Chapter Six

Summary, Discussion, Conclusions and Recommendations of the Study

6.1 Summary

6.1.1 Introduction

This study set out to undertake an evaluation of HIV and AIDS education on awareness, prevention measures and services among CWDs in Kenya. The specific undertakings of the study are recounted in this research report, which is organized into six chapters. The first chapter forms the introduction, and it presents the background information for the study, statement of the problem which was to ‘evaluate the HIV and AIDS education on awareness, preventive measures and services among children with disabilities in Kenya’ and definitions of important terms used in the study. Others sub-sections include objectives of the study and research questions, need and significance of the study, scope, limitations and delimitations of the study as well as assumptions and conceptual framework for the study. The objectives that guided data collection for the study include:

- To assess the level of HIV and AIDS awareness, education, prevention and treatment services among CWDs in Kenya
- To analyze HIV and AIDS awareness models for CWDs in Kenya
- To examine the vulnerability of CWDs to HIV and AIDS in Kenya
- To suggest strategies for effective HIV and AIDS education for CWDs in Kenya

Chapter two presents review of related literature, and it is arranged in three major sections according to the region where they were conducted. In the first section of the chapter, studies that were reviewed from around the world are presented. The second section presents related studies which were done in India, and the last section presents related studies done in Kenya, the country of study. In each of the sections, the title of the study, the researcher(s), findings and recommendations are provided. The study objectives, methodology, design and data collection instruments are also presented in the instances where they were included in the reviewed studies. This review provided basis for understanding the problem of the study with more clarity, and to select the methodology, scope and data collection instruments for this present study.
Chapter three provides more literature that was related to the study but was not as specific as literature presented in chapter two. Specifically, the information provided within the chapter highlights on the status prevalence of disability in Kenya, categorization of the different disabilities and the legal aspects involved, evolution and development of special education across the world and in Kenya, the Kenyan general system of education, HIV and AIDS and its effects and connectedness with disability in Kenya, and HIV education and the different approaches used for teaching the same.

The fourth chapter of the thesis is on research methodology, and it opens with a brief introduction of the chapter followed by population and sample of the study, sampling procedures and instruments for data collection. Others sub-sections within chapter four are validity and reliability, data collection procedures, ethical considerations, data analysis and research design used.

The fifth chapter provides data analysis and presentation of findings. It presents the findings in percentages whereby the pattern followed is presentation of the particular objective, findings according to the various sub-objectives and observations made from the findings. Graphical representation of the findings is provided, and tables, pie and bar charts are used. Conclusions drawn from the findings are also provided in this chapter five.

Last is the sixth chapter which provides summary, discussion, conclusions and recommendations of the findings. Each of these sub-titles in chapter six form sub-sections whereby under the summary section, an impression of the entire research report is provided according to the different chapters. In the discussion section, each of the findings is written about more elaborately. The discussion is objective-wise, and shows the connectedness between the finding according to the present study and reviewed literature from chapter two.

6.1.2 Size of the Sample

Five different categories of respondents were sampled and these included five children with disabilities from five disability areas who totaled 630, their teachers among whom 180 were sampled, 200 parents, and 9 heads teachers of institutions for CWDs and 13 heads of organizations that dealt with issues of HIV and disabilities.
6.1.3 Tools used for Data Collection

The major tool used for data collection for this study was the questionnaire, and five different sets of questionnaires were used, each for the different category of respondents who included the CWDs, parents, teachers, heads of institutions for CWDs and heads of organizations that worked with CWDs in issues of HIV and disability.

6.1.4 Test of Validity and Reliability

Validity of the questionnaires was examined through content validity whereby the prepared questionnaires were given to experts in the field of education for CWDs. The professionals determined the relevance of the questionnaire items by rating each on a scale of 1 to 5. The item rated 1 was most irrelevant and the one rated 5 was most relevant. After this rating by professionals, the researcher selected items for use in the questionnaires starting with those which had been rated at 5. A few items that had been rated at 4 were revised and added into the questionnaires after consultation with the experts.

Reliability was tested through test-re-test, which is also called coefficient of stability reliability procedures. This involved preparation of questionnaires for the 5 sampled groups of respondents and then sending them to experts for evaluation of dependability each with a 5 point rating scale. Modification of the questionnaires according to the professional judgment was done, after which the different copies were sent to the respective groups of respondents for filling in with the required data. Like with validity testing, the item rated 1 was most inconsistent and the one rated 5 was most consistent. After all items were rated, the researcher selected items for use in the questionnaires starting with those which had been rated at 5, and if so required, those rated at 4 were revised and then included in the questionnaire.

6.1.5 Data Collection Procedures

This study used both primary and secondary data. Primary data were obtained from responses given by the respondents in the five questionnaires used, while secondary data were acquired through document analysis. After the research proposal was approved
by the Research and Recognition Committee of the University of Pune, a research permit was sought and obtained from the National Council for Science and Technology, an agency of the ministry of Higher Education, Science and Technology in Kenya. The permit gave authorization for data collection from the selected schools for this study. Permission to gain access to schools and organizations for data collection was requested from the District Education Officers (DEOs), and from the head teachers of the selected schools. A copy of the certificate was attached to each of the questionnaire copies sent out to respondents. Throughout the process of data collection, two major issues namely access and ethical considerations guided were considered due the nature of the study as recommended by Blaxter, Hughes & Tight (1996). An ongoing access to schools, school administrators, teachers, parents and members of organizations that worked with the CWDs was maintained by the researcher for the purposes of access whenever data were required. Because of time and logistical limitations, the study used contact teachers and one research assistant to distribute and collect the questionnaire copies to and from the sampled populations.

