



**REPORT ON UPTAKE OF HIV, SRH & GBV SERVICES AMONG  
ADOLESCENTS AND YOUNG PEOPLE WITH DISABILITIES IN THE 13  
VILLAGES OF KIBERA**

GIFTED COMMUNITY CENTRE, GCC  
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## **ACRONYM**

<b>ANC</b>	<b>Antenatal Care</b>
<b>AYPWD</b>	<b>Adolescents and Youth with disabilities</b>
<b>CFK</b>	<b>Carolina for Kibera</b>
<b>ENT</b>	<b>Ear, Nose and Throat Assessment</b>
<b>FGD</b>	<b>Focus Group Discussions</b>
<b>GBV</b>	<b>Gender-Based Violence</b>
<b>GCC</b>	<b>Gifted Community Centre</b>
<b>HIV</b>	<b>Human Immunodeficiency Virus</b>
<b>IDI</b>	<b>In-depth Interviews</b>
<b>LVCT</b>	<b>Liverpool Voluntary Counselling and Testing</b>
<b>PEP</b>	<b>Post-exposure Prophylaxis</b>
<b>PWDs</b>	<b>Persons with Disabilities</b>
<b>SHOFCO</b>	<b>Shining Hope for Communities</b>
<b>SLIs</b>	<b>Sign Language Interpreters</b>
<b>SRH</b>	<b>Sexual and Reproductive Health</b>
<b>SRHR</b>	<b>Sexual and Reproductive Health and Rights</b>
<b>STIs</b>	<b>Sexually Transmitted Infections</b>
<b>VCT</b>	<b>Voluntary Counseling and Testing</b>
<b>V.I</b>	<b>Visually Impaired</b>

## **BACKGROUND**

Due to limited research on uptake of SRH, HIV, and GBV services among adolescents and young people with disabilities in Kibera, Gifted Community Centre through LVCT's support conducted embarked on research to determine uptake of HIV, SRH & GBV services amongst adolescents and youth with disabilities in the 13 villages of Kibera. The research was conducted between August and September 2021. The data collected informed the activities going forward helping to inform the advocacy agenda and continuous improvement of services.

### **1.0 THE STUDY AREA**

The assessment was carried out within Kibera in the 13 clustered slum villages (Gatwekera, Soweto, Kianda, Lindi, Kisumu Ndogo, Mashimoni, Baba Ndogo, Corner Club, Lain Saba, and Kamukunji) Nairobi County. The assessment population involved 100 adolescents and youths with disabilities age group (15-28 years).

### **2.0 OBJECTIVE OF THE NEEDS ASSESSMENT**

The main objective of this needs assessment is to inform the advocacy agenda and continuous improvement of services.

The specific objectives of the assessment will be as under:

- i. To bridge the gap between AYWD with health facilities in getting HIV, SRH & GBV services.
- ii. To map out service delivery points and develop a service directory including relevant hotline numbers.
- iii. To sensitize healthcare providers on AYPWD responsive services packages of care, SRH, GBV & HIV needs together with the county health management teams. This need assessment removes this uncertainty by exploring what AYWD's specific needs are and the actions it can take to attain them. Assess the experiences and perception of AYWD on HIV, SRH & GBV services.
- iv. To conduct digital campaigns to ensure the meaningful involvement of AYWD.

### **3.0 METHODOLOGY**

The proposed assessment mainly explored qualitative techniques data collection methodologies were employed to obtain the information. However, the qualitative approach was the one mainly used and it entailed conducting focus group discussions (FGDs) which guided discussions with AYPWD and these groups were homogeneous in terms of the nature of the disability, and in-depth interviews (IDIs) to gather data according to the objectives of the study.

The target population was adolescents and youth with disabilities residing in Kibera. All the respondents were residents of Kibera. The exercise occurred between August and September 2021. The population was sampled using a random sampling method. To ensure the success of the assessment, the process involved the development of the tools and holding a one-day virtual training for the enumerators and sign language interpreters on the tools; mobilization of AYWD to organize for the FGDs and making appointments with participants for in-depth interviews. Prior inception meetings were also held by the GCC team to prepare for the exercise and to find ways to ensure the validity of the data collected.

