THE IMPACT OF HIV/AIDS ON VISUALLY IMPAIRED WOMEN IN NAIROBI AND THIKA DISTRICTS, KENYA.

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DECLARATION

I hereby declare that this project paper is my original work, and has not been presented for a degree in any other university or institution

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APPROVAL

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DEDICATION

This work is dedicated to my parents, Mr and Mrs Walter Kimani, my brothers, Robert and Antony, and my sister, Susan

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LIST OF ABBREVIATIONS

ADCs: AIDS Control Councils

AIDS: Acquired Immunodeficiency Syndrome

AIDSCAP: AIDS Control and Prevention Project

CIDA: Canadian International Development Agency

EDF: European Disability Forum

FGDs: Focus Group Discussions

FHI: Family Health International

FPPS (K): Family Planning Private Sector, Kenya

HBC: Home- based care

HIV: Human Immunodeficiency Virus

IAS: International AIDS Society

IEC: Information Education and Communication

KENWA: Kenya Network of Women with AIDS

MoH: Ministry of Health

NACC: National AIDS Control Council

NASCOP: National AIDS/STDs Control Programme

NGOs: Non- Governmental Organizations

PLWAs: People Living With AIDS

SAfAIDS: HIV Information Center for Southern Africa

STDs: Sexually Transmitted Diseases

UN: United Nations

UNAIDS: Joint United Nations Programme on HIV/AIDS

UNDP: United Nations Development Programme

UNHCR: United Nations Center for Human Rights

U.S.A.: United States of America.

USAID: United States Agency for International Development

U.S. NICHCY: United States National Information Center for Children and Youth with Disabilities.

VCT: Voluntary Counseling and Testing

WHO: World Health Organization.

WOFAK: Women Fighting AIDS in Kenya

CHAPTER ONE

1.0 INTRODUCTION

HIV/AIDS is a disease caused by Human Immunodeficiency virus (HIV). AIDS applies to the most advanced stages of HIV infection. It is transmitted through sexual contact with an infected partner, infected blood, sharing of needles or syringes with infected persons and from infected mother to child. Piot (2000), observed that, "Because of AIDS, poverty is getting worse just as the need for more resources to curb the spread of HIV and alleviate the epidemic's impact on development is growing".

Global estimates of the HIV/AIDS epidemic, by the UNAIDS (2003) indicated that 40 million people were living with HIV/AIDS. Five million people were newly infected in the year 2003. 4.2million of this population were adults, while 700,000 were children under fifteen years. It also indicated that in that same year, three million people lost their lives to the disease. Although one in every 100 adults in the most sexually active age bracket (15 – 49) is living with HIV, only a tiny fraction knows about their infection. Because people can live for many years with HIV before showing any sign of illness, the virus can spread unobserved for a long time.

The situation in the developing world shows concentration of HIV infections, mostly in countries least able to afford to care for infected people. As indicated by UNAIDS (2003), HIV prevalence in sub-Saharan Africa has remained relatively steady – generally at high levels – for the past several years across much of the region. This is due to the fact that high levels of new HIV infections are persisting and are now matched by high levels of AIDS mortality. 26.6 million people in this region were living with HIV, while approximately 2.3 million people had died of the virus.

According to the same report, Southern Africa is home to about thirty percent of people living with HIV/AIDS worldwide, yet this region has less than two percent of the world's population. Figures released in Zimbabwe suggest that national adult HIV prevalence to be twenty-five percent and that the country is turning its epidemic around.

In Kenya, the first case of HIV/AIDS was reported in 1984. A report by WHO (1999) indicated that about 1.5 million people have died of the disease and the total number of those infected was 2.2 million. In addition, there are about 200,000 people infected every year and 700 people die daily. Also, the life expectancy was projected to be reduced from 59 years in 1989, to 53 years in 2000, and 40 years between 2000 and 2010, due to AIDS. A report by NACC (2000) indicated that about seventy three per cent of those infected live in the rural areas. AIDS has been reported in every district in Kenya, and it is estimated that fifteen percent of adults in the main urban areas are HIV/AIDS positive.

As a result of the overwhelming nature of HIV/AIDS, the former president of the Republic of Kenya, Mr. Daniel Toroitich Arap Moi, declared HIV/AIDS a national disaster in 1999. The age bracket most affected by AIDS is 15-49 years, which is also the most productive age – NACC (2000). These are the young adults, where women tend to be infected at younger ages than men are.

AIDS in Kenya, just like in many countries in Sub-Saharan Africa, has had a negative impact on women. It erodes their ability as spouses and mothers as well as to play their traditional role as primary health care providers. If the above statistics are anything to go by, the country will be rendered less productive, owing to the many deaths and ill health.

The Kenya National HIV/AIDS Strategic Plan (2000) identified the major challenges faced in trying to control the spread of HIV/AIDS. They include the ability to widen the scope of interventions, which are severely constrained by weak economic performance. Secondly, the health sector budget is strained by increasing HIV/AIDS patients countrywide. Thirdly, there is slow change of sexual behavior, related to deep-seated beliefs and practices and the high level of poverty.

In addition, the number of orphans as a result of having lost their parents due to the HIV/AIDS epidemic is growing fast in Kenya. Often times, these children become malnourished, lack proper education and shelter and have to take care of their younger siblings. This has led many of them to live in the streets, involve themselves in deviant behavior in order to meet their needs, and forego their education opportunities for lack of fees.

A report by NACC (2002) indicated the rates of infection among women aged between 15 – 49 years, by end 2001. According to the report, globally, 18.5 million women were infected; 15.0 million in sub-Saharan Africa and 1.4 million women in Kenya. In the same report, the rate of infection among men was as follows: globally, 18.6 million men were infected; 10.9 million men were in sub-Saharan Africa, and 0.9 million men were infected, in Kenya.

According to UNAIDS (2003), women are considerably more likely – at least 1.2 times – to be infected with HIV than men, in sub-Saharan Africa. This is attributed to several factors. They include the biological fact that HIV generally is more easily transmitted from men to women (than vice versa). As well, sexual activity tends to start earlier for women, and young women tend to have sex with much older partners.

HIV has spread through sex between men and women, the presence of socially and culturally accepted practices, which infringe on the rights of women. Some of these practices include wife inheritance, polygamy, acceptance of men to have multiple sex partners besides their wives, and male control during sex, where women are unable to negotiate for safe sex. This is not the case in other regions, where the virus initially spread most quickly among men by male-to-male sex or drug injecting.

Four out of five HIV positive women in the world live in Africa. The UNAIDS (2003) report indicated a trend analysis of antenatal clinic sites (between 1997 and 2002) among pregnant women. In (Gaberone) Botswana, forty percent of pregnant women tested HIV positive, almost sixteen percent in Blantyre (Malawi), twenty percent in Lusaka (Zambia), forty percent in Manzini (Swaziland), and eighteen percent in Maputo (Mozambique). In South Africa, surveillance data showing the average rate of HIV prevalence in pregnant women attending antenatal clinics was twenty-five percent in 2000-2002.

According to Onyango (2001), out of 700 people in Kenya infected, more than half are women. In addition, reports from antenatal clinic at semi-urban sentinel sites estimated that the number of 15-49 year old women living with HIV/AIDS in Kenya was 1.1 million. HIV prevalence among antenatal women in Nairobi increased from two percent in 1985 to twenty percent in 1999.

In the course of this study, the prevalence of HIV/AIDS among visually impaired women was noted. Many of them got to know of their seropositive status after suffering from opportunistic diseases. Since they often needed guides to take them to the hospital for treatment, often their seropositive status was also revealed to the person who accompanied them to the hospital. Some of them claimed they had been infected by their husbands and did not know what they were suffering from until they had gone to hospital to seek treatment for an opportunistic infection. In many cases these partners were long dead. Though the most prevalent mode of HIV/AIDS infection was through sexual intercourse with their marriage partners, one young girl claimed that she had been raped when she was younger and the man had also died of the virus.

For many of the women who are totally blind, they do not know of their status. After discussions, some talked about friends where both husband and wife had died and they now thought that these friends had died of the virus. Some of the women interviewed in the course of this study cited harassment by security personnel at the government hospital as a reason why they do not go to seek medical assistance often. They claimed that in former years, whenever they would go to hospital, the security personnel would promptly help them to get assistance. But in the recent past, the security personnel would ask them what they came to do at the hospital without the guides who lead them when they would go out to beg on the streets.

This study seeks to find out the impact of HIV/AIDS on visually impaired women, some of the problems they encounter as a result of their impairment in comparison to the visual women. The study will also find out ways in which they can be helped and be integrated to become productive citizens in our society, able to leave a legacy.

1.1 Statement of The Research Problem

In many societies in Kenya, women bear the responsibility of ensuring the health and stability of their families. They take responsibility for the healthy upkeep of their children as well as that of their husbands. Division of labor is not equal among family members; the woman bears the larger share of the roles as she is the mother, wife as well as care giver, in most households. They also bear a greater burden in regard to illness, due to the gender related roles. They- mothers, daughters, sisters and wives- are more often than men the care-givers for disabled children and adults in the family.

Disabled women and girls form at least ten percent of the total population of women. According to Farmer (2000), global estimates of women who have mental and physical disabilities are three hundred million. Women with disabilities, for example, the visually impaired, are the poorest of the poor around the world. In every sphere of life, those in the developing world experience a triple bind: they are discriminated against because they are women, because they are disabled and because they are from the developing world.

