Intersection between Disability and HIV and the Impact of Poverty on Persons with Disability. A case Study of VCT Centers of Menlik II Referral Hospital, Mekdim National Association and Saris Health Center in Arada and Nefas Silk-Lafto Sub-cities of Addis Ababa

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Intersection between Disability and HIV and the impact of Poverty on Persons with Disability

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Acronyms

BCC	Behavioral change & Communication
CSA	Central Statistics Authority
CWD	Children with Disability
EDHS	Ethiopian Demography and Health Survey
FENAPD	Federation of Ethiopian National Associations for Persons with Disability
FGD	Focus group Discussion
GTP	Growth and Transformation Plan
HAPCO	HIV AIDS Prevention and Control Office
IEC	Information, Education & Communication
ILO	International Labor Organization
MARPS	Most at risk population
MoE	Ministry of Education
MoLSA	Ministry of Labor and Social Affairs
MoUDAC	Ministry of Urban Development and Construction
PWD	People with Disability
RH	Reproductive health
SPM	Strategic Plan Management
STD	Sexually Transmitted Disease
TB	Tuberculosis
VCT	Voluntary Counseling and Testing
PLWHA	People living with HIV/AIDS
WHO	World Health Organization
UNAIDS	United Nations AIDS
UNCRPD	United Nations Convention on the Rights of people

Abstract

According to the UNAIDS 2012 report there were favorable trends in many countries. However, compared to other regions, of Sub-Saharan Africa, which has just over 10% of the world's population, has remained the most affected region, where more than two thirds of all HIV positive people are found. As one of the Sub Saharan African countries, Ethiopia is facing similar challenges of the epidemic. According to the report of Federal HAPCO 1.2 million people were HIV positive with the adult population with prevalence of 2.4 percent .The Prevalence in the capital Addis Ababa was estimated to be 4.5 %.

The objective of the study is to depict the interlink/intersection of disability, HIV and poverty as influencing factor and indicate the need for multi sector inclusive development programming that address hidden problems of PWDs such as sexual, HIV Knowledge, Attitudes and Practices of men and women with disabilities, as well as the factors determining their utilization of HIV services.

This study has attempted to assess the factors that contribute the intersection/inter link between HIV and Disability and impacting influence of poverty. With this reference, data on persons with disability from three VCT centers[1] was collected and focus group discussion with inputs from experts as key informants has been employed. The findings gathered from the above methods were analyzed both qualitatively and quantitatively.

The findings of the study indicate that the average prevalence of HIV among PWDs in Addis Ababa is about 4.3% which is a little bit less from Addis Ababa's average (4.5%). This figure indicates the picture which is quite different from the rural areas, where PWDs have less exposure to education and HIV awareness.

1. VCT centers are either permanent or temporary sites located in different parts of the city, where voluntarily people go to request for HI services.

Chapter One:

1.1 Introduction

HIV has been an impediment for the last three decades on the developmental efforts of the world in general and on East Africa in particular by aggravating already existing poverty, over utilizing the medical/health budget, diminishing the productive labor force section of the population and distracting governments' attention and efforts from focusing on other essential services. According to the UNAIDS 2012 report, there were favorable trends in many countries. However, compared to other regions, of Sub-Saharan Africa, which has just over 10% of the world's population, has remained the most affected region, where more than two thirds of all HIV positive people are found.

As one of the Sub Saharan African countries, Ethiopia is facing similar challenges of the epidemic. According to the report of Federal HAPCO[1] 1.2 million people were HIV positive with the adult population with prevalence of 2.4 percent .The Prevalence in the capital Addis Ababa was estimated to be 4.5 %. The report also explained that the overall incidence rate for the city has been slightly declining over the last few years. However, with the high rural-urban migration, it has contributed to the relatively ascending nature of the epidemic in the city.

Generally, there have been a lot of efforts made to curb the spread of the virus in Ethiopia by both the government and other non government stakeholders. According to the Ethiopian Ministry of Health Report, some segments of the Ethiopian society are more vulnerable to HIV than others (MARPS)[2]. The report indicates that young adults, children, women, commercial sex workers, truck drivers, soldiers and adolescents are the most affected groups. These high risk population groups have been given special attention in halting the spread of the virus with interventions such as projects run by Population service International in collaboration with HAPCO. In addition, a number of researches have been carried out in the area of HIV concerning these segments of society.

2. Most at risk population are people who are categorized based on the magnitude of risk they are exposed to. The risk exposure is measured from their work environment, socio demographic factors drivers. Such as Long distance track drivers, mobile workers, commercial sex workers, Baggage drivers.

However, people with disabilities have never been considered as high risk groups by most of the responsible stakeholders with the exception of the Federal HAPCO which has incorporated the issue in its strategic plan II. In most cases, PWDs are not addressed as a target group for prevention education (like IEC and BCC) because there are quite number of misconception that they are asexual and free of the virus. Contrary to these assumptions, studies conducted in Cameroon, Kenya, Uganda and Rwanda have depicted that PWDs are facing high risk of contracting the virus even in some cases higher than the national averages. Despite lack of disability focused HIV programs, inaccessible services, stigma and discrimination have deprived the rights of PWDs to obtain services like any other citizens of the country.

Apparently it is assumed that realities in Ethiopia are not significantly being different from those countries which have conducted similar studies. The existing misconceptions on disability and inaccessible services along with lack of knowhow on mainstreaming disability in to HIV programs have excluded them from sharing the resources of society. Poverty of PWDs is another prominent factor for their exposure to HIV transmission. A study shows that HIV related information is less accessible for people with all types of disabilities since majority of them depend on other for transportation or sign language interpretation.

According to WHO and World Bank (2011) global report, 15% of the world population as of 2010 (over a billion people) was estimated to be living with disability making them world's largest minority group. The same report estimates the number of people with disabilities in Ethiopia as 17.6 % of the total population. As Elwan has indicated 1 in 5 world's poorest people has a disability, which takes to an argument that poverty is both a cause and consequence.

1.2 Statement of the problem

Although there has been research focused on the disabling consequences of HIV, there has been very little documented information about HIV for disabled people prior to infection. Scholars in general agree that little is known about the intersection/interlink among poverty, HIV and Disability. I strongly believe that this grey intersection is an area of interest to

further study with the aim of addressing the following research questions. More number of researches and legal enforcement declarations and covenants affirm that person with disabilities to entitle equal rights concerning to access in reproductive health services. This includes the rights for accessing information, counseling and family planning services among many others. However, several reports like the World Bank report (2009) revealed that people with disabilities face various challenges and barriers[3] in terms of accessing and utilizing RH services provided by either government or non-government organizations.

Ethiopia is one of the countries with poor accessible education service. The school enrollment of children with disability (CWD) both in private and government schools is very low. According to report of MoE for the academic year of 2012/2013, of all the children enrolled for the academic year only 3.2 % of them were children with all cross impairments. As a result, one can assume the high rate of illiteracy among PWDs which in turn has a direct impact on their employment opportunity. Several factors contribute for the overall poor education system of the country in general and the lack of inclusive education services in particular. To mention but few factors poverty, gender inequality, unavailability of accessible service providing facilities and trained personnel, poor quality of the existing inclusive education services, gender inequality and poor education seeking behavior of parents due to stigma are important.

