Access to Health Services for People with Disabilities in Zimbabwe – a case of Mutasa, Mutare Urban and Mutare Rural Districts in Manicaland Province

A literature review, written by Poverty Reduction Forum Trust (PRFT)
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Introduction

People with disability (PWDs) in Zimbabwe make up an estimated 9% of the population, which represents more than 1.2 million people, according to the Zimbabwe National Statistics Agency in its 2017 Inter-censal Demographic Survey. This prevalence is 9.4% female and 8.5% male (ZIMSTAT, 2017a).

ZIMSTAT (2017b) also notes that poverty levels are higher for PWDs with 74.1% of them in poverty compared to 69.5% for those not disabled, and 32.2% PWDs in extreme poverty compared to 28.5% for those not disabled. As the available data show, the PWDs constituent is vulnerable in many different ways and needs government protection.

In Manicaland province where the programme *Evidence and Collaboration for Inclusive Development* (ECID)[1] operates, the disability prevalence rate is 9.2% (9.6% female and 8.6% male) while, in Matabeleland North province, the rate is 8.9% - 9.1% female and 8.6% male (ZIMSTAT, 2017a). Of the two ECID sites, this research will be focusing on Manicaland where the disability prevalence for females as a marginalized group is higher.

PWDs in Zimbabwe still face challenges such as lack of disability friendly infrastructure in schools, hospitals, stigma and discrimination, limiting opportunities available for them. In governance, central and local government consultations platforms such as

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[1] ECID Website https://evidenceforinclusion.org/

parliament public hearings and local council budget consultations still lack adequate infrastructure such as sign language interpreters and brail materials. Also, meetings are not held in places accessible or platforms for the PwDs to participate effectively.

The barriers faced by PWDs in accessing quality health services and decision-making processes are complex and multifaceted. Experiences of PwDs within the healthcare system are not well understood and research-based health services improvement interventions commonly exclude the participation of PWDs.

The ECID programme aims to support the visibility of disability issues in these processes through research and programmatic work. The 2020 ECID Zimbabwe baseline survey identified health, education, WASH, and social welfare or employment, as priority services for PWDs. This research will focus on PWDs' access to health. Data from the baseline also showed that 89.5% of the people surveyed found it important for the most marginalised to be involved in decision making processes (ECID, 2020).

This reseach seeks to contribute to this broader program by pursuing the following research objectives: (1) Assess and understand the nature and extent of barriers to access health services by PWDs; (2) Explore the extent and impact of marginalisation of PWDs in health service decision making; and (3) Proffer recommendations towards improving access to affordable and quality health services by PWDs.

The research question and subquestions we followed for this study are:

What are the challenges faced by PwDs (these include women and men above the age of 18 years) in Mutasa, Mutare Urban and Mutare Rural Districts in accessing health services ?

1. What are the impacts of marginalisation of PwDs in Mutasa, Mutare Urban and Mutare Rural Districts in decision making?
2. How can existing policies and programmes be improved to increase access of PwDs to quality health services?

The next sections of the literature review will focus on the following areas: (1) approaches to disability and access to health; (2) African belief systems and understaning of disability; (3); disability rights and protection in the world, Africa and Zimbabwe; (4) general barriers to PWDs' health; and (5) impact of marginalization on pwds in health services decision-making; and (6) emerging gaps. This is followed by the conclusion and the references.

1. Approaches to disability and access to health

Disability and access to health and other social services as a field of research has evolved over many years. Disability management has evolved from a charity approach to a medical approach, to a social approach, to a human rights approach, and an intersectional approach. This evolution of the models is a result of the emergence of human rights, internationally and nationally, with a significant impact on the manner in which disability is perceived and managed.

The moral or charity approach treats PWDs as passive objects of kind acts or of welfare payments rather than as empowered individuals with rights to participate in development. What characterizes this approach is that PWDs are not considered able to provide for themselves because of their impairment. Consequently, society provides for them. Albert (2004) argues that the PWDs are denied the opportunity to participate and decide on their health or development issues since they are incapacitated by their impairment.