### 6.1.6 Data Analysis

Data analysis for this study involved editing, coding, classification and tabulation of the information provided by the respondents in the questionnaires. It was later summarized and displayed in tabular form for further analysis by use of both descriptive and inferential analysis procedures. The descriptive analysis procedures included frequencies and percentages, and were done with the help of Statistical Package for the Social Sciences (SPSS) Version 11.5, a computer based package for quantitative data. Both quantitative and qualitative data were accessed and analyzed thematically and in accordance with the objectives, and this gave the study a mixed methods’ approach. During coding, data was broken down, conceptualized and put back together in new ways, and codes were assigned units of meaning to the information obtained as guided by Struwig & Stead, 2001:169 and Wiersma, 2000:203. Coding helped to reduce the bulky data into more manageable portions and then the identified relationships were validated and categories that needed further refinement and development substantiated as suggested by De Vos (2005).
6.1.7 Interpretation of Results

Closed-ended questions which required pre-destined responses were used in the questionnaires. Most items were dichotomous questions, and they allowed the respondents to choose one of two answer choices namely ‘Yes’ or ‘No’ as explained by Brace (2004). Coding of the data was done by assigning numbers 1 and 2 for each response choice. The closed-ended survey responses were then entered into a data file of SPSS analysis program for statistical analyses for generation of tables and graphs in percentages. One of the questions was presented in a five-point rating scale seeking to rate the level of support that was given to HIV and AIDS education by different stakeholders, according to guidelines given by Meric and Wagner (2006). The respondents were to pick either ‘Yes’ or ‘No’ response against the level of support offered by each category of stakeholders, ranging from ‘highly supportive’ to ‘not supportive’. Frequencies and percentages of the responses were then presented graphically. The ‘Yes’ responses per questionnaire item were then added up, then divided by the number of the total responses.

6.1.8 Major Findings of the Study

Under the first objective which sought to assess the level of HIV and AIDS awareness, education, prevention and treatment services among CWDs in Kenya, the following findings were generated:

- Although majority of the CWDs studied had awareness on HIV and AIDS, still a considerable percentage of 33.6 percent did not have the awareness so there was need to step up efforts to create awareness to all the CWDs
- The leading sources of awareness of HIV and AIDS among the CWDs were the teachers, parents and friends of the CWDs at percentages of 20, 19 and 18 respectively. Health and VCT centres and audio-visuals contributed the least at 14 and 13 percent respectively
- On awareness of measures of prevention for HIV, 26 percent identified avoidance of sharing of needles and other sharp objects. The least measures of prevention of HIV according to the CWDs were the use of condoms as identified by 11 percent
of the respondents and use of disinfectants according to 10 percent of the respondents. However, there were various misconceptions held by the CWDs on prevention of HIV, among them avoidance of sexual encounters with strangers according to 28 percent of the respondents, and playing with people who were HIV positive according to 15 percent of the respondents.

The second objective sought to analyze HIV and AIDS awareness models for CWDs in Kenya, and the findings generated were that:

- The only available HIV and AIDS services for CWDs within the school was counseling as reported by 13.9 percent of the respondents while only VCT and counseling where the only HIV and AIDS services for the CWDs within the local health centres.

- On the status of infrastructure, 26 percent of the CWDs said they were taught HIV education, 25 percent understood the messages used for awareness of HIV and AIDS and only 8 percent agreed that their teachers used teaching aids during HIV education lessons.

- To answer this sub-objective, document analysis was used. The various programs that were used in creating awareness on HIV and AIDS awareness were analysed, and results obtained showed that CWDs were not a target in the various methods of awareness. For instance, use of the curriculum, media, and peer education, public health and workplace policies did not target the CWDs since only about 2 percent of them accessed education programs in any form. Most of them experienced inaccessibility to HIV and AIDS education programs as a result of their disabilities, and/ or were socially excluded. For instance, CWDs with HI could not access auditory messages on HIV and AIDS, those with VI could not access messages through the print media and those with PH could not access services due to lack of disability-user conditions while CWDs with MH were intellectually limited to understand the messages, most of which are not explicitly articulated.

On vulnerability of CWDs to HIV infection, the study found that:
Voluntary sexual involvement and sexual abuse were the leading modes of HIV transmission according to 24 percent of the responses given. While drug abuse came second according to 18 percent of the responses, use of unsterilized objects and mother-to-child modes were the last as identified by 17 percent of the respondents.

The CWDs had awareness on the symptoms of HIV and AIDS whereby the highest identified symptoms were unexplained weight loss, looking pale and skin rash according to 12 percent of the respondents. However, the CWDs held several misconceptions about the symptoms.

The CWDs were found to be highly at risk of contracting HIV because most of them engaged in sexual activities at a very tender age, either voluntarily or through abuse. According to 70 percent of the responses, the CWDs had their first sexual contact at the ages of 10-15 years, and this was with people who were closest to them such as 51 percent of the CWDs who engaged with their religious teachers and 34 percent with their fathers or friends. While 31 percent of the CWDs had been forced into sex by their friends, 30 percent had been abused sexually by their relatives, and 36 percent had multiple sexual partners.

Most of the CWDs did not report acts of sexual abuse committed against them for various reasons. The leading reason for not reporting such cases was feelings of shame according to 24 percent of the responses followed by ‘no reason’ and ‘no action would be taken against the abuser’ according to 20 and 17 percent of the responses respectively.

The attitude of the CWDs towards friends of the opposite sex also heightened their vulnerability to HIV infection. Some of the attitudes include ‘need for discipline in order to relate with such friends and fear that such friends could mislead them and that having such friends was ‘against God’s wish’ according to responses of 12, 11 and 10 of the respondents respectively.

Most of the CWDs did not visit VCT centers unless they were escorted by their parents or referred by the doctor or their partners demanded to know their HIV status as indicated by 17 and 16 percent of the respondents. However, 46 percent could not visit the VCT centre for HIV testing because they were not sick,
could not visit because they had only one sexual partner, 14 percent had no sexual partner while 13 percent had no one to accompany them to the VCT centre. This shows that according to the CWDs, sexual involvement was the only mode of HIV transmission

- Suggested strategies that could help to prevent HIV infection amongst CWDs were educating people about the needs and rights of CWDs as indicated by 15 percent of the responses. Another 14 percent of the respondents identified provision of serious punishment to perpetrators of sexual abuse to CWDs, providing suitable transport and physical infrastructure for CWDs, addressing knowledge gaps and misconceptions about HIV and AIDS and addressing risks, needs and preferences of CWDs in issues of HIV and AIDS. The least but illogical suggestions made were to ‘jail all people infected with HIV and allowing CWDs to practice sex amongst them so as to learn condom use according to 9 and 8 percent of the respondents

On the last objective which sought to identify strategies to address HIV infection among CWDs in Kenya, the following findings emerged:

- The attitude of different stakeholders towards HIV and AIDS education for CWDs needed to change. For instance, very low percentages of 5.6 of the teachers and learners and 2.8 of the parents and support staff highly supported HIV and AIDS education for CWDs, and none of the head teachers highly supported such an education for CWDs. Teachers were the most supportive at a percentage of 69.4 followed by the parents and head teachers at 44.4 percent

- On specific strategies that were suggested for improvement of HIV and AIDS education for CWDs, the leading was use of disability-responsive pictures and illustrations in the media according to 12 percent of the respondents. This was followed by 11 percent of the respondents who suggested use of appropriate language in HIV education for the various categories of CWDs. Other suggested strategies were improving HIV education for CWDs, adoption of suitable HIV education curriculum, provision of access to school, retention and completion for
CWDs and inclusion of CWDs into their HIV education programmes according to 10 percent of the respondents

6.2 Discussion of the Results

6.2.1 Awareness of HIV and AIDS by CWDs in Kenya

From the information under this objective, the study concludes that there was still a considerable number of CWDs in Kenya who lacked awareness on HIV and AIDS, yet it was deemed very important that all CWDs gained this awareness. This is especially because they were considered to be more vulnerable to HIV infection due to their already disabling condition. On the sources of HIV and AIDS for CWDs in Kenya, respondents who included the CWDs, their teachers, parents, head teachers and heads of organizations that worked with CWDs in issues of HIV and disabilities identified the leading the teachers, parents, and friends of the CWDs as the leading sources. Other identified sources included religious organizations, health and VCT centres and audio-visuals.

The CWDs were aware of the various measures of HIV and AIDS prevention. Such means as identified included the need to avoid sharing of sharp objects, use of sterilized needles and sharp objects, the need to be faithful to one sexual partner, avoidance of drug abuse, use of disinfectants when in contact with other people’s body fluids and use of condoms. The responses provided clearly show that an average number of CWDs were aware of HIV and AIDS from dependable sources, and were also aware of the various methods of HIV prevention. However, there is need to raise the existing level of awareness on HIV and AIDS for the remaining 33.6 percent of the CWDs, and on the means of HIV prevention among them especially condom use, which is considered critical in prevention of HIV and is medically and universally promoted as a lifeline in HIV prevention.

These findings correspond with earlier findings by GoK and UNICEF (2000); Catalan, et al. (2005); UNICEF (2007) and GoK (2009). Unfortunately, major documents for the welfare of the PWDs in Kenya did not mention HIV and AIDS awareness as a concern. For instance, the Persons with Disabilities Act of 2003 makes no mention of HIV and AIDS anywhere in its simplified version, although its objective no. 2 is on implementation of a national health programme for PWDs according to NCPWD (2010).
The Child Rights Act of 2001 mentions HIV, but in relation to requirements that the children must fulfill for adoption. These omissions may have contributed to the low awareness on HIV and AIDS for CWDs and lack of planning of related programmes and enforcement.

There should also be a distinction on the level of awareness that CWDs have on HIV and AIDS. This is based on the premise that although most people have heard about HIV and AIDS, they did not have specific information about the same, a situation that brings about stereotypic and unfounded information. Such kind of information may lead to stigma, and cannot therefore aid successful fight against HIV and AIDS. Notably, the heads of organizations worked on the ground on issues of disability and HIV and AIDS, and were therefore presumed by this study to present a very important position on the status of awareness of HIV and AIDS by CWDs, but their percentage on the same is dismal.

Similar trends on diversities of awareness of HIV have been identified by researchers Marrow, Arunkumar, Pearce and Dawson (2007), who noted that their existed diversity in levels of HIV understanding and awareness among the sample. People with visual impairments had more education and greater HIV knowledge than their physically impaired counterparts, and overall, males were more knowledgeable than females. Some respondents had no awareness at all while others from disability organizations incompletely lacked of awareness of HIV and appropriate prevention strategies. This observation concurs with an inferred position of this current study that although some respondents may have heard of HIV and AIDS, they may not have had any further knowledge about it.

There is need to raise awareness on the various means of HIV prevention among CWDs so as to put in check their cycle of vulnerability to HIV. This will enable success of the fight against HIV, and enhance attainment of personal, national and international development as required by the Millenium Development Goals (MDGs) among other endeavours. Without raising awareness on the various means of HIV transmission modes, it is evident that a large percentage of CWDs will not seek medical attention for instance if they were sexually abused by people they knew. This is because from their responses, strangers, older, dirty and thin people were the ones who could infect them with HIV.
This is critical based on the known premise that majority of perpetrators of sexual abuse are people known to those they abuse. The fact that all other misconceptions presented attracted YES responses from CWDs in relation to methods of HIV prevention undercores the need for all stakeholders to apply concerted efforts to replace them with the correct measures of prevention in order to fight vulnerability of CWDs to HIV.

These misconceptions cited by the CWDs in the Kenyan situation with regard to HIV and AIDS are not in isolation according to UNESCO (2002). Among similar misconceptions cited by UNESCO as advanced in India are that ‘HIV and AIDS are the same thing, that HIV/AIDS can only be contracted through vaginal sex, touching and kissing an infected person, sharing food, and mosquito bites.’ Others are that if ones home and environment were clean they cannot contract HIV, people not suffering from any STIs will not contract HIV, and that it is prevalent only among slum dwellers and lower classes, as they frequent sex workers whereas among the lower class and slum dwellers, HIV/AIDS is contracted by the rich, as they have the money to frequent sex workers. Other misconceptions which are similar to those held in Kenya are that sex with virgins cures STIs, including HIV, urinating immediately after sex, one won’t get any STIs and that a healthy looking person will not have HIV and that HIV can be cured if detected early among many other myths and misconceptions.

