Access to health services for people with disabilities in Zimbabwe – a case of Mutasa, Mutare Urban and Mutare Rural Districts in Manicaland Province

A research report, written by PRFT, August 2021

Contents

List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AMTO	Assisted Medical Treatment Order
CRPD	Convention on the Rights of Persons with Disabilities
ECID	Evidence and Collaboration for Inclusive Development
FDPZ	Freedom to the Disabled Persons in Zimbabwe
HIV	Human Immunodeficiency Virus
ICF	International Classification of Functioning Disability and Health
MDGs	Millennium Development Goals
MWDs	Men with Disabilities
NDP	National Disability Policy
NDS 1	National Development Strategy 1
NGOs	Non-Governmental Organization
PRFT	Poverty Reduction Forum Trust
PWDs	People with Disabilities
RBFH	Results Based Financing Health
UNFPA	United Nations Population Fund
WHO	World Health Organization
WWDs	Women with Disabilities
ZIMSTAT	Zimbabwe National Statistics Agency

1. Background and Introduction

People with disabilities (PWDs) are a key constituent in Zimbabwe with the overall disability prevalence being 9 percent (9.4 percent female and 8.5 percent male), according to Zimbabwe National Statistics Agency (ZIMSTAT, 2017a). According to their Zimbabwe Poverty Report (ZIMSTAT, 2017b), poverty levels are also higher for PWDs with 74.1 percent in poverty compared to 69.5 for those not disabled, and 32.2 percent PWDs in extreme poverty compared to 28.5 percent for those not disabled. Available data show the PWDs constituent is vulnerable in many 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 has been undertaken in Manicaland where the prevalence for females as a marginalized group is higher.

The June 2020 ECID Zimbabwe baseline survey identified Health, Education, WASH and Social Welfare or Employment as priority services for PWDs. This research will mainly focus on PWDs' access to Health. Data from this baseline also shows that 89.5% of the people surveyed find it important for the most marginalised to be involved in decision making processes (ECID, 2020).

Section 22 of the Constitution of Zimbabwe Amendment (No.20) Act 2013 recognises the rights of persons with physical or mental disabilities and instructs government institutions at all levels to avail resources that assist PWDs achieve their full potential and minimise disadvantages suffered by them. However, anecdotal data shows that PWDs in Zimbabwe are not enjoying the rights enshrined in the Constitution. In 2018, during the African Union Summit, Zimbabwe endorsed the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities protocol having signed to the Convention on the Rights of Persons with Disabilities (CRPD) in 2006 (Moyo, 2018). Zimbabwe ratified the CRPD and its Optional Protocol on 23 September 2013 (Mandipa and Manyatera, 2014). As a state party to the CRPD, Zimbabwe assumed the obligations to domesticate, promote, protect and enforce the rights of PWDs. Part of this was the recognition of and prohibition of discrimination-based disability in the new constitution (2013). The commitments made by the government have however failed to translate into tangible benefits for PWDs.

The studies done to date do not fully show the extent of the intersectionality of challenges faced by PWDs, and how they inform inclusive participation in social service delivery.

PWDs in Zimbabwe still face challenges such as the 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 Parliament public hearings and local council budget consultations still lack adequate infrastructure such as sign language interpreters and brail materials, hence inhibiting effective participation in processes that impact their lives. 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.

Zimbabwe's Government launched the country's new five-year development plan, the National Development Strategy1 (NDS 1) on the 16th of November 2020. All line ministries are expected to develop their respective strategic plans in line with the NDS1. It is therefore important that the implementation of these plans is informed by disaggregated data to ensure the mainstreaming of disability issues especially in social service delivery.

The ECID programme aims to support the visibility of disability issues in these processes through research and programmatic work. This research thus seeks to contribute to this broader program by pursuing the below research objectives and questions (see Box 1).

Box 1: Research objectives, research question and sub-questions

Research objectives
1. Assess and understand the nature and extent of barriers to access health services by people with disabilities. 2. Explore the extent and impact of marginalisation of people with disabilities in health service decision making. 3. To proffer recommendations towards improving access to affordable and quality health services by people with disabilities.
Overall research question
What are the challenges faced by people with disabilities (these include women and men above the age of 18 years) in Mutasa, Mutare Urban and Mutare Rural Districts in accessing health services?
Sub-research questions
1. What are the impacts of marginalisation of people with disabilities in Mutasa, Mutare Urban and Mutare Rural Districts in decision making? 2. How can existing policies and programmes be improved to increase access of people with disabilities to quality health services?

Source: own elaboration

2. Methodology

The research used a mixed approach with quantitative and qualitative methods. For the quantitative part, surveys were undertaken. On the other hand, key informant interviews and focus group discussions were used to gather qualitative data. Details on data collection, data analysis and ethics can be read in the following sub-sections.

Quantitative data: the survey. The research employed a survey of PWDs in the three Manicaland districts of Mutasa, Mutare Rural and Mutare Urban with 407 PWDs interviewed. The sample size was calculated using the Rao soft sample size calculation. According to the 2012 national census, the total population of PWDs in the three districts is estimated at 19161. Using a 95% confidence interval, 5% margin of error and 50% measure of dispersion, the sample size obtained was 377 persons in the three districts. The sample was allocated into the three districts using probability proportional to size as shown in Table 1.

Table 1: Sample distribution of the study, by district

	People with disabilities	Sampled people	Actual people with disabilities surveyed
Mutare Rural	1355	27	40
Mutasa	9731	191	192
Mutare Urban	8075	159	175
Total	**19161**	**377**	**407**

Source: own elaboration

However, during the survey it was not possible to use the simple random sampling as a significant number of listed persons could not be found or were said to have relocated especially in Mutare Urban. As a result, the research ended up using the snowballing method with a total of 407 PWDs surveyed. Mutasa had 192, Mutare Urban 175 and Mutare Rural 40 people with disabilities interviewed.

In the survey, disability was defined by using the six questions developed by the Washington Group Questions on Disability. The questions cover six domains: difficulty in hearing, seeing, walking, remembering, self-care and communicating. Answer alternatives are: i) no difficulty; ii) some difficulty; iii) a lot of difficulty; and iv) cannot do at all.

Qualitative data: key informant interviews and focus group discussions. A total of 8 key informant interviews targeting 3 government, 3 local authority officials and

2 traditional leaders were conducted. Four focus group discussions of 10 PWDs each were conducted to harvest information on the access to health services of PWDs. The focus groups were split between males and females to understand the gender perspectives of access to health by PWDs. An interview guide and a focus group discussion guide were developed and used as tools for information harvesting. The research instruments were peer reviewed by academic professionals to validate their alignment to the research objectives and research questions. All the participants from the focus group discussions were drawn from Mutasa [rural areas] and Mutare Urban whereas participants of the key informant interviews were from Mutasa [rural areas], Mutare Urban, Mutare Rural, and the national level (Harare).

Data analysis. Interviews were audio-recorded with the permission of interviewees and transcribed into English. Interview transcripts were coded by the lead researcher (PRFT) and key themes and sub-themes were checked and verified with the co-researcher (ZIMSTAT). A thematic analysis of key issues was undertaken using an iterative process of both a priori codes and emergent new themes which emerged from the analysis of the data.

The quantitative data used a questionnaire for PWDs, with a range of disability-relevant variables including questions on functional difficulties and access to services. The data was checked and validated by the co-researcher of ZIMSTAT. The analysis and management of quantitative data was done by ZIMSTAT using CSpro and Stata.

Ethics. PRFT's research ethics plan was guided by its core values and code of conduct standards which guide the organisation's operations. PRFT's core values are as follows: Dignity; Teamwork; Networking and Partnerships; Accountability; Commitment; and Inclusivity. PRFT's Code of Conduct Standards, Ethics Principles Guiding Research, Data Management and Complaints and Reports are provided as Annex 1.

3. Results

The presentation of results follows the five modules of the survey: (1) sample demographic characteristics; (2) adult functioning domains; (3) current state of health access; (4) barriers to access health care; and (5) the impact of marginalization in decision-making. Qualitative data from key informant interviews and focus group discussions has been integrated for comparison when relevant in each section.

3.1. Sample demographic characteristics

This first module focuses on the demographic and background profile of those PWDs surveyed.

Table 2 presents the distribution of PWDs according to various demographic and background characteristics. A total of 407 PWDs were interviewed in the three districts. From Mutasa, 192 (47.2%) were interviewed and from Mutare Urban, 175 (43%) were interviewed while in Mutare Rural, a total of 40 (9.8%) PWDs were interviewed. Males constituted 53.3% of PWDs that participated in the study.

With regards to age, the majority of respondents, 67.1%, were in the age group of 18 to 50 years. From age 51 onwards, the number of PWDs generally decreased with age.

As for education, over a quarter (27.8%) of PWDs had lower secondary as the highest level of education completed, while 23.6% had completed the full primary course. About 8% had completed some tertiary education while 9.6% had never been school. Out of the PWDs who had never been to school, 61.5% were female while 38.5% were male.

Importantly, a majority, 88.5% of the PWDs were not covered by any medical aid scheme.

Table 2: People with disabilities by demographic characteristics, in frequency and percent distributions

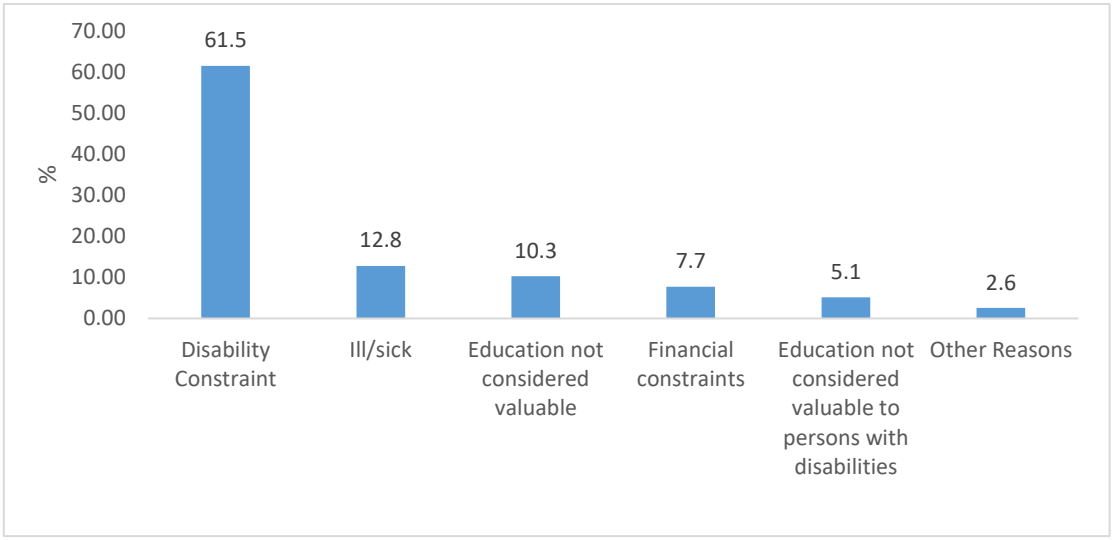
		Frequency	Percentage
Sex	Male	217	53.32
	Female	190	46.68
District	Mutare Rural	40	9.83
	Mutasa	192	47.17
	Mutare Urban	175	43.00
Age	18 – 35	160	39.3
	36 – 50	113	27.8
	51 – 65	74	18.2
	66+	59	14.5
	Not Known	1	0.2
Education	Early Childhood Education	27	6.63
	Some Primary	80	19.66
	Primary	96	23.59
	Lower Secondary	113	27.76
	Upper Secondary	18	4.42
	Tertiary	34	8.35

	None	39	9.58
Medical Aid Scheme	With Medical Aid Scheme	47	11.55
	Without Medical Aid Scheme	360	88.45
Total		**407**	**100**

Source: PRFT access to health survey 2021

Education. Among the 9.6% PWDs who have never been to school, 61.54% indicated that they had never attended school due to disability constraints, with 12.82% citing illness. About 10% indicated that to them education was not considered valuable (see Figure 1).

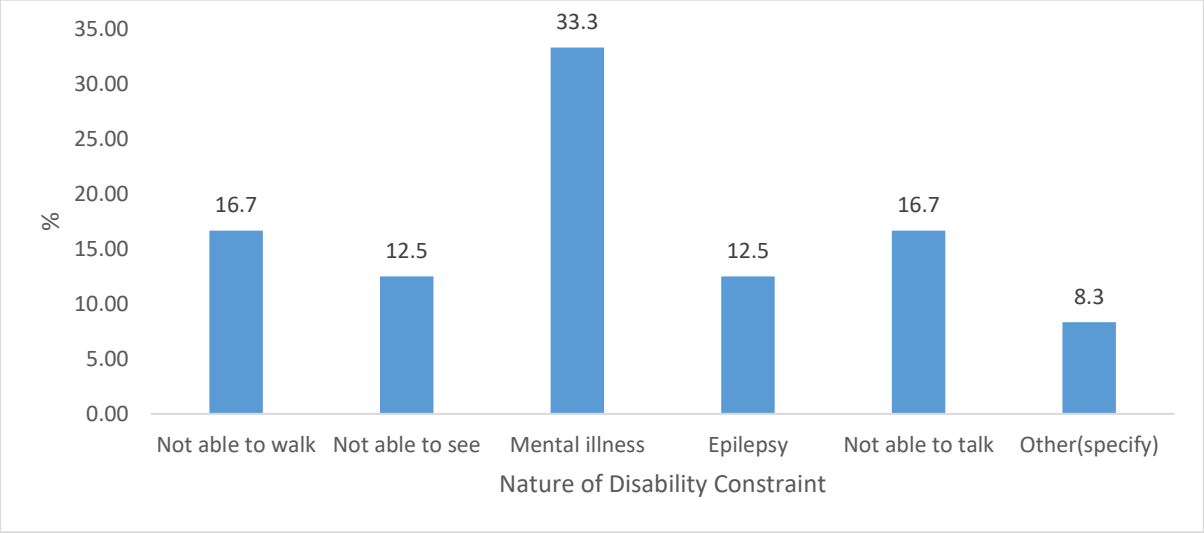
Figure 1: Reasons for having never been to school among people with disabilities, in percentages



Source: PRFT access to health survey 2021

PWDs who indicated that they have never been to school due to disability constraints were asked for the nature of the constraint. Results in Figure 2 show that 33.3% cited mental illness and the constraint of disabilities in walking and talking were each mentioned by 16.7% of the respondents.

Figure 2: Nature of disability constraint for persons with disabilities who have never been to school, in percentages



Source: PRFT access to health survey 2021

Activity status. The survey collected information on activity status of the PWDs for the past 12 months. The analysis of activity status of a PWDs gives a picture of the human power that they are providing in an economy and it also shows where they are lagging behind.

In this survey, the "economically active persons" refers to the total number of persons available to produce goods and services as realised in national income statistics. The economically active population includes paid employees and employers, unpaid family workers, own account workers, and those unemployed. On the other hand, homemaking, studying, and being sick or too old, are examples of activities of the economically inactive population. It is important to note that most respondents in Zimbabwe, as observed in other surveys conducted by PRFT, tend to report that they are homemakers even though they combine housework with other economically productive activities.

