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An Exploration of the Experiences of Women with Disabilities in a Rural Setting: the case of Insiza District, Zimbabwe

ALBERT TONDORI

850441

A research report submitted to the Department of Development Studies in partial fulfillment of the requirements for the degree of MASTER OF ARTS IN DEVELOPMENT STUDIES

Supervised by Dr Rajohane Matshedisho

September 2016

Declaration

I, **Albert Tondori**, am submitting this research report to fulfil the requirements for the Masters degree in Development Studies at the University of Witwatersrand, Johannesburg. I declare that this thesis is my own work and has not been submitted for any other degree or examination at any other university.

Signature……Date…….

Tondori Albert

Dedication

I dedicate this thesis to **Brot für die Welt (BfdW)**. May God bless you all.

.....YOU MAKE ME PROUD.....

Acknowledgements

I wish to express my deepest acknowledgement to *Brot für die Welt (BfdW)* for awarding me a Masters Scholarship which made possible the completion of this research component, as well as the coursework. With emphasis, I say a heartfelt thanks to my fellow Masters students for helping me in preparing this thesis: Tongai Maodzwa, Patricia H Ndlovu and Thatshisiwe Ndlovu whose support and valuable insights contributed immensely to this study. Without the initiative and confidence of these colleagues, this study would never have been undertaken. Thanks a million times for your invaluable motivation, support and encouragement.

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It is also a pleasure to acknowledge with appreciation the unflagging perseverance and expertise of my supervisor, Dr Rajohane Matshedisho whose labour and enthusiasm made a real contribution to the entire study. I am also thankful to the authors from whose texts I extracted some facts and opinions to broaden this study, and in such cases I have made due acknowledgements. Where no acknowledgements have been made, the ideas and views concerned are mine. Finally, I sincerely acknowledge the cooperation and patience of all the participants who provided information for the study. Despite their busy schedules they were willing to sacrifice their valuable time to share their experiences with me.

Abstract

This study aimed to explore the challenges experienced by women with disabilities in a rural setting, and the coping strategies they adopt in a time of economic crisis in Zimbabwe. The study made use of a qualitative exploratory design which necessitated the use of interviews (in-depth and semi-structured) and focus group discussions (FGDs) conducted in Insiza District, Matabeleland South Province in Zimbabwe. The study consisted of two different categories of participants which were: key informants (community leaders, government officials, non-governmental officials) as well as the subjects of the study who are women with disabilities. The study aimed to explore the experiences of rural women with disabilities. In this endeavour the study also illuminates how the economic crisis in Zimbabwe further constrains the already disadvantaged women with disabilities in a rural setting, who have to contend with multiple identities: being persons with disabilities, being poor women and inhabitants of a rural setting where resources are scarce, and being citizens of a country experiencing an economic downturn. The findings from the study were understood through the explanatory framework of the Capabilities Approach (CA). The study argues that the approach to disability in Zimbabwe is unsystematic, individualistic and paternalistic, thereby imposing upon women with disabilities multiple levels of oppression.

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CA	Capabilities Approach
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
DPA	Disabled People's Act
ESAP	Economic Structural Adjustment Programme
FGD	Focus Group Discussion
GDP	Gross Domestic Product (GDP
HIV	Human Immune Virus
ICF	International Classification of Functioning, Disability and Health
ILO	International Labour Organisation
MDC/M	Movement for Democratic Change – Mutambara
MDC/T	Movement for Democratic Change – Tsvangirayi
MDGs	Millennium Development Goals
NASCOH	National Association of Societies for the Care of the Handicapped
NGO	Non-Governmental Organisations
NSDH	National Survey on Disability and Health
PwDs	People with Disabilities
SAFOD	Southern Africa Federation of the Disabled
UN	United Nations
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
WHO	World Health Organization
ZANU/PF	Zimbabwe African National Union/ Patriot Front

CHAPTER ONE

INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 Preface

This research was influenced by my interest in the field of development studies and disability, owing to the fact that I am employed by an organization which implements disability programmes in some parts of Matabeleland province, Zimbabwe. Therefore, this study grows out of my personal commitment to disability discourses and my interest in contributing significantly to the ongoing efforts to strengthen development programmes in impoverished communities, and create greater opportunities for development for Zimbabwean people who live with disabilities, especially women who experience specific challenges as a result of their disabilities on multiple levels. The challenges are varied in context, and necessitate different coping strategies applied by these women in their different roles in the community.

As a humanitarian worker, I have been privileged to engage in development work, community organising efforts, education reform, and the implementing, documenting, monitoring and evaluation of development programmes, as well as advocacy of subaltern groups, including women with disabilities. This knowledge and experience is what has motivated me to write this research report which focuses on the experiences of women with disabilities in a rural setting. My choice to research this topic is based on the conviction that they have long shouldered an unfair burden in their respective societies due to a wide range of challenges. These challenges result from their experiences, and intersect with gender and disability, among other multiple identities. This leads to undue hardships and untold suffering, which gives rise to a wide range of coping strategies which are relatively ineffective in the face of the severity of the challenges experienced.

1.2 Introduction

This chapter provides an overview of and background to the study. To this end, it sets out the context of the study and provides a rationale for the objectives and the research question which reads: What are the challenges and coping strategies of women with disabilities in a rural setting set against the background of the economic crisis in Zimbabwe? The chapter illustrates how the problem explored in this study shapes the research question and provides the basis of the argument, that the approach to disability in Zimbabwe is unsystematic, individualistic and paternalistic, thereby rendering women

with disabilities vulnerable to multiple oppressions. In addition, the chapter provides a justification for why the study is conducted, and also presents the direction to be taken in the study.

The study applies the Capabilities approach (CA) to process the research findings on the basis of the conviction that this model is useful in illuminating the challenges experienced by women with disabilities. The CA presents a cogent approach which extends practical solutions to contextualised individual challenges experienced by women with disabilities. With the CA as an overarching analytical framework, the study has further benefitted from intersectionality as a tool for analysis. When applied to disability, intersectionality highlights the fact that the experiences of disabled women cannot be understood only in terms of their being disabled or having an impairment, but must include the interaction of factors which frequently reinforce each other to further disadvantage them (Davies, 2008).

In order to achieve its aims and objectives, this study employed a qualitative methodology underpinned by interviews (in-depth and semi-structured) as well as focus group discussions (FGDs). The study is based on the findings drawn from research in Insiza District's three wards in Matabeleland South Province in Zimbabwe. The District is one of the areas in Matabeleland South Province which suffers from persistent droughts due to erratic rainfall, and this presents livelihood challenges for the disadvantaged groups who have to cope with life in this environment, in the face of an economic crisis besetting the country.

Given all these factors, the question that emerges is: Why focus on the experiences of women with disabilities only, when the experiences of living with a disability affect both men and women? The reason for my selection of women with disabilities in rural areas, as research subjects is based on the fact that they have long shouldered an unfair burden in their respective societies due to particular challenges. In this study these challenges are categorized as follows: social/cultural, economic, structural and political. The challenges which result from their experiences intersect with gender and disability, in the context of multiple roles, and all told, this leads to immense hardships and suffering. This particular predicament is combined with the fact that the environmental barriers, both structural and attitudinal, traditional patterns and deep-rooted cultural prejudices against disability are far more intense in rural than in urban areas (Eide and Ingstad, 2013). The fact that these biases are difficult to fight in rural settings makes the situation even more acute for rural women. These women also experience specific challenges which include lack of access to resources and the domination of

patriarchal control, which contributes towards gender inequalities and other acts of social injustice (Abimanyi-Ochom, 2014). This will be unpacked in subsequent discussions.

1.3 Background

The study was conducted in Zimbabwe, a country which is currently facing an economic crisis. The past decade has seen the country face challenges of catastrophic proportions, with droughts, hyper-inflation, near-complete economic collapse, political volatility and the almost total implosion of public services (Millennium Development Goals Report (MDG), 2010). The background to this economic crisis is briefly highlighted in the following description of events. At the start of the 21st century, a series of socio-political and economic blows such as inflation, liquidity crunch and job retrenchments severely affected the economy of Zimbabwe. In the time period especially 2005-2009, Zimbabwe's agriculture-based economy was severely affected and it deteriorated further (Masunungure, 2009a).

The collapse of the economy led to an avalanche of retrenchments and crippling poverty for the majority of people, and this crisis was magnified two and threefold for women with disabilities. Inflation rose to unprecedented levels (Sachikonye, 2007). The vagaries of hyper-inflation and HIV and AIDS continued to take their toll on the society's poor, with a ruthless effect on women with disabilities in rural areas where resources are scarce and service delivery is poor (NASCOH, 2012). At the height of the crisis, women with disabilities in a rural setting were at a disadvantage in accessing basic foodstuffs, shelter, assistive devices, health care and other basic social services due to inflationary woes. Failure to access resources and services by women with disabilities in a rural setting has continued up to the present day despite the fact that inflationary woes have eased somewhat.

In addition to this, Zimbabwe has been caught up in heated political contestations since the year 2000 with the entry onto the scene of a new political party formed by civic society groups. These political contestations spawned intra-state conflicts which resulted in socio-economic challenges that affected the livelihood of local communities. This economic crisis resulted in poverty, mainly affecting orphans and women with disabilities, since these groups had challenges in accessing resources which were in short supply or were never available (NASCOH, 2012). Inflation, as a result of the economic crisis, ate away at the public assistance scheme and eroded the purchasing power of disability grants, resulting in PwDs experiencing more challenges. The economic and socio-political crisis finally reached a tipping point, thereby forcing the three main political parties (MDC-T, MDC-M and

ZANUP/F) in Zimbabwe to enter into a political compromise so as to avert a humanitarian tragedy (Gandure, 2009). In an attempt to manage the inflation and to restore sanity to the economy, the inclusive government introduced the multi-currency regime, which in turn affected the public assistance scheme that had been employed to benefit PwDs in Zimbabwe. This has had a negative impact on the general populace of Zimbabwe and PwDs, especially women, who are the worst affected.

The Zimbabwean National Survey on Living Conditions among Persons with Disability (NSDH) (2013), conducted in 2013 has it that the prevalence of disability in Zimbabwe is estimated to be around 7%, and this amounts to approximately 914 287 persons. Figures are based on the total Zimbabwean population of 13 061 239 (Zimbabwe 2012 Population Census). Further to this, various recent studies reveal that this segment of the Zimbabwean population faces a number of perilous socio-economic problems that exacerbate their already susceptible status (NSDH in Zimbabwe, 2013). Linking this to a global statistic, the World Disability Report (WHO, 2012) has found that an estimated 15% of the world's population live with some form of disability. According to the same report (WHO, 2012), the number is expected to rise owing to ageing populations, as well as the global increase in chronic health conditions. From a global perspective, the International Labour Organisation (ILO) holds that PwDs make up an estimated twenty percent of the poorest populations in the world (ILO, 2011). There is, however, growing consensus among academics in disability discourses that the main challenge that PwDs face globally is not their specific disabilities but rather the lack of equitable access to resources and services such as education, employment, health care, and social as well as legal support systems (WHO, 2012).

The National Survey on Disability and Health in Zimbabwe (2013) records that PwDs in Zimbabwe do not have equal access to health care, education, and employment opportunities, as they do not receive the disability-related services that they require, and this results in exclusion from daily life activities. Such instances of social injustice against PwDs are worse and more widespread in developing countries where social protection is poor or at times unavailable (Eide and Ingstad, 2013), and where disability is still viewed as a personal tragedy. Social injustice leads to poverty and social exclusion (Munsaka, 2014). Jones (2011) bears credence to this as he argues that PwDs are undoubtedly among the most vulnerable groups of people due to social exclusion. In low-income countries, including Zimbabwe, there is inadequate information on disability. This in turn translates as limited information on which to base advocacy, policy development and effective resource mobilization and utilization (NSDH in Zimbabwe, 2013). Poverty does not merely signify a lack of

income but also includes the denial of social rights to health, housing, food, safe water, education, internationally agreed upon civil and political rights such as access to a fair trial and participation in the daily activities of life, leading to the loss of opportunities (Palmer, 2013).

Research has shown that poverty affects women more than men, hence it is even worse for women with disabilities, who face multiple disadvantages as a result of multiple identities levels of disadvantage, which are the result of an interaction between disability and other social factors (Swartz, 2014). These factors include being a woman in a patriarchal society, having a disability, and being a poor inhabitant of a rural area in a country experiencing economic challenges. The effect that the multiple levels of disadvantage (identities) have on women with disabilities is that they relegate these women to the extreme margins of society, through injustices practised by that society, thereby suppressing their freedom and choices**.** Linked to this is the under-representation of women with disabilities in developing countries. In Zimbabwe for example, the disability movement has been reluctant to deal specifically with challenges affecting women with disabilities in a bid to avoid weakening the quest for social justice. The assumption here is that collective efforts are needed to fight for the acceptance of disability in general before dividing people into specific and discrete groups (Choruma, 2007). Given this scenario, the study explores the challenges experienced by women with disabilities in rural areas, and the coping strategies they employ to cushion themselves against the hardships they experience.

The study emerges at a time when the emergence of the sustainable development goals (SDGs) has created the space for a focus on disability discourses. Despite the link between poverty and disability, PwDs were not included in the SDG's predecessor framework, the Millennium Development Goals (MDGs). This served to reinforce their marginalisation and did little to ameliorate discrimination against them. Generally, the MDGs have been the most important international development time-bound, quantified targets to bring about important progress in tackling poverty (Palmer, 2013). However, the MDGs and the indicators set had gaps in their scope and design as the needs of PwDs were not addressed, thus leading to their invisibility in development discourses (United Nations, 2010). This invisibility led to the fact that PwDs were left out of actions and plans designed to fight poverty and other forms of injustice. This resulted in continued inaccessibility and discrimination for the disabled. Visibility in development discourses is what PwDs are fighting for (Yeo and Moore, 2003) since invisibility and exclusion reinforce the misapprehension that disability is a personal tragedy.

This new agenda set by the SDGs includes several important references to disability. Zimbabwe ratified the UN Convention on the Rights of Persons with Disability, (UNCRPD) (United Nations, 2008) and its Optional Protocol in September 2013, and this calls for the social protection of PwDs in all facets of life in a bid to facilitate an equalisation of opportunities (Mandipa, 2013). The UN Convention on the Rights of Persons with Disabilities (UNCRPD) will be an important compass to guide the implementation of the SDGs and ensure accessibility and inclusion in all programmes. The SDGs with their principle of universality and their strong human rights basis will inform and guide the strategic work of governments and other institutions, in developing more inclusive policies regarding PwDs. The UNCRPD and the SDGs mark the beginning of a new phase, in which disability is being considered a development issue, one which has become one of the world's time-bound events for addressing poverty and inequality for PwDs (Palmer, 2013). The convention marks a shift of paradigm, from viewing PwDs as recipients of charity, medical treatment and social protection, to viewing them as active agents with rights. Given all these developments, time will tell what the SDGs will mean in practice for PwDs. Implementation of the UNCRPD by member states that ratified to the convention remains to be seen.

This study, which aims at examining the challenges currently experienced by women with disabilities in a rural setting, therefore fits very well into the current global discourses when issues of gender, women's empowerment and emancipation are topical even within Zimbabwe. The discourses on development in Zimbabwe have been on the agenda "with Ministry of Women's Affairs, Gender and Community Development almost stealing the show during the 2006 and subsequent years' debates in parliament and outside of it, with its Domestic Violence Bill, which has now been enacted into law" (Mungwini, 2007:124). Up to the time of writing, the economic meltdown persists and there is widespread evidence that the social safety nets for the poor and other vulnerable groups like women with disabilities are no more. It is against this background that I seek to explore the challenges experienced by rural women with disabilities, and the coping strategies they employ, within the context of Zimbabwe's economic crisis.

1.4 Statement of the Problem

The main problem which the study seeks to address is that women with disabilities experience challenges, especially those who live in rural areas. The situation is worse in developing countries like Zimbabwe. However, despite this being common knowledge, the specific challenges experienced by women with disabilities in Insiza District in Zimbabwe are not widely known. According to

Mapuranga and Mutsangwa (2014) the general unemployment rate in Zimbabwe is at least eighty percent and for PwDs it is ninety nine percent, with disabled women accounting for seventy four percent of this total. This problem arises from the fact that the plight of rural women with disabilities in post-colonial Zimbabwe has not been sufficiently considered and explored. It is important to point out that a comparison between women with disabilities in rural areas and those in urban areas shows that women with disabilities in rural areas have to face additional challenges, owing to the fact that rural areas are usually characterised by remoteness and are less developed, which means that even social services are not the same as in urban settings (NSDH in Zimbabwe, 2013). In addition to living in remote rural areas devoid of resources, not only do women with disabilities have to deal with the physical limitations imposed by their impairments, but they also have to put up with the "insensitivities and prejudices within their communities and wider society" (Munsaka, 2014:183) which are the building blocks of social injustice.

The study therefore attempts to explore the challenges experienced by rural disabled women, challenges which arise from their disabilities. The study also explores how they attempt to cope with the challenges. Also under consideration in the study, is how the economic crisis has exacerbated the challenges which they already experience. In a study conducted by NASCOH (2005), it emerged that before the advent of the current era in Zimbabwe, local communities had the capacity to manage challenges experienced by women with disabilities through traditional or indigenous coping strategies, such as extended family care and support systems. These strategies in communities had at base the perception of PwDs as charity cases, owing to the influence of the medical model. Given all this, there has not been an attempt to empower PwDs through enhancing their capabilities and functioning so that they can have freedom and choice to achieve what is in the scope of their capacity, so that they lead independent lives. However, the advent of the present economic crisis in Zimbabwe has escalated the problem to unprecedented levels, so that in the current situation, traditional coping mechanisms no longer apply, and PwDs have to fend for themselves. This has led to approaching the phenomenon of disability in Zimbabwe as a personal predicament, which necessarily calls for individualized solutions.

In addition, as a result of increased poverty in Zimbabwe, the living conditions of disabled women in rural areas have deteriorated considerably. Also as a result of the economic crisis, the ability to provide resources needed for their care and support has been stifled. Masunungure (2009a) describes the Zimbabwean economy as mainly characterized by the collapse of industry and the underperformance of the public service institutions. Consequently, the capacity of the government to

take responsibility for the care of women with disabilities, and other disadvantaged groups, has gradually diminished. Inasmuch as disabled rural women are attempting to address the ongoing challenges, this study finds that the coping strategies adopted contribute short-term solutions which do not effectively address the severity of the challenges experienced. To make matters worse, biting, persistent poverty, massive unemployment, family collapse and famine have compounded the challenges of the government in its attempts to provide viable and complete care to rural women with disabilities, and their families (NASCOH, 2005).

Furthermore, the social and economic exclusion of women with disabilities does not typically affect only the individual. Rather, it results in excessive economic reliance on family members and relations (NSDH in Zimbabwe, 2013). The disabled women are incapable of sustaining their lives and many of them resort to begging; due to the lack of economic empowerment. This dependency leads to low self-esteem and a lack of confidence, as well as the helplessness of daily witnessing the erosion of their rights (JJA Annual Report, 2012).

Looking after women with disabilities becomes a challenge for extended families and caregivers because of economic instability and lack of resources (Choruma, 2007). This therefore has led to a widespread belief that disability is more a personal tragedy than a social problem. This perception is based on the belief that there is no systematic way to enhance capability and capacity in order to equalize opportunities for women with disabilities in their respective societies. In addition, the meagre monetary resources allocated to development programmes, by various non-governmental organisations and government institutions, do not target women with disabilities. This results in glaring economic imbalances which have been exacerbated by the current economic crisis. It is in view of the above that this study seeks to explore the challenges experienced by disabled women who live in rural areas, and sets out to examine the coping strategies they adopt to respond to their challenges.

1.5 Main Research Question

The focus of this study is to explore the experiences of rural women with disabilities, but to focus mainly on challenges, and how, by adopting different coping strategies, the women attempt to address the challenges posed by living with a disability. Thus, the overall research question for this study has been developed and defined as follows:

What are the challenges and coping strategies of rural women with disabilities set against the background of the economic crisis in Zimbabwe?

1.5.1 Sub-Questions

To address the main question, this study will also examine the following related sub-questions:

1. What are the challenges experienced by women with disabilities in rural settings?
2. What strategies have been adopted by disabled women to mitigate the challenges they face due to the current economic crisis in Zimbabwe?
3. To what extent are the coping strategies helpful in mitigating the challenges experienced by disabled rural women?

1.6 Research Objectives

The research objectives are to:

1. Identify and explain the challenges experienced by rural women with disabilities in the face of the economic crisis gripping the country, as well as other social/cultural, structural and political constraints.
2. Identify the coping strategies adopted by rural women with disabilities in the light of the current economic crisis and other social/cultural, structural and political constraints.
3. Analyze the extent to which the coping strategies adopted by rural women with disabilities are helpful in mitigating the challenges experienced.

1.7 Significance of the Study

In the current discourses on disability, there is very little research and documentation on the experiences of rural disabled women in Zimbabwe. While the reviewed literature offers invaluable insights into the challenges experienced by women with disabilities, there is a gap in that even where data is current, it is almost silent on how these women survive the challenges, especially in a rural context set against the backdrop of the economic crisis in Zimbabwe. Inasmuch as research on disability reflects on the experiences of PwDs and in the process makes generalizations by treating them as a homogenous group, they are for all intents and purposes a heterogeneous group even in the manner in which they cope with their experiences. The research that focuses on gender-defined or gender-nuanced experiences on disability in Zimbabwe is scarce. Therefore, the study does not assume that women with disabilities have the same experiences in general, as a result of their

disabilities and it is neither theoretically useful nor empirically appropriate to regard women as a single, singular, and stable category. This view concurs with that of Saler (1997), who argues that women are not only stratified by race, ethnicity, and class but also by other social markers including age, marital status, level of income, level of education, sexuality and position in the family.

The limits of lumping women together as a single category ignores the diversity of women as a group with different experiences, backgrounds, and histories (Saler, 1997). The bulk of the literature on disability falls short of providing a thorough description of the experiences of PwDs on the basis of the intersection of disability and gender. Thus, by exploring the experiences of disabled women, focusing on their challenges and coping strategies, the study partly addresses this gap by adding a voice that resonates with the current studies on gender and disability. Further to this, most studies on disability have focused on the experiences of PwDs in urban settings and this has rendered women with disabilities in rural locations invisible in the disability discourses. This is, despite the fact that the situation is even worse for women with disabilities in rural settings, who have to contend with acute poverty. Their experiences are significant and they present an interesting case in that these experiences are complicated by factors such as gender, limited or no access to resources, education and employment, and also by patriarchal domination. Therefore, the social meaning they construct as a result of their experiences of living with disability, and how these meanings shape their current identities, necessitates this study.

1.8 Structure of the Research Report

This research report consists of six chapters outlined as follows: Chapter One provides the motivation for the research, the problem statement, and the overall objectives of this study. Chapter two focuses on the literature review, models of disability and the theoretical framework. Chapter Three deals with the research design and methodological issues, which include the sample, ethical considerations and data analysis among other aspects. Chapter Four presents the findings from the study. Chapter Five discusses the findings of the study. Chapter Six presents the implications and recommendations for future research.

1.9 Summary

This chapter has offered an overview of the study, thereby providing the background to the study. Within this background, the chapter has also provided the rationale for the research question and how it leads to the argument, that the approach to disability in Zimbabwe is unsystematic, individualistic and paternalistic, thereby rendering women with disabilities vulnerable to multiple oppressions. In the

next chapter, the study deals with the relevant literature and how it contributes towards enriching this study. In addition to the aforesaid functions, the chapter provides justification as to why the study is conducted and thereby presents the direction to be taken throughout the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The chapter acknowledges the valuable insights provided by different authors and it situates the study within the broad scope of literature which details and describes the plight of women with disabilities. The use in this thesis, of descriptions of the plight of women with disabilities is guided by the research question for the study which reads: What are the challenges and coping strategies of rural women with disabilities set against the background of the economic crisis in Zimbabwe? On the basis of the research question, the study pursues the argument that the approach to disability in Zimbabwe is unsystematic, individualistic and paternalistic, thereby rendering women with disabilities vulnerable to multiple oppressions. In order to give a scholarly character and direction to this argument, in the first section of this chapter, I contextualize this study within disability discourses from the following perspectives: global, regional, and finally zeroing in on the Zimbabwean context. In the light of this, the chapter also presents a discussion on the complexity, multidimensionality and dynamism associated with disability and in the process shows how different models of disability conceptualize it from different perspectives. Building on these models of disability, this study draws specific attention to the variables which the research question has identified. On this basis, it demonstrates how the CA appreciates the complex nature of disability by presenting an analytical instrument whose lens can assist in understanding the challenges experienced by rural women with disabilities.

2.2 Contextualizing Disability Issues in Zimbabwe within the Global and Regional Development Discourse

From a global perspective, disability as a field of inquiry has always been a controversial discipline attracting a series of research studies and debates from various contexts. Therefore, defining disability in academic discourses has always been a bone of contention as there has not been a consensus on the universal definition of disability worldwide, including the terminology to be used (Munsaka, 2014). WHO and World Bank (2011) in The World Report on Disability admit to the complexities and

dynamism underpinning disability, citing its multidimensionality, owing to different perspectives on how it should be understood and what it constitutes. Therefore, a considerable quantity of literature has been published on the subject. Be that as it may, Devlieger (1995) asserts that disability studies have been largely dominated by westerners, hence the philosophy underpinning disability discourse in the bulk of the literature is also largely influenced by western traditions of thinking. Compounded with this idea is the fact that recent evidence suggests that disability has always been researched and conceptualised in isolation of other social characteristics such as gender (Moodley and Graham, 2015). The generalizability of much published research on how disability intersects with other social markers is a cause for concern.

