
**DFID SCOPING
STUDY:
DISABILITY
ISSUES IN
ZIMBABWE**

July, 2007

Final Report

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Acknowledgements

The consultants would like to take this opportunity to thank all those who assisted in this consultancy and production of this report. In particular, we would like to thank Philippa Thomas, Social Development Adviser at DFID Zimbabwe for all her unstinting work and support in initiating this Disability Scoping Study. Also we would like to thank Erica Keogh at TLC for all her assistance in arranging the logistics of the study.

Finally, we would like to thank all those who were interviewed during the fieldwork, who were very generous in that time that they gave as well as being very open and frank in their discussions.

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July, 2007

Abbreviations

AIDS	Acquired Immune Deficiency
ARI	African Rehabilitation Institute
CRS	Catholic Relief Services
FCTZ	Farm Community Trust of Zimbabwe
DFID	Department For International Development
PWDs	People With Disabilities.
DPOs	Disabled Person's Organisations
DWSO	Disabled Women's Support Organisation
FAO	Food and Agriculture Organisation.
FODPZ	Federation Of Disabled Persons of Zimbabwe
HIV	Human Infections Virus
ICRAF	International Centre for Research in Agroforestry
ICRISAT	International Crops Research Institute for the Semi-Arid Tropics
MAC	Matebeleland Aids Council
MDAZ	Muscular Dystrophy Association of Zimbabwe
MOES&C	Ministry of Education Sport and Culture.
MOH&CW	Ministry of Health and Child Welfare
NCDPZ	National Council of Disabled Persons of Zimbabwe
NASCOH	National Association for the Care Of the Handicapped.
NFDP	National Foundation of the Disabled Persons
NGO	Non-Governmental Organisation
NGOs	Non-Governmental Organisations
PAFOD	Pan – African Federation Of the Disabled
PRP	Protracted Relief Programme
QUAPAZ	Quadriplegics and Paraplegics Association of Zimbabwe
SAFOD	Southern African Federation Of the Disabled
SC - UK	Save the Children – UK
SIAZ	Spinal Injuries Association of Zimbabwe
TLC	Technical and Learning Coordinating Unit
UNICEF	United Nations Children's Fund
ZAVHU	Zimbabwe Association of the Visually Handicapped
ZSAPD	Zimbabwe Sport Association for People with Disabilities.
ZWIDE	Zimbabwe Women with Disability in Development
ZWRCN	Zimbabwe Women Resource Centre and Network.

Section One

Executive Summary

1.1 Introduction

This Disability Scoping Study was commissioned by the Department for International Development (DFID) Zimbabwe. The objectives of the study were threefold. First, to provide an overview of the general situation of disabled people in Zimbabwe, including the prevalence rates of disability and the channels of the support that are available to disabled people, drawing upon existing published literature. Secondly, to provide an assessment regarding to what extent disability issues have been included in the Phase I of that DFID funded Protracted Relief Programme (PRP). Thirdly, to make policy recommendations regarding how disability can be effectively incorporated into the second phase of the PRP programme, scheduled to commence in April, 2008.

The evidence upon which the substantive findings and recommendations contained within this report are primarily based on a 10 day field visit to Zimbabwe, which took place between the 1st - 10th July 2007. During that time, key informant interviews were held with officials from DFID, representatives from international and national NGOs who are currently PRP Phase I partners, as well as representatives from the Government of Zimbabwe. In addition, two focus group workshops were held to elucidate the respective opinions and views of disabled people's organisations (DPOs) and NGOs regarding how disability and be effectively incorporated into the Phase II of the PRP programme. These were complemented by questionnaires that were sent out to DPOs and NGOs prior to the commencement of the fieldwork. In addition, this study has utilised the methodology of the stepping stool for inclusion, which analyses the respective roles played by the state, non-governmental organisations and DPOs with the regard to disability in Zimbabwe. A comprehensive explanation of this methodology can be found in the Terms of Reference for this consultancy (Appendix E)

This report is written within the context of a country which is currently experiencing a severe political and economic crisis, and that faces unprecedented developmental challenges. Currently, the inflation rate in Zimbabwe is running at 10,000% and continues to rise. It is estimated that over 3,000 people die as a result of HIV/AIDS every week. During the time when the fieldwork was undertaken for this consultancy, with the imposition of price controls by the Government of Zimbabwe, have resulted in there being no staple food, including bread and maize in the shops.

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Consequently, the vast majority of the population of facing acute hunger and possible starvation. Within this bleak scenario, it is crucial to be realistic in assessing what can be achieved, in short to medium-term, with the regard to the development of disability policy and practice.

1.2 Key Findings and Observations

General Situation of Disabled People

The background literature review, complemented by the evidence gathered during the fieldwork for this study, categorically demonstrates that disabled people one of the most marginalised, socially excluded and poorest groups in Zimbabwean society. It is estimated that there are approximately there are 1.4 million disabled people in Zimbabwe, although there are no real reliable statistics to verify this. In reality, it is very hard to make an accurate estimate regarding how many disabled people at the in Zimbabwe, and this is compounded by the impact of HIV/AIDS. Furthermore, many babies are being born with HIV/AIDS, many of whom will become orphans.

