ORIGINAL RESEARCH ARTICLE

Perceptions of Deaf Youth about Their Vulnerability to Sexual and Reproductive Health Problems in Masvingo District, Zimbabwe

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Abstract

This article examined the perceptions of deaf youth about their vulnerability to sexual and reproductive health problems in Masvingo District of Zimbabwe. A quasi-survey was employed to carry out the field study. Therefore, a snowball sampling procedure was used to identify the respondents mainly because the target population constitutes one of the hard-to-reach groups. A sample of 50 deaf youth aged between 15 – 24 years was conveniently determined due to lack of comprehensive data of deaf population in the study area. Therefore, conclusions made in data analysis only referenced to the sampled population. Fifty questionnaires were administered among the deaf youth to collect quantitative data. Ten in-depth face-to-face interviews were carried out with deaf youth in order to qualify the magnitude of perceptions of deaf youth about their vulnerability to sexual and reproductive health problems. Sexual activity is taking place among the sampled deaf. The perceptions they had about vulnerability to sexual and reproductive health problems are mainly shaped by sexual socialization than their sensory conditions. Understanding the factors which influence the perceptions of deaf youth about sexual and reproductive health problems is significant mainly because the sexuality of people living with disabilities is poorly understood and neglected thereby putting them at risk of sexual and reproductive health problems as well as exposed to sexual violence. The study recommends that the government may adopt a human-rights approach to the provision of sexual and reproductive health services to ensure universal access information and inclusivity (*Afr J Reprod Health 2012 (Special Edition); 16[2]: 271-282).*

Résumé

Cet article a étudié des perceptions des jeunes sourds de leur vulnérabilité aux problèmes de la santé sexuelle et de reproduction dans le district de Masvingo au Zimbabwe. Nous avons mené l'étude sur le terrain à l'aide d'une quasi-enquête. En conséquence, nous nous sommes servis d'une procédure basée sur un échantillon de boule de neige pour identifier les interviewés, surtout parce que la population visée constitue un des groupes qui ne sont pas facilement atteints. Un échantillon de 50 jeunes sourds âgés de 15 à 24 ans a été facilement déterminé à cause d'un manque de données compréhensives de la population sourde de la région. Pour cette raison, les conclusions à la fin de l'analyse des données ne concernent que la population échantillonnée. Cinquante questionnaires ont été administrés auprès des jeunes sourds afin de collecter des données quantitatives. Dix interviews en profondeur ont été réalisées auprès des jeunes sourds afin de qualifier l'étendue des perceptions des jeunes sourds par rapport à leur vulnérabilité aux problèmes de santé sexuelle et de reproduction. Les activités sexuelles se produisent parmi les sourds échantillonnés. Les perceptions qu'ils ont à l'égard de la vulnérabilité aux problèmes de la sante sexuelle et de reproduction sont surtout façonnées plus par la socialisation sexuelle que par leurs conditions sensorielles. Comprendre les facteurs qui influent sur les perceptions des jeunes sourds par rapport aux problèmes de la santé sexuelle et de reproduction est significatif surtout parce que l'on comprend mal et néglige la sexualité des personnes souffrant d'un handicap, les exposant ainsi aux risques des problèmes de la sante sexuelle et de reproduction ainsi qu'à la violence sexuelle. L'étude recommande que le gouvernement adopte une approche des droits de l'homme pour la dispensation des services de la santé sexuelle et de reproduction afin d'assurer l'accès à l'information et à la diversification universelle (*Afr J Reprod Health 2012 (Special Edition); 16[2]: 271-282).*

Keywords: Disability, Deaf, Sexual and Reproductive Health, Perception, Vulnerability

Introduction

It is estimated that one tenth of world population is living with a disability and three quarters of people living with disabilities (PLWDs) - about 450 million - are said to be living in developing countries.[1] The challenges faced by people living with disabilities especially in developing countries are by and large a product of socially, medically, politically and structurally constructions than biophysical limitations. Disability is often addressed as a medical concern[2] thereby neglecting the developmental needs of PLWDs. People with disabilities had, until recent, been viewed as incapable of conceptualizing life issues and therefore regarded as dependents. In short, disability was equated with inability.[3]

In addition, the general lack of respect of human rights in most developing countries has double-edged impacts on PLWDs. Rights and needs of PLWDs are practically neglected in the provision of sexual and reproductive health services. Notwithstanding that the official discourse on the universal character of the fight against the AIDS pandemic is becoming more persistent, paradoxically there are very few prevention, care, support and HIV (and other reproductive health problems) treatment initiatives targeting PLWDs.[4]

