DRAFT August 2007

TASO Training Center

A Report on a Rapid Training Needs Assessment among People with Disabilities in Masaka, Gulu and Soroti.

In collaboration with the National Union of Disabled People of Uganda (NUDIPU)

A trainer helps a PWD in administering the TNA questionnaire in Awer IDP Camp in Gulu.

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LISTOF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti Retroviral Treatment
CBO's	Community Based Organisations
CWDs	Children with Disabilities
DAC's	District AIDS Commissions
DDHS	District Directorates of Health Services
FGD	Focused Group Discussion
HIV	Human immunodeficiency virus
MOH	Ministry of Health
MTCT	Mother to Child Transmission
NUDIPU	National Union of Disabled Persons of Uganda
PHA's	People Having AIDS
PMTCT	Prevention of mother to Child Transmission
PWDs	People With Disabilities
PWDA's	People with Disabilities having AIDS
SNE	Special Needs Education
STDs	Sexually Transmitted Diseases
TASO	The AIDS Support Organisation
UAC	Uganda AIDS Commission
UNAIDS	Joint United Nations Programme on AIDS
WHO	World health Organisation
WWD's	Women with Disabilities

ACKNOWLEDGEMENTS

On behalf of TASO Training Center, the Team wishes to express its firm, innermost and heartfelt appreciation to NUDIPU and the whole TASO Management, for the honour, trust and confidence, extended to us throughout the assignment.

We are highly indebted to many individuals and organization who contributed information and ideas on this rapid study as we could not have satisfactorily performed our task without their cooperation and collaboration. They include the Chairpersons of the Disability Persons Organizations (DPOs) of Masaka, Gulu and Soroti; the Administrator MADIPA Mr. Ssengaali David, The Development worker of Gulu Office and his two Assistants for their great mobilization work in Awer IDP Camp. We are further grateful to Ms Jane Alum of SODIPU for her ability to adopt at such a short notice.

We are further grateful to the various individual respondents who acted on our questionnaires and interviews. Their active involvement and views were informative towards understanding of how best TASO Training Intervention can effectively address the emerging challenges of working as partners with people with disabilities.

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CHAPTER 1 BACKGROUND

Six hundred million people around the world are affected by disabilities. Most of them live in developing countries, and most of them are poor. There is a growing awareness in the development community that people with disabilities must be included in the development equation, not only to improve their economic and social welfare, but because they themselves can contribute to the development process.
Research shows that the disabled are caught in a vicious cycle: disabilities can cause people to fall into poverty, and the poor more often fall victims to disability (so it is both a cause and consequence of poverty). This means therefore, that there is a disproportionately high number of disabled people among the poor, especially in the developing countries (*Development Outreach*)

The disabling effects of HIV/AIDS on previously healthy people has been the subject of attention by AIDS researchers, however there is a striking absence of attention to the risk of HIV infection in individuals who have a physical, sensory, intellectual or mental health disability prior to acquiring the virus.

To many people it seems a contradiction in terms to work on the risk of HIV/AIDS infection within the disabled population and it is indeed an area filled with myths. One common misconception is that disabled people are not sexually active and therefore not at risk of being infected. Another that substance abuse, sexual abuse and violence, homosexuality and bisexuality does not exist among disabled people. These are all wrong assumptions that lead to exclusion from HIV/AIDS prevention and care services of a large group of individuals that face all known risk factors for HIV/AIDS at equal to up to three times greater risk of infection than do non-disabled individuals (Yale/World Bank Global Survey).

Uganda has achieved a lot over the years in responding to the HIV/AIDS epidemic. Since 1992, HIV prevalence in Uganda has dropped by more than 50%, and significant changes in HIV-related behaviors have been documented. The overall HIV/AIDS prevalence in the country is 6.4% with urban populations having roughly 10.7% and

rural populations 6.0%. Uganda's response to HIV/AIDS is widely viewed as a model for the rest of Sub-Saharan Africa, and comprises of strong public commitment, mass mobilization and education campaigns, political openness, involvement of communities, political vision and recognition that HIV/AIDS is a threat to development.

However, policy makers, implementers and all major actors in the area of HIV/AIDS in Uganda have failed to appreciate the *"forgotten tribe"* (Mwesigwa Martin Babu). Issues and needs of this tribe have not been given their due and appropriate attention in the fight against the epidemic. This therefore means that the impact and implications of the HIV/AIDS epidemic among the disabled people may not have been well represented in the general prevalence situation of Uganda.

This Rapid Training Needs Assessment was initiated by TASO Training Center and NUDIPU to determine whether and to what extent, the 3 million individual Ugandans who live with a disability are at risk of acquiring HIV/AIDS and what measures are being taken to ensure that they are able to access HIV/AIDS information, Care, Support and Prevention services.

Who are people with Disabilities?

World Health Organization (WHO) defines people with Disabilities (PWDs) as individuals with physical sensory, intellectual and mental health impairments. Worldwide it is estimated that roughly 1 in 10 people is a PWD. There are thus about 3million PWDs in Uganda going by this approximation. The Uganda Bureau of Statistics (UBOS) survey estimates PWDs are 4% of the population
There are two common interpretations of disability. The medical and the social interpretations. The medical model looks at disability as 'the lessening or absence of a particular motor, sensory or mental function. It looks at disability as a physical impairment (it can be a loss of limb, or sense or other impaired bodily function) that compromises the health and activity or quality of life of an individual.

The social model is a more recent developed theory. That cites the medical theory as shallow and procrustean. The social model argues that disabled people are not disadvantaged or incapable of leading normal lives because of their physical impairments per se but rather

limited by the social, economic, cultural and environmental barriers around them. These barriers are social discrimination, exclusion and inconsideration to the disabled peoples special needs because they are seen as an exception rather than the norm in what is ideally an able bodied society.
The majority of non-disability health organizations, which in this case is negligible, because most of the health services in the country are provided by general health institutions that may not specifically cater for PWD HIV/AIDS health needs in the country.
Only a quarter of health organizations provided services for all disability groups. They were not equipped to handle all disability health concerns. Epilepsy (13%), Blind/low vision (13%), mentally ill (12%) and the deaf (10%) are served respectively. However intellectually disabled, chronically ill and multiply disabled people are least attended by health organizations

Justification of the assessment
There are glaring gaps in understanding the challenges that disabled people go through especially dealing with AIDS. To date the HIV/AIDS information, education and counseling packages have had little impact on PWD community especially in developing countries. PWDs face unique challenges like they have low incomes and yet they require higher incomes than able-bodied people to maintain the same living standard. For this reason they are highly vulnerable to give into sex for financial favors or security stigmatization and neglect are also a huge problem.