Even though, the inclusive education service of the country shows some progress in the last few years, it is still lagging behind. According to Addis Ababa university president's speech during the inauguration of accessible ramp for girls' dormitory, he mentioned that the total number of higher education attendees with disabilities is less than 500 in 2013/2014 academic year.

According to World Bank, the poorest, most underdeveloped region in the world, Sub-Saharan Africa faces by far the highest rate of HIV infection. Though the region accounts 10% of the world population, 85% of AIDS deaths have occurred in this region.

3. Barriers for PWDs are environmental, attitudinal, communication, physical, institutional which hider them from executing the daily tasks.

For Ethiopia HIV/AIDS remains still one of the major health/social problems. The prevalence varies depending on the regions and urban and rural settings. The EDHS 2011 shows an urban adult HIV prevalence of 4.2%, while rural adult HIV prevalence was 0.6%. In terms of administrative regions, it varies from 0.9% in SNNPR and 1.0% in Oromiya region to 5.2% in Addis Ababa and 6.5% in Gambella region[4].

It's true that the country has made a great effort to acknowledge the rights of PwDs. The ratification of the UN convention of the right of Persons with Disabilities (UNCRPD), new laws like in the construction code and other positive undertakings shows the commitment of the government. The 2006 Convention on the Rights of Persons with Disabilities commits State Parties to:

> ***"provide persons with disabilities with the same range, quality and standard of free or affordable health care and programs as provided to other people, including in the area of sexual and reproductive health and population-based programs" (Article 25) and to "take appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain their maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life" (Article 26).***

However, much remains to be done. Starting from changing the attitude of the society up to implementation of those policies need dedication and perseverance of all stakeholders. Resources are limited but fair and equitable services must be provided to ensure the rights of the citizens among whom woman and men with different impairments are present.

Unfortunately, researches undertaken by organizations whether governmental or non-governmental do not include the situation of PWDs, which hinder the inclusion of accessible services.

For example the Ethiopia Demographic and Health Survey (EDHS) undertaken in 2011 did not disaggregate the data by type of impairments. Thus, it is impossible to get information to design and provide inclusive services for persons with different impairments and this calls for disability focused researches to fill the gap.

4. Gambella is a region located in the western part of the country. Higher prevalence is recorded in this region due to several factors such as polygamy, inheritance of wives of deceased brother, misconceptions, increased number of development project sites, presence of abundant commercial workers.

1.3 Objective of the study

1.3.1 General objective

To depict the interlink /intersection of disability and HIV with poverty as influencing factor and indicate the need for multi sector inclusive development programming that address hidden problems of PWDs sexual and reproductive Knowledge, Attitudes and Practices of men and women with disabilities, as well as the factors determining their utilization of SRH and HIV services.

1.3.2 Specific objective

- To assess HIV Knowledge, Attitudes and Practices of persons with disabilities
- To investigate factors that contribute to viciousness of poverty, HIV and disability
- Indicate the inter relationship of Disability, HIV and poverty and the importance of inclusive planning based on disaggregated disability data.

1.4 Research Questions:

. Is there a justifiable correlation between HIV and Disability?

. Does poverty play a strengthening role for the inter link between disability

1.5 Study Area

Addis Ababa, the capital city was established in 1886, with an altitude reaching 2400 meters, it is one of the oldest and largest cities in Africa. According to the 2007 census the population of Addis is estimated to be 2.7 million (47.6% male and 52.4% female) though UN agencies estimates around 4 million (UN-Habitat, 2008). According to the 2007 population census, the number of male with disability is estimated 17, 931, and female with disability 14,699. The city has an important role within Africa as it hosts the Headquarter of the African Union and other UN agencies. Addis Ababa is also the highest urbanized city in Ethiopia. The migration from rural areas to major urban cities will continue increasing putting pressure on the services provided to the population. By 2050, 7 in 10 people will live in urban areas. Every year, the world's urban population increases by approximately 60 million people. Most of this growth is taking place in low- and middle-income countries (UNICEF, 2012).

However, the city is reported achieving a lot in terms of service delivery, local empowerment, community participation, employment creation and housing provision.

The current health coverage in the capital has increased to 85 percent, the distance traveled to find a health facility is less than 2 kilometers, vaccination coverage is 95 percent, and the rate of HIV/AIDS infections have started to decline (EDHS, 2005).

Ethiopia is divided into nine regional states and two city administration councils. Addis Ababa, the capital city is one of the two city administration councils, accounts for 2.7 million (CSA, 2007)[5] habitants and is composed of ten sub cities. The sub cities used to be divided further into Woreda and Kebele. But due to the structural revision, the sub cities are currently divided only into large Woredas (districts).

The study will be conducted in two sub-cities of Addis Ababa city Administration, where it is believed PWDs do dwell majorly. The sub-cities are characterized differently with reasonable distance between them.

1.6 Study design

Designing a research is the process of making all decisions related to the research project before they are carried out (Blaikie, 2000). The steps of the research that is study area, methods of the study, sampling techniques, source and instrument of data collection, data collection procedure and methods of data analysis are discussed accordingly. This study has used both qualitative and quantitative research methods. Registry based comparative study and focus group discussion (FGD) is deployed to produce quantitative and qualitative data in response to the major research questions.

1.7 Study period

The study has been carried out in three months time.

5. Central Statistical Authority is a government institution responsible for socio-demographic surveys and data collection in all aspects of life in the country.

Chapter II

2.1 Data source

As this study utilizes both qualitative and quantitative methods, the source of the data is from two origins. One is the health registry books of the health service provision sites namely Menelik II referral hospital, Mekdim National Association and Saris health center. The data is recorded from November 2012 till August, 2013 by VCT practitioners in all the three sites. The PWDs have visited these centers coming from all sub cities of Addis Ababa. The VCT registry books captured data on age, sex, disability type, pretest counseling offered, HIV test accepted, post test counseled, received HIV result, screened for STD, screened for TB, etc.

The second source is from FGDs conducted with PWDs, health/VCT practitioners and key informants**.**

2.2 Instrument and Methods of Data Generation

For the purpose of this study, qualitative and quantitative data gathering tools were used to get in-depth information about flower farm workers. The use of qualitative and quantitative approaches encourages data triangulation – use of multiple data collection techniques (De Vault, 1996). The quantitative method was used as a support for the qualitative one.

A three stage process was followed in the study, namely Literature review, field observation, focus group discussion and discussion with key informants and analysis and synthesis.

Step 1. Involved a comprehensive review of both published and un published literature on Disability, HIV and poverty in Ethiopia. On the basis of this review key issues relating to disability, poverty and HIV in the country were identified

Step 2. This phase is the actual field work focusing on the FGD with people disabilities, VCT practitioners and semi-structured discussion with key informants from Addis Ababa HAPCO, HIV monitoring and control department staff.

Step 3. Was a detailed analysis of the findings from the study through discussion and synthesis.

2.3 Data Processing and Analysis

2.3.1 Qualitative Method

In qualitative research, the researcher is an important element of the research process; the researcher enters in to the lives of the participants (Marshal and Rossman, 1995). Qualitative research is aimed at discovering new experiences.