Globally, traditional cultures used to and still view disability with contempt; condoning a culture of exclusion as well as instilling feelings of self-blame and worthless in people living with disabilities.[5] People with disabilities have experienced a mixture of attitudes ranging from persecution to tolerance due to cultural misconceptions and myths.[6] In the context of sex and sexuality, these myths and superstitions perpetrated the idea that PLWDs are incapable of initiating sexual and marital relations similar to those of non-disabled people thereby likely to be excluded – intentionally or unintentionally - from normal sexual lives which are an integral part of human reproduction and pleasure. This misconception of regarding PLWDs as asexual or less sexual is reminiscent of the idea that they do not have sexual desires and feelings. Moreover, it is a violation of sexual and reproductive health rights of people with disabilities as well as exposing them to sexual violence. The unprecedented spread of HIV and AIDS particularly in sub-Saharan Africa increased the risk of PLWDs to sexual abuse, rape and even to ritual murders by some people living with HIV in desperate search for healing of HIV and AIDS as prescribed by unscrupulous traditional and religious healers. A study by the Federation of Disability Organisations in Malawi (FEDOMA), in 2004, noted that there are also some claims and beliefs within the Malawian communities that if HIV+ people have sex with people with disabilities, they will be cured of their infection.[7]

These misconceptions and myths tend to conceal real sexual relations and practices of people living with disabilities. Previous studies[8,9,10] have confirmed that PLWDs initiate sexual relations and engage in sexual practices which are more or less similar to those of non-disabled people. A study carried out in selected districts in Malawi in 2004 showed that most people with disabilities are sexually active; with 76% reporting that they have had sexual intercourse.[11] In Cameroon, the average age of first sexual intercourse was 17 years for men and 16 years for women, with 25% of all the respondents, men and women, reporting having had this experience before the age of 15 years.[12] This reveals that PLWDs are equally or at greater risk of contracting HIV and AIDS and suffer from other reproductive health problems than non-disabled young people. Conventional knowledge showed that PLWDs are up to three times more likely to be victims of physical and sexual abuse and rape and have less access to physical, psychological and judicial interventions.[13]

The Prevalence of Disability in Zimbabwe

Reliable data are not available to determine the actual prevalence of disability in Zimbabwe due to socio-economic, political and logistical constraints. Virtually, little is known about the actual prevalence of disability in Zimbabwe due to lack of national disability censuses or surveys and also the absence of a single definition. For instance, a study noted widely contrasting estimates of the prevalence of disability carried out in Zimbabwe.[14] They noted that The 1997 Inter-

Censal Demographic Survey estimated that there were 57,232 children with disabilities while a UNICEF study, during the same year, revealed that there were 150,000 disabled children within the country – 3 times as higher as the Inter-Censal Demographic Survey.

However, data available show an increasing proportion of people living with disabilities in Zimbabwe. In 1997, there were about 218 421 people with disabilities in Zimbabwe.[15] In 2007, it was estimated that there were approximately 1.4 million disabled people in Zimbabwe.[16] The percentage of PLWDs also significantly increased from 2% to 10% during the same period. The causes of this increase are not clear but the impact of HIV and AIDS on disability must not be over-emphasised. Although it is controversial and subjective, some scholars suggest that people infected by HIV and AIDS and those who are terminally ill because of any other causes are classified as disabled.[17] UNICEF echoed this suggestion and argued that pregnant mothers infected by HIV/AIDS are at risk of giving birth to children with disabilities.[18]

Determinants of Vulnerability of People Living With Disabilities to Sexual and Reproductive Health Problems in Zimbabwe

Misconceptions about the aetiology of disability

Generally, misconceptions about the aetiology of disability in Zimbabwe are based on traditional myths, taboo systems, superstitions and religious beliefs which link disability with witchcraft, angry ancestral spirits (*midzimu*) and avenging spirits (*ngozi*).[19] this world view hypothesises disability as a by-product of an asocial or immoral behaviour and therefore conceives superficial but prejudicial images about disability. Although people cannot openly express their feelings overtly, verbally or non-verbally, there is a taboo still existing in traditional Shona culture which encourages a pregnant woman to avoid looking at unpleasant sights, anything grotesque or people with deformities because the desire is for the infant to look like a known person with good character or some admirable physical appearance.[20] Practically, the society has prejudice attitudes which perpetrate feelings of dependence or anxiety among PLWDs. People living with disabilities are over-protected, neglected and even ignored thereby denying them their rights to determine their destinies and to pursue their aspirations.[21] These societal attitudes have reduced the confidence of PLWDs to enter into sexual relations since their movements are restricted by the societies in which they are living.

