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**Title: HOW AND IN WHAT WAYS CAN WESTERN MODELS OF
DISABILITY INFORM AND PROMOTE THE EMPOWERMENT OF
DISABLED PEOPLE AND THEIR PARTICIPATION IN
MAINSTREAM ZIMBABWEAN SOCIETY?**

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Abstract

The history of people with impairments is generally littered with horrendous and shocking stories of their exclusion, discrimination and even extermination at the hands of a society organized by and for non-disabled people. In this study, there is a clear recognition of the differences in conceptions of disability across societies owing to the unique socio-political and cultural histories of these societies. Zimbabwe, which is the main focus of this research study, went through an evolutionary process in its history, which is largely dominated by colonialism and globalization. As a result of colonialism, western-inspired models were imposed on unsuspecting and powerless disabled people despite their insensitivity to the Zimbabwean cultural values and traditional beliefs. These are the same individualistic medicalised models which encompass and underpin institutionalization, rehabilitation, care, charity and the control exercised by professionals on disabled people which have been vehemently discredited in western societies. Yet, they were foisted on disabled people of Zimbabwe as developmental initiatives when as a matter of fact they seemingly perpetuated their 'oppression'. This study therefore explores how the redefinition and reinterpretation of disability in Zimbabwe could inform a paradigmic shift from this medicalised orthodoxy to a empowering socio-political view

that promotes social change and inclusion. I have suggested that by establishing networks and sustainable partnerships with other disability movements from across the world and mobilizing resources, the disability movement in Zimbabwe could ensure wider politicization and empowerment of disabled people. Mainstreaming disability issues into all activities and the adoption of the concept of 'independent living' have also been identified as strategies for the empowerment of disabled people which are consistent with and are supported by the social model of disability.

List of Abbreviations

DALYS	Disability Adjusted Life Years
DPOs	Disabled Peoples Organisations
DFID	Department for International Development
ICF	International Classification of Functioning, Disability and Health
ICIDH	International Classification of Impairment, Disability and Handicap
NASCO	National Association of Societies for the Care of the Handicapped
SEN	Special Educational Needs
UNICEF	United Nations' Children's Fund
UNESCO	United Nations Education, Scientific and Cultural Organisation
UPIAS	Union of the Physically Impaired Against Segregation
WHO	World Health Organisation

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Chapter 1: Introduction

This research study critically reviews, analyzes and utilizes existing disability research and literature and also draws from reflexivity in order to provide a framework within which the 'oppression' experienced by disabled people in Zimbabwe can be understood. As Barnes (2008: 15) rightly points out, "...disability research should strive to produce a radical critique of the disabling society". In this study, I therefore trace, interrogate and analyse the development of the conceptual and theoretical understanding of disability in Zimbabwe. Some earlier models of disability that were brought to Zimbabwe such as the administrative/charity and the 'individual/medical' models seem to continuously perpetuate the discrimination and exclusion of disabled people. However, I explore how other more radical socio-political and related western models could inform and promote the politicization and empowerment of disabled people (Finkelstein, 1999 in Stone, 1999).

It is generally accepted that disabled people throughout the world experience the same kind of oppression as a result of failure by society to adequately provide for their needs. However, I try to illustrate in this

study that conceptions of disability and related practices vary widely across societies and are clearly influenced by unique sociopolitical and cultural histories of those societies (Mpofu and Harley, 2002). I also suggest that there may be many factors that necessitated the transportation of Western ideologies to low-income countries such as Zimbabwe but chief among them is indeed the fact that, as the struggle by disabled people (in developed countries) for a barrier-free society gained momentum, International Non-Governmental organizations and so-called humanitarian agencies decided to export their ideas 'to places where they are less likely to be challenged' (Finkelstein, 1999 in Stone, 1999). As a result of disabled people living in abject poverty and being less politicised and generally disempowered in Zimbabwe and indeed in other low-income countries, coupled with the incapacity of their Governments to provide for them, they accept these conditional Western ideas and assistance. I therefore further suggest that this is what seems to be perpetuating the prevailing situation in Zimbabwe in which service provision is underpinned by a culture of 'welfare and charity for the vulnerable', and disabled people are perceived of as requiring 'special needs' and specialized attention. To this end, having weighed all options available to me, I decided to use the desktop research approach in this study given the current socio-politically and economically prohibitive

situation in Zimbabwe, the contextual relevance of the approach to the problem being addressed and the research questions emanating from it.

Desktop research (also known as secondary research or library study) involves the accessing of information from both published resources and non-published sources which include relevant books, articles, the use of archival material and extensive use of the internet (www.delaneywoods.com/au/desktop_research.html). My choice for conducting this study using this approach was largely necessitated by a number of factors. First, it is less expensive than other forms of research, especially those that involve field work. As an international student on a scholarship, my resources are so limited that I could not afford carrying out field work in Zimbabwe. Second, the limited time within which the research is to be completed and the issue that it was to be carried out in Zimbabwe, posed immediate challenges. Given the prevailing general instability in Zimbabwe, it could still have been difficult if not impossible to even organize electronic or telephone interviews due to constant power cuts and technological systems failure in the country. Third, even if some of the material accessed and obtained through this approach may be unreliable, cannot easily be corroborated and/or verified, it undoubtedly exposes me to enormous amounts of data which

would evidently provide a better view of and basis for trends, relationships and outcomes that relate to this particular study (dstraub.cis.gsu.edu:88/quant/7glossary.asp). Lastly, this kind of approach is relatively free from the challenge of direct ethical restrictions as is the case in empirical study.

This research study essentially attempts to address four key questions: What impact has the different models of disability had on disabled people in Western societies? How has traditional beliefs and cultural values influenced the general perception of disability in Zimbabwe? What effect has colonialism, globalization and western models had on service provision for disabled people in Zimbabwe? and How can the redefinition and reinterpretation of disability inform the empowerment of disabled people and their participation in mainstream Zimbabwean society?.

Following this introductory chapter, there are five other chapters that specifically focus on the various elements and issues encapsulated in this study. Chapter 2 discusses the traditional, the individual/medical, the socio-political, the relational and related models of disability and

highlights the impact they have had on disabled people in ‘developed’ countries (Europe and North America). Chapter 3 begins by providing the description of the research context – the important geographical and historical information about Zimbabwe. I then, more importantly, examine the impact of Zimbabwean traditional beliefs and cultural values on societal attitudes towards disabled people and the general perception of disability. Chapter 4 critically evaluates the highly contentious and controversial issue of exporting/importing western ideas – analyzing the effects of ‘colonialism’ and ‘globalisation’ in relation to general service provision for disabled people in Zimbabwe. Chapter 5 suggests various ways in which the redefinition of disability could inform and promote inclusion of disabled people and their participation in mainstream Zimbabwean society. In the concluding chapter, I attempt to bring all the ‘strands’ together, linking the concerns highlighted in the study, the theoretical and conceptual issues raised throughout and the implications or suggestions that emanate from the research in a bid to signpost for further research on this issue.

Chapter 2: Western Models of Disability: a Global Perspective

Introduction

In order to provide a better understanding of the challenges facing disabled people in Zimbabwe specifically, it is vital, in addressing the first research question, to first critically interrogate the evolutionary process that characterizes the historical and contemporary understanding of disability from a global perspective. In this chapter, various western models of disability are discussed in order to illustrate how they have been used to represent the disability phenomenon and, the effects they have had on disabled people's lives in western societies. While I briefly discuss the rehabilitation, the administrative, the charity, the scientific and the affirmative models, my main focus is on the four major models – the traditional, the medical, the social and the biopsychosocial models of disability. These four models undoubtedly epitomize two ideologically divergent extremes - the desire by non-disabled people to maintain power and control over disabled people thereby perpetuating their exclusion and oppression on one hand, (Davis, 1998; Abberley, 1987) and the need for wider politicization and empowerment of disabled people on the other (Barnes and Mercer, 2003; Finkelstein, 1999). The chapter also briefly touches on the

contentious issue of the foisting of these Western models on powerless disabled people in so-called 'developing countries', an issue discussed in detail in chapter 4.

