Sex Disabil (2014) 32:311–321
DOI 10.1007/s11195-014-9343-y

ORIGINAL PAPER

Experiences and Perceptions of HIV/AIDS and Sex Among People with Disabilities in Windhoek, Namibia

Gert Van Rooy · Pempelani Mufune

Abstract The aim of this study was to investigate the experiences of people with disabilities (PWD) with regard to issues of sexuality and HIV/AIDS. More specifically, we investigate how PWD perceive social and sexual relationships, how they experience sexual and reproductive health (SRH) care including HIV/AIDS. This study relied on key informant (5) interviews and focused group interviews (FGDs). The three FGDs consisted of midlevel to senior officials (5), females with disabilities (5) and a mixed group of males and females with disabilities (12). The study supports the view that PWD experience differential treatment within extended families. The public has negative attitudes towards PWD who engage in sex in general and female PWD who fall pregnant particularly. It largely supports the literature that PWD are at great risk of physical and sexual abuse and are often denied reproductive rights. It points to the difficulties PWD find with HIV/AIDS education as a lot of the materials is not written in Braille or otherwise fail to take into account the different disabilities. People with disability also face problems accessing reproductive health services because of the negative attitudes of healthcare providers. There is a need for the government and society to focus on the SRH of PWD if the fight against HIV/AIDS is to succeed. There is also need to focus on PWD in the context of sexuality if the inalienable human rights and freedoms of all its citizens including PWD is to be realized.

Keywords People with disabilities · HIV/AIDS · Sexuality · Windhoek, Namibia · Sexual and reproductive health

---

G. Van Rooy
Multidisciplinary Research Centre, University of Namibia, P/B 13301, Windhoek, Namibia

P. Mufune (✉)
Department of Sociology, University of Namibia, P/B 13301, Windhoek, Namibia
e-mail: PMufune@Unam.na

Introduction

HIV/AIDS in Namibia

It is estimated that there are about 200,000 people with HIV and AIDS in Namibia and more than 100,000 orphans and vulnerable children affected by the virus. The Ministry of Health and Social Services [1] 2012 sentinel survey shows that 18.2 % of the Namibian population is infected with HIV despite continued promotion of the ABC (abstinence, being faithful and condoms) approach to fighting the disease. This actually represents a slight reduction from 18.8 % in 2010. The overall HIV prevalence for the age group 15–24 years is 10.3 %. This is a decline since 2004 from 15.2 % to 14.2 in 2006, 10.6 % in 2008 and 10.3 % in 2010 respectively among this age group. Although AIDS researchers have studied HIV/AIDS and the disabling effects of HIV/AIDS on previously healthy people, little attention has been given to the risk of HIV/AIDS for individuals who have a physical, sensory, intellectual, or mental health disability before becoming infected [2].

People with Disabilities (PWD) in Namibia

Despite the fact that there are an estimated 150,000 people with disabilities (PWD) in Namibia the focus is on able bodied people. The 2011 Population and Housing Census [3] revealed that 4.7 % of Namibia's populations live with disabilities. More people in rural areas (5.7 %) than in urban areas (3.3 %) have disabilities. Lower Limbs (22.6 %) is the most common type of disability in the country. Altogether people affected with upper and lower limb disability constitute 33.6 % of PWD. It is followed by visual Impairment and mental disability which affects 17.4 and 14.2 % of PWD respectively. Most PWD in Namibia have little or no access to healthcare, education and opportunities to get a job and support themselves. The lack of focus on HIV/AIDS risk for PWD is also despite the Namibian Constitution's explicit recognition of the inalienable human rights and freedoms of all its citizens including PWD. Article eight (1) explicitly states that "the dignity of all persons shall be inviolable", while Article ten emphatically states that "all persons shall be equal before the law" and "no person shall be discriminated against on the grounds of sex, race, colour, ethnic origin, creed or social or economic status" [4]. The Government of the Republic of Namibia's Vision 2030 aims to achieve equity in healthcare for all Namibians including those with disabilities. It states that PWD must be treated with dignity, honor and respect [5]. It indicates that economic and social structures will be in place to eliminate marginalization as PWD will be given the necessary assistance to enable them to participate effectively in education and employment opportunities.