It was found that disabled people encounter multiple attitudinal, environmental and institutional barriers that militate against their effective inclusion with Zimbabwean society. It is a common perception within Zimbabwe that disabled people are passive and economically unproductive, and therefore constitute a "burden" upon society.

A number of studies, complemented by anecdotal evidence gathered during the fieldwork, demonstrate that disabled people are less likely to complete primary education than their non-disabled counterparts. This in turn further reinforces their marginalisation and social exclusion, because due to a lack of education and requisite skills, in a far more difficult for those with disabilities to secure long-term sustainable employment. Therefore, the negative cycle of poverty and disability is compounded. It would also show that there is an inadequate supply of aids and appliances (such as wheelchairs and prosthetics) to meet the potential demand. Those that were available were far too expensive for the large majority of Zimbabweans to afford.

Margonwe and Mate's 2007 study of disabled children in Zimbabwe provides a very insightful sociological analysis of the barriers that disabled people and their families encounter. It is argued that in general, children in Zimbabwe are seen as a form of social insurance for providing for the needs and wellbeing

of past generations. Obviously, this is often not possible where there is a disabled family member. Also, Margonwe and Mate argue that insufficient or non-existent amounts of human, social, physical and financial capital significantly compounds the exclusion and marginalization of disabled people in the country.

The plight and situation of women with disabilities is particularly precarious, who are invariably subjected to harassment, sexual abuse and exploitation. Also, within a patriarchal society, disabled women are less likely to benefit from the scant, inadequate services that are available than men.

The Disability Movement

Zimbabwe has been a breeding ground on some of the most dynamic and most influential disabled people in the world, who have been at the forefront of the development of the international disability movement. Notwithstanding this, the 35 to 40 DPOs that do exist are small, lack sufficient organisational capacity, and are populated by single implement groups. In recent years, attempts have been made to establish national, multi-impairment DPO – the Federation of Disabled People in Zimbabwe. However, it currently lacks sufficient capacity to play a lead catalytic role at national level, in terms of advocating for disability policy development.

The Role of the State

Zimbabwe was one of the first countries in the world to enact disability discrimination legislation. However, the Government has not developed the necessary administrative infrastructure for its effective implementation. Responsibility for disability issues resides with Department of Social Welfare, in the Ministry of Public Service and Labour. Disabled issues have a low priority within the Government of Zimbabwe, despite the establishment of the National Disability Board and the recent appointment of a Presidential Advisor on disability issues.

Disabled people are entitled to receive disability grants, but their monetary value is so grossly inadequate to have a significant impact upon the quality of life of disabled people. The vast majority of services are provided by international NGOs.

A full analysis of the support available to disabled people can be found in Table 4.2 of this report on page 30.

Involvement of Disabled People in PRP Phase I

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Notwithstanding the fact that some PRP partners have made explicit reference to disabled people are being explicit target beneficiaries in their programmes, there is little evidence to suggest that there had been any sustainable, a long-term positive impact upon their quality of life. This can be partially attributed to the fact that disabled people are largely "invisible", particularly in rural areas, and are not encouraged to attend community meetings when PRP project activities are discussed. Also, PRP partners openly acknowledge that they do not have sufficient knowledge and experience to effectively incorporate disability into their core activities.

1.3 Recommendations

The Recommendations made within this report have been made within the prevailing political and economic crisis that is currently engulfing Zimbabwe. Therefore, a concerted effort has been made to ensure the recommendations are very practical and, perhaps more importantly, achievable.

A total of 19 recommendations have been made, which have been clustered into five main categories. The most salient and important recommendations are listed below.

A) Mainstreaming Disability Issues into PRP Phase II

- PRP partners should be encouraged to actively include disability issues and disabled people in their future programmes activities. This could be done by requiring applicants in calls for proposals to articulate how they will include disabled people in their activities.
- All PRP partners should receive disability awareness training. This should be provided by representatives of DPOs.
- That PRP partners intending to prioritise disabled people, as a key target beneficiaries with Phase II be encouraged to develop effective outcome indicators that demonstrate what positive impact project activities have had upon the lives of disabled people.
- That the beginning of PRP Phase II, a workshop/seminar is held for all PRP partners to develop meaningful outcome indicators for inclusion of disability issues within PRP Phase II project activities

B) Disability Advisors in PRP Phase II Management Structure

- That three part-time Disability Advisors should be appointed to the Programme Management Team to advise on disability issues at strategic level. Three part-time advisers are proposed instead of one full-time adviser to ensure that a range of impairments are represented

and that no one DPO or group should be seen to be dominating. Three advisers could also cover different geographical areas.

C) DPO Involvement in PRP Phase II

- That a consortium of DPOs being encouraged to submit a joint project proposal during the PRP Phase II.
- This consortium should be made up of at least five DPOs.
- In addition individual DPOs should be encouraged to submit joint proposals with PRP partners, thereby facilitating the mainstreaming of disability issues with PRP Phase II core activities.

