

HIV/AIDS EDUCATION IN KENYAN SCHOOLS FOR THE DEAF: TEACHERS' ATTITUDES AND BELIEFS

Thesis submitted to the University of Oxford for the degree of M.Litt.

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Department of Education
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ABSTRACT

How do teachers' attitudes and beliefs impact how HIV/AIDS education is implemented in Kenyan schools for the deaf? How do these attitudes and beliefs reflect how teachers think about Deafness?

While there is extensive literature exploring in-school HIV/AIDS-related education in East Africa, there are few studies focusing on segregated schools for the deaf. There are also few studies exploring how educators think about Deafness as culture in this region. Western Kenya offers a useful site for the exploration of these topics with mandated, in-school HIV/AIDS curriculum and a high density of schools for the deaf. Related research also argues that teachers' attitudes and beliefs and the politics of schooling are useful in exploring socio-cultural constructions of Deafness.

While previous studies have argued that "Deaf-friendly" HIV/AIDS education is not occurring in this region, this study found examples in these schools. Data from this study also revealed that this education was shaped by the beliefs and attitudes teachers held about sexuality, and Deafness and sign language. Furthermore, this study found that these attitudes and beliefs revealed underlying beliefs about Deafness that illustrate a range of constructions within this group of teachers.

This study spanned 15 weeks of fieldwork gathering data through interviews, questionnaires and observations with 81 participants. Data focused primarily on interviews and questionnaires with 43 teachers in three segregated schools for the deaf in the Nyanza and Western provinces. There were 8 Deaf teachers who participated from these school sites supplemented by an additional 24 Deaf participants working in schools across Kenya to balance data.

This study found that while the nationally-mandated HIV/AIDS course curriculum was not implemented in these schools, there was a significant presence of "embedded" and informal HIV/AIDS education. Teachers had a range of feelings about this education, some of which were unique to teaching Deaf children and children using sign language. They also reported how "Deaf stereotypes" shaped how they approached and implemented this education.

In some cases these beliefs and attitudes simply heightened preexisting concerns about HIV/AIDS education in similar ways to parallel studies of "regular" schools in this region. However the most striking conclusion from this research was that the presence of "Deaf culture" and the use of sign language among the student population changed the way teachers approached, implemented and reflected upon this education in unique ways not seen in "regular" schools. Interviews also showed that some teachers rationalized their approach to this education because they felt that the Deaf were "different" in certain ways, especially in terms of sexuality. These conclusions are helpful for those in HIV/AIDS education, Comparative and International Education, Disability Studies, Deaf Studies and Medical Anthropology.

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CHAPTER 1: INTRODUCTION

This paper presents the culmination of three years of research having evolved from a small pilot study of “Deaf-friendly” HIV/AIDS education with NGOs in Nairobi to an in-depth exploration of teachers’ attitudes and beliefs about this education in schools in western Kenya. During this pilot research and after reviewing the literature I began to ask, “Is any HIV/AIDS education happening in the schools for the deaf, and if so, what does it look like? What shapes it?” Initial interviews quickly pointed to the personal attitudes and beliefs teachers and NGO workers held about this education, about HIV/AIDS and about Deafness as a culture. It followed to ask, “What attitudes and beliefs do teachers in schools for the deaf hold about this education? Why? How does it impact the way they approach and implement this education?”

What followed was unexpected. Teachers were candid and open about a range of beliefs, often strong. These teachers presented a consistent range of perspectives rather than simply corroborating the current literature that argues teachers are “uncomfortable” talking about HIV/AIDS. While their reactions were different within each school, these differences were patterned into recognizable themes that were consistent across school sites. What became even more interesting was that those perspectives that seemed to shape how they approached and implemented HIV/AIDS the most were rationalized by

beliefs about Deafness itself. This study quickly evolved into a study of the dynamic, two-way relationship between beliefs about HIV/AIDS education and Deafness resulting in new questions about how teachers in these schools vary in their constructions of Deafness.

To summarize, the primary conclusions of this study are:

- HIV/AIDS education *does* occur in these schools, though in imbedded and informal ways rather than in the mandated, official curriculum
- Educators held a consistent range of beliefs and attitudes about this education
- These beliefs and attitudes shaped HIV/AIDS education in different ways
- Those beliefs and attitudes that shaped HIV/AIDS education more directly tended to be based on underlying beliefs and attitudes, or individual constructions, about *Deafness* itself.

STRUCTURE OF THIS STUDY

The structure of this study begins with a review of literature that helps to inform the research questions, offering key studies that explore how teachers' attitudes and beliefs influence sex and HIV/AIDS education. It also reviews studies on HIV/AIDS and d/Deafness, arguing that while there is research to show the need for studies on this topic, there have been few detailed, qualitative studies of the specific interactions between teachers and this education in sub-Saharan Africa. Research from Deaf studies does offer similar research of this kind, though not in this context and argues that the politics of schooling are important for understanding Deafness as an identity and culture. This chapter concludes with a review of what literature exists on d/Deafness and hearing impairment in sub-Saharan Africa.

The *Methods* chapter outlines how the research questions were explored and how

some pilot research built upon the literature to ask these research questions. These methods were built upon pilot research as well as the lessons from key studies that are reviewed.

Chapters 4-6 describe in detail the data collected and conclusions drawn. They contain descriptions of HIV/AIDS education in these schools and different analyses of how teachers responded to different questions about this education. These chapters also show the relative strengths and weaknesses of different methods used. The *Discussion* chapter offers a deeper analysis of this data, concluding with a discussion of theoretical research on Deafness and disability in this context.

Attached to this study are a series of *Appendices* containing relevant background information and data tables not included in the body of this paper because of word count limitations. The second *Appendix* contains an explanation of analytic terms used within this study, which, having been built upon a range of disciplines with differing terminology and perspectives, require definition. This is especially true for the central theme of this study, *Deafness*. The following table outlines what these *Appendices* contain and to which chapters they correspond.

Table 1: Appendices and their related chapters

	Title	Content	Related Chapter
Appendix 1	<i>Analytic Terms</i>	Rationale for the use of specific definitions within the scope of this study	All chapters
Appendix 2	<i>Personal Background</i>	A supplementary personal history of the researcher providing background on rationale and methods	Chapter 2: <i>Literature review</i> and Chapter 3: <i>Methods</i>
Appendix 3	<i>Participants</i>	Detailed descriptions of the different kinds of participants of this study and their local environments, and the school sites	Chapter 3: <i>Methods</i>
Appendix 4	<i>Tools</i>	Rationale for and detailed descriptions of research tools used	Chapter 3: <i>Methods</i>
Appendix 5	<i>Interview Tables</i>	Descriptions of the interviews conducted with participants	Chapter 3: <i>Methods</i>
Appendix 6	<i>Quantitative Analysis</i>	Supplementary data tables	Chapter 4: <i>Data from questionnaires</i>

PREFACE ON A SITUATED CONSTRUCTION OF DEAFNESS

This study offers original data that is relatively unique within the literature of HIV/AIDS education as well as data that confirms some of the current trends in this literature. Additionally, this study also offers an original theoretical examination of this education that builds upon current debates in the fields of Disability Studies and Deaf Studies. This exploration of these individual *constructions* of Deafness is limited to this study and aims to offer new questions about this context rather than attempt to replace current theories. The *Discussion* chapter describes the potential of a *situated construction of Deafness* as being useful for analyzing the kind of data that this study found.

Before embarking on the literature review, it is helpful to preface how the evolution and re-evaluation of terms such as *disability* and *Deafness* were required in order to analyze this data. This analysis was largely shaped by three specific arguments made by authors in the field of Deaf Studies and Disability Studies that, combined with this data, offered support for a *situated construction of Deafness*. While there are many ways of approaching Deafness and disability, these three perspectives were particularly useful in framing the data, the methods, and even how literature was reviewed.

First, Thomas' *social relational* perspective argues that one way of exploring disability is to examine the social interactions between people as reflecting one aspect of the disability experience (2004, 2006, 2007, 2009). Thomas argues that the notion of disability is modulated by everyday interactions between people. These interactions are as varied as the people and circumstances involved. Schools, therefore, make useful contexts for exploring disability because they are shaped by the politics of disability and education. For the purposes of this study, *disability* and *Deafness* are notions that can be examined through the interactions between teachers and their students. What influences teachers to

interact with their students in these different ways is important in understanding how *Deafness* is shaped in this context.

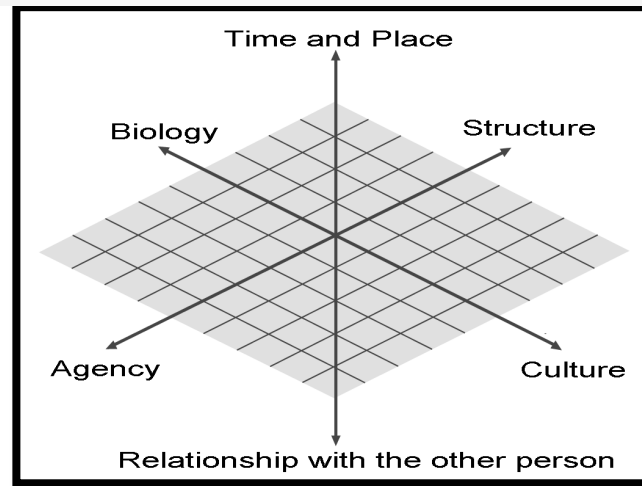
I use this perspective to frame this study and its conclusions with the added discussions of Shakespeare on social theories of disability. Co-authored with Watson, Shakespeare offered a particularly useful description of the potential influences on disability, arguing that disability is a “complex variable” and that it is,

...Situating at the intersection of **biology** and **society** and of **agency** and **structure**. Disability cannot be reduced to a singular identity: it is a multiplicity, a plurality (2001, p. 19).

From this quotation I have borrowed the term *situated* to describe how these ‘spectrums’ influence disability. While there is a heated debate as to whether Deafness is or is not a ‘disability’, this study takes the perspective that given these different influences, the *range* of the interactions between teachers and students can similarly construct Deafness as a *range* of abilities and disabilities.

Figure 1 illustrates my interpretation of this quotation put into the context of a *social relational perspective* that I have interpreted as a *situated construction of Deafness*. This figure illustrates visually the “multiplicity” Shakespeare and Watson describe and how this study views Deafness: as a range of possibilities shaped by context of each interaction.

Figure 1: Using Shakespeare and Watson's framework of disability contextualized within Thomas's *social relational perspective*, I have framed this study with what I call a ***situated construction of Deafness***. This figure visually depicts the two influencing spectrums of biology vs. culture and agency vs. structure as **x** and **y** axes with the added dimension of interpersonal interaction as the **z** axis. Data from this study was explored through teachers' accounts of the different interactions involved in HIV/AIDS education (occurring along the **z** axis) that were shaped by attitudes and beliefs that were in turn influenced in different ways by the **x** and **y** axes.



This figure visually interprets this perspective using the metaphor of a Cartesian coordinate system with three axes similar to a three-dimensional graph using **x**, **y** and **z** axes. This study does not argue that the polar extremes of each axis are practically observable, but rather that attitudes and beliefs about HIV/AIDS education appeared to sit at some point between their influencing points. As Shakespeare and Watson argue, two spectrums or axes might be biology vs. culture and agency vs. structure, though there are potentially other influencing factors or definitions. Thomas' *social relational perspective* situates them within interactions between teachers and students, in this case activities relating to HIV/AIDS education.

Corker's notion of difference as a unit of measure was helpful in operationalizing this perspective (1996). Some of the more interesting reflections from teachers talked about HIV/AIDS education as needing to be *different* for Deaf people as compared to

their hearing peers. In order to explore how Shakespeare and Watson's spectrums of influence were manifesting in these statements, they were first grouped according to what extent the participant was arguing that "Deaf people" or "Deaf culture" was somehow *different* or the *same* as compared to hearing people and/or culture. This produced interesting trends that later chapters tie to current debates in these fields. Alternatively, the reverse was also true. Sometimes if statements were grouped according to influencing spectrum (biology vs. culture, agency vs. structure), a subsequent grouping by *sameness* vs. *difference* also yielded interesting results.

This paper argues that this kind of analysis was useful in allowing reflections on both culture and structure to be compared simultaneously, something that the literature, as later reviewed, notes as particularly problematic for studies on d/Deafness.

SUMMARY

This study is situated at the intersection between HIV/AIDS education, Disability Studies, Deaf studies, and Comparative Education. Conclusions from this study are useful for comparing similar research and current debates but also open up new questions about the nature of HIV/AIDS education in "Special education" settings in regions such as East Africa. Results also offer insight into the theoretical implications of conducting research on notions such as Deafness and disability in these contexts, and are relevant for the additional fields of Communication, Medical Anthropology, and the Sociology of Education.

CHAPTER 2: REVIEW OF LITERATURE

INTRODUCTION

There is a large body of literature on both HIV/AIDS education as well as on disability, d/Deafness, and education. This chapter does not intend to accurately summarize these entire fields, but rather pull from the specific sub-fields and major debates to provide necessary background literature and rationale to support this study's research questions.

This chapter is structured to reflect how these research questions surfaced during pilot research. First, it became apparent that there might indeed be some form of HIV/AIDS education occurring in Kenyan schools for the deaf. What does it look like? How often does it happen? What influences whether it happens or not and how it is implemented? This literature offers insight into how others have studied these same questions, often in the very same region of this study, western Kenya.

Then, after interviewing teachers about these activities I found that they had strong, consistent beliefs about the sexual and communicative behavior of the Deaf that was described as “culture”. What kinds of beliefs do teachers have in these schools? How do they specifically impact HIV/AIDS education? What influences these beliefs?

Consequently, this chapter follows with a review of key studies that explore how

professionals working with people with disabilities think about sex and HIV/AIDS education, arguing that there are unique beliefs and attitudes held about disability and sexuality.

Because pilot research concluded with the importance of beliefs and attitudes teachers held about Deafness as a social construction or culture, I include a review of relevant literature on this topic. This section argues that there are unique cultural and political dynamics within schools for the deaf requiring special examination.

Finally, this section provides a summary of the available literature on d/Deafness and schooling in sub-Saharan Africa and Kenya. This literature comes from a range of perspectives and helps to better contextualize this study since most similar studies on Deafness took place in very different contexts.

Later, in the *Methods* chapter, there is additional review of relevant literature on methods, theoretical frameworks and context. This chapter focuses on those studies that were pointedly influential in providing background on the topics of HIV/AIDS education, teachers' attitudes and beliefs, and Deaf schooling.

HIV/AIDS AND SCHOOLING

This section provides background literature on HIV/AIDS-related¹ education with a focus on Kenya. This body of literature on sex education argues that attitudes and beliefs of teachers shape this education especially in terms of “culturally sensitive topics” such as abstinence, condoms, and abortion. “Desirable” attitudes and beliefs about HIV/AIDS-related education are a central topic of this research, especially when evaluated in higher-prevalence regions such as Kenya where the efficacy of these interventions is under scrutiny.

¹ Though there are many ways to become infected with HIV, “HIV/AIDS education” tends to focus

These studies tend to be designed to evaluate to what extent educators hold “desirable” beliefs and attitudes about HIV/AIDS with the understanding that this is the most useful predictor for implementation and efficacy².

THE IMPORTANCE OF TEACHERS’ ATTITUDES AND BELIEFS

Studies on sex education often focus on the attitudes and beliefs of students as a way of evaluating the effectiveness of interventions (Yankah and Aggleton, 2008). These studies also point to the importance of the pre-existing attitudes and beliefs of the teachers and other educators implementing this education (Aggleton and Campbell, 2000; Donovan, 1998; Mitchell, Walsh and Larkin, 2004; Oshi, Nakalema, and Oshi, 2005; Rogow and Haberland, 2005). These studies argue that “positive” or desirable beliefs increase the implementation of this education while “negative” or undesirable beliefs inhibit to what extent teachers implement pre-existing curriculum. Outside of resource constraints, the biggest barrier to “successful” sex education, researchers argue, is how teachers feel about talking with students about the topics in the curriculum.

Several studies collected data specifically on the attitudes, knowledge and “comfort” level of teachers who were instructed to teach sexual and reproductive health education (Cohen, Sears, Byers and Weather, 2004; Moore and Rienzo, 2000; Levenson-Gingiss and Hamilton, 1989a; 1989b; Kirby, 2000; Yarber, Torabi, and Haffner, 1997). These studies often found that teachers were more likely to implement the aspects of the curriculum they felt were “important”. They also tended to deem topics as “unimportant” if they also felt “uncomfortable” with them.

One common undesirable belief that research has shown impedes this education is

² This correlation is itself debated, as there is little *biological* evidence of this relationship in the region of East Africa.

the belief that providing such education encourages sexual experimentation outside of local cultural mores (Aggleton and Crewe, 2005; Orji and Esimai, 2003; Patton, 1996)³. The popularity of “Abstinence-only education” and the “Abstinence, Be Faithful, use Condoms” (A-B-C) campaigns is argued to be popular because they require less discussions about sexual activity and focuses more on abstinence, rather than evidence of efficacy (Levine, 2002). These studies also show that teachers’ attitudes and beliefs are heavily dependent on the local attitudes and beliefs about sexuality, morality, and religion.

While the local norms seem to influence teachers’ beliefs and attitudes about this education, more distal influences can also impact how teachers approach this education and to what extent it is implemented. Kovara argues that the attitudes and beliefs of politicians aligned with the “Christian Right” in the U.S. significantly impacted the HIV/AIDS curriculum used later in Kenya (2008; 2012). Funding pathways between the U.S. and Kenya allowed for the promotion of what Kovara called, “morality politics”. Teachers altered the “A-B-C” campaign to the more locally ‘palatable’ “Abstinence and Be Faithful for Youth” which eliminated discussions about condoms.

Mufune (2008) found that educators in Namibia supported sex education “in general” but were uncomfortable when it came time to discussing “taboo” topics in the classroom when they felt they had “little or no training” on how to conduct these discussions. Teachers also felt that without including these topics on exams there was little motivation to implement this education given limited time and resources. One of the

³ There is little evidence, however, to show that exposure to this education increases sexual activity but instead increases “safer sex practices” in terms of increased condom use and delays in the onset of sexual activity (Kirby, Laris, & Roller, 2006; Magnani, et al., 2005; Maticka-Tyndale, et al., 2004; Ross, et al., 2007; Speizer, Magnani, and Colvin, 2003; Stanton, et al., 1998).

primary beliefs that inhibited implementation was that it was not the “role” for teachers or schools to educate children on a topic they felt was largely moral and even religious in nature. As a result, this education was often reduced to its most medical aspects such as anatomy and teachers avoided discussing actual sexual behavior. This is in opposition to the strong focus on safer sexual practices of these curricula.

Kinsman et al. (1999) found discrepancies between the attitudes and beliefs of teachers and school officials: while teachers were eager to include what they felt was an important topic into the curriculum, the school officials were afraid of the reactions from parents, local churches and community groups. Teachers also reported that using English rather than local languages to discuss the more “taboo” topics within this education made instruction “easier”.

Aggleton has published research on HIV/AIDS and sexual/reproductive health education since the late 1980s, often arguing for more contextualization of training and evaluation methods to avoid these issues:

HIV/AIDS health education does not take place in a vacuum, but within discrete cultural, political, and social contexts. From the earliest days of the epidemic, this has always been true, but now it is more important than ever to recognise this reality, for unless we do we may never appreciate why certain interventions bring about desired outcomes whereas others fail to do so (1989, p. 167).

Like others in this field, Aggleton argues that a teacher’s personal moralities impact this education. “Problems can also arise when young people are presented with conflicting messages by teachers who may seem more concerned to advance particular moral positions than to deal dispassionately with the facts,” (p. 168). Aggleton argues that this is due to a lack of training, wider cultural mores and the perceived roles of teachers and educators.

It should be noted that while some of these studies provide a theoretical framework

or definition for the terms *attitude* or *belief*, many do not. Some studies reference *cognitive-behavioral approaches* but most fail to rationalize their use of specific belief-statements as being “positive” or “negative”.

What can be learned from this body of research is that teachers’ attitudes and beliefs about HIV/AIDS-related education are key in understanding how and why this education is implemented and what impacts its “success”. Many things can influence these attitudes and beliefs such as local norms and culture, religion, local and distal politics, and economics. There is little consensus as to the “best” way to study these attitudes and beliefs, especially in the under-researched area of East Africa, and so this chapter continues to draw on other disciplines for support on how to explore these concepts.

HIV/AIDS-RELATED EDUCATION IN KENYA

Since the late 1980s, Kenya has been host to a relatively large concentration of research on HIV/AIDS as compared to neighboring countries with similar rates of prevalence and incidence. These studies focus on the efficacy of behavioral interventions implemented through formal and informal education (Balmer et al., 2000; Bauni and Jarabi, 2000; Duflo, Dupas, Kremer, and Sinei, 2006; Pattman and Chege, 2003; Njue et al., 2009; Ngugi et al., 1996; Poulsen et al., 2010; Vandenhoudt et al., 2010; Volk and Koopman, 2001).

In particular, the research conducted by Maticka-Tyndale, Gallant, Brouillard-Coyle, and Sverdrup-Phillips, (2002, 2005) and Maticka-Tyndale, Wildish, and Gichuru, (2007, 2010), is instrumental in understanding the relationship between formalized educational interventions, HIV/AIDS, and the beliefs and attitudes of relevant actors such as teachers.

To understand why these studies focus on in-school, behavioral interventions, it helps to understand the nature of this epidemic in this region. Kenya, like much of sub-Saharan Africa, has a *generalized* epidemic: it has a prevalence and incidence that is similar across many demographics as opposed to being concentrated within higher risk groups such as sex workers or men who have sex with men as in some other regions. Most infections happen through casual, heterosexual sexual contact (Central Bureau of Statistics, Kenya, 2004). Rates are higher for women and most of these infections happen during the late teens by an older man. As many as 1 in 4 women in the Nyanza province, (where most of this study was conducted), have HIV, yet these women are largely unaware that they are infected.

Because no one group of people has a significantly lower risk than others, both international and domestic initiatives have focused on educational interventions starting in primary school in an attempt to reach the widest range of Kenyans. Combined with the recent Free Primary School initiative of 2003, this method has become a way of reaching every Kenyan with messages about HIV/AIDS prevention and treatment.

HIV/AIDS has also had a significant impact on most Kenyans. There are over 2.5 million children who have had at least one parent die from an AIDS-related death and over 1.4 million HIV positive adults (NACC, 2009).

By 1999 the Kenyan government adopted the “Three-Ones” framework that focuses on centralized control for the creation, implementation and evaluation of HIV/AIDS-related programs in order to “reduce redundancy and increase efficiency and effectiveness”. Like other countries using this framework there is one central agency. The National AIDS Control Council (NACC) of Kenya, which works with other ministries and groups to write and revise the Kenya National AIDS Strategic Plan (KNASP). This

has in part resulted in its coordination with the Ministry of Education, Science and Technology (MoEST) to imbed HIV/AIDS education into all public education institutions including tertiary schools using one, systematic intervention.

With the assistance of UNICEF and the World Health Organization, the NACC developed a course syllabus for this intervention that included not only basic biomedical aspects of HIV/AIDS and related Sexually Transmitted Infections but also “life skills” such a “decision making” and ways to reduce stigma (Mwebi, 2008). The NACC and Ministry of Education intended that each secondary student would be exposed to this curriculum daily for at least one term.

It was also “imbedded” within other course curricula in other secondary courses as well as within primary school curriculum. Discussions about HIV/AIDS are included in courses such as Christian Religious Education, Science, Biology, and even History and language classes. For instance, there are word problems in Maths involving HIV/AIDS and readings on the history of this epidemic in Social Studies. While the subject is not ‘testable’ in national primary or secondary school examinations, the topic of HIV/AIDS can arise within questions or essay topics on such standardized tests such as the Kenya Certificate of Secondary Education (KCSE) and the Kenya Certificate of Primary Education (KCPE).

Therefore, according to policy there *should* be a form of HIV/AIDS education occurring in schools for the deaf because these too are publically-funded and are under the auspices of the Ministry of Education. Their students take the KCSE and KCPE like other Kenyan children (with additional time given to “Special Education” students though with no sign language interpretation). Yet Deaf and Disability advocacy groups frequently critique the absence of any such education (Handicap International, 2007;

Henderson et al., 2004; Taegtmeier et al., 2009; Viehmann, 2005; VSO and LVCT, 2010).

Njue et al., (2009) and Duflo, Dupas, Kremer, and Sinei, (2006) evaluated this education extensively in western Kenya arguing that while this curriculum has political support, in reality its implementation is only partial and the attitudes and beliefs of the teachers and parents significantly change the nature of this curriculum's message.

“Political sensitivities and agendas have limited the inclusion of training in--or possibly even the mention of correct condom use” (Njue et al., 2009: p. 172).

In summary, this body of literature argues that one of the primary factors in implementing HIV/AIDS-related education is the personal attitudes and beliefs of the educators. Beliefs about morality and local “taboos” frequently impact to what extent this education is implemented though there are many potential factors that influence how and why teachers implement this education. There is a body of research that has reviewed to some extent the interactions between teachers' attitudes and beliefs and this education in western Kenya specifically. Yet these studies do not mention any inclusion of “Special Education” schools or students. Therefore, a review of this literature argues that there is a gap in the research on attitudes and beliefs of teachers working in “Special Education” schools in Kenya.

HIV/AIDS, DEAFNESS, AND DISABILITY

This section reviews literature on “HIV/AIDS and Disability” which has grown since the mid-1990's to become its own sub-discipline. Within this literature, some studies focus entirely on d/Deaf populations while many simply include these groups within the larger category of disability. This literature argues that HIV/AIDS education for the deaf in sub-Saharan Africa “rarely” exists or that it is “inaccessible”, both due to practical

limitations such as few sign-language interpreters or because of attitudinal barriers of educators and medical workers. While this literature strongly argues that d/Deaf individuals are at an equal or higher risk of infection, they are significantly less likely to have access to “appropriate” HIV/AIDS education.

Some researchers such as Taegtmeier et al. (2009), have begun to explore instances where HIV/AIDS education is occurring as targeted or adapted for people with disabilities. These studies offer useful suggestions for why this education has been implemented and what major factors influence its scope and efficacy. Authors such as Job (2004) have begun to speculate about the unique attitudes educators hold about Deafness and sexuality that impact this kind of education as well. This section argues that while there is ample speculation within this literature surrounding the relationship between Deafness, educators’ attitudes and beliefs, and HIV/AIDS education, there is little research on this intersection specifically.

HIV/AIDS AND D/DEAFNESS

The growing body of literature on the relationship between d/Deafness and HIV/AIDS argues that d/Deaf individuals are a ‘higher risk group’ because they share the same structural inequalities as other ‘higher risk groups’ such as low levels of education, unemployment, malnutrition, and extreme poverty (Enwereji and Enwereji, 2008; Gaskins, 1999; Hanass-Hancock, 2009; Hanass-Hancock and Satande, 2010; Osowole and Oladepo, 2004; Touka, Mbua and Tohmuntain and Perrot, 2010). These systematic risk factors result in low levels of HIV/AIDS-related knowledge and undesirable sexual attitudes and practices such as low rates of condom use, multiple concurrent partners, and engaging in commercial sex.

The conclusion that these risk factors result in d/Deaf individuals being at a higher

risk comes from the comparison of accepted statistics on HIV prevalence and risk factors of ‘hearing peers’ in similar regions. These studies acknowledge there is little data on the *actual* HIV rates among the d/Deaf or people with disabilities in general (Groce et al., 2012). Much of this research uses responses from questionnaires and interviews to “piece together” these systemic risk factors and to project prevalence.

In 2010, Hanass-Hancock and Satande completed a systematic review of the literature on “deafness and HIV/AIDS” focusing primarily on risk factors. They found that,

Deaf people are as likely, if not twice as likely, to be infected with HIV [in part because of] increased instances of multiple partners, sexual abuse and earlier sexual debut, and, in some contexts, decreased use of condoms (p.1).

This is one of the few studies to provide examples of HIV/AIDS education or prevention that are targeted at or specifically made accessible for d/Deaf populations.

Organisations such as ‘AIDS Ahead’ in the United Kingdom and ‘Liverpool VCT, Care and Treatment’ in Kenya and their initiatives for the deaf do address these issues. However, to date, research on deafness and HIV/ AIDS has been limited and particularly scarce in southern Africa (p.1).

Peinkofer, (1994) and Groce, Yousafzai, and Van der Maas, (2007), argue that these risks stems from both language and attitudinal barriers that are unique to d/Deaf populations. Because they use sign language and are labeled by their wider community as “disabled”, d/Deaf populations face a significantly higher level of stigma, lower levels of education, and low access to medical care, all of which compound risk factors.

These studies describe as a whole the reasons why d/Deaf populations make for a “higher risk group” and therefore worthy of inclusion in wider HIV/AIDS studies and interventions. However they are limited in that they often fail to differentiate or focus upon any one kind of risk factor and explore it in detail. For instance, these studies group together medical workers’ attitudinal barriers against people labeled as disabled along side

attitudinal, cultural, and often political barriers against sign language-based education. While the former deals with wider notions about sexuality and disability, the latter deals with the politics of language⁵.

Taegtmeyer et al., (2009), completed what is one of the few studies on d/Deaf individuals and HIV/AIDS in Eastern Africa that includes a description of a targeted HIV/AIDS education program. Not only did their study take place in the same geographic region as this research but it contains some notations about the nuances of how such education might take on a unique nature when in the context of sign language and a local Kenyan “Deaf culture”.

Like other studies, Taegtmeyer et al. argue that the d/Deaf population of Kenya is at an equal or higher risk of HIV infection than their hearing peers while lacking access to “appropriate” HIV/AIDS education.

As in other countries the current HIV/ AIDS campaign strategies do not take into consideration the specific needs of the deaf. There were no HIV/AIDS curricula or training materials in sign language and no sign language interpretation of HIV/AIDS television programming or meetings prior to the establishment of the HIV counseling and testing program for the deaf in 2003. Posters and other written materials were inaccessible due to high rates of illiteracy and poor understanding of written Kiswahili among educated Deaf persons who are taught to read in English. Local Deaf-led education efforts in HIV have been further hampered by the existence of four separate sign languages in common use in Kenya (p. 509).

In response to this argument, like other studies based on prevalence projections from risk factors rather than biological evidence, they designed, implemented and self-evaluated an HIV/AIDS education intervention. Using a peer-education model they trained “Deaf peer educators” and in a collaboration between the Liverpool VCT Centre in Nairobi, (LVCT), the Ministry of Health, and “Deaf organizations”, they opened the

⁵ Later in this *Review of the Literature* and in other chapters, I will return to how some social theorists have attempted to differentiate between these notions that in the context of high HIV prevalence have become “risk factors”.

first ‘Deaf-friendly’ VCT clinics in Nairobi and Western Kenya in 2004.

In discussing the practical factors influencing the implementation of these program, Taegtmeyer et al., also noted the importance of several “cultural attributes” of this Deaf community. These authors found that there was a marked “lack of confidentiality” and that because “news travels fast” amongst Deaf Kenyans, it was necessary to emphasize the nature of medical confidentiality *more* with their Deaf peer educators. They also felt they needed to explain this concept to Deaf participants *more* than they would have with hearing participants in order to encourage participation⁶.

Taegtmeyer et al. noted other specific cultural attributes that enhanced the success of the program using different terms. While the “lack of confidentiality” was described as a “cultural attribute”, the Deaf peer educators’ skills in non-verbal communication were described more as a result of sensory compensation from living with a hearing impairment.

While hearing counselors must spend time to learn attentive listening skills, eye contact, open posture and concentration, the deaf learners were adept at these skills and naturally able to read non-verbal communication or ‘body language.’ Many had experienced stigma and oppression and quickly developed the ability to give clients the core conditions of counseling (empathy, non-judgmental attitudes and genuineness) (p. 509).

The combination of this non-verbal communication skill and using sign language, these authors argue, resulted in a greater influence on visitation of the VCT clinics as compared to posters, or personal interactions with community or religious leaders. Authors argue that there was a stronger relationship between visitation and the Deaf peer educators than hearing participants had with hearing peer educators.

What is implicit in the language of Taegtmeyer et al.’s study is that the less-

⁶ Bat-Chava, Martin, and Kosciw (2005) described this in a similar study taking place in New York calling it the “deaf grapevine”.

desirable “cultural attributes” were considered part of “Deaf culture”. Yet those Deaf attributes that were more desirable for this intervention were described in more neutral terms and were not described in terms of a shared culture. It should also be noted that while this study involved some Deaf investigators, the primary researchers were hearing and foreign.

Other studies were informative for this research though they took place in different environments. Bisol et al., (2008), sought to collect data on HIV/AIDS-related knowledge, attitudes, and practices of Brazilian Deaf youth. Before doing so, they used focus groups with the target population to discuss the wording and style of pre-existing questionnaires (designed for a hearing population) in order to increase confidence and reliability of their study. They concluded that there were specific cultural and linguistic needs unique to this Deaf community of Brazil that required changes to be made to increase the usefulness of this research tool.

The kinds of changes participants of this study requested were mainly linguistic; substituting words by using vocabulary more commonly used by the Deaf community represented. The authors argued, however, that this vocabulary was more common to adolescents in general rather than just to the Deaf community. Words such as *pills* instead of *treatment* referenced a lack of medical terminology rather than an aspect of Deaf culture. Bisol et al. implicitly argued that rather than adapt for a Deaf culture in particular, questionnaires of this nature should be carefully adapted for the adolescent population and then offered alongside a simultaneous video-interpretation as an alternate mode. To a lesser extent they felt that some questions needed simplification or reorganization due to grammatical differences between sign languages and Portuguese. For instance, placing the time and place of an action at the start of a sentence as is common in sign languages:

“How often this month have you had sex?” rather than “How often have you had sex this month?”

This study also noted that a particularly useful method was to allow focus groups to evolve into narratives: “In some groups, discussions reached a level of comfort that allowed or even encouraged them to narrate personal events of their lives, enriching the process of assessing their experiences and sociocultural contexts” (p. 573).

Peinkofer, (1994), is one of the few researchers to describe the unique nature of a local Deaf culture as itself a risk factor that provided rationale for the need for “Deaf friendly” HIV/AIDS education and treatment.

The deaf, though a minority within any given municipality, are closely knit. The great percentage of deaf people interact socially with other deaf people. Gossip and hearsay travels quickly within the deaf community. Those who are anxious about sensitive topics (such as HIV transmission) will tend toward rumor promulgation. Fear of isolation from his or her own community becomes so great that using medical and social services may be compromising for deaf persons with HIV. Confidentiality is of great importance. Walking into an HIV testing site or to an AIDS treatment clinic may be postponed indefinitely if the person fears being seen by a deaf acquaintance (p. 391).

This description of risk factors is unusual within this body of literature because Peinkofer constructs Deaf culture in terms of both language and social marginalization. Peinkofer defines Deaf culture partially in terms of behaviors that are in response to or a result of perceived attitude of others. This results in a unique relationship between Deaf culture and HIV/AIDS.

Woodroffe, Gorenflo, Meador, and Zazove, (1998), hypothesized that among other reasons the Deaf community of southeastern Michigan had a “different understanding of AIDS than the hearing population”, the Deaf community also had unique “cultural traditions, and relative isolation of many of its members” (p. 379). Yet after an in-depth study of this community’s interactions with HIV/AIDS information, education and

treatment, these authors failed to expound on these “cultural” traditions outside the following speculation:

In the Deaf community, there is often an “us” versus “them” attitude with the rest of the world, the result of years of discrimination. Even in today’s world, a time when the legitimacy of ASL are being outwardly recognized and the Americans with Disabilities Act is in effect, many [Deaf and hard-of-hearing] persons remain hostile towards the rest of society... This attitude, in addition to the communication barriers, may help explain why [Deaf and hard-of-hearing] persons have trouble receiving accurate information about AIDS (pp. 384).

These studies by Peinkofer and Woodroffe, Gorenflo, Meador, and Zazove implicitly argue that the unique relationship Deaf culture has with HIV/AIDS is due to perceived beliefs about the Deaf as being different from “the hearing” and how each group responds to these perceived beliefs.

Fitz-Gerald and Fitz-Gerald produced a series of articles in the late 1970s and early 1980s on the topic of sexuality and Deafness that offers some additional insight into the potential relationship between education and schooling, HIV/AIDS education, and d/Deafness. Though written in a somewhat different time and much different environment than present-day Kenya, these authors offer a rare clue into interactions between Deaf students the attitudes and beliefs of hearing adults with power in their immediate environment.

“The deaf...are forced to use a graphic, non-verbal communication system, including gestures, drawings, homemade signs, and/or sign language, for human contact and interaction. For example, a young deaf child pointing to his/her genitals or imitating urination might be expressing a desire, asking a question, or indicating his/her knowledge of an experience...The deaf adolescent quickly learns the taboos of being so graphic, and carries his/her communication “underground”. Thus, even more barriers are built up to prohibit communication and interaction and the deaf person is further isolated. (1978, p. 62).

These studies, like many that explore sex or HIV/AIDS education and d/Deaf students, tend to define Deafness as a separate group from “disability” and rarely

reference studies on disability and sexuality or HIV/AIDS. Job (2004) offers a useful synthesis of this literature to help explain the unique relationship between Deafness and sex education while remaining adamant that Deafness is *not* a “disability”.

Job uses a review of literature to discuss the complex interactions between educators’ (and parents’) beliefs and attitudes, culture, sexuality, and sign language. Job found that research on the broader category of disability and sexuality was particularly useful in understanding how educators, (as well as parents and community members), project beliefs about a “disabled sexuality” onto Deaf individuals. Using a framework proposed by Griffiths (1993), Job connects “mythconceptions” about disabled sexuality with their Deaf counterparts arguing that “society” tends “to other” Deaf sexuality.

For instance, Job aligns Griffiths’ “mythconception”⁷ that “disabled individuals need to live in environments that restrict and inhibit their sexuality to protect themselves and others” with an example from Sullivan, Vernon, and Scanlan, (1987):

[They] observed that deaf children tend to be more curious and are highly naive about sexual norms and values. Combined with a conditioned tendency to comply with authority, be fearful of threats, and be susceptible to bribes and promises of rewards, deaf children are extremely vulnerable to sexual abuse (p. 268).

Griffiths’ other “mythconceptions” cited by Job are as follows:

- People with developmental disabilities are eternal children and asexual.
- People with developmental disabilities need to live in environments that restrict and inhibit their sexuality, to protect themselves and others.
- People with developmental disabilities should not be provided with sex education, as it will only encourage inappropriate behavior.

⁷ It should be noted that Griffiths’ “mythconception” framework is largely based on anecdotal professional experience working in Special Education in Canada and little systematic study. However, it makes for an interesting starting point for researchers such as Job to consider the “disabling” of Deaf sexuality. Griffiths and her colleagues, Richards, Fedoroff, and Watson, describe some of this research in their book on sexuality and people with developmental disabilities as well (2002).

- People with developmental disabilities should be sterilized because they will give birth to children who are also disabled.
- People with developmental disabilities are sexually different from other people and are more likely to develop diverse, unusual, or deviant sexual behavior.
- People with developmental disabilities are oversexed, promiscuous, sexually indiscriminate, and dangerous, and you have to watch your children around them.
- People with developmental disabilities cannot benefit from sexual counseling or treatment.

Job acknowledges while she and many in Deaf studies distance themselves from labeling Deaf people as “disabled”, the wider society still impacts their lives by equating the Deaf community with people with intellectual disabilities in terms of their sexuality.

Job also lists the ways that Deaf children might exhibit behaviors that are different from hearing peers leading educators and parents to assume there is a different kind of “Deaf sexuality.” These behaviors, Job argues, are a result of linguistic isolation and “incidental learning”, arguing that Deaf adolescents can become confused because of the “incompleteness” of information.

This review also concludes that the beliefs and attitudes of parents and guardians act as a barrier to engaging in discussions about sexual and reproductive health. Citing Schirmer (2001) and Ajzenstat and Gentles, (1988), Job argues that guardians are sometimes “embarrassed” by using manual signs that to them feel “graphic”. Parents and guardians also reported they felt inhibited because of their own lack of knowledge and uncertainty about underlying moral issues. They also felt that schools “ought” to teach these topics and not guardians. Guardians also felt and “an underlying fear that discussion would encourage experimentation”.

While the majority of other studies on Deafness and HIV/AIDS-related education

tend to focus on the results of low knowledge and undesirable attitudes and behaviors in order to rationalize identifying Deaf populations as higher risk groups, Job attempts to explore how and why this group might pose a unique challenge for implementation of this education. Job's discussion of this literature points to the complex interaction between beliefs about sign language and a 'disabled sexuality', as opposed there simply being a communication barrier.

Other studies implicitly argue that *if* sign language-based HIV/AIDS education were accessible, the Deaf would no longer be a 'higher risk group'. Yet within these studies reviewed here there are consistent 'side-notes' reflecting Job's argument that there are deeper societal beliefs and attitudes about the sexuality of people labeled as "disabled" which commonly includes the Deaf. There is also something unique occurring in the minds of educators and parents about the perceived role of manual/visual modes of communication that implies a different kind of sexuality.

While Job is one of the few researchers to make this added rationale for the study of attitudes and beliefs of educators working with Deaf students, the following section reviews literature from the wider category of HIV/AIDS and disability that also make these observations.

HIV/AIDS AND DISABILITY

As with HIV/AIDS and Deafness, the broader category of HIV/AIDS and disability is growing, though still relatively spare as compared to the relative worldwide population of people with disabilities. In a critical review of this literature in 2012, Groce and colleagues found that even with only 5-6 articles published per year, this discipline was largely represented by studies conducted in North America (69) and only one from Kenya. South Africa was better represented with 18 published articles though most other

African countries boasted merely one or two in the past decade.

Given the vast amount of research around HIV and AIDS and the thousands of articles on the subject published in the peer reviewed literature annually, the continuing lack of attention to HIV and AIDS among this at risk population, now estimated to make up 15% of the world's population, is striking (Groce et al. 2012, p. 2).

Groce et al. argue that people with disabilities have higher rates of risk combined with low levels of knowledge and higher rates of high risk sexual behaviors and incidence of sexually transmitted infections⁹. Specifically, many researchers specifically call for further study on barriers that result in the lack of access to HIV/AIDS education and treatment¹⁰:

...including attitudinal barriers on the part of service providers who may have ambivalent or negative attitudes about the sexuality of people with disabilities or who may not even consider the possibility that people with disabilities may be sexually active (Groce et al., 2012, p. 4).

There is more research on this in relation to people with intellectual disabilities or mental disabilities, (Collins 2001, 2006; Coverdale, Falloon, and Turbott, 1997; Katoda, 1993; MacDonald, Murray, and Levenson, 1999; Murray, MacDonald, and Minnes, 1995; Rohleder and Swartz, 2009). These studies offer helpful background on the kind of attitudes and beliefs that exist about sexuality and these differences because as Job argues, they are often transposed onto Deaf people.