The sexuality of people with disabilities is poorly understood and often not recognized or discussed by society and family members, and therefore people with disabilities are not commonly regarded as a community that is vulnerable to HIV or affected by AIDS.[22] Even in marital unions, their sexual and reproductive health rights are likely to be neglected and ignored. In Zimbabwe, people with physical and mental disabilities do not command respect in society because some communities shunned them as outcasts.[23]

Low Levels of Education

Despite significant and notable strides Zimbabwe has made in education since 1980, receiving kudos for the highest literacy rate in sub-Saharan Africa, Special Education has not been high on the list of governmental priorities.[24] A study conducted by The Foundation for Scientific and Technical Research (Norway) in 2003 revealed that 36% of disabled people in Zimbabwe had some primary schooling and 32% had some education beyond primary level.[25] These exceptional low levels of literacy worsen challenges of unavailability and inaccessibility of reproductive health information to PLWDs. This is because illiteracy is intimately associated with poverty while poverty exacerbates the vicious cycle of ignorance.

Socio-economic Status

People with disabilities are much less likely to engage in formal economic activities than the rest of the population in Zimbabwe.[26] Due to miserable low levels of literacy among PLWDs, formal employment opportunities are nearly absent. In towns and cities of Zimbabwe, people with disabilities are disproportionately represented among beggars and street-dwellers. Therefore, the manifest of poverty among disabled people in

Zimbabwe makes them one of the most vulnerable and disadvantaged groups in the society. About 78% of respondents agreed that disability is related to poverty.[27]

The pathetic economic situation of people with disabilities is also a by-product of marginalisation and even absence of disability issues in government economic policies. While the provisions of the Disabled Persons Act [Chap. 17; 1996] prohibit the discrimination and marginalisation of PLWDs in employment, it remains a dream rather than a reality because disability issues do not feature in national policies as such and are labelled as 'charity'. There is lack of an inclusive developmental approach insofar as disability issues are concerned. Studies have shown that poverty, *per se*, is inextricably related to risky sexual behaviour.[28] In other words, disabled people, especially women, are either more likely to engage in risky sexual behaviour in order to earn a living or are exploited due to their economic marginality.

Policy Framework

The policy environment does not sensitize disability in sexual and reproductive health education and communication programmes due to lack of disability-friendly services and facilities. People with disabilities are invisible because generally the Zimbabwe's social amenities have not been structured in a way that is inclusive for people with disabilities.[29] Disabled people are discriminated physically, socially and economically in most of the programmes. In the case of deaf people, there is no legal provision which obligates health providers to ensure that the message is communicated using sign language. Practically, all reproductive health facilities and health centre do not have at least one staff member who can use sign language. Disability has not been put on the national agenda as part of development planning and is viewed largely as a social welfare issue.[30] This has vicarious effects on ensuring availability and accessibility of sexual and reproductive health information among people with disabilities. The Zimbabwean government neither recognizes nor prioritises disability in educational planning. In the education system, there is more integration than inclusion; where the former means that the child must make adjustments to the requirements of the school while the latter refers as to that the school must make adjustments to accommodate or include the child.[31] Moreover, mission stations and other church-based organisations are at the forefront in providing basic needs and services to people with disabilities but more driven by humanitarian concerns than by the develop-mental needs of such children. For instance, the provision of education among the deaf has been largely left to mission stations which are adamantly against the idea of discussing sex and sexuality open with young people due to their religious beliefs. Thus, the exposure of deaf youth to comprehensive information about human sexuality and reproduction is fragmentary.