D) Monitoring and Evaluation

- That disability issues should be incorporated into the monitoring and evaluation frameworks for PRP Phase II.
- A minimum of three DPOs be funded to undertake monitoring and evaluation activities or this could be undertaken by the disability advisers in the Management unit.

E) International Disability Day

- That DFID Zimbabwe should host an event targeted at other donors to raise the profile of disability issues on International Disability Day, which is the 3rd December.

Section Two

Introduction and Structure of the Report

This report delineates the findings, inferences and policy recommendations of the Disability Scoping Study, commissioned by the UK's Department for International Development (DFID) Zimbabwe in 2007. The study's *raison d'être* is threefold. Firstly, it provides a general overview, drawing on existing published literature, of the situation of disabled people in Zimbabwe at the current time, including an analysis of the prevalence rates of disabled people within the country, combined with an assessment of the channels of support (both governmental and non-governmental) that are available. Secondly, the report analyses the extent to which that disability had been mainstreamed into Phase I of the DFID-funded Protracted Relief Programme. Thirdly, it makes policy recommendations for the inclusion of disability issues into the programme's second Phase, scheduled to commence in April, 2008.

What follows should be perceived within the context of an ever deteriorating political, social and economic situation within Zimbabwe. During the 10 days of fieldwork undertaken for this study, it was apparent that the country is heading for a period of sustained political instability. At the time of writing, there was hardly any staple foods that were available to the vast majority of the population. Severe price controls imposed by the Government of Zimbabwe has resulted in a situation whereby it is uneconomic to produce food. In the medium-term, this could have a fundamental impact on the international donor community and international non-governmental organisations (INGOs) working in Zimbabwe. If the situation fails to improve, it may be the case that donors and INGO's have to reallocate their funding and activities into providing direct food aid, to the exclusion of other longer-term developmental activities. Consequently, the viability of effectively implementing the policy recommendations contained within this report is seriously compromised by the deteriorating political situation. This report assumes that there will be a period of relative political stability within Zimbabwe during the next two years, but it is fully acknowledged that this is a large assumption to make.

The Terms of Reference and methodology employed in this study are contained within Appendix E of this report. In summary, in order a contextual background to the study, a literature review of existing, published reports and statistics was undertaken. This examined the prevalence and incidence rates of disability, as well as providing a qualitative assessment of the daily life encountered by disabled people in Zimbabwe.

The vast majority of the evidence contained within this report is based on key informant interviews and focus group discussions, that took place between 2nd - 12th of July, 2007. Key informant interviews were held with officials within DFID Zimbabwe, senior officials of international non-governmental organisations participating in the PRP Phase I, as well as officials advising the President of the Zimbabwe on disability issues. In addition, two focus group discussions were held with NGOs (in Harare) and DPOs (in Bulawayo) respectively, to ascertain their opinions regarding to what extent disability had been effectively included in PRP Phase I, as well as making recommendations as to how disability can be effectively mainstreamed into PRP Phase II core activities. A comprehensive list of individuals and organisations that participated in this study can be found in Appendix C and Appendix D.

The study also utilised the "stepping stone to inclusion", originally developed by Philippa Thomas, now working as Social Development Advisor within DFID Zimbabwe. This assesses the relative role, strengths and weaknesses of the state, non-governmental organisations, and disabled people's organisations, working within the disability sector. This methodology is fully explained in Appendix E.

The remainder of this report has been structured in the following manner. Section Three reviews the current published literature regarding the situation of disabled people in Zimbabwe, including an assessment of the prevalence rates and causes of disability. It also provides an analysis of the principal attitudinal, institutional and environmental barriers that result in the deep-seated social exclusion and marginalisation of disabled people in Zimbabwe. Section Four presents the key findings and observations that were made during the fieldwork undertaken for this study. This Section considers the current political and economic situation in which the substantive issues that this study seeks to address must be placed; the present and future role of DFID Zimbabwe; and some general observations concerning the situation of disabled people, disability policy and practice. The Section concludes by presenting an analysis of the stepping stool to social inclusion. Finally, Section Five presents the policy-focused recommendations that will hopefully facilitate the inclusion and participation of disabled people into mainstream development initiatives in Zimbabwe.

Section Three

Background Literature Review

3.1 Introduction

This section provides the contextual background for the Disability Scoping Study. It reviews the existing, published literature regarding the political, social and economic situation of disabled people in Zimbabwe. During the past 10 years, there had been a number of studies that have been written with regard to this field. In particular, this paper draws upon the key findings, inferences and policy recommendations of three studies. They are: -

- 1) *Living Conditions Among People with Activity Limitations in Zimbabwe*, published by SINTEF, (a Norwegian Health Research Institute) in December, 2003;
- 2) *The Forgotten Tribe: People with Disability in Zimbabwe*, published by Progressio, in January, 2007; and
- 3) *Children with Disability: Their Households' Livelihoods and Experiences in Accessing Key Services*, by Nelson Marongwe and Rekopantswe Mate, published in January, 2007. This report was commissioned by the United Nations Food and Agriculture Organisation.