Sexual Health in Namibia

In general Namibia has a good sexual and reproductive health (SRH) service with antenatal (ANC) services available in 80 % of health facilities [6]. Despite this the Namibian Demographic Health Survey (NDHS [21]) indicates poor access to SRH information and services in Namibia, particularly family planning. For example only 46 % of women aged 15–49 use modern contraceptives. Contraceptive use is limited by cultural, economic, religious, geographic barriers and low literacy rates of communities. There is also an absence of comprehensive sexuality education in schools [7]. Consequently, few children know their sexual rights, thus compromising their reproductive health. Adolescent boys generally lack knowledge of sexually transmitted infections. Similarly, adolescent girls are at risk of unwanted pregnancy as they lack accurate information on reproductive health services. Girls are more vulnerable than boys to sexual abuse and rape. Namibia has few adolescent friendly health services (AFHS).

Sexual Health in Namibia for PWD

Although SRH services exist in Namibia they are not specifically tailored for PWD. The reported poor access to SRH information and services in Namibia and absence of a comprehensive sexuality education in schools also affects PWD. This paper investigates the experiences of PWD with regard to issues of sexuality and HIV/AIDS. More specifically, we investigate how PWD perceive social and sexual relationships, how they experience SRH care including HIV/AIDS and how they experience and perceive HIV/AIDS education. The rationale for the research is that studies on SRH and HIV/AIDS in Namibia have focused on experiences and perceptions of young people in general. Few of them have connected PWD to HIV/AIDS and sexuality despite the fact that in Namibia PWD are at great risk of physical and sexual abuse and are denied their reproductive rights. This study was designed to examine the links between disability, sexuality and HIV/AIDS in order to inform policy and programmes.

Literature Review

Sexuality and Disability

PWD have the same needs to form close relationships as others including participation in sexual activity. Although this is the case, PWD sometimes experience seclusion and segregation that limit them from sexual relations with others. PWD may feel inhibited about relationships, fear rejection on the basis that they have a disability or otherwise experience an emotional or psychological burden that may inhibit them from fully participating in relationships. They may equally suffer from sexual harassment, assault, and domestic violence. The recognition that PWD are not asexual is relatively new [8, 9]. According to Anderson and Kitchen [10] cultural representations of PWD as "sick and sexless" are supported by myths such as asexuality, lack of biological sex drive, inability to partake in sex and a lack social judgment to be sexually responsible. According to Grant et al. [11] less than 50 % of the countries in Eastern and Southern Africa recognize disability as an issue of concern, or specifically recognize the vulnerability of PWD to HIV and AIDS within their National Strategic Plans.

Knowledge and Misconceptions About HIV/AIDS Among PWD

With regard to HIV/AIDS education the literature indicates that PWD, like non-disabled persons, also exhibit misconceptions about HIV/AIDS [12]. According to Groce et al. [13] studies both in North America and Europe have found that deaf individuals lack access to AIDS information, due to problems in communication, low literacy and tightly woven social networks within the deaf community. According to Hanass-Hancock [14] surveys reveal that PWD have less knowledge about HIV than other people. Wazakili et al. [8] claimed that their sample of PWD showed limited factual HIV knowledge and their sexual behavior was not informed by their knowledge. This was mainly due to the fact that PWD have less access to HIV information and interventions [14]. According to Rohleder et al. [15] barriers to HIV/AIDS information include lack of interpretation in “sign language, in Braille formats, or that is understandable to persons with intellectual disabilities, and accessing services that are inaccessible to wheelchair users”.

Sexual Practices Among PWD

In terms of social relations PWD, as a group, tend to be economically, educationally, and socially disadvantaged which, in itself, suggest that they are a high-risk group for HIV infection. Despite the myth of asexuality, research increasingly indicates that PWD often have known risk factors for HIV infection [13]. For example, people with physical and or developmental disabilities may, for a number of reasons, be disadvantaged in negotiating safer sex, particularly if they are with a partner willing to exploit their vulnerabilities. For some disabled people, social marginalization increases the likelihood that they will be involved in a series of unstable relationships. Unfortunately, however, PWD are rarely the targets of HIV/AIDS interventions designed specifically to address their particular prevention needs [13].

Men and women with disabilities are greater victims of violence or rape, but are less likely to be able to obtain police intervention, legal protection or prophylactic care [16, 17]. People with physical or developmental disabilities are also at increased risk for sexual exploitation and abuse. The reasons for this include (1) dependency on other people for care; (2) denial of human rights that result in feelings of powerlessness; (3) perpetrators’ perception that they will not be caught; (4) perception that disabled victims will not be believed; (5) lack of education about appropriate versus inappropriate sexual behaviour; (6) social isolation and increased risk of manipulation; (7) greater vulnerability in public places [9].