Personal Limitations

There are inherent sources of vulnerability inextricably related to physically, mentally or sensory dysfunctional. Inherent bio-psychosocial factors of disability also contribute to sexual vulnerability in addition to stigmatization and discrimination.[32] PLWDs lack access to information about sexual and reproductive health due to mobility and sensory dysfunctional constraints. The main media used in Zimbabwe to disseminate the information are not sensitive particularly to those with sensory dysfunctional disabilities. The programming of youth sexual and reproductive health activities largely revolves around the emphasis on using peer-interactive methods such as dramas, music, poetry and peer groups which are not practically compatible with the challenges the youth living with sensory dysfunctional disabilities face during their day-to-day interactions in their attempts to mix and socialize with their non-disabled counterparts. Apart from print medium, non-governmental organizations, government agencies and other stakeholders in Zimbabwe disseminate the information using the auditory medium which is not easily accessible to deaf people. In addition, Zimbabwe has one state-run television station which is poorly equipped and facing acute shortage of staff who can communicate in sign

language and script writers. Virtually, all talk show programmes about sexual and reproductive health education are not readily translated into sign language and even subtitles are not shown.

Analytical Framework

The article adapted the social model of disability in
attempting to understand the perceptions of deaf youth about their vulnerability to sexual and reproductive health problems. It proceeded from the major argument of the model which postulates that disability is a loss or limitation of opportunity brought about by social and physical barriers and, therefore, appropriate solutions are the transformation of policies, laws, and societal attitudes.[33] This study argues that the vulnerability context of deaf youth to sexual and reproductive health problems is influenced by the background factors (socio-economic environment, political context, societal beliefs and norms) and proximate factors (demographic factors as well as psychosocial and physical factors) (Figure 1). Processes and structures are indispensable elements of the framework. This is mainly because, on one hand, societal, political and economic factors operate through processes and structures to influence the vulnerability context of deaf youth while on the other hand demographic, psychosocial and physical factors are a manifestation of processes and structures. In other words, national policies and the macroeconomic environment have a direct bearing on socialization and integration of people living with disabilities into the mainstream society and ultimately affect the mental and psychological development of deaf youth.

Societies had invariably engendered beliefs, perceptions and attitudes towards PLWDs and also in the general population. These influence how people with disabilities view themselves, their potentials, needs and limitations. People with impairments are disabled by the fact that they are excluded from participation within the mainstream society as a result of physical, organizational and attitudinal barriers which prevent them from gaining equal access to information, education, employment, public transport, housing and social/recreational opportunities.[34]

In the context of sexual and reproductive health, the perceptions deaf youth have about their vulnerability to sexual and reproductive health problems are much to do with lack of aspirations in life due to limited opportunities and poor socialization which entrenches a sense of purity and passionless. Societal prejudices and attitudes towards the deaf inculcate feelings of dependence and low self esteem. People with disabilities are often referred to as 'Children of God' (*sic*) who do not engage in sex.[35]

Aim and Objectives of the Study

The article aimed at investigating perceptions of deaf youth about their vulnerability to sexual and reproductive health problems in Masvingo District. The study was guided by the following objectives:

- To assess sexual experiences of deaf youth;
- To investigate the sources and dimensions of knowledge of deaf youth about sexual and reproductive health problems;
- To understand the linkage between deaf youth's perceptions and vulnerability to sexual and reproductive health issues; and
- To make recommendations for policymakers.

Justification of the Study

People living with disabilities constitute one of the most vulnerable groups to sexual and reproductive health problems, yet little attention is given to disability issues in sexual and reproductive health programmes in most regions of the developing world including Zimbabwe. Investigating into sexual and reproductive issues PLWDs face is essentially for a number of reasons. Firstly, most of the studies focused particularly on the knowledge and attitudes of disabled people towards HIV and AIDS,[36,37] yet their perceptions about vulnerability to other reproductive health problems is little known or unknown. Secondly, it is important to understand the problems they face from their own perspective because they are generally ignorant of basic facts about themselves, their bodies, and their rights to define what they do