Physically challenged women like other women have also not been spared by the AIDS scourge. In Kenya, for example, HIV has been prevalent for the last about twenty years. It is only now that interventions for preventing its spread among the physically challenged persons, is gaining recognition and momentum. The efforts are however, very minimal and more needs to be done for them. This study seeks to investigate the prevalence, level of awareness, impact, coping strategies of HIV/AIDS by visually impaired women

1.2 Objectives

1. To find out the prevalence of HIV/AIDS among the visually impaired women.
2. To find out the factors that predispose visually impaired women to HIV/AIDS.
3. To determine the level of awareness of HIV/AIDS among the visually impaired women and the socio economic impact of HIV/AIDS on the visually- impaired women.
4. To find out the societal attitude toward women suffering from HIV/AIDS.
5. To identify and document the coping strategies of visually impaired women living with HIV/AIDS.
6. Suggest measures that should be instituted in order to assist the visually- impaired women cope with the HIV/AIDS scourge.

In order to achieve the objectives of the study, the study will be guided by the following questions:

1. How prevalent is HIV/AIDS among the visually impaired women?
2. What are the factors that pre-dispose visually impaired women to HIV/AIDS?
3. What is the level of HIV/AIDS awareness among the visually impaired women and what is the socio- economic impact of HIV/AIDS on the visually- impaired women?
4. What is the societal attitude towards women suffering from HIV/AIDS?
5. What are the coping strategies of visually- impaired women living with HIV/AIDS?
6. What measures should be instituted to assist visually impaired women come with the HIV/AIDS scourge?

1.3 Rationale.

The HIV epidemic is challenging accepted ways of understanding health and human development in our societies and demanding new forms of expertise and holistic responses. The research on the impact of HIV/AIDS on visually impaired women is one of great importance. Physically challenged women are prone to exploitation and various forms of violence either from their families or the community. They are increasingly becoming targets of rape because of the notion that they are "virgin territory" hence free from HIV/AIDS (Daily Nation, September 5, 2001). They are, however, hardly able to represent themselves to have the offenders punished, due to their disability. For those who are visually impaired, they may not be able to identify those who sexually violate them in a court of law. This also makes them vulnerable to contracting HIV/AIDS.

Due to the disability in visually impaired women, they are usually sent away for prostitution out of their will, in order to earn an income for their families.
These women also stand lesser opportunities of getting formal education and employment due to their disability.

According to the European Disability Forum (1997), education for people responsible for portraying disabled women and girls and their issues, such as journalists, media and filmmakers is essential in order to obtain positive images. Most HIV/AIDS education is directed towards the visual people. This is through, for example, television and booklets. Promotion of positive non-stereotyped images of women and girls with disabilities, in co-operation with organizations of persons with disabilities, should be encouraged.

The status of women has a positive co- relation with their health and education status. Therefore, targeting women with interventions has inherent benefits, which will ensure the safety of their offspring. It will, therefore, be important to address factors that make women more vulnerable to HIV/AIDS and at the same time empower them to be able to protect themselves against infection.

Women's attainment of healthy and fulfilling lives is influenced by factors operating at many levels of society, including traditional/ cultural politics and legislation, which do not allow full expression of women's potentials and abilities. Many women are powerless to take steps to protect themselves. They are also disproportionately responsible for the care and added burden of those infected and affected with HIV/AIDS, often without sufficient information, medication supplies, counseling and support.

An understanding of the factors that affect women is critical to any effective measures to contain the spread of HIV and to deal with its effects for both women and men. The vulnerability of women to HIV must be understood in the broader context of deeply embedded social and gender inequalities, which lie at the heart of women's inability to deal effectively with the risks and needs created by the epidemic. Unless the interaction between HIV infection, cultural values and the rights and needs of women is recognized, the fundamental changes that are required to stem the epidemic would be unattainable.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.0.1. Factors That Play A Role In Kick-Starting A Sexually Transmitted HIV Epidemic

According to the UNAIDS Epidemic Update (2000), there are many factors that play a role in kick-starting a sexually transmitted HIV epidemic or diving it to higher levels. Among the behavioral and social factors include, little or no condom use; large proportion of the adult population with multiple partners and overlapping sexual relationships- individuals are highly infectious when they first acquire HIV and thus more likely to infect any concurrent partners. In addition, there are large sexual networks (often seen in individuals who move back and forth between home and a far-off workplace); 'age mixing', typically between older men and young women or girls; and women's economic dependence on marriage or prostitution, robbing them of control over the circumstances or safety of sex.

The above factors are also identified in the Ministry of Health, Kenya (1997) paper. In addition, the male ego, and need to glorify virility, exerts pressure on men forcing them to demonstrate these virtues through sexual experimentation and conquests and multiplicity of sexual relationships. The status of the African woman within the society is contingent on child bearing with preference for male offspring. This affects decisions on family size, fertility and sexuality. Some women will continue bearing children, with the knowledge of the possible risk of HIV infection, thus exposing their lives and that of their offspring to the risk of HIV infection.

2.0.2 Social and Cultural Determinants of HIV Infection in Women.

The UNDP (1993) indicated that the social and cultural determinants of HIV infection in women are very different from those for men. This is because they relate to the role of women within relationships, families and communities, which, in turn, determine the nature and patterns of sexual activity and other factors that place women at risk of HIV infection.

Lowenson (1993) stated that women are more vulnerable to HIV/AIDS infection because they have less secure employment, lower incomes, less entitlement to assets and savings and little power to negotiate sex. This is particularly true for the visually impaired women. In many African countries, women are brought up largely to submit to men, be they husbands, fathers or brothers. In the larger society, they are still in submission and even to sexual demands without their consent. The primary risk activity for women globally is the sex act.

For married women, inheritance patterns, economic subordination and the absence of restraint on the number of sexual partners a man may have, all weaken marriage as a protective institution against HIV transmission. She has little or no power to negotiate the basis upon which her sexual relationship with her husband will take place. Once married, women are usually expected to remain faithful, but are unable to compel fidelity in return. Advocating the reduction of sexual partners is less relevant to the many women who have no other sexual partners than their husbands or regular partners. This means that women are more heavily affected in Africa than in other regions, where the virus initially spread most quickly among men by male-to-male sex or drug injecting. The only safe options are abstinence, fidelity, sex without penetration or sexual intercourse protected by condom use.

2.0.3 Vulnerability of Women to HIV/AIDS Infection.

During the regional workshop by the African Network of Women with Disabilities in Johannesburg in November 2001, it was recognized that women and children with disabilities are at high risk of contracting HIV/AIDS and are particularly vulnerable to abuse of their sexual and reproductive rights due to the following reasons:

1. Exclusion and discrimination in terms of access to education, health services, family life and employment;
2. Low self-esteem and confidence, which results from a life of discrimination and exclusion;
3. Misconceptions, myths, prejudice and negative attitudes held by society, which perpetuate the exclusion and abuse.

The Ministry of Health, Kenya (1997) stated that the low status of women in society reduces their capacity for decision making in matters related to sexuality, fertility, and their lives in general. Majority of women, therefore, lack bargaining power and are unable to negotiate desirable and safe relationships. It also indicated that HIV prevalence rates peak earlier for women than men. One reason for this was that young girls become sexually active at an early age. Women are more susceptible to heterosexual transmission because of biological factors, illiteracy, ignorance and lack of skills forcing them to be dependent on men for economic support. Social cultural influences also play a part in the vulnerability. The cultural emphasis on reproduction, submissiveness and child marriages increase the risk of women contracting HIV infection. This situation is worsened by deteriorating economic conditions, which makes it difficult for women to access health and social services.

A study by NASCOP (1999) indicated that when a member in a family has HIV/AIDS, it is usually the women who care for the person. As the primary caregivers, women must often forego productive activities or employment opportunities in order to fulfill their duties. At times they lack the basic skills for caring for PLWAs and are at risk of infection themselves. Young girls may have to stay home instead of be in school in order to help with chores around the home, thus, their education may be cut short. The family may also exhaust savings and investments to pay for drugs and funeral expenses. The result is that families become poorer, children's education may suffer and the standard of living of the entire family declines. There may also be the onset of child-headed households or children opting to live on the streets.

2.0.4 Stigma and Discrimination.

According to Farmer (2000), it is estimated that 300 million women have mental and physical disabilities globally. He also stated that disabled women account for ten percent of all women worldwide. CIDA (2001) noted that women with disabilities are the poorest of the poor around the world. Those in the developing world experience a triple bind: they are discriminated against because they are women, because they are disabled, and because they are from the developing world.

In Kenya, there is still a lot of discrimination and stigma surrounding PLWAs. Fearing rejection, many of them are not able to openly talk about their seropositive status to their family members and ultimately, to the general public. A research done by FPPS Kenya (2001) showed that in many regions in Kenya, there was considerable prejudice towards people known or believed to have HIV/AIDS. This was due to ignorance about the nature of the disease. The association between HIV and "promiscuous" sexual behavior had created a belief that people who are infected with HIV somehow "deserve" their fate. The situation in Kenya today is that one is either infected or affected by HIV/AIDS.

