

Disability and HIV & AIDS;

A participatory rapid assessment of the vulnerability, impact, and coping mechanisms of the disabled people

*on
HIV/AIDS.*

**Commissioned by;
Zimbabwe Parents of Handicapped children (ZPHCA),
Bulawayo Branch**

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Background and Justification;

HIV&AIDS is a major development concern in the developing world. Recent studies by development NGOs have indicated that the millennium goals might never be achieved if HIV&AIDS is not addressed. Major interventions around HIV&AIDS prevention, care, support and mitigation have been done, but little or none has targeted the disabled people as a special category. For example awareness based interventions that have a strong component of information, education and communication have not looked at the needs of the visually impaired the deaf. Even when AIDS service organizations promote safer sex life styles like condom use, those without arms, how can they put on the condoms! According to HIV &AIDS and disability conference report, Namibia June 2003, Page 10. The disabled people said “ Policy makers and development agencies continue to talk about us without us” As if talking about them is not enough, people have gone ahead to do things they think are right for the disabled people, e.g. In the same report page 4, “and then the woman was put in a room with a man, because a blind woman will need a child to take care of her”

Given the above background, ZPHCA and ICD designed a participatory rapid assessment of the vulnerability, impact and coping mechanisms of the disabled people on HIV&AIDS to answer some of the under listed critical questions around HIV&AIDS and disability,

- Does disability increase vulnerability to HIV&AIDS infection?
- Is HIV&AIDS a concern to the disabled people?
- What is the impact of HIV&AIDS on the disabled people?
- How are the disabled people and those who care for them coping with HIV&AIDS and disability?
- What are the myths and misconceptions that surround disability and HIV&AIDS?

The answers to the above questions would then give ZPHCA and ICD information to design a HIV & AIDS advocacy program.

Executive summary

The rapid assessment was commissioned by ICD to assess the vulnerability, impact and coping mechanisms of disabled people on HIV&AIDS and suggest strategies for developing a HIV and AIDS program for Disabled people's organizations (DPOs) partner to ICD. The study used participatory methodologies of inquiry and involved 22 respondents; 15 females and 7 males representing; King George, Muscular Dystrophy Associations of Zimbabwe, Jairos Jiri and National council of the disabled people of Zimbabwe (NCDPZ) and association of disabled people (ASSOD).

Among the many findings, the study found out that disabled people like any other people were vulnerable and affected by HIV & AIDS. The disabled people perceived themselves to be at higher risk of HIV infection due to disability regardless of the awareness levels.

The disabled people's social exclusion from the mainstream HIV/AIDS services make the situation worse, for example, the VCT services don't offer counseling in sign language, information, education and communication materials on HIV and AIDS are not offered in brail for the visually impaired and those physically handicapped depend on their sexual partners to put on condoms, all these situations increase their vulnerability to infection. Importantly, most disabled people were not aware of the reproductive health rights a factor that puts them at risk of infection, confirming their exclusion from the reproductive health programs.

Myths and misconceptions; The study revealed that a lot of myths and misconceptions around HIV and disability increases the vulnerability of the disabled people, for example the belief that sex with a disabled person cleanses of HIV and AIDS.

The study revealed that, there were high levels of stigmatization and discrimination by the community, being stigmatized and discriminated due to both HIV and AIDS status and disability. However, the disabled people too, stigmatize each other over HIV and AIDS status and there are also elements of self-stigmatization and discrimination by the disabled people themselves.

The study found out that, there was limited access to HIV & AIDS information and utilization of services like VCT, HBC and OVC by people with disabilities mainly because of the nature of disability, location of the facilities and attitudes of the service providers.

In conclusion, the study revealed that, the people with disabilities are at a higher risk of infection to STI/HIV and AIDS due to exclusion from mainstream HIV interventions. The situation is further exacerbated by lack of policy framework on disability and HIV and AIDS.

The study recommends that, a target specific interventions should be designed and implemented for people with disabilities to address issues of HIV & AIDS, empowerment & gender issues and sexual reproductive health.

Objectives

Overall Objective: To assess the vulnerability, impact and coping mechanisms of the disabled people and their families to HIV&AIDS and suggest strategies for developing a target specific HIV and AIDS program for the disabled people.

