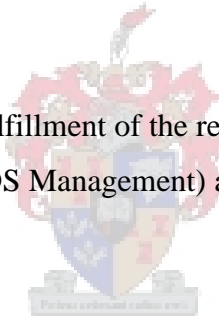


The mainstream HIV/AIDS intervention strategies being rolled out in Botswana:

A study of the HIV/AIDS outreach efforts for the blind people

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of Philosophy (HIV/AIDS Management) at Stellenbosch University



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## **DECLARATION**

By submitting this assignment electronically I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

March, 2009

## **SUMMARY**

The study aimed at building a qualitative base for the HIV/AIDS advocate groups, policy makers and the civil society organisations on the exclusion of the blind people from the mainstream HIV/AIDS intervention programmes since the country first recorded its HIV case in 1985.

The study was conducted in Mochudi, Kgatleng district, at Molefi Senior Secondary School, the only senior secondary school that admits learners with visual impairment (VI) which is 50km away from Gaborone, the capital city of Botswana. Molefi is co-education; therefore, both the female and male with VI come to the institution. The Researcher chose only the totally blind (TB) to participate in the survey. The institution is privileged to have two TB academic staff that was also included in the survey to represent the out of school youths. One of the staff is a newly-blinded person thus has not yet grasped Braille. Molefi was chosen because it has a substantial pool of people with VI unlike to go in search of the unknown who are scattered in the country.

The mainstream HIV/AIDS intervention programmes currently going on have not been modified so that the blind people can also access them. The civil society (CS) organisations and the government sector (GS) responsible for the HIV/AIDS outreach efforts do not even carry out a survey to find out if their target population is composed of any blind people before meeting the target group. They are all taken on as if they are sighted. Even if they visit a place where there are blind, they still go about with their usual approach which does not benefit those with visual impairment.

## **OPSOMMING**

Die blindes in Botswana kan huidiglik nie toe gang kry tot hoofstroom MIV/VIGS voorkomingprogramme in Botswana nie.

Die doel van hiedie studie is om die behoefte van die blindes in MIV/Vigs voorkoming aan te spreek en aan te toon hoe daar sinvol vir die insuiting van die blindes in programme en intervensies voorsiening gemaak kan word

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I must also take this opportunity to thank the leadership for the Botswana's organisation for people with disabilities who made it possible for me to attend one crucial workshop in April 2008. Here, the participants from different disabilities met the HIV/AIDS policymakers, advocates and campaigners to discuss issues concerning the exclusion of the disabled persons from their outreach efforts. This workshop gave me a lot of insights into the problems that are experienced by the disabled during the HIV/AIDS era.

Finally, I hope that this Report will enable other HIV/AIDS programme advocates, Key government sectors, leaders for the different disabilities and the Civil Society in any Country to realise that the blind and other disabled are among the high risk groups just like the sex workers, truck drivers and other mobile populations. Hence drastic measures need to be taken to minimise the transmission of infections among the disabled persons who are not reached by the Anti-HIV/AIDS campaigners.

## **LIST OF ABBREVIATIONS**

TB	Totally Blind/blind
VI	Visually Impairment
NACA	National Aids Coordinating Agency (GS)
PEPFAR	President Emergency Plan for Aids Relief (USA funded organisation)
NGOs	Non- Governmental Organisations (CS)
BOFWA	Botswana Family Welfare Association (CS)
F B Os	Faith Based Organisations (CS)
ACHAP	African Comprehensive HIV/AIDS Partnership (organisation for Bill & Melinda Gates Foundation and Merck Company Foundation)
PMTCT	Prevention of Mother-to-child HIV transmission (GS)
ARVs	Antiretroviral
VCT	Voluntary counselling and testing
HIV	Human Immunodeficiency virus
AIDS	Acquired Immune Deficiency Syndrome
MDG	Millennium Development Goal
BONASO	Botswana Network of AIDS Service Organisation (CS)
BOTUSA	Botswana- United States of America
CS	Civil Society
GS	Government Sector
MSM	Men who have sex with men
DPOs	Disabled People's Organisations

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## CHAPTER 1: INTRODUCTION

### 1.1 Background and Rationale

The term blind people refer to the people who are totally blind. Vision is one of the five senses that are responsible for the observations using the eyes such that it makes conceptualisation of concepts easy to read and understand.

Botswana has had a good number of people without vision dating back to 1946 census which found 1,881 totally blind people and 2,714 blind in one eye out of the population of 217,906 (two hundred and seventeen thousand, nine hundred and six) persons (<http://books.google.com/books?id=OVNeNLcDD2cC&pg=PA158&1pg=PA158&dp=population+of+blind+people+in+Botswana>). At that time, blindness was a more general problem that concerned the **colonial administration** and **medical missionaries** who worked under the auspices of both **church** and **colonial government**. Currently, the statistics reveal that out of the total population of 1,815 508 people in Botswana, childhood blindness prevalence (per 1000) is 0.6% and the adult blindness prevalence is 1.0% ([google.oseafrica.org/publications/section\\_4one.pdf](http://google.oseafrica.org/publications/section_4one.pdf)). The 1991 census also reveal that 3,347 persons were totally blind, while 11,211 were partially sighted, then the total population of the country was 1,570 000 This large population for the blind goes unnoticed by the HIV/AIDS advocates, policy makers and civil society organisations.

Groce ([http://globalsurvey.med.yale.edu/Disability\\_HIVFinalReport.doc](http://globalsurvey.med.yale.edu/Disability_HIVFinalReport.doc)) pointed out the reasons that attribute to the blind not to be noticed by the HIV/AIDS policy makers, advocates and civil society organisations as follows; Society commonly and incorrectly assume that an individual with a disability is sexually inactive; unlikely to use drugs or alcohol; are at less risk of rape or any abuse.



### **The exclusion of the blind people from HIV/AIDS outreach efforts in Botswana**

Botswana is one of the few countries in the southern Africa which still pays the veterans and the destitutes a monthly allowance for upkeep. This initiative came into existence because of the responsibility of the social welfare department which carried out its duty diligently. Therefore, the exclusion of the blind people may be due to the fact that the relevant HIV/AIDS advocate groups, policy makers and the civil society organisations have not done their home work of consultations with the relevant groups of disabilities, as a result the central government and other sectors are not aware that the blind people are not reached.

The director for the youth council admitted that they have excluded the blind people because they are not reminded that there was a population left out of the posters that they had published. All the posters were in ink and visual pictures. The director pointed out that the department does not have an established post for a representative of the disabled people. This came to light when the people with disabilities organised a workshop where they met with the relevant HIV/AIDS stakeholders (2008, April).

Societal attitudes may be a factor in being unnoticed by the outreach efforts. One of the workshop participants informed the house that he once visited a local clinic to collect condoms but the official on duty laughed at him and asked, 'you are blind, how do you see a woman' he was turned back and he left.

The societal attitudes have seriously contributed to the exclusion since the first case of HIV was recorded in 1985 until 2008 April when the disabled people complained about the exclusion at the workshop. The HIV has been circulating for 23 years and yet the blind people have not been reached. The institution where the researcher is, for example, does not receive any adapted materials or adapted teaching methods by the Anti-HIV campaigners who come.

The magazines and newspapers have good advertisements about HIV but they are all in print format. The researcher has not yet come across an advertisement in print form which has a picture of a blind person (with a white cane, a symbol of blindness) or anybody in a wheel chair to show the readers that the disabled are sexual beings, too. At least our students receive anecdotes of HIV/AIDS information (though unmodified) during the guidance and counselling lessons for 20 minutes once per week. The topic on HIV/AIDS may appear only once per term and some teachers may not handle it with the attention it deserves due to stigma.

**The reasons why HIV/AIDS approaches and resources must be modified.**

The lives of the people with blindness are no less valuable than the lives of all other citizens and there can be no substantive argument that justifies assigning individuals with blindness to the bottom of an HIV/AIDS priority list;

The exclusion of the blind people from the HIV/AIDS outreach efforts will jeopardise the efforts to slow the spread of the virus, having in mind the large proportion of the blind population which is excluded;

The HIV/AIDS epidemic is still glimmer for Botswana, is still rated the world's second highest HIV infection rate with almost one in four or 23.9% of 15 to 49 year olds are HIV positive, 113,000 are on ARV treatment and it is focused that 220,000 Batswana will need treatment by 2016 (Botswana agrees to loan from world bank to curb AIDS epidemic; Bloomberg.com, December 4, 2008, by Joseph Balise)

Meanwhile, Botswana declared at the August conference 2005 in Francis town that they must achieve a Zero HIV infection transmission by the year 2016.

## **1.2 Objectives**

In general, this study aimed at investigating the mainstream HIV/AIDS intervention strategies if they indeed minimise high risky sexual behaviour of the blind people in Botswana.

Specifically, it attempted to find out the:

- The number of the blind people (in percentage) who receive HIV/AIDS outreach efforts
- The frequency of HIV/AIDS out reach efforts
- If the HIV/AIDS outreach efforts are modified or adapted to suit the blind people
- The type of outreach efforts that the blind people receive (verbal or Braille text)
- The effectiveness of such outreach efforts to a blind person.

## **1.3 Theoretical framework**

The blind people experience concrete learning when the relevant modifications and adaptations are made to the learning materials. The mainstream HIV/AIDS intervention strategies for the blind people must be built on information that includes the following:

- modified and adapted HIV/AIDS intervention resources; embossed diagrams/pictures where possible, brailled texts, audio recorded programs, accessible environment, modified condoms;
- individualised attention
- specialised knowledge on the part of the implementer/tutor

## 1.4 Hypothesis

The researcher was primarily interested in finding out how **modified/adapted** approaches and resources contributed to the minimised risky sexual behaviour of the blind people. By investigating how the correct format of the resources contributed to the minimised risky sexual behaviour, the researcher laid down the groundwork for the investigation of how risky sexual behaviour of the blind people in unadapted environment may lead to increased HIV infections in the community. Taking into the account the varying social contexts and moral fibre for the blind people, it seems plausible that the blind people under the influence of peer pressure; religious beliefs; different motives for the sexual intercourse may or may not risk the HIV infection. For instance, strong religious beliefs may encourage some blind people or the able bodied to uphold abstinence. On the other hand, it may be obvious that the lack of modified approaches and resources can contribute to high risk of HIV infection. The current study attempts to determine if the lack of modified mainstream HIV/AIDS intervention strategies will increase high risky sexual behaviour of the blind people.

The following hypothesis guided the research:

**The mainstream HIV/AIDS intervention strategies do not minimise high risky sexual behaviour of the blind people**

The researcher was also aware of the following confounding variables; peer pressure, religious beliefs, and different motives for the involvement in sexual activities; as they are some of the factors which could either increase or decrease the HIV infections.

## CHAPTER 2: LITERATURE REVIEW

Hornby (2000: 713) define mainstream as the ideas and opinions that are thought to be normal because they are shared by most people. The concept is used in the study to imply the HIV/AIDS intervention strategies currently going on in Botswana. They are referred to as mainstream because the programme planners /implementers regard their initiatives as inclusive; that they take on board every body regardless of any disabilities. But nature dictate that we have people with different abilities physically, mentally and sensory. Therefore, the mainstream will always put those with disabilities at a disadvantage in terms of accessibility.

An example of a school situation, some blind learners find that although they go to mainstream school, due to some convenience such as the only school within reach, no appropriate adjustments are made and that results in no learning at all. The following extract illustrates the frustrating experience of a newly blinded person at a mainstream school:

‘...my visual impairment was picked up on the school medicals when I was in primary school...I didn’t get any qualifications before I left school because my sight was deteriorating so that I wouldn’t see. They brought me nearer to the (black) board but it didn’t work. It doesn’t work for me if you just make things bigger. It doesn’t help, it doesn’t make any difference. And I struggled. And later when I went to ...college it took 3 weeks (after the course started) ...I had to rely on my memory to follow the course. It was frustrating again (to not be able to access course material),’ (Levin: 1997)

The preceding illustration demonstrates the learning experiences of a TB person whether newly blinded or experienced in blindness in an unadapted environment. In the study, the researcher has also used the concept of ‘inclusive’ as one of the key strategies to address issues of marginalisation and exclusion. The fundamental principle of the inclusive-

school is that all children should learn together, wherever possible, regardless of any difficulties or differences they may have...Inclusive schools must recognise and respond to the diverse needs of their learners, accommodating both different styles and rates of learning

and ensuring quality education to all through appropriate curricula, organisational arrangements, teaching strategies, resource use and partnerships with their communities (Salamanca framework for action: 1994). This definition fits all situations that involve people with different disabilities of all ages.

The new international classification of functioning and disability (ICF), developed and adopted by the World Health Organisation (WHO) in 2001 ([www.who.int/icf](http://www.who.int/icf)), organise disability along two dimensions: functioning and disability (including body functions/structures and activities/participation in society), and contextual factors (environmental and personal) (ibid). According to ICF's objective, focus must shift from disability as an innate deficit to disability as constructed through the interaction between the individual and the environment. The ICF encourages focus on kinds and levels of intervention appropriate to the disablement needs of individuals within specific contexts, and is consistent with the social model of disability that is upheld by disability rights organisations and many disabled people (ibid).

The study has used the terms 'impairment' and 'disablement'. Impairment is the loss or limitation of physical, mental or sensory function on a long term or permanent basis and disablement is the loss or limitation of opportunities to take part in the normal life of the community on an equal level with others due to physical and social barriers (Rieser: 2000). The distinction between impairment and disability is important for inclusive education. Focus on the environment means schools, CS organisations and tutors, teachers must accommodate to individual learners. While a focus on individual student or learner means that student must either be cured or fit in if they do not want to be denied access to regular education. The preceding literature on inclusive education has been used to demonstrate how the government sector, civil society organisations and policy makers can use the knowledge so that they can be able to include the blind and the reasons why they must include them.

According to the literature used by the researcher, 335 million people are estimated to live a pre-existing physical sensory impairment worldwide, out of which 80 million live in Africa (Groce: 2006: 3). According to 1991 Botswana census, it reveals that 3,347 were totally blind while 11,211 were partially sighted out of the country's total population then of

1,570,000 (Google.ethnologue report for Botswana). Meanwhile we are told that 7,500 HIV infections worldwide take place every day (E:\VOANews-WorldAIDS Day Focuses on Prevention.mht) and that the infection rate is happening at 2.7 times faster than the increase in number of people receiving ARV treatment. This illustration confirms Botswana's gloomy situation as it is rated as the world's second- highest HIV infection rate with almost one in four or 23.9% of 15 to 49 year olds are HIV positive; out of 1.8 million, 113000 people are on ARV treatment (opcit). The high HIV prevalence statistics raise concerns after realising the large totally blind population not reached by the outreach efforts. Besides, it is this population which defeats the HIV intervention efforts currently taking place in the country. The HIV infection statistics has been used in the study to demonstrate the significance of modifying and adapting the mainstream HIV intervention strategies in order to minimise the HIV infection rates among the blind people.

Groce (2006) identifies barriers to accessing the mainstream HIV/AIDS intervention strategies for the TB as follows:

- Personal (social capital);
- Attitudinal;
- Environmental.

Groce's categories provide a useful framework, and are utilised in the study. Groce elaborates on each heading to highlight that the TB people have less skills and educational achievements because they access the curriculum which is meant for the able bodied such that sometimes modifications become practically impossible. For instance, a visual glossy picture about youths performing an activity may have a very significant impact on the minds of those observing it visually and learning take place immediately. But the same picture adapted in to a descriptive story the TB individual listening will just develop imaginary visuals different from the original picture; the description will yield a different impact here, the leverage of the learning process is different thereby putting the TB individual at a disadvantage in terms of the acquisition of skill and educational achievement.

Attitudinal (negative) barriers stem from their exclusion from participating in various community projects because of some dangerous gadgets or/ and surrounding involved in the processes. This demonstrates to the able bodied that the TB people are less valuable in the community and they cannot perform certain tasks. Some able bodied go to an extent of perceiving the TB people as sexually inactive thus no need of HIV prevention awareness for them.

Fulbright reveal that the children, adolescents and adults who live with disability have gone unnoticed in HIV/AIDS outreach efforts...because society commonly and incorrectly assume that individuals with disability are not sexual beings, undesirable, not sexually adventurous...when most people think 'sexy', they don't think disabled...people with disabilities aren't sexual beings (mhtml: file//C: \Documents and Settings\br\My Documents\FoxNewsComFoxse...). This societal attitude might be an insight as to why people with disabilities are left out from the agendas of several international and national HIV/AIDS conferences. For instance, the recent 17<sup>th</sup> international conference which was held in Mexico discussed on issues concerning the men who have sex with men since they are recognised as a population at high risk while there was no mention about the blind or any other disability and yet they too, are at high risk of HIV infection.

Locally, the Botswana millennium development goal six whose target is to halt and begin to reverse the spread of HIV/AIDS by 2015 omitted the blind and other disabilities from their programme. The government documentation about HIV/AIDS has not included the blind as a population at high risk of HIV infection. The local conference on HIV/AIDS 'towards zero transmission' which took place in 2005, only recognised the alcohol users, truckers, miners and military personnel as groups at high risk of HIV infection. This demonstrates the reasons for the exclusion of the blind people from the mainstream HIV intervention strategies.





## **CHAPTER 3: METHODOLOGY**

### **3.1 Overview**

This study has been guided by the social model concept of disability that focus on environment as the main factor in the acquisition of knowledge by the blind person, taking into account the aim of modifying and adapting the mainstream HIV/AIDS intervention strategies. By environment, the researcher implies that the civil society organisations, the government sector and their implementers/teachers must accommodate to individual TB people in need of information on HIV. The method chosen is a survey as the most appropriate to ensure a suitable fit between objectives and method.

### **3.2 Survey Methodology**

The researcher used the survey which is a descriptive research technique which focuses on describing some phenomenon, event or situation and tries to describe the relationship that exists between variables. The researcher used the ex post facto study where the variables of interest to the investigator were not subject to direct manipulation instead were chosen after the fact.

The study was chosen because neither the mainstream HIV/AIDS intervention strategies (the independent variable) nor minimise high risky sexual behaviour (the dependent variable) was under the experimenter's control and were not subject to direct manipulation but were chosen after the fact. There was no control over the participant's response, others said yes while others said no. The participants were free to play around with their views and language.

The questionnaire was used by the TB participants. The researcher used 95% close-ended questions and 5% open-ended questions.

In an open-ended question, the respondents answered in any way they pleased, whereas closed-ended questions required the respondents to choose from a limited number of predetermined responses. Open-ended questions were valuable because I needed to know what the participants were thinking about and at the same time I was able to know when the dimensions of a variable were not well defined. The researcher knew that the open-ended questions needed more time for coding and categorising; sometimes responses given did not make sense and could not be categorised. To avoid such agony, the researcher only used 5% open-ended questions which were strategically positioned. Besides, the researcher used 95% closed-ended questions because the dimensions of the variable were known, thus the questions were appropriate.

The researcher chose all the TB people that were available in the institution, and only managed 11 out of a total of 32 people with visual impairment found in the institution. Given the larger population of the blind people in the country, the researcher would have loved to have 20 to 30 TB respondents. However, 11 respondents from the same institutions were used and chanced two out of school youths.

The researcher had to translate the questionnaire into braille so that the TB respondents could access them individually. The process of the braille production was easy because the researcher is braille literate and the institution has appropriate equipment needed for the braille production.

The answer scripts for the respondents were not named, in short they were written anonymously. This approach encouraged the respondents to express themselves freely knowing the fact that he or she would not be identified.

For the two who could not read and write for themselves, the questionnaire was done in a free atmosphere such that he or she could not withhold any information. The survey took place on different days suitable to the individual respondent thus the survey lasted for three weeks. The duration of the survey also accommodated the Researcher to fulfil the daily official duties.

### **3.3 Sampling Design**

The study did not use random sampling and experimental manipulation of the variable since the researcher did not have access to the independent variable instead just observed the mainstream HIV/AIDS intervention strategies as they were being rolled out by different government sectors and civil society organisations.

### **3.4 Purposive selection criteria**

The study used the definition of mainstream HIV/AIDS intervention strategies to mean any preventive measures that are currently being rolled out to minimise high risky sexual behaviour that lead to HIV infections. Thus it is considered as a primary characteristic. The second characteristic is the lack of visual vision, total blindness (TB) which has been chosen to reflect in the hypothesis. The other variables which were considered in the selection criteria are peer pressure and religious beliefs.

### **3.5 Data Management and analysis**

The researcher conducted the statistics question by question, for instance you calculate the number of married people in percentage form and the number of those who were not married in percentage form or how many respondents answered statement (a), (b), or (c). The open-ended questions had predetermined answers which were anticipated and they were given appropriately. The aggregated structured responses in percentages and graphic representations have been written in the appendices page 36.

Finally this chapter has detailed how the research study was planned, organised and executed. It has detailed how the data gleaned from the research was managed and analysed. Chapter 4 will now examine the generated data, and the analysis in more detail.

## **CHAPTER 4: RESEARCH FINDINGS AND ANALYSIS**

### **4.1 Research findings**

The civil society HIV/AIDS outreach providers who were met by the researcher admitted failure to meet the needs of the blind people during their campaign initiatives. They have so far not conducted a preliminary survey to find out about the availability of any TB people in their target population before they go out on their campaign. Even if they knew about their existence, they would still go about with their usual unadapted approach. They do not see any thing wrong in their approach. They also said that the blind people are not sexual beings; that they can not fall in love.

At one of the workshops for people with different disabilities, the civil society organisations that were invited to workshop the disabled on issues of HIV/AIDS did not modify their approaches in order to meet their needs. The workshop was used as the evidence that all mainstream HIV/AIDS intervention providers use and it was a spring board for the complaints concerning the unadapted approaches.

At the same workshop, the Director of youth council who stood in for the government sector, acknowledged the oversight and attributed it to the lack of a portfolio filled up by a disabled person or a specialist for people with disabilities at their department. The director admitted not having adapted any materials or approaches to suit the disabled people. The director also regretted sponsoring a television programme on HIV/AIDS preventions as it left out the blind who cannot view visual pictures. At another conference on legislative and policy framework-youth and disability, the acting executive director for Botswana national youth council (BNYC) said, ‘My main worry is, as we create posters and radio or television adverts, do we ever bother to know that some people will not understand?’ (Sekhobe: 2).

This question was an indirect acknowledgement that the government sectors together with the CS organisations do not modify their mainstream HIV/AIDS intervention resources to meet the needs of the people with disabilities.

The BNYC Acting Executive Director pointed out that the BNYC disadvantaged people with disabilities because of the absence of provisions made specifically for them (ibid). He further pointed out that even though there were key strategies on the policy targeting youth, people with disabilities failed to utilise programmes due to lack of appropriate modifications made to them. At the same conference, the representative of the non formal education said that the non formal education had experienced a lot of problems in accessing mainstream HIV/AIDS programmes that could suit the needs of the people with disabilities... (ibid)

In Botswana, there is no evidence or information that people who are blind are among the high risk groups. For instance the conference for 'Towards Zero HIV Transmission' held in September 20-22, 2005 in Francistown, Botswana, only recognised the 15-24 year olds, alcohol users, truck drivers, miners and the military personnel as the only groups at high risk of HIV infection. Therefore, they were the only ones mentioned to be the targets by the Lover's Plus male condom and Care female condom's social marketing goal (Towards Zero Transmission: 13). This explains why the condoms (female and male) are not adapted to suit the needs of the blind people.

Given the latest census data for Botswana, 1% of the adult population is visually impaired; this is 1% of the total population of 1,815,508 ([google.oseafrica.org/Publications/section\\_4one.pdf](http://google.oseafrica.org/Publications/section_4one.pdf)). This adult blind population is sexually active and engage themselves in sexual intercourse. Besides, the modes of transmission for the blind people are exactly the same as the able-bodied people.

For instance, the blind people in rural areas migrate to urban areas in search of jobs and better life while some even visit transactional sex workers. Some blind people engage in pre and extra marital sex while some women who are blind and HIV positive have been infected

by their partners who are either blind or able-bodied. Some blind women work as sex workers while others have been abused or raped by HIV positive men and they are now infected by HIV. Furthermore, some blind people are alcohol or drug users. It must also be noted that a good number of people living with HIV have lost their sight completely after becoming HIV positive through opportunistic infections. Some of these people were already actively involved in sexual activities and now have joined the blind community further putting the other negative blind people at risk of HIV infections. This is the reason why the mainstream HIV/AIDS intervention campaigners must adapt their programmes to suit the needs of the blind people in order to minimise HIV infections. The 1% blind adult population is too big to be ignored.

The fact that the TB people remain excluded from the mainstream HIV/AIDS intervention outreach efforts it means that they remain unaware of the HIV risks and therefore do not ask for any information or access to the HIV/AIDS information.

However 90% of the researcher's target population are students who receive guidance and counselling lessons; one or two lesson on HIV/AIDS are offered per term which enables the TB learners to be aware of the HIV risks. Again, the teachers in charge of the guidance lessons do not bother to adapt their approaches since it is not an examinable subject. Moreover the duration of the guidance lessons is 20 minutes once per week. The institution also receives some CS organisations to give talks on HIV/AIDS preventions.

Again the TB students stay away from the talks because the approaches employed by the CS organisations do not accommodate the TB students, in other words their methods are not modified to meet their needs.

These CS organisations are aware that the institution has some TB students but they do not possess the technical skills on how to teach the blind, as such the TB remain unattended to in terms of HIV/AIDS prevention education.

Of course mutual engagement and joint collaboration is the only way to overcome the existing gap in the mainstream HIV/AIDS intervention programme. But it is unrealistic to

expect the HIV/AIDS outreach CS organisations to become experts suddenly on communication with the TB people and very unreasonable to expect the TB people become experts in HIV/AIDS issues.

## **4.2 Result analysis**

A questionnaire using 95% close-ended questions and 5% open-ended questions was designed to confirm the levels of understanding and awareness of HIV among the TB people, and their perceptions of vulnerability to HIV infection.

The questionnaire had a total number of 19 questions and was divided into 2 sections; background information and awareness of HIV/AIDS among the TB people. The study used 13 TB people who participated in the survey. Although the majority of the participants could read and write braille, two did not know braille, hence the researcher wrote the responses for them. The questionnaire with the aggregated responses is in appendix 1, page 36.

The target population is located in Mochudi, Kgatleng district of Botswana where there is a high prevalence of HIV/AIDS infections; it is roughly at 34.2%. Therefore, the CS organisations are expected to have carried out a vigorous campaign among the TB people, thereby raising a higher level of HIV awareness among the blind people.



## Demographics

**Gender:** 69% was male while 31% were female;

**Age:** 15% was 45 years and above; 8% was 30-45 years; 15-30 years were 77%.

(77% were adolescents while 23% were adults)

**Occupation:** 15% employed, 69% students, 8% self employed;

**Education attained:** 15% degree, 8% cert. 31% in form 5, 39% in form 4, 8% form 3;

**Marital status:** 15% married, 85% single;

**Residence:** 31% home with family, 69% in boarding school;

**Impairment:** All totally blind;

Age when sight was lost	Aggregate number of the TB
0 years	1
5 years	1
9 years	1
12 years	1
13 years	1
14 years	1
15 years	2
16 years	1
17 years	2
18 years	1
29 years	1

Knowledge of braille- Yes 85%,  
No 15%

## HIV/AIDS AWARENESS

77% of the respondents had received HIV information considering the fact that 69% are students receiving guidance lessons, therefore, the 77% is not surprising. Although 77% had received HIV information, the degree of understanding is a cause for concern. So far the information received was never adapted in to braille to suit the needs of the TB people. This is confirmed by the response to question 9 in the questionnaire where they all said the work was never translated in to **braille**. Again the response to question **11 a. is 23%, 11 b.38%, 11 c. 30%, 11 d. 8% and 0% for e** (refers to graph in appendix 2 and aggregated response in appendix 1). **11 b. 38%** is the highest score which says ‘a **little** about HIV/AIDS such as ‘‘what it is, the causes, risks’’. The phrase ‘**a little**’ is the one that raises concern about the degree of understanding of what was exposed to them.

Question 10 listed a variety of information on HIV that they received; 10 a. scored 85%, 10 b. scored 53%, 10 c. scored 69%, 10 d. scored 62%, 10 e. scored 31% (refer to graph in appendix 2 and aggregate response in appendix 1). Here the scaring evidence is that only 53% received information on safer sex- how to use the condom (10.b). Again 10.c and 10 d responses are sufficient enough to say that they know information about STDs and drugs but out of these only 53% can handle condoms. Thus in times of pressure those who do not know how to use the condom will compromise their ignorance and indulge in unprotected sex. Furthermore, 31% lack information on STDs while 38% lack information on dangers of drugs and alcohol use meanwhile another 31% does not know any of questions 10.

Question 15 (had 2 options) asked about how one can prevent him or herself from STDs and; 15 a. Scored 15%, 15 b. scored 38% and 46% said none. Therefore, 62% of the TB respondents did not know how to protect themselves from STDs (refer to aggregated response in appendix 1).

Question 17 listed a variety of information about the reasons why a TB can be at a risk of HIV infection. Question 17 a. scored 77%- she or he is sexually active as the general population; 17 b. scored 77%- is vulnerable to sexual abuse; 17c scored 62%- is targeted by others as they are assumed not to be sexually active and therefore they are safe from HIV; 17d scored 77%- they use drugs and alcohol; 17e scored 62%- have no access to HIV prevention programmes; and 17 f scored 38%- families do not let them participate in HIV/AIDS programmes (refer to graph in appendix 2 and aggregated response in appendix 1 ). 77% has the highest frequency- a, b and d; c and e scored 62%. All this evidence has been confirmed by the literature review. The only new finding is the response for f which scored 38%- it says ‘families do not let them participate in HIV/AIDS programmes for fear of exposing them to too much “**don’ts**”, they fear to confuse them.

Question 18 asked about the knowledge of HIV status; 38% male and 8% female said Yes; while 31% male and 23% female said NO. Out of the total 69% male participants only 38% knew the HIV status while out of the total 31% female participants only 8% knew the HIV status.

Question 19 was an open-ended predetermined question which read as follows-‘how does your Christian/religious belief help you in managing your sexual life?’ Surprisingly, all the respondents said that their Christian/religious beliefs urge them to uphold abstinence. Apparently, this is one of the confounding variables which have been confirmed that the TB people may minimise HIV infection due to the influence of their religious/Christian beliefs.

## CHAPTER 5: DISCUSSION

The goal of the study was to highlight the gaps which have been observed within the mainstream HIV/AIDS intervention strategies. No implication was made here that mainstream HIV/AIDS intervention strategies do not minimise high risky behaviour of the blind people.

The study was driven, however, by a desire to establish:

- How modifications or adaptations to the mainstream HIV/AIDS intervention strategies can minimise risky behaviour of the blind people;
- Whether during risky situations the blind people will take necessary measures to protect themselves from contracting HIV, thereby minimising the HIV infections

The study discovered that unmodified mainstream HIV/AIDS outreach efforts do not meet the needs of the blind person. The findings suggest that the mainstream HIV/AIDS intervention strategies do not minimise risky behaviour. The survey yielded similar findings to demonstrate that the resources are not modified; this has been confirmed by question 9 of the aggregated responses where all the respondents said that the information that they received was not translated into braille, no embossed diagrams or described pictures. This simply demonstrates that learning did not take place. This is 100% confirming the hypothesis that the mainstream HIV/AIDS prevention strategies are not modified to meet the needs of the TB people, therefore, the mainstream HIV/AIDS intervention programmes currently going on in the country totally exclude the TB people.

This study was composed of 69% students who have the opportunity to receive guidance lessons at least for twenty minutes once in a week. Therefore it is highly probable to have 46% that have tested for HIV.

The 77% HIV awareness results also confirms the large number of student participation in the survey. But the degree of understanding the mainstream HIV/AIDS intervention strategies is low and this notion is supported by the responses to question 11 where 23% said they understood a lot (a); 38% understood a little about HIV/AIDS (b); 30% understood enough to know the risks and how to protect themselves (C); 8% only know the words HIV/AIDS and nothing else (d); 0% for I know nothing at all (e). Here, 23% represents the people who understood a lot from the information that they received while 38%, the highest score, understood a little about HIV/AIDS.

This means that 77% did not understand a lot about the mainstream HIV intervention strategies. The results to question 11 support the hypothesis since the percentages yielded about the understanding of the mainstream HIV/AIDS intervention strategies are low, the highest being 38% while lowest is 8%, this leaves 62% not to understand anything. This means that 62% is exposed to high risky sexual behaviour. Again, we have 62% because 69% of the participants are students who receive guidance lessons. Otherwise, the percentage for those who do not understand could have been higher than 62%. The overall aggregate percentage of the understanding of the mainstream HIV/AIDS intervention strategies that are so far received is 19.8%. This result implies that the objective of minimising HIV infections among the TB people has not been met.

Now let's take a scenario where we have a population of non formal education which does not access guidance lessons; the aggregate response for those who understand mainstream HIV/AIDS prevention strategies would be lower than 23%; and the overall percentage would be lower than 19.8% which is absolutely a different story. This can be the case because they do not have access to the mainstream HIV/AIDS intervention programmes and it has been confirmed by the representative of the non formal education group that the group has been under pressure to have programmes for the people with disabilities (Sekhobe: 2).

The Acting Executive Director for Botswana National Youth Council (BNYC) also confirmed that the government has put in place key strategies on the policy targeting the youth but because the government has omitted some specific provisions for the people with disabilities, people with disabilities have failed to utilise the programmes (ibid).

The aggregated responses to question 17 of the questionnaire (refer to appendix 1) show us who the blind person is in order to counteract the societal attitudes concerning sex and the TB blind people. It is this same attitude which has engulfed the government sectors and the CS organisations responsible for the mainstream HIV/AIDS intervention strategies. The results to question 17 confirm the reasons why the TB people must not be left out of the mainstream HIV/AIDS intervention strategies.

Abstinence, as preached by different religious and CS organisations, is just lip service to most people including the blind people since they do not abstain. A person who has never indulged in sex or received blood transfusion may stay away from VCT. Therefore, those who go for testing are those who are actively engaged in sex or those whose entry requirement into the new job is HIV testing first. From the study's statistics, we are told that 46% (refer question 18, appendix 1) of the participants had taken an HIV/AIDS test and they know their HIV status. This confirms that abstinence is not effective. Even the 54% (refer appendix 1) who have not tested and do not know their HIV status, can not be excluded from those who indulge in sexual intercourse, because their lack of knowledge of their HIV status might be attributed to either the lack of HIV awareness, their proximity to the testing centre or stigma. The ineffective abstinence is further demonstrated by Dyer from the Washington post- (<http://www.washingtonpost.com>) study reveal that:

‘Premarital abstinence pledges are ineffective. Research shows that whether they wear purity rings or make other pledges that they will protect their virginity; more than half of American

teenagers become sexually active before they get married. It was further said that teenagers who pledge to remain virgins until marriage are just as likely to have pre marital sex as those who do not promise abstinence and are significantly less likely to use condoms and other forms of birth control when they indulge in sex. Study also finds that more than half become sexually active before marriage regardless of whether they had taken a virginity pledge; making a pledge does not seem to make any difference at all in any sexual behaviour’.

Adolescent behaviour is the same regardless of the country where they are, whether able-bodied or disabled. Therefore, youths of Botswana cannot be excluded, they are the same. However, the result on abstinence (question 19 appendix 1) was expected to be 100% because Botswana is a nation with deep rooted religious beliefs which also contradicts with their relaxed social life style which is punctuated heavily with a nomadic life style. There is frequent movement between cities and villages over weekends and short vacations. This demonstrates the kind of population Botswana has; it is mobile and it is one factor of HIV infection. Finally, the Botswana government needs to adapt/modify their mainstream HIV/AIDS intervention strategies in order to minimise the HIV infections among the TB people so that their HIV/AIDS outreach efforts are not upset by the transmissions by the TB people.

One limitation of the survey was that 69% of the participants were drawn from one institution and were students between the ages of 15 to 30 years, while 23% were adults who were above 45 years. All the participants belonged to the same area/village. The researcher opted to one institution because it has a reasonable pool of the TB people drawn from all parts of the country since it is the only institution that offers senior secondary school education to the blind learners in the country.

Thus the study has a poor representation of the non formal education group or out of school youths who are not exposed to guidance lessons. This difference may weaken the generalisation of the research findings. Furthermore, having confined the participants’

selection to one institution yielded a more restricted sample which was not representative of the typical population of the TB people.

The limitations aside, the survey has demonstrated to the government sectors and CS organisations that the TB people seriously need to be attended to in terms of mainstream HIV/AIDS intervention programmes. In addition, the research has highlighted the gaps that are in the mainstream HIV/AIDS intervention programmes.

## **5.1 Suggestions**

Reference is made to appendix 3, page 43, which is composed of three types of strategies for the inclusion of the blind people in HIV/AIDS outreach efforts.

**Type 1** is about the inclusion as part of the general HIV/AIDS outreach with no adaptations such as brailled text or enlarged materials. Here, the blind individuals are included in HIV/AIDS outreach efforts and services as members of the general population requiring little or no additional adaptation.

All the service providers have to do is to make sure that their campaign pictures, pamphlets and theatre include blind people with their canes so that the general public realise that the blind people too, are at risk of HIV infection.

**Type 2** has moderate adaptations to the general programmes that foster inclusion. In this type, the existing mainstream HIV/AIDS materials meant for the sighted population are adapted to suit the available blind individuals who are part of the general population. Here, they may have embossed diagrams, pictures described, ink print transcribed into braille text and **some** individualised attention so that the blind can also participate in the mainstream HIV/AIDS intervention programme. The blind will be part of the general population but people with special skills will be assigned to attend to them as teacher aides



**Type 3** is a specific mainstream HIV/AIDS intervention programme for the blind people alone. There are some blind people who may not be reached due to braille illiteracy especially those literate people who have been blinded late in their life; and those who have never been to school. These people need more time to themselves and a high degree of individual attention. The individuals are met separately away from the general population.

## CHAPTER 6: CONCLUSION

The aggregate responses to the questionnaire has confirmed that the mainstream HIV/AIDS prevention intervention strategies must be modified in order to meet the needs of the TB people. The government has failed to recognise the blind as the most-at-risk populations. They have only recognised sex workers, MSM and prisoners. Again, despite the government's recognition, gaps still existed in service delivery for most-at-risk population (NCPI trend analysis: 15).

The government must evaluate their MDG six whose focus is to combat HIV/AIDS...the target is to halt and begin to reverse the spread of HIV/AIDS by the year 2015 meanwhile the TB women keep on transmitting the HIV within the community. The MDG six does not have specific provisions for the blind women and men (<http://www.sarpn.org.za>).

Finally, the government sectors, civil society and FBOs must conduct an epidemiology of the HIV/AIDS epidemic among the blind population. The data will provide a more effective argument to include the blind in HIV intervention programmes.

## **BIBLIOGRAPHY**

Botswana Agrees to loan from world bank to curb AIDS epidemic, by Joseph Balise, Bloomberg.com; December 4, 2008.

Debility and the moral imagination in Botswana, by Julie page 158;  
<http://books.google.com/books?id=OVNeNLcDD2cC&pg=PA158&1pg=PA158&dp=population+of+blind+people+in+Botswana>

Groce N et al (2006), (Google; guidelines for inclusion of individuals with disabilities in HIV/AIDS outreach efforts), Yale University.

Google; Oseafrika.org/publications/section\_4one.pdf; East African Journal of ophthalmology, May 2008-view as HTML

Google; Ethnologue report for Botswana- 1991 census;  
[www.ethnologue.com/show\\_author.asp?name=bw](http://www.ethnologue.com/show_author.asp?name=bw) cached

Hornby A. S (2000) Oxford Advanced Learner's Dictionary of Current English, Oxford University press, UK

[http://www.sarpn.org.za/documents/d0001779/Botswana\\_Child\\_UNICEF\\_Sept2005.pdf](http://www.sarpn.org.za/documents/d0001779/Botswana_Child_UNICEF_Sept2005.pdf)

<http://www.washingtonpost.com/wpdyn/content/article/2008/12/28/AR2008122801588.html?hpid=topnews> (Dyer Jonathan)

Levin (1997), doing what is naturally: Full inclusion in accelerated schools. Baltimore: Paul H Brooks Co.

NCPI trend analysis, policy/strategy development & implementation, Botswana 2007: Government of Botswana Country Report, UN General Assembly Special Session on HIV/AIDS, December, 2007.

Rieser R (2000), History of our oppression. Why the social model in education is inclusive education. Paper presented at the international special education congress, Manchester, England, July 13 2000.

Salamanca Statement on principles, policy and practice in special needs education, Sekhobe Bonang, Policy disadvantages people with disabilities, Daily News, page 2, July 28, 2008. No.140

Towards Zero New HIV Infections, Zero transmission, making prevention work for Botswana, National HIV prevention conference report, September 20-22, 2005, Francistown, Botswana

[www.unesco.org/education/educprog/sne/salamanc/stateme.html](http://www.unesco.org/education/educprog/sne/salamanc/stateme.html)

## LISTS OF APPENDICES

### APPENDIX 1: AGGREGATED RESPONSES

#### PART A - BACKGROUD INFORMATION

<b>TOTAL PARTICIPANTS = 13</b>									
<b>1. Gender</b>	Male	69%	<b>4. Marital Status</b>						
	Female	31%	Married 15%						
			Single 85%						
<b>2. Age range</b>			<b>5. Residence</b>						
	45 above	15%	Living with family 31%						
	30-45	8%	Boarding school 69%						
	15-30	77%							
	15 below	0%							
			<b>6. a. Age when lost sight</b>		<b>Aggregate number TB people</b>				
<b>3 a. Occupation</b>			0				1		
	Working	15%	5				1		
	Studying	69%	9				1		
	Unemployed	8%	12				1		
	Self employed	8%	13				1		
			14				1		
<b>3 b. Education Attained</b>			15				2		
	Degree	15%	16				1		
	Cert	8%	17				2		
	Form 5	31%	18				1		
	Form 4	39%	29				1		
	Form 3	8%							
			<b>b. Knowledge of braille</b>						
			Yes 85%						
			No 15%						

**PART B- HIV/AIDS AWARENESS**

7. Have you ever received HIV/AIDS information?

Yes 77%

No 20%

8. Cancelled

9. If yes (to question 7) was the information:

A. brailled text – Yes 0%

No 100%

B. described pictures- Yes 0%

No 100%

C. embossed diagrams- Yes 0%

No 100%

10. From the information below, choose examples of information that you have received; write as many as possible.

A. General information on HIV/AIDS - 85%

B. Safer sex e.g. how to use a condom- 53%

C. Sexually transmitted diseases- 69%

D. Drugs and alcohol use- 62%

E. Others- explain briefly- 31%

11. How much did you say you understood? Choose only one answer.

A. A lot- 23%

B. A little about HIV/AIDS such as ‘what it is’ the causes, risks- 38%

C. Enough to know risks and how to protect myself 30%

D. Only know the words HIV/AIDS and nothing else 8%

E. I know nothing at all- 0%

2. Write ways through which a person can catch HIV. Choose the correct one.

- |                                     |      |
|-------------------------------------|------|
| A. Using the same utensils e.g. cup | 0%   |
| B. Using the same toilet            | 0%   |
| C. Sexual intercourse (unprotected) | 100% |

13. Do you have a wife/husband, girl/boyfriend?

- |                      |     |
|----------------------|-----|
| A. Yes- wife/husband | 15% |
| Girl/boyfriend       | 54% |
| B. No-               | 23% |

14. Excluded

15. How would you protect yourself against STDs. Choose one.

- |                        |     |
|------------------------|-----|
| A. Contraceptive pills | 15% |
| B. Use of a condom     | 38% |
| C. None of the above   | 46% |

16. If you are given a male or female condom, can you;

- |                               |                   |     |
|-------------------------------|-------------------|-----|
| A. Identify it-               | Yes – male condom | 77% |
|                               | Female condom     | 0%  |
|                               | No                | 23% |
| B. Open it correctly-         | Yes               | 46% |
|                               | No                | 54% |
| C. Insert it on without help- | Yes – male condom | 54% |
|                               | Female condom     | 0%  |
|                               | No                | 46% |

17. Why do you think a TB person might be at risk of HIV infection? Choose the letters for the answers that fit you. Choose as many as possible.

- |  |     |
|--|-----|
| A. He or she is as sexually active as the general population       | 77% |
| B. Is vulnerable to sexual abuse                                   | 77% |
| C. Is targeted by others   | 62% |
| D. They use drugs and alcohol                                      | 77% |
| E. Have no access to HIV/AIDS prevention programmes                | 62% |
| F. Families do not let them participate in HIV and AIDS Programmes | 38% |

18. Have you ever been tested for HIV and know your status?

- |           |     |
|-----------|-----|
| Yes- male | 38% |
| Female-   | 8%  |
| No- male  | 31% |
| Female    | 23% |

19. How does your Religious/Christian belief help you in managing your sexual life?

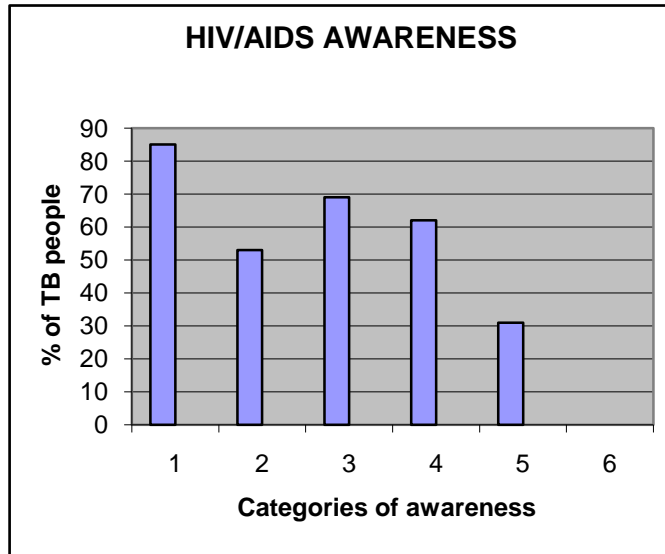
Give a brief answer.

Answer- 100% said that their Religious/Christian belief has taught them to uphold abstinence.

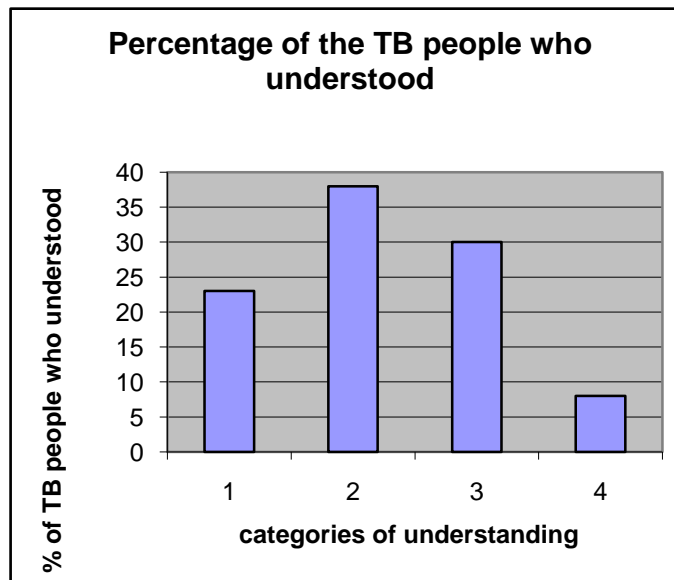


APPENDIX 2: Graphic Presentation

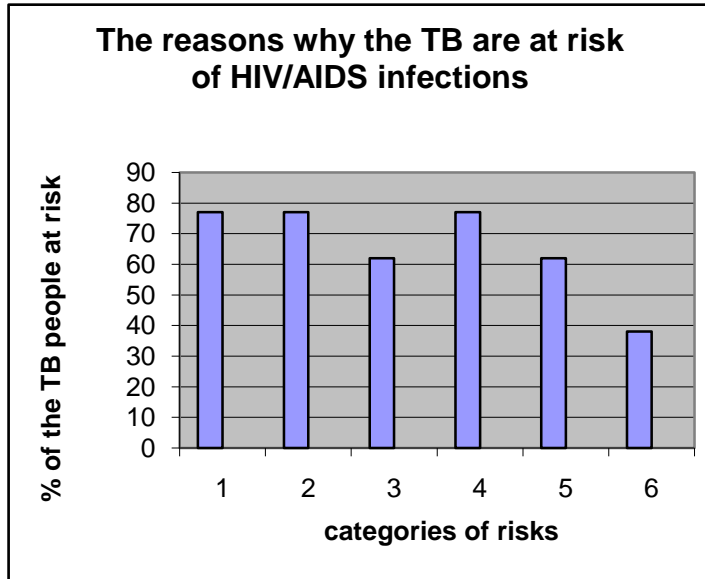
Question 10



QUESTION 11



**QUESTION 17**



APPENDIX 3: Sample of modified guide for outreach efforts

**Suggested guide for the inclusion of the totally blind people in HIV/AIDS outreach programmes (adapted from Groce et. al: 2006).**

**Table 1: Low modifications to existing programme**

Strategy	Purpose of the strategy	Suggested activities	Examples of suggested activities	Check points
Type 1	To enable the blind people who are in the community access HIV/AIDS outreach programmes	<p>1. use the materials already available to general public, incorporating simple adaptations to ensure accessibility by the blind people (totally blind &amp; partially sighted)</p> <p>2. Ensure that AIDS educational outreach and services available to the general population include blind people</p>	<p>1.1 Depicting individuals with visual impairment (partially sighted &amp; a totally blind person who uses a white cane) in aids posters and bill boards that are produced. Also include examples of blind people in published materials</p> <p>2.1 Moving HIV/AIDS education, testing and service delivery programmes as well as drug, alcohol and domestic violence programmes to accessible meeting places</p> <p>2.2 Making sure that blind people in the community are aware of the AIDS activities being offered and know that they are invited to attend</p>	<p>1.1.1. Are blind people depicted in posters, billboards, theatre etc especially those that are intended to show that even blind people are at risk?</p> <p>1.1.2 Are there blind people in the stories and vignettes used to illustrate HIV/AIDS issues?</p> <p>2.1.1 Is the place where you are holding your programme accessible for blind people; does the venue require people to walk long distances?</p> <p>2.2.1 Have the field staff invited the blind people from the area or encouraged them to participate in the programme's activities</p>
		<p>3. Inform AIDS educators, outreach workers, clinical and social service staff about challenges faced by the blind people</p> <p>4. Establish a partnership with local DPOs to educate AIDS outreach workers about visual impairment issues.</p>	<p>3.1 Making simple adaptations in AIDS prevention interventions to ensure that messages are understood by the Braille users, the totally blind.</p> <p>4.1 Partner with local NGOs to make sure presentations and language used are as inclusive as possible.</p>	<p>3.1.1 Do you pass a condom so the blind people in the community could and where they can source for the condoms and HIV testing?</p> <p>4.1.1 Have you called upon local DPOs for support in reaching blind people who cannot otherwise be reached?</p>

**Table 2: Moderate modification and/ or additions to existing programmes**

<b>Strategy</b>	<b>Purpose of strategy</b>	<b>Suggested activities</b>	<b>Examples of suggested activities</b>	<b>Check points</b>
Type 2	Adaptations are made to outreach campaigns to ensure that blind people are included as members of the general public	<p>1. Adapt existing HIV materials to ensure that messages are accessible and available to the blind people</p> <p>2. Ensure access to and dissemination of HIV/AIDS information in either large print or braille</p>	<p>1.1 AIDS public service announcements adapted for the blind community</p> <p>2.1 Making AIDS materials available for the blind in inexpensive cassette formats</p>	<p>1.1.1 Is the AIDS announcements clear and well formatted in Braille?</p> <p>2.1.1 Are AIDS messages available on inexpensive tape or CD versions to distribute individuals who are blind or partially sighted?</p> <p>2.1.2 Is there a local radio station that will be willing to talk about HIV/AIDS using simple messages that could reach blind individuals?</p> <p>2.1.3 Is there a local programme specifically targeting the blind?</p>
		3. Establish a partnership with local DPOs and identify training needs	<p>3.1 Developing a training of trainers curriculum with relevant topics to train AIDS outreach workers about visual impairment</p> <p>3.2 Train individuals who are blind to be AIDS educators for the whole community</p>	<p>3.1.1 Are members of the HIV outreach team in contact with DPOs for guidance and oversight to ensure they understand visual impairment issues and concerns?</p> <p>3.2.1 Have you identified individuals with blindness willing to help disseminate HIV/AIDS messages? Have you worked with local DPOs to ensure outreach to all blind people?</p>

**Table 3: Specific programmes targeting the harder-to-reach blind people**

Strategy	Purpose of strategy	Suggested activities	Examples of suggested activities	Check points
Type 3	Adaptations for the blind are made existing materials and new materials are developed to reach blind individuals outside the bounds of the general public, targeting harder to reach individuals	<p>1. Develop outreach efforts specifically for the blind</p> <p>2. Train disability advocates to be AIDS educators specifically for the blind community</p>	<p>1.1 Train/hire AIDS educators and staff to specialise in issues related to serving specific blind population</p> <p>1.2 Working in collaboration with local DPOs and others, identify all the hard-to-reach and identify a local strategy to reach these individuals</p> <p>2.1 Develop and test training curriculum with people who are blind</p>	<p>1.1.1 Is sex education available in integrated schools with blind learners?</p> <p>1.1.2 When blind learners are integrated into the regular classroom, are they allowed to be part of the sex education lessons or are they sent out because teachers do not think they need this information?</p> <p>1.1.3 When there are special programmes for street children, are blind children, adolescents included?</p> <p>1.1.4 Do you have sessions that would attract blind individuals with similar life experiences and concerns to meet, discuss and become empowered? For example, blind adolescents, adults, women, men etc</p> <p>1.2.1 Do you know how many blind people live in your area?</p> <p>1.2.2 Do you know how many of these are being reached by AIDS outreach efforts?</p> <p>1.2.3 Have ever assessed what their knowledge, attitude and practices about HIV/AIDS are in comparison with the surrounding able-bodied population?</p> <p>2.1.1 Is there a TB individual who is a braille user who could provide information to peers?</p>