A research done for UNAIDS on HIV and AIDS related discrimination, stigmatization and denial by Aggleton (2002) shows that social responses of fear, denial, stigma and discrimination have accompanied the HIV/AIDS epidemic. Discrimination has spread rapidly, fuelling anxiety and prejudice against groups most affected as well as those living with HIV/AIDS.

According to the study, in 1989, the UNHCR organized the first international consultation on HIV/AIDS and human rights. This forum reaffirmed the public health rationale for the prevention of HIV/AIDS- related discrimination and the promotion and protection of human rights in the context of HIV/AIDS- a view reaffirmed in UN General Assembly resolutions in 1990 and 1991.

In late 1996, the second international consultation on HIV/AIDS and human rights was convened jointly by UNAIDS and the office of the High Commissioner for Human Rights. Twelve international guidelines on HIV/AIDS and human rights were drafted at this meeting, the majority of which emphasized, once again, the need to avoid HIV/AIDS-related discrimination and to ensure the promotion and protection of the human rights of people living with AIDS. In Kenya, however, stigma and discrimination of people living with HIV/AIDS is still very high, thus, many of those who are infected do not talk openly about their plight.

Milner (1991) and Whiteside (1993) stated that governments and national authorities contribute to HIV/AIDS- related stigmatization. This is for example, where they cover up and conceal cases or fail to maintain reliable and transparent reporting systems. Daniel, et.al. (1991) indicated that ignoring the existence of HIV/AIDS, neglecting to respond to the needs of those living with HIV infection and failure to acknowledge epidemics in the belief that HIV/AIDS "can never happen to us" are some of the most widely reported responses of denial. He also stated that HIV/AIDS-related stigmatization may be influenced by the stage of the epidemic, age, gender, social status and whether individuals feel they are open about their seropositive status. Stigmatization causes a kind of social death in which individuals no longer feel part of civil society and are no longer able to access the services and support they need.

2.0.5 Approaches to Prevention and Cure.

In Kenya, researches have been done with focus on the general public, on HIV/AIDS to provide information needed for developing effective approaches to prevention and cure. However, there has so far been little information available, about the impact of HIV/AIDS on visually impaired women. Some have focused on HIV/AIDS and the family, and also on orphans. For example, Tony Johnston et al. (1999) carried out a research on adolescent AIDS orphans. One of their observations was that it is morbidity and mortality of the mother in an AIDS- affected environment which appear to have the most devastating impact upon family structures and the economic welfare and social well being of its children. This provides strength to this research and the fact that the needs of women need to be addressed in order to provide a holistic approach in curbing the AIDS scourge. It also strengthens the observation that women's health is essential in ensuring the stability and survival of the family unit.

However, women's rights are inseparable from economy and there is much poverty that envelops the African continent. Poor hygiene and limited health care foment sexually transmitted diseases, which strike women more than men and make HIV transmission more likely.

Women need to have a chance of self-determination in matters relating to sex. Still, there is some skepticism over the cost, acceptability, and proper use of the female condom. But, Helen Jackson, director of SAfAIDS, a HIV information service for southern Africa headquartered in Zimbabwe, says that, 'the female condom is for use when male condoms won't be used,' leaving the woman with no protection at all.

There are studies that show the advantages and disadvantages of the female condom. The advantages include the fact that the women control them, they are designed to prevent both STD's and pregnancy, no medical conditions appear to limit use, and there are no apparent side effects, no allergic reactions. The disadvantages are that they are very expensive at this time, and women also need to be educated on its use and care. It has also been noted that some women wash them, and then share with their friends. They are also not accessible to most women in terms of cost and availability. However, it is not a common practice especially among the women in the rural areas and it is not yet common in the Kenyan market. For the visually impaired women, accessibility is next to nil and alternative methods should be sought and efforts aimed at curbing the spread of HIV/AIDS should also be made to cater for the needs of the physically challenged.

CHAPTER THREE

3.0 STUDY METHODOLOGY

3.1 Study Design

A cross-sectional study on a group of visually impaired women from Nairobi and Thika districts in Kenya.

3.2 Operationalization Of Variables

1. **Age** – This refers to the total number of years one has lived since birth.
2. **Marital Status** – This refers to whether one is married or not, either at church, District Commissioner's office, traditional or simply mutual agreement between the man and woman.
3. **Number of Children** – This refers to the total number of children one has.
4. **Education** – Total number of years spent in formal and/or informal learning.
5. **Modes of transmission** – This refers to the various ways in which HIV/AIDS is transmitted from one person to another.

3.3 Variables

3.3.1 Independent Variables

Demographic Characteristics

1. Age
2. Marital Status
3. Number of children
4. Ages of the children
5. Education
6. Socio-economic status

Knowledge about HIV/AIDS

1. Modes of transmission
2. Methods of prevention

3.3.2 Dependent Variable

Awareness of programmes on HIV/AIDS prevention and support.

1. Type of programme known and degree of accessibility
2. Level of participation

3.4 Study Area: Thika And Nairobi

Kenya is divided into eight provinces, namely Nairobi, Central, Eastern, North-Eastern, Rift Valley, Coast, Western and Nyanza. It is further divided into 46 districts. The population of Kenya is estimated at thirty million people, with at least ten percent who are physically challenged. The study was done in Thika district, which is in Central province and in Nairobi, which is the capital of Kenya. Nairobi is divided into eight (8) administrative divisions, namely, Embakasi, Kibera, Dagoretti, Pumwani, Westlands, Central, Makadara and Kasarani. The study area was Korogocho, in Kasarani division. Thika is one of the seven districts that form Central province. It is divided into six (6) administrative divisions, namely, Thika Municipality, Kakuzi, Gatanga, Kamwangi (Gatundu North), Gatundu-South and Ruiru. The study area was Kiandutu, in Thika Municipality division.

3.4.1 Korogocho/ Kiandutu

Korogocho in Nairobi and Kiandutu in Thika district are both slum areas, which are densely populated. The inhabitants are a low-income group who are under-employed and unemployed people, who have come to the city to look for job opportunities. Due to the high level of poverty in these areas, the crime rates and social misbehaviors are also high. There are also quite a number of visually impaired people, and in both districts, many of them live close to each other.

3.5 Study Population

These were visually impaired women who were either infected or affected by the HIV/AIDS scourge. They were also exposed to some form of education on the control of the spread of the HIV/AIDS epidemic.

3.6 Sampling

3.6.1 Sampling Unit

The sampling unit consisted of visually impaired women who were either infected or affected by the HIV/AIDS scourge in Korogocho in Nairobi district and Kiandutu in Thika district.

3.6.2 Sampling Procedure

Two sites were included in the study, these are Korogocho and Kiandutu. The subjects interviewed were the ones found in their homes during the study period. It was difficult to randomly select the study population due to poor physical address, poor security in some areas and also the fact that some worked far from home and it was not possible to trace them at their place of work. Thus, those respondents who were at home and in safe areas were the ones who were included in the study.

3.7 Sample Size

The sample size was to be fifty visually impaired women, who were from both Nairobi and Thika districts. However, thirty women responded and their questionnaires were analyzed, for these districts.

3.8 Data Collection

3.8.1 Methods Used

Primary Data

Primary data was sourced through use of in-depth questionnaires, HIV/AIDS networks, use of key informants like home-based care programmes, VCT centers, and institutions dealing with visually impaired persons. In addition, focus group discussions (FGDs) were carried out with the women. The questionnaire, which was in english, included both open and closed ended questions, as well as both qualitative and quantitative questions. The interviews were conducted at the client's home or at the NGO where they received assistance.

Secondary Data

Secondary data was collected from institutions and organizations that deal with the HIV scourge, and home-based care programmes as well as from community health workers. Confidentiality of the data collected from the interviewees was emphasized to the women.

3.8.2 Data Collected

1. Socio-demographic data including age, marital status, number of children, education level, and socio-economic status.
2. Whether there were support groups present in their communities and their participation in these support groups.
3. Knowledge on modes of transmission and prevention of HIV/AIDS.
4. Detailed information was collected on the visually impaired women using questionnaires, and focus group discussions. These methods gave a detailed

account of the impact of HIV/AIDS on their lives. An observation was also made of the surroundings to determine the socio-economic status of the visually impaired women interviewed.

3.9 Data Analysis And Processing

The questionnaire was pre-coded. Data analysis was done using SPSS computer package. A database was created and data fed into the computer and different variables compared. Univariate variables analysis in order to describe the sample was done. This was not only to clean the data but also to compute bivariate and multivariate distributions, after which the bivariate relationship between variables was determined using cross tabulations. This was to test the nature of the relationship between variables. Chi square test was then used to test the significant of these relationships.

Data collected during the in-depth interview was done using a question guide. Data was presented through the use of tables, graphs and pie charts.

3.10 Inclusion Criteria

1. Visually impaired women who were willing to join the study.
2. Visually impaired women who were either infected or affected by HIV/AIDS.

3.11 Exclusion Criteria

1. Visually impaired women who were not willing to join the study.

3.12 Ethical Consideration

The purpose of the study was explained to all potential participants. They were also assured of confidentiality of all the information obtained from them. Any participant was at liberty to refuse to participate in the study or terminate the interview at any time. However, this never happened during data collection.