Under the medical approach, individuals with some form of disability can be "fixed" through medical professionals or rehabilitation to get back to society. Thus, as Seelman (2004) notes, the medical approach does not necessarily assume or encourage PWDs to be active in seeking participation and access to decision making in society until their rehabilitation is completed.

The social approach introduces a very different thinking. As Waddington (1995) notes, the social model puts the person at the centre, not his/her impairment, recognizing the values and rights of PWDs as part of society. This approach facilitates the inclusion of PWDs. Individuals with disabilities become the decision makers. This is summed up in the slogan “nothing about us, without us!”. In this approach, the person with disabilities assumes different roles and self-expression in health, education, and citizenship. The social approach resonates with the International Classification of Functioning Disability and Health (ICF) which was officially endorsed in 2001. The ICF changes the balance on the discourse on disability from bodily and individual shortcomings to the sociocultural and physical barriers to participation. With ICF, disability is defined as "the interaction between the environment and a person with impairment” (WHO, 2011). Similarly, the Feminist Disability Studies group argues that disability is a social construction in which standard practices in society fail to embrace disability but instead relegate disability to a category of inferiority (Peta, 2017).

The human rights approach to disability builds on the social approach by acknowledging PWDs as subjects of rights and the State and others as having responsibilities to respect these persons (Quinn and Degener, 2002). It treats the barriers in society as discriminatory and provides avenues for PWDs to complain when they are faced with such barriers.

More recently, intersectional approaches linking disabilities to other inequalities have emerged. For example, this means that a person that is both a woman and disabled is likely to suffer twice from discrimination. Peta (2017) argues that looking at women with disability from a feminist disability studies lens encompasses key tenants of intersectionality that make disability intimately connected to other identity markers such as gender, culture and class.

2. African belief systems and understandings of disability

According to Devlinger (1995), Talle (1995) and Ingstad (1995), the primary interest with regard to disability in many African societies is in explaining *why* these people are as they are. In this regard, disability is a condition related to culture and religion. Talle (1995) states that in order to understand the concept of disability, one needs to look at cultural beliefs as well as contextual analysis in order to grasp the phenomenon in its full social and cultural setting.

However, within the cultural and religious premise, different African communities tend to hold different beliefs. A study undertaken among the Tonga community in Zimbabwe established that disability was accepted more as an act of God and a kind of ‘natural integration’ was found whereby families did their best to look after their disabled children without reservation. Bodily imperfections were seen as important only to the extent that they impaired normal functioning in society and life was seen as superior to death. Disability was seen as secondary, as in one of their proverbs that says: “*kocilema kunywigwa maanzi”* [It is better to be disabled than dead] (Eide and Ingstad, 2011: 175).

However, in a study by Peta (2017), the notion of linking disability to witchcraft was rife as well as an attitudinal negativity towards women with disability who wanted to exercise their reproductive rights.

An African approach to disability is thus concerned with the meaning that biological deviations have for society, for the family and for the individual. The African understanding of disability recognizes that it is not simply an abnormality of an individual but also a disruption in the family. This is in contrast to the modern Western biomedical approach that is more technical, with a focus on the improvement of functions and activities of daily living.

Cross-cultural differences in interpretation of disability show that lives of people with disability are made more difficult not so much by their specific impairment as by the way society interprets and reacts to disability (Peters, 2009).

3. Disability rights and protection in the world, Africa and Zimbabwe

The first United Nations Decade of Disabled Persons (1983-1992) encouraged full participation and equality of disabled people in the development process, especially in education, health and social protection issues. Since then, the United Nations has encouraged governments worldwide to mainstream disability in their national development frameworks. In his “*The Challenge of Inclusion”* speech as World Bank President, James D. Wolfensohn argued that it was time for the Bank, NGOs, governments, private sector, and development experts to include women and bring “into society [those people, especially the disabled] who have never been part of it before” (Wolfensohn, 1997: 1-2).

As the world was still trying to get direction on how best to handle issues of inclusion in development, political participation, service provision and decision-making, the United Nations adopted a new international human rights treaty, the *Convention on the Rights of People With Disabilities* in December 2006. The Convention demystified the notion of viewing PWDs as "objects” of charity, medical treatment and social protection towards viewing PWDs as "subjects" with rights, who are capable of claiming those rights and making decisions for their lives based on their free, and informed consent as well as being active members of society. The Convention covers a wide range of areas including health, personal security, independent living, and access to information. The Convention under Article 9 compels States Parties to respond appropriately:

> To ensure to PWDs access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas (United Nations, 2006).