Poignantly, even amongst the non-disabled groups, there are many recurrent misconceptions about HIV and AIDS as noted by Rampay, Madhuranan, Rafiq, Krupp, Chakrapani and Selvam in a study conducted in India in 2008. In Kenya, some challenges that have hindered 100 percent awareness on HIV and AIDS as identified by Tostensen (2004) include the government’s state of denial during the initial years when the disease was reported in the country as a strategy to array fears over the loss of inward investment and tourism which is key to the economy, lack of policy response, pervasive corruption and a troubled political context through the 1990s, therefore making it difficult to bridge research and policy on HIV in Kenya. Other challenges include the existence of non-functional NGOs that were merely shell organizations as was established by this study whereby only one of the organizations studied offered HIV and AIDS services to CWDs. Although most religious organisations have adopted a supportive stance on the fight against HIV and AIDS, many have refused to endorse condoms which are identified as
important for HIV prevention. They also have divergent opinions on the issue of the sex education curriculum for primary schools. Finally, the media, although largely free, has not played as active a role on HIV issues as in other countries.

### 6.2.2 Analysis of available HIV and AIDS awareness models for CWDs in Kenya

From information provided under this objective, although HIV education was taught to majority of the CWDs sampled for this study, it is unfortunate that only 29 percent had their teachers using teaching aids, and unfortunately, only 25 percent understood meanings of HIV and AIDS messages. On the programs available for creating awareness on HIV and AIDS in Kenya, information from different documents indicate that HIV and AIDS awareness and education in Kenya is passed onto the public in various models among them integration into the curriculum at all levels of education, use of media, peer education, public health and workplace HIV and AIDS policies. However, in almost all these models, the CWD is almost invisible as a target in HIV awareness efforts. This is because although the government introduced FPE in an effort towards education for all, less than 2 percent of CWDs access any education program.

Other issues that inhibit effective HIV and AIDS education for CWDs included lack of specific objectives for HIV and AIDS education, perception of teachers to HIV education integration as ‘waste of time’, lack of clarity in the MoE directive on HIV and AIDS education, negative attitude of teachers, inadequate content and curriculum materials, financial constraints and lack of current literature on the area among other challenges. As such, there is no data on the level of awareness of HIV and AIDS among CWDs. The same awareness is a lower among PWDs since information on HIV and AIDS is not adapted to suit the PWDs, and most caregivers do not make efforts to pass information on HIV and AIDS to them either due to lack of appropriate skills, their attitude towards HIV and social exclusion of the CWDs from issues of HIV and AIDS among others.

Among the different categories of disabilities, only the HI had increased awareness on HIV and AIDS, which is enabled through the efforts of several non-governmental organizations such as the Handicap International, VSO and the Liverpool VCT, Care and Treatment (LVCT). The Kenya Institute of Special Education (KISE) has
accessible HIV counseling and testing centre and a mobile service for PWDs with regard to HIV testing but unfortunately, these services appear not to target CWDs, and where they do, they appear confined to urban areas. Overall, there is mismatch in the laid down and recorded HIV and AIDS education policies in all sectors, and the actual execution of the same especially for CWDs whose access to the general education is very limited (Kwedho, Simatwa and Ondigi, 2010; Handicap International, 2009 and The African Campaign on Disability and HIV & AIDS, 2009). As mentioned elsewhere, key government documents such as the Disability Act of 2003 and The Children Rights Act of 2001 do not mention HIV and AIDS education for CWDs.

The HIV and AIDS Services available for CWDs were only VCT and counseling services were available for CWDs in the local health centre, while counseling was the only available service in the school as indicated by 13.9 percent of the respondents.

These findings contrast with Article 26 of the Universal Declaration of Human Rights of 1948, the 1989 UN Convention of the Rights of the Child (CRC), the 1990 African Charter on the Rights and Welfare of the Child, the Salamanca Statement of 1994 among others, and the 2006 Convention on the Rights of Persons with Disabilities (Article 25) which commits State parties including Kenya as a member to provide PWDs with the same range, quality and standard of free or affordable health care and programmes as to all other people. These programmes include sexual and reproductive health and population-based programmes, and taking appropriate measures such as peer support so as to enable PWDs to attain and maintain their maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life (Article 26), Article 53 of the Kenyan Constitution and the Children Act (Cap 586) which is supposed to establish the National Council for the Administration of Children Services as one of its major responsibilities. This contrasts objective 2 of the PWDs Act of 2003 which commits to implement a national health program for PWDs among which CWDs fall for free medical services, provision of essential health services and prompt attendance by medical personnel. The philanthropic and welfare attitude towards issues of CWDs may be a contributor to lack of infrastructure for HIV and AIDS education for these children, and this violates key international and national proclamations on HIV and AIDS and disability.
There is need to improve infrastructure of HIV and AIDS education for CWDs. The Kenyan education system can borrow some strategies which have been employed elsewhere for successful teaching despite limited resources. For instance, UNESCO (2009) concedes with this study that limited resources require the use of cost effective and innovative approaches through programs designed to raise the quality of classroom teaching and to improve student learning through effective classroom practices. Hence, teaching practices should be designed to address specific local situations and needs, in this case different disability areas as was the case with Zambia where ‘Teaching in the Window of Hope’ or TWH approach provided new teachers with methodologies and skills that would enable them effectively develop life skills for HIV/AIDS prevention in collaboration with their students.

In Kenya this can work well in teaching HIV and AIDS to the different categories of CWDs by overcoming the many barriers teachers face in implementing classroom based HIV prevention. Such barriers include difficulty speaking about HIV and AIDS, lack of information on the drivers of the country’s epidemic, lack of understanding about gender issues like cross-generational sex and concurrent partners in relation to HIV and AID, and lack of training and experience in using participatory teaching methods.

A key pre-requisite for good health is access to health care which includes location, economic and social access. However, a large number of CWDs are unable to access health services. Access is also integrally related to cost of health care. Although health services have been extended to public health centres and sub-centres in Constituency Development Fund (CDF), this strategy may not register success in reaching CWDs. Government health infrastructure is grossly inadequate in most parts of Kenya even for the general population, and like highlighted in India by (DPOD, 2008), high utilization of the public system reflects poor development and inaccessibility to the private health care system. High levels of poverty and low incomes presumably restrict the demand for private health care. There are some differences in the pattern of utilization of health care facilities between the rural and the urban sectors. A slightly higher number of in-patients are treated in public hospitals in the urban sector, reflecting their urban locations and easier access.
In Kenya, reproductive health issues including reproductive health, education of girls and empowerment of women which have a special significance for HIV/AIDS largely remain women’s prerogative since heterosexual transmission is the most common mode of HIV transmission according to KAIS, 2007 in GoK (2008). The man is more likely to infect the woman with HIV with estimates showing that transmission from man to woman is between 1.5 to 4 times more than from woman to man due to physiological reasons as cited by DPOD (2008). Transmission of HIV increases sexually transmitted infections (STIs) as they cause lesions, inflammation and other damages that facilitate transmission of the virus during sexual intercourse.