3.13 Problems Encountered

1. There was risk to the research team because the respondents' location was hostile or unsafe. Thus, some respondents from some areas were not interviewed.
2. Some of the peer counselors normally did research work for various NGOs and were used to receiving payments for their input in the research. At times they proved difficult as they demanded payments, in spite of the fact that the nature of the research had been fully explained to them.
3. For those respondents who were beggars, their time which would have been otherwise spent begging was taken up during the interviews and they demanded compensation.
4. Initially, it was not easy to interact with the women as they were wary of visitors. This was probably because many of the visually impaired women lived near each other and were not used to interacting freely with those who are not physically challenged. In addition, the women complained that many people had come to talk to them, and some had even promised to help them improve their living conditions, but nothing had been done for them so far, and so they felt used.

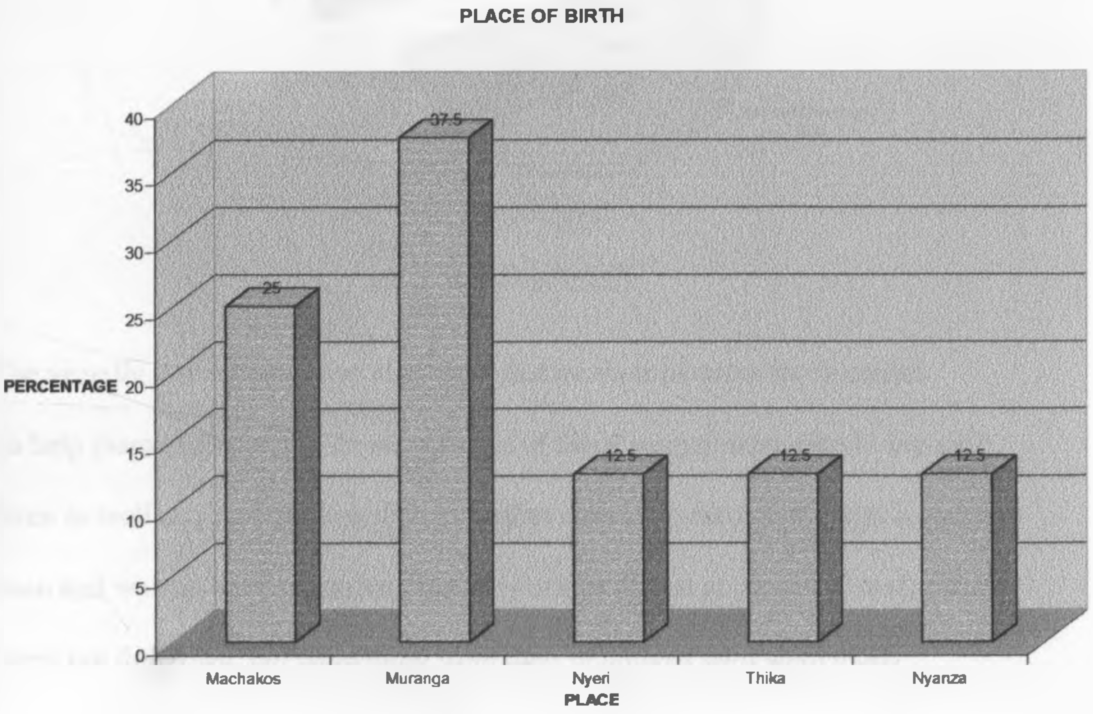
CHAPTER FIVE

5.0 RESEARCH FINDINGS

5.1 DEMOGRAPHIC DATA

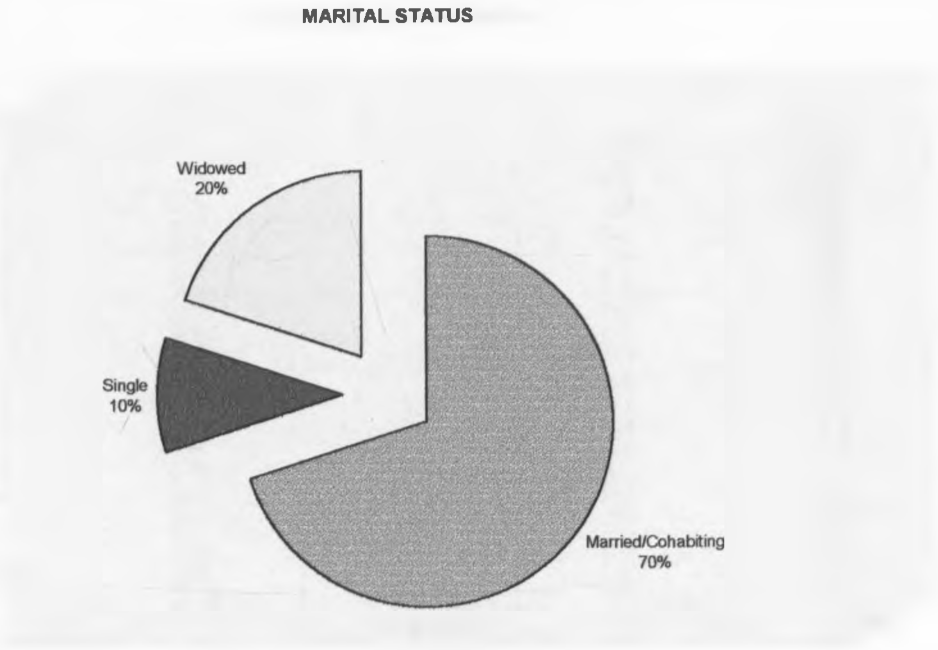
The research was carried out in Thika and Nairobi districts and it involved women who were visually impaired. There is a large number of visually impaired persons living in these districts. Twenty percent of those interviewed were in the age bracket of 20 – 30 years and 51 – 60 years, while thirty percent of those interviewed were in the age bracket of 31 – to 40 years and 41 – 50years. In addition, they lived in different places; eighty percent lived in Thika, while twenty percent each, lived in Korogocho and Kayole. However, many were not born in these places, but had come here in search of a better living. Figure 1 below shows the distribution of the women's place of birth.

FIG. 1



It was also noted that many of the women were either married or cohabiting. This is indicated in Figure 2 below. They valued marriage as this was seen as a form of security for the women, many of whom were of child-bearing age. For many of them, their partners were also visually impaired. They also lived with them for protection against harassment by would be offenders.

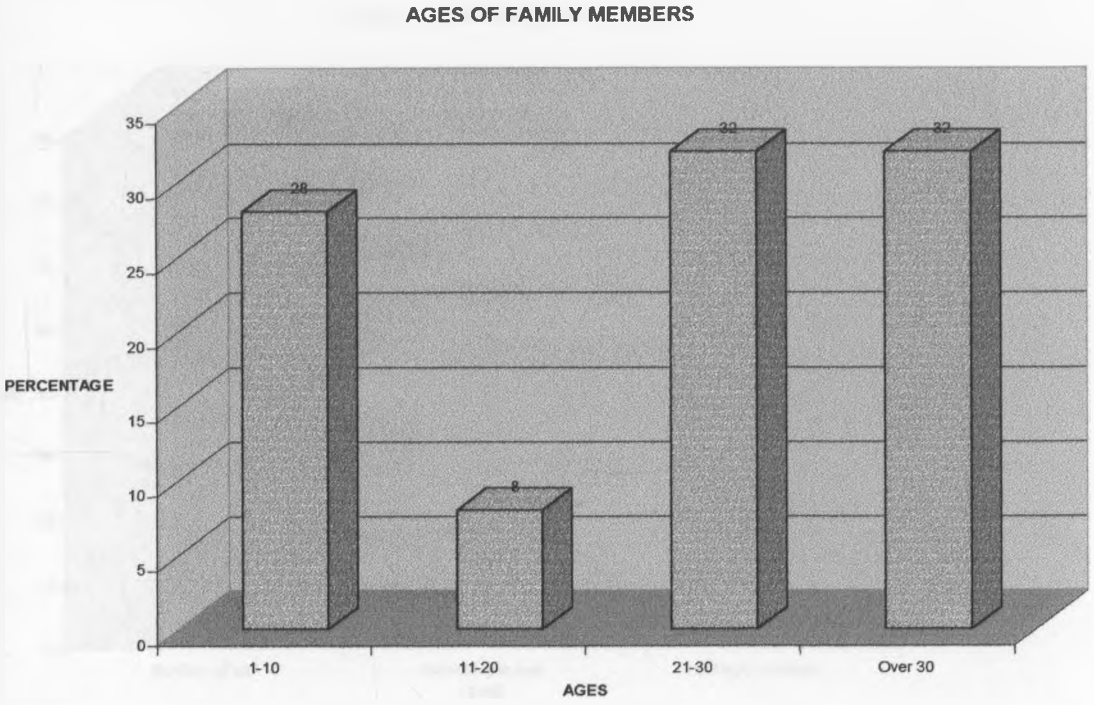
FIG. 2



The visually impaired women also depended on their partners for financial support, to help them make their ends meet. Some of these women were also living with their children as well as grandchildren. For those that earned an income through begging, both the man and woman went out to beg and they used children as guides. Usually, these children were not their own, but were hired from their neighbors who were more financially constrained than themselves. Mostly, boys who were hired, while girls were either in school or helped do house chores.