Qualitative methods are also considered important to a researcher for evaluating the nuances of the social phenomena important to an analysis of disability. Qualitative methods provide rigorous, reliable, verifiable data which helps to test an empirical hypothesis Olson (2005). Qualitative research is described as discovery research – trying to explore the environment PWDs experience in their life. Qualitative methods are preferred since they provide a way to study a phenomenon in its natural setting. In addition, qualitative research involves a set of empirical documents such as personal experience, case studies, observation and life history (Thomas, 2003).

Key informant discussion, Observation, and Focus Group Discussion are employed in this study.

2.3.2 Focus Group Discussion (FGD)

The Focus Group Discussion has been arranged with the purpose of supporting the data obtained from the health registry books. A group of nine PWDs and another group of five VCT practitioners (two of them were deaf) were organized for the FGD. Three major and six supportive questions were used as a guideline for the FGD and tape recorder used for collecting the data and used during the analysis.

2.3.3 Observation

The researcher has also utilized observation as one research instrument for gathering relevant information. Using observation as one data gathering tool, the researcher was able witness provision of accessible services in the study sites and how communication in sign language facilitates understanding between the deaf client and counselors. Different pictures were

taken in support of the observation in gathering first hand information, for this reason this method helped the finding to be more reliable and valid

2.3.4 Quantitative Method

Quantitative method helps the researcher to put facts in numeric terms. Quantitative data puts human behavior in numerical terms so that there is an accurate measurement (Jones, 2005). It is a way of getting a specific aspect of a phenomenon in numerical measurement by reducing personal involvement with the research subjects.

In this study also the quantitative method is applied on data extracted from the health registry books. The researcher tried to present recorded facts in from the VCT exercise conducted in the three health service provision sites.

In this study a total of 948 men and women with disability have participated and their individual records are used for the quantitative method applied. All the raw data enshrined on the health registry books from the three sites is used to produce quantified information in forms of tables and percentage.. The purpose of collecting quantitative information was to complement the qualitative data gathered through FGDs.

2.4 Limitations of the study

First the terms “impairment” and “disability” are referred by a single Amharic (local language) term meaning both. Therefore, this term is very widely used by respondents to refer to those with physical impairment either upper or lower limbs. There is quite high likelihood of ignoring the rest of the people with other impairments such as intellectual, epileptic etc. Methodologically, t he second limitation relates to conceptualizing and defining disability. First in adopting the social model, the researcher encountered some difficulty in identifying who is disabled “on the basis of social exclusion” Both PWDs and DPOs (institutions of and for disabled people) frequently referred to disability as pertaining to particular individuals and not as deterring environment that disables and/or excludes those individuals. Since some of the issues raised are associated with human rights, it was difficult for the researcher to entertain them because right issues are considered as exclusive mandate

of the government. The third limitation of the study is related to non availability of literature that links poverty, disability and HIV. Finally, resource constraints such as time and finance limited the extent and depth of the study.

2.5 Significance of the study

Researches made on persons with disability have shown the predicaments faced by persons with disability. The findings can show the magnitude of stigma and discrimination they face in their daily life. UNFPA's study revealed that persons with disabilities are at increased risk of HIV/AIDS. Persons with disabilities are up to three times more likely to be victims of physical and sexual abuse and rape and have less access to physical, psychological and judicial interventions. Moreover, agonizingly, persons with disabilities often experience forced sterilization, forced abortion and forced marriage.

Adolescents and adults with disabilities are as likely as persons without disabilities to be sexually active. Thus, they also have a need to have information about sexuality and the responsibilities that go along with exploring and experiencing one's own sexuality. They have to know how to protect themselves against unintended pregnancies, HIV and AIDS and other sexually transmitted infections, and sexual and gender-based violence. UNFPA report averred that globally, only 3 percent of persons with disabilities, and only one per cent of women with disabilities, are literate. Some persons with disabilities experience mechanical and psychosocial difficulties in sexual relationships and need support. Negative and stereotyped attitudes in society and the lack of disability-related support often lead to low self-esteem and psychological barriers in terms of sexuality.

PWDs are among vulnerable groups of society due to their physical, mental, or Psycho-social limitations which also often makes them economically disadvantaged, and among the poor, and thus less able to access health services including HIV prevention and care. Health education materials for those with hearing and visual impairment are often not easily available. As a result, they are less informed, and hence at risk of making choices and decisions on sexual matters that, expose them to sexual violence and HIV infection.

However, there are no studies to ascertain the extent of the problem in Ethiopia. The gap of knowledge on status of HIV/AIDS and factors that may predispose people with disabilities hinders the capacity of the national program to devise targeted interventions that would address the needs of this vulnerable group (FHAPCO, UNAIDS, WHO, 2012).

The World Health Organization in its part has stated in its 2011 report the following:

> *'To achieve the long-lasting, vastly better development prospects that lie at the heart of the 2015 Millennium Development Goals and beyond, we must empower people living with disabilities and remove the barriers which prevent them participating in their communities; getting a quality education, finding decent work, and having their voices heard'.*

Though efforts are be exerted to ensure the rights of People with different impairment through development of laws, provision of services are still at their infancy stage. One of the major documents designed by the government is the Growth and Transformation Plan (GTP) (2010/11-2014/15) which is a strategic framework aiming to sustain rapid and broad-based growth path witnessed during the past several years and eventually end poverty. Among other issues, the GTP document includes also ensuring the legal protection and rights of children, women, People living with HIV/AIDS and people with different impairments. This is a great achievement as most of the policy documents bypass the issue of disability.

The SPM II includes specifically people with different impairments. SPM II specifies that all preventive services need to be made available to the broader population in both urban and rural areas (FHAPCO/UNAIDS/WHO, 2012). In addition, the country has identified the specific needs for HIV needs prevention programs based on various documents like the EDHS. However, it is noted that the EDHS does not incorporate specific disaggregated data on persons with different impairments. Thus, unless this gap is filled services will not include the needs of people with different impairments.

Despite the claim of some organizations working on disability and HIV programs, the knowledge, attitudes, practice and service utilization of persons with disability remains obscured and bungling.

Thus, the rationale to study the intersection/interlink among Disability, HIV and poverty of persons with disability proves to be important and timely and narrows the information gap on the interplay of the parameters and further magnifies the importance to meet the needs and concerns of PWDs in this aspect.

2.6 Method of Data Analysis

Recording and Processing Data

In documenting both FGDs conducted with PWDs and VCT practitioners, a digital voice recorder has been used with the consent obtained from participants for recording their voices. The recorded information was transcribed and major thematic issues were developed around certain discussion areas impacting the life of the PWDs. The recorded data were detailed as much as possible, including possible solutions sought by participants.

2.7 Ethical considerations

As part of explaining important ethical issues to the participants of the study, the following ethical considerations were given:

- The purpose of the study was explained for the study subjects (both respondents and key informants) and their consent to participate in the study was sought. It was indicated that participation is voluntary.
- It was explained to the participants that the information given by informants and their identities would be kept confidential. There would be no negative effect in participating in this study. No harm or extra cost would be effected to the research participants. Rather, the moral satisfaction of responding to the questions is given due attention.

- ❖ The right of respondents/informants to walk away at any stage of the exercise was fully explained and respected.

This research has the aim of reflecting the concerns of every one by focusing on PWDs and other vulnerable groups. Moreover, this research proposed to bring the attention of service providers and concerned government authorities and PWDs by creating awareness. Their voices would be heard and their situations would be given due attention. This research also used the participation of PWDs and health practitioners in order to point out the situation that they needs to be improved.

