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Review Article

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Gender, HIV/AIDS and Disability as Cross-Cutting Issues in Ethiopia

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Abstract

Background: *Gender refers the socially given attributes, roles, activities, responsibilities and needs connected to being men (masculine) and women (feminine) in a given society at a given time, and as a member of a specific community within specific society, while HIV is a virus that attacks immune cells called CD4 cells. Notably, disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on equal basis with others. However, the relationship between HIV and disability has not received due attention. Therefore, this study aims to analyze the cross cutting issues of gender, HIV/AIDS and disability in Ethiopia.*

Methods: *All relevant and available documents addressed in related with gender, HIV/AIDS and disability. In the review, the obtained quantitative and qualitative data was comprehensively and comparatively analyzed using documenting analysis.*

Results and Conclusion: *Gender inequity and inequality is a pervasive problem in Ethiopia. Still now a day, women in Ethiopia occupy low status in the society. Gender based discrimination, lack of protection of basic human rights, education and training, basic health services and employment are widespread throughout Ethiopia. The HIV/AIDS epidemic remains one of the public health challenges in Ethiopia since it was first recognized in the mid-1980s. The HIV is a life-changing illness; a person can live a long and full live with it. People transmit HIV in their bodily fluids, including: blood, semen, vaginal secretions, anal fluids and breast milk. Women represent almost half of the 40 million people worldwide living with HIV. Due to women's greater physiological, socio-cultural and economic susceptibility to HIV infection, it is likely that the proportion of female adults and young women living with HIV will continue to rise in many regions of the world. It is estimated that 1 billion people (15% of the world's population) have a disability. Therefore, gender and disability as cross-cutting issues in the response to HIV also calls for broader social, cultural and economic development which is person centered and disability-inclusive to addresses the unique barriers that face people with disabilities in particular women and people living with HIV.*

Keywords: Gender, HIV/AIDS, Disability, Cross- Cutting, Meta-Analysis

Background

Principally, gender refers to social attributes that are learned or acquired during socialisation as a member of given community. Because this attributes are learned behaviours, they can and do change over time and, different from one society to another, across culture and from place to place (with increasing rapidly as the rate of technological change intensifies). Gender identity in a given society governs the allocation of resources, tasks and power at the level of the individual, household and society. Hence, we should be able to understand and be sensitive to the existing gender relationships in a given society and act or plan and design our interventions. If we want equal positive results for all, we have to make a difference in how we approach the different groups of people co-existing in the community. This is due to the fact that the starting positions of men and women different. It is true that in all societies, social factors underlie and support gender based disparities. Globally, the number of orphans due to AIDS shot up from 11.5 million in 2001 to 15 million in 2003. HIV/AIDS is particularly catastrophic because it generally kills both parents. SSA is home to an estimated 12.3 million children who have lost one or both parents to HIV/AIDS.

In 11 of the 43 countries in the region, at least 15 percent of children are orphans. In 5 of those 11 countries, HIV/AIDS is the cause of parental death more than 50 per cent of the time. By 2010, more

than 18 million children in the region will have lost one or both parents to the disease [1]. HIV pandemic has adversely affected the pace of human development in many countries in Sub-Saharan Africa (SSA). At the national level, the Government of Ethiopia has made tremendous progress towards reducing overall HIV prevalence to 2.5 percent by 2015. In fact, recent data indicates that in 2010, the country's HIV prevalence rate fell to 2.7 percent and is expected to reach one percent by 2015. However, HIV/AIDS prevalence among mothers in reproductive ages (15-45) increased from 0.9 percent in 1990 to 8.6 percent in 2005 before slowing down to 5.6 percent in 2007. The MDG target seeks to reduce HIV prevalence rates to less than 4.5 percent by 2015, and significant progress has since been made to achieve this target. The government has increased facilities providing HIV counseling and testing (HCT), Prevention of Mother to Child Transmission (PMTCT) and Anti-Retroviral Treatment (ART) to 1,469, 877, and 420 facilities in 2009 from 525, 877 and 32 facilities for HCT, PMTCT, and ART in 2005, respectively [2]. An estimated 650 million people, or 10% of the world's population, have a disability [3]. The relationship between HIV and disability has not received due attention, although persons with disabilities are found among all key populations at higher risk of exposure to HIV. People living with HIV may develop impairments as the disease progresses and may be considered to have a disability when social, economic, and political or other barriers hinder their full and effective participation in society on an equal basis with others [4]. In one study girls with motor and hearing impairment have inconsiderateness and discouragement on the part of teachers to be serious constraints [5].