⁹ (Blanchett, 2000; Brown et al., 1997; Cambridge, 1996; Carey et al., 1997; Carey et al., 1999; Carey et al., 2001; Carey et al., 2004a; Chandra et al., 2003; Choquet et al., 1997; Chopra et al., 1998; Chuang & Atkinson, 1996; Collins et al., 2008a; Collins et al., 2008b; Davidson et al., 2001; Devieux et al., 2007; Gordon et al., 1999; Grassi et al., 1999a; Grassi et al., 1999b; Kalichman et al., 1994; Katz et al., 1994; Kelly et al., 1992; Kelly et al., 1995; Maart & Jelsma, 2010; Meade & Sikkema, 2007; Meade & Sikkema, 2005; Menon & Pomerantz, 1997; Menon et al., 1994; Myer et al., 2009; Ogunsemi et al., 2006; Olaleye et al., 2007; Otto-Salaj et al., 1998; Randolph et al., 2009; Rohleder, 2010; Rosenberg et al., 2001; Smit et al., 2006; Susser et al., 1995; Thompson, 1994; Touko et al., 2010; Venable et al., 2007; Weinhardt et al., 1998; Walkup et al., 1999).

¹⁰ (Brown & Jemmott, 2002; Chireshe, Rutondoki, and Ojwang, 2010; Desai & Rosenheck, 2004; Fremont et al., 2007; Goldstein et al., 2010; Hanass-Hancock, 2009b; Mallinson, 2004; Neri, Bradley, and Groce, 2007; Philander & Swartz, 2006; Rohleder et al., 2010; Smith, Murray, Yousafzai, and Kasonka, 2004; Wazakili, Mpofu, and Devlieger, 2006, 2009; Yousafzai, Edwards, D'Allesandro, and Lindstrom, 2005; Yousafzai, Dlamini, Groce, and Wirz, 2004)

Two studies in this discipline are especially useful for background to this study. Both Collins (2006) and Rohleder and Swartz (2009) interviewed health educators implementing HIV/AIDS education for people with disabilities in South Africa. Both studies found that the beliefs and attitudes of these educators had a significant impact on how pre-existing curriculum was implemented. In turn, both studies also found a multi-directional flow of influence between the existence of HIV/AIDS in the community and personal beliefs and attitudes about disability.

Collins (2006) used detailed, qualitative interviews to explore the relationship between high rates of HIV and mandated curriculum on HIV/AIDS for people with mental disabilities. In segregated, residential institutions for people with “mental health issues and illness”, the staff was expected to implement mandated health education curriculum that focused largely on HIV/AIDS prevention through sexual and reproductive health education. Collins argued that the juxtaposition of the high rates of HIV in this area heightened the staff’s pre-existing attitudes and beliefs about sexuality and disability. These attitudes and beliefs, in turn, impacted to what extent and how this curriculum was implemented.

Staff in these institutions expressed “worries” and “fears” about patient sexuality. Collins argued that the main barriers to implementing the pre-existing HIV/AIDS education,

...Operate at the individual level, the institutional level, and the societal level. At the individual level providers’ perceptions of psychiatric symptoms shape their outlook on intervention with psychiatric patients. At the institutional level disruptive transitions in service delivery relegate HIV services to lesser importance. At the societal level, personal beliefs about sexuality and mental illness have remained slow to change despite major political changes (p. 979).

Collins found that many staff felt that this population had an increased risk of infection because of the difficulty for “normal” sexual relationships to continue within

such institutions and the stigma of being labeled as “mentally ill”.

Caseworkers spoke of patients jilted by boyfriends or spouses once the mental illness was discovered. Some relationships survived only because of the disability grant that patients received and then contributed to the family finances. These painful experiences contributed to HIV risk in the eyes of some providers. A nurse on general hospital’s psychiatric ward commented, ‘Usually when they label you that for life nobody will come near you. That’s why these women strip and follow these guys. Nobody will ever come to you.’ (p. 985).

While some participants of this study felt that the residents in these institutions exhibited a “hypersexuality”, it was not clear to what extent this was perceived as a result of the disability or changes in societal values.

When manic patients come onto the ward and they’re hypersexual—there [are] problems. I can imagine in the community it’s even a bigger problem. Family structures are not as they used to be. There’s a lot of promiscuity. There’s a transition from old cultural values to new ones that’s caused a loosening of family relationships (p. 986).

However, Collins also found staff arguing this stigma resulted in lower risk of infection.

What I have realized is because of the rejection by the community, that thing somehow saves them from most of the things [like HIV]. When you get mentally ill in the community they don’t accept you as readily. There’s stigma or rejection. They think maybe you are bewitched. Your closest friend rejects you and then in that process you’re facing the rejection -- you’re protected by your family. You have no boyfriend and everybody’s afraid. I think that’s why a lower number of psychiatric patients have HIV (p. 985).

While most other studies reviewed so far simply concluded that a major impediment to this education was “attitudinal barriers” of educators, Collins explored what they looked like, how they were articulated, and why educators rationalized these attitudes and beliefs, concluding there was a range rather than uniform set of beliefs. This study also argues that similar examples and experiences from educators’ professional knowledge were used to rationalize a range of beliefs and attitudes.

Rohleder and Swartz (2009) explored the attitudes and beliefs of educators who

focused primarily on HIV/AIDS-related education for people with intellectual disabilities in South Africa and the specific ways it impacted this education. These authors found that cultural and religious beliefs about sexuality, HIV/AIDS, and disability all impacted how teachers implemented pre-existing curriculum, often changing or abbreviating it.

While no teacher was strongly opposed to implementing HIV/AIDS education though it contains explicit sexual content, when faced with teaching these topics to individuals with intellectual disabilities, participants expressed significant tensions and fears they did not otherwise experience with “normal” students.

Their interview narratives revealed some ambivalence about topics of sex and sexuality, for persons with learning disabilities. There appeared to be a tension between a ‘human rights’ discourse and a discourse of needing to restrict sexual expression. On the one hand there was a recognized human rights need to allow persons with learning disabilities to lead fully sexual lives, but there was also a more implicit need to control their sexual behaviours and sexual relationships, in relation to constructions around morality and what is regarded as appropriate, moral sexual behavior (p. 605).

The “moral” issue was heightened by the fact that many of the organizations who employed them were Christian that and many of the teachers and staff themselves identified as Christian. This resulted in ambivalence within the teachers and staff about the ‘role’ they played and the morality of allowing the students/residents to engage in sexual activity. Residential sites as a rule did not allow sexual activity and part of barring this was also withholding the provision of condoms because staff felt would encourage residents to engage in sexual activity.

Rohleder and Swartz also found that the conversations with staff showed contradictions: residents were often discussed as being both sexually uninhibited *and* asexual or innocent. Subsequently staff feared that in teaching students about sex they will “release the dis-inhibition”.

‘People with intellectual disability, I have seen people, oh, oh my goodness,

are, I mean would sleep with anyone and everyone' (Participant D) (p. 607).

'I always fear, is someone going to go off and prove the, the fear that I think is around sexuality education, that that means that they are going to go off and act out what we have been teaching them' (Participant B) (p. 607).

The issue of homosexuality was also significant: staff identifying as Christian were opposed to any kind of homosexual activity as well as feeling it was a cultural 'taboo'.

While the curriculum included discussions about homosexuality alongside other sexualities, staff edited content based on their moral beliefs and personal comfort levels.

Staff felt anxiety over the impact they would have on residents in teaching about sexuality; since they residents had intellectual disabilities, they thought residents might simply 'act out' what they had been taught. Staff also felt that possible sexual abuse, something they saw as a common threat to the residents, was enough of a problem to warrant the need for this education. Authors argued that these tensions created an atmosphere that influenced staff to focus on morality when implementing the HIV/AIDS education, discussing sex in terms of danger, death and immorality, something associated with abuse and disease.

Swartz and Rohleder argue, in summary, that the context of disability in these cases heightened pre-existing beliefs and attitudes that in turn had a significant impact on how HIV/AIDS education was taught.

These studies offer several useful lessons. It is useful to explore the attitudes and beliefs of educators who work with Deaf students or students with disabilities for look for potential barriers to implementation. In addition, this literature argues that these attitudes and beliefs are a reflection of wider societal beliefs about sexuality, disability and language. Furthermore, there is little consensus about how these attitudes and beliefs might be studied. Some researchers such as Job and Griffith list manifestations in terms of "mythconceptions" and make the assumption that they therefore are all undesirable and

barriers to this education. Other such as Swartz and Rohleder organize these notions in terms of their implied source: beliefs about human rights versus religious and other moral beliefs. The latter authors focuses on the “tensions” within educators between opposing attitudes and beliefs while authors such as Job focus on which beliefs and attitudes are undesirable and therefore need to be “fixed”. Because this study is exploratory and in the an under-researched context, it is more aligned with the style of Swartz and Rohleder who are careful to not assume which beliefs and attitudes are desirable or undesirable, but instead explore the complex nature of these beliefs regardless of their impact on efficacy thereby expanding the potential range of data.

DEAFNESS, SIGN LANGUAGES AND EDUCATION

While there are only a few studies focusing on educators’ attitudes and beliefs about HIV/AIDS education in the context of d/Deafness or disability, there is some literature offering insight into the study of education and d/Deafness more generally. This literature, though often focusing on efficacy levels of different kinds of instruction with an emphasis on literacy, does provide useful background on the culture of schools for the deaf.

This literature is also useful in expanding the previous section’s conclusions about the usefulness of exploring teachers’ attitudes and beliefs not only for practical concerns of efficacy but also as a way of exploring wider notions about Deafness, disability, and language. Unlike studies on Deafness or disability and HIV/AIDS, research from Deaf Studies often explicitly targets these social constructs as the focus of studies, providing valuable insight into the methods and theories potentially useful in this kind of research. This section offers insight into potentially unique contextual variables of Deaf education.

STUDIES OF DEAFNESS AND “SCHOOLING”

Research on people who are d/Deaf or hard-of-hearing comes from a range of disciplines with different perspectives and definitions including Medicine, Special Education, Anthropology and Deaf Studies (Rose and Kiger, 1995). The latter two disciplines offer useful background and methodological lessons for this study because they tend to focus on the social and cultural dynamics between teachers and students in schools for the deaf¹¹.

These studies often use a sociolinguistic perspective defining Deafness as a culture based on the common use of sign language rather than a medical condition (Wilkins and Hehir, 2008) or as some call it, the “pathology model” (Rose and Kiger, 1995). This latter perspective many studies are opposed to is also often equated with calling Deafness a “disability”.

Sociolinguistic studies of Deafness often focus on life in residential schools for the deaf (McIlroy, 2008). They critique the historic use of “oral methods” (teaching lip reading and vocalizations through speech therapy) and the common rejection of sign languages. Much of the literature on “the Deaf experience” refers to the educators who were trained during this time with derogatory label of “oralists” (Jacobsson and Akerstrom, 1997; Johnson and Nieto, 2007). In the recent decades, especially in Europe and the U.S., the focus has shifted to promoting sign language as the “natural” language of the Deaf.

This literature often equates “Deaf culture” with sign language-based culture,

¹¹ As discussed in *Appendix 2*, here the lower case *deaf* denotes the ambiguity: students come to these schools sometimes based on a medical diagnoses of hearing impairment but also because they were born to Deaf parents and identify with this culture. These schools are not instituted based solely on the sociocultural definition of Deafness but also because of deafness as hearing impairment.

though not universally. The educational policy of these schools often includes the promotion Deaf culture as a minority culture alongside hearing culture (Jacobsson and Akerstrom, 1997):

Their aim is to achieve a fully developed sign-language setting, where deaf children can establish their identity within a community of deaf people...At the time when this study was conducted, a debate was going on as to whether the 'School for the deaf' should change its name to 'the Sign-Language Primary School' (p. 557).

This research often focuses on the culture and politics of schooling. While the wider “hearing world” is portrayed as controlled by the hegemony of “hearing culture”, segregated boarding schools for the d/Deaf are described as “safe and happy places” where the d/Deaf feel “normal” (Corker, 1996; Preston, 2001). Deaf accounts of schooling show a stark difference between home life where they feel “isolated and ostracized” and school life where they feel “loved and accepted” (Marschark, 2002; McDonnell and Saunders, 1993). Foster argues that this results in the in tightly-knit communities, often born directly from these schools, that define what Deaf culture means for these different groups (1989).

Much of this literature defines Deaf culture as a minority culture distinct from “disability”, using Padden and Humphries’ (1988) statement:

A particular group of deaf people who share a language—America Sign Language (ASL) ...use it as a primary means of communication among themselves, and hold a set of beliefs about themselves and their connection to the larger society (p. 2).

While Deaf culture itself is describes as distinct from “disability”, its minority status is largely experiences in relation to the “disabling” of “the hearing”. Accounts from Deaf studies on schooling highlight negative experiences with hearing teachers and hearing culture, describing oral methods and schooling as ‘tortuous’ and severely impacting their self-esteem. Studies argue that these methods and the general culture of these schools

implicitly taught d/Deaf children that sign language was not “good enough”, that they were always compared to hearing children, and that they consequently can never “measure up.”

Schools for the d/Deaf that did not use sign language as their primary mode of instruction are described as having “violent” curriculum and education. These accounts also include anecdotes of emotional, physical and sexual abuse in these schools, exacerbated by the residential nature of these institutions and the power relations between the minority Deaf culture and majority hearing culture. McIlroy’s auto-ethnographic account of growing up Deaf in South Africa is one of the rare accounts of this in sub-Saharan Africa (2008) and mirrors these consistent trends in the literature.

Deaf culture has consequently been in part defined by these experiences of “otherness” or as being socially and economically disabled by the hearing majority. Deaf culture is often studied in terms of sign language usage, fostered within schools for the deaf, and in opposition to the hegemonic hearing culture and its primary representatives: teachers and staff within these schools (Emerton, 1996; Grosjean, 2010; Ladd, 2003; Padden and Humphries, 1988, 2005).

Many researchers in this field are strongly in favor of a socio-linguistic perspective of Deafness in order to counter-balance the history of research that used medical and pathology models that limited descriptions of Deafness to “disability” and ignored “positive” cultural attributes. This perspective, though not useful for an exploratory study of this nature, helps as a reminder to remain critical of teachers’ accounts of “Deaf culture” and “Deaf identity” and of the potential politics of these schooling contexts in Kenya. As later chapters reveal, much of the history of American deaf schooling has been mirrored in western Kenya and there is the potential for similar cultural and linguistic

conflicts to have arisen.

ATTITUDES AND BELIEFS ABOUT THE DEAF

One sociolinguistic method for exploring Deafness is focusing on the attitudes and beliefs of educators and professionals working with or near Deaf people (Shaver, Curtis, Jesunathadas, and Strong, 1987). Cooper, Rose, and Mason, (2004) explored the attitudes of clinical and forensic psychologists towards deafness arguing that these professionals could be grouped into those who had “positive” or “negative” attitudes. Cooper, Rose, and Mason measured these attitudes using a questionnaire tool created with the collaboration of a Deaf focus group that defined “positive” attitudes as those reflecting a sociolinguistic perspective.

Deaf people consider a negative attitude toward them to be one that reflects a ‘disability’ or ‘impairment’ model of deafness...For example, one focus group member said, “It’s just like, you know, ‘You’re deaf, you’re medical, you need to be made better.’” A more desirable attitude would be one in which people who are deaf were recognized as “able,” and equal to hearing people (p. 388).

Studies such as those completed by Cooper, Rose, and Mason often make their purpose explicit: to locate, describe, and promote specific attitudes and beliefs that support a sociolinguistic perspective of Deafness. Therefore, the usefulness of this kind of literature is limited to supporting a critique of data collection analysis methods and to provide background on current debates in this field.

Even so, at times these sociolinguistic studies of Deafness come to similar conclusions as those drawn by Hanass-Hancock and Satande (2010) who reviewed studies on Deafness and HIV/AIDS. Anderson and Miller (2004) argue that a common experience in the lives of the Deaf is “encountering obstacles to educational opportunities” that is not simply because of ‘being Deaf’ (or the use of sign language and attribution of this culture), but also the “sociopolitical and economic contexts of their

lives” (p. 30). Anderson and Miller as well as Corbett (2003), explored Deaf individuals who are also part of ethnic minority groups, arguing that it is important to incorporate how these individuals felt “others” perceived them.

Branson and Miller (1993, 2002) explored the social construction of “Deafness as disability” by providing a historical account of deaf education in Europe. They argue that vocal and hearing culture are “oppressive hegemonies” that interact with the Deaf individual primarily through educational activities.

[The Deaf are] inevitably involved with a range of professionals, concentrated particularly in the educational sphere, who control their every move. The professionals are hearing, English speaking and status conscious, protective of their professionalism and scornful of any suggestion that their expertise might be ill-founded. Convinced that their charges must be reoriented towards 'normality' they concentrate on promoting hearing of and speech in the dominant language (2002, p. 30).

Branson and Miller’s book takes a critical stance towards ‘mainstreaming’ or ‘inclusive’ programs where d/Deaf students are taught using a combination of Signed Exact English (SEE), lip reading and sign language, also known as “total communication” such as is still found in many schools in Kenya. Their focus on the “normalizing” intentions of teachers resulting in a social disabling of Deafness is instructive. Branson and Miller’s conclusions offer a critique to the body of literature that defined d/Deafness as a disability because of a ‘failure’ to use oral language “correctly”. While the experience and culture of using sign language as one’s native language is itself a linguistic difference and not a “disability”, Branson and Miller argue, “disabling” attitudes of teachers defining oral language as “better” create the very experience and presence of “disability”, largely through activities in these schools.

Kiger’s study offers insight into one method for exploring these attitudes and beliefs: through the “stereotypical or discriminatory” behavior or comments that in Kiger’s case

reflected how a sample of U.S. undergraduates felt about “Deaf people” (1997). While most previous studies reviewed here use the more general phrase “attitudes and beliefs” or some variation, Kiger specifically focused on their representation through “stereotypes” finding that:

The structure of attitudes toward persons who are deaf are systematically different from the structure of attitudes toward persons with other disabilities...respondents’ attitudes were shaped by affective elements of the cultural imagery... When respondents were asked to list characteristics of persons who were deaf, the terms varied: happy, alone, angry, and friendly. None of those descriptors is threatening. Attitudes, then, may tend to be positive because persons who are deaf do not pose a political, social, or economic threat to nondeaf people (p. 559).

Kiger argued that these attitudes and beliefs required a different framework from those about “disability” in general because often included “positive” stereotypes and beliefs. In conclusion Kiger asked,

...It could well be that attitudes toward deaf persons are so positive precisely because there is little intergroup conflict... What would happen to attitudes if political activity by people who are deaf became more prominent around, say, educational policies and practices? (p. 559).

Kiger’s study will become particularly important later in the analysis of interviews with teachers. While much of the conclusions drawn from studies so far in this literature review focus on undesirable and/or “stigmatizing” beliefs and attitudes, during the course of data collection it quickly became clear that many of the attitudes and beliefs found in these Kenyan schools for the deaf were, at least on the surface, “positive”, “enabling”, or even “romantic”. Kiger’s analysis of “different” attitudes represented by “cultural imagery” offers a particularly useful alternative way of describing beliefs and attitudes about Deafness in terms other than the dichotomous and presumptive desirable/undesirable.

While much of this research in Deaf Studies explores “disabling” or “othering” attitudes and contexts, there are a few singular studies of the opposite situation offering

insight into potential methods for data collection and analysis. These are studies of “shared-sign language communities,”¹² or small towns or villages where sign language has been incorporated into the local cultural and linguistic norms by most people, regardless of hearing status. In these cases sign language and its culture are “normal”. While it is still not the dominant language and culture, there is a noted lack of stigma in these situations and less focus on a “lack of ability” linked to the language.

Examples of thoughtful studies on such communities that have influenced this study are Kisch’s study of the Bedouin shared-sign community in Israel (2008), the Yucatec Maya shared-sign language community (Johnson, 1991; Le Guen, 2012), Nyst’s 2007 study of the Adamorobe shared-sign language community of Ghana, and Nonaka’s description of the Indonesian Ban Khor shared-sign language community (2012). These studies primarily focus on the linguistics of each unique sign language but their ethnographic methods allowed for rich descriptions of how these languages interact with the local context including the social interactions involved in education and healthcare.

One of the most famous of these studies is described in the book, *Everyone Here Spoke Sign Language: Hereditary Deafness on Martha's Vineyard* (Groce, 1985) which documents historic accounts of centuries of sign language use and hereditary hearing impairment in an isolated island on the east coast of the United States. Originating in a village in England, immigrants brought over the already endemic sign language that pervaded their local culture with the last remaining users dying in the 20th century. Groce found that islanders, regardless of hearing status, used sign language alongside oral language even when talking to hearing individuals, and reflected on sign language as a secondary

¹² These are sometimes called “sign language communities” or “Deaf communities” though technically only communities where all members use sign language or identify with a Deaf identity are best represented by these terms. “Shared sign language” implies that the extent to which all members are fluent in sign language is vague or partial.

language “everyone” grew up with. Because such a large percentage of the island population was consistently deaf or hard-of-hearing (roughly 1 in 150 people) the inability to hear became “normalized” as un-stigmatized difference. Sign language was not associated with “disability” but rather a different mode of communication used when at least one person in the vicinity was deaf or hard-of-hearing or between hearing people when more useful than oral language. For instance some circumstances required communication across a distance too far to hear but still in sight or when sound was problematic. Some thoughts and sayings were expressed “better”, in this culture, by sign language rather than spoken language.

Groce remains careful to make the two separate conclusions from this data that sign language was “normalized” and that having hearing limitations was less stigmatized without arguing a causal relationship, though it is implied in this and similar studies.

Since its publication, this study has been used as a kind of “utopian ideal” and, as Kisch argues, it has been “romanticized” (2008): because the Deaf and sign language were normalized in this instance, they are not *innately* ‘disabled’ (Kusters, 2010; Kyle and Pullen, 1988; Pray and Jordan, 2010; Rayman, 2009). Other instances of naturally occurring shared-sign communities,

...Are characterized by the existence of a sign language shared between deaf and hearing community members. The use of signed communication in everyday activities appears to facilitate a high degree of integration of deaf and hearing community members. The communicative ease with which deaf individuals function within these rural communities has sometimes led to a naïve conception of these villages as Deaf utopias” (De Vos and Zeshan, 2012, pp. 7).

The generalization that the common understanding of sign language causes an elimination of stigma is implicitly used by many researchers to rationalize the definition of specific attitudes and beliefs as “un/desirable”. Such conclusions reveal the limitations of

some of these debates about whether or not Deafness is a “disability”. These and other authors purport that “if everyone knew sign language” that there would be no stigma from Deafness and this would eliminate its construction as a disability, arguing that this was the case in Martha’s Vineyard. However Groce was careful to note that many islanders did not know sign language or had very limited understanding. Yet, because there was a cultural recognition, this language was “normal” and those people who solely relied upon it were not stigmatized, were not believed to be less intelligent or to have other limitations unrelated to sensory impairment as other Deaf communities often reported to be.

This nuance is an important aspect of this debate in terms of informing this study. It separates fluency in sign language from attitude *about* sign language, both of which can have different relationships with culture.

Kisch’s recent exploration of the Bedouin shared-sign language community noted that although there was a shared history of sign language use and common hearing impairment, “disabling” situations or activities could still be observed.

Whereas most hearing Al-Sayyid persons have access to both spoken and signed modes of communication, deaf people’s communication remains largely restricted to the signed mode (hence, the asymmetry)... In this context, deafness is not easily subjugated to its medical model. However, encounters with the medical and educational establishment present a series of challenges that may severely exacerbate deaf people’s structure of opportunities (p. 283).

Kisch here offers a critique to those who purport that the acceptance of sign language and Deafness is an either/or dichotomy. While within this community sign language was “normalized” to the point that it was not stigmatized overall, it was still a limiting factor to people with hearing impairment when they interact with some institutions or activities within the community. The lesson here is that constructions of Deafness and attitudes towards sign language that are described as wholly “enabling” or

“disabling” might be reductive, especially in “non-Western”, under-researched settings and are therefore avoided within this study. It is also instructive to refrain from defining “Deaf culture” wholly in terms of sign language use but rather to gather as much information on how participants themselves define this culture.

These nuanced descriptions are especially instructive when attempting to plan a study on the population of educators who frequently have many years of experience working with Deaf people. While knowledge of and experience with sign language might be negligible for the average Kenyan resulting in stigma and “disabling” attitudes, this is less likely amongst teachers who often have actively chosen to work in schools for the deaf.

Later in this study the data reveals that many of these teachers were specifically drawn to this profession because of their interest in sign language itself, yet they hold “disabling” and “negative” beliefs and attitudes if this study were to use the same perspectives as many reviewed in this chapter. While many teachers are arguably unable to communicate effectively in Kenyan Sign Language and instead rely on Signed Exact English or even limited signs, they still interact with Deaf children and adults on a daily basis, and make up a “gray area” between those who are fluent or identify as Deaf and those who make up the general population.

CONTEXTUAL BACKGROUND: D/DEAFNESS AND SIGN LANGUAGE IN SUB-SAHARAN AFRICA

Ethnographic studies on shared-signing communities reviewed in the previous section offer a rare glimpse into the nature of d/Deafness, Deaf culture and its interactions with local actors in “non-Western” environments. However, for the context of East Africa there are few such studies. Therefore this section brings together what

relevant background and contextual descriptions are available supplemented by some information gathered during pilot research. While not a shared-sign language community, the unusually high concentration of Deaf activities in western Kenya offers a unique case study of Deafness in East Africa.

HEARING IMPAIRMENT IN KENYA

Rates of hearing impairment in this region are considerably higher than in North America or Europe, largely because of preventable childhood illnesses. In studies completed in the Nyanza province of western Kenya, researchers found the prevalence of hearing impairment to be between 3-4% of children attending schools (Hatcher et al., 1995; Omondi, Ogol, Otieno, and Macharia, 2007)¹³.

Ndurumo who worked with the Deaf community and in deaf education through the Ministry of Education for several decades placed the total number of d/Deaf individuals in Kenya between 650,000 and 750,000 (2008a). Because the most common causes of hearing impairment in this region are not genetic or developmental, the average Deaf or hard-of-hearing Kenyan was born with at least some hearing and was later “deafened”, often after learning some oral language. There is one local belief that the iodine sometimes used to treat malaria can cause hearing impairment in children, and so in the highly malarial areas around Lake Victoria, this sensory impairment is not unexpected. Still, there are few resources available for most families with a child with a hearing impairment. While “outreach” is increasing, some accounts claim that most children with a hearing impairment grow up with less ability to communicate with their families and communities than their hearing peers.

¹³ Omondi, Ogol, Otieno, and Macharia caution that these numbers are low, given that the threshold of 85 decibels was used to define ‘hearing impaired and argue that this definition is not necessarily accurate in contexts where ambient noise can reduce validity of test environments.

Upon entry into a special school, there are two groups of children; those from hearing parents who constitutes 97.9% and have no structured language whether signed or spoken except a few gestures acquired naturally. On the other side of the spectrum is a group of deaf children of deaf parents who constitute about 2.1% and who come to school better adjusted, socialized, have positive attitudes due to developed sign language, cognition and socio-emotional skills critical for education (Adoyo, 2007, p. 2).

With little research on the lives of people with hearing-impairments in this region, there is little consensus regarding quality of life and educational opportunities. Wilson and Kakiri (2011) claim that recent political violence exacerbated the already difficult situation of most Deaf Kenyans but that,

...Even in peaceful times...deaf people in Kenya don't fare well. We are often asked some very bizarre questions with crude gestures...The mainstream of Nairobi dismisses us as lunatics when they see us signing just because they do not realize that sign language is bona fide language...People who are hard of hearing or deaf are sometimes even killed in Kenya. Deaf Kenyans have very little access to resources, and opportunities are severely limited. In all of Kenya we have only eight deaf people with university degrees and thirty deaf people who have been trained as teachers. Most deaf adults have at most a marginal elementary school education and currently are unemployed or underemployed (p. 279).

As Kakiri notes, there are attitudinal barriers to social inclusion and knowledge of sign language as a "true" language is low. Yet there have been some advancements and these few accounts show that Kenya hosts more educational opportunities for Deaf people than other countries in the region because of an unusually high concentration of schools for the deaf.

SCHOOLS FOR THE DEAF IN KENYA

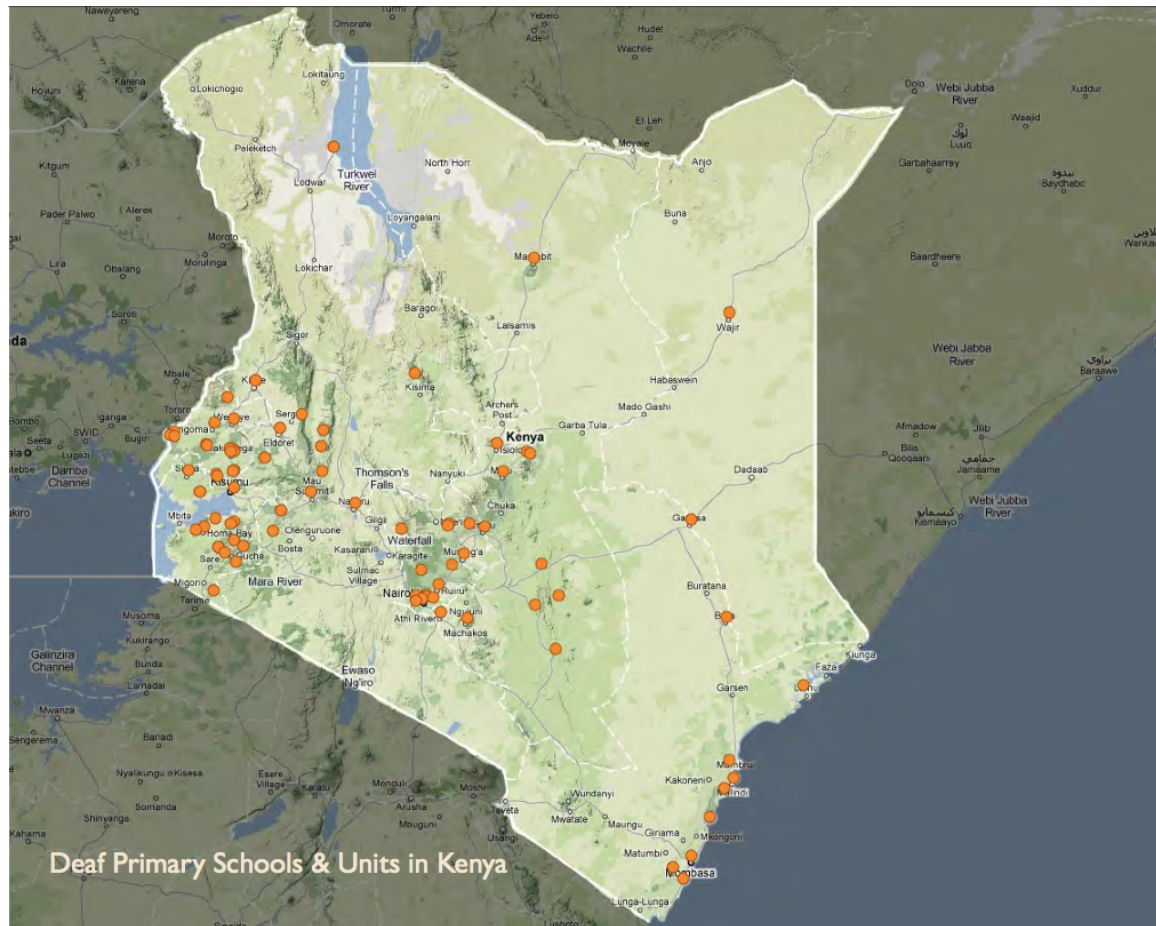
Mumias and Nyang'oma Schools for the deaf are the oldest of such educational establishments in Kenya and along with a few similar schools in Uganda they are the oldest in East Africa. Both founded in 1953, they were originally funded and affiliated with local Catholic missions in the western coast of Kenya but are now in part supported by the Kenyan government (Finnish Association of the Deaf, 1988). Graduates from these

institutions, having originally been born elsewhere, sometimes continue to reside in nearby towns because of the higher number of people in the region sharing their language and culture. Consequently the Nyanza and Western provinces of Kenya have been called a “cradle for sign language” and Deaf culture for East Africa (Ndurumo, 2008a, p. 3) and part of a central “hub” for “Deaf culture” similar to those “hubs” in Nigeria and South Africa (Adoyo, 2007; Finnish Association of the Deaf, 1988; Kiyaga and Moores, 2003; Morgan and Mayberry, 2010; Viehmann, 2005; U.S. Peace Corps, 2007).

This is heightened by the opportunities for vocational and technical schooling here, as these schools host inclusive courses in carpentry, tailoring, agriculture and other skills, often enrolling local students regardless of hearing status. Many Deaf students stay on as staff and even teach within their schools after graduation and hearing teachers in these schools are more likely to hire Deaf maids and workers¹⁴. Ndurumo (2008a) argues that this propels a “Deaf sub-culture” in the Nyanza region. Rather than being a shared sign language community, the region is host to a larger Deaf community than would otherwise be likely without these educational opportunities. While there are several accounts of this “hub” of Deaf activity, Kakiri and Wilson (2011) argue that there is also a concentration of Deaf individuals in and around Nairobi seeking employment.

¹⁴ Anecdotal evidence from interviews showed that teachers were very likely to hire a Deaf ex-student for small jobs not only because they knew them personally but also because of the same “positive” stereotypes held about the Deaf that will later be discussed in the data analysis as impacting HIV/AIDS education.

Figure 2: Map of “46 primary schools, 4 secondary schools, 35 units (serving 8300+ students) (U.S. Peace Corps Survey 2007)” (Morgan and Mayberry, 2010).
Reproduced with permission from the authors.



These schools are similar to other schools for the deaf across sub-Saharan Africa in terms of history, pedagogy and funding. In the 19th and early 20th centuries, Christian missions interested in education for children with hearing-impairments borrowed methods from institutions in the UK and France using the “oral method” (Andersson, 2011). Kiyaga and Moores (2003) argued that this stigmatized the hand-signs which were often used in the play yard or in home villages. Both academic and advocacy accounts describe these traditions and eras as ‘oppressive’ to the Deaf community and are still recalled by teachers who have worked in their respective schools for more than 20 years (Akach, 2000, 2010; Andersson, 2011; Steadman Group, 2007; Wilson and Kakiri, 2011).

In 1985, after relying on only these oral methods of instruction, the Ministry of Education piloted the use of sign language in Machakos School for the deaf with “good results”, and to this day “Kenyan Sign Language”, or KSL, is officially the primary mode of instruction in schools for the deaf in Kenya. Sign languages and dialects from local deaf communities were integrated into the ‘standardized’ Kenyan Sign Language, though it also borrowed from American Sign Language (ASL) and British Sign Language (BSL), with the first edition of Sign Language For Schools published by the Kenyan Institute of Education in 1990 (Morgan and Mayberry, 2010). Some accounts argue that there are still political and cultural tensions between the different uses of ASL, KSL, “village sign” and other local dialects (Andersson, 2011).

While KSL is taught daily in these schools and now included in the Kenyan constitution as a testable subject in the KCEOP, there are variable rates of fluency amongst teachers (Mbugua, 2007). In 2008, Kigingi surveyed fluency and attitudes towards KSL, English and Signed Exact English, (SEE), in one urban technical school for the deaf in Nairobi, finding significant disparities between student needs and teacher abilities. This study mirrors the complaints within deaf education across the region in that only about 1 in 8 of these teachers have *any* training in sign language or deaf education let alone fluency (Storbeck, 2003). During observations within these schools this study also found that teachers instructing the course on KSL were frequently hearing teachers with questionable fluency while fluent Deaf teachers sometimes preferred to teach other courses such as Math.

Lack of teacher training in sign language and other shortcomings in the educational instructions for the deaf in Kenya contribute to the disparity in academic performance of d/Deaf students as compared to their hearing peers. This is recognized by the Ministry

of Education, and scores by “Special Education students¹⁵” are allowed a full 10% less on any test scores than their peers for entrance exams into public institutions. They are also offered more time for standardized tests. Still, the average scores for Deaf secondary students hover well below 50% in most subjects. This has resulted in some pessimism about deaf schooling.

Deaf children [would go] to schools with great enthusiasm only to leave them more deaf and more mute than when they entered them...[They] went ... believing that they were being prepared for national examinations like hearing children only to realize years later that they did not have primary and secondary school certificates to enable them proceed to college or university (Ndurumo, 2008b, p. 5).

Though not a subject of much peer-reviewed study, my initial observations did show that at least one school site attempted to review these tests for cultural appropriateness in addition to the provided accommodations. Figure 2 shows handwritten charts that represent the main concerns teachers had about the language and topics within one of these tests, noting questions about sounds were particular unfair for Deaf and hard-of-hearing students. They also made notes about word choice, sometimes arguing that certain words were not used in KSL but also arguing that “The Deaf should be given short, straightforward passages because of their inability to acquire advanced language skills.” While many accounts show that improvements are being made to promote KSL and overall quality of education, there are still strong criticisms of these institutions and of the teachers employed.

¹⁵ This is any student labeled as requiring “Special education” which includes any student with a hearing impairment as identified by an official audiologist.

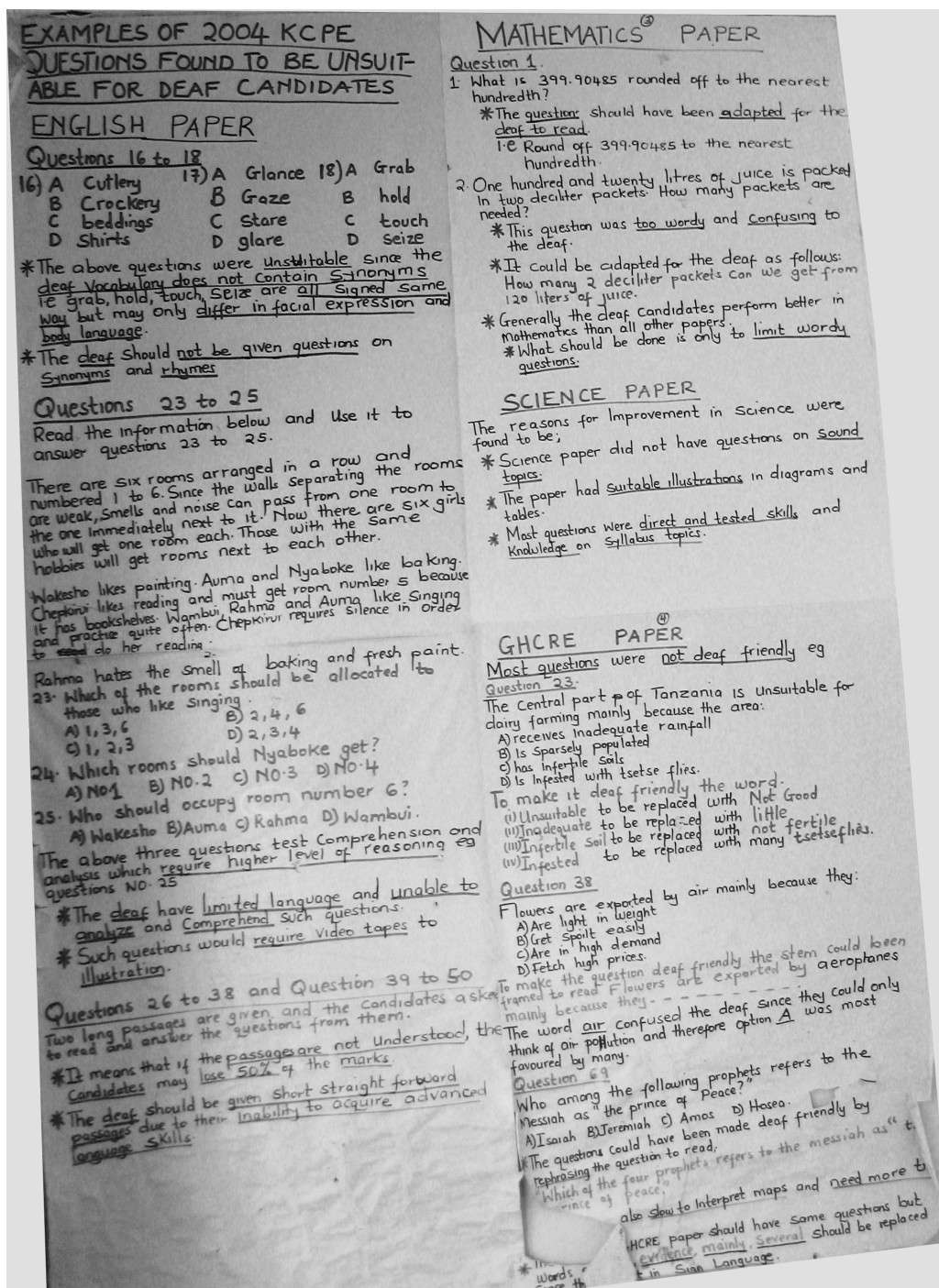


Figure 3: At some point in the recent past, teachers at this school site had summarized their concerns with some of the required tests.

In summary, while there is limited peer-reviewed literature on d/Deafness and education in East Africa, there are some accounts of the general context in which this education occurs. In particular, this literature parallels studies on Deafness and education

in the U.S. and Europe that highlight the politics of schooling and sign language that are often highly critical of hearing teachers whose language proficiency and attitudes towards sign language are ambiguous. Even with these limitations and tensions, Kenyan deaf education offers a unique context in which to explore how these concepts interact with HIV/AIDS education because of both higher prevalence of HIV and a relative concentration of Deaf activity and education.

CONCLUSION

While there is little research on this topic in particular, a review of the literature offers insight into how others have approached the study of HIV/AIDS-related education and the impact of teachers' attitudes and beliefs, Deafness and HIV/AIDS, schooling and Deafness, and deaf education in Kenya. Reviewing this literature requires a critical stance because of the many perspectives that are at times contradictory. For this reason, I save my discussion of theoretical perspectives in the literature for the subsequent *Methods* section.

The lessons learned from this literature review are a combination of “what has been done” and “what not to do”. While teachers' attitudes and beliefs are consistently explored for their relationship with HIV/AIDS education efficacy, there is little consensus as to which attitudes and beliefs are “best.” This becomes even more problematic in the context of Deafness and disability where additional competing beliefs about “disabled sexuality” heighten tensions among educators. Literature from studies on Deafness and sign language argue that the politics of schooling in these contexts is complex and interrelated with Deaf culture and identity. Finally, western Kenya provides a useful site for the exploration of these notions with its higher rates of HIV and concentration of Deaf education and activity, of which there is some commentary in the literature.

The main conclusion drawn from a critical review of this literature is that there is a strong rationale for the study of teachers' attitudes and beliefs about HIV/AIDS education in Kenyan schools for the Deaf using detailed, qualitative methods. This rationale is argued in two ways.

First, there are practical considerations. These attitudes and beliefs are hallmarks of how HIV/AIDS-related interventions can be expected to perform and simply collecting this information also helps document what HIV/AIDS education, if any, is occurring in and around these schools. As there is little research on the attitudes and beliefs of teachers working with students with disabilities in this region, such explorations are useful in supporting the growing efforts in this field. This conclusion directly supports the research questions regarding the existence of HIV/AIDS in Kenyan schools for the deaf and its influences.