Actual presences of HIV/AIDS programmes are important. However the study was needed to realize how usable or accessible these services are by PWD's bearing in mind their demography, mobility and sensory or perception limitations. PWDs can only benefit if they are able to fully access HIV/AIDS information and services and effectively communicate the effectiveness of these programmes.
If we assume that PWDs are able to reach these or know about these services at all. It is imperative to know if PWDs get equal services and opportunities as their able bodied counterparts. Lastly are they facilitated or catered for with respect to their individual handicap. This is important because PWDs are not homogenous group but are also disaggregated by their different sometimes multiple handicaps.

Assessment goal

To identify the training needs and gaps in terms of knowledge, information and attitudes among potential people to champion, care and provide support services among the PWD fraternity

Objectives of the assessment

- To assess what knowledge, information, skills and attitudes PWDs have about HIV and AIDS.
- Specifically there is need to determine/assess what knowledge and attitudes PWDs have about sexual and reproductive health practices and experiences in relation to HIV and AIDS
- To assess the accessibility and inclusiveness of the existing HIV AIDS programmes to PWD's.
- Develop practical recommendations for intervention so as to redress the identified gaps in mainstreaming PWD concerns and challenges into the general fight against AIDS.

CHAPTER 2: METHODOLOGY

Assessment area and population

The survey area was carried out in the districts of Gulu, Masaka and Soroti. The study population was PWDs though no particular desegregations by handicap or age group was done as the targeted population forms a minority. It was argued that the whole disabled community had a stake in this exercise

Tools for data collection:

The assortment of data collection tools included

Method	Justification
Review of secondary sources	Reviewing a combination of policy, academic and press records of PWD related health issues. Some previous studies by DPO's were also read. The purpose was to see the pertinent issues for this study and be able to feed in or relate field information into this study
Semi structured Questionnaire	To obtain individual awareness levels, attitudes and sexual practices of PWDs
Observation	This was useful in assessing the depth and gravity of the issues affecting PWDs in relation to HIV AIDS that could not be revealed by the other tools and yet are critical in making a study like this .For example the mobility, communication infrastructure, levels of participation and demographics of the PWD community

The Questionnaire that was the main source of data collection and the focus of the data analysis was structured in the following manner:

1. Respondents' biodata, which included place of residence, sex, age, religion, marital status and type of disability

2. Knowledge about AIDS, mediums of information about it and attitudes or beliefs on Aids transmission methods, personal risk level assessment.

3. Assessment of measures perceived to prevent HIV spread these included abstinence, exclusiveness of sexual partner, faithfulness, use of condoms and how they feel about fellow PWD's in the community (social attitude)
4. Attitudes and readiness to utilize available HIV/AIDS prevention, treatment and care services. As well as assessing the accessibility of the PWDs to these services. In terms of mobility restriction, neglecting PWD specific sensory needs

The sampling procedure

The survey was designed with facilitation and time constraints in mind and was adapted to conditions in the field. The main aim was to get individual respondents mobilized in the district of Gulu, Masaka and Soroti. The minimum target was 50 respondents per district. It was not possible to meet the same minimum requirement in all districts because of logistical challenges.

Data management and analysis

Data was entered into a pre prepared computer database using EPINFO 2004.Data cleaning was done. The statistical characteristics of PWDs were obtained and cross tabulations done. Qualitative data analysis was done and interpretations were got from the triangulation of responses.

Team composition

The team was composed of 3 members with expertise in HIV AIDS related training. They were supported by the DPO staff at the district level especially in mobilization and translation of the contents of the questionnaire before it was administered.

Limitations of the assessment

The greatest limitations were logistical in nature. It was intended to be a quick and rapid study but the numbers of respondents to consider and their mobility challenges were underestimated. This had the implication of traveling to individual homes of PWDs but this was not totally possible. Thus it was not possible to meet the target numbers in all districts because there was no facilitation for example transport refund to encourage large turn ups in group as was envisioned. This was a problem particularly in Masaka.

Actual administration of the tool was also not easy because in some cases it was not confidential, as we would have hoped considering the nature of the questions. This is because interpreters were used to help answer for the blind

CHAPTER 3; ASSESSMENT FINDINGS

General situation:
Individuals with disability were at significant risk of becoming HIV infected. The following interim observations and deductions can be drawn based on the survey data analyzed. All risk factors associated with HIV are increased for individuals with disability.
1) Poverty
Even among the very poor, it is generally recognized that those with disability are the poorest members of the community. As James Wolfensohn(former WB president) noted: "unless disabled people are brought into the development mainstream, it will be impossible to cut poverty in half by 2015 or to give every girl and boy a chance to achieve a primary education by the same date." There is a cycle of disability and poverty: the poor are more likely to become disabled due to poor nutrition, lack of medical care, dangerous housing, injuries on the job, and violence. The World Bank estimates that individuals with disability may account for as many as one in five of the world's poorest.

2) Lack of education
Children with disability are shut out of education because they are not considered in need of an education, are assumed to be a distraction in schools, or because it
is believed that they are not capable of learning. Schools are physically inaccessible.
As a result, the global literacy rate for all individuals with disability may be as low as 3% and as low as 1% for disabled women. Even if in school, disabled children and adolescents are less likely to receive science and health education, and are more likely to be excused from sex education courses. According to UNICEF, one-third of all street children are disabled.

Lack of information and resources to ensure '*safer sex*'. There is an incorrect assumption among the general public, and within the HIV/AIDS research community as well that individuals with disability are not sexually active. Adolescents and adults with disability are as likely to be as sexually active as their non-disabled peers. Adolescents with many (although not all) types of disability reach puberty at the same age as their peers. However, individuals with disability are less

likely to receive messages about AIDS and are less likely to have access to condoms or other prevention methods.

3) Elevated risk for violence and rape and lack of legal protection in specific relation to this risk by individuals with disability is up to three times more likely to be victims of physical abuse, sexual abuse, and rape. Most individuals with disability have little or no access to police, legal counsel, and courts for protection

Should sexual abuse/rape occur, individuals with disability have less access to medical interventions, including psychological counseling and prophylactic care, than their non-disabled peers.