Feminist researchers and writers in their ongoing efforts to address gender issues have also neglected and under-researched the specific experiences of women with disabilities (Moodley and Graham, 2015). In a few studies in which feminists have dealt with disability issues, women with disabilities have not been in evidence (Hall, 2011) for the simple reason that "feminist imaginaries of strong and powerful competent women were in conflict with stereotypes of disability" (Mohamed and Shefer, 2015). Several studies exploring the experiences of women in general have been carried out but the researches with a specific focus on gendered experiences on disability are scarce (Fine and Asch, 1988). In most cases, research on disability has always treated women with disabilities as a homogenous group. This phenomenon points to a paucity of literature on disability and gender. This research report therefore seeks to address this gap by looking into the experiences of rural women with disabilities focusing on their specific challenges and coping strategies in living with a disability.

Since most of the research on disability was conducted in the West, the dominance of the global politics of knowledge cannot be ignored (Mohamed and Shefer, 2015). The discourses of normalcy underpin the way the social world is constructed, thereby determining relations between people (Mohamed and Shefer, 2015). The normal/abnormal binary is systematically interwoven into the structures of existing power and privilege but basically reflect the European social order (Afolayan, 2015). The European social order creates abnormalities such as the disabled, poor, malnourished and illiterate which it seeks to reform. The apparatuses of normalcy rationalise the marginalisation of and discrimination against women with disabilities on the basis of their failure to measure up to the standard of a particular culture's acceptable standard.

Social constructions within which disability is experienced, based as it is on the global politics of knowledge, thus results in an isolated community characterised by stereotype, prejudice and

exclusion. The global politics of knowledge are reflected in the contemporary discourses on disability which are predicated on a culture which attaches to the disabled, images of dependence, helplessness, neglect and oppression, as well as limited capacity (Afolayan, 2015). The stereotyped misrepresentations of disability that result from the interaction between gender and disability play a role in rationalising and reproducing hegemonies of male dominance and able-bodiedness. It is the discourse of ability or normalcy that defines relations between the able-bodied and the disabled (Davies, 2008). The Medical Model (as will be demonstrated later in the subsequent sections of this study) has contributed to the reinforcement of the discourses of normalcy which have given rise to and shaped the negative ways in which PwDs are viewed. In terms of this particular study, an understanding of this perspective will be used to explain the challenges experienced by women with disabilities resulting from the social order which reinforces the perspective. The concept of normalcy will be used to help understand and illuminate the effects of such categorizations and how they lead to the marginalization and oppression of disabled women in society.

In 2011 the World Health Organisation and World Bank declared disability an international development. However, so far disability discourses are hardly perceptible in the MDGs. The MDGs have been ranked as the foremost international development instruments in tackling poverty, as they have been considered the world's time-bound, quantified targets for addressing extreme poverty in its many manifestations while promoting gender equality, education and sustainability (Palmer, 2013). All these focus areas are important to women with disabilities as they may be at increased risk of experiencing continuous poverty, living as they do in environments characterised by a network of social constructions which revolve around sexuality, gender and disability. In the context of this research, being inhabitants of a rural setting compounds their state of poverty, stemming from non-access to resources and services.

An oversight of the actual expenses women with disabilities incur as a result of their physical condition aggravates their poverty. What is known is that disabled women find it extremely difficult to access micro-finance, with some notable exceptions, throughout the developing world, and that there are few designated social protection programmes for them (Palmer, et al., 2015). What is then ignored is the fact that there are additional economic costs associated with having a disability (Terzi, 2007), for example the purchase of assistive devices and transport costs to access services in distant places. These additional costs have a great impact on them as they are directly responsible for the care of their families, and seeing to it that all basic family needs are provided for.

Palmer et al. (2015) in their social anthropological study of disability in Tamil Nadu noted that there were additional direct costs for medical treatment, indirect costs regarding the provision of care, as well as the opportunity cost of income forgone that is a direct result of having impairment. In such a scenario, the society adopts a paternalistic attitude towards women with disabilities, whereby those in authority get to decide what is best for and only give them what they presume is needed. This invariably reduces them to poverty as their welfare then depends on what society can spare.Loss of opportunities, which is always the case with PwDs worldwide, deepens poverty and economic disability.

PwDs have often been ignored by society and their needs trivialised and this leads to their being socially excluded. One of the faces of social exclusion as propounded by Palmer (2015) is economic exclusion, which effectively means exclusion from employment and access to property or credit. This condemns women with disabilities, among other vulnerable groups, to a life of poverty. The findings of the WHO and World Bank report (2011) asserts that women with disabilities worldwide have fewer chances of accessing educational, sanitary and economic opportunities than women without disability. Women in this group are more likely to suffer extreme poverty than their able-bodied counterparts as they have an intersection of vulnerabilities which include among others, disability, advanced age, illiteracy and poverty.

Current debates and discourses on disability are beginning to show that the challenge of poverty among persons with disabilities and households with disabled members may be more complex and nuanced than originally thought (Groce et al., 2011). The relationship between poverty and disability is such that either one may cause the other, or their presence in combination may be very likely to inflict challenges that are devastating to the individual and her household. Eide and Ingstad (2013) posit that the Foundation for Scientific and Technological Research (SINTEF) together with the Southern Africa Federation of the Disabled (SAFOD) and other institutions conducted a survey on living conditions of PwDs in seven countries – all in Southern Africa. From the studies, it was established that there are gaps in access to services for PwDs especially those in rural areas who cannot afford even the basic assistive devices, for example wheelchairs and crutches. From this research, key indicators in education, health and employment to mention but a few, indicate that there are gaps in access to services for PwDs as a direct result of the between disability and a low standard of living (Eide and Ingstad, 2013). Women with disabilities in rural areas were found to be worse off compared to their counterparts in urban areas. This study takes account of these factors and findings, namely that the relationship between poverty and disability might be more complex than it at first

appears, and secondly, the differences in context and the heterogeneous traits of the population in different contextual settings (Eide and Ingstad, 2013).

In 2002, the former President of the World Bank, James Wolfensohn, stated that without addressing disability issues, the United Nations Millennium Development Goal objectives would not be realised (UN MDGs, 2013). The fact that PwDs are not included in any of the MDGs and related targets and indicators, represents a lost opportunity to address the pressing social, educational, health and economic concerns of this marginalised group (United Nations, 2010). From a global perspective, it appears there are two main reasons why the international community did not include disability on the global development agenda. These reasons have a strong connection to this study. They are as follows: Firstly, disability has largely been perceived as a personal tragedy owing to the fact that PwDs have been incorrectly seen as subjects whose lives are determined by their impairments and therefore by their medical needs. Secondly, PwDs are largely seen as passive recipients of charity and support; this is based on the assumption that their capabilities and functionings are non-existent.

Be that as it may, development practitioners and agencies are gradually identifying disability as an issue of paramount importance, inexorably linked to the extension of human rights, economic empowerment and citizenship (Nussbaum, 2004). On the international scene, as far as disability is concerned, a significant milestone was that the United Nations, working with civil society institutions, has successfully negotiated a convention concerning disability rights, ratified at the 61st Session of the General Assembly in December, 2007. The signing of the UNCRPD is a crucial international milestone supporting the international disability rights movement. It adds a new dimension to the rights of PwDs by moving away from a perception of them as objects of charity, medical treatment and social protection, and towards a different perception, as equal citizens with rights (ILO, 2013). States and countries that have ratified to the UNCRPD are still to implement the convention for the benefit of PwDs.

The World Disability Report (WHO and World Bank, 2011) indicates that an estimated 15% of the world's population lives with some form of disability. Of these, 75% live in developing countries and constitute one of the most marginalized, poor and socially excluded groups in any society (Eide and Ingstad, 2013). This has prompted research into the exact nature of the challenges PwDs experience, with a focus on women with disabilities in rural Zimbabwe with its unstable economic environment. Women with disabilities, regardless of where they live, are statistically more prone to unemployment and illiteracy; they have lower levels of formal education and limited access to advanced support

networks and social wealth than their male counterparts (Jones, 2011). In the context of this study, this compromises their individual agency (a construct of the Capabilities Approach, expounded in chapters 2 and 5) because instead of being given fair opportunity to negotiate their standard of living, they are automatically branded as dependants.

While public attitudes are changing, illiteracy rates among women are falling and more women are entering the labour market, the situation is different for women with disabilities, who remain a burden to their families or the state and are likely to be dependent for the rest of their lives (Rehabilitation International, 2000). The consequences of disability are particularly serious for women as they are also more likely to be unmarried or socially isolated due to stigma, myths and fear associated with disability. They are usually subjected to social, cultural and economic disadvantages which impede their full participation in community development programmes (Camay and Gordon, 1998). The International Labour Organization (2002) echoes this finding, that if women are physically or mentally disabled, their chances of overcoming challenges are diminished, which makes it all the more difficult for them to take part in community life. In families, the responsibility for child care lies with the women and this limits their freedom in taking part in other initiatives. This situation is significantly exacerbated by the unsystematic approach to disability, where interventions to incorporate the disabled into societal structures and systems are non-existent in Zimbabwe.

Mitra et al. (2011) assert that women in capitalist economies suffer the effects of capitalist exploitation of the working class, and alienation from the means of production. This therefore implies that PwDs are largely excluded because they are perceived to hinder the progress of capital growth (Oliver, 1996) because they are unproductive as a result of their impairment. This promotes the understanding of disability as a personal tragedy, as PwDs continue to live as dependants whose welfare should have individualised solutions (Bitar, 2013). This leads to their attempts to engage in a wide range of coping strategies to cushion themselves from the effects of the challenges experienced in living with disability. This study takes a mixed approach (socio-economic, political and cultural) aspects (Mitra et al, 2011) in order to facilitate the exploration of its theme – the experiences of disabled women in rural regions, with a specific focus on their challenges and coping strategies. Thus it follows that PwDs are excluded not only because of the capitalist mode of production, but also because of socially constructed prejudices which are enshrined in cultural representations and myths.

Regionally, the literature on disability indicates a lack of research on the complex relationship between the effects of disability and gender. The social constructions associated with gender and

disability produce discourses which reinforce social stigmatising and dehumanise women with disabilities. Africans are generally religious, spiritual, mystical and superstitious (Mbiti, 1992). These attributes influence their perceptions, attitudes and reactions towards and about many issues, including disability. Given such a scenario, the African conception of disability is also mystical, spiritual or magical.

The aforementioned perception of disability results in certain misconceptions (harmful myths/societal perceptions) about women with disabilities, which undermine their agency. Therefore in the context of this study, this perception of disability was also ranked as a factor that contributes to the challenges currently experienced by women with disabilities. This perspective reinforces the notion of perceiving disability in a paternalistic manner as women with disabilities are infantilized and imagined as helpless victims (Barnes and Mercer, 2010). The cultural beliefs and practices are a backdrop to stereotyping, discrimination, stigmatization which eventually leads to social exclusion. When women with disabilities are excluded from mainstream activities, they are left to fend for themselves, resulting in the adoption of a variety of coping strategies. In this study, these coping strategies have been found to be stop-gap measures which offer temporary remedies to the on-going challenges posed by living with disability in a rural setting.

The disability survey conducted in Zimbabwe revealed that individuals with disability, especially women, reported being divorced or widowed as a result of discrimination, stereotyping and stigmatisation more often than able-bodied women (NSDH, 2013). Stereotypes and misconceptions about disability generate negative attitudes towards women with disabilities, leading to their being under-valued in society, and not viewed as equal citizens with legal rights (Swartz, 2014). The personalistic view of the disabled, that characterizes disability as a personal tragedy, finds breeding ground in such attitudes. Munsaka (2014) has it that social exclusion refers also to those processes by which a group or some groups of people are pushed to the margins of society, whether this be in the labour market or the welfare system, and that these processes lead to intergenerational poverty. The experiences of disabled women in rural areas and the bi-directional link between poverty and the lack of resources, and gender results in discrimination which in turn exposes women with disabilities to social injustices (UN, 2010). Further, due to discrimination, employers may not be willing to employ a person with a disability (Mapuranga and Mutswanga, 2014; ILO, 2011).

The research conducted by DFID in 2007 revealed that PwDs encounter multiple attitudinal, environmental and institutional barriers that militate against their effective inclusion in Zimbabwean

society (Lang and Charowa, 2007). It is a common perception in Zimbabwe, especially in rural areas, that PwDs are passive and economically unproductive and therefore constitute a burden upon society. Marongwe and Mate's 2007 study of disabled children in Zimbabwe provides a very insightful sociological analysis of the barriers that PwDs and their families encounter. They argue that insufficient or non-existent amounts of human, social, physical and financial capital significantly compound the exclusion and marginalization of PwDs in the country (Marongwe and Mate, 2007). In the case of Zimbabwe, where there is an economic crisis, availability of any form of capital to assist women with disabilities is just a pipe dream.

The plight of women with disabilities in rural areas is particularly precarious, as they often lack opportunities which the mainstream population have and are usually among the marginalized in society (Munsaka, 2012). Women with disabilities are generally discriminated against and regarded as sub-humans who cannot do anything on their own and have to rely on the goodwill of others for survival. This discrimination suffered by disabled women is often ignored or goes unnoticed because they are not considered to be equal human beings who are capable of taking control of their lives, and therefore their agency is suppressed (Mitra et al., 2011). For a woman, stigmas related to gender and disability renders her powerless and compromises her autonomy in making decisions based on her freedom and choice. It is against this background that this study strives to explore the challenges experienced by women with disabilities, and examine how these challenges reflect on aspects of exclusion which result from being excluded from international development discourses.

Traditionally in Zimbabwe, as in many other countries, the families of PwDs have been responsible for taking care of them. However, the pressure of economic crises at times leads to urbanisation and changing patterns of employment, which in turn leads to urban migration. This has resulted in the breakdown of the extended family system (Peters and Chimedza, 2001). Due to limited family support, women with disabilities have been locked up in houses and placed in institutions and are generally seen as burdensome (Peters and Chimedza, 2001). Tolerance of PwDs has also tended to diminish sharply during periods of economic hardship (Turnbull, 1992), hence their efforts in engaging in the informal sectors of the economy to fight their challenges.

In Zimbabwe, the current economic situation has made things even more difficult for women with disabilities, especially those currently living in rural areas. On the one hand the Zimbabwean government is clearly focusing on turning the economy around, while on the other hand the need to develop effective responses to HIV and AIDS has taken precedence, reducing the scope for

addressing a wider range of social needs for women with disabilities in Zimbabwe. Further, as a result of the economic meltdown in Zimbabwe, there is substantial evidence that social safety nets for the poor and vulnerable groups including women with disabilities have been rendered ineffective (Gandure, 2009).

The findings derived from this study confirm the notion that women with disabilities in a rural setting do not have access to services and resources. This agrees with the findings which were recorded in a study conducted in Zimbabwe by the Disability HIV and AIDS Trust (DHAT) in 2011 which established that access to information, education and communication (IEC) material on HIV and AIDS by PwDs was characterised by limitations. This challenge is compounded by the fact that information available on sexual reproductive health and HIV and AIDs is not found in accessible formats to PwDs who have visual impairments, or speech and hearing challenges (DHAT, 2011). The health centres available in rural areas are located far from the majority of PwDs, posing challenges to those who have mobility constraints. Even those that are available, though very distant from the homes of disabled women, do not have trained personnel to deal with PwDs. For example, they do not have sign language interpreters or communication aids to facilitate communication with PwDs (DHAT, 2011). This then leaves no option for the PwDs, but to invent coping mechanisms, short-lived as they may be, to survive in an environment that hardly acknowledges their existence or the needs they have in their everyday life.

Challenges for women with disabilities in rural areas arise from lack of IEC material on HIV and AIDS. They are victims of sexual abuse and rape, where most of the cases are not reported due to lack of adequate information on the proper procedures to apply in such cases. Proceeding from the above assertions, similarly, when women lack access to a range of services, for example, modern methods of contraception, they are less likely to be able to plan if and when they want to have children. This can lead to poor health outcomes, including higher rates of maternal mortality and morbidity as well as poverty (Sexual Rights Initiative, 2013). These findings confirm what was advanced by DHAT (2011), who identified the neglect of PwDs' sexual and reproductive health as a result of a number of factors, which include the erosion of their rights and freedoms due to marginalization, the denial of the right to establish relationships and to decide when and with whom to have a family in some instances, and the assumption that they are sexually inactive. Further, these findings are in line with observations made by NASCOH (2005) which revealed that PwDs have limited mobility due to lack of assistive devices which would aid them in enhancing their functionalities. Inevitably, the personal agency of the PwDs is grossly violated.

Legislation defines a set of entitlements which reinforce the equitable sharing of available resources and opportunities, thus it becomes the principle by which every human being can claim justice and equality (Nussbaum, 2011). The availability of supportive legislation through policies and laws (Mandipa, 2013) underpins the provision of such entitlements which accord them the rights of access and provision of services as well as capabilities and functionings, which are freedoms that PwDs should enjoy (Sen, 1992; 2005). The absence of such entitlements on the basis of legal provisions, in Zimbabwe, restricts disabled women's access to services and resources, thus depriving them of their capability sets and functionings (Sen, 2005). In the absence of enabling legislation, efforts towards fighting social injustice affecting women with disabilities in various spheres of society may not be considered fairly. This is especially true in the case of people with disabilities, where this sector of the population is referred to as a minor group (Munsaka, 2014).

It is important to point out that the Zimbabwean government has enacted policies of recognition and empowerment targeting women. The Disabled Persons Act (DPA) of 92/96, together with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) which the government ratified in September 2013, became a milestone to support the government's endeavours, mainly earmarked to alleviate the consequences of different factors inflicting social and economic insecurity on women with disabilities and their able-bodied counterparts. These policies and legislation that exist on paper have not worked successfully and with the emergence of the recent economic crisis and of the challenges experienced by PwDs, the policies and legislation, which remain paper policies only, have been rendered almost useless. This is because the situation of those who are supposed to benefit from it has not changed despite the existence of the legislation. In fact, the available legislation on disability continues to be removed from the everyday realities of life for disabled people (Munsaka, 2012).

Section 83 of the Zimbabwean constitution states that provisions will be availed to PwDs 'if and when resources allow'. The phrase 'if and when' denotes a conditional approach to intervening in certain situations, one which does not oblige the government to act. What this implies is that, in the ongoing economic crisis, characterised by retrenchments and liquidity crunch, the promise of intent spelt out in the constitution but constrained by the conditional phrase, 'if and when' may never materialise. This is the unsystematic approach to disability that plagues the lives of women with disabilities in Zimbabwe in the crumbling economic environment. In addition to this, cultural beliefs

and practices complicate the matter further. The onus is then on women with disabilities to forge ways of coping in their various communities.

The absence of a functional and robust disability policy in the country (Mandipa, 2013) has led to a situation whereby PwDs have fallen between the cracks and women with disabilities are the most affected as they suffer stereotyping, stigma and discrimination which in turn lead to low levels of formal education and a lack of access to information and services. This results in socio-political and economic exclusion (Hedge and Mackenzie, 2012). National policies on disability should inspire aspirations in individuals through helping them to understand the platforms that they could use. These policies should also provide entitlements and rights rather than restrict PwDs, as this creates capability deficits (Nussbaum, 2011). Therefore, through using the CA as a framework for the formulation of policies for PwDs, a government is able to effectively evaluate and assess the well-being of individuals (Robeyns, 2005) and provide an ethical foundation for the pursuit of the social and economic empowerment of women with disabilities so that they can have equal opportunities to pursue their desires and aspirations.

2.3 Disability Models

Models of disability create the basis upon which disability in society is conceptualised. Given such a scenario, there is unanimity among scholars that the experiences which characterise the life of PwDs are influenced by particular philosophies and ideologies that underpin the values of that society. In general, these models contribute an insight into the stereotypes, prejudices and misconceptions of disability. Sibanda (2015: 219) argues that "…the models on disability should not be viewed as if they were in competition for superiority but as providing a continuum of social attitudes towards disability". In this case therefore, the study does not present the models as theories of disability per se, but as Michael Oliver has argued, 'Models are ways of translating ideas into practice' (Oliver, 1990: 19). The models in this study are therefore briefly discussed to highlight how some of them might have contributed to the stereotypes, prejudices, paternalism and discrimination currently being experienced by disabled women in society.

According to Munsaka (2013: 22), 'in common use of language, a model is a simple and sometimes simplistic representation to help understand the more difficult properties of a real-life situation, and inadequate to explain or interpret a phenomenon'. Models result from certain milieus and they are fashioned to respond to certain questions relating to a given phenomenon. In responding to these questions, owing to certain backgrounds, models clarify and organise a set of practices which might

be solutions to certain challenges (Munsaka, 2013). In this case the CA is used as a lens through which the study findings will be viewed and understood in order to illuminate the challenges experienced by rural women with disabilities, as will the coping strategies they adopt to cushion themselves against the challenges. This is the context in which the CA is to be understood in this study. In what follows, the study briefly discusses the models of disability, showing their strengths and weaknesses while at the same time highlighting some of their gaps in understanding, of the experiences of PwDs, gaps which the CA has the potential to close.

2.3.1 The Medical Model of Disability

This model is very common in traditional frameworks and reactions towards PwDs, as it was fashioned within the paradigm of understanding disability as a personal attribute. It appears that the model is not associated with individual scholars and therefore it has been argued that it was coined by disability activists who were critical of the dominance of the clinical approach to disability just after the Second World War (NASCOH, 2012; Yeo, 2001). It is a model which focuses on and emphasizes the impairment rather than the capabilities of the individual affected by disability (Mitra, 2006). Thus, disability in this model is viewed as a direct product of an individual's impairment (Oliver, 1990) which leads to a loss in their functional ability. In this case, impairment is regarded as a disease whose cure lies in medical or technical interventions offered by experts or health professionals (Shakespeare, 2004).

This means that treatment and rehabilitation are at the centre of dealing with the plight of PwDs as they are considered to be sick (Parsons, 1975), despite the fact that it may not be possible to medically treat or correct most of the disabilities that such people will have (Shakespeare, 2013). The model also emphasises the role of specialist schools and other similar institutions and reduces PwDs to passive benefactors of the help of well-wishers in society (Mtetwa, 2012). The implication of the Medical Model is that a person with impairment has limited capacity and his/her life is characterised by dependency, and being recipients of charity and hand-outs from able-bodied people (Oliver, 1990; Finkelstein: 2001). Since the model foregrounds pity and the need to help PwDs, it is home to the paternalistic approach to disability in Zimbabwe. As such, the model promotes the role of charity as a solution to the problems brought by disability, which has the negative effect of isolating and segregating people from mainstream society.

Whilst the model can be celebrated for acknowledging the role of medical requirements for a person with a disability, it is silent on the notion of equalizing opportunities for PwDs as part of an effort to

alleviate the challenges they experience, by way of addressing issues of social equality and access to their fundamental and inalienable human rights (Oliver, 1990; Mitra, 2006). The major constructs of the Medical Model seem to promote the notion of understanding disability as a personal tragedy, especially when efforts to rehabilitate and correct the impairment of an individual fail. The fact that PwDs are regarded as sick people deprives them of the rights to freedom and choices, and to live life according to their full potential.

In the context of this study, the Medical Model therefore fails to take into account how cultural beliefs and practices can play a role in subordinating women to acts of social injustice which contribute towards limiting their opportunities in life. Thus, this perception prevents society from addressing the structural patterns that compromise their agency and independence in life (Shakespeare, 2004). The model has also largely been erroneous in generalizing and therefore categorizing PwDs as a homogenous group that suffers from medical challenges (Shapiro, 1993). In most cases, the model has been blamed for leading to the oppression of PwDs, especially as it affects their personhood (Shakespeare, 2013). Therefore, the Medical Model has been a significant contributor to the stigmatization, discrimination and isolation of people with disabilities globally (Mtetwa, 2012).

The relevance of the Medical Model of disability discourses, however, should be acknowledged in addressing the effects of the impairment on an individual to enhance their capabilities and functionalities, and become active agents of change regarding their plight in society. Focusing on an individual's impairment in order to address its effects is a step towards equalizing opportunities for a person with a disability so that they can participate in mainstream society (Shakespeare, 2004). However, with the passage of time, it was suggested that there is need to have a more sustainable positive impact on the life of an individual with a disability, by addressing the structural causes of disability rather than focusing on it as an individual attribute. This conceptualization of disability gave rise to the Social Model.

2.3.2 The Social Model of Disability

The Social Model emerged on the scene in the 1970s (Shakespeare, 2004) as a product of the structuralist paradigm. It entered the realm of scholarship as a result of the publications of Finkelstein (1980) and Michael Oliver (1990). It differs from the Medical Model in that disability from the perspective of the Social Model is not a result of impairment (Munsaka, 2012; Oliver, 1996) but rather a result of society's failure to take note of different barriers that stand in the way of PwDs becoming independent people. This model is therefore a departure from the Medical Model especially

as it presents a shift from the focus on the individual with a disability, to the environment and society, especially the ways in which it excludes, discriminates and segregates PwDs (Mitra, 2006). The Social Model arose as a challenge to the traditional approaches to disability which championed medical and rehabilitation interventions. In this endeavour, the Social Model pushed for the removal of barriers, and for policies against discrimination. These barriers, it argued, have a social origin but cannot be addressed by medical and rehabilitation interventions (Michael Oliver, 1996). Munsaka (2011: 26) argues that the Social Model emerged from the platform of resistance against the Medical Model, "representing an attempt to redress the power balance between disabled and non-disabled people". Thus, the Social Model became a force to reckon with in the disability field as it took centre stage in advocating for disability mainstreaming in most societies (Mtetwa, 2012).

The Social Model proposes that disability is viewed in the light of the rights which people are entitled to and in this it shares some commonalities with the Capabilities Approach (Bickenbach et al., 2014) in that both models take the position that social justice is a key issue in addressing disability challenges (Nussbaum, 2011). With this understanding, both models provide the lens through which the notion of disability as a personal tragedy can be addressed by taking into account how disability can be perceived from a structuralist perspective. Therefore, the challenges experienced by rural women with disabilities should not be wholly understood as emanating from the effects of their impairments only, but also from structural and other socially-constructed factors.