The literature indicates that PWD have similar access to HIV/AIDS prevention, education and care. For instance PWD have very high awareness of condoms in Malawi [12]. Despite this awareness there was disjuncture between knowledge and practices. Amongst those with disabilities the number of condom users was low, and those who used them did not always know how to use them effectively. Conod and Servais [18] argue that “Condom use by persons with intellectual disabilities requires adapted sex education, since a large majority of persons with intellectual disabilities have nil or minimal understanding of how to use a condom correctly”. In South Africa both abled and disabled youth fail to practice safe sex [8, 15]. There is very little uptake of voluntary testing and counseling among PWD [14]. This is partly “because transport and medication might be unaffordable, clinics might not be accessible, voluntary counseling and testing (VCT) might not be disability specific or counseling may violate basic requirements of confidentiality” [14]. Wazakili et al. [8] reported that although PWD in their South African sample knew about VCT they feared testing because of the possibility of testing positive. Groce et al. [19] point to literature showing that PWD face barriers to accessing VCT including negative attitudes of health providers.

Methodology

The methodology was designed to elicit perceptions of healthcare delivery held by persons with disabilities living in Windhoek, Namibia. This pilot study relied on key informant

Table 1 Characteristics of the respondents

	N (%)
Sex	
Male	10 (37.0)
Female	16 (63.0 %)
Type of disability	
No disability	8 (29.6 %)
Visual disabilities	5 (18.5 %)
Physical disabilities	11 (40.7 %)
Hearing disability	3 (11.1 %)

interviews and focused group interviews. The five (5) key informants were a project manager in the Disability Organization of Namibia (DPO), an advocacy officer for Namibia National AIDS Service Organizations (NANASO), a researcher with the Ministry of Gender Equality and Child Welfare (MGECW), an Advisor to the Prime Minister of Namibia on Disability issues and an educational officer whose portfolio includes disability issues. There were three (3) focused group discussions (FGDs); the first included five (5) mid-levels to senior officials from the Ministry of Health and Social Services (MoHSS)—the government department that is responsible for issues of disability in Namibia). This FGD was organized with the approval of the relevant ministry. The second FGD was a mixed male and female group consisting of twelve (12) individuals with different disabilities. Three of these had a hearing disability, two (2) had visual disabilities and the rest had physical disabilities. The third FGD consisted of five (5) individuals that were all female. Three of them had visual disabilities and two had physical disabilities. This group only consisted of women because we learnt that some of the women were not too keen to discuss and elaborate on reproductive health issues in the presence of men. All the PWD included in this research were members of the Disability Peoples Organization (DPO) that is based in Windhoek. The research used a sign language interpreter.

Examples of items used in the interview schedule were: what is your understanding of sex, do you access sexual healthcare in the same way as everyone else in your family and community, what factors make it difficult for a person with disabilities to access healthcare, what difficulties do PWD face in sexual relationships? (Table 1).

Results

The data in this research was organized according to four themes.

- Social relationship
- Sexuality and gender
- Sexual and reproductive health care
- Access to HIV and AIDs prevention, education and care

Social Relationships and Disability

It emerged that in many cultural groups if a child is born with some form of disability the family often believes that there is a curse resting on that household. Households that have disabled children are on the periphery and find it difficult to interact with the rest of the extended family. This creates an environment in which the household is denied full association with society at large. "In the tribe I come from –Otjiherero—people believe that to give birth to a baby with a disability is a curse and that you must not be among others—you must be like an animal somewhere there. Sometimes it depends on the way your parents treat you from childhood" (FGD 2). It seems that disabled people are not expected to be in relationships or have children. People with disability should be cared for by able body persons, they should not have a free life otherwise they would be rejected by members of society. In many cases disabled people are denied sexual and reproductive services. According to one Key informant from DOP (himself with physical disability) PWD are perceived as incapable of sexual engagement and regarded as asexual; "able people do not want to associate themselves with disabled people sexually, they do not want to marry them yet not all of us are born with disability, disability is not a curse from birth, but it is just an unfortunate situation". People with disability often blamed culture for some of the discrimination. If a man has a child that is disabled, he leaves "both the woman and child for he does not want to be associated with that family. Some say that the child cannot be mine. In some cases due to pressure from friends and family the child is left indoors or taken to the village to stay with the grandparents" (Male, FGD 3). Other forms of exclusion include parents avoiding to be seen with a disabled child or refusing to spend time with the child by avoiding taking the child on shopping excursions.

