As It Is

Research findings on the knowledge, attitude, practice and access to HIV and AIDS information and services amongst persons with disability.
Acknowledgements

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Handicap International commissioned this study to obtain scientifically processed information concerning the knowledge, attitude and practice among persons with disabilities on HIV and AIDS in Kenya. The findings of this study will be used to guide the planning and implementation of HIV prevention and management programmes for people with disabilities. It was conducted in Nairobi, Mombasa, Kisumu and Thika.

The findings herein confirm that persons with disabilities need special focus in the fight against HIV and AIDS pandemic in Kenya. Awareness of HIV by persons with disability stands at 91 per cent. This is lower compared to the national awareness score of 98.4 per cent for women and 99.3 per cent men, according to Kenya Health Demographic Survey, 2003.

People with Mental Disability are most challenged with regard to access to HIV programmes followed by the visually impaired. There is little adaptation of information to suit these disabilities. More than 50 per cent of the caregivers are not making effort of passing information on HIV and AIDS to people with mental disability.

HIV testing among persons with disability, except those impaired of hearing is low. Eighty three per cent (83 per cent) of persons who are deaf people with physical disability (44 per cent), visually impaired (34 per cent) and people with mental disability (19 per cent) have had HIV test. None of the rural mentally challenged people had taken an HIV test. Fifty three per cent (53 per cent) of those who have had HIV test did so only once with the mentally challenged and visually impaired recording the highest proportion at 70 per cent and 62 per cent respectively.

Knowledge on HIV and AIDS has not translated to behaviour change, particularly among the deaf. Twenty per cent of the Deaf, 14 per cent of persons with physical disability and 11 per cent of the visually impaired who are sexually active recorded multiple partners in the six months preceding the survey. Men are twice likely to have multiple partners compared to women. Persons with disability also keep serial partners. Thirty four per cent of those who engaged in sex with non-marital or cohabitating partners did not use condoms. Study findings suggest that poverty may be closely linked to irresponsible sexual behaviour. A quarter (25 per cent) of persons with disabilities who are sexually active admitted having engaged in sex for pay.

The study confirmed that persons with disabilities are at risk of contracting HIV through sexual violence, especially the women. Regrettably, caregivers do not get to know all cases of sexual violence on people with mental disability with most rape cases go un-reported. Only three per cent of those who have been sexually violated sought post-exposure prophylaxis. Findings from the study suggest that persons with disability are engaged in substance abuse, which is closely linked to risky sexual behaviour and HIV spread. Twenty five per cent of persons with disability self reported to be current users of at least one substance of abuse.

Whereas safe male circumcision has been acknowledged as an HIV prevention measure, the study indicates that male circumcision among persons with disability is lower than that of the general population. Seventy two per cent (72 per cent) of male with disabilities aged 15 years and above had gone through circumcision.

The study recommends mainstreaming of disability issues at the national level, so that it can trickle down to the various service providers on the ground.

**Key insights**
- Championing of programs aimed at addressing the specific vulnerability to infection of people with disability
- Need to mainstream HIV and AIDS intervention and policies
- Availing consumable information materials to the disabled
- Easy access and holistic treatment
2.0 Background

Handicap International has been serving people with disabilities worldwide for over 25 years and its services have been pivoted on the principle of equalisation of opportunities, inclusion and social integration. It has been implementing a comprehensive programme on disabilities and chronic illnesses such as HIV and AIDS through combined efforts of people living with disabilities, their families and communities and the appropriate health, educational, vocational and social services. While Handicap International has been involved in the fight against HIV and AIDS for over a decade, the main focus has been on programmes aimed at addressing the specific vulnerabilities to infection of people with disabilities. In view of its growing field experience, focus on research and lobbying for the rights of people with disabilities, Handicap International – Kenya is probably better placed to play a leading role in the fight against HIV and AIDS among people with disabilities.

In a bid to reduce the risk of this population contracting HIV and AIDS, it is suggested that access to information paramount. Unfortunately, mainstream HIV and AIDS intervention programmes largely ignore a good proportion of people with disabilities. The visually impaired, for example, cannot read communication materials unless produced in Braille. There is therefore need to gather information on people with disabilities and then gauge their levels of knowledge, attitude and practices towards HIV and AIDS.