In the more recent adoption of the 2030 Agenda for Sustainable Development, the Member States of the United Nations pledged to leave no one behind, including marginalized women, girls, and PWDs. The 2030 Agenda for Sustainable Development is a set of seventeen aspirational "Global Goals" with 169 targets between them (SDGs). The SDGs have a time horizon of 2015 to 2030. Disability is referenced in various parts of the SDGs and specifically in parts related to health, service delivery, inequality, and accessibility of human settlements.

Historically, this shows important progress. Thomas (2005) notes that although the issues of inclusion were important in all development endeavours, disability was conspicuously absent from the former celebrated Millennium Development Goals (MDGs), precedessors of the SDGs. Disability was covered neither in the targets nor in the indicators of the MDGs. They were missing in most guidelines, policies, programmes and conferences that promoted and monitored MDGs. However, over 80 national reports to the United Nations had already referred to PWDs and the need to mainstream disability issues in development (Eide and Ingstad, 2011).

At the African level, the African Union adopted the African Decade of People with Disabilities (1999–2009) in July 1999 in Algiers, Algeria. The decade was extended for the period 2010–2019 in Namibia in October 2012. The objective of the two decades was to achieve health, full participation, equality and empowerment of PWDs in Africa. The Continental Plan of Action of the African Decade of PWDs (2010–2019) summarised the priority areas for the eight strategic thematic areas for implementation at national level. The sixth theme is adequate standard of living, health and social protection for PWDs, and the promotion of inclusion of PWDs in all sectors of society.

In 2018, during the African Union Summit, Zimbabwe endorsed the African Charter on Human and Peoples' Rights on the Rights of PWDs protocol. Zimbabwe had also signed the *Convention on the Rights of People With Disabilities* in 2006. The Zimbabwe Government ratified the Convention and its Optional Protocol in 2013 (Mandipa and Manyatera, 2014). By ratifying the Convention, Zimbabwe agreed to "adopt all appropriate legislative, administrative and other measures" necessary for implementation of the rights established in the Convention including measures that would ensure the full and effective participation and inclusion of PWDs in all spheres of social, economic and political life in the country. Part of this was the recognition of and prohibition of discrimination based disability in the new 2013 Constitution.

Section 22 of the Constitution of Zimbabwe Amendment (No.20) Act 2013 stipulates that the State must recognize the rights of persons with physical or mental disabilities and instructs government institutions to avail resources that assist PWDs achieve their full potential and minimise disadvantages suffered by them. In this regard, Zimbabweans with disabilities legally have equal rights to access all services, including quality health, education, justice, and information. To ensure PWDs can claim their rights, access to health services without discrimination, and necessary and appropriate modifications or ‘reasonable’ accommodations must be availed. However, anectodal data shows that PWDs in Zimbabwe are not enjoying the rights enshrined in the Constitution.

More recently, the Government of Zimbabwe has launched the country’s new five-year Development Plan, known as the National Development Strategy One in November 2020. All line ministries are expected to develop their respective strategic plans in line with the Strategy. More recently, in June 2021, the Government of Zimbabwe launched the National Disability Policy. It is important that these plans and policies are informed by disaggregated data to ensure the mainstreaming of disability issues especially in social service delivery.

4. Barriers for people with disabilities in health services

The biggest barriers for PWDs to accessing health in Sub-Saharan Africa, especially in rural Zimbabwe, are poverty, culture and the lack of adequate information on available services. As Devicienti and Poggi (2011) note, many PWDs have limited access to healthcare and rehabilitation care. This, combined with chronic poverty, low education, and inadequately trained healthcare professionals, substantially lowers their quality of life. Several variables intersect when it comes to barriers to accessing health for PWDs. These are economic, legal, organizational, physical, communication, and cultural barriers (UN Enable, 2014).