Following from the aforementioned sentiments, the model takes into account the social effects of having a disability and emphasises the role of physical, political, cultural and economic forces in producing a disability (Oliver, 1996; Shakespeare, 2013). It also emphasises the problems of exclusion, discrimination and oppression of PwDs by several social and economic barriers (Shakespeare, 2013). Thus the model defines disability as arising from various structural characteristics within different societies (Oliver, 1990). The model therefore posits that if the environment in which a person with a disability exists is made more appropriate to their impairment, then their disability has minimal effects. As such, it is a model that highlights the role of policies and interventions to help ameliorate the plight and concerns of PwDs.

In brief, the importance of the role of the Social Model cannot be underestimated in the discourses on disability. However, there are also some limitations to the Social Model. Like the Medical Model, the Social Model falls into the trap of treating PwDs as a homogenous group as it fails to recognize that different individuals with impairments do not encounter exclusion, discrimination and oppression in

the same manner, and as such have slightly different experiences (Shakespeare, 2013). For example, in the context of this study, the Social Model has no capacity to engage with problems of customary gender roles, which everyday experiences of women with disabilities, especially those in a rural setting, who experience specific and multiple challenges owing to their multiple identities. The Social Model has thus been criticized for its failure to account for the ambiguities that operate when individuals with disabilities relate to their different environments.

The model neglects the role of impairment and how it affects a disabled person's functionality (Shakespeare, 2004). The gap in literature which this study seeks to complement is how women with disabilities experience specific challenges owing to their personal experiences in their respective societies, especially on the basis of their impairments. Impairments remain a major challenge even where accessibility challenges have been addressed. By excluding the individualised experiences, a lacuna is left, which other approaches attempt to fill. All of these approaches have individual lenses to analyse specific individual experiences. The criticism levelled against the Social Model poses important insights that are relevant to the main research question of this study, focusing as it does on the individual challenges of rural women with disabilities, and the coping strategies they employ against the rising severity of those challenges. In the next section, the study explores how disability is understood and conceptualised from a cultural/religious model of disability.

2.3.3 The Cultural/Religious Model of Disability

This model of disability portrays a completely different perspective on disability when compared to both the Social and Medical Models of disability. It is underpinned by religious/cultural perceptions of disability as opposed to scientific conceptions of disability seen in the Medical and Social Models of disability. From a historical perspective, different social groups have been known to enforce different norms and values which are socially distinct. Africans are generally religious, spiritual, mystical and superstitious (Mbiti, 1992). These attributes influence their perceptions of, and attitudes and reactions to many issues including disability. Given such a scenario, the African conception of disability is also mystical, spiritual or magical. The aforementioned perception or conception of disability results in certain misconceptions and harmful myths about PwDs. This African worldview is full of stereotyped concepts, prejudices and negative attitudes about disability which are so deeply rooted that they greatly influence the way disability is perceived in many societies (Chiparaushe et al., 2011).

Mtetwa (2012) has it that Zimbabwe as a country has specific cultural values and traditions, like any other country, which contribute towards the relegation of PwDs as a result of cultural beliefs and practices. These cultural practices and traditions breed negative attitudes which normalise the notion that PwDs are objects of pity (Choruma, 2007) and in this way they are relegated, isolated to the periphery of the society where they live in obscurity, silent misery and total social and economic dependency (Eide and Ingstad, 2013). When such things happen, then disability remains a personal tragedy as PwDs are left to devise ways and means to cope with the challenges experienced in living with disabilities. These cultural values are a product of traditional and primitive practices based on religious and superstitious beliefs (Mbiti, 1992). The patriarchal hold has had a strong influence on power relations between men and women, resulting in socio-political, economic and cultural power being vested in able-bodied men as opposed to women with disabilities. The discourses of disability therefore have been conceived within the precincts of both cultural and religious beliefs, resulting in disability being perceived as a personal tragedy. This is further compounded by the fact that it happens in a society which lacks a systematic way of equalising opportunities or a way of addressing the challenges experienced by PwDs through the enhancement of capabilities and functionings.

The African worldview has influenced the way in which disability is understood in Zimbabwe. A number of Zimbabweans' perspectives on disability are based on spiritual beliefs, which are reflected in attributing the causes of disability to evil spirits, witches and wizards, family or ancestral curses, disobedience to ancestors and gods, societal violations of traditional rituals and taboos, and a lack of faith in God (Chiparaushe et al., 2011). Given such a scenario, it is apparent that women with disabilities in Zimbabwe constitute one of the most poor, socially excluded and marginalized groups within the country owing to these cultural or religious beliefs. As a result, they have always been perceived to be a burden to their family members who in turn may neglect them since disability still remains a personal tragedy more than a social condition. This is compounded by a failure by society to facilitate their economic independence by equalizing opportunities through the enhancement of capabilities and functionings.

Therefore, the Cultural/Religious Model is underpinned by notions of giving out hand-outs to PwDs since they are perceived as 'minors' (Munsaka, 2012) who should be taken care of for the rest of their lives. Such beliefs based on culture, are far from realising the agency that PwDs have in bringing about change in their lives. Stigma, stereotyping and discrimination affecting rural women with disabilities are direct products of cultural and religious practices which promote social injustice among PwDs. Such beliefs and practices are not based on "objective, scientifically based knowledge"

(Munsaka, 2012: 36). The cultural model like the Medical Model created a dependency syndrome which formed the basis of begging as a survival strategy, which has become synonymous with disability today in Zimbabwe (Munsaka, 2014).

2.3.4 The International Classification of Functioning (ICF)

This model, which is also referred to as the Bio-Psychosocial Model of disability (Bickensack, Chatterji, Badley and Ustun, 1999), was developed in the early 1980s by the World Health Organisation and it was by then referred to as the International Classification of Impairments, Disabilities and Handicaps [ICIDH] (Mitra, 2006). Later on, the constructs of the model were revised leading to a change in name and it is now currently referred to in modern disability debates as the International Classification of Functioning, Disability and Health (ICF). The ICF was developed in a bid to integrate the Medical Model and the Social Model (Altman et al., 2001). The World Health Organisation (2011), in its attempt to explain the emergence of the ICF, adduces that the model aims to synthesize the views of medical and social models coherently so that there is a fair representation of different perspectives from a biological, individual and social perspective. The ICF maintains that disability is a result of health conditions that create impairment in an individual, which in turn leads to activity functional limitations and restrictions in participation in a given context (Bickensack, Chatterji, Badley and Ustun, 1999).

The ICF defines impairment as a problem emanating from bodily operations or functions, thereby creating a loss or deviation (Mitra, 2006) in the way individuals should function. Mitra (2006:238) further argues that according to the ICF, "an activity is the execution of a task or action by an individual and participation is the lived experience of people in the actual context in which they live". Altman (2001) posits that participation according to the ICF should not be conceptualized in terms of the roles an individual has to play but should take cognizance of the involvement of an individual in life's daily activities, as well as their need to access resources vital to sustain their lives. According to the ICF, disability and functioning are the main terms in understanding the major tenets of the model. Functionality includes the functions of the body in its entirety including the structures, activities and participation, whereas disability is marked by impairments, limitations in activities and also restrictions in participation (WHO, 2011).

According to Mitra (2006) the ICF's uniqueness as a model emanates from its attempt to offer a classification of individuals on the basis of two concepts, namely capacity qualifier and performance

qualifier. A capacity qualifier according to the model provides a measurement of a person's ability to perform tasks in a standard environment, to curb the impact of the environment on the performance of an individual. A performance qualifier provides a measurement of the lived experiences of persons with disabilities in the context in which they actually live. On this basis there is therefore a connection in terms of emphasis on the definition of disability presented in this approach (ICF), as well as the one that the capabilities approach proposes (Walker, 2006).

However, as a weakness in the ICF, the World Health Organisation (2001) notes that in the ICF, there is an acknowledgement that a person might have a restriction in terms of participation due to a number of factors, including personal characteristics. In doing this, however, Bickensack, Chatterji, Badley and Ustun (1999) note that the ICF does not do justice to other circumstances which are non-health related, for example socio-economic factors. Therefore, the ICF limits itself to the issues that are health related. The ICF takes into account the fact that what an individual achieves economically is a result of the remuneration she gets from her employment, as well as the economic benefits she derives from participation. This, however, does not take into consideration how the resources available to an individual and the economic environment contribute to someone's disability (Mitra, 2006). The ICF simply mentions these issues but neglects to give them proper attention in in the discourse on disability.

In the current disability discourses, there has been a recognition that both social and environmental factors contribute to disability as a phenomenon. The transition from the medical perspective (in which disability issues were individualised), to a structural, social perspective (Shakespeare, 2013) has been described as a shift from the Medical Model to the Social Model, in which disability is conceptualised as a product of structural and social aspects rather than an attribute of a person (WHO and World Bank Report, 2011). With the emergence of the ICF, views from both the medical and the social models were synthesized in an attempt to create a fair representation of different perspectives from which disability as a concept could be discussed (Altman et al., 2001).

2.3.5 Capabilities Approach

Nussbaum and Sen's versions of the CA will be advanced as a framework of analysis for this study as these authors emphasize how social injustices affect the wellbeing of individuals with disabilities. Common to the CA and the human rights based approach is the belief that all people, by virtue of their humanity, have a few core entitlements which society has a duty to respect and protect (Rioux and Riddle, 2011; Nussbaum, 2011). Nussbaum and Sen's version of the CA contributes towards

understanding why disability is a human rights issue by concentrating on the aspects of social injustice that affect an individual's well-being. This is demonstrated by attempts to understand why failure to address the adverse impact of disability on functionings such as education and employment is a matter of social justice (Munsaka, 2012). MacKenzie (2012) weighs in on this matter by arguing that the CA can be a tool with which to work towards inclusive societies where every person is treated with respect and valued as a worthy member of society.

However, even though it has been chosen as a framework of analysis for this study on the basis of its relevance in engaging with discourses of disability and development (Munsaka, 2013), the CA did not emerge as an approach to address disability issues per se. As such, the CA has been used in a variety of disciplines including welfare economics, development, social policy and political philosophy (Munsaka, 2013). As a result, it has been subject to academic debates and different scholarly interpretations whose contributions will be illuminated in subsequent discussions (Brighouse and Robeyns, 2010). However, despite divergent views from different scholars, emphasis on how social injustices affect the wellbeing of persons with disabilities (as the major construct of the approach to be used in this study) has remained almost uniform.

The CA owes its credit to the economist Amartya Sen and the philosopher Martha Nussbaum, the two foremost contributors to the development of the approach. Sen was influenced by his background in economics and therefore he writes about the dominance and inadequacies of the Gross Domestic Product (GDP) as a measure of the well-being/quality of life of people, or as an indicator to measure human development (Munsaka and Charnley, 2013; Vizard et al., 2011). In welfare economics, one of the major weaknesses of the GDP (as an indicator) was its neglect of important aspects of development such as income inequalities, unemployment and disparities in access to opportunities and services like health and education (Nussbaum, 2011). However, in place of GDP, the CA argues for the vitality of individual functionings and capabilities (Sen, 1999) as indicators to measure the well-being of people. Hence, in using the CA as a framework of analysis, the ultimate goal in this study shifts from a narrow concern about economic growth and other economic indicators to the overall well-being of women with disabilities. By implication therefore, empowerment and participation of women with disabilities on the basis of social justice become crucial aspects of the CA which benefit this study. Within this context, the CA places the definition of disabilities within the wider spectrum of human development, shifting the focus from the specificities of the disabling situation to looking at establishing equality in terms of access to real opportunities, freedoms and choices.

The CA goes beyond the traditional models on disability by putting emphasis on individuals' well-being (Trani et al., 2011). Within this scenario, well-being revolves around two main concepts: capabilities and functionings – aspects which were not explored in other disability models. Existing models of disability are limited in their understanding of the challenges experienced by women with disabilities. In this study, the CA poses a better approach in understanding the multiple oppressions which result from social injustice. Furthermore, the models of disability do not address the freedoms and choices of disabled women. It is in this context that I situate this study, using the CA as a framework of analysis whose lens focuses on individual well-being, while taking account of the relationship between the individual and social structures and dynamics which may be the source of social injustices which in turn affect the individual's ability to be functional (Mutanga and Walker, 2015).

Following Sen's CA, 'capability' is defined as a practical opportunity and 'functioning' is defined as the actual achievement of an individual through the activities he or she does (Sen, 1999; Robeyns, 2005; Mitra, 2006). Capabilities as practical opportunities are based on an individual's freedom and choices in a just society (Sen1985a; 1985b; 2002), thus he often equates capabilities with freedoms, which he says are of primary moral importance (Robeyns, 2011). The study acknowledges that the presence of impairment affects the practical opportunities and freedoms an individual should have (Mitra, 2006). From the perspective of the CA, deprivation, and failure to access opportunities for an individual with impairment are what leads to disability (Mutanga and Walker, 2015; Mitra, 2006). In the context of this study, women with disabilities face the challenges of deprivation and failure to access opportunities as a result of social exclusion, which bars them from achieving their potential, coupled with the challenges of failing to participate in society. In the context of this study, the CA contributes a lens that helps to illuminate the social and cultural interactions and dynamics which make up the society in which women with disabilities live. The model casts light on public policies, social norms, practices that unfairly discriminate, as well as patriarchal domination and other aspects of power relations (Robeyns, 2005).

By taking into consideration how social injustice affects disabled women's freedom and choices, the CA moves beyond the dual framing of disability in the individual (stigmatizing the disabled) or the social environment (treat all as equal, including the disabled) to a relational approach that considers both individual impairment and the social arrangements (Mutanga and Walker, 2015). In this way, the CA alerts us to be aware of individual disparities (such as those based on gender, class, ethnicity, and

level of education), and those that exist between communities and nations. The interventions for individual and society have to be different (Terzi, 2010). Thus, the CA can also be used to redefine the negative attitudes towards women with disabilities in order to design more inclusive policies targeted at addressing their challenges and taking into consideration what they are able to do, rather than putting emphasis on their limitations (Terzi 2005).

In this study, this is one way in which the significance of the CA compared to other disability models is demonstrated. The exercise of individual freedom and choice (which is overlooked by other disability models) is important in shaping the well-being of women with disabilities. The discourses of normalcy arising from cultural beliefs and practices as well as the global discourse on knowledge emphasise individual differences. In this study, the use of the CA will foster the notion that instead of focusing on medical condition, policies would be targeted at addressing subtle forms of inequality in society that perpetuate social injustices (Mutanga and Walker, 2015). It considers the contextualised individual situations and what they are able to do. In this manner, it goes beyond seeing women with disabilities as lesser beings; it sees them as citizens with rights. The framework allows PwDs full participation in activities they value in their societies.

Nussbaum's perspective on the CA was influenced by the Aristotelian idea of what constitutes a good life (Nussbaum, 2011). Therefore, central to Nussbaum's idea is social justice which is central to a human being who hopes to lead a life worthy of dignity (Mitra, 2006). In her conception of the CA, Nussbaum argues that the CA can be seen as a kind of human rights based approach, as it supplements its language by being concrete, practical and connected to everyday life (Nussbaum, 2011). In its quest for development that focuses on people's needs and entitlements, the CA clarifies what a right entitlement based on social justice really secures. In this study therefore, it stands to be one of the robust ways of conceptualising disability, retaining a commitment to equality and justice for women with disabilities (Shakespeare, 2004). Therefore, based on these convictions, the CA, through its language of human rights, justifies claims to certain services and provisions that secure disabled women access to opportunities.

From the perspective of the CA, ensuring that justice prevails in society helps to ensure that the values most central to women with disabilities – empowerment, autonomy, inclusion, realisation of potential and dignity (Rioux and Riddle, 2011) – are all effectively promoted. The CA elucidates a comprehensive framework for promoting the well-being of women with disabilities, irrespective of the social construction of their abilities. It also provides better principles of social justice. In this

study, the CA through its articulation of social injustice, as it affects women with disabilities, identifies the major causes of inequality that are embedded in socio-cultural institutions that sustain the structures of discrimination (Turmusani, 2011). Having identified the sources of inequality, the CA then articulates a positive remedial approach to the problem of discrimination, and more generally to the exclusion and disempowerment of women with disabilities. A central feature of this remedial programme is facilitating access to equality on the basis of social justice. Working within the confines of a social justice framework necessitates developing rights and legal doctrines that can be enacted to guarantee the constitutional rights of women with disabilities.

The lens of the CA directs attention to any sources of social injustice that might constrain disabled women's access to opportunities in life. In the context of this study, the CA's framework of analysis helps in illuminating the social injustices which result from a failure by society to provide the enabling conditions that promote disabled women's quality of life; these injustices lead to their multiple levels of oppression. Therefore, according to Nussbaum (2011) social justice for PwDs should include the special arrangements required for them to lead a life of dignity, thereby contributing to the discourses of policies at national level. Sen (1999) states that people with disabilities may need different types and varying amounts of capability inputs (policies, resources, social norms changes, infrastructures, etc.) to reach the same level of well-being as the able-bodied. The notion of disability as a personal tragedy, common in Zimbabwe, based on the Medical Model does not necessarily address the need for policy changes.

Social justice emphasised in the CA (Nussbaum, 2011) would be best served by public policies which contribute to equalization of opportunities in promoting the well-being of women with disabilities. The CA further highlights how the challenges experienced by women with disabilities have to be addressed as a matter of social justice, since this contributes to the equalization of opportunities to achieve well-being (Mutanga and Walker, 2015). Focusing on the notion of social justice for women with disabilities provides a way of seeing past differences pertaining to their disability, in stigmatizing or discriminatory ways. Instead, it redirects focus from their impairments, to the opportunities available to them. Thus, in this study, it puts emphasis on factors that limit an individual in achieving her/his potential, thereby focusing on transforming barriers into opportunities prioritising one's experiences and desires.

Further, the CA is used in this study to illuminate how social injustice deprives disabled women of opportunities to develop their capabilities and achieve a state of well-being. Therefore, in this study,

the CA and the human rights approach can be said to pursue a common goal, as they both believe that all human beings have core entitlements which society has a duty to respect and protect (Nussbaum, 2004), and they both see the need to move away from the traditional ways of analysing disability issues. Nussbaum (2011) argues that it is the duty of Government to provide everyone with those freedoms, and failure to do so is regarded as a form of social injustice. This study explores the experiences of women with disabilities in Zimbabwe where the Government is so far incapacitated by economic woes that it is unable to make available such core entitlements. Nussbaum (2011) states that the capability approach aims to give people the necessary conditions of a life with human dignity.

In Nussbaum's CA, respect for dignity is considered to be a foundational principle which champions equality. Thus, in this study, the CA provides a platform to engage and to frame matters of justice for women with disabilities in the language of basic constitutional guarantees, and move from this consideration to place basic demands on governments in securing services and enabling the achievement of the rights of the disabled (Terzi, 2005). The approach promotes the participation of women with disabilities in development, and therefore the Government which mandates all development programmes should ensure that disability does not remain a personal tragedy. The CA enables the expansion of capabilities that foster social empowerment for women with disabilities. In this way, it contributes towards building a culture of acceptance, respect and inclusion of women with disabilities in mainstream activities.

2.4 Summary

This chapter has acknowledged the valuable insights provided by different authors in situating the study within the broad scope of literature, thereby describing the plight of women with disabilities. The description of the plight of women with disabilities was guided by the following research question set for the study: What are the challenges and coping strategies of rural women with disabilities set against the background of the economic crisis in Zimbabwe? On the basis of the research question, the study pursues the argument that the approach to disability in Zimbabwe is unsystematic, individualistic and paternalistic, thereby rendering women with disabilities vulnerable to multiple levels of oppression. In order to give a scholarly shape to this argument, in the first section of this chapter, I contextualized this study within disability discourses from the following perspectives: global, regional, and finally zeroing in on the Zimbabwean context.

In the light of this, the chapter also presented a discussion on the complexity, multidimensionality and dynamism associated with disability and in the process showed how different models of disability

conceptualize the phenomenon from different perspectives. Building on these models of disability, this study drew specific attention to the variables which the research question has identified. On this basis, it demonstrated how the CA appreciates the complex nature of disability by presenting a framework of analysis whose lens can assist in understanding the challenges experienced by women with disabilities in a rural setting. In the following chapter, the study looks at how the research question was used to gather relevant data for this study using a qualitative methodology.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter presents the discussion of the research design and methods that were used in the study to answer the following research question: What are the challenges and coping strategies of rural women with disabilities set against the background of the economic crisis in Zimbabwe? Using a qualitative research design, in this chapter I demonstrate how I answered the research question by arguing that the approach to disability in Zimbabwe is unsystematic, individualistic and paternalistic, thereby rendering women with disabilities vulnerable to multiple oppressions. To this end, the research instruments used in the study are discussed, and among these are interviews (in-depth and semi-structured), as well as focus-group discussions (FGDs) which were used to acquire primary data from the participants. The chapter describes the research site, Insiza District in Zimbabwe's Matabeleland South Province. This will be followed by a discussion on the paradigm of the research, i.e. the qualitative research design. Also discussed are the sampling procedures used in the study. The chapter then goes on to discuss data collection and analysis, and finally it addresses ethical considerations and limitations of the study.

3.2 Research Site

The research was undertaken in Insiza District which is located in the Matabeleland South Province of Zimbabwe. The district has a total population of 111,184 and is home to about 31,796 households (Insiza District Profile, 2008)[1]. Of the District's twenty-three wards, I selected only three wards, namely Sibasa (Ward 3), Sidzibe (Ward 5) and Ntute (Ward 11). These three wards were chosen because they are ranked high in terms of disability prevalence (JJA Baseline Survey Report, 2013). Further, like most rural areas in Zimbabwe, Insiza District is characterised by poor road networks which are not navigable by motor vehicle. My choice of these wards was therefore based on accessibility in this regard – most of the areas cannot be reached by road. The wards were also selected based on the assumption that seeking access to the participants through the focal persons or local leadership would not be problematic since I work for one of the humanitarian organisations implementing projects in these areas. Given this scenario, there were methodological implications for the study in terms of access. This will be discussed in the sections which follow.

3.3 Sample Size and Sampling Procedure

The research study consisted of two different categories of participants. These were: seven (7) key informants and ten (10) women with disabilities. Due to time constraints and the nature of the study, the sampling size was therefore kept at seventeen (17) to ensure efficiency in data gathering, and facilitate analysis. Women with disabilities constitute the first and primary category of my research participant population. For this reason they participated in both in-depth interviews and focus group discussions. Further, my choice of women with disabilities in rural areas was based on the conviction that they have long shouldered an unequal burden in development discourses due to discrimination and stigmatisation on the basis of gender and disability, among other factors. Rural women with disabilities also experience specific challenges, which include lack of access to resources and the domination of the patriarchal hold. These contribute towards gender inequalities.

Being pressed for time and having limited resources, I decided to work with a small sample of 10 women with disabilities; these women had visual and physical disabilities. The small sample of 10 women with disabilities was reasonable to work with given the fact that the research had to be conducted within a short period of time (12 months of the study). Despite these limitations, I ensured that the diversity of my research participants also constituted, as far as practicable, a representative sample in terms of age, gender, social class, level of education, and marital status, among other relevant variables, rather than categorising participants according to disability alone. However, the hearing impaired and intellectually challenged women were excluded from the study due to the fact that I chose to deal with a more representative sample – the disabilities of the women in my sample were ranked very high for prevalence in the area. The issues affecting the hearing impaired and intellectually challenged women require specific researches which target their challenges. For the hearing impaired, providing for varied means of communication for the participants, for example, sign language was not easy since I am not conversant in that language. Therefore, dealing with the physically and visually impaired was a more practical proposition, given the limited time within which the research was to be conducted.

Convenience sampling was used to select women with disabilities based on their proximity, being the closest and most available subjects. I was guided by Kothari's (1997) convenience sampling, which selects participants for inclusion in the sample on the basis of ease of access. Patton (2002) warns researchers that, whilst convenience sampling is a widely used sampling procedure, any study that uses it is in danger of being accused of lacking any clear sampling strategy. This is because the researcher chooses the sample according to ease of access and what is convenient for him. This

creates a challenge in that a balanced sample may not be achieved during data gathering. With regard to this research, some of the participants which I felt could present a better articulation of issues could not be reached because of poor road networks and I battled with accessibility issues during data gathering, hence the decision to use convenience sampling.

The exploration of the experiences of disabled women in rural areas also involved seeking the perspectives of seven (7) key informants who constituted the second category of research participants. Using purposive sampling, I selected two government officials whose professional duties are relevant to the study. One informant works in the Department of Social Services mandated to administer the implementation of the development agenda at district level, including disability issues, and the other, in the Ministry Of Women Affairs, Gender and Community Development that oversees gender mainstreaming in government activities in all Districts.

Two key informants, also working in areas relevant to the study were drawn from World Vision – an organisation that implements development programmes in the district, and the Jairos Jiri Association – an organisation implementing development programmes specifically targeting PwDs in that District. Three (3) further key informants (community leaders or focal persons) were selected from the three wards, one from Sibasa (Ward 3), one from Sidzibe (Ward 5), and one from Ntute (Ward 11). They were selected because they oversee the implementation of development programmes within their respective wards. The key informants were selected because they were judged to be good sources of information on disability issues in their respective departments/institutions/areas. This idea concurs with the view of Kothari (1997), who argues that purposive sampling involves a deliberate selection of particular individuals on the basis of specific characteristics. Therefore, the key informants were selected so that the study could benefit from their expert knowledge on dealing with vulnerable groups, especially people with disabilities (PwDs).

3.4 Research Paradigm: Qualitative Approach

Presenting a precise definition of a qualitative approach is not an easy task since the term is used as an overarching category encompassing a wide range of approaches. Denzin and Lincoln (2000) argue that qualitative research is an endeavour that involves situating the researcher in the natural world in an effort to make the world visible through the use of certain naturalistic interpretive practices and skills. This implies that qualitative research studies things in their natural state in an attempt to make sense of or interpret phenomena in terms of the meanings people attach to the social world (Bryman, 1988). Lewis and Ritchie (2003: 3)provide a comprehensive definition: “Qualitative research is

characterised by aims which are directed at providing an in-depth and interpreted understanding of the social world of research participants by learning about their social and material circumstances, their experiences, perspectives and histories." Its design enables the use of qualitative research, in order to address research questions that require explanation or understanding of social phenomena and their contexts. This research study sought to answer the following research question: What are the challenges and coping strategies of disabled women in rural settings, set against the background of the economic crisis in Zimbabwe?