Specific objectives

- Review existing policy framework on HIV&AIDS in relation to disability issues.
- Review DPO's previous work related to HIV&AIDS
- Assess the knowledge levels, awareness, attitudes, behaviors and sexual practices of the disabled people in relation to HIV and AIDS.
- Assess the Impact of HIV&AIDS on the disabled people and their families and explore the existing coping mechanisms to HIV&AIDS.
- Assess accessibility to services related to HIV&AIDS care and support including sexual reproductive health facilities by the disabled people.
- Assess the vulnerability of the disabled people to STI / HIV&AIDS infection
- Assess capacity and potential of the disabled people to participate in HIV&AIDS prevention, care, support and mitigation programmes.
- Assess the capacity of DPOs to deal with HIV&AIDS among its membership and recommend possible approaches and networks for collaboration.
- Provide options and recommendations on how to develop a program that can effectively contribute to tackling HIV and AIDS with full participation of the disabled people.

Methodology;

The participatory assessment took a qualitative approach, that used participatory tools and methods (PLA) to collect data, the methods were,

- Focus group discussion by gender
- Buzz Groups
- Mixed group discussions
- Semi structured interviews
- Literature reviews

The choice of methodology was guided by the need to make the process interactive, learn from each other and give basic information about HIV&AIDS. For example where respondents indicated that they had never heard of a female condom, the team demonstrated it.

In addition, the respondents being disabled people, the methodology took cognizance of the disability needs e.g. the need for sign language specialists for those with hearing impairment.

STUDY POPULATION; the assessment was done in Bulawayo, targeting disabled people in various organizations. A total number of 22 respondents, (15 females and 7 males) representing 5 DPOs namely, King George, MDAZ, ASSOD, Jairos Jiri, and NCDPZ participated. The respondents had different disabilities. Some of the respondents were married, some students, others single. Some staff from DPOs were interviewed separately.

FINDINGS

1. Disabled people's knowledge on policies related to disability and HIV / AIDS.

The majority of respondents (80%) were not aware of any policies related to disability and HIV & AIDS. However, (20%) knew about the disability policy, they talked of non-discrimination as the key issue in the policy but they said it was not addressing HIV and AIDS issues. All the respondents were not aware of the National HIV&AIDS Policy. An analysis of the national AIDS policy revealed that there no mention of the disability issues in relation to HIV and AIDS.

- 2. Basic knowledge on HIV / AIDS;** The Majority of the respondents (85%) had a relatively high level of awareness on HIV & AIDS. For example, they knew what HIV and AIDS is, the difference between HIV and AIDS, the signs and symptoms, some modes of transmission and prevention. However, they had very limited information on vertical transmission from the mother to the child and it how it could be prevented.

3. Perception of disabled people to the risk of HIV infection.

The majority of respondents (90%), mostly women perceived themselves at risk of HIV infection. Most women indicated that most men want to experience sexual intercourse with a disabled woman or a woman with albinism hence the risk of STI/HI infection. However, (10%) mostly disabled men perceived themselves to be at lower risk to infection. The reasons for this, were that some men had not yet indulged in sexual activity and others had no multiple partners. However, they talked of having serial partners i.e. having a partner for some time and then another one.

This indicates that although the knowledge on HIV&AIDS is high they still have misconception on the modes of transmission of HIV. They believe that transmission is only through sexual contact and through multiple relationships, yet the risk in serial partner relationships could be equal to the multiple partners' relationships.

All the respondents also indicated that the female disabled person is at higher risk because they can be easily be raped.

The respondents acknowledged the role of literacy in access to information on HIV&AIDS, however, the majority of the disabled people are illiterate and the access to information is further hampered by the nature of disability. Those who are visually impaired have difficulties in reading STI/HIV&AIDS messages, which puts them at risk of infection.

In terms of age, all the respondents indicated that, the older disabled female people are at higher risk of HIV infection because of the belief that if you have sex with a disabled woman or a women with albinism, one get cleansed of HIV and AIDS. However, the young disabled girls regardless of the nature of disability, are were perceived to be at relatively lower risk as they are with parents most of the time, though, they talked of some cases of sexual abuse of disabled girl children by relatives or care givers.

4. Knowledge on HIV & AIDS prevention;

75% of the respondents knew of the following modes of transmission of HIV, Blood contacts and through unprotected sex with an infected partner. They didn't mention prevention of mother to child transmission of HIV. They also knew of safer sex life styles as preventive measures to

HIV infection e.g. condom use, faithfulness and abstinence. However, all the respondents (100%) had never seen a female condom and 30% had seen the male condom.