There were 120 economically active respondents and 287 economically inactive in this survey. Table 3 shows that out of the economically active population, 19.2 percent were unemployed or looking for work. The majority 60.8 percent of the economically active persons were own account workers, paid employees were 13.3 percent while employers constitute less than one percent. There are no significant sex differentials as the pattern was the same for both males and females.

For the economically inactive persons, 28.6 percent reported that for the past 12 months preceding the survey they were sick/too old/retired to engage in any

economic activity. Only 5.6 percent indicated that they were students, and the majority 59.2 percent were homemakers as shown in Table 3.

Table 3: People with disabilities by economic activity status and sex, in percentages

Economically Active	**Male**	**Female**	**Total**
Employer	1.25	0.00	0.83
Paid Employee	12.50	15.00	13.33
Own Account Worker	61.25	60.00	60.83
Own Account Worker[2]	5.00	7.50	5.83
Looking for work/Unemployed	20.00	17.50	19.17
Total	100	100	100
Economically Inactive	**Male**	**Female**	**Total**
Student	3.65	7.33	5.57
Homemaker	54.74	63.33	59.23
Retired/sick/too old	32.85	24.67	28.57
Other (specify)	8.76	4.67	6.62
Total	100	100	100

Source: PRFT access to health survey 2021

Figure 3 shows the distribution of activity status by district. It highlights that the two predominantly rural districts (Mutasa and Mutare Rural) have more persons who are economically inactive (Mutasa 77.6% and Mutare Rural 85.0%). In Mutare Urban there is a significant proportion of economically active PWDs (40.6%).

Figure 3: Economic activity status, by district, in percentages

Source: PRFT access to health survey 2021

3.2. Adult functioning domains

The second module of adult functioning domains is based on the set of questions developed by the Washington Group on Disability Statistics – a United Nations City Group established under the United Nations Statistical Commission. These questions reflect six domains for measuring disability: seeing, hearing, walking, cognition, self-care and communication. Although the survey was conducted on to PWDs, it is still worth to know the type and severity of disability that PWDs have, as screened by the Washington Group set of questions.

Adult functioning domains and demographics. Table 4 shows the six functional domains tabulated against demographic characteristics. It shows statistics among each domain, for example, among persons who have difficulty seeing more than half 52.2 percent were females. There was no observed pattern when the domain was cross tabulated with age groups.

Table 4 shows that generally all PWDs rarely have medical aid schemes despite the domain of adult functioning. Above 87.2 percent of all individuals in each domain do not have a medical aid scheme.

For the PWDs who have reached tertiary education, it seems there are proportions of less than 5 percent each among domains of hearing, cognition and communication.

Table 4: Adult functioning domains by demographic characteristics, in percentages

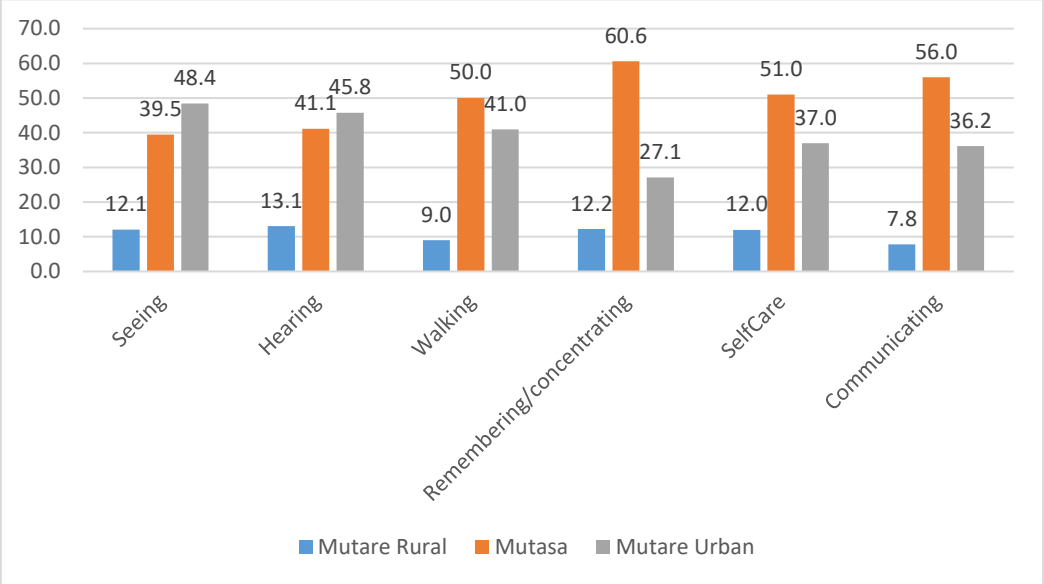
	Seeing	Hearing	Walking	Remembering/ concentrating	Self-Care	Communicating
District						
Mutare Rural	12.1	13.1	9.0	12.2	12.0	7.8
Mutasa	39.5	41.1	50.0	60.6	51.0	56.0
Mutare Urban	48.4	45.8	41.0	27.1	37.0	36.2
Sex						
Male	47.8	47.7	54.1	48.4	55.2	53.9
Female	52.2	52.3	45.9	51.6	44.8	46.1
Age						
18 - 19	3.2	7.5	4.1	5.9	3.1	7.8
20 - 24	8.3	9.3	7.9	11.2	10.4	11.3
25 - 29	5.7	15.0	7.9	9.6	5.7	14.2
30 - 34	6.4	11.2	8.3	11.2	11.5	16.3
35 - 39	8.3	8.4	10.5	8.0	12.0	9.9
40 - 44	6.4	12.1	10.5	11.7	10.9	9.9
45 - 49	8.3	7.5	8.6	5.9	7.8	8.5
50 - 54	9.6	2.8	6.8	4.8	6.8	2.8
55 - 59	8.9	2.8	6.0	4.8	6.3	3.5
60 - 64	7.6	5.6	6.4	9.0	6.8	4.3
65 - 69	8.3	3.7	7.5	5.9	5.7	4.3
70 - 74	4.5	2.8	3.4	4.8	3.6	2.8
75 - 79	7.0	5.6	5.3	2.7	4.2	3.5
80+	7.0	4.7	6.4	4.3	5.2	0.7
Education						
Early Childhood Education	6.4	3.7	6.4	11.2	7.8	13.5
Some Primary	20.4	20.6	19.9	27.1	22.4	19.9
Primary	26.1	26.2	26.3	27.1	22.9	21.3
Lower Secondary	29.9	30.8	22.6	14.9	20.3	19.1

Upper Secondary	2.5	3.7	4.9	1.6	3.6	2.8
Tertiary	5.7	2.8	9.4	3.7	6.3	4.3
None	8.9	12.1	10.5	14.4	16.7	19.1
Activity Status						
Employer	0.0	0.9	0.0	0.0	0.0	0.7
Paid Employee	0.6	2.8	3.0	1.6	2.1	1.4
Own Account Worker	21.0	7.5	19.9	12.2	15.6	11.3
Own Account Worker 2[3]	0.6	0.9	2.6	1.1	0.0	0.7
Looking for work/ Unemployed	2.5	6.5	5.6	4.3	6.3	7.1
Student	2.5	4.7	2.3	3.7	2.1	4.3
Homemaker	43.9	51.4	38.0	43.1	37.5	37.6
Retired/sick/too old	26.8	19.6	25.2	29.3	30.7	26.2
Other (specify)	1.9	5.6	3.4	4.8	5.7	10.6
Medical Aid Scheme						
With Medical Aid Scheme	9.6	9.3	12.8	10.1	10.9	10.6
Without Medical Aid Scheme	90.4	90.7	87.2	89.9	89.1	89.4

Source: PRFT access to health survey 2021

Adult functioning domains by district. Figure 4 shows the distribution of respondents by domain and district. In general, Mutasa has higher proportions of difficulties across all domains except for seeing and hearing.

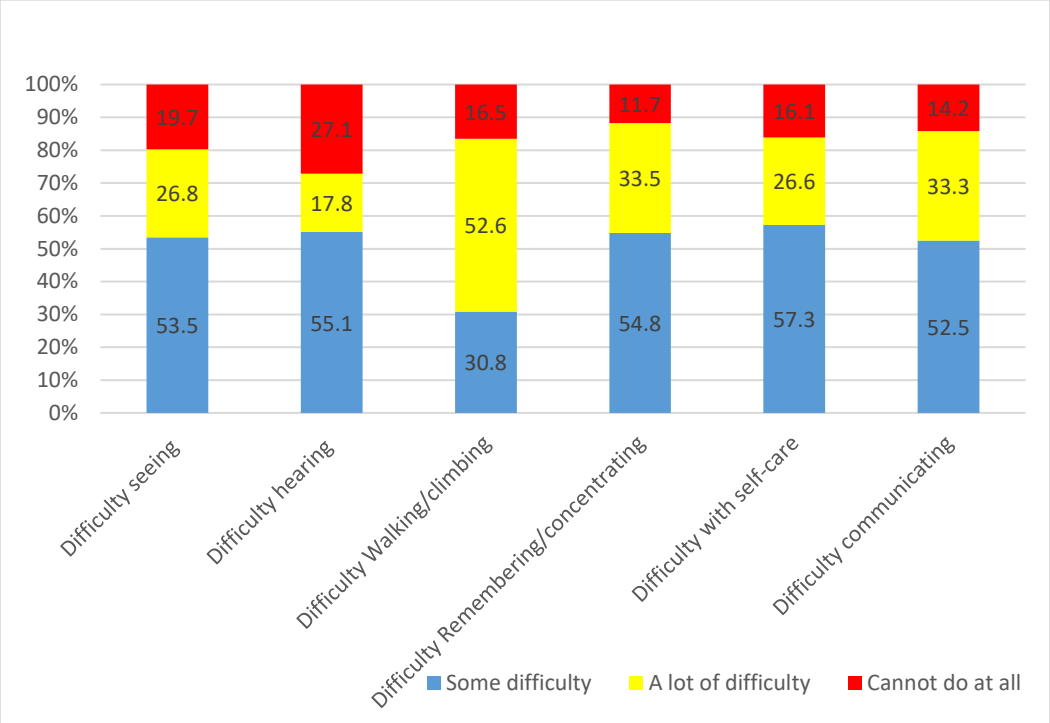
Figure 4: Adult functioning domains, by district, in percentages



Source: PRFT access to health survey 2021

Severity of disabilities. Figure 5 depicts the severity of the functional difficulties of the respondents by domain of functioning. The red part of the bars shows the proportions of persons who are critical as they cannot perform the given domain, followed by those in yellow who have a lot of difficulties in performing the given domain task. Proportions in blue are for those who have moderate disabilities as they indicated that they have some difficulties in performing the domain tasks. More than half (52.6%) of the respondents with difficulty walking have a lot of difficulty and 16.5% cannot walk at all. This shows that there are 69.1% respondents that have severe disability in the domain of walking and 30.8% is moderate. More than a quarter (27.1%) of respondents who have difficulties in hearing cannot hear at all and 19.7% of the respondents with difficult seeing were totally blind.

Figure 5: Severity of the disabilities, by adult functioning domain, in percentages



Source: PRFT access to health survey 2021

Adult functioning domain and health facility visited. Table 5 shows that PWDs usually visit public health facilities no matter what their domains of functioning are. All other health facilities have proportions that are less than 10% in each domain, except for hearing where about 10 percent of persons with difficult hearing are mainly visiting private health facilities.

Table 5: Respondents by adult functioning domain and health facility visited, in percentages

Health Facility	Seeing	Hearing	Walking	Remembering	Self-Care	Communicating
Public clinic/ hospital	82.80	78.50	82.33	76.60	78.65	78.01
Private clinic/hospital	7.01	10.28	5.64	7.45	5.73	5.67
Mission Clinic/hospital	3.18	4.67	5.26	6.38	7.29	5.67

Traditional Healers	1.27	2.80	1.50	2.66	3.13	3.55
Spiritual Healers	3.82	1.87	3.38	3.72	2.08	2.84
None	1.91	1.87	1.88	3.19	3.13	4.26
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: PRFT access to health survey 2021

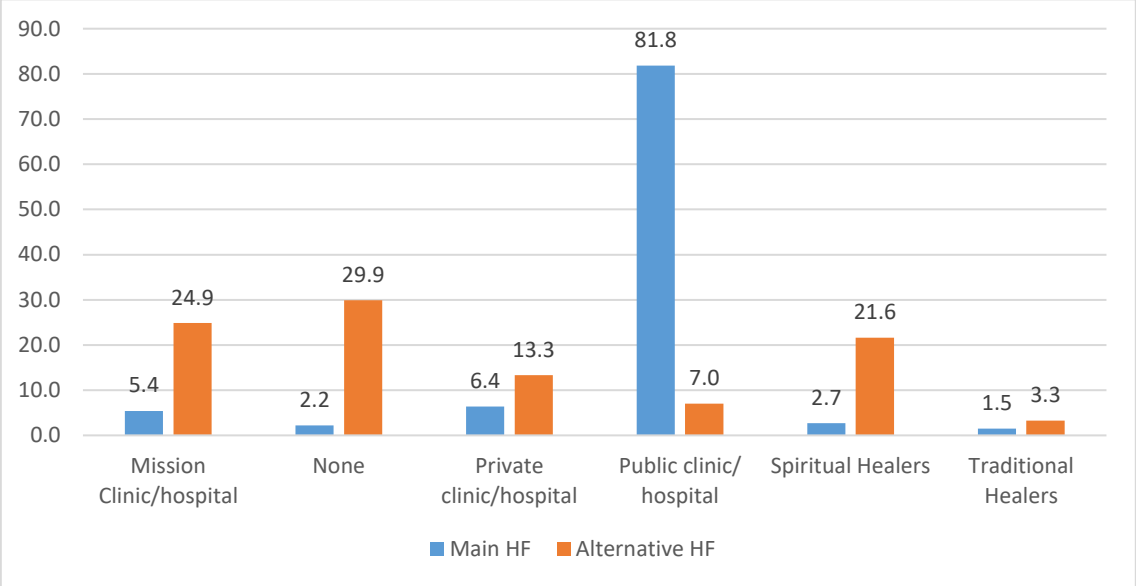
3.3. Current state of health access

This third module sought to obtain information regarding the current situation on health access for PWDs. Questions covered: the main and the alternative health facilities preferred; the frequency of visits to a health facility; the dependency of PWDs on public health institutions; the preparedness of local health facilities regarding PWDs; physical and financial assistance required by PWDs; and, finally, the policies supporting health access for PWDs.

Type of health care service preferred. Figure 6 shows the main and alternative health facilities that are used by the respondents to access their health needs. About 82 percent of all respondents indicated that they use public health facilities as their main health facilities. Very few respondents indicated that they use private health facilities (6.4%) and mission health facilities (5.4%).

Respondents were then asked for the alternative health facility they would use if they are not going for their main health facility. It shows that most people when they are not accessing public hospitals which is their main facility, they have nowhere else to access health services as seen by the 29.9 percent of the category 'none'. Mission hospitals and spiritual healers have a significant share as alternatives for health facilities, indicated by 24.9 and 21.6 percent respectively. Traditional healers seem to have lost their popularity in both as a main (1.5%) and also as an alternative (3.3%) health facility.