It is important, at the beginning of this study, to make some reference to global trends and developments regarding disability in developing countries, and the dynamics of international disability politics. Disabled people comprise approximately 10% of the world's population, 75% of whom live in developing countries, and constitute one of the most poor, marginalised and socially excluded groups in any society (DFID, 2005, Barron & Amerena ed. 2007). Disabled people, irrespective of where they live, are statistically more likely to be unemployed, illiterate, to have less formal education, and have less access to developed support networks and social capital than their able-bodied counterparts. Consequently, disability is both a cause and consequence of poverty (Yeo, 2005).

Development agencies and practitioners are increasingly recognising disability as a key issue, inexorably linked to poverty, the extension of human rights and citizenship. In 2002, James Wolfensohn, former President of the World Bank, stated that unless disability issues were addressed, the UN Millennium Development Goal targets would not be met. Furthermore, the United Nations, in collaboration with civil society institutions, has successfully negotiated a convention regarding disability rights, ratified at the 61st Session of the General Assembly in December, 2007.

Notwithstanding the high profile given to disability and development issues, there remains scant consensus on what are the most appropriate, sustainable strategies and operational modalities that should be employed for effective interventions within the disability sector. In 2000, DFID published its issues paper on disability and development, advocating a “twin-track approach” whereby DFID would fund projects specifically targeted at disabled people, as well as encouraging mainstream development projects to incorporate a disability component into generic development programmes (DFID, 2000). Since its publication, more emphasis has been placed on mainstreaming, in the belief that including disabled people in generic development activities will ultimately result in building more inclusive, sustainable societies (Voluntary Services Overseas, 2006). Nevertheless, development agencies are struggling to develop effective, sustainable operational modalities for mainstreaming disability issues into generic development programmes. This can be partially explained by the contention that surrounds what is precisely meant by “mainstreaming”.

The past 40 years has witnessed, throughout developed and developing countries, the emergence of the international disability movement. Disabled people's organisations (DPOs) now constitute a critical and essential component of civil society. The *raison d'être* of DPOs is to advocate for the advancement and enforcement of rights of disabled people, in the belief that, at its foundation, disability is a human rights issue. Typically, DPOs are ran and managed by disabled people. During the past decade, DPOs have become increasingly instrumental in working with national governments, as well as the bilateral and multilateral institutions, in developing policies and operational modalities that the effective social inclusion of disabled people in the societies in which they live.

The ideological foundation of the international disability movement is the social model of disability. This maintains that disability arises from the attitudinal, physical and institutional barriers that systematically exclude disabled people from fully participating in society. Therefore, rather than focusing on the physical and/or psychological limitations of individuals, the emphasis of the analysis focuses upon the empowerment, social inclusion, choice and human rights. Furthermore, the clarion call of the movement is “nothing without us about us”, which emphatically emphasises that disability policy and practice should not be developed and implemented without the non-tokenistic involvement of disabled people and their democratically elected organisations. The tenets of the social model of disability have become the ideological hegemony of disability policy and practice in the 21st century.

Southern Africa has some of the strongest DPOs in the world, particularly in South Africa and Zimbabwe. They can be partially attributed to the fact that

the struggle to secure disability rights has been closely aligned to analogous struggles for liberation. Furthermore, the Southern African Federation of the Disabled, founded in 1986, has its headquarters in Bulawayo, Zimbabwe. It provides strategic leadership for the advancement of disability rights in 10 countries – Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe.

The remainder of this section has been structured in the following way. First, the published statistics regarding the prevalence and cause of disability was reviewed. Secondly, attention is given to reviewing the living conditions survey conducted by SINTEF, which provide a basis and foundation for subsequent sections of the report. Thirdly, consideration is given to the attitudinal, institutional and social barriers that exist and that militate against the effective social inclusion of disabled people into contemporary Zimbabwe society.

3.2 Prevalence and Causes of Disability in Zimbabwe¹

There are few sources of reliable statistics regarding the prevalence of disability within Zimbabwe. This is partially attributed to the fact that there is no universally agreed definition of what constitutes "disability", as well as it being socially and socially constructed. By way of parenthesis, it is interesting to note that the UN Convention on Disability Rights does not define disability, despite protracted debates on this very issue during its negotiation process. The World Health Organisation estimates, that approximately 10% of the global population can be considered to have a disability, although there are wide fluctuations in estimates between countries. This is particularly the case within developing countries where prevalence rates tend to be much lower. This can possibly be attributed to the fact that in high income countries, the provision of welfare benefits provide a strong incentive for people to declare that they have an impairment

In the Zimbabwean context, contrasting prevalence for disability are presented in different studies that have been undertaken. For example, in 1997 the Zimbabwe Inter-Censal Demographic Survey found 218,421 disabled people, which was approximately equivalent to 2% of the population. In this survey, 56% were men and 44% were women. Furthermore, it was estimated that approximately 70% of disabled people live in rural areas. This is very similar to analogous surveys conducted in other developing countries. By contrast, the Zimbabwe's Housing and Population Census, conducted in 2002, estimated a prevalence rate of 2.9%, with 45% being males and 55% being female.