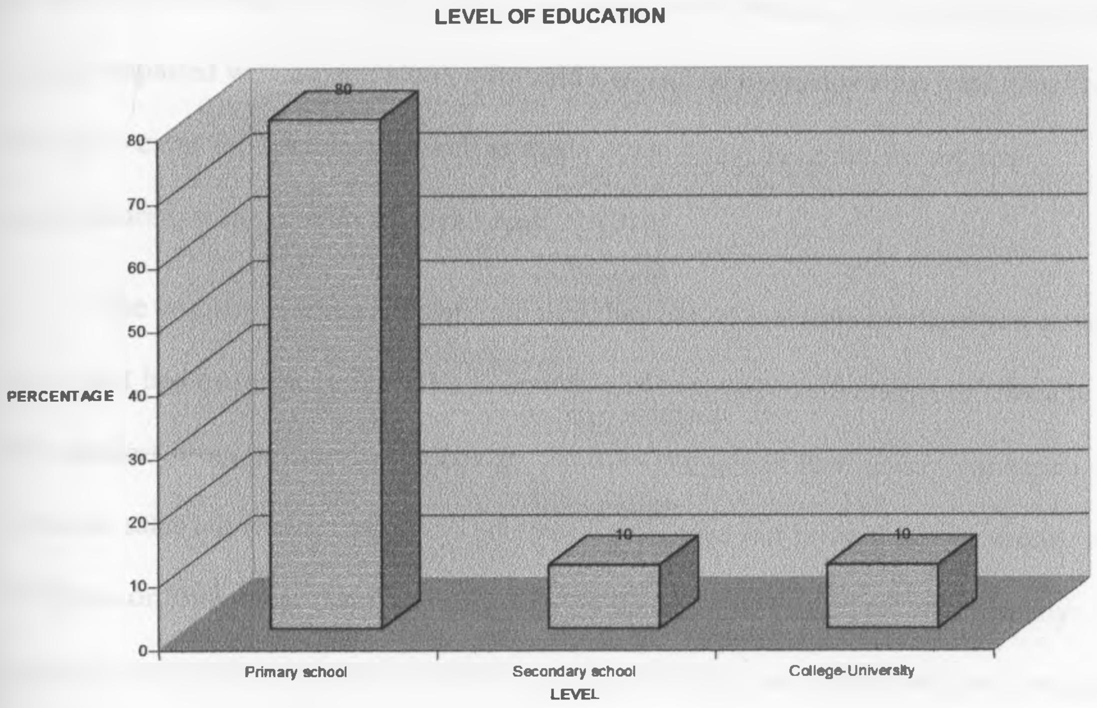
The age distribution for their children is shown in Figure 3 below. They cited unemployment as the major reason for their low economic status and that they were, therefore, unable to cater for their needs as well as that of their immediate family.

FIG. 3



As shown in Figure 4 below, many physically challenged persons do not have access to formal education at higher levels, that is secondary and college level. It was noted that many parents with physically challenged children do not educate them to higher levels of education. It was viewed as a waste of resources since they believed that these children would not amount to much in the future. Their younger siblings who were not physically challenged were educated while they were left in the house. In fact, one parent of a physically challenged child was said to have taken her child to school after she was threatened with arrest by the government, should she fail to do so. Many physically challenged persons go to school when they are older than other children in the same class and many of them do not manage to finish their education as they feel they are too old.

FIG. 4



5.2 SOCIO-ECONOMIC DATA

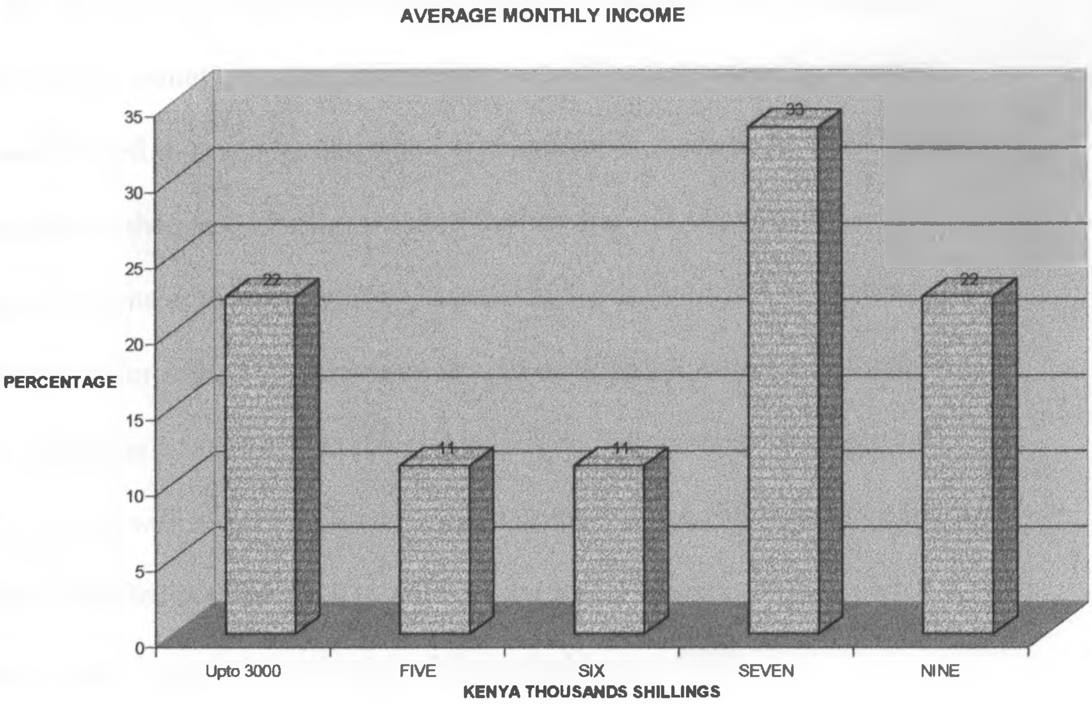
In the course of the study, it emerged that many people who are visually impaired did not have a sustainable source of income. Many of them are also not able to access formal job opportunities, due to their low level of education and physical challenge. Many of the respondents interviewed during this study were beggars on the streets. For those respondents who were from Thika, they usually traveled to Nairobi daily, together with their guides, and spent their day begging.

This did not yield a good income for them and they supplemented it with their husbands' income, many of who were also beggars, or with the sale of goods, for example, charcoal It was, however, difficult and as one visually impaired woman said, she had been conned by people who gave her less money than was required, yet had insisted that it was the correct amount. Others gave her Tanzanian currency that was of less value than the goods they demanded for. She ended up closing the business, having lost much money Another one said how she had been arrested and locked up in a prison cell by city council officers, by allegedly littering the streets with her presence, while begging. There was also another visually impaired woman, a widow, who said that her salary as a teacher was never been enough to cater for her needs as well as those of her sons, daughter-in-law and grandchildren, some of who she lived with

The women interviewed also said that they had at one time invested in a self-help group, but had been discouraged because they had been taken advantage of. Initially, their brokers brought back the money gotten from the sale of their goods-cardigans, but when the sales increased, those who acted as brokers did not bring them the money or the cardigans or even assist them anymore. One of the counselors said that the visually impaired women do not trust each other and when there is any proposed joint venture for them, each of them seeks to be the chairperson. They fear that whoever is given the position will use it to benefit alone and not assist the rest or share the benefits/ profits Thus, in their opinion, begging was more secure as they handled the income themselves

It was evident, however, that the women lacked a system of saving or investing for future use, since what was collected was used during the day It was difficult for them to cater for the needs of their families. Some visually impaired women complained that they had very bright children who had performed well academically, but they had not been able to educate them since they lacked the finances to do so. Figure 5 below shows a distribution of the respondents' monthly income.

FIG. 5



4.3 Peer Education

For the respondents interviewed during the course of this study, it emerged that many of them did not know where to seek support, social or financial, for people living with HIV/AIDS. Some of those from Thika stated that they had received spiritual support from the Salvation Army. Those from Nairobi said that they did not know of any support groups that existed in their area. This is probably because for many visually impaired women, knowledge about their seropositive status is secretive and only in very few cases is the status known to family members or friends. It may also be because of their visual impairment. It emerged after discussions, that indeed they were aware of some members of their community who were rumored to have died of HIV/AIDS.

