIV and AIDS pandemic continues to affect every level of society in Lesotho as it took its toll on the population in terms of death, disability, lost productivity and numbers of orphans and vulnerable children. In 2001, the Government of Lesotho pronounced its commitment to combating HIV and AIDS as a national priority by mandating its government agencies to designate two percent of their budget for HIV and AIDS activities. The nation-wide infection rate in Lesotho at the end of 2001 was 31 percent (National AIDS Commission, 2008).

On preventive measures, research findings by (UNAIDS/UNFPA/WHO, 2004) revealed that the male latex condom is the most efficient available technology to reduce the sexual transmission of HIV and other sexually transmitted infections. To get ahead of the epidemic, there is growing recognition that HIV prevention efforts must be scaled up and intensified (UNAIDS, 2005).

According to research by Angola Network of AIDS Services Organization (ANASO) 70 percent of youths in the country do not use condoms, despite their awareness of HIV. The network plans to partner with the Ministry of Education and communities throughout Angola to mobilize and educate 340,000 young people through 2010 (Kaiser, July 2008).

The disability survey that was carried out in Zimbabwe by the Ministry of Labour, manpower, planning and social welfare in 2003 revealed that; Negative attitudes towards persons with disability by the society prevent them from accessing the

mainstream health services, as well as information, education and communication programmes on HIV and AIDS and lack of access to information on HIV and AIDS for the blind, hearing and intellectually impaired persons is making these groups more vulnerable to the disease (Musakanya, 2003).

The HIV and AIDS and Disability Conference in Namibia reported that South Africa, through a strong lobby from Disabled People South Africa (DPSA), has an HIV and AIDS programme at the ministerial level, targeting people with disabilities; action by the governments of other countries lags far behind. The disability movements in various countries do recognize the gravity of HIV and AIDS and most of them are doing something to educate their members. For example, Federation of Disability Organization in Malawi (FEDOMA) organizes workshops for their membership.

In Namibia, the National Federation of People with Disability (NFPDN) first became involved in HIV and AIDS activities in 2002 and it organized the first Southern African Workshop on HIV and AIDS for disabled people together with Voluntary Service Overseas and Regional Aids Initiative of South Africa (VSO-RAISA) in February 2003. In 2005 the NFPDN started several new initiatives to educate its members about HIV and AIDS including peer education and training programmes for HIV and AIDS counsellors. It revealed that knowledge on HIV and AIDS was very limited among people with disability. The following suggestions were made; training people with disability as HIV and AIDS trainers,

peer educators and counsellors and designing, printing and distributing specific materials (e.g. Braille) pro HIV and AIDS (VSO-RAISA, Feb, 2003).

In Botswana National Association of the Deaf noted that although some people say HIV and AIDS rates in Botswana are declining, people with disabilities have not been reached. It also argued that the country's existing laws on HIV and AIDS intervention strategies address the problems of non-disabled people, adding that Botswana's response to HIV and AIDS is not serving people with disabilities. "We cannot make significant progress on national AIDS statistics unless government and community efforts better respond to the needs of people with disabilities" (Kaiser, April- 2008).

The general overview in Southern Africa concerning HIV and AIDS and disability is that, various stakeholders in the fight against HIV and AIDS pandemic are raising concerns over the non availability of health care services and preventive measures towards persons with disabilities.

2.4 The Zambian Context

The Zambian government developed a strategic plan for addressing HIV and AIDS as early as the mid-1980s. The current National HIV and AIDS Strategic Framework, finalized in 2000, covers the period 2000–2004. Its aim is to reduce the rate of new infections and to mitigate the effects of the epidemic by working in partnership with all ministries, non-governmental organizations, and bilateral

and multilateral donors. The National AIDS Bill, passed by Parliament in December 2002, formally established the National AIDS Council and the AIDS Secretariat.

ZAPD was created by the Persons with Disabilities Act, 1996, and is Placed under the MCDSS. ZAPD has the responsibility to coordinate the implementation of the National Policy on Disability, and to establish a Fund, in line with Schedule 9 of the Persons with Disabilities Act, 1996. Its stated functions include: planning, promoting, coordinating and providing services for people with disabilities, including training services; welfare and rehabilitation; keeping statistical records of incidence and cause of disability; promoting research on rehabilitation programmes for people with disabilities; and advising the Minister on the well-being of people with disabilities. In preparing this report, no information could be found on services currently provided by ZAPD (ILO, 2007).

The Ministry of Health (MoH) (2005) estimates that 90 percent of HIV transmission in Zambia is as a result of having sex with an infected person. Alta (2001) also confirms that HIV is sexually transmitted primarily through unprotected vaginal or anal intercourse. Furthermore, UNAIDS (2005) reported that, female adolescents are especially vulnerable to HIV infection because their genital tracts are not yet fully mature.

However, Ministry of Education (MoE) (2001-2005) HIV and AIDS Strategic Plan puts emphasis on activities targeting the age group of 5 – 14 years as they are most likely to be HIV free and constitute the window of hope for the future.

Furthermore, the MoE (2003) states that, HIV and AIDS education co-curriculum should encourage anti-aids clubs, drama, cultural clubs and peer counselling. The MoE (2006) also states that, for the education sector to respond effectively to the challenges of HIV and AIDS, there is need to develop a national strategy for addressing HIV and AIDS issues as they affect the entire education system.

The MoE (2006-2007) focused on the situation of HIV and AIDS in high schools. It was observed that the majority of Zambian high schools had; poorly developed and uncoordinated HIV and AIDS preventive education programmes for young people, insufficient support for orphans and vulnerable children, lack of competence and confidence of teachers to teach HIV and AIDS, loss of trained and experienced staff and insufficient structures and systems to mitigate the impact of HIV and AIDS.

Guidelines for Voluntary Counselling Centre (VCT) administration have been introduced based on international standards in Zambia (MoH 2005). WHO (2000) defines 'Voluntary Counselling' as a confidential dialogue between a client and care provider aimed at enabling the client to cope with stress and take personal

decisions related to HIV and AIDS. VCT has emerged as a major strategy for the prevention of HIV and AIDS infection in Africa (Mkaya-Mwamburi et al., 2000).

Abstaining from sex, being faithful to one sexual partner and correct and consistent use of a condom every time one has sex (ABC) are also preventive measures towards the HIV and AIDS pandemic (SHARES 2003).

Other notable strategies for the prevention of HIV and AIDS infection are knowledge of modes of transmission of HIV, coupled with choice and willingness to abstain and/or consistent use of condoms. A survey conducted on 1228 students, aged 16-24 years, from 12 institutions of higher learning, including the University of Zambia (UNZA), showed high levels of awareness and knowledge on the mode of transmission of HIV. Among those who were sexually active, three quarters of the students knew about condoms preventing infection. Despite that, only about a third reported always using condoms. Not only was condom use among the respondents low but its use was inconsistent also (SHARES, Ibid).

As much as the adolescents with disability would like to change the behaviour towards sex as a prevention measure towards HIV and AIDS, poverty makes it very difficult to engage in safer sex. Studies in Zambia and other countries like Angola and Malawi consistently show economic setbacks in households that have experienced an AIDS related chronic illness (MoH, September 2004).

2.5 Summary

The chapter reviewed literature related to HIV and AIDS. The HIV and AIDS epidemic is of major concern worldwide. Eradication of HIV and AIDS can only be successful if all categories of persons are catered for, more especially the vulnerable groups in society. As noted, exclusion of persons with disabilities from the HIV and AIDS prevention and healthcare programmes is a reality. Given the statistics that one in ten or as many as 600 people worldwide live with disabilities (UN 1999) inclusion of this category of persons in the fight against HIV and AIDS paramount.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

The methodology chapter aims at outlining the process of the study. Various aspects are dealt with under the following headings; research design, population, sample size, sampling procedure, research instruments, data collection, and data analysis.

3.2 The Research Paradigm used

The study utilized a combination of qualitative and quantitative paradigms. A paradigm is a framework that organizes broadly based views. Paradigms create boundaries within which the search for answers occurs and circumscribe or delimit what is important to examine in a given field of inquiry (Ulin, et al., 2002).

In quantitative research, options have been predetermined and a large number of respondents are involved. By definition, measurement must be objective, quantitative and statistically valid (Anderson, 2006).

On the other hand, research utilizing a qualitative paradigm focuses not only on objective verifiable facts but also on the many subjective meanings that people attach. Qualitative inquiry typically focuses on in-depth or on relatively small

samples, even single cases, selected purposively. It views the world as constructed, interpreted and experienced by people in their interactions with each other and with wider social systems (Ulin, et al., 2002).

Basically, quantitative research is objective while qualitative research is subjective. Blaxter et al. (2001), contend that the most common paradigms that researchers are introduced to are those termed quantitative and qualitative. These offer the basic framework for dividing up knowledge.

3.3 Research Design

Achola and Bless (1988) perceive a research design as a programme that guides a researcher in the collection, analysis and interpretation of observed facts. Ghosh (2002), also states that a research design is the arrangement of conditions, analysis of data and interpretation of observed facts in a manner that combines relevance to the research purpose with economy in procedure.

According to Cohen and Manion (1994), a survey is a collection of information or data at a particular point in time with the intention of describing the nature of existing conditions or identifying standards against which the existing conditions can be compared, or determining the relationship that exists between specific events.

3.4 Population

A population is the entire set of objects, people or events that one would be interested to study or it is the set of people or entities to which findings are to be generalized (Merriam and Simpson, 1995). This agrees with Borg and Gall, (1979) who state that target population or universe refers to all the members of a real, hypothetical set of people, events or objects to which we wish to generalize the results.

At the time of the study there were a total of 238 pupils at Munali High School Special Education Unit in Lusaka province.

3.5 Sample Size

The total sample comprised of 104 respondents who responded to questionnaires and took part in the interviews. These were categorized as follows: 99 deaf pupils, 4 blind pupils and 1 pupil who did not indicate the disability. 51 were males and 53 were females.

3.6 Sampling Procedure

Sampling is a process through which the study subjects are chosen from a population (Treece and Treece, 1986). Sampling helps focus the study on precisely the characteristics of interest. There are two groups of sampling methods, namely probability and non-probability (random and non-random) sampling.

Probability sampling provides a statistical basis for saying that a sample is representative of the study or target group population. In this type of sampling, every member of the target population has a non zero probability of being included in the sample (Fink, 1995). Probability sampling implies the use of random selection.

Non-probability sampling involves choosing samples based on judgement regarding the characteristics of the target population and the needs of the study. With this method, some members of the eligible target population have a chance of being chosen while others do not.

Non-random sampling method, specifically purposive sampling technique was used to select respondents. This is a sampling technique where there is non-equal chance of individuals to be selected as a sample or being included in the sample. The non-random sampling is based on the researcher's judgement or convenience and the characteristics of the sample (Merriam and Simpson, 1995). In this method, some members will have a chance to be selected while others will not. This method was used to select all respondents at the Special Education Unit at Munali High School for the blind and deaf pupils. The criteria for selection involved willingness to participate in the study and being in the targeted age bracket of adolescents.

3.7 Research Instruments

It was decided that the most effective course of action in terms of gathering the necessary data would be to administer questionnaires and interview guides. Bell (1993), states that questionnaires and interviews are a good way of collecting information quickly and are relatively cheaper.

Other strengths of the questionnaire are that, it secures standardized results that can be tabulated and treated statistically. It can be mailed when the field of research is vast and the respondents are scattered over a very large area. A large sample may also be drawn and all groups of people can easily be covered and contacted. The method places less pressure on the subject for immediate response and gives more time to the respondents to answer questions. Information obtained through this study is more valid and reliable.

Interviews are flexible and applicable to different types of problems in that the interviewer may change mode of questioning if the occasion demands. Unclear responses from the respondents can be clarified by rephrasing the questions. Interviews, especially the semi-structured ones, give the respondent the opportunity to ask the interviewer to explain or clarify certain things where he or she is not sure. In interviews, the interviewer has the opportunity to engage more closely with the respondents and can therefore play a role in fostering an environment which is more conducive to open a frank discussion. In this study, questionnaires were used to collect data.

3.8 Data Collection Procedure

In this study the researcher personally visited the study area identified as Munali High school Special Education Unit to administer questionnaires to the deaf respondents and conduct interviews with the blind respondents.

Data was collected over a period of 5 days (12th – 16th February, 2007). The researcher used one of the trained sign language teachers as a Research Assistant to clarify certain questions administered in the questionnaire to the deaf pupils. The pupils were divided into five groups, a maximum of twenty pupils per day. As for the blind pupils, the researcher conducted interviews by reading out the questions in the questionnaire to each of them and coded the responses. To ensure anonymity and confidentiality, no names were written on the questionnaires.

3.9 Data Analysis

The quantitative data collected in the study was entered, cleaned and analysed using the Statistical Package for Social Sciences (SPSS). Thereafter, the data were computed and presented as percentages with the use of bar charts and tables. The qualitative data, on the other hand, was used to explain the findings.

3.10 Summary

Chapter three described the process of the study. It presented the approaches adopted for data collection and data analysis. In this regard, the researcher

followed suggestions made by several research methodology experts by using a combination of quantitative and qualitative paradigms. The criteria used to choose the methods and the analytical categories applied in the study have been presented in detail. Finally the chapter has outlined the procedures used to analyze the data gathered from the field. The next chapter presents the finding from the study in relation to themes under which the data were analyzed.

CHAPTER FOUR

PRESENTATION OF FINDINGS

4.1 Introduction

The essence of any study is to collect data that will invariably represent the problem in the study. However, it is important that data collected is not only keenly analyzed and tabulated, but that it also represented the responses of the population under study. This chapter presents the findings of the study. It gives the information that was gathered in the field in an organized manner in order to provide meaning.

4.2 Characteristics of Respondents

The main focus of the research enterprise was to determine whether adolescents with disability between the ages of 13 – 21 years old are catered for in the fight against HIV and AIDS. The choice for the mentioned age bracket came as a result of the nature of the problem under study, which is HIV and AIDS and adolescents with disability. This age group is often likely to be sexually active. Also being visually and hearing impaired, such youth require unique communication skills which need to be interpreted from the normal language to either sign language or Braille for them to understand what HIV and AIDS is all about.

Table 4.1: Sex distribution of all respondents

Gender	Frequency	Percent
Male	51	49
Female	53	51
Total	104	100

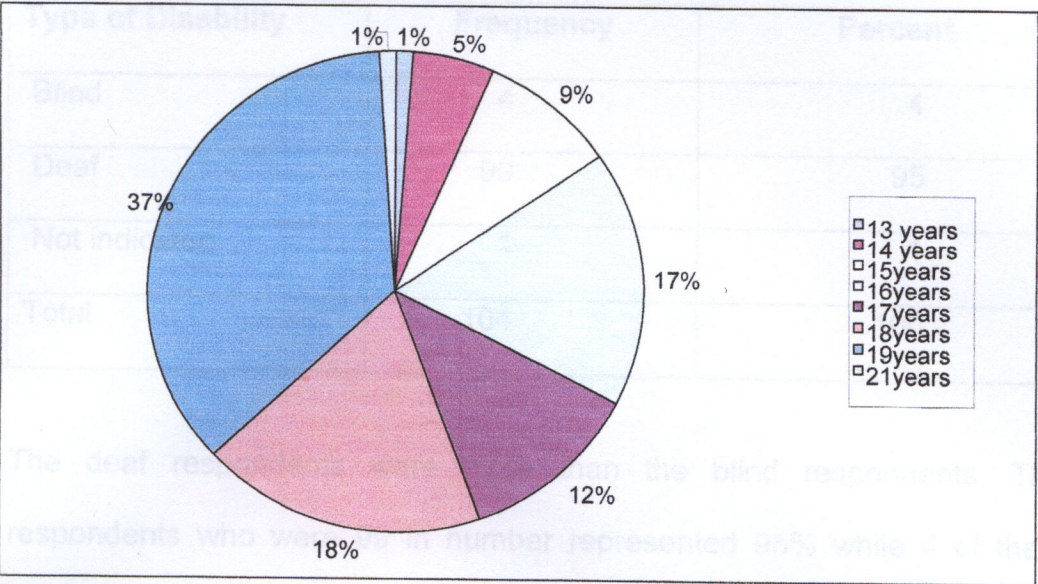
Almost an equal number of females and males participated in this study. There were 49 % male and 50 % female respondents.

Table 4.2: Distribution of Grade among the respondents

Grade	Frequency	Percent
8	27	26
9	23	22
10	13	13
11	16	15
12	12	12
Grade not indicated	13	13
Total	104	101

The highest number of the respondents (26%) was from grade 8 and the next group (22%) was from grade 9. Respondents from higher grades were as follows: 13% were in grade 10, 15 % in grade 11 and 12% in grade 12. 13% did not indicate the grade. An error margin of 1% was detected.

Figure 4.1 : Age distribution of all respondents in the sample



The majority of respondents were 19 years old, representing 37%. This group was followed by the age group of 18 years old, representing 18%. The next group was 16 years old, representing 17%. The age group of 17 years represented 12% of the sample size. The 15 and 14 year olds represented 9% and 5%, respectively. The least number of respondents were 13 and 21 year olds who contributed 1% each.

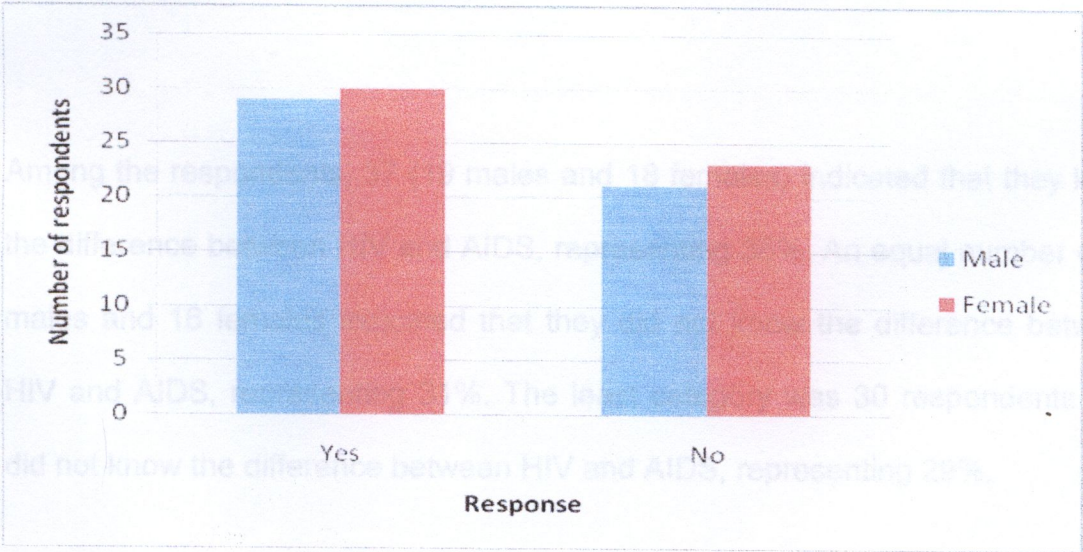
Table 4.3: Distribution of respondents according to disability

Type of Disability	Frequency	Percent
Blind	4	4
Deaf	99	95
Not indicated	1	1
Total	104	100

The deaf respondents were more than the blind respondents. The deaf respondents who were 99 in number represented 95% while 4 of them were blind. Only 1 respondent did not indicate the disability. As indicated above a total of 104 respondents took part in the study.

Figure 4.2 : Distribution of respondents according to Knowledge of HIV and

AIDS



There were 59 respondents who indicated having knowledge about HIV and AIDS (29 males and 30 females representing 57%) and 44 respondents (21 males and 23 females representing 42%) had no knowledge about HIV and AIDS. 1 respondent did not answer the question.

Figure 4.3 : Distribution of respondents according to knowledge on the difference between HIV and AIDS

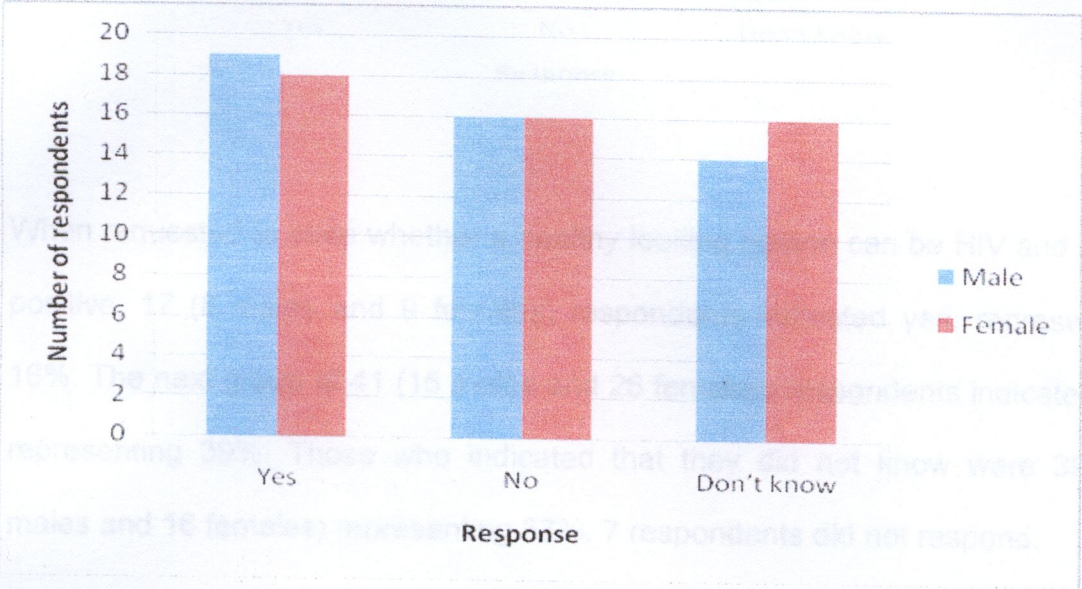
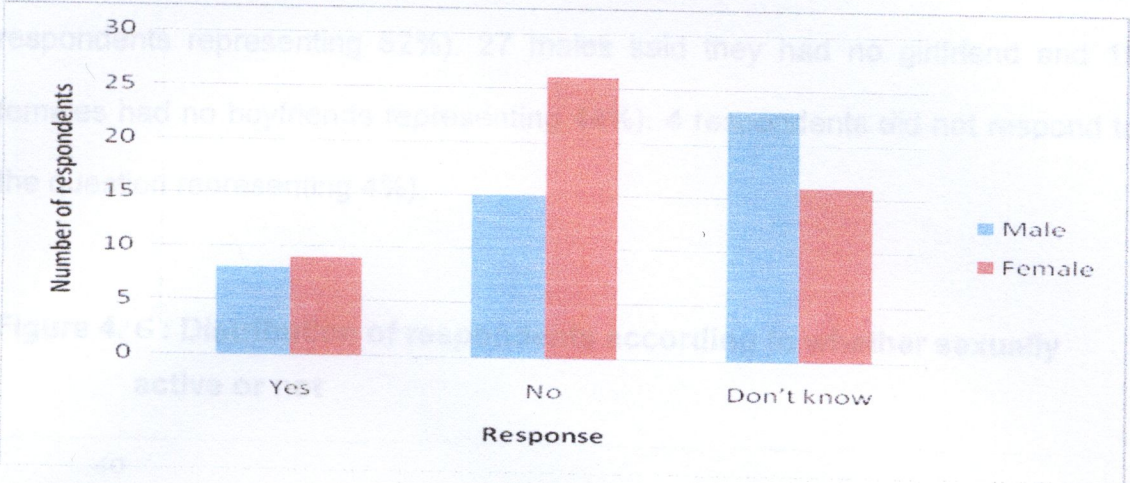


Figure 4.5 : Distribution of respondents according to whether they had a boy or girlfriend or not

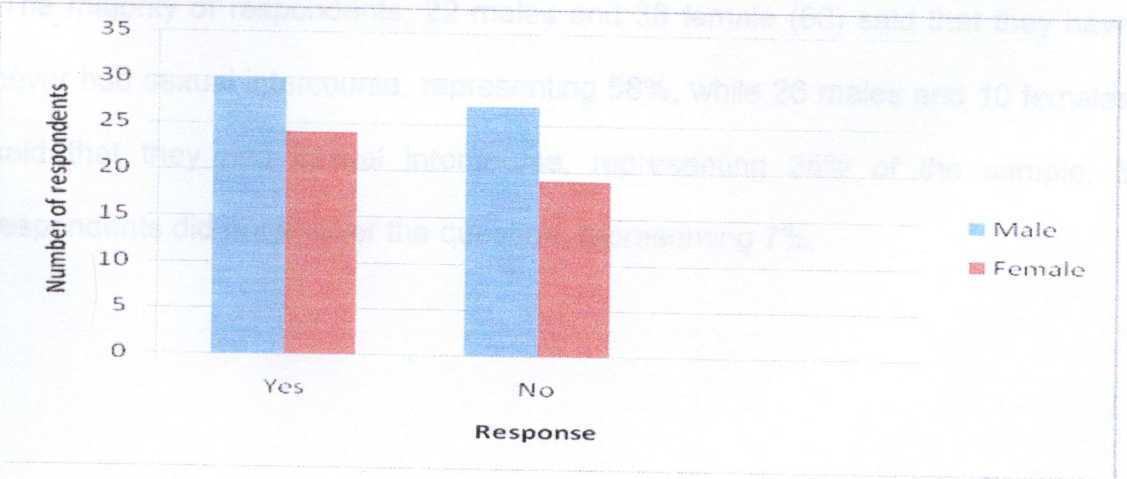
Among the respondents, 37 (19 males and 18 females) indicated that they knew the difference between HIV and AIDS, representing 36%. An equal number of 16 males and 16 females indicated that they did not know the difference between HIV and AIDS, representing 31%. The least category was 30 respondents who did not know the difference between HIV and AIDS, representing 29%.

Figure 4.4: Distribution of respondents according to responses on visual Identification of an HIV positive person



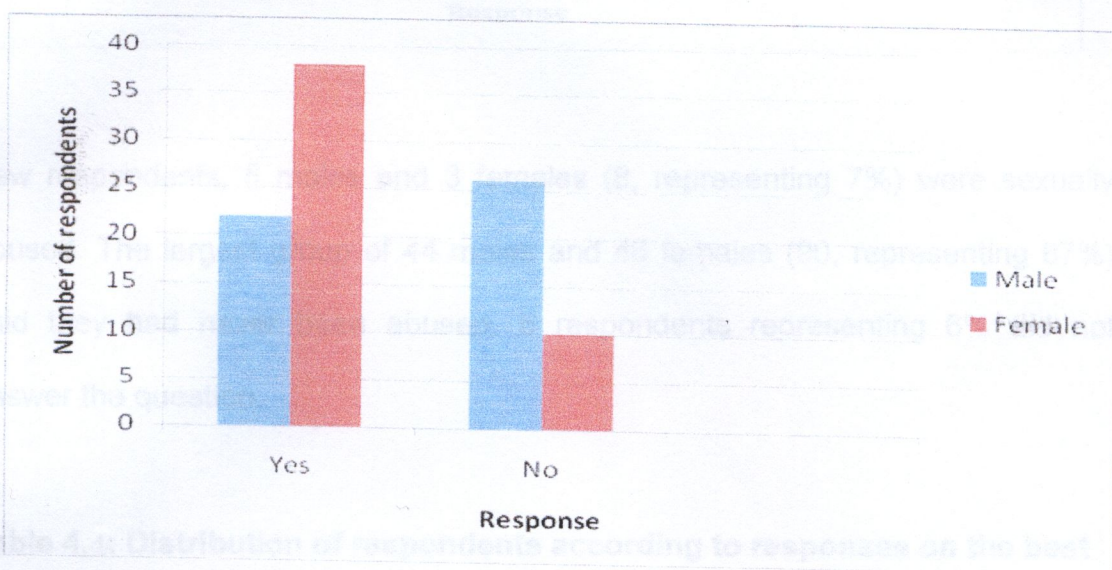
When requested to state whether a healthy looking person can be HIV and AIDS positive, 17 (8 males and 9 females) respondents indicated yes, representing 16%. The next group of 41 (15 males and 26 females) respondents indicated no, representing 39%. Those who indicated that they did not know were 39 (23 males and 16 females) representing 37%. 7 respondents did not respond.

Figure 4.5: Distribution of respondents according to whether they had a boy or girlfriend or not



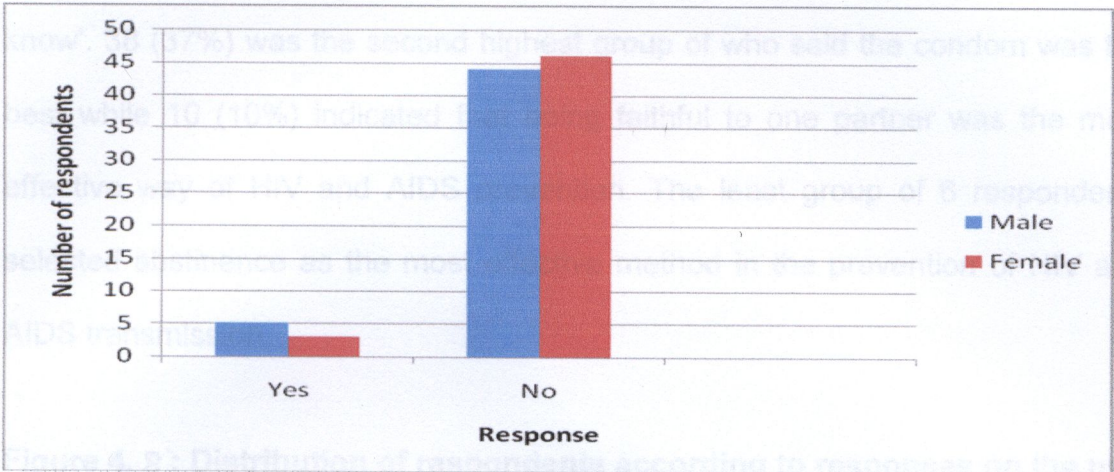
Most respondents indicated that they had either a girlfriend or a boyfriend. 24 females said they had boyfriends and 30 males said they had girlfriends (54 respondents representing 52%). 27 males said they had no girlfriend and 19 females had no boyfriends representing 44%). 4 respondents did not respond to the question representing 4%).

Figure 4. 6 : Distribution of respondents according to whether sexually active or not



The majority of respondents, 22 males and 38 female (60) said that they have never had sexual intercourse, representing 58%, while 26 males and 10 females said that they had sexual intercourse, representing 35% of the sample. 8 respondents did not answer the question, representing 7%.

Figure 4.7 : Distribution of respondents according to responses on sexual abuse



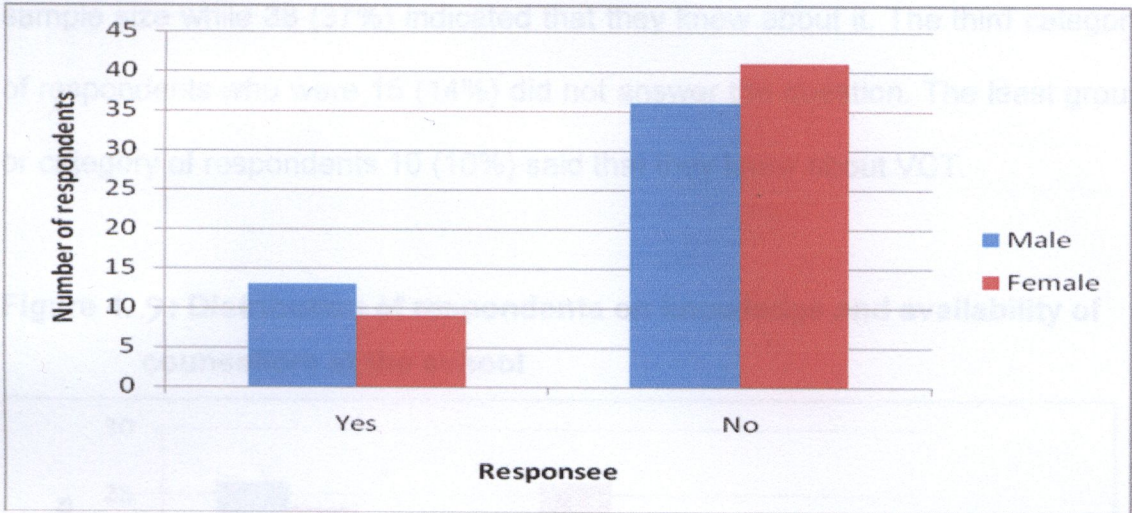
Few respondents, 5 males and 3 females (8, representing 7%) were sexually abused. The largest group of 44 males and 46 females (90, representing 87%) said they had never been abused. 6 respondents representing 6% did not answer the question.

Table 4.4: Distribution of respondents according to responses on the best preventive method against HIV and AIDS

Method	Numbers	Percent
Abstinence	6	6
Being faithful to a partner	10	10
Using condom	38	37
Don't know	50	47
Total	104	100

50 (47%) constituted the highest number of respondents. These did not know the best preventive method against HIV and AIDS and were in the category of 'Don't know'. 38 (37%) was the second highest group of who said the condom was the best while 10 (10%) indicated that being faithful to one partner was the most effective way of HIV and AIDS prevention. The least group of 6 respondents selected abstinence as the most effective method in the prevention of HIV and AIDS transmission.

Figure 4. 8 : Distribution of respondents according to responses on the use of a condom



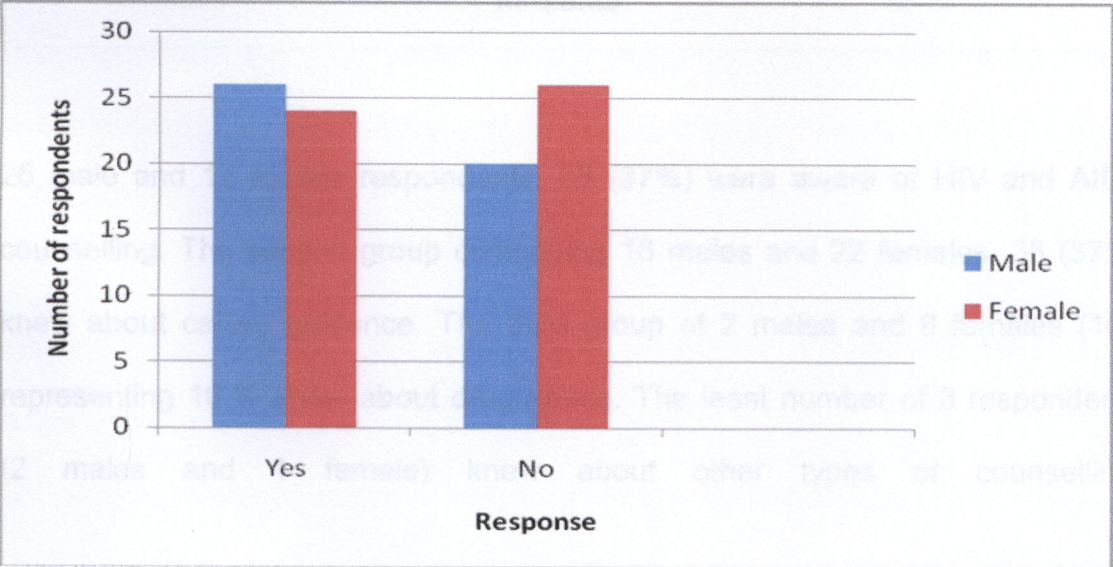
The use of the condom was not popular. 13 males and 9 females, 22 in total, representing 21% acknowledged having used a condom while 36 males and 41 females (77), representing 74% said they had never used a condom. 5 respondents did not answer the question. The graph above shows that more females than males had never used a condom.

Table 4.5 : Distribution of respondents according to knowledge about VCT

Responses	Numbers	Percent
Yes	10	10
No	38	37
Never heard	41	39
No response	15	14
Total	104	100

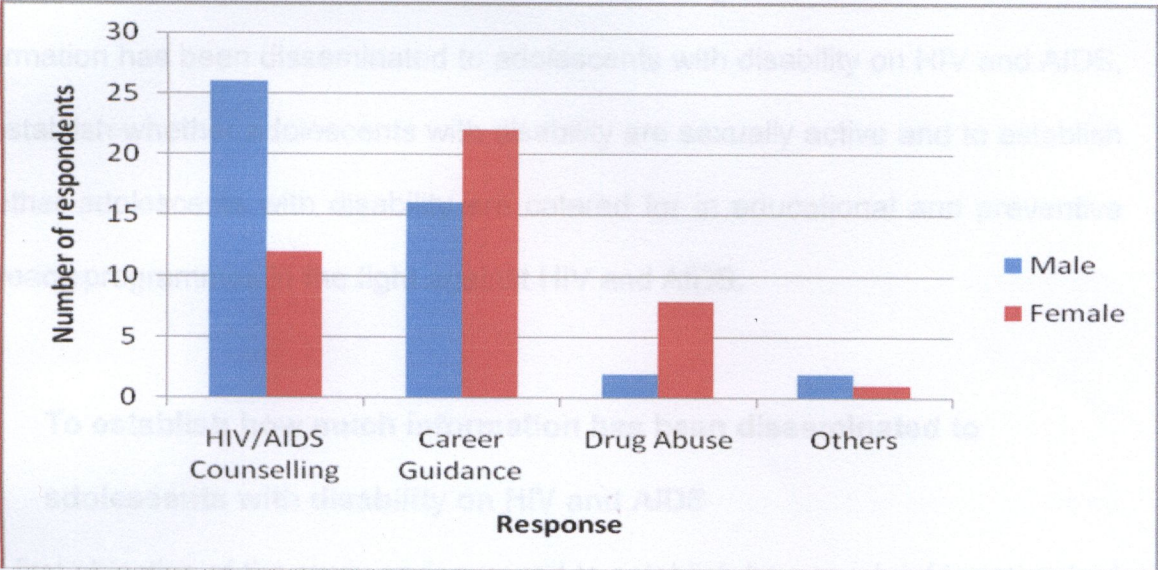
VCT was not known by the majority of respondents, that is 41 (39%) of the sample size while 38 (37%) indicated that they knew about it. The third category of respondents who were 15 (14%) did not answer the question. The least group or category of respondents 10 (10%) said that they knew about VCT.

Figure 4. 9: Distribution of respondents on knowledge and availability of counsellors at the school



When asked whether the school had counsellors, 50 (26 male and 24 female) respondents said 'yes', representing 48%, while 46 respondents (20 males and 26 females), representing 44% said 'no'. The number of respondents who said 'yes' was more than those who said 'no'. 8 of the respondents did not answer the question.

Figure 4.10: Distribution of respondents according to responses on types of counselling services available



26 male and 12 female respondents, 38 (37%) were aware of HIV and AIDS counselling. The second group comprising 16 males and 22 females, 38 (37%) knew about career guidance. The third group of 2 males and 8 females (10), representing 10 % knew about drug abuse. The least number of 3 respondents (2 males and 1 female) knew about other types of counselling.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 Introduction

In the preceding chapter, the findings of the study were presented by the use of a pie chart, bar charts, tables of frequencies and percentages. This chapter discusses the findings of the research which sought to establish how much information has been disseminated to adolescents with disability on HIV and AIDS, to establish whether adolescents with disability are sexually active and to establish whether adolescents with disability are catered for in educational and preventive outreach programmes in the fight against HIV and AIDS.

5.2 To establish how much information has been disseminated to adolescents with disability on HIV and AIDS

The first objective of the study endeavoured to establish how much information had been disseminated to adolescents with hearing and visual impairments at Munali High School Special Education Unit.

In the study, 95 percent of the respondents were deaf and they needed sign language to understand certain concepts in the questionnaire. To this effect, a trained sign language research assistant interpreted such concepts in the

questionnaire. The researcher had to subject 4 of the respondents who had no sight to interviews because the questionnaire was not written in Braille.

Knowledge can only be acquired in a language which one understands. The study revealed that 57% of the respondents had knowledge about HIV and AIDS while 42% declined and only 1 respondent did not respond to the question. However, when further asked whether they knew the difference between HIV and AIDS, only 36 percent admitted that they knew the difference. There seems to be a contradiction in the responses because if a substantial number of respondents (57%) had knowledge about HIV and AIDS, then the same number of respondents should have known the difference between HIV and AIDS. It is either the respondents did not understand the question or the majority had no educational background on HIV and AIDS.

Janssen's (2005) findings revealed that messages to the general public often do not reach people with disabilities because their handicap prevents them from accessing the information offered, or because they simply do not understand the languages used.

It is important that, sign language and messages in Braille for the dissemination of HIV and AIDS messages need to be used to reach out to these categories of persons in society. Ignoring this category implies that 600 million people worldwide living with a physical, sensory (deaf or blind) intellectual or mental health

impairment (UN, 1993), are excluded from the preventive and HIV and AIDS outreach programmes.

Further findings in this study revealed that indeed the respondents had very little knowledge about HIV and AIDS because only 16 percent affirmed in to the question when asked if a healthy looking person can be HIV positive. The majority, 84 percent of the respondents, did not know.

In line with the above findings, Schriner (2003) reports that, Jacob Zuma, the Deputy President of SANAC advised that people with disabilities must be involved in HIV and AIDS programmes to overcome the current focus on “normal” people. He is quoted as saying “We must acknowledge that our Aids education had mainly been targeted at people who are considered ‘normal’ and people with disabilities have been left without any knowledge about HIV and AIDS and the protective measures needed to be taken to prevent the spread of the disease or infection”.

Despite growing numbers and their striking needs, adolescents with disability have historically fallen through the cracks. General programmes that are intended for adolescents and young adults rarely include those with disabilities. Programmes for disabled populations where they do exist are unfortunately no more inclusive. Particularly, outside the developed world, programmes for those with disability are generally either intended to provide services and general advocacy for all disabled members of a society. Alternatively they fall decisively into one of the two

categories – programmes for disabled children or for adults with disability (Wallace, 1990).

Improving the accessibility to information production pertaining to HIV and AIDS through the production of Braille, AIDS awareness materials and training of sign language interpreters in order to absorb the hard of hearing, the deaf and the visually impaired into the programmes was one of the aims of SAFOD towards the rights of children and young adults in SADC countries (Musakanya, 2003).

A survey by MoE, (2006–2007) confirmed that the majority of Zambian High Schools had poorly developed and uncoordinated HIV and AIDS programmes for young people. If the so called ‘normal’ young people have a problem in acquiring information from the educational system in the country on HIV and AIDS, then those with disabilities face even greater challenges.

The preliminary findings from the Yale and World Bank study strongly recommended that disabled people can—and should—be included in all HIV and AIDS outreach and service efforts. Much of this work can be done at little or no additional expense. Other programmes need only slight modification to be made significantly more inclusive. Disability-specific measures will also be needed to reach some subgroups within the larger disabled population (World Bank, 2004).

However, Coleman and Hendry, (1999) argued that even in schools where sex education is taught, adolescents still feel unprepared for the changes of puberty, suggesting that these important topics are not being dealt with in ways that are most useful to them. Consequently, virtually nothing is known about how the disabled population can best be reached as part of general HIV and AIDS outreach efforts or through disability-specific programmes. Currently, interventions that include individuals with disability are rare, most are short-term, and almost all lack monitoring or evaluation (Groce, 2004).

This lack of information generally leads to an assumption that adolescents with disability are not at high risk of contracting HIV and AIDS. They are not targeted specifically in campaigns and in many cases are virtually excluded from receiving information on HIV and AIDS (Janssen, 2005).

Taking into account the issues raised above, it is important for the government and other stakeholders interested in the education of the disabled to include in their programmes the needs of the disabled if information is to be meaningfully and effectively distributed. Dissemination of information can only be understood by the receiver of the message in a language that he/she understands. As long as ordinary communication is used in HIV and AIDS preventive and outreach programmes, adolescents with the hearing and visual impairments will remain disadvantaged and excluded in the global effort to address the epidemic. The

HIV/AIDS epidemic is not a problem for the non-disabled alone but for all humanity.

5.3 To establish whether adolescents with disability are sexually active

The second objective of the study sought to establish whether adolescents with disability are sexually active.

Adolescents with disability have needs very similar to the needs of all other young people, as clearly stated in Article 23 of the United Nations' Convention on the Rights of a Child (UNICEF, 2000). These needs are so great at adolescence due to rapid physical and psychological developments.

The study revealed that 52% of the respondents had either a girl friend or boy friend and 35% admitted having had sexual intercourse. Yet as noted above, too often, adolescents with disability have not been included in HIV and AIDS prevention outreach efforts because it is assumed that they are not sexually active and at little or no risk of HIV infection. The Global Survey on HIV and AIDS and Disability has proven this assumption wrong. Individuals with disability have equal or greater exposure to all known risk factors for HIV infection. The survey findings proved that adolescents and adults with disability are as likely as their non-disabled peers to be sexually active (Groce and Trasi, 2004).

A similar study on non-disabled peers revealed that, the effects of HIV and AIDS among adolescents and young adults between the ages 13-24 years in the United States, has continued to be an increasing concern. The average duration from HIV infection to development of AIDS is 10 years. Most adults with AIDS were likely infected as adolescents or young adults. Most HIV-infected adolescents are exposed to the virus through sexual intercourse. Approximately 25% of sexually transmitted infections (STIs) reported in the United States each year are among adolescents countries (Musakanya, 2003).

Murphy and Young (2005) also observed that adolescents with disability seem to be participating in sexual relationships without adequate knowledge and skills to keep them healthy, safe, and satisfied. Although their sexual development may be hindered both by functional limitations and by intentional or unintentional societal barriers, the formal and informal opportunities for adolescents with disability to develop into sexually expressive and fulfilled persons do exist.

It is evident that adolescents with disability engage in sexual relationships, hence, HIV infection cannot be ruled out among this group. An estimate of 90 percent of HIV transmission in Zambia is as a result of having sex with an infected person (MoH, 2005).

The present study further revealed that 8 percent (5 males and 3 females) were sexually abused. 87 percent denied being abused while 6 percent did not answer

the question. Since sexual abuse is a sensitive issue, there could have been a possibility of fear among the respondents to tell the truth. Groce (2003), pointed out that individuals with disability usually suffer victimization, marginalization and stigmatization; more often than not, this group of people is highly vulnerable to sexual abuse.

Schriner's (2003) point of view was that, disabled adolescents are vulnerable to sexual abuse as chances of a perpetrator being brought to book are slimmer than when one abuses a person without a disability. The disabled are usually not aware of their rights and violations, and when they are, they may not have the capacity to fight for the exercise of these rights.

Though the findings in the study revealed that more males (5) than females (3) were abused, the study by Groce (2003), revealed that the idea that sex with a virgin can cure Aids has fuelled some violence because disabled female adolescents are often assumed to be asexual and therefore virgins. They are systematically raped by people who are desperate to get rid of their infection. Similarly, the study of Murphy and Young (2005), revealed that adolescents with disability were more than twice likely to be sexually abused compared to adolescents without disability.

From the discussions above it is unfounded for the authorities concerned to work on assumptions that the disabled are sexually not active because on the contrary,

this study has revealed that quite a high number of the respondents indicated that they had either a girl friend or boy friend and admitted having had sexual intercourse. This is an indication that even the disabled people are at high risk of contracting HIV and AIDS and need the same protection as the normal.

5.4 To establish whether there were preventive measures against HIV and AIDS for adolescents with disability

Finally, the last objective of the study sought to ascertain preventive measures of HIV and AIDS towards adolescents with disability.

Worldwide, less than one in five people at risk of becoming infected with HIV have access to basic prevention services. Of people living with HIV only one in ten has been tested and knows that he or she is infected. One group for whom no statistics are available, however, is people with disabilities (UNAIDS, 2004).

When asked to select the best preventive method against HIV and AIDS, the highest number of respondents 38 (37%) indicated the use of a condom as the best method. The next group 10 (10%) felt that being faithful to one partner was the best method. The least group 6 (6%) were of the view that abstinence was the best method. However, 50 (47%) did not know which one of the listed methods was the best.

The above findings correspond to research findings by UNAIDS/UNFPA/WHO, (2004) which revealed that the male latex condom is the most efficient available technology to reduce the sexual transmission of HIV and other sexually transmitted infections. However, though this study revealed that 37% of the respondents selected the use of a condom as the best method, only 21% used condoms.

A similar survey conducted on 1228 students, aged 16-24 years, from 12 institutions of higher learning, including the University of Zambia, showed high levels of awareness and knowledge on the mode of transmission of HIV. Among those who were sexually active, three quarters of them knew about condoms as a means of preventing infection. Despite that, only about a third reported always using condoms. Not only was condom use among the respondents low but its use was also inconsistent (SHARES, 2003).

Similarly, research findings by ANASO in Angola revealed that 70 percent of youths in the country do not use condoms, despite their awareness of HIV. The network plans to partner with the Ministry of Education and communities throughout the country to mobilize and educate 340,000 young people through 2010 (Kaiser, July 2008).

VCT has emerged as a major strategy for the prevention of HIV and AIDS infection in Africa (Mkaya-Mwamburi et al. 2000). However, this study revealed that only 10 percent had knowledge about VCT while 37 percent said they did not have any



knowledge, 39 percent said they had never heard about VCT and 14 percent did not even attempt to answer the question.

Further findings from the present study revealed that 48% of the respondents and another 37% of them acknowledged that there were counsellors at Munali High School. On the other hand, 44% and 8% did not answer the question.

Access to medical and counselling services is very important for everyone including persons with disability. In relation to disability and HIV and AIDS, counselling may be helpful for adolescents who have suffered sudden impairments to deal with disability. Counselling may also help a disabled adolescent in dealing with their HIV status, and is particularly important if the adolescent has been sexually abused (Schriner, 2003).

However, UNICEF's (1993), concern was that, activities that help adolescents develop self-esteem and thus make them less likely to engage in risky behaviour rarely receive adequate attention. Nor do adolescents have access to counselling or health services that help them deal with sexuality, reproduction and HIV and AIDS.

Findings from this study on information provision and preventive measures against HIV and AIDS also concurs with the UN (2004) report which showed that cases of HIV and AIDS among adolescents are due to unsafe sexual relations, lack of appropriate sex education and ignorance of the means of protection. In relation to

persons with disability, Groce (2004) concluded that there is a striking absence of attention to the risk of HIV infections in individuals who have a physical, sensory, intellectual or mental health disability prior to acquiring the virus. To get ahead of the epidemic, there is growing recognition that HIV prevention efforts must be scaled up and intensified (UNAIDS 2005).

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

As noted above, the human rights conceptual framework was relevant to this study because the focus was on the way information on HIV and AIDS, and prevention is disseminated by different stakeholders including educational institutions to adolescents with disability. Without deployment of awareness programmes in Braille and Sign language, the rights of adolescents with disability to information cannot be realised.

Data from the field revealed that dissemination of information on HIV and AIDS to adolescents with disability is still lacking. Respondents had very little knowledge about HIV and AIDS. Educational institutions seem not to be doing much in educating and promoting HIV and AIDS programmes to adolescents with disability in Braille and sign language.

Adolescents with disability are as sexually active as their non-disabled peers. The assumption that they are asexual is not true. The population of adolescents with disability is not negligible to be ignored in the fight against HIV and AIDS because they are human beings who also have sexual feelings and indulge in sexual activity.

Though the use of a condom is considered to be the best preventive method against HIV transmission, it still remains unpopular among young people as revealed by the data in this study. Furthermore knowledge of preventive measures against the HIV and AIDS pandemic is very little among the respondents. Indeed, education has a key role to play both in the prevention of HIV and AIDS and in mitigating its effects on individuals, families, communities and society, but what is taught and how, has a major bearing on the specific target group (Janssen 2005).

6.2 Recommendations

The study was designed to examine the situation of HIV and AIDS and adolescents with disability at Munali High School Special Unit in Lusaka province.

Based on the findings, the following recommendations are proposed:

1. Research at the National level should be taken to yield valid statistics on HIV and AIDS and adolescents with disability so that this population can be included in strategic educational, social and economic planning by the Central Statistics Office and the National AIDS Council.
2. The Ministry of Education should include HIV and AIDS in teacher training and school curriculum so that all teachers can disseminate information of HIV and AIDS at any level.

3. Ministry of Education should embark on training of peer trainers and counsellors among adolescents with disability would be an added advantage in the fight against HIV and AIDS pandemic.
4. Mode of communication on HIV and AIDS preventive and health care outreach programmes should cater for the blind and the deaf in Braille and interpreted in sign Language under the Ministry of Information in conjunction with the Ministry of Education.
5. VCT centres should be established at High School level with qualified counsellors under the Ministry of Education in collaboration with the Ministry of Health.

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APPENDIX

QUESTIONNAIRE FOR PUPILS WITH DISABILITY

I am a postgraduate student at the University of Zambia undertaking a Master of Education Degree in Special Education. I am carrying out a research on HIV and AIDS and Adolescents with Disability at Munali High School Special Unit in Lusaka District.

You are kindly requested to participate in the research by responding to the questions raised in this questionnaire.

The information will be used for purely academic purposes and treated with high confidentiality.

INSTRUCTIONS: Please read the questions carefully and **Tick (✓)** or **Write** in the spaces provided.

Question	Response and Coding	Skip to
1. Demographic characteristics		
1.1 Sex	1.Male <input style="width: 40px;" type="checkbox"/> 2.Female <input style="width: 40px;" type="checkbox"/>	
1.2 How old are you?		
1.3 What grade are you doing?		
1.4 What kind of disability do you have?	1. Blind <input style="width: 40px;" type="checkbox"/> 2. Deaf <input style="width: 40px;" type="checkbox"/>	

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2. Knowledge of HIV/AIDS		
2.1 Have you ever heard about HIV/AIDS?	1. Yes ☐ 2. No ☐	
2.2 What is the difference between HIV and AIDS?	1. HIV is a virus, AIDS is an illness ☐ 2. There is no difference, its one thing. ☐ 8. Don't know ☐	
2.3 Do you think a healthy looking person can be infected with HIV?	1. Yes ☐ 2. No ☐ 8. Don't know ☐	
3. Sexual behaviour		
3.1 Do you have a boyfriend/girlfriend?	1. Yes ☐ 2. No ☐	
3.2 Have you ever had sexual intercourse?	1. Yes ☐ 2. No ☐	
3.3 Have you ever been sexually abused?	1. Yes ☐ 2. No ☐	
If yes, who abused you?		
3.4. Which of the following is the most effective way of preventing HIV transmission?	1. Abstinence ☐ 2. Being faithful to one sexual partner ☐ 3. Using a condom ☐ 4. Don't know ☐	

4. Condom use		
4.1. Have you ever used a condom?	1. Yes	☐
	2. No	☐
5. Knowledge of VCT		
5.1 Have you ever heard about Voluntary Counselling Testing?	1. Yes	☐
	2. No	☐
	3. Never	☐
5.2. Do you have counsellors at your institution?	1. Yes	☐
	2. No	☐
5.3. If Yes, what types of counselling services are available	1. HIV/AIDS	☐
	2. Career guidance	☐
	3. Drug abuse	☐
	4. other, please specify	
		

Comments:

THANK YOU VERY MUCH FOR YOUR TIME!