#### **3.1 Instruments**

An assessment guide was developed earlier and identified concerns including service delivery, access to information. 97 respondents were interviewed. A template (Guide) for focus group discussions (FGDs) and in-depth interviews (IDIs) was developed covering the qualitative side of the assessment.

#### **3.2 Sampling Size**

In total 97 participants were interviewed using the caregivers/ guides. For deaf we had three groups ranging in attendance from 10-25 respondents, other disabilities ranged from two groups of 20-24 respondents, and the last group of 16-16 respondents in different FGDs sessions. The groups were ranged in this manner because direct communication between deaf/hard of hearing and hearing respondents is often difficult and makes participation by all members of the group a challenge. The purpose of these groups was for AYWD to express their concerns directly.

#### **3.3 Data Collection**

This research was a community-based study aimed at informing the advocacy agenda and continuous improvement of services. Data were collected by trained enumerators using the qualitative guides. The enumerators alongside SLIs attended a one-day training to receive background information on the assessment, familiarize themselves with the assessment tools and consent documents, and refresh their skills on effective interviewing.

The tools used for the study were translated into Swahili and challenges with the tools were addressed before the data collection that was carried out in August 2021. During enumeration, supervisors kept in constant communication with the enumerators to ensure a smooth flow of field activities.

Before any assessment, written consent was obtained. Enumerators obtained consent individually for each respondent before the FGD and IDI, based on the age of the adolescents and youth with disabilities. A moderator and a note-taker facilitated each FGD session, while an interviewer conducted the IDIs. All data collection sessions were conducted in safe spaces due to the ongoing COVID 19 pandemic; all sessions were captured through note-taking with the consent of respondents. Adolescents and young people with various forms of disabilities were interviewed and the use of disability-friendly methods was also embraced, e.g., through the use of sign language interpreters where the deaf were present for interviews. The interviews were conducted utilizing mainly scripted questions that did not vary greatly between the groups interviewed. Included here are those questions that provided the most revealing information.

The respondents for this assessment were AYPWD members of the community of Kibera and from the target population, the following categories of people were interviewed using both FGD and IDI guides: Adolescents and young people with disabilities aged 15 – 28 years; parents (mothers, fathers or caregivers) of adolescents and youths with disabilities. By the end of fieldwork 5 in-depth interviews and 6 focus group discussions had been conducted.

### 3.4 In-depth interview (IDI)

This involved a direct face-to-face interview with randomly selected adolescents and youth with disabilities in Kibera. The IDIs took thirty-five minutes to forty minutes and were conducted at the convenience of the respondents. All in-depth interviews/discussions were transcribed, and transcripts were used for analyzing the data and preparing the report.



*Figure 1: In-depth interview with a deaf respondent with the help of a sign language interpreter at A.I.C Kibera Hall.*

### 3.5 Focus Group Discussions (FGD)

We had six focus group discussions. The first three were with 10-25 adolescents and youth with disabilities. The second three comprised of other adolescents and youth with disabilities (20-24) and (16-16) adolescents and youth with disabilities living in Kibera. They were moderated by enumerators who also recorded verbal responses in writing.



*Figure 2: Focus group discussion session at A.I.C Kibera.*



## 4.0 ASSESSMENT STRENGTHS AND LIMITATIONS

This assessment had various strengths. We gained in-depth insights into the experiences of adolescents and youth with disabilities accessing HIV, SRH, and GBV services within Kibera. In addition, the inclusion of a mix of various respondents provided rich information, which is critical to addressing barriers to accessing HIV, SRH, and GBV services.

Various limitations were also noted. This assessment had initially set out to cover 100 adolescent and young persons with disabilities but eventually reached 97 because the target group was in school despite the needs assessment session which was on a weekend, and also there were ongoing competitions football and volleyball hence some couldn't make it. At the same time, some participants came in late as the sessions were ongoing. Some of our beneficiaries were illiterate and so their understanding is low so most responses received were not aligned to the questions asked. Male participants felt the female adolescents and youth generally are more empowered and they are always the focus on most GBV, HIV & SRH issues forgetting the men to experience the same challenges hence neglected and they are afraid to speak up.

## 5.0 SUMMARY FINDINGS

### 5.1 Knowledge of HIV, SRH & GBV

For universal knowledge of HIV, SRH, and GBV; nearly 100% of male and female adolescents and youths with disabilities across all ages reported that they knew and had heard of HIV, SRH, and GBV.

*“HIV is an incurable virus, there is no medicine to cure though it is manageable. It is a sexually transmitted disease and you can get infected through injection, sexual intercourse, blood transfusion, or intercourse. Through rape a time or even breastfeeding.”*

*“GBV is gender-based violence. Violence can be through youths using drugs and not getting married because of the use of drugs. GBV violence at times can be rape cause time some parents don't take care of their children, neglect and parental feuds and through such an environment the child can feel lonely then raped e.g., stepmother violence with the children and since there is no peace the children will move to the streets hence lack education.”*

## 5.2 Community perception in accessing HIV, SRH & GBV services for AYPWD

Ninety eight percent of respondents in the FGD and in-depth interviews overwhelmingly reported that due to lack of training and awareness amongst community members hence the negative attitude towards AYPWD in accessing HIV, SRH & GBV services remains a major hindrance to their equal and full participation in society. The most common community perception among adolescents and youth with disabilities that was mentioned in all FGDs and IDIs was ignorance and/or low knowledge about the rights of the AYPWD in accessing HIV, SRH & GBV services and the need to protect those rights. This is further entrenched by cultural beliefs in some communities that do not recognize that AYPWD also has rights. Response from an FGD;

*“Some members of the community advise the young PWD against accessing SRH services while some community members educate them on how to protect themselves against the abuse. Some relatives take their children to hospital or even have an interaction with them to try and advise them, counsel them and ask them to avoid bad groups.”* The FGDs brought out the fact that stigma and discrimination are still very common against adolescents and youths with disabilities in terms of accessing or needing community support to access these services.

Another common misconception is to do with the causes of disability where some communities associate having disabled children with prolonged use of contraceptives, as reflected by the following statement by a youth:

*“They say that our parents must have ‘used’ family planning for a long time and that’s why we are disabled more so this applies to the mentally disabled children.” “The community has a negative attitude towards us because of our physical looks and appearance and hence when reporting even sexual violence and abuses they are not bothered neither do they take any action towards the perpetrator”*

*“Some community members say maybe you went to prostitute around and got infected with the virus and maybe you were raped because you have no power to defend yourself and also you lack knowledge on what to do when raped cause when raped you need to go take medicines that prevent you from getting infected from HIV/AIDS.”*

Thirty-six percent of females reported that the absence of parental teachings on HIV and SRH discouraged the use of care services. HIV and SRH matters were rarely discussed at home;

culturally, SRH is not a topic discussed much because adolescents are perceived as children and not as young adults with active sexual life.

*“Parents do not want to give their children time to access this information, maybe because they feel it is not the right time....., but generally somebody who is 15 years, that one to me needs lots of counseling and guidance from both home and outside the home”*

### **5.3 Vulnerability and Risks to Sexual Violence and Abuse for AYPWD**

In all in-depth and focus group discussions; findings show that 96% of AYPWD are more vulnerable and therefore at risk of being sexually violated and abused, relative to the able-bodied adolescents and youth with disabilities. Reasons given for this vulnerability were several and included: the nature of disability itself which tends to predispose them to be defenseless; inability to see/recognize the violator; inability to communicate/report; lack protection – e.g., by being left alone at home. While some respondents said that both youth and adolescents with disabilities are equally at risk of being sexually violated, many of the respondents felt that younger women (from age of 9 – 20 years) are the ones at more risk than the older ones. Many also stated that sexual abuse against AYPWD is more common from the age of 10/11+ years and at the onset of puberty when the girls are starting to mature physically and their femininity is starting to show. But what came out clearly in all the discussions was that adolescents and youth with mental disabilities are the most vulnerable and often faced the highest risk of being sexually abused. Reasons cited for this included: (i) low ability to recognize and/or report the molester; (ii) low ability to understand what is happening to them; (iii) their inclination to leave home and just roam around in the neighborhood; (iv) they are usually friendly and therefore easy to be taken advantage of; (v) being left alone at home; and, (vi) highly dependent on others who end up taking advantage of them.

*“Girls with mental disability who appear to be friendly (but are often) unaware of their surroundings are more likely to suffer sexual abuse”.* (Caregiver to a mentally disabled adolescent who also encountered the same experience.)

Certain misconceptions in society also tend to put AYPWD at risk of sexual abuse. One such misconception is the belief among many community members that AYPWD can help cure HIV once you engage in sexual intercourse with them. So, the men take advantage of these adolescents and youth with disabilities through false promises of marriage to be able to have sex with them.

Such a view came out from one visually impaired respondent. Another risk factor lies in the fact that some men want to have sexual intercourse with an adolescent or youth with a disability out of curiosity.

Nearly 84% of the respondents in this assessment identified sexual abuse as the most common type of violations against AYWD which manifests itself either as rape or defilement. Most respondents in both the FGDs and IDIs also identified stigma and discrimination as another type of violation experienced by the AYWD. Such stigma and discrimination are manifested through isolation, segregation, neglect, and abandonment; being called names (verbal insults) by some health care workers and police officers when going to access and report HIV, SRH, and GBV describing or portraying their disability and, denial of education and health care services whenever there is need was also cited as a form of violation.

To better understand the profile of the perpetrators of violence and abuse of AYWD, it was important for this assessment to find out from the respondents who exactly these people are. The cited perpetrators of sexual abuse are mostly: close relatives/family members, drug users/addicts, and drunkards; guardians; neighbors, and strangers. On the latter, one caregiver reported: *“My mentally disabled 19-year-old girl was almost sexually abused by a neighbor in exchange and the community went ahead to say they should let the man be since they weren’t sure that anything happened”*. *“But when it comes to emotional abuse, it is the parents, relatives and the community in general that are the perpetrators. But when it is sexual abuse, it is the neighbors and sometimes relatives who are the culprits”*, observed in the FGD. All in all, most perpetrators of violations (especially sex abuse) are those who are known to the AYWD.

#### **5.4 AYWD and Rights in accessing HIV, SRH & GBV services**

Even though 100% of the respondents who participated in this assessment agreed that AYWD has and should enjoy equal rights like everybody else in the society, as enshrined in the Constitution of Kenya and the Disability Act, further discussions revealed that, often, this is not always the case.

*“No, they don’t enjoy the same rights e.g. When a deaf girl goes for an HIV/AIDS test, the doctor will just do the test then you wait for results and as the doctor wants to tell you you’re status, he/she comes with a picture and asks whether you know. The main issue is to explain in-depth for the person to understand better so we don’t access information on HIV.”* A deaf youth explains. A participant who is physically handicapped had this to say about the need for equal enjoyment of rights by AYWDs; *“Everyone needs to enjoy their rights regardless of their disability but this is not the case because when you go to the hospital, the doctor might ask you how you got the disease and yet you are disabled and maybe you were born with it. But we are also the same human beings.”*

As to whether the AYWD enjoy the same rights when it comes to accessing HIV, SRH, and GBV services as everybody else in the society, 100% of the respondents confirmed that more often than not, the rights of the AYWD are violated and this is demonstrated in many different ways, such as by being stigmatized and discriminated upon at the facilities and police stations, being locked up in houses and isolated. They reported that young children who are left with different caregivers abuse them because the parents are so busy that they cannot notice any change in the child, more so for PWDs due to communication barriers and fear.

#### **5.5 Reporting Mechanisms and Processes**

The assessment indicates that the mechanisms and processes for reporting the abuses start at the community level beginning with the Chief’s office. Assistant chiefs and chiefs are often the first to receive the cases of abuse because they are the ones closest to the people, readily available and in most cases know both the survivors of abuse and the perpetrators. A greater proportion of adolescents reported that most of the cases reported do not go beyond the chief’s office unless there are serious injuries that may require medical interventions and/or involvement of the police or children's office. But generally, over 70% agreed that the community and AYWD are not well

educated on the steps to follow when adolescents and youth with disabilities who live with them have been abused and even when their rights in accessing HIV and SRH services too have been violated.

To gauge the regularity and intensity of reporting and the processes involved in obtaining redress for the abuses experienced by the AYWD, several questions were put to the respondents in different ways. The AYWD who had experienced any form of sexual abuse and violence were asked if they reported the abuse and to who or where they reported and if this was always the case (less than 10% had reported the abuse); it is interesting to note that 50% sited the police station as a place to report GBV cases as much as they lack confidence in the services offered and not guaranteed of any justice to be served.

Education and training were stated as a need to learn more about sexual violence and abuse as a crime and to be made aware of available community resources. Many reported not knowing the telephone numbers to call for help beyond calling the police. Suggestions for services to be more welcoming to adolescents and young persons with disabilities include the following: including health facilities, Chief's offices, and police departments; using a relay service; making health facilities available that can be adapted for low-vision users, availability of sign language interpreter for the deaf, ramps to more easily access a building.

## **5.6 Service Delivery**

Adolescents and young persons with disabilities face myriad obstacles regarding reaching out for help. Self-identification and trusting "outsiders" were reported throughout the group interviews. AYPWD is a largely underserved population that either does not identify sexual violence or sexual abuse as a crime and/or is largely unaware of the services and resources available. Another barrier mentioned by a majority of the adolescent respondents was the negative attitudes of health care workers, which discouraged many adolescents from visiting health facilities even when they needed care, as expressed by the adolescent below:

*"Some go to the hospital for the first time and find that the doctor is not friendly. They start fearing the doctor because he is harsh. They become afraid to go back for treatment."*

Poor experiences with service providers and law enforcement were on par with fear of not knowing what to expect when involving systems, a respondent states her ordeal with one health care worker,

*“even this disabled person has gone to look for the disease with a surprised face as if we are not also human beings”*. The vast majority report the importance of privacy and confidentiality more so for the deaf when it comes to HIV testing and counseling services. A shared experience of being condescended to was reported with a strong expectation of respect as an important aspect toward building the trust necessary to increase the reporting of sexual violence and abuses or contacting outside agencies for help.

Overall, lack of understanding by both service providers and law enforcement about adolescents and young persons with disabilities and urged education on the topic of HIV, SRH & GBV. Repeated suggestions were made to include a person with a visible disability as part of the training. Beyond shading light on service delivery, the interviews revealed that education and training were some of the core components of enhanced reporting and increased visibility and access to the services available. Both groups report that reciprocal training is necessary; persons with disabilities need training as do service providers and law enforcement. The ninety-seven adolescent and young persons with disabilities surveyed reported the need for further training and education on HIV, SRH & GBV services. As expressed by an adolescent below:

*“SLI should be employed at health facilities to have full information. I know I have a right to be pregnant normally but when I went to deliver, the doctor said I needed to undergo CS (Caesarean Section) without even explaining why. They don’t explain the reasons they choose for you. The right to make decisions is so violated. For example, I have ulcers and I try explaining my condition. The doctor insists since he/she is in charge they say they know what to offer and it is painful because I cannot speak and make the decision and that makes me bitter.”*

Lack of Sign Language Interpreters was highlighted as the main issue within the health facilities more so at the VCTs and emphasized confidentiality policy. As one female adolescent put it;

*“I went to VCT for testing and it was done without any prior testing. I was just told am fine and should go home”* Every woman should have access to the free ANC.

With regards to HIV, SRH & GBV service delivery points, most AYWD sited out different health facilities to access the services e.g. for counseling they sited Kibera South, DC’s office and SHOFCO; HIV testing and counseling most preferred Kibera South, Kenyatta Hospital, LVCT, SHOFCO, Amref; Maternal and newborn health they mentioned Mbagathi Hospital, Kenyatta

Hospital, CFK, and Laini Saba; Family planning, Mama Lucy, Kibera South, Lindi, SHOFCO, DC though some commented that it was far in terms of accessibility; Prevention of unsafe abortion most participants weren't aware where to get such services from apart from the few who mentioned Marie Stopes; Psychological therapy at DC's office though a respondent reiterated by saying, *"Psychological therapy is not easily accessible due to lack of finances to pay the therapist so you can just go to your pastor or talk to your friends and that's it."* Gender-based violence reporting at Nairobi Women's Hospital, GCC, LVCT, Amref, SHOFCO, Chief's office, police station though most respondents opposed the idea because when matters or issues were reported they were viewed lightly and no assistance was offered, some said at some point they also requested for bribes for them to push or follow up on your case, one respondent mentioned, *"I report the cases to the police but if I feel my case is not taken seriously, I look for an organization such as GCC which I know can help me. At the chiefs' office too."*

An adolescent expressed that; *"NYS Hospital Kwa DC where they offer diabetes tests, pressure, family planning, ANC, HIV and any other sickness. At Mbagathi Hospital we get disability reports e.g., if you want to know more about ENT (Ear, Nose, and Throat Assessment), they do check-ups. LVCT, offer HIV tests and counseling and also give free self-test kits, free male and female condoms. South Kibera Wanga you can get family planning. Nairobi women's hospital provides services for the prevention of unsafe abortions. Most GBV reports are done at Nairobi Women Hospital. For counseling, you can discuss with a friend whom you trust most."* Another youth added, *"because of cases such as GBV, I think Nairobi Women's Hospital is more accessible, it normally takes care of every victim and even PWDs."*

AYWD reported ignorance about what exactly they are supposed to do in case there have been violated or rights in accessing HIV, SRH & GBV services infringed – i.e., whether to take the survivor to health facility first before reporting the matter to the authorities or if it is to be vice-versa. But in some forums, the AYWD had an idea of what to do especially in cases of sexual violation. Two percent said they would take the survivors to the hospital, wrap their clothes in newspaper and not in polythene bags, to preserve evidence, and then report the matter to the police. *"They are supposed to be taken to hospital within 72 hours without bathing them"*, said a respondent. The same respondents incited the following reporting channels – the police; phone hotlines though they don't know the numbers. A respondent also reiterated the need to preserve



evidence by wrapping survivor's clothes (exhibits) in a paper, not cutting your fingernails nor bathing. A participant also confirmed that the survivors are taken to the hospital and *"then to the police to record a statement..."*

Lack of adherence to local legislature, limited pressure or accountability to follow up due to limited resources with regards to law enforcement when AYWD are seeking services. Limited awareness of how to report or what to report, the community and AYWD need to be informed and educated on reporting mechanisms. This also needs to be written and posted in accessible formats all disabilities can understand (people with visual impairment)

### **5.7 Access to Information**

During the discussions, 100% of respondents cited out different channels where they often access information regarding HIV, SRH, and GBV, one respondent said, *"From social media and sometimes LVCT and GCC group. For GBV they normally give you steps to prevent yourself from social media. LVCT gives us information on the use of protection or Prep and PEP and also how to avoid a rape-like situation ways to escape. GCC normally brings a facilitator who trains on HIV, GBV, and all other SRHR."* In addition, *"Mostly I use social media, google because they have a lot of information which is also easy to access. Facebook too has a lot of information some pages offer all services through writings even on youtube they capture the sessions. Google is what I use mostly because it has lots more information than Facebook and organizations have websites where they store such information which makes it easy to access."* Others added, *"I can easily access information through my phone on social media cause it's easy to cause a time from the radio at times I miss some discussion whenever am away from home though I prefer to receive information on HIV, SRH, and GBV on the radio because that is what the majority can afford assuming they have no TV."*

None of the participants were aware of the hotline number that you can call in any case related to HIV, SRH violation & GBV, a respondent cited, *"Not aware of any outline numbers."* Very few respondents were aware or informed of the procedures or steps to take once one has been violated of their rights in regards to HIV, SRH & GBV, *"For example, rape, as a deaf person, you are not supposed to change the clothes that you have, you shouldn't wait for more than 72hrs and then go*

*to the hospital where they do a check to prevent you from getting HIV, STI and pregnancies afterward they give you a report to be taken to the police.”*

## **6.0 CONCLUSION AND RECOMMENDATIONS**

Our assessment, in general, demonstrated that there is a lack of comprehensive knowledge, appropriate practice, and favorable attitude of AYPWD regarding accessing different HIV, SRH & GBV-related issues and services and recommend parents, and other care providers are sensitized to help AYWD meet their health needs.

Our findings thus clearly indicate the need for strategies and programs to raise access to HIV, SRH & GBV-related awareness and to help AYPWD to bridge the gap between AYPWD with health facilities.

The research recommends thorough awareness creation to health service providers and community members about disability mainstreaming.

The research recommends trained sign language interpreters and accessible materials at health facilities.

The research recommends involvement of adolescents and young persons with disabilities on SRH/GBV/HIV policies and programming.

The research recommends going beyond health facilities and creating awareness to victim services staff, law enforcement, disability service providers, and adolescent and youth with disabilities.

Finally, we hope our findings will enrich project implementation strategies, county planning and positively inform the county leadership teams on HIV, SRH, and GBV decision-making.

**END**

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