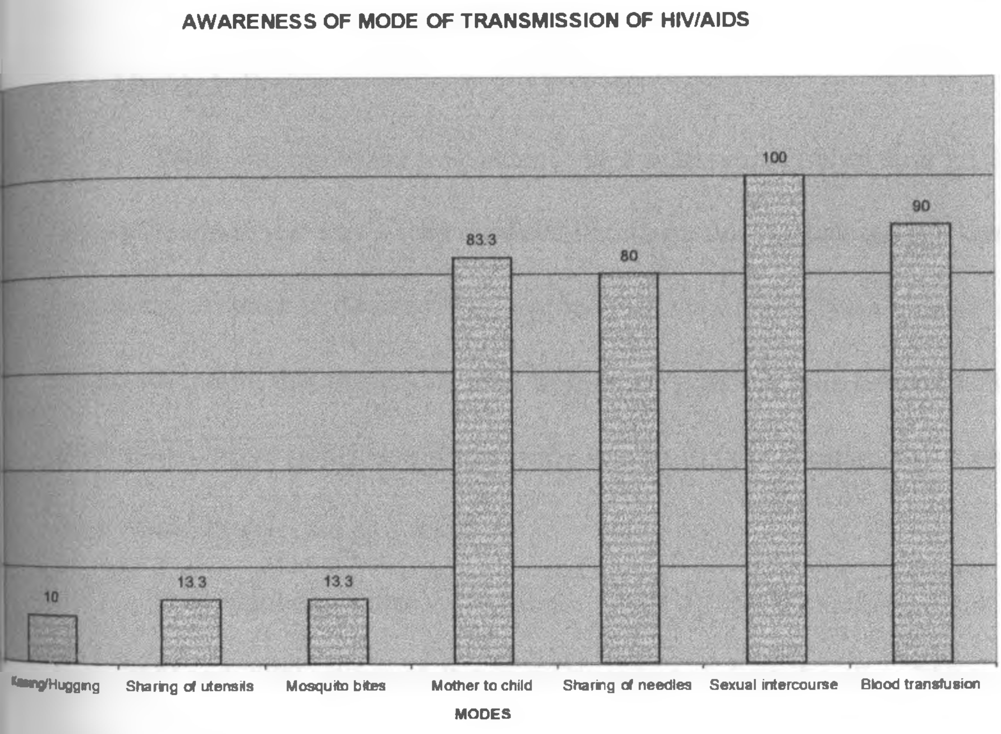
It was also noted that many visually impaired women found it difficult to access voluntary counseling and testing services. Many of those from Thika stated that in the recent past, the security personnel at the town's major hospital had been unfriendly to them. Whenever they would go to the hospital, they would be stopped at the gate and asked why they had left their guides and who they expected to guide them at the hospital, yet in some instances the reason for their visit to the hospital was confidential.

In Nairobi, some of the women were assisted by friends or relatives to access treatment. However, for some of them, the situation was different. One visually impaired woman had confided in a friend whom she said helped her get treatment from a government clinic, as well as receive social support from an organization catering for the needs of women infected with HIV/AIDS. She did not want her seropositive status disclosed to her family members as she feared they would reject her.

Many visually impaired women living with HIV/AIDS experience a double tragedy, of being visually impaired and also due to the stigma and discrimination that surrounds PLWAs. They are not properly cared for and for the most part they usually need assistance in their daily living. For many of them, the cost of living, leave alone treatment, is very high, since they lack a sustainable source of income and so succumb to sometimes treatable or manageable opportunistic infections. This is rarely the case for their visual counterparts, who often have a better income and are able to get treatment, know what to eat and what to avoid, as well as where to access treatment. This is because many programs on care and management of HIV/AIDS are accessible to the visual.

Many of the women hardly went to hospital for treatment, but depended on off the counter medication. They also practiced midwifery among themselves and this posed as a major risk to HIV/AIDS infection among them. They did not take the necessary precautions against infection. Many of the women were also aware of the modes of HIV transmission and this is indicated in Figure 6 below.

FIG. 6



The respondents were also questioned further on the methods of HIV transmission. One visually impaired woman stated that creating awareness on the methods of HIV/AIDS transmission among people was a means of prevention. Their responses varied and the results are shown in Table 1 below. Many of them were also of the view that there was no cure, only God could heal one of the disease.

TABLE 1

	Yes	No	I do not know
Can HIV/AIDS be prevented by abstinence	100%	-	-
Can HIV/AIDS be prevented by using a condom	20%	80%	-
Can HIV/AIDS be prevented by faithfulness to one's partner	50%	50%	-
Can HIV/AIDS be prevented by consulting a witchdoctor	-	100%	-
In your opinion, is it possible to be infected after first sexual contact	90%	-	10%

4.4 Hiv/Aids Profile

When talking to the respondents during this study about their HIV status, it was assured them that it was a very confidential discussion as they did not want their seropositive status to be known to people. It was mainly through counselors whom they had confided in, that the discussions were made possible. The general fear was that if their seropositive status would be openly known to others, especially friends and family, they would be rejected as a result.

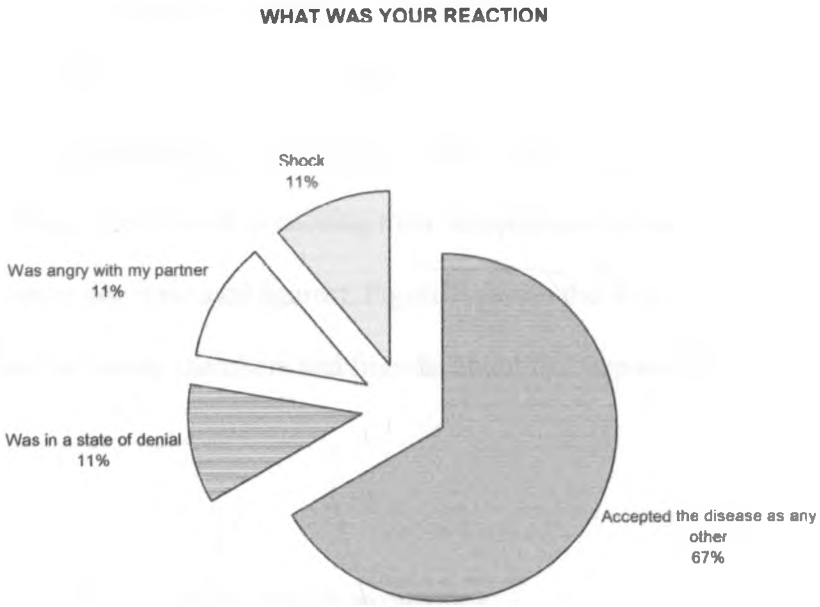
The respondents discovered about their HIV/AIDS positive status between the year 2000 and 2003, although they may have been infected earlier. This was after having suffered from diseases such as malaria, diarrhea and vomiting and when they sought for treatment from hospital, they were tested. One lady who was totally blind had been admitted to hospital and during the visits by the doctors, she would hear them say, 'this one is the one that has AIDS'. This would sometimes be in the presence of her children. Though she could not see who was being pointed at, she assumed they were talking about her. There was also another visually impaired lady who said that she had not been faithful in her sexual relationships and this was probably how she got infected. Others did not know how they had been infected, though they said they had had multiple sexual relationships. In another instance, the visually impaired woman said that she had been raped and suspected that that was how she had been infected.

During the interview, there were not many cases of women who got infected through rape. However, this was one of their fears since it was easy for them to be waylaid and raped. Many of the respondents also said that they suspected their husbands had not been faithful to them, and that they had had extra marital affairs.

Many of their partners visited bars and took alcohol before going to their homes. It was also in these places that they involved themselves with prostitutes, exposing themselves to the risk of HIV/AIDS infection. The prostitutes took them in as customers and would be paid for their services. One woman had been abandoned by her husband after he discovered she was HIV/AIDS positive, and she was nursing a small baby. She suspected he was the one who had infected her.

The reaction of the respondents on finding out their seropositive status varied. Some were in a state of denial and shock, while there were those who had accepted their status and viewed the disease as any other. There is one visually impaired woman who said that she had been infected through a rape ordeal. She had become very lonely and hardly spoke to anyone. Her family had accepted her status, and provided for her needs, but she was very bitter as her opportunity to develop herself in her career had been cut short. Many of the visually impaired women who were HIV/AIDS positive thought that they would not live for long and this was also a cause for their bitterness. They had children and they wondered what would become of them after they were gone. Figure 7 shows the distribution of the reaction for the women, on realizing they were HIV positive.

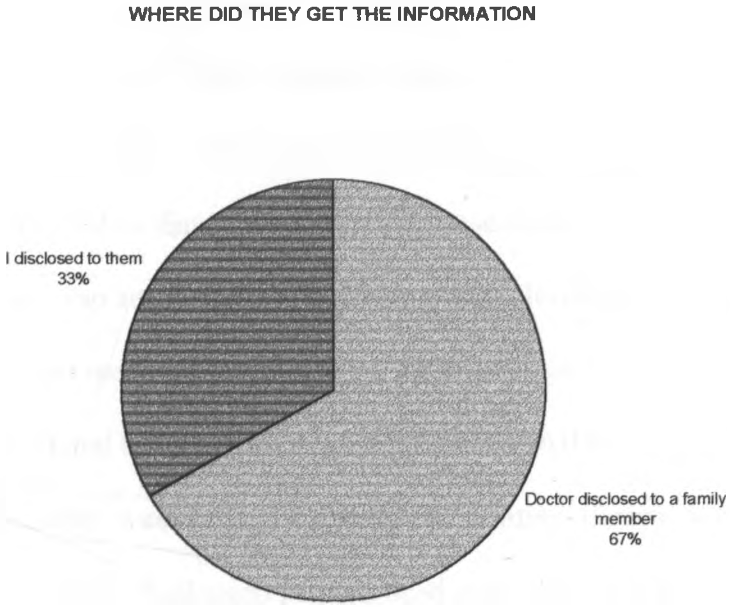
FIG. 7



For many of them, their partners did not know of their seropositive status. This was either because they had since died, or they had had no regular sexual partners. However, after the women became aware of their seropositive status, those with no regular sexual partners stopped having these relationships and sought out for menial jobs, to meet their needs.