Studies show that disabled individuals face discrimination in employment. The magnitude is severer for women. Similarly, once employed the opportunity for promotion, further training and other privileges were found to be scarcer for female disabled than male disabled. Several studies show that disabled women are exposed to several forms of violence: physical, sexual violence, psychological as well as various forms of hard labor [5]. In a national baseline survey undertaken in 1995, among the 5085 households was administered 14.7% had persons with disabilities. Most of the disabled persons fell under: impaired vision (30.4%), mobility disorder (30.9%), and chronic health problems such as epilepsy and leprosy (10.3%). Close to 40% were women. A study conducted in six regions of Ethiopia on girls who have visual and hearing disability and mental retardation showed, visually and hearing impaired girls do not have early childhood educational experiences [6].

Objectives

- The Rationale for Considering Gender: Why gender makes difference?
- Seriousness of the HIV/AIDS problem? Causes? Prevalence? Consequences? Challenges of people living with HIV/AIDS especially women and disable individuals?
- Disability and Special Needs: Disability and impairment? Causes? Types? Consequences / Challenges?
- The relationship between Gender issues, HIV/AIDS and Disability issues in real context of Ethiopia

Materials and Methods

All relevant and available documents addressed in related with gender, HIV/AIDS and disability were identified and document review was undertaken. The main sources considered in the document search were books and journals. In the review, the obtained qualitative data was comprehensively and comparatively analyzed using documenting analysis. The reviewer highly recognized the sources which are applied in all contents of the analysis and paraphrase all the literatures used in the systematic review and comprehensive analysis of gender issues, HIV/AIDS and Disability on their causes, prevalence's and challenges in discourse of gender studies, HIV/AIDS and special needs education across different times in the world.

Results and Discussion

The Basics of Gender Issue

The word gender is often used these days by different people all over the world. However, there is some problem in understanding what does it really mean. The conceptual distinction between sex and gender is that ***sex*** refers to the biological differences (chromosomes, external and internal genitalia, hormonal state and secondary sex characteristics) between men and women, which are universal and do not change. Gender therefore refers to the socially given attributes, roles, activities, responsibilities and needs connected to being men (masculine) and women (feminine) in a given society at a given time, and as a member of a specific community within specific society. Gender identity determines how women and men are perceived and how they are expected to think and act as men and women. Sometimes there is a tendency to refer to women when dealing with gender without looking at their relationships with their male counterpart. Many mistakes the difference among the gender groups as if not brought about by socio-cultural factors, and consider it as a natural phenomenon. We should therefore take care not to consider gender as to women, but to the relationship between women and men.

The Rationale for Considering Gender: Why gender makes difference?

Gender identity in a given society governs the allocation of resources, tasks and power at the level of the individual, household and society. Hence, we should be able to understand /and be sensitive to the existing gender relationships in a given society and act /plan and design our interventions. If we want equal positive results for all, we have to make a difference in how we approach the different groups of people co-existing in the community. This is due to the fact that the starting positions of men and women different. It is true that in all societies, social factors underlie and support gender based disparities through institutional arrangements, legal systems, socio-cultural attitudes and religious practices. Such differences between men and women should therefore, be part of the baseline situation to plan for development interventions.

The **two basic reasons** to deal with gender issues can be seen from two perspectives.

a) The instrumental argument- to reach at basic objectives in development interventions, it is important to look at the gender

differences in a given community. E.g. if a project deals with improved milk processing &marketing, it definitely should consult women because they are more responsible for this activity.

b) The fairness argument- some development interventions might achieve their goals without taking gender in to account, but since women are not in equal position with male counterpart and the intervention even might worsen the situation of women, and hence women problems need attention to benefit the community as a whole.