Unfortunately, there is lack of large-scale data on the incidence of STIs. This study observes that CWDs have limited access to health care facilities due to cultural taboos, restrictions on mobility, non-availability of user-friendly services and lack of resources. Most CWDs are likely to bear the suffering of STIs and HIV in silence due to ignorance and also because of ‘culture of silence’ over issues regarding sexuality and reproductive health. There is a strong stigma associated with STIs. Over and above the suffering from STIs many of which may be remain asymptomatic, sexual trauma, forceful penetration and early age of women engaging in sexual activity also lead to damage of the vaginal lining, subsequently increasing the possibility of transmission of the HIV infection to women, in the case of an already infected partner, and this is as concurred by DPOD (2008).

6.2.3 Vulnerability of CWDs to HIV infection

Findings indicate that most CWDs could not seek HIV testing and counseling unless they were referred by their parents and doctors, or requested to take the test by their partners or were always falling sick. Other reasons that could prompt them to seek HIV counseling and testing were if they had sexual encounter with strangers or if they were sexually abused, or if their teachers encouraged them, or if they were accompanied by their friends. Some CWDs could not go for testing because they had only one sexual partner. Others saw no reason to go since they were not sexually active, or they lacked of someone to accompany the CWDs to VCT centres, feared that the medical staff would be unkind to them, or lacked knowledge on where they could get the HIV counseling and
testing services. The least of the reasons that made the CWDs not to seek HIV testing were that they could not acquire HIV and AIDS and that they did not want other people to know their status.

Although little is known about HIV/AIDS in populations with pre-existing disabilities, their vulnerability to HIV infection is sure to increase with the most recent statistics released by UNAIDS (2011) showing that 2010 alone saw 34 million people around the world living with HIV in 2010, up from 33.3 million in 2009. This shows an increase of 2.7 million new HIV infections worldwide, of which 70 percent were occurred in SSA, of which Kenya is a member. DPOD (2008) advance that PWDs of whom CWDs are a part of, are generally considered more likely to become HIV-infected than the average population. Conversely, in the absence of prevalence studies in Kenya to show the exact representation, it suffices to assume that this population accounts for the same proportion of people living with HIV in the general population, that is, 10 percent of 1.8 million people and thus come up with an approximation of 180,000 PWDs living with HIV in Kenya. This number makes it grievous to ignore involvement of the disabled in the struggle against HIV/AIDS.

There is little in-depth knowledge of the sexual health of CWDs especially in developing countries like Kenya, yet existing evidence indicates that they have an increased risk of contracting HIV. This is as conceded by Ostergaard (2007) that this category is likely to suffer *high prevalence of untreated STIs, less likelihood to use condoms, more frequent but unreported violence and rape, harmful traditional practices, infections at hospitals, stigmatization and discrimination and sex, love and affection.*

The stigma experienced by CWDs may enhance a feeling of insecurity as acceded by DPOD (2008), and this may in turn drive them into behaviours that expose them to HIV infection such as having several sexual partners as already established in this study, and being unable to rejects sexual advances since they see it as a gesture to being appreciated. CWDs share many experiences with people living with HIV in relation to feelings and actual acts of stigmatization since they belong to a marginalized group from the outset, and testing HIV positive trips the scales to more stigmatization. Moreover, the incidence of new disabilities as a result of HIV/AIDS is often insufficiently taken into account and not responded to in an adequate manner (Catholic Relief Services, 2011).
Literacy rates for CWDs are exceptionally low as cited by Morrow et al. (2007), Cambridge (1997). Disabled women are uniquely vulnerable because they encounter high risk of gender-based violence, they lack access to sexual and reproductive health (SRH) services such as family planning and maternal health, are not aware of mother-to-child HIV transmission and have lesser access to rehabilitation services (ESCAP, 1995).

This is despite there being a HIV and AIDS Prevention and Control Act, 2006, which has the potential to promote women’s protection against rape and other sexual abuses and other forms of injustices related to sex and gender. This is because it prohibits transmission of HIV knowingly (section 26 thereof); provides measures for the prevention, management and control of HIV and AIDS, provides for the protection and promotion of public health and for the appropriate treatment, counseling, support and care of persons infected or at risk of HIV and AIDS infection; and prohibits discrimination in the work place, schools, health institutions including prohibiting any restriction on travel or habitation or inhibition from public service or denial of burial services, or exclusion from credit and insurance services on the grounds only of actual, perceived or suspected HIV status. Discriminatory acts and practices are handled as criminal offences according to the Act, but unfortunately, it is yet to be realized since enactment from April 30, 2009.

The responses captured on the attitudes that CWDs towards friends of the opposite sex indicated that there was lack of social maturity among many CWDs with regard to such friendships. This was observed in some of the reasons that ‘having friends from the opposite sex could mislead the CWDs, only bad students associated with friends from the opposite sex, such friendship could be offensive to parents and teachers and that they felt ashamed to have such friends. This predisposed the CWDs to vulnerability because with lack of social skills enabled through social relationships, they lack social and life skills that could not help them from falling into unnecessary relations that could expose them to HIV infection.

It is noted in this study that sexuality and HIV/AIDS are issues that are shrouded in a lot of mystery for the average Kenyan population, made more complicated by hundreds of myths and ‘false beliefs’ on sexuality and HIV/AIDS that have been nurtured by the development and progression of HIV by the different communities. The same has
been noted across nations and societies, for instance many religious and mythological notions in India have been interpreted in different ways at different points of time based on limited knowledge. Commonly, people have a tendency to construct social prescriptions for themselves which disregards scientific knowledge. Most young people grow up with numerous misconceptions and guilt about issues of sexuality, and largely believe in the knowledge they acquire from their peers, with absence of clearly-defined, transparent and socially-accountable sexual mores. The prevalence of these fostered myths and secrecy that enwrap HIV and AIDS spell disastrous implications not only for its spread, but also on how to tackle it.