¹ The statistics quoted in this section are taken from Choruma, (2007)

There are also widely contrasting estimates of the number of children with disabilities in Zimbabwe. The Inter-Censal Demographic Survey estimated that there were 57,232 children with disabilities. However, a study conducted by UNICEF, also in 1997, estimated that there were 150,000 disabled children within the country – 3 times as many as the Inter-Censal Demographic Survey.

In reality, it is very hard to assess with any degree of certainty how many disabled people actually live in Zimbabwe at the present time. This is exacerbated by the fact that a significant number of Zimbabwe's population are now dying from HIV/AIDS. Furthermore, a significant proportion of babies are now being born with HIV/AIDS, many of whom will also become orphans.

Table 3.1 tabulates the principal causes of childhood disability, as found by the Zimbabwe Department of Social Services in 1982.

TABLE 3.1 – CAUSES OF CHILDHOOD DISABILITY		
Source: Zimbabwe Department of Social Services (1982)		
Cause	0-4 Years (%)	5-15 Years (%)
Disease	61.5	60.1
Accident	9.6	23.0
Abnormal Birth	7.3	4.1
Malnutrition	9.6	1.7
Hereditary	1.9	2.8
War	1.9	5.1

These statistics can be compared with those recorded in SINTEF Disability Living Conditions Survey (Eide et al. 2003), which provides a more nuanced breakdown of the causes of disability.

TABLE 3.2 – CAUSES OF DISABILITY		
Source: SINTEF'S Disability Living Conditions Survey (Eide et al 2003)		
Cause	Number	%
Illness, disease, infection	312	23.3
Injury, accident	224	16.7

Congenital	167	12.5
Witchcraft	133	9.9
Old Age	129	9.6
Other Causes	96	7.2
Birth related (child)	47	3.5
Natural	38	2.8
Violence (war)	37	2.8
Violence (domestic)	36	2.7
Stroke/CVA	32	2.4
Burns	31	2.3
Amputations	24	1.8
Psychological stress	16	1.2
Bites (snakes etc)	10	0.7
Asthma/allergy	7	0.5
Total	1,339	100.0

This later study identified 2,071 disabled people, where cause of disability was self-identified. Care should be taken when drawing comparisons between the two data sets, as 46.5% of disabled people in the SINTEF sample were aged under 18.

Within Zimbabwean society, disability is invariably perceived in very negative and pejorative ways, which provides a constant theme that runs throughout this report. The study by Marongwe and Mate (2007) shows that the cause of disability is often attributed to witchcraft and the occult. They poignantly state that:-

Sometimes disability is seen as a sign that the woman's ancestors are angry and wish to be appeased. Or, it is attributed to other causes often associated with the baby's mother's family or her (immoral) behaviour. Men are given to saying that because there are no known PWDs [persons with disabilities] in their family the child disabilities should not belong to their family. They effect this by deserting. Crabtree and Krijgh (2006) also found this to be a common refrain. A definitive diagnosis therefore marks a point of stress, despair, marital discord and for some lingering doubt that perhaps something can be done to reverse, cure or purge disability. Repeated visits to healthcare centres for physiotherapy and other procedures might heighten tensions because of the strain on the household budget. Where disability is attributed to witchcraft by envious kin, spouses may be united in the fight against outside enemies as they search for herbal fortifications, herbs to purge the child of disability or to otherwise exorcise it. (Marongwe and Mate 2007:25)

Other evidence provides a convincing argument that there are institutional and structural factors that have a direct, causal impact on disability and

impairment. These include the lack of access the health service, poor, substandard housing, difficulties in finding employment.

3.3 Disability Living Conditions Survey (SINTEF, 2003)

It is instructive at this juncture to review SINTEF's 2003 Disability Living Conditions Survey, as it is one of the few studies of its kind to provide a statistical analysis of the actual living conditions and quality of life of disabled people in a developing country context. This study was a collaborative venture between SINTEF, the South African Federation of the Disabled, and the University of Zimbabwe. The methodology employed in this research enables a comparative analysis between disabled and non-disabled individuals and disabled and non-disabled households. Furthermore the research design will allow for longitudinal, follow-up studies to be conducted, thereby enabling changes in living standards to be monitored over time. Two separate studies were conducted as part of this research. Firstly, a comparative analysis between disabled and non-disabled individuals and households was undertaken. Secondly, a separate study investigating the difficulties and barriers encountered by disabled people in participating within mainstream society was commissioned.

The study was conducted in three administrative regions: Matabeleland, Manicaland and Midlands, which accounts for 44% of the total population. A total the study identified 1,943 households with disabled members and 1,958 households without a disabled member.