Sex, Disability and Gender

In Otjiherero sexual activity is referred to as *Orakatuko* and in Oshivambo it is refered to as *IIhulo or Okulalathana*. For the most part respondents defined sexuality as making love (sexual intercourse between two people). In each of the Namibian cultural groups reviewed parents often tell their male children not to play with girls, and vice versa, but there is no straight talk about sex. Furthermore, respondents in all FGDs were of the opinion that sex is hardly spoken about. According to them people with disability are often victims of family abuse. "If a disabled person falls in love with an able bodied man, the man suffers abuse at the hands of his family resulting in him abusing the partner. This mostly in the Oshiwambo culture, were a person is not allowed to be involved with a disabled person" (Male, FGD 3). One female in FGD 2 related her experience as follows:

> I am talking from my experience Okay! We were five girls in the house about the same age but my parents were always worried about me. They did not allow me to stand with boys but allowed the others to. We were all ladies about the same age but some were allowed and I was not allowed. What was the difference? When I grew up I realized that the difference was I am a disabled. The problem is also that the parents think the person with disability should be taken care of like a kid. In the village I come from I know a lady that is disabled. She has five kids but none of them has a father. She doesn't know who the father is because the parents built her a house far from the others. Any man who wants to comes because there is no one. If you are disabled using a wheel chair, when already in the bed, you can't go back to close the door. It will be open and anyone can come and have sex with you because there is no one who can protect you as your family has rejected you (Female, FGD 2).

It seems that people that do not live with disabilities forget that, "we have feelings just like any other person, that's why sometimes we engage in sexual acts, even with people we don't know (as long as you are approached)" (Female, FGD 2). Discrimination is directed not only towards women with disabilities, but also able bodied women who have children with disabilities.

> When the father of my son died it was really difficult because my child couldn't sit, he couldn't walk, couldn't do anything. Men came to propose to me and then when they saw my boy they said 'Aha" okay! You could just see by their expression that they would run away. Anyway I told them that I have a special child—the way you are going to love me is the way you have to love him also. You know the modern life we are living; only few men can be expected to take care of a disabled child. So when men came I said 'no', I cannot have any relationship with you or any love for you if you don't commit yourself to taking care of my child. They went. The man I am staying with now—the one I married—was different. He is the only one who agreed to take care of my child. If you are a parent of a disabled child, only few men will come and propose to you and only few men will stay with you, otherwise men run away (Female, FGD 2).

According to our respondents, people with disability mostly get married only if they are coming from a very wealth background, but if they are poor marriage is out of the question. Problems of discrimination for PWD do not stop with marriage. "I was blind and got married. I am suffering humiliation at the hands of my in-laws. The family always asks my husband why get married to this person. Why did you not look for another one? The family did not even attend our wedding vows; right now they are not visiting us"(Female, FGD 2). Women suffer the most. If it happens that a disabled woman falls pregnant, people say "what is this" "What did they do to her? These are the experiences that, we encounter and are mostly as the result of ignorance, meaning we are denied the kind of activities and the kind of social lifestyle that others enjoy" (Key Informant, DPO). A female respondent said, "I got involved with this person, but when we got out or visited friends, he would always ask me to wait outside as he wanted to see who was inside. According to him people would discriminate against me and will ask where you got that womuvazapi uasanango (meaning one who looks that way)". Able bodied men, "who are involved with us, visit us in the quite hours of the night and leave early in the morning for fear of been seen by others" (Female, FGD 3). "When a man (not disabled) approaches you, as a disabled woman the first thing that comes into your mind is that he is not serious, he must have a hidden agenda. In most cases, men are only ours when we are not at a public place; otherwise they do not want to be seen with us" (Female, FGD 3). According to another informant, "Normal men run away from us because, if you suffer from backache, your man might complain that you are boring in bed as you do not make certain moves during intercourse" (Female, FGD 2). It seems women with visual impairments are more vulnerable and at higher risk "in Oshiwambo culture, when two blind persons get married they are often called all sorts of bad names like 'Iikanga yi pwikika', which simply means 'using a broken clay lid to cover another broken clay lid'" (Female FGD 3).