Still now a day, women in Ethiopia occupy low status in the society. In spite of their contributions to the well-being of their family and community affairs, women experience lower socio-economic status and hence is marginalized from decision making processes at all levels. They are facing multiple forms of deprivation. However, gender based discrimination, lack of protection of basic human rights, violence, lack of access to productive resources, education and training, basic health services, and employment are widespread throughout the world: the same is true in Ethiopia [7].

Principally, girls' enrolment in education at all levels is much lower than boys. Male's literacy rate is 49.9 % while that of female is 26.6 % [8]. The illiteracy rate among young women (15-24) is higher than among men. Out of the adults enrolled in adult and non-formal education program run by government and non-governmental organizations in Tigray and Oromia Regions, women constitute 30.9 % only. The GER of female at primary and secondary levels in the academic year 2004-2005 were 67.6 and 17.9 percent respectively, while male's GER in the same levels were 80.4 and 28.3 percent respectively.

In similar manner, female education is hampered mainly by sexual division of labor, which confines girls to household activities, early marriage, and the un-favorable societal attitude towards the education of girls and by the restriction on their physical movements in relation to the distance of the school from their homes. Parents particularly the resource poor would rather invest in their sons, because boys are perceived as bread winners and support for old parents, while girls are preferably employed at the household [7].

Additionally, poverty reinforced by cultural attitudes and practices cause high rate of girl dropouts or non-enrolment, early marriage mainly for economic reasons or forced to engage in commercial sex work. Lack of education and harmful traditional practices (HTPs) including early marriage, abduction, and large family size, are factors affecting women's economic situation, and poverty is a serious impediment to progress in all sectors [9]. The Ministry of Women's Affairs (MoWA) was also established in October 2005 and got its force by proclamation No. 471/2005. The ministry is entrusted with the responsibility of initiating recommendations on the protection of the rights and interest of women at national level and follow-up their implementation; ensuring the gender sensitivity of policies, legislations development programs of the federal government; ensuring the creation of that opportunities for women to take part in development process; identifying discriminatory practices that affect women; submitting recommendations on the application of affirmative measures; ensuring that adequate attention is given to place women to decision-making positions in various government organs (Proc. No. 471/2005) [10].

Definition and Concepts of HIV/AIDS

HIV stands for human immunodeficiency virus, which is the virus that causes HIV infection. The abbreviation "HIV" can refer to the virus or to HIV infection. AIDS stands for acquired immunodeficiency syndrome. AIDS is the most advanced stage of HIV infection. HIV attacks and destroys the infection-fighting CD4 cells of the immune system. The loss of CD4 cells makes it difficult for the body to fight infections and certain cancers. Without treatment, HIV can gradually destroy the immune system and advance to AIDS [11].

"*While HIV is a life-changing illness, a person can live a long and full live with it".*

Human immunodeficiency virus (HIV) is a virus that attacks immune cells called CD4 cells, which are a type of T cell. These are white blood cells that move around the body, detecting faults and anomalies in cells as well as infections. When HIV targets and infiltrates these cells, it reduces the body's ability to combat other diseases [12]. HIV is the virus that causes HIV infection. AIDS is the most advanced stage of HIV infection. HIV is spread through contact with the blood, semen, pre-seminal fluid, rectal fluids, vaginal fluids, or breast milk of a person with HIV. In the United States, HIV is spread mainly by having anal or vaginal sex or sharing injection drug equipment, such as needles, with a person who has HIV [11].

Causes

People transmit HIV in bodily fluids, including: Blood, semen, vaginal secretions, anal fluids and breast milk. In the United States, the main causes of this transfer of fluids are: anal or vaginal intercourse with a person who has HIV while not using a condom or PrEP, a preventive HIV medication for people at high risk of infection, sharing equipment for injectable illicit drugs, hormones, and steroids with a person who has HIV. A woman living with HIV who is pregnant or has recently given birth might transfer the disease to her child during pregnancy, childbirth, or breastfeeding. The risk of HIV transmitting through blood transfusions is extremely low in countries that have effective screening procedures in place for blood donations [12].

How is HIV spread?