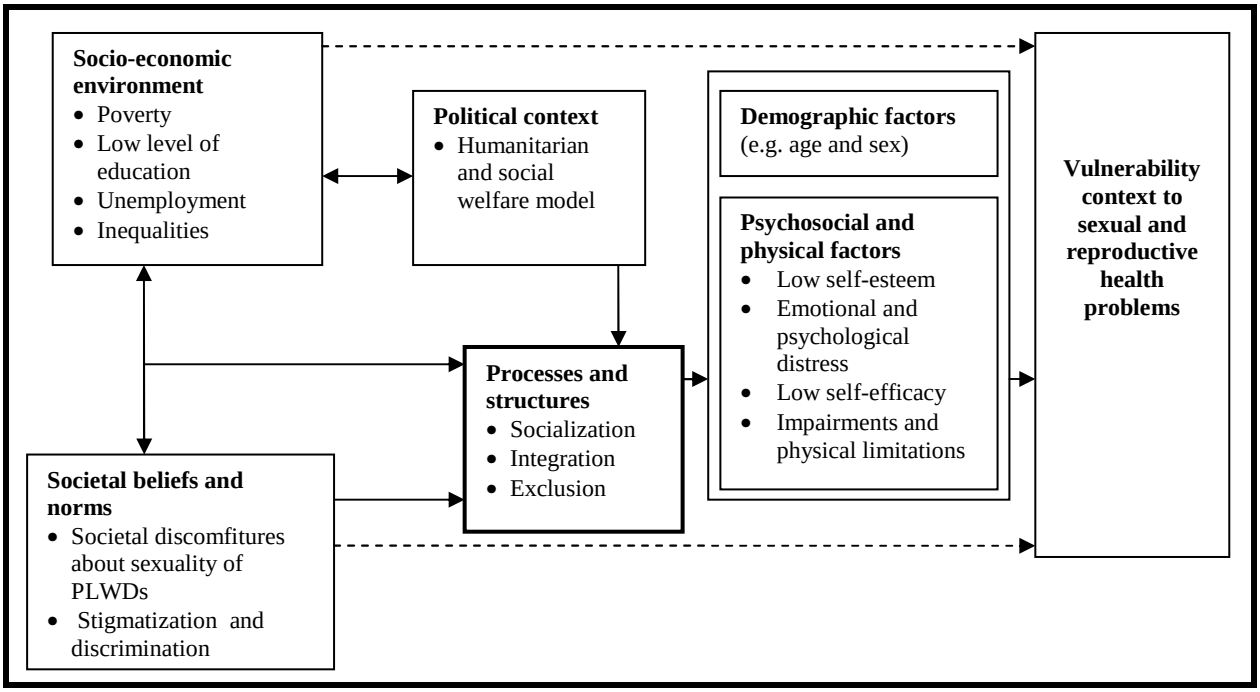

Figure 1: Factors which influence the vulnerability context of deaf youth to sexual and reproductive health problems

and do not want.[38] This should assist programme managers to sensitise disability issues in sexual and reproductive health programmes. Third, given that deaf youth are sexual active and wish to enter into sexual relationships and start families, it is imperative to explore how they understand circumstances which might lead to the formation of sexual relations.

Methodology

Study Design

A quasi-survey was employed to carry out the field study mainly because the target population was not easily identifiable. Quantitative and qualitative methods were triangulated to collect data. The sample was conveniently determined due to lack of comprehensive data on deaf population in the study area and in Zimbabwe, in general. Therefore, conclusions made in data analysis only referenced to the sampled population. A purposive sampling procedure was applied in identifying the deaf youth. Permission to conduct the fieldwork was sought from the responsible authorities that is, District Education Officer, community leaders and ward councillors. Informed consent was sought first from parents or guardians of deaf youth before the administering of questionnaires or conducting in-depth interviews.

Target Population

In accordance with the UNFPA definition of youth, the
study targeted the deaf youth aged 15-24 years in Masvingo District.[39] In this study, deafness is defined as profound or complete loss of the ability to hear from both ears. This excludes the youth with mild to moderate hearing loss. It is imperative because those with profound or complete hearing loss are nearly always or always alone due to communication barriers and they usually make friends among themselves if they allowed to playing outside the home. They exclusively use sign language which is not used by the general population.

Sample Size and Sampling Procedures

A sample size of fifty deaf youth was determined. A purposive sampling procedure was employed mainly because this group constitutes one of the hard-to-reach or hidden groups.[40] Respondents were identified through the application of the "snowball" sampling procedure. Identified deaf youth were asked whether they knew a deaf youth in the local area. Respondents were also identified in schools and other institutions for the deaf.

Data Collection Methods and Instruments

Data for the study was collected using questionnaires and in-depth face-to-face interviews carried out with deaf youth. It is important to point out that the data was exclusively collected from deaf youth because the aim of the study was to understand the perceptions of deaf youth about their vulnerability to sexual and reproductive health problems.