Handicap International is currently providing technical support to eight local associations to enable them implement HIV and AIDS preventive activities targeting people with disability. Viability of this kind of support depends on scientifically collected information concerning the knowledge, attitude and practice among people with disabilities on HIV and AIDS. Having closely worked with other disabled people’s organisations since 2005, it has acquired lessons which include; first, that disability issues should be mainstreamed into HIV and AIDS interventions and policies, secondly, HIV and AIDS information and services need to be in an appropriate format that is readily available and understood by the disabled and non-disabled population, thirdly, easy access to frontline treatment is crucial for HIV and AIDS treatment and, finally, that service providers need sensitisation on the needs of the disabled population.

This is a study on the knowledge, attitude, practices and accessibility to information on HIV and AIDS infection, besides also assessing the exposure to and appropriateness of HIV and AIDS programmes to the needs of people with disabilities.
3.0 Rationale

Increasing literature recognises the vulnerability of persons with disability to the HIV pandemic, making this a major area of concern (Mulindwa I.N, 2003, Yousafzi, a et al, 2004). According to an advocacy paper on the situation of persons with disability in Kenya, persons with disability are more susceptible to contracting HIV and AIDS compared to the non-disabled persons, mainly because of social exclusion factors such as being deprived of information, education and communication, and in particular the women and children who are exposed to sexual exploitation due to society’s likening of disability with less essential, desperate and fruitless people. It is not inevitable for many to assume that persons with physical and sensory (deafness, blindness), or intellectual disabilities are not at high risk of HIV infection.

Worse still, wrong perception that persons with disability are not sexually active, unlikely to use drugs or alcohol, and at less risk of violence or rape than their non-disabled peers is shocking. Risk factors for individuals with intellectual disability have received more attention. Research and programming for this population lags behind compared to what is available for the general population. The term disability is multi-dimensional and subjective in nature and, as such, there is no single universally agreed definition.

Broadly, the term may be taken to mean a range of different functional limitations occurring in any community, where persons may be disabled physically, intellectually or sensorily, medical conditions or illnesses. These impairments limit the ability of affected persons to take part in the active life of the community on an equal level with others. Traditionally disability was seen as a medical condition.

Discovered in 1984, and declared a national disaster in 1999, HIV and AIDS has been on a steady rise. Data from the Ministry of Health (AIDS in Kenya 2001) indicate that there have been 1.5 million deaths due to AIDS and about 2.5 million others are currently infected with the virus. The AIDS pandemic is the single most serious threat to sustainable development in Kenya. Over 10 per cent of the population is infected and around 800 people die of AIDS each day. A study in 2000 indicated that, in Kenyan secondary schools, 20 per cent of students are infected, out of which 16 per cent are girls and 4 per cent boys.

The HIV and AIDS impact has been socially and economically devastating, eroding greatly the economic and human capital, and leaving about 1.5 million orphans. It is estimated that Kenya loses about Ksh200 million daily in form of reduced productivity, absenteeism from work, deaths and funeral expenses, replacements and training of new personnel. HIV and AIDS most deeply affects those least able to enjoy their rights, the poorest, the weakest, the least educated and the most sidelined and marginalised (Sida/GoK, 2002 p12).

For persons with disability, there is no national census or statistics in Kenya nor are there surveys on the implications of HIV and AIDS on persons with disabilities. The World Health Organisation (WHO) estimates that 10 per cent of the population constitutes persons with disabilities. Rapid assessments have also revealed that persons with disability are sexually exploited and vulnerable to HIV and AIDS.

Dominant but false societal notion that persons with disability have no sexual desire and that are constantly supervised has made it difficult for them to voice concerns. Thus persons with disability will often be found to engage in sex with each other on occasions when they can secure time alone. Extreme poverty and social sanctions against marrying disabled people mean that they are unlikely to get partners, and thus become involved in a series of unstable relationships.

Social exclusion is defined as “the process through which individuals or groups are wholly or partially excluded from full participation in the society in which they live” (European Foundation 1995, cited in Francis, 2002: 74). Social exclusion emphasises two factors: first, that exclusion can be the consequence of many factors, such as disability, gender or ill health; secondly, that different societies have different ways of excluding people so that “the poor of different times and places differ between themselves in virtually every aspect of their condition”. Persons with disability in Kenya are acutely aware of their marginalisation.
The study used both secondary and primary research. The purpose of secondary data was to review other research that has been carried out in this area, policy documents relating to HIV and AIDS and how they have incorporated the persons with disability, interventions on the HIV and AIDS directly dealing with people with disabilities and lessons from these interventions. It was also used to derive indicators of knowledge and attitude towards HIV and AIDS that were used in the subsequent components. Primary research was conducted using both qualitative and quantitative methods. Qualitative phase preceded the quantitative phase.