Figure 6: Main and alternative health facility visited by respondents, by type of health facility or service, in percentages



Source: PRFT access to health survey 2021

During the focus group discussions in Mutasa and Mutare Urban, the PWDs highlighted that both women and men access their health service needs from clinics such as Tsvingwe clinic (council/public) and Redwing clinic (privately owned) which are locally accessible to people in Penhalonga area under the Mutasa District. Other health institutions which are accessible to PWDs in Penhalonga area under Mutasa are Old Mutare Hospital (Mission) and Mutare/Victoria Chitepo General Hospital (government) which are approximately 8km and 20km away respectively.

In Mutare Urban, the PWDs highlighted local council clinics such as Sakubva clinic and the government-owned Mutare Provincial hospital.

However, the group of men with disabilities (MWDs) in Mutasa indicated that the local clinics only provide for minor health services such as headaches, flues or colds but for major health services they are referred to Mutare General Hospital which raises issues of extra costs that are required to access services in Mutare Urban. The view that most services are not available to PWDs leading to referrals to Mutare General Hospital was also corroborated by one Mutasa community leader during key informant interviews. PWDs are finding it difficult to access private hospitals for services not available in public health institutions. As a result, they depend on appeals to NGOs and the public for assistance.

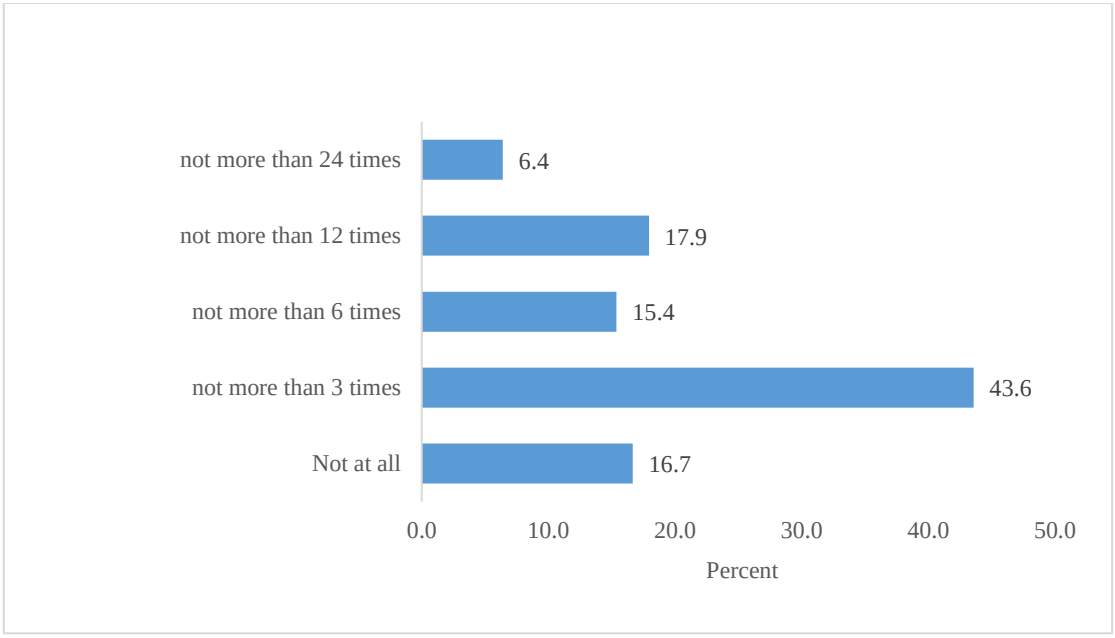
It was also noted by PWDs in Mutare Urban that rehabilitation services are not readily available for them despite their importance and increased frequency for some. In cases where the rehabilitation services are available, PWDs in Mutare Urban noted that the services are expensive and they are charged the same as those

involved in car accidents, for example. Where there are subsidised services, these were noted to be substandard and inadequate.

The Ministry of Public Services, Labour and Social Welfare representative pointed out that Zimbabwe has a number of rehabilitation centres for PWDs across the country, although these were noted to be inadequate in coping with the current and future demands. Examples include the National Rehabilitation Centre in Ruwa (which has a section that makes assistive devices) and the Beatrice Rehabilitation and Lowden in Mutare (for girls with disabilities). The Ministry is responsible for financing the rehabilitation centres to produce assistive devices that would then be given to PWDs for free.

Frequency of visits to a health facility by people with disabilities. Figure 7 shows the frequency of visits of PWDs to a health facility. The highest percent of PWDs (43.6%) indicated that they visited the health facility not more than 3 times in the past year, followed by those who visited no more than 12 times (17.9%) and those who said they visited not more than 6 times (15.4%). About six percent of the respondents indicated that they visited the health facility not more than 24 times. Nearly 17 percent did not visit the health facility at all.

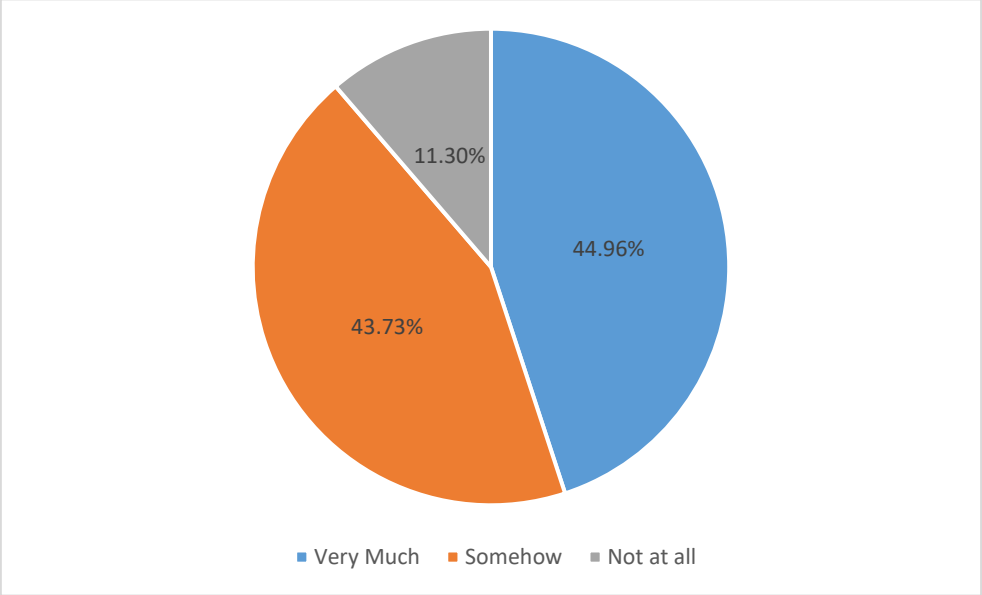
Figure 7: Frequency of visits to a health facility by people with disabilities in the past year, in percentages



Source: PRFT access to health survey 2021

Dependency on public health institutions. Figure 8 presents information on the level of dependency on public health institutions by PWDs. Overall, 44,96% of PWDs indicated that very much depend on services offered by public health institutions while an almost similar proportion, 43.7% indicated they somehow depend on public health institutions. About 11% of the PWDs do not all depend on services offered at public health institutions.

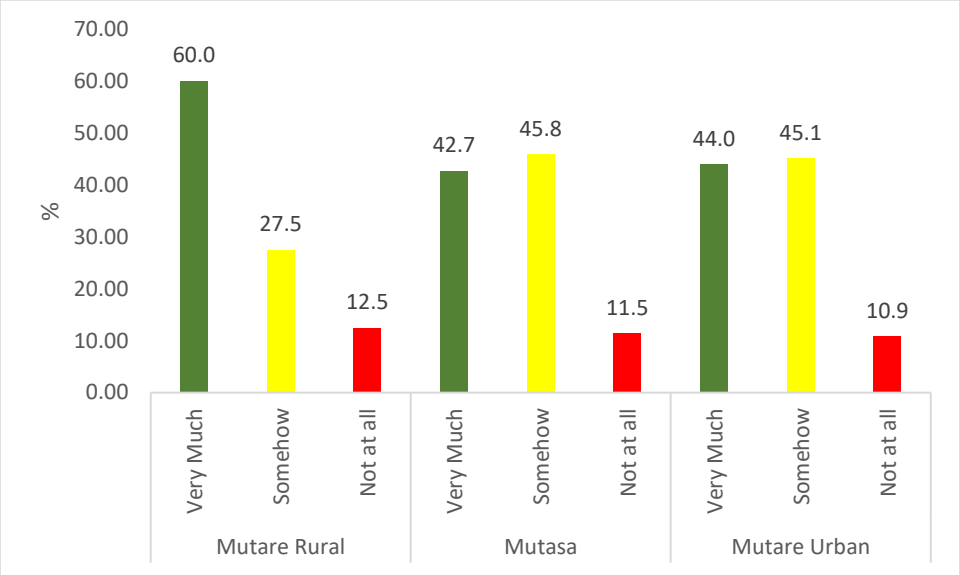
Figure 8: Levels of dependency on public health institutions among people with disabilities, in percentages



Source: PRFT access to health survey 2021

At district level, the pattern is a bit different from the overall picture. In Mutare Rural, the majority of the PWDs who were interviewed (60%) indicated that they depend very much on public health institutions, compared to Mutare Urban and Mutasa where the proportions were 42.7% and 44%, respectively (see Figure 9).

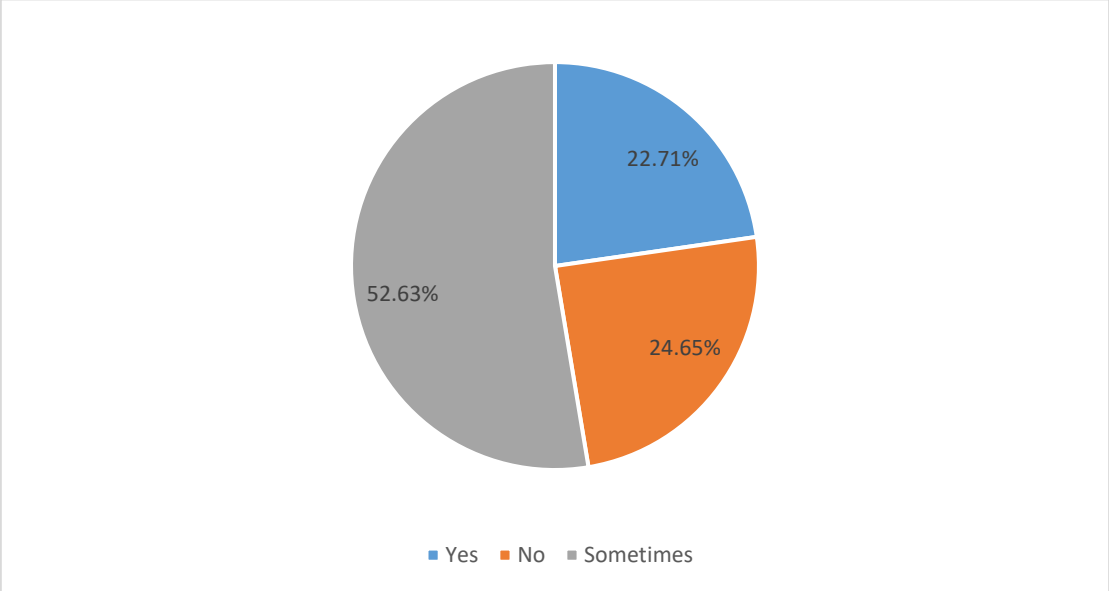
Figure 9: Levels of dependency on public health institutions among people with disabilities, by district, in percentages



Source: PRFT access to health survey 2021

Among the PWDs who depend on public health institutions, more than half (52.6%) indicated that they sometimes get the assistance they need from public health institutions with 22.7% citing that they always get the assistance they require. It is important to note that close to a quarter (24.7%) of PWDs do not get the assistance they require from public health institutions (see Figure 10).

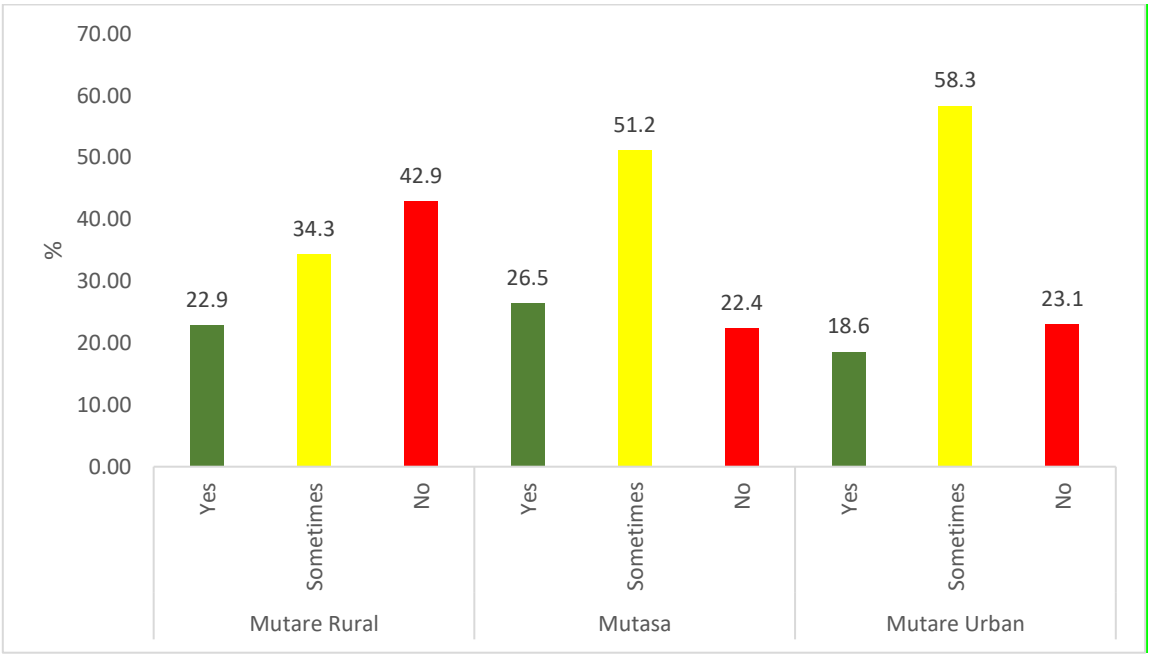
Figure 10: People with disabilities who depend on public health institutions by whether they get the assistance they require, in percentages



Source: PRFT access to health survey 2021

At district level, 42.9% of PWDs in Mutare Rural indicated that even though they rely on public health institutions, they do not get the assistance they require from the facilities at all. The proportions were much lower in Mutasa and Mutare Urban at 22.4% and 23.1%, respectively (see Figure 11).