Chapter III - Literature review

3.1 Disability

In addition, a study conducted by World Vision, United Kingdom has clearly revealed that the underlying causes of disabilities in Ethiopia are poverty, ignorance, war, disease, harmful traditional practices and drought. On top of this, inadequate nutrition, limited access to health care and absence of educational services add fuel to the problems of individuals with disabilities in Ethiopia (WVUK, 2000).

There are many different ways of understanding and interpreting disability. Disability takes various forms and is quite difficult to understand for both non-disabled persons and people with Disabilities (Handicap International/CBM, 2006). Thus different definition as well as different prevalence is found on disability and each country has its own way of defining disability.

The definition provided in the UN Convention on the Rights of Persons with Disabilities (UNRPD) is also accepted by many countries. The convention defines persons with disability as:

"A long-term physical, mental, intellectual or sensory (vision & hearing) impairment which in interaction with various barriers may hinder full and effective participation in society on an equal basis with others" (UNCRPD, 2006)

In Ethiopia disability is defined as 'A disabled person is any person unable to ensure by himself or herself a normal life, as a result of deficiency in his or her physical or mental capabilities" (JICA, 2006)

Another important point is to differentiate *impairment* from *disability*. *Impairment* is a problem in body function or alteration in body structure (like paralysis or blindness) (WHO, 2011).

Impairment is also defined as *"Limited or total loss of functioning in parts of the body or organ of the body"*

Disability is the disadvantage or restriction of activity caused by a contemporary social organization which takes no or little accounts of people who have physical impairment and thus excludes them from participation in the mainstream of social activities whereas

impairment is lacking part or all of a limb, or having a defective limb organ or mechanism of the body (Giddens, 2006). Therefore, since disability is an evolving concept, various states and organizations had been defining it on the basis of their socio-political philosophies.

Disability has been viewed and defined in various ways. Summary of the two prominent disability models are presented in the paragraphs below.

3.2The Individual model / medical model of disability

This model contends that individual model of disability has been dominant. This model contends that individual limitations are the main cause of the problems experienced by disabled people. In the individual model of disability, bodily abnormality is seen as causing some degree of 'disability or functional limitation-an individual 'suffering' from quadriplegia is incapable of walking, for example. This functional limitation is seen as the basis for a wider classification of an individual as 'an invalid'. Underpinning the individual model is a 'personal tragedy approach' to disability. The individual with disability is regarded as an unfortunate victim of a central role in the individual model because it is their job to offer curative and rehabilitative diagnosis to the problems suffered by the individual. For this reason the individual model is often described as the 'medical model' (Giddens, 2006).

3.3The Social Model of Disability

The social model of disability defines 'disability' in social terms. This challenged conventional understandings of the term. Within this model, disability is understood in terms of the social barriers that people with impairments faced in participating fully society (Macionis and Plummer, 2008).

Disability is a crucial issue in development. This has recently been highlighted by, amongst others, Healthlink Worldwide who state that the Millennium Development Goal of halving poverty cannot be addressed without responding to the needs of people with disabilities across sub-Saharan Africa (Healthlink Worldwide, 2004). Indeed, disability and poverty are

two sides of the same coin. The relationship between poverty and disability has led to various ideas on how to alleviate the situation for disabled people. Since the 1990s, one way has been to increase the participation of disabled people in community-based rehabilitation.
This remains a mainstream approach within contemporary development, particularly as it underlines the rights of people with disabilities to be an integral part of their own development (Sweeney, 2004).

The social model has been enormously influential in shaping the way that we think about disability today. Although it originated in the UK, the social model is gaining global influence, which is currently has grown to human rights model. In focusing on the removal of social barriers to full participation, the social model allows disabled people to focus on a political strategy. This has led some to argue that in accepting the social model people with disability have formed 'a new social movement'. In replacing the individual model, which identifies the 'invalidity' of the individual as the cause of disability, with a model in which disability is the result of oppression, the social model has been seen as liberating' by some people with disability.

The World Health Organization argues that the main cause of "chronic disease and long term impairments in developing countries is poverty, inadequate sanitation, poor diet and bad housing. Injuries, such as broken bones, will often result in long-term impairment in developing counties that would not occur if treatment and rehabilitation facilities had been available, as they generally are in the west. Iron deficiency, 'anemia' and chronic infections of the pelvis are major causes of impairment leading to disability in women in many developing countries (Giddens, 2006).
The causes for disability are several. Key causes of disability in Ethiopia include: prenatal and postnatal care and treatment issues, communicable diseases and infections (i.e. HIV/AIDS, malaria and tuberculosis), harmful traditional practices (i.e. early marriage, marriage by abduction, female genital cutting), accidents, and conflict (WHO, 2011). Moreover there is a myth and misconception that disability is a result of wrath of God.

- Past sins of parents
- Sin of the person in a previous life
- Wrath of God/gods
- Evil spirits
- Hereditary
- Teaching models for other persons
- Inflicted by other persons through witchcraft

3.4 Poverty

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others (UNCRPD, 2006)

The total population of PWDs in developing countries is continuously ascending due to war, drought, poverty, malnutrition, poor health services, etc. It is believed that about 80% of PWD live in developing countries (Helander, 1998) and one out of five world's poorest people has a disability (Elwan, 1999). Poverty is both a cause and consequence of disability

People with disabilities (PwDs) are among the most socially and economically disadvantaged segment of the population. Besides their physical suffering and immobility, these individuals are socially distressed from various forms of stigma and discrimination, mental anxiety, dependency and rejection.

Speaking on the occasion of the interview with "Biruh tesfa, "Late Prime minister Meles Zenawi has said that ensuring the inclusion of persons with disabilities in different economic, political and social activities and be benefited from the rights and results is a prior agenda of the government. (Biruh Tesfa 2011) Ethiopia, being one of the poorest countries in the world, faces many social problems. The government acknowledges these problems and strives to improve the countries undesirable situation. The Health sector is one major sectors of attention. The major problems in this area remain largely to be preventable communicable diseases and nutritional disorders.

Despite major progresses have been made to improve the health status of the population in the last one and half decades, Ethiopia's population still face a high rate of morbidity and mortality and the health status remains relatively poor .

According to the Federal Negarit Gazeta(2008), "unless the nature of the work dictates otherwise a person with disability having the necessary qualification and scored more to that of other candidates shall have the right without any discrimination to occupy a vacancy post in any office or undertaking through recruitment, promotion, placement or transfer procedure or to participate in training programme to be conducted either locally or abroad". Even if the constitution depicts the rights of PWDs in such a manner, a recent study on employability of graduate students confirms that PWDs have a serious problem of recruitment and training opportunities in both government and the private sector. Legislations need to be supported by awareness raising interventions to bring attitudinal changes of the general public.

3.5 HIV

To reduce HIV infection among reproductive age groups and improve the quality of life of those living with the disease, the set strategy is optimizing the synergies between RH and HIV/AIDS service. Level of integration of PMTCT and VCT service to routine antenatal/delivery/postpartum care, family planning service and STI clinics are the targets chosen. Unfortunately, the strategy doesn't reflect or include the needs related to Persons with Disabilities.