As would be expected, the study showed that in a multiplicity of ways, the living standards and quality of life was considerably lower for disabled individuals and households, in comparison with their non-disabled counterparts. This is demonstrated by considering the study's principal findings and conclusions, which are tabulated in Table 3.3 below.

TABLE 3.3 – PRINCIPAL FINDINGS OF THE DISABILITY LIVING CONDITIONS SURVEY
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Source: Eide et. al. (2003)

Demographics

- | |
|--|
| <ul style="list-style-type: none">▪ Irrespective of geographic region or urban/rural localities, households having at least one member with a disability are significantly larger than households without;▪ While no significant gender difference was observed in the composition of the households, those with disabled members were, on average, older than their non-disabled counterparts;▪ There was no significant difference between disabled and non- |
|--|

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disabled household with respect to marital status;

Education

- 10% of disabled children never attended school, in comparison with 29% of non-disabled children – a three-fold differential;
- 34% of disabled females and 22% of disabled males never attended school compared with 12% of non-disabled females and 8% of non-disabled males).
- Those with hearing, visual and intellectual impairment are significantly more likely never to attend schools than those with physical impairments;

Employment

- No significant differences were found in the unemployment rates found between disabled and non-disabled people. (This is probably due to the very high unemployment rate found across Zimbabwe).
- However, 83% of disabled women are unemployed, compared to 74% of disabled men;
- There was not statistically significant difference in the mean salaries between disabled and non-disabled workers. Nevertheless, for both groups, men earn more than did women;
- More households with one or more disabled family members have no one employed (55%) as compared to the non-disabled households (50%), in both rural and urban areas;
- Households with disabled members have lower (mean) income, less (mean) expenses regardless of seasonal fluctuations than households without disabled members;
- Fewer disabled households stated that salaried work was the primary source of income – (23% disabled households versus 31% non-disabled households)

Service Provision

- Overall, 73.9% or almost three-quarters of disabled people who expressed a need for some service did in fact not receive that service;
- Of those who did receive services, 50.5% stated they were too expensive, and 33.2% considered them to be inaccessible;
- With the exception of counseling and vocational training, over 50% of disabled people were aware of the services that are available;
- There was a big gap between the expressed need and the actual provision of services. For example, only 22.7% of disabled people expressing a need for vocational training actually received any form of service provision. The corresponding figures for welfare services and assistive devices were 23.6% and 50% respectively.
- Only 12.3% of disabled people were in receipt of a disability grant.

3.4 Barriers to Social Inclusion of Disabled People in Zimbabwe

As has already been demonstrated above, there are a plethora of attitudinal, institutional and physical barriers that preclude disabled people in Zimbabwe from participating in everyday life, as well as being unable to exercise their basic human rights. Within this report, it was not possible to provide a comprehensive analysis of the multiple barriers that systematically exclude disabled people within contemporary Zimbabwean society. However, what follows provides some indication the major obstacles that disabled people and their families' encounter.

Marongwe and Mate's 2007 study regarding the situation of disabled children in Zimbabwe provides an interesting and insightful sociological analysis of exclusion and marginalization. They argued that within Zimbabwean culture, wealth creation is a prime motivator for having children. Therefore, child rearing is perceived as a form of "social insurance" that will enable future generations to care for their older family and relatives. However, in the case of children with disabilities, and this often will not be possible. As a result, families do not consider it necessary, nor economically viable to invest in the future of their disabled children. It is commonly held that girls with disabilities will not provide suitable marriage partners and that adolescent boys will be unable to be breadwinners when they become adults. Consequently, disabled children are often subjected to abuse, neglect and concealment. This situation is further exasperated and compounded by entrenched negative social attitudes of the local communities, particularly in rural areas.

It is also argued by Marongwe and Mate that the concept of "livelihoods" is very important in understanding the situation of disabled children. Broadly, it refers to the mechanism by which people are able to make a living. It also refers to "People's capacities (skills and experiences); assets and resources and entitlements to services, resources and assistance)". Marongwe and Mate identify four main factors, which compound the marginalization and social exclusion of disabled people, which are listed below. Although this report focuses on the issues which are of particular relevance to disabled children, there is no reason to believe that they are not applicable to all disabled people in Zimbabwe.

1. Human Capital: Access to education and training for personal development, which is often a prerequisite for gaining employment. Due to the negative social attitudes surrounding disability issues in Zimbabwe, the vast majority of disabled children do not benefit from receiving an adequate primary education, which further compounds their difficulties in securing sustainable and long-term employment.