The qualitative phase was exploratory in nature and sought to gain deeper insights on motivators, perceptions and attitudes. It also sought information on challenges in reaching people with disabilities with information on HIV and AIDS. This approach used Focus Group Discussions, observations, in-depth interviews and field diaries. Focus Group Discussions were conducted in institutions for the youth, both female and male youth in institutions. Female Focus Groups were held separately from male Focus Groups. Each group was composed of 8-10 participants. All groups were conducted within the respective institutions. However, confidentiality was assured. A total of 11 in-depth interviews were carried out with community-based organisations, heads of institutions, church based organisations, policy makers and heads of service providers.

Observations were carried out through mock HIV test for persons with disabilities at a Voluntary Counselling and Testing Centre. The purpose of this exercise was to evaluate HIV services offered at a Voluntary Counselling and Testing Centre and establish if there are any barriers or gaps that would affect accessibility of services to people with disabilities. Besides, each interviewer was asked to keep a field diary to record any observations on HIV information in the area. In addition, the diary captured other information relevant to objectives of the study, which was obtained from interviews or observations but was not captured in the questionnaire. A field debrief was conducted with the field team and all the relevant observations and additional information were analysed qualitatively.

The quantitative phase targeted people with disabilities aged 15 years and above living in Nairobi, Thika, Kisumu and Mombasa. These regions tend to have a high concentration of persons with disabilities. There were four major disability categories, namely physical, mental, blindness and deafness. The sample size was 616. Sample size was determined based on a reasonable number that would yield statistically viable data rather than level of precision. Sample distribution in the four regions assumed that the higher the population, the higher the probability of having a person with disability. Respondent selection was through snowball method. The rationale for using this sampling method was informed by lack of a sampling frame for persons with disability or information on population distribution of persons with disabilities.
5.0 Research Findings

5.1 Sample Characteristics

The study covered 157 caregivers. It captured those with severe and mild intellectual disability. Those that attended normal school did not go beyond lower primary. Most (69 per cent) of the People with mental disability covered in this survey were in the range of 18 to 35 years. In the case of the blind, deaf and physically challenged, the majority who participated in this study were aged between 25-45 years (67 per cent). The sample was equally distributed across the disability category. However, this study was skewed to urban areas.

Out of the 616 respondents, 517 of people with disabilities (84 per cent) had accessed formal education. However, persons who are deaf are more likely to access education compared to people with physical disabilities and the blind. Nearly all the mentally challenged depend on the parents or guardians. However, 4 per cent were found to depend on handouts from well-wishers. Another one per cent with mild retardation had been employed as house servants.

<table>
<thead>
<tr>
<th>Group of People</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons with disability in employment or self employment</td>
<td>51%</td>
</tr>
<tr>
<td>Persons with disability living in one roomed houses</td>
<td>48%</td>
</tr>
<tr>
<td>Able bodied using charcoal</td>
<td>66%</td>
</tr>
<tr>
<td>Persons with disability using charcoal</td>
<td>26%</td>
</tr>
</tbody>
</table>

HIV and AIDS campaign should understand the lifestyle of people with disability in order to communicate effectively. People with different disabilities have slightly different lifestyles. The visually impaired have a very strong interest in getting information and spend a lot of time either listening to news or reading. The women who are visually impaired are restricted in their movement at night and have to read in the rooms. For the mentally challenged respondents, their leisure time is spent largely helping in household chores. Despite their disability, the physically challenged engage themselves in games like swimming and also spend it reading books and watching television. Persons who are deaf on the other hand are more physically focused and like spending free time playing.

The main challenge highlighted across all types of disabilities is stigmatisation and discrimination. It was apparent that the youth are more comfortable in school than outside. Their concern goes beyond social economic opportunities, which reduces their chances of being economically independent. Other than social concerns, persons with disability have health concerns, which are closely related to poverty. The main concern of mentally challenged is acceptance and mistreatment by their peers. The people in the community take advantage of their disability. Home environment was said to be unfriendly. They are overworked and sometimes harassed by family members and the neighbourhood.