Sexual abuse against females PWD is not uncommon. "There is this woman with four children. She was abused by able body men and she does not know who the fathers of her children are. Men would often enter her room, touch her and do their "thing" and leave. She does not know if they are from her own place or their position in life. Nobody in society wants to admit to her children—because she is blind, who wants to be associated with a blind women. The result is that the woman suffers emotionally and financially, as nobody wants to assist her" (Male, FGD 3). The Key informant who is a researcher in the Ministry of Gender and Child Welfare related the following story from his village.

> There is a girl who is mentally retarded in my own village—she cannot talk. Some guys came and sexually abused her and she became pregnant. The villagers gathered and asked her to point who she had sex with but she didn't know who was responsible for the pregnancy. All the guys denied and no one could do anything without the oral testimony of the girl. When guys come for a disabled person, she may feel she is lucky because many men do not come for her. It is not that there is love but because only guys taking advantage of the girl (Key informant, MGCW).

Female parents with disabled children are faced with domestic violence, especially as their partners reject or even divorce them. This is because many men are scared of the responsibilities of caring for disabled family members. This leads to single motherhood and vulnerability. The treatment they get from in-laws is another challenge. Negative influence from family members leads male partners to divorce or treat a disabled person badly.

Sexual and Reproductive Health Care

According to the World Health Organization SRH care refers to improving antenatal, delivery, postpartum and newborn care; providing high-quality services for family planning, including infertility services eliminating unsafe abortion; combating sexually transmitted infections (STIs), including the human immunodeficiency virus (HIV), reproductive tract infections (RTIs), cervical cancer and other gynecological morbidities; and promoting sexual health, as well as the larger cross-cutting issues of gender-based violence, human rights, and male involvement [20] .

Most of the respondents in this sample (FGD 2 and 3) indicated that they have attended health education/awareness discussions addressing SRH issues. The average attendance for such discussions was two times. They indicated attendance of:

- "My Future is My Choice" dealing with making the right choices about relationships
- "Good Hope" dealing with Christianity and reproductive health
- Workshops on "gender and disability"
- Workshops on HIV/Aids and visually impaired persons
- Workshop on the Rape Act and the writing of one's will and testament
- Training on how to use condoms
- A workshop on how the hearing impaired can protect themselves against HIV/Aids and prevent unwanted pregnancy by using condoms.

In Namibia most of the SRH services are provided by the Ministry of Health and Social services through its clinics, health centres and hospitals.

The commonest problems experienced by people with disability in accessing reproductive health services were attitudinal. Health care service providers question their need for such services, "People with disability access information in the same way as able bodied persons. No distinction is made with regard to the various forms of disability and this result, in us not having the necessary information at hand. Secondly, we are subjected to the attitude of these service providers. They do not know how to communicate with us and therefore we are not properly advised. We do not receive proper attention, when we are in need of it" (Female, FGD 3). Respondents in both FGD 2 and 3 indicated that they are subjected to various forms of questioning by service providers. "They often question the need for people with disability to have access to contraceptives, meaning they are not entitled to it, or there is no need for them to be provided with contraceptives as they are not supposed to be in any sexual relationship”. One informant was told by a health provider, “but you are not allowed to do these things—it is just a waste of condoms—these things are not for you”. One other female with disability who got pregnant was subjected to the following tirade by a nurse, “what did they do to this poor woman? Who is the cruel man that did this?” “When nurses learn that a disabled person is HIV positive, their attitude is very bad. They refuse to give them the necessary information and services or they give insufficient information. In most cases disabled people are not aware of their status because they are told this is a ‘killer disease’ and you have no business with it” (Female, FGD 3).

Some respondents indicated that only when they are assertive do they get their hands on contraceptives. One key informant from DPO summarized the challenges PWD face with regard to SRH as, “if you look at the health system the starting point should be at the community level. People with disability are in most cases regarded as people that are not entitled to a family life and are not supposed to marry or engage in sexual related activities. The thinking of society is that people with disability are sick persons and that these activities cannot be exercised by them. The end result is that this type of thinking also influences our health system, especially the mind set of service providers”.