4) Disabled AIDS Orphans
Children with disability orphaned because of their parent's death through AIDS; whether they themselves are HIV+ or not. Require extra care (feeding, toileting, etc.) from already overburdened caregivers with many other children to care for. CWDs are more likely to be malnourished, neglected, institutionalized and abandoned.
Low or no access to and affordability of Care if Individuals with disability become HIV+. Health care facilities are often physically inaccessible (stairs, lack of sign language interpreters, etc. Health care is unaffordable for the impoverished disabled.
Health care professionals are unaware of the needs of individuals with disability and, and often deny disabled individuals access to HIV testing, AIDS care, and place a lower priority on disabled individuals with AIDS when scarce AIDS drugs and services need to be rationed.
Services, such as drug and alcohol programs, domestic violence, intervention programs, and places where condoms are distributed and where AIDS education materials are available are also inaccessible and non-inclusive.

5) Stigma
Stigma has been associated repeatedly with AIDS. Stigma has also been repeatedly associated with individuals who are born with or who acquire a disability. Individuals with disability who become HIV+ are doubly stigmatized, particularly within the "charity model" framework.

Reasons People with Disability Are Not Being Reached
1) Lack of education inhibits ability to obtain and process information.
2) Information is in inaccessible formats.
a) Radio campaigns miss the deaf.

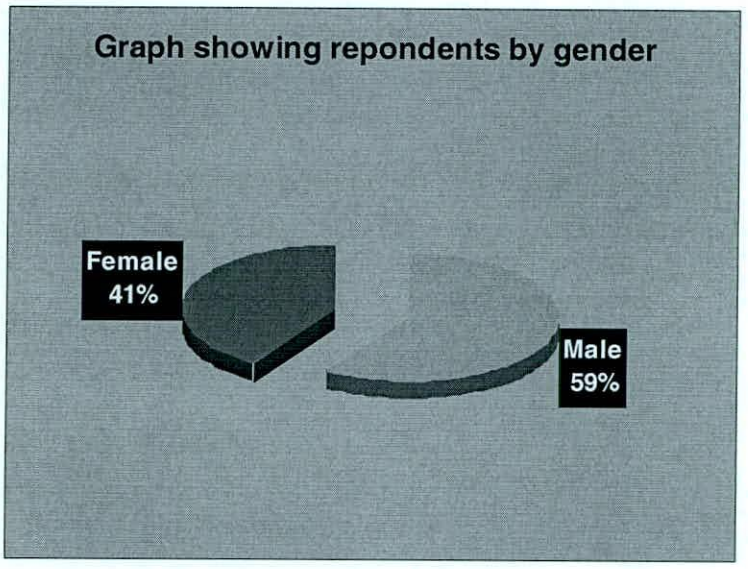
b) Billboards do not reach the blind.
c) Complex or vague messages do not reach those with intellectual impairments.
d) Clinics/services are inaccessible.

People with disability are not being included either implicitly or explicitly in most HIV/AIDS outreach efforts. Lack of knowledge of disability and awareness of disability issues among AIDS workers, government ministers, NGOs, etc., is the primary barrier. Unfamiliar with disabled
Populations, they are unaware that individuals with disability are sexually active or otherwise at risk. Most view individuals with disability largely as a medically dependent, childlike population, isolated from the real world.

Subgroups at Still Higher Risk
Women with disability, compared with both non-disabled *and* men with disability are:
1) Less likely to be educated
2) More likely to be unemployed or marginally employed
3) Less likely to marry
4) More likely to live in a series of unstable relationships
Disabled members of ethnic and minority populations:
1) Are marginalized within their own societies as well within the larger, national society
2) Have lower levels of education, employment, and access to disability programs
3) Are less likely to be reached by national AIDS education and outreach
4) Face "triple discrimination" if they are women

ASSESSMENT FINDINGS

Gender



Overall 41% of the respondents were women and 59% men. It is very important in particular to have raised this amount of female respondents. Not only are WWDs actually more vulnerable to HIV/AIDS like all women but even more importantly they have the extra challenge of women having less freedom of the choices they make and rights they can claim in a predominantly patriarchal society. It helps to establish if women with disabilities are really more vulnerable than the men.

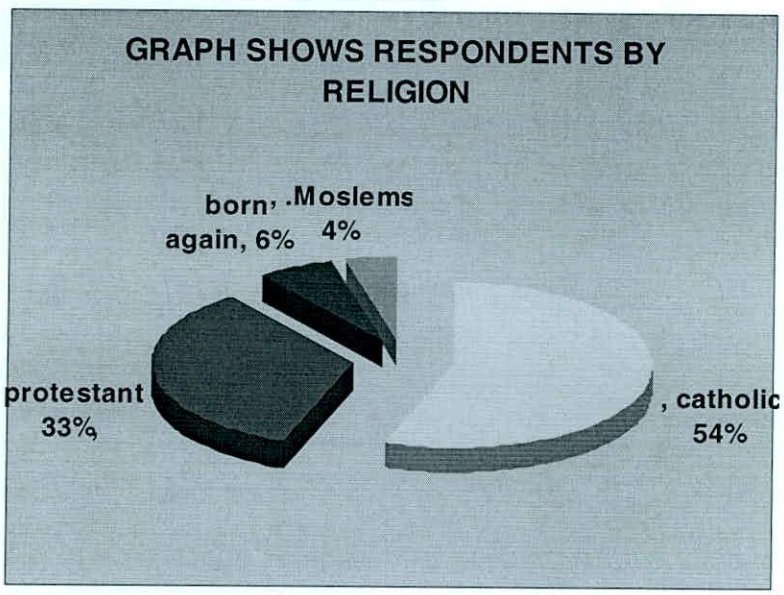
Age:

The age groups recorded were predominantly adult and could be termed as sexually active. It was noticed that among the higher age group (60 years plus) men recorded higher responses than women. As a result of the varied age groups, the following categories participated:

Age Group	Frequency
14 - 18	4
19 - 23	14
24 - 28	17
29 - 33	15
34 - 38	11
39 - 43	9
44 - 48	6
49 - 53	7
54 - 58	6
59 - 63	5
64 - 68	2
69 - 73	1
74 - 78	1