Models of Disability

A model is a simple, and sometimes simplistic representation to help grasp the more difficult properties of a real life situation, or to explain or interpret a phenomenon

(www.update.org.uk/documents/wordingdocuments/factsheet/models/december.doc). It is a representation of a particular structural theory which seeks to explain phenomena by referring to an abstract system and mechanism (Llewellyn and Hogan, 2000). However, models are artificial and do not explain anything but, as Finkelstein (2001) explains,

“A good model can enable us to see something which we do not understand because in the model it can be seen from different viewpoints (not available to us in reality) and it is this multi-dimensional replica of reality that can trigger insights which we might not otherwise develop” (Finkelstein, 2001).

As Simpson and Cheasman (2000) rightly observe, understanding of disability is influenced by prevailing models which are based on widely differing assumptions. The notion of models of disability has therefore dominated academic and/or activist disability discourse for the past three to four decades. At the heart of this overall disability debate is, what 'disability' itself means, how it relates to impairment and whether or not it is caused by it. The various models seek to provide answers to these issues with some having been advanced from chillingly atrocious to strangely weird ideas; and others offering from radical, ideal and empowering to simply unrealistic and unachievable conceptions.

Braddock and Parish (2001: 11) in Albrecht et al. (2001) contend that, "Throughout western history, disability has existed at the intersection between the particular demands of a given impairment, society's interpretation of that impairment, and the larger political and economic context of disability"(Braddock and Parish, 2001: 11).

It is this contrast between disability and impairment which essentially underlies the knowledge base of the different models of disability.

The Traditional Model

The traditional model of disability is based on a cultural and/or religious determination of knowledge, views and practices in a society (Seelman, 2004). In this model, which is historically regarded as the oldest and is also referred to as the 'moral' model (see Deborah Kaplan, www.accessiblesociety.org/topics/demographics_identity/dkaplanpaper.htm), disability is associated with sin, shame, guilt and punishment. In this model, various societies exhibit a broad range of perceptions of disabled people stretching from human to nonhuman (Seelman, 2004), from 'participant to pariah' (Barnes and Mercer, 2003; Ingstad and Whyte, 1995) and as demonic or outcasts (Coleridge, 1993). It is therefore underpinned by cultural relativity rather than objective scientifically-based knowledge. The Old Testament clearly exemplifies these competing attitudes of society towards disabled people in ancient times. On one hand, society seemed to be reminded of its charitable and protective obligation, while on the other, disability was perceived as punishment from God. Leviticus (19:14) says,

“Thou shalt not curse the deaf nor put a stumbling block before the blind, nor maketh the blind to wander out of the path”(Leviticus

19:14 cited by Braddock and Parish, 2001: 12 in Albrecht et al., 2001).

This Hebraic command, as Daniels (1997) cited in Braddock and Parish (2001: 11) argues, is the first attempt by any nation to legislate for the protection of the deaf and the blind. In contrast, in Deuteronomy (28:15, 28-29), the Old Testament strongly warns that, “If you do not carefully follow his commands and decrees... all these curses will come upon you and overtake you: the Lord will afflict you with madness, blindness and confusion of mind. At midday, you will grope around like a blind man in the dark” (Deuteronomy 28:15, 28-29 cited by Braddock and Parish, 2001: 12 in Albrecht et al., 2001). It is a model which has led to infanticide in some societies (Seelman, 2004) and has generally resulted in social ostracism and self-hatred on the part of disabled people.

The Individual/Medical Model

With the arrival of the age of ‘enlightenment’ (the 19th century) came the advances in modern medicine and society’s general enhancement of the authority of medical professionals over disabled people who were

regarded as sick. This gave rise to what is referred to today as the individual or medical model.

The individual/medical model is essentially an embodiment of professional/patient 'power' and 'control' dynamics underpinned by Parsons's (1951) 'sick role' theory, and characterized by a personal tragedy approach (Oliver, 1990). It defines disabled people by their illness or medical condition and hence views them as sick and in need of cure. The model is therefore guided by a 'bio-medical perception of normalcy and the narrow band of legitimate knowledge' which is medical and health-related (Seelman, 2004). The explanation of disability is reduced to the impairment level, impairment is seen as the cause of disability and, as a result, curing or managing the illness or disability revolves around diagnoses and appropriate intervention strategies such as 'care' and 'rehabilitation'. This obsession with finding medically-based interventions is usually what distracts society from focusing on the real causes of disabled people's exclusion and 'disablement' (Oliver, 1996, 2004; Tregaskis, 2004; Oliver and Barnes, 1996). The professionals allied to medicine wield so much power and control that disabled individuals' choices are only limited to the options provided and approved by these experts. The model is therefore characterized by the

dependence of disabled people and stereotypes of disability that elicit manifestations such as pity, fear and patronizing attitudes (oliver, 1990).

Central to the medical model is the widely used definitional scheme or framework of the World Health Organisation – the International Classification of Impairments, Disabilities and Handicaps (ICIDH) which was developed by three ‘experts’ Mike Bury, Elizabeth Badley and Phillip Wood in 1980. It states that:

“Impairment: In the context of health experience, impairment is any loss or abnormality of psychological, physiological, or anatomical structure or function.

Disability: In the context of health experience, a disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.

Handicap: In the context of health experience, a handicap is a disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfillment of a role that is normal (depending on the age, sex, social and cultural

factors) for that individual."(Wood, 1980: 27-29 cited by Oliver, 1996 in Barnes and Mercer, 1996).

It is this conception of disability which clearly dominated disability discourse since the 19th century and, to this day, regrettably still guides policy making and programme implementation in many countries particularly low-income countries such as Zimbabwe.

Other Related Medically-based Models

There are a number of other 'offshoots' or models which are firmly grounded in, consistent with, and are guided by the medical model. These include the 'rehabilitation', the 'charity', the 'administrative' and the 'scientific' models of disability.

The 'rehabilitation model' is similar to the medical model. It views disabled people as in need of services from rehabilitation professionals. The services include training, therapy, counselling and other services 'to make up for the deficiency caused by the disability' (www.accessiblesociety.org/topics/demographics_identity/dkaplanpaper).

[htm](#)). It gained momentum following World War ii when many disabled veterans required to be rehabilitated into society.

The 'charity model' is based on the so-called voluntary work of the ever-growing number of charities dedicated to particular impairments or conditions which provide information, advice and care to those regarded as having that particular impairment. Most of these charities are controlled by non-disabled people and they use sufficiently negative and stereotyped images of disabled people whom they portray as 'sufferers' and 'victims' in order to raise money (www.ju90.co.uk/res.htm).

The 'administrative model', which is evidently a bi-product of the 'medical' and the 'charity' models is described by Frances Blackwell as, "Based on both the medical model and the charity model and relates to us, defining our impairments in order to get benefits and receive an education" (www.ju90.co.uk/res.htm).

One other interesting but rather strange model whose roots are firmly in the 'medical' model has been suggested by a disabled scientist who works for the National Institute of Medical Research in UK. Funded by

the Wellcome Trust in 2006-07, the scientist explores the ideas of 'normality' within what they called a 'scientific model' of disability (www.scientificmodelofdisability.co.uk). In this model, as in the medical model, disabled people are viewed as abnormal and that this is the primary cause of their problems. The scientific model reflects how society could use science to conceptualise disability and treat disabled people (www.scientificmodelofdisability.co.uk). Its major tenets are that, disability is only a minority experience and scientists are all-powerful and experts on disability and will therefore soon eliminate it. Consequently, it follows that making fundamental changes to society in order to accommodate the 'minority' disabled people is a pointless waste of money, as it will soon be unnecessary (www.scientificmodelofdisability.co.uk).