HIV was first detected in Ethiopia in 1984 and the first two AIDS cases were reported in 1986. A National HIV/AIDS taskforce was established in 1985 and the National AIDS Control Program was established at a Department level at the MOH in 1987. (Policy issued 1998)

Later on, the Government approved the first national policy on HIV/AIDS in 1998 as the Policy on HIV/AIDS of the Federal Democratic Republic of Ethiopia. The policy has the overall objective of providing an enabling environment for the prevention and mitigation of HIV/AIDS.

The specific objectives were to:

- Establish effective HIV/AIDS prevention and mitigation strategies to curb the spread of the epidemic;
- Promote a broad, multispectral response to HIV/AIDS, including more effective coordination and resource mobilization by government, NGOs, the private sector, and communities;
- Encourage government sectors, NGOs, the private sector, and communities to take measures to alleviate the social and economic impact of HIV/AIDS;
- Support a proper institutional 'home and community' based healthcare and psychological environment for PLWHA, orphans, and surviving dependents;
- Safeguard the human rights of PLWHA and avoid discrimination against them;
- Empower women, youth, and other vulnerable groups to take action to protect themselves against HIV;
- Promote and encourage research activities targeted toward preventive, curative, and rehabilitative aspects of HIV/AIDS.

The overall adult HIV prevalence in Ethiopia has remained low. The HIV prevalence among adults age 15-49 in the 2011 EDHS is stated as 1.5 percent (confidence interval 1.2-1.7 %), and it was 1.4% (confidence interval 1.1-1.8 %) in the 2005 EDHS. The government has made a tremendous effort to reduce the spread of HIV through different strategies and Ethiopia is one of the few sub-Saharan countries showing a decline of more than 25% in new HIV infections. Yet there are still 800,000 people living with HIV, and the country remains highly affected by the epidemic (FHAPCO/UNAIDS/WHO, 2012).

Centre for Developmental Disability Health has made a study on people with intellectual and developmental disabilities sexuality and has provided the recommendations. It states that People with intellectual and developmental disabilities have the same diversity of sexual needs and desires as the rest of the community. They often have different life experiences and limited opportunities to learn and sometimes require assistance to understand the

complexities of human relationships and the rights and responsibilities of sexuality and how this can be incorporated into their lives.

The report underlines also People with intellectual disabilities are more vulnerable to sexual abuse and are more likely to be abused because they often do not understand what is happening to them, are less able to protect them, are unlikely to report abuse, likely to be believe even if they do report sexual abuse.

In Ethiopia, the 2011 EDHS states that 10.9% of young women and 1.2% men aged 15-24 had sexual intercourse before they reached 15 years of age. Less than 1% of women and 4% of men between 15-49 years had intercourse with more than one partner in one year period.

"A key group that is being largely ignored in efforts to stop the spread of AIDS is the global population of some 600 million people who live with a physical, sensory, intellectual, or mental health disability" (World Bank, 2003).

Given the lack of precision on disability statistics, it is unsurprising that statistics do not exist on how many people with disabilities are currently living with the virus or have died of AIDS-related diseases. Thus the relationship between disability and HIV/AIDS in development has been given minimal attention, particularly in sub-Saharan Africa (Banda, 2003). Research which has been completed on disability and HIV/AIDS points to a common belief that people with disabilities are not sexually active, that having a disability is synonymous with being asexual (DFID, 2000) and that disabled people are therefore in little need of HIV/AIDS education (World Bank, 2004). Yet people with disabilities are often denied access to these initiatives.

In particular, little attention has been paid to HIV/AIDS and the sexual abuse of women with disabilities in sub-Saharan Africa. However, there is increasing evidence to suggest that women with disabilities are more susceptible to the HIV virus as a result not only of the lack of access to HIV/AIDS information, education and communication (IEC) but also because of

sexual exploitation. This implies the extent to which people with disabilities are socially excluded from their society (Sweeney, 2004).

The findings of the researchers for the World Bank/ Yale University Global Survey on HIV/AIDS and disability show that there are common themes throughout the world. These are:

- Health Professionals often assume that Disabled patients are not sexually active and are less likely to be targets of sexual violence.
- PWDs are up to three times more likely to be victims of physical abuse, sexual abuse or rape as members of the general population as they are often perceived as easy targets for violence by would be perpetrators. During the survey, it was also witnessed that there is believe to consider women with different impairment as asexual and curable. Thus, many virgins are raped.
- PWDs are less able to defend themselves from attack and find it more difficult to seek recourse through the courts, which are often physically inaccessible or do not have sign language interpreters available.

Chapter Four: Data Presentation, Analysis, and Discussion

Introduction

This chapter presents results of the FGD data collected from the PWDs, Health professionals (VCT practitioners) and key informants or experts from Addis Ababa HAPCO. The educational background of the respondents ranges from illiteracy to tertiary level education. The majority of them are from regions mainly from the rural community. The second part deals with the analysis based on the finding from both quantitative method. The analysis flows according to the specific objectives stated in chapter one by combining findings from the manipulation of the quantitative data gathered from the registry books, FGD and observation.

4.1 Findings of the FGD discussions

4.1.1 Economic status/poverty

Respondents and key informants mentioned that poverty is a social phenomenon that can be observed either at individual level or state level. Countries which have low economic development do experience of limitations in providing services to their citizens up to standard. This can be reflected with the number of health professional against the total population; number of hospitals per total population; number of health facilities per village, etc. Therefore, the capacity of the state to cover all regions of Ethiopia is a quite difficult task that demands lots of investments from both the government and the private sector. Even if there is a incredible achievement in terms of producing health professionals every year, the capacity to meet the needs of the people seem a long way.

Apparently the capacity of the Ethiopian government to render all services like education, agricultural extension, infrastructure, employment, communication seeks huge investment. As a result, sections of the society are devoid of these opportunities due to several factors. Among those are the vulnerable groups that constitute elderly, children, women and PWDs. In the contrary, majority of the people in the country are experiencing a meager income which is not even enough to cover the cost of basic necessities. Therefore, there is a direct

link between poverty and disability. However, it does not mean that all PWDs are poor or all poor people are disabled. As the respondent have mentioned most of them engage in begging, petty trade and complete dependent on other members of their family

4.1.2 Education and Employability

In the last two decades, the education sector in the country has expanded its coverage at a wider scale in all level of education. The number of schools in both elementary and secondary has grown more than double and the number of universities has ascended from three to more than twenty five. Some of the universities have opened new departments related with needs of special education and graduates from these universities are assigned in schools. The education sector as per its strategic plan is strongly working to meet MDG by providing basic education for all. Despite all these efforts children with disabilities enrolled or students with disabilities who have graduated from the universities is very extraordinarily low. This is an antagonistic dilemma that remains unsolved within the MDG period. As respondents have mentioned, some of the challenges in this aspect are inaccessibility of school environment (class rooms, toilet, and smooth walkway), negative attitudes of the community against their children with Disabilities and inadequate resources for learning are among the many. As one female respondent has mentioned, when her child goes to school every morning, his peers abuse him mentioning my disability (the son of the crippled woman). One day I went to his school to see the head master and informed him the whole story how my son has suffered due to the stigma levied on him. The head master called the kids and asked them why they refer the boy's mother impairment as a nick name. Boldly the kids answered that our mother are calling her the same way they have called the boy. After listening to all this conversation, my son cried bitterly and decided to quit schooling. This is the outcome of the stigma and discrimination due to negative attitudes of the society for persons with disability.