Respondents complained that service providers often do not have a separate queue for people with disability. They must use the same line as able-bodied person, and are subjected to abuse by service provider. The view expressed by PWD is that in banks you find a queue for senior citizens, but this is not the case in hospitals, clinic, or any institution that deals with SRH services (Female, FGD 2)

Transport and distance also present challenges to people with disability in accessing SRH services, “I was on my way to the hospital. The taxi driver was not prepared to take a blind person like me because I did not know where to get off at the hospital. Furthermore, he was reluctant because he thought I did not know how to pay him. He feared that I would not pay him. Another person came to my rescue as she was also on her way to the hospital and was prepared to accompany me. The taxi driver again showed his unpreparedness as she was also partly disabled. In the end he obliged and took us to our destination” (Female FGD 3). Those that are visually impaired claimed that nurses and other service providers do not know how to interact with them when assisting them.

HIV and AIDS Education

NANASO—the umbrella civil society organization dealing with HIV/AIDS recognizes the need for HIV education to PWD. According to NANASO’s advocacy officer,

> As much as I have the right to get involved in sexual activities, the disabled person has to have the same right. The disability does not deny him/her the right to get whatever she might desire. People with disability have the right to reproduce; the right to say ‘NO’ I do not want to be pregnant and the right to say I do not want to have children. No one should have the right to say, people with disability should not do ABC. NANASO however finds itself in a very unfortunate situation – lack of resources in terms of HIV/AIDS. Consequently, the disabled are not assisted.

He elaborated on this as “the visually impaired do not have materials on HIV/AIDS (in Braille), neither are there materials specific to the deaf and those with physical disabilities. Consequently, they do not fully participate in activities of NANASO” (Key Informant 2). Despite this information people with disability are quite well informed about HIV and AIDS related issues. Respondents in both FGD 2 and 3 know about voluntary testing and counseling (VTC) and where it is located in their area. Furthermore, they are also aware that HIV is transmitted through unprotected sex intercourse, through blood transfusion, and the sharing of needles, although they were unsure if they could get infected with HIV/AIDS if they shared food with an infected person. These findings are broadly in line with those of the NDHS [21]. Knowledge of AIDS in Namibia is almost universal (99 % for both men and women age 15–49). Similarly, 84 % of women and 87 % of men mentioned condom use. Even the misconception that a person can become infected by sharing food with a person with AIDS is quite common in Namibia [21].

People with disability are aware of the availability of anti-retroviral treatment and knew about Lironga Eparu the organization for people with HIV/Aids. They knew where to get ARV's services as well as how to deal with mother-to-child-transmission. They also knew about a Centre in Katutura (the local township) that provides food to those who are on ARVs. People with disability adequately pointed to the factors that put them at risk of HIV/AIDS infection. They also added that, "others see us as having unmet sexual needs. The notion that our 'needs' need to be satisfied puts us at risk. For it means able-bodied people want to engage with us sexually, and as a human being often we play into their hands. There is also the notion that we are supposed to be HIV/AIDS free, due to the fact that people shy away from us. This attracts people that usually engage into risky sexual activity to us and we are often not in a position to negotiate the sexual terms".

Another challenge in accessing HIV information pointed to by PWD is the "buddy system". PWD are required to have a "buddy" with them. The "buddy" sometimes attends information session on their behalf and is the one given information for the disabled person. The problem is that at times the "buddy" can also abuse the person with disabilities. People with disability felt that they are not trusted and this is a drawback in seeking health assistance.

Discussion and Conclusion

The findings of this study are based on a small sample and therefore may not be generalized. It is a study designed to produce personal subjective and localized knowledge. It is also important to note that participants were asked questions on sex, sexual health and personal relationships (a very difficult issue), and despite assurances of confidentiality, they may have felt some restrictions in how they responded to the questions. Nevertheless, within the context of qualitative studies the findings of the study largely support other studies about the dynamics of people with disability and SRH issues in Africa [8, 14, 16]. The study points to the difficulties PWD find with HIV/AIDS education. People with disability face problems accessing reproductive health services because of the negative attitudes of healthcare providers. It largely confirms the literature that PWD are at great risk of physical and sexual abuse and often denied their reproductive rights. It confirms the differential treatment of PWD within families and the negative attitudes towards female PWD who fall pregnant. The study points to the many challenges faced by Namibia in ensuring the inclusion of PWD in HIV/AIDS education and programmes.