The Social Model of Disability

The social model of disability is founded upon the view that disability is

'something imposed on top of disabled people's impairments through discrimination, prejudice and exclusion from full participation in society' (Union of the Physically Impaired Against Segregation, UPIAS, 1976: 14).

Disabled people are conceived of as oppressed (Abberley, 1987) and hence, struggling for social change and their emancipation is central to this model. The model was developed in the mid-1970's by Mike Oliver, a disabled sociologist, from his careful and detailed exploration and analysis of the UPIAS's social interpretation of disability. It essentially breaks away from the "victim-blaming individual/medical model and provides a socio-political definition of impairment and disability. In describing this distinction between impairment and disability, Davis, (2000: 56 cited in Braddock and Parish, (2001: 11 in Albrecht et al., 2001) notes that,

"Disability is not so much the lack of a sense or the presence of a physical or mental impairment as it is the reception and construction of that difference. ...an impairment is a physical fact, but a disability is a social construction".

In this model therefore, impairment is the physical, sensory or mental functional limitation within an individual; while disability is the loss or limitation of opportunities to take part in community life on an equal level

with others due to physical and social barriers (Disabled Peoples' International, DPI, 1982).

The social model therefore interprets disability not as a result of impairment, but as a direct consequence of the failure of society to take account of the differing needs of disabled people and remove the barriers they encounter. These barriers range from (but are clearly not limited to) individual prejudice to institutional discrimination, inaccessible public buildings to unusable transport systems, segregated education to excluding work arrangements (Oliver, 1996: 3). Reeve (2004: 83) reiterates that disability is 'a form of social oppression, like racism and sexism'. Philpott and McLaren (1997: 2) go further to categorise it as 'apartheid of disabled people' because disabled people do not have access to the same opportunities as others simply because of a physiological characteristic (impairment).

However, Bury (2000: 1075), who calls the social model an 'oversocialised' model, writes,

"I do not believe that the "social model" has really engaged with the real issues facing the vast majority of disabled people,

and, despite its rhetoric and undoubted attractions to some, it has not produced a cogent approach which can serve the real practical needs of disabled people, or indeed the research community”(Bury, 2000: 1075)

To this end, Oliver (1996) argues that the social model does not declare that if all barriers are removed, impairments will disappear. He acknowledges that there are some impairments that affect some disabled people’s daily lives which may therefore require medical intervention from time to time, but he strongly argues that, in this model, the emphasis is on the real barriers which affect participation and disabled people’s right to choose and control their own lives. Barnes (1998) therefore contends that the ‘cure’ to the problem of disability lies in ‘changing society’. This can be achievable through the principle of ‘universal design’. Universal design relates to measures which simplify life for everyone by making products, communications and the built environment more usable by as many people as possible at no extra cost (Holm, 2006). This may include constructing ramps alongside stairs, installing automatic doors, providing information in Braille and other accessible formats, providing appropriate accessible technology and

putting in place many other measures that will ensure the empowerment and full inclusion of disabled people in mainstream society.

The Affirmative Model of Disability

Swain and French (2000) advance what they term an 'affirmative model of disability' which is essentially built on the social model and revolves around a disability culture characterized by a positive identity of an individual as both a disabled person and a person with an impairment. The model also rejects the concepts of tragedy, dependency and abnormality that are generally associated with the individual/medical model. It therefore seeks to emphasise the significance of disabled people's total ownership of their impairments and their own bodies.

The Biopsychosocial Model of Disability

As a result of the realization that, on their own, the various models of disability are inadequate to sufficiently represent the disability phenomenon, there was an attempt to reconcile, integrate and synthesize the two major models –the medical and the social, into a framework called (ICF) which would provide a relational approach and a multi-perspective view to the classification of functioning, disability and

health (WHO, 2002). The International Classification of Functioning, Disability and Health (ICF) scheme retains a three-dimensional perspective in which, on the first level, what was previously referred to in ICIDH as impairment now relates to 'body function and structure'. On the second level, what was 'disability' is now referred to as 'activity', and on the third level, what was 'handicap' is now termed 'participation', and "disability" is the overall term for all the three levels of functional difficulty (Barnes, 2003; Hurst, 2000). In the biopsychosocial model, as Imrie, (2004: 290) points out,

"Disability is the variation of human functioning caused by one or a combination of ...the loss or abnormality of a body part (i.e. impairment); difficulties an individual may have in executing activities (i.e. activity limitations); and/or problems an individual may experience in involvement in life situations (i.e. participation restrictions".(Imrie, 2004: 290).

The proponents of this ICF framework are convinced that the "biopsychosocial" model has the capacity to signpost 'the improvement of participation of disabled people by removing or mitigating social hindrances and encouraging the provision of social supports and facilitators' at biological, psychological and social levels (WHO, 2001: 4).

Effects of the Models of Disability on Disabled people

Having been influenced by the United States civil rights movement in the 1960s, a new form of social movement for disabled people emerged in North America and Europe, and was particularly active in the United Kingdom from the mid-1970s. The disabled people's movement, whose rallying point was the social model of disability, stepped up their campaigns against the continued 'medicalisation' of disability. They strongly lobbied for anti-discrimination legislation in the form of a comprehensive and enforceable civil rights bill (Morris, 1993; Davis, 1998). By this time, large numbers of disabled people had moved out of institutional care and had set up their own support schemes for their members with the Derbyshire Coalition of Disabled People, now Derbyshire Centre for Inclusive Living and the Hampshire Centre for Independent Living, leading the way (Priestley, 1998). This resistance by the disability movement heralded wider politicization and empowerment of disabled people, and had a telling effect on disability related policy issues as demonstrated by the recognition by charities, aid agencies and Government that disabled people have a right to control their own lives through 'independent living' and other 'user-led' schemes.

Consequently, the medically-based interventions and ideas which were being vehemently resisted and discredited by disabled people, activists and academics in western societies began to find their way to and were foisted on countries and communities in the 'non-industrialised world' (Groce, 2000) where they were not likely to be challenged (Finkelstein, 1999 in Stone, 1999). Due to lack of own resources to run disability related programmes, all forms of western-modelled programmes were adopted in Zimbabwe and in many other low-income countries despite the many conditionalities the western aid organizations and funding agencies attached to their funding. Regardless of the fact that these interventions, ideas and/or models would only benefit a few urban based people, and that they may not have been culturally responsive to disabled people in these communities, they were still forced on them without any form of prior consultation which further disempowered and disenfranchised disabled people (Groce, 2000).

Summary

This chapter was an attempt to illustrate that disability discourse is characterized by numerous competing and often conflicting viewpoints on the nature and determinants of disability. These views range from those within the realm of the individual/medical model in which disability

is caused by impairment and is therefore presented as a personal tragedy or problem to those influenced by the social model in which disability is as a result of disabled people's social exclusion and oppression and is presented as a socio-political problem. However, apart from these two main models, there are other models of disability which were discussed such as the traditional, the rehabilitation, the administrative, the charity and the scientific models which are reflective of, grounded in or influenced by the individual/medical framework. On the other hand, the affirmative model which is premised on 'disability culture' and a 'positive identity' is essentially informed by the social model while the biopsychosocial model is a relational approach and an integrative synthesis of the medical and social models of disability. In the chapter, I also briefly highlighted the effect these models of disability and medically-based interventions had on disabled people and how resistance against them gained momentum in the 1980s resulting in their transportation to low-income countries, an issue to be discussed in depth in chapter 4. Having laid out this global view of the perception of disability in this chapter, the next chapter will critically examine and analyse the impact of traditional beliefs and culture on the perception of disability in Zimbabwe.