4.1.3 HIV Information

A key informant from HAPCO and a deaf person from the national association mentioned that here in the country, there are number of NGOs and CBOs working in the area of HIV

awareness creation, treatment and care. Almost all organizations working on HIV produce different IEC and BCC materials for the purpose of changing the attitudes and behaviors of beneficiaries to control the spread of the virus with abundant resource invested. However, except very few organizations, none of them produce disability friendly IEC and BCC materials. As respondents indicate prior to their visit to VCT centers, they had experienced unsafe sex without any protective measures. Even to some, the main factor for the transmission of the virus was not sexual intercourse. They complained that they do not get proper and accessible information either from electronic media or print media. A blind woman among the respondents mentioned that one morning she was begging on the side of the street and she listened to a car stopping by. After a while she heard a gentleman's voice asking her whether she needs material and financial assistance from the organization he works. Thinking about her future opportunities she agreed to come in to the car and drove together with the man she does not know his identity. After a while he said to her that his house is also on the way to the organization and asked her if they want to have some food and drinks. Before she responds, she started asking herself when she had the last meal. Ok, that was eighteen hours before and with no hesitation she responded positively. Once they arrived at his home, he started cooking and ushered her a sweet drink. After few minutes, he took her to a bed and instructed her to get naked. He forcefully threw her on to the bed and pressed her down with all his weight. That was her first sex with a man that she does not know. Lately she got sick and visited the hospital. During the conversation with the counselor she told the whole story and came to realize that she had contracted the virus.

As a result the kind of HIV information, the PWDs received is either none or distorted to a certain extent. Even if some materials are produced to be used by PWDs, materials with sign language, Braille, large font prints have not reached to all PWDs in the country.

4.1.4 Accessible service

During the discussion with key informants they explained that

- To start with the number of VCT centers in the city is limited and not equitably stationed.

- Health professional like any other community members are not aware of disability mainstreaming in their work.
- VCT centers physical structure is not accessible meaning there are no standard ramps.
- Even if PWDs appear at the centers for testing, they don't get the proper service due to stigma and discrimination.
- Since counselors are not trained in sign language, PWDs face communication problem especially women with hearing impairment and multiple impairments.
- If a third party is involved in the counseling session to ease the communication problem, the issue of right on confidentiality is violated.
- There are no as such tailored HIV programs designed for various types of disability types.
- Lack of support from the government to monitor the services rendered at health centers to PWDs
- Since HIV is related with several dimensions of human health, other health services
- such as pre and post natal should incorporate needs of PWDs

4.1.5 Impacts of HIV

As one of the key informant, who has greatly involved in the ***"HIV and Disability project"*** of Handicap International has mentioned the twin track nature of the interlink between HI and Disability has mentioned HIV causes

- Opportunistic infections; caused by viral, bacterial & parasites(helemitasis& others)
- Tuberculosis (a bacterial infection that can affect the lungs, spine, and bone) causes paralysis (Partial oral limbs, hands, legs).

- meningitis (a viral infection of the brain or central nervous system) results in hearing , visual and mental impairments
- Toxoplasmosis can result in paralysis of all body

Mental impairments associated with HIV infection include: due to bacterial and viral

- HIV-associated dementia or AIDS dementia complex, loss of memory
- Adjustment disorders, environmental and other copying mechanism
- Mood disorders, including major depression can result in other disability
- Anxiety disorders, including generalized anxiety disorder, panic disorder, and post-traumatic stress disorder
- Substance-related disorders (substance dependence, abuse, intoxication etc.)
- Some viruses cause vision impairment, blindness etc.
- HIV Can Cause to develop cancer hence result in all types of disability

HIV/AIDS treatment (some ART drugs)

Drug related side effects cause disability (if not properly managed). Such as

- Abnormal distribution of body chemicals, EG, Fats, lipids and other cause physical impairment
- Some drugs cause neuropathy, paralysis, physical impairment,

In general as Disability can be a factor for HIV prevalence due to the stated cases, HIV in the same manner causes disability due to the medication, termination of the medication, absence of proper diet during medicine intake.

4.1.6 Quantitative findings

Center - Menelik Refferal Hospital

Ser no.	Disability Type	Sex/Age				Final test result				Total No	Remark
		Male		Female		NR		R			
		< 18 yrs	18+ yrs	< 18 yrs	18+ yrs	M	F	M	F		
1	Visual Impairment	0	179	4	124	173	121	6	7	307	
2	Hearing Impairment	0	48	2	43	47	41	1	4	93	
3	Physical Impairment	4	189	0	91	185	77	8	14	284	
4	Intellectual Impairment	0	0	0	0	0	0	0	0		
5	Mental Impairment	0	2	0	2	2	1	0	1	4	

Table 1- No of PWDS who have been counseled and tested

Menelik referral hospital is one of the oldest referral hospital in the city where it has some specialized departments, such as VCT, Eye bank and autopsy. The total number of PWDs that have attended the VCT are 688.From this total figure of PWDs, 41 of them are positive. The highest prevalence of the virus is observed at people with physical impairment. When we compare those positive ones, positive female population is almost higher than male by 80%. This figure indicates that women with disabilities are more vulnerable than men. Secondly in terms of disability type, the people with physical impairment have more positive (53.6%).

Menelik Referal Hospital VCT Center (12/12/12 - 25/04/13)

Ser no.	Disability Type	Service Type								Total No	Remark
		Pretest Counseling	HIV test accepted	Post test counseling	Recievied Result	Final result					
						Male		Female			
						<18		>18			
						R	NR	R	NR		
1	Non disabled	821	821	821	821	0	2	39	328	821	
Total		**821**	**821**	**821**	**821**	**0**	**2**	**39**	**328**	**821**	

Table 2: No of Non-PWDS who have been counseled and tested in the same hospital

The above table indicates that the total numbers of non PWDs who have been counseled and tested are 328 of which the positive ones are 39. Amazingly all non PWDs who are positive are women, which lead to a conclusion that Women are more vulnerable to HIV infection than men.

Summary table

PWD	M	%	W	%
Visual Impairment	238	40.5%	167	46.4%
Hearing Impairment	83	14.1%	76	21.1%
Physical Impairment	258	43.9%	113	31.4%
Intellectual Impairment	4	0.7%	2	0.6%
Mental impairment	5	0.9%	2	0.6%
Total	588	100.0%	360	100.0%
	62.0%	948	W	%

Table 3: Summary table for all observations in the three VCT centers

As the above table illustrates, 948 people with different impairments (38% of women; 62% of men) decided to get voluntary HIV counselling and testing (HCT) from three main health facilities that were under Handicap International project. Out of the total, 58 PWD (6.1%) tested positive for HIV. Specifically, women with disabilities (WWD) represented 56.9% (33) while men with disabilities (MWD) constituted 43.1% (25) of those who tested positive.