HIV is spread through contact with certain body fluids from a person with HIV. These body fluids include: Blood, semen, pre-seminal fluid, vaginal fluids, rectal fluids, breast milk. The spread of HIV from person to person is called HIV transmission. The spread of HIV from a woman with HIV to her child during pregnancy, childbirth, or breastfeeding is called mother-to-child transmission of HIV. In the United States, HIV is spread mainly by having anal or vaginal sex

with someone who has HIV without using a condom or taking medicines to prevent or treat HIV sharing injection drug equipment ("works"), such as needles, with someone who has HIV [11].

Prevalence and Extent of HIV/AIDS

HIV prevalence among women and men aged 15-49 in Ethiopia is 0.9 percent. HIV prevalence is higher among women than men [13]. The HIV epidemic in Ethiopia is heterogeneous by sex, geographic areas and population groups. Among women and men combined, HIV prevalence is seven times higher in urban areas than in rural areas (2.9 percent versus 0.4 percent). HIV prevalence is 3.6 percent among women in urban areas compared with 0.6 percent among women in rural areas. Seven out of the nine regional states and two city administrations have HIV prevalence above 1 percent. Looking at HIV prevalence by region, it is highest in Gambella (4.8 %), followed by Addis Ababa (3.4%), Dire Dawa (2.5%), and Harari (2.4%).

In 2017, there were an estimated 613,000 people living with HIV, of whom 62 percent female, in Ethiopia. Notwithstanding the different prevalence rates in the regions, is important to look at the absolute number of PLHIV per region as population size differs from one region to the other. Three fourths (74%) of PLHIV are from Amhara, Oromia and Addis Ababa. Forty-nine percent of women and 69 percent of men know that consistent condom use and having sex with only one uninfected partner can reduce the risk of HIV infection; 58 percent of women and 77 percent of men know that using condom during sexual intercourse can reduce the risk of HIV. However, only 20 percent of women age 15-49 and 38 percent of men aged 15-49 have comprehensive knowledge about HIV transmission and prevention [13].

Globally, the number of orphans due to AIDS shot up from 11.5 million in 2001 to 15 million in 2003. HIV/AIDS is particularly catastrophic because it generally kills both parents. Sub-Saharan Africa is home to an estimated 12.3 million children who have lost one or both parents to HIV/AIDS. In 11 of the 43 countries in the region, at least 15 percent of children are orphans. In 5 of those 11 countries, HIV/AIDS is the cause of parental death more than 50 per cent of the time. By 2010, more than 18 million children in the region will have lost one or both parents to the disease [1]. HIV pandemic has adversely affected the pace of human development in many countries in Sub-Saharan Africa (SSA). At the national level, the Government of Ethiopia has made tremendous progress towards reducing overall HIV prevalence to 2.5 percent by 2015. In fact, recent data indicates that in 2010, the country's HIV prevalence rate fell to 2.7 percent and is expected to reach one percent by 2015. However, HIV/AIDS prevalence among mothers in reproductive ages (15-24) increased from 0.9 percent in 1990 to 8.6 percent in 2005 before slowing down to 5.6 percent in 2007. The MDG target seeks to reduce HIV prevalence rates to less than 4.5 percent by 2015, and significant progress has since been made to achieve this target. The government has increased facilities providing HIV counseling and testing (HCT), Prevention of Mother to Child Transmission (PMTCT) and Anti-Retroviral Treatment (ART) to 1,469, 877, and 420 facilities in 2009 from 525, 877 and 32 facilities for HCT, PMTCT, and ART in 2005, respectively [2].

Globally, women represent almost half of the 40 million people worldwide living with HIV. Due to women's greater physiological, socio-cultural and economic susceptibility to HIV infection, it is likely that the proportion of female adults and young women living with HIV will continue to rise in many regions of the world as has already been seen in Sub-Saharan Africa and the Caribbean [14].

Through lack of access and stigma and discrimination, HIV-positive women and adolescent girls are often denied their rights. In the absence of informed choice and adequate reproductive health services (including care and treatment for reproductive morbidities that may be exacerbated by their HIV infection) HIV-positive women are at even greater risk of morbidity and mortality. They are a group whose needs are complicated by the enormous social stigma and discrimination associated with living with HIV [14]. HIV prevalence among the general adult population was 1.5% according to the 2011 Ethiopia DHS. However, prevalence rates varied markedly by age (from 0.1% among 15-19 year olds to 2.9% among 35-39 years olds), by gender (1.9% of adult women vs. 1.0% of adult men), by residence (4.2% urban vs. 0.6% rural), and by region (from 6.5% in Gambella to 0.9% in SNNPR).