Chapter 3: The Impact of Traditional Beliefs and Cultural Values on the Perception of Disability in Zimbabwe

Introduction

In any society, conceptions of disability are undoubtedly influenced by socio-cultural beliefs, assumptions and/or myths and indeed fears prevalent in that particular society. This notion justifies the inclusion of this chapter in this study as it seeks to address the second research question relating to the influence of Zimbabwean traditional beliefs and culture on the perception of disability. (Groce, 1999, 2000) and (Barnes and Mercer, 2005) contend that understanding traditional beliefs and related practices about disability within a specific socio-cultural context is of vital importance. However, as Sheldon (2005: 119 in Barnes and Mercer, 2005) rightly forewarns, “Indigenous beliefs and attitudes, when described and interpreted by western/western trained researchers often illuminate more about western prejudices and belief systems than they do about the societies of which they claim to be gaining an understanding.”(Sheldon, 2005: 119 in Barnes and Mercer, 2005).

Mindful of this potential hazard, in this chapter, I therefore attempt to carefully explore the impact of traditional/cultural beliefs and practices on disability from a Zimbabwean perspective.

Brief Geographical and Historical Facts about Zimbabwe

Zimbabwe is a landlocked Southern African country situated north of the Tropic of Capricorn between the Zambezi and the Limpopo Rivers. The country stretches 797 kilometres from north to south and 813 kilometres from east to west. It has a total area of 390,580 sq km, of which 386,670 sq km is land and 3,910 sq km is water (World Fact Book, 2006). The country is bordered by Zambia to the north, South Africa to the south, Mozambique to the east, and Botswana to the west. It is part of a great plateau, which constitutes the major feature of the geography of Southern Africa.

The country derives its name from Great Zimbabwe, the twelfth to fifteenth century stone-built capital of the “Rozvi” Shona dynasty which means ‘great stone esteemed houses’ (Mpofu, 2002). According to current estimates, the population of the country is 12,236,800, of which 98% are indigenous blacks and about 70% of the population lives in rural areas (World Fact Book, 2006). These estimates explicitly take into

account the effects of excess mortality due to AIDS; this can result in lower life expectancy, higher infant mortality and death rates, lower population and growth rates, and changes in the distribution of population by age and sex than would otherwise be expected (World Fact Book, *op cit.*). Zimbabwe is divided into two major tribes, the Shona and the Ndebele, which are further divided into numerous but minor tribal dialects (**Shona:** e.g. Manyika, Zezuru, Karanga, Korekore, and Ndau; **Ndebele:** e.g. Tonga and Kalanga). These groups of people have their own traditions, social-cultural values and belief systems unique to them, which essentially determine how individuals think, act, behave, and generally conduct themselves (Mbiti, 1992).

Zimbabwean Traditional and Cultural Trends

Hensley and Schott (1999, p2) define culture as:

“A shared set of values, assumptions, perceptions and conventions, based on a shared history and language, which enable members of a group or community to function together.”

Our culture therefore essentially affects every aspect of our daily life; thus how we think and behave, and the judgements and decisions we make. It is like a set of lenses through which we look at the world that

defines both what we see and how we interpret it. Like air we breathe, our culture is all around us from birth and we acquire most of it unconsciously in early childhood (Hensley and Schott, 1999). Hensley and Schott (*op cit.*) perceive culture as one layer of human mental programming of the mind, which distinguishes the members of one category of people from another. They argue that culture is something that is not genetically inherited. Rather, it is acquired during childhood when we are systematically taught the basic values and norms by which our family, community and society live.

Generally speaking, the Zimbabwean culture emphasises the philosophy of 'unhu' (Shona), 'ubuntu', (Ndebele/Nguni) or 'beingness' (Mbiti, 1992). Mbiti (*op cit.*) explains "ubuntu" as being honest, accommodative, sharing, saving life at all cost, and respecting young and old. The concept is synonymous to valuing human dignity. Beingness is defined by qualities of the individual's participation in valued family and community activities. Participation in family and community activities is therefore valued more than individual differences or other human attributes.

The Shona concept of “*ukama*” (being related to other people) also places inclusiveness at the core of humanness. Through ¹‘totems’ (adopted symbols of natural objects or animals believed to have traditional and spiritual significance to all members of society) and marriages, most Zimbabweans are related to each other.

“*Ukama*” conveys a sense of wholeness of human situatedness with the “human world [individual], the natural world [accepted or expected], and the spiritual world [religious or sacred]” (Gonese, 1999, p38).

For example, through “*ukama*,” one can be linked to present and past relatives. Similarly, the Shona dictum, “*munhu wese ihama yako*” (everyone is your relative) may be considered a strong representation of and basis for inclusiveness.

The Role of Family and Community in Zimbabwe

The family is a very strong cultural institution in Zimbabwe with responsibilities between family members taken seriously. The bond that brings them together is manifested in such activities as having meals

together and also holding consultations on various issues affecting the family [*dare*] (Pulse of Africa Survey, 2004). All children are members of a broad extended family and arrangements for their care and upbringing are the concern of not just their biological parents, but also an extensive network of relatives (Nyambedha *et al.*, 2003). A family comprises of biological parents, children, paternal and maternal grandparents, uncles, aunts, nephews, nieces, cousins, and sons and daughters in-law (Nyamukapa and Gregson, 2005). Therefore, members of the extended family automatically become part of the immediate family members. The nuclear family is a foreign concept that came to Zimbabwe with colonisation (Peters and Chimedza, 2000). Any family member can pledge their willingness to take care of any of the wider family relations. Thus, responsibilities would include but are not limited to, providing clothing, food and school fees, for example.

In Zimbabwe, as in many other African countries, the community comprises of a cluster of families or clans. Its major responsibility is to ensure that all the children follow community values, norms and beliefs religiously, the understanding being that it takes the whole village to raise a child. Mutual assistance and sharing of burdens (*kubatsirana*), within the community, signify the morals of community behaviour in

mutual help and a close bond of households (Nyamukapa and Gregson, 2005). Therefore, as Mbiti (*op cit.*) points out, an individual has little latitude outside the context of the traditional African family and community. He goes further to say that:

“Whatever happens to the individual happens to the whole group, and whatever happens to the whole group happens to the individual. The individual can only say: ‘I am, because we are; and since we are, therefore I am.’ This is a cardinal point in the understanding of the African view of man.”

(Mbiti, 1992, p109)

However, the mere arrival of a disabled child in a particular family immediately presents numerous challenges to the family concerned and the community in general. It immediately ushers in all sorts of perceptions and friction which, in most cases, may unsettle the family bond and community cohesion. As Douglas (1966) cited in Barnes and Mercer (2005) acly describes it, “Responses to perceived physical, sensory or cognitive difference involve deep-seated psychological fears of ‘anomaly’.”

Perception of Disability in Zimbabwe

Culture and traditional beliefs inevitably shape the society's perception of disability and the social responses that result from them. There is a clear connection between perceptions of impairment and a non-human 'liminal' status (Barnes and Mercer, 2005: 4). Therefore, society's negative perception of impairment has always resulted in the social exclusion of disabled people since time in memorial.