Persons who are deaf are concerned about getting good education. Majority appears to have experienced family difficulties, which makes them feel discriminated against. They also face difficulties in the job market, finances and neighbours. The main concern for the visually impaired females is equal treatment as men and people with no disability. The physically challenged are mainly concerned about studying and attainment of career goals. Social acceptance affects persons with disability’s ability to relate with the society. This was eminent in field diaries, which reported loneliness of respondents.

According to institutions and Community Based Organisations dealing with HIV and AIDS, the persons with disability face other health problems such as malaria, under nourishment and HIV and AIDS. The health concerns are linked to poverty and lack of proper upkeep. Many come from poor backgrounds and their concerns are actually diseases that habitually affect the poor.
5.2 Sexually Transmitted Illnesses (STIs)

Awareness of specific diseases was unaided. The study could not establish awareness of the mentally challenged. Therefore this section presents findings for the visually impaired/low vision, physically challenged and hearing impaired. Persons with Disability have high awareness of STIs in general at 94%. Awareness across gender and different types of disability at 90% respectively.

To establish depth of knowledge of sexually transmitted infection and the link between sexually transmitted infections and HIV, respondents were asked on illnesses that can be sexually transmitted. Persons with disability closely link sexually transmitted infection to HIV. Lower abnormal pain as a sign of STI (18%) and Weight loss as a sign of STI (6%).

5.3 Awareness of HIV

The study established that there are those who think of HIV as a sexually transmitted infection and those who do not link it with sexually transmitted infection. Those who were not aware of sexually transmitted infection or did not mention HIV as an sexually transmitted infection were prompted on awareness of HIV.

<table>
<thead>
<tr>
<th>Group of People</th>
<th>Awareness percentage on HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non disabled (Source: Kenya Health Demographic Survey, 2003)</td>
<td>99%</td>
</tr>
<tr>
<td>Persons with disability awareness on HIV)</td>
<td>91%</td>
</tr>
</tbody>
</table>
5.4 Knowledge of HIV and AIDS

Abstaining from sex, being faithful to one uninfected partner and using condoms (ABC) are the most important ways to avoid spread of HIV. To ascertain the depth of knowledge on HIV prevention respondents were asked specific question on how one can protect oneself from the HIV. Unlike other studies with the general population where being faithful get higher mention, persons with disability are likely to have a reverse order of priority prevention method. Use of condom is likely to be more applicable to this population than abstinence and being faithful. This may be attributed to the fact that most are sexually active but lack a marital or cohabitating partner.

<table>
<thead>
<tr>
<th>Group of People who knew HIV positive persons in their area</th>
<th>Awareness percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of respondents in general who knew person(s) who are HIV positive in their areas,</td>
<td>51%</td>
</tr>
<tr>
<td>Rural area residents</td>
<td>58%</td>
</tr>
<tr>
<td>Urban area residents</td>
<td>49%</td>
</tr>
<tr>
<td>The deaf</td>
<td>65%</td>
</tr>
<tr>
<td>Persons with physical disability</td>
<td>48%</td>
</tr>
<tr>
<td>The blind</td>
<td>40%</td>
</tr>
</tbody>
</table>

Knowledge of Anti-Retrovirals is average.

<table>
<thead>
<tr>
<th>People With Disability</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ignorant of Anti-Retrovirals</td>
<td>30%</td>
</tr>
<tr>
<td>Who know Anti-Retrovirals are available for free</td>
<td>48%</td>
</tr>
<tr>
<td>Who believe that all HIV+ persons must take Anti-Retrovirals</td>
<td>51%</td>
</tr>
<tr>
<td>Who know that Anti-Retrovirals do not cure, they only prolong life</td>
<td>80%</td>
</tr>
</tbody>
</table>

5.5 Stigma towards people living with HIV

Stigma affects social life of people living with HIV and discourages those who do not know their status from taking a HIV test. Stigma reduction is a strategy in managing HIV and AIDS. Stigma was measured by understanding how the community treats people who are HIV positive.

| The respondents who are aware of Persons Living With HIV in the community and cited that the community prejudiced and/or discriminated against them | 54% |
| Rate of prejudices in urban areas                           | 56% |
| Rate of prejudices in rural areas                           | 49% |
| Male who reported discrimination against HIV positive persons | 59% |
| Female who reported discrimination against HIV positive persons | 49% |
| The deaf who reported discrimination for HIV positive people | 61% |
| Persons with physical disability who reported discrimination for HIV positive people | 57% |
| The blind who reported discrimination for HIV positive people | 43% |
| Those who sympathised with the persons                       | 13% |
| Those that denied the disease                                | 25% |
The incidence of HIV testing of mentally challenged has been reported separately from the other categories. The study found out that there is a gap in Voluntary Counselling and Testing Centre staff skills and attitude towards persons with disability. The staff should consider persons with disability as normal people with sexual needs.