Second, there are theoretical considerations. Much of this literature shows that the exploration of educators' beliefs and attitudes about sexuality and Deafness offers insight into deeper societal beliefs about these and related concepts. As there is so little qualitative study of Deafness or disability in this region, this exploration is valuable and fills a gap in the literature on social constructions of d/Deafness in this complex context. This supports the research questions that explore the deeper relationships between HIV/AIDS education activities and beliefs about Deafness among teachers. Because this literature did not suffice to rationalize any one definition or perspective on Deafness because of a lack of research in this context, the following chapter continues with this discussion.

Finally, this review argues that much polarities and dichotomies in such a study are to be avoided for their potential limitations on data and analysis. Within this study Deafness is not limited to be being either a sensory impairment or a linguistic minority,

but rather a range of experiences and embodiments. Attitudes and beliefs are not “positive” or “negative” but rather expressing difference, making it vital to explore their rationale as well in hopes of better understanding these relationships.

CHAPTER 3: METHODS

INTRODUCTION

A review of the literature highlights the different ways to explore teachers' attitudes and beliefs about HIV/AIDS education in the context of Kenyan schools for the deaf. This literature also offers useful critiques for what kinds of methods and limitations to avoid. This study was informed by these lessons as well as the iterative process of pilot research. Participatory methods also supported the evolution of this study and especially the tools used to collect data. Assistance and critiques from key participants were also crucial in informing the appropriateness of these methods.

This chapter describes these methods, beginning with research questions, followed by an additional review of literature found to be particularly useful within this section. The following sections articulate in detail how data was collected and analyzed and the ethical concerns and limitations of this study.

RESEARCH QUESTIONS

This study asked the following questions:

- Does HIV/AIDS education occur in Kenyan schools for the deaf?
 - If so, what does it look like?
 - What influences its implementation both in terms of breadth and depth?

During the pilot study, initial data revealed that teacher reflections on HIV/AIDS education seemed to be impacted by underlying beliefs about d/Deafness frequently expressed as “Deaf stereotypes”. This study evolved, therefore, into an exploration of these underlying beliefs and attitudes about Deafness in the context of HIV/AIDS as well as well. Therefore this research focuses more on the following questions:

1. What beliefs and attitudes do these teachers have about this education?
 - a. How do they reflect on HIV/AIDS education in general?
 - i. Do teachers feel that it is their or their school’s duty to teach about sexuality and reproductive health?
 - ii. What are their comfort levels in addressing these topics?
 - iii. Do they feel that they are adequately trained to teach these topics?
2. What beliefs and attitudes do these teachers have about d/Deafness?
 - a. Do teachers believe that “the Deaf are more promiscuous,” and why?
 - b. Do teachers believe that “the Deaf cannot keep secrets” and “love to gossip,” and why?
 - c. Do teachers believe that “the Deaf are more likely to be HIV+” and why?
3. What beliefs and attitudes do these teachers have about the interaction between HIV/AIDS education and d/Deafness?
 - a. Do teachers believe that the Deaf need this education more or less than hearing people? For what reasons?

- b. Do teachers feel more or less comfortable teaching Deaf students these topics? Why?
 - c. What makes teaching HIV/AIDS education to Deaf students *different* than to hearing people? Why?
4. For teachers who themselves are Deaf, how do they feel their role is *different* from hearing teachers?

These questions were explored in multiple ways. Within interviews and with the help of questionnaires, teachers were offered many chances to explain their responses using different prompts, eliciting detailed rationale for their beliefs. These responses were considered within the context of first-hand observations of classroom activities including HIV/AIDS education as well as critiques from the literature.

METHODOLOGICALLY INFORMATIVE LITERATURE

This section briefly revisits the specific studies that most informed the methods of this research: questionnaires, in-depth interview and observation. The use of these methods and their respective tools is informed by methods and perspectives found in Public Health, Deaf Studies, Disability Studies, and Comparative Education.

HIV/AIDS EDUCATION RESEARCH AND THE QUESTIONNAIRE

Studies on HIV/AIDS and d/Deafness or Disability often used questionnaires and interviews (both individual and group) to adapt and replicate much of the Knowledge, Attitudes and Practice/Behavior research of HIV/AIDS prevention. Though they have their origin in Public Health, these tools are repeatedly accommodated and adapted for sign language and inquiries into populations defined by a “disability” label or related needs. Therefore this study also uses similar tools to explore teachers’ beliefs and attitudes about HIV/AIDS education, especially in relation to d/Deaf students.

While some researchers define the “gold standard” of evaluation methods as

including a randomized-controlled trial of an intervention and standardized tools, many of these same authors employ additional qualitative methods and purposive sampling to answer specific research questions about “why” and “how” an evaluation succeeded or failed.

Maticka-Tyndale, Gallant, Brouillard-Coyle, and Sverdrup-Phillip published research between 2002 and 2005 (as well as Maticka-Tyndale, Wildish, and Gichuru, 2007; 2010), on in-school HIV/AIDS education evaluations in Western Kenya. These studies are useful because they describe common data collection methods for exploring attitudes and beliefs in the same geographic and near-same institutional context as this study.

In 2004, they systematically reviewed studies on school-based educational interventions on HIV/AIDS targeted at youth across sub-Saharan Africa between 1990 and 2002 as a precursor for a subsequent evaluation program of their own. In all 11 studies reviewed, the authors used “some form of survey or questionnaire to measure knowledge, attitudes, intentions, and behaviours” (p. 1339). Four studies used an adapted version of a pre-existing, standardized questionnaire such as the “WHO/UNESCO knowledge, attitudes, beliefs and practices survey instrument for adolescents” (World Health Organization, 1989), or the “Americans Toward a Healthy Tomorrow instrument” (Stanton et al., 1998). Three of these studies used additional focus groups (Kinsman et al., 2001; Kuhn, Steinberg, and Mathews, 1994; Visser, 1996).

Maticka-Tyndale, Gallant, Brouillard-Coyle, and Sverdrup-Phillip (2005) argue that in addition to the useful quantitative data garnered by these studies, qualitative data derived from interviews and focus groups was imperative to understanding some of the successes and limitations of these interventions. When Maticka-Tyndale, Gallant,

Brouillard-Coyle, and Sverdrup-Phillip attempted their own HIV/AIDS education evaluation of the “Primary School Action for Better Health (PSABH) HIV/AIDS prevention programme”, they chose questionnaires, in-depth interviews and focus groups with both teachers and students with non-standardized tools in over 2000 schools in Kenya. Rather than use randomized methods for choosing participants:

...Teachers assisted in the selection of focus group participations, approaching those who were generally more outspoken in class to ascertain their willingness to talk about issues related to HIV/AIDS and sexuality. ...Focus group discussion guides were created to explore perceptions of HIV/AIDS, personal risk, dating, and sexual activity and expectations (p. 30).

Maticka-Tyndale, Gallant, Brouillard-Coyle, and Sverdrup-Phillip also used a more iterative process of analysis as compared to most previous HIV/AIDS intervention evaluation studies. Rather than coding results once by the research team alone,

...The themes, scripts, and contexts that were drawn from the transcripts were presented to several different groups in Kenya. Members of these groups confirmed that the analyses produced descriptions consistent with local events, meanings, understandings and interpretations. They were also reflected back to young people in a second set of focus group discussions where they similarly confirmed the credibility of the descriptions and interpretations (p. 30).

Researchers who explored this topic in relation to disability or d/Deafness also relied on qualitative methods such as interview and analyzed data using an iterative process. These studies used such methods in addition to pre-existing surveys and questionnaires in order to explore how the variable of disability or sign language specifically interacted with both research tools and the wider notion of HIV/AIDS risk.

When Taegtmeyer et al. (2009) were planning the first “Deaf-friendly” VCT clinics and training Deaf peer educators, they involved Deaf groups such as churches and clubs. This resulted in the location of VCTs being appropriate for the needs of local Deaf communities and the support of these communities. Through this process it was also established that a peer education framework was more appropriate than other forms of

education.

The peer education program proved popular in the Deaf community. Church and community meetings were well-attended and a sense of ownership in the local Deaf community was successfully established (p. 513).

Taegtmeyer et al. combined qualitative and quantitative methods to make their research both comparable to other similar studies as well as offer specific lessons for conducting such research with the Deaf community of Kenya. Like other VCT sites, the “Deaf friendly” clinics completed the same “national data form” for each client during the counseling process. These gathered demographic and medical data that allowed this population’s HIV/AIDS-related data to be compared to national data for the first time. Simultaneously these methods were adapted specifically for the needs of this population.

The national VCT counselor certificate course was lengthened from 3 to 4 weeks to allow for additional sessions such as video taping of counseling and mobilization practice and additional time given to the topic of confidentiality (through role plays based on scenarios in a deaf community setting). Exercises were modified to incorporate more visually interactive sessions. The longer training also allowed for the VCT counseling sessions in sign language to take longer than the average spoken counseling session where necessary (p. 509).

One specifically useful aspect of Taegtmeyer et al.’s study was their methods for site selection. Pilot “Deaf friendly” VCT clinics were established in Nairobi, Kisumu and Mombasa because,

...The sites were located in densely populated areas of the cities, located near popular meeting points for the Deaf. The proposed site locations came from well-established associations for the Deaf in these cities (e.g. the Kenya National Association of the Deaf, the Nairobi Association of the Deaf and The Kenya Society for Deaf Children) and from Deaf training institutions all of which were directly involved (p. 509).

In the same manner, I used the input of Deaf NGOs and teachers currently working in schools for the deaf to choose sites that would not only better represent participants through numbers but that were also near these “Deaf meeting points.”

Both Collins (2001, 2006) and Swartz and Rohleder (2009) argued that semi-

structured interviews and focus groups were useful for their exploratory work on disability and HIV/AIDS education. Collins used snowball sampling and verbal consent for participation in interviews lasting between 30 and 90 minutes beginning with the direct question, “What might be some of the barriers to effective HIV prevention in this population?” followed by follow up questions on the following topics:

- patients’ vulnerability to HIV infection
- the impact of mental illness on sexuality
- barriers to effective HIV prevention
- reproductive health
- the family’s response to sexuality in the individual with mental illness
- perceptions of patients’ attitudes toward sexuality
- culture and sexuality
- and special considerations for developing HIV prevention programs in South Africa (Collins, 2001)

Interviews were transcribed and data analysis used “open and selective coding” over several readings with additional codes developed as needed. Collins sought out educators to re-examine initial findings during group interviews and integrated participants’ feedback on research methods during this study.

Rohleder and Swartz (2009) chose four “key figures” associated with an organization specializing in providing education to students with intellectual disabilities. These authors targeted people who had experience in providing HIV/AIDS related education. They supplemented this small number of participants with a group interview with three teachers working in similar environments. Rohleder and Swartz’s study shares a number of methodological aspects in common with this research in that,

...It is not the aim of this article to attempt to generalize findings of the research, but to use a case study of an organization, committed to providing sexual health education to persons with learning disabilities, so that we may learn what some of the potential struggles and anxieties are for educators

attempting to provide services within a particular type of organization, particularly organizations with a strong Christian moral ethos.... In so doing it provides some indication of the sorts of struggles that may be faced at other similar organizations (p. 604).

Rohleder and Swartz apply the critiques of Hollway and Jefferson (2000) to the “traditional” tools for evaluating beliefs and attitudes about HIV/AIDS education such as those found in Gallant and Maticka-Tyndale’s systematic review (2004). They conclude that the predominant use of open-ended interviews with an “interview schedule” or outline was more useful in exploring these topics with teachers. Hollway and Jefferson’s critiques of standardized, Likert-scale based surveys such as those reviewed in Gallant and Maticka-Tyndale’s study (2004), are extremely useful for balancing methods used for this study.

Participants were given the opportunity to narrativize freely their own experience, with the aim of allowing interviewees to express their anxieties about addressing HIV, sex and sexuality with the disabled people they work with.

Data was then analyzed for themes using Discourse Analysis, as described by Banister, et al. (1994) and Marshall (1994), and focused on interpretive repertoires or “clusters of words, terms and phrases that together construct a particular discourse” to analyze ‘how the participants talk about the provision of sex education with persons with learning disabilities’ (p. 604).

In summary, studies exploring attitudes and beliefs of educators who are implementing HIV/AIDS education use a combination of qualitative methods, relying primarily on different kinds of questionnaires. However, these authors reviewed in this section argue that in order to explore the “why” and “how” teachers have such attitudes and beliefs on a small scale, it is more useful to use open, qualitative methods that allow participants to explain their reflections. Research exploring the interaction of these notions and disability or d/Deafness also found it necessary to adapt pre-existing questionnaires and to use iterative processes of analysis to incorporate the feedback of participants on the nuances of their respective contexts.

THEORETICAL CONSIDERATIONS FOR INTERVIEW AND OBSERVATION

METHODS

In the *Literature Review*, several key studies were presented that explored d/Deafness as situated and constructed in part through the attitudes and beliefs of local communities (Branson and Miller, 1993; Groce, 1985; Kisch, 2008). There are a few additional studies that, while not focusing on HIV/AIDS education, do offer useful lessons for how to conduct a detailed, thoughtful exploration of specific activity or experience in the context of a local community. These studies have a common link in that they use a perspective that critiques the use of what Corker (1996) calls *essentialist* terminologies or frameworks: each of these authors attempt to break from a trend of similar research by using open, often anthropologically-informed methods.

Corker's body of work explores the intersection between Deafness and disability through theoretical debates and extensive "Deaf narratives" Corker consistently argues that the ongoing debate over whether or not d/Deafness is a "disability" represents a false divide' between Deaf and Disability studies as a result of the lack of theoretical nuance (1998, 2000a, 2002b)¹⁶.

Corker critiques some Disability Studies research for its reliance on a "strong social model" focusing almost entirely on lack of access to social inclusion (as a result of both attitudinal and environmental barriers) as *defining* the nature of disability.

Corker also critiques the tendency for some research within Deaf Studies to define the Deafness solely in terms of a linguistic minority and oppressed culture. This literature, Corker argues, relies too much on the legitimization of Deaf culture by denying any

¹⁶ See also Corker, 1996, 1998, 1999a, 1999b, 1999c, 2000a, 2000b, 2001a, 2001b, 2002a, 2002b and Corker and Thomas, 2002.

experience of “disability”, “impairment”, or “limitation” that arguably can impact this culture and experience regardless of the legitimacy of sign language.

Disability Studies, Corker argues, relies strongly on the examination of **structure** (political, social, cultural, environmental, etc.) as constructing the nature of “disability” whereas the latter Deaf Studies relies on examination of **culture** (Deaf culture and sign language cultures) as defining “Deafness.” While for their own purposes these foci are useful, they are problematic when researchers attempt to compare the two discourses like the metaphoric apples and oranges.

Instead, Corker uses extensive “Deaf narratives,” (the life stories of Deaf individuals participating in counseling sessions), to map out ways in which their experiences reveal the combined influences of both structure and culture. As a result of her analysis, Corker argues that it is more useful to explore Deafness in terms of a “**structural** penetration of **culture** and **cultural** penetration of **structure**” (my emphasis) if one is to capture a wider range of Deaf experiences including those of people who identify as hard-of-hearing or hearing-impaired.

While the shared use of sign language does indeed create a local, “natural” **culture**, this **culture** is interdependent on wider **structures** in each individual’s environment such as access to sign language-based schooling and the legal rights of people with hearing impairments in their country. In turn, the legitimization of sign languages as “natural languages” and recognition of the **cultural** aspects of Deafness also influence these **structures** in the form of laws and policies that promote of these educational institutions. Deaf **culture** is described as coming from the “ground up” and while **structural** influences come from the “top down” and together they interact more ecologically than dichotomously.

The logic of ‘either/or’ is an intellectual artifact, and that each side of the various dichotomies do not after all represent discrete entities; ...If this were so, it reinforces the view that both the social model of disability, with its ‘top-down’ emphasis on the individual-society dichotomy and its inherent conflicts of agency **versus** structure, and the linguistic minority construction of deafness, with its ‘bottom-up’ view that individuals determine society, and its insistence that Deaf and hearing are discrete, are essentialist (1996, p. 34).

Corker argues that by excluding the middle and privileging extremes “hides a variety of marginalized and repressed discourses which might provide clues to our tensions and how they can be removed.” Though useful for analytic purposes, the terms Deaf vs. hearing are themselves “essentialist” and are not necessarily practical realities.

This critique was vital in planning and implementing the methods used for this study. Early on in the pilot study much of the responses from teachers began reflect the strong influence of both structural and cultural rationale or simply failed to be easily categorized into one of the more common categories used by previous studies. Corker’s critiques allowed for these methods to refrain from being limited by “essentialist” conceptualizations of key analytic terms. It also kept interviews open and questions focusing on how participants themselves defined these notions as well as separating “advocacy” rhetoric from the teachers’ personal beliefs and practice.

This “openness” was best served by focusing on the notion of *difference* as a core concept of both data collection and analysis. Corker asks the reader to question,

...What model of disability or impairment is assumed by the research and, in particular, what emphasis does it give to impairment, structure and/or agency, the individual and/or society and **difference** and/or **sameness**? [my emphasis] (1998, p. 124).

In Corker’s own analysis of Deaf narratives, *difference* is used as a way of analyzing quotations from d/Deaf individuals over a range of complex topics and experiences. With the intention to refrain from imposed assumptions about personal or local understandings of such concepts as “impairment” and “agency”, I instead focused on notions of *difference*

to ground understandings.

This was especially true for interview questionnaires about d/Deafness in the context of HIV/AIDS. For instance, rather than asking what kinds of barriers d/Deaf people faced when attempting to get HIV/AIDS-related information or treatment (as many similarly studies do), I asked teachers, “How does being Deaf make getting this information or treatment *different*?” Follow-up questions used *difference* to encourage clarification when advocacy-based catch-phrases were used or when it was suspected that the participant was simply reiterating policy rather than their own personal beliefs¹⁷.

Other studies using anthropologic methods were also influential. Staples (2003, 2004, 2005) uses participant observation to conduct research on the dynamic nature of leprosy as both disabling and enabling within detailed descriptions of local contexts. Staples uses both interviews with participants and detailed observation of social, political, economic, cultural and environmental environments to make nuanced arguments about the complex nature of leprosy in India. Staples’ studies inform this research through his careful resistance against using a particular set of definitions for disability or impairment, and instead compared participant’s reflections on their experiences with these notions in different times and places.

Stambach’s anthropology of gender and education in Tanzania (1998), though not focusing directly on disability, offers another useful parallel for why this research is best served by using such open, qualitative methods. In addition to focusing more on the symbolic nature of education rather than economic or intellectual outputs, this study was intentionally distanced from others sharing a similar geographic context. While other studied focus on either “modern schooling” or “African tradition,” Stambach attempts to,

¹⁷ See Appendix 4 for a more detailed explanation of these methods as well as later within this chapter.

...[Examine] the ways people construct and explain differences in terms of the two and how, in so doing, they classify the natural world according to cultural ideas about identity and human difference (p. 15).

In this same manner I attempted to explore how these teachers constructed and explained their beliefs about HIV/AIDS education for the d/Deaf as potentially different from that of education aimed at hearing students in their own terms. Subsequently, these constructions and explanations, termed “rationale” within this paper, expose underlying perspectives about d/Deafness, disability and *difference*. As Stambach positions her work between anthropologies of “modern schooling” and “African tradition,” this study is situated between those public health studies on HIV/AIDS education and disability, and studies such as Kisch’s exploration of Bedouin sign communities (2006).

CRITICAL PERSPECTIVES OF “WESTERN” METHODS

I made the assumption going into this study that my own background as an American having gone to school and trained as a teacher in California would impact how I conducted research in an different setting like Kenya. Apart from being reflexive about my own assumptions about Deafness, disability, HIV/AIDS education and schooling, I also was influenced by the writings of several authors who similarly questioned the relevance of outside frameworks.

A group of scholars in Disability Studies have begun to develop a “Southern Perspective” of disability, arguing that because most of the disabled people of the world live in the “Global South”, there ought to be more consideration of how disability is constructed in these settings. They often critique the disability frameworks of the majority of Disability Studies literature because it either explicitly or implicitly defines disability in terms of the economic and cultural needs of those living in the United States, Canada and parts of Europe. This is especially critiqued in terms of how disability and education

interact. There is less scholarly work using this perspective on Deafness but the lessons from Singal, Meekosha and Ghai are useful for framing this study in this sense.

For instance, Singal (2007, 2010) argues that in the lower resource areas such as Kenya and India, while the functional skills gained in “Special education” environments might seem lower by “Western” standards, what is far more important for the families and students is the social inclusion in formal education. The act of attending school, wearing a school uniform, and sitting in classrooms sends a cultural message to communities and to the children with disabilities themselves of a symbolic inclusion. Singal argues that the symbolic interaction between being included in public schooling, whether in segregated schools or not, is in itself a significant aspect of what “inclusion” means in these regions, contradicting the common definition of “inclusion” in North America and Europe.

The methods for this study were also informed by the arguments of Meekosha (2004, 2008, 2011) and Ghai (2002a, 2002b, 2003), about the tendency for researchers to transplant foreign frameworks of disability that are tied to American and British advocacy using a “strong social model”. Meekosha critiques international agencies and some authors in Disability Studies for assuming certain attitudes and beliefs are desirable and “positive” while others are undesirable and “negative” based on “western” experiences and realities. In particular Meekosha critiques the over-use of a “strong social model” that equates any medicalization of disability with “negative” attitudes. Within post-colonial contexts especially, Ghai argues that the physical effects of “Northern violence” have resulted in higher rates of preventable disabilities. These disabilities can easily be prevented through childhood vaccines, maternal health, for instance, and the medicalization of these disabilities, Ghai argues, in fact helps to ameliorate the situation.

Both Meekosha and Ghai argue that the “disability experience” in countries such as Kenya is intimately tied to notions of medicine whereas in high-resource countries, because most preventable disabilities are actually prevented, the “disability experience” is defined more in terms of social structures and culture.

By looking at the inadequacy/irrelevance of northern concepts we come to see the need for developing southern theories. Impairment/disease/disability cannot be so easily separated. Lack of clean water and sanitation and poor housing give rise to HIV-AIDS, ill health and disability. The ultimate goal for many disabled people in the Global South is survival (Meekosha, 2008, p. 10).

While Geissler’s studies critique the over-medicalization of behaviors in this context, Ghai, Meekosha and Singal all critique the tendency for those in Disability Studies to ignore medical realities as making up part of the disability experience.

In summary, in addition to adapting questions used by other studies focusing on HIV/AIDS education, I also employed in-depth interview and observation in order to explore the “how” and “why” teachers held their specific beliefs and attitudes. Framing these methods and informing some of the wording choices used during data collection were influenced by authors such as Corker, Staples, Geissler, and Stambach which encouraged me as the researcher to be reflexive of my own biases and potentially restrictive definitions.

The sections that follow outline what research tools were specifically adapted or cultivated and how they evolved in light of participant input and these most recently reviewed studies.

TIMELINE

During the summer of 2009 I made contact via email with an NGO that claimed to be providing “Deaf friendly” HIV/AIDS education in Kenya. This was in direct opposition to much of the literature arguing that such education was non-existent and so I

planned pilot study to explore this education. During the course of three trips, this study was designed and implemented largely with the cooperation of this NGO and their founder and director, a woman who chose the pseudonym “Fina.” This NGO chose the pseudonym “Saini Elimu” which for the purposes of this paper is abbreviated as “NGO S.E.”

I spent a total of 13 weeks in Kenya across three trips, two of which were used primarily to gather background information, gain access to school sites and to design research tools in cooperation with key participants. During the final visit I spent 6 weeks in Kenya visiting school sites where I was hosted between 7 and 10 days at a time. During pilot study trips and in between visiting schools I was hosted in the home of Fina on the outskirts of Nairobi. This is summarized in Table 2.

During the first trip, lasting 3 weeks between February and March, I explored what, if any, “Deaf-friendly” HIV/AIDS education existed in Kenya and collected background information on schools for the deaf.

The second trip lasted four weeks in June of 2010 during which time I “shadowed” Fina and other workers of NGO S.E. on two of their training seminars where initial interviews were conducted with teachers. This trip offered me the valuable opportunity to observe HIV/AIDS education (implemented by NGO S.E.) for the d/Deaf students in action¹⁸.

¹⁸ These two seminars both lasted 3 days and gathered 4-5 teachers each from 3 different schools as well as around 40 children for a concentrated class on HIV/AIDS peer education, intended to foster HIV/AIDS and health clubs in their respective schools. I was offered the opportunity to take part in some of this education while simultaneously gathering initial interviews with teachers.

Table 2: Research timeline

	Trip 1	Trip 2	Trip 3
Dates	February-March 2010	June 2010	January - March 2011
Locations	Nairobi	Nairobi, Embu (Central province), Kisumu (Nyanza province)	Nairobi, three school sites in Nyanza and Western provinces
Hosts	NGO S.E.	NGO S.E.	NGO S.E. and School administration
Goals	Background on HIV/AIDS educational activities targeting Deaf Kenyans	Background on potential participants and school sites, designing and testing research tools, initial interviews and observations with teachers and NGO workers	Primary data collection with teachers

Preliminary data collection methods during these trips included obtaining research clearance from the Kenyan government, securing the cooperation of key participants at school sites and obtaining the informed consent of a substantial number of teachers. The interview tools and methods were tested and revised during this trip as well. These included the interview outline and its corresponding questionnaire as well as language within the Informed Consent and Research Brief that were edited with the participation of Deaf and hearing participants for clarity.

The final trip lasted six weeks between the months of January and March 2011. I spent most of this trip staying in the three school sites though in between some visits I stayed with Fina who, as a licensed interpreter and former teacher in schools for the deaf, interpreted video-recorded interviews with Deaf participants. During this final trip one Deaf employee of NGO S.E. was trained to conduct a few interviews with Deaf teachers in the region and to participate in the interpretation of these and other recorded interviews.

After returning from Kenya, the data was compiled and all names were replaced

with a number given to each participant. Interviews and questionnaires were transcribed compiled into participant files. Then data was analyzed by grouping responses by question and theme with subsequent thematic grouping as new themes were revealed. Finally, this study was written up between mid-2011 through the end of 2012.

ETHICS

The ethical framework used in this study was based on the requirements of the University of Oxford, suggestions from literature reviewed in the previous chapter, and my own personal and professional background in education. As a Special Education teacher in the litigious environment of southern California, I was intensely aware of issues of confidentiality both for the teachers and for students with disabilities. Though it turned out to be less of an issue within the school cultures visited, my habits tended towards more cautious methods.

Informed Consent was obtained at the start of each interaction if possible but reiterated in person before any interview was recorded. Some anonymity was promised and it was made clear that this study did not intend to collect data on the HIV status or personal behaviors of individuals. As the Informed Consent states in *Appendix 4*, I acknowledged that I would be collecting “some demographic information” including “educational background, gender, and location” but not names or other “identifying information.” I intentionally left this open to interpretation according to each participant’s needs and to potentially increase anonymity of a participant if they wished.

CONFIDENTIALITY

Appendix 4 includes a figure of the Informed Consent and Research Brief used for this study which was approved by the University of Oxford in early 2010 prior to data

collection. Some anonymity was promised. Teachers were informed of this using the example, “a female/male teacher working in a school for the deaf in X province in Kenya.” Because many of these teachers had friends in other schools for the deaf from training or past employment, it was important to keep quotations as anonymous as possible especially from administrators and public officials. However, there was a large enough population within the concentration of these schools in the Nyanza and Western Provinces for these labels to be used.

Interview transcripts and completed questionnaires were always kept secure and never shared with administrators or participants which was a concern of some teachers. The names of each school visited were also kept confidential and though teachers frequently asked where other interviews had taken place, the response remained, “schools across Kenya.” Because administrators and teachers from across schools interacted, it was expected that the scope of this study would become known. Still, during fieldwork every attempt was made to keep interactions anonymous. The exception to this was using the personal reference of NGO S.E. with Deaf teachers and some hearing teachers who had interacted with this NGO before. However I also stated that “other NGOs” were interviewed.

The labels “Site A” etc. are used throughout this study but with the combined descriptions of these sites and knowledge of schools for the deaf in Kenya it is expected that complete anonymity of school names might be compromised. Participants were more concerned with anonymity of each individual interview especially from school administration and local officials.

INFORMED CONSENT

Participants were given paper copies of the appended Research Brief and an

Informed Consent form (see *Appendix 4*: Figure 17). The intent of these tools was reiterated in person at least once per participant with the exception of the posted questionnaires . Because the administrators at each school often introduced me, it was made clear that participation was not required and data would not be shared with administrators or officials. It was also made clear that this study was conducted with the approval of the University of Oxford for a graduate degree and was not affiliated with any Kenyan institution or NGO. This point seemed important to many participants.

While teachers were told they could take a day or so to consider this, most completed the form immediately. At one site, another researcher from a local university was also conducting a study simultaneously and several teachers reflected that they were accustomed and comfortable with such research and eager to help.

RECIPROCITY

This study was supported and even embraced by many participants and organizations. I was frequently welcomed into the offices and homes of participants who were not only generous with their input but often their food and conversation. In each school I was offered free accommodation, unlimited access to classrooms and school activities as well as some access to school documents. Because of this trust and generosity I made a strong effort to “give back” in some ways, though it was made clear that financial support for the institutions was not possible.

When housed in the personal accommodation of participants, I purchased groceries for the week and sometimes offered to help with chores. Because of the extensive support of NGO S.E., I provided free training, support and have acted as a professional reference for some of the activities where there was need such as help with grant proposals and evaluation tools.

The Deaf research assistant was paid a stipend equal to his hourly wage with NGO S.E. equivalent to one week's worth of work. He and Fina were also given the extra office supplies and tools using during the study and I brought children's books from the U.K. for their families during the final trip.

Within school sites a specific form of reciprocity was offered. I have extensive training and experience in specific Special Education methods such as Applied Behavioral Analysis. I summarized these topics into short classes and pamphlets offered to teachers. At two sites the administration welcomed this as an "in-service training". Some teachers also sought out guidance on how to obtain higher-level degrees, especially in U.K. universities while others requested my support with specific teaching strategies or "challenging" behaviors in their classrooms.

At the final school site visited I left all my remaining art supplies with a Peace Corps teacher who had been asked to teach a class of students with multiple disabilities.

CONTEXT: SCHOOLS FOR THE DEAF

This section offers additional background information on education for children with hearing impairments in Kenya including the numbers of schools from which the sample was chosen and relevant details about these schools. In particular this section provides background on some of the unique characteristics of these schools that make their culture different from "regular" schools in the region. More details are provided in *Appendix 3*.

DEAF EDUCATION IN KENYA

Though still limited, access to education for children with disabilities in Kenya is growing. The Kenya Society for Individuals with Intellectual Handicaps (KMSH)

recently popularized the theme “Hide me no More” to encourage parents to enroll their children with disabilities in schools rather than keep them at home while the Kenya Institute of Special Education (KISE) has attempted to “sensitize” the public to the needs of students with disabilities (Koay, 2004). Teachers referenced efforts by international organizations such as UNICEF to recruit children with disabilities living in Internally-displaced People’s camps in northern parts of Kenya to attend school, offering them funding for basic school expenses and travel (also referenced in Youngs, 2010).

Government-funded ‘deaf education’ in Kenya is now categorized under “Special Education” and uses the same ‘8-4-4 system’ as “regular” schooling. As part of the “Universal Free Primary Education (UFPE)” initiative of 2002, all children who wish to be educated should technically be offered this freely regardless of sensory impairment or disability. UFPE saw a rise in enrollment “Special Education” schools across Kenya (Njue, et al., 2009). Privately funded deaf education was offered through churches and other organizations prior to this. Now the government subsidized each student enrolled in a “Special Education School” at about U.S. \$120 each. Local religious institutions, NGOs, and parents/guardians often provide the additional costs of room and board.

The government also subsidizes teacher’s salaries. Headcounts of students are reported to local district administration and from this the number of teachers required at the 12:1 ratio is calculated. The government, through KISE, pays the salaries to the schools. “Head Teachers” can request KISE to place a certified teacher in their school if required because of increased enrollment over the year. However, Head Teachers sometimes choose to bring in additional instructors from the local community at their own cost, which, according to interviews with administration “reduces costs.” Interviews and observations found that this practice resulted in instructors with little to no training or

experience in Special Education, Sign Language or teaching. Head Teachers and Deputy Head Teachers are expected to teach full time and it is possible the 12:1 ratio includes this expectation whether or not it is fulfilled.

Primary school ideally spans 8 years (or classes 1 through class 8) while secondary school and ideally spans 4 years (form 1 through form 4). For the Deaf and hard-of-hearing this tends to come in the form of larger, segregated, residential schools as well as small units attached to “regular” schools comprised of 2-3 teachers and up to 20 students. As discussed in the *Literature Review*, many students with hearing impairments stay in “regular” schooling with no required accommodations or adaptations such as sign language interpreters, note-takers or assistive devices provided.

Though schooling is technically offered freely through year 8, deaf education in Kenya is marked by a lack of resources and overcrowding. In one interview a head teacher reported, “In primary schools it is becoming worse due to the introduction of free primary education which has increased our workload.” Teachers reported that though dormitories are often full, additional children are rarely turned away because schools want to encourage parents sending d/Deaf children to school.

Within “regular” schools, children’s ages are fairly proportional to their year of schooling while in schools for the deaf there is a wide range of ages even within primary schools. Adults as old as 23 are sometimes enrolled in deaf primary schools because of two reasons: children with disabilities frequently start school late because upon entering are placed into year/class 1 regardless of age and these children are also frequently “held back” because of low performance.

School culture is subsequently impacted by this lack of consistency in age groups. Staff and teachers frequently remarked on the issues related to having “full grown men”

treated as the same as young teenagers with the same social and even physical restrictions of children. What is considered “not age appropriate” in other primary schools becomes negotiable in schools for the deaf. With older female students enrolled in primary school whilst reaching puberty and marriageable age, drop-outs are not uncommon.

Reports on the number of schools and units for the deaf in Kenya vary. Both Johnstone and Corce (2010) and the Kenyan Society for Deaf Children report that there are 41 schools and 76 units, while Ndurumo (2008) references 33 “programs.” The U.S. Peace Corps has placed volunteers in schools over the past decade and conducted some research on these schools. In their 2007 unpublished report they claimed there are “49+ schools and 39+ units,” with an average of 153 students and 13 teachers per school. About 8% of teachers were reported to be deaf themselves though 57% of schools for the deaf employed at least one staff member (house-mother, etc.) who was Deaf.

According to most sources the proportion of schools in the Nyanza and Western provinces is higher as compared to the population (See Appendix 3: Figure 12). I intentionally focused on this higher density area because of three reasons: these schools were also older and larger and closer to more “Deaf activity” such as Deaf VCT clinics and clubs offering more interactions between teachers and “Deaf culture.” Two schools sites included secondary schools out of a total of four such schools in all of Kenya and the only secondary school for deaf girls in eastern Africa, drawing students from neighboring countries as well as local girls. I assumed secondary school culture was more likely to present opportunities to observe and interview about HIV/AIDS education though it turned out teachers were actively considering this education and interacting with aspects of it at all age levels. Units attached to “regular” schools were not chosen for participation because the culture of a segregated, boarding institution was the focus of the study rather

than more inclusive settings.

PARTICIPATING SCHOOLS

Choice of school sites was influenced by this background information as well as numerous recommendations from pilot study participants. Independent of each other, of these recommendations pointed the usefulness of conducting research in what will now be referred to as Sites “A,” “B,” (Nyanza Province) and “C” (Western Province close to the border of the Nyanza Province).

Within this study the term “school site” is used rather than “school”. Each “school” is listed (according to different sources) by either the town name or its official name which is often the name of a Catholic saint. However, primary, secondary and vocational schools all have their own official names even if they share the same physical, economic, and even human resources. For instance, St. Jerome’s Technical school, St. Bernadette’s School for Boys (secondary), and St. Thomas’s Primary School (co-educational)¹⁹ might all be referred to as ‘Kisumu’ colloquially. These is made even more complicated in that ‘vocational schools’ and ‘technical schools’ take separate names and “Deaf-blind units” are sometimes named separately though they are literally physically part of a primary or secondary school. Within one school site these ‘schools’ all share a funding structure, administration with teachers socialize communally and children sharing the same school yard. Children board with those of similar ages and the same gender with secondary students assisting and disciplining primary students.

Other participants included in this study worked in both primary and secondary schools across Kenya representing every province. Deaf teachers who participated by

¹⁹ This is a hypothetical school site as there are several smaller school sites in and around Kisumu

completing the posted extended questionnaire represented most provinces. Additional teacher interviews were conducted during a training seminar that hosted teachers from Central and so these have a higher representation among the “other” teacher population. See Appendix 3: Tables 12 and 13 for more details on this representation.

PARTICIPANTS

This study focuses on the attitudes and beliefs of teachers²⁰ who are currently working in segregated, residential schools for the deaf in the Nyanza and Western provinces of Kenya. However within this study the term “participants” means a wider population of educators and related professionals. During pilot research several Deaf employees of NGO S.E. were instrumental in providing background information and assisting later in interpretation of sign language-based video-recorded interviews. Some participants were employees who had previously worked as teachers or interpreters or were employed by related NGOs and frequently worked with Deaf individuals. In total there were 81 participants, 70 of which were teachers and of these teachers, 43 worked at the School Sites A, B, or C.

Teachers working in visited school sites remain the focus of this study because many completed both an extended questionnaire and an interview based on this tool, and so responses were sometimes comparable. I also took into account my observations and side conversations with teachers, staff and sometimes students during my stay on each school site. For at least one full week I lived on campus, attended staff meetings, visited classrooms, and generally followed the different school activities throughout each day.

Appendix 3 includes a summary of the professional training and background of these

²⁰ Within this study, “teacher” denotes any participant who was currently employed at a school for the deaf during the time of data collection. Staff members and NGO workers are noted as needed.

teachers that was gathered either through these conversations, additional literature review or document analysis.

With only a few Deaf teachers working at each school site, I wanted to collect as much information from a “Deaf perspective” as possible on these topics. This additional data came from posted questionnaires that were sent to the 42 members of the Kenyan Federation of Deaf Teachers (KFDT) in a list shared with me. Twenty-four teachers responded, often with lengthy answers that took a range of perspectives on these research questions, like in-school interviews. These are sometimes used in the data analysis to compare how a Deaf teacher thought about what hearing teachers were saying about them.

Male and female participants were somewhat balanced with 43 male and 38 female participants though within school sites there were equal numbers of male and female participants. There was only one female Deaf teacher who participated within a school site though additional Deaf female teachers and other participants were interviewed elsewhere.

While this study did not intend to be representative, it is useful to note that within school sites Deaf teachers were extremely well represented with 8 out of 9 Deaf teachers interviewed and 74% of Deaf teachers listed in the Kenyan Federation of Deaf Teachers participating. The total number of teachers within school sites participating was also good with about half of teachers participating by either survey or interview. This study represents about 17% of all teachers working in schools for the deaf in Kenya which the U.S. Peace Corps (2007) estimates is roughly 402 teachers.

This study, though not intended to be representative of the wider populations it sampled, does reflect a significant portion of the teachers in schools for the deaf in Kenya.

This is even truer for those teachers who are Deaf. School sites were chosen because they had greater numbers of teachers and were in a geographic proximity to each other in an ideal part of Kenya for this study. While this was not a true ethnography because observation only took place across a few weeks, as much data as possible was taken into account on the local cultures, environments and daily activities. See Table 3 below for a comparative analysis of participants and populations.

Table 3: Demographics of Participants

		Percent of total number of teachers in Kenyan schools for the deaf	Percent of total Deaf teachers in Kenya	Percent of total teachers in schools visited	Percent of Deaf teachers in schools visited	Percent of Participating teachers in any school	Percent of participating teachers in schools visited	Percent of Deaf teachers interviewed anywhere	Percent of participating Deaf teachers in any schools
Total number of teachers in Kenyan schools for the deaf ²²	402	100%							
Total number of Deaf teachers in Kenya ²³	42	10%	100%						
Total number of teachers in schools visited ²⁴	78	19%		100%					
Total number of Deaf teachers in schools visited	8	2%	19%	10%	100%				
Participating Teachers in any school	70	17%			11%	100%			
Participating teachers in school sites visited	43	11%		55%		61%	100%		
Participating Deaf teachers interviewed anywhere	10	2%	24%			14%			
Participating Deaf teachers in any schools	31	8%	74%			44%			100%
Participating Deaf teachers in school sites visited	7	2%	17%	9%	88%	10%	16%	70%	10%

DATA COLLECTION

The design of the study built upon lessons from previous studies, as reviewed earlier, and experiences with these teachers and NGO workers during pilot research. I also took into account my own experience as a classroom teacher as reviewed in *Appendix*

²² Source: (Peace Corps, 2007).

²³ Source: (KFDT, 2010).

²⁴ Source: Posted teacher lists in each school

1.

This section describes how the questionnaires were developed and evolved over time as interview outlines. I also describe how I elicited responses from teachers about sensitive topics in an ‘advocacy’ culture. Within this section there are several tables providing an overview and comparison of the population and sample sizes to reflect to what extent participants were representative of their populations.

Table 4: Demographics of questionnaire respondents

					Percent of total participants	Total participants surveyed	Deaf participants surveyed
Total participants		81	100%				
Surveys			Total participants surveyed	64	79%	100%	
			Deaf participants surveyed	24	30%	38%	100%
			Participants who completed an In-school extended questionnaire (interview outline)	30	37%	47%	
	Pilot	By post	Participants who completed pilot questionnaire in group training	11	14%	17%	
			Participants who completed pilot Deaf questionnaire (posted)	11	14%	17%	46%
			Participants who completed Deaf extended questionnaire (posted)	15	19%	23%	63%

DESIGN

The design of this study was informed by the methods of similar studies, my own personal experience conducting in-school research and the extensive feedback of key participants. They also reflect the needs of each research question. The purpose of this study was to explore an under-researched topic and context, and therefore the design of this study does not lend itself to generalization. The sample size and choice was purposively small to allow for highly detailed methods using tools that were specially

designed with the cooperation of key participants rather than borrowed from another source.

To answer the research question, “Does HIV/AIDS education occur in Kenyan schools for the deaf?” I used multiple qualitative methods to collect data. I took digital photos of the educational environment including examples of visual HIV/AIDS advocacy culture targeting the Deaf community in specific. Photos and notes were taken of relevant documents such as printed curriculum and pamphlets²⁵. At each school site the “Science” teacher immediately made themselves known to me and that I could observe them teach the “HIV/AIDS class” imbedded in their curriculum which implied that this was pre-arranged for my benefit (described in the following chapter in detail). In each case the teacher agreed to be recorded digitally. Some questions about the existence of this education was included in the questionnaires as well.