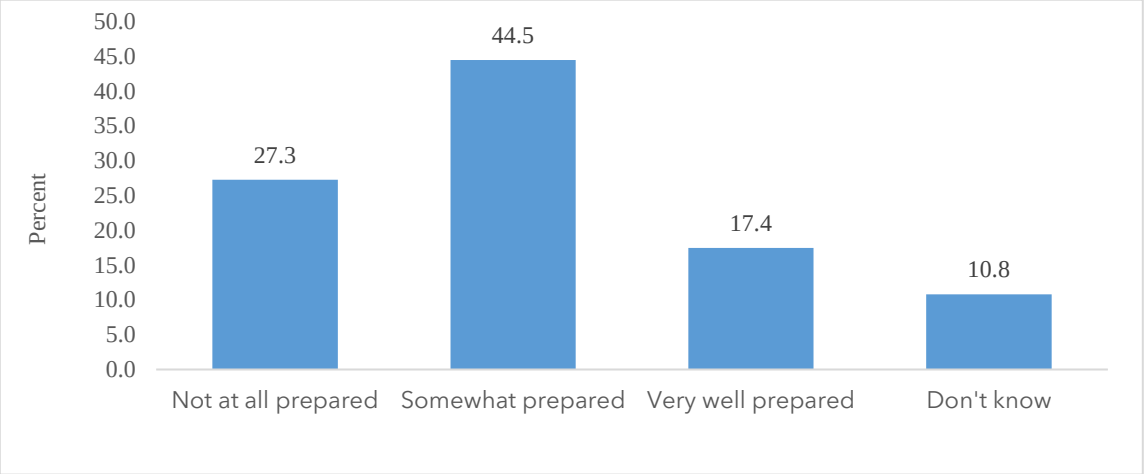
Figure 11: People with disabilities who depend on public health institutions by whether they get the assistance they require, by district, in percentages



Source: PRFT access to health survey 2021

Preparedness of local health facilities. Respondents were required to indicate their opinion on the preparedness of local health facilities in taking care of health needs of PWDs. PWDs' opinions are indicated in the following Figures 12a and 12b. It is evident that nearly 45 percent of PWDs' local health facilities are somewhat prepared in meeting the needs of PWDs. About 17 percent indicated that they were very well prepared and 27 percent said that they were not prepared at all (see Figure 12a).

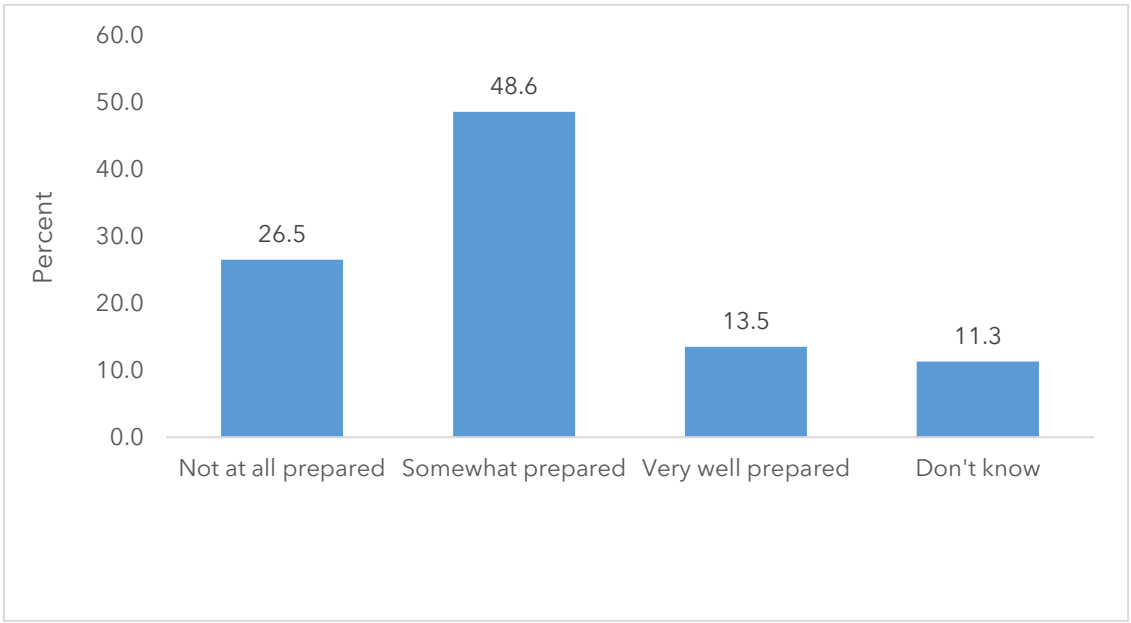
Figure 12a: Preparedness of local health facilities in meeting the health needs of people with disabilities, in percentages



Source: PRFT access to health survey 2021

In relation to PWDs' opinions on preparedness of health facilities in providing information on available health care services, 48.6 percent had the opinion that the local health facilities were somewhat prepared, 13.5 percent said that the local health facilities were very well prepared and 26.5 percent indicated that they are not all prepared (see Figure 12b).

Figure 12b: Preparedness of local health facilities in providing information on available health care services to people with disabilities, in percentages



Source: PRFT access to health survey 2021

In an interview, the Mutare Social Development representative noted that the Ministry of Public Services, Labour and Social Welfare is doing the most it can with the available communication channels such as radio and television to conduct awareness-raising programmes. As a result, the Ministry has seen more inflows of PWDs through walk-ins and calls at both local and national level. To ensure that the platforms are inclusive, the Ministry is ensuring that on TV programme, especially the main news broadcast, there is a sign language interpreter and text on the screen. The radio programmes are also used to complement the awareness-raising although it was noted that there is need to strengthen these platforms. The Mutare Social Development representative noted that information in braille is limited and conceded that it is rare to find a pamphlet in braille.

However, the discussion group of women with disabilities (WWDs) in Mutasa argued that they access limited health service information, e.g., COVID-19 information. Their male counterparts in Mutasa indicated that they are getting most of their health information from civil society organizations, school children after being educated at school with health officials, and the mainstream media such as Diamond Radio FM. The situation is different from MWDs in Mutare Urban who seem to have a variety of sources of information such as mainstream media, Social Development Department meetings, civil society organization meetings, and social media groups for PWDs.

PWDs in Manicaland province believe the information they are getting is reliable but are concerned that the platforms currently providing them with information are not inclusive. For instance, the radio excludes those with hearing impairments. Load shedding of electricity is posing access to information for PWDs in urban areas whilst, on the other hand, newspapers were considered inaccessible because of the high costs. PWDs argued that they are using the information they are getting from the various sources to make decisions about their health needs, e.g., making COVID-19 vaccination decisions.

One of the major concerns of PWDs in Mutasa was that the information they are getting is of a general nature and is not targeted at PWDs and their health needs. They noted the lack of COVID-19 information in braille for the visually impaired and a lack of sign language interpreters for those with hearing impairments. One woman from Mutasa indicated that they only got audio mp3s which contain COVID19 information and rights of PWDs from the NGO *Freedom to the Disabled Persons in Zimbabwe* (FDPZ). WWDs in Mutare Urban also concurred with WWDs from Mutasa that they received COVID-19 information from associations such as FDPZ. WWDs in Mutasa also indicated that some people with physical disabilities have difficulties in walking to COVID-19 road shows and they rely on second-hand information. Some information is provided with sign language on the national television, but it was established by the Mutare Social Development representative that most people

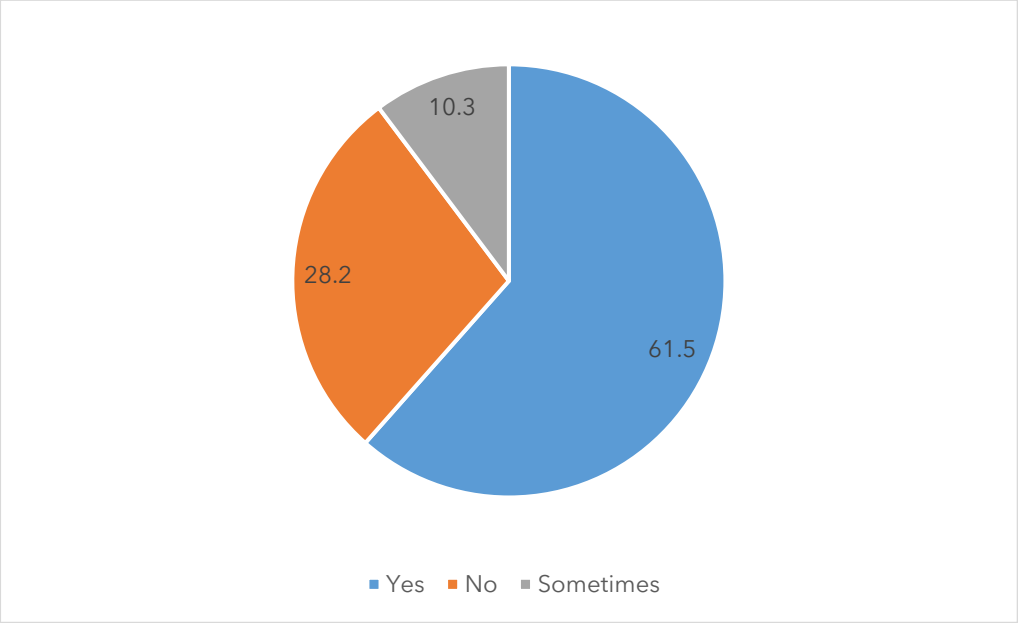
with hearing impairments cannot afford to buy television sets; hence, they are left out in terms of getting information.

In Zimunya ward, Mutare Rural, WhatsApp groups are used to convey health information and also council meetings platforms. These, including the local council platforms, are believed to be inclusive because they use sign language interpreters. However, the situation in Dora, another ward in Mutare Rural, highlighted that PWDs are not getting information as their immobility and lack of assistive devices is depriving them of the much-needed health information which has become more important during this COVID-19 era. The Councillor in Dora ward 35 indicated that they are using their local council structures to try and pass information to PWDs.

Although the chieftainship in Mutasa does not have resources to support PWDs access health services, they are playing their part by offering support through disseminating information that urges or encourages the community to treat PWDs with care, respect and love.

Physical assistance to visit health facilities and financial assistance. Apart from frequencies of visits to the health facility in the previous year, PWDs were also asked whether they require physical assistance from someone when they visit the health services facility. The survey revealed that the majority of PWDs (61.5%) from the three districts require physical assistance to go to a health service facility. About 10 percent said they sometimes require physical assistance (see Figure 13).

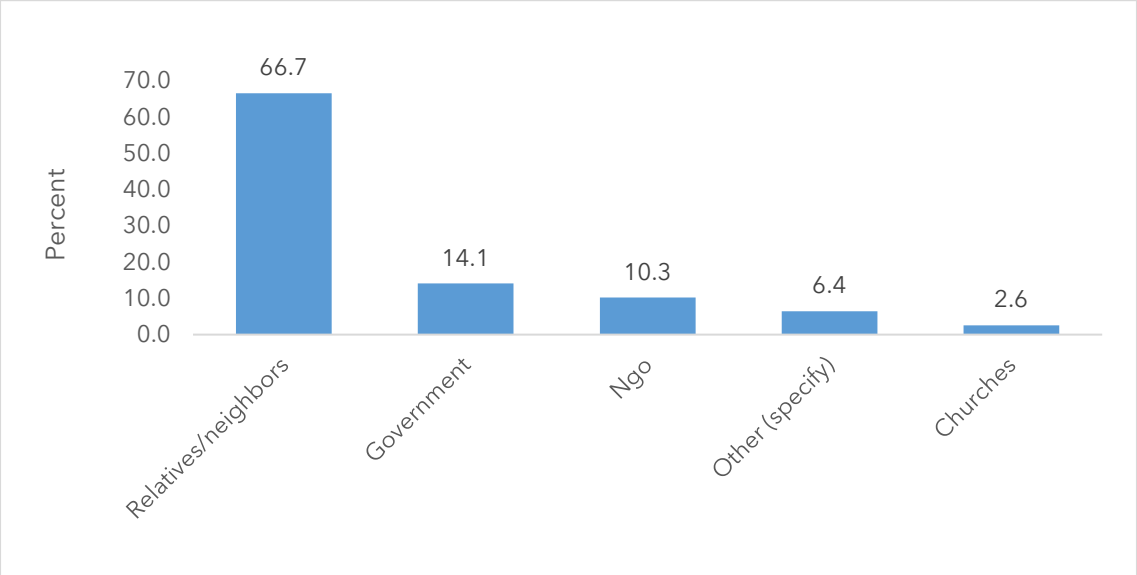
Figure 13: People with disabilities who require physical assistance to visit health facilities, in percentages



Source: PRFT access to health survey 2021

Figure 14 presents sources of financial assistance to access health services. PWDs mostly get financial assistance from relatives/neighbours (66.7%) while assistance from the government is only fourteen percent. About 10 percent of PWDs get financial assistance from NGOs.

Figure 14: Sources of financial assistance provided to people with disabilities, in percentages



Source: PRFT access to health survey 2021

During the focus group discussions, MWDs in Mutasa noted that they are not getting any financial assistance from anyone whilst their female counterparts indicated that they get their health financial assistance from well-wishers like family, church and community members. One woman noted that although they get financial assistance from community members, the support is not enough to finance medication and physiotherapy exercises, which is costly. WWDs in Mutare Urban and community leaders in Mutasa cited that they also get assistance from PWDs associations such as FDPZ who at one point assisted them with wheelchairs, crutches and hearing devices.

On the other hand, some PWDs in Mutasa and Mutare Urban indicated that they got financial assistance to access medical services through the Assisted Medical Treatment Order (AMTO). AMTO is a social protection scheme for vulnerable people including PWDs by the Department of Social Development in the Ministry of Public Services, Labour and Social Welfare. However, the major concern with AMTO is that it can only be accessed at government health institutions and is not accepted at local council clinics and private clinics or private hospitals.

There was concern among PWDs that some officials at government medical facilities do not seem to understand how the AMTO scheme works. As a result, PWDs endure long periods of time whilst waiting for the scheme to be verified by the hospital accounting departments before they can be attended to. The frequency for ATMO financing is poor, as it takes time before health institutions are paid, resulting in poor services for those relying on AMTO.

It seems there is a lack of coordination between the Ministry of Public Services, Labour and Social Welfare and the Ministry of Health and Child Care. The Ministry of Public Services, Labour and Social Welfare representative conceded that it is not clear who is responsible for the provision of assistive devices upon request by a person with a disability between both Ministries. The Ministry of Public Services, Labour and Social Welfare argued that they help those who approach their offices for assistance.

WWDs in Mutasa indicated that there are challenges to accessing health care as a result of high costs of service fees. The WWDs in Mutasa noted that AMTO takes time to obtain, citing many deterring procedures. One woman argued that because AMTO is difficult to obtain, it is not suitable for emergency situations including that it cannot be used for ambulance services. The other challenge is that supplementary funds are needed when treated using the scheme. Thus, WWDs in Mutasa request affordable consultation fees for PWDs in the area. The women also cited that there is no medication at Mutare general hospital and at Tsvingwe clinic, hence the AMTO scheme is only being used for consultation.

MWDs in Mutare Urban indicated that they are getting financial assistance from the government through the AMTO scheme but cited low awareness-raising around the scheme as a contributing factor to low uptake by PWDs as many are not aware of it. The Mutare Social Development representative noted that there is a fund for PWDs assistive devices but due to current inflation levels, by the time the disbursements are made, they will be inadequate to purchase the equipment.