Questionnaires

Fifty questionnaires were distributed to deaf youth to collect quantitative data. Questionnaires sought to collect data on the following broad themes: socio-demographic characteristics of respondents; risk behaviour and sexual experiences; sources and knowledge of sexual and reproductive health information and perception about vulnerability to sexual and reproductive health problems. The term "sex" was specifically used to refer to the penile penetration of the vagina. A research assistant, proficient in sign language was recruited to administer questionnaires.

In-depth interviews

A total of 10 in-depth face-to-face interviews were conducted with the deaf youth in order to qualify the magnitude of perceptions of deaf youth about their vulnerability to sexual and reproductive health problems. An interview guide was prepared containing open-end questions which sought information about the linkage between deaf youth's perceptions and vulnerability to sexual and reproductive health issues. The 10 interviewees were purposively selected and were those which the research assistant created a good rapport with during the administration of questionnaires.

Results

Socio-demographic Characteristics of Respondents

About 63% were males while females constituted 37% of the respondents. A summary of age distributions showed that 53% of respondents were in the 15-19 years age cohort while 47% were aged between 20-24 years. Table 1 shows exact age percentage distribution of respondents and the majority of the deaf youth were aged 17 years while the minority were aged 23, constituting 20% and 3% of the respondents, respectively. The mean age was 19 years. All the deaf youth who participated in this study were unmarried. The level of education refers to the highest level of education attained but not necessarily completed. The study noted that the highest level of education attained by all respondents was primary education. About 97% were student and 3% were self-employed. All respondents reported that they watched television. About 93% of deaf youth said they read newspapers and magazines while 7% did not read.

Table 1: Age Distribution of Respondents

Age	Percentage (%)
16	10
17	20
18	13.3
19	10
20	16.7
21	10
22	10
23	3.3
24	6.7

N = 50

Risk Behaviour and Sexual Experiences

Almost one quarter (23%) of deaf youth drank alcoholic drinks while 10% reported that they smoked. About 77% had either a boyfriend or girlfriend. The study noted that 79% of the males had a girlfriend while 73% of deaf youth females

reported that they had a boyfriend. About 40% had ever had sex and 60% did not yet initiate sexual intercourse. As shown in Table 2, more males (42%) had ever had sex than females (36%). Of the youth who reported that they had ever had sex, the earliest sexual debut was 14 years for males and 15 years among females. About 42% had sex before the age of 16 and all had sex before the age of 18. The mean age at first sex was 15.8 years. Among those who had ever had sex 50% reported that they had sex with a school mate, 42% with either a boy/girlfriend and 8% with a stranger. Overall, 42% of sampled deaf youth mentioned that they had sex to experiment, 25% need experience, 25% feeling grown up and 8% to get pregnant or impregnate. However, there are gender differentials on the reasons for having sexual intercourse (Table 3). For example, more females (75%) cited the need to experiment as the one of the reasons they had sexual intercourse compared to 25% of their male counterparts. About 38% of male respondents mentioned the need for experience while no female reported the need to get experience. The study noted that about 67% of the youth reported that they or sex partner did not use a condom the last time they had sex while 33% mentioned that they or sex partner did so. However, more males (37%) were more likely to mention that they or sex partner used a condom the last time they had sex than females (25%) (Table 4). About 36% of female respondents reported that they had been sexually touched by a boy or man without their consent and 5% of male respondents had sexually touched a girl without her consent. It is interes ting to note that all deaf youth who participated in this study mentioned that they are looking forward to get married.

Table 2: Ever had Sex by Gender

Did you ever have sex?	Gender		
	Male	Female	Total
Yes	42.1%	36.4%	40%
No	57.9%	63.6%	60%
Total	100%	100%%	100%

N = 50

Table 3: Reasons for having sex by gender

Reasons for having sexual intercourse	Gender		Total
	Male	Female	
Experiment	25%	75%	41.7%
Need experience	37.5%	0%	25%
Feeling grown up	25%	25%	25%
To get pregnant or impregnate	12.5%	0%	8.3%
Total	100%	100%	100%

N = 50

Table 4: Condom Use in the Last Sexual Intercourse

Did you or your sex partner use a condom the last time you had sex?	Gender		Total
	Male	Female	
Yes	37.5%	25%	33.3%
No	62.5%	75%	66.7%
Total	100%	100%	100%

N = 50

Sources and Knowledge of Sexual and Reproductive Health Information

The study noted that 87% of deaf youth had ever had heard about contraceptives and 13% mentioned that they did not. Among those who mentioned that they knew about contraceptives, 59% knew a condom, 37% the pill and 4% injectables. About 83% of respondents had received HIV and AIDS education. Of those who received HIV and AIDS education, 84% received the education in school, 8% at a workshop and 8% at home. The study revealed that 83% of the respondents read about HIV and AIDS in a newspaper or magazine. Nearly three quarters (73%) reported that they had watched a programme about HIV and AIDS on the television either communicated in sign language or showing subtitles.