There is a need for the government, civil societal organizations to focus on the SRH of PWD if the fight against HIV/AIDS is to involve everyone. There is also need to focus on PWD in the context of HIV and sexuality if the Namibian Constitution's recognition of the inalienable human rights and freedoms of all its citizens including PWD is to be realized. One way forward is to intensively review the current status of HIV/AIDS education involving PWD. It is assumed in Namibia that the sex and sexuality education given in schools and by parents is enough to arm every citizen with the information to fight the disease but this may not apply to PWD. Namibia should also invest more in training SRH for PWD. Survey research would be needed to investigate the extent to which PWD are subjected to physical and sexual abuse and denial of reproductive rights. This is important in a cultural context where PWD are deemed incapable of sexual activities.

References

1. The Ministry of Health and Social Services (MoHSS) Sentinel Survey MoHSS Windhoek (2012)
2. Groce, N.E.: People with disabilities. In: Barry, S., Levy, B.S., Sidel, V. (eds.) Social Injustice and Public Health, pp. 145–159. Oxford University Press, Oxford (2006)
3. Namibia Statistical Agency.: Namibia 2011 Population and Housing Report NSA Windhoek (2012)
4. Lang, R.:Disability policy audit in Namibia, Swaziland, Malawi and mozambique southern african federation of the disabled Bulawayo zimbabwe (2008)
5. Government of the Republic of Namibia.: Vision 2030. Windhoek: National Planning Commission. (2004)
6. Desert Soul HDC.: Formative research on sexual reproductive health and rights amongst youth. Windhoek (2011)
7. Mufune, P.: Changing patterns of sexuality in northern Namibia: implications for the transmission of HIV/AIDS. Cult. Health Sex. **5**, 425–438 (2003)
8. Wazakili, M., Mpofu, R., Devlieger, P.: Experiences and perceptions of sexuality and HIV/AIDS among young people with physical disabilities in a South African township: a case study. Sex. Disabil. **24**, 77–88 (2006)
9. Digiulio, G.: Sexuality and people with physical or developmental disabilities: a review of key issues. Can. J. Hum. Sex. **12**(1), 53–68 (2003)
10. Anderson, P., Kitchin, R.: Disability, space and sexuality: access to family planning services. Soc. Sci. Med. **51**, 1162–1173 (2000)
11. Grant, K., Strode, A., Hannass-Hancock, J.: Disability in National Strategic Plans on HIV and AIDS A review on the national response to the interrelations of disability and HIV in Eastern and Southern Africa HEARD-University of KwaZulu-Natal) (2010)
12. Munthali, A., Mvula, P., Ali, S.: Effective HIV/AIDS and reproductive health information to people with disabilities. Center for Social Research, University of Malawi. (2004)
13. Groce, N., Yousafzai, A., van der Mass, F.: HIV/AIDS and disability: differences in HIV/AIDS knowledge between deaf and hearing people in Nigeria. Disabil. Rehabil. **29**(5), 367–371 (2007)
14. Hanass-Hancock, J.: Disability and HIV/AIDS: a systematic review of literature on Africa. J. Int. AIDS Soc. **12**, 34 (2009)
15. Rohleder, P., Braathen, S., Swartz, L., Eide, A.: HIV/AIDS and disability in Southern Africa: a review of relevant literature. Disabil. Rehabil. **31**(1), 51–59 (2009)
16. Groce, N., Trasi, R.: Rape of individuals with disability: AIDS and the folk belief of virgin cleansing. The Lancet **363**, 1663–1664 (2004)
17. Katuta, S.: Sexual behaviours and vulnerabilities to HIV: a case study of the hearing and visually impaired pupils of munali boys and munali girls high schools in Lusaka. Med. J. Zambia **38**(3), 22–35 (2011)
18. Conod, L., Servais, L.: Sexual life in subjects with intellectual disability salud pública de méxico/vol. 50, suplemento 2 de 2008 (2009)
19. Groce, N.E., Rohleder, P., Eide, A.H., MacLachlan, M., Mall, S., Swartz, L.: HIV issues and people with disabilities: a review and agenda for research. Soc. Sci. Med. (2012). doi:10.1016/j.socscimed.2012.10.024
20. WHO, 2008 Technical guidance for round 8 global fund hiv proposals: cross-cutting issues—sexual and reproductive health http://www.who.int/hiv/pub/toolkits/Sexual%20and%20reproductive%20health.pdf Accessed 5 Dec 2012
21. Ministry of Health and Social Services, Namibian Demographic and Health Survey (NDHS) MoHSS Windhoek (2007)