From pre-colonial Zimbabwe up to today, disabled people have been marginalised and treated as if they are second-class citizens. Disability is equated with inability and has largely been understood as meaning the same as 'impairment'. The Shona and Ndebele words for a disabled person, "*chirema*," and "*isilima*" respectively, have been used to mean inability to function and stupidity. In Shona, the object or animal-referent "*chi*" prefixes the word "*rema*". Therefore, an indigenous Zimbabwean conception of disability considers a disabled person as the borderline between a human being and an animal (Devlieger, 1998). As a result, disabled people have, for a long time, been perceived by the society as lacking clear social role functions.

Throughout history, disability was viewed as a form of punishment by some ancestral spirit unhappy with the family or, a result of bewitchment by enemies of the family (Addison, 1986; Kisanji, 1995) and similar beliefs and attitudes towards disability have been found elsewhere in Africa; for example, in Nigeria (Onwegbu, 1979) and Zambia (Phiri, 1979). In either case, the target of the punishment was the family, and the disabled person would suffer on its behalf. As highlighted earlier on, in this context, family meant the extended family.

In some cases, rituals and cleansing ceremonies were held to 'cure' or 'heal' the disabled person and dispel the evil spirits from the family, and all family members attended these functions in solidarity to solve a 'family problem' (Peters and Chimedza, 2000). In such a situation, the disabled person enjoyed sympathy, support, and empathy from the entire family and village. Disability was therefore a responsibility for the family and village. This is exemplified by the experiences of one late Zimbabwean disability activist who went through such a ritual as cited in Chimedza and Peters (2001):

"I was taken up a mountain and I was left overnight on the mountain on my own. They were to collect me the following

morning, traditional rituals were performed. It was expected that was the way of really helping me out. It was terrible.”

(Chimedza & Peters, 2001, p157).

The above situation is confirmed by a study commissioned by The United Nations Children's Fund [UNICEF] (2001). The study established that some relatives saw the birth of a disabled child as a bad omen to the family. As a result, they did not want to be associated with the situation. In the study, parents of disabled children pointed out that some family members came to support only if there were “family rituals to cleanse the disabled child, thus removing the bad omen” (UNICEF, 2001, p76). This suggests that other family members were supportive of, not the disabled child, but rather, the desire to eliminate the impairment (the bad omen) from the family. Even today these “attitudes and beliefs towards disability are still prevalent and strong,” although at times people pretend that they no longer exist (Avoke, 2002, p79).

Tilstone (2003) emphasises that mythical beliefs are hard to eradicate, as they easily become the crystallised opinions and attitudes of society. In Zimbabwe, there were other numerous mythical beliefs that were

associated with disability. For example, a general belief that one should not laugh at a person with a disability lest the curse is transferred to the scornful person was common (Mpofu, 2000). In some way, this resulted in society being more tolerant to disabled people, because of fear that the disability might be shifted onto them. It was also believed that pregnant women should not look or associate with disabled people or they may give birth to a disabled child. This assumption is evident from the personal experience of a disabled man cited in the National Association of Societies for the Care of the Handicapped (NASCOH) Newsletter:

“Then sometime last year in the afternoon, my pregnant secretary was brave enough to ask me a straightforward question. ‘Mr X, what chances do I have in giving birth to a disabled child since I am working with disabled people?’ She was simply trying to crosscheck the truth in the belief that when a pregnant woman comes across a disabled person, she must spit at her tummy so as not to give birth to a disabled child. My secretary could not imagine spitting at herself every time disabled people visited the office. She was also aware that our association regularly held workshops and seminars with disabled members. Therefore, could she always spit at herself at

every workshop? Such dangerous beliefs in our culture are a thorn in the flesh for our modern society” (NASCOH, 2002: 2).

This indicates that beliefs can be transcended from one generation to another, but could also change with time because of the advent of new thinking on disability. Societal attitudes disable people, and this is often manifested in their reaction to disability with horror, fear, anxiety, distaste, hostility, and patronising behaviour (Kisanji, 1995; Coleridge, 1996). What society believes to be the cause of disability is usually internalised by families.

The idea of the family as a social unit that takes the burden of responsibility for its disabled members is an old one in Zimbabwe. Under pressures exerted by urbanisation and changing patterns of production and employment, however, the institution of the family has weakened substantially. In colonial Zimbabwe (Rhodesia), the consolidated extended family broke down and was replaced gradually, by the nuclear family system with a very loose extended family base. The disabled person became the responsibility of the nuclear family. Due to this limited family support and because family members had to work for

colonial masters in their fields and factories, disabled people began to be locked in houses, chained to trees, and generally ill treated and seen as a burden (African Rehabilitation Institute, 1991). The introduction of education for disabled persons, beginning in the 1920s by the missionaries, was therefore a great relief to the families of the few disabled children who were fortunate enough to get a place in a school (Peters and Chimedza, 2000). These were institutions where disabled children were institutionalised away from home and most families valued these institutions more as custodial homes than as education centres.

The above situation means that from early childhood, young disabled children in Zimbabwe therefore get the message that they are unclean, inferior, and unworthy. This is against the background that the growing disabled child needs love, respect, friendship, responsibility, group learning, and participation.

Families are often torn apart by the birth of a disabled child. From experience as a special educational needs (SEN) teacher, 90% of the disabled children in the classes I taught between 1993 and 1999 came from single mothers who were divorced because they were being

blamed for causing the disability, especially if no such thing has ever happened in the family lineage. Although divorce is common amongst families of disabled children elsewhere (Hogan, 2004), in Africa, and particularly in Zimbabwe, it is more pronounced and a common practice for the man's relatives to blame a woman who has given birth to a disabled child (Charowa, 2005). Tatenda, a mother of a disabled child shares her experience with Charowa (2005):

“I separated from my husband who could not come to terms with the disability of our child and was under pressure from his relatives’ (Charowa, 2005: 2).

If parents believe that the disabled child is a ‘curse’, they may hide the child as a way of coping with the affliction and retaining social equilibrium. United Nations Educational, Scientific and Cultural Organization (UNESCO, 2001: 10) establishes that:

“Often these children are excluded from society. They might be hidden away at home if they look different because of fear and superstition Often their needs are not recognised and they are thought to have little to contribute to their community. But

this exclusion reduces children's opportunities to learn, grow and develop." (UNESCO, 2001)

This was also evident during my career as a special educational needs teacher when we were involved in outreach programmes searching for school-aged disabled children. In some cases, the family would deny that they had a disabled child in the family until we had to go via the local chief, only to find out that the child was hidden, mostly in the granary. In other cases, we also found disabled children being used by relatives to scare away baboons and monkeys from eating crops in the fields by beating the drum everyday throughout the farming season.

Summary

As Barnes and Mercer (2005: 4) point out,

"To understand the significance of impairment and how and why certain individuals and groups are considered 'abnormal' or 'incompetent' and how control and resistance is exercised, it is necessary to explore these issues within specific cultural contexts". (Barnes and Mercer , 2005:4)

This chapter has illustrated how traditional beliefs, cultural values and related practices seem to have largely influenced the general perception of disability in Zimbabwe throughout history. It is however evident that attitudes towards disabled people have inevitably been going through an evolutionary process owing to such factors as colonisation and globalization. In any case, views about disability as being the atonement for sins seem to be outdated, as “increased modernisation seems to be diluting the effects of traditional belief systems” (Choruma, 2006; Avoke, 2002: 771). In some social settings, disabled people are invisible because generally the country’s social amenities are not structured in a way that is inclusive (Choruma, 2006). As such, disabled people are less likely to participate in most social activities in Zimbabwe. The following chapter will interrogate and critically discuss the introduction of western ideas/models in Zimbabwe through colonialism and globalisation and the impact this has had on the general service provision for disabled people.