A representative from Mutare City Council noted that challenges to access health services for people with epilepsy were often similar to those of PWDs. However, as epilepsy is not treated as a disability, people with epilepsy cannot benefit from AMTO yet they require support from the government. As such, the official recommended the need for people with epilepsy to be considered under AMTO.

The *Results Based Financing* (RBF) Health programme is the only programme available in Zimunya and Dora, both in Mutare Rural, which is providing support to all people including PWDs. The programme rewards health facilities based on their performance – its performance determines the amount disbursed. It is funded by the Health Development Fund donors in 42 rural districts of Zimbabwe, while the remaining 18 districts are funded by the Government of Zimbabwe and the World Bank (UNICEF, 2020).

Under the RBF scheme, PWDs do not pay for health consultations or medicines at the local council clinics. The Zimunya Ward 32 Councillor (Mutare Rural) indicated that he is part of the local community RBF committee, which reports to the RBF. In their reports, they also raise issues on PWDs concerns. The RBF fund is inclusive in the manner that it covers for the general population and is not specific to PWDs.

However, the Zimunya Councillor indicated that the local clinic is overwhelmed because RBF caters for everyone. Neighbouring wards (6, 13, 14) have no clinics; hence, they access the Zimunya Clinic, causing drug shortages for the local people. Other people from Mutare Urban centres such as Dangamvura and Sakubva also take advantage of the free services because their local clinics charge user fees. The situation has resulted in depletion of medication at alarming rates and shortages for the local Zimunya community. According to the Dora Councillor (Mutare Rural), the local clinic should set aside medicines for PWDs to ensure that, even if medicines are depleted for the general population, PWDs will continue to have access to medication.

Apart from the RBF, there is no specific funds targeting PWDs. However, the Councillor from Zimunya revealed that they receive devolution funds from the government but cited challenges in the untimely manner of the disbursement. The councillors indicated that they are given a budget each year and that disbursements are supposed to be done in January each year. However, the Zimunya Councillor noted that they were allocated ZWL$ 55 million as a district for the year 2020 but only received 5.5 million. For 2021, the allocated budget of ZWL$ 260 million for the district had not been disbursed at the time of the research (May 2021). Local authorities can use these *Devolution funds* to fund programmes such as health, education, roads, and water and sanitation.

Traditional leaders in Marange, Mutare Rural, are liaising with local organizations working on disability such as the FDPZ based in Mutare Urban to solicit assistive devices such as wheelchairs for PWDs in their areas. Other organizations such as Nzeve Centre are assisting PWDs with the testing and provision of assistive devices to persons with hearing impairments. The Office of the Manicaland Provincial Development Coordinator noted that development partners are coming on board to partner the government in the provision of assistive devices and other development partners are in the process of registering with the Ministry of Local Government to provide support. The Mutare City Council representative also noted that NGOs are providing food assistance to PWDs with food hampers such as cooking oil and rice.

Policies supporting health access for people with disabilities. In addition to the RBF and AMTO programmes supporting the financing of access to health for PWDs and other vulnerable groups, there are other policies in place such as the *National Disability Policy* (NDP).

The government launched the NDP in June 2021, which is pushing for the access to health by PWDs as one of the targets. The representative of the Ministry of Public Services, Labour and Social Welfare at the national level noted that the NDP will improve access to health for PWDs. In particular, Section 3.7 of the NDP is providing for the free access to health by PWDs. The Ministry representative argued that the government is in the process of drafting an Act to ensure that the policy becomes law. The Ministry representative argued that they received cases where PWDs are abused and discriminated upon in health care centres. To deal with such challenges the Ministry believes the PWDs Act will prosecute and discourage PWDs discrimination and abuse, conduct massive awareness-raising on disability, and ensure that health personnel is trained on disability.

The Ministry representative highlighted that the Treasury is supporting the implementation of the NDP. The representative also argued that there is a disability fund for PWDs where PWDs health care costs are met by the government and the fund is being administered through AMTO.

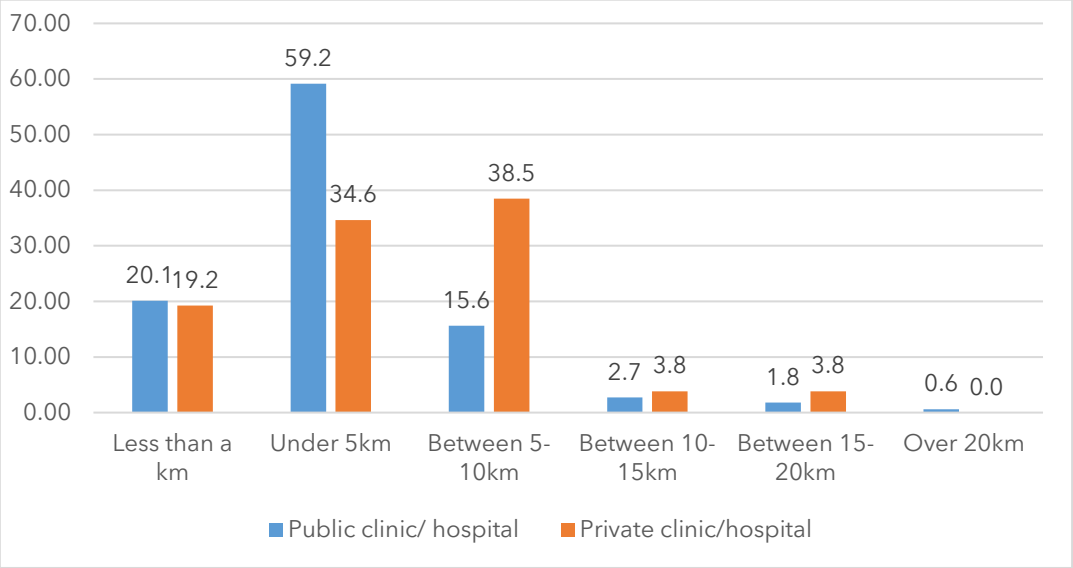
3.4. Barriers to access health care

Barriers to accessing health services can come from the demand side or the supply side. Demand-side determinants are factors influencing the ability to use health services at individual, household or community level while supply-side determinants are aspects inherent to the health system that hinder service uptake by individuals, households or communities.

In this fourth module, the focus is on the demand side at the individual level. Questions asked to PWDs included: the distance to health facilities; the availability and affordability of transport to health facilities; disability friendly infrastructures; health care costs; attitudes of health care workers; quality of health care provision; and cultural barriers.

Distance to health facilities. Figure 15 depicts the distances of the health facilities from the communities where PWDs live. About 79 percent of public health facilities are within 5km from the respondent's home. Less than 5% of respondents have to travel more than 10km to access a public health facility.

Figure 15: Distance to the nearest health facility, by type of health facility, in percentages



Source: PRFT access to health survey 2021

According to community leaders in Mutare Rural, there are inadequate clinics in the Marange area. PWDs in Marange Ward 17 are serviced by two clinics, the Chibariro Clinic, which is approximately 8km away from the growth point, and the Bakorenhema Clinic, which is approximately 7km away from the growth point in a different direction to Chibariro Clinic. In Dora Ward 5, Mutare Rural, the local Councillor noted that the distance to the local clinic (Madziro clinic), which is approximately 14km, poses inclusivity challenges for the physically impaired. The local Councillor indicated that PWDs are not benefitting from the health services available to the extent that they expect councillors to cater for their needs. The same was also the view from a community leader in Mutasa who noted that the dispersed nature of the health centres in Tsvingwe affected health access for PWDs.

Availability and affordability of transport. PWDs from the three districts (Mutasa, Mutare Rural and Mutare Urban) were asked to indicate the mode of transport they mainly use to get to the nearest health facility. From the responses obtained, the majority (60%) of the PWDs walk to the nearest health facility. About 17 percent use public transport (see Table 6).

Of those who have difficulty seeing, 56.7 percent walk to the nearest health facility, 20.4 percent use public transport and 9.6 percent use cars. About 67 percent of the PWDS who have difficulty hearing walk to the nearest health facility, 15 percent use public transport and six percent use cars. Half (50%) of the respondents with difficulty walking mentioned that they walk to the nearest health facility, 20.7

percent use public transport and 12.8 percent use cars. Sixty-seven percent of the respondents with difficulty remembering indicated that they walk to the nearest clinic, 13.3 percent use public transport and 9.6 use wheelbarrow. Half (50%) of the respondents with difficulty in self-care mentioned that they walk to the nearest health facility, 19.8 percent use public transport and 13.5 percent use cars. The majority (68.8%) of PWDs who have difficulty communicating indicated that they walk to the nearest health facility, 14.9 percent use public transport and 8.5 use wheelbarrow.

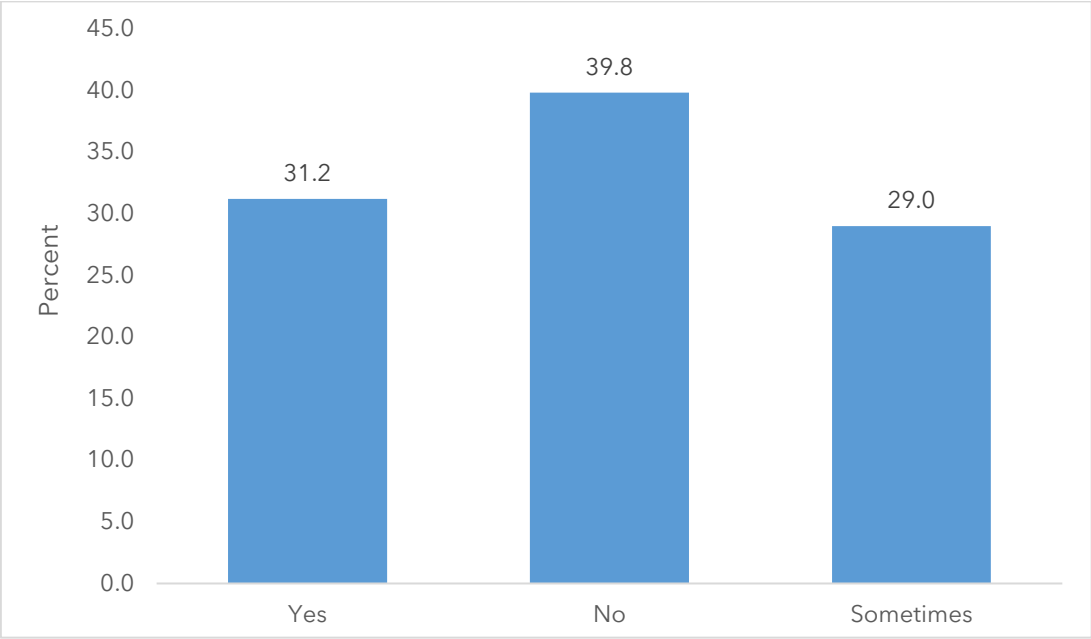
Table 6: People with disabilities by mode of transport and adult functioning domain, in percentages

Mode of Transport	Adult functioning domain						
	Difficulty Seeing	difficulty Hearing	Difficulty Walking	Difficulty Remembering	Difficulty Self-Care	Difficulty Communicating	Total (%)
Car	9.6	5.6	12.8	6.9	13.5	4.3	8.8
Foot	56.7	67.3	50.0	67.0	50.0	68.8	60
Scotch Cart	2.5	0.9	1.1	1.1	2.1	0.0	1.3
Public transport	20.4	15.0	20.7	13.3	19.8	14.9	17.4
Wheel barrow	8.3	7.5	10.5	9.6	9.4	8.5	9
Wheel Chair	2.5	3.7	4.9	2.1	5.2	3.5	3.5
Total (%)	100	100	100	100	100	100	100

Source: PRFT access to health survey 2021

The lack of access to transportation is one of the reasons for a PWD being prevented from accessing health care. PWDs were asked whether transport is available for them to access services each time they want to use it. The results of this question are reflected in Figure 16. As can be seen, 39.8 percent indicated that transport is not available each time they want to use it while 31.2 percent said that transport is always available. Twenty-nine percent mentioned that transport is sometimes available.

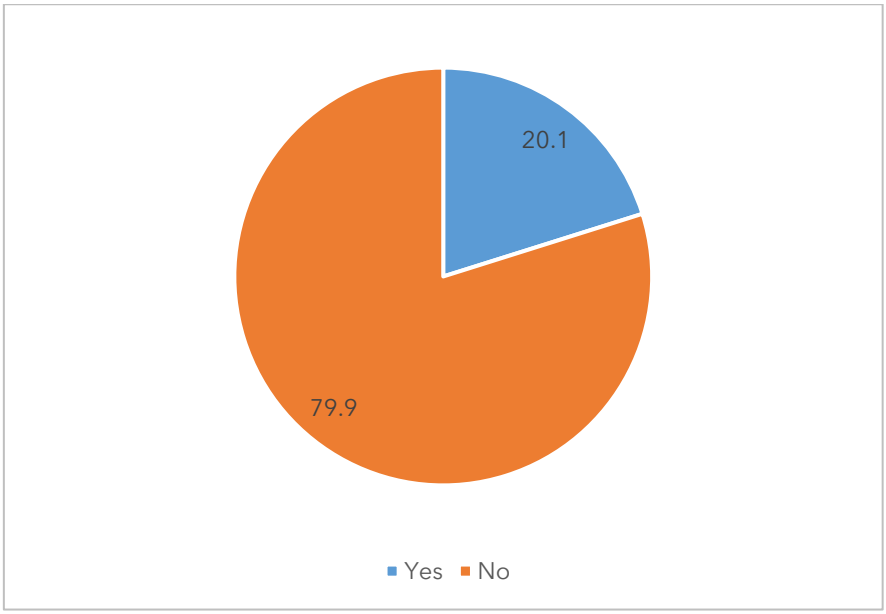
Figure 16: Availability of transport for people with disabilities to access health services, in percentages



Source: PRFT access to health survey 2021

About 80 percent of PWDs from the three districts mentioned that they cannot afford transport costs to access health services care each time they want to use it (see Figure 17).