The practicalities of using a condom by the visually and physically handicapped were raised by the respondents as a challenge, for example, proper use of a condom necessitates reading of the expiry date, the respondents indicated that the visually impaired couldn't read, those without arms would find it difficult in putting on the condom, the respondents said they depend on their sexual partners if they ever planned to use condoms. The dependency on the partner for safer sex, compromises one's protection thus increasing the vulnerability to HIV infection.

5. Basic knowledge on reproductive health issues.

All the respondents (100%) were not aware of their sexual reproductive health rights. This implies that they are at risk of sexual harassment and abuse because they are not aware of their rights. They also indicated that because of the nature of the disability, even if one is aware of the rights, can still be abused resulting in HIV infection. For example, One female respondent said, “*I have all the information on HIV&AIDS but due to my disability, I cannot protect my self*”.
Family planning; The majority of the respondents 75% were aware of what family planning is except the few. Most of the respondents who were not aware were mostly deaf, this could be due to how the information on family planning is packaged and targeted.

The respondents expressed high preference of traditional / biological methods to family planning because to them, they do not have side effects. They mentioned the withdrawal method, thigh sex, exclusive breast-feeding for a longer time and the safe period.

Though according to the respondents the decision to initiate family planning and methods lies with the women and not men, most of their preferred traditional or biological family planning methods are controlled by men, implying that women have very little to contribute to the decisions around family planning.

6. Knowledge on Sexually Transmitted Infections

All the respondents were aware of the existence of sexually transmitted infections and listed 6 sexually transmitted infections that is; Syphilis, Genital herpes, Gonorrhoea, Genital sores, Boils / abscesses, Buboec. The respondents were aware of the relationship between STD and HIV and had similar concern on prevention of STIs as they had on HIV/AIDS.

7. Traditional beliefs and other sexual practices.

Most respondents knew of traditional and other practices that predispose them to HIV infection. They named widow inheritance, polygamy, incest, and sugar daddies. However, the respondents acknowledged of traditional practices that are positive like virginity test, and felt it should be carried forward.

All the respondents acknowledged that, the disabled people's sexual behaviors are influenced by a number of factors most importantly, the societal expectations around femininity and masculinity, degree of wealth, social status, poverty and alcohol, however, these factors have a double effect on the disabled people, they said if one is a female, poor and disabled, the risk to infection is relatively high.

All the male respondents, acknowledged that among disabled people the practice of multiple sex partners is lower, however, to the disabled, they get serial sex partners. The reasons according to the respondents is that, they are regarded as inferior in society, so they don't get stable relationships; they keep getting new sex partners after one has run away to a none disabled person. To cope with unstable relationships, some opt to get disabled sex partners, though they also go away whenever they get a partner who is not disabled.

All the respondents (100%) indicated that the communities have a belief that disabled people are free of HIV hence a safe target. As result many disabled people have become victims of rape, defilement and sexual harassment.

The majority of respondents (75%) wanted to know the origins of HIV; the respondents had a number of theories and misconceptions about the origin of HIV, these ranged from, the virus being a biological warfare tool by the western world against Africans to a curse from God due to immorality.

The respondents' interest in knowing the origin of HIV indicated that, the discussion around the origin of HIV takes most of their time instead of concentrating on preventive measures.

All the respondents indicated that if one tested HIV positive in a relationship, they would break up. This indicated an element of labeling and blaming attitudes. There is also stigmatization of fellow disabled people if one was believed to have HIV & AIDS.

IMPACT OF HIV and AIDS ON DISABLED PEOPLE

All respondents (100%) acknowledged that HI V and AIDS is also affecting the disabled people, in their own words, "many disabled people have died due to HIV & AIDS ". Respondents indicated that a lot of orphans are left with no one to take care of them due to the collapse of social support systems like extended families.

Respondents acknowledged the ever-increasing medical costs due to treatment of opportunistic infections that come with AIDS. Though the disabled people are supposed to get free medication, there are no drugs for most AIDS related infections in public hospitals forcing them to receive treatment from private hospitals at a very high cost.

The respondents talked of the need for proper diet in the care for HIV&AIDS people, however, the food shortages in the country, the relations through which food is accessed and discrimination of disabled people makes it difficult for them to access the food, thus making the disabled people with HIV infection deteriorate faster into AIDS due to dietary needs.

The respondents also indicated that AIDS is one factor that may cause or aggravate the disability condition of an individual.

Coping mechanisms

Majority of respondents indicated that they were finding it difficult to cope with the problem of HIV and AIDS because of the nature of their disability. According to one respondent, "there is

nothing, we just sit and watch”. However, some of the disabled people are vending, begging, and relying on services offered by DPOs.