Perceptions about Vulnerability to Sexual and Reproductive Health

Table 5 presents the problems which deaf youth fear can happen to them if they had sex before marriage. Nearly half (47%) feared HIV and

AIDS, 20% unwanted pregnancy, 20% rejection, 3% not marriageable and 10% nothing. An analysis by gender revealed gender inequalities with regards to perceptions about the problems of premarital sex. About 68% of males feared HIV and AIDS compared to 9% of female respondents. However, more females vis-à-vis males feared problems which they know they would assume more responsibility and which would attract stigma. For example, 36% of females compared to 11% of males feared unwanted pregnancy and 46% and 5% feared rejection, respectively. About 9% of the female respondents feared that they would not be marriageable while no male respondents mentioned as such. A female aged 21 years said. "*If my boyfriend rejects me after having sex I will not find another who will marry me*. It is interesting to note that 10% of male respondents feared nothing.

Table 5: Problems of Premarital Sex Feared by Deaf Youth by Gender

What problems do you fear can happen to you if you have sex before you are married?	Gender		Total
	Male	Female	
HIV and AIDS	68.4%	9.1%	46.7%
Unwanted pregnancy	10.5%	36.4%	20%
Rejection	5.3%	45.5%	20%
Not marriageable	0%	9.1%	3.3%
Nothing	15.8%	0%	10%
Total	100%	100%	100%

N = 50

Fifty eight percent of the respondents mentioned that if they agreed to have sex there would be issues they would want to talk with the sex partner before sex while forty two percent said that they did not have anything they would like to talk about. Among those who said they had issues they would want to talk, most of them mentioned that they would like to talk about using a condom in order to protect each other from HIV and AIDS and unwanted pregnancy. It is interesting to note that some male respondents were worried about whether the sex partner had either a baby or another lover. One male aged 17 years reinforced this argument by saying; "*I want to know first whether I am the only lover because I can't share a woman with others*".

Deaf females were asked whether there is something they would do if raped. About 64% of respondents mentioned that they would do something while 36% said they would do nothing. Of those who would do something, they mentioned that they would report to the police (17%) and tell mother (50%) or a friend (33%). Those who would do nothing mentioned that they would be afraid to report or feel shy to tell someone. One girl aged 18 years remarked, "*I will not tell anyone because I will be shy to play with my friends when they know that is what happened to me*". Deaf youth were asked about whether a woman can get pregnant or a man can impregnate a woman when he or she has sex for the first time. As shown in Figure 2, 63% of deaf youth professed ignorance about whether a woman can get pregnant or a man impregnate a woman for the first time they had sex, 13% disagreed, 13% agreed, 8% strongly agreed and 4% strongly disagreed. About 25% of the respondents perceived that they could tell that a person has HIV by looking while 75% mentioned that it is impossible.

Discussion

Traditional societies worldwide had long tried to suppress the sexuality of the youth in general by way of stigmatizing, monitoring and even physically punishing those who showed an interest in expressing their sexual desire. Sex was to be enjoyed in marriage and any desire to express it outside cultural appropriate marital unions invited ridicule and discomfiture. Sexual life was considered sacred and sexual pleasure important.[41] However, with secularization of many cultures due to modernity and, recently, globalization many youth are now entering into sexual relationships before marriage. The study revealed that sexual activity is taking place among the sampled deaf youth. A study in Cameroon also noted that 80% of the deaf were sexual active.[42] Deaf youth who mentioned that they had ever had sex initiated sexual intercourse earlier while they are still looking to get married. Some had initiated sex as earlier as 14 years. In Malawi, 14% of PLWDs