4.1. Economic, legal and organizational barriers

Poverty appears as the most reported barrier to PWDs’ access to health. In addition to significant financial costs associated with impairments, disabled people are frequently dragged further and further into poverty as a result of exclusion from mainstream social, economic and political opportunities throughout their lives (Yeo and Moore, 2003).

With the ever-increasing prices of basic social services due to market liberalization measures, healthcare is no longer free even in missionary medical facilities were it was free in the past. Besides, most public hospitals and clinics are overcrowded and unclean, lacking funding and professional staffing, being mannered by demotivated staff (Shillingford, 2020).

To make things worse, most PWDs, especially in rural areas, are unemployed and find it difficult to contribute towards family income including costs for their special health care needs. In most rural communities, the general lack of financial support to PWDs by family and relatives was cited in several studies as a barrier to seeking medical attention.

Poverty and disability seem to be inextricably linked. World Bank studies as reported by Yeo (2001: 8) indicate that half a billion disabled people are indisputably amongst the poorest of the poor and estimated to comprise 15-20% of the poorest in developing countries. PWDs are at risk of being and remaining among the poorest. Ill health, poverty and disability reinforce each other (Brock, 1999).

A study by Nota et al (2015) points out that caregivers of children with congenital diseases in Zimbabwe were more motivated to take their children to therapy sessions if incentives, such as toys, transportation money, food, assistive devices, and clothes, were given at the rehabilitation department.

Institutional barriers and policy barriers including laws also add to financial barriers. These often inhibit communities from benefiting from their local resources. Limited awareness about available services and bureaucratic obstacles are significant barriers (Saloojee et al, 2007).

Despite the pronouncements made by the United Nations and the World Bank, most development partners such as NGOs, government and the private sector, especially those in Sub-Saharan Africa, grapple with accommodating disability issues. They do not have disability inclusion budgets, disability specific program objectives, and disability indicators to guide their work. Challenges include limited organizational capacity to deal with disability issues, lack of disability statistics, limited or no funds allocated for disability inclusion and problems in identification of PWDs within communities (Yousafzai et al, 2005).

4.2. Physical barriers

Physical barriers have to do with distance and bad roads. Travassos and Martins (2004) affirm that geographic accessibility is an important factor for the effective use of health services which could reduce or increase the difficulties in access.

Frenk (1985) as quoted in Castro et al (2011) defined "accessibility" as the product of the relationship between effective availability of health services and access to these services by individuals. Effective availability occurs when the availability of health services is analysed along with the resistance that the environment creates against it.

Hendriks (2009) notes that persons with physical disabilities or visual impairments heavily rely on the help of a family member or a close relative to accompany them as they move around. This creates a sense of dependence and fragility. A caregiver has an important role in the health of a person with disabilities, especially with contacts that the caregiver has with health professionals, financial expenses in transportation and difficulties in health services.

Problems with accessibility to health services by certain groups contradict the principle of equity. As Harrison (2006) observes in a Brazilian family where PWDs have no sufficient waiting places due to physical obstacles including the absence of ramps to access buildings, adapted toilets and accessibility of physiotherapy clinics, it is the burden of the caregiver to find alternatives. More interestingly, PWDs, though appreciating the assistance rendered by caregivers in making appointments and moving around reportedly complained of the lack of privacy and confidentiality. There has always been suspicion that the assistant will always gossip about them and issues surrounding their impairment.

4.3. Communication barriers

Communication and information barriers include language barriers, and poor telecommunication infrastructure.

In Zimbabwe, PWDs, especially the deaf, bemoan challenges that they are encountering on accessing sexual and reproductive health services in health facilities due to communication barriers. Agness Chindimba, Director of *Deaf Women Included*, said that the failure to assign sign language interpreters by most health institutions has qualified language barriers as a chief impediment to access health services (Ndangana, 2020).

This is corroborated by Peta (2017) in a case study where a woman with speech impairment believed she lost her two babies during labour because the doctors and nurses could not use or understand sign language. PWDs with hearing or speech impairments more often feel excluded from the local health services due to the non-use of sign language, as local staff are incompetent to communicate in the language they understand.