Chapter 4: Western Models of Disability in Zimbabwe: Effects of Colonialism and Globalisation

Introduction

All too frequently, to most international development agencies and Governments of low-income countries such as Zimbabwe, the assumption is that disability beliefs will always have to move from traditional attitudes and practices to a western based charity or medical model (Groce, 2000). In addressing the third research question, I suggest in this chapter that the notion which considers everything western as 'good' and 'civilised' and hence developmental, is fundamentally flawed. I further suggest that 'colonialism' and 'globalisation' have had a significant effect on development in general and service provision for people with impairments in particular.

Effects of Colonialism in Zimbabwe

To believe that colonialism can just come to a sudden end upon attainment of a nation's political independence is certainly naïve. Colonialism, which brings with it

“new values, new beliefs, foreign languages, alien traditions” and in most cases, is tantamount to total brain washing, “cannot be shed like the skin of a snake and then tossed away and forgotten” (Ashcroft, *et al.*, 1995: 2).

It will always leave something behind, some form of colonial ‘hangover’ which manifests itself through people’s conceptions of reality as postulated by Nelson Mandela,

“We were taught and ‘believed’ that the best ideas were English ideas, the best government was English government, and the best men were English men.”(Mandela, 1994: 53).

Political independence therefore, does not automatically translate into total socio-economic emancipation and empowerment of the marginalised and oppressed people. There is still bound to be evident vestiges of colonialism even after such declarations of political freedom.

Like in any other newly independent nation, the immediate challenge for the Zimbabwean government in 1980 was about “national development and modernisation” (Chung and Ngaru, 1985: 86). The inherited colonial systems had to be phased out, expanded and/or modified to serve new

economic and social needs in the face of this new political dispensation. For instance, since education is regarded as the vehicle for socio-cultural, economic and political change, the Government immediately sought to invest heavily in educational expansion and diversification (Chung and Ngara, 1985). However, the education and most of all other service provision for disabled people was left in the hands of missionaries and NGOs, and by engaging intellectuals from other countries, foreign philosophies were also brought along and imposed on disabled people without any possible cultural adaptations being taken into account (Mpofu, 2001).

The NGOs' vision of Africa was largely informed by images of exoticism and adventure. Caught in the torrent of upheavals that characterised the victory over colonialism, it was easy for these Western NGOs to become romantic and blinkered by their own enthusiasm for "bringing development to the people" of newly independent Zimbabwe (Manji and O'Coill, 2002: 7). But the real problem was that the dominant discourse of development was framed not in the language of inclusion and empowerment, but in the vocabulary of charity, technical expertise, neutrality, and a deep paternalism as its syntax. As with the racist ideologies of the past, development continued to define non-Western

people in terms of their perceived divergence from the cultural standards of the West, and it reproduced the social hierarchies that had prevailed between both groups under colonialism. This is essentially why the majority world and its inhabitants were (and are still) described only in terms of what they are not,

“They are chaotic not ordered, traditional not modern, corrupt not honest, underdeveloped not developed, irrational not rational, lacking in all of those things the West presumes itself to be. White Westerners were still represented as the bearers of ‘civilization, and acting as the exclusive agents of development, while black, post-colonial ‘others’ were still seen as uncivilised and unenlightened, destined to be development’s exclusive objects.”(Manji and O’Coill, 2002: 7).

Thus, while the vision of development appeared to offer a more inclusive path to “progress” than had previously been the case, the discourse was in fact little more than a superficial reformulation of old colonial prejudices. As Crush puts it,

“Development is fundamentally about mapping and making, about the spartial reach of power and the control and

management of other peoples, territories, environments and places.”(Crush, 1995: 7).

Development discourse has therefore provided a means subverting popular aspirations for radical change in the context of independence struggles while legitimising the continued marginalisation of the Zimbabwean people, and this has had a significant impact on disabled people who are already disproportionately marginalised (Mpofu, 2001).

Conversations between Western and African cultural representation of disability have tended to be unequal and in favour of Western cultures. They have been unequal in the sense that technologies and practices are adopted from Western countries and often applied to African communities without any cultural adaptations (Mpofu, 1996). Problems associated with the importation of these western constructions into the Zimbabwean setting include the use of technologies. For instance, children are being diagnosed as having mental retardation (sic) by western-trained Zimbabwean professionals using Western instruments in the form of ability tests and adaptive behaviour measurements which are normed on European or North American children such as the Wide

Range Achievement Test (WRAT) (Mpofu & Nyanungo, 1998; Serpell, 1988). Undoubtedly, the behaviours that are sampled by these psycho-educational tests and on the basis of which decisions are made about competence in Zimbabwean children are clearly based on the medical model of disability and may be irrelevant. Practices of institutionalisation, rehabilitation and regarding people with impairments as objects of charity which are informed by this model have also been prevalent since the colonial era. Professionals from medicine and allied disciplines wielded all the power and therefore had total control over the lives of disabled people whom they used (and still do even to this day) to source for funding to sustain their 'businesses' as noted by Sheldon (2005: 115 in Barnes and Mercer, 2005) who writes, "Disability in the majority world is big business". The NGOs have therefore regrettably become 'gatekeepers to a host of largely institutionally based services' (Groce, 2000) as the Government (both colonial and postcolonial) virtually seded 'trusteeship' for all matters relating to disability to these western controlled disability NGOs. However, Miles (1999: 228 in Stone, 1999) is critical of this 'incautious export/import' of much of the European disability ideology, planning and strategy because of difficulties experienced by locals to base policies and plans on their own cultures and concepts, either independently or with some blend of appropriate foreign elements (Miles, 1999: 228 in Stone, 1999).

It is therefore evident that any imported model needs to be weighed in relation to the country's life style and cultural beliefs rather than wholesomely adopted without question. Thus, there is need to be wary of the 'recolonisation' of Zimbabwe through disempowering western ideas which are packaged as development aid. This means that if assistance is to be rendered, it has to be respectfully offered, and not undermine local expertise and cultural values. In this way, knowledge transfer and exchange can be promoted in a more impartial way – hence promoting fair trade through globalisation.

Globalisation

Today, perhaps more than ever before, the interdependence among nations is becoming more apparent and more difficult to overlook. Information, money, goods and services produced in one part of the world are increasingly available in all parts of the world. International travel and communication are now more frequent and faster. This phenomenon is referred to as 'globalisation' (Beck, 1999). Thus, globalisation can be summarised as the growing interdependence of countries world-wide through the ever-increasing volume and variety of

cross-border dealings in goods and services, and also through the more speedy and widespread flow of technology (Mengisteab, 2006). The issue here is whether globalisation entails that individual nations have to abandon their way of life, or whether a culturally responsive global networking is possible. Nsibambi (2001: 1) stresses that,

“Globalization is not a value-free, innocent, self-determining process. It is an international socio-politico-economic and cultural permeation process facilitated by policies of governments, private corporations, international agencies and civil society organizations.”(Nsibambi, 2001: 1).

The growing integration of economies and societies over the past two decades has touched off a storm of controversy. Proponents consider globalisation to be the answer to the social, political, and economic ills plaguing developing countries. However, critics argue that it “creates inequalities, loss of jobs, and environmental degradation” (Prasad, *et al.* 2003: 6). Nsibambi (2001) argues that as cultures interact, some cultures become diluted and/or destroyed at the expense of others and negative values spread across the world with relative ease. As a result, an intense debate has emerged in both academic and policy circles on the effects of globalisation within developing nations and their

economies. Some countries are taking globalisation as a big problem, and thereby missing the opportunities it is offering, while others have grasped it as a movement offering development potential and hence use it to advance their growth and development as well as their own interests. However, most developing countries are taking it as a dangerous process of exploitation where rich countries and big international corporations are getting bigger and richer at the expense of the poor ones, and as a form of recolonisation.