In order to answer the follow up question, “What influences its implementation both in terms of breadth and depth?” there were specific questions included in the questionnaires that doubled as interview outlines. The same was true for the subsequent research questions on what kinds of attitudes and beliefs teachers have about this education and its relationship with Deafness.

These questionnaires that also worked as interview outlines were designed after being repeatedly tested with considerable feedback from both hearing and Deaf participants during pilot research (see *Appendix 3*: Figure 19).

Each participant was given a number and a coded “tag” denoting demographics such as school site, province, title and gender for analysis purposes (See *Appendix 3*: Tables 14 and 15).

²⁵ ...as photocopying was not an option.

Each participant was designated a file where their responses, from both questionnaire and interviews, were stored. There was both a physical and digital file for each participant. Each participant's *Informed Consent* form was detached and stored elsewhere so that actual names were not stored with responses, as was promised to participants.

I began analysis of the initial data as early as during the first pilot study and continued this ongoing analysis throughout the fieldwork, allowing me to make my methods for efficient and appropriate as I learned more from teachers.

RESEARCH TOOLS

The paper-based tools used in this study were initially informed by similar studies exploring teachers' attitudes and beliefs about sex and HIV/AIDS education. While many studies explore this topic, few publish the actual questions or formats used. Instead they sometimes refer to standardized tools such as those offered by the World Health Organization (1999). The paper-based tools used for this study were informed both by these similar studies (in terms of topics covered, as wording is rarely described), and the training and my experience in designing similar tools for use in schools in California. Of particular use was the experience in wording questions and designing visual formatting to elicit quantitative results from what are otherwise qualitative topics.

For instance, in person I might ideally ask, "Tell me how you feel about discussing condoms in the classroom?" While open-ended questions such as these were included in the pilot surveys, over several drafts and initial data compilation it became necessary to digitize potential responses using common answers. This question might be transformed into a Likert scale-based question or a similar array of scaled choices. *Appendix 3: Figure 19* shows the final questionnaire used to collect data within school sites that uses a

combination of scale-based questions and open questions to elicit responses, sometimes on the same topics.

In this sense the questionnaire tools evolved over time and with the feedback of participants. Deaf participants provided feedback on the choice of words and the request of lines for writing qualitative responses rather than open boxes. They also specified the wording of the “Deaf stereotypes”. These “stereotypes” were initially beliefs and attitudes that were consistent in both content and form: participants used the same phrases or terms to describe “Deafness” more generally²⁶. When asked about these consistent terms and phrases, participants often described them as “stereotypes” of the Deaf. Both hearing and Deaf participants provided feedback about the vocabulary used and confirmed that any teacher working in these schools would be comfortable enough with English to comprehend and respond to the questions. This helped reduce the limitations imposed by my lack of experience in designing and implementing questionnaires in this specific locale and population, though I cannot assume entirely. I assumed, especially, that my use of a written, English-based questionnaire with Deaf teachers was not ideal and very likely limited the data I collected using this tool.

SCHOOL-BASED QUESTIONNAIRE

The large majority of written responses come from the two related questionnaires disseminated during the final portion of fieldwork during school site visits or by post. The first are termed “school-based questionnaires” and were used as interview guides/outlines (see *Appendix 3*: Figure 19). In order to elicit specific questions from Deaf teachers at school sites about their unique perspectives on these topics, there was a second version of

²⁶ This research intentionally does not have a prescribed framework or definition for “stereotype”, but rather uses the participants’ understanding of this concept.

this questionnaire with a few additional questions re-formatted based on the feedback of key Deaf participants (see *Appendix 3: Table 16*). However, all but one Deaf teacher chose an in-person interview and so the questions were tailored to the situation similar to interviews with hearing teachers.

The school-based questionnaire was disseminated to all teachers physically present at the school sites including administration, (though no administration chose to complete them and preferred in-person interviews). They were handed out after I was introduced to the staff at which time I explained and offered *Informed Consent* forms. Teachers and staff were asked to take a day to read the Informed Consent and return the questionnaire at a later date if they wished. However, most teachers simply completed the questionnaire and attached the *Informed Consent* at the same time. At the time of introduction and dissemination I also explained that I was open and eager to interview teachers alongside receiving questionnaire-based responses.

At each school I was offered a work space either in a private office or within the teachers' workroom where I could be reached at most times during the day. Teachers and staff frequently brought their *Informed Consent* and responses, if applicable, to these places offering a chance for me to conduct an interview using the school-based questionnaire. I was able to interview many teachers as they brought me their completed questionnaire, giving them the opportunity to immediately reflect on their responses and use the form as a visual aid. This was exceptionally helpful with Deaf participants or when teachers seemed inhibited about the sensitivity of certain topics

Though each participant completed an *Informed Consent* form that included description of the use of an audio recorder (or video in the case of sign language users), verbal (or signed) consent was additionally obtained before an interview began. In no

cases did participants reject this or act uncomfortably.

Using the school-based questionnaire was useful not only as a visual aid during interviews but also as a prop with which to elicit responses during casual interactions. I carried copies of the school-based questionnaire (as well as the *Research Brief*, *Informed Consent* and my C.V.) along with my notebook during fieldwork. The school-based questionnaire could be quickly retrieved as an aid in turning casual conversation into interview material. Some teachers also offered feedback that they enjoyed being able to complete the school-based questionnaire first to gather their thoughts and understand the questions before talking with me later.

The extent to which these questionnaires were completed was surprisingly high based on my previous experiences as a teacher. Those teachers who submitted questionnaires to me completed virtually every section, often with lengthy written explanations where space was offered. I found this tool be extremely useful at getting a much more detailed account of their experiences and feelings on this topic than I had expected from a paper-based tool.

INTERVIEWS

I spent my majority of my time in these schools trying to interview as many teachers as possible during my short stay. While the questionnaire responses proved extremely valuable, I focused on interviews as my primary data collection method because pilot research had shown that I could elicit much more detailed explanations for how teachers reflected on this education. I was also increasingly adept at coaxing teachers to explain how they personally thought about different aspects of Deafness as being either *different* or the *same* as corresponding hearing attributes and ways. I also became bolder, as I found that many teachers, especially administration, were far more candid about their personal

convictions on these topics than I had expected.

I collected a total of over 15 hours worth of “good” interview material, with each averaging about 40 minutes each. This does not include the side conversations I did not record but later took notes about or reflected upon. Fifteen participants completed both an interview and school-based questionnaire offering comparative analysis between responses. In only two cases did the teachers change their minds about their answers between these tools, which are noted when appropriate.

There were more male than female participants (by 7) though there were more female teachers in schools than male. This is partially due to the fact that there were almost no female administrators or Deaf teachers and I targeted these participants specifically. Teachers interviewed had on average of 10 years of experience.

POSTED QUESTIONNAIRE

Posted questionnaires describe an amended version of the school-based questionnaire including only the qualitative, open questions sent by ground mail to Deaf teachers (see *Appendix 3*: Table 16). Many of these participants used the entire space (almost a full page, oriented sideways) to answer their questions. Posted questionnaires were stapled along with the *Informed Consent* and *Research Brief* and were mailed to members of the Kenyan Federation of Deaf Teachers including a self-addressed, stamped envelope (addressed to me in care of the NGO S.E.’s office in Nairobi). These were posted during the first week of the final fieldwork trip in early 2011 and those that returned came back within a few weeks and throughout the following year. Those that were returned after I had left Kenya were scanned and emailed as well as posted by a colleague to my U.K. address.

DOCUMENTATION

In addition to written responses from teachers, I used a battery-powered digital audio recorder to capture oral interviews. Each time I began recording I re-affirmed oral consent for its use.

I also took many digital photos with my small camera that was also used to take short videos of some classroom activity. The act of taking photos of some of the visual culture of HIV/AIDS present in these schools was a useful method for engaging participants in how they felt about the messages.

A notebook was used for note-taking as well as planning and documenting contacts. The note-book doubled as a sketchbook as well. I am a classically-trained artist and enjoyed using the act of sketching during low-activity times to enhance observation²⁷. I quickly found that participants were pleased that I was drawing their activities. From experience as a former teacher myself, I knew that being “observed” was never a neutral activity. Though not intentional at first, I increasingly began to use the act of sketching students and teachers as a more ‘passive’ way to observe classroom and school activities (while my audio recorder was often on and I later transcribed relevant comments). Teachers also seemed less hesitant to approach me after they saw dozens of their students looking at my drawings and asking me to draw them. One teacher even commented that I seemed less “intimidating” because of this practice.

As participants submitted *Informed Consent* and questionnaires, I labeled each with an individual participant number and color-coded stickers indicating Deaf/hearing status and which school site they came from for my own analysis. I took notes on the

²⁷ The drawing from the title page of this paper is one such sketch. Others can be found between chapters in *Education and HIV/AIDS: Education as a Humanitarian Response* (2011).

demographics of most participants during interviews and coded these into an extended participant number used for my own analytic purposes only, kept separate from *Informed Consent* to as to increase anonymity.

Copies of required and useful documentation such as the research permit application (submitted to the Ministry of Science and Technology) and ethical approval from the University of Oxford were kept on hand during fieldwork but were not requested by participants.

Digital data and transcribed notes were daily backed up onto three separate memory files all of which were password-protected: a laptop hard drive, a separate portable hard drive and a memory stick. Some data was also backed up via email to a secure hard drive in my U.K. office²⁸.

INTERVIEWS WITH SIGN LANGUAGE-USERS

There were 6 teachers who preferred to use sign language in their interview. One teacher identified as Deaf but with the use of a hearing aid and having been deafened as a child he preferred to use oral language with me. Two Deaf teachers used sign language that was a mixture of KSL, Signed Exact English, (SEE) and oral language, the latter probably for my benefit.

Many hearing teachers incorporated sign language into their interviews either by habit or in order to quote a Deaf person or saying. In the following chapters, sign language is noted by bolded capital letters²⁹.

²⁸ While many of these concerns and measures now seem unnecessary considering the relaxed nature of these schools as compared to my previous experiences in California, I do believe that my intentions were felt, and that these attempts were received as signs of respect for these participants' professionalism.

²⁹ It is customary to denote sign language simply with all capital letters but within this paper the bolding is used to reduce confusion with abbreviations such as "AIDS."

Having conducted over 6 weeks of pilot research in collaboration with NGO S.E. that employs several Deaf individuals, I was able to learn conversational KSL from Deaf and hearing individuals as well as interact with Deaf teachers, staff and students casually. I also learned the specific signs corresponding to the common questions asked in interviews.

I was by no means fluent or even capable enough in KSL to adequately comprehend the *full* meaning of the signed interviews and so I planned ahead for alternatives. First, each interview with a Deaf participant was planned for a specific time and place that was private (out of sight and sound from other teachers for privacy which was a concern for them) and my digital camera to record video on a small tripod. The Deaf teachers' informed consent included this option and no teacher rejected this option given that the video would only be used for interpretation purposes.

Each Deaf teacher knew the designated interpreter (Fina), and her Deaf assistant socially and professionally, and they approved this method as long as I would not upload them to the Internet (the more common concern) or share them in other ways with the public. Working closely with Fina and her Deaf assistant, we viewed each interview several times and I transcribed Fina's interpretation. The Deaf assistant participated by clarify the nuanced use of some signs .

During each interview the questionnaires were available and we used them as guides and visual aids. Both myself and the Deaf participant would point to important words or questions for clarification or sometimes for emphasis. Sometimes we engaged in written exchange on more difficult language. These teachers had all completed some tertiary education as well as primary and secondary education in English, the language of these questionnaires. Still, this was not the ideal method for these interviews.

In addition to the interviews I conducted with Deaf teachers, a Deaf employee of NGO S.E. also conducted four additional interviews. This assistant was ideal because he had already participated in this study by helping to word some of the questions and in the past he had also helped Fina conduct similar research for their own pre- and post-tests on HIV/AIDS awareness with students.

For one afternoon he and I reviewed the posted questionnaire to be used as either an interview outline or, if the participant wished, used as a sign language-facilitated written questionnaire. With Fina's interpretation, we discussed the purpose of each question and the meaning of the Informed Consent form. The assistant borrowed my digital camera and trained to use its video-recording function, subsequently recording one full interview with a Deaf teacher³⁰. I paid him slightly more than his hourly rate for his work with Fina for this assistance.

DATA ANALYSIS

The analysis of this data was iterative and continued up until the final submission of this paper. This form of analysis is called theme content analysis. Both quantitative and qualitative results were repeatedly coded and organized for comparison. Information was first organized by participant but also subsequently by themes. Initial data analysis was done during pilot research often simultaneously with data collection and creating a symbiotic relationship between the data and re-drafting of research tools and methods. Literature was also reviewed during revisions and so the final stages of analysis reflect a reconsideration of the literature.

³⁰ Initially I thought he would be able to access more Deaf interviews than I would because he was fluent in the local dialects and socially connected with many Deaf teachers. Yet many teachers specifically requested an interview with me instead and preferred not to have an interview with him. Fina later commented that it was possible they were concerned about confidentiality but also they might have "looked down on him" because they had completed more schooling than he did.

PILOT STUDY

The first stages of this study collected data on a wide range of issues relating to HIV/AIDS education and Deafness. Initially data was analyzed for different research topics than appear here and focused more on the act of adapting HIV/AIDS education for Deaf culture. However, these initial interviews revealed data that was rarely covered in the literature and so the focus of the study was diverted to these “stereotypes” and the impact of beliefs and attitudes on implementation.

QUANTITATIVE ANALYSIS OF DATA

While almost all data collected in this study was qualitative in nature, some was quantified because of the closed nature of the questions allowed for this systematic analysis. This was not the primary focus of this study but rather a useful way to compare themes that arouse in highly qualitative and subjective analysis of the rest of teachers’ responses.

All versions of the questionnaires, (with the exception of the posted questionnaire, contained a group of similar or identical questions asking about the extent to which HIV/AIDS education was occurring in participants’ schools and how they felt about this activity. These questions were inputted as column titles into a Microsoft Excel spreadsheet. Responses were coded. For instance for dichotomous questions, a “yes” was input as 1 while a “no” was input as 0. Some questions offered an “I don’t know” or “maybe” in which case a $\pm$ was used as the code.

Multiple-choice questions were divided by possible answer. For the question, “How often do these discussions happen,” each possible response was given a column. If a participant marked an “x” for one of the answers, that column received a 1 while the

others a 0.

The same method was used to count the number of participants using different tools or having different demographics. Arithmetic functions were used to tabulate totals and separate tables were created that grouped data according to the following subjects:

- School site
- Gender
- Deaf/hearing status
- Should schools address HIV/AIDS?
- Frequency of discussions
- Feelings about this education
- Feelings about this education for deaf students
- Deaf stereotypes
- Deafness as difference or sameness

In order to potentially compare written responses with dichotomous or multiple choice responses, one spreadsheet included cells with these transcriptions. This table was used as a data bank for responses and while responses were too long to be useful viewed within the spreadsheet, it was useful to have one table incorporating almost all data. This table also included every participant as a row regardless if they did not answer all questions. This was because some interviews could be extrapolated for some of the more important quantified questions to provide quantitative data on a topic across the entire sample. Questions were color coded and organized according to some of the major themes for case of analysis. See *Appendix 4*: Table 21 for supplementary results not found in *Chapter 4*.

QUALITATIVE ANALYSIS OF DATA

I analyzed data for qualitative results through an iterative process requiring repeated re-readings of the transcripts and grouping responses by themes. I highlighted

key words and phrases with different colors and copy and pasted quotations together into new documents. Transcripts, notes and questionnaire responses were re-read over more than a year's time, allowing for reflection on the overall state of the data and repeated examination of themes.

First I grouped responses based on the three themes of HIV/AIDS education, Deafness, and an interaction between these two notions. This revealed that many responses reflected beliefs about either HIV/AIDS education or Deafness individually, but that some tied the two together.

Within these themes, three new themes began to emerge: sexuality, communication, and a general "human rights" or "equality" argument. Teachers often tended to respond to questions in terms of one of these themes and so a different colored highlighter was used to mark each of these on the printed transcripts.

These were then grouped into files and re-printed with each quotation labeled by participant and other relevant notes such as whether or not this quotation contradicted something said or the observed practice.

At this time I began to use Corker's notion of *difference* to separate these groups of beliefs even further. Each group of quotations was highlighted for references to Deaf sexuality, Deaf communication or Deafness in general as being somehow "different" from the hearing equivalent. For instance a quotation would be highlighted if a teacher directly compared a generalization about Deaf behavior with that of hearing peers. The same was done for the alternative; when teachers argued that Deaf behavior or Deafness was somehow *the same* as for their hearing peers, this was grouped.

Subsequent to this analysis, the ways teachers rationalized these beliefs about *difference* were grouped. As will be discussed in detail later in the *Discussion* chapter, there

were strong themes in how teachers offered rationale for their beliefs about the Deaf.

Each quotation is appended with descriptions of the participant where relevant, such as whether or not they were deaf, more experienced or a head teacher. Participants who I had extensive discussions with are given pseudonyms (which they themselves often chose) and are described once and referenced by this pseudonym thereafter. Other participants are cited with a number I have associated with the transcripts of their responses and that can be reviewed in *Appendix 3: Table 15*.

LIMITATIONS

This study was limited in several ways. First, as an exploratory study the design of this research was not intended to include a representative sample of the population nor did I intend for my tools to be standardized for potential comparative analysis with previous studies. Rather, this study gathered information on an under-researched topics and setting offering evidence for the inclusion of new questions in such standardized tools as the ones used by Maticka-Tyndale et al. in this region (2002, 2005, 2006, 2007).

This study is also not intended to be replicable because methods were intensely tailored not only to the culture of each school and group of teachers but often to each participant. These valuable methods sometimes acted as limitations because of the internal politics within and between these schools.

For instance among Deaf teachers and Deaf individuals it was more useful to highlight my relationship with NGO S.E. and Fina because they had a long-standing relationship with each other (over 10 years in some cases). However, these same participants warned me that amongst administration and many hearing teachers to be known as connected with a “Deaf NGO” incited suspicion.

Whether or not this was true, I intentionally highlighted this study’s “Oxford”

connection with administrators and officials because this seemed increased interest and participation³¹. This participation itself also became problematic as a close alliance with school administration was viewed with suspicion by some teachers, worried that their testimonies would be shared. This was especially important within the first school site where I was actually hosted in the head-teacher's home with his family. To reduce these fears, I spent considerable time discussing the Informed Consent and levels of anonymity possible as well as immediately connecting with teachers who seemed to be well-respected by their colleagues.

The most significant limitation of this study was the language barrier between me and the sign-language users, including my reliance on English both for interviews and questionnaires. With little sign language experience of any kind prior to this study, I was forced to learn the basics quickly and rely on my experience as a Special Education teacher for adaptive skills. Though all participants had some skill in reading English and most had used English as their primary language in school (through tertiary education), it was still apparent that fluency in Swahili and even some knowledge of Luo or Luuya would have been useful. While at the time I wished I could be fluent in KSL, retrospectively I found that this allowed many hearing, non-fluent teachers to feel “safe” being honest with me about their beliefs about Deafness as I was not a “clear” Deaf ally³².

For these reasons I spent considerable time and effort attempting to gain the trust and support of participants through my interpersonal skills. My background as a teacher, in this respect, was invaluable because I was able to acclimate quickly to each school

³¹ This was important also in counterbalancing their consistent ‘shock’ at my age, or lack thereof.

³² If I had been more obviously “chummy” with Deaf participants and students it is possible that hearing teachers might have changed their responses to be more aligned with what they thought I wanted to hear, something which I suspected already occurred to some extent and which frequently occurred in my experience as a teacher in California.

environment and classroom activities. In some cases teachers included me in their instruction or asked for advice on teaching methods. Some participants seemed to view me more as a colleague rather than a researcher which was quite helpful.

CONCLUSION

This study asked the following research questions:

Does HIV/AIDS education occur in these schools and if so, what does it look like?

- What beliefs and attitudes do these teachers have about this education?
- What beliefs and attitudes do these teachers have about d/Deafness?
- What beliefs and attitudes do these teachers have about the interaction between HIV/AIDS education and d/Deafness?
- For teachers who themselves are Deaf, how do they feel their role is *different* from hearing teachers?

In summary, these questions were answered by pilot study-informed research methods that were also influenced by related literature. Participatory methods were used to create questionnaires that were used as interview outlines. Ethics for this study reflect both the standards of the University of Oxford and my own personal ethics as well as informed by lessons from the literature about “sensitive” research topics.

This study incorporated the reflections of over 81 participants while focusing most of the data on responses from 43 teachers in three school sites in Western Kenya, chosen for their size and geographic proximity. Within these sites almost all Deaf teachers were interviewed and an additional 24 participated from other schools to balance these reflections

Most data was qualitative and iterative methods were used to analyze responses for themes such as beliefs about Deaf sexuality and communication patterns. This study was

limited by the sample size and does not intend to be generalizable. It was also limited by my language skills and so sign language interpreters were used with Deaf participants.

The following chapters present the content of this data as they follow each research question they answer with some analysis of trends. While some of these conclusions are new and even surprising as compared to the literature, this description of methods supports their validity. Many of the conclusions drawn in the following chapters also deal directly with these research methods and the limitations they placed on what data was able to be collected or how it could be analyzed. The final *Discussion* as well draws conclusions that are pertinent to methodologies used for similar studies. In many ways, this study was as much an exploration of what research methods were useful for this kind of research as it was about answering these research questions.

CHAPTER 4: DATA ON HIV/AIDS EDUCATION OCCURRING IN KENYAN SCHOOLS FOR THE DEAF

INTRODUCTION

During pilot study as well as throughout fieldwork I observed different kinds of HIV/AIDS-related education occurring or learned about their existence through interviews. I also learned to what extent teachers felt this education was occurring. This data reflects a combination of my own observations, what recorded “evidence” was available as well as teachers’ testimonies about different forms of this education existing in these school sites. This chapter also begins with a brief description of the context of HIV/AIDS advocacy in this region adding to the general climate in which these teachers work and live.

After analyzing this data, I concluded that there were three kinds of HIV/AIDS-related education reflected upon by teachers each with a range of degrees of implementation. First, policy statements and teachers referenced to an “HIV/AIDS

course” that while being mandated at the secondary level was not taught in any of these school sites.

Second, most teachers argued that HIV/AIDS education did occur in their schools because related topics were “imbedded” within almost all formal curriculum. There were many examples of this inclusion in different course syllabi which focused on a range of perspectives of HIV/AIDS from its history to prevention and even sociology.

Thirdly, some of the most interesting data came from teachers’ reflections on “informal” HIV/AIDS education. This occurred either as supplementary trainings and activities offered by local NGOs or other community groups, or the informal conversations teachers and staff had with students during extra-curricular hours or as counselors. The nature of this education was significantly influenced by the ethos of the NGO or group, or the personal beliefs and attitudes of teachers engaging in these “side” discussions or counseling sessions.

This section of data argues that while no formal coursework on HIV/AIDS was offered systematically, school culture was still significantly impacted by the presence of other forms of HIV/AIDS-related education. Teachers’ commentaries on the “how” and “why” these forms of education occurred or did not occur offer insight into both the practicalities of this education as well as its reflection on such deeper cultural issues as Deafness, impairment, health, sexuality and human rights. These conclusions provide the rationale for the further study of teachers’ reflections on these activities reviewed in the subsequent two data chapters.

HIV/AIDS-RELATED ADVOCACY IN AND AROUND THESE SCHOOLS

Roughly thirty years before I began this study, HIV/AIDS was identified and

named, initiating advocacy for research, treatment and prevention by different groups first affected. While it was only in 1999 that Kenya made their educational response “official” by creating a course syllabus (Ministry of Education/Kenya Institute of Education, 1999), other agencies have responded through advocacy spreading what is colloquially called “awareness”.

By the time I first visited Nyanza in 2010, messages about HIV/AIDS were pervasive; there were billboards promoting safer sex practices, signs for local Voluntary Counseling and Testing (VCT) clinics, and the ubiquitous “red ribbon” in both the city centers and rural villages. It is something people are used to discussing but not necessarily voluntarily or explicitly. Almost every visual suggestion of this virus also carried with it the logo of some foreign, often U.S.-based, institution. While teachers did not necessarily take their tea and biscuits while discussing the latest HIV prevalence, no one seemed surprised or uneasy with the fact that yet another American researcher wanted to know how they felt about this disease.

The schools I visited were in the same province as those fishing villages on the banks of Lake Victoria where some of the first instances of HIV were documented in Africa across the lake in Uganda. This is the same region where the Liverpool Clinic conducted research on Deaf peer HIV/AIDS education (Taegtmeyer et al., 2009), and where driving into one of the schools sites I passed by one of their signs advertising “Deaf VCT.”

It is within this culture that teachers travel to and from schools and in this environment that they reflect on their students’ hearing impairments and Deaf culture. While so many of the documents put forth by disability advocacy groups made claims that

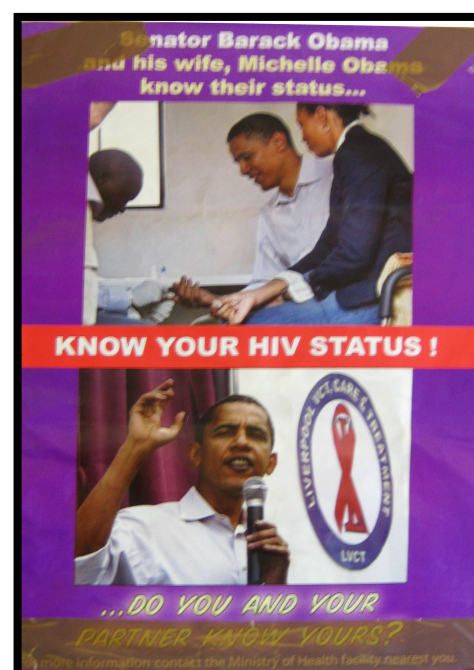
Figure 4: This sticker was on a door in the main office of one school at eye-level, interpreting an AIDS-advocacy slogan into sign language.



these youth “never” learn about HIV/AIDS information³³, I found this hard to believe. Maybe what they learned was inaccurate or incomplete, but they must be aware that something is going on. This skepticism was my first rationale for the pilot study and it was only fed by what I saw when I walked through each school site alone, taking photos and making notes about these environments.

Virtually every vertical space within each school site displayed of an array of posters or stickers that frequently referenced HIV/AIDS or related topics such as sexual health and safety. There were other kinds of paraphernalia especially religious motifs and sayings (all Christian),

Figure 5: HIV/AIDS-Advocacy poster featuring U.S. President Barack Obama: This study collected data in the region from where President Obama’s Kenyan relatives are from and still live.



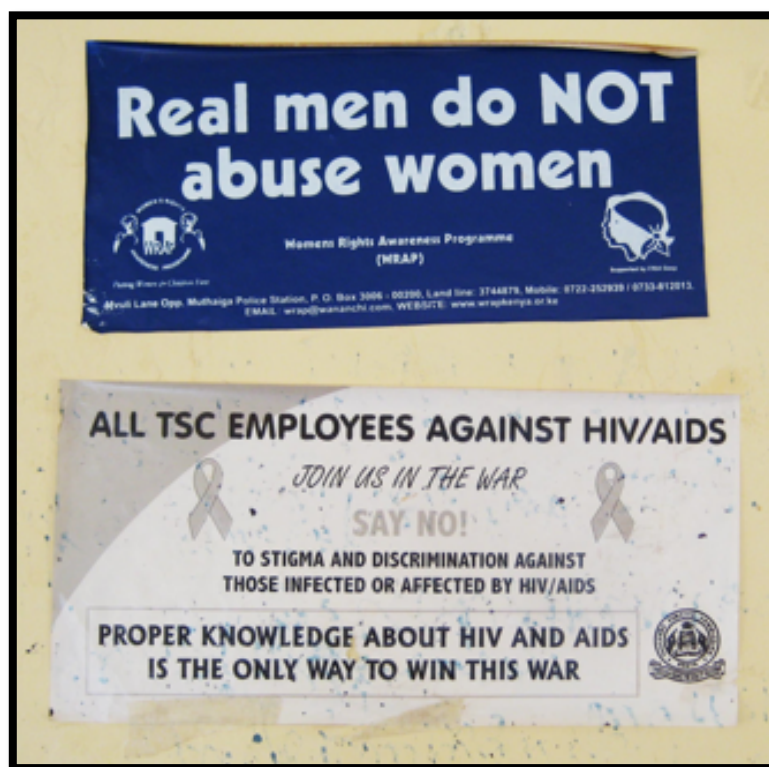
³³ Within Kenya: (African Campaign on Disability and HIV, 2008; African Union of the Blind, 2007; Canadian Minister of Health, 2009; Disability-Kenya, 2010; Henderson et al., 2004; Liverpool VCT Care and Treatment, 2010; Sahaya Deaf Kenya, 2008; Steadman Group, 2007; Viehmann, 2005), and in the region: (Chireshe, Rutondoki, and Ojwang, 2010; Choruma, 2006; Disability and Development Partners, 2008; Enwereji and Enwereji, 2008; Janssen, 2009; Malundah, 2008; Murangira, 2004; Narib, 2003; Nganzi and Mataonhodze, 2005; Ntlatlapa, 2008).

or positive statements about ability, but HIV/AIDS was second only to the Bible for topical imagery and statements. Most of this paraphernalia was well-worn and displayed in high-trafficked common areas such as the main office, on the sides of classrooms or classroom doors.

Teachers' homes as well boasted posters and calendars (often more than one displayed at a time even if outdated) which were advertising local business but depicted popular imagery such as President Barak Obama or local political figures. In-home paraphernalia was less likely to depict HIV/AIDS-related imagery than those found in school common areas.

I got the impression that with such limited resources in these schools, any free decorative or informative posters or stickers, (called *schwag* in the U.S.), were displayed, something one teacher agreed with, lamenting the barren walls of her own classroom. This changed the perspective I had on the 'intention' behind these displays. In the

Figure 6: AIDS-advocacy stickers were seen throughout these school sites and were often some of the only 'decoration' or teaching aids. Most AIDS-related paraphernalia displayed a UNAIDS, UNICEF, WHO or USAID symbol, often along with other supporting organizations. They were almost all in English though some were in Swahili.



American schools I was used to teachers had the luxury of choosing which visuals to put up thereby making their displays more of a pedagogical performance. Here, I questioned to what extent these images were part of an intentional pedagogy and whether or not I should “read into them”. Later interviews with teachers revealed that some teachers were very intentional in this practice, revealed by the rich displays of these products in areas in which they had full control such as their office/classroom. This makes the intentions behind stickers and posters about HIV/AIDS and Deafness I found on common area doorways and hallways more vague.

Still, this visual culture of advocacy was apparent, and with several stickers and posters including sign language interpretations, they were clearly meant by “someone” to target this population with specific messages about HIV/AIDS.

FORMAL HIV/AIDS CURRICULUM

At each school site I visited, I checked the course schedule and inquired with the head teachers about the supposed “mandatory” HIV/AIDS course with no record of there being such as class offered at either primary or secondary levels. Teachers and administration commented on this arguing there was no time when there were so many other courses that needed to be covered for their students to have a chance at passing exams. They also felt that because their students often tested far more poorly than hearing students, there was even more motivation to focus on these “academic” courses. Three administrative teachers reported that they felt that with the “imbedded” HIV/AIDS education being taught, especially in Science classes, this was enough given these circumstances.

Interviews with U.S. Peace Corps volunteers working at other schools revealed that they felt they were more likely to be asked to teach such a course, offered as a unit or

short-term course for older students in secondary schools. While during my stays no such courses were offered, these apparently had occurred in the past though it was unclear for what duration and whether or not this class was based on the national curriculum. This was an interesting point because not only does it possibly imply that Kenyan administrators viewed American teachers as “more suited” or better in some way to teach these topics but also because these Peace Corps volunteers all had high levels of sign language ability, some being fluent and one even studying the linguistics of KSL during their stay.

The U.S. Peace Corps has a history of Deaf-targeted AIDS advocacy in this region with part of their 2007 report specifically gathering data on the presence of materials or related activities in these schools. They found that while there were some visiting lectures by the Deaf-VCT clinics and the presence of posters and some books, there was no “formal” curriculum. Their involvement with this advocacy was evidenced by their logo on many of the posters depicting sign language statements on HIV/AIDS-related topics noted later in this chapter.

EMBEDDED HIV/AIDS CURRICULUM

The second form of HIV/AIDS education referenced by teachers was embedded within other course syllabi. Teachers called this “infusion” and referenced this as what “HIV/AIDS education” meant in these schools. This is an important point for researchers studying rates of this education because previous studies noted they were only counting complete courses on HIV/AIDS as “evidence” for this education. This data argues that the presence of this embedded education creates a gray area.

Many teachers, especially the older, more experienced faculty, were enthusiastic and supportive of this kind of education. During casual interactions with teachers in the

workrooms they were eager to bring to me their course guides (similar to a Teacher's textbook) and point out where HIV/AIDS was embedded as a one-time topic within their subject.

Science teachers especially felt that they were the primary teachers for this education within their schools because within their curriculum it was embedded over several lessons as part of a wider series of topics on health and disease. All primary and secondary students attended a "Science" course at some point during the week, according to the course schedules posted in these school sites.

At two school sites, two of these science teachers were apparently told that I would be coming and that I was interested in HIV/AIDS education; they were prepared that week to cover these sections. I was able to observe and record their teaching and the way they implemented the outline. Because it was clear from my Research Brief that I was interested in HIV/AIDS education, I assumed they planned on teaching this topic during my stay for my benefit and that this was not a coincidence. However, my talks with them gave me the

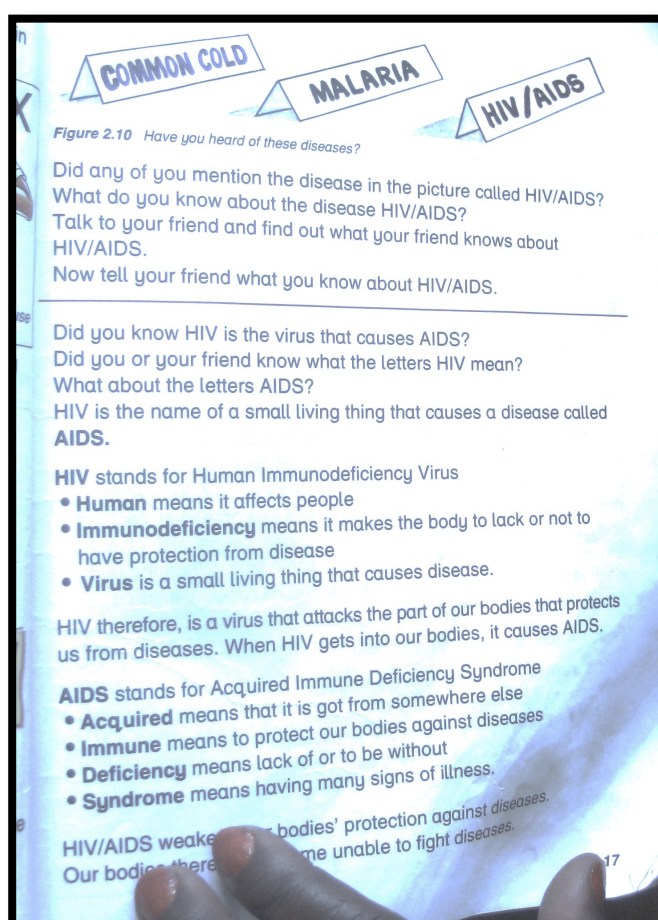


Figure 7: An example of imbedded HIV/AIDS education instructing the teacher to remember to include specific statements in their lesson.



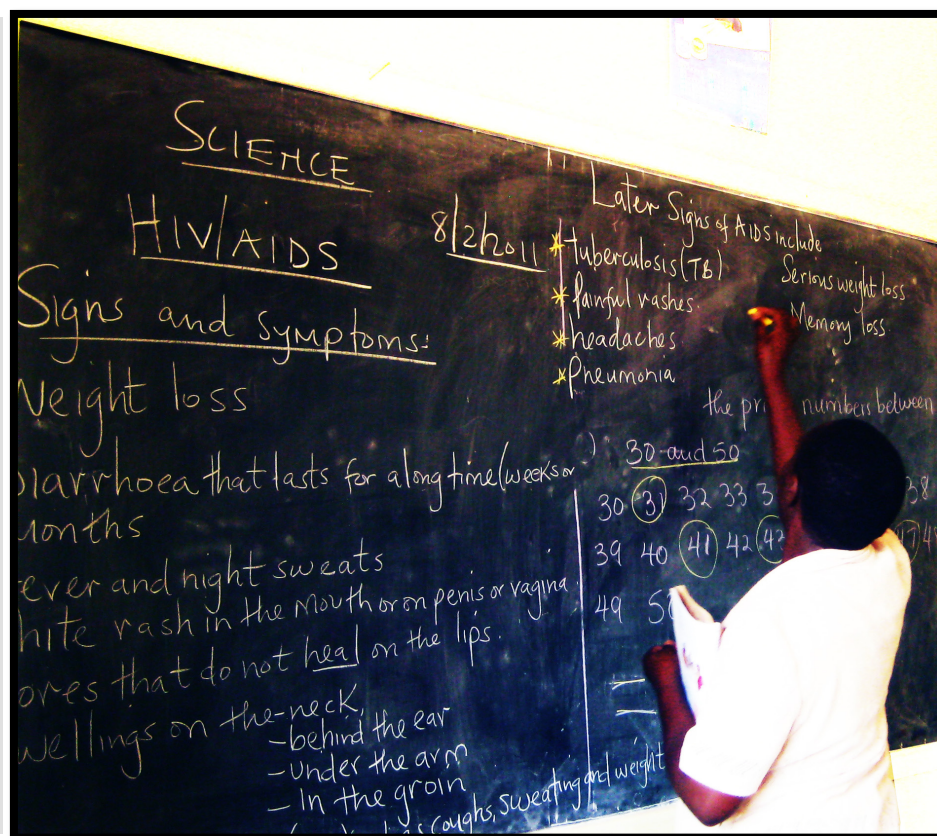
Figure 8: Teachers in school sites A and B reflected the message of this NGO-sponsored poster: they argued that it was very important to discuss stigma because of the number of HIV+ children in their schools.

impression that they would have taught this section at some point in the year. What was unclear was to what extent their observed pedagogy was a “performance” for me as opposed to what would be their natural teaching style.

During these observations, I noticed an emphasis on the definitions of HIV/AIDS-related words and the more medical aspects. Yet during interviews with these teachers they commented on their personal emphasis on stigma. One teacher said that she and her students all knew which students were in fact HIV+: each day the students reminded each other when to visit the nurse to receive their anti-retroviral treatments (pills). Because of the presence of these students in their classrooms, these teachers had a personal motivation to reduce the stigma of being HIV+ and they added extra discussions about all of the interactions with HIV+ people that were safe and non-contagious. I observed this with one teacher but while both made this claim, the other did not discuss stigma during my observation.

Teachers reported that it was possible for HIV/AIDS to come up as a topic within a nation-wide test though it was not itself a testable course. At first the pedagogy of the

Figure 9:
This teacher
at Site B
allowed me to
observe and
record her
implementing
the Science
curriculum's
embedded
HIV/AIDS
lesson which
lasted 3 days.



two teachers relied on the lecture style most other classes were also taught in. Students participated only by copying down whatever was written on the board, memorized the words and statements and reiterated these for a quiz the following day.

Both teachers changed their teaching style during the second half of each day's class towards an open discussion. One focused on stigma and tried to get students to discuss all the safe ways to interact with "friends with AIDS" while the other engaged in a discussion about prevention and treatment. This was unusual for this classrooms as almost all other class observations showed a strong adherence to the lecture format regardless of topic.

INFORMAL HIV/AIDS CURRICULUM

The third kind of HIV/AIDS education present or reported upon by teachers was informal. These were voluntary and had no regulated curriculum consistent across schools but rather depended on the personalities and interests of the related parties.

Teachers reflected on occasional or ongoing "health clubs," within schools. These

groups were voluntarily formed by teachers (often Deaf) who felt a personal responsibility to ensure candid and “honest” discussion about HIV/AIDS-related topics. There were at least 2-3 faculty or staff in each school site who reported coordinating such groups while almost all teachers knew of their existence. They were in part supported by NGOs or Faith-Based Organizations (FBOs) such as the Salvation Army with training, literature/supplies, guest speakers and sometimes funding for faculty.

Two of such faculty members were also the designated school “Counselor” with formal tertiary training in this field. One “health club” had a designated room with locked cabinets full of health related DVDs, a TV and DVD player, pamphlets and books and even games and other leisure activities. This “health club” was coordinated by a male Deaf teacher and a female hearing teacher, who, during my observation, hosted a visiting group of university students. While I was impressed with the efforts of these faculty, an NGO employee familiar with this school criticized this club as “in name only” and that the room was “only opened for visitors”. There was no documentation of

Figure 10: Site B was host to a “Health Club” with its own room and cabinets full of supplies including DVDs and other paraphernalia on HIV/AIDS-related topics. One male Deaf teacher and one female hearing teacher were in charge of coordinating this club though no activities were observed. While the presence of these materials shows that some effort was made to gather them, there were no reports or evidence of ongoing activity.



ongoing student participation either to confirm how many students attended this club nor how often. This was also the case in the other school sites where teachers reflected on the existence of such clubs. These observations and interactions highlight the difficulties in defining “evidence” of the existence of HIV/AIDS education in these schools without corroboration from students or detailed documentation.

Visual evidence of either clubs or ongoing informal education was present in the classrooms of teachers who felt more strongly about “creating awareness”. Some posters I found on the walls of these classrooms were created with the help of the Peace Corps and

Figure 11: One teacher displayed a wide array of posters in his classroom/office. They displayed the logos of the U.S. Peace Corps and USAID, and showed photos of sign language interpretation of statements and words related to HIV/AIDS. Some of these were quite explicit with one poster warning against the dangers of female genital mutilation (FGM) and drawings of male and female reproductive parts. He felt that no changes needed to be made to the content of this education but that simply offering “truth” and facts was the most important thing to “save lives.”



were aimed directly at the Deaf community by using photographs of local Kenyans signing HIV/AIDS advocacy messages and naming related anatomy. Two teachers in particular displayed these images in their office/classrooms, both having the dual duties of classroom teacher and school audiologist. Another was a school counselor.

One of these teachers covered almost an entire wall of his classroom/office with posters at a child's eye-level in his primary school. I took photos of these images while we chatted one afternoon and they sparked our conversation about his concerns for the Deaf community in light of the HIV/AIDS epidemic. Figure 10 shows a poster encouraging adults to bring children into Voluntary Counseling and Testing (VCT) clinics if they suspect sexual abuse depicting a forlorn-looking young boy and asking, "Was he raped?".

He, like many teachers, told me that the common threat of sexual abuse motivated them to talk to his students about safety and their rights, whether or not it was in the curriculum. Though he was older, perhaps in his 60s, he felt that relevant actors like the church and schools needed to change and become more comfortable with explicit discussions about these topics in order to "fight" HIV/AIDS.