The respondents also said that they had not informed many people of their seropositive status. Many of them said that this was due to fear of rejection from their families or from those they depended upon for support. Even when they needed medical attention, they sought it secretly. There were, however, those whose families knew of their seropositive status and were very supportive of them and also provided for their needs. One woman told her children that she was infected, but they told her that they already knew, they had been informed by her doctor. They were very supportive of her. Another woman had informed a peer counselor working with an NGO that deals with HIV positive women. The counselor took her for clinic whenever she needed medication. For those who were working, they feared disclosing their seropositive status to their colleagues, for fear of being discriminated against. Figure 8 shows the distribution about the source of information by family members and friends, about the respondents' seropositivity status.

FIG.8



The communities in which they lived were also not very supportive of them. One peer counselor who was questioned whether there were any visually impaired women in her community who were infected said, “We do not have such here. If we did, who would take care of their needs? They are so demanding!” This only goes to show the attitude that most of the society has towards the physically challenged persons. One visually impaired woman had died as a result of neglect by her family, when they discovered she was infected. This made the others fear to disclose their status. Thus, they are discouraged from seeking assistance, be it social, spiritual or even financial, on account of their seropositive status. Some women, however, did not know where to seek this assistance, or whether it was available in their community.

It was also noted that the respondents were hardly able to purchase antiretroviral drugs, since they are very expensive. When they suffered from opportunistic infections, for example, malaria, they would purchase the drugs from chemists. The women were of the opinion that the drugs should be administered to them as well as to other physically challenged persons, free of charge. This is because their meager income was not enough to meet their needs, that of their families and also purchase antiretroviral drugs.

The respondents also suggested ways of promoting information, education and communication (IEC) as a means to fight the HIV/AIDS scourge among them. These included use of seminars and conferences, production of HIV/AIDS material that communicates to them, that is, use of sign language and printing of such material in braille. In addition, physically challenged persons need to be trained as peer counselors and employed to work in VCT centers specifically designed to cater for their needs as this will create job opportunities for them. For the seminars and conferences, it would be needful to transport them to and from the venue. The visually challenged women also said that there would be a bigger impact when they listened to one of their own talk to them about HIV/AIDS. This would be even if such a one was living with the virus. Much counseling would, however, be needed for the person to be able to speak out. In addition, they were of the view that the AIDS Control Councils (ADCs) country wide should have physically challenged persons in their boards since here they would be better placed to air their views and have them implemented.

The respondents were also of the view that all community leaders should sensitize their communities against discrimination towards people with disabilities, which results in illiteracy, unemployment, isolation, lack of leadership opportunities for them, among others. They also said that the government should educate their children and that they too should be supported socially and financially. This is by helping them to start and run small-scale businesses, and protecting them against harassment.

CHAPTER FIVE

5.0 DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Discussion

5.1.1 Demographic Characteristics

Both Korogocho and Kiandutu are slum areas that were densely populated. The respondents interviewed were mainly of child bearing age and had at least one child whom they provided for. Their level of education was also low as about eighty percent of them had received only primary level of education. Others had also received some vocational training. Due to this, some of them involved themselves in risky sexual behavior, sometimes for financial support. Their children were also not very educated and also did manual jobs to help supplement incomes. Some even had families of their own, yet they were still living with their parents.

Data from the study also showed that many of the respondents were in stable relationships. Seventy percent were married/ cohabiting, twenty percent were widowed, while ten percent were single. However, many of them suspected that their husbands were not faithful to them and thus, put them at risk of contracting HIV/AIDS. The women from Thika did not access proper medical care, but depended on off the counter medication, to treat ailments.

5.1.2 Socio-Economic Status

It was noted that majority of the women were poor and did not have a sustainable source of income. In addition, they had no formal employment due to their low level of education. They were involved in begging, doing casual jobs, or running small businesses, when the opportunity arose. For example, to supplement their incomes, some of the women from Thika sold charcoal.

The vocational training some of the women had received included, weaving baskets, sewing cardigans, and training in telephone operation. However, many of them did not utilize their skills, as they had been taken advantage of before, by people who had promised to support and assist them to sell their goods. These brokers had instead stolen their goods and left them without aid. The respondents were of the opinion that when begging on the streets, they were the managers of their income and no one could steal from them as they handled the income themselves.

It was clear that although these women earned some income, they did not use it to invest as most of what was gathered each day was spent to meet their basic needs. Their income was never enough to cater for all their personal needs as well as those of their family members. They had no proper system of savings and though they had their own support groups, these were to assist a needy family in case of an emergency, not to help them invest. In an effort to improve the lives of these women, they should be supported to be able to sell their own wares and be protected against harassment and theft. This would be through setting up organizations for and by them. There is also need to educate these women on financial management as well, so that they may be able to have income-generating projects and have sustainable incomes. The women interviewed expressed willingness to have such groups and support themselves through such programmes.

During the course of this study, majority of the respondents said that they spent most of their time sourcing for their livelihood. In addition, they did not involve themselves in much social or even community activity. In their view, they were not accepted as other citizens of their community and so their associations were mostly among themselves only. The community should be sensitized on the need to be engaged on activities and programmes that promote the welfare of physically challenged persons, protect them against harassment and abuse of their rights. Physically challenged persons should also be integrated into community activity, in an effort to reduce stigma and discrimination. Its success will take the concerted effort of the government, church leaders, NGOs, and the community at large.

5.1.3 Peer Education

Many of the respondents interviewed during the course of this study said that they did not know of any organization that dealt with the plight of visually impaired women living with HIV/AIDS. In spite of the fact that HIV/AIDS has been present in Kenya for the last about twenty years, it is only now that the plight of those PLWAs who are visually impaired or those having other forms of physical challenges, is being addressed. However, very little has since been done and there is need to empower them and educate them on positive living and development.

Education is a key in the improvement of the lives of all humanity. However, though it is a right for all, the physically challenged have been marginalized in programmes and policies on education. These have not been thoroughly implemented among them. For example, there is hardly any IEC material on HIV/AIDS targeting the physically challenged, for example, the deaf and the visually impaired.

The respondents said that they got much of their information about HIV/AIDS among themselves, and this information was sometimes distorted. They knew that one who suffered from the virus, was lean and very sickly, yet this is mostly true when one is in the last stages of the HIV/AIDS infection. They disputed the fact that one can appear healthy and yet be infected. Many of them viewed some of the opportunistic infections such as TB, malaria, diarrhea and vomiting, as common ailments and not as possible indications to HIV/AIDS infection.

It was noted that some of the respondents practiced midwifery among themselves and they were oblivious of the fact that this posed a high risk to HIV/AIDS infection for them, as they did not adequately protect themselves against infection during such practices. There is a need to educate these women on safe delivery practices, and on how to take precaution against HIV infection. This would also mean providing the women with the necessary kits for such work, carrying out a training course, as well as supervising them. It would also be needful to advice them on the need to seek professional help from hospitals.

One visually impaired woman living with HIV/AIDS received support from KENWA, which provided her with counseling and also accompanied her during her visits to hospital. However, it is necessary for many more organizations to extend their awareness programmes, support and care to visually impaired women and those with other forms of disability, by establishing contacts with them.

The women also need encouragement so as to join support groups, where they would be assisted on how to live positively, as well as learn how to take care of themselves. They are already a people who are marginalized and view themselves as unaccepted by society, and some have been abused. Much counseling is needed with them. There is also a need to train counselors to be able to work with those with special needs as they demand individual attention many times.

Many of the NGOs and institutions also that cater for the visually impaired persons or those people living with HIV/AIDS visited during the course of this study indicated that they had not extended their support to the visually impaired. Seminars and conferences that were held for women PLWAs did not include them. This was due to many factors. For example, many of the visually impaired women did not know of the existence of such organizations. In addition, financial constraints may also hinder such work, as dealing with this group be it in seminars or home-based care is quite expensive and involving. The NACC had started producing material on HIV/AIDS in Braille. The society in which we live in does not also help solve the situation, as some people wonder how physically challenged persons, for example, the visually impaired can have gotten the disease, yet they are visually challenged. This suggests that they do not engage in any sexual activity. These people have, indeed, a social obligation to love, to be loved, to marry and bring up children just like other members of the community.

Much needs to be done in terms of research, advocacy and policy, and the actual involvement of NGOs as well as the government, in addressing the needs of those who are physically challenged, and promoting their welfare in the phase of the HIV/AIDS pandemic. VCT centers and other health centers, medicines and doctors/ counselors should be made easily available and accessible to them.

It would also be necessary for the government to assist in support of such women and others with different kinds of physical impairments, since carrying out such tasks is very expensive and tedious. It would mean producing material in Braille, hiring of sign language professionals, building of infrastructure that is accessible to them, and so on. The government should also help in meeting the physical, social and financial needs of these people.

5.1.4 Knowledge about HIV/AIDS

Majority of the women were aware of the means of contracting HIV/AIDS as well as prevention methods. This included transmission through sexual intercourse (100%), mother-to-child (83.3%), sharing of needles and syringes (80%), and through blood transfusions (90%). However, some of the information was flawed; for example, some thought that whereas a baby could get infected with HIV/AIDS through childbirth, the reason was because during birth, the baby drank the mother's blood. Some believed that HIV/AIDS could be transmitted through mosquito bites (13.3%) and sharing of utensils with infected persons (13.3%). The respondents were also of the view that HIV/AIDS could be prevented through abstinence and faithfulness to one's partner. However, it was difficult to ensure that their partners were faithful to them. Use of condoms was also not a common practice among their husbands and the female condoms were not available to them. Thus, it would also be necessary to educate and involve the men, in programmes on HIV/AIDS prevention among them. In addition, female condoms should be introduced and used as a means of protection among them, where the male condom is not used.