The conceptual framework for this study was developed from the CA. The selection of the CA was based on the assumption that it has the right lens through which certain relevant concepts can be used to describe and illuminate broadly the experiences of disabled women in rural areas. The perspective from which the lens of the CA addresses the experiences of disabled women proved quite prominent in situating this study within the qualitative research design. Following the argument pursued by Denzin and Lincoln (2000), that qualitative research is a naturalistic, interpretative approach concerned with understanding the meanings which people attach to phenomena, actions, decisions, beliefs and values within their social worlds, I was able to articulate the situation through participants' own words, in the accounts of their experiences in living with disabilities in rural areas. All this was done to expound broadly the argument that the approach to disability in Zimbabwean society is informed by unsystematic, individualistic and paternalistic attitudes, thereby rendering women with disabilities vulnerable to multiple oppressions.

Bryman (1988:8) bears credence to the above assertions raised by Denzin and Lincoln (2000) stating that, "the way in which people being studied understand and interpret their social reality is one of the central motifs of qualitative research". The use of qualitative approaches also enabled me to articulate the experiences of women with disabilities in rural areas from a contextualised perspective devoid of generalised narratives that treat of their experiences as if they belong to a uniform category. This was done owing to the conviction that there can be little value in adopting a blanket standardised approach to disability because individual experiences of disability vary markedly on the basis of many factors (Robeyns, 2005). These factors differ from person to person, and include gender, age, coping skills and lifestyle.

In general, the qualitative research design contributed to a construction of nuanced and detailed descriptions of the experiences of women with disabilities, which cannot be accommodated by the use of quantitative methods. The experiences the women spoke about focused specifically on the challenges and coping strategies they employ to counter the escalating problems posed by living with

a disability in a rural area, in a society in which disability is perceived to be a personal tragedy. In what follows, the study discusses the data collection tools which were employed to collect data on the individual experiences of disabled women. In this study, the qualitative approach is associated with interviews (in-depth and semi-structured) and focus group discussions, and data collection methods as discussed in the following sections.

3.5 Data Collection Methods

3.5.1 Focus Group Discussions: Accessing and Selection of Participants

Lewis and Ritchie (2003) observed that FGDs allow participants to hear from others, just as they provide an opportunity for reflection and refinement. This process, they say, can deepen participants' insights into their own experiences. Through this platform, participants are given space to express opinions and ideas freely as well as refine what they have to say (Neuman, 2011). Convenience sampling was the procedure used to access participants for FGDs based on their availability and willingness to participate in the study. Further, women with disabilities were recruited to participate voluntarily, taking into consideration their differences in age, marital status, household composition, level of education and income level. This became an advantage as it added to the diversity and complexity of the range of experiences discussed, and so enriched the study. It is also important to highlight that in this study, the FGDs comprised women with disabilities (physically and visually impaired) only. Ritchie and Lewis (2003), argue that in-depth interviews and FGDs are often used in the same study to complement each other. For data collection procedures in this study, FGDs were used as an initial stage to raise and explore relevant issues, which were then taken forward through in-depth and semi-structured interviews. Once potential participants were identified, they were informed about the research, its aims, the research process and their role.

Participation was strictly voluntary. Upon volunteering participants were provided with participant information sheets (see Appendix VI), which outlined the purpose of the research and what was expected of them as well as their rights. The form also assured the participants of the researcher's highest regard for confidentiality. FGDs were conducted, each group comprising a minimum of eight but not exceeding a maximum of ten participants. Some of the women with disabilities who took part in the FGDs also participated in in-depth interviews. This was done to check on the consistency and accuracy of data gathered. FGDs were conducted at various designated points within the three selected wards, with one FGD per ward. Therefore, a total of three (3) FGDs were held for the purposes of this study.

In as much as FGDs proved to be handy in gathering data, they also presented limitations. According to Braun and Clarke (2006), while FGDs are naturalistic, they should not be left to chance and circumstance as their "naturalism" has to be carefully contrived by the researcher. Some of the participants in FGDs naturally attempted to take over my interviewing role, thereby subjecting me to the status of mere listener. This resulted from some participants' wanting to dominate group discussions. These participants as they spoke at length about their own personal views. Some made extensive reference to their own personal situations, spanning a range of topics. In such cases, I remained verbally active, asking further questions and moderating the discussion and ensuring that it remain on course. I was guided in this by Braun and Clarke's assertion (2006), that FGDs have a disadvantage in that the group exerts pressure on participants to conform to socially acceptable viewpoints and not talk about irrelevant views or experiences.

It is also important to point out that it was difficult to truly guarantee confidentiality in FGDs, even with confidentiality forms. This is because the unique nature of the group setting prevents the researcher from ensuring that confidentiality will be maintained. Therefore, while I would always try to lay the basis for preliminary ground rules, I made it clear that participants should also be aware that what they say might be disclosed beyond the group. This is because inasmuch as I would assure participants that everything they share in the FGD will would be treated as confidential, I could not promise that other members of the focus group would do the same. For this reason, I put in place certain measures to give participants a certain level of anonymity. For example, participants' real names could not be used during the FGDs. Further, I emphasised that participants should respect each other's privacy and anonymity and not share information outside the group.

3.5.2 Interviews (In-depth and Semi-structured): Accessing and Selection of Participants

Interviews were conducted at two levels. Firstly, in-depth interviews with ten (10) disabled women selected through convenience sampling constituted my primary research method; the women chosen were the most accessible, under the circumstances. This is in line with the definition given by Lewis and Ritchie (2003) that a convenience sample is a sample for study taken from a group which is conveniently accessible to a researcher and as such it can be useful when the researcher is unable to access a wider population due to budgetary and time constraints. Following from this, I dealt only with participants who were geographically accessible since the area is characterised by poor road networks.

This also helped as some of the participants were physically impaired people who found travelling hugely problematic. I chose to conduct in-depth interviews based on the conviction that they do not restrict individuals that they in fact allow participants to speak openly about their individual experiences (Munsaka, 2012). In-depth interviews were used to gather data from disabled women (see Appendix 1 and 11). The use of in-depth interviews in this study was based on the fact that these generally take place at a location of the participant's choosing. This kind of interview is therefore more accessible to potential participants than group discussions (Lewis and Ritchie, 2003), ideal for participants with mobility constraints, like the physically impaired.

Lewis and Ritchie (2003) say that in-depth interviews provide an opportunity to gain insight into people's personal perspectives on and interpretation of their experiences and the meaning they attach to them. I found that in-depth interviews were particularly suited to the research question as they allowed an understanding of the complexity of the experiences of disabled women. This is because of their depth of focus and the opportunity they offer for clarification and detailed understanding. In actual fact, since disabled women are not homogenous group, in-depth interviews afforded me an opportunity to relate different issues to individual personal experiences in line with the research question. In so doing, the research took into consideration Lewis and Ritchie (2003)'s definition of an interview, that it is a conversation with a purpose. This definition is complemented by Neuman (2011) who purports that interviews create a fundamental process through which knowledge about the social world is constructed in normal human interaction. So it was through in-depth interviews that the research was able to probe deeper, to explore the experiences of disabled women.

Secondly, I used semi-structured interviews with seven (7) key informants: three local community leaders/focal persons chosen from the three wards, two government officers from government departments and two programme officers from two local NGOs. The study used semi-structured interviews which took an unstructured pattern, in which the key informants were given ample time to explore deeply the experiences by women with disabilities in rural areas. Using purposive sampling, these participants were selected on the basis of their expert knowledge on disability issues. Fielding and Thomas (2008) argue that semi-structured interviews are used to explore relevant issues in detail as they allow the interviewer to use flexible questioning styles. These flexible questioning styles allow probes and proper clarifications of ideas as they are presented.

In order to conduct semi-structured interviews, appointments were made a week in advance with the relevant officials from both government departments and non-governmental organisations. When the

appointments were made, the participants were briefed about the purpose of the research. Interviews were held at their respective offices to allow them enough freedom to participate in the study. The research used interview guidelines to conduct semi-structured interviews (see Appendix 111). All interviews were and were conducted in Ndebele, recorded and translated into English during the process of transcribing. Notes were also written in addition to recording where clarification was needed. The interviews lasted between forty and sixty minutes.

It is important to note that the interviews with participants proved vital to the study as I was able to observe body language cues – facial expressions and gestures –of the participants during the interviews. This observation is supported by Bryman (1988) who argues that interviews can be preferable to questionnaires as facial expressions and other non-verbal cues can be captured, which are impossible to access when using questionnaires. During the interview sessions, conversation with the participants took on a natural tone and I allowed them enough time to relate their experiences in light of the questions. In order to cement my relationships with the participants during the interview sessions, I sustained a close and harmonious relationship with them in order to create a conducive environment, which promoted normal conversations. This was made possible through the fact that I was familiar with the context and culture of the people. This scenario enhanced the process of acquiring the research data. Following this working rapport which I had with them, they were able to trust me with some of their private and confidential information which was important in the analysis of the data.

It is, however, important to point out that despite the fact that I was embedded, and intimate with the participants because of prior work engagement with them, I adopted a wholly different approach by drawing a clear line between myself and the participants. This made it possible for me to enable the participants to speak from a different context altogether. This was done by explaining to them that the information being gathered was for an academic report and they were therefore not supposed to treat me as the humanitarian worker they had known earlier on. The embeddedness that helped me to access the participants can be justified using Weiss' argument that what is essential in conducting interviews is to maintain a working research partnership (Weiss, 1994). This is because what the researcher cannot avoid is establishing a partnership with the participants in the process of data gathering (Weiss, 1994).

However, strong research partnerships do not guarantee that the gathering and providing of information is a trouble-free process (Dickinson, 2014). For example, participants sometimes

rambled, got side-tracked and became repetitive, thereby detracting from the focus of the interviews. In such instances, I would probe by asking direct, structured questions which gave less scope for long replies. Participants at times also gave less detailed responses than I required on the grounds that they assumed I knew what I was looking for. Thus, in order to ensure impartiality, I had to also observe, watch the events, probe, solicit additional opinions but most importantly, I selected the information carefully in order to answer the questions posed for this study.

Rubin and Rubin (1995) stress that qualitative interviews should aim to achieve empathy without the researcher becoming over-involved in their experiences. Even though this situation (of having known the participants in a work-related context) was my greatest methodological tool, it also became a methodological limitation. I encountered challenges with some participants who digressed from the intended conversations, narrating their experiences in a way that was aimed at soliciting individual benefits from me in my position as a researcher. This forced me to abandon a set of questions in order to allow them enough time to relate what they felt was valid information. This resulted in my succumbing, and sympathizing with some of them, thus defeating the principle of complete objectivity and neutrality that are required when conducting research.

The reactions of some of my participants were indicative of traumatic experiences which they had had as a result of living with disabilities in rural areas. However, since my intention was not to subject them to further trying situations and circumstances, I made sure interviews with them were conducted in places which did not exacerbate their conditions. For example, some were interviewed in the security of their homes. I moved around with two of my colleagues who had more expertise than I in dealing with disability and with their help, debriefing sessions were conducted after interview sessions and focus group sessions by local experts, to refresh the participants' memories in a way that did not cause psychological harm. This strategy was meant to help participants who, as a result of interviews, found their participation traumatic and upsetting.

My experience of conducting semi-structured interviews with key informants presented challenges. The challenges emanated from the fact that during the course of conducting semi-structured interviews with key informants, I realised that the interviews did not yield as much information as I had expected them to, because the participants gave superficial answers which could not sustain a detailed interview. Owing to the need to abide by the Official Secrets Act, government officials were not at liberty to share privileged information with me. The same applied to the NGO officials who tried as much as possible to dodge lengthy conversations, citing time constraints. Interviews with

focal persons or community leaders followed the same pattern. This was due to the fact that they considered some of the information to be sensitive and at times they would deliberately confess ignorance on certain questions.

3.6 Data Analysis

Data analysis usually begins once the initial activities in research have begun to take place, therefore it becomes an ongoing process (Braun and Clarke, 2006). What this implies is that "analysis cannot be easily distinguished from transcription" (Munsaka, 2012: 117). Primary and secondary data were used for qualitative analysis; this involved the identification of categories and themes developed as a result of the researcher's interpretation of the data. I used an interpretive approach to the data in a bid to provide a deeper understanding of the situations described by participants, as presented in the research question. Interpretive analysis encourages an understanding of the way participants view events and interpret their experiences. This, however, requires a comprehensive and contextualized description. Thus, interpretive analysis is useful in identifying similarities and recurring themes in participants' responses. For this reason, interpretive analysis was used to categorize data obtained through field notes, interviews and transcriptions of the interviews. The data categorization enabled searching for recurring patterns and ultimately resulted in the formation of several themes. The data collected was transcribed in English and was followed by thematic analysis. Braun and Clarke (2006) indicate that thematic analysis offers an accessible and theoretically flexible approach to analysing qualitative data.

The information gathered from the field through in-depth interviews and focus group discussions was transcribed soon after the interviews. Data was checked for accuracy and compared with the transcribed notes. Further, within the process of analysing data using thematic analysis, I also made use of comparative analysis, which was used to compare and contrast data from different participants (Kothari, 2011). The comparative analysis was especially useful in that I could move backwards and forwards between the data (Kothari, 2011). I took note of the themes that were irrelevant to the study but had nonetheless emerged during data gathering. Themes were then categorised according to the interview questions, although not exclusively, as there was a tendency for them to overlap. Data were not analysed according to disability types; I looked at individuals' experiences and did not classify them according to their impairments. This was done to avoid the common assumption made about PwDs, i.e. that they are a homogenous group. This is supported by Mitra (2006) who argues that

inasmuch as there is need for information about disability, it is not of much use, as experiences differ according to context.

3.7 Reflection on Data Collection Experiences: Reflexivity

It is important at this juncture to submit that since the research was conducted in the District in which my organisation implements development projects for PwDs (people researcher had had prior relationships with as a humanitarian worker), reflexivity became essential as a methodology in the study. The reality of having known my participants owing to my prior work engagement with them warranted a substantial degree of control to avoid the fundamental pitfall of compromising the data collection procedures and the quality of data gathered. Thus, I was immersed wholly in the research to grapple with reflexivity issues.

As the situation demanded, I had to consciously and cautiously take note of my roles and actions throughout the whole research process in order to avoid the risk of overlap as a result of my previous experience with the participants. Sometimes they treated me as one of them and not as a researcher. While this prior experience with them in humanitarian work was a stepping stone towards gaining access to them, I tried as much as possible to avoid developing a bias towards certain aspects which would otherwise compromise the quality of my data. In addition to this, I was caught in a dilemma as I was approaching them as a researcher yet they knew me in normal encounters as a humanitarian worker who usually visited to implement projects targeting vulnerable groups. This made the situation even more complicated, as participants expected some tangible aid hand-outs since providing these had been part of my duties.

It is also important to state that I noted in my interaction with participants that my prior engagement with them through work-related issues at times caused them to ignore my role as a student who was doing research for a university qualification. Most women with disabilities indicated that they were more than willing to present their experiences of living with disabilities, as women and inhabitants of a rural area. While this was an advantage, it also presented challenges for me, as some participants made assumptions that I was very much aware of their individual experiences owing to my prior engagement with them in humanitarian work. This made me realise the need to further probe certain responses which had taken for granted that I was aware of their narratives. This is indicated in the interviews that are laden with recurring statements such as: '*I know you are aware of our suffering...*' '*I cannot go into details on this because your organisation once assisted us with...*' and this alerted me to the realisation that if I did not probe further, I risked failing to gather qualitative data.

I admit there were some exceptional cases in which I was defeated by emotions, enough to stray from my original intentions. An example that comes readily to mind is the seventh interview, with an aged single woman with a physical disability. During my interview with her, she shared emotional narratives and revelations that caused me to break down emotionally. Even though I had dealt with them before, it was the first time I had engaged with them on a one-on-one basis, or on a platform that gave them the opportunity to unreservedly present their experiences of disability as individuals. I had gotten used to a scenario where their experiences were presented on paper, and they were regarded as a homogenous group. In this situation I had not had contact with their individual experiences. I also found myself immersed in a situation where I failed to remain neutral and extricate myself from the emotional content of the interviews, in order to allow the phenomena to speak for themselves. Therefore, situating myself within the research process in such a way that my emotions were not affected proved rather difficult at times, even though this principle had to be observed for the purposes of gathering quality data.

Further, being a man and able-bodied, I was aware that the research space was complex because of gender dynamics and disability politics embedded in the discourses of disability, especially between able-bodied and PwDs in a humanitarian context. I was confronted with a scenario of male dominance in rural areas, which almost became an obstacle to this study. The notion of patriarchal hold characterised the space in which I conducted my research. Mindful of my gender, I maintained sensitivity throughout the period of interaction, especially with men who were sometimes inquisitive about why I wanted to interview their wives. Therefore, in the case of married women with disabilities, I had to seek permission from their husbands in order to speak to them.

On another level, I had to grapple with the challenges of analysing and presenting what the participants had said without diluting the experiences of living with disabilities that they had presented to me. Exercising rigour in order to avoid misrepresenting what the participants had said was a challenge I had to face, especially when selecting representative quotes to back up specific arguments. This was an area which participants had no control over, since I selected and shaped some of their narratives in view of the approach whose lens I used to interpret the findings. While practically this may be inevitable, I tried as much as possible to present the selected participants' quotations in their original form, even though where to situate them in particular arguments was a domain I maintained total control over as a researcher.

However, it is important to note that when the current study was proposed I had considered using in-depth interviews with government and NGO officials as well as focal persons or community leaders. During the course of the interviews, I realised that the interviews did not turn out to be as in-depth as

I had hoped they would be because the participants gave superficial answers which could not sustain an in-depth interview. The government officials, for example, sifted the kind of information they would give to me as a direct consequence of their observing the Official Secrets Act. The same applies to the NGO officials who tried as much as possible to avoid in-depth conversations, citing time constraints. Interviews with focal persons or community leaders could not be in-depth either. This was due to the fact that they considered some of the information sensitive, and they pleaded ignorance on certain questions.

3.8 Limitations of the Study

The limitations to this study are predominantly predicated on the constraint of having used a small sample of participants, chosen from only three wards. The sample was not sufficiently representative to capture more voices of disabled women. The information gathered and presented for this research report is based on generalisations from this sample. Another challenge was that of the inaccessibility of certain areas which I could have visited, to create a more balanced sample of the participants. The study also specifically focused on physically and visually impaired women in a rural setting, thereby excluding the hearing and intellectually impaired women. Further, the diverse experiences of disabled women in urban areas were not explored to expand the scope of the study. This might have affected the quality of the study owing to generalisations that do not emanate from a larger sample, since disabled women are not a homogenous group.

3.9 Ethical Considerations

Following ethics is an important part of the research. Hence the research was approved by the ethics committee of the University of the Witwatersrand (see Appendix XI). Throughout the whole study, the researcher paid keen attention to ensure that the study was conducted in line with the basic ethical considerations for research studies involving human subjects, as discussed in the following sub-sections:

3.9.1 Informed Consent

Informed consent plays a pivotal role in research that involves human subjects. The pledge by the researcher is that during the process of data gathering, the rights and safety of participants will be protected. The basic assumption underlying informed consent is that participants need certain information so they can exercise self-determination, and this is done to protect their rights and

welfare. Informed consent therefore is observed to make sure that participants fully understand the procedures, benefits, and risks involved in participating in the research process.

Informed consent was sought from all individuals involved in the study; they signed consent forms before they participated in the research. Even after their enrolment, participants were given latitude to withdraw from the study at any time if they felt that their integrity and confidentiality were being compromised. To achieve the informed consent of the participants, I followed traditional structures of authority and made a courtesy call to the community's traditional leaders, and also informed them about the research so that they could grant me the opportunity to conduct the research in the area. Further, I also requested for their participants' consent before recording their voices, and they agreed to being recorded for the purposes of this study.

3.9.2 Confidentiality and Anonymity

Confidentiality was strictly observed and I made efforts to interview the participants at their homesteads or in places which they chose as convenient for themselves. However, while the ethics of participation were respected at all times, confidentiality could not be guaranteed for participants who took part in FGDs. Further, in this study sample members' informed consent to participate was obtained. I provided them with information about the purpose of the study, who I was, how the data would be used and what participation would require of them as well as how much of their time was required.

Anonymity for interview participants was guaranteed. Efforts were also made to ensure that individual responses remained anonymous. Pseudonyms were used in the final report to ensure the anonymity of Focus Group discussion participants. All participants were voluntarily enrolled in the study and no form of inducement was used for this purpose. Interviews were undertaken in an informal manner, so as not to raise excessive curiosity within the community, and cause anxiety among participating families. Questions in the study tools focused on the subject and as much as possible, nothing outside the scope of the study was discussed.

3.9.3 Voice Recording

I recorded all the interviews after the participants had consented to being recorded (see Appendix X for a consent form on voice recording). My recording of the interviews created a permanent information record, to which I would refer as I analysed my data for the research. The in-depth interviews and information gathered from the FGDs were also transcribed to create a permanent written record, from which material could be drawn in the preparation of the final research report. This permanent record was backed up by the notes that I took in the field, especially on important

aspects which were deemed necessary and proper reference points for the research. This was to ensure that a permanent record of the important concepts was kept in its original form. Translation also posed methodological challenges as I had to translate the information gathered into English and as with other quotations, it was not easy to get English equivalents. This forced me to make further consultations on certain terms so that I could avoid distortion of information.

3.10 Summary

This chapter has presented the discussion of the research design and methods that were used in the study to answer the following research question: What are the challenges and coping strategies of disabled women in a rural setting, set against the background of the economic crisis in Zimbabwe? Using a qualitative research design, in this chapter I demonstrated how I answered the research question, arguing that the approach to disability in Zimbabwe is unsystematic, individualistic and paternalistic, thereby rendering disabled women vulnerable to multiple oppression. To this end, the research instruments used in the study to acquire primary data from the participants, in order to respond to the research question and to develop the argument, are discussed. These include interviews (in-depth and semi-structured) as well as focus-group discussions (FGDs). The chapter describes the research site, which is Insiza District in Zimbabwe's Matabeleland South Province. This is followed by a discussion on the paradigm of the research, which is qualitative research design. The chapter also discussed the sampling procedures used in the study. This is followed by a discussion of data collection and analysis. Finally, the chapter addresses ethical considerations, and the limitations of the study. In the following chapter, the study presents findings gathered from the participants, which in turn are used to answer the research question and to develop the argument.

CHAPTER FOUR

PRESENTATION OF FINDINGS

4.1 Introduction

This chapter presents the data gathered from the participants through interviews (in-depth and semi-structured) and focus group discussions (FGDs). The purpose of this chapter is to present findings gathered for this study which will help in answering the following research question, "What are the challenges and coping strategies of women with disabilities in rural areas, set against the background of the economic crisis in Zimbabwe?" These findings are useful in developing the argument that the approach to disability in Zimbabwe is unsystematic, individualistic and paternalistic, thereby rendering women with disabilities vulnerable to multiple oppressions. To this end, emerging themes and sub-themes that include lack of education and skills, intersectionality of age, gender and disability, lack of resources, discrimination, accessibility, cultural beliefs and practices, partial implementation of disability and legislation, and the exclusion of women with disabilities are explored. The chapter also demonstrates through empirical data how the coping strategies have a limited capacity in mitigating the many challenges posed by living with a disability in a rural setting.

4.2 Demographic Profiles of the Participants

I included the demographic characteristics of the participants, namely their age, marital status, disability, family composition, their level of education and their employment status. The findings from this study present the number of participants who took part in the study in terms of age, employment and levels of education, as indicated:

Table 4.1 shows the number of participants who took part in the study as well as their ages. There was one (1) participant in the age group of 18-30 years. Two (2) participants were aged between 31 and 40 years; two (2) participants were in the age range of 41-50 years. There were two (2) participants who were in the age range of 51-60 years. There were three (3) participants in the age range of 61-65 years.

Table 4.1 Demographic Data for Women with Disabilities

Demographic variable	Number	Percentage
A. Age		
18-30	1	10%
31-40	2	20%
41-50	2	20%
51-60	2	20%
61-65	3	30%
TOTAL	**10**	**100%**

N= 10

Of a total of ten (10), five (5) participants had never been to school. Three (3) participants had attained only primary education and only two (2) had attained their secondary education. None of the participants had attained either vocational or professional courses.