HIV prevalence is increasingly concentrated in large urban areas and along major transport corridors. Urban residents accounted for 17% of the national population but 64% of PLHIV in 2011. Between 2005 and 2011, HIV prevalence remained relatively stable in large cities with a hint of increase from 4.3% to 5.1% but fell sharply and significantly in medium and small size towns from 8.2% to 3.1%. Concentration of the epidemic along main transport corridors also intensified as the ratio of HIV prevalence within 5 kilometers of a major road relative to more distant locations increased from 2.5 to 4 times higher. Urban areas that border major roads regardless of region or town size yield HIV prevalence equivalent on average to the largest cities (5.5%) [15].

The HIV/AIDS epidemic remains one of the important public health challenges in Ethiopia since it was first recognized in the mid-1980s. The epidemic has passed through various stages, from a localized and concentrated epidemic among most at-risk populations during the initial phase of rapid transmission, to the current mixed epidemic that is sustained in roughly equal measure by new infections from most at-risk groups and the general population. As a synthesis report showed the Ethiopian epidemic to be almost uniquely heterogeneous with strong contrasts by urban-rural residence proximity to transport corridors, gender and occupation. Ethiopia is undergoing profound social and economic transformation which offers new opportunities and threats, and corresponding reasons for vigilance and adaptability in program response [15].

The risk of becoming infected during unprotected sex is two to four times greater for women than for men. For young girls, the risk can be even higher. An immature genital tract can easily tear during sexual activity, especially if it is forced or violent, raising

the chances of exposure to infections. In many societies, gender norms and expectations keep women uninformed about their bodies and sexual health. They are often denied health services, especially reproductive health care, which cuts them off from treatment and information about HIV risks. Additionally, cultural mores may encourage men to have many sexual partners. The result is that a man's partner remains at risk for contracting HIV even when she has been faithful to him [1].

In Ethiopia, 24 percent of women aged 15-24 and 39 percent of men aged 15-24 have comprehensive knowledge of HIV. Significant proportions of young women (40%) and men (12%) 15-24 have sex before age 18. Nine percent of young men and three percent of young women had intercourse with a non-marital, non-cohabiting partner in the last 12 months. Condom use at last sex with a non-marital, non-cohabiting partner was 24 percent among young women and 55 percent among young men. Condom use at last sex with a non-marital, non-cohabiting partner is higher in urban areas than in rural areas [13]. In EDHS 2016, 2 percent and 7 percent of women and men respectively reported to have had sexual intercourse in the past 12 months with a person who was neither their spouse nor lived with them. Condom use at last sexual intercourse among these adults with a non-regular and non-cohabiting partner in the past 12 months was 20 percent and 51 percent for women and men respectively [13]. In Ethiopia, there is widespread HIV-related stigma and discrimination among the population, which might adversely affect people's willingness to be tested as well as their initiation of and adherence to antiretroviral therapy (ART) [13].

How is AIDS diagnosed?

AIDS is the most advanced stage of HIV infection. Once HIV infection develops into AIDS, infections and cancer pose a greater risk. Without treatment, HIV infection is likely to develop into AIDS as the immune system gradually wears down. However, advances in ART mean than an ever-decreasing number of people progress to this stage. By the close of 2015, around 1,122,900 people were HIV-positive. To compare, figures from 2016 show that medical professionals diagnosed AIDS in an estimated 18,160 people.

Progression to AIDS: The risk of HIV progressing to AIDS varies widely between individuals and depends on many factors, including: The age of the individual, the body's ability to defend against HIV, access to high-quality, sanitary healthcare, the presence of other infections, the individual's genetic inheritance resistance to certain strains of HIV and drug-resistant strains of HIV [12].