Such coping mechanisms are not directly related to HIV and AIDS or its effects, they are mostly related to disability and the economic hardships they face thus, the very means of coping with HIV/AIDS could predispose them to HIV infection or re-infection.

ACCESS AND UTILISATION OF HIV and AIDS SERVICES AND FACILITIES BY THE DISABLED PEOPLE

The majority of the respondents were aware of the existence of HIV and AIDS programmes and services in their communities. They named VCT, HBC, MAC, Youth Programme and Orphan care. However, the access and utilization of these services by the disabled people was limited because of stigma and failure to communicate using sign language. E.g. the deaf could not easily communicate with health official in hospitals, for they do not understand sign language. Even in voluntary counseling and testing centers, there are no services like counseling in sign language. All respondents mentioned that, they were not participating in most programmes because they are not invited, lack of support services in respect to some types of disabilities; facilities not user friendly like climbing stairs.

On treatment in hospitals, the majority of respondents said they are ignored or mistreated. However, discussions indicated that there was also an element of self-stigmatization and discrimination on the part of the disabled people, where they could be invited and they don't participate. This arises from the attitudes and previous treatment received by the disabled people from the non-disabled people.

All the respondents expressed interest and willingness to initiate and participate in HIV & AIDS programmes, if they are specially designed to suit their specific disability needs and managed by the disabled people or non-disabled people who are sensitive to the disability needs.

ACCESS TO INFORMATION ON HIV & AIDS BY THE DISABLED PEOPLE

Respondents said disabled people were accessing HIV&AIDS information from the following sources, T.V, Schools, Newspapers, Magazines, Peers, radios, hospitals and seminars.

However they indicated that there should be a special packaging of information materials which are target specific, for example, more sign language programmes on Television, Seminars for the disabled people, AIDS information in Braille and dramatizing HIV & AIDS information for the deaf and singing.

The majority of the respondents also indicated that information centers were not accessible to all disabled people, hence the belief that the information is not for them.

Health seeking behavior for disabled people

The respondents were knowledgeable of the opportunistic infections of HIV & AIDS; their first preference for treatment in case of infection was public hospitals because of free treatment. However, they indicated that disabled people seek treatment from other sources like private clinics, churches, traditional healers, self-medication and private doctors. Despite the need for

treatment, the choice of curative option was guided by the financial ability of the person, belief and location.

Respondents shared that, some treatment centers are located at a distance which requires public transport, yet public transport vehicles do not allow wheel chairs, that they occupy a lot space in vehicles. As a result, people with disabilities seek treatment from traditional healers with in their communities that do not require transport.

CAPACITY OF DPOs TO ADDRESS HIV & AIDS AMONG THEIR MEMBERS

Respondents indicated that their organizations are not implementing any activities to address HIV&AIDS. Some of the reasons given were that, they do not have funds, lack of capacity in terms of manpower and skills, lack of interest and HIV&AIDS not being their priority.

However, Jairos Jiri and King George had conducted HIV awareness sessions using drama for its members. King George being a school, HIV&AIDS education is part of their syllabus, its not clear whether it was taught as an examinable subject or targeting behavior change among the disabled people.

All respondents wanted their organizations to start HIV and AIDS programs. As said by one respondent, *‘we want to start now because most of us have limited information on HIV &AIDS’*.

Disabled people’s expectations from their organizations to address HIV and AIDS

- Provision of HIV&AIDS information and education for the workers and members in a user-friendly manner.
- Financial support for activities such as drama on HIV and AIDS in organizations.
- DPOs to formulate committees to advocates for funding of HIV and AIDS programmes.
- Source and distribute free condoms, especially the female condoms
- Source IEC materials both in alphabet and brail and distribute to resource centers in organizations
- Networking, collaboration and sharing information on HIV& AIDS among different DPOs.
- Encourage members to have regular meetings or sharing sessions on HIV & AIDS.
- DPOs to lobby for the inclusion of disabled people in National Aids Council structures.
- DPOs to create partnership with organizations such as Youth Chat line, MAC, Abatsha Balamuhla, World Vision, ZNNP+, HBC, Ministry of Education.
- HIV and AIDS programmes to spread and include disabled people within the community
- Organizations to plan and implement workshops on AIDS awareness and the rights of disabled people.
- The DPOs to advocate for provision of Anti –retroviral drugs for disabled people

HOW THE DISABLED PEOPLE WANT HIV&AIDS PROGRAMMES TO BE MANAGED IN THEIR ORGANISATIONS.