We used to not talk about condoms; the church really stigmatized it saying they were sinners and they blamed them for spreading AIDS. But now they are encouraging us to have counseling sessions, to love them. **AIDS WEEK RED**. You know in those days they would **KNOW HAS HIV** and move away, but now it can't happen because people now know how AIDS spreads. [It is a] freely changing society. [The church has] given us all the materials, the techniques to fight stigmatization (Participant 41).

He described the hesitancy of other teachers and educators had regarding condoms and sex as "shame", telling me emphatically,

...Where is my shame if you die? This was the topic, "sex", that you could not talk about in those days, and it's all over now. There has been a lot of teaching and life experience and everyone is affected. All over schools and in church people have died. So... people must find out how must we control this and then a lot of education (Participant 41).

While the previous teacher felt comfortable advocating in explicit ways, another

teacher who organized a “health club” felt greater tension about these topics and reacted in ways more aligned with previous studies on this region or HIV/AIDS and disability discussed in the Review of Literature.

We don't tell them to use condoms. If we talk about condoms, we just talk about general ways to use them to prevent infection from HIV and AIDS. We don't tell them, ‘If I were you, these are options that I have.’ We tell them ‘There is a right time to marry and you should have tests to confirm you are negative,’ and that, ‘Sex is only for marriage.’

But the truth is that they get into these things [sex] so much. So we catch them using condoms; we know [they are having sex].

So we tell them they are better off using condoms. The ones we feel are getting involved [with sex, we tell them], ‘Try and abstain, but if by bad luck [you do have sex] then you must [be safe].’

I think we should do this, personally, I would do it, but there is the society, the government; [they] don't do this. (Participant 12).

These representations of informal education show a range of ways teachers approached these discussions. Previous studies focus on the previous two perspectives as “more desirable” because these attitudes, they argue, have a higher correlation with safer sex practices. I also talked with teachers who were involved with or ran health clubs who held attitudes and beliefs that have been labeled as “undesirable”.

One hearing woman who taught older girls in a vocational class was also working with a local NGO to provide health education. She gave me a flyer from them (Figure 12), printed on heavy cardstock in full color and shiny like a postcard.

Her reflections on this education mirrored this flyer’s message that Abstinence-only education was “best”. As Duflo, Dupas, Kremer, and Sinei (2006) also found, this teacher felt they had to scare children into abstaining first from sex rather than talking about safer alternatives such as pointing out the limits of safer sex practices such as condoms such as breakage. She did not feel it was “appropriate” to discuss getting tested or treatment for HIV/AIDS.

I don't think they do 'bad' things. We ask them, 'Do you have a friend?' And they say, 'No! No! No! It's bad! It's bad! I don't want to get pregnant. I don't want to get AIDS. AIDS is bad! If I have AIDS I will die and I don't want to die'. The others have such stories and they fear, and that's good (Participant 62).

Figure 12: This flyer was evidence of an outside group providing abstinence-focused HIV/AIDS-related education within one school site (Both front and backsides shown).

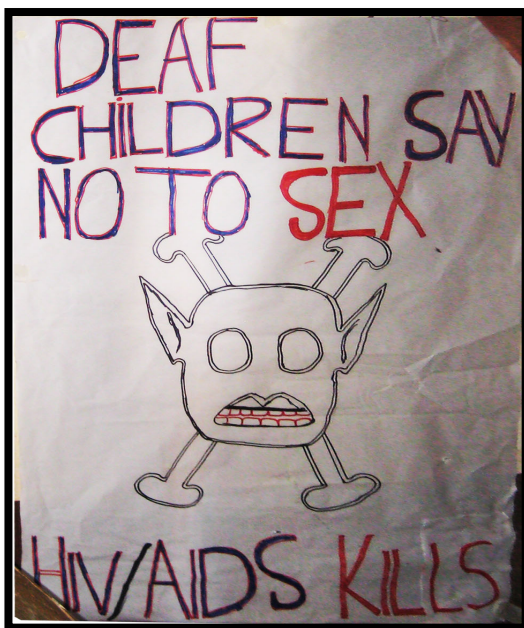
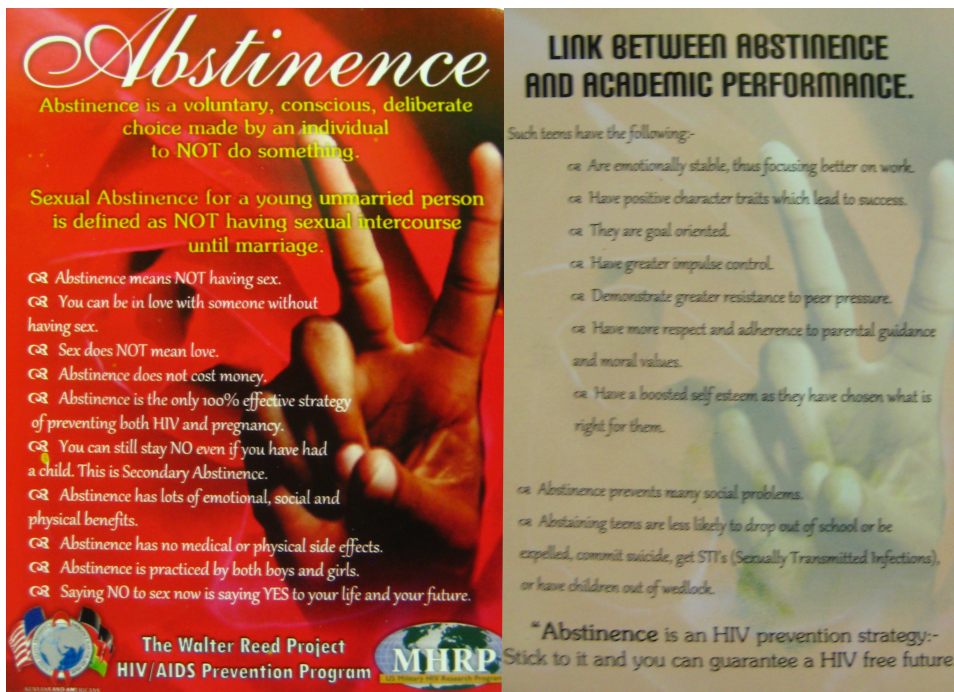


Figure 13: One teacher collaborated with a local community group to have regular discussions about HIV/AIDS with her vocational students. She felt that Deaf students needed simpler, more direct education compared to hearing students because of their limited intellectual abilities. She used this argument to rationalize Abstinence-only education and HIV/AIDS with death.

During one of these health club sessions, her students created posters about what

they had learned depicted in Figure 13. When we discussed this poster and its message, it became clear that this teacher focused on abstinence partially because she felt that discussion would prompt experimentation (something the literature frequently finds as well) but also because she believed her Deaf students required more “simplistic” arguments and could not comprehend the complexity of “safer sex” messages. She pointed to the student’s poster and argued that because they used “only their eyes” that the red of “kills” helps them understand. She repeated throughout the conversation that her students were “different” from hearing students because they needed “direct, simple” messages about HIV/AIDS. Discussions about condoms, testing, treatment and other aspects common to HIV/AIDS education were omitted because she felt that her students couldn’t comprehend these “complexities”.

During my discussions about these examples of outside groups providing HIV/AIDS education within these schools, teachers often referenced local “Deaf NGOs”. These “Deaf NGO’s” were either run by Deaf Kenyans or specifically targeted only Deaf individuals (as opposed to other disabilities). Teachers told me that they felt these NGOs had a stronger relationship with the Deaf students because they hired Deaf educators and that “the Deaf like each other”. Both hearing and Deaf teachers told me that they felt Deaf students tended to trust other Deaf teachers, including Peace Corps volunteers who were Deaf, over hearing teachers who were sometimes treated with “suspicion”. Deaf educators, some teachers argued, were able to be “more truthful and open” with students about “sensitive” topics because they had better sign language abilities and could quickly and efficiently explain things using language that administrators were unaccustomed to.

One Deaf employee of such an NGO told me that they use this strategy to talk

about more “taboo” topics through the use of metaphors and allegories, not only avoiding the censorship of administration but also providing the students with a “secret” vocabulary about these topics that they could use later within the schools. If questioned, these metaphors were excused as “morality stories” which seemed vague enough to dismiss suspicion. They intentionally used local imagery such as animals and plants that the students experienced in their daily life so that they could easily become part of local Deaf culture and slang. Condoms or anti-retroviral therapy pills could become local birds or household items, allowing free discussions about concepts that administration was known to try and censor.

Employees of this NGO and Deaf teachers as well felt that administration also became “suspicious” whenever “the Deaf get together”. Employees of NGO S.E., for instance, told me that they felt specific hearing teachers had been sent to participate in one of their activities for the sole purpose of “spying” for administration. I had helped this NGO write and format a post-test for students to complete to help gather data on what they had learned during this 3-day seminar on HIV/AIDS which included one question about condoms. After the tests were submitted to me for analysis I was surprised to find that someone had used a black marker to block out the question about condoms and even applied masking tape on top of that to further obscure the words.

CONCLUSION

This study established that there were some forms of HIV/AIDS education occurring in and around Kenyan schools for the deaf, though not necessarily the forms that policy dictated were mandatory such as the “required” course on HIV/AIDS. Not only was the local environment saturated with HIV/AIDS messages often clearly targeted at sign language-users but formal and informal education in these schools occurred as

well.

Teachers reflected enthusiastically on the “imbedded” HIV/AIDS topics that were primarily found in Science courses but were also referenced in most other course syllabi. This education was limited by the language abilities of teachers which according to the literature and my own observation was varied and unreliable.

The form of HIV/AIDS education that offered the most interesting remarks and practices was informal “clubs” and side discussions between teachers or staff and their students. The nature of this education, however, was significantly altered depending on the personal beliefs and attitudes of each teacher or the group offering this education. Some teachers felt strongly that “all the facts” should be offered regardless if it made people uncomfortable. Some teachers felt tension between beliefs about offering facts and attempting to dissuade students from engaging in undesirable behaviors. Finally, some teachers argued that the available information needed to be amended not only because this was, in their belief, the “best” way to teach these topics but because they also felt Deaf students required a different, less “complex” message about HIV/AIDS because of their perceived limited cognitive abilities.

There were also interesting dynamics between “Deaf NGOs” and hearing teachers and administration at these schools. Each group seemed to distrust the other and I observed some potential rationale for this distrust. However, there were limited observations and interviews on this point specifically so I could only conclude that there was at least the “perception” of mutual distrust.

I initially started this study exploring the technical ways these “Deaf NGO’s” adapted and changed this education when they targeted Deaf individuals, and this chapter offered much of these conclusions. As I interviewed teachers about these

activities, however, it became clear that there were consistent themes in how teachers felt about the act of teaching HIV/AIDS education to Deaf students that were as yet unseen in the literature in this region. It was during these initial interviews that the consistent beliefs and attitudes here called “Deaf stereotypes” began to emerge as rationale for why and how teachers either altered or chose not to alter the available information and education on HIV/AIDS. The following chapter presented data from questionnaires that derived from these initial experiences observing and inquiring about existing HIV/AIDS education in these schools.

CHAPTER 5: DATA FROM QUESTIONNAIRES

INTRODUCTION

After concluding that there was a significant presence of HIV/AIDS education activity in and around these schools, I designed questionnaires aimed at gathering more information on these practices, namely how teachers felt about them. These questionnaires gathered data in the form of close-ended questions as well as open-ended questions eliciting qualitative responses. Questions were grouped by themes but there were often several questions asking about the same kinds of experiences or reflections in order to try and pinpoint how each teacher actually felt about these activities. Details about how this questionnaire was designed and how data was analyzed can be found in Appendix 4.

Within this chapter I offer results in terms of how “the majority”, “most”, or “almost all” of teachers responded. These are defined respectively as “over half”, “more than 2/3rds”, and “over 85%” roughly. The same is true for their respective counterparts, “the minority” and “few”. I intentionally do not offer the exact count or percentage of each response because not all teachers who submitted a questionnaire

answered each question, making comparative percentages problematic. With such a small sample, these results remain informative with the simplified terminology. When actual numbers are useful, they are specified and actual responses are listed in the tables offered in this chapter.

The first section of this questionnaire asked general questions about how often HIV/AIDS education occurred and their overall feelings on this topic. In the second set of questions teachers were asked to respond to this education in terms of specific “Deaf stereotypes”. The third section asked teachers to reflect on various relationships between HIV/AIDS-related issues and Deafness.

Data from these questionnaires revealed that teachers had frequent discussions with students about HIV/AIDS-related topics and that they felt that they were adequately trained and felt comfortable talking about these topics. However more training and resources were often desired. Teachers felt that their students were engaging in sexual activities but were not likely to get information on HIV/AIDS at home. These questions mirrored previous studies on HIV/AIDS education in “regular” schools in this region.

Teachers had mixed feelings about common “Deaf stereotypes” such as “Deaf people are more promiscuous”, “Deaf people love to gossip” and “Deaf people are HIV+”. At least one third of teachers agreed with these stereotypes and over two-thirds of teachers felt that “Deaf people cannot keep secrets” and “gossiped”. Teachers’ rationale for their stance on these beliefs offer insight into the complexities of these beliefs and how the impact this education.

The primary conclusion drawn from this data is that while these teachers shared many of the concerns and reflections about HIV/AIDS education as “regular” teachers from other studies, the context of “Deafness” has a significant impact on these practices.

However this data also strongly concludes that “Deafness” interacts with this education in different ways, according to different teachers and there is no one consensus about its impact. Analysis of this data also reveals that offering teachers a chance to provide their personal rationale for their stance on beliefs is vital for understanding their potential impact on this education. While questionnaires were found to be useful in gathering descriptive details of educational practices, it was a limited tool for gathering “accurate” understandings of the deeper beliefs and attitudes teachers held about the complex relationships between education, HIV/AIDS and Deafness.

RESPONSES ABOUT HIV/AIDS EDUCATION IN KENYAN SCHOOLS FOR THE DEAF

This questionnaire found that teachers had largely positive feelings³⁴ about HIV/AIDS education in general and within their own schools. The first question asked, “Should schools address HIV/AIDS and reproductive or sexual health?” All participants answered this question, and with rare exception they responded positively.

Teachers were also asked how often discussions about HIV/AIDS or sex occurred between them and their students. This was intended to gather information on a wider definition of education than just curriculum-based education. Note that few respondents reported “never” and most women responded “often”. These terms were defined within the questionnaire for participants as:

1. Never: These discussions NEVER come up with my students.
2. Rarely: A few times a year
3. Sometimes: Maybe 1 - 2 times a month
4. Often: Around once a week

³⁴ Teachers felt that such education was a good thing. The term “positive” denotes their response, and not that such an attitude is in itself “positive”.

5. A Lot: A few times a week or more

Table 5: “Do discussions about HIV/AIDS or sex come up between you and your students? Check one.”

Option	NEVER	RARELY	SOMETIMES	OFTEN	A LOT
Site A	0%	50%	25%	0%	25%
Site B	9%	18%	18%	25%	27%
Site C	0%	8%	23%	46%	23%
Deaf	33%	33%	33%	0%	0%
Hearing	0%	16%	20%	36%	28%
Women	0%	20%	7%	53%	20%
Men	7%	14%	36%	7%	29%
Total	4%	18%	21%	31%	25%

The sole participant who checked “Never” to this question represented in Table 6 was also Deaf, and argued in both his written and verbal response that,

Deaf learners who are underage...if you introduce such a topic about sex and the spread of HIV/AIDS and start teaching them about safe sex...they may end up not understanding what is meant and may start experimenting themselves with sex following safe methods taught rather than abstinence. This issue is confusing and makes me as a teacher uncomfortable talking about sex and the spread of HIV/AIDS (Participant 1).

As the table shows, his answer was unusual with only three participants feeling that it was “not their place” to talk to students about sex, an answer predicted by similar studies to be much more popular.³⁵ On the contrary, almost all teachers reported that they wished there was more time and resources for this education though they also felt that they were adequately trained to conduct it. These responses suggest there is a difference between *wanting* more training and *needing* more training. It suggests perhaps that teachers wish to be viewed or feel that they are educated *enough* for the current requirements, but that given the significance of this issue, perhaps, they would always

³⁵ Mfune (2008) found that the majority of teachers felt it was not their role to discuss these topics with students and both Collins (2006) and Rohleder and Swartz (2009) found that educators ambivalent about their role in impacting the sexual morality of the individuals with disabilities they worked with.

welcome more training.

Most teachers also agreed that their students were not getting this education at home yet they were sexually active. One limitation of this questionnaire is that there were no questions about what age-levels each participant taught. While it might be assumed that teachers working primarily with very young children would be more opposed to these discussions, within these schools teachers often taught a range of age groups in different years as well as interacting with all age groups around the school sites outside of their home classrooms. Several of the teachers subsequently interviewed discussed at length their mentoring and guidance of older children on campus while they taught young children within classrooms. If this is the case, teachers regardless of current classroom assignments might have equal desire or need to be given training and support for HIV/AIDS education.

Most teachers felt that their teaching did make an impact on the behavior of students and only five teachers felt that talking to students about sex would make “others” suspicious. Responses from questions 35-38 show that these teachers did not link discussions about these topics with higher rates of behavior on the respective topic though much of the literature suggests this “negative” or “undesirable” belief is prevalent in this region. Alone, this data suggests the potential that within the context of deaf education, this “attitudinal barrier” against “effective” HIV/AIDS education might be less prevalent.

However, when I compared these responses to those on this topic from interviews and qualitative responses I felt that these initial 74% approval might have been misleading. This questionnaire was limited because the phrases, “talking about sex” and “with students” were ambiguous and not sufficient for describing HIV/AIDS-related

education. Observations showed that only a small minority of teachers engaged in active discussions with students while the majority of teachers “performed” one-way lectures, almost word for word from syllabi. The syllabi was largely medical in nature with teachers listing definitions of words for memorization rather than engaging in candid discussions about sexually explicit or “taboo” topics such as abortion, masturbation, condoms, female genital mutilation, etc. Perhaps in theory these teachers felt that they would be comfortable talking to students about these topics but this information has limited usefulness without observations of practice.

While this question was perhaps too vague, additional data in other questions asking about comfort levels or beliefs about discussing more specific aspects of HIV/AIDS showed surprising results. Questions 35-38 intentionally asked about the commonly more “taboo” topics that previous studies had shown teachers often censor from the curriculum. It is interesting to note that while “abortion” and “treatment” were not considered particularly contentious topics, “condoms” were still significantly troublesome for six of the teachers. Yet, the most common fear recorded by those studying sex education worldwide was only felt by two of these teachers. The notion that discussing sex with youth will “encourage” them to practice sex is a pervasive belief preventing teachers from implementing this kind of education worldwide, according to the literature.

I pursued this topic in interviews and a larger number of teachers (though still not the majority) reflected this fear as well and so I argue that while these answers are slightly misleading, the unusually “comfort” felt by teachers is worth noting. While I argue that, given in-person testimony, teachers probably checked “disagree” because they thought it was the “right answer”, this is still not as big of an “attitudinal barrier” to this education

within these schools as previous research suggests.

Table 6: Questions 7-16; 35-38: How do teachers feel about the HIV/AIDS education occurring in their schools?

#	Statement	Blanks	Positives	Percentage
7	I worry about the safety of my students	2	20	74%
8	My students are experimenting with sex	5	14	58%
9	My students are taught all they need to know about sex at home with their families	5	2	8%
10	My students talk about sex and relationships with each other a lot	6	13	57%
11	I feel comfortable talking with students about sex	2	20	74%
12	I know enough about HIV/AIDS and sexual health to give my students good information	2	25	93%
13	I feel that other teachers might be suspicious about me talking with students about HIV/AIDS or sex	4	5	20%
14	I want to help, but it is not my place to talk to students about sex	3	3	12%
15	I wish there was more time and resources to educate my students about sex, health and relationships	2	25	93%
16	Sometimes I feel like no matter what I do, the students will do as they please	5	4	17%
35	If I talk about sex in the classroom, this will encourage them to have more sex	3	2	8%
36	If I talk about how to use condoms, they will be encouraged to have more sex	2	6	22%
37	If I talk about what an abortion is, they will be more likely to get one	3	1	4%
38	If I talk about ART and HAART drugs (that keep you healthy and alive when you are HIV+) then they will think AIDS is not a problem, and have unsafe sex	2	2	7%

RESPONSES ABOUT D/DEAFNESS

During initial interviews and observations, the usefulness of discussing perceived “Deaf stereotypes” became apparent, and were included in this questionnaire. When teachers had discussed “Deaf stereotypes” it was unclear to what extent they meant “Deaf identity”, sign language culture, hearing impairment or other potential aspects of this notion. Therefore the results are qualified as beliefs about “d/Deafness” to denote this

ambiguity³⁶.

Table 7 summarizes the reactions within questionnaires to these statements about d/Deaf behavior. Almost a third of these teachers believe that “Deaf people are more promiscuous” than hearing people and that they are more likely to be HIV+. This is an unusual account that few studies have referenced anywhere in the world, let alone in this region. In addition to these numbers, interviews showed that though most teachers did not “openly” agree with these statements, they did acknowledge that these beliefs were believed by “other” people and had an impact on the culture of the schools as well as this education. Two administrators, in fact, discussed their agreement with all three of these beliefs while knowingly being recorded and one of these administrators discussed his belief that Deaf colleagues working in his school exhibited these behaviors. Many, but not all, Deaf teachers also assumed that or hearing teachers held these beliefs about them.

Table 7: Questions 17-19: To what extent to teachers agree with Deaf “Stereotypes”?

	Question	Blanks	“Yes”	Percent of total
17	Do you agree that "Deaf people are more promiscuous."	0	9	31%
18	Do you agree that "Deaf love to gossip. They cannot keep secrets."?	0	20	69%
19	Do you agree that "Deaf people are HIV+"?	2	8	30%

In the following chapter I review in detail how teachers reflected on these beliefs because their feelings on to what extent these beliefs were “true” and why were useful starting points for getting teachers to discuss underlying issues and beliefs. It allowed teachers to comment on beliefs about d/Deafness that they might feel were “undesirable”

³⁶ It should be made clear that these results do not imply any “actual” behavior amongst d/Deaf people in this region, but rather how teachers believed “the Deaf” behaved.

but without the consequence of appearing to hold these beliefs themselves. It also focused the conversation and promoted reaction to the notion of Deafness as culture or identity.

Like most sections of this questionnaire there was room for added remarks and teachers were more likely to offer an explanation for their answers here than for other questions. All but one teacher chose to explain their responses and less than 3 responses indicated unsure or neutral feelings about the proposed statements. The following table contains teachers written rationale for their disagreement with the statement, “Deaf people are more promiscuous.” This selection is provided because in the following chapter, this belief becomes central to the complex interaction between beliefs about Deafness and HIV/AIDS education.

It is interesting that interviews were more likely to garner an agreement to this statement than written responses. This was expected, as teachers often started out responding to questions in interviews with advocacy-sourced slogans, perhaps wanting to appear to agree with whatever perspective they believed I also had about the topic³⁷. During interviews, however, I made an exceptional effort to elicit more “truthful” responses by showing empathy with the practice of teaching and using the vague statement, “I have heard from other teachers that these stereotypes are true. What do you think about that?” By showing them that I was withholding judgment from others who agreed, they tended to open up more and discuss their true feelings.

In Tables 8-10, I have grouped teachers’ rationale for their responses based on whether or not they agreed with the belief that “the Deaf are more promiscuous”. Within Table 8, the shaded responses highlight the respondent’s ambiguity, calling into question

³⁷ I speculated that because most NGOs and international disability-related initiatives were funded by “western” countries and groups, that they consequently tended to associate these “strong social model”-related beliefs and statements with “westerners” or *mzungus* like myself. They assumed I defined these beliefs (by opposing these “stereotypes”) as “desirable”.

their initial response.

For instance, Participant 41 initially disagreed with this belief circling “No”, but in their comments seems to imply that while the observation of the behavior might be accurate, it is questionable that it is more prevalent amongst Deaf as compared with hearing people. Participants 42 and 50 use similar rationale. While both Deaf and hearing participants used the term “stereotype” and the phrase “the Deaf are promiscuous” they also used the phrases “there is this idea that...” and “the Deaf love sex”. The connotations of each of these statements might be different enough to warrant different responses. While within interviews, I was able to quickly alter my language based on an immediate impression in order to be specific about which word or concept was objectionable, this was impossible within a questionnaire³⁸.

I define these responses as “ambiguous” answers because the question itself proved to be limiting, by only asking whether or not the respondent felt that the behavior was stereotypical, and not systematically asking to what extent teachers agreed with the different sources of this perceived behavior. This nuance, while not particularly useful for policy-makers and practitioners, is extremely interesting from the point of view of those researching social and cultural constructions of Deafness and disability. This point is expounded upon in the subsequent two chapters.

*Table 8: Qualitative responses to those who **disagreed** with Question 17: “Do you agree that ‘Deaf people are more promiscuous.’”*

Participant	“No, I disagree” because...
1	Deaf people like any other group of people have feelings but they too are able to behave properly. To some extent they too have careful thoughts unless one is mentally ill.

³⁸ Some questions eliciting binary responses about these nuances were included in the questionnaire, but they were placed at the end and in a longer list of statements, garnering fewer responses from teachers overall.

2	Deaf people are the same as any-body in society. We can take them individually on other matters. The only category that put them in a single group is the difficulty of hearing and speech.
4	They have relationships like others but when they get disappointed they break their relationships and take too long before they make another of relationships
6	Their body is the same as that of talking people so promiscuity in them can just be same as in speeched persons
15	People who do not understand the deaf tend to think like that but the behavior of the deaf is more or less the same like that of the hearing people. Promiscuity is a fact much with the hearing than the deaf.
18	Not all deaf populations/peoples are promiscuous. There is a population that is promiscuous and it is mainly for money and guest for favors from the hearing populations. When it is Deaf having sex with Deaf (DSD) they believe that they are safe and their partners have no AIDS.
19	The stereotype that "Deaf people are more promiscuous is false since Deaf people are just like human being like their hearing counter-part this assumption is wrong and only aimed abusing Deaf people
21	This maybe a misconception by hearing people but it is not true. The deaf are very assertive people but they just lacks information.
38	It is just a stereotype and it will remain like so. I've interacted quite a lot with Deaf people and I've never seen them be promiscuous
39	Deaf people are not promiscuous as such in fact the ladies fear having relationship with hearing person as they say their one they are sick or pregnant the hearing dupe them
40	Deaf people are not promiscuous as such because if that was the case then there would be no professions like teachers, tutors and even lecturers. The only thing that has contributed to this perception is the negligence that our ancient fathers had about the Deaf, but if more sensitization about the need to educate Deaf people is done, then they are also a group of the people who could contribute to the national income of the country
41	It is just because they lack vital information that people take advantage of their situation
42	The hearing people take Deaf for granted in the sense that they can not express their feeling to them. Hence do not understand them and lure them into sexual activities some by forcing them or even raping them.
43	If the deaf children are given the opportunity to do what they can then they are capable and can excel very well
45	My interaction with the deaf has taught me that the deaf are just as hearing in terms of sexuality
47	- Like hearing people, Deaf people have feelings; They marry more than one wife according to their cultural believes; There are Deaf prostitutes like hearing people. therefore this does not mean that Deaf people are more promiscuous than hearing
49	I don't think that Deaf people are more promiscuous. This is an imagination because they are more free and have friends just general friends and not intimate friends as any other person can have. People just don't understand the psychology of the deaf and that's why they may label them being promiscuous. Well perhaps a few of them could be but the way I understand the Deaf people they are very conscious about themselves.
50	Hearing people think that Deaf are simple. Time you buy them gifts they accept. Some force them into sex or rape them.

In Table 9, responses Participants 3 and 5 both state that they have seen Deaf students have relationships at school, but these do not necessarily offer support for the

Deaf being *more* sexually active. Participants 13 and 20 offer interesting comments that reflect interviews articulating beliefs that social isolation leads Deaf people to “overcompensate” sexually. Participants 20 and 46 imply this “overcompensation” but imply that this is an inherently Deaf trait for some reason.

Table 9: Qualitative responses to those who agreed with Question 17: “Do you agree that ‘Deaf people are more promiscuous.’”

Participant Number	“Yes, I agree” because....
3	There have been many cases of boyfriend and girlfriend relationship
5	Yes, we have many cases of girls falling in love with boys in the school here.
13	The deaf feel they are not wanted in the family, community and in schools. the Deaf themselves think, they are special people and they are in their own world. They don't like advice from other people. For this they face dangers in being infected by HIV/AIDS.
14	The deaf want to experiment with sex to know more about it.
20	The deaf belief that when a lady or woman gives in for sex to another man, that woman is the best woman for sexual intercourse. All other deaf men will go for the one who have accepted sex. The deaf get addicted to sex very easily and coming out or controlling themselves becomes hard. In other words whatever behavior deaf learns becomes very hard to be unlearned.
46	They are more promiscuous because that's the only way they can comfort themselves. And show love to each other. they feel loving to have sex and they belief sex is a way of showing love.
48	Once well advices they follow the advice and can end up being good citizens and succeed in life

In the brief table showing comments to those who responded “neutral”, Participant 8 offers reasons for both answers: on one hand the Deaf “copy others” and are “not well informed” which, they imply, leads to promiscuity. On the other hand, the Deaf are “responsible” and can “understand” and because of this potential, perhaps, this situation is not inherent but a result of low access to information.

On a more practical point, these comments are also useful in that they imply it might better to ask participants to rank the level of “promiscuity” of Deaf individuals and of hearing individuals separately. These latter participants might have argued that “promiscuity” is a wider social problem shared by all, and that Deaf individuals have

been made into “scape-goats” similar to ethnic minorities.

This final comment is extremely useful and is mirrored later by a number of key interviews where teachers agreed that these stereotypes had some truth but that they were less a result of “inherent” Deaf traits or culture and were more a result of social, cultural, political and economic inequalities.

Table 10: Qualitative responses to those who felt neutral about Question 17: “Do you agree that ‘Deaf people are more promiscuous.’”

Participant Number	“I feel neutral” because....
8	YES: Because they would like to do lots of discoveries; they copy others. they are not well informed. NO: They understand, inquisitive and responsible. Need to be well informed so as to take/make informed choices
44	Yes because, before they learnt the reality of life being promiscuous was a privilege. For instance a deaf secretary who practiced prostitution and became a promoter of lesbianism. She said the woman she got married to gave her a lot of money and she has risen from below poverty line and uplifted the parents and her siblings. As a role model to other Deaf, promiscuity became the game. No, Deaf people are not more promiscuous than the hearing. There are many Deaf people who respect themselves and have had a good example.

QUESTIONS ABOUT THE RELATIONSHIP BETWEEN HIV/AIDS EDUCATION AND D/DEAFNESS

The remainder of questions attempted to elicit reactions to statements about how Deafness and HIV/AIDS related to each other. These responses are listed in Table 11. Answers to questions 20, 21, 33 and 34 all received strong majority agreement. These questions were intended to counteract the potentially inaccurate responses of previous, more direct questions on Deaf sexuality. Few people felt that “Deaf people are less sexually active than hearing people” but most people did not feel that they were more so than hearing. Question 24 was included to test to what extent participants understood the wordings of these questions and to break down possible meanings of “promiscuous”. Participants were more likely to disagree with “more sexual partners” than to “are more

sexually active” yet the numbers were not complimentary to the responses of Questions 30 and 31 which in theory should have yielded opposing answers. As I commented earlier, the limitation of these questions is that I did not offer a chance for teachers to record their beliefs about “hearing” people alone.

Some of these questions restate previous questions but with slightly different wording and elicited similar answers such as Question 26 showing that teachers consistently feel that their students are not getting this education at home.

Questions 28, 30 and 31 all received highly ambiguous answers with many participants responding neutrally. This is interesting as compared to other responses because teachers actively communicated their ambiguity here while other questions elicited very consistent “yes” or “no” responses.

The small sample size of these questions makes generalizations difficult but they do show a range of beliefs and attitudes as well as potential difficulties in the language used for elicit responses. If the sample size had been larger, there might be useful correlations between these and other questions.

Table 11: Questions 20-34: Beliefs about Deafness, sexuality and HIV/AIDS

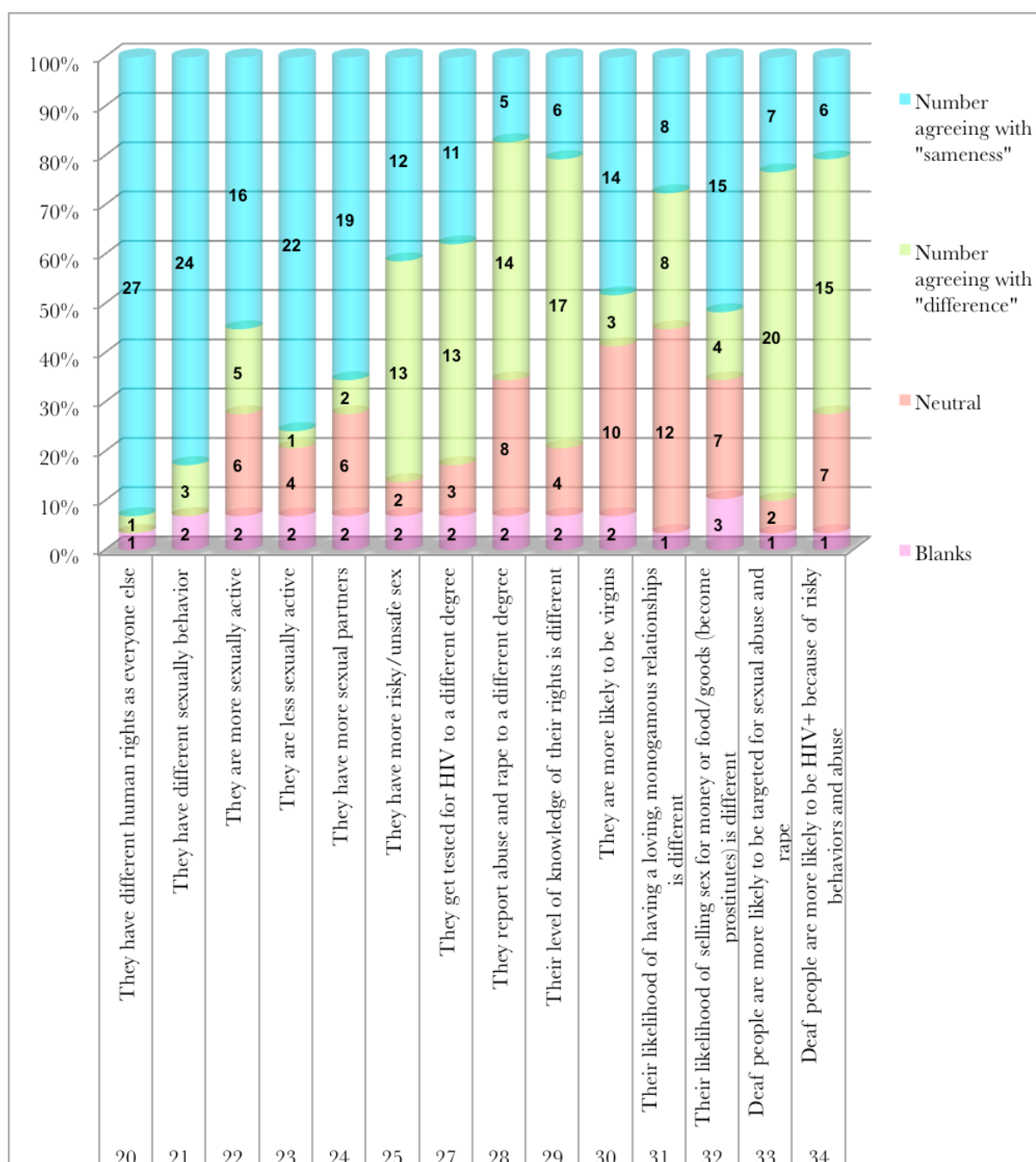
Question	Blanks	Agree	Disagree	±	% agreed
20 Deaf people have the same human rights as everyone else	1	27	1	0	96%
21 Deaf people are just as sexually active as hearing people	2	24	3	0	89%
22 Deaf people are more sexually active than hearing people	2	5	16	6	19%
23 Deaf people are less sexually active than hearing people	2	1	22	4	4%
24 Deaf people have more sexual partners than hearing people	2	2	19	6	7%
25 Deaf people have more risky/unsafe sex than hearing people	2	13	12	2	48%

26	Deaf people get good information about sex or HIV/AIDS from their family	2	1	24	2	4%
27	Deaf people get tested for HIV just as much as hearing people	2	11	13	3	41%
28	Deaf people report rape and abuse when it happens just as much as hearing people do	2	5	14	8	19%
29	Deaf people know their rights just as much as hearing people	2	6	17	4	22%
30	Deaf people are more likely to be virgins	2	3	14	10	11%
31	Deaf people have loving, monogamous relationships	1	8	8	12	29%
32	Deaf people are more likely to sell sex for money or food/goods (become prostitutes)	3	4	15	7	15%
33	Deaf people are targeted for sexual abuse and rape because they are Deaf	1	20	7	2	71%
34	Deaf people are more likely to be HIV+ because of risky behaviors and abuse	1	15	6	7	54%

The following table in Figure 14 displays some of these responses in a different way.

I extracted responses from questions about the Deaf being “the same as” or “different from” hearing people in some way. I hypothesized that the way teachers reflected on these statements revealed nuanced about an underlying belief about Deafness as being “different”. This method of analysis was used in light of the literature presented in the *Methods* chapter highlighting the importance of beliefs about “difference”. Some of these questions posed the notion that the Deaf are “different” because of something while others posted that the Deaf are “the same” because of something. In order to compare these responses I shifted all responses in terms of teachers’ agreement with the notion of “sameness”.

Figure 14: Beliefs about Deafness as “difference” in the context of HIV/AIDS.



Using this format it is easier to see the range of beliefs since the statements are now aligned. It also reveals that questions posing Deafness as different directly might be more accurate than those that implied different but asked directly only about sameness, or vice versa. For instance, question 31 posed the statement, “Deaf people have loving, monogamous relationships,” to which teachers agreed, disagreed, remained neutral or left

blank. This statement implies that if a teacher agreed they were remarking on the sameness of Deaf people but if they disagreed they felt that Deaf people were different because they didn't have these kinds of relationships. It is unclear, however, if the respondent would have then agreed with the statement that "Deaf people have less monogamous, loving relationships" or its complement. This is a shortcoming of this research tool and it reveals that when considering notions of difference versus sameness, such discrepancies become important.

This analysis also shows the importance of offering different alternatives to what might otherwise be assumed to be the same idea. Questions 21-24 break down all possibilities of what people meant by the word "promiscuous" or the phrase "love sex". These responses show that while most teachers felt that the Deaf had a different kind of sexuality, they were in less agreement about whether or not it was hyper- or hyposexual as compared to hearing people. While they were in strong agreement that the Deaf were different because they got less information about HIV/AIDS, they were less agreed upon the resulting consequence of this low level of information: engaging in "risky" sex.

The numbers of responses are too low to make much of these contradictions or trends. The main conclusion I draw from this analysis is that in order to adequately collect trends in how teachers think about these perceived differences, questions need to be even more carefully worded and asked in several ways. This kind of research tool is less useful for the study of these complex beliefs and is more useful for collecting information on the occurrence of educational activities and the comfort level of discussing specific terms and notions.

CONCLUSION

The questionnaire completed by teachers collected data primarily on their beliefs

and attitudes about Deafness, HIV/AIDS education and its relationships. While some conclusions can be drawn about relative comfort levels and beliefs about common “stereotypes”, I argue that this data offers few strong conclusions about the more complex relationships between these notions. It was surprising that, given previous studies, these teachers seems to feel very comfortable with a range of “taboo” subjects and that they were not hindered by a belief that talking about such subjects would increase related behavior in students.

It was also surprising that both hearing and Deaf teachers had a variety of levels of agreement with statements about “Deaf stereotypes”. These results showed that these beliefs were present in all schools and almost all teachers were aware of their presence. Even those that at first disagreed with their representation of reality showed to have more ambiguous feelings once they were allowed to explain themselves.

Another major conclusion from collecting this data and attempting to analyze it for themes and trends was that these terms and phrases seemed to be emotionally charged. Teachers sometimes had a tendency to respond in contradictory ways revealing the possibility that when asked to physically document on paper their beliefs and attitudes, they might be less likely to be honest. I intentionally offered them the chance to respond both expressively (writing out “why”) as well as receptively (checking a box in agreement/disagreement) in order to counteract their potential hesitancy in writing out statements they felt to be “politically incorrect”. This might have worked given how less than a third of teachers agreed with the “stereotype” about Deaf sexuality while slightly more teachers agreed with statements about the Deaf having more sexual partners more often. Though teachers themselves used the term “stereotype”, hence its inclusion in this questionnaire, it still might suggest a stigma that teachers want to avoid associating with.

Finally, these results strongly argue that in order to adequately explore these notions, it is more useful to use different, less limiting methods such as in-depth interviews. The following chapter reviews the experiences and results of these methods that allowed for more maneuvering in and around these tenuous topics.

CHAPTER 6: DATA FROM INTERVIEWS

INTRODUCTION

Initially interviews were planned with teachers to supplement questionnaires and offer perhaps some interesting background on data gathered. However, as some of the first questionnaires came back during pilot study it became clear that many of the more nuanced research questions could not be adequately answered through the more systematic questionnaire tools. This chapter presents the data gathered in these interviews which over time began to focus on notions of difference as underlying the many beliefs and attitudes teachers had about Deafness and HIV/AIDS.

However, each interview tended to start around the discussion point of, “How do you think HIV/AIDS education is different for Deaf students as opposed to hearing students?” While underlying constructions of Deafness as difference became a focus of this study, its initial focus on the ways teachers adapted and changed this education in light of perceptions about Deafness remain here as an analytic tool. Teachers’ responses are groups according to how intimately they were tied to the ways HIV/AIDS education happened or was reflected upon in these schools. Within these sections, however, these

beliefs are further broken down into what extent they were rationalized by statements about Deafness as difference. Even within these groupings of sameness and difference there were sub-groups that are discussed as well. Each categorization is exemplified with a quotation from a teacher's interview or common phrases used by many teachers.

The first section groups responses around the theme of Deafness and sexuality and the stereotype, "The Deaf are more promiscuous". When teachers talked about how they felt about HIV/AIDS education, they most frequently began discussing their beliefs about Deaf sexuality being either the *same* or *different* from hearing sexuality. This group of beliefs more closely tied to the actual practice of HIV/AIDS education and how it teachers changed the materials in some way. It was also the most closely tied to what extent teachers were motivated to teach this education.

The second section groups responses around the theme of Deaf communication. While discussing their reflections on HIV/AIDS education, teachers sometimes discussed how Deaf people were either different or the same as hearing people because of how they communicated with each other. This was both in terms of function (sign language) as well as content (what was being signed). While this was a more common topic of conversation about "Deafness" in general, it was less directly tied, in the minds of teachers, to the practical application of HIV/AIDS education.