Table 4.2 Level of Education

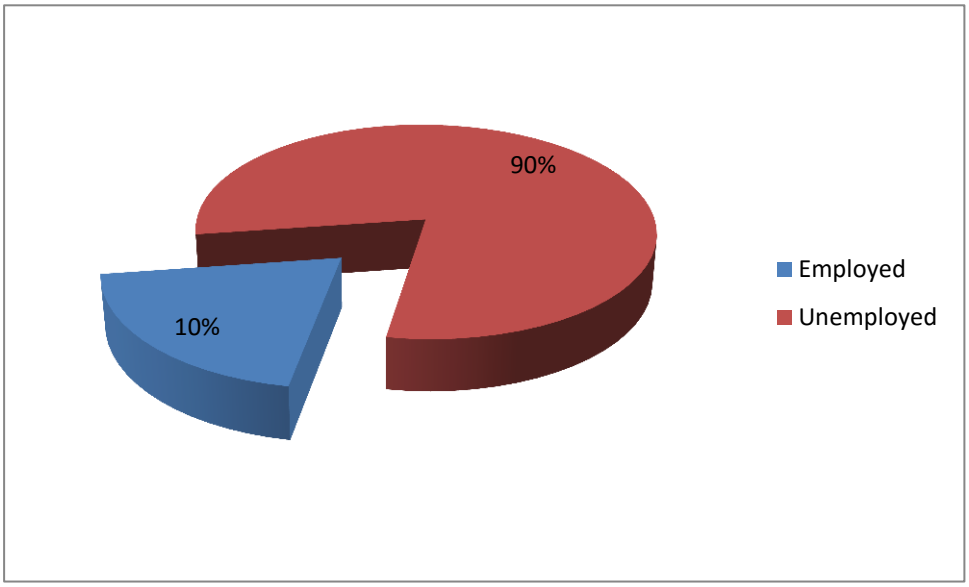
Level of Education	Number	Percentage
Never been to school/No formal education	5	50
Primary education	3	30
Secondary level	2	20
Professional qualification	0	
Vocational Training	0	

N=10

Figure 4.3 Employment statuses of the participants

Further, of the ten (10) participants, it was found out that only one (1) was employed whilst the rest (9) were unemployed, as depicted in the pie chart below:

Fig 4.1: Employment Status



4.3 Challenges Experienced by Women with Disabilities in Rural Areas: Themes

4.3.1 Lack of Education and Skills

From the study, lack of education and skills was identified as one of the most critical challenges currently being faced by women with disabilities, despite the key importance of education in increasing human capability and choice as will be demonstrated in Chapter 5 of this study. It was found that most of them had never attended school, or had dropped out of school, especially when they became disabled during the course of their education. The majority of women with disabilities who participated in the study echoed the sentiment that their suffering from poverty and their failure to meet their daily needs in life results from a lack of education. Eight (8) participants out of ten (10) highlighted the need for education for one to become a fully productive member today's world. For them, poverty on the part of women with disabilities is a result of a lack of education. One of the participants echoed the following sentiment:

> *I am living in poverty because of my disability, which contributed towards my failure to go to school. There are no jobs in this country and even if there were plenty of jobs, some of us would not be employed because obviously there is need for a qualification which I do not have. I did not go to school and never got trained in any skills.*
>
> (Interview, Ellen, visual impairment, 16 June 2014)

In trying to explain the effects of lack of education on them, 7 (seven) participants, made reference to the bidirectional link between poverty and disability, especially on the part of an uneducated woman with a disability. For them, education prepares a person for a full life, and enhances one's capabilities

in building the skills inherent in a person so that they can be employed, or engage in self-help entrepreneurial activities in order to eke out a living. This is best captured in the following assertion:

> *In this world, at least one should have education. As for me there is nothing to talk about because I know the reality is I am an uneducated woman with a disability who has to face poverty for the rest of her life. I have noted that where there is no education and there is a disability too, then there is poverty and the three have links which are very easy to see. Move around and see how many women with disabilities have been to school and ask them why they have not been to school. After all that, try to observe how they are living then you will see the link between poverty, lack of education and disability in rural areas.*
> (Interview, Vanessa, physical impairment, 07 June 2014)

The majority of participants, if not all, pointed out that they had not been in a position to complete a full cycle of education and some of them had never been to school in their lives. All ten (10) of the women with disabilities were quick to point out that the scenario whereby women with disabilities do not have access to education is not a new phenomenon that came about as a result of the current economic crisis in the country only. This has been the pattern in the rural areas for a long time, because of the cultural belief that a woman with a disability has no need of education. In their own stories, the participants pointed out that the majority of people in these communities were socialised to believe that a woman with a disability has no need for education since she has to beg, depend on family members and the community in general, for her survival.

Generally there was a feeling that there has been a notable and disturbing trend, where the children of women with disabilities were not attending school. This alarming development became a recurring theme in many interviews and was given proper explanation by one of the participants who echoed the following sentiments:

> *I attribute most of my problems to lack of education and this has affected my own ability to come up with an alternative to live my own life. I tried to go to school but had serious challenges forging the rough rural terrain here without a guide. No one readily offers a hand, so now I depend on my child, who has to forgo schooling to help me get by.*
> (Interview, Ellen, visual impairment, 16 June 2014)

4.3.2 Intersectionality of Age, Gender and Disability

There were several factors that were found to significantly interact with disability, thereby creating more disadvantages for women with disabilities, for example, age and gender. As will be shown in

Chapter 5, the predicament resulting from the interaction of these variables is even worse for women with disabilities. Of the ten (10) participants, all women with disabilities, six (6) were taking care of dependants, including their own children and those from the extended family and in some cases, these were among the elderly women with disabilities in the community. One of the participants (a woman with disability) aged fifty-nine (59) stated that:

> *Age has caught up with me and the challenge that worries me most almost on a daily basis is that I am no longer able to bath on my own due to my disability and age. I need someone to bath me on a daily basis but this is impossible because I am staying with four little girls who are not even able to bath themselves properly. They lost their parents and I am the only one left to take care of them in the family. What it means is that I have to instruct them on how to prepare meals since I cannot do anything. I now have the burden to look after them and after myself. I never saw this coming.*
>
> (Interview, Ivy, physical impairment, 27 June 2014)

One of the participants also stated how the size of her family was compounding her poverty and how she regrets having a big family as a disabled woman in her old age:

> *I am an old disabled woman with a total of six children – with four girls and two boys. On top of that I have three grandchildren. It is actually a struggle to raise such a big family if you are an old unemployed woman with a disability in a rural area. I regret having a big family as a disabled woman because my challenges are increasing on a daily basis as the children grow. I need to make sure they eat and they have clothes. This is very difficult in a country like ours in which getting a dollar is an unexpected blessing. My ability to fend for the family is affected by my age and disability because I am no longer as productive as I used to be in my early thirties through to the forties. I used to do piece jobs mainly by cleaning people's yards but I can no longer do manual work anymore*.
>
> (Interview, Charity, physical impairment, 24 June 2014)

> *I cannot propel my wheelchair now because it is too old and it requires a lot of energy to push especially in this sandy soil. My son, don't you see that I am as old as my wheelchair. At this age, you only need an assistant especially if you have the type of disability I have. My life as a widow with a disability is terrible as I have to contend with problems of widowhood and disability in a rural setting, which is unproductive. The economy which is performing badly has made it worse for me because I survive on very little to eat, in fact little to keep the body and the soul together.*

(Interview, Ivy, physical impairment, 27 June 2014)

One of the participants said that the image of disability in this area has been intensified by gender discrimination and disempowerment, where in some women with disabilities, a sense of intensified passivity and helplessness was expressed in the interviews:

> *I know that with my disability and as a woman living in an area dominated by men on top of that, I cannot do anything and therefore I have ceased to bother myself about attempting to do even a single activity in life. There is nothing productive you can do with a disability. An attempt to be productive in life when you have a disability – worse if you are a woman – is to fight a losing battle. I simply have nowhere to start and am not the only one being affected by such problems as we are many in this area.*
>
> (Interview, Key participant, 09 June 2014)

A few of those who were married confirmed having borne the burden of taking care of the family after their husbands had left the country for greener pastures in South Africa, following the economic crisis in Zimbabwe. This once again conforms to gender roles as understood in rural Zimbabwe because it casts light on a common feature of poor rural households, i.e. that there are more female-headed households in the area than male-headed households. This has also affected women with disabilities. This claim is best captured in the following statement:

> *On the basis of culture, women generally are expected to perform their domestic roles in their homes regardless of whether they are disabled or not. This is because women have hands-on care of the family and therefore if they are disabled they have far greater chances to remain in the home or may have a double trouble of taking care of a child with a disability when in fact they need to be taken care of too.*
>
> (Interview, Caroline, physical impairment, 18 June 2014)

4.3.3 Lack of Resources

From the findings of the study, it was also discovered that women with disabilities did not have adequate resources and assistive devices to aid their functionality in the rural setting. Some of the participants lived a life of deprivation as they did not have assistive devices and other resources for use in their day-to-day lives, and this added to their challenges. The issue of lack of resources as proxies in determining women with disabilities' functionality has been largely explored in Chapter 5 of this study. Seven participants (all being women with disabilities) made reference to the fact that their capabilities and functionalities are limited because of a lack of assistive devices which are now too expensive, especially considering that the majority of them are informally employed or have

nothing productive with which to occupy their time. The devices include mobility aids, for example wheelchairs, walking canes and crutches, to mention but a few. Lack of resources and assistive devices as a challenge confronting women with disabilities in rural areas has also been worsened by the economic problems that Zimbabwe has seen and is still facing since the turn of the century. The following words were spoken by one of the participants:

> *I do not attend social gatherings because I do not have a wheelchair. My second option is to be put in a scotch cart so I can be out of this home either for a visit or if I am sick and in need of medical attention. This problem of lack of a wheelchair makes me unproductive in the family. It also means that one does not attend social gatherings and will have a limited web of socialisation.*
>
> (Interview, Caroline, physical impairment, 18 June 2014)

Some women with disabilities lamented that one of the main hindrances they faced in their efforts to survive, especially in informal businesses, for example, buying and selling in rural areas, is access to capital, either in the form of loans or accumulated savings. This is well articulated in the following voice from one of these women:

> *I am capable of starting a business in buying and selling as well as running poultry projects but I do not have start-up capital to make this happen. I am confident that I can do it because I have done it before successfully. My poultry projects got affected by the economic crisis in the country. I have heard people in this village talking about loans from some ministry but the information is unclear on who should benefit from the loans.*
>
> (Interview, Cecilia, visual impairment, 12 June 2014)

In regard to the financial institutions, one focus group participant cited the following:

> *Financial institutions in the rural areas (mainly stationed at district level), are not in the position to give out loans to women with disabilities in the rural areas as most of them are perceived to be a credit risk, chiefly because they lack collateral security. Even the unemployed able-bodied women in the rural areas were sufferers to such problems.*
>
> (Focus Group Discussion Participant, 17 June 2014)

Most of the participants agreed that if women with disabilities cannot access start-up capital, then their only option is to rely on family and friends. In most cases the kind of capital acquired is limited in the highly unlikely event that one even gets it. There was general agreement from among participants that there were indeed sporadic microfinance programmes, particularly micro credit and revolving loan funding offered by the Ministry of Gender and Women in Zimbabwe. However, they

concurred that the administration of such programmes has followed the traditional pattern that women with disabilities cannot have access to micro lending as they are perceived to be unproductive members of society.

Women with disabilities who participated in this study also said that they had no access to services on sexual and reproductive health (hereinafter referred to as SRH). All too often, the SRH for women with disabilities has been overlooked by both the community and the service providers and this leaves women with disabilities among the most marginalized in terms of access to services, yet they have the same need of health services as everyone else. In fact, they may actually have a greater need for SRH education and care than women without disabilities due to their increased vulnerability to abuse. The challenges of SRH they face are not necessarily part of having a disability, but instead often reflect a lack of social attention, legal protection, understanding and support. A focus group participant highlighted this in the following statement:

> *Women with disabilities face many barriers to care and information about SRH in the rural areas. The first reason for this is the frequent assumption that they are not sexually active and therefore do not need SRH services. This reason ignores the basic fact that they are as sexually active as persons without disabilities. Despite this, too often our sexuality has been ignored and our reproductive rights, denied. At best, most existing policies and programmes concentrate on the prevention of unwanted pregnancies but ignore the fact that women with disabilities will eventually have children of their own. At worst, forced sterilization and forced abortion often have been imposed on women with disabilities secretly using traditional ways thereby infringing on our rights and autonomy to decide what we want in life.*
> (Focus Group Discussion Participant, 23 June 2014)

> *In this community, a significant number of women with disabilities marry and have children. However, many others do not because they have grown up being socialized into believing that they could not. A very good challenge that affects their decisions in life is that they often lack access to sexual and reproductive health information and services. I want to highlight that many women with disabilities do enjoy the experiences of marriage and family life if one is privileged to be part of that. However, because of stigma and discrimination, lack of access to information and services, especially on sexual and reproductive health, many of us do not marry and have children the rest of our lives.*
> (Interview, Edith, visual impairment, 09 June 2014)

4.3.4 Discrimination

One of the major challenges affecting women with disabilities in rural areas is discrimination; the women noted that society seems to display negative attitudes towards them. The majority of the participants in this study expressed the view that discrimination has led to even greater exclusion and prejudicial treatment in socio-economic and other development activities. These, they say, are initiated at either community level or national level but it applies also to those implemented by NGOs. Prejudice and discrimination as indicated in Chapter 5 of this study continue to pose challenges for women with disabilities in rural areas. These women are assumed to be dependent on able-bodied people as well as charity for the entire duration of their lives. Other participants felt that most people in the rural areas still hold on to the discriminatory attitudes which enforce the practice of looking upon women with disabilities as individuals incapable of doing anything useful, be it in the home or in decision-making forums at family level.

The consequence of such perceptions in society is the perpetuation of perceived truths, which leads to stigmatisation about disability. These stigmas further entrench discriminatory attitudes towards women with disabilities. The life of a woman with a disability in a rural setting is centred in the home where she is expected to live her entire life without contact and social interaction with the outside world. However, due to the economic crisis in the country, for these women's families, providing social opportunities for them is simply not a priority compared to other pressing issues, like getting food for the family. One of the participants expressed this, saying:

> *I have never been exposed to any recreational activities since I was born, save for church functions. The main reason for this was that I was born in a polygamous family and finances for that were erratic not to mention that even if finances were there, I was not going to be a priority in the family. I was the reason why my mother became the least loved amongst other wives because she had given birth to a person with a disability which was considered to be a misfortune and bad omen within that big family. Further, I was perceived to be incapable of doing anything.*
>
> (Interview, Charity, physical impairment, 24 June 2014)

Findings from this study showed that quite a significant number of women with disabilities were single; they had never been married before or their marriages had broken down irretrievably owing to discrimination. The effects of discrimination seem to have profound effects on visually impaired women, more so than those with physical impairments. In rural areas, very few people would readily

consider marrying a visually impaired woman. They are considered objects of pity and charity resulting in their being relegated to the lowest status in the community. In most cases, they are isolated, confined to the corner of the house and they live in obscurity, silent and in misery, dependant on society in every way. For the physically impaired, disability further entrenches their (often) inferior role, even in their own households. The stigma of disability with its myths and fears increases their social isolation. In rural areas where no rehabilitation facilities are available, they become immobile and housebound and their isolation is complete. These words from one such woman:

> *I personally feel that as a visually impaired person, stigmatisation, discrimination and stereotyping affects me more than it does to the physically impaired women. These are my perceptions because people in the rural areas do not settle for marriages with visually impaired people but they at least consider marrying a physically impaired woman. The main reason for this is the myths and fears associated with disability on the basis of cultural beliefs and practices. Society believes that a blind woman is useful for nothing, but a liability instead.* (Interview, Edith, Visual impairment, 09 June 2014)

4.3.5 Accessibility

This study also found that women with disabilities are continuously being affected by the problems of inaccessibility, and environmental constraints which have also been worsened by the economic crisis currently affecting Zimbabwe. The challenges emanating from failure to have a source of income means that women with disabilities have mostly failed to get the aid necessary in their day to-day lives, such as wheelchairs and crutches, which will allow them access to the outside world. This has made their lives difficult, especially in rural areas, where mobility becomes a major challenge which can lead to loss of opportunities and exclusion from development projects initiated either at community or national level.

The inaccessibility challenges they face also make it difficult for them to meaningfully engage in socio-economic activities for their own benefit. It came to light that what hinders the women with disabilities' access to the broader society, and opportunities in societal ventures in their rural setting, is mainly the terrain of their environment. Some of the wheelchair users said that they are not in a position to use the wheelchairs effectively and to their benefit due to the physical environment – they are unable to propel the wheelchairs in the muddy and sandy soil that characterises most rural settings. This was captured in one of the participant's words:

The major challenge is that my movement is restricted as a wheelchair user and being a wheelchair user entails having an assistant who has to push you around in order for you to be productive and take care of the family. I cannot propel my wheelchair now because it is too old and it necessitates a lot of energy to have it pushed especially in this sandy soil that characterises this area.

(Interview, Blessing, physical impairment & visual impairment, 20 June 2014)

They pointed out that the terrain of the area was not easy to navigate as well as being unfavourable to a woman with a disability if she depends on a wheelchair to move around. This limits their mobility opportunities and leaves them at the mercy of family members or members of the society they live in. More likely than not, this feeds the general public perception of the disabled as objects of pity. The following statement was made by one of the participants:

I do not move out of this home since I started using this wheelchair because the terrain in this rural area is bad and does not allow a smooth propelling of the wheelchair. It is even worse when it rains because I cannot even get out of the house without anyone pushing me. Therefore, I have two basic needs for me to be functional, a wheelchair and a pusher. However a pusher is not always available. Only those who feel pity for me or who think what I want to do at that moment is good for me, offer their pushing services.

(Interview, Charity, physical impairment, 24 June 2014)

In the discussion on physical barriers, eight (8) participants reported the lack of transport in rural areas as a major obstacle for a woman with a disability to access other environments outside their own homes. Public transport was considered expensive in the rural areas, especially for those participants using wheelchairs, since they have to pay extra for a wheelchair that does not fold, when using public transport. Whatever efforts are made to exercise individual agency and initiative are further frustrated because it costs them a great deal of money to run businesses that require them to travel to suppliers of wares and back to their customers, so their businesses are not cost-effective. On this issue, one of the women who participated in this study said:

One's effort in trying to overcome the challenges is affected by inaccessible public transport systems. For example if you are a wheelchair user, your wheelchair may not be accepted on the public transport because it is purported that it occupies space. If one happens to be accepted on the transport with their wheelchair, then they have to pay for it. This problem also works together with the problem of failing to access markets in Gwanda and Bulawayo. As a result of problems of inaccessibility of transport, markets and customers, women with

disabilities have problems in doing business as they face mobility challenges which contribute towards their failure to access markets.
(Interview, Vanessa, physical impairment, 07 June 2014)

Findings from the study took note of the fact that the rural-urban divide also has a major bearing on disability and gender, as gender-based roles are more pronounced in rural than urban areas. For instance, the customary gender roles such as fetching water and collecting firewood are mainly the domain of females. For the disabled couples, this is inescapable as a woman remains confined to domestic work, thereby suffering the pain of disability more than her urban counterpart who is in a similar situation. In urban areas, the availability of electricity and piped water reduces these burdens on women with disabilities. Although both urban and rural areas in Zimbabwe are hit by water and electricity problems as a result of the economic crisis, the situation is worse in rural areas as most households have never been connected to reliable services.

This negatively impacts women with disabilities in rural areas as they are made to perform their household duties in an environment which has too few resources to support their agency. Therefore the environment becomes a major challenge as it affects the functionality of women with disabilities in rural settings more than it affects their urban counterparts. Participants shared the view that this situation means that women with disabilities in urban areas often find themselves with several alternatives to earn a living, which is not always the case in rural areas. Participants were of the opinion that, compared with rural women, women with disabilities in urban areas, though they may be unskilled, enjoy the privilege of doing piece jobs and also accessing health facilities as well as transport, opportunities closed to rural women with disabilities. This view was shared by from other participants who said the following:

Most desperate women with disabilities in an urban setting can even resort to begging (even though not an ideal practice) and have an opportunity to have many well-to-do sympathisers who can benevolently give towards lessening their plight. In rural areas that may not be the case as poverty is rife and the majority cannot part with the little resources they have by donating to people with disabilities. (Interview, Edith, Visual impairment, 09 June 2014)

At least women with disabilities in urban areas have an option to beg from the streets (even though begging is not an option). You cannot do this in the rural areas. In fact long ago, here in rural areas people felt they had a responsibility to help the vulnerable people for example PwDs and orphans through traditional coping mechanisms and it was sort of like an

obligation on the part of the community in rural areas to do that but these are now folktales in Zimbabwe as the economic crisis has dismantled the so-called family ties. You simply need to negotiate your own coping mechanisms in order to survive the challenges you encounter as a person with a disability.

(Interview, Polite, visual impairment, 12 June 2014)

4.3.6 Cultural Beliefs and Practices

Six (6) participants pointed out that the experiences that they have with their disabilities are a result of how their communities treat them almost on a daily basis. As far as they are concerned, women with disabilities are suffering at the hands of the community's cultural beliefs and practices. Old predetermined truths are entrenched in how the society understands disability. Participants lamented the prevalent view of women with disabilities as incapable of doing anything productive in life, hence their exclusion from community development programmes. They were convinced in their narrations that the basis of such beliefs was the community culture, coupled with micro-politics. The political dynamics, they say, manifest as power from below, as expressed by the local leadership and other family members. One participant expressed it in the following way:

To be considered for any influential position as a disabled person is difficult because the ancient beliefs that disabled people are a curse and good for nothing still holds strong in people's minds. There is a need for a buy-in from the local leadership, if women with disabilities are to be included in community empowerment programmes. There have been activities on lobby and advocacy by NGOs on disability in this area in an attempt to educate the communities on the rights of people with disabilities as equal members within their society. The lobby and advocacy programmes by these NGOs have also highlighted the idea that women with disabilities have agency which can be developed for them to become economically and socially independent in their homes. In most cases the community makes certain commitments on how they will change their attitudes and also on how they will implement the ideas in order to help women with disabilities. However, as soon as the educators leave (NGOs in most cases), the communities do not put that into practice because their predetermined knowledge influences them more than the new knowledge taught by the foreigners (NGOs). The local leadership plays a conscious role in making the predetermined truths about disability subsist because when beneficiaries for certain community development programmes are being selected, the voice of the local leadership is very influential.

(Interview, Ellen, physical impairment 16 June 2014)

This was supported by one of the key informants who said the following:

> *NGOs have come in this area to educate the communities on how to mainstream disability in all programmes initiated at community level either by non-governmental organisations or locals. The people (able-bodied) have been educated on how to include PwDs in community initiatives using indigenous knowledge systems. The inclusion has never materialized because the local leadership, together with other members of society can pose resistance to such ideas and therefore it ends like that. Exclusion from community initiated programmes has been largely the basis of their poverty in this community.*
>
> (Interview, Key Informant, 25 June 2014)

4.3.7 Partial implementation of Disability Legislation

Some women with disabilities who were interviewed expressed ignorance of any legislation on disability. This shows that women with disabilities in rural areas are deprived of important information in their lives, therefore they cannot claim their entitlements and freedoms. Those who at least expressed some knowledge also pointed out that the so-called legislation and policies have never helped them in any way. When asked whether there were any development and assistance programmes offered to women with disabilities by the department of social services to address socio-economic challenges, a representative response given by the key informant interviewed was that:

> *The current economic crisis in the country has had a negative impact on the availability of resources, particularly those provided by the government to women with disabilities. The economic crisis has eroded almost everything including the social safety nets which used to buffer women with disabilities from poverty and other problems they face on a daily basis. These resources have been increasingly subjected to withdrawal threats as budgets are cut or at times are never available to assist them in the country, especially since the economy has continued performing badly. The government is currently struggling to revive such schemes which have since collapsed and there is no legislation to take government to task as far as the challenges are concerned. The liquidity crunch has also added on to the crisis making it difficult, if not impossible, to resuscitate such schemes in the shortest time possible.*
>
> (Interview, Key Informant, 19 June 2014)

In fact the views expressed by participants revealed that many traditional charities targeting PwDs in the country have witnessed significant declines in the amounts donated, with some charities having closed down owing to the economic crisis in the country. Disabled women have taken the brunt of these budgetary cuts and dwindling social services in rural areas, leading to the intensification of the

challenges they currently face. The discussions held during the interview sessions also revealed that the basic needs and interests of women with disabilities with any other person with a disability, have now been put in direct competition with those of other vulnerable groups – for example orphans. HIV and AIDS has shifted the government's attention from disability to HIV/AIDS since the emergence of the economic crisis. It would appear that HIV and AIDS as a health challenge to the nation invariably draws greater budgetary attention and social priority.

In other explanations, it was clear that participants felt that the continued economic crisis would only exacerbate existing and deeply entrenched structural forces that perpetuate the poverty, social exclusion and marginalisation of women with disabilities, especially in the rural areas. One key informant stated the following with regards to legislation:

> *The major problem is that Zimbabwe as a country does not have a national policy on disability. A national policy is very important with regards to implementation of disability laws and acts. Zimbabwe does not have a disability policy to guide the implementation of the 1992 (reviewed in 1996) disability act. Zimbabwe was the first country to establish the disability act in the region but this disability act has never been implemented and effectively used in the country for the benefit of women with disabilities, hence their continued suffering.*
> (Interview, Key Informant, 22 June 2014)

It was also asserted by one of the key informants that there should be a strong link between what is on paper and what happens on the ground for women with disabilities. According to him, people should be practical instead of merely formulating policy in offices, and the application of these policies should be filtering down to the grassroots to help people with disabilities:

> *The rhetoric of international rights and legislation in Zimbabwe does not put food on the tables for women with disabilities in rural areas and basic needs may pre-empt the abstraction of the rights. In reality, there is a tension that exists between the necessary articulation of human rights, the applicability of legislation and the fundamental requirements of food to eat, a place to live and a means of livelihood for women with disabilities in rural areas. The government does not have articulate policies and legislation related to social protection in general for PwDs.*
> (Interview, Key Informant, 19 June 2014)

4.3.8 Effects of Migration on Households

The women who participated in the study lamented that the family members especially in rural areas used to be the primary support system for PwDs, but due to constraints as a result of the economic crisis, the capacity for family members to meet this obligation is on the wane. Further, the participants introduced me to another phenomenon of female-headed households which they cited in relation to the migration of male household leaders the area. Women with disabilities whose husbands and children had migrated to neighbouring countries cited that their burden was worse in taking care of the families. They also reiterated that the economic crisis in Zimbabwe had pushed their husbands and children to migrate in order to look for greener pastures. According to them, family solidarity, which used to be the fabric of the rural communities, was now a thing of the past. This is best captured in the following words from the participants:

> *A lot of us who were married by non-disabled men have been left behind because our husbands and children have moved out of the country for greener pastures but never to return again. For them to leave some of us had to sell our cattle to finance the journeys but it is now difficult to replace those cattle. The majority of us are now female heads of households and this is even characteristic of families without disabilities. This area has a lot of female headed households.*
>
> (Interview, Vanessa, physical impairment, 07 June 2014)

> *The current economic situation in the country has disrupted family ties in this area which is one of the reasons why disabled women suffer. Most people have migrated and because of that we are no longer living as a family like we used to do. People are now scattered all over, some have gone to towns, some are in South Africa and all over the world, and therefore a compact family is hard to come by nowadays. The family members would not simply watch their fellow family member starving to death. Such commitment to one another is now hard to come by, since the majority of people are also starving and so they do not have enough to spare and to give to a disabled woman, worse off if you have your own children.*
>
> (Focus Group Discussion Participant, 25 June 2014)

4.3.9 Exclusion of Women with Disabilities from Development Programmes

Women with disabilities who participated in the study all agreed that they are always side-lined in development programmes and they would count themselves lucky to be part of such programmes. They explained that they are excluded and denied access to mainstream economic activities, due to discrimination arising from negative perceptions of their abilities and potential, arising from outdated

notions and myths about disability in traditional societies. This exclusion from mainstream economic activities is the reason why they have limited participation in social and economic development processes. The following assertions capture these sentiments as expounded by the participants, one being a woman with a disability and the other one being a key informant representing one of the government departments:

> *We are perceived as bad risks, are denied loans by micro lenders and peer lending groups. Economic empowerment programmes do not target women with disabilities but they target the whole community, yet it is at the level of selection that we are shut out of the programmes by our own fellow community members based on incorrect assumptions that we are not appropriate for business services and we just have to get charity assistance.*
> (Focus Group Discussion Participant, 17 June 2014)

> *The loan schemes we are currently administering within the country do not target women with disabilities but women in general. If women with disabilities are to benefit from these schemes, they can do so through the mainstream society. The ministry makes use of the structures on the ground* – communities have representatives at village levels, *who should assess the potential beneficiaries.*
> (Interview, Key Informant, 07 June 2014)

4.4 Coping Strategies adopted by Women with Disabilities

In response to the social/cultural, economic and political challenges they face, women with disabilities show their agency as they adopt a variety of coping strategies. The following were cited as coping strategies: subsistence farming, market gardening, buying and selling, asset disposal, piece jobs in the form of casual labour, self-help projects and livestock rearing. Others that were mentioned, though not common to many disability households are: gold panning and fishing. In addition to this, most of the participants reported to be surviving on donations from other family members, remittances, gifts and prostitution, and these bring very little income to the family. Most of the participants in the focus groups echoed that they squeezed out a living in the most hostile of environments with poor rainfall patterns, poor soil, serious climate changes, lack of agricultural inputs, among others. The sub-headings below present the strategies adopted by the women with disabilities in dealing with the constraints they are currently facing.