- The respondents indicated that there should be in-house coordinators of the HIV&AIDS program activities, with the following characteristics, should be disabled and knowledgeable in sign language and HIV&AIDS prevention, care, support and mitigation issues.

- In case of committees to run HIV/AIDS programmes, they should have people living with HIV & AIDS and with disabilities.
- Disabled people themselves should participate in HIV & AIDS training workshops with in the DPOs and out side not their leaders who are in most cases not disabled in case of Jairos Jiri.

CONCLUSIONS

- The disabled people had a relatively high awareness levels of HIV&AIDS prevention, However, the majority of them had not seen condoms, those who had access to condoms, the practicality of using a condom was a challenge depending on the type of disability for example, the visually impaired and physically handicapped have to depend on their partners for proper use. Faithfulness was not reliable, as the disabled people could not easily monitor the movements of their partners especially the non-disabled partners, which indicates that the disabled people are not in control of their sexual life hence the risk of infection.
- Disabled people are not knowledgeable of the policy issues related to disability, HIV & AIDS and reproductive health; as a result, the disabled people are subjected to discrimination, stigma, sexual abuse and violation of their rights. Limited knowledge on policy and rights makes it difficult for the disabled people to protect themselves from HIV & AIDS.
- The national AIDS policy doesn't mention of people with disabilities as a special category people with special needs.
- Severe disabilities affect efforts of the disabled people on how to protect themselves against sexual violence leading to HIV&AIDS infection.
- Majority of the disabled people perceive themselves to be at risk of HIV infection due to their disability and the beliefs in the communities about disability. However, the females disabled people are at a relatively higher risk than the male counterparts due to beliefs that one get cleansed if you have sex with a disabled woman, women can easily be raped than men and also the fact that the able-bodied men always want to have sex with a disabled women to experiment.
- There is limited knowledge about the sexual reproductive health rights among the disabled people hence the risk of HIV infection.
- The disabled people are aware of the practices that pre-dispose them to HIV infection; these practices are influenced by societal expectations, poverty, relative wealth, gender and nature of disability. However, the disabled people are not empowered enough to deal with the issues.

- Serial sexual partners among the disabled people as opposed to multiple partners common among the non-disabled people pose the same risk to HIV&AIDS infection of the disabled people
- Due to stigma, discrimination, self-discrimination and non-accessibility to services and facilities, the disabled people do not participate in other development programmes. As a result, the impact of HIV&AIDS on the disabled people is relatively high, though there is no deliberate effort to document. Disabled people have already experienced deaths, orphans and family resource depletion due to AIDS.
- The disabled people are trying to cope with the effects of HIV&AIDS at individual and family level, however, the current coping mechanisms are more linked to the effects of disability than HIV&AIDS, as a result, the very coping mechanisms put them at risk of HIV infection.
- Access to HIV&AIDS information by all the disabled people is still low due to literacy levels, nature of disability, location, media and the packaging of the information. The disabled people have media preferences for HIV & AIDS messages, which would accommodate sign language and brail. The current communication channels e.g. television, seminars, drama, pamphlets, music and singing have not taken cognizance of disability needs.
- There are no target specific HIV&AIDS programs for the disabled people within DPOs and other the organizations. Target specific programs need to be developed that recognize the special needs of the disabled people

RECOMMENDATIONS

- DPOs should initiate HIV & AIDS and reproductive health programmes that will focus on issues like STIs, Family planning, prevention, care, support and mitigation for the disabled people. The disabled people should coordinate the HIV&AIDS programs. All disabled people should be encouraged to participate.
- Through a participatory and consultative process involving people with disabilities, DPOs should formulate HIV & AIDS policies that will enable the implementation of HIV & AIDS programmes for their membership and staff.
- DPOs should educate their members on the existing policies on HIV&AIDS, reproductive health and disability. Resources permitting, the policies should be translated to local languages.
- DPOs should implement empowering programs for the disabled people to enable them deal with social, economic and cultural factors that pre dispose them to HIV & AIDS infection, we recommend to adopt the STAR (stepping stones and reflect) programme to empower people with disability.