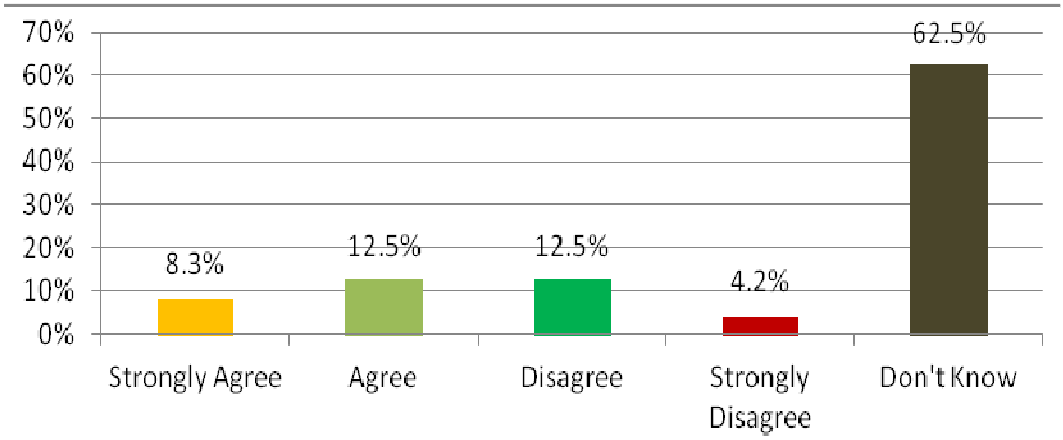

Figure 2: Perceptions about whether it is impossible for a Woman to get Pregnant during first sexual intercourse (N=50)

were sexual active by the age of 15 years.[43] Despite reluctance of the mainstream society to acknowledge that PLWDS are also having sex and looking forward to get married, of the deaf who mentioned that they had ever had sex all became sexual active before the age of 18 years. They are engaging in sexual practices mainly stimulated by psychosocial and physical needs. They enter into sexual relationships mainly driven by the desire to experiment, emotional attachment and curiosity, among other reasons.

Societal norms and expectations are profoundly shaping the perceptions of deaf youth about their vulnerability to sexual and reproductive health problems than their sensory conditions. The perceptions and fears of reproductive health problems vary by gender. Female respondents were much concerned with problems which they knew that they would assume more responsibilities (for example, unwanted pregnancy) and those which had undesirable psychological implications such as rejection and not marriageable. In traditional African culture, for a girl, virginity is a virtue, a source of pride and honour and an idyllic quality of being marriageable. The concern showed by some deaf males to first know whether the girl does not have a baby before having sex is embedded in African culture. It brings debasing labels and loss of pride to marry a woman with her own child because premarital sex of women is seriously condemned. It is not biology, but gender differences in sexual socialization that are more important in influencing who women and men partner, when and in which circumstances.[44]

Moreover, the ignorance professed by these sampled deaf youth about sexuality and the implications of cultural constructed gender inequalities is a source of concern. Sexual violence and rape have implications not only during an epidemic of a sexually transmitted disease but also to all sexual and reproductive health issues.[45] More than one third of deaf youth females who participated in this study mentioned that they would not report if they would be raped because they would be shy or afraid. This revealed excessive sexual socialization these deaf youth females received which synonym abstinence with silence and also attempts to suppress the sexuality of PLWDs. Even if they know the implications of such risk behaviour they would not feel empowered to talk about it because they feel that no one would listen.

Conclusion

This study noted that the perceptions about vulnerability to sexual and reproductive health problems among the participant deaf youth are inextricably linked to sexual socialization rather than their sensory dysfunctional. Differentials in fears about the undesired consequences of premarital sex between males and females reflected "gendered sexual socialization".[46] The most striking feature about their sexual patterns is that they are not motivated by expectations of an economic benefit such as cash or gifts. The

majority of the sampled deaf youth are forming sexual relations among themselves. The vulnerability of these youth to sexual and reproductive health problems interfaces physiological and psychological factors. This is associated with the desire to explore sexual pleasure stimulated by the excitement of growing up.

Recommendations

- The government may adopt a human-rights approach to the provision of sexual and reproductive health services to ensure universal access information and inclusivity. This may include disseminating of information in media which are accessible to deaf people.
- The government and non-governmental organizations must sensitise sexuality of people with disabilities in sexual and reproductive health education in order to change misconceptions and negative attitudes the society holds towards the sexuality of people with disabilities.
- There is need to scale-up sexual and reproductive health programmes by ensuring that the needs of PLWDs and the deaf in particular are included in prevention, care and support initiatives. This will help to improve safer sex by promoting use of condoms and provision of information about the risks of unsafe sex.
- Governmental and non-governmental organizations may improve their programmes by including people living with disabilities from formulation to evaluation of programmes.

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