To address HIV infection among CWDs in Kenya, the respondents identified various means of prevention of HIV infection among them the need to educate other people on the needs and rights of CWDs, address risks, needs and preferences of CWDs in issues of HIV and AIDS, provide suitable transport and physical infrastructure for CWDs as means to reduce sexual abuse and therefore HIV infection among them. The need to address knowledge gaps and misconceptions about HIV and AIDS for CWDs, to give serious punishment to perpetrators of sexual abuse and to use PWDs as role models and service providers for CWDs were also captured from the responses.

Unfortunately, although there are vital documents that guide services and welfare of PWDs in Kenya like the Disability Act of 2003, they do not list sexual abuse against PWDs as an offence. Offences that are listed such as discrimination in employment and unjustifiable access to premises attract a very lenient fine of up to Kshs 20,000 and up to one year imprisonment or both. Lack of constitutional definition of disabilities in the Kenyan constitution and an interpretation of the Persons with Disabilities Act in any court of law in the country and the use of derogatory terms like ‘idiots and imbeciles’ in reference to persons with mental handicaps in Kenya dilutes its commitment towards the welfare of PWDs. Sadly, sexual violation committed against these ‘idiots and imbeciles’ is not listed as rape but as ‘defilement’, and it therefore attracts lenient charges. The legal process involved in cases of sexual abuse and violation in Kenya are at times very traumatizing, and they discourage those who are sexually abused from seeking justice.

There is therefore a lot that needs to be done to ensure that CWDs were equipped rightly to fight HIV infection. None of the responses attracted a very high percentage of
the CWDs even though some were deemed by this study as critical in fighting HIV transmission. Other responses are totally untenable in fighting HIV, yet they attracted the CWDs’ YES responses. For example 41 percent of the CWDs said that they should be ‘allowed to kill people who sexually abused them while another 30 percent agreed to the suggestion that all people who are infected with HIV be jailed, and 23 percent said that they should be allowed to practice sex amongst themselves so as to learn the use of condoms. Across the categories of respondents, the highest supported strategies are to give serious punishment to perpetrators of sexual abuse to CWDs, avail suitable transport and physical infrastructure for CWDs so as to curb abuse among CWDs, educate others on the needs and rights of CWDs to make them less vulnerable to HIV, and the need to address risks, needs and preferences in issues of HIV and AIDS for CWDs. however, some responses were totally untenable in fighting HIV, yet they attracted the head teachers’ YES responses. Such responses include allowing CWDs to practice safe amongst themselves so as to learn how to use condoms, and to avoid getting infected from the non-disabled people.

CWDs in Kenya should be consciously included by the government in its initiative to minimize stigma associated with HIV through a newly introduced programme called ‘Routine HIV Testing’, which is currently being rolled out in public health facilities in the country to encourage people to take HIV tests. The programme is on a pilot basis, and aims to encourage every visitor into public and private hospitals to voluntary take HIV test regardless of their health status so as make testing an everyday issue and demystify HIV in the process while informing people of their HIV status according to Nascop (2011).

Kenya can borrow several ideas which have recorded success stories in fighting HIV transmission. For example, India has used kite flying whereby the colourful kites carry messages on HIV and AIDS are flown so that they carry the messages to distant places. There has also been use of a seven-couch train called 'Red Ribbon Express' that offers counseling and training services, HIV testing, treatment of sexually transmitted diseases (STDS) as well as HIV/AIDS education and awareness and ‘Human Daisy Chains’ among other strategies (UNAIDS, 2010). This will help reduce the stigma
associated with both HIV and disability whereby most people perceive the two as ‘a problem of the other person’.

Provision of education for CWDs remains the single most important tool for them to fight HIV. This is because as they go out to access education, the CWDs will have a chance to be included in everyday life different from that of disability. As they interact with this world, they will be understood as they also understand it, and this will lead to acceptance as myths about them that lead to discrimination and stigma will be dispelled. Wijngaarden and Shaeffer (2005) underscore the role of education in the fight against HIV.

6.2.4 Strategies to Improve HIV and AIDS Education for CWDs in Kenya

From responses of all the sampled categories presented under section 6.2.8, it is evident that HIV education for CWDs in Kenya needs to be improved in line with the Sessional Paper no. 1 of 2005, PWDs Act of 2003, specifically under objective no. 2. The government’s commitment to education of CWDs through the signing of Article 26 of the Universal Declaration of Human Rights of 1948, the 1989 UN Convention of the Rights of the Child (CRC), the 1990 African Charter on the Rights and Welfare of the Child, the Salamanca Statement of 1994, the Framework for Action on Special Needs Education of 1999 and the MDGs ‘Education for All’ by 2015. The government has tried to fulfil this through establishment of FPE in 2003 and free-tuition in secondary school education in 2008.

One of the major impediments in provision of effective HIV education of CWDs was the attitudes of the school community towards HIV education for CWDs in Kenya. Findings indicated that most of the stakeholders did not support HIV and AIDS education, and those who did offered limited support. This may be as a result of Kenya being a conservative country whereby issues of sexuality were not openly discussed, a gap that other channels such as FM radios and print media may fill but with disastrous results since they may lack concrete facts about the subject. According to the World Bank, HIV/AIDS education is a window of hope in curbing the spread of HIV. However, how to effectively provide this education especially for the CWDs remains largely
unclear since sexual health education is not easily delivered through the traditional educational system. A case in support of this is abolishment of sex education in favour of yoga in six some Indian states (Zaheer, 2007) on the assumption that it ‘may be necessary in Western countries, but not in India’, for fear that it may adversely affect the young minds if allowed (Gentleman, 2007 and Sify, 2007).