- DPOs should mainstream HIV & AIDS and disability issues in their advocacy programmes e.g. advocating for HIV & AIDS information written in brail, counseling in sign language at VCT Centers and Hospitals and disabled people to be part of the advocacy teams for funding raising for HIV &AIDS programs.
- DPOs should initiate training of disabled people in HBC, counseling in sign language, peer education and orphan care etc. The disabled people should be encouraged to participate in the existing Home based care programs with in their communities than starting a special HBC program for the disabled people unless it is with in an institution. During the trainings, non-disabled people should be trained on how to care for the disabled people within a home-based care program.
- This was a rapid assessment; we recommend that the issues raised in this report be further explored. This report should be used as starting point into further understating of issues of disability and HIV&AIDS

Checklist of issues- DPOs

1. Policy issues;

- Existing policy frame work on HIV&AIDS and disability

3. Assessment of knowledge, attitudes, practices (behaviours) of PWD on HIV&AIDS.

- Knowledge (facts and misconceptions about HIV and AIDS)
 - What is HIV? And what is AIDS?
 - Can a person be HIV+ with out AIDS or the reverse?
 - What are the modes of transmission of HIV?
 - What are the methods of prevention
 - Do you know of any HIV&AIDS Treatment
 - What are STDS, name the types of STDS you know or common in your community.
 - Family planning; what is family planning? What family planning methods do you know? Which ones do you use and why? Who makes decision around initiating family planning in a home and the methods to use?
 - Sexual reproductive health rights; Do you any reproductive health rights, please name them.
- **Attitudes and Values**
 - Traditions around sex and sexuality that may pause a risk to HIV infection.
 - Which practices do you feel should be carried forward or negated?
 - Safer sex practices-Condoms, (female and male condoms), abstinence, faithfulness, delayed sex
 - Beliefs around HIV&AIDS
 - Hopes and fears around sex and reproduction
- **Practices**
 - Why we behave the way we do? Influencing factors- social, economic, cultural and religious factors. Focus Group discussion by Gender
 - How does your behaviour or practices affect people around you and those who depend on you?
 - Sex practices-

4. Vulnerability/ risk factors assessment of disabled people to HIV&AIDS/STI infections

- Perception analysis of vulnerability to infection with HIV/ STI.
- Analysis of vulnerability in relation to Gender, rural/ urban/ age/ literacy.
- Following the given risk factors, how do you protect your self?
- Vulnerability assessment tree for DPOs' staff.

5. Impact of HIV&AIDS at individual, household and organisational level.

- Impact analysis; What are the observable impact of HIV&AIDS among the disabled people and families
 - As a disease-

- **Death due to AIDS**
 - **Impact of HIV&AIDS at DPOS level-**
- 6. **Analysis of coping mechanisms of the disabled people to the Impact of HIV&AIDS**
 - a. What are the current coping mechanisms to HIV&AIDS at individual, household level and organisational levels?
 - b. Advantages and disadvantages of the coping mechanisms (short and long term implications)
 - c. Which coping mechanisms do you feel should be carried forward or negated?
- 7. **Accessibility to HIV&AIDS services by the disabled people.**
 - Knowledge of existence of services and facilities related to HIV&AIDS.- namely?
 - Accessibility and utilisation of the available services and facilities
 - Health seeking behaviour- curative options
 - Access and utilisation of information
 - Media preference to access information
- 8. **Assess the participation, capacity and potential of the Disabled people to participate in HIV/AIDS prevention, care, support and mitigation of HIV and AIDS**
 - What are the existing HIV&AIDS programs in your community
 - How many are participating (why) by gender
 - How many are not participating (Why) by gender
 - Are you willing to initiate HIV&AIDS programs and participate in future? What are the programs that you are interested in, why, (by gender).
- . **What are DPOs doing in the field of HIV &AIDS?**
 - Are DPOs doing anything on HIV&AIDS? If yes, what is it? Who? How was it done and when. If not, why?
- 9. **Assess the capacity of DPOs to a deal with HIV&AIDS among its membership and recommend possible processes, approaches and networks for collaboration.**
 - Staffing levels
 - Skills on HIV&AIDS/ STI/ reproductive health
 - Financial resources
 - Time
 - Potential partners working on HIV/AIDS with in the locality
 - HIV and AIDS work place Policy- issues for ZPHCA and the secretariat
- 10. **Concluding questions;**
 - What should DPOs do to effectively help you deal with HIV&AIDS at individual and household level.
 - What are the achievable, high priority steps for near term improvement of HIV&AIDS prevention, care, support and mitigation among DPO members?
 - What partners/ networks should DPOs enter into to deal with HIV&AIDS among its members
 - With whom
 - Level
 - Roles of DPOs
 - DPO's expectations from partners
 - How should HIV/AIDS activities in DPOs be coordinated to effectively have an impact on the membership?