As Sheldon (2005: 116 in Barnes and Mercer, 2005) rightly observes,

“...the roots of the biting poverty found in the majority world are located in the global capitalist system and its inequitable distribution of wealth”.

Disabled people in many low-income countries such as Zimbabwe, who are among the poorest of the poor have become more marginalised and oppressed as a result of capitalist tendencies rooted in colonialism and globalisation as these have now virtually ‘crippled the economies, societies and politics’ of these countries (Harrison 1993 cited by Sheldon 2005: 116 in Barnes and Mercer 2005). The political instability and economic melt-down that currently characterise Zimbabwe whose inflation is at a staggering 11,000,000 percent, the unemployment rate of 80 percent and acute food shortages not only worsens the situation

regarding service provision for disabled people, but also make them feel that having an impairment is 'a tragedy'.

It is extremely regrettable that despite disability NGOs having 'spread their reach to almost every corner of the globe' (Sheldon 2005), disabled people remain poor. In Zimbabwe, the mere fact that disability is regarded as a welfare issue and that disabled people should be receivers of charity, are factors that have largely kept people with impairments excluded and disempowered. NGOs have not sought to empower disabled people through income-generation initiatives for example, as this would inevitably enable them to be independent and thereby have the NGOs' power and control over them drastically reduced. They therefore, in most cases, keep their charity work targeted at rehabilitation, care and advocacy programmes which only reach less than 2 percent of disabled people who live in the cities, and, which also ensure that they maintain a firm grip on power and control over them (Groce 2000; Miles 1999).

However, despite the numerous challenges faced by disabled people as a result of globalisation and the importation of western ideas to Zimbabwe, there is clearly a more vibrant disabled people's movement and a fairly politicised disabled population – incentives that can be

attributed to global partnerships and networking with other disabled people's organisations across the world. Disability is therefore increasingly informed by these processes of globalisation and therefore, its complexities can now only be fully understood within this global setting (Barnes and Mercer 2003: 133).

Summary

This chapter was an attempt to highlight the effects of colonialism and globalisation on Zimbabwe in general and their bearing on service provision for disabled people. I also discussed the challenges emanating from the 'transportation' of western ideas into Zimbabwe and how this has not led to the expected levels of development, empowerment and inclusion of disabled people. In the next chapter, suggestions are made of how a redefinition and reinterpretation of disability could inform the empowerment and inclusion of disabled people in Zimbabwe.

Chapter 5: Redefining Disability: Strategies for Empowerment and Inclusion of Disabled People in Mainstream Zimbabwean Society

Introduction

The empowerment and full participation of disabled people in mainstream Zimbabwean society can most likely be guaranteed by a redefinition of disability and a complete paradigmatic shift and reorientation from the traditional medicalised perspective of disability to a more radical socio-political one. Having thoroughly examined and discussed both the global and the Zimbabwean conceptions of disability and their effects and bearing on disabled people In previous chapters, this chapter attempts to address the fourth research question by exploring the justification for the redefinition of disability in Zimbabwe. I suggest that, for empowerment and full participation of disabled people in all mainstream activities to be realized, the social model of disability and other related empowerment strategies should be adopted in and adapted for the benefit of disabled people in Zimbabwe. These strategies and ways I suggest include, but are not limited to, strengthening the disability movement in Zimbabwe through wider politicization and empowerment of disabled people, mainstreaming

'disability', as well as their reclamation of control over their own lives through the concept of 'independent living'.

Strategies for the Empowerment and politicization of Disabled People in Zimbabwe

The Zimbabwe disability movement today faces an extremely daunting task of trying to remain relevant in an increasingly disenfranchised, profoundly frustrated and hopeless society. The level of political instability, economic disintegration and poverty which characterize everyday life in Zimbabwe have virtually relegated issues pertaining to the rights and needs of people with impairments to the lowest 'rung' of the national priority ladder. However, this study envisions a future in which society should be convinced that disabled people are an irreplaceable integral part of the general population (Phiri, 2003: 5). It is therefore crucial that disabled people's organizations in Zimbabwe, first and foremost, establish links and partnerships with other oppressed people across the world who are engaged in the same struggle (Charlton, 1998). This development of a 'global political economy of disability' (Sheldon, 2005; Thomas, 2004) would inevitably promote information exchange and resource mobilization among disabled people across the world and undoubtedly strengthen the capacities of the DPOs

in Zimbabwe. This would, in turn, ensure the empowerment of the generality of disabled people as a result of “dynamic processes that involve the interaction of disabled people with their social and political environments” (Teixeira and Menezes, 2008).

Empowerment has an intuitive appeal because it essentially implies ‘independence’ and ‘assertiveness’ and it is both a process and an outcome (Dempsey and Foreman, 1997). Baistow (1995: 35) defines it as,

“the process by which individuals, groups and/or communities become able to take control of their circumstances and achieve goals, thereby being able to work towards maximizing the quality of their lives”(Baistow, 1995: 35).

While Dowson, et al. 1998) concur with this view, they further suggest that empowerment, from a practical perspective, involves having information, being listened to, getting a response based on what has been said and sharing power with others who are appropriate to hold some of the power. Disabled people in Zimbabwe could therefore be said to have been empowered if they have access to information, are

able to make choices, become more assertive and have high self-esteem (Chamberlin, 1997). This 'liberational model' of empowerment concerned with changing the position of oppressed groups in society such as disabled people, is consistent with the social model of disability and is in sharp contrast to the 'consumerist model' of empowerment which focuses on giving people choice within professionally defined services informed by the medical model of disability (Croft and Beresford, 1995).

The most important attribute of empowerment is that it has both an individual and a group dimension (Chamberlin, 1997). At the individual level, in order for disabled individuals to have a positive attitude towards disability and themselves, the disability movement in Zimbabwe should 'embrace the social model of disability', unequivocally identify with the theory of social oppression and ensure that their members realize that an impairment is nothing to be ashamed of (Swain and Cameron, 1999). This is the basis of the 'affirmative model of disability' (Swain and French, 2000) which is premised on the 'evolving disability culture' that asserts a person's positive identity as both a disabled person and as a person with an impairment (www.enham.co.uk/core/documents/download.asp).

At the national (group) level, the disability movement in Zimbabwe will need to campaign and lobby vigorously for constitutional recognition of the rights of disabled people, a national disability policy and a new anti-discrimination Act which would replace the largely ineffective Disabled Persons' Act of 1992. DPOs could also embark on campaigns targeted at ensuring that their members are aware of important disabled people's rights instruments such as the United Nations' Convention on the Rights of Persons with Disabilities and many others done prior to it. Just the fact that the Zimbabwe Government has not ratified this Convention for example, makes this exercise much more important as matters of citizenship and disabled people's rights cannot be fully guaranteed in the current situation in which people with impairments have literally been condemned to the dustbins of 'welfare', 'charity' and poverty.

Mainstreaming Disability

Disabled people in low-income countries such as Zimbabwe are often among the poorest of the poor and measures to tackle poverty are unlikely to be successful unless their rights and needs are taken into account (Department for International Development, 2000). However,

the seemingly perennial exclusion of 'disability' from the international development agenda (e.g. the United Nations' Millennium Development Goals) is extremely ludicrous given its rampant prevalence in developing countries and its mutually constitutive relationship with poverty (Butler and McEwan, 2007). In Zimbabwe, Mainstreaming steps are required to ensure that disabled people are able to participate fully in community activities and claim their rights as full and equal members of society (Butler and McEwan, 2007).