### 5.6 Sexual Behaviour and condom usage

39% of the married or have a cohabitating partner, whose significant proportions are engaging in sex with non marital partners. Persons with disability who engaged in sex the first time because they desired to do so was at 90%. The incidence of rape at first sexual encounter was higher among the visually impaired (11 per cent) compared to people with physical disability (5 per cent) and persons who are deaf (5 per cent). Three quarter (75 per cent) of persons with disability had their first sexual activity with boy/ girlfriends. This indicates that premarital sex should be a key of focus for HIV and AIDS programme targeting persons with disability. This is also supported by the fact that 29 per cent engaged in sex at or before age 16. Persons with disability in rural areas engaged in sex earlier than urban area (39 per cent versus 27 per cent).
5.7 Risky behaviour

While engaging in sex is normal, multiple partners without consistent use of condoms in every sexual encounter increase the risk of contracting HIV.

Half of the youth with disabilities aged 18-24 years have engaged in sex in the last six months mainly with the girl/boy friends. Although the number of the youth in this study was small, it indicates that they are keeping multiple partners. Of greater concern is that one out of the 23 youth received payment for sex. The findings were supported by Focus Group Discussions with youth in institutions of learning. Most of the youth admitted to be sexually active. Teachers claimed that they suspect that some mentally challenged girls are sexually active. Teachers and parents play a very vital role to these females in educating them about sexual relationships. Although the youth acknowledge that they are sexually active, the institutions would like to believe that the students do not engage in sex. This may pose a barrier to availability of HIV and AIDS information at the institutions.

Religion plays a big role in the respondents’ perception of sex. The youth in institutions who are not engaging in sex base it on religious beliefs. They believe that sex is gift from God and needed time to plan for it.
5.8 Knowledge on condoms

Condom usage is only helpful if persons with disability can use it effectively. Currently knowledge on correct usage of condoms among persons with disability stands at 64%.

There are a few misconceptions about condom usage. Some girls do not trust condoms to protect them against HIV virus, as they argue condoms have pores. Females with mild intellectual disability believe that condoms sold in shops are recycled. Majority of blind female respondents also said manufacturers have compromised on quality.

Although the knowledge on sources of condoms is high, it has not translated to usage of condoms. This may be explained by qualitative findings where the youth who are deaf reported communication challenge when buying condoms since most sellers do not understand sign language. They therefore prefer buying in a place where they can pick the condoms themselves. Condom non usage may be attributed to the perception that using condoms in a relationship imply that one does not trust the partner, condom reduce sexual pleasure and perception that condoms are not effective in HIV prevention, religious beliefs that discourage use of condoms, lack of knowledge on how to use condoms and lack of condoms at the time of need.

Ability to negotiate for safer sex was established through an understanding of who initiated use of condoms in the last sexual encounter.
5.9 Perceptions

The respondents were asked whether they consider people with the specific disability to have a higher risk of contracting HIV and AIDS compared to other members of the community. Overall, 80 per cent feel they are at risk of contracting HIV and AIDS. Persons with physical disability have a lower risk by at least 15 per cent compared to the deaf and blind. Perception of risk was almost similar across setting (rural/urban) and gender, though slightly higher for women. Across the region the risk was perceived to be high in Mombasa at 89 per cent compared to other regions, which reported 78 per cent and below.

Caregivers of persons with mental disability shared the same perception with 82 per cent feeling that a person with mental disability is at a higher risk of contracting HIV. Unlike the other entire region the proportion of caregivers who accent that persons with mental disability is at a higher risk is lower in Nairobi at 73 per cent. Overall, the two major factors that put persons with disability at a higher risk were lack of information on HIV and AIDS and vulnerability to sexual violence or sexual exploitation. Closely related to lack of access to HIV and AIDS information is the appropriateness of the information.

It is interesting to note that 100 per cent of the deaf response mentioned lack of access of information put them at risk as compared to the blind (41 per cent) and persons with physical disability (47 per cent), this could imply that the information is not available on the sign languages which they understand. Other reasons included multiple sexual partners and lack of access to HIV prevention programs.