The third section reviews teachers' beliefs about general worth and Deaf intelligence. While discussing their reflections on HIV/AIDS education, sometimes teachers described their beliefs in terms of underling beliefs about Deaf intelligence and human worth. This was discussed as being either the *same* or *different* from how hearing intelligence or human worth. Teachers often felt that the wider society and culture valued Deaf people less than hearing people and grouped them with people with intellectual

disabilities and mental illness, which in turn impacted their lives in significant ways. These broader beliefs perceived to be present in “others” had a strong impact on how teachers approached HIV/AIDS education indirectly.

This chapter argues several conclusions. Firstly, the open, in-depth interview was by far the most useful tool for exploring teachers’ range of beliefs about Deafness and HIV/AIDS as well as their individual underlying constructions of Deafness as difference. Paired with questionnaires collecting information on the general occurrence and reactions to this education, these tools offer a well-rounded image of what influences this education and which beliefs and attitudes might be important for further studies and practice.

However, this tool was limited in that I was only able to conduct lengthy interviews with roughly 4-5 teachers at each school. While other teachers and staff were interviewed for less time and with less depth, due to time constraints, those teachers who participated in lengthy interviews were also those teachers who appeared to “care” more about this kind of education, thereby skewing the nature of this data. For this reason, I qualify results from these in-depth interviews with broader trends I found in more cursory interviews and in questionnaire data. This usually supported the results of the in-depth interviews but when I noticed contradiction between these methods they are clearly noted.

BELIEFS ABOUT DEAFNESS, SEXUALITY AND HIV/AIDS

EDUCATION

“HIV/AIDS” education often means “sex education” in these schools, because the primary means of infection is through sexual contact in this region. Though it is not always the case, in my experience, that epidemiology matches pedagogy, I did note this consistent definition.

Interviews during the pilot study with NGO workers focused immediately on the interchangeable statements, “the Deaf love sex”, and, “The Deaf are more promiscuous”. This stereotype was initially found in interviews with adult Deaf women who had some education but who lived in the large, urban slum of Kibera. While NGO workers and these Deaf women made these statements frequently and used them interchangeably, teachers working in schools discussed sexuality in a slightly different way.

Teachers discussed more environmental and social issues that they first offered as their rationale for changing HIV/AIDS education in some way or feeling differently about it as compared to a hearing student population. For instance, abuse and rape of Deaf children was a very common concern and one of the first things many teachers reported as something that motivated implementing this education *more* for their students as compared to a hypothetical hearing population.

Teachers discussed the dangers of student travel to and from the school sites. Most students came from other parts of Kenya requiring at least a day or more of travel at the start and end of each school term, with some students coming from as far as Rwanda and Uganda. Because parents could not always afford to accompany their children, some teachers made a point of warning students to “be safe” and not allow hearing people to abuse and rape them in transit. One woman in her 60s recalled how she worried each school vacation about her teenage female students who she felt were preyed upon by hearing men.

One younger female teacher pointed in the direction of the local stream that during the dry season supplied the students’ bathing water. “I tell them not to walk through the forest because they will rape you” (Participant 60). Later when introducing me to her nursery class she said, “I think [HIV/AIDS education] is very important, yes, because

you see, these little ones, you can tell when they have been raped. They walk funny, so you know they had been abused the night before. When it has happened you can see it, and they need to know these things”.

Such comments were common especially among female teachers who each were required to spend time as “house mothers” during their careers. One clear trend was that HIV/AIDS education was *more* important for Deaf girls in particular due to these risks. For Deaf boys, rape and abuse was also a consideration but HIV/AIDS education was more seen as helping them to ensure their consensual sexual activity was safe.

All segregated schools for the deaf are residential and have a strict rule of no sexual or even romantic relationships permitted among students. Yet each school site hosted students ranging from 4 to 25 years old because students were either repeatedly held back or entered these schools at a later age but enrolled in the “nursery” class regardless. “There are full-grown men running around here and this is a primary school” said one teacher, “and some ask if they can get married. We tell them ‘No, wait till you finish your schooling’, but what can you do? They are grown men!” (Participant 57).

While these comments were certainly interesting and relevant, I remained curious about the strong statements made by the Deaf women of Kibera and the Deaf NGO workers, and often used this segue with teachers: “I have interviewed Deaf and hearing teachers in other parts of Kenya who tell me that there is a stereotype that the ‘Deaf love sex’, and that they are ‘promiscuous’. What do you think about this?” Only some teachers also discussed Deaf sexuality itself as being different in some way either as a result of these kinds of incidents or in spite of them. Regardless of whether or not teachers also felt that they Deaf had a different kind of sexuality themselves, these external influences were strongly felt by teachers as motivators for ensuring this education happened and that it

was effective.

The following sections describe the instances when teachers actively described Deaf sexuality as itself being different in some way to hearing sexuality. There is a subsequent section describing the ways teachers felt strong opposition to these beliefs as well. About one third of teachers agreed with this statement at some point in an interview while the remaining two-thirds still disagreed, arguing that the Deaf had a similar *range* of sexualities or behaviors as hearing people. Still, the perceived presence of these “stereotypes” was something almost all teachers interacted with and reacted to, sometimes by being motivated to “teach well” in order to “prove” these beliefs “wrong”.

“THE DEAF LOVE SEX”: BELIEFS ABOUT DEAF SEXUALITY AS DIFFERENT

“If you give them a choice of food and sex, they will go hungry”, said John, an experienced teacher who was completing his degree in school psychology (Participant 38). John sat in my ‘office’, his back to the window where curious children peeked their heads in through the steel bars watching us talk about his experiences in this and other schools for the Deaf. He was often “on duty” during leisure times and was required to do dormitory “checks” where students’ personal items were checked for contraband. “If you open their bags, condoms just pour out”. Not only did he believe that his Deaf male students were engaging in a lot of consensual sexual activity but they also were *more* safe about this than hearing students because they paid attention to the HIV/AIDS education offered. “You just don’t see Deaf girls getting pregnant by Deaf boys. If a Deaf girl gets pregnant, you know it was a hearing boy”.

Some of his remarks were not uncommon. About a third of the teachers I spoke with felt strongly that the Deaf had more sexual partners than the hearing, and this behavior was part of a “Deaf culture”. This belief was also more likely to come from male

teachers who were more experienced and who had additional responsibilities within the school like this school psychologist. For instance, every teacher but one who self-identified as a school counselor had this belief, and all administrators interviewed also felt this way. The one female administrator available in these schools declined to participate in this study and there were no female teachers who identified as having additional school responsibilities. One female teacher who made similar statements to these taught the “vocational unit”, however, and only worked with older teenage girls (Participant 49).

One administrator never completed a questionnaire but instead sat with me on a concrete slab overlooking the schoolyard one afternoon. Knowing I was recording his testimony, he used a softer voice than usual to describe his beliefs about not only the Deaf students but also the sexuality of some of his own teachers who were Deaf. “It is a problem, yes. They do these things; trade wives. One died from this last year, from doing these things and we all knew. The Deaf, they like to do these things” (Participant 51).

When these teachers talked about their belief in this hypersexuality, the tone made it sound more as a ‘fact of life’ rather than something they stigmatized. Only when discussing their Deaf colleagues such as with the administrator above was this done with a more secretive tone. I asked them why they felt this way or why these things happened, to which they commonly linked the kinds of external “abuses” and situations I initially described in this section as becoming integrated into “Deaf culture”.

Deaf people are mostly introduced to sex even before they start schooling. This is because many people take advantage of their disability to sexually abuse the Deaf child. As the child grows, it this sex is normal (Participant 54).

While many teachers offered these situations as simply reasons to heighten HIV/AIDS education, those teachers that argued the Deaf had an inherently different sexuality did so on the basis that Deaf culture was partially defined by how others treated

the Deaf and how the Deaf reacted to this treatment. Those that changed or heightened HIV/AIDS education in some way based on these contexts without defining Deaf sexuality as different were implicitly arguing that Deaf culture was not necessarily defined in terms of how others treated them. It might also have been the case that these latter teachers felt that Deaf sexuality itself was the same, and that the only sexual behavior that was different was non-consensual, and so it was not part of this sexuality. This difference remains unclear.

Among those teachers who explicitly argued that the Deaf were hypersexual also often argued that it was due to the low self-esteem Deaf girls especially felt because they internalized “hearing oppression”. When Deaf girls grew up without much social interaction even within their families, they internalized the idea that they were “worth less” than their hearing peers. Several teachers argued that this was why they accepted any attention they could get from the hearing peers or elders as validation. Some of the resulting sexual behavior was semi-consensual but it also combined with the tendency for hearing men to target Deaf girls for rape and abuse believing that there were no legal consequences or that the Deaf girls “didn’t care”. “They take anything the men give them,” one teacher said (Participant 7).

Sometimes the way teachers discussed these differences were more complex and are better described as systems of beliefs rather than individual beliefs. One system of beliefs will be explored in more detail later and dealt with how teachers perceived sign language interacted with hearing impairment and Deaf sexuality. One of the first “stereotypes” I collected amongst NGO workers and the Deaf women of Kibera was that the Deaf “love to gossip”. This was sometimes interchanged with the notion that the Deaf “cannot keep secrets”, had no understanding of “confidentiality” as well as having no

“taboos”.

Initially this seemed important to those people attempting to talk about HIV/AIDS in Deaf community groups which required confidentiality and the promise not to “gossip” about what was said during these meetings. Educators had to alter their curriculum to include more time spent on discussing the meaning of “confidentiality” with the Deaf than with hearing people. Later within the schools I found that these beliefs were also tied to how some teachers perceived Deaf sexuality in as different.

For instance, there was a common belief that one of the main topics of conversation amongst the Deaf was sexual activity, and that the Deaf passed much of their time describing to each other what it was like to have sex with a specific person. This in turn generated excitement between friends about this other person, inciting desire to ‘go after’ them. This could be amongst men/boys or women/girls, but was always about the opposite sex. Homosexual or bisexual relationships were heavily stigmatized, except for one female Deaf teacher who remarked on having gay and lesbian friends. One hearing teacher said,

The Deaf believe that when lady or woman gives in for sex to another man, that woman is the best woman for sexual intercourse. All other Deaf men will go for [that woman]. The Deaf get addicted to sex very easily and...controlling themselves becomes hard. In other words, whatever behavior Deaf learns becomes very hard to be unlearned. (Participant 20).

Another teacher said, “Because the Deaf are visual, [they are] very much interested in stories on sex. When an individual is talking about sex, they seem to be more elated than other topics” (Participant 44).

One Deaf teacher described Deaf sexuality in terms of food and taste. “Most of us

feel [that having sex with only] one partner daily is like feeding on ugali with kale daily.”³⁹

This belief was much more likely to be shared by both hearing and Deaf teachers.

However, it was also discussed separately from any belief about Deaf sexuality as different, with “gossip”, “no secrets”, and “no taboos” being a much more common set of beliefs.

“THE DEAF ARE CHASTE”: BELIEFS ABOUT DEAF SEXUALITY AS DIFFERENT

There were roughly 1-2 teachers per school who argued that the Deaf, especially Deaf women, were *less* sexually active than hearing people. This belief of Deafness as difference, in this case highlighted by a belief of hyposexuality, revealed some interesting underlying beliefs about the nature of schooling and impairment.

"Deaf women are the most chaste. They are faithful; they abstain. They will be faithful for life," one teacher commented (Participant 49). Teachers that felt this way often said that this was because in school the Deaf learned how to behave “properly” and that because they had more “discipline” than the hearing, they ended up following “rules” better.

In this sense, formal schooling was seen as a tool for ‘normalizing’ the Deaf, and promoting ‘proper’ behavior which seemed to be equated to hearing behavior. These few teachers described Deaf children as coming to school like “blank slates” who, unlike hearing children, did not have the outside influences of being able to talk with family and friends. These teachers perceived the communication barrier these children lived with in

³⁹ *Ugali* is a white cornmeal (maize) paste eaten in large quantities in almost every meal, filling the stomach and providing energy. While not precisely ‘tasty,’ it is filling and a staple of the diet in this region, alongside cooked kale (dark, leafy greens) that have been stewed with salt, spices and cream-rich milk. A common slang term for the kale dish translates to ‘*just gets you by.*’

the community and in their home village as an opportunity to be the only influence in their lives.

This prompted me to ask about children who never attended school. Did being Deaf also mean being “chaste” and “virtuous” for them? They would immediately qualify their answer, with one teachers replying that, “these village Deaf have not learned proper behavior and are just like that” (Participant 61). I therefore quickly learned to be specific when I asked about Deaf sexuality and behavior, asking about what they called “educated Deaf” and “village Deaf” as different groups.

These teachers were implicitly describing Deaf culture as being something that was only cultivated within schools for the Deaf. “Educated Deaf” shared a culture while “village Deaf” had behaviors that were a result of not learning how to “behave properly”, but this was not a culture. These teachers were not representative of the entire sample but in each school someone articulated these beliefs and did so with strong conviction. These were also teachers who actively sought out additional HIV/AIDS education resources for their students and offered physical evidence of these activities. No Deaf teacher articulated these beliefs and when I asked other teachers about such beliefs they were commonly dismissed as “lack of awareness” by both hearing and Deaf participants.

BELIEFS ABOUT “DEAF SEXUALITY” AS THE SAME

About half of the teachers felt that the Deaf had relatively similar sexual behaviors as the hearing. When asked about this stereotype, most teachers simply said that each person is different, so some Deaf are “promiscuous” like some hearing are as well, and vice versa.

When asked why such a belief was present in “others” they often felt that “lack of awareness” or experience with Deaf culture was the problem. I would tell them that

occasionally Deaf people would tell me these things themselves. To this they would begin to qualify their answers referencing some of the external influences like abuse and rape. While a minority of teachers used these situations to argue that Deaf culture integrated these experiences resulting in a hypersexuality, the majority of teachers did not. Rather, they argued that indeed these “unfortunate” realities were a significant influence on how they approached and implemented HIV/AIDS education, but in the hopes of neutralizing them. Part of why these realities existed, they argued, was that most students had little knowledge of their human rights, had less education and little to no ability to communicate with most hearing people, and most hearing people stigmatized the Deaf in multiple ways. These were all preventable situations that better HIV/AIDS education, as part of better education in general, was meant to ameliorate. Many teachers identified with this motivation and felt that they as educators of the Deaf had a unique role in their communities.

A few teachers also remarked on why they felt such beliefs about hypersexuality existed in “others”. At one school site there were some teachers who had been placed there by the U.S. Peace Corps and one woman was teaching the HIV/AIDS unit as part of her science course. During a lunch with three of these Americans I asked the group the same questions I asked Kenyan teachers. They agreed that in general the Deaf “love sex” and seemed to “get around,” but the secondary teacher qualified this by saying that it was “more of a Kenyan problem than a Deaf problem” feeling that the Deaf were being blamed for a common social problem.

Three other Kenyan teachers made this same argument, that the Deaf are “oppressed this way by the hearing” and though they shared the same “problematic” sexual behaviors, they were stigmatized for it.

In summary, beliefs about Deaf sexuality were mixed. Many teachers felt that the Deaf were more likely to be hyper-sexual, with a smaller number of teachers feeling they were hyposexual. Though there was little consensus across most teachers about Deaf sexuality, almost all teachers had strong feelings about to what extent the Deaf were hyper-, hypo- or similarly sexual as compared to hearing people⁴⁰. These strong feelings, in turn, either motivated them to teach HIV/AIDS education *more or more efficiently* if possible. Sometimes the way they perceived Deaf sexuality altered the way they implemented this education. This will be discussed in greater detail in the *Discussion* chapter because I argue that it illustrates some of the current theoretical debates about Deafness and disability in recent literature.

WHAT BELIEFS DO TEACHERS HAVE ABOUT DEAF COMMUNICATION AND SIGN LANGUAGE?

While beliefs about Deaf sexuality were more directly tied to HIV/AIDS education practices, beliefs about Deaf communication were more consistent amongst the entire teacher population. Teachers differentiated Deaf culture not only by its use of sign language but also because they often believed that content of Deaf conversation was different from hearing conversations. As introduced in the previous section, Deaf culture was strongly linked to “no secrets” and a lack of “confidentiality,” “gossip”, and “no taboo”. It was also consistently argued that these aspects of Deaf culture were not

⁴⁰ While *hypersexuality* is a commonly used term in the reviewed literature to describe the belief that someone with a disability has little to no self restraint with their sexuality, there is rarely reference to its compliment: *hyposexuality*. Yet this belief or experience was described both in the literature and by my own participants. *Hyposexuality* has traditionally been pathologized in the literature on Mental Health, in such clinical guides as the *Handbook of Clinical Sexuality for Mental Health Professionals* (Levine, Risen and Althof, 2010), though rarely is its social construction explored. For the purposes of this study, *hyposexuality* is a term used to group the beliefs and attitudes of teachers who argued that Deaf students has a different sexuality from hearing students marked by a lack of interest in the opposite sex, sexual activity or discussions about sex.

necessarily inherent but a result of the “communication” barrier between hearing and Deaf people and its resulting consequences on Deaf life. These beliefs were complex with teachers discussing the impact of economics, culture, social structures and the environment, making these better describes as belief *systems*.

During interviews about teacher’s experiences with HIV/AIDS education, the conversation would almost always drift into a discussion about Deaf communication. Over two-thirds of teachers discussed Deaf communication in terms of difference. Within the following sections I summarize these belief systems first by describing how difference was rationalized. Sometimes teachers focused on the perceived implications of using the manual mode of sign language. Other teachers discussed Deaf communication as different in terms of the stereotypes about “gossip” and “no taboo”. While sometimes they were described discretely, it was much more common for these to have interrelationships with each other as well as with wider influences.

These perceptions were described with different tones as well. A large portion of hearing teachers “romanticized” these differences as making the Deaf inherently “better” than the hearing, especially within the culture of schooling. Others felt that these differences were undesirable and led to negative consequences. I also summarize how these different *tones* impacted how teachers approached and implements HIV/AIDS education in different ways.

BELIEFS ABOUT SIGN LANGUAGE AS DIFFERENT

I tried to ask every teacher the question that is also at the start of the questionnaire: “How long have you been teaching in schools for the deaf, and how did you first come to work with the Deaf?” This wasn’t central to my research questions but rather it allowed teachers to share something personal and usually positive with me. After analysis I found

that some of these results actually helped to better understand the belief systems around Deaf communication and tangentially how HIV/AIDS was approached and implemented.

Many of these teachers cited a Deaf individual in their childhood: a neighbor, a cousin, or later in life some discussed a niece or their own child having some level of hearing loss. The use of sign language was something that drew many of the hearing teachers to become Special Education teachers in these schools. Some were “curious” about this different kind of language while others simply wanted to be able to communicate with a loved one. Interest and curiosity about sign language was pathway to teaching the deaf, learning about Deaf culture and the Deaf community.

“In the early sixties I lived in a village with a deaf cousin...we played together using natural signs,” recalled an older female teacher, (Participant 7), sitting in her nursery level classroom on very low, wooden seats. She had worked at this school site for over 34 years. She came here for Catechism and when later she was baptized she saw the Deaf children using sign language, “got interested in how they talk.” After completing her Special Education teacher training, she requested to be transferred back to this school site, and since then has taught all levels as well as being the school guidance counselor.

Another teacher at a different school site smiled as she proudly described the dancing abilities of her students, saying that a few years back she had attended a regional music and dance competition with her old school, a regular school without provision for special education (Participant 20). She was amazed and curious about how children who were Deaf could be competitive and even win awards in dance though they had hearing impairments, and she became even more interested when she saw the ease with which they communicated to each other through sign language. Later requested transfer to a

school for the deaf and learned sign language on the job.

These stories were somewhat common, though without systematically asking each teacher about these routes I cannot conclude if this was the majority or just a vocal minority. Fourteen teachers out of 31 asked said they had over 10 years of experience and this was also the mean number of years experience. Startled by this trend I asked if this was common⁴¹. “It’s a very good job. If you get it, you keep it,” she replied (Participant 60).

Though hearing teachers initially found sign language interesting, novel even, I asked them about how using sign language made communication *different*. Responses were sometimes contradictory, with hearing teachers at first saying that there was no difference. “It is the same as with us, this language. They can do like is. They are able” (Participant 20).

However these same teachers shared anecdotes that made me feel that these advocacy-sounding statements were shallow. Specifically when asked about how HIV/AIDS education might need to be different for the Deaf, they told me stories or examples that revealed beliefs about sign language as inherently different in some way to oral languages.

One major difference was that they felt it was impossible to keep secrets or be “sly” with sign language. This difference was seen as both a negative and positive quality by teachers and it was a very consistent belief. Teachers felt this trait was “desirable” because it made some teachers feel that their students could never lied to them and were innately more “honest”. They witnessed students signing words and ideas that for them felt “taboo”, especially sexually explicit topics. Teachers then interpreted this to mean that

⁴¹ In the U.S. turnover in Special Education is extremely high, with an average of 2-3 years per teacher staying in the profession.

the students felt no “taboo” or “shame” about talking about such concepts, and this was then projected onto Deaf culture in general. A relationship with HIV/AIDS education manifested in two ways. First, this meant many teachers across all schools, genders and experience levels felt that teaching HIV/AIDS education was *easier* and more “comfortable” with Deaf children because there were no “taboos”.

The American Peace Corps teacher recalled that within her secondary classroom of all girls she noticed this belief amongst the hearing students who were included. “They are more likely to ask questions about sex in the class with the Deaf girls; they feel more comfortable.”

Feeling that the students were “comfortable” discussing explicit topics helped teachers to shed these feelings. This is a unique finding that is exceptionally important for the study of sex and HIV/AIDS-related education in this region because there is little record of any such pervasive beliefs being linked to a group of people, let alone a “higher risk group”.

Secondly, teachers projected the “ability” for students to talk about sexually explicit topics without “shame” or “taboo” as meaning that Deaf culture inherently embraced these topics. This was linked to the perception that all Deaf people “gossiped” about was sexual exploits.

When I asked Deaf teachers about this supposed *difference*, it was often rejected. One Deaf teacher showed me examples of how to sign “in whisper” or more discreetly and talked about “code signs” they used to be “sly.” “The hearing that think these things just don’t know signs that well, so they only see the obvious signs and think that’s all that’s being said” one staff member dismissed (Participant 17).

While Deaf teachers dismissed the belief that Deaf people had no “taboo” but

rather felt that this was hearing teachers' lack of sign language fluency, over half of Deaf participants agreed that "gossip" was central to their culture.

These beliefs culminated in the stereotype, "The Deaf love to gossip". I would sometimes ask teachers to, "Tell me what it means to be Deaf" or "Tell me about Deaf culture". The two things they would say the most were "They love their language" and "They love to gossip." This idea of "gossip" was strongly linked to the idea of not being able to keep secrets and being "open". One Deaf teacher wrote,

The Deaf love to gossip and for them it is the hardest to keep a secret. For instance, if you find yourself in the wrong side of the law or have a family issue and a Deaf friend gets wind of the same, you surely [will] end up the talk of the town for several days, and thus spread miles away from your settlement.

Keeping a secret is difficult, for example when a Deaf man has had sex with a Deaf girl, the same guy will not quit but tell any Deaf person he meets about how the game was. Hence the Deaf girl becomes a laughing stock (Participant 37).

One Deaf teacher wrote the following response into their questionnaire: "Not all Deaf [cannot keep secrets]. We are just like any human being. We do sins just like others...just like hearing people, most of them don't keep secrets" (Participant 23).

Another wrote, "I disagree! Both are the same, period! I have experienced the same way with both hearing and Deaf so anyone [can be the] same [or] different in many ways. Both can gossip ...or keep to themselves," (Participant 24).

I asked teachers why they felt this belief existed with so many teachers if they themselves disagreed revealing an interesting network of beliefs about external influences to Deaf culture.

The stereotype only comes [from how] the Deaf are usually deprived of news, so whatever information that comes their way, they would like to share it either to confirm the validity or as a way of getting more [information] (Participant 26).

One hearing teacher said to me, "[I disagree with this stereotype because] the

major problem is the language. Many of us are informed but not good enough in signing. This hinders information-giving and receiving,” (Participant 8).

These teachers felt that the limited options for sign language-based communication meant that what might be perceived as “gossip” might be in fact a more neutral ‘information-gathering’ method. One woman NGO worker and ex-teacher replied, “The deaf, because they don’t hear...[they] lack information they need, [so they] get the information from the people around... I think it encourages a lot of gossip” (Participant 80).

Some teachers agreed that the Deaf “gossiped” but that this was just as likely to be true among hearing people. As with sexuality, some teachers felt that this belief was a way of making the Deaf into “scapegoats” highlighting a problem amongst everyone⁴².

THE RELATIONSHIP BETWEEN BELIEFS ABOUT DEAF COMMUNICATION AND SCHOOL CULTURE

Teachers discussed the complex relationships between these beliefs and school culture and structure. Many hearing teachers thought that being ‘unable to lie’ but more likely to ‘gossip’ was highly “desirable” within their school culture of strict rules, especially about sexual conduct. Some hearing teachers felt strongly that school rules were *easier* to enforce because their students were more likely to know what was going on with each other and were more likely to tell teachers and staff the truth.

This had two relevant consequences. First, some teachers who had more communication with students learned about these sexual exploits but also had open

⁴² Three teachers out of the entire 81 participants told me that there was also a stereotype that the Deaf were “gluttons”. One of these teachers felt that the two beliefs had parallel origins and used this as a way of negating the stereotype about “gossip”: they were weaknesses in most culture but exaggerated for the Deaf because of the overall stigma associated with this group (Participant 32).

communication about safer sex practices and felt that they quickly saw how their efforts were successful in changing student behavior. One example of this is the teacher quoted earlier who reported seeing dozens of condoms “falling out” of students personal bags.

Secondly, many teachers had limited sign language skills and less trust from the students (according to both them and other teachers). Yet they felt that what they did learn from the students about alleged sexual behavior was “fact” because these students were “more honest” and unlike hearing students they “could not lie”. Therefore when there were no rule infringements being reported, many teachers avowed that their students were, therefore, following all the rules. This was then interpreted as their students being more ‘prudent,’ ‘disciplined,’ and even ‘chaste.’ “Our students love God; they are not doing these things” (Participant 62).

“If you tell them to wake up at 5am, just once, they will do it forever. They have that in their heads forever. They are disciplined like that [because] all they have is sight so they believe whatever they are told and they do it” (Participant 20). This particular teacher explicitly argued that there was a physical difference in the head’s of Deaf people that was the biological cause for this difference, placing her hand on the skull of a nearby young girl and pointing to an apparent bump, which I myself could not discern.

Not all teachers agreed with this, and some hearing teachers felt that they were not being told the entire truth because Deaf students did not trust them completely and instead only confided with Deaf teachers. A few hearing teachers who identified themselves as fluent in sign language and as Deaf advocates also agreed with this and felt that students would tell them more things than non-fluent hearing teachers, but still not as much as Deaf teachers.

They have more confidence in the Deaf adults. They would rather go and share their problems with them. I even see it here in this classroom. They

would rather go to my deaf assistant because they are deaf. They run to them. I then interview them and that's how I find out the problem (Participant 61).

This teacher was older, experienced and worked as both a vocational teacher for older students as well as a guidance counselor, implementing health education. She lamented about how the students would not trust her with personal information though she wanted to help, but also professed that students completely adhered to all school rules because the deaf were more 'chaste,' 'disciplined' and "Godly" than the hearing students. Within the same conversation, however, she related a very personal story about one of her students becoming pregnant and leaving school once before⁴³.

As some of the previous research suggests, some teachers felt that sign language was functionally different from oral languages and therefore Deaf communication was less useful as well. Sign language was sometimes seen as less useful for conveying complex and theoretical ideas than oral language. Feelings about this were mixed with some teachers arguing that this belief was a manifestation of low-fluency among hearing teachers as well as low expectations of students. One visual example of this was included in the first data chapter, but interviews also reflected this belief amongst a minority of teachers.

One Deaf teacher wrote, "Most hearing teachers are unable to pass good information to deaf students because they are not competent in KSL and they don't understand Deaf culture" (Participant 52).

I was careful to compare how teachers remarked on sign language with observations of their use of sign language with students. While my own abilities in sign language were limited, I could, nevertheless, tell when a teacher was using Signed Exact English and not KSL, or as was more often the case, relying on lip-reading and the

⁴³ I realized about 5 minutes into this story that this very students was sitting only feet from us. Since we were using only oral language the teacher assumed the student was unaware her teacher was divulging personal information to me.

interpretation of one or two hard-of-hearing students.

One very young teacher working part time and with no training was learning sign language on the job and asked if I would come and observe her class. Her assignment was to teach English to Year 2 (young men ranging 16-19 years old). She taught orally and expected that one young man in the front row who used a hearing aid would interpret what he could to the class. The topic on this day was English suffixes. She wrote three examples of the suffix “-ate” on the chalkboard and instructed the class to use dictionaries to find 10 more.

I myself found her terms confusing and since I personally have a bachelor’s degree in English Literature was deeply suspicious to what extent the young man could successfully interpret for her. I asked him a few questions in sign as well as writing them, and discovered that when she said “letter” he was interpreting this as a physical piece of paper stamped to be mailed, not a phonetic written unit in language such as the letter ‘A’. Before much more could be discussed, the bell rang and class was over⁴⁴. On our way out the door she confidently said, “You see? They are just slower. Things take longer. If this was a hearing class, they would have gotten it” (Participant 6).

This encounter was relatively unique to my experiences in these school sites and most teachers, if lacking fluency, were willing to admit that their limitations impacted on student achievement. Yet this is the kind of practice that the few studies on sign language and education in this region report is the norm. I found the situation to be less monogamous than these reports claim, but this is a tenuous observation given my limitations.

At one site, a Deaf teacher offered early morning courses to supplement the

⁴⁴ I learned quickly that these bells, clearly, were for the benefit of the hearing teachers alone.

teachers' fluency in sign language. Teachers could bring in words from future lesson plans and get them interpreted by this teacher for better instruction. I observed Deaf teachers socializing during off hours with hearing teachers engaged purely in sign language and Deaf children approaching some hearing teachers in signs that I did not understand.

Still, it was apparent that there were prevalent beliefs about Deaf communication and sign language as being "lesser" to hearing equivalents. One participant of this study was the first Deaf teacher to complete teacher training in the 90s and did so without sign language interpretation or support. He continues to take an active role in HIV/AIDS and related education within his school as well. He related experiences in teacher training courses where instructors warned student teachers that the Deaf students could only be expected to score about 20%. After he himself scored relatively well in class he felt that a "change in the attitude" began amongst his colleagues. Another Deaf teacher who had completed his bachelor's degree in Special Education, a feat rare amongst even the hearing teachers, commented on the low academic achievement of most Deaf students.

...The majority of Deaf students perform dismally...for lack of Deaf role models who are well educated like me. [There is] this stereotype [that the] deaf are stupid or illiterate yet they are not to blame. The government is not doing enough to [give] them adequate learning facilities (Participant 27).

These latter beliefs linking low educational performance to intelligence and general worth were related to a group of beliefs I summarize in the next section. However, beliefs about Deaf communication as different were the most complex, making them more systems of beliefs rather than individual ones. They relied on underlying beliefs about sign language or Deaf culture as different, but these were both stigmatized and romanticized by teachers because of their perceived interactions with school culture and HIV/AIDS education.

HOW DO THESE TEACHERS DISCUSS DEAFNESS IN TERMS OF INTELLIGENCE?

This section presents quotations on how teachers discussed Deaf people as being either *different* or the *same* as hearing in terms of intelligence and general worth. These beliefs and attitudes were not as directly tied to experiences with HIV/AIDS education but they were central to most interviews and important to the participants. They do reveal some of the themes in how teachers conceptualized being Deaf in this context and offer insight into wider beliefs about disability that interact with Deafness in this context.

‘AM DEAF, NOT STUPID’: REJECTING THE BELIEF THAT THE DEAF ARE DIFFERENT INTELLECTUALLY

If you are a hearing person and visiting a school for the deaf in Kenya, one of the first things you will be told is that “the Deaf are *not* stupid”; “the Deaf *can* achieve”; “the Deaf *can* learn”. These statements are posted on bulletin boards, painted into signs leading into the schools and even printed on the t-shirts worn by teachers.

These statements were repeated to me consistently in almost every conversation I had with hearing teachers. It was a constant rejection of stigma against the Deaf based on a belief that the deaf are less intellectually capable than hearing people. The teachers who themselves are Deaf would also reject this belief.

This group of beliefs was different from those about sexuality or communication in that teachers almost universally rejected a perceived belief of *difference* from “others.”

Deaf people are the same as anybody. We can take them individually on other matters (Participant 2).

Deaf people experience same biological processes involved in daily life. The only difference is that they are unable to give a vocal speech (Participant 6).

[Deaf] are not lower than the hearing - people forget that there are also

hearing [people] who cannot learn...just like the same.

We are just like any human-being. We have sense just like any other person. We know when we are hungry, feel toilet, know how to bathe, we can also sense when danger is about to attack (Participant 23).

This last teacher wrote in her response the following statement. “I am proud to be Deaf because this I see [as] no different. I am just special and wonderful.”(Participant 29). These quotations represent a trend in the ways teachers invoked *sameness* when discussing intellectual capacity; the idea that the Deaf body was linked to intelligence and an overall human worth. Some teachers including those that were Deaf laughed about ‘others’ questioning whether or not a Deaf person could have children, or engaged in other basic physical human acts in the same way.

These statements affirming *sameness* were more spontaneous, with teachers expressing a sense of pride about who they are or what they do. Rejecting the alternative belief that the Deaf were less intelligent came about both spontaneously as well as direct and indirect interview questions.

The two opposing beliefs were often discussed at the same time, affirming *sameness* as a rejection of *difference*. Rather than rationalizing these beliefs with anecdotes or other underlying beliefs, the way beliefs about difference had been, these were simply contradictions. One young Deaf teacher still in training but volunteering part time in a school used both vocal language and signs to communicate with me his feelings about being called “primitive.”

Deaf people are not primitive! I accept nothing! I have normal brain! ... The problem [is] with the Deaf who are in the villages who do not go to school; they do not understand, but the Deaf in the school do. The Deaf have their own minds. They are normal people. They simply [use sign language] to learn things, but they are not primitive (Participant 1).

Beliefs about the Deaf as being intellectually *different* was described with words like “primitive,” “mad,” “abnormal,” or “daft.” What I found interesting was that in the

culture of schooling, the stigma of mental illness, intellectual disability, and physical disability all seemed to be conflated, and equated with general human worth. The term ‘daft’ especially was used to describe a kind of intellectual inferiority mixed with mental illness that constituted being less-human.

This resulted in a slogan-like saying that NGO workers would use to summarize their efforts: “They are *deaf*, not *daft*.” When signed in KSL, the word “Deaf” is a gentle pat on the hear and “daft” is like a salute to the temple with a slight wiggle pushing the hand in a couple times into the side of the head. When signed together it makes for an elegantly simple phrase; a poetic play on words.

One experienced Deaf teacher, using the pseudonym Jeremiah, used the ‘daft’ sign while orally saying the word ‘*buubu*.’ Fina later interpreted ‘*buubu*’ for me as “just what they call ‘Deaf’ in the village.” While she felt this was a neutral, Kiswahili term for deafness or hearing impairment, the teacher used the term with a strong derogatory connotation, almost a slur.

According to Mbugua, (2007), it is originally a Gĩkũyũ word meaning ‘one who does not speak,’ but that often includes deafness and can be derogatory when used casually. ‘*Buubu*’ came up sometimes in other conversations so perhaps if I had been fluent in KiSwahili or Luo teachers might have been used more.

A lot time ago they just used to think [a Deaf person can] only eat and sleep, so they could just be a watchman...the stereotyping is there among the hearing where they call the Deaf, ‘*buubu*.’ They believe that the deaf person cannot talk; [their] mind is not working. They think that we cannot access education so they ignore us but slowly they are thinking differently because they see some are employed so they begin to take children to school and changing [their] attitude (Participant 80).

When Fina helped interpret some of these interviews, she was stunned the disdain for this word and the preference for the English word “Deaf” (vocalized) and what she felt

was a more “Westernized” sign for “Deaf.”

She concluded that though the words and signs *ought* to have the same meaning but were associate with stigma because they were more often used by ‘villagers’ who were more likely to treat Jeremiah and other Deaf people badly.

On the other hand, people who used English words and ASL signs also tended to have more formal education on Deaf issues and sign languages. These people probably treated Jeremiah better and so terms in English or ASL had a more neutral or positive connotation. To be ‘*buubu*’ was to be *different* holistically whereas to be “deaf” was to simply use a different language but overall be equal or the *same*.

I include this summary of these beliefs of sameness for several reasons. Though they were not used to rationalize how teachers changed HIV/AIDS education as other belief systems did, these statements were used to rationalize the sheer inclusion of whatever education hearing children were receiving. These statements also reveal that beliefs about sameness were less supported by experiences or beliefs, but as a baseline understanding and “norm” that had yet to be “proven wrong”. When teachers talked about Deafness in terms of difference they used concrete examples but when they argued sameness it was because there were no examples to prove otherwise.

CONCLUSION

There were differences in the consistency of these beliefs across the entire sampled teacher population, how strongly they were felt and to what extent they directly related to HIV/AIDS. About one third of teachers argued that the Deaf had a different kind of sexuality from the hearing and this was more strongly associated with some kind of change to how HIV/AIDS was taught. Beliefs about Deaf communication as different were far more prevalent, but while these had a distal interaction with HIV/AIDS

education, it was less apparent. Finally, the strongest set of beliefs was about Deaf human worth and intelligence, but this had the weakest relationship with HIV/AIDS education though it still interacted with it to some degree.

The most interesting conclusions from this data are those that are not reflected in literature on HIV/AIDS education in this region or sex education and people with disabilities elsewhere. First, other studies on teachers attitude and beliefs about HIV/AIDS education in this region do not specify to what extent any schools for the deaf were included, let alone if this ‘variable’ altered data. This data strongly supports the conclusion that it does, though not in a uniform way.

Of those teachers most interested in HIV/AIDS education there were also strong beliefs about Deaf sexuality as different. Teachers sometimes felt that Deaf culture was marked by hypersexuality, often from a combination of learned behaviors from abusers as well as lower self-esteem. This was sometimes linked to the belief that the Deaf loved to “gossip” especially about sexual activity. There were some teachers, however, who felt that the Deaf were more “chaste” because schooling had “normalized” them to more “proper” behavior. They felt that the Deaf were more “disciplined” than the hearing because they had limited understanding as well as being more “honest” and “unable to lie.”

Much of the literature on Deafness and HIV/AIDS discuss the “lack of Deaf-friendly education” in existence (Bat-Chava, Martin, and Kosciw; 2005; Bisol et al., 2008; Groce, Yousafzai, and Van der Maas, 2007; Hanass-Hancock, 2009; Hanass-Hancock and Satande, 2010; Osowole and Oladebo, 2004; Peinkofer, 1994; Taegtmeyer et al., 2009; Touka, Mbua and Tohmuntain and Perrot, 2010). Yet these interviews showed that not only was there a range of beliefs and abilities with sign language but that the

content of Deaf communication itself was something teachers “adapted” for. This alters the potential definition of what “Deaf-friendly” HIV/AIDS education means for teachers. Some felt that it required changes to the curriculum based on related beliefs about sign language or Deaf culture.

One of the most unique findings was that one consistent belief across teachers and schools was that the Deaf were “easier” to teach otherwise “taboo” subjects within HIV/AIDS education. Teachers were much more “comfortable” discussing these topics with Deaf students as compared with hearing students, something that those studying teachers’ attitudes and beliefs about HIV/AIDS education in this region might find unusual.

After this analysis, many of the beliefs and attitudes about HIV/AIDS education revealed to be based on deeper beliefs about Deafness. Those beliefs that influenced teachers to change the curriculum in some way or alter their methods tended to be based on beliefs about the Deaf being *different* in some way. The use of *difference* in this analysis was extremely useful in separating the different attitudes and beliefs without presupposing desirability, as the following chapter will discuss further.

CHAPTER 7: DISCUSSION: TOWARDS A *SITUATED* *CONSTRUCTION OF DEAFNESS*

INTRODUCTION

Those studying HIV/AIDS education, especially for people with disabilities or the Deaf, will find many of the conclusions drawn in the last three chapters to be interesting and useful. I also argue that the most interesting conclusion drawn from this data deals with theories of Deafness itself. The ways teachers reflected on HIV/AIDS education and how they feel it should be implemented for Deaf students revealed complex underlying beliefs and, at times, systems of beliefs. It was also interesting that there was little consistency to these beliefs, or as I argue in this chapter, *constructions* of Deafness. Certainly there were themes within the data but the overall conclusion was that there was no one way of constructing either Deafness as a way of being or as a culture. The impact that

these constructions had on HIV/AIDS was equally as varied.

First, I continue my analysis of this data to explore in greater depth how teachers rationalized beliefs about Deafness as *difference*. I use Shakespeare and Watson's framework of disability to reveal different ways teachers conceptualized Deafness by privileging different influences. Beliefs about Deaf sexuality are used to explore this potential because they were more closely linked to how teachers reflected on HIV/AIDS education. This analysis supports the use of what I call a "situated constructed of Deafness" that references several theorists.

Finally this chapter offers some thoughts on the limitations of this research. While these results were extremely interesting, there is little that can be generalized or compared because of the small sample. Future research should take note of specific challenges and improve upon the methods used within this study, especially in terms of the wording of questions in questionnaire.

SUPPORT FOR A SITUATED CONSTRUCTION OF DEAFNESS

It was easier to analyze this data in search for when teachers talked about changing HIV/AIDS education for the Deaf in some way, or were differently motivated to implement this education. What was extremely challenging was to consider these varied reflections, especially when teachers offered rationale for their reflections, given the current debates about Deafness and disability. If I attempted to apply any one theory it often made it difficult to reconcile some of the more complex statements made by teachers that, as this section argues, manipulated a range of constructions.

THOMAS' SOCIAL RELATIONAL PERSPECTIVE

This study highlighted the usefulness of exploring the complex beliefs about

HIV/AIDS, education and “Deafness” through teachers’ reflections on their interactions with students and this curriculum. Thomas has argued that this is because disability is a relationship that takes place in the interactions between people in a given time and place (2004, 2006, 2007, 2009). Thomas’ *social relational* perspective focuses on the interactions between people with disabilities and other people in their lives, often whose power limits the lives of people with disabilities through “ableism”.

This perspective is limited when used by itself to explore Deafness because of its reliance on assuming the presence of “ableism” and stigma. I found that there were many cases where teachers were not consciously stigmatizing their students with “ableistic” beliefs. For instance teachers often describes “Deafness” in terms of “talent”: the Deaf students were more “disciplined” and “truthful.” Whether or not this inherently is a form of “ablesim” because it is generalizing based on assumptions about underlying “limitations,” these teachers themselves believed they were articulating positive, beneficial attributes. If asked, these teachers would argue that to be “Deaf” is in no way to be less than others. To make this perspective appropriate, researchers must be wary of such beliefs and maintain a critical stance about general statements, digging deeper to the richer “rationale” for such beliefs to expose what might potentially be euphemistic stereotyping.

Because this perspective was useful but limited, I applied additional theories to help analyze this data.

SHAKESPEARE AND WATSON’S FRAMEWORK OF DISABILITY

The complexity and variety of responses from this study were surprising. Much of the reflections of teachers, especially from longer interviews and interviews with Deaf teachers, contradicted either the literature from Deaf Studies or ‘mainstream’ HIV/AIDS

education research as I summarized in the previous chapter. While Deaf studies often argues that “Deafness” can be wholly defined in terms of a minority, stigmatized or oppressed language and culture⁴⁵, this study found that other factors were also important and it was unclear which beliefs might be “positive” or “negative”. While such literature often describes trends in the attitudes and beliefs of teachers as ‘negative’ and full of ‘anxiety’, much of these interviews found that teachers were *more* comfortable with this education because of underlying beliefs about Deafness.

One of the biggest challenges in analyzing these results was reconciling these disparate reflections, often within the same conversation with one individual. The writings of Shakespeare⁴⁶, and in one case Shakespeare and Watson, were useful in articulating how such complex interactions might make sense.

In one article co-authored by Nicholas Watson (2001) they together argue,

Disability is the quintessential post-modern concept, because it is so complex, so variable, so contingent, so situated. It sits at the intersection of **biology** and **society** and of **agency** and **structure**. Disability cannot be reduced to

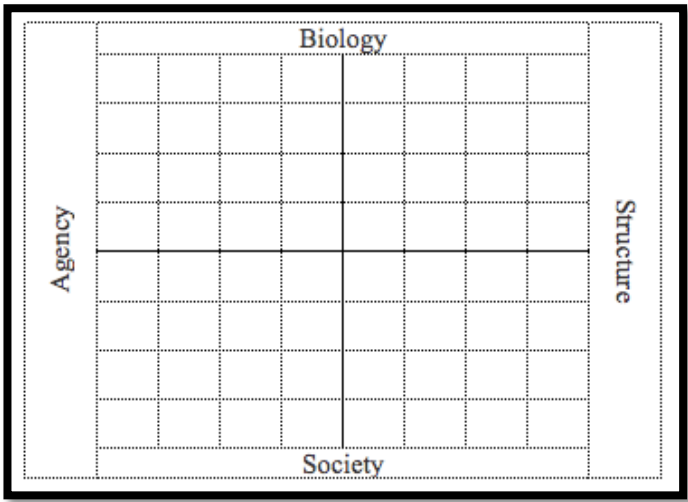


Figure 15: "Spectrums of Disability," a diagram illustrating Shakespeare and Watson’s argument that disability, “...sits at the intersection of biology and society [culture] and of agency and structure”, (2001, p. 19).

⁴⁵ See: Grosjean, 2010; Ladd, 2003; Cooper, Rose and Mason, 2004; Merton, 1996; Padden and Humphries, 1988; Rose and Kiger, 1995; and Wilkens and Hehir, 2008.

⁴⁶ See: Shakespeare, 1992; 1993a ;1993b; 1994a; 1994b; 1994c; 1994d; 1996; 1998;1999; 2000; 2005; 2008.

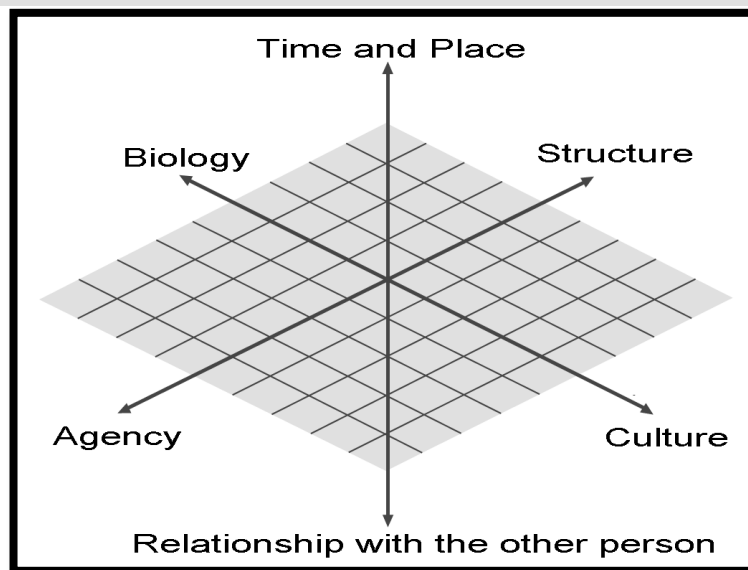
a singular identity: it is a multiplicity, a plurality (p. 19)⁴⁷.

They argue that different perspectives privilege some of these ideas more than others, often for practical purposes or because of the motivation for uncovering specific findings. Using this conceptualization of disability, any number of perspectives can be validated given their usefulness for the particular piece of research they serve.

Shakespeare and Watson avoid defining disability solely in terms of ‘oppression’ or ‘ableism’ and they also avoid the dualism of “top-down” versus “bottom-up” as Corker warned (reviewed in the *Methods* chapter and later here). This conceptualization of disability is useful for this study because it allows for multiple influences. In an attempt to visualize this framework, I offer the diagram shown in Figure 15 representing this intersection.

These axes of influence are further situated within the time and space and personal relationships that Thomas describes as constructing disability. Within the day-to-day

Figure 1 revisited: I return to this first figure illustrating the situated construction of Deafness that was useful in analyzing the trends in this data.



⁴⁷ “Culture” is incorporated into “society”, they later argue.

interactions in and around HIV/AIDS education in these schools, teachers impacted the nature of Deafness by their pre-existing beliefs about biology/impairment, social structures, “Deaf culture” and personal agency. I have added to the initial set of axes this added axes of time/space and personal relationships in Figure 1, repeated from the *Introduction*. I feel that this ‘situated construction of Deafness’ most accurately represents how teachers manipulated beliefs about difference and sameness within the different ways they interacted with HIV/AIDS education.

DEAFNESS AS DIFFERENCE

As discussed in the chapter on *Methods*, Corker offers the notion of *difference* as a useful unit from which Deafness can be explored (1996). Corker rationalizes the use of *difference* rather than other more ‘traditional’ frameworks for studying Deafness because, like Shakespeare and Watson, she argues there are multiple influences working together at different times and places. She critiques more common frameworks for their limiting reliance on either structure or culture rather than an interaction between the two. Deaf studies, Corker argues, tends to define Deafness in terms of culture: because sign language builds up a culture, Deafness is a culture and not a disability. Disability Studies defines disability in terms of structure: structural inequalities that disable individuals and that if those structures change, the disability is removed. This in turn creates a false divide between these two constructions and promotes the heated debate over whether or not Deafness is indeed a “disability”.

Corker argues that these perspectives are “essentialist ideologies” that are useful for political and social change but become problematic when applied to in-depth, qualitative, academic studies of Deafness such as this study. Corker’s conclusion was that tensions between the two sides result from the lack of recognition that each side privileges a

different forces over others, in this case *structure* and *culture*.

The logic of ‘either/or’ is an intellectual artifact, and that each side of the various dichotomies do not after all represent discrete entities; ...If this were so, it reinforces the view that both the social model of disability, with its ‘top-down’ emphasis on the individual-society dichotomy and its inherent conflicts of agency **versus** structure, and the linguistic minority construction of deafness, with its ‘bottom-up’ view that individuals determine society, and its insistence that Deaf and hearing are discrete, are essentialist (1996, p. 34).

Corker continued to argue that by excluding the middle or privileging one over the other “hides a variety of marginalized and repressed discourses which might provide clues to our tensions and how they can be removed”. In other words, taking into consideration both *structure* and *culture* might be useful in exploring new contexts such as HIV/AIDS education practices in Kenyan schools for the deaf. Specifically, Corker argued that researchers should reflect on how they themselves privilege Shakespeare and Watson’s four notions as well as two *additional* terms.

What model of disability or impairment is assumed by the research and, in particular, what emphasis does it give to impairment, **structure** and/or **agency**, the individual and/or **society** and **difference** and/or **sameness**? [my emphasis] (1998, p. 124).

Here Corker separated *individual* and *impairment* that arguably could be equated to Shakespeare and Watson’s *biology*, but adds on notions of *sameness* and *difference*.

Difference is what Corker used as a methodological unit of measurement and starting point for understanding these other notions. She used *difference* as a way of analyzing lengthy interviews with Deaf, hearing-impaired and hard-of-hearing individuals called ‘life courses’ exemplified in her book *Deaf Transitions* (1996). This method of analysis at first appealed to me because Corker’s study focused on similarly lengthy and in-depth interviews often about how “others” saw the Deaf. After I tested this method it became clear that it was useful for revealing trends in the data that were otherwise obscured.

Unlike Thomas and others who defined disability in terms of stigma, many of the

interviews I conducted revealed beliefs held by teachers that exposed beliefs of *difference* without any explicit stigma. Teachers described interactions with their students and HIV/AIDS education as highlighting the underlying ‘nature’ of Deafness but not necessarily as a stigmatized nature. It was important to me, given the newness of this research, to not assume that beliefs about Deafness as difference were necessarily stigmatizing.

This method also helped to bypass the advocacy rhetoric that saturated this environment. When teachers attempted to answer questions using advocacy slogans about equality, I probed their answers deeper by asking how the Deaf were different, how Deaf culture was different, and how sign language was different. This line of questioning was much more useful in garnering concrete examples of interactions rather than generalizations based on what were potentially less-truthful ideals.

Difference also became a starting point from whence I could ask myself how each quotation could be categorized. I looked at every statement made about Deafness or sign language for how this teacher was arguing sameness or difference. From there, Shakespeare’s framework began to be more practically employed, further categorizing beliefs of sameness or difference because of the influences of personal agency, culture, biology or structure. I concluded that it was extremely useful to situate Deafness within the combination of these three ways of thinking.

CONTINUED ANALYSIS OF RESULTS: DEAFNESS AS *DIFFERENCE*

In this section I apply this situated construction of Deafness to a deeper level that speaks to some of the current debates in these related fields of Disability and Deaf studies. Within this situated construction of Deafness, it is helpful to keep in mind the two “spectrums” of biology versus culture and agency versus structure. I argue that this data

reveals that teachers were explaining their beliefs about HIV/AIDS education and the Deaf based on their tendency to privilege one of these influences over the others at different times and for different circumstances. In particular, teachers who felt that Deaf sexuality was the *same* as hearing tended to privilege personal agency over other influences because Deaf people were as varied as hearing people depending on personality. However, within the group of people who felt that Deaf sexuality was *different*, there were two competing constructions.

Those who argued the Deaf were hypersexual tended to privilege the influence of structure over culture and that structural inequalities had a strong impact on local Deaf culture. Those who felt that the Deaf were hyposexual felt that local Deaf culture was more influential than the wider social structures.

BELIEFS ABOUT DEAF SEXUALITY AS “THE SAME”

Approximately half of teachers interviewed discussed Deaf sexuality as being relatively similar to hearing sexuality, marked by a perceived range of sexualities. As I have noted before, while many teachers agreed with the statement “the Deaf ‘love sex’ one American Peace Corps teacher felt that this was “more of a Kenyan problem than a Deaf problem.” Others remarked that indeed “promiscuity” might be a problem but no more so than within the hearing community.

These teachers privileged personal agency or “personality” over the alternative influences of structure, (educational or legal limitations), culture, (Deaf culture), or even biology, (having a hearing impairment).

Deaf people are equally human beings as any other people. They have feelings and they can control themselves. Gossip is both in the Deaf community and hearing alike. Promiscuity is the same (Participant 27).

It was interesting to note that most teachers referenced these other influences of

structure, culture, and biology, but that these were secondary to personal agency. Even in dismissing others who argued the Deaf had a different kind of sexuality, they repeatedly referenced that while these other factors influenced sexual behavior, there was no inherent “Deaf sexuality” but only “human sexuality” impacted by Deafness.

HYPERSEXUALITY BELIEFS AND RATIONALE

Approximately one-third of the participants felt strongly that the Deaf had *more* sexual partners than the hearing, and this behavior was part of their “Deaf culture.” These participants consistently invoked structural inequalities as causing this difference, removing implicit blame from the “Deaf community”. Not only did these teachers feel that wider structures limited and impacted the sexual behavior of Deaf people, but they often argued that this was part of Deaf culture. These teachers tended to interact with HIV/AIDS education in much the same ways as those teachers who privileged agency because both groups recognized the strong impact of structural inequalities on the lives of the Deaf. The difference was that the latter explicitly defined “Deaf culture” in a more *social relational* sense and included these interactions with hearing people as part of this culture. The former group implicitly did not include this in their understanding of “Deaf culture” arguing that any such behaviors were secondary.

Another example of this slight difference in construction is how participants discussed internalized beliefs about human worth and its impact on sexuality. Especially for girls, these teachers argued, being Deaf meant linking sex with social validation. Both groups of teachers felt that these structures impacted how they approached and implemented HIV/AIDS education in similar ways.

Yet, there was a nuanced difference in how their reflections illustrated underlying constructions of Deafness and Deaf culture. Teachers who privileged personal agency and

articulated sameness recognized the presence of this internalization and its resulting behaviors but they did not use this to construct their understanding of Deaf culture. Those teachers who did include these interactions into their personal constructions of Deafness and Deaf culture seemed to argue that this was unfortunate and avoidable. This is an example of what Corker called the “structural penetration of culture”.

In summary, teachers who believed the Deaf were hypersexual tended to privilege structure over other influences but constructed Deafness as a dynamic relationship that was significantly changed by the presence of education. Teachers who believed the Deaf had a similar range of sexualities as the hearing tended to privilege personal agency over other influences but constructed Deafness in a more static sense.

The same kind of analysis revealed different conclusions about the ways teachers rationalized beliefs about Deaf communication as different “Gossip” as part of “Deaf culture,” and a lack of “taboos” was seen as something that drove hypersexuality. One teacher said, “Because the Deaf are visual, [they are] very much interested in stories on sex. When an individual is talking about sex, they seem to be more elated than other topics” (Participant 45).

Here the use of sign language as a mode of communication is being perceived as impacting the content of communication and resulting in the promotion of sexual activity. Teachers like this one seemed to link the use of hands and body in communicating through sign language with being inherently more “physical” and “sensual”. This teacher is privileging the perceived biological influence of a visual/manual language and being physically hearing impaired. When it came to learning about sexual topics, Deaf people were more “eager” because of their physical difference. This same teacher, however, cited the more structural influences on their behavior at other times. This is an example of how

teachers who defined Deafness as a dynamic relationship tended to move between privileging different influences on how they constructed Deafness given different interactions with different people.

HYPOSEXUALITY BELIEFS AND RATIONALE

A small group of teachers felt that the Deaf were different because they were hyposexuality. Deaf women, especially, were described by these teachers as being more ‘chaste’ than hearing women because the Deaf were more “disciplined” and when educated in schools they learned to “behave properly”. This proved to be an example of how Corker described a structural penetration of culture. “Deaf culture” was something fostered only within these schools (something that “village Deaf” did not have) and it could be manipulated through the information these teachers chose to provide. The structural power relations of these schools impacted the organic Deaf education that was cultivated between students together learning their shared sign language.

This set of beliefs was interesting because each teacher also implied an inherent difference in the biology of the students. These were the teachers who discussed Deaf students as being “simpler” and “more honest” in a manner that seemed to be a romanticized “othering”. I was unsure to what extent this “othering” or was because of some perceived biological impairment linked to hearing impairment or it was a limitation of sign language and non-oral languages. I lean towards the former because there was the alternative implication that the “village Deaf” were equally as “simple” and “trusting” but had the “improper” education of what they saw and experienced in the village.

While these beliefs and attitudes are themselves worth study, my analysis focused the use of these beliefs as a lens through which to explore how teachers manipulated different constructions of Deafness and Deaf culture. At first these seemed contradictory

and at times random, with teachers pulling from different influences to rationalize beliefs. The same set of interactions with HIV/AIDS were rationalized by very different explanations for their beliefs, based on the privileging of disparate influences. When I applied this situated construction of Deafness framed by the four competing influences of biology, culture, agency and structure, these beliefs became more systematic and potentially predictable.

These different ways of constructing Deafness reflect current debates in related fields; is Deafness a cultural/linguistic notion or rather a Disability marked by lack of access and oppression? Should Deafness be defined as more stable, static language and related culture, or a dynamic construct “penetrated” by structural influences? Rather than attempting to argue whether any of these perspectives is “better” or “worse”, I prefer to simply argue that this framework and related methods were exceptionally useful for revealing how these teachers reflected these debates in their own reflections on HIV/AIDS education.

CONCLUSION

This study explored different understandings of d/Deafness in the context of HIV/AIDS education as well as how in turn they impacted HIV/AIDS education. This study might be described as “grounded” or using “open” methods and frameworks, but I was intent on making sense of this data beyond simply presenting it within broad categories. I concluded that combining three ways of thinking about Deafness into a situated construction of Deafness was extremely useful. This resulted in several further conclusions that speak directly to current debates about Deafness and disability.

These discussions offer insight into the nature of research on disability and Deafness especially in school settings and under-researched, low-resource settings like Kenya. It

also shows that the unique context of HIV/AIDS and Deafness offers equally unique complexities in how Deafness can be experienced but that such a context requires a thoughtful and nuanced theoretical perspective.

CHAPTER 8: CONCLUSION

ORIGINAL CONTRIBUTION OF KNOWLEDGE

This study started as an exploration of an under-researched topic: HIV/AIDS education in Kenyan schools for the Deaf. Because much of the related literature focuses on the practical outcomes of this kind of education, I was at first more interested in how teachers were perhaps adapting pre-existing curriculum for Deaf students. After I had the chance to observe these activities and talked with these teachers, I came to realize that there were much more complex interactions occurring between school culture, teachers' beliefs about Deafness and sign language, and beliefs about sexuality. In the end, my conclusions reflect this growing awareness. This data shows that indeed some HIV/AIDS education was occurring in these schools though not necessarily the kind that systematic studies are designed to collect. I also found that this education was significantly impacted by the personal beliefs and attitudes teachers had about Deafness, sexuality and communication, highlighted by several "Deaf stereotypes" present in these schools.

Finally, I argue that this data illustrates the ways teachers manipulate and interact with different constructions of Deafness that are highly situated, influenced at different times by structure, culture, agency and biology.

This study is especially useful for the growing field of HIV/AIDS and Disability because it is most closely aligned with this interdisciplinary field. There have recently been systematic reviews of the literature showing that there is a gap in the literature that this study helps to fill both in context and methodology. This data contributes to the growing body of literature that argues that people with disabilities are not only just as susceptible to this disease but often experience it in a different way.

Finally, this study is useful for those in Deaf and Disability Studies. This study offers insight into the limitations of different methods as well as an illustration of the variety and depth of constructions of Deafness present in these three schools.

SUGGESTIONS FOR FUTURE STUDIES

This study, being exploratory, is potentially most valuable for how it reveals the possibility of future research questions. These questions align with some of the limitations of this study. For instance, how do the students in these schools think about these activities and interactions? It would be extremely valuable to collect data on these “stereotypes” and constructions of Deafness from Deaf students who have grown up with HIV/AIDS as a pervasive part of their lives.

Data analysis also focused primarily on those questionnaires collected in-person or interviews conducted within the three main school sites so that I could contextualize these remarks within the added data from observations and document analysis. Out of the eight possible Deaf teachers, seven were interviewed and these, because of my own language limitations, were not as extensive. Only two interviews with Deaf teachers were lengthy

because they were conducted with an interpreter they trusted. It would be useful to use the same detailed methods used with hearing teachers on the Deaf teacher population of Kenya and other Deaf educators.

There was also an interesting dynamic occurring in how teachers reflected on the relationship between HIV/AIDS, sexuality, education, disability, Deafness as culture and sign language. This dynamic appeared to be influenced by their personal experiences, Deaf advocacy, NGOs, international organizations, religious institutions, and the culture and structure of their own schools. More research is needed in how these teachers negotiated these influences, especially when discourses about disability originating from the U.S. and the U.K. contradicted their own beliefs or those of local influences. How are these contradictions experienced and subsequently performed in the act of teaching? How do school cultures reflect these contradictions?

CLOSING REMARKS

In closing, this study offers new evidence about HIV/AIDS education in schools for the deaf in Kenya which are useful to those in Public Health, Special Education, International and Comparative Education, Disability Studies, and Deaf Studies. In addition to the added data on the existence, or lack thereof, of different forms of HIV/AIDS education occurring in these schools, this study found that this topic itself acted as a lens through which to explore deeper societal constructions of d/Deafness itself. The very practice of HIV/AIDS education in these schools acted as a metaphoric magnifying glass for these beliefs and attitudes, revealing that there are a consistent range of beliefs and attitudes about Deaf sexuality as being *different* from hearing sexuality.

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APPENDIX 1: PERSONAL BACKGROUND OF THE RESEARCHER

An examination of the literature will uncover several gaps in the research; there is little study of the relationship between Deaf culture, sign language, and HIV/AIDS education globally, let alone in Kenya where rates are high and there is a concentration of deaf educational opportunities. Yet the initial interest in this topic stems from my own personal experiences working with students with “moderate to severe” disabilities in urban San Diego, California. Many of the decisions made during the course of this study were based on a “gut instinct” from having worked as a teacher and educator for many years and recognizing many of the similar experiences teachers in Kenyan schools for the deaf faced.

During my student teaching (internship) in 2005 in inclusive middle and high school settings, I found a significant discrepancy between the provision for and need of sex and health education for students with “moderate to severe” disabilities. The issues of sexual and physical abuse, rape, unwanted pregnancy, and “undesirable behaviors” (masturbation or public exposure) was on the forefront of guardians’ and teachers’ minds. Yet these topics were rarely discussed in teacher preparation courses or in our textbooks. While tremendous time and effort was put into curriculum for increasing literacy and

arithmetic, these more “sensitive” topics were often a daily struggle for teachers and guardians. The California State curriculum includes these topics, even for students with significant disabilities, but it was my experience that the discomfort felt by the educators was the largest barrier to its implementation. Individual interventions were sometimes designed and implemented, but they were just that: interventions created after a ‘situation’ had become so pressing that action was required.

Some teachers or guardians intervened more than others and while policy dictated an adequate inclusion of material on these topics, it became clear to me that the personal attitudes and beliefs of each educator made a significant impact on whether or not this curriculum was implemented. Furthermore, the personal morals and attitudes of my fellow educators influenced *how* this curriculum was implemented. While this would be considered unacceptable in other disciplines like history or math, the emotional and moral ties to the topic of sex made this vacillation of standards commonplace.

In reality, one of my own students became pregnant and at other times I repeatedly witnessed guardians accusing previous educators of sexual abuse in my own and other schools. Guardians voiced rampant fears of abuse and rape in the future when their children would move into “group homes” or live independently. Students themselves were interested in romantic relationships and sometimes engaged in physical displays of affection with each other. When I brought up this topic in my graduate class, a colleague retorted, “But...our students don’t have sex!”

This issue became central to my graduate research conducted during the Master’s Degree in Special Education at San Diego State University. Through extensive discussions with colleagues and faculty I found that most others agreed the primary barrier was not resources, (human, temporal or financial, as these were well-funded

classrooms), but attitudinal. We even had a strong motivation to keep our students safe because in this environment one of the most pressing concerns was the potential liability of teachers, staff and schools if students were ever abused or raped.

Yet, the more significant a disability a student had, the greater the attitudinal barrier for the educator. In addition there was a contradictory emotional response to the interaction between disability and sex education. While my colleagues felt they needed to “protect” the “innocence” of their students, regardless of age, they also admitted they feared students would “act out” what they had been taught because of a lack of inhibition.

I wasn’t initially as comfortable talking about these topics with students either, but simply being aware of the significant discrepancies between knowledge and risk was enough to make me comfortable and motivated to implement and even build on this education. Meanwhile, in the back of my mind I continued to wonder why this information wasn’t enough for others to do the same?

I applied my initial research to practice gaining valuable insight into the actual practice of sex and reproductive health education for students with disabilities such as Autism, intellectual disability and multiple disabilities. I spent over a year adapting curriculum designed for students with what in the U.S. are called “learning disabilities” (such as dyslexia) to be more appropriate for students with little or no language, various physical, mental and emotional limitations and often a different home and social life than the “average” student.

I learned through implementing it with my own students that “adaptation” means more than just changing the mode or level of language, but rather considering how a specific population might have a slightly different cultural experience with “risks” and sexual behavior.

For instance, research showed that a student with a severe disability was most likely to be abused in some way by a close family member, often their own guardian in terms of neglect. This is vastly different from the “gold standard” of safety training we were taught of “Stranger = Danger” and “tell your parents”. Students with significant medical issues also had much more common interactions with different professionals who often helped with dressing, personal hygiene and other activities where what was physically “private” for them was very different. Simply making the language of this curriculum simpler would not accurately interpret the point of this curriculum. How do you teach these students about the difference between sexual abuse and the appropriate changing of a catheter or diaper? I myself took part in these kinds of activities on a daily basis, often with students with substantial language abilities too, making even the original curriculum less useful.

These experiences helped me later when I interviewed teachers because I knew to question whether simply interpreting curriculum into sign language or using more visuals was in fact all the “adapting” that was going on. I knew to ask about whether teachers considered this tacit knowledge about their students’ lives when they approached this education the way I had back home in California. In fact, sharing these common experiences with teachers helped to facilitate these discussions and gave them a stronger sense of my shared experience. I quickly found out that we as teachers had a lot in common.

APPENDIX 2: ANALYTIC TERMS

This study is based in a nexus of research areas that use different terminology. This study is intentionally distanced from literature that either borrows one specific set of terms for consistent use or attempts to create essentialist or universal terms. As an exploration into an under-researched setting, this study references the terms used by others with the understanding that they sometimes are debated or in contradiction.

“PEOPLE WITH DISABILITIES”

For the purposes of this study, the umbrella category of “people with disabilities” is defined as by the “International Classification of Functioning, Disability and Health” (ICF) that describes disability in terms of an interaction between the two domains of body functions/structure and activity/participation (WHO, 2001).

Since an individual’s functioning and disability occurs in a context, the ICF also includes a list of environmental factors. It acknowledges that every human being can experience a decrement in health and thereby experience some degree of disability. Disability is not something that only happens to a minority of humanity... ICF takes into account the social aspects of disability and does not see disability only as a 'medical' or 'biological' dysfunction (p. 1).

This definition, by referencing the importance of context, can at times include Deaf individuals either in terms of hearing impairment or the stigmatization of sign language. It acknowledges that in some environments such as a Deaf club where all individuals use sign language and there is no reliance on oral or audio communication, people with hearing impairments who are fluent in sign language are not disabled. However, in

environments where this is not the case, this difference becomes a disability in that any refusal to acknowledge or use sign language will be disabling to the Deaf person. Using this definition, the term *disability* includes deafness though not necessarily Deafness unless it is within scare quotes denoting ambiguity or debate.

This definition was also chosen because it has been found to be useful by similar studies on HIV/AIDS and disability.

The most pressing need is inclusion of a disability perspective in HIV and AIDS research, by including measurements of disability and human functioning (ICF) in surveys and intervention studies...Use of a broad disability lens to elucidate risk factors for particular groups...[to show that] it is not only the disorder itself which increases risk, but also stigmatization, social exclusion and impoverishment” (Groce et al., 2012, p. 19).

Using this definition, this study is as much about disability as it is about Deafness.

The final conclusions about a *situated construction of Deafness* could just as easily be a *situated construction of Disability* if used to frame a study where this was necessary because it does not rely upon but rather is inclusive of notions of language and culture.

“D/DEAF”, “DEAF”, “DEAF”, HEARING IMPAIRMENT AND “SIGN LANGUAGE/S”

For the purposes of this study, these terms are used to denote very specific aspects of this broader notion of *Deafness*. Unless specific by these alternative terms, *Deafness* is the term that this entire study sought to try and define in one small context rather than starting out with a prescribed definition. Even so, the conclusion of this study was that there is no one kind of *Deafness* according to teachers’ responses and it is, like Shakespeare and Watson’s commentary a *multiplicity*. The following terms are used for the purposes of this study based on current literature in related fields.

Deaf: The capitalization of Deaf denotes a linguistic minority-based culture and “way of being” as described by authors such as Ladd, (2003) and Woodward (1972).

While it is common for a Deaf person to also have a hearing impairment, Deafness or DEAFHOOD describes the lived experience of this culture and language especially in contrast to hearing culture. Sociolinguist literature on deafness frequently explores the concepts of Deaf culture, Deaf community and Deaf identity which are central to this study as well but can at times be distinct from the following terms.

deaf: The use of the lower-case deaf denotes the ambiguous category of people who have a significant hearing impairment and who might or might not identify with Deaf culture such as someone who has little or no hearing but reads lips and uses a hearing aid. However, many of those who do so still identify with Deaf culture, especially in contexts such as Kenya where there are far more people with hearing impairments who do not have systematic sign language training and in a culture where the label is placed upon them by others.

Within this study *deaf* is more commonly used to describe schools, as in *schools for the deaf*. This is because it is ambiguous to what extent all students identify as Deaf and the schools themselves do not necessarily promote Deaf culture or use sign language in all activities.

d/Deaf: This is used at times in this study to highlight multiplicity. Sometimes it is unknown which category the speaker/signer references or is choosing to reference both possibilities. Other times it is used instead of deaf because it is known that a group contains both Deaf individuals and people who do not identify as Deaf but all of whom are grouped by an activity. It is a simplification from stated both the Deaf and people with hearing impairments. The term deaf can at times potentially mean a group of people where no one identifies as Deaf while d/Deaf necessarily includes this possibility.

Hearing impairment: This term is used when the medical condition diagnosed

by a hearing test needs to be differentiated from d/Deafness. This was also the technical term used in Kenya, shorted to HI by teachers as they discussed their training and expertise. When paraphrased, it is often replaced with *deaf* because while there is potentially a difference, in this context they were used interchangeably. For instance, many students had hearing impairments but with the use of hearing aids they were not deaf and could hear and speak “normally”. Yet they identified as Deaf and the wider society treated them as deaf. This is one instance where the foreign term of *hearing impairment* has limited usage.

Sign language/s: This term references a manual mode of communication with its own grammar and lexicon. The term sign language is often used as an ambiguous category meant to include any and all sign languages and systems used in a given context though this is not accurate linguistically but only useful within the confines of paper.

Sometimes it references the most common sign language used in one setting. Within Kenyan schools for the deaf, Kenya Sign Language, or KSL, is designated as the primary mode of instruction and has been accepted by the Kenyan Constitution as a minority language. However, scholars have described several dialects, “village sign”, and the predominant use of American Sign Language and British Sign Language in Kenya. Teachers sometimes equated Signed Exact English with *sign language* though this is inaccurate. Because participants rarely articulated attitudes and beliefs about the differences between these languages and sign systems, the more general *sign language* is used. Scare quotes will be used to highlight the vagueness, at times, in its use.

APPENDIX 3: PARTICIPANTS

INTRODUCTION

This Appendix contains information on the participants of this study including the local school context. First the three school sites are described offering background into the local culture and environment. Second, there are detailed descriptions of how populations were sampled and background on these participants.

This section also includes tables describing which provinces participants represented and from which institutions. These demographics are compared to the wider populations from which they were sampled as well as to each other.

TEACHERS

Statistics on the population this study sampled should be approached critically. The Kenyan Institute for Special Education (KISE) is the governmental institution in charge of keeping accurate numbers. These only represent teachers whose salaries are provided by the Ministry of Education and many schools hire additional teachers. In each school site there was a teacher schedule posted in the common room with a copy posted in the administrative office documenting which individuals were assigned to courses. Because these lists described active teachers available for participation in this study, this number is used rather than those provided elsewhere. The discrepancies between these lists and other sources were as high as 8 teachers.

KISE did not have information on the number of teachers who identify as Deaf or Hearing-Impaired though the Peace Corps did include these figures from 2007. The Peace Corps have roughly 30 individuals working in schools for the deaf or on education

for the deaf in Kenya and nearby countries. Though they were well-poised to collect more accurate numbers on schools, units, teachers, students and activities, their report claims to use the documentation provided by schools themselves as well as through first-hand data collection. For this reason the “402 teachers” working in schools for the deaf is only an estimate and since it comes from 2007 it is probably a low estimate.

The number of total Deaf teachers working in schools across Kenya comes from a third source: the membership list⁴⁹ of the Kenyan Federation of Deaf Teachers which includes both teachers-in-training and those working full time. According to Deaf teachers interviewed this was the most accurate source for this number because any Deaf individual working as a teacher or in training knew to subscribe to this group while the government had no system for keeping track of such teachers.

Teachers’ various faiths were recorded in the administrative documents with the large majority being “Protestant Christian” with a smaller percentage being “Catholic”. Less than 5 teachers reported to their administrations that they were “Muslim” or “Seventh Day Adventist”.

TRAINING AND EXPERIENCE

Amongst the participating teachers within the school sites the average teaching experience was 10 years but ranged from only a few weeks to several decades of experience. Most administration and specialists also have full time teaching duties, so the four administrators interviewed and additional audiologists and psychologists were also counted as teachers.

⁴⁹ This list, though private and not published for outside use, was shared with me to help ensure that “Deaf Kenyans” could “have a voice” in this study, and I am indebted to the leaders of this organization for their instrumental support. This list not only included their names but which schools they worked at or were training in but also their addresses, allowing me to post them the questionnaire.

A “teacher” working in schools for the deaf in Kenya can mean several things. Many are formally trained, primarily through the Kenyan Institute of Special Education (KISE) which offers relatively low cost and sometimes free (through scholarships) in “Special Education” with a focus on “Hearing Impairments” or HI. A few of the teachers interviewed (less than 10) reported having or pursuing a B.A. in Special Education and the goal of this and further degrees was extremely important for most teachers; it was a point of discussion they raised frequently.

In order to teach primary or secondary education in Kenya the Ministry of Education requires at least a “certificate,” supplied by many teachers colleges and other tertiary institutions for approximately 1 year’s worth of study after completing secondary school. A “diploma” requires upwards of 2 years worth of classes and this is the training KISE more frequently provides before placing a teacher in a Special Education school though it is also offered by other institutions. This “diploma” provides the teacher in training with a wide background in different disability needs including training in Kenyan Sign Language and Braille.

Within these “diploma” programs students can choose to spend their final months specializing in one area such as ‘Hearing Impairment’ (HI) and spend time in a local school working with students with disabilities. Several such teachers in training were interviewed as part of this study as they engaged with deaf children in the schoolyard during one such “field visit” as part of their course of study.

Though technically the majority of teachers should have some training in KSL, according to KISE policy, some research suggests that fluency in a sign language is lacking in these schools, resulting in lower test scores among students (Adoyo, 2002; Kigingi, 2008; Koay, 2004). While all schools participating in this study reported the use

of KSL as their primary mode of instruction, observations and interviews reflected a range of fluency and use of Signed Exact English (SEE).

CULTURE AND HOME LIFE

Most of the teachers interviewed were originally from the same region in which they were currently teaching and identified with the Luo or Luuya ethnic groups. Many also retained a 'homestead' in their home village to which they would visit during school holidays. Men, especially, worked during school terms and returned to their 'homestead' during these vacation times to be with their families. In the meantime many teachers resided on the school site in specially designated teacher and staff housing. One lengthy interview took place on a visit to one such homestead that was a 30-minute drive from the school site and home to the teacher's extended family.

Many teachers had 'side jobs' to supplement their income. One interview took place in the on-campus home of one older female teacher who used this school-time housing to store huge piles of grain sacks that she sold in order to help pay for own her children's school fees. Her primary homestead was over an hours' drive away.

On-campus housing ranged from a few meters to a 10-minute walk from the classrooms, offering 2 to 3 bedrooms in a small, concrete and wood structure roofed with corrugated steel. Most teachers living in these accommodations kept chickens and even cows in their small gardens. Other teachers lived nearby in private accommodation and motels.

DEAF TEACHERS

There is no special accommodation in teacher training programs for trainees who are Deaf or have a hearing impairment though there is a program in Machakos that

invites any Deaf students with higher test scores to enroll in their teaching program. The Special Education “diploma” offered by KISE and other institutions is conducted solely in English with the exception of one required course in KSL to provide all teacher trainees some background in this sign language. Deaf teachers reported using the assistance of friends in these courses for notes and other information.

Only in recent years have Deaf students been recruited to attend teacher training colleges and return back to their home schools to teach. The first of these former students who currently teaches and organizes HIV/AIDS education and advocacy at his school site also successfully completed his bachelor’s degree and was interviewed extensively for this study, offering insight into how a Deaf person engages in Kenya’s educational system.

I was first educated here at this school, a student, and Deaf. At 9 years old I was sick with meningitis. I was born hearing and [after getting sick I] took 2 years at home with no school. Then [I was] brought [here] to start learning. I finished class 8 in 1995 and then went to secondary school till 1999 where I finished form 4. I then joined the teachers training college and finished in 2002, but I came back and started teaching here. That's the only thing I do: teaching, teaching, teaching...8 years (Participant 7).

Deaf teachers interviewed taught a range of courses and were not more likely than their hearing colleagues to teach KSL though interviews found that they were considered some of the few “truly” fluent teachers on campus. Staff interviews showed that Deaf teachers were perceived as being closer to students and had greater trust with them because of their shared language fluency, although other hearing teachers with similar fluency could and often did attain the same level of trust.

OTHER PARTICIPANTS AND ‘GATE KEEPERS’

Two staff members (non-teachers) at two different schools were interviewed, one extensively. During the interviews these staff members reflected on their multiple duties within the school sites that did include some informal educational activities such as

informal counseling and ‘yard duty’. Staff members are therefore included in the broader term “educators” though within this study they are not included within the group “teachers.”

Staff from the NGO S.E. and cooperating NGOs were interviewed and sometimes participated in questionnaires. Two of NGO S.E.’s employees were former teachers in schools for the deaf but were not counted as current teachers in schools. Three of these staff members were Deaf. Two teachers who participated were in the U.S. Peace Corps, one being Deaf as well. One participant was a student in a nearby university studying Special Education with a focus on Hearing Impairment (HI) and was not counted as a teacher.

This research could not have been conducted without the valued cooperation of several key participants. The director of NGO S.E., who asked to be referred to as “Fina,” not only was a licensed interpreter with extensive knowledge of these schools and environments but she also connected me with many of the Deaf participants. Over the course of fieldwork it became clear that it was extremely useful for this study to be connected with NGO S.E. in terms of reaching Deaf participants. NGO S.E. has a longstanding relationship with the Kenyan Deaf community and employs several Deaf individuals. Even before I contacted many Deaf teachers they were already aware and ready to participate in this study.

One of these employees was a Deaf man who Fina had worked with for over 10 years and who completed secondary school in one of the schools for the deaf in Nyanza. Apart from being a helpful tutor in Kenyan Sign Language he also acted as a personal reference with other Deaf individuals. During the final weeks of fieldwork he also acted as a research assistant and procured data from four Deaf teachers.

PARTICIPANT FEEDBACK AND CHOOSING SITES

Fina recommended first visiting Site A not only because it is one of the largest and most established schools but the administration was cooperative with NGO S.E. and this kind of research. In the past NGO S.E. had conducted similar studies with the students in many of these schools and so their intimate knowledge of each school climate was invaluable. Since Site A was among the schools that many other participants recommended I visit, I chose this as my first site for fieldwork.

The administrators at Site A then offered to personally introduce me to the administration of Sites B and C which I had already independently chosen as ideal research sites. During interviews with these administrators it was revealed that most “head teachers” and “deputy head teachers” of school for the deaf in Kenya know each other well from annual conferences and in sharing information on resources and experience. Therefore it was extremely useful to have at least one administrator of a school supporting this research to act as a reference with the others.

A fourth site was potentially planned for a visit but with limited time remaining in Kenya and an abundance of data, I decided to limit this study to the three sites.

At each school site there was also at least one or two teachers who acted as “informants.” These teachers were immediately more open and welcoming, often older females, and showed an interest in the research. These informants were valuable in offering candid advice and feedback about research methods and day-to-day needs including my safety and comfort. These key participants also offered candid reflections on the interactions between local Luo and Luuya cultures and this research, often taking me into their nearby homes for meals and in one case “happy hour” which added depth to the understanding of these teachers’ lives. It certainly opened me up to the local cuisine

and in one school site I was even given a Luuya name by the female teachers.

SCHOOLS SITES

This section uses first-hand observations, interviews and critical review of documents to describe the context of this study because there is little peer-reviewed literature describing the school environments and teachers on which this study focuses. Subsequently there are three sections describing relevant details about the participants of this study such as demographics, teacher training offered and received and details specific to participants who were d/Deaf.

The school sites I chose to study were in the Western and Nyanza provinces. I have promised my participants that I would not specifically use the names of the schools or even their towns (as many are known simply by the town's name), though they realize that there are few such schools and to anyone who knows this community is easy to guess where I collected data. For the purposes of this study, however, I refer to them simply as school sites in this region and describe their attributes.

Table 12: Participant representation by province

	36	3	14	2	7	17
Province	Nyanza	Coast	Nairobi	Rift Valley	Central	Western

Physically, at each site there was an administrative office where the Head Teacher, a Deputy Head teacher and often an assistant or secretary had desks, bulletin boards, and files. At the start of each school year, in January, teachers submit to the administration which courses and years they wish to teach. At one site, they had a choice ranging from nursery to Form 4. At another it was nursery to year 8, but also vocational education in the unit. At a third site, teachers had the choice of teaching anything from nursery to year 8, but also Deaf-Blind or vocational unit. As might be expected, certain ‘subjects’ or areas were often taken by the same people, such as with the Deaf-Blind unit or vocational education; teachers with experience and comfort in this education. At one site, teachers stayed with a ‘class’, moving from year 1 to teaching the same students the next year in year 2, covering a handful of subjects across years with the same group of children.

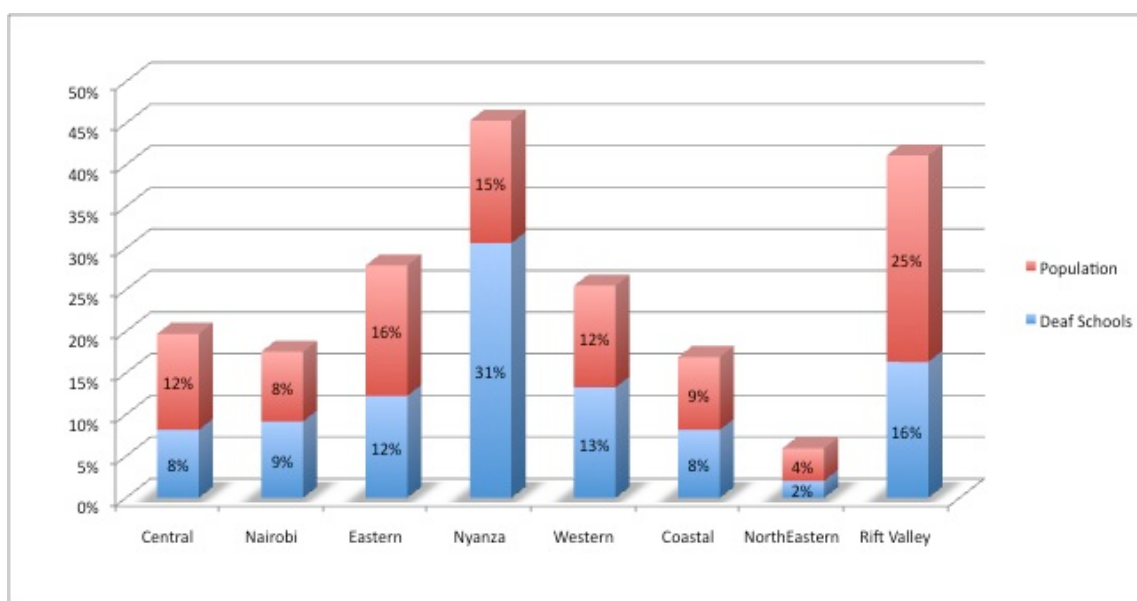


Figure 16: Total percentages of schools per region as compared to population density: Nyanza and Western Provinces have a higher concentration of educational opportunities for children with hearing impairments

Other teachers taught a wide range of subjects to only older students.

Administration reported that they weighed the strengths and personal preferences of teachers against the needs of the school, and after getting teacher requests, they

determined first which teachers would instruct which grade levels. These were grouped into “Lower Primary”, or years 1-4, including nursery which was not always year 1, but sometimes children slightly younger who were going to school for the first time. At one site, when a child came to school ‘late’, for whatever reason, and perhaps was older, they would still attend the ‘nursery’ school to get the basics of KSL. Then teachers would determine an appropriate time for them to join their ‘year’, or the most appropriate age level group, although again, ages were not always uniform. I was not able to determine if this was the usual practice.

“Upper primary” was years 4-8, and ‘Secondary’ was Form 1-4. Teachers, having been placed into one of these three categories, would then work together to put together a timetable, deciding who would teach what subjects on which days. At one site, this was completely up to teachers, but it was unclear if this was universal. Timetables are posted in all administrative offices and in teacher work-rooms, which are visited by almost all teachers daily. They are hand-written, in pencil for modification during the year, and the poster-sized paper is color-coded. At one site, lower primary was always on pink poster paper, for instance. Other levels were in green, white, yellow, etc.

Teachers do not teach the same subject at the same time each day. Often they will teach, for instance, Math to year 3 students on Mondays and Tuesdays in the morning, but later in the week it will be in the afternoons. Each grade or year or form stays in one class all day, stationary, as teachers move from class to class. All schools visited seemed to have roughly the same schedule, with several hours of classes in the morning, a short tea break, classes, another short break, lunch, classes and then ‘games’. Classes were about 30-40, minutes long, and this schedule allowed for teachers to instruct a wide range of subjects. Some subjects were taught every day, while others only were taught a few days a

week. Lower primary students had slightly shorter days than older students, though all students were expected to be in their classrooms in the evenings to study. Students came to class regardless if there was a teacher present or not. A significant portion of the times I visited classrooms, there was no teacher, and students worked on homework or studied.

Staff was also hired full time for security, usually a group of 3-4 men who used a security office at the gate as headquarters, cooking staff, house-mothers, and maintenance staff. These people also had on-campus housing, sometimes near the teachers but sometimes separate.

At each school I played a slightly different version of the ‘guest’, given the different interactions and relationships with administration, where I physically stayed, and my own experience and comfort level within the schools as a researcher.

Table 13: Participant representation by school site

Total participants	11	15	17	28
School site	Site A	Site B	Site C	other schools

SCHOOL SITE A

At the first school site, the head teacher, using the pseudonym Joseph, offered to pick me up from the airport and to stay with his family on campus. While this meant continuous access to him for interviews and background questions, I was also seen as the guest of the administration. Later I would ask a few teachers how they felt about this, and whether it was better to stay in the separate guest quarters. They felt that my personality and eagerness to spend time with teachers in their classrooms made up for the fact that I was linked to Joseph by staying within his home with his family.

Like most middle-class permanent concrete homes in Kenya, there were three bedrooms, often with bunk-beds in each, a kitchen, living/dining room, washroom, and

toilet. With one out of the three daughters (and a baby boy) away at boarding school, I was offered her room consisting of a bunk-bed, desk, window and, gratefully, a working outlet. This house, like other teachers' accommodations at most of these schools, is adjacent to classrooms and dormitories, only yards in fact, and edged with hedges, acacia and palms. Children from the school, neighbors and those belonging to other teachers freely wander through the head teacher's back yard thick with banana and other trees, as well as their own chickens. I would leave with the head teacher in the morning to walk the few yards to the school, situate myself in the staff room or attend any meetings or events happening in the auditorium, but frequently walk back to make coffee or rest during the day.

The 'deaf school' community in Kenya is small, and just before I came to stay at the first school site there had been a head teacher meeting in Nairobi where most all of the head teachers of schools for the deaf gathered. During this meeting Joseph introduced my research cover letter to the head teachers of schools I mentioned I would like to visit, and so the second school site was expecting my arrival. While I had arranged a driver, Joseph and his wife both felt uneasy about my traveling through these rural roads, and so compensating him for gasoline, he and his driver took me. Joseph brought the driver because he was also uncomfortable driving alone, let alone after dark through these areas, even though this was his homeland.

This school not only had primary students but a "Deaf-Blind Unit" with three teachers and between 5-7 students. These students shared dormitories with the other students and received assistance from staff to navigate the school site when needed. There was also a "Vocational Unit" attached to the back end of the school. The classrooms were part of the same structure and the rest of the school and teachers also

seemed to be within the general administration as the primary school teachers. Though this was a primary school, a quick survey of the school yard might imply otherwise and many of the boys especially were on the verge of manhood, some standing taller than many teachers. These students were also of Somali origin and according to one teacher had recently joined formal schooling having lived in refugee camps for years in the north. This site more than the others had a larger population of these boys who stood out with their lighter skin and tall, lean physique.

When asked about the cultural differences between these older, paler, taller Muslim students and the local Luo children, one teacher felt that such differences were made irrelevant by their Deafness. “The ‘Deaf tribe’ comes first,” she claimed (Participant X). However minutes later I inquired with two younger boys about these new students. One boy signed that they did not associate with the Somali students other than playing football in the yard and that he did not “like” them.

SCHOOL SITE B

The second school site was run by a female monastic of the Catholic church who greeted us in the courtyard. I was offered a guest room located at the end of one wing of classrooms in the corner of a large grassy yard, spotted with goats, acacia and a water pump. This wing was home to the Year 1-4 boys, so the oldest students in the school, as few girls stayed on through these years. A house-mother was assigned to my needs, bringing me yellow plastic jerry-cans of water for bathing. As with the first school site, I left in the morning to join with the daily flag-raising and updates, then situating myself in the staff room and returning to my room periodically. I learned the usefulness of having my own private guest room, as both teachers and students would come by to chat, to give

me their questionnaires where I would then take the opportunity to interview them based on their responses, sitting outside on the concrete veranda.

This school site was extremely rural, and adjacent to a couple other schools and convent, with a weekly market out on the main road that I browsed on the first day. Teachers' accommodations were just down the road about a half mile and not adjacent to classrooms. While I was farther from teachers' home lives, I accepted invitations for lunch or tea in their homes, and was able to get a better idea of their home lives. The caveat was that being so near to the students who spent hours each night studying and socializing in their classrooms, I increased my sign language conversation skills and simply got to know the students better.

Joseph's driver, who I will call Ezekiel, not only accompanied me to the second school site but drove me to and from the airport once as well as to my final school site. Being an introspective and talkative man who genuinely was interested in eaf culture and their community, I found these drives fruitful. He was more than willing to allow me to use his thoughts for my research, of which he had many. The drive to the final school site was through lush sugar-plantation land, relatively wealthy from these farms and factors that produce the beige crystals used to sweeten Kenyans' daily tea.

SCHOOL SITE C

This site was the oldest not only of my sample, but the oldest school for the Deaf in East Africa. Established alongside a hospital, medical college and other educational institutions set up by the Catholic church originally, these schools were now run by a mixture of Protestant, Catholic and other representatives, both lay and ecclesiastical. Here I was also offered a guest room, being told that I would have had an entire cottage to myself with the teachers but 'the Peace-Corps man' was using it. This was the second

representative of this organization I would meet and interview who was mainly working with the Deaf, though there is a significant presence in Kenya.

Having learned the rhythms of these schools, at ease with my sign language and fluid in my interview/data collections skills at this point, this last school site proved the most enjoyable. Again, I followed the daily schedule of the school, attending morning flag-raising (at the first site they only did this on Mondays whereas most schools raised their flag daily in pseudo-military style), situated myself in the staff room, visited classrooms and welcomed interviewees and curious parties into my sitting room. This guest room, like the previous, was between classrooms in a wing of the school overlooking a small quad. My sitting room offered an outlet, desk and mirror, with a bedroom and bathroom/toilet adjacent. Children would poke their heads in between the iron bars on my window when my curtains were drawn, watching me type or draw until older students came by and hit their legs with switches made of tree branches. I always felt guilty that I was a source of temptation to be punished. One girl with an intellectual disability would sit beneath my window after I defended her equal right to curiosity which attracted excessive and discriminatory condemnation by her peers. I gave her colored pencils and paper, and she would draw for me the numbers, letters and pictures of basic words she was learning in her 'special' classes, just one room down from my own room and taught by 'the Peace Corps guy.'

Table 14: List of participant codes used during data collection and analysis.

Participant number	Participant code	School site	Teachers in schools	teachers in school sites visited	Deaf teachers in schools	Deaf teachers in school sites	Deaf teachers interviewed	All interviews	Interview minutes	Surveyed	Pilot survey group training	Pilot survey posted Deaf	In-school extended survey	Posted extended Deaf survey	Deaf Participants	women 0 / men 1	Teachers	years teaching
1	1-D-M-T-7-N/B	B	1	1	1	1	1	1	20		0	0	1	0	1	1	1	7
2	2-H-M-TA-5-n/B	B	1	1	0			1		1	0	0	1	0	0	1	1	5
3	3-H-M-T-2-N/B	B	1	1	0			1	54		0	0	1	0	0	1	1	2
4	4-H-F-T-13-N/B	B	1	1	0			0		1	0	0	1	0	0	0	1	13
5	5-H-M-T-10-N/B	B	1	1	0			0		1	0	0	1	0	0	1	1	10
6	6-H-F-T-1-N/B	B	1	1	0			0		1	0	0	1	0	0	0	1	1
7	7-H-F-T/C-34-N/B	B	1	1	0			1	55	1	0	0	1	0	0	0	1	34
8	8-H-F-T/H-16-N/B	B	1	1	0			1		1	0	0	1	0	0	0	1	16
9	9-H-M-T/C/V-N/B	B	1	1	0			1	9	0	0	0	0	0	0	1	1	
10	10-H-M-T/H-3-N/B	B	1	1	0			1		1	0	0	1	0	0	1	1	3
11	11-H-F-T/C/H-N/B	B	1	1	0			1	30	0	0	0	0	0	0	0	1	
12	12-D-M-T/H/C-8-N/B	B	1	1	1	1	1	1	60	0	0	0	0	0	1	1	1	8
13	13-H-F-T-19-N/B	B	1	1	0			0		1	0	0	1	0	0	0	1	19
14	14-H-M-T-4-N/B	B	1	1	0			0		1	0	0	1	0	0	1	1	4
15	15-H-F-T-3-N/B	B	1	1	0			0		1	0	0	1	0	0	0	1	3
16	16-D-M-T-N/A	A	1	1	1	1	1	1	20	1	0	1	0	0	1	1	1	
17	17-H-M-S-N/A	A		0	0			1	40	0	0	0	0	0	0	1		
18	18-H-M-T-7-N/A	A	1	1	0			1	37	1	0	0	1	0	0	1	1	7
19	19-D-M-T-8-N/A	A	1	1	1	1	1	0		1	0	0	1	0	1	1	1	8
20	20-H-F-T-3-N/A	A	1	1	0			1	98	1	0	0	1	0	0	0	1	3
21	21-H-F-T-7-N/A	A	1	1	0			0		1	0	0	1	0	0	0	1	7
22	22-D-F-T-C/O	O	1	0	1			0		1	0	1	0	0	1	0	1	
23	23-D-M-T-Na/O	O	1	0	1			0		1	0	0	0	1	1	1	1	
24	24-D-F-T-N/O	O	1	0	1			0		1	0	0	0	1	1	1	1	
25	25-D-F-T-N/O	O	1	0	1			0		1	0	0	0	1	1	1	1	
26	26-D-F-T/PC-2-N/O	O	1	0	1		1	0		1	1	0	0	1	1	0	1	
27	27-M-D-T/C/H-15-N/O	O	1	0	1		1	1	60	1	0	0	0	1	1	1	1	
28	28-D-M-T-C/O	O	1	0	1			0		1	0	1	0	0	1	1	1	
29	29-D-F-T-C/O	O	1	0	1			0		1	0	1	0	0	1	0	1	

30	30-D-M-T-R/O	O	1	0	1			0		1	0	1	0	0	1	1	1	
Participant number	Participant code	School site	Teachers in schools	teachers in school sites visited	Deaf teachers in schools	Deaf teachers in school sites	Deaf teachers interviewed	All interviews	Interview minutes	Surveyed	Pilot survey group training	Pilot survey posted Deaf	In-school extended survey	Posted extended Deaf survey	Deaf Participants	women 0 / men 1	Teachers	years teaching
31	31-D-M-T-R/O	O	1	0	1			0		1	0	1	0	0	1	1	1	
32	32-D-F-T-Na/O	O	1	0	1			0		1	0	1	0	0	1	0	1	
33	33-D-F-TT-E/O	O	1	0	1			0		1	0	1	0	0	1	0	1	
34	34-D-F-T-W/O	O	1	0	1			0		1	0	1	0	0	1	0	1	
35	35-D-M-T-C/O	O	1	1	1			0		1	0	1	0	0	1	1	1	
36	36-D-F-T-Na/O	O	1	0	1			0		1	0	1	0	0	1	0	1	
37	37-D-M-T-Na/O	O	1	0	1			0		1	0	0	0	1	1	0	1	
38	38-H-M-T/C-18-W/C	C	1	1	0			1	45	1	0	0	1	0	0	1	1	18
39	39-H-F-T/V-23-W/C	C	1	1	0			0		1	0	0	1	0	0	0	1	23
40	40-HI-M-T-4-W/C	C	1	1	1	1	1	1	10	1	0	0	1	0	0	1	1	4
41	41-H-M-T/A/C-22-W/C	C	1	1	0			1		1	0	0	1	0	0	1	1	22
42	42-H-F-T-15-W/C	C	1	1	0			0		1	0	0	1	0	0	0	1	15
43	43-H-F-T-1-W/C	C	1	1	0			1	35	1	0	0	1	0	0	0	1	1
44	44-H-F-T-10-W/C	C	1	1	0			0		1	0	0	1	0	0	0	1	10
45	45-H-M-T-4-W/C	C	1	1	0			0		1	0	0	1	0	0	1	1	4
46	46-H-F-T-10-W/C	C	1	1	0			0		1	0	0	1	0	0	0	1	10
47	47-D-F-T/C/H-9-W/C	C	1	1	1	1	1	1	10	1	0	0	1	0	1	0	1	9
48	48-H-F-T/V-15-W/C	C	1	1	0			0		1	0	0	1	0	0	0	1	15
49	49-H-F-T/V-12-W/C	C	1	1	0			1	50	1	0	0	1	0	0	0	1	12
50	50-H-M-T-18-W/C	C	1	1	0			1		1	0	0	1	0	0	1	1	18
51	51-H-M-T/DHT-W/C	C	1	1	0			1	18	0	0	0	0	0	0	1	1	
52	52-D/M-T/H-W/C	C	1	1	1	1	1	1	10	0	0	0	0	0	1	1	1	
53	53-D-F-T-C/O	O	1	0	1			0		1	0	0	0	1	1	0	1	
54	54-D-M-T-Na/O	O	1	0	1			0		1	0	0	0	1	1	1	1	
55	55-H-F-T-W/C	C	1	1	0			0		1	0	0	1	0	0	0	1	
56	56-H-M-T/HT-N/A	A	1	1	0			1	170	0	0	0	0	0	0	1	1	
57	57-H-M-T/DHT-N/A	A	1	1	0			1	91	0	0	0	0	0	0	1	1	
58	58-H-M-T-N/A	A	1	1	0			1	36	0	0	0	0	0	0	1	1	
59	59-H-F-T/H-N/A	A	1	1	0			1	4	0	0	0	0	0	0	0	1	

60	60-H-F-T-N/A	A	1	1	0			1	8	0	0	0	0	0	0	0	1	
Participant number	Participant code	School site	Teachers in schools	teachers in school sites visited	Deaf teachers in schools	Deaf teachers in school sites	Deaf teachers interviewed	All interviews	Interview minutes	Surveyed	Pilot survey group training	Pilot survey posted Deaf	In-school extended survey	Posted extended Deaf survey	Deaf Participants	women 0 / men 1	Teachers	years teaching
61	61-H-F-T/V/C/H-N/A	A	1	1	0			1	37	0	0	0	0	0	0	0	1	
62	62-H-M-TT-N/O	O	1	0	0			1	23	0	0	0	0	0	0	0	1	1
63	63-D-M-T-Na/O	O	1	0	1			0		1	0	0	0	1	1	1	1	
64	64-D-F-T-Na/O	O	1	0	1			0		1	0	0	0	1	1	0	1	
65	65-H-F-N/O	O	0	0	0			0		1	0	0	0	1	0	1		
66	66-H-M-Na/O	O	0	0	0			0		1	0	0	0	1	0	1		
67	67-H-M-Na/O	O	0	0	0			1	30	1	0	0	0	1	0	1		
68	68-D-F-Na/O	O	0	0	0			0		1	0	0	0	1	1	0		
69	69-D-F-Na/O	O	0	0	0			0		1	0	0	0	1	1	0	0	
70	70-H-F-Na/O	O	0	0	0			1		0	0	0	0	0	0	0	0	
71	71-D-M-Na/O	O	0	0	0			1	30	0	0	0	0	0	1	1		
72	72-D-F-T-N/O	O	1	0	1		1	1	1	1	1	0	0	0	1		1	
73	73-H-F-Na/O	O	0	0	0			1	60	1	1				0	0		
74	74-H-F-T-N/O	O	1	0	0			1	60	1	1				0	0	1	
75	75-H-F-T-N/O	O	1	0	0			1	60	1	1				0	0	1	
76	76-H-F-T-C/O	O	1	0	0			1	60	1	1				0	0	1	
77	77-H-F-T-C/O	O	1	0	0			1	60	1	1				0	0	1	
78	78-H-F-Na/O	O	0		0			1	60	1	1				0	0	0	
79	79-H-M-T-C/O	O	1	0	0			1	60	1	1				0	1	1	
80	80-H-M-T-C/O	O	1	0	0			1	60	1	1				0	1	1	
81	81-H-F-T-C/O	O	0	0	0			1	60	1	1					0	1	
	Totals							43	1631	64	11	11	30	15	30	men 38	71	10
			70	43	28	7	10		43.17							wo men 43		10

Table 15: Participant code legend

Participant ID	#	Arbitrary
Deaf Status	D	Deaf
	H	hearing
	HH	hard-of-hearing, hearing-impaired
Gender	M/F	Male or Female
Role	T	teacher
	C	Health Club organizer
	V	Vocational tech teacher (works mainly with older students, non-college track)
	S	Staff, non-teacher
	A	Head or Deputy-head teacher
	TT	teacher in training
Experience	#	years experience
Province	N	Nyanza
	W	Western
	C	Central
	Na	Nairobi
	Co	Coast
	NW	North-western
School	A	School site A
	B	School site B
	C	School site C
	O	other
Questionnaire	1	Pilot survey
	2	School-based Questionnaire
	3	Posted Questionnaire
Interview	00:00	Hours: Minutes

APPENDIX 4: RESEARCH TOOLS

This appendix contains a copy of the research brief and consent form used, described in the *Methods* chapter as well as greater detail on how the final questionnaires were written and formatted. These details are provided because particular effort was made to design and implement a tool that was linguistically and culturally appropriate as well as methodologically useful for these research questions and later analysis. Special care was taken to word and format questions in ways to avoid leading the participant, minimize fatigue and to maximize comprehension. Overall, these tools were extremely successful at eliciting valuable and rich responses whether implemented in person or independently.

Figure 17 shows a copy of the *Research Brief* and *Informed Consent* form which was collected from each participant and stored separately from their responses. These forms were reviewed by the University of Oxford ethics review using the guidelines for working with human participants.

Figure 17: Research Brief and Informed Consent

	Nalini Asha Biggs, M.A., M.Ed., Doctoral Candidate Department of Education, University of Oxford 15 Norham Gardens, Oxford, OX2 6PY Kenya Mobile: (254) 072 946 2904 INFORMATION SHEET The relationship between disability and HIV/AIDS education: A case study of Kenyan schools for the Deaf Background: Understanding the ways educators feel about teaching sex and reproductive health education, including HIV/AIDS education, is important to help improve training and support for teachers. Many teachers around the world say that they are uncomfortable teaching topics related to sexuality, and some feel that their personal or religious values sometimes make it hard to carry out government-mandated curriculum. This is frequently even more challenging for educators who work with student with disabilities, or students who are deaf or hard-of-hearing. The rate of HIV/AIDS among the Deaf of Kenya are around the same or more as hearing people, yet there are many misconceptions about the Deaf. While there is some research on HIV/AIDS education for the Deaf in other parts of Africa, there is little information on how Kenyan teachers are coping with this issue. Methods: This study is conducted between January and March 2011, and uses primarily interviews as well as some observation to gain a better understanding of how educators in schools for the Deaf feel about teaching HIV/AIDS and sex education. What are the major challenges? What has worked so far? Interviews and observation notes are recorded by hand by as well as digitally when possible, and then analyzed for major themes. This research will be helpful for policy-makers in Kenya and in similar regions to help train and support teachers implementing HIV/AIDS and sex education for Deaf students. Research Ethics: Where possible, written consent will be obtained, and if this is not possible I record oral/signed consent. For Deaf participants, when possible I will visually record the interview, and transcribe responses before destroying video, unless otherwise indicated. Deaf participants can choose to have their testimony recorded only by hand. While some demographic information will be recorded such as educational background, gender and location, your name or other identifying information will not. I will always use pseudonyms or a number when recording and analyzing these interviews. There will be no interviews or observations of the students or volunteers under the age of 18 involved in this program without written consent of guardians. I do not ask and will not record any information about whether or not individuals are HIV+. All records of interviews will be kept secure at all times. Taking part in this research is voluntary and subject to informed consent which can be renegotiated at any state. This research is intended to be used for my D Phil thesis in Education, and my research conforms with the British Educational Research Association's "Revised Ethical Guidelines for Educational Research, 2004." If you have further questions.... please contact me! Nalini Asha Biggs: NALINI.BIGGS@EDUCATION.OX.AC.UK If you wish to make a formal complaint please contact christa.ballinger@admin.ox.ac.uk who will pass on your complaint to the University Ethics Committee.
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	Nalini Asha Biggs, M.A., M.Ed., Doctoral Candidate Department of Education, University of Oxford 15 Norham Gardens, Oxford, OX2 6PY Research Consent Form Project Title: "The relationship between disability and HIV/AIDS education: A case study of Kenyan schools for the Deaf" Researcher: Nalini Asha Biggs: NALINI.BIGGS@EDUCATION.OX.AC.UK Declaration of Consent: I declare that Ihave read the participant information sheet, ...have the opportunity to ask questions about the study and receive satisfactory answers to questions, ...that my participation may involve both interviews and observation in formal and informal settings my the researcher, ...understand that I may withdraw from the study without penalty at any time by advising the researcher, and any data already recorded will be discarded ...understand that this project has been reviewed by, and received ethics clearance through, the University of Oxford Central University Research Ethics Committee, ...understand that my personal data will be treated in total confidence, kept securely in a password-controlled ...understand how to raise a concern and make a complaint, ... I and agree to voluntarily participate in this study. How can we document your interview? <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">☒</td> <td style="width: 15%;">We can make a video of the interview. My name or school will NOT be attached to this video, or shown to anyone outside of this research. Please destroy video after you have written down what I have said.</td> </tr> <tr> <td style="text-align: center;">☒</td> <td>I will answer questions on paper. My responses will be kept safe, and not linked to my name or school.</td> </tr> <tr> <td style="text-align: center;">☒</td> <td>I will answer some questions on paper. I will answer some question on video my name or school.</td> </tr> <tr> <td style="text-align: center;">☒</td> <td>I will dictate my answers to the interviewer</td> </tr> </table> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Participant's name:</td> <td style="width: 40%;">Date:</td> </tr> <tr> <td colspan="2">Participant's signature:</td> </tr> <tr> <td colspan="2">Participant's best contact information: Province:</td> </tr> <tr> <td style="width: 60%;">Researcher's name</td> <td style="width: 40%;">Date:</td> </tr> <tr> <td style="width: 60%;">Researcher's signature</td> <td style="width: 40%;">Mrs. Nalini Asha Biggs</td> </tr> </table>	☒	We can make a video of the interview. My name or school will NOT be attached to this video, or shown to anyone outside of this research. Please destroy video after you have written down what I have said.	☒	I will answer questions on paper. My responses will be kept safe, and not linked to my name or school.	☒	I will answer some questions on paper. I will answer some question on video my name or school.	☒	I will dictate my answers to the interviewer	Participant's name:	Date:	Participant's signature:		Participant's best contact information: Province:		Researcher's name	Date:	Researcher's signature	Mrs. Nalini Asha Biggs
☒	We can make a video of the interview. My name or school will NOT be attached to this video, or shown to anyone outside of this research. Please destroy video after you have written down what I have said.																		
☒	I will answer questions on paper. My responses will be kept safe, and not linked to my name or school.																		
☒	I will answer some questions on paper. I will answer some question on video my name or school.																		
☒	I will dictate my answers to the interviewer																		
Participant's name:	Date:																		
Participant's signature:																			
Participant's best contact information: Province:																			
Researcher's name	Date:																		
Researcher's signature	Mrs. Nalini Asha Biggs																		

Though there were several drafts and version of the questionnaires used in this study there were a core group of topics guided by the research questions. There were questions about the existence of HIV/AIDS education in these schools which were primarily informed by the Primary School Action for Better Health (PSABH) survey used by Maticka-Tyndale, et al. (2002) to collect similar data in “regular” schools in this region. Because few studies on teachers’ attitudes and beliefs publish their exact wording, these questions were informed by interviews and trials conducted during the pilot study. Questions about Deafness were derived from the same interviews and trials as well as informed by topics covered by local Deaf advocacy groups such as human rights. Unless specified, the wording in each of these questions is original and all questions were reviewed and approved by Deaf participants as well as hearing former-teachers.

Participants were encouraged to respond to these topics often through multiple questions using different strategies and formats. For instance participants were asked to choose their comfort level in teaching the supplied curriculum on HIV/AIDS from a series of 5 comfort levels as well as asked to explain their choice. Later in the questionnaire the participant was asked to agree or disagree with several statements about teaching theses topics such as “I feel like if I talk about abortions then my students will be encouraged to get abortions.”

The length of these questionnaires was intentionally kept to under two physical pages, printed on both sides with the exception of the Posted Questionnaire. Questions were separated by placing each into its own cell in a table. This encouraged not only perseverance but helped the participant recognize the themes used for each section to help elicit thematic responses. This was in part informed by the (PSABH) survey. See Figure 18 as an example of their formatting using defined sections for to both separate questions and define answers more clearly.

Q21. If there is no Question Box, why not?		* ☐ ☐	
GO TO Q26a			
Q22. If Yes, is the box in an accessible place?			
Yes ☐		No ☐	
Q23. If there is a Question box, what evidence of it being used did you see?		* ☐ ☐	
Q24a. On average, how often are questions answered?			
Daily ☐		Once a week ☐	
Once every 2 weeks ☐		Once a month ☐	
Not yet ☐			
Q24b. IF LESS than once a month, why?			
☐ Don't know the answer to the questions put in the box			
☐ No time in the time table			
☐ Questions are unsuitable			
☐ No trained staff			
☐ Others (specify) _____		* ☐ ☐	
Q25: What is the most commonly asked question?			
_____		* ☐ ☐	
_____		* ☐ ☐	
_____		* ☐ ☐	

Figure 18: A similar survey conducted by Maticka-Tyndale, et al. (2002) separates questions into a table format and offers different ways of responding including dichotomous answers, multiple choice, a rating scale and open ended

SCHOOL-BASED QUESTIONNAIRE

The cadence of the school-based questionnaire employed an intentional strategy learned from pilot trials of previous drafts. Each questionnaire began with a neutral question not related to HIV/AIDS or feelings about Deafness (see Figure 19): “How long have you been teaching in schools for the Deaf? How did you first come to work with the Deaf?”.

The following question, “Do you think that schools for the Deaf need to address the

sexual and reproductive health of their students? Why?” is intentionally skewed to elicit a positive response. Experience with teachers in this study as well as in the past showed an almost universal agreement with this statement. While it is useful to gather this data from an as-yet under-researched population it is also a psychological tool to begin surveys with such questions eliciting easy, “yes” responses. After analysis it was confirmed that no teacher marked “maybe” or “no” to this question and many used the space provided to articulate their enthusiasm for this need.

Question 3 asked for information about the presence of informal HIV/AIDS education. While most studies on “Special Education” contexts and HIV/AIDS argue that this curriculum is never taught, it was the hypothesis of this study that at least some informal education was occurring. The choices and their clarifications come from common responses from pilot interviews. This is a similar question to the one asked by the PSABH survey (Maticka-Tyndale, et al. 2002).

Question 4 evolved from several trial surveys and interviews where over time the format was chosen as being the most efficient for eliciting the responses required. Rather than ask teachers to respond to each statement in individual questions (as some surveys do) or asking how they feel about each topic, this question streamlines the statements into quick dichotomous choices. This allows for ease of completion by participant as well as for later analytic input.

As the reader might notice, several of these statements are redundant. They intentionally are randomized so that the participant does not feel that all “yes” or all “no” answers is “correct.” Some are intentionally meant to elicit an almost-universal positive or negative reaction in order to make the participant feel secure in their answers.

Questions 5-7 were the result of pilot interviews where these “Deaf stereotypes”

were repeatedly recorded as being held by Deaf individuals, hearing teachers and related educators. The question intentionally asks “What do you think about the stereotype that...” rather than simply asking the respondent to agree or disagree with a statement. This is because out of all beliefs and attitudes collected during pilot study, these were the most unique and complex. Therefore this extra focus was given to elicit direct responses about these beliefs as “stereotypes,” a word teachers used themselves. Calling them “stereotypes” was important because it allowed teachers who disagreed with these beliefs to comment on whether or not “others” believed them.

Question 8 begins with a statement meant to elicit an almost-universal positive response because, like the first question, it prepares the participant to pay attention and feel confident. These statements about “The Deaf” re-examine some of the same topics as before in this questionnaire but from the standpoint about how the participant views “the Deaf community” or “Deaf culture.” Other statements meant to elicit specific responses (either positive or negative) are intentionally scattered throughout the list. The final four questions summarize the potential interaction between beliefs about HIV/AIDS education and Deafness succinctly.

Questions 4 and 8 use tables of semi-dichotomous statements requiring the same choice of responses and only a ‘check mark’ or ‘x’ so that participants could easily focus on comprehending the statements rather than having to decide how to answer. The quickness of response and rapid pattern is more likely to elicit an honest, instinctual reaction. Receptively responding to answers rather than having to write in “yes” or “no” also makes respondents feel more anonymous and more likely to be honest.

These questions reflect similar ones found in other surveys such as the PSABH Question 11, “What do you consider to be the most important message to get to children

about HIV and AIDS?” While initial drafts included such open-ended questions, the pilot study had shown a range of common answers and so these were used as multiple-choices instead to increase the efficiency of this tool. Space was provided for additional answers if the participant required.

Figure 19: Questionnaire given to all teachers in each of the three main school sites and also used as an interview outline.

Teaching in Schools for the Deaf and HIV/AIDS		
A Questionnaire for Educators		
Please answer as best you can. Your responses will remain anonymous. Please add comments or stories!		
1. How long have you been teaching in schools for the Deaf? How did you first come to work with the Deaf?		
2. Do you think that schools for the Deaf need to address the sexual and reproductive health of their students? Why? (Check one)		
☐	Yes	
☐	Maybe	
☐	No	
3. Do discussions about HIV/AIDS or sex come up between you and your students? Check one		
☐	Never	
☐	Rarely: A few times a year	
☐	Sometimes: Maybe 1 or 2 times a month	
☐	Often: Around once a week	
☐	A Lot: A few times a week or more	
4. How do you feel about these discussions? (choose as many as you want)		
☐	☐	Yes
☐	☐	No
☐	☐	I worry about the safety of my students
☐	☐	My students are experimenting with sex
☐	☐	My students are taught all they need to know about sex at home with their families
☐	☐	My students talk about sex and relationships with each other a lot
☐	☐	I feel comfortable talking with students about sex
☐	☐	I know enough about HIV/AIDS and sexual health to give my students good information
☐	☐	I feel that other teachers might be suspicious about me talking with students about HIV/AIDS
☐	☐	I want to help, but it is not my place to talk to students about sex
☐	☐	I wish there was more time and resources to educate my students about sex, health and relationships
☐	☐	Sometimes I feel like no matter what I do, the students will do as they please
Other feelings: (You can share stories about times when you have mentored a child about their health and safety, or relationships. You can talk about taboos, or being uncomfortable or worries. Anything!)		
5. What do you think of the stereotype that “Deaf people are more promiscuous.”		
☐	☐	Do you feel it is true?
☐	☐	Yes
☐	☐	No
Explain your answer:		
6. What do you think of the stereotype that “Deaf people love to gossip. They cannot keep secrets.”		
☐	☐	Do you feel it is true?
☐	☐	Yes
☐	☐	No
Explain your answer: (Taboo topics like sex, being HIV+, sexuality, are often talked about in confidentiality. Do you think this affects how educators talk to students about these issues?)		
7. What do you think of the stereotype that “Deaf people are HIV+.”		

Do you feel it is true?	Yes	No
Explain your answer: (Do you think educators approach discussions about sex or HIV/AIDS differently with Deaf students because some think that preventing HIV/AIDS is hopeless)		
8. Tell us whether you agree or disagree with each statement about the Deaf community in Kenya		
Yes	Neutral	No
Deaf people...		
		...have the same human rights as everyone else
		...are just as sexually active as hearing people
		...are more sexually active than hearing people
		...are less sexually active than hearing people
		...have more sexual partners than hearing people
		...have more risky/unsafe sex than hearing people
		...get good information about sex or HIV/AIDS from their family
		...get tested for HIV just as much as hearing people
		...report rape and abuse when it happens just as much as hearing people do
		...know their rights just as much as hearing people
		...are more likely to be virgins
		...have loving, monogamous relationships
		...are more likely to sell sex for money or food/goods (become prostitutes)
		...are targeted for sexual abuse and rape because they are Deaf
		...are more likely to be HIV+ because of risky behaviors and abuse
As educators of the Deaf I feel that if we...		
		...talk about sex in the classroom, this will encourage them to have more sex
		...talk about how to use condoms, they will be encouraged to have more sex
		...talk about what an abortion is, they will be more likely to get one
		...talk about ART and HAART drugs (that keep you healthy and alive when y they will think AIDS is not a problem, and have unsafe sex
9. Please add anything else you would like to share, even If it does not relate to HIV/AIDS or sex education. What are your biggest struggles? What do you think your school does well? What are you proud of?		

POSTED QUESTIONNAIRE

The design of the questionnaire offered to Deaf teachers by post was more qualitative than the school-based questionnaire given to teachers in school sites visited. It also included different questions aimed at eliciting different data from this population.

In retrospect this tool would have ideally included much of the multiple choice and dichotomous questions of the posted questionnaire not only for easier comparison (some of this data was extrapolated from written responses) but because of lessons learned over the course of the study. The primary lesson learned was that despite having completed the same schooling as their peers, many of the Deaf teachers had considerably lower

literacy skills than their hearing colleagues. Much of the writing was more difficult to understand because of phrasing that research on this topic argues comes from the grammatical differences between English and sign languages. Deaf teachers were also more likely to use “catch phrases” common to Deaf and disability advocacy in order to answer open-ended questions about their personal feelings on a topic. However, at the time this questionnaire was written, I was more concerned about providing the opportunity for the Deaf teachers to “be heard,” and to “have a voice,” which was a common concern of the participants.

While the school-based questionnaire was formatted to fit onto two double-sided pages (based on data collection experience as the ideal maximum number of pages) the posted questionnaire was longer. At the request of Deaf participants the posted questionnaire presented one question per page, using a landscape orientation with printed lines for ease of writing and a note to use the back of the paper if necessary, totaling 8 pages stapled together.

Like the school-based questionnaire, this questionnaire begins with an open, more neutral question to engage the participant on a personal level. The second question was included for the Deaf population in order to gather some background on the possible differences between past educational practices and current ones in schools for the deaf, if that was where the participant was enrolled.

Question 4 was useful in that many Deaf teachers used the space to provide their own wording of “Deaf stereotypes.” The predicted beliefs offered as choices i-iii in the question were among the answers as well as other beliefs that proved useful for later comparative analysis. Again, the wording of these questions came directly from how teachers, both Deaf and hearing, phrased these beliefs in pilot research.

Question 5 was the most important question that differed from those included in the school-based questionnaire because it collected data that only Deaf teachers could offer. Pilot study interviews with Deaf teachers highlighted the strong belief that many hearing teachers, especially those in positions of power, believed that their Deaf colleagues were less intelligent or professional.

Question 6 was included because previous studies had explored the impact of gender roles on how teachers implemented HIV/AIDS-related education. With so little data on the perspectives of Deaf teachers it was included though it was not the focus of this study. The same is true for Question 7.

In general Deaf teachers who participated through this questionnaire included longer responses often including personal stories and reflections on their experiences than their counterparts who completed the school-based questionnaire in school sites. This was possibly due to the fact that far more space was offered and only open-ended questions. However the feedback of some participants highlighted the possibility that this was also because there were very few opportunities for Deaf teachers to participate in studies such as this, especially ones that specifically asked for their input as Deaf educators. Through the “Deaf grapevine,” as they called it, news spread fast about this study and participants were eager to contribute.

Table 16: Posted Questionnaire questions and format (with space for answered removed for brevity).

1. Tell me what was school like for you?
a. What kind of school did you go to? b. How do you feel about your schooling experience?
2. When do you remember first hearing about HIV/AIDS?
a. Did teachers in your school ever talk about it? b. Did they ever talk about sex education, or reproductive health? c. Do you think this was the best way or could it have been better for you? d. Do you feel like learning about these things would have been different if you were hearing?
3. What do you think about teaching HIV/AIDS and sex education now?
a. Is it difficult or easy? b. What resources do you have, and what would you like to have? (time, training, etc). c. How could the government train you better d. Who is best for Deaf student to learn about sex from?
4. Let's talk about stereotypes of the Deaf. Do you think there are any?
a. Tell me how you feel about them such as: i. Deaf love to gossip, and cannot keep secrets ii. The Deaf are promiscuous, and that they cannot have boy-girl friendships and abstain from sex iii. Deaf are stupid, and cannot help themselves, they cannot learn b. Other stereotypes you know of?
5. Do you think hearing teachers believe these things just as much as others? More Less?
a. Do you think these beliefs change how they treat students?
6. Do you think government officials or head teachers believe these things?
a. Does it change how they write curriculum or approach HIV/AIDS education in school? (such as, do you they think HIV/AIDS is harder with the Deaf because 'they cannot keep secrets' and 'are promiscuous' and 'are stupid'?)
7. Gender Roles: What about the difference between boys and girls?
a. Do you think HIV/AIDS education, and sex education, needs to be different for them? b. Do you think it is taught differently already in schools? c. Do you feel like when you were in school, you got different messages about sex and health than people of the opposite gender? How so? What do you think about this? d. Do you think this is different for hearing children? e. Do you think hearing teachers talk to boys and girls differently about these topics?
8. Religion and Personal Values and Beliefs
a. Many teachers have a hard time when HIV/AIDS curriculum asks them to talk about things that is against their religion or moral values. Do you think this happens in Deaf schools? b. Tell me about times when you have felt uncomfortable talking about sex, condoms, abortion, or other issues relating to HIV/AIDS and sex education
9. Is there anything else you would like to share about your experiences in school, and how this has changed your life?

APPENDIX 5: TABLES ON PARTICIPANTS WHO WERE INTERVIEWED

Table 17: Summary 1 of teachers interviewed in school sites

Provinces	Nyanza		Western
School Sites	A	B	C
Total Teachers Interviewed	9	9	9
Total	27		

Tables 18: Summary B of teachers interviewed in school sites

Total hearing teachers interviewed	21
Total Deaf teachers interviewed	6
Total minutes of interviews recorded	907 minutes
Average interview length	41 minutes
Participants who completed both a questionnaire and interview	15
Female Participants	10
Male Participants	17
Participants who were also administration	4
Average years experience per teacher	10.5

Table 19: Summary of Interviews

				Percent of total participants	Percent of total participants interviewed	Percent of Deaf participants interviewed	Percent of teachers interviewed	Percent of teachers interviewed at school sites	Percent of Deaf teachers interviewed at school sites
Total Participants				81	100%				
Interviews	Teachers		Total participants interviewed	43	53%	100%			
			Deaf participants interviewed	13	16%	30%	100%		
			Teachers interviewed	41	51%	95%	100%		
		on school sites	Teachers interviewed at school sites	28	35%	65%	68%	100%	
			Deaf teachers interviewed at school sites	7	9%	16%	54%	25%	100%
			Interviews with administration at school sites	4	5%	9%	10%	14%	0%
			Interviews with staff	2	2%	2%			
			Interviews with other participants	6	7%	14%			

Table 20: Interview Lengths

Time	Total interview time in minutes	1635
	Average interview length of any participant	43
	Average interview length with a Deaf teacher	34
	Average interview with any teacher	48

APPENDIX 6: QUANTITATIVE DATA TABLES

QUESTIONS ABOUT STEREOTYPES

The following tables show data on how participants responded to questions directly about “Deaf stereotypes”.

Table 21: Responses to stereotype questions by demographics

	Do you agree "Deaf people are more promiscuous"?			Do you agree that "Deaf love to gossip. They cannot keep secrets."?			Do you agree that "Deaf people are HIV+"?		
	Blanks	“Yes”	%	Blanks	“Yes”	%	Blanks	“Yes”	%
Site A	0	1	25%	0	2	50%	0	2	50%
Site B	0	5	42%	0	7	58%	1	6	55%
Site C	0	3	23%	0	11	85%	1	0	0%
Deaf	0	0	0%	0	1	25%	1	0	0%
Hearing	0	9	36%	0	19	76%	1	8	33%
Female	0	5	33%	0	13	87%	1	5	36%
Male	0	4	27%	0	7	47%	1	3	6%
Totals	0	9	31%	0	20	69%	2	8	30%