Disability awareness is associated with education while attitudes are associated with personal or cultural beliefs. In Uganda and Rwanda, the personal attitudes of health workers lead to youths with disabilities refraining from using local health care services as they saw it as a waste of time and money. There is a story of a nurse in Uganda who would not provide HIV related services including blood tests to a girl with a physical disability due to misconceptions that youth with physical disabilities were not sexually active (Yousafzai et al, 2005).

Chindimba (Ndangana, 2020) pointed out that the attitudes of local clinic staff exacerbate this misconception as:

> Some people ask stupid questions. For example, if they see a person with disabilities pregnant, they ask if they had sex when it's obvious. It is not the Holy Spirit. People tend to see the disability before reflecting that we are also human beings… So you can imagine if this is happening in urban areas, what more in rural setups where they don't have access to information and privileges.

Onai Harai from *Deaf Women Included*, who has been working with deaf women and girls in rural areas, said being deaf puts women in a vulnerable position as, "It's even difficult for them to negotiate for sex hence most of them end up being victims of gender-based violence." (Ndangana, 2020). This leads to increased vulnerability to sexually-transmitted infections.

4.4. Attitudinal and cultural barriers

Attitudinal barriers are linked to stigma and discrimination. As Devlinger (1995) notes, relatives and family beliefs and attitudes in traditional rural societies are key to whether PWDs access healthcare and proper medical treatment or not. Prejudice towards disability often vary from one type of disability to the other, with those with mental health conditions experiencing the worst disadvantage.

An Ethiopian study aimed at estimating the extent to which stigma as perceived by relatives of mentally ill individuals prevented them access to healthcare concluded that those suffering from schizophrenia or major affective disorders were concealed from the public and could only access prayers from churches or health remedies from traditional healers once their illness was attributed to supernatural forces (Shibre et al, 2001).

The other problem with family members or caregivers noted in the Ethiopian case is the negative impact of their attitude on health access when they believe that nothing substantial will be done to the PWD even if they sought medical treatment. Community negative attitude about disability can decrease both the motivation of health workers and that of relatives, hindering the PWD's access to health and rehabilitation services.

Stigma, including experienced stigma and fear of stigmatization, is a barrier. WEI (2016) notes that given the stigma and patriarchy in society, women with disabilities often have low expectations of their capabilities and worthiness, which dissuades them from seeking health services altogether. Lack of disability awareness in the communities has often acted as a substantial barrier to PWDs seeking treatment, despite how adequate health personnel were.

In some rural families, relatives of PWDs especially those of children with disabilities do not acknowledge the need to seek medical attention. Some believe that supernatural forces, which included birth complications, epilepsy or religious cause, disabled their child and as such, they did not require medical attention. For their treatment, they relied on traditional healers and spiritualists.

Aldersey’s (2014) study observed that some families of children with disability in Kinshasa hid their children at home in order to avoid fellow community members seeing the impairment, which was perceived as the family’s punishment for participating in supernatural practices. In addition to this, younger mothers were more likely to take their children for medical and rehabilitation services than older ones.

Another finding by Aldersey (2014) was that family size determines the response to disability. Smaller families had higher probability of taking their disabled children for health care services than bigger families.

A study by Zuurmond et al (2019) in Cameroon and India established that barriers to accessing health services by PWDs were at individual, family and community levels where beliefs and understanding of the nature of impairement shaped the attitudes and decisions made towards the person with the impairement. This observation is corroborated by Coleridge (1996) who says that the attitudes towards disability by those with power also play a critical role. For example, Coleridge notes that attempts to estimate the number of children and youth with disabilities in Palestinian camps were hampered by the reluctance of leaders in these camps to acknowledge that disability was even a problem.

Some reports to the UN pointed to the vulnerability of PWDs to HIV/AIDS as most health workers assumed the absence of unprotected sex among PWDs (United Nations, 2011). Such assumptions meant the PWDs were denied access to information on contraceptives, adequate services and treatment. Many times, PWDs who are sexually active are for cultural and religious reasons bent on preventing promiscuity and denied access to contraceptives when they actually need them. This has more often than not resulted in unwanted pregnancies and associated complications. Optimizing the health and well-being of PWDs is emphasized as essential to achieving the Sustainable Development Goals 4, 10, 11 and 17 (Sightsavers, 2015).