Considering those who claimed that persons with disability are not at risk, perception that persons with disability are discriminated against in sexual relations (44 per cent) and that they are sexually inactive (39 per cent) are the major reasons why they believe that they are not at risk. Only 24 per cent based it on the fact that they have information to protect against HIV and AIDS.

5.10 Vulnerability of Persons With Disability to HIV

Various writings on disability and HIV and AIDS concur that there are factors that increase the persons with disability’s chances of contracting HIV. Some of the factors discussed include sexual violence, wife sharing, stigmatisation, poverty, traditional practices, and failure to get the husband of choice. (Mulindwa, I.N, 2003, Groce, E. N. 2003, Munguti, K., Yousafzi, A, 2004).

Sexual violence is a major predisposing factor. As discussed elsewhere, out of the persons with disability who felt that persons with similar disability are at a higher risk of contracting HIV than other members of the community, 80 per cent of caregivers, 70 per cent of the physically impaired, 67 per cent of persons with physical disability and 34 per cent of the deaf attributed this perception to sexual violence. Eight per cent of the mentally challenged have been raped, with females recording 15 per cent compared to 3 per cent for males. When looking at incidence of sexual violence among persons with mental disability, caution should be taken because not all cases get to the attention of the caregiver. The caregiver in most cases gets to know only the cases that result to pregnancy or physical harm.

Seven per cent of the 410 persons with disability (visually impaired, persons who are deaf and the physically challenged) who are sexually active were sexually violated in their first sexual encounter. The incidence was high among female (13 per cent), blind (11 per cent) and urban (8 per cent). Although rape is affecting female more than male, 3 per cent male recorded that their first sexual encounter was through rape.

Seeking medical treatment after rape is important to provide rape survivors with post-exposure prophylaxis, which can reduce the risk of contracting HIV. Only 3 per cent, all of them visually impaired, sought HIV test and prevention. This is also compared to one out of twelve caregivers who sought for them medical treatment after rape. This indicates a huge gap in seeking medical attention after rape.
5.11 Chronic medication

Due to the pre-existing medical conditions, persons with disability may be on drugs that may have counter reaction with Anti-Retrovirals. In addition, some of the drugs may be administered through injections, meaning that persons with disability are exposed to more injections than a person without any disability. Eight per cent of the persons with disability are on chronic medication (Epilepsy, Diabetics, Leprosy, TB etc). Persons with mental disability recorded higher drug use (21 per cent) followed by persons with mental disability (12 per cent) compared to the deaf (6 per cent) and blind (6 per cent). Substance abuse leads to risky sexual behaviours. Injectable substance abuse increases the risk of transmitting the HIV virus through unsterilised and sharing syringes. Current drug usage measures use of the substance abuse in the last 30 days. Overall, alcohol is the main substance of abuse used by persons with disability. Although physically challenged persons try alcohol more than the deaf, the latter have a higher usage at 15 per cent compared to the former at 10 per cent. Men are more likely to use any substance compared to women.

5.12 Early sex

Age 16 years is considered in Kenya as the consent age for sex. Sex at or before 16 years is likely to take place among non-married people and takes place as soon as the chance presents itself therefore there is no time to buy protection. Therefore early engagement in sex increases the vulnerability of persons with disability. Nearly a third (29 per cent) of persons with disability (persons who are deaf, visually impaired and physically disabled) engaged in sex before the age of 16 years. The proportion was higher among the deaf (37 per cent), rural areas (39 per cent) and Kisumu (35 per cent). HIV programs should consider targeting adolescents and the youth with disability.

In any case, most persons with disability are poor. They have little or no education. Engaging in sex for pay reduces the persons with disability negotiation for safe sex. Given that the motivation is to get payment or even pay for sex, it reduces the chances of evaluating the sexual partner. These factors predispose persons with disability to contracting HIV. Overall, a quarter (25 per cent) of the deaf, blind and physically challenged have engaged in sex for pay or to obtain special favours; The deaf are more likely to engage in sex for monetary gain with 34 per cent. This has a high occurrence in urban areas (28 per cent) compared to rural (13 per cent) and in Nairobi 32 per cent compared to other regions.

5.13 Circumcision

There is conclusive epidemiological evidence to show that uncircumcised men are at a much greater risk of becoming infected with HIV than circumcised men. According to UNAIDs and who, evidence that male circumcision is efficacious in reducing sexual transmission from women to men is compelling. Overall, 28 per cent of the male who are deaf/blind/physically challenged were not circumcised. Compared to Kenya Demographic Health Survey 2003, 84 per cent of men aged 15 years and above had gone through circumcision compared to 72 per cent in this survey. Therefore, it can be concluded that male circumcision among persons with disability is below the national level.