2. Social Capital: This refers to relational bonds and other social networks that exist between relatives, friends and other members within the community. Once again, due to negative social attitudes, disabled children and their families invariably have depleted social capital. This is further exasperated by the impact of HIV/AIDS, which in turn has resulted in a vast increase in orphanhood, as well as seriously depleting "traditional safety nets" provided by family members. This study also showed that the birth of a disabled child puts tremendous strain upon domestic family life, which sometimes involved the mother or father leaving the marital home. Marongwe and Mate state that: -

To complicate matters, indications are that households with children with disability or rely on social networks if there is no likelihood of members of the networks interacting with the child with disability. Thus support is available when it is not about the child with disability. The unintended effect of this is that children with disability are exposed to unintentional neglect, abuse and violence as parents are forced to lock them up, conceal them and/or to be over protective and to believe that no one else is capable of caring for the child. ... These conditions perpetuate the isolation and marginalization of especially low-income households with children with disability. (Margonwe and Mate 2007:14)

3. Physical Capital: This refers to access to physical infrastructure - for example, roads, transport, schools, health clinics and so forth. Due to the nature of many impairments, the inhospitable physical infrastructure, particularly in rural areas, profoundly hampers disabled people from accessing mainstream services. This is further compounded by the additional and often prohibitive transport costs that are necessary to enable disabled children and their families to attend schools, health clinics and so forth.
4. Financial Capital: In common with most other developing countries, disabled people and their families find it extremely difficult to access and secure loans and other forms of credit. Mainstream financial institutions, including those providing microcredit, perceive disabled people and their families as a high credit risk, and therefore very reluctant to lend in such situations. Once again, this further compounds and reinforces the native's cycle of poverty and disability, which in turn leads to ever more entrenched social exclusion.

The provision of wheelchairs is especially difficult in Zimbabwe, which severely restricts freedom of movement and the ability of disabled people to participate in community activities. A workshop was held in Harare in September 2006, to consider this very issue (Motivation UK and DWSO, 2006).

Motivation UK estimates that there are approximately 20 million people in low income countries who are in need of a wheelchair but do not have one. This is compounded by the fact that 80% of disabled people in low-income countries live in rural and remote areas. Consequently, this state of affairs seriously impedes the mobility of disabled people.

Within Zimbabwe, there are two Government Departments that are responsible for the provision of wheelchairs - the Ministry of Public Service Labour and Social Welfare, as well as the Ministry of Health and Child Welfare. However, both of these Ministries are inefficient in providing wheelchairs and other appliances. In addition, in common with many developing countries, wheelchairs are imported from Western countries. Consequently, they are too expensive for the vast majority of Zimbabwean disabled people. A further difficulty is that their design is not appropriate to the physical environment. Motivation UK has undertaken some very innovative work in designing wheelchairs that are suitable for use in developing countries.

Any further deep-seated problem facing disabled people in Zimbabwe, that has already been referred to, is the impact of HIV/AIDS. Despite the fact that this has been previously mentioned, it and not be overstated that this is a major and intractable problem. Within a society in which 18-20% of the population is HIV positive, where an estimated 3,000 people die of HIV related illnesses every week, it is inevitable that this has a devastating impact on the lives of disabled people. This can be explained by a multiplicity of reasons, which results in disabled people being particularly at risk. It is a very common misconception that disabled people are asexual beings, and do not have any sexual relations. Furthermore, due to low literacy levels, a great deal of disabled people do not have access to HIV/AIDS information. This situation is further compounded by the fact that many disabled children have become orphans, with both parents having died of HIV. Commenting on the relationship between HIV/AIDS in Zimbabwe, Progresso has candidly stated:-

The sexuality of people with disabilities is poorly understood and often not recognized or discussed by society and family members, and therefore people with disabilities are not commonly regarded as a community that is vulnerable to HIV or affected by AIDS. Indeed, people with disabilities are often referred to as "Children of God" and do not engage in sex. Yet people with disabilities themselves claim to be very active sexually, despite faced with attitudes that include the need for them not to marry, that if they have children it creates a bigger burden for the extended family, and that females with disabilities should have their ovaries removed. (Choruma 2006:13

3.5 Conclusion

This review of the existing published literature has conclusively demonstrated that, within contemporary disabled people encounter a plethora of obstacles and barriers that militate against their effective involvement and inclusion within contemporary Zimbabwean society. This is particularly the case in accessing primary education, and is compounded by an inadequate policy infrastructure for the effective provision of services. The strong, prevailing negative social attitudes to disability and disabled people further compounds their sense of isolation and social exclusion.

Section Four

Findings and Observations

4.1 Current Political Situation

Zimbabwe is experiencing a protracted humanitarian crisis. The economy has shrunk by over 40% in the last 10 years. Official figures put inflation at 7500% but it is probably much higher. Unemployment stands at 80%. The WFP estimates that 4 million people will be reliant of food aid by the end of 2007. Zimbabwe is being ravaged by HIV& AIDS with over 3000 people dying everyweek from AIDS related diseases. One in four children are orphans (the highest figure in the world).

The causes of Zimbabwe's decline are highly contested. The government argues that it is due to 'illegal sanctions'; periodic droughts, the impact of HIV & AIDs, and withdrawal of international aid. The West emphasises poor governance and economic mismanagement and point out that the 'sanctions' are targeted measures against the leadership of Zanu PF.

Since the beginning of the year the decline has hastened. The imposition of price controls has resulted in severe shortages of all staple items. Electricity cuts are widespread and long. The water and sanitation infrastructure is near collapse with raw sewage polluting water courses.

