Access to HIV/AIDS services for disabled persons in Uganda - problems of stigma and discrimination?

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Persons with disabilities are a large and largely overlooked population in the fight against HIV/AIDS.

1. Background

The UN has estimated that 10% of the world's population experience some form of disability or impairment. This means approximately 2.5 million disabled persons in Uganda.

Few HIV/AIDS interventions have directly targeted individuals with disability. They have gone unnoticed in HIV/AIDS outreach efforts, because it is commonly and incorrectly assumed that disabled persons are sexually inactive, unlikely to use drugs and alcohol and are at low risk of violence and rape than their non-disabled peers.

Problems with access and confidence are often reported as important issues regarding attendance at HIV/AIDS services for disabled persons. Those obstacles are there, but according to this fieldwork these physical barriers in the "healthcare-system" do not seem to be as important as barriers outside the "system".

Looking at the stigma PWDs have to face related to HIV/AIDS, the challenge seems to be related to normative expectations in society. Especially roles and rules related to the "expected self" and the "supporting husband" seem to be determinants when disabled persons are not considered eligible marriage partners, and thus are not expected to be asked to participate in the reciprocal exchanges inherent to such relationships.

However, persons with disabilities have the same desire for "wholeness" and "social value" including the need to be loved as anybody else. They may engage in more informal relations, which may be looked upon as "improper". In addition, being diagnosed HIV positive reveals that one has somehow behaved "immorally". Especially disabled women seem to fear being labeled as prostitutes, but disabled men also have the feeling that sex is not looked upon by society as being ok for them.

Being HIV positive evokes feelings of guilt and blame, which combined with the feelings of being looked upon as less worthy and less acceptable as disabled, intensify "felt" stigma. The fear of stigma and its consequences such as social exclusion seems to pattern their behavior, when Persons with disabilities "choose" to cover up their serum-status instead of coming forward to be tested or treated. TASO Kampala can be seen as a good example of meeting this challenge. They employed a disabled counselor who as a plus actively conducted PWID in the communities that care and treatment could prolong their lives and maintain or improve their quality of life. TASO Kampala was the only clinic in this study which had disabled clients.

This study points to the fact that this internalized stigmatization leading to a kind of self-regulating exclusion seems to be a central reason why persons with disabilities do not attend HIV/AIDS services. However self-regulated exclusion should be seen as dictated by circumstances and not necessary as a "chosen" behavior.

2. Methodology

This study is based on five-week ethnographically inspired fieldwork in May 2006 in the Republic of Uganda in which the interaction between health workers and disabled persons was explored with a focus on HIV/AIDS.

Uganda was chosen because of contacts to The Danish Council of Organizations of Disabled Persons and their umbrella partner in Uganda, The National Union of Disabled Persons of Uganda. However these organizations have no political or financial interests in the project.

The theoretical and analytical framework is inspired by sociologist Richard Jenkins' theory about social identity, and sociologist Erving Goffman's theory about stigma.

3. Results

No discrimination could be observed between health workers and disabled clients in this study. Instead it was observed that persons with disabilities did not attend HIV/AIDS clinics.

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4. Perspectives

The real challenge seems to be how to target the normative expectations which produce stigma in the first place and pattern the behavior of PWID when they "choose" to cover up their serum-status instead of coming forward to be tested or treated. TASO Kampala can be seen as a good example of meeting this challenge. They employed a disabled counselor who as a plus actively conducted PWID in the communities that care and treatment could prolong their lives and maintain or improve their quality of life. TASO Kampala was the only clinic in this study which had disabled clients.

This study suggests that interventions must focus on the social value of PWID and their ability to participate in processes of reciprocal exchange in areas such as education, job placement, marriage etc. These issues have to be addressed at all the way from policy level to community level. This may be a way of meeting some of the underlying functions of stigma and challenge the boundaries that society creates between "normals" and "outsiders".

However, these may be seen as long-term interventions. If one seriously wants PWID to be included in HIV/AIDS efforts, the "healthcare-system" has to create a link to PWID, their families and the rest of the community by using outreach efforts, because this study shows that fear of stigma prevents PWID from attending HIV/AIDS services by themselves, even if they knew that they might be HIV positive.

It seems important to train HIV/AIDS educators, outreach workers, clinic and social staff on disability and stigma issues.

A Triple Burden

Disabled—HIV positive—prostitute

Especially disabled women seem to be frightened of HIV testing, because a HIV diagnosis may suggest that they have behaved immorally, for which reason they will be labelled as prostitutes.

If it is commonly assumed that disabled persons are not sexually active or considered eligible marriage partners, then these assumptions result in disabled women being looked upon as prostitutes or as persons who have behaved immorally if they are diagnosed HIV positive.

I would like to thank MUJUVI (The National Union of Disabled Persons of Uganda) for permission to use the photos in this poster.

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