If circumcision is not conducted using sterilised tools, it can pose a risk of contracting HIV if it had been used before on a person who is HIV positive. Circumcision in a hospital/health centre reduces the chance of unsterilised tools because of using qualified personnel who follows the recommended procedures. Most of the deaf, blind and physically challenged were circumcised by a traditional circumciser. The proportion of those handled by traditional circumcisers are much higher in the rural areas (62 per cent), among the females (79 per cent) and among the blind (79 per cent).

Key insight

• Nearly a third (29 per cent) of persons with disability (persons who are deaf, visually impaired and physically disabled) engaged in sex before the age of 16 years. The proportion was higher among the deaf (37 per cent), rural areas (39 per cent) and Kisumu (35 per cent). HIV programs should consider targeting adolescents and the youth with disability.
5.14 Stigmatisation

This study established that society assumes persons with disability have no sexual feelings. The immediate people close to those living with disabilities will for this reason not engage in sex discussion or HIV and AIDS. Loneliness and social rejection increases the vulnerability of persons with disability. This was seen to contribute greatly to infection and re-infection despite the fact that the person may have knowledge on HIV and AIDS. Thanks to social rejection, persons with disability tend to keep multiple and or serial partners. In most cases these are also partners who are persons with disability. In addition, they also share multiple partners among themselves.

More than half (55 per cent) have never married or have divorced. Only 46 per cent of the men and 29 per cent of the female are married or living with a partner. According to the Kenya Health Demographic Survey, 2003, 60 per cent of women and 51 per cent men aged 15 years and above are married or living with a partner. Despite the sampling differences these findings indicate that persons with disability face a challenge in finding an appropriate partner, especially the females. Considering that 89 per cent are engaging in sex, it is reasonable to argue that majority of persons with disability are engaging in high risk behaviour.

5.15 Blood transfusion

Generally, due to the medical conditions of persons with disability, they are exposed to more blood transfusion compared to persons without disabilities. This research found that 13 per cent have had blood transfusion. Surprisingly a slightly higher proportion of men (17 per cent) have had blood transfusion compared to women (14 per cent) who may be expected to have blood transfusion due to childbirth. Persons with physical disability recorded the highest incidence of blood transfusion at 21 per cent while the intellectually challenged and blind recorded the lowest incidence at 5 per cent and 8 per cent respectively. Out of the 72 respondents who have ever had blood transfusion, 71 per cent had it over two years ago; very few respondents (13 per cent) have had blood transfusion in the last twelve months.

The visually impaired, persons who are deaf and physically challenged youth agree that they are at risk of being infected with HIV. Male respondents are aware that having multiple partners poses a higher risk. Amongst the physically handicapped, they also felt that being exposed to pornography materials and explicit soap operas that glorified sex weakened their resolve to keep away from sex.

Some communities in western Kenya carry out cleansing ceremonies after the death of a man leaving behind a widow. Part of the cleansing ceremony entails engaging in sex with the widow. In the past, some community members used to carry out the ritual. But with increased awareness on the dangers of HIV, community members are hesitant to be involved. Persons with mental disability are now being taken advantage of.

5.16 Access to information and treatment

Nearly all (91 per cent) acknowledge that they have received HIV and AIDS information, with the deaf rating at 95 per cent, blind 91 per cent and persons with physical disability 87 per cent. Majority (69 per cent) of the respondents received the information no later than six months ago, with persons with physical disability rating at 78 per cent, the visually impaired 73 per cent and persons who are deaf 58 per cent.

The main focus of information was on transmission and prevention. Source of information varies across the disability. According to the study, radio is the most preferred source of information among the visually impaired (41 per cent) and the physically challenged (35 per cent). However, the deaf prefer several modes of information, which are mainly, inter personal communication; that is, disability support group (15 per cent), seminars (15 per cent) and family/friends (13 per cent).
Closely related to the most important source is the effective source of HIV and AIDS information. For the visually impaired and physically challenged, radio proved to be the most effective source of information. Yet seminars and workshops are the most effective source of information for the deaf. Disability support groups, family/friends are also effective for persons who are deaf and the visually impaired. Hospital clinics and television are other effective channels for the physically challenged.