Figure 17: Affordability of transport costs to access health services, in percentages



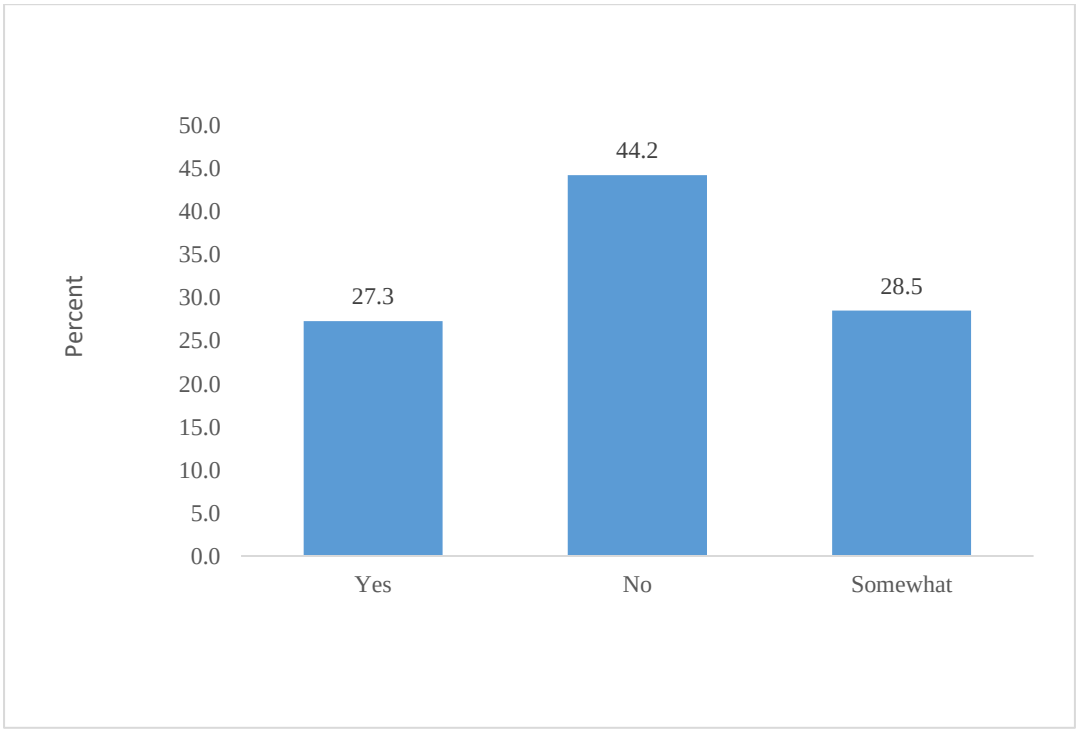
Source: PRFT access to health survey 2021

The lack of transport was also cited by WWDs at the focus group discussions as a barrier that has at some point prohibited them from accessing health services when they needed them. One woman noted that: 'the clinic is too far of which I had no crutches nor bus fare in those days'.

On the other hand, the Dora Councillor interviewed (Mutare Rural) indicated that PWDs face challenges of getting resources to get medicines and transport when referred to a major hospital in Mutare Urban. One community leader in Mutasa highlighted that the high cost of transport and long distances to health centres is forcing PWDs to resort to traditional leaders and churches when they have health challenges. PWDs are being ferried on bicycles, wheelbarrows and scortcharts as modes of transport due to public transport which is inadequate in Marange area of Mutare Rural. Another challenge cited was the poor treatment of PWDs and non-PWDs by the hospital staff, deterring PWDs from visiting the local clinics again when they have a health situation.

Disability friendly infrastructures. PWDs were asked whether the nearest health facility they use have disability friendly infrastructures. The results of the question are shown in Figure 18. About 44.2 percent indicated that the health facility they use does not have disability friendly infrastructure while 27.3 percent said the health facility used has disability friendly infrastructures.

Figure 18: Health facilities with disability friendly infrastructures, in percentages



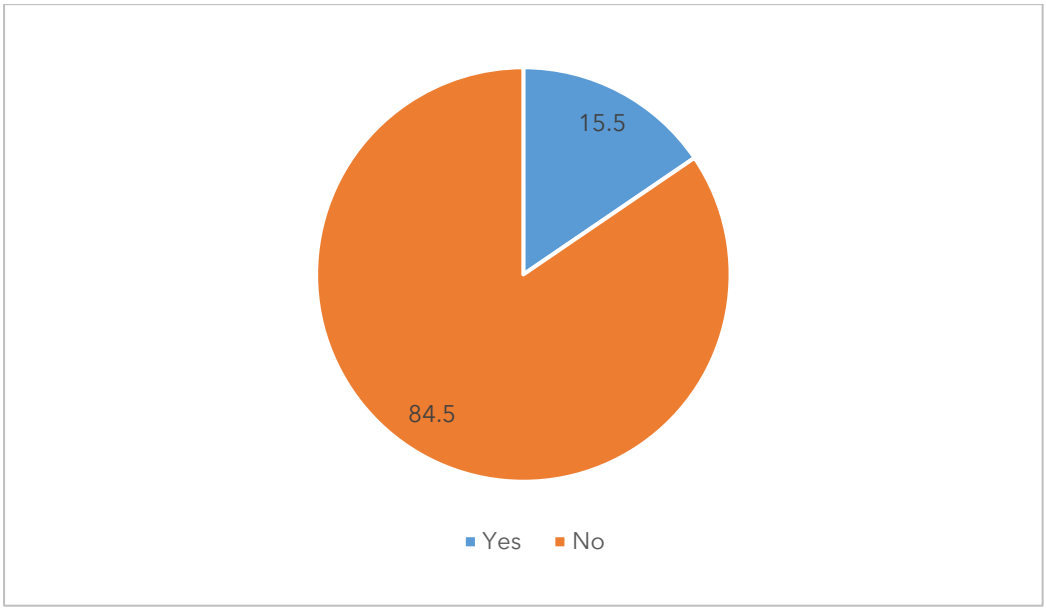
Source: PRFT access to health survey 2021

The lack of disability-friendly infrastructure is also supported by evidence from the key informant interviews. According to one community leader, the local clinics in Marange, Mutare Rural, do not have disability-friendly facilities such as toilets that PWDs can access. Those with walking impairments lack assistive devices such as wheelchairs, hence *vanogwesha (they crawl)* and it becomes difficult for them to practice hygiene when they access toilets used by non-disabled persons**.**

The Ministry of Public Services, Labour and Social Welfare highlighted that public premises are being renovated to meet disability-friendly requirements in line with government policy although gaps exist. For example, the Mutare City Council Hall and some offices remain inaccessible to PWDs using wheelchairs. This was corroborated by a Mutare City Council official interviewed who also noted that PWDs are not happy with services being provided by the local authority and stressed out that the challenges are around a lack of disability-friendly infrastructure such as toilets and unavailability of ramps.

Affordability of health care costs. Respondents were required to indicate whether they can afford health care costs. Nearly 85 percent said that they cannot afford health care costs, as shown in Figure 19.

Figure 19: People with disabilities who can afford health care costs, in percentages



Source: PRFT access to health survey 2021

The WWDs who participated in the focus group discussions in Mutare Urban noted that they pay ZWL$270.00 (approximately USD$3) as consultation fee at local health institutions. MWDs in Mutare Urban indicated that hospital fees range from USD$5.00 for consultations to USD$20.00 for a scan and USD$30.00 for an Xray. These fees are beyond the reach of many PWDs. The MWDs in Mutasa indicated that the fees are reasonable at less than USD$2.00 but they are out of reach for PWDs who have low incomes and do not have meaningful livelihood options and opportunities.

MWDs in Mutare Urban also indicated that the user fees they are subjected to pay are a burden to them as the PWDs are the most hit groups by poverty. One woman argued that:

> User fees are a burden to us because we are not able to perform duties considered normal. Also, most people do not want to employ disabled persons. We are stigmatised and looked down upon that we cannot work.

This is also supported by community leaders in Mutasa who indicated that PWDs are failing to access medical care due to the high poverty levels in PWDs. The men in Mutare Urban also noted cases of alleged corruption where PWDs are referred to private facilities for services such as scans with the excuse that quality of scans at public institutions, which are cheaper, are substandard.

As a result of user fee costs, PWDs resort to alternatives such as over-the-counter medication without any consultations with medical specialists, traditional medicine, and backyard or unapproved informal pharmacies. The understanding of PWDs in Manicaland Province is that the user fees that are charged by public health institutions are for the general upkeep and maintenance of health institutions.

WWDs in Mutare Urban indicated that at times they fail to access health services because they do not have the finances required for consultations and medication, and in the event that they visit the public hospitals without money, they are told that only people with mental illness are exempt from hospitals fees. There was consensus from WWDs in Mutasa and Mutare Urban that only people with mental illness are exempted from paying health care charges at government health institutions without any challenges.

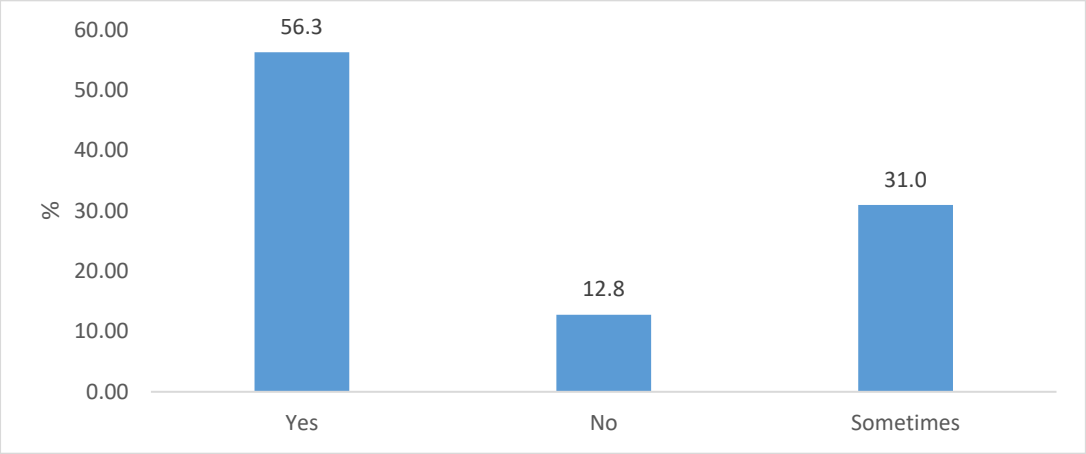
Another challenge highlighted was the high cost of medication and non-availability at government hospitals. One woman in Mutasa indicated an incident where she failed to access health care services due to non-availability of medication at the government hospital pharmacy. As a result, she could not access the medication anywhere else because she uses the Ministry's social protection scheme AMTO, which is only accepted in government hospitals and pharmacies.

One man from Mutasa indicated that he could not get treatment after he had developed a skin disease as the medication was not available at the local clinic but

got a prescription, which he used to get the medication from a private pharmacy. The discussions also revealed that, in some cases, PWDs get small allocations of the required medicines from public health institutions when drugs are in short supply. For instance, one can get a week's supply of the drug, yet they require a month's supply.

Attitude of health care workers. PWDs where asked if they believed that health care workers had had the right attitude when attending to them. Results show that 56.3% believed that health care workers had the right attitude when attending to PWDs and 31% indicated that sometimes the health care workers used the right attitude towards PWDs. About 13% stated that health care workers did not use the right attitude towards PWDs as shown in Figure 20.

Figure 20: Opinion on whether health care workers have the right attitudes towards people with disabilities

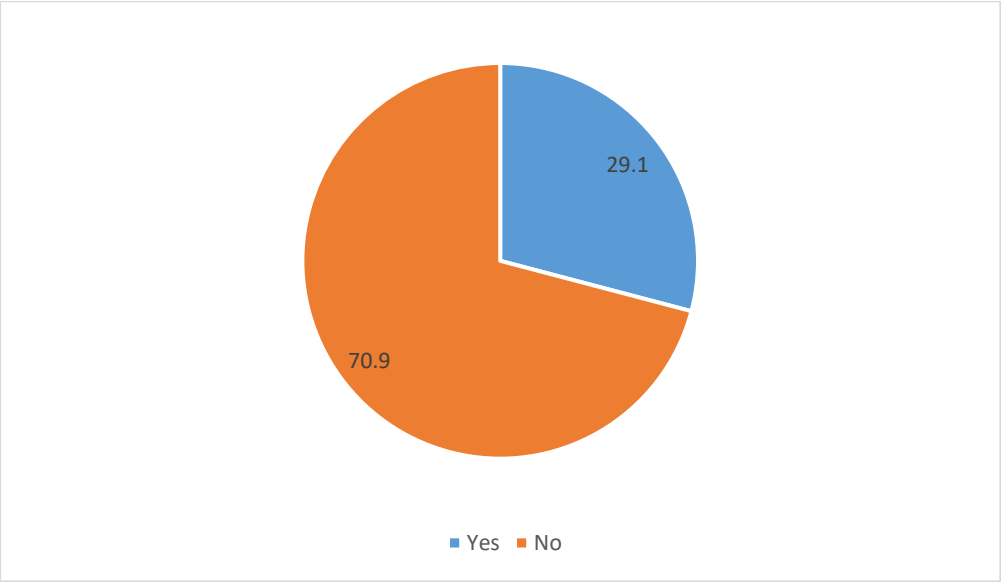


Source: PRFT access to health survey 2021

Among the PWDs who felt that health care workers did not, or sometimes did not, have the right attitude when attending to them, 80.3% did not do anything about it in trying to have the situation corrected.

With regards to discrimination due to disability, 29.1% of PWDs have been discriminated against at some point while accessing health care services. Discrimination could have been either from health care workers or from fellow patients (see Figure 21).

Figure 21: Distribution of people with disabilities that have been discriminated against, in percentages



Source: PRFT access to health survey 2021

Despite a general positive outlook on the attitude of health care workers, the treatment of PWDs is not short of incidents. WWDs in Mutare Urban alluded during focus group discussions that they access health services such as physiotherapy, pre- and post-natal care but face attitudinal challenges from nurses. One WWD from Mutare Urban noted that "when we come for pre-natal health services nurses gather around us, asking who impregnated us and all sorts of questions". MWDs in Mutare Urban indicated that they face discrimination when it comes to sexual and reproductive health, e.g., sexually transmitted disease cases. One man indicated that PWDs are treated as if they are not supposed to be sexually active. This is corroborated by one community leader in Marange, Mutare Rural, who gave an example of a mentally impaired man in Marange, who contracted a sexually transmitted infection but was laughed at when he approached the local clinic for help. As a result, MWDs in Mutare Urban conceded that they would prefer male nurses for sexually transmitted infection-related health needs.

WWDs in Mutasa noted that the lack of sign language interpreters for communication between PWDs with hearing impairment and health care workers in accessing health care services is a major challenge. As a result, WWDs in Mutasa face poor services and wrong treatments due to communication breakdowns. One woman stressed that, because of the communication breakdown, PWDs, mostly women, are experiencing harassment from health care workers due to ignorance and lack of awareness that the patient is disabled.

Similarly, a community leader noted that there are no sign language interpreters at local clinics in Marange, Mutare Rural, to assist those with hearing impairments.

Local initiatives by the church, in particular the Seventh Day Adventist Church in Marange, are incorporating and teaching sign language to their congregants.

Overall, some WWDs indicated that, in some cases, they had been treated positively and with more respect. MWDs in Mutasa indicated that they mostly interfaced with female staff at public health institutions such as local clinics and, from their experiences, they have always been treated with respect and in a good way. One man from Mutare Urban indicated that he faced discrimination from a doctor of which he reported the matter to the police only to return to the hospital and be told that the doctor is no longer available at the hospital to attend to him. According to the man, this showed that reporting discrimination was not helpful as, in the end, he did not get any services after reporting the doctor to the police.

MWDs in Mutare Urban noted that treatment at health facilities varies with the personality of the health worker available at the service point and their different attitudes should not be generalised. Challenges of communication were also cited to be contributing to what might appear as negative attitudes. One man from Mutare recounted an event where one pregnant female with a hearing impairment went for an HIV test and tested positive but, because there was no sign language to offer her counselling, she collapsed upon getting the positive HIV result. There seems to be understanding or appreciation from MWDs in Mutasa that, if they have been mistreated at local health institutions, they can report to the Superintendent of the local council clinic in the case of a council clinic.