Mainstreaming is a process of "reconstruction" of the physical spaces and services so that they meet the needs of all people (Phiri, 2003). In this process, there is need to conceptualise a new society that is inclusive and planned for all the people; and, central to this process should be the principles of 'universal design' (Phiri, 2003; Butler and McEwan, 2007). By definition, Universal Design means that the design of products and environments has to be usable by all people and to the greatest extent possible without the need for adaptation or specialised design (Holm, 2006). The purpose of Universal Design is to simplify life for everyone by making products, communications, and the built environment more usable by as many people as possible at no extra cost. Such arrangements are indeed more likely to benefit all people of

all ages, abilities or circumstances in Zimbabwe (Phiri, 2003; Holm, 2006). However, some disability scholars argue that universal principles are more likely to favour traditionally dominant groups, or assert the normality and morality of non-disabled people (Corker 1998; Imrie 2004). In addition, Flood (2005: 180 in Barnes and Mercer, 2005) also argues that, for some agencies such as the United Nations' Children's Fund (UNICEF), "Mainstreaming disability issues has effectively meant that disability issues fall off the international rights agenda". More importantly however, I contend that unless disabled people are brought into the development mainstream, it will be difficult if not impossible to realize the inclusion of an empowered disabled population in all aspects of human endeavour.

The Concept of Independent Living in Zimbabwe

Independent living' is arguably the single most important and wide-ranging philosophy and practice in which empowerment of disabled people is the foundation. It encapsulates a full range of human and civil rights across the whole spectrum of personal, social, educational and economic life experiences (Pearson, 2000). Independent living is premised on four basic principles. According to Barnes (2007) these are:

- “1. that all human life, regardless of the nature, complexity and/or severity of impairment is of equal worth.
2. That anyone whatever the nature, complexity and/or severity of their impairment has the capacity to make choices and should be enabled to make those choices.
3. That people who are disabled by societal responses to any form of accredited impairment – physical, sensory or cognitive – have the right to exercise control over their lives.
4. That people with perceived impairments and labelled ‘disabled’ have the right to participate fully in all areas, economic, political and cultural, of mainstream community living on a par with non-disabled peers”(Barnes, 2007: 4-5).

Independent living is widely practiced with relative effectiveness in western countries where there are significant resources for its practical implementation. With schemes such as ‘direct payments’ and ‘individualised budgets’ at the centre of service provision in developed countries, it is evident that more and more disabled people are increasingly getting reasonably empowered. I am however convinced that it is a philosophy which is so universally adaptable that it can inform

and guide the development of disability policy in Zimbabwe though the issue of resources could always be cited as the stumbling block to its effective implementation.

According to Malinga (2003), the concept of independent living is still largely theoretical in Zimbabwe owing to lack of resources and political commitment, ignorance of disability issues and the philosophy of independent living on the part of policy-makers as well as leaders of DPOs. He asserts that, in Zimbabwe, (as is the case elsewhere) 'independent living is consumer controlled and revolves around programmes and projects (Malinga, 2003). Income-generating projects are therefore seen as a critical way of economically empowering disabled people. A few DPOs run a few sheltered workshops and wheelchair and other prostheses manufacturing ventures. Some disabled people have also been supported by their DPOs to embark on farming projects. However, due to lack of resources, only a limited number of disabled individuals benefit from such projects.

Another important aspect in independent living which has been developed and hence could be hugely beneficial to disabled people in

Zimbabwe is 'peer counselling'. DPOs have training programmes for peer counsellors who support people who will have just acquired impairments, helping them become aware that 'disability is merely an alternative way of living' (Malinga, 2003). It is my contention that despite the numerous current hurdles, all these are immensely important small steps in the practice of independent living and should therefore be continuously strengthened until disabled people of Zimbabwe can realize the full package of the 'independent living' ideals.

Summary

In this chapter I attempted to demonstrate that through a socio-political interpretation of disability, disabled people can be empowered and hence participate in mainstream Zimbabwean society. I identified the strengthening of the disability movement in Zimbabwe, mainstreaming of disability issues and 'independent living' as significant practices of empowering people with impairments in Zimbabwe. However, I also acknowledged the numerous challenges that disabled people in Zimbabwe face in their quest for empowerment, inclusion and participation in society. These include the political instability and economic melt-down the country is currently going through. I suggested the establishment of partnerships with fellow disabled people across the

world and resource mobilization as key factors for Zimbabwean disabled people's struggle for control over their own lives.

Chapter 6: Conclusion

In this study, I have demonstrated through research evidence that western-style models of disability have variously had an immense impact on people with impairments throughout the world, especially in low-income countries such as Zimbabwe. I explored the various models of disability from the traditional, the rehabilitation, the administrative, the charity, the scientific models - all encapsulated in the individual/medical model of disability. Their effects which are largely characterized by total dependence of people with impairments on 'professionals allied to medicine' which appear to perpetuate their oppression are also critically examined. I highlighted how this individualistic, medical and 'personal tragedy' orthodoxy and related models which have underpinned the 'oppression' of disabled people for centuries has largely been discredited and rejected by disabled people, activists and academics in western societies. It is this open resistance against 'oppression' in the 1960s and early 1970s in Europe and North America which ushered in 'a new epistemology of disablement' called the social model (Stone and Priestley, 1996) formulated by disabled people themselves. This resulted in these discredited medically-inspired models being transported to Zimbabwe as well as other low-income countries through colonialism

and later globalization and foisted on resource-starved and powerless disabled people.

Colonialism virtually destroyed Zimbabwean family and community structures and diluted its traditions and cultural values and rendered communities incapacitated and unable to provide for their members with impairments. Where previously the provision and care for members with impairments was the responsibility of the communities through the extended family and “ukama” (relatedness) phenomena, disabled people began to be either hidden away or sent to “special” institutions for respite care. Institutionalisation, rehabilitation and charity have therefore consequently resulted in the sustained oppression suffered by disabled people in Zimbabwe to this day. Formulation of the various policies and programmes initiated for disabled people are largely informed by the medical approach and, more worryingly, more attitudinal barriers are promoted by bodies such as the World Bank through health measurement instruments such as the Disability Adjusted Life Years (DALYS) which focus on the ‘cost benefit’ analysis on impairment (Russell, 2003 cited in Flood, 2005 in Barnes and Mercer, 2005).

It is in view of this situation that I suggested that the hope disabled people in Zimbabwe have for their empowerment, inclusion and full participation in mainstream society rests on a redefinition and reinterpretation of disability. I strongly believe that the social model perspective can appropriately be adopted in and adapted for Zimbabwe so that disability can then be perceived of as a socially constructed and culturally produced form of structural oppression created by a disabling environment and disabling attitudes (Finkelstein, 1980; Oliver, 1990; Abberley, 1987; UPIAS, 1976).

It is also argued in the study that globalization is viewed differently in different countries. However, I am convinced that through it, the disability movement in Zimbabwe has over the years had mutually beneficial conversations and interactions with disability movements across the world. I therefore contend that by further strengthening the disability movement in Zimbabwe through resource mobilization, networking and the establishment of sustainable partnerships with other disability movements, mainstreaming disability issues, and adopting and adapting the philosophy of 'independent living', the social model can indeed effectively inform the empowerment and participation of disabled people in mainstream Zimbabwean society. This is not to say that the social

model is 'a quick fix' to the desperate situation to which people with impairments are relegated. The suggestion is merely that the model offers more realistic opportunities for their empowerment and inclusion.

This study is by no means meant to be the ultimate solution to the numerous challenges the disabled people of Zimbabwe currently face during this period of political instability and economic decline. It is an attempt to highlight concerns surrounding the oppression of disabled people in Zimbabwe, suggesting how embracing the social model of disability could guarantee an all-inclusive society and promote equal opportunities for all people in Zimbabwe. It is also meant to provide the basis for further research into issues relating to 'disability' in a way that would lead to social change and promote disabled people's 'rights' and total control over their own lives.

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