5. Impact of marginalization on people with disabilities in health services decision-making

Social inclusion and participation in the community are essential to achieving the Sustainable Development Goals. Development will only be sustainable and of long-term impact if citizens, especially people with disabilities, participate in deciding their own future.

In their study in Cameroon and India, Zuurmond et al (2019) noted how higher levels of participation in community life in Camerron correlated with the provision of social support structures, for example, membership to Disabled Persons Organizations, village savings schemes, and church groups. These networks also facilitated information sharing hence there was a high level of awareness of available health care services as well as PWDs rights to services. In contrast, the same study found that in India, PWDs felt they were alienated and a burden to the family and community.

According to studies undertaken by Peters (2009) in Lebanon, Syria and Jordan, statistics of PWDs as a subgroup and their lived experiences as individuals more often reveal a picture of social exclusion. Peters notes that exclusion of PWDs occurs in combination with several forms of discrimination including gender bias, unequal employment opportunities, lack of access to education, inadequate health services and patriarchal or religious norms. For instance, a study by the *Women Academy for Leadership and Political Excellence* found out that women with disabilities are not represented in all the 31 Wards of Mutasa District, not even a single Councilor or MP was from that constituency (WALPE, 2020).

With regards to engagement with health service providers, Zuurmond et al (2019) established that trust and acceptability play a key role. Lack of trust was related to perceptions of previous experiences of not being treated with dignity or views not being taken seriously and considered.

Cultural links to disability constitute a critical influence on marginalization (Peters, 2009). Given the cultural traits in most rural areas in Africa, especially the belief in hiding the disabled at home, there is generally scant information regarding the disability prevalence, living conditions of PWDs and knowledge on the impact of available services. Negative attitudes and beliefs among health staff and communities makes life more difficult for PWDs. For instance, midwives at a local rural clinic who fear delivery complications from women with disabilities end up doing unnecessary referrals to a tertiary maternity facility, which is outside the patients' locality, which turns out to be too costly and difficult to reach (Smith et al, 2004). This is likely to be due to general stereotyping.

Most referral tertiary facilities are centralized in urban areas, which means expecting women with disabilities have to travel long distances to access them. Money for transportation is usually not available. Resultantly, most of these women are brought to the referral centre too late or they seek alternative health care from traditional birth attendants. Thus, due to financial and transport related problems, pregnant women with disabilities are not monitored for conditions such as diabetes, hypertension, malnutrition, bacterial and viral infections, which can complicate pregnancy and affect foetal development. Smith et al (2004) further note that the national consequences are that more women with disabilities die of pregnancy and birth-related problems in rural areas.

Disability costs fall on entire families, though mostly women and girls bear the burden of caregiving. Shaun (2009) notes that the burden is so huge in rural communities that neighbours often speak of the 'disability family'. Family members are unable to work in the fields or do some income generating projects as they take care of a PWD. Schoolgirls are known to miss or drop out of school to take care of a family member with disabilities. The home-based care approaches practised for PWD in rural communities create a vicious cycle of chronic poverty within the family.

In countries like Zimbabwe, Zambia and Malawi, government welfare departments are responsible to reach out and assist PWDs. Yet, these often reach a small percentage of those in need and they are unequally distributed with the intention of covering the different types of impairments (Nota et al., 2015). With reduced social expenditure, government itself struggles to meet the needs of individuals and institutions established to assist PWDs, leaving most of them resorting to street vending and begging.

Finally, childhood disability in the Sub-Saharan Africa is associated with poverty. When children miss essential treatment for basic illnesses such as fever and diarrhoea or miss vaccinations, these treatable illnesses often evolve into lifelong disabilities (UNICEF, 2011). Disability in children from impoverished families is associated with inadequate healthcare services for pregnant mothers. Similarly, disability among children persists and continues because of the community’s socio-economic, political and cultural situation (African Child Policy Forum, 2014).

6. Emerging gaps

A number of data gaps emerge from studying issues of exclusion of PWDs from health service provision, mainstream development services, and decision-making.