4.4.1 Peasant Farming and Market Gardening

Peasant farming and market gardening emerged as the most commonly used coping strategies cited by women with disabilities who participated in this study. Market gardening and peasant farming, which are done in rural areas but on a small scale, provide a relatively secure source of food and other non-food items, but this is not always the case since the land is ever dry due to poor rainfall patterns. Poor soil, serious climate change, lack of agricultural inputs are some of the limitations which pose challenges to women with disabilities engaged in peasant farming and market gardening. For example, despite most irrigation schemes being gravity-fed, most of the dams in the area dry up or the water levels are too low to support irrigation schemes which are currently a source of hope for the communities in general.

This has reduced the irrigated area by half and has led to limited crop diversification and increased consumption-led production by all people in general, women with disabilities included. This means that women with disabilities who have small plots in the irrigation schemes are inclined to consumption-led production rather than a market-based production approach. One of the participants said the following:

> *Irrigations in this area are a source of hope than proper farming in the fields because this area is a drought prone area which receives erratic rainfall. However, the major challenge I experience is that crop production in the irrigation scheme suffers from challenges posed by natural problems, for example the dams can dry up any time of the year and this affects the yields. I also experience problems in terms of labour supply as I do not have children who can work for me, which is the opposite when I compare myself to my colleagues in the irrigation scheme. I have to find people who work for me in return for payment.*
>
> (Interview, Caroline, physical impairment, 18 June 2014)

However, despite geographical factors posing challenges to some of the coping strategies, an intersection of factors converges to disadvantage women with disabilities who are engaged in peasant farming and market gardening in rural areas. Peasant farming and market gardening are labour intensive activities which constrain mostly women with disabilities in terms of labour supply, therefore benefits accrue mostly to disabled women who have children as a source of labour. The labour intensiveness of peasant farming and market gardening poses a serious challenge for the women, and stands in the way of their becoming full time contributors to the enterprise. The physical demands of this type of labour can worsen the disability by straining the muscles, and may therefore be regarded as a life-threatening activity. Children become an important buffer for women with

disabilities who have such challenges, as they assume labour duties on behalf of their caregivers and parents. In this case therefore, women with disabilities especially those with severe physical disabilities and visual impairment, who are single, find it difficult to participate in such ventures that need casual labour. In relation to the above sentiments, one of the participants revealed that:

> *Market gardening provides a relatively secure source of food and other non-food items but not always, since the land in this area is ever dry. Market gardening is my source of income because I have my own personal garden which I constructed after failing to own a piece of land in the irrigation area. The garden provides me with food in most cases and other non-food items. I am no longer active as I used to be a long while back because my age is also restricting me, not to mention my disability. My children water the garden for me and they are responsible because they know that this is our only source of income in a dry land like this.*
> (Interview, Mildred, visual impairment and physical impairment, 25 June 2014)

4.4.2 Microfinance

Some women with disabilities who participated in this study engage in self-help projects that are funded by a local disability organisation operational in the areas in which the study was conducted. Some of the women with disabilities interviewed were funded by a local NGO to start self-help projects, which include sewing, poultry, animal rearing, peanut butter making, as well as the buying and selling of second-hand clothes. The intention of the local disability NGO in offering microfinance services to women with disabilities is to empower them economically and to eradicate poverty by allowing them to be agents of change regarding how they live with disabilities. Through those projects, women with disabilities are able to buy clothes, food and take care of their families. However, the loans availed to them in order to allow them to engage in productive projects are very minimal. They are also limited in terms of accessing microfinance services from other institutions. One participant stated:

> *I got a small loan from one of the NGOs operational in the area to start on a retail project, therefore the only way that makes me survive is buying and selling vegetables like rape, tomatoes and onions to the local community. The amount I got was too small to start on a big project therefore I am not getting much since the proceeds are only used to buy food for the family. The local community buys what I sell on a humanitarian basis, out of pity because they know how I survive. Since buying and selling usually does not allow me to get enough, I supplement this by asking for donations from people around.*

(Interview, Caroline, physical impairment, 18 June 2014)

However, the majority of women with disabilities have not been able to access loans due to a number of reasons. The criteria include collateral security among other things so the starting point itself excludes the majority of women with disabilities who may not have the collateral security. Those who have benefitted from the services have not been in a position to alleviate poverty for their families as expected in the goals of the programme. This is because the scant profit accumulated is channelled towards covering basics like buying food and clothes among other things, basically consumption only. In short the money is used for consumption purposes and not for productive purposes. This is best represented in the following:

> *In actual fact, microfinance cannot be argued to be of benefit to women with disabilities because most projects formed out of these little funds have not been able to thrive for a long time. This is because the self-help projects being run by women with disabilities in this area are not viable in terms of profit making. They face quite a lot of challenges including lacking access to viable markets in the rural areas. The economic crisis has contributed to their failure as well because people in the rural areas have no money to buy some of the products since the majority are not employed. Therefore, the little profits generated are directed towards food for consumption which in turn will eat into the budget until the projects collapse. So the idea of empowering women with disabilities fails altogether before it even achieves its results.*
>
> (Interview, Key Informant, 22 June 2014)

Further, women with disabilities also have fallen victim to the cultural beliefs. For example, while the credit is received by women with disabilities, it is almost always used by their husbands. In cases such as these there is a strong chance that the women borrowers are not the end users of the money, which makes it doubtful that the loan itself empowers women. Tied to this idea is the notion that women with disabilities may not always be the ones to take the decision on how to use the money borrowed, but when it comes to repayment, they are held responsible. This adds to the social and economic burden of women with disabilities in rural areas. This is shown in the following statement by one of the key informants:

> *Men will always have a say on how the money is used and in most cases it is the man who decides on how the money should be used. Since this programme by my organization targets women with disabilities only, the community feels that women with disabilities should not benefit in any other programmes because they have microfinance which is benefitting them (which is their programme).*

(Interview, Key Informant, 19 June 2014)

Another participant had this to say:

> *I must safely say that there has not been a remarkable progress recorded in the income generating projects for women with disabilities being sponsored through microfinance by my organisation. Most microfinance projects for our clients are failing at an alarming rate due to quite a number of reasons, for example the larger part of the profits realised can be channelled towards consumption instead of sustaining business, leading to a collapse of that microfinance enterprise. With this trend, clients will end up failing to pay back the loans.*
>
> (Interview, Key Informant, 19 June 2014)

This is reiterated in one of the interviews. This disabled woman said:

> *In most cases, we end up borrowing from local loan sharks in order to pay back the money borrowed. The loan sharks borrow us money at high interest rates therefore microfinance end up disempowering us instead of empowering us.*
>
> (Interview, Ellen, physical impairment, 16 June 2014)

The goal for microfinance is poverty alleviation and socio-economic empowerment of women with disabilities. However, it has so far not achieved these goals, as indicated in the sentiments by one of the key informants:

> *There is no economic independence being created as the majority of beneficiaries cannot engage in viable commercial ventures which are mainly dominated by able-bodied women. This in actual fact does not create economic independence, neither does it create participation outside the family social activities and inside family. It further confines them to the informal sector which is currently a major source of income for people in the country but not a good area so far for PwDs because it is characterized by competition. Women with disabilities have not been able to educate their children even though they have been at least given loans to start micro businesses. My argument is based on those that have benefitted so far since 2010. There has not been a change in the levels of income in their homes, hence my argument that microfinance has not created any economic independence so far for them.*
>
> (Interview, Key Informant, 26 June 2014)

4.4.3 Buying and Selling

It was confirmed in the focus group discussions that buying and selling is one of the major activities undertaken by women with disabilities in the area. However, it was also highlighted in agreement by the focus group discussions that in-as-much as getting into the business of buying and selling was easy for women with disabilities; the economic crisis was a major constraint for them as the majority of them ended up broke. One participant in a focus group discussion had this to say:

> *Starting business projects in the rural areas now is a daunting task in this economic crisis. The informal sector is now flooded and people compete for customers, failure to get customers means getting broke. As women with disabilities we end up engaging in businesses that are already oversubscribed, like selling second-hand clothes, vegetables and fruits since these are fairly easy to get into. This is difficult as one faces quite a lot of challenges, for example, markets in rural areas are limited, and we are also competing with able-bodied women in business which spells doom for a woman with a disability. The result is that one gets broke faster than is usual, owing to a number of factors beyond an individual with a disability's control.*
>
> (Focus Group Discussion Participant, 23 June 2014)

4.4.4 Asset Disposal

In relation to the aforementioned issues, some women with disabilities were found to be coping by way of selling through the sale of assets which they had accrued through self-help activities and projects. In doing this, they try to exercise their agency in a bid to fight the challenges they experience as a result of living with disabilities in rural areas. These assets include animals like cattle, goats and in addition to this some reported having sold ox-drawn ploughs and other household valuables. Therefore, some of them had a comparative advantage in coping with their impairments and challenges due to access to income, and this resulted in access to more resources on the basis of assets and other entrepreneurial activities which they engage in. Although the sale and consumption of small livestock, especially chicken and goats is common to most disabled women who own these, this coping mechanism does not significantly reduce vulnerability and suffering because of the small amount of money they fetch from the market. However, a relatively large proportion of women with disabilities do not own any livestock and thus the benefits of owning and selling livestock are denied them. This fact was reflected in the response of one of the key informants:

> *The building up of stocks of food and other viable assets can be cited as one important coping strategy for all rural women, including those with disabilities. However, very few women with*

disabilities have access to land even though land is not sold but inherited in rural areas, and this impacts negatively on their potential to store grain and other staple food when it rains.
(Interview, Key Informant, 19 June 2014)

A thirty-six (36) year old disabled woman expressed the idea that the challenges of living with a disability in a country experiencing an economic crisis poses serious challenges to her family and therefore she had resorted to selling a few assets to cope with the challenges:

I have borne and felt the burden of the economic crisis in this country. I had a few cattle, goats and sheep but since the beginning of the crisis, I keep on selling them to provide food for my family as well as covering other expenses in cases of emergency, for example, a funeral in the family. This is the only way I have been surviving together with my family.
(Interview, Ivy, physical impairment, 27 June 2014)

Most women with disabilities who had sold assets confirmed having sold livestock and the main reason for selling assets in most cases was to buy household food. One of the informants said:

Although the selling and consumption of small livestock, especially chicken and goats, is common to most women with disabilities who have them, this coping mechanism does not significantly reduce vulnerability and suffering because of the little money these fetch on the market. The selling of assets, if relied upon too much, can, in the long run, increase drought risk, as women with disabilities will not have enough productive assets to prepare for future droughts and challenges.
(Interview, Key Informant, 26 June 2014)

4.4.5 Remittances

Women with disabilities who participated in the study also cited that they cope through remittances which can be in form of cash or goods. The remittances can be from children, relatives, husbands and well-wishers. Most women with disabilities who participated in the study had their relatives, children and husbands in South Africa, Botswana and other neighbouring countries, who then sent remittances at times in the form of cash or goods through unconventional channels like traders, travel agencies *malayitsha*s and bus companies. These remittances are an important buffer against household poverty in that they are a source of food. The remittances are aimed at reducing poverty, especially through food provisioning, but on the other hand they can also be a source of income for a woman with a disability.

It is also important to note that not all women with disabilities are as privileged as to get remittances. Only those whose children, relatives and husbands have gone abroad amid the economic downturn in Zimbabwe can do so. Further, the sustainability of remittances as food provision, as well as mitigating the challenges experienced by women with disabilities in rural areas, remains an issue as they do not have control over the continuous supply of these remittances. In this study, remittances were found to be stop-gap measurements in times of hardship. A forty-two (42) year old woman with a disability stated that:

> *In addition to buying and selling of second hand clothes, I also survive on groceries and very little cash which is sent to me by my relatives in South Africa and Botswana. At least I know I will receive something even though the remittances may not be enough to last long in sustaining the family's needs. The goods are normally delivered by the malayitshas. I do not know if I was going to survive had it not been for the groceries and some little cash I receive from my relatives.*
>
> (Interview, Cecilia, visual impairment, 12 June 2014)

4.4.6 Casual Labour

Casual labour in the form of piece jobs (which is also seasonal), is another predominant coping strategy for women with disabilities in the rural areas. This coping strategy, as established by the study, is also seasonal and erratic as piece jobs are hard to come by in rural areas due to economic challenges currently affecting the country. This contributes to the suffering and hardship of women with disabilities. The scarcity of job opportunities in the off-season period presents livelihood challenges for the majority of women with disabilities dependent on casual labour. However, within the process of providing casual labour in return for payment, women with disabilities are exploited in the sense that the labour they provide is not equivalent to the payment they get. This further works against their agency in trying to address the challenges they experience as a result of living with disabilities. Further, casual labour too is an endeavour that requires physical fitness and individuals who have the capacity to do manual jobs. The negative attitudes to disability in the society prevails to such an extent that a woman with a disability may not even secure the piece jobs in the community. For instance, a forty-seven (47) year old woman with a disability stated that:

> *In most cases I survive on casual labour\piece jobs in order to take care of my family. In return I get mealie-meal, sugar, salt and soap as my payment. My disability does not allow me to do manual work as I constantly feel pain, time and again but I have an obligation to feed my children, therefore, I end up forcing myself to work and this happens against the recommendations made by the medical doctor that I should not do manual work.*

(Interview, Blessing, visual impairment and physical impairment, 20 June 2014)

The key informants concurred that casual labour in the form of piece jobs and food aid from non-governmental organisations (which is seasonal) are the major sources of food for women with disabilities. The key informants also agreed in their sentiments opinion that casual labour is normally provided by the children, especially in cases where certain disabilities may or may not allow a person to do certain jobs, or if one is allowed to work, it may be to a limited extent, as demonstrated in the following assertion:

> *Casual labour is one of the major sources of income for women with disabilities in this area but just like food aid, it is also seasonal. However, whilst it is the major source of income, it mainly benefits those women with disabilities who have children to give support in terms of labour. Otherwise, the majority of women with disabilities cannot commit themselves to this task without some form of labour back up – children.*
>
> (Interview, Key Informants, 07 June 2014)

4.4.7 Food Aid

Food aid is one of the seasonal coping strategies cited by the participants, who point out that it is not permanent, and so the extent to which it is helpful cannot be determined with precision, because on the food is distributed as an emergency measure, as articulated in the following statements:

> *I must also point out that the majority, if not all, women with disabilities in Insiza district are depending on food aid from World Vision being implemented on an emergency basis. In this programme it is notable that they benefit and whoever does not benefit in this programme, is owed an explanation by her community and or family members. However, this is not a permanent programme since it is seasonal. The programme is unsustainable and creates a serious dependency syndrome on the part of the community as a whole.*
>
> (Interview, Key Informant, 25 June 2014)

The key informants also said that the rate at which droughts were occurring has actually caused more socio-economic challenges for women with disabilities in this area than any other hazard. In this regard, women with disabilities who participated in this study lamented that they were more prone to vulnerability or loss in the face of different hazards like drought, but that the effects of these kinds of natural disasters were exacerbated by the impact of gender, disability and age discrimination. They pointed out that they normally find it difficult to reconstruct their livelihoods following natural disasters such as drought.

The basic needs of women with disabilities as with any other disabled persons, have now been put in direct competition with those of other vulnerable groups, for example orphans, but HIV and AIDS has shifted the government's attention from disability since the emergence of the economic crisis. Concomitant with the numerous stressors that are embedded within the current situation, the national development agenda has shifted many resources to the HIV and AIDS arena. The government has cut down on outreach programmes to rural areas as a result of the economic downturn. Thus, it can reasonably be assumed that the continuation of the crisis will only deepen entrenched structural forces that perpetuate the poverty, social exclusion and marginalisation of women with disabilities, especially in the rural areas. Whatever options of relief are left for them is temporary and unsustainable. The following sentiments speak to the claims:

> *The current economic crisis in the country has had a negative impact on the availability of resources, particularly those provided by the government to women with disabilities. The economic crisis has eroded almost everything including the social safety nets which used to buffer women with disabilities from poverty and other problems they face on a daily basis. The government is supposed to provide social security schemes such as social safety nets for the vulnerable groups through this department (Social Services), but these schemes have since been eroded and subjected to withdrawal threats, as budgets are cut or at times are never available to assist them especially since the economy has continued performing badly. The government is currently struggling to revive such schemes which have since collapsed. The Government is facing challenges in mobilizing resources and therefore at the moment the priority in its resource mobilization is targeting the HIV/AIDS sector and not disability. Therefore at the moment, it seems disability is not a priority hence women with disabilities are currently facing serious challenges. However, where informal social security mechanisms exist especially in some NGOs, they are weak, unstructured, and unsustainable and are in any case inaccessible to most women with disabilities who have to benefit through the mainstream society. It is also important to highlight that, other things being equal, social schemes have never been adequate enough to sustain the lives of women with disabilities in rural areas.*
> (Interview, Key Informants, 24 June 2014)

4.4.8 Prostitution

Discussions in the focus groups also drew attention to the idea that due to the destruction of livelihoods, assets and means as a result of the economic crisis, women with disabilities and their

children in this area are in danger of using sex as a survival strategy, especially in areas where gold panning is done. One focus group participant said that:

> *Coping strategies by women with disabilities differ from individual to individual and from household to household. I survive on begging and for me it is a better option because some of my fellow women with disabilities have been to gold panning areas where they engage in prostitution with gold panners for them to survive especially in these difficult times. So far I know two women with disabilities who died early this year in my village and rumour says they died of HIV and AIDS. Those women used to stay in gold panning areas for a couple of days trying to get food to take care of their children.*
>
> (Focus Group Discussion Participant, 23 June 2014)

The effects of the disease were noted by the key participants who also expressed the same sentiments that in the area, like elsewhere in the country, the economic crisis reinforces unsafe practices, especially where sex is a currency. Some women with disabilities and their children are frequently expected to pay for life's opportunities as permission for accessing other resources in order to survive. One of the key informants stated that:

> *Some women with disabilities in this area go to the beer halls at night and to my surprise they do not drink and one wonders what brings them to the beer halls if they do not drink. My suspicion is that they are prostituting in order to survive. In my thinking, prostitution is their way of getting money and probably the easiest one. Some of them will end up having children, but no cases of abuse are reported.*
>
> (Interview, Key Informant, 19 June 2014)

4.5 Summary

The purpose of this chapter has been to present, in a descriptive manner, the data gathered from the participants through interviews (in-depth and semi-structured) and focus group discussions (FGDs). The data presented is meant to respond to the following research question: "What are the challenges experienced by women with disabilities in a rural setting, and which coping strategies do they adopt in a time of an economic crisis in Zimbabwe?" Strictly related to the aforementioned sentiments, the findings presented will contribute significantly towards developing the argument, that the approach to disability in Zimbabwe is unsystematic, individualistic and paternalistic, thereby rendering women with disabilities vulnerable to multiple oppressions. This chapter, however, provides a context within which to understand Chapter 5, which demonstrates the argument raised for this study, on the basis of the data gathered, which is largely located within the discourses of disability and development.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 Introduction

On the basis of the data which was drawn from interviews (in-depth and semi-structured) as well as focus-group discussions (FGDs), this chapter constitutes an attempt to demonstrate the argument that the approach to disability in Zimbabwe is unsystematic, individualistic and paternalistic, thereby rendering women with disabilities vulnerable to multiple oppressions. The argument will be demonstrated within the broader framework of the challenges experienced by women with disabilities and the variety of coping strategies they employ in a bid to counter the rising challenges posed by living with disability in rural Zimbabwe. Thus, as will be elaborated further in the paper, in demonstrating the study's argument, I will be answering the following research question: What are the challenges and coping strategies of women with disabilities in a rural setting when considered against the backdrop of the economic crisis in Zimbabwe? The CA serves as a framework of analysis whose lens will be used for the purposes of demonstrating the argument, which is situated within the framework of the empirical data generated in this study, for the purposes of understanding the experiences of women with disabilities in rural areas.

5.2 Challenges Experienced by Women with Disabilities in a Rural Setting

Deeply entrenched cultural stereotypes and prejudices about disability expressed in images and stories from the traditional past (as detailed in Chapter Four of this study) were cited as the major contributing factors towards the negative attitudes faced by women with disabilities who participated in this study. These perceptions seem to emanate from preconceived truths about disability which are reinforced by myths and traditional practices from the past. In the context of this study, these perceptions are acts of social injustice which feed and entrench inequalities, which in turn manifest in multiple oppressions such as marginalisation and discrimination. If this problem is viewed through the CA's lens, we become aware that these acts of social injustice affect women with disabilities' well-being by depriving them of individual opportunities, opportunities which are hindered by social arrangements which compromise their ability to function in a manner that will benefit them (Mutanga and Walker, 2015; Nussbaum, 2011). The social and cultural arrangements that make up the society in which women with disabilities live, such as social norms, beliefs and practices, work against them, and this leads to social exclusion and eventually to the notion of disability as a personal tragedy

(Robeyns, 2005). Social exclusion affects their autonomy, which is referred to in the CA, which uses terms such as self-determination, self-governance and independence (Sibanda, 2015).

Evidence from the study as shown in Chapter 4 of this study demonstrates that the stigma of disability with its myths and fears from traditional beliefs are often more debilitating for women with disabilities than the disability itself. In traditional societies, the general perception is that cultural beliefs and practices must always be upheld because they represent values that have always existed (Mungwini, 2007), and that what has always existed is useful and normal. Given the fact that disability is still widely perceived as a medical condition (Mutanga and Walker, 2015), women with disabilities are perceived as victims deserving of sympathy and not rights. For women with disabilities who participated in this study, this perception is offensive and strikes to the core of their self-esteem and well-being. Turmusani, (1999) argues that over-emphasis on disability as a medical condition leads to neglect of economic marginalisation, thereby risking the perpetuation of subtle injustices, tragedy and suffering. This is besides the factors that lead to the exclusion of women with disabilities. Thus, as noted by Rioux and Riddle (2011), eradicating systemic conditions of injustice through the disestablishment of ideologies and structures of subordination is a necessity, and in fact a prerequisite for individual human justice and equality, as expounded in the CA (Nussbaum, 2011).

The effect of this injustice is that women with disabilities suffer from the invisibility syndrome; because of prejudice they are viewed in general as lesser beings and a subordinate minority group (Munsaka, 2012). In addition to this, women with disabilities have to suffer being seen as minors (Munsaka and Charnley, 2013) who are always passive and dependent on society for their survival. This results in over-protection and neglect and they are denied their right to determine their destinies and to pursue their aspirations (Nussbaum, 2011; Sen, 2005). In this way, society displays a patronising attitude, which is a subtle form of paternalism and an act of social injustice. Paternalism infringes on their rights (Sibanda, 2015) and denies them the freedom and choices which define full citizenship, as they are not given the opportunity to have autonomy over their lives and make their own decisions (Nussbaum, 2011). This means that women with disabilities are treated as if they were ‘children’, and they are coerced to behave in a certain manner regardless of their right to be recognised as citizens. This necessarily infringes on their rights to social justice (Sen, 1992; 2005, Nussbaum, 2011) and this eventually leads to deprivation and social exclusion.

Participants in this study bemoaned the severity of the challenges they experienced, such as exclusion due to a combination of factors, both social and economic. Chapter 4 of this study bears credence to

this. Evidence from the study also suggests that the obstacles they face are not merely of social exclusion, but also of economic deprivation. Rioux and Riddle, (2011) support this by arguing that the intersection of these two forms of deprivation and how they affect women with disabilities in rural areas has been inadequately addressed by the models of disability. Social exclusion is interpreted both as a static situation of deprivation and as a process leading to it (Terzi, 2005). Trani et al. (2011) argue that economic constraints are an important factor in determining social exclusion. Robeyns, (2011) supports this view, arguing that during economic downturns, women with disabilities become more vulnerable and they bear the brunt of the harshness of the economic woes. This leads, they say, to greater inequality and social exclusion. Using the principle of social justice, the CA turns to the task of dismantling those disempowering social attitudes and structures that affect women with disabilities, thereby promoting their access to opportunities in life in order to fight exclusion (Nussbaum, 2011; Rioux and Riddle, 2011).