Early Symptoms of HIV Infection: Sweats are an early sign of HIV, but many people do not know they have the disease for years. Some people with HIV do not show symptoms until months or even years after contracting the virus. However, around 80 percent of people may develop a set of flu-like symptoms known as acute retroviral syndrome around 2–6 weeks after the virus enters the body. The early symptoms of HIV infection may include: Fever, chills, joint pain, muscle aches, sore throat, Sweats particularly at night, enlarged glands, a red rash, and Tiredness, weakness, unintentional weight loss, and thrush. These symptoms might also result from the immune system fighting off many types of viruses. However, people who experience several of these symptoms and know of any reason they might have been at risk of contracting HIV over the last 6 weeks should take a test [12].

The HIV and AIDS myths and facts and many misconceptions circulate about HIV, which is harmful and stigmatizing for people with the virus. The following cannot transmit the virus: shaking hands, hugging, kissing, sneezing, touching unbroken skin, using the same toilet, sharing towels, Sharing cutlery, mouth-to-mouth resuscitation or other forms of "casual contact" the saliva, tears, feces, and urine of a person with HIV. Symptoms such as fever, weakness, and weight loss may be a sign that a person's HIV has advanced to AIDS. However, a diagnosis of AIDS is based on the following criteria: A drop in CD4 count to less than 200 cells/mm^3. A CD4 count measures the number of CD4 cells in a sample of blood and the presence of certain opportunistic infections. Although an AIDS diagnosis indicates severe damage to the immune system, HIV medicines can still help people at this stage of HIV infection [11].

Definition and Concepts of Disability

What is Disability?

Globally, it is estimated that 1 billion people (15% of the world's population) have a disability. Of those aged over 15 year's approximately 110 up to 190 million (2.2–3.8%) experiences significant disabilities. Disability is increasing in prevalence due to ageing populations, trauma, accidents and the increase in chronic health conditions, including HIV [16]. Persistent discrimination against and exclusion of people with disabilities, in particular women and girls with disabilities, increases their vulnerability, including their risk of HIV infection. While the Millennium Development Goals were silent on disability, the new Sustainable Development Goals feature a strong will to "leave no one behind", including people with disabilities [17].

Similarly, the United Nations Convention on the Rights of Persons with Disabilities (CRPD) *(3)* calls on state parties to ensure the rights of people with disabilities to participate and be included in all spheres of life, including specific articles relating to the right to access health services, including sexual and reproductive health, and rehabilitation services. CRPD also recognizes that "women and girls with disabilities are at greater risk" and need specific protection from negligence and violence.

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. Disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective in participation in society on an equal basis with others [18]. The UNAIDS 2016–2021 Strategy calls to Fast-Track the HIV response and to reach the people being left behind. The strategy highlights the

bold effort needed to reach the 90–90–90 targets, to close the testing gap and to protect the health of the 22 million people living with HIV who are still not accessing treatment. To reach this goal requires zero discrimination, person-centered responses, equal access to health programs and services, including sexual and reproductive health and rights, and integration of rehabilitation into HIV care to enhance quality of life [19]. An estimated 650 million people, or 10% of the world's population, have a disability [3]. The relationship between HIV and disability has not received due attention, although persons with disabilities are found among all key populations at higher risk of exposure to HIV. People living with HIV may develop impairments as the disease progresses [4].

Disability as a Cross-cutting Issue

Various factors such as infectious diseases, malnutrition, and war, episodes of drought and famine and problems related to pre-and post natal care of mothers and children have dramatically increased the number of disabled population in Ethiopia. Poverty and ignorance exacerbate the problems. Knowingly and unknowingly disabled children are exploited and excluded from normal family routines. Harmful traditional practices also play their part in raising the number of disabled individuals. For girls, FGM, fistula caused by obstructed labour accompanying early marriage and pelvic deformity, maternal related risks, incision of lower limbs, maternity related risks contribute significantly to increasing the number of disabled women [5].

In a national baseline survey undertaken in 1995, among the 5085 households in which the questionnaire was administered 14.7% had persons with disabilities. Most of the disabled persons fell under: impaired vision (30.4%), mobility disorder (30.9%), and chronic health problems such as epilepsy and leprosy (10.3%). Among these, close to 40% were women. A study conducted in six regions of Ethiopia on girls who have visual and hearing disability and mental retardation showed that, visually and hearing impaired girls do not have early childhood educational experiences. The problem was worse for visually impaired. However, public schools and in some cases NGO supported schools were the major service providers for girls with visual and hearing disability. Looking at access to education for visually and hearing impaired individuals, the trend over the years shows that the attendance rate of girls was much lower than that of boys. For example, for the academic years 1995/96, 1996/97, 1997/98, 1998/99 and 1999/00 the percentage of visually impaired female students in primary cycle, that is, from grades 1–4 were 32.6%, 31.1%, 31.7%, 37.3%, and 37.9% respectively.

In addition to the limited opportunities girls have in terms of access to school, the unfavorable school environment is another constraint they face. Unavailability of toilets, school distance, unavailability of disability specific instructional materials, low qualification of teachers were found to be some of the problems girls with disabilities encounter [6].

In one study girls with motor impairment and hearing impairment reported that inconsiderateness and discouragement on the part of teachers to be serious constraints [5]. Studies show that disabled individuals face discrimination in employment. The magnitude is severer for women. Similarly, once employed the opportunity for promotion, further training and other privileges were found to be scarcer for female disabled than male disabled. Studies and personal testimonies also reveal that disabled women have much more constraints in social engagements and marital relationships than do male disabled. Several studies and day-to-day observations show that disabled women are exposed to several forms of violence: physical including sexual violence, psychological, as well as various forms of hard labor [5].

Including disability in the HIV response requires commitment to counteract underlying inequality and discrimination across all sectors and a shift towards integrating HIV with disability and rehabilitation services. Disability as a cross-cutting issue in the response to HIV also calls for broader social, cultural and economic development that is person centered, is disability-inclusive and addresses the unique barriers that face people with disabilities, in particular women and girls with disabilities, and people living with HIV. In most countries, disability-inclusive development is a new concept. Therefore, regional, national or organizational strategies to improve disability inclusion will be a necessary first step for all sectors [20].

Conclusion

Women in Ethiopia occupy low status in the society. Ethiopian women suffer from work stereotype and gender distribution of labor, more are occupy in economically invisible work. Nonetheless, women are poor in terms of access to resources, services and employment. Regardless of women's immense contribution, they often lack productive assets particularly land, and are underserved with agricultural extension, credit, labor, oxen and farm implements. Women's representation in the permanent employment of both regional and federal civil services is also lower than men; in comparison to the large number of unemployed women. HIV pandemic has adversely affected the pace of human development in many countries in Sub-Saharan Africa (SSA). At the national level, the Government of Ethiopia has made tremendous progress towards reducing overall HIV prevalence to 2.5 percent by 2015. In fact, recent data indicates that in 2010, the country's HIV prevalence rate fell to 2.7 percent and is expected to reach one percent by 2015. However, HIV/AIDS prevalence among mothers in reproductive ages (15-24) increased from 0.9 percent in 1990 to 8.6 percent in 2005 before slowing down to 5.6 percent in 2007. HIV prevalence among women and men aged 15-49 in Ethiopia is 0.9 percent. HIV prevalence is higher among women than men. An estimated 650 million people, or 10% of the world's population, have a disability. Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

Recommendations

- ✓ Gender mainstreaming and gender analysis should be conducted at organizational/sectoral levels, at community levels and at the country level to reduce gender inequality and

inequality for attaining gender equality in a well manner throughout the country.

- ✓ ART is recommended for everyone who has HIV. ART can't cure HIV infection, but HIV medicines help people with HIV live longer, healthier lives.
- ✓ To reduce your risk of HIV infection, use condoms correctly every time you have sex, limit your number of sexual partners, and never share injection drug equipment. PrEP is an HIV prevention option for people who don't have HIV but who are at high risk of becoming infected with HIV.
- ✓ Antiretroviral therapy (ART) is the use of HIV medicines to treat HIV infection. People on ART take a combination of HIV medicines (called an HIV regimen) every day.
- ✓ Education and continuous awareness transference, and training have to provided among all sections of the societies within the country. It is an important tool in the fight against gender based discrimination, HIV/AIDS and stereotypes based on impairments. School cultures and creating conducive environment can also contribute to reduce gender-based violence and violence against women's and / girls in Ethiopia. Special needs and inclusive education, special needs support and rehabilitation centers should be expanded and provided among all levels of schools as well as with in different sections of the societies among regions of the country.

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