Chapter Five: Summary and Recommendation

5.1 Summary

People with different impairments are among the most vulnerable groups in Ethiopia. The country has made an effort to ensure the rights of PWDs. The UN convention for Persons with disabilities has been ratified in 2010. Thanks to the work of Civil Society, Disabled People Organizations and Disability focused organizations, different laws ensuring the rights of PWDs are present. Laws related to employment and constructions can be sited as example. The Ethiopian government announced proclamation No.101/1993, following ILO rules and regulations on the employment of persons with disabilities. However, the diversified cultural and traditional believes of the society, though improved through several sensitization programs, still hiders People with different impairments to fully exercise their rights. Up to now, the relationship between HIV and disability has not yet received due attention, although persons with disabilities are found among all key populations at higher risk of exposure to HIV. People living with HIV may develop impairments as the disease progresses, and may be considered to have a disability when social, economic, and political or other barriers hinder their full and effective participation in society on an equal basis with others (UNAIDS, WHO and OHCHR).

"A key group that is being largely ignored in efforts to stop the spread of AIDS is the global population of some 800 million people who live with a physical, sensory, intellectual, or mental health disability" (World Bank, 2003).

The average prevalence of HIV among PWDs in Addis Ababa is about 4.32% which is a little bit less from Addis Ababa's average (5.4%). This figure indicates the picture which is quite different from the rural areas, where PWDs have less exposure to education and HIV awareness.

5.2 Recommendations

Health care in general and HIV awareness, treatment and care needs of people with disabilities in particular are only marginally addressed in Ethiopia. Barriers related to health care for people with disabilities include: lack of physical access, including transportation and/or proximity to clinics; lack of accessible facilities and equipment, such as ramps and adapted examination tables; lack of accessible information and materials (such as information provided in Braille, large print, simple language, pictures); lack of sign language interpreters; limited knowledge and skills of health care providers on disability, physical barriers, and accessibility of service, and related lack of training options on these issues; exclusion of disability information from medical data collection and record keeping; and lack of funding or health care insurance. In addition, due to lack of awareness and stigma/discrimination, people with disabilities in Ethiopia are generally not accessing HIV/AIDS and related services.

Tailored interventions and adaptive disability-sensitive methodologies (Twin track approach) enabled PWD to get HCT, who otherwise, would not have had the opportunity to be targeted and included in HIV prevention services. Moreover, community mobilization through peer educators and strong involvement of DPOs enhanced the motivation of PWD to know about their HIV status, and act upon it as early as possible. These preliminary data may be the tip of the iceberg of the extent to which PWD are infected by HIV. Based on the above lessons learned, a recent critical review of the literature on HIV and disability and a growing interest from the National AIDS Council and various AIDS organizations to include disability in their programming, more disability mainstreaming is necessary in HIV prevention and response, as well as comparative research to respond to the growing needs of PWD in relation to HIV and AIDS and to reach universal access for all.

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Annexes

AMekdim and Saris health centers

Center- Mekdim Ethiopia National Association

Ser no.	Disability Type	Sex/Age				Final test result				Total No	Remark
		Male		Female		NR		R			
		< 18 yrs	18+ yrs	< 18 yrs	18+ yrs	M	F	M	F		
1	Visual Impairment	1	26	1	22	26	22	1	1	50	
2	Hearing Impairment	0	0	0	0	0	0	0	0	0	
3	Physical Impairment	0	7	7	1	6	8	1		15	
4	Intellectual Impairment	0	0	0	0	0	0	0	0	0	
5	Mental Impairment	0	0	0	0	0	0	0	0	0	
Total		**1**	**33**	**8**	**23**	**32**	**30**	**2**	**1**	**65**	

Table 4. Number, age, sex and status of PWDs counseled and tested

Mekdim Ethiopia National Association VCT center (12/12/12 - 25/04/13)

Ser no.	Disability Type	Service Type								Total	Remark
		Pretest Counseling	HIV test accepted	Post test counseling	Recievied Result	Female					
						<18		18			
						R	NR	R	NR		
1	Non disabled	575	575	575	575	0	7	16	164	575	
Total		**575**	**575**	**575**	**575**	**0**	**7**	**16**	**164**	**575**	

Table 5. Number, age, sex and status of Non PWDs counseled and tested

Center- Saris Health Center

Ser no.	Disability Type	Sex/Age				Final test result				Total	Remark
		Male		Female		NR		R			
		< 18 yrs	18+ yrs	< 18 yrs	18+ yrs	M	F	M	F		
1	Visual Impairment	0	32	0	16	29	12	3	4	48	
2	Hearing Impairment	1	34	0	31	34	29	1	2	66	
3	Physical Impairment	1	57	2	12	55	14	3	0	72	
4	Intellectual Impairment	3	1	1	1	4	2	0	0	6	
5	Mental Impairment	2	1	0	0	2	0	1	0	3	
Total		**7**	**125**	**3**	**60**	**124**	**57**	**8**	**6**	**195**	

Table 6. Number, age, sex and status of PWDs counseled and tested

Saris Healt center VCT data (12/12/12 - 25/04/13)

Ser no.	Disability Type	Service Type								Total	Remark
		Pretest Counseling	HIV test accepted	Post test counseling	Received Result	Male		Female			
						<18		18			
						R	NR	R	NR		
1	Non disabled	1,334	1,334	1,334	1,334	3	18	56	623	1,334	
Total		1,334	1,334	1,334	1,334	**3**	**18**	**56**	**623**	1,334	

Table 7. Number, age, sex and status of NonPWDs counseled and tested

Annex 2. Informed consent for participants of the study

On the following paragraphs you find the informed consent. Please tick the boxes that ask wether you agree to participate in the study and if your data can be archived for later use or not.

Name _____

Anonymous name _____

Case _____

1. I received the information for the above mentioned study

   A) YES _____ B) NO

2. I agree to the condition of the mentioned FGD

   A) I agree_____ B) I don't agree _____

3. I agree the pictures of me will be published. Pictures will be exclusively used for scientific purpose by the researcher who is obliged to data protection.

   A) I agree _____ B) I don't agree

4. I agree that the anonymised data of me will be archived for scientific use

   A) I agree _____ B) I don't agree

Signature _____ Date _____

Annex 3. Focus Group Discussion with PWDs

FGD Venue_____

Date_____

Moderator_____

Note taker_____

Starting time _____Ending time_____

1. What is you means of income?
2. What type of jobs do you do?
3. What is your daily income earned from begging?
4. Do you have any information on HIV transmission, treatment and care?
5. Do you know prevention methods for HIV
6. From whom did you get HIV information?
7. Do you remember when you had unsafe sex last?
8. Was it forced sex or did you do it voluntarily?
9. Are the rest of your family also infected?
10. What will you do to inform others?

Annex 4 Focus Group Discussion with medical professionals

1. As per your experience, what are the major causes for HIV transmission among PWDs?
2. From among PWDs, people with which impairment do visit VCT?
3. In communicating with PWDs in the counseling room, what are the challenges you face most?
4. How do you solve communication problems with PWDs?
5. What are factors which women with disabilities mention for their infection?
6. Form which economic sectors do you council PWDs
7. What do you think should be done for PWDs from getting infected by HIV?
8. Will you please mention major factors for intersection/interlink between disability and HIV

Annex 5

PROFORMA FOR SUBMISSION OF MA (RD) PROPOSAL FOR APPROVAL

Signature **:** **……..**

Name & **:** **…….**

Address of Guide **:** **……**

Name & Address of the Student **:** **……**

…….

……

Enrollment No. **:** **……..**

Date of Submission **:** **……..**

Name of Study Center **:** **……**

Name of Guide **:** **……**

Title of the Project **: Intersection between Disability and HIV and the impact of Poverty on Persons with Disability**

Signature of the student **:** **……..**

Approved/ Not Approved

Date:

Annex 6

Declaration

I hereby declare that the Dissertation entitled “INTERSECTION BETWEEN DISABILITY AND HIV AND THE IMPACT OF POVERTY ON PERSONS WITH DISABILITY” submitted by for the partial fulfillment of the MA in Rural Development to Andria Gandhi National Open University, (IGNOU) New Delhi is my own original work and has not been submitted earlier either to IGNOU or to any other institution for the fulfillment of the requirement for any course of study. I also declare that no chapter of this manuscript in whole or in part is lifted and incorporated in this report from any earlier work done by me or others.

Place: **Signature**

Date: **Enrolment No.**

Name

Address

Annex 7

Certificate

This is to certify that Mr. Esknder Dessalegne Tekle Michaels student of MA(RD) from Indiral Gandhi National Open University, New Delhi was working under my supervision and guidance for his Project Work for the Course of MRDP-001 HIS PROJECT Work entitled " Intersection between Disability and HIV and the impact of Poverty on Persons with Disability", which he is submitting, is his genuine and original work.

Place: **Signature**

Date: **Name**

Adress of the Supervisor

Picture 1: Health professionals from the three VCT centers attending sign language training

Picture 2: PWDs waiting for VCT service and accessible walk way

Picture 3: Accessible poster depicting the importance of physical accessiblity

Intersection between Disability and HIV and the impact of Poverty on Persons with Disability

Project proposal prepared for the fulfillment of MARD program

Researcher: Esknder Dessalegne

Supervisor: Professor Dr. S.Nakkiran

Submitted to: Saint Mary University College/IGNOU

Date of Submission: March 2014

Introduction:

HIV has been an impediment for the last three decades on the developmental efforts of the world in generally on East Africa in particular by aggravating already existing poverty, over utilizing the medical/health budget, diminishing the productive labor force section of the population and distracting governments' attention and efforts to focus on other essential services. According to the UNAIDS 2012 report there were favorable trends in many countries. However, compared to other regions, of Sub-Saharan Africa, which has just over 10% of the world's population, has remained the most affected region, where more than two thirds of all HIV positive people are found.

As one of the Sub Saharan African countries, Ethiopia is facing similar challenges of the epidemic. According to the report of HAPCO 1.2 million people were HIV positive with the adult population with prevalence of 2.4 percent .The Prevalence in the capital Addis Ababa was estimated to be 4.5 %. The report also explained that the overall incidence rate for the city has been slightly declining over the last few years. However, with the high rural-urban migration, it has contributed to the relatively ascending nature of the epidemic in the city.

Generally, there have been a lot of efforts made to curb the spread of the virus in Ethiopia by both the government and other non government stakeholders. According to the Ethiopian Ministry of Health Report, some segments of the Ethiopian society are more vulnerable to HIV than others (MARPS). The report indicates that young adults, children, women, commercial sex workers, truck drivers, soldiers and adolescents are the most affected groups. These high risk population groups have been given special attention in halting the spread of the virus with interventions such as projects run by Population service International in collaboration with HAPCO. In addition, a number of researches have been carried out in the area of HIV concerning these segments of society. However, people with disabilities have never been considered as high risk groups by most of the responsible stakeholders with the exception of the Federal HAPCO which has incorporated the issue in its strategic plan II. In most cases, PWDs are not addressed as a

target group for prevention education (like IEC and BCC) because there are quite number of misconception that they are asexual and free of the virus. Contrary to these assumptions, studies conducted in Cameroon, Kenya, Uganda and Rwanda have depicted that PWDs are facing high risk of contracting the virus even in some cases higher than the national averages. Despite lack of disability focused HIV programs, inaccessible services, stigma and discrimination have deprived the rights of PWDs to obtain services like any other citizens of the country.

Apparently it is assumed that realities in Ethiopia are not significantly being different from those countries which have conducted similar studies. The existing misconceptions and inaccessible services along with lack of knowhow on mainstreaming disability in to HIV programs have excluded them from sharing the resources of society. Poverty of PWDs is another prominent factor for their exposure to HIV transmission. A study shows that HIV related information is less accessible for people with all types of disabilities since majority of them depend on other for transportation or sign language interpretation.

According to WHO and World Bank (2011) global report, 15% of the world population as of 2010 (over a billion people) was estimated to be living with disability making them world's largest minority group. The same report estimates the number of people with disabilities in Ethiopia as 17.6 % of the total population. As Elwan has indicated 1 in 5 world's poorest people has a disability which takes to an argument that poverty is both a cause and consequence.

Although there has been research focused on the disabling consequences of HIV, there has been very little documented information about HIV for disabled people prior to infection. Scholars in general agree that little is known about the intersectionality among poverty, HIV and Disability. I strongly believe that this grey intersectionality is an area of interest to further study with the aim of addressing the following research questions.

. Is there a justifiable correlation between HIV and Disability?

. Does poverty play a strengthening role the correlation between disability and HIV?

Methods and Materials

The methods followed to conduct the study are desk review of health registry book used in three health service provision sites in Addis Ababa namely Menlik Referral Hospital, Mekdim National Association of people living with the virus and Saris Health center. The recorded data for nine months is taken as a sample. This specific period is the time when Handicap International had a joint program with these institutions.

Study Area

The study will be conducted in two sub-cities of Addis Ababa city Administration, where it is believed PWDs do dwell majorly. The sub-cities are characterized differently with reasonable distance between them.

Study period

The study will be carried out from March to May 2014.

Study design

Registry based comparative study and focus group discussion will be deployed to produce quantitative and qualitative data in response to the major research questions.

Sample size

The sample size for the study will be 980 individual records. Also, a focus group discussion of two groups from those addressed at the counseling and testing centers.

Sampling technique

The overall guiding principle of the study sample will be governed by the nature of the target population. To estimate quantitatively utilization of HIV service, a total population received the service will be used. Even if the data is extracted from three centers, the target population is from all sub-cities.

Data collectors

Data will be collected by well informed three data collectors for each center under close supervision of the researcher. A total of three data collectors be assigned based on their Educational back ground, data collection experience. Accordingly, all data collectors will be graduates with work experience on HIV and Disability.

Statistical analysis

The data will be tabulated and an analysis is done with statistical applications to observe and making the data ready for analysis in form of percentage and will be calculated to describe the study population.

Quality Control measures

To assure the quality of the data well designed, translated to Amharic and retranslated and pretested facilitating questions will be used for the FGD and the collected data will be reviewed and checked for consistency.

Ethical Clearance

Written informed consent will be obtained from the study subjects prior to FGD exercise through briefing the benefit, harm and objective of the study. Confidentiality will be assured by omitting names of the respondents during the course. In addition Confidentiality will be maintained by the data collectors and investigator throughout the study.

Limitation of the study

Due to sensitivity of the subject matter data collection is based only on data from the registry book and focus group discussions whereby study subjects, health professionals and sign language interpreters/councilors are involved.

Work plan:-

No	Activities	Feb	March	April	May
1	Topic selection	X			
2	Proposal development		X		
3	Approval of the proposal		X		
4	Setting up of the study process		X	X	
5	Training of the data collectors, revision of the research tools			X	
6	Data collection			X	
7	Data entry and analysis			X	
8	Report writing				X
9	Final report submission				X