Despite missing disability in the MDGs, there is now a global commitment to ensure that PWDs have equal access to health care and other social and economic opportunities. The World Bank summed it up by saying:

> People with disabilities in developing countries are over-represented among the poorest people. They have been largely overlooked in the development agenda so far, but the recent focus on poverty reduction strategies is a unique chance to rethink and rewrite that agenda (Wolfensohn, 2004).

What is missing is the political willingness to invest resources and implement, as the conventions, legal documents and policies are already in place in many countries.

Poverty, disability, discrimination and stigma are influenced by policies of government, donors and NGOs. Unlike in developed countries where policies and conventions are often supported by resources, too many national problems and priorities crowd out the welfare of PWDs in most developing countries including Zimbabwe. Issues of PWDs, especially those in rural communities, seem to remain on the national agenda as something that will be done properly tomorrow. Given the link between poverty and disability, the two should be addressed in terms of balancing relief and rehabilitation concerns in the short term, and development and poverty reduction in the long-term (UNICEF, 2011).

Although developing countries, especially those in Sub-Saharan Africa attained economic growth, averaged over 5 per cent of growth in GDP, that has not translated into ‘meaningful social development outcomes’ as development is attached to inclusiveness (Vidojević, 2017). For example, in South Africa, exclusion and inequality have made high levels of absolute, chronic and multidimensional poverty the order of the day. Basic social services remain unavailable, unaffordable and inaccessible to many people. Social inclusion of the disabled and marginalized in rural communities remains a prerequisite for achieving inclusive and sustainable development.

As in most Sub-Saharan African countries, poverty, physical inaccessibility, attitudinal problems, and inadequately trained health professionals in rural areas are the major barriers to PWDs access to health care access. Families, relatives and communities rely on socio-cultural coping strategies instead of medical health facilities to obtain hope and meaning. As such, incentives, more training for health care staff and support to PWDs and their families are required. Given the widespread problem of poverty, as a major barrier to seeking medical care for most in rural communities, government social welfare grants, support from non-governmental organizations (NGOs) and charity organizations is a strong facilitator to PWDs accessing health services (Nota et al., 2015).

The negative attitudes of health professionals to PWDs is a barrier to their access to health care. Women with disabilities in rural settings are one of the most discriminated groups as health professionals often ignore their child bearing and motherhood needs. The inclusion of sexual reproductive health and disability courses in the curriculum of student health professionals will go a long way in alleviating the negative attitude towards women with disabilities.

It is also prudent for the health sector recruitment policy to consider the inclusion of women with disabilities at all levels (Mgwili and Watermeyer, 2006). Women with disabilities including those with Down syndrome, schizophrenia, intellectual and other impairments desire to marry, have families and children of their own. There is need to train health professionals, mostly in rural areas, in that women with disabilities require sexual reproductive health information and services just like other women. PWDs are entitled to consult health care issues that have nothing to do with their disability, especially access to contraceptives or for pregnancy related issues.

Equity is still not being employed as as a principle of social justice. For PWDs, it is not enough to have the same opportunities if there are no conditions to take advantage of them. Rather, Carneiro Junior and Elias (2006) characterized equity as “positive discrimination” aimed at socially disadvantaged population groups with planning and policies of healthcare that seek to eliminate inequalities.

Conclusion

Current development literature still has serious gaps on successful strategies to support the PWDs to access health services in rural areas. There is a lack of disability awareness, services, and research in almost all of the Sub-Saharan African countries. More research is required to understand how PWDs can be moved from “tokenism” into meaningful participation in development initiatives, especially access to health services in rural communities (Beckwith et al, 2016). Continuous and rigorous research and evaluations to monitor strategies intended to improve the participation and inclusion of PWDs are required.

As Adugna et al (2020) note, there is limited access to healthcare services for PWDs in most rural areas [including Mutare rural and Mutasa districts] due to poverty, low education, inadequate healthcare systems, and shortage of healthcare professionals. It is evident that there are socioeconomic, cultural, and physical related impediments that affect PWDs access to the required healthcare services. Policy development, improved physical accessibility, public disability awareness, and support from the community are some of the key facilitators to access healthcare services.

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(All links were accessed on 19 March 2021)

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