Trani et al. (2011) argue that in social exclusion, failure is interpreted as an inability to participate and, therefore identifies functioning failures. Confirming this opinion, Rioux and Riddle, (2011) claim that historically, women with disabilities have suffered from the 'invisibility' syndrome which basically refers to their exclusion from society in all forms and at all levels due to discrimination and marginalisation. In Zimbabwe, the absence of a welfare system and of positive policies that promote the integration and participation of women with disabilities cause the existing exclusion to continue (Turmusani, 1999). The social exclusion they experience is based on what they cannot do and focus is not maintained on what they are able to do (Sen, 1999; 2005). This results in social injustice which manifests in various kinds of oppression. Social exclusion denies them the opportunity to live a life of dignity. Hopelessness, as well as the absence of zeal to fight stigma, discrimination and exclusion, puts pressure on women with disabilities to adopt different coping strategies (an aspect that will be discussed in the subsequent sections of this study).

Participants in this study also raised concepts of "othering" and incompleteness which result from the social dynamics associated with disability. Underpinning these dynamics is that contemporary perceptions of disability are predicated on the discourses of normalcy (Afolayan, 2015) and the Medical Model is home to the discourse of normalcy (Mohamed and Shefer, 2015). On the basis of the Medical Model, disability is individualised, and therefore characterizes women with disabilities as incapacitated. Thus it fosters the idea that disability is a personal tragedy. In this paradigm, a gendered perspective on the basis of a normal/abnormal binary plays to the balance of existing power

and privileges, with the able-bodied purporting to know what is best for the disabled (Munsaka and Charnley, 2013).

Gender roles assigned to women with disabilities subordinate them to the patriarchal system in which they are perceived to be different, and unworthy of equal opportunities, as their lives are expected to revolve around the home. The idea of normalcy therefore excludes women with disabilities from the mainstream and subjects them to multiple forms of oppression which arise from their particular position in a patriarchal society, and from a state of inequality that denies them access to opportunities and economic resources. Finally they also suffer from oppression which is a result of discrimination against the disabled, which results in social exclusion. By taking into consideration the importance of freedom and choices and how these contribute towards an individual's well-being, the CA moves beyond the dual framing of disability within which the disabled person is typically stigmatized. It also moves beyond an approach which examines society and advocates for the disabled to be treated as equals. The CA advances a relational and integrated approach that considers both individual impairment and social arrangements (Mutanga and Walker, 2015).

Existing in the context of a power structure characterised by patriarchy, women with disabilities have also come to accept exclusionary practices as the norm (Afolayan, 2015, Terzi, 2005). They may not understand that the exclusionary practices and structures are a result of the social structures, practices and systems as they fail to exist in sync with established structures which are regarded as 'normal' (Moodley and Graham, 2015). Thus, they may think that exclusionary practices and structures are as a result of their impairments and not the system which perpetuates social injustice. Within this scenario, women with disabilities are subjected to social injustices and their lives are characterised by dependence, resulting in marginalisation and exclusion. Further, labels resulting from these discourses impact on women with disabilities' self-image and this leads to the standard response of pity by the able-bodied in society, thereby encouraging a culture of dependence. A combination of these factors leads them to carry the burden of disability as a personal tragedy (Medical Model) (Sibanda, 2015). In Zimbabwe, behaviour towards disabled women, informed by pity, charity and paternalism infringes on their capacity and rights, thus denying them the opportunities which create freedom and choices to develop (Sibanda, 2015).

The study established that most of the participants lacked knowledge on the existence of legislation on disability in Zimbabwe, and some felt that it was not being implemented. The legislative framework on disability in Zimbabwe lacks implementation due to a lack of political will and

ineffective prioritisation, coupled with resource constraints linked to the economic crisis. In the CA, legislation defines equitable sharing of available opportunities and resources, thus it becomes the principle by which every human being can claim justice and equality (Nussbaum, 2011; Sen, 2005). The availability of supportive legislation through policies and laws (Mandipa, 2013) underpins the provision of such entitlements and accords the disabled the right of access to and provision of services, as well as the freedom and choices that women with disabilities should enjoy (Sen, 1992; 2005). The fact that women with disabilities are denied justice has resulted from most existing policies in Zimbabwe spreading their net to try and cover all vulnerable groups. This has meant insufficient attention and focus on disability issues.

Women with disabilities in Zimbabwe do not, as a rule, benefit from legal provisions. They are therefore restricted as to access to services and resources, and thus deprived of the right to lead decent lives (Mandipa, 2013; Sen, 2005). The absence of a functional and robust disability policy in the country (Mandipa, 2013) has led to a situation whereby women with disabilities are more affected than disabled men, owing to their position on the bottom rung of the social ladder (Hedge and Mackenzie, 2012). Consequently, women with disabilities are left at the mercy of paternalistic policy-makers, and the general public. The problem is further compounded by the lack of systematic intervention which entrenches the notion of disability as a personal tragedy. This approach tends to leave women with disabilities to their own devices. The study refers to this phenomenon as "coping strategies". In Zimbabwe, the Disabled Persons Act of 1996 prohibits the discrimination and marginalisation of PwDs in employment, but its provisions exist only in principle and are non-existent in practice. The situation is also compounded by the fact that disability issues in Zimbabwe have not been put on the national agenda and are largely viewed within the realm of medical and social welfare frameworks (Sibanda, 2015), frameworks in which the problems are largely individualised. As a result of this approach to disability, there has been a total neglect of the wider political, social and economic needs of PwDs in Zimbabwe, as they are perceived to be incapable of independence (Sibanda, 2015).

In a statement of appreciation, among other efforts, on the 23rd of September 2013, Zimbabwe made great strides towards recognising the rights of people with disabilities by ratifying the UN Convention on the Rights of Persons with Disability (UNCRPD, 2008) and its Optional Protocol. In addition, the enacting of the new constitution of Zimbabwe in 2013 meant significant advancement towards recognising disability rights in the country (Constitution of Zimbabwe, 2013). Riding on such policy level advancement, various institutions and organisations should contribute towards addressing

challenges faced by women with disabilities in Zimbabwe. Further, although Zimbabwe has ratified the UNCRPD, the legal instrument has not yet been adapted for domestic needs, so that it can guarantee practical application in the service of Zimbabwe's disabled women.

Developed countries, and a few developing countries where advocacy has been very effective have formulated social security provisions, for instance, disability insurance. This, however, has to be provided for in the national constitutions of the member states themselves. In Zimbabwe, women with disabilities are not entitled to any disability insurance, nor are they entitled to any disability allowances. Of special interest is that Section 83 of the Zimbabwean constitution states that PwDs will be assisted "if and when" resources are available (Constitution of Zimbabwe, 2013). This condition suggests that the legislation is a matter of privilege and not a right. Mythical beliefs seem to add insult to injury, when they are considered side by side with the state's weak promises of intent. This all results in women with disabilities being deprived of access to resources and services. Given this situation, their functionality and well-being are further prejudiced (Robeyns, 2005; Sen, 1999).

Participants in this study cited that failure to acquire formal education is the major reason they have limited practical opportunities to shape their future. The absence of education and training opportunities for women with disabilities due to discrimination and neglect, is as a by-product of the non-existence of systematic intervention aimed at enhancing opportunities for them. No efforts are being made to create a shift from paternalistic attitudes, to recognising them as people with rights. Women with disabilities who participated in this study confirmed that there is the lack of a functioning system that will allow them to receive an education, be enrolled in vocational training of their own choice, and be appropriately employed, based on qualifications and skills. This will end their reliance on charity.

The literacy levels of this sector are low, and it is difficult for them to find employment. This serves only to exacerbate their vulnerability to social exclusion. This separation deprives them of their ability to fully exploit their freedom and choice in planning a future. In this study, the problem caused by poor literacy for women with disabilities contributes towards limited prospects for finding safe (even sheltered) employment (ILO, 2011). Evidence from this study points to a high likelihood that the absence of education and skills may transmit social and economic disadvantages which have lasting inter-generational effects for the welfare of affected household.

Human capability attained through education is important because it refers to the substantive freedom of people to lead the lives they have reason to value and to enhance the real choices they have (Sen, 1999; Swartz, 2014). Recent scholarship acknowledges that education, for example, is crucial beyond its role in production, its most important role being that of increasing human capability and therefore choice (Sen, 1999; Robeyns, 2005; Mitra, 2006). The level of education for an individual represents a potential effective indicator of the level of working capacity, but also implies other less observable, but equally significant skills (Sibanda, 2015; Mapuranga and Mutswanga, 2014). Women with disabilities usually cannot reach satisfactory levels of literacy either by choice or compulsion, thereby being consigned to social exclusion (Nussbaum, 2011).

These findings concur with what was reported in the disability survey conducted in Zimbabwe, which established that fewer females than males with disabilities have had access to formal education. The majority reported having primary education as their highest level of education (Disability Survey in Zimbabwe, 2013). Literature on disability is awash with educational and employment inequalities which result from disability and gender issues, but this gap is much wider for women with disabilities than it is for their able-bodied counterparts (Mitra et al., 2011; Sibanda, 2015). The intersection between gender and disability is reflected in relation to education and employment outcomes in which the under-employment and/or unemployment of women with disabilities results from lack of access to education.

Participants in this study reported a lack of resources to purchase assistive devices, which made their lives in inaccessible environments even more difficult. These much needed assistive devices are costly and unobtainable in rural areas as there are no orthopaedic workshops to repair them. In addition to this, rural settings are typically poorly resourced, yet access to services and resources are factors which are critical in determining a PwD's functionality in a particular social setting (Robeyns, 2005; Mitra, 2006). Focusing on the aforementioned factors, the majority of the participants mentioned how expensive assistive devices are, in a country where social safety nets and disability grants become unavailable or are completely withdrawn because of economic constraints. Foregoing critical expenditures for persons with disabilities deprives them of participation in productive, domestic and community life, which has spill-over effects on the lives of other family members (Palmer et al., 2015).

Further, during a time when NGOs and other institutions are reducing their funding to Zimbabwe, the target shifts to areas that are generally considered to be 'needy' and disability is simply not one of

those areas. In fact, the basic needs and interests of women with disabilities, like any other person with a disability, have now been put in direct competition with those of other vulnerable groups – orphans and those living with HIV and AIDS – which has shifted the government's attention from disability (NASCOH, 2005; DHAT, 2011). This has led to government cuts on disability outreach programmes and women with disabilities, especially those in rural areas, have borne the brunt of the budgetary cuts and dwindling social services. In fact, many traditional charities which used to support women with disabilities in Zimbabwe have witnessed significant cuts in aid. Some charities have shut down as a result of the economic crisis. This in turn has exacerbated the challenges they experience. This seems to indicate that lack of equitable access to resources and services such as healthcare, education, employment and opportunities (WHO and World Bank, 2012; (JJA, 2012) contributes towards economic deprivation for women with disabilities. Further, the study speculates that an ongoing economic crisis will only deepen already entrenched structural forces that perpetuate the poverty, social exclusion and marginalisation of women with disabilities, especially in rural areas.

5.3 Coping Strategies Adopted by Women with Disabilities in a Rural Setting

Absence of systematic means to address the challenges experienced by women with disabilities in rural areas, the paternalistic view of disability, and an ineffective implemented disability legislative framework, results in multiple levels of oppression, thereby compromising issues of social justice. Social exclusion denies them a life of equality and dignity. The zeal to fight these layers of oppression puts pressure on women with disabilities to adopt a range of coping strategies. Wisner, et al. (2004) is of the view that coping is the manner in which people act within their means to save themselves from adverse situations. Noteworthy is that coping does not only involve the management of limited resources but also how disadvantaged members of society cope in unusual, abnormal and adverse situations (Wisner, et al. 2004). Coping strategies may therefore take different forms, some of which may even be discouraged by members of a social group or gender. In the light of this, in what follows, the study discusses the coping strategies adopted by women with disabilities in rural areas to cushion themselves against the challenges they experience as a result of disability.

The study established that the most common coping strategies used by women with disabilities are peasant farming (unproductive when not under irrigation), market gardening, buying and selling, casual labour and livestock rearing and remittances. Others that were mentioned, though not common to many women with disabilities who participated in the study, were gold panning, beer brewing, gathering firewood for sale, asset disposal, prostitution and fishing. In addition to this, most of the participants reported surviving on support from family members, gifts, alms, piece jobs and self-help

projects that bring in very little income. Further, this study discovered that some adult women with disabilities resorted to skipping meals, rationing, going entire days without food, and eating unusual wild fruits, vegetables and other foods. In all this, there is an aspect of feminisation of poverty, where women with disabilities shoulder the burden of ensuring that the family is fed.

In this study, microfinance offered by a local NGO was the primary means through which women with disabilities accessed funds to start self-help projects, for example buying and selling, even though the freedom to use the money which they had borrowed was compromised. The loans borrowed were offered at subsidised interest rates. However, married disabled women who participated in this study said that they were not free to use the money borrowed, as their husbands would assume custodianship of the money and spend it themselves. The notion of diverting money owing to the interference by men speaks to patriarchal domination in which disabled women are infantilised and perceived as helpless (Barnes and Mercer, 2010, Munsaka, 2012). It is essential to note the cultural pressure exerted on women with disabilities who are burdened by the need for independence and acceptance in society, as citizens with a right to decent lives (Nussbaum, 2011). This practice speaks to the oppression suffered by women with disabilities as gender interacts with disability to breed social injustice. In this case they are deprived of the autonomy to decide how resources can be used. Accessing loans at subsidised interest rates still further burdens them since they drown in a series of debts (Karim, 2011) as they make endeavours to pay back the money.

An analysis of such practices reflects marginalisation which manifests in subtle forms such as paternalism, which is based on the assumption that women with disabilities are not able to make decisions. Paternalistic tendencies breed harmful and patronising attitudes on the part of men and this results in women with disabilities having limited freedom and choice, as well as lower aspirations. They also tend to accept as given, their dependency. Disability therefore often worsens the already inferior role even within their households. Society does not promote their self-reliance and work capability, thereby reflecting restrictive societal expectations of what women with disabilities are able to do and be (Palmer et al., 2015, Sen, 1999). Seen from the perspective of the CA, these acts of social injustice,, when discussed within the context of coping strategies, diminish self-worth, self-respect and dignity, premium qualities which are at the core of what decent life entails (Mohamed and Shefer, 2015; Moodley and Graham, 2015).

However, women with disabilities who participated in this study pointed out that inasmuch as the interest rates charged by the NGOs are reasonable, the low profitability of the coping strategies

complicates their ability to repay the loans. Failure to pay back the loans then pushes women with disabilities to sell assets, a practice which was also noted to be one of the coping strategies in this study. Therefore, some of the women with disabilities who participated in this study had a comparative advantage in coping, due to access to a few resources and other entrepreneurial activities which they engage in. Compounding this challenge is that a relatively large proportion of women with disabilities have difficulty in engaging in this activity as most of them do not own any livestock. Other cited coping strategies include remittances which can be in the form of cash or goods given mainly by children, relatives, husbands and well-wishers in South Africa, Botswana and other neighbouring countries. In addition to this, food aid from NGOs operational in the area was also cited. The remittances which are aimed at reducing poverty through provision of food can also be a source of income for them even though its main purpose is to address an immediate need. Further, the seasonal food aid and sustainability of remittances in mitigating the challenges experienced by women with disabilities remain issues, as they do not come with guarantees.

Food aid and remittances are synonymous with welfare, charity, and the paternalism of women with disabilities. Such practices result in the paucity of individual enterprise and increase the likelihood of becoming poor and dependent (Munsaka, 2012, Sibanda, 2015). This is because they do not encourage personal development and exploration to create equality of opportunities and treatment in society. This further promotes dependency, and leads to begging, which has become synonymous with disability in Zimbabwe (Munsaka, 2014). In this study therefore, remittances and food aid are seen as stopgap measures in times of hardship. Sander and Maimbo (2003) weigh in on this, arguing that generally the bulk of remittances in times of crisis are used for consumption, especially by disadvantaged people, thus they do not lead to poverty alleviation. This viewpoint is in agreement with a survey by the Southern African Migration Project (SAMP) in five SADC countries, which concluded that ninety percent of households manned by disadvantaged members purchase food and other basic goods with remitted funds (Hughes, Kajee and Peberdy, 2007). Food aid and remittances reinforce the notion of disability, and can be seen, perhaps, as paternalistic measures, since they do not contribute towards equalisation of opportunities for women with disabilities. The sustainability of such endeavours in the current global trend and in a country experiencing economic challenges remains an issue.

Findings confirmed that most women with disabilities, especially those with severe physical disabilities and visual impairment, had difficulty in participating in labour intensive tasks as they engaged in different coping strategies. This scenario depicts and appreciates the idea that even within

the sisterhood of disability, there are some whose impairments arouse even greater attention, particularly the visually and physically impaired. Further, poor rainfalls caused by climate change, as well as lack of agricultural inputs and poor soils, pose limitations affecting women with disabilities engaged in peasant farming and market gardening. These limitations affect the sustainability of the coping strategies adopted by women with disabilities in a rural setting. These limitations bring to the fore the notion of conversion handicap which demonstrates the fact that women with disabilities are a heterogeneous group whose abilities to convert resources and skills into functionings are not uniform. In expounding the CA, Sen (1999) makes reference to the notion of 'conversion handicap' in a bid to explain the additional challenges experienced by PwDs in converting resources and skills into functionings (Munsaka, 2014). Conversion handicap refers to an individual's inability to access and use resources and skills, and convert them into functionings (Munsaka, 2014).

The fact that disability is perceived as a personal tragedy in an environment which does not offer supportive measures to women with disabilities, means loss of opportunities in life. Findings suggest that their individual coping strategies are also limited by accessibility barriers, which result in added direct and indirect costs. Women with visual impairment encounter limited mobility and functionality due to environmental barriers when engaging in most coping strategies. Further, lack of paved terrain in rural areas poses challenges for physically impaired women using wheelchairs. The physical environment is therefore a barrier to women with disabilities which renders their coping strategies ineffective in the long term eradication of poverty. Sen (1999) conceptualises poverty as capability deprivation.

Capability deprivation for women with disabilities is thus further entrenched through the physical inaccessibility of the environment surrounding them. The stereotypical misrepresentation of disability owing to negative attitudes towards disability also constitutes environmental barriers. Negative attitudes create a culture of silence among PwDs as most have been socialised to believe that they are incapacitated and abnormal. The culture of silence destroys the inner self, leading to low self-esteem. Thus, the negative attitudes associated with disability are "as handicapping as are the physical barriers" (Sibanda, 2015: 222). The assistance given by caregivers, friends and relatives, inasmuch it is necessary, compromises their independence and freedom of choice (Sen, 1999) in their endeavours to cope with the physical and social constraints.

Old age presented additional complications for some of women with disabilities who participated in this study. Certain coping strategies were found to be labour intensive. As their already limited

capacities diminish with age, any degree of independence they may have achieved is jeopardised, contributes to limited freedom and choices in achieving their life goals (Robeyns, 2005; Sen, 1999). Therefore, for elderly women with disabilities, functional limitations and daily challenges are aggravated by the convergence of gender, disability and age, and this produces debilitating results. Segregation and neglect then worsen, given that disability is perceived as an individual plight. Lack of social programmes to support individual initiatives aimed at combating daily economic challenges prompts women with disabilities to use their children as buffers. They take them out of school to provide labour and take on care-giving responsibilities. The result is lower accumulation of human capital on the part of disability families (Namatovu, et al., 2012; Mapuranga and Mutswanga, 2014).

Participants said that some of the women with disabilities have joined the informal sector, and also engage in prostitution (which mainly occurs at the site of illegal mines) to make ends meet. It is however, not a favourable coping strategy when viewed in relation to culture and health, given the scourge of the HIV/AIDS pandemic in the country and in the region. In using prostitution as a coping strategy, women with disabilities are prone to contracting sexually transmitted infections (STIs), including HIV and AIDs (DHAT, 2011). The complex combination of the effects of disability, together with HIV and AIDs brings about a double tragedy for the life of a woman with a disability, as it results in further discrimination and stigmatisation. The health centres available in rural areas are located far from the majority of women with disabilities, posing challenges to those who have mobility constraints. This can lead to poor health, including higher rates of maternal mortality and morbidity as well as poverty (Sexual Rights Initiative, 2013). Prostitution engaged in by women with disabilities results from the notion of disability as a personal tragedy in a society which lacks systematic intervention to address the plight of vulnerable groups.

On the whole, the coping strategies adopted by women with disabilities in a rural setting, while addressing some immediate challenges posed by their disabilities and other factors, do not successfully eradicate poverty and other major barriers that present threats to their welfare. Further, the coping strategies have no capacity to address the social injustices that manifest in different forms, e.g. paternalism, discrimination, stigmatisation and exclusion. The study infers from the findings that the coping strategies they employ are a response to a complex matrix. This includes the economic downturn in Zimbabwe, the incessant stereotypical misrepresentation of disability as inability, and the reluctance by the state and extra-parliamentary actors to address their socio-economic plight. Then too, the coping strategies do not present sustainable ways of combating the multiple levels of oppression they experience, which include the following: being persons with disabilities, being poor

women living in an environment dominated by patriarchal attitudes, and being inhabitants of a rural setting in which cultural values are still adhered to and where resources are scarce in a country experiencing an economic downturn and other social problems. The aforementioned factors refer to the disproportionate burden of coping with disability which is shouldered by women with disabilities in a context in which social injustice pervades all aspects of existence.

5.4 Summary

The chapter has demonstrated the argument on the basis of data which was drawn from interviews (in-depth and semi-structured) as well as focus-group discussions (FGDs). The overall focus of this chapter was to demonstrate the argument pursued for this study, which is articulated as follows: The approach to disability in Zimbabwe is unsystematic, individualistic and paternalistic, thereby rendering women with disabilities vulnerable to multiple kinds of oppression. This argument was demonstrated within the parameters of the challenges experienced by women with disabilities as well as the range of coping strategies they employ in a bid to counter the rising challenges posed by living with disability in a rural setting. Thus, in demonstrating the study's argument, the chapter responds to the following research question: What are the challenges and coping strategies of women with disabilities in a rural setting set against the backdrop of the economic crisis in Zimbabwe? The CA was used as an overarching framework whose lens was employed in thinking through the study findings. The next chapter concludes this study with a summary, recommendations and implications of the study.

CHAPTER SIX

SUMMARY AND CONCLUSIONS

6.1 Introduction

This chapter provides a summary of the study and highlights the objectives. In so doing it provides a recap of the methodological and theoretical approaches employed in the study. Chapter 6 goes on to draw conclusions from an analysis of results and then make recommendations based on the analysis. In essence, the chapter interprets the results and what advises what actions should be taken as a result of those findings. These conclusions and recommendations were based on the following research question: What are the challenges and coping strategies of women with disabilities in a rural setting, when viewed against the background of the economic crisis in Zimbabwe? This research question provided the basis for the argument that the approach to disability in Zimbabwe is unsystematic, individualistic and paternalistic, thereby rendering women with disabilities vulnerable to multiple oppressions. With the research question and the argument as its foundation, the chapter also draws attention to the implications, limitations and areas of future research for the study.

6.2 Summary

The study was undertaken to explore the experiences of women with disabilities in rural settings in Zimbabwe, focusing on their challenges in the post-colonial political economy, which is currently going through a critical period. In addition, the study also explored the coping strategies employed by women with disabilities in rural areas in an attempt to mitigate the challenges they experience. The findings presented and discussed in this study were drawn from Insiza District's three wards in Matabeleland South Province in Zimbabwe. In order to achieve the study's aims and objectives, a qualitative research design was adopted. The objectives guiding the study were to identify the challenges experienced by women with disabilities in rural areas, and also to identify the coping strategies they adopt in responding to their challenges. Finally, the study explored the extent to which the coping strategies are helpful in mitigating the challenges experienced, given the particular conditions in rural areas, as well as the fact that these women are disabled.

The study was guided by the following research question: What are the challenges and coping strategies of women with disabilities in a rural setting set against the background of the economic crisis in Zimbabwe? In responding to the research question, the study developed the argument that the approach to disability in Zimbabwe is unsystematic, individualistic and paternalistic, thereby

rendering women with disabilities with various kinds of oppression. The individualisation of disability as a personal tragedy, coupled with discrimination and stigmatisation resulting from deeply entrenched cultural beliefs and practices, lead to exclusion. The economic crisis, low unstable income, and ongoing health care and other disability-related costs cause women to use a range of coping strategies.

In order to analyse and present the findings, the study made a review of the associated and relevant literature to situate the study within scholarly debates, and prominent empirical and theoretical discourses on disability. Among the issues covered in the literature review of the study were theoretical models of disability, such as the Medical Model, the Social Model, the Cultural Model, the ICF model and finally the Capabilities Approach. The last-named approach provided the lens through which the study findings were analysed. This review summarized the major constructs as well as the strengths and weaknesses that have resulted from the use of earlier theoretical models of disability. In this regard, the study highlighted the development of the CA, through continuous improvement, which the study adopted as its main conceptual framework. The study has also benefitted from the CA as it makes use of intersectionality as a strategy to illuminate the multiple roles that women with disabilities have to contend with in their lives, and how these contribute to, and complicate the challenges they experience.

The review of the literature also provided insights into global and regional dynamics in the field, thereby zeroing in on the Zimbabwean context, and focusing specifically on the experiences of women with disabilities. The intention of the study in doing this was to contextualize disability issues in Zimbabwe within the international development discourse, in a bid to locate the study within the broader discourses on disability. The review of the literature in this study served to demonstrate that there is a dearth of research probing the experiences of women with disabilities, and that this is the consequence of an interaction of social constructions and dynamics revolving around gender and disability. These dynamics are analyzed against the backdrop of the economic crisis in Zimbabwe, which has exacerbated the challenges. Further, on the basis of literature review, the research also showed how previous studies have treated women with disabilities as a homogenous group who, whilst experiencing similar challenges, are a varied and heterogeneous group even in the manner in which they cope with their individual challenges, which include gender, age, access to resources and coping skills, among others.