Religion

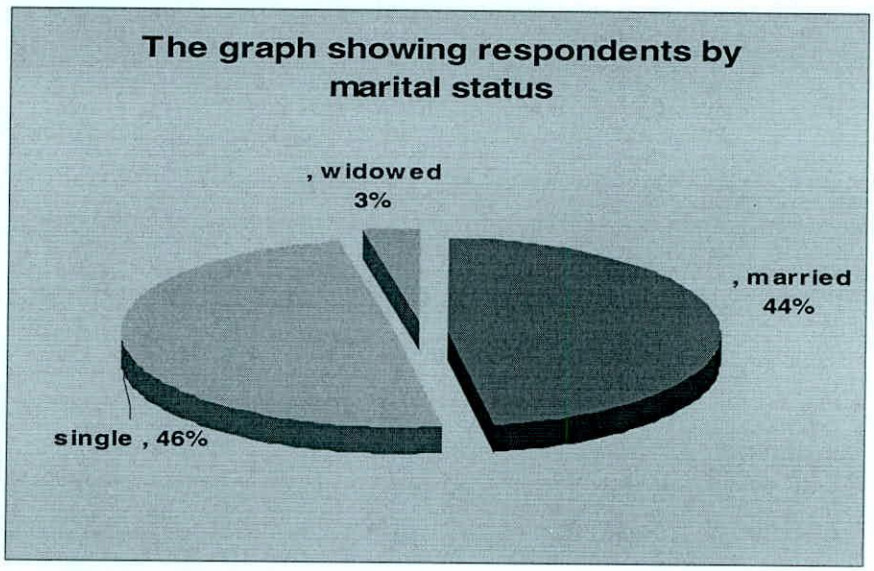
RESPONDENTS BY RELIGION



The significant majority of the respondents were Christian throughout the districts. 54% were catholic, 33% were protestant, 6% born again and only 4% Moslems. This was considered vital the analysis of sexual attitudes and if religious affiliation had any bearing or influence on individuals

Marital status

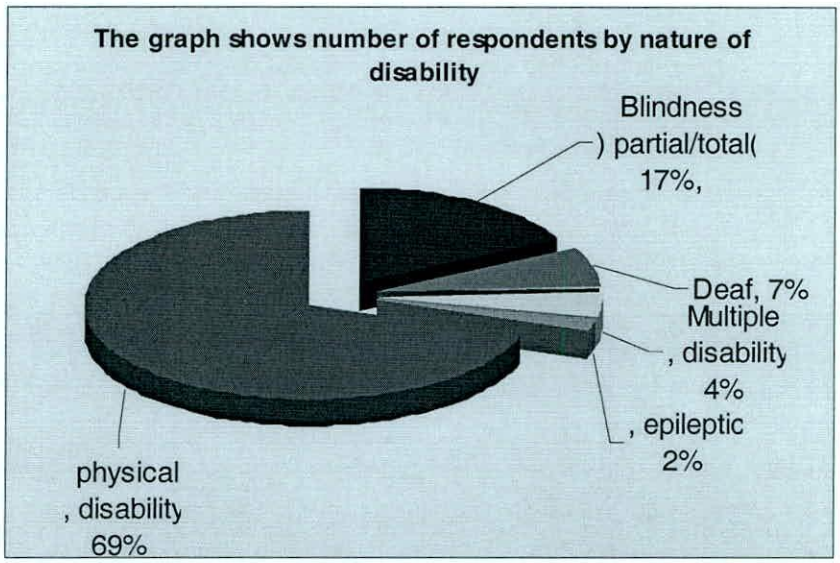
RESPONDENTS BY MARITAL STATUS



The respondents were 44% married, 46% single and 3% widowed. However this could not be independently verified and some that stated 'married' in the biostatistics did not corroborate this through the follow on answers. A significant majority of the respondents who were single were at some stage in the past lived with a partner and this could definitely be attributed to the difficulty in finding permanent sexual partners.

Types of disability.

RESPONDENTS BY NATURE OF DISABILITY

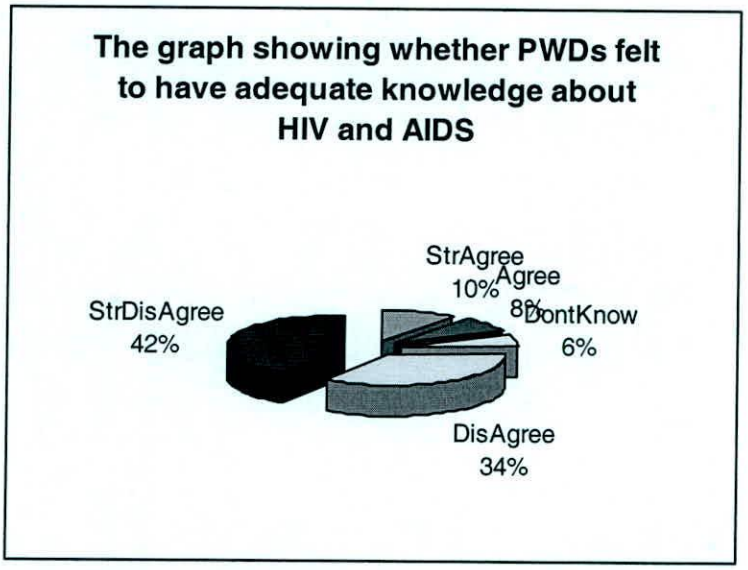


The main disabilities that figured among all respondents were as follows 17% Blindness (partial or total), 7% Deaf, 69% physical disability, 4% Multiple disability and 2% epileptic.

Knowledge about HIV and AIDS and its transmission

This section presents findings on the knowledge and attitudes of the respondent PWD's towards HIV infection and disease.

I have adequate information about HIV and AIDS

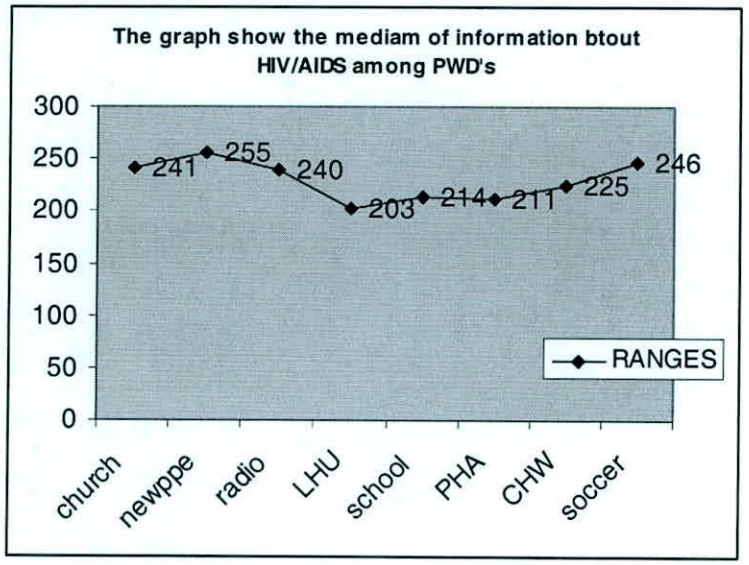


According to the needs assessment findings 10% of the respondents strongly agreed, 8% agreed, 6% didn't know, 34% disagreed and 42% strongly disagreed that they have adequate information about HIV and AIDS. This shows that 78% agree to the lack of adequate information about HIV and AIDS. There is a positive view on this because this shows that the bulk of PWDs yearn for education or deeper information and understanding about HIV and AIDS. It also shows that they are aware that they probably know less than they would want to.

I get to know about HIV and AIDS through

RANGES	
0-99	Never
100-198	Once/ Hardly
199-297	Occasionally

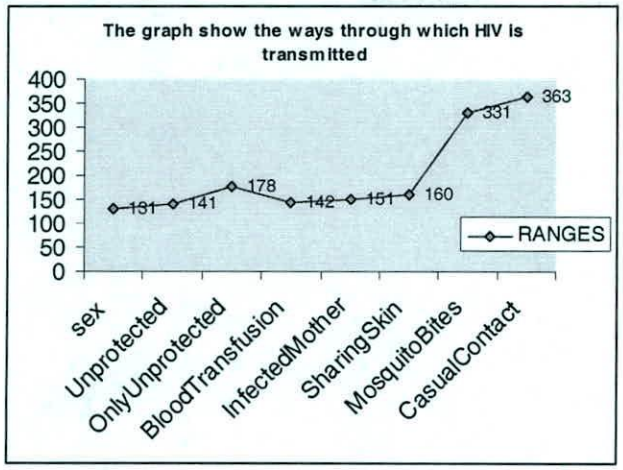
298-396 : most times
367-495 : All the time



By the use of inferences, the ranges as calculated and derived above show the ranges for all the different channels of information lay between 203 and 255.This means that all these channels on aggregate " occasionally" become sources of information about HIV and AIDS given the different types of disabilities among PWD's.

I know that HIV is transmitted through

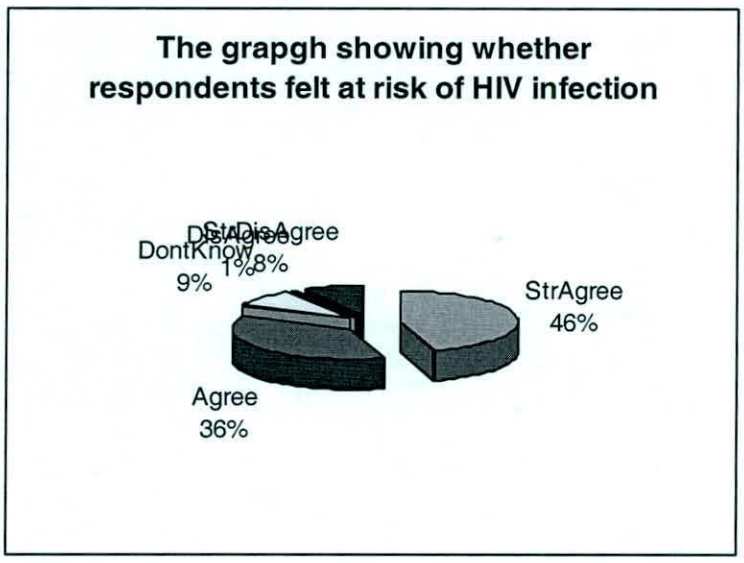
RANGES
0-99 Strongly agree
100-198 Agree
199-297 Don't Know
298-396 Disagree
367-495 strongly disagree



Here the inferred data shows that the respondents agreed to the fact that anything to do with sex causes HIV transmission. As we observe, respondents agreed more with plain sex than only unprotected sex with an HIV infected person. On the other hand the ranges seem to indicate that the respondents were knowledgeable about the variables that carried less risk of HIV infection as seen on the scores on mosquito bites and casual contact.

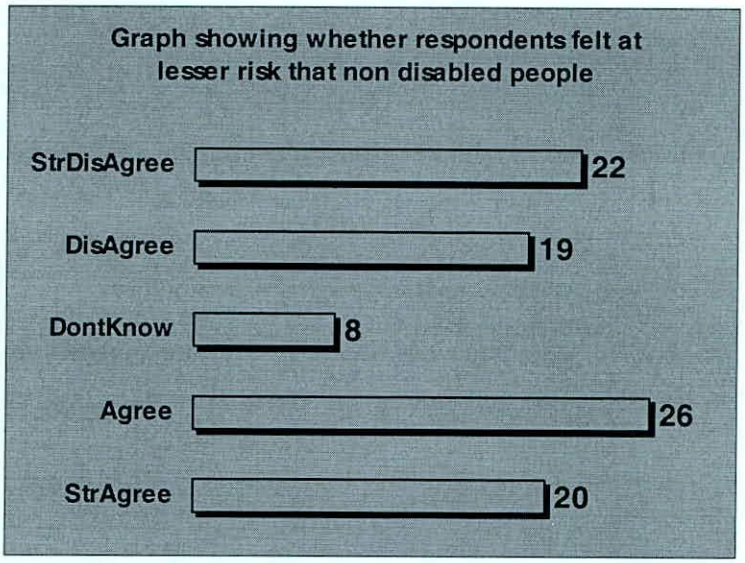
Attitudes among PWDs on AIDS

I am at risk of HIV infection



When looking at individual risk of HIV infection 46% strongly agreed, 36% agreed, 9% dint know, 1% disagreed and 8% strongly disagreed. Data here seems to indicate that over 80% of the respondent PWD's agree that they are at risk of HIV infection. For some reasons, there also those who either don't know or think they are not at risk at all

I believe that I am at a lesser risk of HIV infection than non disabled people.