The Dora Councillor interviewed (Mutare Rural) noted that the bad treatment of PWDs by health staff is deterring PWDs from visiting the local clinics again when they have a health situation. To address the issue of staff attitude and treatment, the Dora ward 35 Councillor stated that the local clinics should have a dedicated personal desk that deals with PWDs issues; employ PWDs as council clinic staff; and lastly, support PWDs with funds to start income generating projects. This was supported by an official from the Manicaland Provincial Development Coordinator office who also stressed the need for preferential treatment for PWDs and availability of safe spaces for PWDs to present their grievances to service providers.

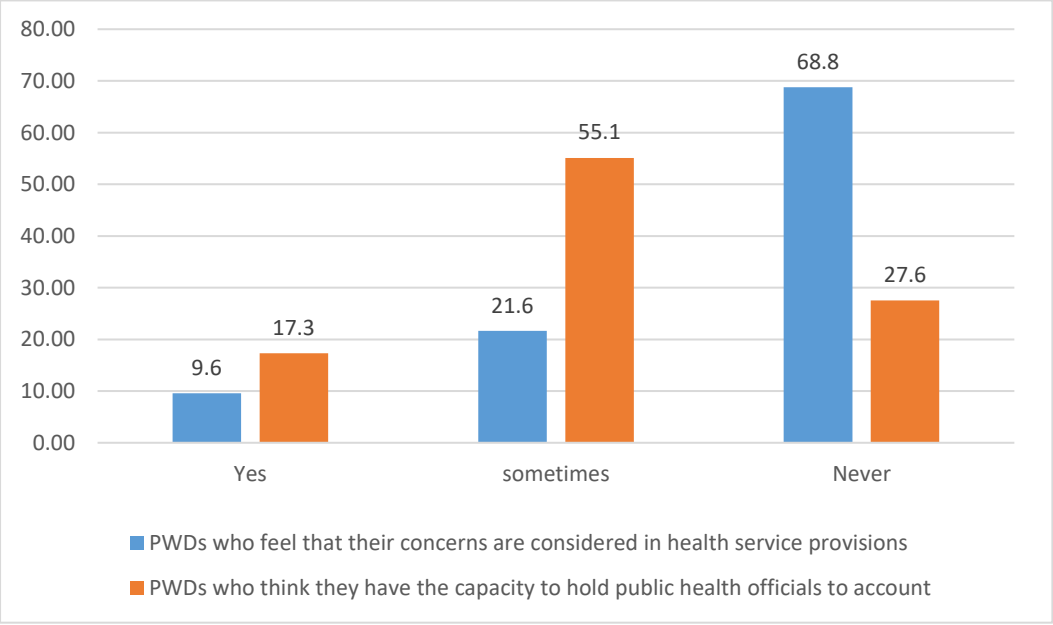
According to an official in the Ministry of Public Services, Labour and Social Welfare, the Ministry is pushing for 15% of health staff to be PWDs so that they are not regarded as objects. The Ministry representative argued that the next recruitment of health personnel should guarantee a 15% quota for PWDs as a strategy for the inclusion of PWDs as professionals. The Ministry of Public Services, Labour and Social Welfare and the Ministry of Health and Child Care should embark on a professional development programme to raise awareness on disability in public health institutions. In rural areas, community care workers and village health workers should also be included in the professional development programme as a way of strengthening their capacity to respond to disability issues. The Mutare Social Development official in the Ministry of Public Service, Labour and Social Welfare suggested that the Department of Disability, under the Ministry of Public Service,

Labour and Social Welfare, should be cascaded down to the local level to facilitate mainstreaming of disability issues in local development planning.

Quality of health care provision for PWDs. PWDs were also asked if they believed that their disability concerns are considered in health service provision and also if they are able to take health officials to account whenever they have been treated unfairly. Figure 22 shows that a majority of PWDs, 68.8 percent, felt that their concerns are never considered in health service provision, while only 9.6 percent felt their concerns were considered.

According to the survey, most PWDs are in fear of holding public health officials into account whenever they have been treated badly, so they do not react all the times. 55.1 percent said they had sometimes challenged health officials while close to 28 percent said they had never challenged health officials even though they had been treated unfairly.

Figure 22: Opinion on whether disability concerns are considered in health service provision, and on whether people with disabilities can hold public health officials to account, in percentages



Source: PRFT access to health survey 2021

The survey asked opinions of respondents on the status of their nearest health facilities. The questions asked about the status of consultation rooms, maternity/delivery rooms, and disability friendly toilets. Questions also asked about the availability of water, electricity, staff with sign language skills, as well as whether staff at the health facilities are adequate.

The majority of respondents reported that generally there are good conditions of consultation rooms in their nearest health facility. This is regardless of whether it is public, private or mission as indicated by higher proportions in the 'good condition' category. However, still a significant proportion of respondents suggested that consultation rooms are of poor conditions (34.2% for public clinics/hospitals versus 31.8% for mission clinics/hospitals) as shown in Table 7.

More than a quarter (26.4%) of respondents reported that public health facilities do not have disability friendly toilets and 42.3% reported that they are of poor quality.

Respondents were also asked if they think the staff at their nearest health facilities are adequate and 46.9% of them shared that the type of staff is not adequate in public health facilities. Across all health facilities (public 67.9%, private 65.4% and mission 59.1%), higher proportions showed that there are no health staff with sign language skills.

Water and electricity is reported to be universally available in all health facilities save for a few public health facilities.

Table 7: Opinions of people with disabilities on the status of their nearest health facility, per type of health facility, in percentages

	Type of health facility		
Status of health facilities	**Public clinic/ hospital**	**Private clinic/hospital**	**Mission Clinic/hospital**
Consultation rooms			
Not available	3.90	7.69	4.55
Poor Condition	34.23	11.54	31.82
Good condition	57.66	65.38	63.64
Don't know	4.20	15.38	0.00
Maternity/delivery rooms			
Not available	0.60	0.00	0.00
Poor Condition	24.02	15.38	18.18
Good condition	33.93	23.08	31.82
Don't know	41.44	61.54	50.00
Disability friendly toilets			
Not available	26.43	11.54	18.18
Poor Condition	42.34	23.08	45.45
Good condition	22.52	50.00	31.82
Don't know	8.71	15.38	4.55
Adequate Staff			
Not Adequate	46.85	30.77	36.36
Adequate	37.54	42.31	45.45
Don't know	15.62	26.92	18.18

Staff with sign language skills			
Yes	5.11	7.69	0.00
No	67.87	65.38	59.09
Don't know	27.03	26.92	40.91
Water Availability			
Yes	95.80	100	100
No	3.30	0.00	0.00
Don't know	0.90	0.00	0.00
Electricity Availability			
Yes	90.99	100	100
No	7.51	0.00	0.00
Don't know	1.50	0.00	0.00

Source: PRFT access to health survey 2021

Most PWDs in Manicaland Province are not satisfied with the current health service provision levels as shown from the feedback during focus group discussions. PWDs cited the lack of ambulances, disability friendly buildings and toilets as key drawbacks. One woman in Mutasa cited that: '*vamwe tinonoka pakutaura manurses haana patients dzekumirira kuti upedze kutaura*', which translated means that 'some nurses have no patience and cannot give us enough time to speak because we are slow in speech'.

MWDs in Mutasa indicated that clinic toilet facilities do not have adequate water provision hence they end up using pit latrines which are not disability friendly. PWDs in Mutare Urban highlighted that toilets at public health institutions are usually dirty, inaccessible and need regular cleaning for PWDs to be able to access them. High costs of accessing health services were also noted by MWDs in Mutare Urban as one of the reasons for dissatisfaction with the services.

One man from Mutare Urban noted that USD$5.00 is required to buy a rubber for one walking crutch, which is expensive for PWDs. PWDs also noted that they have to travel 5-6km to the nearest government health institution, which accepts the Ministry's support scheme AMTO. This is turn brings mobility and transport challenges.

This viewpoint is supported by evidence from key informant interviews. The local council Councillor in Zimunya ward 35 (Mutare Rural) indicated that the current local health system is not inclusive because PWDs are not benefiting as a result of facilities that do not cater for their needs. The local council councillors interviewed argued that local clinics do not have disability friendly facilities such as ramps for wheelchairs and there are no nurses trained in sign language to assist PWDs with speech and hearing impairments.

While the representative of the Ministry of Public Services, Labour and Social Welfare noted that the current health system is inclusive, there was agreement that

more needs to be done to achieve universal design to access physical health facilities and information. Key issues noted included gaps within the hearing impairment community to communicate with health care staff hence the need for sign language training for health personnel.

The Ministry representative noted that there is need for adequate training of health staff such as nurses so that they become responsive to disability issues and change their attitudes. The Ministry representative attributed the negative attitudes of health staff to ignorance and lack of understanding of disability issues.

The village health workers that are in Dora, Mutare Rural, corroborated the Ministry official's viewpoint that most health workers lack the requisite skills to assist PWDs. The local Councillor in the area suggested the appointment of village health workers that are dedicated to serve PWDs and trained on disability. The training that was proposed includes communication skills on disability and sign language. The local Councillor in Zimunya (Mutare Rural) stressed that it is important that training for community care workers be informed by PWDs so that they direct them or guide them on what and how they need to be handled and/or assisted.

Cultural barriers. Cultural challenges also hinder PWDs from accessing health services as local people associate disability with family misfortunes or as a result of something that happened in the family. Because of that, PWDs, especially those with mental impairments, are not accepted culturally and are regarded as *ngozi*, which means "avenging spirits".

The Apostolic Sect, which is dominant in the Mutasa region, guided by its church doctrine, does not allow any of its members – including PWDs – to go to clinics or hospitals. Accessing health services at a medical facility is deemed a harmful practice according to the Apostolic Sect. The Apostolic Sect in Mutare Rural, known as Johan Marange, discourages their congregants from getting medical help. They argue that western medicines are evil and believe in praying for their sick and afflicted. Those seeking western medicines are regarded as being blemished (stained) or *kun'ora*. There are other local customs where people hide PWDs from the community, especially children.

Disability is associated with evil spirits, a taboo which results in attitudes in the health care system. The Ministry of Public Services, Labour and Social Welfare representative noted that:

> Women have told us that when they give birth to a child with a disability, the amount of scorn, abuse and discrimination they face at times, gives them thoughts of waking up in the night and steal other people's babies or having thoughts of committing suicide.

Another example was given where once health staff saw a medical card marked 'mental illness' on a pregnant woman. They neglected the mentally-ill pregnant woman in labour as they associated it all with evil spirits.

The Mutare Social Development representative noted that one of the challenges faced is that people are not patient with PWDs. This was attributed to the wrong perception that PWDs are short-tempered; yet, they experience difficulties in expressing themselves. To enhance understanding of disability inclusion, the Mutare Social Development representative suggested that inclusivity programmes should be started in schools to teach the community about disability issues at an early age.

An official interviewed from the Manicaland Provincial Development Coordinator noted that there is need to have multi-stakeholder sensitization fora to discuss disability issues using all structures – from the traditional leaders to councillors and government departments. The need to establish disability champions was also noted as one way of improving awareness and ensure that disability issues are taken seriously. The Mutare City Council representative argued that the media has a major role to play in changing people's perceptions on disability so that PWDs can get the respect they deserve.

3.5. Impact of marginalization in decision making

This fifth and last module examines the impact that the marginalization of PWDs has in decision-making. It includes an analysis of the existence of databases on PWDs; membership of people with disabilities to PWD associations or associations working on disability. It also analyses the relationship between the knowledge of PWD associations by people with disabilities, their participation in community health decision-making, and their ability to hold duty bearers to account. The last sub-section explores the existence of platforms for health service delivery accountability.

A database on people with disabilities. The lack of a comprehensive PWDs' database is a cause for concern as it implies a further marginalisation and invisibilisation of PWDs.

Councillors interviewed noted that health service planning is done through the health committees in the local authorities, which utilise councillors' databases. The local Councillor in Dora, Mutare Rural, alluded that they make use of social development distribution lists and school records to target PWDs in their local area. The councillors stressed the need to have the data on PWDs consolidated from the ward to the district level.

As an initiative, the Councillor in Ward 35 Dora stated that his office had tasked the ward disability representative to consolidate data on PWDs in the ward. However,

there are challenges for the disability representative to undertake the tasks such as transport and human resource support. Community leaders in Mutare Rural also bemoaned the lack of a database, which makes it difficult to establish the extent and nature of the challenges faced by PWDs in accessing health services in the district.

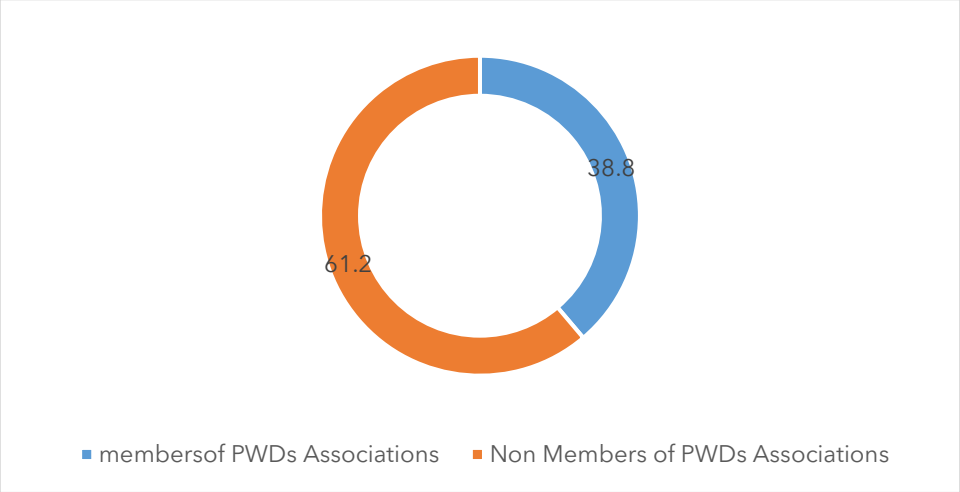
The Ministry of Public Services, Labour and Social Welfare representative conceded that, at the present moment, they do not have current reliable data for planning. However, the Ministry is working with ZIMSTAT in coming up with PWD modules for the 2022 national census.

The Mutare Social Development representative argued that resources are required to create PWD databases at all levels of the community. To deal with the current data challenges, the Ministry of Public Services, Labour and Social Welfare is also partnering with ZIMSTAT to develop a database and with the Ministry of Health and Child Care to share disaggregated data on children born with disabilities through inter-ministerial arrangements.

Despite the inadequacy and inaccuracy of the data, there has been some improvement with the support of donors, and available data on PWDs is being used in development planning. It was noted that, at the moment, PWDs are getting help at the local level through a referral system.

Membership to people-with-disabilities associations. It is of paramount importance to have PWDs affiliated to associations of PWDs or that work with PWDs. First, this is where they can share their challenges and problems as well as organise themselves for them to be able to receive funding or help from government, donors and other organizations. Additionally, most donors and organizations that help PWDs prefer to work with PWD associations than with individuals. The survey showed that most PWDs (61.2 percent) are not members of PWD associations, as shown in Figure 23.

