

**EFFECTS OF HUMAN IMMUNE VIRUS /ACQUIRED IMMUNE DEFICIENCY
SYNDROME (HIV/AIDS) AMONG PEOPLE LIVING WITH DISABILITY OF
KAMPALA DISTRICT**

BY

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BGC/10009/81/DU

**A RESEARCH PROJECT SUBMITTED TO THE COLLEGE OF HUMANITIES AND
SOCIAL SCIENCES IN PARTIAL FULFILMENT OF BACHELOR'S**

DEGREE OF GUIDANCE AND COUNSELING OF

KAMPALA INTERNATIONAL

UNIVERSITY

JULY, 2013

DECLARATION

I, **Enid Mugume Ahimbisibwe** hereby declare that this research report is original and has never been submitted to any other institution for an award of any academic qualification.

mugume

Date 3rd August 2013

Signed

APPROVAL

This is to certify that this research report has been produced under my supervision and guidance and it is now ready for submission to the University with my approval.

Signed by..... Date.....

MS. NAKALEMA FAITH

SUPERVISOR

DEDICATION

I dedicate this book to my husband, children Faith, Praise, Cohen and Clinton.

ACKNOWLEDGEMENT

I humbly take this opportunity to thank God, the almighty who sustained me and gave me courage to continue under conditions which were difficult throughout my study. If it was not for him, I would not have succeeded.

My sincere gratitude also goes to Ms Nakalema Faith, my supervisor, who tirelessly mentored, guided and encouraged me to the completion of this study.

Special respect goes to my mum, E.N.T Staff especially Dr. Wambete from Mulago and my husband for being there for me during this period of my study. God continue blessing you.

Special thanks goes to my lecturers like Mr. Omuya Ronald, Shamirah Nassiwa and others of Kampala International University for their guidance, they have offered me throughout this course. May God bless you.

Thanks to all my course mates, friends and all relative. God bless you always

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ABSTRACT

The purpose of the study is to examine the effects of HIV/AIDS among people living with disability of Kampala District. The study had four specific objectives, which included; i) determining the profile of respondents in terms of gender, age, educational qualification and marital status; ii) to determine the level of barriers associated with HIV/AIDS among people with disabilities; iii) to determine the level of preventive strategies; and iv) to determine the relationship between the levels of barriers and preventative strategies associated with HIV/AIDS among people with disabilities. The researcher employed descriptive correlational survey design and the researcher employed self administered questionnaire to collect data on effects of HIV/AIDS among people living with disabilities. The findings indicated that most respondents (64%) were females who are in vulnerable groups, aged between 30-39 years, majority were in certificate (38%) and over 38% were married. The level of barriers was generally very rarely with mean (1.5502) which indicated that most of respondents strongly disagreed. The level of preventive strategies is generally rarely (overall mean=2.0373) they disagreed. And also indicated a positive significant relationship between the level of barriers and preventive strategies associated with HIV/AIDS among people with disabilities ($r=0.723$, sig. =0.000) the more the government has tried to eliminate the barriers, the people with disability will be able to go for voluntary counseling and testing, able to disclose their status and get rid of stigma. From the findings and the conclusions of the study, the researcher recommends there is need to sensitize people with disability to avoid stigma, despite the fact that they are vulnerable and access the HIV/AIDS services, there is need to uplift the educational level of people with disability since most of them were certificate holders and in order to increase acceptance and uptake of HIV testing, sensitization should be thoroughly done more especially in communities.

CHAPTER ONE

1.0 Introduction

This chapter consists of background to the study, statement of the problem, purpose of the study, objectives of the study, statement of the null hypothesis, research questions, and scope of the study and significance of the study.

1.1 Background of the Study

HIV/AIDS is without doubt the most serious health threat in the world today, with the burden of the epidemic being felt most acutely in Sub-Saharan Africa. Since it was first identified in 1980, 20 million people worldwide have died of AIDS, with 40 million people currently living with HIV (Demographic & Health Surveys, 1998). Across the globe, 1200 adults and 2000 children are infected with HIV every day. Frighteningly, at least 95% of these new infections occur in developing countries, with more than 50% affecting women and young children (Lamprey et al, 2002). Without a co-ordinated and substantial response to the pandemic, it is projected that worldwide there will be 45 million new infections by 2015 (Goliber, 2007). In this context, it is shocking and surprising that notwithstanding the efforts of many disabled people's organizations (DPOS) to develop responses to the epidemic, and government supported initiatives in the disability / HIV field, such as the work of the policy project, a USAID-funded initiative of the department of Health, it remains true to say that in terms of systematic large scale research, the impact of HIV/AIDS on disabled people has widely ignored (Dott, 1997).

Over the past few decades, HIV/AIDS has become a growing global epidemic (United Nations Programme on HIV/AIDS [UNAIDS, 2005]). There has been significant scientific and social research into the causes and effects of HIV/AIDS on global populations. Much of this research has focused on the physical and psychological disabling effects of HIV/AIDS. Research into the effects and risks of HIV/AIDS on people with disabilities is limited but is beginning to be addressed. Recognizing that

persons with disabilities are at risk of contracting HIV/AIDS (Groce, 2004; Mulindwa, 2003; Munthali et al, 2004), this MRP will examine the disconnect between HIV/AIDS prevention measures and what is made available to persons with disabilities in sub-Saharan Africa. The key argument that I will make is that persons with disabilities are prevented from accessing HIV/AIDS prevention measures, not just because of physical barriers, but because of attitudinal barriers that prevent HIV/AIDS policy makers from accepting that persons with disabilities are at risk.