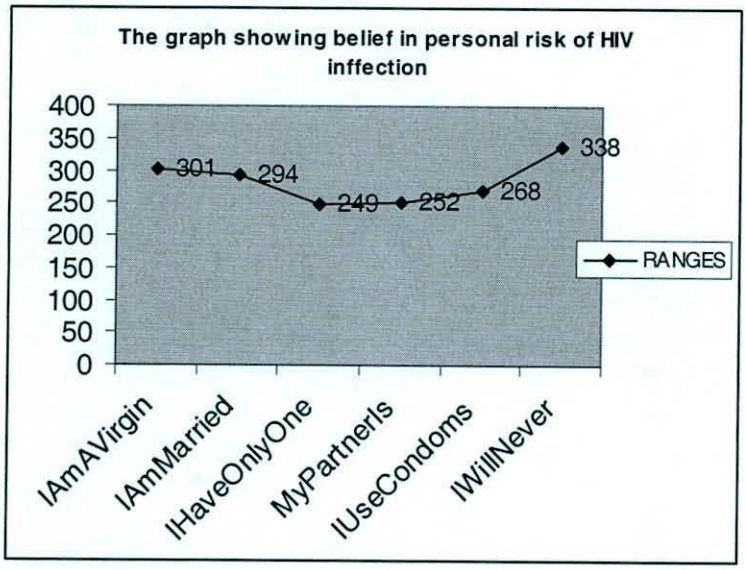


In the belief about being at lesser of HIV infection as compared to those people who do not have disabilities, 22 of the respondents strongly disagreed, 19 disagreed, 8 didn't know, 26 agreed, and 20 strongly agreed.
41 of the respondents felt that being disabled did not make their risk situation any less and yet 46 other respondents felt that in comparison with the non disabled they were in a less risky situation. 8 were not sure.

Reasons why respondents felt of being at lesser risk than non disabled people

RANGES

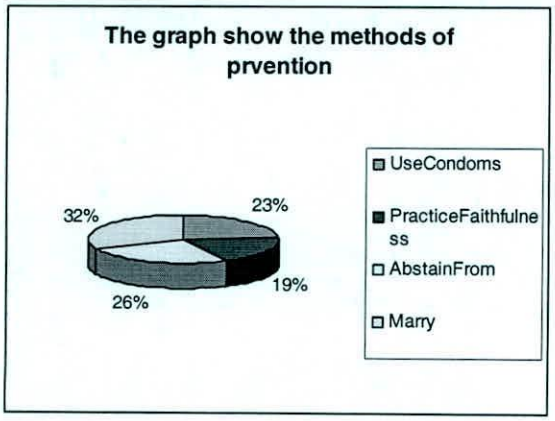
0-99	Strongly agree
100-198	Agree
199-297	Don't Know
298-396	Disagree
367-495	strongly disagree



Information from our ranges seems to indicate that the reasons for the belief about they (PWD's) being at lesser risk lie between 240 "don't know" and 394 "disagree".
So if 46 respondents in graph ---- above think that they less risk as compared to the non disabled and the ranges in graph --- indicate that they don't know why, then there is need to understand and bridge this gap.

To avoid HIV infection I

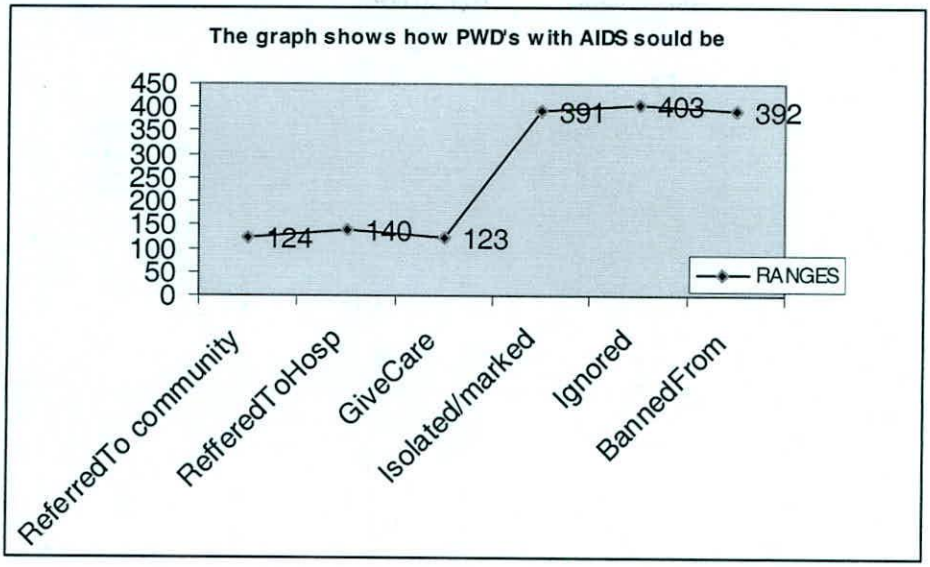
RANGES	
0-99	Strongly agree
100-198	Agree
199-297	Don't Know
298-396	Disagree
397-495	strongly disagree



This graph shows that to avoid HIV infection 32% have married, 26% are abstaining, 23% use condoms and 19% practice faithfulness.

PWDs' with AIDS should be ignored marked, banned from the community given care, referred to CHW or referred to hospital:

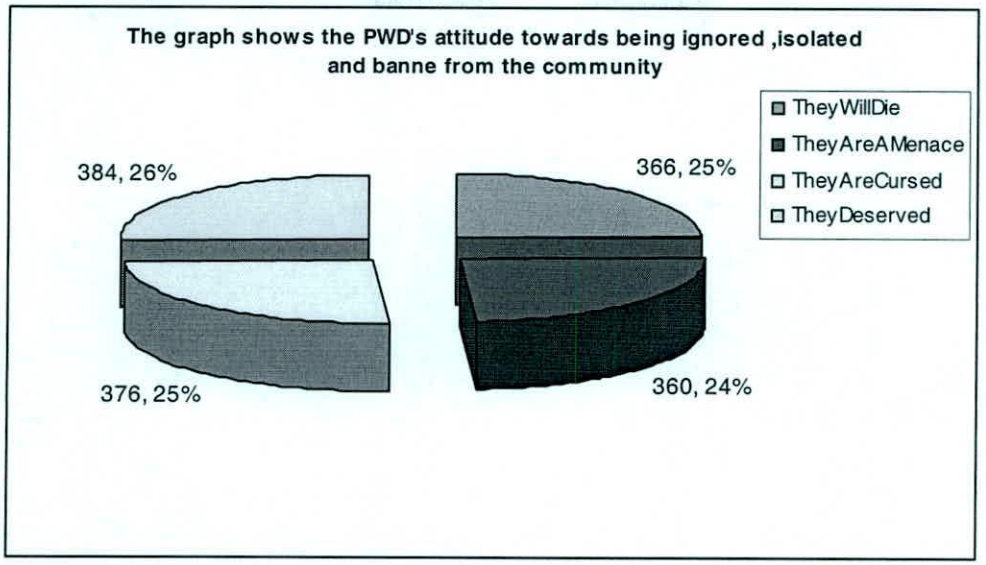
RANGES	
0-99	Strongly agree
100-198	Agree
199-297	Don't Know
298-396	Disagree
397-495	strongly disagree



The ranges for ignore, marked/isolated and banned from the community lay between 391 – 403 (strongly disagree) indicating that, all the respondents were not in favor of actions of either getting ignored, getting marked/isolated or being banned from the community. The ranges of being given care, referred to CHW or to hospital lay between 123 and 140, indicating that all the respondents agree to this gesture.

I think PWD's with AIDS should be ignored, isolated, banned from the community

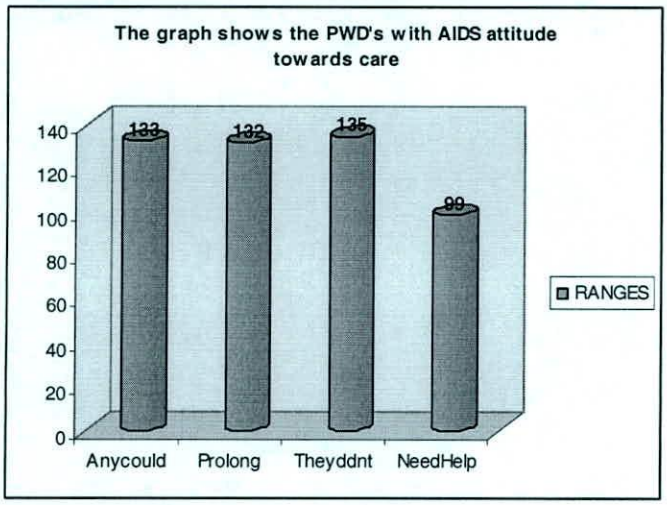
RANGES	
0-99	Strongly agree
100-198	Agree
199-297	Don't Know
298-396	Disagree
397-495	strongly disagree



On how the respondents felt about PWD's with AIDS being ignored, isolated or banned from the community because either they deserved it, or are a curse from God, or because they are a menace to the community or because they will die anyway, the ranges lay between 360 and 384 meaning that they either disagreed or strongly disagreed with the idea.

I think PWD's with AIDS should be cared for, referred to CHW's or hospital:

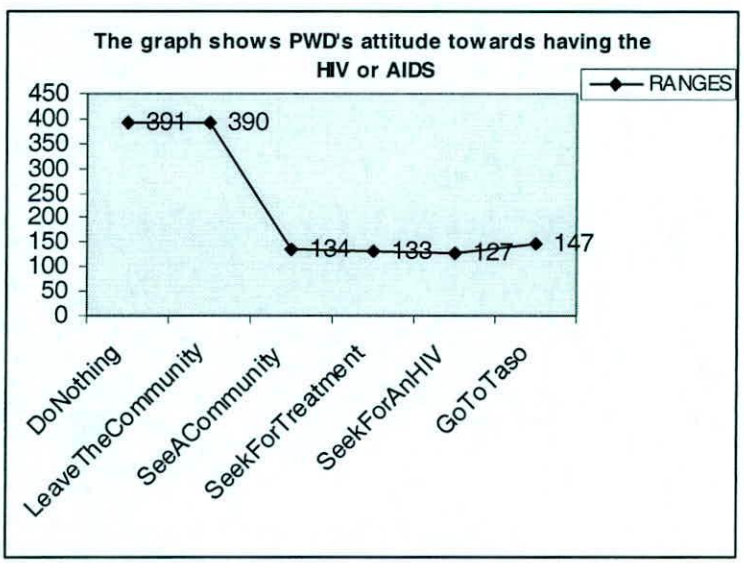
RANGES	
0-99	Strongly agree
100-198	Agree
199-297	Don't Know
298-396	Disagree
397-495	strongly disagree



Whether PWD's with AIDS should be provided with care and referral the range lay between 90 and 130, which meant that they either strongly agreed or agreed with the idea.

If I suspect to have HIV or AIDS I would:

RANGES	
0-99	Strongly agree
100-198	Agree
199-297	Don't Know
298-396	Disagree
397-495	strongly disagree

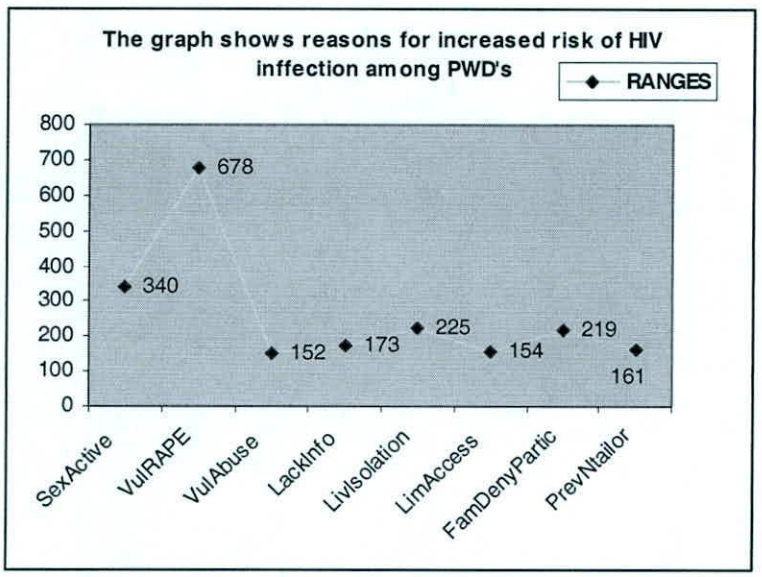


On what the respondents would do if they suspected to have HIV or AIDS, the ranges were 391 for doing nothing (disagree), 390 for leaving the community (disagree), 134 for seeing a community health worker (agree), 133 for seeking for treatment (agree), 127 for seeking an HIV antibody test (agree) and 147 for going to TASO (agree). This means an average range of 132 (agree) on seeking for care to adopting to maladaptive bahaviours.

Accessibility and inclusiveness of existing HIVAIDS services to PWDs

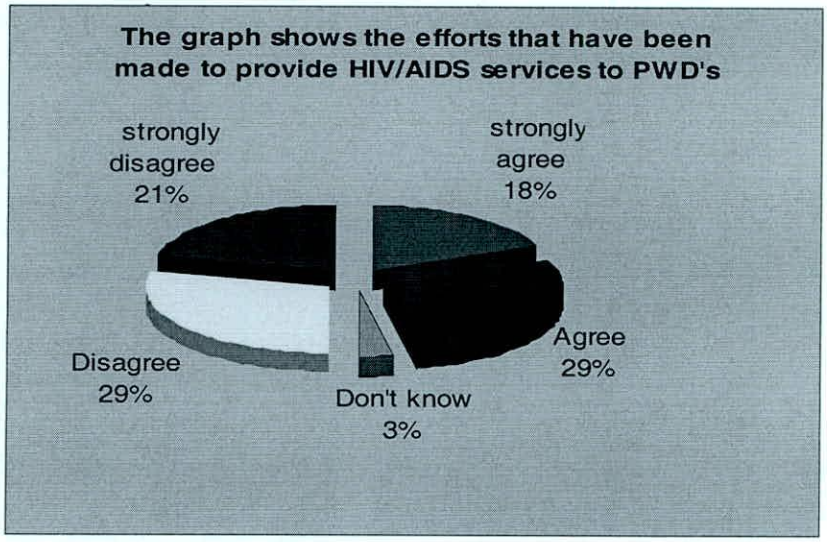
PWD's are at increased risk of HIV infection because:

RANGES	
0-99	Strongly agree
100-198	Agree
199-297	Don't Know
298-396	Disagree
397-495	strongly disagree



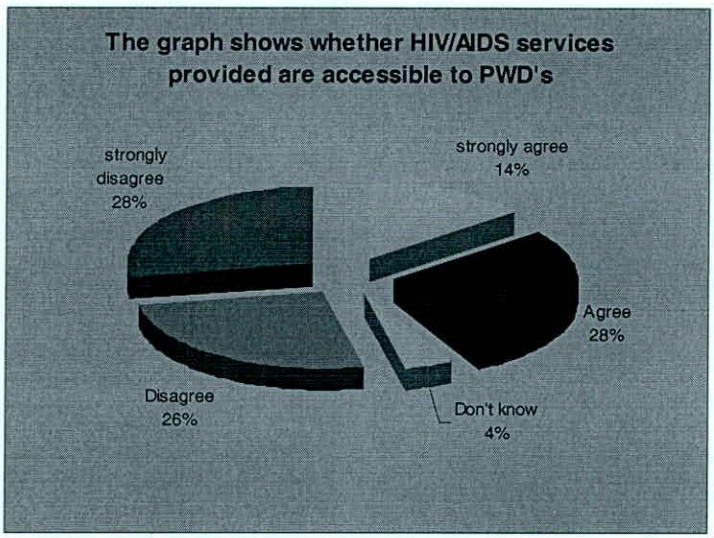
For the reasons why they felt that PWD's were at increased risk of HIV infection, for all the variables, the respondents agreed but strongly agreed for being vulnerable to rape and being sexually active.

Efforts have been made to provide HIV/AIDS services to PWD



Information here indicates that 29% disagree, 21% strongly disagree, 29% agree, 18% strongly agree and 3% don't know whether efforts have been made to provide HIV/AIDS services to PWD's.
So, whereas 50% disagree, 47% agree that efforts have been made to reach PWD's, the controversy could be attributed to the varying types of disability and how they affect access to services.

These services (HIV/AIDS) that are provided are accessible to me:



When asked if they felt they had limited access to AIDS prevention programmes 14% agreed strongly, 28% agreed, 4% don't know, 26% disagreed, and 28% disagreed strongly. Again 54% disagreed and 46 % agreed to this question of accessible services. Here again the controversy could get factored in the different types and categories of disability among the responding PWD's

CHAPTER 4 RECOMMENDATION

- The respondents felt they did not have adequate knowledge about HIV and AIDS which may seem to explain why that little knowledge may have failed to stimulate the desirable practices. Therefore there is need to enhance the PWDs level of knowledge to adequate levels.

- Analysis of the medium as a source of information about HIV and AIDS shows that all the alternatives provided on the questionnaire mere ***'occasionally'*** provides them with this information. So there is need to reengineer, derive and strengthen these and other channels to help in the delivery of information about HIV and AIDS to the general population of PWDs given their different disabilities.

- Over 80% of the respondents agree that they are at risk of HIV infection but again they seem to be helpless when it comes to what they can do to this vulnerability. So it is important that user friendly (disability sensitive) strategies are adopted to help the disabled people with the different disabilities in prevention.

- This rapid assessment strongly observes the need to involve PWDs themselves in HIV and AIDS work but it is important that this involvement takes the position of "meaningful involvement" to avoid attaching added and unnecessary stigma to the process.

  The process of meaningful involvement should be handled in a mainstreaming approach because almost all the respondents still want to be helped and identified with and in their communities.

- TASO as an organization should endeavour to do all is possible to have in place both structures and human resource that should seem responsive to the needs of PWDs. Almost all respondents were positive or have no difficulty in going to TASO for HIV and AIDS services.

- Specifically PWD partners should assist the health services and AIDS advocacy groups and other coordination organs to address the unique language, communication and mobility problems of the PWD community. HIV/AIDS messages should be effectively translated into sign language and Braille, ramps constructed at health centers and hospitals. Plus all PWD sensitive or modified material should be availed.

- Poverty Reduction programmes to empower disabled people should also address their HIV/AIDS communication gaps. Therefore HIV/AIDS funds from organizations should also target PWD groups
- All stakeholders in the PWD movement should advocate for the mainstreaming of sign language and other relevant mobility and communication aids in support of the ability of health providers in communicating and effectively addressing the HIV/AIDS concerns of the PWD community

- TASO should support efforts to establish a framework to monitor and evaluate progress made in mainstreaming PWDs in its system and other health, and HIV/AIDS communication systems

- Instruction, Education and training as well as advocacy institutions should all obtain training in sign language, brailed text to effectively communicate information to concerned PWDs.

- District PWD leadership should ensure that Faith based organizations like churches and mosques champion the cause of PWDs in combating stigma, integrating them into the larger community and especially sensitizing them how they can avoid the epidemic through prevention and abstinence.

- Parents with CWD's should be bound by law to avail education to their children and prohibited from hiding or denying their children access to HIV and AIDS programmes and services.

- TASO with other disability organizations should widen and deepen the network and programmes targeting the PWD community through wider liaison with public private and civil societies and initiatives