This attitude especially by teachers may be attributed to the observation that teachers find it hard to communicate HIV/AIDS issues to learners due to the sensitive nature of the subject and secrecy surrounding sexuality as affirmed by Onyango (2009). Studies show that teachers in Kenya are not only finding it difficult to communicate with their students about HIV/AIDS and sexuality, but are also choosing the comfort of the transmission approach to teaching, avoiding engagement with the learners in ways that can draw on their life experiences and contexts. For instance teachers have cited inadequate teacher preparation to teach about HIV/AIDS and the sensitivity surrounding sexuality education as barriers to teaching as observed by Boler, Ibrahim, Adoss and Shaw, 2003; Farah, Kavuma, Mwingi and Onyango, 2009 and Njue et al., 2009. Preparation of teacher for HIV and AIDS education in Kenya is usually done on one-off seminars and workshops adopted by the Ministry of Education, and are based on the belief that changes in teachers practice can be achieved through giving information and knowledge to teachers in consistency with Clarke and Hollingsworth, 2002; Guskey, 2002. However, such programmes may not lead to change in the teachers’ beliefs and attitudes, and they therefore do not lead to change in classroom practices and behaviours as they are initially believed to (Clarke and Hollingsworth, 2002). The seminars only pass to teachers abstract and general ways about strategies that might be used in the classroom without tangible examples and models hence lack of deep understanding and practice of the strategies. Unless teachers are able to deal with and overcome their own social feelings of discomfort, biases and prejudices about HIV and AIDS, they will not teach the subject even with mastery of new teaching techniques.

Responses for this objective that have attracted higher percentages of responses across the respondents include adoption of appropriate measures to improve HIV education for CWDs, the need to use appropriate language for each category of disability followed by the need to increase funds for HIV education and services for CWDs. Others
include the need to ensure access to school, retention and completion for CWDs. The responses coincide with a position of this study that HIV education does not address the needs of CWDs, and where it does, a lot of challenges deter its meaningfulness to the disabled population.

A strategy advanced by the respondents on the need to increase funding for HIV education for CWDs by the government is as observed by DPOD (2008) that although funding of HIV/AIDS work has been growing rapidly, most programmes target at risk population groups such as sex workers, drug users and youth but not PWDs living with HIV who face risk factors due to disability are similar to those leading to HIV/AIDS. Notably, PWDs are hardly reached by conventional HIV/AIDS projects, and they largely remain almost invisible in HIV/AIDS organizations. Furthermore, combating HIV does not feature prominently on the internal agenda of disability organizations as was realized in this study.

On the need to use appropriate messages for HIV and AIDS for the different disability areas, Marrow, Arunkumar, Pearce and Dawson (2007) and Mulindwa (2003) got similar findings that mainstream HIV messages and services were unlikely to reach majority of PWDs because of reasons that ranged from being 'hidden' and housebound, non-engagement in the community, social exclusion and poverty, lack of awareness of their rights and available programs, physical barriers that limited effective access, attitudes of health professionals and the wider community perceived inconvenience or stigma related to seeking services, and type of disability. They also established that HIV services were physically inaccessible for PWDs, and identified the importance of having assistants to provide greater confidentiality for individuals who would otherwise rely on family or friends to access such services a separate and specialized HIV services for PWDs, as was earlier observed by UNFPA (2003). This current study concurs with their findings that there was connection between stigma and HIV vulnerability and access to HIV prevention and care.

Use of CWDs as peer educators in HIV and AIDS education training and involvement is a strategy to increase skills and self-esteem of CWDs, and to help break down barriers between CWDs and the general population as attested by DPOD (2008), Morrow et al. (2007) and Campbell & MacPhail (2002). All known practical, financial
and logistical obstacles for HIV programmers and disability service providers for CWDs in relation to HIV and AIDS should be removed to grant them access to them.

Knowledge gaps that exist amongst children including CWDs include origins, causes, transmission and control of HIV/AIDS. These gaps become significant when viewed against a backdrop of the many years of HIV/AIDS education and messages that have been passed on to the community, difference between HIV and AIDS, how HIV came to Kenya, and how the disease works to destroy white blood cells to eventually lead to AIDS if unchecked (GoK & UNICEF, 2000).

A milestone strategy was the establishment of the UN Convention on the Rights of Persons with Disabilities in 2006, which marked a paradigm shift in attitudes and approaches to PWDs of which CWDs are part of. The Convention is a human rights instrument with an explicit, social development dimension that adopts a broad categorization of PWDs and reaffirms human rights and fundamental freedoms for all PWDs and identifies areas where adaptations are required for PWDs to effectively enjoy their rights, areas of violated, and also reinforcement for protection of rights (United Nations Enable, 2006). Kenya set up the National Council for Persons with Disabilities (NCPWD) was set up by Act of parliament in 2004 to propagate the rights of PWDs.

Critical human rights areas covered by the convention include rights to life, access to justice, to personal mobility, education, work and health including HIV/AIDS. Further commitment of the Convention to the State Parties was that countries that had enacted Disability Acts and ratified the UN Convention (Article 25) include or contemplate inclusion of disabled people in their policy agenda so as to provide them with the same range, quality and standard of free or affordable health care and programmes like for everybody else. They also need to appropriately include them through peer support for attainment and maintenance of maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life (UNAIDS, 2009). However, efforts by the Kenya government to enact this as bound by the Convention are not yet very visible in some areas of disabilities in issues of HIV and AIDS albeit initiation of the Persons with Disabilities Act of 2003. A look at the activities of most organizations in Kenya show that their main areas of focus in programmes for HIV and AIDS were the HI and VI even though findings of this study.
established that CWDs with MH were more vulnerable to abuse which predisposed them to HIV infection.

6.3 Recommendations of the Study

The study recommends that there is need to:

- Improve infrastructure for HIV and AIDS education for CWDs in Kenya by all stakeholders. This is because education has a protective effect in HIV transmission among disabled populations as observed by Mulindwa (2003) for instance that condom use among people with visual, hearing and movement impairments living in Uganda increased with level of educational achievement

- Broaden contextualization of HIV and AIDS beyond the medical/ public health model into all development paradigms because HIV and AIDS related issues are ingrained in the community’s traditions, values and thought processes and cannot be viewed in isolation. Notably, community’s beliefs on sex and sexual behaviour are entrenched in societal norms and a discussion about them in many parts of Kenya is a taboo.