Overall, caregivers perceive the family members as the main source of information for persons with mental disability with 32 per cent with a higher mention in the urban areas compared to urban areas (35 per cent versus 21 per cent). Over a third (36 per cent) in rural areas feels that it is a waste of time to try and communicate with persons with mental disability because they cannot understand. This is an indication that such persons have been locked out of HIV programs even by the caregivers. Media and age mates were also mentioned by 18 per cent and 11 per cent respectively as sources of information. This implies that persons with mental disability have been left out in accessing information tailored to their level of understanding.

Whereas caregivers spend most of the time with the persons with mental disability, less than half (40 per cent) of the caregivers make an effort of passing information on HIV and AIDS. This further confirms that persons with mental disability are disadvantaged in accessing information on HIV and AIDS. A third (31 per cent) of the caregivers said that they offer advice on HIV and AIDS. However, an equal proportion (32 per cent) uses restriction of movement and close monitoring as away of protecting the persons with mental disability from the diseases. This was more in urban areas (42 per cent) than rural areas (28 per cent). The study found out that, lack of skills stifle communication with persons with mental disability in their care. Low mental abilities, communication barriers and getting the persons with mental disability to settle and listen are the major challenges among care givers with a mention of 33 per cent, 31 per cent and 25 per cent respectively.

5.17 Organisations reaching Persons with Disability

There is low presence of grass root organisations reaching persons with disability with HIV and AIDS information. Only 29 per cent of visually impaired/persons who are deaf/physically challenged mentioned that they have organisations in their areas trying to reach persons with disability. However, across disability, persons who are deaf appear to be well served with a mention of 49 per cent, blind 23 per cent and persons with physical disability 17 per cent. Persons with mental disability appear to be the most neglected with only 6 per cent mentioning that they have organisations reaching them. The few organisations in existence appear to be concentrated in the urban areas. Kisumu and Mombasa recorded no organisation serving the persons with mental disability on HIV and AIDS information.

Organisations seem to have concentrated on prevention measure/safe sex (78 per cent) and sexual transmitted diseases (78 per cent). A fifth of these organisations are also passing information on drug abuse (21 per cent). Respondents were asked whether there is any organisation that has tailored HIV information to fit their specific disability. Only 27 per cent of the respondents acknowledged such efforts.

Only 3 out of 157 caregivers acknowledged that they have organisations putting HIV information into a format that can be understood by persons with mental disability. These findings indicate a big gap in adapting HIV and AIDS messages.

5.18 Conclusion

The findings of this study have shed light on some areas that were initially grey. For instance, it can now be acknowledged that persons with disability is a special group and HIV related issues affecting this group are broad, involving the Kenyan community as a whole and as well as calling for policy review. Disability issues go beyond organisations dealing with persons with disability. Awareness of HIV among persons with disability is lower compared to the national awareness. There is knowledge gap on Mother to Child Transmission, Prevention of Mother to Child Transmission and Anti-Retrovirals, correct identification of HIV infection, positive living, correct condom usage and post-exposure prophylaxis.
Besides, there is a gap in correct and consistent use of condoms. Premarital sex among persons with disability is an area of concern. Knowledge on HIV has not translated to behaviour change particularly among the deaf. Persons with mental disability are the most challenged in accessing HIV prevention and management programmes. Caregivers’ attitude towards HIV and persons with mental disability and lack of skills are the major barriers to accessing information on HIV and other HIV programs. While the physically challenged can access most of the programmes meant for the general community, there is a gap among the visually impaired. Research findings show clearly that persons with disability are engaged in substance abuse, which is closely related to risky sexual behaviour. They are also vulnerable to be used as drug supply agents. Whereas male circumcision has been acknowledged as a HIV prevention measure, it is yet to be taken up seriously among persons with disability. Male circumcision is lower than in the general population.

References

10. ILO. Employment of People with Disabilities: The Impact of Legislation (East Africa) ILO March, 2004
12. Munguti, K Assessment of Reproductive Health needs of Persons with Disabilities in Makueni District (Paper submitted to Belgium Tech Cooperation/AMREF)
13. Sexual Offenses Act, 2006
17. Weiss HA, Quigley M, Hayes R. Male circumcision and risk of HIV infection in Sub –Saharan Africa : a systematic review and meta-analysis. AIDS 200; 142361-70
18. WHO/UNAIDS, Technical Consultation; Male Circumcision and HIV Prevention: Research Implications for Policy and Programming Montreux;– Conclusions and Recommendations 6-8 March 2007