The exact number of persons with disabilities in sub-Saharan Africa infected with HIV is unknown, but it is presumed that prevalence rates among this group are high. According to the World Health Organization (WHO), it is estimated that a total of 600 million individuals are currently living with a disability. Of this total, approximately eighty percent of people with disabilities are living in the developing world (WHO, 2005). Most persons with disabilities are considered to be the poorest citizens (WHO, 2005; Department for International Development [DFID], 2000; Elwan, 1999) and the least educated (Groce, 2004, DFID, 2000; Elwan, 1999). Although current HIV prevalence in Uganda is estimated at 5.4 percent (UNAIDS 2008), it is uneven with regard to region, gender, and age. Prevalence is highest in Kampala and the Central and North Central regions (over 8 percent) and lowest in the northeastern and West Nile regions (below 4 percent). Prevalence is also higher in urban areas. With regard to gender, more women (7.5 percent) than men (5 percent) are HIV positive (UAC 2007). Women are more susceptible to HIV due to biological factors, and are even more vulnerable "given their low status, lower educational attainment, higher unemployment, and weaker negotiating skills within relationships" (Garbus & Marseille 2003).

In Uganda, HIV prevalence increases with age and peaks between ages 35 to 44 (9 percent) for men, and ages 30 to 34 (12 percent) for women (UAC 2007). While persons with disabilities are vulnerable to HIV since HIV/AIDS can also cause disability. This occurs when the particular opportunistic infections (OIs) impair the physical, sensory, or mental capacities of HIV-positive persons to such an extent that their day-

to-day functioning is compromised. Such impairments may be temporary if ART or other medications are able to restore functionality (Gifford et al, 2007).

In Kampala, PWDs are in all probability of stigma which takes many forms and can be defined as rejecting, isolating, blaming and shaming. This stigma impacts on access to health care services and may lead to discriminatory attitudes of health workers. For example, service providers may ask inappropriate questions and may not respect confidentiality. They may not directly address PWDs seeking care, but instead talk with the accompanying person. Health practitioners can often lack the necessary knowledge, skills and resources to provide accessible, appropriate services to PWDs at risk for, or living with, HIV/AIDS (Christian et al, 2002).

1.2 Statement of the Problem

PWDs face a multitude of challenges when accessing information about HIV/AIDS prevention and support, voluntary counseling and testing, care and treatment. There is also a common misperception that PWDs are sexually inactive, and are unlikely to use drugs or alcohol, and therefore PWDs have often been left out of prevention campaigns and the development of programmes (Elwan, 1999). These omissions severely limit the ability of PWDs to obtain proper education about safe sex and HIV prevention and to develop capacities to negotiate safer sexual behaviors. The aspects highlighted included PWD unique problems, low incomes yet they actually require higher incomes than able-bodied people to maintain the same living standards, poverty as a hindrance on be hidden by families/and or they themselves retreat into solitude and above all, that since the majority are denied formal education, and or are unable to fully learn in non-special needs education (SNE) institutions, their low literacy levels transform into inability to grasp the general principles of maintaining better health conditions, fully utilizing health information e.g. on hygiene, primary health, family planning, nutrition, immunization, HIV/AIDS prevention, care and treatment and other STDs, among others (ADD, 1996).

1.4 Purpose of the study

The purpose of the study was to test the null hypothesis, validate the theory and identifying the strengths and weaknesses of the study.

1.5 Research Objectives

General: The study examined the correlates of HIV/AIDS and Disability among people living with Disability of Kampala District

Specific: To sought further in this study as follows:

1. What is the profile of the respondents in terms of:
 - 1.1 Gender
 - 1.2 Age
 - 1.3 Educational level
 - 1.4 Marital status
2. To examine the barriers associated with HIV/AIDS among people living with disability of Kampala District.
3. To determine the preventive strategies associated with HIV/AIDS among people living with disability of Kampala District.
4. To determine the significant relationship between HIV/AIDS and disability among persons living with disability of Kampala District.

1.6 Research Questions

The study sought to answer the following research questions:

1. What is the profile of the respondents in terms of:
 - 1.1 Gender
 - 1.2 Age

1.3 Educational level

1.4 Marital status

2. What are the barriers associated with HIV/AIDS among people living with disability of Kampala District?

3. What are the prevention strategies associated with HIV/AIDS among people living with disability of Kampala District?

4. What is the significant relationship between HIV/AIDS and disability among persons living with disability of Kampala District?

1.7 Null Hypothesis

There was a significant relationship between HIV/AIDS and disability among persons living with disability of Kampala District.

1.8 Scope

Geographical scope

The study was conducted in selected health centers of Kampala District for Persons with disability.

Content scope

The study intended to examine the barriers associated with HIV/AIDS among persons with disability in Kampala District, and the relationship between independent variable and dependent variable.

Theoretical scope

This study was based on critical disability theory by Henry, (2008) which was disproved.

1.9 Significance of the Study

The following disciplines benefited from the findings of the study.

The **persons with disability** learnt their rights hence developing socially, economically and politically.

The study helped the **counselor** to learn how to handle persons with disability while counseling them hence improving their saving their lives from stigma.

The study helped the **government** to train more personnel to handle persons with disability in health centers.

The study encouraged more **students** to trains as special needs facilitators to help communicate effectively with persons with disability.

The **future researchers** utilized the findings of the study to embark on the related study.

1.10 Operational of Key terms

HIV: refers to the virus that transmit AIDS

AIDS: refers to the collection of diseases.

Disability: refers to the inability to fully participate in the community services.

Effects : refers to the consequences or outcome of something.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.0 Introduction

This chapter covers a broad background of available theoretical and empirical information related to the problem of the study.

2.1 Concepts/ Opinions/ Ideas from Experts

HIV/AIDS

HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome) are the names given to a relatively new disease epidemic that is plaguing the global human population. In medical terms, HIV is "a continuum of progressive damage to the immune system from the time of infection to the manifestation of severe immunologic damage by opportunistic infections, or low CD4 lymphocyte count that define AIDS" (Osmond, 1998:1). The time it takes for a person to progress from HIV to AIDS varies greatly, ranging anywhere from 1 year or less in some persons, to over 20 years in some individuals (Osmond, 1998).

Acquired Immune Deficiency Syndrome (AIDS) is caused by a human immunodeficiency virus (HIV) that weakens the immune system, making the body susceptible to and unable to recover from other opportunistic diseases that lead to death (Caldwell, 1998). The predominant mode of HIV transmission is through heterosexual contact, followed in magnitude by perinatal transmission, in which the mother passes the virus to the child during pregnancy, delivery, or breastfeeding. Other modes of transmission are through infected blood and unsafe injections.

HIV can be transmitted from an infected person to another through: Blood (including menstrual blood), Semen, Vaginal secretions and Breast milk. Blood contains the highest concentration of the virus, followed by semen, followed by vaginal fluids, followed by breast milk. These are activities that can easily transmit HIV/AIDS through:- Unprotected sexual contact, Direct blood contact, including injection drug needles, blood transfusions, accidents in health care settings or certain blood products, Mother

to baby (before or during birth, or through breast milk), Sharing injection needles (Cotton, 2004): An injection needle can pass blood directly from one person's bloodstream to another. It is a very efficient way to transmit a blood-borne virus. *Sharing needles is considered a high-risk practice*, Mother to Child: It is possible for an HIV-infected mother to pass the virus directly before or during birth, or through breast milk. Breast milk contains HIV, and while small amounts of breast milk do not pose significant threat of infection to adults, it is a viable means of transmission to infants (Cotton, 2004).

Disability

Disability as an individual pathology characterizes it as a phenomena of comparative incapacity, whereby there exists a standard measure of incapacity in relation to non-disabled persons. It uses the individual as the "unit of analysis for research and policy purposes" (Rioux, 2003:291). The bio-medical approach defines disability as a medical incapacity, which can be prevented, diagnosed, treated and cured through medical and scientific measures. The functional approach, like the biomedical approach, focuses on the deficiencies of individuals and their condition. The key difference between the biomedical and the functional approach is that the functional approach treats disability from the vantage of understanding the condition in terms of functional capacity (Rioux, 2003). Treatment would be based on the use of technologies to assist the person to live their life as close to 'normal' as possible.

Some examples of how the individual pathology is characterised would include an emphasis on disability prevention through genetic testing, medications or education. Approaching disability as a social pathology leads to an examination of the relationship of the individual to society, and looks at the societal barriers that affect the lives of persons with disabilities. The environmental approach sees disability not as an individual issue but rather as based on "the interaction between individuals and their environment" (Rioux, 1997:105; 2003:294). Instead of treating the individual disability,

focus is placed on lessening the impact of environmental barriers on the individual by adapting the environment. The human rights approach focuses on "broad systemic factors that keep certain people from participating as equals in society" (Rioux, 1997:106; Barnes et al, 1999). This approach recognizes that the wide variation in abilities is inherent to us as human beings, and consequently advocates that these variations in abilities should not limit a human's ability to participate in society (Rioux, 2003).

Disability, in terms of social pathology, would lead to questioning social structures that prevent the equal treatment of individuals, whether it is structurally or attitudinally. As well, the inclusion and participation of persons with disabilities would be encouraged and it is their right.

2.2 Barriers that hinder persons with disability from accessing the services for HIV/AIDS related

Attitudinal Barriers and physical Barriers

Attitudinal barriers include assumptions and prejudices, discrimination, stereotypes, and misunderstandings that create barriers for persons with disabilities. These barriers can come from both outside and inside the disability community. When looking at the attitudinal barriers that have prevented persons with disabilities from accessing HIV/AIDS prevention programs in sub-Saharan Africa. The first barrier is the assumption that persons with disabilities are not at risk of contracting HIV and therefore do not require access to HIV prevention. Another barrier that stems from this is the assumption that persons with disabilities are not sexually active. One other related barrier is the assumption that persons with disabilities are not a significant group that would warrant special attention.

An indirectly related barrier that usually comes from persons with disabilities themselves is the fear that an HIV positive status would be a double burden, especially

for women with disabilities. The double burden of being HIV positive and having a disability is often met with denial or fear.

The assumption that persons with disabilities are not at risk of contracting HIV/AIDS may stem from misunderstandings about the realities of life for persons with disabilities. Poverty, lack of formal education and employment are all factors that can lead to increased susceptibility to HIV/AIDS (Hope, 1999). There is evidence in the literature that shows that persons with disabilities experience high levels of poverty, which increases their risk of contracting HIV/AIDS. Groce's study (2004) found that poverty is a risk factor that places persons with disabilities at significant risk of becoming HIV infected. Persons with disabilities are the poorest members of the community, and the World Bank estimates that persons with disabilities may account for 20% of the poorest citizens in the world (Groce, 2004).

The vicious cycle of poverty is both a cause and effect of disability. For people living in poverty, their chances of developing some form of disability is increased (DFID 2000). People who are poor are more likely to become disabled due to poor nutrition, insufficient access to health care and vaccination programs, poor sanitation, bad hygiene and violence (Groce, 2004; DFID, 2000). Many of the disabilities created by such situations would be preventable for the citizens of Africa if there was adequate access to health services, vaccination programs and nutritional supplements (DFID, 2000).

Poverty is related to poor education and employment opportunities, especially for persons with disabilities (DeVries, 2004). Access to education is an ongoing problem for people with disabilities, not just in sub-Saharan Africa, but throughout the world. Children with disabilities are shut out of the educational system because of the inaccessibility of many schools (Groce, 2004). There is very little encouragement given to children with disabilities to attend school and some parents are unwilling to send their children because they feel it is a waste of time or money (Munthali et al, 2004). Some schools are unfriendly towards children with disabilities and try to prevent them

from attending (Mulindwa, 2003; Groce, 2004). There is also the attitude that going to school is a waste of time for persons with disabilities because they will be unable to gain employment after graduation (Munthali et al, 2004).

Many of the respondents said that they were not married because of their disability. One feeling was that non-disabled people were afraid to marry individuals with disabilities because they felt it would be a burden and that they would have to do all the household chores (Munthali et al, 2004). Cultural sanctions against marrying a person with a disability may mean that they are likely to become involved in a series of unstable relationships (SAfAIDS, 2003). Even supposedly committed relationships outside of marriage with persons with disabilities are often fraught with sexual exploitation and unwanted pregnancies (Mulindwa, 2003). Women with disabilities are sexually exploited by men, in part because of men's fear to identify themselves with girlfriends who have disabilities. Sexual exploitation has led to risky and reckless behaviour among women with disabilities themselves. "Girls with disabilities offer themselves to men because they think that no man would ever approach them for true love" (Mulindwa, 2003:24). Stigma and sexual exploitation has led to many persons with disabilities fearing that they cannot always trust their partner, and that they are therefore at risk of contracting HIV/AIDS (Munthali et al, 2004; Mulindwa, 2003).

The assumption that persons with disabilities are not sexually active has led to their exclusion from the reproductive health service delivery system (Mulindwa, 2003; DFID, 2000). Reproductive health sensitization and awareness-raising programs systematically exclude persons with disabilities. "We are not invited to these reproductive health workshops which are always held at the health centres" (Mulindwa, 2003:26). The unfriendliness of health service providers towards persons with disabilities is also a barrier to accessing services. "Nurses ridicule, laugh and abuse us when we emerge with reproductive health problems. They always insult us by asking questions like; how did you get this pregnancy you crippled woman" (Mulindwa, 2003:69; Yousafzi & Edwards, 2004).

There is an elevated risk for violence and rape for persons with disabilities (Groce, 2004). Abuse and violence directed towards people with disabilities has been well documented, however the prevalence varies greatly from one study to another. Some estimates are that people with disabilities are more than twice as likely to be assaulted as people without disabilities (McPherson, 1990; DFID, 2000); however, Groce (2004) estimates that individuals with disabilities are up to three times more likely to be victims of physical abuse, sexual abuse and rape. Abuse among women with disabilities ranges from 31% to 83%, or double to quadruple the rate found among women in general (Nosek et al, 2004). Rape and abuse increase the susceptibility of persons with disabilities to contract HIV/AIDS. Forced sex, including incest and rape, is particularly risky because condoms are rarely used and, therefore, exposure to HIV/AIDS is increased (Mgalla et al, 1997).

Communication difficulties prevent some people with disabilities from being able to report their abuse; people who are visually impaired cannot identify their abuser; and those with hearing impairments cannot tell the police unless there is a sign language interpreter (Yousafzi & Edwards, 2004). Also, persons with physical disabilities may be too weak to fight off their assailants (Mulindwa, 2003). Myths, such as if people with HIV have sex with virgins they can be cured of their infection, have given rise to incidences of rape, and persons with disabilities are even more vulnerable (Munthali et al, 2004). Because of the misconception that persons with disabilities do not engage in sexual relations, most are assumed to be virgins, and are therefore a target for virgin cleansing (Groce & Trasi, 2004). Misconceptions about persons with disabilities and the vulnerabilities they experience can help to explain why many HIV/AIDS service providers have not directed information towards them (Janssen, 2003).

The assumption that persons with disabilities are not sexually active has also led to students with disabilities being excluded from AIDS education in schools. The teachers assume that they will not benefit from the information as they are unlikely to become sexually active and are therefore not at risk (Groce, 2005). It is clearly evident

that persons with disabilities are sexually active, have less access to HIV/AIDS prevention programs, and yet are vulnerable to contracting the disease.

2.3 Preventative strategies of HIV/AIDS among persons living with Disability

Reduction of stigma and discrimination

Stigma and discrimination are daily realities for people living with HIV and for people belonging to groups particularly vulnerable to HIV infection. Such groups include sex workers, men who have sex with men, people who inject drugs, prisoners and people with tuberculosis. Members of these groups are already stigmatized and are more likely to face more discrimination than others when diagnosed with HIV, including being refused services (Bicego, 2003). The layered stigma that people in these groups experience further heightens the challenge of meeting their needs with respect to HIV. Members of these groups often avoid, or delay, seeking needed services for fear of being “found out”, humiliated, and/or treated differently by health workers, and, in some instances, prosecuted and imprisoned.

Youth who are females, tend to experience greater stigma and discrimination than men, are more likely to experience its harshest and most damaging forms, and have fewer resources for coping with it. Violence is a severe consequence of stigma faced principally by women. Both women and girls report increased violence at the hands of their partners for requesting condom use, accessing voluntary testing and counseling, refusing sex within or outside marriage or for testing HIV-positive (Bicego, 2003).

Magnified Effects among Socially Vulnerable Groups Build an understanding of and commitment to stigma and discrimination reduction by using existing tools for measuring stigma and discrimination to “know your epidemic” in terms of the prevalence of stigma and discrimination and their impact on the response to HIV (Bicego, 2003). Provide leadership on the necessity of reducing stigma and

discrimination in national AIDS responses. Inspire leadership, understanding, and high-level commitment regarding the need to seriously expand efforts to address stigma and discrimination in national AIDS programmes.

„ Facilitate the inclusion of stigma/discrimination reduction in national HIV strategic planning, funding and programming activities. Ensure that planning, funding and programming efforts include attention to stigma and discrimination and support the implementation of promising programmes to address stigma and discrimination (Bicego, 2003).

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter consisted of research design, population, and sample size, sampling procedures, instruments, validity and reliability of the instruments, data gathering procedures, data analysis, ethical considerations and limitations of the study.

3.1 Research Design

The study employed a descriptive correlation design that used both qualitative and quantitative methods of data collection. It is Quantitative in the sense that it based on methodological principles of description, and use of statistical measurements as expected by the researcher. Qualitative data was presented on tables (Wildler,2002).

3.2 Research Population

This refers to the group that the researcher focused on. The researcher believes that this group has vital information. Therefore, the target population was one hundred persons living with disability (100) respondents in of selected health centers of Kampala district.

3.3 Sample Size

The Slovin's formula was used to determine the minimum sample size.

$$n = \frac{N}{1 + N \alpha^2}$$

N= Target population

n = Sample size

$\alpha^2=0.05$ (level of significance)

3.4 Sampling procedures

The purposive sampling was to utilize to select the respondents. From the list of qualified respondents were chosen basing on the inclusion criteria, the systematic random sampling was used and finally select the respondents with consideration to the computed minimum sample size.

Research Instruments

The research tool that was used in this study include the following: (1) *face sheet* to gather data on the respondents' profile;- (gender, age, education qualification and marital status); (2) *researcher devised questionnaires* to examine the barriers and preventive strategies. The response modes and scoring are as follows: *for barriers and preventive strategies* - 1) strongly disagree (2); disagree (3); agree (4); strongly agree.

3.5 Validity and Reliability of the Instruments

Content validity was ensured by subjecting the researcher devised questionnaires on barriers and preventive strategies (who shall estimate the validity on the basis of their experience) such as persons with disability of selected health centers of Kampala District.

The test-retest technique was used to determine the reliability (accuracy) of the researcher devised instruments to 15 qualified respondents, from some selected health centers. These respondents were included in the actual study. In this test- retest technique, the questionnaires were administered twice to the same subjects.

3.6 Data Gathering Procedures

An introduction letter was obtained from the college of humanities and social sciences for the researcher to solicit approval to conduct the study from respective officials on persons living with disability, respondents were requested to answer completely and not to leave any part of the questionnaires unanswered and the data gathered collated, encoded into the computer and statistically treated using the Statistical Package for Social Sciences (SPSS).

3.7 Data Analysis

The frequency and percentage distribution were used to determine the profile of the respondents.

The means and standard deviations were applied for the barriers and preventive strategies of persons living with disability.

The following mean ranges were to arrive at the mean of the individual indicators and interpretation:

Mean Range	Response Mode
3.26-4.00	strongly agree
2.51-3.25	Agree
1.76-2.50	Disagree
1.00-1.75	strongly disagree

To determine whether there is a significant relationship between HIV/AIDS and Disability, Pearson linear correlation coefficient (PLCC) was used to compute the influence of the independent variable to dependent variable.

3.8 Ethical Considerations

Confidentiality of the information provided by the respondents were maintained, a researcher sought for permission from officials and the respondents' names were not reflected.

Acknowledge the authors quoted in this study and the author of the standardized instrument through citations and referencing.
Present the findings in a generalized manner

3.9 Limitations of the Study

Extraneous variables which were beyond the researcher's control such as respondents' honesty, personal biases and uncontrolled setting of the study.

Attrition: Not all questionnaires were answered and returned in time.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.0 Introduction

This chapter shows the profile of respondents; examine the barriers associated with HIV/AIDS, the preventive strategies associated with HIV/AIDS among people living with disability of Kampala District and the significant relationship between HIV/AIDS and disability among persons living with disability of Kampala District among people with disability in selected HIV/AIDS centers in Kampala District. The presentation here is based on data as collected from the field and as analyzed by the researcher.

4.1 Profile of the respondents

Respondents in this study included people with disability living with HIV/AIDS and the first objective of this study set out to determine the profile of respondents in terms of gender, age highest level of education and marital status. In each case, the respondents were asked to provide their profile characteristics, using a closed ended questionnaire. Their responses were analyzed using frequencies and percentage distributions as indicated in table 1 below;

Table 4.1 : Respondents' Profile

Profile of respondents	Frequency	Percentage (%)
Gender		
Male	29	36
Female	51	64
Total	80	100
Age		
20-29	20	25
30-39	30	38
40-49	15	18

50 and above	15	19
Total	80	100
Highest level of education		
Primary	16	20
Secondary	20	25
Certificate	30	38
Diploma	8	10
Degree	6	7
Total	80	100
Marital status		
Married	30	38
Single	10	13
Divorced	25	31
Widowed	15	18
Total	80	100

(Primary source,2013)

Results from Table 4.1 indicate that most of the respondents were female that is to say 64% and minorities were males with 36% Therefore, females dominated in this sample.

As far as age is concerned, 38% respondents were in the age bracket of 30-39, followed by 20-29 years of age (25%), 40-49 and 50 and above were all 15%.This means that most of the respondents were youths.

Pertaining the class of respondents, majorities were having certificate with a frequency of 30(38%) and minority were 6(7%) with degrees. This is means that a person is able to read and write hence getting correct information from them.

Concerning marital status of respondents 38% of the respondents were married, followed by 31% were divorced and 13% were single.

4.2 Level of barriers associated with HIV/AIDS among people living with disability of Kampala District

The first independent variable in this study was barriers associated with HIV/AIDS for which the researcher required to determine its level. It was measured using qualitative questions in which respondents were required to indicate the extent to which they agree or disagree with each of the items by indicating the number that suits their perceptions. Each of these questions were measured on a 4-point likert scale, means and standard deviations were used as indicated in table 4.2

Mean range	Response mode	Interpretation
3.26-4.00	strongly agree	very often
2.51-3.25	Agree	often
1.76-2.50	Disagree	rarely
1.00-1.75	Strongly disagree	very rarely

Table 4.2 to show the barriers associated with HIV/AIDS among people living with disability of Kampala District

Categories on Barriers	Mean	Std. Deviation
Stigma		
I fear to tell friends and relatives that I have HIV	1.00	.000
People with HIV lose their jobs when their employers find out	1.85	.359

It is easier to avoid new friends than worrying about telling someone that I have HIV	1.05	.219
I am very careful who I tell that I have HIV	1.64	.484
I can't take my ARVS when people are around me.	1.97	1.006
Average mean	1.5025	.29510
Access to HIV/AIDS services		
Health workers normally uses abusive words especially when they are taking to us	2.75	1.278
People on ARVS are treated like out casts especially disabled ones.	1.15	.480
Lack of transport to access them from Health centers	1.38	.487
I feel some times not going to health centers because of how health workers look at me	1.00	.000
We have no enough materials about HIV/AIDS written by Brailles	1.46	.502
If I happen not to have somebody to give me a lift I can take myself to a health center to get my Pills	1.85	.748
Average mean	1.5979	.36427
Overall mean	1.5502	.31601

(Primary source, 2013)

The means in Table 2 indicated that people with disabilities rated the level of barriers was on only one item namely Health workers normally uses abusive words especially when they are taking to us (mean=2.75). The overall mean (1.5502) indicates that on average, most of respondents strongly disagreed meaning that they have learnt to stay with HIV/AIDS with regardless of how they are treated, perceived and people's attitude towards them.

4.3 Level of preventive strategies associated with HIV/AIDS among people living with disability of Kampala District

The second dependent variable in this study was preventive strategies associated with HIV/AIDS for which the researcher required to determine its level. It was measured using qualitative questions in which respondents were required to indicate the extent to which they agree or disagree with each of the items by indicating the number that suits their perceptions. Each of these questions were measured on a 4-point likert scale, means and standard deviations were used as indicated in table 4.2

Mean range	Response mode	Interpretation
3.26-4.00	strongly agree	very often
2.51-3.25	Agree	often
1.76-2.50	Disagree	rarely
1.00-1.75	Strongly disagree	very rarely

Table 4.3 shows the preventive strategies associated with HIV/AIDS among people living with disability of Kampala District

n=80

Categories on Preventative strategies	Mean	Std. Deviation
You are able to associate with others and discuss about HIV/AIDS	1.78	1.211
You are able to disclose your HIV status to your friends and relatives	1.83	.880
You are able to take ARVS around other people despite the fact that they are not on ARVS	2.33	1.101

You freely interact with your friends despite the fact that you are on ARVS and they are comfortable with it	2.42	1.428
You are able to go for voluntary counseling and testing	1.49	.698
You are able to share with friends about your experience of being on ARVS though you are disabled	2.25	.720
You are helped by specialists to read for you materials concerning HIV/AIDS	2.13	1.381
You access information in sign language but transmission of HIV/AIDS	2.26	1.122
Average mean	2.0373	.56707

Results in Table 3 reveal that the preventative strategies generally rarely (average mean=2.0373). The findings indicate that home based care was rarely on five items that is You are able to take ARVS around other people despite the fact that they are not on ARVS (mean=2.33), You freely interact with your friends despite the fact that you are on ARVS and they are comfortable with it (mean=2.42), You are able to share with friends about your experience of being on ARVS though you are disabled (mean =2.25), You access information in sign language but transmission of HIV/AIDS (mean=2.13) this means that most of respondents rarely associate with others and discuss about HIV/AIDS and able to disclose your HIV status to your friends and relatives.

4.4 Significant Relationship between Barriers and preventative strategies associated with HIV/AIDS among people living with disability of Kampala District

The fourth objective was to establish whether there is a significant relationship between barriers and preventative strategies associated with HIV/AIDS among people living with disability of Kampala District. The researcher tested a null hypothesis that there is no significant relationship between barriers and preventative strategies associated with HIV/AIDS among people living with disability of Kampala District. To test this null hypothesis, the Pearson's Linear Correlation Coefficient (PLCC) and the results are indicated in table 4.4

Table 4.4 Significant Relationship between Barriers and preventative strategies associated with HIV/AIDS among people living with disability of Kampala District

Variables correlated	r-value	Sig	Interpretation	Rejected
Barriers Vs Preventative Strategies	.743	.000	Significantly correlated	Rejected

The results in Table indicate a significant relationship between barriers and preventive strategies ($r=0.743$, $\text{sig.} = 0.000$). The findings also indicate that barriers and preventive strategies are positively correlated. This means that once the barriers have been eliminated, among people with disabilities, the easier to curb the stigma levels and access to HIV/AIDS services. The r coefficient of 0.743 indicates that the once barriers are got rid of also the people with disability are able to go for the services. Basing on these results, the null hypothesis was rejected and the alternative was accepted. A conclusion was made that there should be also ways on how to communicate with people associated with HIV/AIDS at 0.05 the level of significance.

These findings are shows that Stigma and access to HIV/AIDS center are daily realities for people living with HIV and for people belonging to groups particularly vulnerable to HIV infection. Such groups include sex workers, men who have sex with men, people who inject drugs, prisoners and people with tuberculosis. Members of these groups are already stigmatized and are more likely to face more discrimination than others when diagnosed with HIV, including being refused services (Bicego, 2003). The layered stigma that people in these groups experience further heightens the challenge of meeting their needs with respect to HIV. Members of these groups often avoid, or delay, seeking needed services for fear of being “found out”, humiliated, and/or treated differently by health workers, and, in some instances, prosecuted and imprisoned.

CHAPTER FIVE

5.0 SUMMARY, CONCLUSION AND RECOMMENDATIONS

This chapter presents a summary of major findings, conclusions and recommendations plus the suggested areas that need further research.

5.1 Summary of Findings

The purpose of the study is to examine the effects of HIV/AIDS among people living with disability of Kampala District. The study had four specific objectives, which included; i) determining the profile of respondents in terms of gender, age, educational qualification and marital status; ii) to determine the level of barriers associated with HIV/AIDS among people with disabilities; iii) to determine the level of preventive strategies; and iv) to determine the relationship between the levels of barriers and preventative strategies associated with HIV/AIDS among people with disabilities.

The findings indicated that most respondents (64%) were females who are in vulnerable groups, aged between 30-39 years, majority were in certificate (38%) and over 38% were married.

The level of barriers was generally very rarely with mean (1.5502) which indicated that most of respondents strongly disagreed.

The level of preventive strategies is generally rarely (overall mean=2.0373) they disagreed. And also indicated a positive significant relationship between the level of barriers and preventive strategies associated with HIV/AIDS among people with disabilities ($r=0.723$, sig. =0.000) the more the government has tried to eliminate the barriers, the people with disability will be able to go for voluntary counseling and testing, able to disclose their status and get rid of stigma.

5.2 Conclusions

From the purpose of the study, the researcher concluded by the following:-

Strengths and weakness

The level of barriers were often on the following:-Health workers normally uses abusive words especially when they are talking to us, People with HIV loose their jobs when their employers find out and I can't take my ARVS when people are around me.

The level of preventive strategies was often on the following: You freely interact with your friends despite the fact that you are on ARVS and they are comfortable with it.

To test null hypothesis of the study

The significant relationship was positive significantly correlated between the level of barriers and preventive strategies associated with HIV/AIDS among people with disabilities. And this means that the more the government has tried to eliminate the barriers, the people with disability will be able to go for voluntary counseling and testing, able to disclose their status and get rid of stigma.

5.3 Recommendations

From the findings and the conclusions of the study, the researcher recommends there is need to sensitive people with disability to avoid stigma, despite the fact that there vulnerable and access the HIV/AIDS services

There is need to uplift the educational level of people with disability since most of them were certificate holders.

In order to Increased acceptance and uptake of HIV testing, sensitization should be thoroughly done more especially in communities.

Areas for Further Research

More studies can be conducted on Counseling on stigma, discrimination, adherence to Anti retroviral therapy and so on.

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APPENDICES

APPENDIX I: QUESTIONNAIRE ON EFFECTS OF HIV/AIDS AMONG PERSONS LIVING WITH DISABILITY

Dear respondents

Kindly I request you to fill for me this questionnaire, am carrying out an academic research on **"EFFECTS OF HIV/AIDS AMONG PERSONS LIVING WITH DISABILITY IN SELECTED HEALTH CENTERS OF KAMPALA DISTRICT"**. Within this context, may I request you to participate in this study by answering the questionnaires? Kindly do not leave any option unanswered. Any data you will provide shall be for academic purposes only and no information of such kind shall be disclosed to others.

May I retrieve the questionnaire within one week (7) days

Thank you very much in advance.

Yours faithfully,

MS. MUGUME AHIMBISIBWE ENID

Instruction

- i) Do not write your name any where
- ii) Tick in any appropriate box

Section A

1 (a) Profile of respondents

Male ☐

Female ☐

(b) Age i) __ (20-29), ii) __ (30-39) iii) __ (40-49) iv) __ (50-and above)

c) What is your highest level education?

1. primary ____

2. Secondary ____

3. Certificate ____

4. Diploma ____

5. Degree ____

d) Marital status

i) married ----- ii) single ____ iii) Divorced ____ iv) Widowed ____

APPENDIX II: QUESTIONNAIRE TO EXAMINE THE BARRIERS OF ASSOCIATED WITH HIV/AIDS AMONG PERSONS LIVING WITH DISABILITY OF SELECTED HEALTH CENTERS OF KAMPALA DISTRICT

Direction: Please describe the extent unto which you are hindered from accessing treatment and care on each item by using the scoring scale guide below. Kindly write your best rating in the space before each item. Be honest about your options as there is no right or wrong answers.

Score	Response	Description
4	strongly agree	you agree with no doubt at all
3	agree	you agree with some doubt
2	disagree	you disagree with some doubt
1	strongly disagree	you disagree with no doubt at all

Stigma	1	2	3	4
I fear to tell friends and relatives that I have HIV	1	2	3	4
People with HIV lose their jobs when their employers find out	1	2	3	4
It is easier to avoid new friends than worrying about telling someone that I have HIV	1	2	3	4
I am very careful who I tell that I have HIV	1	2	3	4
I can't take my ARVS when people are around me.	1	2	3	4
Access to Health centers				

Health workers normally uses abusive words especially when they are taking to us	1	2	3	4
People on ARVS are treated like out casts especially disabled ones.	1	2	3	4
Lack of transport to access them from Health centers	1	2	3	4
I feel some times not going to health centers because of how health workers look at me	1	2	3	4
We have no enough materials about HIV/AIDS written by Brailles	1	2	3	4
If I happen not to have some body to give me a lift I can take my self to a health center to get my Pills	1	2	3	4

APPENDIX III: QUESTIONNAIRE TO EXAMINE THE PREVENTIVE STRATEGIES OF ASSOCIATED WITH HIV/AIDS AMONG PERSONS LIVING WITH DISABILITY OF SELECTED HEALTH CENTERS OF KAMPALA DISTRICT

Direction: Please describe the extent unto which preventative strategies from accessing treatment and care on each item by using the scoring scale guide below. Kindly write your best rating in the space before each item. Be honest about your options as there is no right or wrong answers.

Score	Response	Description
4	strongly agree	you agree with no doubt at all
3	agree	you agree with some doubt
2	disagree	you disagree with some doubt
1	strongly disagree	you disagree with no doubt at all

Preventative strategies	1	2	3	4
You are able to associate with others and discuss about HIV/AIDS	1	2	3	4
You are able to disclose your HIV status to your friends and relatives	1	2	3	4
You are able to take ARVS around other People despite the fact that they are not on ARVS	1	2	3	4
You freely interact with your friends despite the fact that you are on ARVS and they are comfortable with it	1	2	3	4
You are able to go for voluntary counseling and testing	1	2	3	4

You are able to share with friends about your experience of being on ARVS though you are disabled	1	2	3	4
You are helped by specialists to read for you materials concerning HIV/AIDS	1	2	3	4
You access information in sign language but transmission of HIV/AIDS	1	2	3	4

Thanks for your participation