- Have researchers and organizations to listen to the CWDs’ voices and to involve them during HIV and AIDS project design, implementation, and evaluation

- Sensitize communities and institutions working with CWDs on the psycho-social impacts and needs of CWDs in relation to HIV and AIDS so as to enable care givers and structures for affected children to incorporate appropriate interventions besides basic needs. There is also need to build capacities to address their needs

- Train all teachers and specifically those involved in guidance and counseling in order to address some of the psycho-social needs of CWDs in issues of HIV and AIDS and disability

- Address the stigma associated with HIV and AIDS and to educate communities so as to accept and assist CWDs. They should also be educated on the rights of all children and especially CWDs affected by HIV/AIDS

- Enforce all the laws passed to protect all children and in particular those living in difficult circumstances. Owing to the reported sexual abuse and exploitation that
child laborers and street children are exposed to, it is important that they are educated on the risks of HIV/AIDS infection so that they can protect themselves

- Encourage HIV/AIDS interventions within communities so as to integrate safe procedures in socio-cultural practices that could expose children to HIV/AIDS infection, for example by use of alternative rituals and rites of passages
- Institute immediate intervention measures in schools for guidance and counselling of infected and affected children
- Sensitize schools and communities on the need to provide for special needs of CWDs infected or affected by HIV and AIDS
- Train all the teachers to specifically teach issues pertaining to HIV/AIDS, and to make available resources for the dissemination of information to all areas and to increase HIV/AIDS awareness and education in schools bearing in mind that teachers and pupils are still getting infected of HIV
- Follow up on the implementation of policy on HIV/AIDS education for the CWDs so as not to deny them access to knowledge and skills that check their vulnerability to HIV
- Re-evaluate and re-target existing HIV/AIDS messages and campaigns and to design and disseminate appropriate HIV/AIDS messages that target CWDs in and out of school so as to curb occurrence of new cases of HIV infection. There is therefore the need to CWDs need education in life skills, drugs and substance abuse and clear information on condoms use for protection. There is need to train core groups of young people as peer educators and counselors within the communities
- Institute a cultural approach to HIV prevention and care activities so as to enable a holistic dimension to fight and manage HIV and AIDS. An analysis of cultural factors will help to refine policies and programmes for HIV and AIDS education for CWDs since the complexity of cultural contexts in Kenya makes the risks equally complex
- Network and coordinate activities for disabilities and HIV and AIDS to achieve an edge in the fight against HIV among CWDs and the entire population of PWDs
at the national, county, district and community levels by the various partners and stakeholders in HIV and disabilities

- Help all CWDs to internalize HIV and AIDS messages so as to depict positive images free of demonization. While designing campaigns, all members of the society should be factored in and targeted by HIV and AIDS messages in order to avoid a feeling of alienation and re-stigmatization. Campaigns should create an enabling environment where PLWA and CWDs/ PWDs have a dignified life characterized by full self-awareness and self-esteem

- Have IEC campaigns that fully generate awareness for change of behaviour through behaviour change communication (BCC) interventions where people are trained to learn life skills and to develop positive attitudes. They need to develop the ability to communicate effectively, to pre-empt a risk situation, and to decline offers for unsafe sex or injecting drugs, to take sound decisions about their lives

- Build empowering behaviour change communication interventions that engage target groups through simulation exercises, games, role-play, and case methods among others so as to help all people to perceive risks and to practice skills acquired to fight HIV and AIDS

- Prioritize understanding of the cultural approach to HIV and AIDS prevention

- Advocate for effective and long-term engagement against the AIDS epidemic among social scientists and academic institutions so as to instill competence and adequate understanding of issues of HIV and disabilities

- Tailor-train different target groups involved in interventions and enhance capacities for expanded response to issues of HIV and disability and provision of care programmes

- Make HIV and AIDS and sex education part of the curricula right from pre-school throughout the levels of general education and that of CWDs

- Reconstruct the curricula and goals of education at all levels of education in Kenya to include clear and adequate information about scientific sexual education and prevention of HIV and AIDS

- Develop teaching and learning materials that enhance clear conceptualization of healthy HIV and AIDS and sex education free of misconceptions
• Develop suitable audio-visual aids for awareness on HIV and AIDS for all people regardless of disability
• Develop an evaluation procedure that is specific for HIV and AIDS education
• Include methods of teaching HIV and AIDS and sex education in teacher education and equip all teachers across the levels with adequate training to confidently teach the same and instill a sense of duty, responsibility and commitment in them to teach these critical subjects
• Provide funds to institutions engaging in research to develop HIV prevention medication
• Carry out a survey within and outside schools so as to identify at risk children who are highly susceptible to HIV infection
• Introduce and strengthen facilities for prevention, treatment and management of HIV within the schools
• Train teachers, parents, head teachers and heads of organizations to change their negative attitude towards HIV and AIDS education

6.4 Implications of the study

Suggestions for adoption by the government and other stakeholders in issues of HIV and AIDS and disability based on the findings, literature reviewed and discussion are:-

• Need to improve infrastructure for HIV and AIDS education for CWDs in Kenya by all stakeholders. This is because education has a preventive effect in HIV transmission among disabled populations as observed by Mulindwa (2003), for instance that condom use among people with visual, hearing and movement impairments living in Uganda increased with level of educational achieved
• Efforts should be made to make CWDs internalize HIV and AIDS messages so as to depict positive images since demonizing the pandemic will only inhibit success in combating its spread and effects. While designing campaign programmes for HIV and AIDS, all members of the society should be factored in and targeted by the messages so as to avoid alienation and exclusion, which in turn lead to stigmatization. Campaigns should be enhanced to enable an environment where CWDs to access information and services on HIV whenever they needed them
HIV and AIDS need to be contextualized beyond the medical/public health model and into the broader development paradigm. In Kenya, most communities’ beliefs on sex and sexual behaviour are entrenched in societal norms, traditions, values and thought processes, making an open discussion about them a taboo, and this subsequently inhibits successful fight against HIV and AIDS. If HIV and AIDS education and services were embedded in these beliefs and traditions, the community could easily identify with them and therefore be equipped to effectively fight HIV and AIDS.

6.5 Suggestions for Further Research

- There is need for an in-depth ethnographic study to determine the risks within the cultural context particularly of the disabled population including CWDs
- A study needs to be carried out to establish the prevalence of HIV and AIDS on CWDs, and the entire PWD population in Kenya. The impact the disease has had on this population needs to be studied too
- Research should be carried out to find out the disabling effects HIV has on the already disabled PWD population