The participants for the study were drawn from two main categories, namely key informants (participants from NGOs and government ministries that deal with matters concerning women with disabilities), community leaders/focal persons, as well as women with disabilities themselves, selected from Insiza District's three wards. In total, ten women with disabilities participated in the study. There were also two government officials chosen from two different government departments. Finally, two NGO officials were chosen from two NGOs operational in the area, and three community leaders/focal persons were selected from each of the three wards in which the research was conducted. I used convenience sampling to select women with disabilities who participated in the study, such convenience relating to the geographical proximity, as well as the availability of the participants. For the key participants, I made use of purposive sampling, using as criterion their expertise and knowledge in dealing with disability issues. The research instruments used in the study comprised interviews (in-depth and semi-structured) as well as focus group discussions (FGDs). An unexpected consequence of using interviews with key informants was that they gave superficial responses in the interviews. I adhered to such ethical considerations as informed consent, confidentiality, anonymity, as well as the protection of data obtained from the study.

The analysis of data from the study was done using data transcription from the field, inductive as well as thematic analysis. Most of the limitations in the study related to the nature, scope and strategy of the research. Other limitations related to potential bias in the findings of the study, and in the unavailability of time and resources with which to undertake important research activities. The research was delimited by excluding men, the study being confined to women with disabilities in Insiza District and only including women with visual and physical impairments in rural area.

6.3 Conclusions

This study noted that the challenges experienced by women with disabilities are by and large a result of socially constructed prejudices and attitudes about disability, which perpetuate feelings about disability as a personal tragedy. The perception of disability as a personal attribute results in neglect which arises largely from a lack of systematic intervention to cushion them from the increasing severity caused by living with a disability. Further, as a result of paternalistic attitudes, women with disabilities are perceived to be incapable of doing anything for themselves, thus they are regarded as dependants and charity cases. In addition, the general lack of systematic intervention, coupled with weak disability legislation which is slow in its implementation, has a negative impact on them. Due to prejudices, misconceptions and myths based on social constructions, they experience multiple kinds of oppression – discrimination, stigmatization, exclusion and neglect. On the whole, the acute

challenges experienced by women with disabilities are a by-product of the unsystematic, personalized and paternalistic approach to disability in Zimbabwe, a country which is currently experiencing an economic crisis.

This approach to disability causes disabled women to engage in a range of coping strategies. The study infers from the findings that the coping strategies they employ are a response to a complex matrix. This includes the economic downturn in Zimbabwe, the incessant stereotypical misrepresentation of disability as inability, and the reluctance by the state and non-state actors to address their socio-economic plight. The coping strategies also do not present sustainable ways of combating the multiple layers of oppression they experience. These include: being persons with disabilities, being poor women living in an environment dominated by patriarchal attitudes, and being inhabitants of a rural setting in which cultural values are still adhered to, and where resources are scarce in a poverty-stricken country. In the context of this study, the coping strategies contribute short-term solutions to their challenges but pose threats to their welfare, as these strategies push them into abject poverty, in the long term. This is because the coping strategies do not match the rising severity of the challenges experienced in living with a disability in a rural setting devoid of resources, and generally, in a country experiencing economic, social and political crises.

This notion is based on the conviction that the challenges they experience because of their disabilities are increasing daily while the coping strategies are also growing progressively weaker. Their quality of life is deteriorating because they live in the rural areas, where there is low economic production, there are negative cultural beliefs and practices which impede their capacity to engage in meaningful activities. The business environment in Zimbabwe is also currently characterized by low returns as a result of the liquidity crunch – an aspect that affects every woman in the informal sectors of the economy but impacts more on women with disabilities. This is because there are many roles they are called upon to play in their families and communities. That they cope differently with their experiences is indicative of the fact that women with disabilities in rural areas are not a homogenous group and their experiences are not identical.

Given this scenario, the study has made an attempt to explore beyond common and homogenous assertions the challenges experienced by women with disabilities. In this vein, the study employed the explanatory strength of the CA in understanding the study's findings. Through the lens of the CA, it can be concluded that the enhancing of freedom and choices for women with disabilities constitutes one of the many ways of equalising opportunities for them in a society where disability is mainly

perceived as a personal tragedy. This act of equalising opportunities is backed up by a set of entitlements through legal provisions that can be a facilitating factor to the equalisation of opportunities for them. An enhancement of the freedom and choices for women with disabilities promotes their functionality and integration into mainstream society, and also creates an awareness that will contribute towards breaking the stereotypes associated with disability. This will contribute towards their economic empowerment, and very importantly, can be source of respect and dignity in their respective environments.

6.4 Recommendations

From the conclusions of the study, the following recommendations are tabled, to contribute to a solid foundation for addressing the challenges experienced by women with disabilities in Zimbabwe. The recommendations that follow are therefore designed to influence everyday social practices in ways that could help to achieve greater inclusion of women with disabilities in society's mainstream activities. The overall concern is to enhance the public's understanding of women with disabilities as citizens with rights. Recommendations are therefore made to address the following areas: promoting disability awareness, increasing the visibility and meaningful participation of women with disabilities in their communities, and promoting an agenda to create an enabling, disability-friendly environment, through addressing accessibility issues.

Awareness raising promotes critical thinking and reduces prejudice in the public domain. This will influence a shift from understanding disability as an individual personal feature, a realization that disability is also a socially created phenomenon. Historically, women with disabilities have suffered from the invisibility syndrome due to discrimination and marginalization, which results in social exclusion due to negative attitudes rooted in deeply entrenched cultural beliefs. Consequently, women with disabilities are most often seen as objects of pity and charity rather than citizens with rights. In changing these negative attitudes, raising awareness can play a pivotal role, especially nowadays when technology has reached every household.

Further efforts are still needed in creating a serious shift in the mind-set of communities in Zimbabwe when it comes to the rights of people with disabilities. There is therefore a need to develop a functioning system that will see them receiving an education, being enrolled in vocational training courses of their own choice, and being employed according to their qualifications and skills instead of having to find job placements in community service and charity work. There is need for reorientation in terms of perceptions about women with disabilities as subjects with rights, instead of viewing them

in terms of charity and goodwill. The desired outcome is for society to work towards capacitating them, acknowledging what they can do instead of focusing on what they are not able to do. In Zimbabwe, there has not been a significant shift from the Medical Model, which focuses too much on the individual. The communities still need to be sensitized on the need for a shift to embrace models which place more emphasis on recognising women with disabilities as citizens with rights.

Creating a disability-friendly environment in Zimbabwe is a concept yet to be accepted, partly because it entails financial costs. It is always put on the back burner for as long as possible. There is therefore a need for a specified entity responsible for monitoring compliance by the society in creating an enabling environment for women with disabilities. The environment in which women with disabilities live has a great impact on how they experience disability, as it includes more than physical space. It also includes institutional, policy and attitudinal environments in which they conduct their lives. The importance of creating an enabling environment is a factor that contributes to the effective implementation of the rights of persons with disabilities as enshrined in the UN Convention on the Rights of Persons with disabilities (UNCRPD). In the quest to create an enabling environment for women with disabilities, the society needs to look beyond individual medical interventions. This implies that women with disabilities should not be seen as recipients of aid and charity, but as people entitled to rights. In the quest to achieve this goal, women with disabilities should be given advocacy opportunities to influence disability-related policies. The government availing funds for technical assistance to promote the necessary skills and capacity to work on the elimination of environmental barriers will go a long way in addressing, in part, the needs of women with disabilities.

6.5 Implications, limitations and Areas of future Research

The findings generated from this study have a number of policy implications. Understanding the experiences of women with disabilities in rural areas provides a framework within which to gather the relevant information about the specific circumstances surrounding their experiences of life, especially in the light of the current economic crisis. Understanding their experiences can be of use in the mobilization of legislative policies that benefit women with disabilities and are intended to eliminate marginalization and stigmatization, and eliminate barriers. The findings also provide a stepping stone for the journey of women with disabilities in rural areas, on the road to resolving the challenges they experience as a result of their disabilities.

I also noted that while this research report brings to light several insights into the experiences of women with disabilities in rural areas, there were a number of limitations. The first limitation is that the study covered only women with disabilities in the rural District of Insiza's three wards. In a statement of recommendation, I suggest that future studies may have to widen the scope to cover other geographical areas, and a greater range of settings. For example, urban settings may create significantly different experiences for women with disabilities. The second limitation is that this study targeted women with disabilities only because they face specific challenges as a result of their disabilities in rural settings in the face of economic crisis. It is the researcher's suggestion that future studies concentrating on disability will have to target other subjects, or will have to combine both disabled men and women with disabilities in order to make a fair comparative analysis. Lastly, the study could have benefitted from a comparison between urban and rural women with disabilities.

6.6 Commentary

The brief of this chapter was to provide a summary of the study, highlighting the objectives and providing a recap of the methodological and theoretical approaches employed in the study. Chapter 6 also draws conclusions based on an analysis of the results gathered for the study and then makes recommendations. In short, the chapter interprets the results and recommends what actions should be taken as a result of the findings. Generally, these conclusions and recommendations were based on the following research question: What are the challenges and coping strategies of women with disabilities in a rural setting, against the background of the economic crisis in Zimbabwe? On the basis of this research question, the study argues that the approach to disability in Zimbabwe is unsystematic, individualistic and paternalistic, thereby rendering women with disabilities vulnerable to multiple oppressions.

With this research question and the argument as a basis for proceeding, the chapter also draws attention to the implications, limitations and areas of future research for the study. A conclusion based on this study points to the fact that women with disabilities in a rural setting experience multiple levels of oppression, and they contend with multiple social identities, i.e. they are persons with disabilities, poor women, and inhabitants of a rural setting where resources are scarce in a country experiencing an economic downturn. This approach to disability in Zimbabwe causes disabled women to employ a range of coping strategies. However, these coping strategies constitute, at best, only short-term solutions to the various kinds of oppression they experience, but in the long run these strategies pose challenges to their well-being, and fail to benefit them in the desired manner.

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Key participant, *Semi-structured Interview*, 26/06/2014

Key participant, *Semi-structured Interview*, 22/06/2014

Key participant, *Semi-structured Interview* 19/06/2014

Key participant, *Semi-structured interview*, 07/06/2014

APPENDIX

Appendix 1: Interview Guide for Women with Disabilities

Introduction

My name is Tondori Albert, a student at the University of the Witwatersrand. I am carrying out research on the challenges experienced by women with disabilities and the coping strategies they employ to meet the challenges posed by Zimbabwe's economic crisis in Insiza District. The aim is for me to gain an understanding of your knowledge, experience and perceptions with regard to the challenges and coping strategies in the face of this economic crisis. The information that you are going to provide will be used only for the purposes of this study.

Demography Profile

1. Gender

a) Male ☐
b) Female ☐

2. Age Group in years

a) 18-30 ☐
b) 31-40 ☐
c) 41-50 ☐
d) 51-60 ☐
e) 61and over ☐

3. Monthly Income

a) $0-$10 ☐
b) $11-$30 ☐
c) $31-$60 ☐
d) $61-$100 ☐
e) $101-$200 ☐
f) $301-$500 ☐

4. Nature of disability

a) None ☐
b) Mental ☐
c) Physical ☐
d) Hearing ☐
e) Visual ☐
f) Other (Specify) _____

5. Level of Education

a) No formal education ☐
b) Primary school education ☐
c) Secondary school education ☐
d) College or University ☐
e) Skills training ☐

6. What is your marital Status?

a) Married ☐
b) Single ☐
c) Divorced ☐
d) Separated ☐
e) Cohabiting ☐
f) Widowed ☐

7. What sector are you working in?

a) Formal ☐
b) Informal ☐

8. List sources of income and amounts received monthly

9. Religion

a) Christianity ☐
b) Islam ☐
c) Hinduism ☐
d) ATR ☐

10. Family situation

a) Number of households at the homestead
---
b. Number of family members at the homestead

11.Types of marriage

a) Polygamous ☐
b) Inherited ☐
c) Ordinary ☐

Appendix 11: Interview Guide for Women with Disabilities on their experiences of Women with Disablement

Identity (Capabilities Approach)

What does disability mean to you?

What does impairment mean to you as a woman?

How do you perceive yourself? Describe what it means to you to have this condition?

How do you think or believe others perceive you in the community?

Affiliation/Social Capability

What social challenges are you facing as a result of disability?

a) Cultural

b) Religious

c) Recreational

Capabilities

What do you do as an individual to make sure you survive in this community?

Are you able to express your opinions and thoughts and make them count on matters that affect your life in the community?

What is/are your current source(s) of income?

How much income do you get on a monthly basis?

What economic challenges are you facing as a result of disability?

How do these challenges affect your day-to-day life in the community?

What other challenges and difficulties do you encounter as a woman with disabilities in this community?

Are these challenges and difficulties being faced by the whole community?

Conversion Factors (Coping Strategies)

Do you know of any disability legislation?

What supporting structures exist for you in the community?

Have you ever accepted a condition/situation because you think what you really want or need is not achievable?

Personal Conversion Factors

What are the personal characteristics that help you cope with socio-economic challenges?

What are the personal characteristics that restrict you at times in interacting with the environment around you?

What strategies have you adopted to mitigate the challenges you face?

a) Social Challenges

State challenge	**Strategy for mitigation**

b) Economic Challenges

State challenge	Strategy for mitigation

How have these coping strategies helped you at least for now (at this point in time)?

Appendix 111: Interview Guide for Government Departments and Non-Governmental Organisations

1. Name of organisation: ----------
2). Address & contact details
Tel: ----------
Email:……
3) Type of organisation
National NGO International NGO □ Government □
Other □ Please specify……

1. Are there any development and assistance programmes being offered by your organization/institution/department to disabled women, to address socio-economic challenges in this area? Please give details:

2. If you answered Yes to **Q1**, are women with disabilities benefiting from these programmes? Explain.

3. If you answered No to **Q1,** what is the reason for women with disabilities not benefiting from the programmes? Explain.

4. How have these programmes helped to minimize the negative impact of the socio-economic challenges for disabled women? For example, explain how these programmes have helped them especially in the following areas:

a) Economic independence

b) Participation in the family's social activities

c) Participation outside the family social activities

5. Has there been a change in the abilities of disabled women to participate in the community's social and economic programmes?

6. What needs to be done to ensure better inclusion of women with disabilities in development and assistance programmes in their communities?

7. How do you think these challenges are affecting their day-to-day existence?

8. What strategies have they adopted to mitigate these challenges?

9. How have these coping strategies helped to improve their lives?

Appendix 1V: Individual Interview Guide for Community leaders/Focal Persons

What does disability mean to you?

What challenges do you think disabled women are facing in this community?

How do you think these challenges are affecting their day-to-day existence?

What strategies have they adopted to mitigate these challenges?

How do you think these coping strategies have helped to improve their lives?

Are there any development and assistance programmes being offered to women with disabilities to address these challenges in this community? Please give details:

If you answered Yes to **Q1**, are women with disabilities benefiting from these programmes? Explain.

If you answered No to **Q1** what is the reason for women with disabilities not benefiting from the programmes?
Explain.

What are you doing as community leaders/focal persons to enhance the capabilities of disabled women in this community?

What are you doing to minimize the negative impact of the socio-economic challenges for disabled women in this community? For example, explain how your efforts have helped them, especially in the following areas:

a) Economic independence

b) Participation within the family's social activities

c) Participation outside the family's social activities

Appendix V: Focus Group Discussion for Women with Disabilities

Identity (Capabilities Approach)
What does disability mean to you?

What does impairment mean to you as a woman?

How do you perceive yourself? Describe what it means to you to have this condition?

How do you think or believe others perceive you in the community?

Affiliation/Social Capability

What social challenges are you facing as a result of disability?
a) **Cultural**

b) **Religious**

c) **Recreational**

Capabilities

What do you do as women with disabilities to make sure you survive in this community?

Are you able to express your opinions and thoughts and make them count on matters that affect your life in the community?

What is/are your current source(s) of income?

What economic challenges are you facing as a result of disability?

How do these challenges affect your day-to-day lives in the community?

What challenges and difficulties do you encounter as women with disabilities in this community?

Are these challenges and difficulties being faced by the whole community?

Conversion Factors (Coping Strategies)

Do you know of any disability legislation?

What supporting structures exist for you in the community?

Have you ever accepted a condition/situation because you think what you really want or need is not achievable?

Personal Conversion Factors

What are some of the coping strategies that help you cope with socio-economic challenges?

What are some of the barriers that restrict you at times in interacting with the environment around you?

What strategies have you adopted to mitigate the challenges you face?

a) Social Challenges

State challenge	**Strategy for mitigation**

b) Economic Challenges

State challenge	Strategy for mitigation

How have these coping strategies helped you at least for now (at this point in time)?

Appendix V1: Participant Information Sheet for Focus Group Discussion Participants



Faculty of Humanities
Development Studies Department
Participant Information Sheet

Date:

Thank you for considering my request for you to participate in this interview. My name is **Albert Tondori** and I am conducting research for the purposes of obtaining a Masters Degree at the University of the Witwatersrand.
The title of my research is: **An exploration of the experiences of women with disabilities. The case of Insiza District, Zimbabwe**
What you will be asked to do in the Research: You will be asked for your insights and opinions on matters related to the experiences of disability and how these experiences might have been exacerbated by the socio-economic challenges posed by the current economic crisis in Zimbabwe. In particular, you will be asked to explain how these socio-economic challenges have affected the well-being of disabled women. In addition to this, the study will solicit information on the coping strategies adopted by disabled women to mitigate the effects of the economic crisis in Zimbabwe. However, please feel free to expand on the topic or talk about related issues which you feel are relevant to the study and so bring more depth to it.

Voluntary Participation: Your participation in the study is completely voluntary and refusal to participate will not be held against you in any way. Since your participation in this study is completely voluntary, you are not obliged to answer any questions that you are not comfortable with. You may choose to cease your participation at any time. Your withdrawal will not harm or affect any relationship you may currently have with the University of the Witwatersrand.
Confidentiality and Anonymity: All information you supply during the research will be held in confidence and, unless you specifically indicate your consent, your name will not appear in any report or publication of the research. Your responses will be safely stored and only I will have access to this information.

Furthermore, should you find the participation traumatic and upsetting, you are free to terminate your participation. However, it is also important for you to note that after the interviews, there will be debriefing sessions, which will be conducted by local experts in the disability field to assist those who might have found the sessions traumatic and upsetting. This will also be done to refresh the participants' memories in a way that does not cause psychological harm.

If you are willing to participate in the study, you will be required to sign a consent form.
If you have questions about the research in general or about your role in the study, please feel free to contact me on **Cell**: **+27783842288** or email tondorialbert@yahoo.com**.**
You may also contact my supervisor: Dr Rajohane Matshedisho: **Cell+27117174434** or email Rajohane.Matshedisho @wits.ac.za

Thank you in advance for your consideration of my request.

_____
Signature

Appendix V11: Participant Information Sheet for Women with Disabilities



Faculty of Humanities
Development Studies Department
Participant Information Sheet

Date:

Thank you for considering my request for you to participate in this **Focus Group Discussion**. My name is **Albert Tondori** and I am conducting research for the purposes of obtaining a Masters Degree at the University of the Witwatersrand.
The title of my research is: **An exploration of the experiences of disabled women. The case of Insiza District, Zimbabwe.**

What you will be asked to do in the Research: You will be asked for your insights and opinions (as women with disabilities) on matters related to the experiences of disability and how the socio-economic challenges have affected the well-being of women with disabilities, and the coping strategies employed to mitigate the effects of the crisis. However, please feel free to expand on the topic or talk about related issues which you feel are relevant to the study and so bring more depth to it.

Voluntary Participation: Your participation in the study is completely voluntary and refusal to participate will not be held against you in any way. Since your participation in this study is completely voluntary, you need not respond to questions that you do not wish to answer. You may choose to cease your participation at any time. Your withdrawal will not harm or affect any relationship you may currently have with the University of the Witwatersrand.
Confidentiality and Anonymity: It is important for you to be aware, and note that while confidentiality may be desirable, it cannot be guaranteed in this Focus Group discussion. However, participants will remain anonymous and their names will not be used in the final write up.
Furthermore, should you find the participation traumatic and upsetting, you are free to terminate your participation. However, it is also important for you to note that after the Focus Group discussion, there will be debriefing sessions, which will be conducted by local experts in the disability field to assist those who might have found the sessions traumatic and upsetting. This will also be done to refresh the participants' memories in a way that does not cause psychological harm.

If you are willing to participate in this Focus Group discussion, you will be required to sign a consent form.
If you have questions about the research in general or about your role in the study, please feel free to contact me on **Cell**: **+27783842288** or email tondorialbert@yahoo.com**.**

You may also contact my supervisor: Dr Rajohane Matshedisho: **Cell+27117174434** or email Rajohane.Matshedisho @wits.ac.za

Thank you in advance for your consideration of my request.

_____
Signature

Appendix V111: Participant Information for Community Leaders /Focal Persons

Faculty of Humanities
Development Studies Department
Participant Information Sheet

Date:

Thank you for considering my request for you to participate in this interview. My name is **Albert Tondori** and I am conducting research for the purposes of obtaining a Masters Degree at the University of the Witwatersrand.

The title of my research is: **An exploration of the experiences of women with disabilities. The case of Insiza District, Zimbabwe.**

What you will be asked to do in the Research: You have been approached as a **community leader** in the area you represent and therefore participation is not being sought on the basis of your official capacity, but on the basis of your experience in dealing with disability in the local communities here in the District. In particular, the study seeks to find out what are the experiences of disability for disabled women in the current economic crisis in Zimbabwe. This study will also focus on an analysis of the coping strategies that disabled women adopt to mitigate the challenges posed by the economic crisis. You will therefore be asked for your insights and opinions on the matter as well as for any suggestions that you think might advance the research process.

Your participation in this study is completely voluntary and therefore you need not respond to questions that you are not comfortable with. You may also elect to cease your participation at any time. Your withdrawal will not prejudice any relationship which you may currently have with the University of the Witwatersrand.

Confidentiality and Anonymity: All information you supply during the research will be held in confidence and, unless you specifically indicate your consent, your name will not appear in any report or publication of the research. The final research report will be kept in the university's public library as well as on its website but nothing will be traced back to you as respondents.

If you are willing to participate in the study, you will be required to sign a consent form.
If you have questions about the research in general or about your role in the study, please feel free to contact me on **Cell: +27783842288** or email **tondorialbert@yahoo.com**

You may also contact my supervisor: Dr Rajohane Matshedisho: **Cell+27117174434** or email Rajohane.Matshedisho @wits.ac.za

Thank you in advance for your consideration of my request.

_____
Signature

Appendix V1111: Participant Information Sheet for Government and NGO Officials

Faculty of Humanities
Development Studies Department
Participant Information Sheet

Date:

Thank you for considering my request for you to participate in this interview. My name is **Albert Tondori** and I am conducting research for the purposes of obtaining a Masters Degree at the University of the Witwatersrand.

The title of my research is: **An exploration of the experiences of women with disabilities. The case of Insiza District, Zimbabwe.**

What you will be asked to do in the Research: You have been approached as a member of the organisation/institution you represent. However, your participation is not being sought on the basis of your official designation, but on the basis of the experience you have in dealing with disability issues in this area. In particular, the study seeks to find out what are the experiences of disability for women so afflicted in the current economic crisis in Zimbabwe. This will also focus on an analysis of the coping strategies that disabled women adopt to mitigate the challenges posed by the economic crisis. You will therefore be asked for your insights and opinions on the matter as well as for any suggestions that you think might advance the research process.

Your participation in this study is completely voluntary and therefore you are not obliged to answer any questions that you are not comfortable with. You may also elect to cease your participation at any time. Your withdrawal will not prejudice any relationship which you or your organisation/institution may currently have with the University of the Witwatersrand.

Confidentiality: All information you supply during the research will be held in confidence and, unless you specifically indicate your consent, your name will not appear in any report or publication of the research. The final research report will be kept in the university's public library as well as on its website but nothing will lead back to you as respondent.
If you are willing to participate in the study, you will be required to sign a consent form.

If you have questions about the research in general or about your role in the study, please feel free to contact me on **Cell**: **+27783842288** or email **tondorialbert@yahoo.com**

You may also contact my supervisor: Dr Rajohane Matshedisho: **Cell+27117174434** or email **Rajohane.Matshedisho** @wits.ac.za

Thank you in advance for your consideration of my request.

_____
Signature

Appendix X: Participant Consent Sheet for Audio Recording



Faculty of Humanities
Development Studies Department
Informed Consent Form

Please indicate your consent to participate in this research process by signing below:

I _____

Of_____

Hereby consent to participate in the study being conducted by **Tondori Albert** for his Masters dissertation at the University of the Witwatersrand. I have received an information sheet prior to the interview. I understand the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form.

_____ _____
Signature **Date**
Participant

Consent to Record
I _____

Of _____

Hereby consent to the recording of my interview by**Tondori Albert**. I understand the information gathered in this interview is to be used for purposes of his Masters dissertation at the University of the Witwatersrand. I have received an information sheet prior to the interview. I understand the nature of this project, and my right to refuse to answer certain questions, and also that I may ask that the tape recorder be turned off at any point. I wish to participate and agree that the conversation be recorded. I am not waiving any of my legal rights by signing this form.

_____ _____
Signature **Date**
Participant

Research Office

HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)
R14/49 Tondori

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER H14/08/12**
PROJECT TITLE	An analysis of socio-economic challenges and coping strategies of women with disabilities under Zimbabwe's economic crisis from 2005 to 2014. A case of Insiza District, Zimbabwe
INVESTIGATOR(S)	Mr A Tondori
SCHOOL/DEPARTMENT	Social Sciences/Sociology
DATE CONSIDERED	22 August 2014
DECISION OF THE COMMITTEE	Approved Unconditionally
EXPIRY DATE	21/09/2016

DATE 22/09/2014 **CHAIRPERSON** E.M. Take pp (Professor T Milani)

cc: Supervisor : R Matshedisho

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10000, 10th Floor, Senate House, University.

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to completion of a yearly progress report.**

_____ _____/_____/_____

Signature **Date**

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES