

The Zimbabwe Patients' Charter of Rights: Effects on Health Care Access by People with Disabilities Living with HIV and AIDS

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ABSTRACT This study sought to: (a) examine the role of the Zimbabwe Patients' Charter of Rights in enabling health care access by people with disabilities living with HIV and AIDS; and (b) explore policy translational issues influencing access to HIV and AIDS treatment and care services by people with disabilities living with HIV and AIDS. A survey approach was used to collect data in this study. A purposive sample of 35 people with disabilities living with HIV and AIDS in a rural district of Zimbabwe was used. Participants self-reported on their awareness of Patients' Rights in the context of the national charter; perceived access to competent health care and treatment services; access to information on HIV/AIDS issues, national healthy policies and skills available at community level to work with people with disabilities on HIV/AIDS issues. The study found that people with disabilities perceive health care as a basic right. However, people with disabilities also reported significant barriers to access competent healthcare and treatment. Most often, their treatment and care were significantly delayed, and where it was offered, individuals with hearing, visual impairments and intellectual disabilities were stereotyped as incompetent patients unable to represent or articulate their health care needs.

INTRODUCTION

The Patients' Charter of Rights increasingly is proposed by national governments, and mostly from the advocacy of consumer desiring person centered services (Chireshe et al. 2010; United Nations 1993). In recent years the significance of Patients' Charter of Rights have been boosted by the recognition by the United Nations and World Health Organisation that right to basic health is human right (Chireshe et al. 2010; Umeasiegu et al. 2011). Zimbabwe Patients Charter was developed from recommendations by the Consumer Council of Zimbabwe (CCZ) and the Zimbabwe Ministry of Health and Child Welfare to offer protection to consumer and improve health services delivery (Ministry of Child and Social Welfare 2010). The Charter spells out general consumer right to access and treatment.

According to the Zimbabwe Patients' Charter, patients' rights can be described as social and individual rights. Social rights cover aspects such as the quality and accessibility of health care, while individual rights relate to basic human and consumer rights (Ministry of Child and Social Welfare 2010).

The Zimbabwe Patients' Charter focuses on a number of basic health issues. Patients, according to this charter, have the right to access the health system at the time of need, both as paying and non-paying patients (Ministry of Child and Social Welfare 2010). Health services providers are expected to respond to the needs of patients. Patients are also according to the Zimbabwe Patients' Charter accorded rights to hospitality, confidentiality, consent, privacy, human treatment, choice and redress of grievances. These rights of patients in the Zimbabwe Patients' Charter are very important in a world with people living with HIV/AIDS (Umeasiegu et al. 2011).

The World Health Organisation projects that about 10 % of the world population (or approximately 650 million people) has a disability (United Nations 2006a). About 80 % of this population live in developing countries (United Nations

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2006a) with limited or no adequate health services (United Nations 2006b). Health and well being are fundamental rights of people with disabilities living with HIV/AIDS. Health is defined by the World Health Organisation (WHO) as a state of complete physical mental and social well being of absence of disease (WHO 1948). People with disabilities living with HIV can be healthy despite their primary disabilities. Social policies to maintain and sustain health and well being in people with disabilities living with HIV/AIDS are major preoccupations of national governments, non-governmental and multi-lateral agencies around the globe (Prince et al. 2010). Nonetheless, health related qualities of life in people with disabilities around the globe still need serious attention, although it is clearly explained as a human right issue by the United Nations. Healthy communities are not possible if the healths of citizens with disabilities are not taken into account.

The global trends on HIV/AIDS and disability have shown that it is paramount for governments to formulate relevant and critical policies that shall mitigate the impact of the HIV/AIDS pandemic on people with disabilities (Umeasiegu et al. 2011). Progress has been made in the last decade in solid foundation for deepening the struggle against the HIV/AIDS pandemic and registering more stories in typical population of the world (Umeasiegu et al. 2011). Little is known, particularly, on the progress that encompass people with disabilities, the impetus towards the progress of scaling-up HIV prevention, treatment and care in the globe through continuous formulation, revision advocacy and implementation of policies specifically to enhance the inclusion of people with disabilities in HIV/AIDS service delivery has been seen. The integration and reinforcement of prevention, treatment and care for HIV/AIDS unfolds as a bold action exercised across all sectors and level of governments to address the burden of HIV/AIDS for people with disabilities in the attainment of the millennium development goals specifically, 'universal access to affordable health services for all who need it'. There can be no single policy or guideline that blankets over the whole population of people with disabilities but rather have policies tailored for each group as they have diverse needs (Umeasiegu et al. 2011).

The UN Convention on the rights of people with disabilities, the Patients' Charter and the

Disability Act (1997) are among the few existing policy legislatures available in Zimbabwe (Ministry of Child and Social Welfare 2010). However, their effectiveness on the health rights of people with disabilities living with HIV/AIDS is still unknown.

The growing relationship between HIV/AIDS and disabilities is an emerging issue and cause for concern as persons with disabilities are at risk of exposure to HIV (ADD 1996). Additionally, there is a growing understanding that persons living with HIV/AIDS are also at risk of becoming disabled on a permanent or episodic basis as a result of their condition (Chireshe et al. 2010). Like any other person, persons with disabilities' rights are cherished in the Zimbabwe Patients' Charter and therefore require information on HIV/AIDS and access to programmes, services and resources. In most countries the situation of persons with disabilities living with HIV/AIDS is further compounded by societal barriers that hinder their full and effective participation in society including access to education (Choruma 2006; Mpofo 1990). Despite the growing relationship between HIV/AIDS and disability, persons with disabilities living with HIV/AIDS have not received sufficient attention within national responses to HIV/AIDS (Richey 2004). Furthermore, existing HIV/AIDS prevention, treatment, care and support programmes generally fail to meet their specific needs (Chireshe et al. 2010; Choruma 2006). In their Ugandan study, Chireshe et al. (2010) found that although people with disabilities were aware of the HIV/AIDS pandemic, they felt discriminated with regards HIV/AIDS issues. The same study also found that people with disabilities had difficulties in accessing HIV/AIDS services because of communication problems. Other studies show that people with disabilities are often excluded from HIV/AIDS education, prevention and support services because of assumptions that they are not sexually active or do not engage in risk behaviours such as drug use or having unproductive sex (Chireshe et al. 2010; Choruma 2006; NUDIPU 2004). Similarly, literature also suggests that people with disabilities are at risk for HIV/AIDS infection (Rohleder et al. 2009).

People with disabilities are vulnerable to sexual assault or abuse hence are at risk of being infected with HIV/AIDS (Choruma 2006; NUDIPU 2004). This is because of their depen-

dence on others around them who may take advantage of their disabilities through sexually abusing them. Globally, children with disabilities are a large proportion of children not enrolled in school, which results in their exclusion from vital sexual reproductive health education that is often provided in school settings (Shumba and Abosi 2011; Shumba and Taukobong 2009). Low literacy levels among people with disabilities, especially those with intellectual disabilities and lack of HIV prevention information in accessible format make it more difficult for persons with disabilities living with HIV/AIDS to acquire information (knowledge they need about their HIV/AIDS status) (Umeasiegu et al. 2011).

Sexual and reproductive health service providers need to have knowledge about disability issues lest they will be misinformed or develop stigmatising attitudes towards persons with disabilities living with HIV/AIDS (Choruma 2006). Services offered at clinics, hospitals and in other locations must be physically accessible, sign language and Braille or other information alternative such as audio must be available at each and every clinic for accessibility of healthy services by people with disabilities living with HIV/AIDS (Choruma 2006; Helander 1998). Besides special services, adequate medication such as ARVs must be always available. Literature reveals that where there is limited access to medication, persons with disabilities living with HIV/AIDS may be considered a low priority for treatment (ADD 1996; Umeasiegu et al. 2011).

The Zimbabwean Charter was drafted in framework of the UN Convention of Rights of Persons with disabilities (United Nations 1996, 2006a, 2006b) which provides a global policy framework to promote the equal rights for people with disabilities, including sexual and reproductive health, on par with those with disabilities and enable policies to implement HIV/AIDS programming for persons with disabilities and programmes to fight against stigma, discrimination and other barriers faced by persons living with HIV/AIDS. Zimbabwe has adopted anti-discrimination laws such as the Disability Act (1997) that explicitly cover discrimination on the basis of any condition. For example, section 8 (1) of the Zimbabwe Disabled Persons Act (1997:1) stipulates that "No disabled person shall on the ground of his disability alone be denied (a) admission into any premises to which members of

the public are ordinarily admitted; or (b) the provision of any service or amenity ordinarily provided to members of the public unless such denial is motivated by a genuine concern for the safety of the disabled person concerned."

The Zimbabwe Patients' Charter upholds patients' confidentiality of their information (Ministry Health of Child and Welfare 2010). Patients' confidentiality of their information (Cole and Oxtoby 2002) means that personal and medical information given to health care provider will be disclosed to others unless the individual has given specific permission for such release. Because the disclosure of personal information could cause professional or personal problems, patients rely on physicians to keep their medical information private. The situation in some groups of persons with disabilities such as the deaf, mentally retarded and blind becomes a challenge as literature suggests that people with disabilities living with HIV/AIDS are stereotyped as incompetent patients and are unable to represent or articulate their health care needs and hence need someone to explain their condition to the physician breaching their right to confidentiality (Umeasiegu et al. 2011). The promotion of confidentiality rights in the context of HIV/AIDS and disability is imperative to overcome existing forms of discrimination and intolerance. It is also a tool to empower individuals and communities to responds to HIV/AIDS and lessen the impact of HIV/AIDS on the infected and affected access to clear and non judgmental information about sexually transmitted disease is difficult and restricted.

The Ottawa Charter (Umeasiegu et al. 2011) defined health promotion during its 1st international conference on health promotion as the process of enabling people to increase control over and improve their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and realise aspirations, satisfy needs and change or cope with the environment (Chireshe et al. 2010; Choruma 2006). Health is seen as resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources as well as physical capacities. The Ottawa Charter emphasized that the fundamental conditions and resources for health include education, social justice and equity (Umeasiegu et al. 2011). Taking this holistic conceptualization of health promotion and

combining it with disability, it becomes imperative that a close look should be taken at those forms by which a discriminatory society could produce forms of health policy and practices that systematically exclude people with disabilities and once this takes place, even within the much hyped HIV/AIDS responses in vogue in the country (Helander 1998). The damage and therefore injustice would have been done. Thus efforts to include mainstream people with disabilities in health and HIV/AIDS communication care and treatment cannot be delayed at any cost.

In spite of the policy pronouncements that the health systems are all-inclusive, communities still show unfriendly behavior to services provided (especially medical personnel) (Chireshe et al. 2010; Shumba and Taukobong 2009). There are no special programmes from government and the private sector targeting people with disabilities on HIV/AIDS related issues. Persistent negative attitudes of health services and community towards people with disabilities are still projected (Shumba and Taukobong 2009). Exclusion and segregation of people with disabilities living with HIV/AIDS by society as well as many African States has never been viewed as discrimination until recently (Groce 2003). Disability in India has been based on the assumption that the problems faced by people with disabilities such as in accessibility to public health information was inevitable consequences of their condition. It was recently recognised that the inferior social and economic status of people with disabilities could be a result of prejudice and society towards such people (Chireshe et al. 2010).

Statement of the Problem

Equalisation of opportunities for marginalized people has been on the world agenda for the past two decades. The first was the women's decade (1975-1985) and the second was the decade for people with disabilities (1983-1992) (Shumba and Taukobong 2009). However, the generic HIV/AIDS information, education and counseling packages in vogue have had little impact on the HIV/AIDS knowledge needs of people with disabilities in developing context such as Zimbabwe. This is further compounded by the fact that health institutions in Zimbabwe still have limited mobility and

communication infrastructure to meet the needs of people with disabilities living with HIV/AIDS. It is against this background that this study sought to: (a) examine the role of the Zimbabwe Patients' Charter of Rights in enabling health care access by people with disabilities living with HIV and AIDS; and (b) explore policy translational issues influencing access to HIV and AIDS treatment and care services by people with disabilities living with HIV and AIDS.

METHOD

Research Design

A survey approach was used in this study. According to Fowler (1998) in Mpofu (2001), survey approaches are used to collect information on a selected attribute from a sample of respondents drawn from a target population through the use of questions. The survey method has the advantage that the findings can be generalised to the target population (Mpofu 2001). The findings obtained in this study represent the Zimbabwe Patients' Charter of Rights effects on health care access by people living with HIV and AIDS.

Sample

The sample of the study comprised of 35 (23 male, 12 female) people with disabilities living with HIV/AIDS in Mashonaland West Province of Zimbabwe. The respondents had different disabilities (hearing; visual, or physical impairment; mental retardation and speech disorders). This sample was drawn from unknown population of people with disabilities living with HIV/AIDS in the province. Table 1 shows respondents by type of impairment and gender.

Table 1 shows that 4 participants (1 female, 3 male) were drawn from people with hearing impairment, 5 (2 female, 3 male) from those with visual impairment, 10 (6 male, 4 female) had physical disabilities, 6 (all males) had some level of mental retardation, 3 (1 female, 2 male) had speech disorders and 7 (2 females, 5 males) had other disabilities (invisible disabilities).

Instruments

A survey was used to collect data on the Zimbabwe Patients' Charter of Rights effects on

health care access by people with disabilities living with HIV/AIDS.

Table 1: Respondents by type of impairment and gender

<i>Disability</i>	<i>Female</i>	<i>Male</i>	<i>Total</i>
Hearing impairment	1	3	4
Visual impairment	2	3	5
Physical disability	6	4	10
Mental retardation	0	6	6
Speech disorders	1	2	3
Other disabilities	2	5	7
Total	12	23	35

The study made use of 4 persons with disabilities living with HIV/AIDS in its pilot study. The 4 were drawn from a separate province of the country. The purpose of the pilot study was to test the content validity and reliability of the research instruments for the study. The pilot participants were selected using convenient method of sampling. Results from the pilot study indicated that the instruments that is, the interview guide, was consistently reporting the Zimbabwe Patients' Charter of Rights effects on health care access by people living with HIV and AIDS. A five-point Likert scale was also used to collect data in this study (see Table 2).

Table 2: Responses on the effects The Zimbabwe Patients' Charter of Rights on Health Care Access by people living with HIV and AIDS

	<i>Questions</i>	<i>Responses</i>										<i>Total</i>
		1	%	2	%	3	%	4	%	5	%	
3	HIV/AIDS counseling and testing is done for free in our community	20	57	7	20	1	3	3	9	4	11	100
4	I am on a free ART programme	14	40	12	34	3	9	2	6	4	11	100
5	I pay for HIV/AIDS related administrative cost at our local clinic/hospital	11	31	9	26	2	6	6	17	7	20	100
6	HIV/AIDS related opportunistic infections drugs, laboratory tests, X-ray are done for free in government hospitals	3	9	2	6	1	3	9	26	20	57	101
7	Our local clinics are accessible for people with disabilities	9	26	8	23	1	3	4	11	13	37	100
8	HIV/AIDS information from pamphlets is accessible to me despite my disability	12	34	5	14	1	3	10	29	7	20	100
9	Primary health care services providers can communicate with me affecting on HIV/AIDS despite my disability	6	17	8	23	2	6	8	23	11	31	100
10	HIV/AIDS related preventive utilities such as condoms are placed in areas that are accessible by people with disabilities.	4	11	6	17	4	11	11	31	10	29	99
11	I am aware of how HIV/AIDS is transmitted	9	26	10	29	5	14	6	17	5	14	100
12	I am aware of primary health care services available at our local clinic	9	26	10	29	5	14	6	17	5	14	100
13	People with disabilities living with HIV/AIDS are in various health related community based care programmes in our communities	5	14	3	9	4	11	13	37	10	29	100
14	Staff at our local clinic have knowledge of disabilities and HIV/AIDS	3	9	3	9	3	9	13	37	13	37	101
15	Staff at our local clinic have positive attitudes towards clients with disabilities	3	9	4	11	3	9	13	37	12	34	100
16	I report in person my health conditions to physicians when I visit clinic/hospital for medication	8	23	7	20	3	9	2	6	15	43	101

Data Collection

The respondents were identified for the researchers by a no-governmental organisation that is working towards the mainstreaming of people with disabilities in its HIV/AIDS testing and counselling and support services. The researchers made appointments with willing individuals and subsequently conducted the interviews.

Data Analysis

Data were analysed using descriptive statistics in this study. Percentages and tables were used in data presentation because they are easily read and understood.

Ethical Issues

Permission for respondents to take part in the study was sought from the Zimbabwe Ministry of Social Welfare and the participants themselves. Participants in this study who happen to be persons with disabilities living with HIV/AIDS were assured of anonymity and confidentiality in the study. They also took part in the study with informed consent and their participation was voluntary with an option to withdraw at any point in the study.

RESULTS

The results were presented using themes derived from the objectives and descriptive statistics in this study.

(a) *The Zimbabwe Patients' Charter of Rights Effects on Health Care Access by People Living with HIV and AIDS*

In order to provide adequate answers to the research respondents who were people with disabilities living with HIV/AIDS were asked to respond to questions from the interview guide driven from research questions by rating their responses on a five-point Likert scale which was 1=Very True, 2 = Relatively True, 3=Neutral 4=Disagree, 5=Strongly Disagree for each and every statement. Research results are given in Table 2 and analysis of respective research questions are also provided after Table 2.

(b) *How User-friendly are Zimbabwe's Primary Health Care Policies to its Client's Disabilities Living with HIV/AIDS?*

To provide an answer to the above research question, participants were asked to respond to four questions (that is, 3, 4, 5 and 6) which were designed around the research question number 1. Respondents were asked if HIV/AIDS counselling and testing was done for free in their communities. The majority of people living with HIV/AIDS indicated that it was very true that they were being provided with free HIV/AIDS counseling and testing services.

Table 2 also shows that the majority of the respondents said it was very true that they were on a free Antiretroviral Therapy (ART) programme.

Respondents were also asked if they were paying for HIV/AIDS administrative costs at their local clinic/hospital. Table 2 also shows that most of the respondents were in strong agreement that they were paying for HIV/AIDS administrative related costs.

Respondents also gave their opinions on whether HIV/AIDS related opportunistic infection drugs, laboratory tests and X-rays were done for free in hospitals in their communities. Table 2 provides results that show that 9 % of the respondents felt it was true that they were being given free medication for HIV/AIDS infection drugs, laboratory tests and X-rays and others, while 6 % agreed that they were getting the services for free, 3 % decided to be neutral, 26 disagreed that the services were not free and 57 % strongly disagreed that they were being provided with HIV/AIDS related opportunistic infection drugs, laboratory tests and other HIV/AIDS related services for no payment.

(c) *How Accessible are Primary Health Care Services to People with Disabilities with HIV/AIDS?*

Three questions (questions 7, 8 and 9) were asked around research question number 2. Question number 7 asked if local clinics were accessible to people with disabilities. Results in Table 2 show that 26 % of the respondents felt that clinics were very accessible to people with disabilities, 23 % also believed that they were relatively accessible, 3 % of the respondents decided to be neutral, 11 % felt that they were not fairly accessible and 37 % strongly believed that they were not accessible at all. Most respondents who claimed inaccessibility of local clinics were people with visual impairment, physical disabilities and those with hearing impairment.

Respondents were also asked to rate accessibility of HIV/AIDS related information from primary health care givers and community by people with disabilities. Results in Table 2 indicates that 34 % of the respondents felt that the information was very accessible to them, 14 % also believed it was relatively accessible, 3 % decided to be neutral, 29 % felt that they had no access to HIV/AIDS related information and 20 % strongly felt that HIV/AIDS related information was not available in accessible formats for them at all. Most respondents who reported of inaccessibility of HIV/AIDS information were those with visual, and hearing impairment, and few with mental retardation.

Question number 9 of the interview guide prompted respondents to rate if Primary health care services providers can communicate with them effectively on HIV/AIDS despite their disability condition. Results from Table 2 indicate that 17 % of the respondents strongly believed that health care providers were able to communicate with them effectively, 23 % rated the assertion to be relatively true, 6 % decided to be neutral, 23 % disagreed that health providers were able to communicate with them effectively and 31 % cited existence of serious communication barrier between them and health care providers. Communication problem was mostly identified from respondents who had visual and hearing impairment and few with mental retardation.

The study also asked respondents on question number 10 if HIV/AIDS related preventive utilities such as condoms are placed in areas that are accessible for use by people with disabilities. Results indicated that 11 % strongly agreed that HIV/AIDS prevention utilities are available to persons with disabilities, 17 % also relatively agreed that the utilities were available at call, 11 % were neutral, 31 % did not agree that the utilities were available for people with disabilities on call and 29 % strongly believed that HIV/AIDS utilities were not available for them.

(d) What Skills are Available at Community Level to Promote Utilisation of Primary Health Care by People with Disabilities with HIV/AIDS?

Respondents who were people with disabilities living with HIV/AIDS were asked question number 11, 12 and 13 from the questionnaire and if answered adequately it would give an adequate answer to research question number 3. Question number 11 asked respondents if they

were aware of HIV/AIDS transmission modes. Results showed that 26 % of them strongly believed that they know how HIV/AIDS is transmitted, 29 % relatively agreed that they know how HIV/AIDS is transmitted, 14 % decided to be neutral, 17 % did not agree that they know how HIV/AIDS is transmitted and 14 % felt that they were ignorant of how HIV/AIDS is transmitted.

Question 12 was meant to find out if respondents were aware of primary health care services available at their local clinics and hospitals. Results as indicated in Table 2 shows 26 % of them strongly believing it true that they know services available. Ten percent (10 %) also indicated that they relatively agree knowing services available at their clinics, 14 % were neutral, 17 % disagreed that they were aware of services available at their clinics and 14 % strongly confessed ignorance.

Question number 13 was meant to find the participation rate of people with disabilities in community health care activities such as home based care programmes. Results indicated that 14 % of the respondents strongly believed that they were given chance to take part in community health activities, 9 % agreed relatively to the assertion, 11 % decided to be neutral, 37 % felt that they don't agree to the assertion. On the other hand, 29 % strongly disagreed to the assertion that they were given opportunities to take part in community health care programmes.

(e) What Knowledge is Available Among Primary Health Care Providers About Disability and HIV/AIDS?

Question number 14, 15 and 16 from the questionnaire were designed to find out if staff at the local clinic had knowledge of disabilities and HIV/AIDS; and their attitudes towards clients with disabilities. Question number 14 asked respondents if they felt that staffs at their local clinics have knowledge of their conditions in relationship to HIV/AIDS. Results indicated in Table 2 show that 9 % of the respondents strongly believed that health workers at their clinics understand their condition in relationship to HIV/AIDS, another 9 % also relatively agreed, and the same percentage were neutral, while 37 % disagreed and also 37 % also strongly disagreed.

When asked whether health workers at their clinics have positive attitudes towards them having disability and HIV/AIDS 9 % felt that

health workers in their clinics and hospitals have positive attitudes towards them despite of conditions, 11 relatively agreed, 9 % decided to be neutral, 37 % felt that health workers do not love them and 34 % also strongly disagreed that health workers have positive attitudes towards their double condition.

The issue of confidentiality was also covered by question number 16 when respondents were asked if they report their health condition to physicians in person or through someone like relatives. Results indicated that 23 % of the respondents strongly believed it was true that they were responsible for reporting their health conditions to physicians, while 20 % relatively agreed, 9 % were neutral, 6 % reported that they don't agree on the assertion that they were responsible for reporting their health condition to health personnel and 43% strongly disagreed that it's them who report their condition to physicians.

DISCUSSION

The study set out to investigate The Zimbabwe Patients' Charter of Rights effects on Health Care Access by People Living with HIV and AIDS. The findings of the study are presented following four research questions.

Results of the study indicate that Zimbabwe's health care policies are not user friendly to people with disabilities living with HIV/AIDS. People with disabilities living with HIV/AIDS according to this study results were required to pay HIV/AIDS related administrative costs (for example blood tests, consultation fees, X-ray costs, HIV/AIDS related opportunistic infection drugs). When people with disabilities attempt to have access to health care services without paying administrative costs, they are required to evoke their social welfare benefits (Chireshe et al. 2010; Choruma 2006). They are required to go and get a letter from the Ministry of Social Welfare even if the disability is unquestionable (for example, being deaf and dumb, blind or amputated). Social Welfare offices are found in towns and those with mobility problems get their problem compounded by visiting more inaccessible buildings in towns. This discourages people with disabilities from accessing health services as they often do not themselves have the funds to pay for these services (Chireshe et al. 2010; Choruma 2006). Pay-

ing for these costs by people with disabilities is very difficult as most of them live in poverty (NUDIPU 2004). Poverty is both a cause and consequences of disability and disability is inseparable from poverty (Mpofu 1990; Shumba and Taukobong 2009). Both poverty and disability reinforce each other, thereby contributing to increased vulnerability among people with disabilities (Elwan 1999). With the demand of administrative costs to have access to treatment of HIV/AIDS by people with disabilities, people with disabilities are being denied right to health care and humane treatment (Umeasiegu et al. 2011). Health care according to the Zimbabwean Patients' Charter shall be available on the basis of clinical need regardless of the ability to pay and the government is responsible for ensuring that every person has access to health care services (Ministry of Health and Child Welfare 2006). Disability according to United Nations is described as a human right issue and services to people with disabilities should be given from human right perspective which should be non-paying or not in charity form (Umeasiegu et al. 2011). Demanding or requesting cash for health services from people with disabilities becomes a violation of the foundations of the UN human right paradigm shift which are endowed in the concepts of human dignity and autonomy upon which the UN Convention on the rights of persons with disabilities is built. Social policies to maintain and sustain health and well being in people with disabilities are major agencies around the globe (Prince et al. 2010). Social policies must combine social safety supports to provide essential health for people with disabilities.

The study results indicated that primary health care services are not readily accessible for people with disabilities. Zimbabwean health care services are not widespread enough as relatively large numbers of people, particularly in rural areas, find it difficult to access health care units nearest to them (Chireshe et al. 2010; Choruma 2006). The concentration of trained staff in urban areas has left the rural areas under-served. Generally the health service caters are underfunded and ill-equipped (Chireshe et al. 2010; Choruma 2006). Accessibility is a problem, particularly those with reduced mobility or on wheelchair, and those with visual impairment and hearing problems. Besides motoric and communication problems between health care staff and patients/clients, many people often do not

understand the language used in health care units, and these problems are exuberated for people with disabilities (NUDIPU 2004). Awareness-based intervention that have strong information, education and communication components have failed to look at the needs of those with visual and hearing impairments and those that have meant retardation or those with severely physical disabilities (Richey 2004). Currently, there is no HIV/AIDS information in Braille or sign language, no education on voluntary counselling and testing for people with disabilities and have little or no access to contraceptives (Chireshe et al. 2010; Choruma 2006, Helander 1998).

The study found out that little information is available for people with disabilities living with HIV/AIDS. Because of their low level of education, poor communication with healthcare services providers, people with disabilities have little knowledge of healthcare services available in their communities. A good number of them don't even know what clinics around them can do for them and others don't even know their nearest clinics. Because of ignorance of HIV/AIDS relate services offered in their local clinics people with disabilities are not participating enough in primary health care activities of their communities such as home based care programmes (Choruma 2006). With this dilemma people with disabilities are further denied their right to information public health care (Umeasiegu et al. 2011).

This study found on that health care service providers have little knowledge on non- neurological aspects of disability, hence have problems that are communication related (Choruma 2006). The sexuality of people with disabilities by health care providers is poorly understood and hence people with disabilities are not commonly regarded as a community that is vulnerable to HIV/AIDS or affected by AIDS (Groce 2003). Indeed people with disabilities are often referred as children from god by many religions and therefore cannot engage in sex and yet they claim to be equally sexually active like typical others (Umeasiegu et al. 2011). Stigma, discrimination and negative attitudes by health care providers and the greater community (Helander 1998; Mpofu 1990) against people with disabilities emanating from inadequate knowledge and skills among staff and their uncertainty about how to deal with people with disabilities further

deny right to access to competent treatment for people with disabilities. Poor understanding of people with disabilities also tend to abuse the right to confidentiality for people with disabilities as the study reveals that a good number of people with disabilities such as the deaf, mental retarded and blind living with HIV/AIDS are stereotyped as incompetent patients and unable to represent or articulate their health care needs hence needing someone to explain their condition to the physician (Chireshe et al. 2010; Umeasiegu et al. 2011) breaching their right to confidentiality. Promotion of confidentiality rights in the context of HIV/AIDS and disability is not only imperative of justice to overcome existing forms of discrimination and intolerance (United Nations 2006).

CONCLUSION

The study found that little knowledge is available for people with disabilities living with HIV/AIDS. Because of their low level of education, poor communication with healthcare services providers people with disabilities have little knowledge of healthcare services available in their communities, hence little or no skills are available at community level to promote utilisation of primary health care by people with disabilities with living with HIV/AIDS. This study recommends that the patient's charter should ensure the development of HIV/AIDS responses that are specifically designed to address the needs of people with disabilities hence making sure that the sexuality of people with disabilities is appropriately understood to promote the rights of people with disabilities.

RECOMMENDATIONS

The current study found that Zimbabwe's health care policies are not user-friendly to people with disabilities living with HIV/AIDS as they required to pay for HIV/AIDS related administrative costs (for example, blood tests, consultation fees, X-ray costs, HIV/AIDS related opportunistic infection drugs). There is a need for the establishment of an integral approach in providing health care services that are accessible, accountable, applicable and most importantly responsive to the needs of inclusive communities.

The study also found that HIV/AIDS related health care services are not readily accessible for people with disabilities and generally the health service caters are underfunded and ill-equipped. Besides physical inaccessibility by patients /clients with disabilities living with HIV/AIDS, most health staff are ill trained to communicate with clients who are deaf, those with severe physical impairment or to Braille or transcribe. There is need for institutions responsible for training health care personnel to insure that their curriculum includes disability issues. Furthermore, it is necessary for the government to compel its staff and agencies that deal with HIV/AIDS and other health related issues to produce their information in alternative formats.

The study also indicates that health care service providers have little knowledge on non-neurological aspects of disability hence having problems that are communication related. This has led them to develop stigma, discrimination and negative attitudes towards people with disabilities who are living positively with HIV/AIDS resulting into denial of their right to access to competent treatment for people with disabilities. There is need for the Zimbabwean government to raise awareness among health care providers and the community at large about the rights of people with disabilities and eliminate beliefs about HIV/AIDS and disability. This will reduce vulnerability of people with disability to HIV/AIDS.

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