Figure 23: People with disabilities who are members of people-with-disabilities associations, in percentages



Source: PRFT access to health survey 2021

Knowledge of PWD associations, participation in community health decision-making, and holding duty bearers to account. The next three Tables look at the relationships between these three variables in pairs.

Table 8 shows a relationship between knowing PWD associations and participating in community health care service delivery.[4] That is, there is a high chance that a PWD that has knowledge of PWD associations, participates in community health care service delivery decision-making. About 74.36 percent of the people that reported that they participate in service delivery decision making have knowledge of PWD associations. On the contrary, there is also an association between PWDs without knowledge of associations and their non-participation in decision-making as shown by 74.64 percent of those that have never participated reporting that they have no knowledge of associations.

Table 8: Relationship between knowledge of people-with-disabilities associations and participation in community health care service-delivery decision-making

	Participation in community health care service delivery decision making			
Knowledge of PWD associations	Never	Yes	Sometimes	Total
No	209	10	30	249

%	**74.64**	25.64	34.09	61.18
Yes	71	29	58	158
%	25.36	**74.36**	65.91	38.82
Total	280	39	88	407
%	100	100	100	100

Pearson chi2(2)=69.2976; Pr = 0.000 Source: PRFT access to health survey 2021

The second table, Table 9, shows the relationship between knowing PWD associations and holding duty bearers to account on what they have done wrong. From the chi-square measure of association, it shows that there is a significant association between the two variables, meaning there is a higher chance that someone who has knowledge of PWD associations can hold duty bearers to account. As shown in Table 9, about 54 percent of respondents who reported they would hold duty bearers to account had knowledge of PWD associations. For those who have reported unable to hold duty bearers to account, more than half (68.89%) did not have the knowledge of PWD associations.

Table 9: Relationship between knowledge of people-with-disabilities associations and being able to hold duty bearers to account

Knowledge of PWD associations	Able to hold duty bearers to account	Not able to hold duty bearers to account	Total
Yes	74	84	158
%	**54.01**	31.11	38.82
No	63	186	249
%	45.99	**68.89**	61.18
Total	137	270	407
%	100	100	100

Pearson chi2(1)=20.0736; Pr = 0.000 Source: PRFT access to health survey 2021

Table 10 shows that there is also a significant relationship on participation in service-delivery making and being able to hold duty bearers to account. Most people (74.4%) who participated in service-delivery decision-making are also able to hold duty bearers to account whenever they are mistreated. Those who never participated in service-delivery making are the ones in fear of holding duty bearers to account as shown by only 23.57 percent of them indicating that they would be able to hold duty bearers to account.

Table 10: Relationship between participation in community health care service-delivery decision-making and being able to hold duty bearers to account

Participation in service delivery decision making	Able to hold duty bearers to account	Not Able to hold duty bearers to account	Total
Yes	29	10	39
%	**74.36**	25.64	100
Sometimes	42	46	88
%	47.73	52.27	100
Never	66	214	280
%	**23.57**	76.43	100
Total	137	270	407
%	33.66	66.34	100

Source: PRFT access to health survey 2021

Pearson chi2(2)= 49.4897; Pr = 0.000

Platforms for health service delivery accountability. During the focus group discussions, WWDs in Mutasa and Mutare Urban cited the lack of engagement platforms with duty bearers as a challenge to raise awareness on their plight with service providers. One WWD from Mutasa argued that:

> It is right and necessary for us to engage with duty bearers like sisters in charge, so that they educate nurses to handle us and understand our disabilities; also to build toilets which are disability friendly.

MWDs in Mutasa noted that they engage local duty bearers through council meetings and hearings on budgets where they also discuss access to health issues. This was also the case with MWDs in Mutare Urban who indicated that they engage duty bearers on service providers' platforms such as Local Authorities, the National Aids Council, UNFPA Quarterly Forums and PSI Forums. In Mutare Rural, the Zimunya Councillor noted that PWDs participate through platforms created by the National Aids Council. There are also local council budget consultations where they listen and give inputs on issues that concern them.

The Zimunya Councillor also indicated that, as councillors, they also give feedback to PWDs on issues raised with the Council. The Dora ward 35 Councillor (Mutare Rural) argued that PWDs are members of local development committees such as ward development committees, village development committees, school development committees and health centre committees. It is from these platforms that they share their concerns and raise awareness on issues affecting them whilst contributing to development planning.

However, the MWDs in Mutasa felt they can only engage duty bearers up to the local councillor and/or council clinic superintendent, and not beyond. A cause for concern from MWDs is that, although they engage duty bearers at local level, they do not see changes in their fortunes through improvements in social service delivery. PWDs also conceded that feedback from duty bearers is low and cited the need for follow-ups on unresolved issues.

Resource unavailability for PWDs' empowerment was a trending theme. The Zimunya ward Councillor argued that the major challenges for PWDs are related to poverty and there are no resources at the local level to economically empower and enable them to participate during consultations.

While the PWDs do not often participate in health service issues, Mr. Mukahanana, who is visually impaired, was recently elected as Councillor in the Jenya area, under Chief Mutasa in Mutasa District. This is a step in the right direction to ensure that PWDs are represented by people who have disability and understand the disability issues and challenges that PWDs face. This is in line with the Ministry of Public Services, Labour and Social Welfare thinking that PWDs should occupy space at the policy tables at every level of governance.

A Ministry official noted that the government has created platforms for PWDs' participation on policy development and other development planning processes. The Ministry representative pointed out that PWDs throughout the country were consulted during the development of the National Disability Policy.

However, it was noted that there is need for the government to develop a feedback mechanism that will allow a constant two-way communication. It was also noted that the Ministry is in the process of creating institutionalized platforms for PWDs' participation but that, in the meantime, they rely on walk-ins at the head office and district offices for Social Development.

The Ministry representative conceded that the country is at a stage where disability frameworks are still in their formative years and taking shape. The Mutare Social Development Department mobilises all people including those with disabilities to participate in government programmes. However, it was noted that finding places with a disability friendly infrastructure such as toilets to hold the meetings is a problem in Mutare.

The challenges of non-participation in health processes are further marginalisation as the concerns of PWDs are not heard and addressed by services providers. The Councillor interviewed from Dora, Mutare Rural, stressed that:

> Non-participation of PWDs in local service delivery planning kills self-esteem and self-worth. This also results in people looking down upon PWDs, which leads to baby dumping of children born with disabilities as the parents would not have anywhere to go and get help. PWDs will also face abuse as some people take advantage that they have nowhere to take the issues to.

4. Discussion

This study focused on understanding the challenges that PWDs faced in accessing health services in Manicaland Province. The study results indicate that PWDs face a complex web of issues which impedes them from accessing health services.

Key themes from the study included factors such as dependency on public health, health access, financial assistance, barriers to health care services, and impact of marginalisation in decision making. The results mean that there are structural and non-structural issues which need to be addressed to ensure that PWDs access health services.

The study highlighted a relationship between poverty and access to health services. The research discussions established that PWDs are among the most marginalised groups and, as a result, cannot afford health user fees, which are present in both public and private services. The only ones that seem to be exempt from paying fees are people with mental health issues. Most PWDs are not covered by any private medical aid scheme whilst only a knowledgeable few have access to government social protection medical aid schemes. At the same time, the AMTO facility which is available for PWDs can only be used to pay for user fees in government institutions and is not accepted everywhere making it difficult where required services are not available from government institutions. The financial support for PWDs to access health services is mostly provided by relatives and NGOs who almost end taking up an obligation that should be fulfilled by the government. This scenario suggests there is an abrogation of responsibility by the government resulting in a weak governance system.

The study results also established that participation of PWDs in decision making is mediated as it is done through associations of PWDs. While this mediation is applauded, it however still excludes PWDs whose information on the associations is limited and/or PWDs who are not affiliated to any association.

The study results also indicated a pattern where NGOs, missionary hospitals, and spiritual healers are complementing government health service provision. The public health institutions were established by the research as the main source of health services for PWDs. Because the public health institutions are inadequately resourced with drugs and personnel, PWDs access their health services at secondary sources which are complementing public health provision. However, this pattern of secondary sources is not ideal for PWDs – nearly one in three said that they would have no secondary source of health service if the public one failed.

The recently adopted National Disability Policy (June 2021) provides an entry point for civil society organizations to present their research findings on disability studies

to the Department of Disability Affairs. This was in itself an unexpected study finding. The importance of this finding is that it offers an opportunity for non-state actors working on disability to influence disability policy implementation in the country. However, whilst celebrating the new disability policy, other policies have existed before, yet they have not been implemented properly. It is therefore a main emphasis of the study that Zimbabwe's State must implement this acclaimed disability policy well, as well as many others, to avoid a false legitimation of its work through "policy production". This situation is also made possible by non-state actors (especially civil society organizations) which have capacity limitations to hold the government to account. Part of this incapacity is as a result of a shrinking operating space for civil society organizations, both financially and regulatory.

The absence of a publicly shared database for PWDs poses challenges in the development planning and implementation of health programmes. The subsequent result is the poor targeting of PWDs by health and social protection services. Our study concludes that, as a result of a lack of a publicly shared database, social protection programmes that cushion PWDs health needs are poorly designed and financed resulting in poor coverage. This finding is important in that failing to properly identify where the PWDs are located will perpetuate their exclusion and marginalization.

5. Recommendations

Some of the recommendations to improve health care provision for people with disabilities that were suggested during the key informant interviews and focus group discussions in Mutasa, Mutare Urban, Mutare Rural and at provincial and national level include:

- The Government should construct infrastructure (public toilets, roads and pavements, clinics, hospitals, health facility waiting areas, etc) that are disability friendly and enable PWDs to navigate with their assistive devices such as wheelchairs.
- The Government should provide mobile clinics for PWDs to ease access to health care services since they experience difficulties travelling to health centres due to their various impairments.
- The Government, through the Ministry of Health and Child Care, should establish one-stop centres that cater for all the health needs of PWDs. At the moment, very few services are available at the local health centres with PWDs having to be referred to major towns for other specialised services.

- Transport operators should provide buses that have disability friendly features such as lifters for wheelchairs. Operators such as the drivers and the conductors should be trained on disability so that they do not abuse PWDs.
- Public transport should also ensure that they give sufficient time to PWDs when boarding buses and wheelchairs should not pay an extra charge as this is a burden to PWDs. There is need for sensitisation of transport operators' personnel to be sensitive to PWDs needs.
- The Government should enhance a better coordination between the Ministry of Public Service, Labour and Social Welfare, and the Ministry of Health and Child Care, to ensure the adequate and timely financing of the AMTO support scheme.
- The AMTO support scheme should be extended to all medical facilities while the local authorities should remove health user fees for PWDs.
- The Government should ensure that people with epilepsy get free medication at public health institutions.
- The Government and the local authorities should increase public health institutions personnel including doctors who, in some cases, are only available twice a week.
- The Government should ensure it achieves inclusive employment with at least 10% of staff employed being PWDs. These will understand the needs of fellow PWDs. This must be extended to health personnel including nurses and doctors.
- Health facilities should ensure that their staff is trained on disability and the use of the correct terminology when dealing with PWDs. Medical staff training should have modules that teach on disability and how they can handle PWDs. For instance, training should include a module on sexual and reproductive rights for PWDs to deal with issues of discrimination. Personnel at health facilities should also be trained on sign language to enable effective communication with all patients. Health facilities should be staffed by personnel specialised in PWD issues so that it does not become a disadvantage to have a disability.
- There is need for a national database of PWDs. This database should be decentralised to the village level and be regularly updated. Community leaders should collect disability disaggregated data, which details needs of the different PWD categories to enhance inclusive planning that delivers services and programmes that meets PWD needs.

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Annex 1

Ethics at the organization *Poverty Reduction Forum Trust* (PRFT) cover several sections, including: the Code of Conduct Standards; Ethics Principles Guiding Research; Data Management; and Complaints and Reports.

Code of Conduct Standards

1. Uphold the integrity and reputation of the Poverty Reduction Forum Trust by ensuring that my professional and personal conduct is consistent with the Poverty Reduction Forum Trust's values and standards
   - treat research respondents with respect and dignity
   - Observant of all local laws and be sensitive to local customs

2. Not to engage in abusive or exploitative conduct
   - Not to engage in sexual activity with respondents and children (persons under the age of 18). Mistaken belief in the age of a child is not a defence.
   - Not to exchange of money, employment, goods or services for sex, including sexual favours or other forms of humiliating, degrading or exploitative behaviour, is prohibited. This includes any exchange of assistance that is due to beneficiaries of assistance.
   - Not to engage in sexual relationships with beneficiaries of assistance, since they are based on inherently unequal power dynamics.
   - Not to engage in any commercially exploitative activities with children or vulnerable adults including child labour or trafficking.
   - Not to physically assault a child or vulnerable adult.
   - Not to emotionally or psychologically abuse a child or vulnerable adult

3. Ensure the safety, health and welfare of all the Poverty Reduction Forum Trust staff members and associated personnel (volunteers, partners, suppliers and contractors)
   - Comply with any local security guidelines and be pro-active in informing management of any necessary changes to such guidelines.
   - Behave in a manner such as to avoid any unnecessary risk to the safety, health and welfare of myself and others, including partner organizations and communities with whom we work

4. Be responsible for the use of information, assets and resources to which I have access by reason of my employment with the Poverty Reduction Forum Trust
   - Not disclose research data or information to unauthorized persons
   - Always ensure security of the Organization Information Communication Technology, including Computers, Hard drives, Flash Disks and Social Media platforms (include storage and password protection)

5. Perform my duties and conduct my private life in a manner that avoids conflicts of interest
   - Not to accept significant gifts or any remuneration from governments, communities with whom we work, donors, suppliers and other persons which have been offered to me
6. Uphold Confidentiality
   - Exercise due care in all matters of official business, and not divulge any confidential information relating to colleagues, work-related matters or any sensitive information unless legally required to do so.

Ethics Principles Guiding Research

1. Follow informed consent rules
2. Respect Confidentiality and Privacy
3. Professionalism or Conscious of multiple roles (relationships)

Data Management

PRFT has the obligation to protect the data given by research respondents by ensuring that:

1. Participants are made aware about how their data will be used, shared and retained, as well as their rights
2. The use of personally identifiable data is minimized wherever possible
3. There are safeguards in place to protect the data of research participants e.g. limiting access to data to only authorized personnel and not disclosed to unauthorised persons, protected data storage facilities such as password protected hard drive
4. Data from respondents is destroyed 12 months after the completion of the research
5. Participants are made aware of channels they can use to give further data, in the event there are other developments which they feel can add value to the research findings, to PRFT staff to update their earlier responses.

Complaints and Reports

1. Community complaints and feedback will be collected by the PRFT safeguarding and accountability tracker.
2. Communities and respondents will be made aware of the PRFT Safeguarding and Accountability Policy and reporting channels such as WhatsApp Number,

Telephone Number, Emails to forward safeguarding and accountability feedback be made available to the respondents.

3. Complaints and Reports will be handled in accordance with PRFT's Code of Conduct, Safeguarding Policy and other related policies.

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[1] https://evidenceforinclusion.org/
[2] Communal and Resettlement and Peri-urban Farmers
[3] Communal and Resettlement and Peri-urban Farmers
[4] This is shown in a significant association by the value of chi-square of 0.00 meaning.