It was also noted that although these women were aware of the modes of HIV/AIDS transmission, and though some of them suspected that their partners were unfaithful to them, they still remained in such relationships in spite of the risk they placed upon themselves. This was because the men supported them in many other ways, for example, financially and were also their protectors, and so they did not want to give up this support. They did not know what else to do to ensure their protection.

5.1.5 HIV/AIDS Profile

There are many physically challenged persons who are HIV positive, but very few cases are known. This is probably because many of them do not seek treatment, in an effort not to be discriminated against, or they do not know where and how they could seek help. Others also do not think they are sick and have not had to seek urgent medical attention. Majority of the respondents indicated that they had learnt of their seropositive status while being treated for opportunistic infections. While some did not know how they had been infected, others said that they had been infected by their partners, while another said that she had been raped. Some had had multiple sexual partners before, while for others, they suspected that it was their husbands who had been unfaithful to them. One lady, who said that her husband had infected her, spoke of suffering from some of the symptoms that her husband had suffered from before he died. She did not know what had killed her husband, but through the symptoms, she now knew that he had died of the virus. It was noted that among the visually impaired women, visits to the voluntary counseling and testing centers are not common. For the respondents interviewed during this study, they did not even know where the centers were, in their locality, though they expressed interest on a personal level, to go there if they would be taken by counselors and not their family members. The respondents spoke of some of their neighbors and friends who had been rumored to have died of the disease.

For those respondents who took antiretroviral drugs, they expressed concern over the high cost of the drugs, when survival for them was already a struggle. The government should subsidize the cost of the drugs, but the ideal would be to provide the drugs free of charge to persons who are physically challenged. They should also be assisted to get foods that boost their immune system, at subsidized rates. Many succumb to the disease, as they are not able to afford the drugs and lack of knowledge about the essential foods needed to boost their immunity. For others, they struggled to support themselves on a daily basis, and could not concentrate on healthy living because of financial constraints. For others still, they try to keep their disease as secretive as they can and try to live a normal life.

The respondents interviewed indicated that after learning of their seropositive status, they did not want to infect others and encouraged other physically challenged persons not to spread the virus to others, in a bid to seek revenge. They were hopeful that the government would come up with a cure in the near future.

5.2 Conclusion

In order to effectively deal with and be able to contain the spread of the HIV virus, it is essential to understand the factors that affect women. The purpose of this research was to highlight the plight of women who are physically challenged, particularly the visually challenged, in relation to the HIV/AIDS epidemic. They are vulnerable to HIV infection due to physical, biological, cultural, social, economic and environmental factors. A combination of all preventive measures is necessary, in order to combat HIV/AIDS. Unless an interaction between HIV infection, and all these factors is recognized, the fundamental changes needed to effectively deal with the epidemic would be unattainable.

Women with disabilities have the same right as other citizens without disabilities, to contribute to, and also benefit from the society. This includes the right to education, employment, self-determination and independence. In essence, disability is not inability. It is only a living challenge.

5.3 Recommendations

- Deal with the epidemic as one that affects all: one is either infected or affected by the HIV virus. It will, therefore, take the effort of all individuals, NGOs, the government and its development partners, to effectively contain the spread of the virus.
- Include the physically challenged, in programmes and implementation of policy geared towards containing the spread of the virus. For example, VCT centers should be structured to meet the needs of the physically challenged, in terms of location and services offered.
- The government and its development partners should assist in the formation of organizations and support groups for visually impaired persons living with HIV/AIDS, which understand their plight.
- Use of HIV/AIDS awareness programmes that are friendly to the physically challenged persons, especially the visually impaired.
- Provision of financial support by the government and its development partners for self-sustenance and free provision of anti-retroviral drugs, support and care for physically challenged persons.
- Educating the community on care and support for physically challenged persons, in an effort to reduce the stigma and prejudice against them.

- Integrating the physically challenged persons in community activities.
- Ensure that formal and vocational education is offered freely, to physically challenged persons.
- Educational institutions should be structured such that they are easily accessible to physically challenged persons and learning material provided, at all levels.
- Abolish all cultural and traditional practices that foment the spread of HIV/AIDS.
- Ensure legal protection of their related human rights, through strict laws meting severe punishment on offenders.

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INTERVIEW SCHEDULE FOR PEOPLE LIVING WITH HIV/AIDS

I. DEMOGRAPHIC DATA

1. Sex . . . .

2. Name (optional) . . . .

3. Age . . . . years.

4. Place of birth . . . .

5. Residence . . . .

6. For how long have you lived here? . . . . years.

7. If less than one year, where were you living before? . . . .

8. Marital status

1. Married/ cohabiting
2. Divorce
3. Separated
4. Single
5. Widowed

9. Number of children and their ages.

Sex	Ages	Alive	Dead

10. Level of education.

1. Never been to school 2. Primary school
3. Secondary school 4. College/ university
5. Other (specify) . . . .

II. SOCIO-ECONOMIC DATA

11. What is your occupation

1. Formal 2. Informal 3. Student 4. Housewife 5. Other (specify) . . . .

12. What is your average monthly income? Ksh . . . .

13. Does your income adequately meet your needs?

1. Yes ☐ 2. No ☐

14. Please explain. . . . .

. . . .

. . . .

15. What is the type of house you live in?

1. Permanent ☐ 3. Temporal ☐ 5. Other (specify) . . . .
2. Semi-permanent ☐ 4. Traditional ☐

16. Is your dwelling owned by your household or rented, or do reside here without payment?

1. Owned by family or one of its members.
2. Rented
3. Occupied without payment
4. Other (specify) . . . .

17. How many people are living with you?

Adults . . . .

Children . . . .

18. What is your relationship with those you are living with?

1. Parents
2. Husband
3. Relatives (specify) . . . .

4. Other (specify) ....

III. PEER EDUCATION

19. Are there any support groups in your area?

1. Yes ☐ 2. No ☐ 3. I don't know ☐

20. Which type of support groups are in your area?

1. Social 2. Spiritual 3. Government 4. Other (specify) ....

21. Do you receive support from these groups?

1. Yes ☐ 2. No ☐

22. If yes, how often do you receive support?

1. Regularly 2. Not so regularly

3. Rarely

23. What is your opinion about those support groups?

1. Very useful 3. Not useful

2. Useful 4. Other (specify)

IV. KNOWLEDGE ABOUT HIV/AIDS

24. How is HIV/AIDS transmitted? Tick the appropriate answer(s).

1. Kissing/ hugging
2. Sharing of utensils with infected persons
3. Mosquito bite
4. Mother-to-child transmission
5. Sharing needles and syringes
6. Sharing toilet facilities
7. Through sexual intercourse
8. Through blood transfusions
9. Living in the same house with a HIV/AIDS infected person

10. Other (specify)

25. How can HIV/AIDS transmission be prevented? Tick appropriate answer(s).

1. Abstinence
2. Using a condom
3. Faithfulness to one partner
5. Consulting a witchdoctor
4. Other (specify) ....

26. In your opinion, is it possible to be infected on first sexual contact?

1. Yes ☐ 2. No ☐ 3. I don't know ☐

27. How can HIV/AIDS be cured? Tick the appropriate answer(s)

1. Modern medicine
2. Herbal medicine
3. God
4. Other (specify) ....

V. HIV/AIDS PROFILE

28. When did you discover that you are HIV/AIDS positive? (year) ....

29. How did you discover? ....

....

30. How do you think you got infected? ....

....

31. What was your reaction? ....

....

32. Did you inform your partner? 1. Yes ☐ 2. No ☐

33. If yes, how did he react? ....

....

34. If no, why? ....

....

35. Who else is aware of your seropositive status?

1. Family 2. Friends 3. Colleagues 4. Community 5. Other ....

36. Where did they get the information? ....

....

37. How did the others react?

1. Family/ relatives ....

....

....

2. Friends ....

....

3. Colleagues...

....

4. Community/ religion ....

....

5. Other (specify) ....

....

38. What health problems do you experience as a result of your seropositive status? .....

....

....

39. Do you seek treatment? 1. Yes ☐ 2.No ☐

40. If no, why? ....

....

41. Where do you seek treatment?

1. Government clinic 2. Private doctor 3. Pharmacy
4. Self-treatment 5. Traditional healer

42. Does your partner seek treatment? 1. Yes ☐ 2. No ☐

43. Where does he seek treatment?

1. Government clinic 2. Private doctor 3. Pharmacy
4. Self-treatment 5. Traditional healer

44. How often do you seek treatment for HIV/AIDS related illnesses?

1. Very often 3. Rarely
2. Not so often 4. Never

45. How has your seropositive status changed your lifestyle? ....

....

....

46. How do you cope with these changes? ....

....

....

47. What support do you receive from the following?

1. Spouse ....

   ....

2. Family/ relatives ....

   ....

   ....

3. Community/ religious groups ....

   ....

   ....

4. Government ....

   ....

   ....

5. Other (specify) ....

   ....

   ....

48. What measures do you think should be instituted, so as to assist visually impaired women cope with HIV/AIDS? ....

....

....

49. What is your advice to other visually impaired women living with HIV/AIDS? ......

....

....

....

50. What other suggestions do you have pertaining to this study? ....

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