Given this situation, it is difficult to see how disability issues will be prioritised within the context of other development priorities. This is further compounded by the fact that Zimbabwe has yet to sign the United Nations Convention on the Rights and Dignities of Persons with Disabilities, which was formally adopted by the United Nations in December 2006.

TABLE 4.1 - CURRENT STATISITICAL SNAPSHOT OF ZIMBABWE

Source: DFID's Factsheet on Zimbabwe, April, 2007

- The latest official population estimate for Zimbabwe is 11.6 million, (2002 census), although it is likely to be considerably lower than this, due to the impact of migration and the impact of HIV/AIDS.
- 56% of the population live on less than \$1 per day and 80% of less than \$2 per day
- In 2001, almost 70% of the population had access to clean water. However, by 2006 more than 30% of the water systems were not functioning.
- 18.1% the population in living with HIV/AIDS.
- 1 in 12 children die before the age of 5 years.

4.2 Role of DFID Zimbabwe

This study has been commissioned by the Department for International Development (DFID) in Zimbabwe, and has been financed under the auspices of its Protracted Relief Programme (PRP). As previously stated, the rationale for the study, is in part, to assess and investigate how disability and be effectively mainstreamed within PRP Phase II, which is scheduled to commence in April, 2008. However, this report will make reference to broader issues regarding disability issues in Zimbabwe, that fall outside of the strict remit of the PRP initiative. At the outset of this section, is instructive to succinctly describe the role that DFID is currently playing in Zimbabwe and how this study fits with the Department's overall strategic objectives for the country. It is also instructive to briefly describe the Protracted Relief Programme.

DFID is one of the largest bilateral donors currently working in Zimbabwe, spending approximately £33 million during 2006/07. DFID Zimbabwe does not provide direct funding to the Government of Zimbabwe. The main strategic priorities for DFID Zimbabwe are currently saving lives and livelihoods and tackling HIV/AIDS including support for orphans and vulnerable children. Programmes are implemented by civil society and through UN agencies. Given the deteriorating situation, it is extremely unlikely that DFID Zimbabwe will be in a position to fund a major initiative on disability issues in the near future. Consequently, if disability issues are going to be addressed with DFID Zimbabwe's core activities, then the most appropriate and achievable strategy will be through "mainstreaming".

4.3 DFID's Protracted Relief Programme

DFID launched the first phase of its Protracted Relief Programme (PRP) in July, 2004. The objective of the programme is to provide practical support and assistance to the most vulnerable households in Zimbabwe, who are suffering from the cumulative disastrous impact severe economic decline, drought, combined with the impact of HIV/AIDS.

During the first phase, it is estimated that more than 200,000 households, (or 1.5 million people), will have directly benefited from the programme, with an estimated further 50,000 indirect beneficiary households. The programme provides practical relief through international and local NGOs with technical

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support being provided by FAO, UNICEF and the CGIAR centres. The programme is coordinated by the Technical and Learning Coordinating Unit, which provides support with regard to implementation, monitoring and evaluation.

The principal area of PRP programme activities fall within all the main themes, which are delineated in the Table 4.2 below.

TABLE 4.2 PRP PROGRAMME INTERVENTIONS (Source: PRP Briefing Note 1 – May, 2007)			
Agriculture	Livelihoods	Water & Sanitation	HIV & AIDS
Provision of agriculture inputs; Seed multiplication; Conservation farming; Micro-dosing of fertiliser; Gardens; Livestock; Agro forestry.	Non-timber forest products; Savings and landings.	Water points (new and repaired); Latrines; Participatory Health & Hygiene Education.	Training in home-based care and HIV/AIDS; Care provision of the chronically ill. Mainstreaming of HIV & AIDS Households with Chronically ill members targeted for assistance

4.3.1 The Involvement of Disabled People in PRP Phase I

From the key informant interviews and focus group discussions conducted for this study, it is very clear that disabled people have not been included, to any significant extent, in PRP Phase I activities. This is despite the fact that some PRP partners state that disabled people are one of their explicitly targeted groups and recognised as being particularly vulnerable within Zimbabwean society. Consequently, there is no evidence to suggest that, to date, PRP activities have had any sustained, positive impact upon the lives of disabled people whatsoever.

This state of affairs can be explained by a multiplicity of factors. At the community level, due to negative social attitudes, disabled people are often hidden, and are not encouraged to attend community meetings. This is compounded by the fact that disabled people are invariably neglected at household level and where community leaders discourage their involvement and participation in communal village meetings. Consequently, disabled people are invisible, with NGOs finding it very difficult in really identifying them. Furthermore, this state of affairs further compounds the difficulties of

PRP partners in effectively targeting the most vulnerable, including disabled people, thereby ensuring that those who are in the greatest need of assistance in fact receive it.

Another difficulty is that NGOs do not have sufficient knowledge and experience in disability issues effectively incorporate disability into their core activities. This can be partially explained by the fact that NGOs, in common with other stakeholders, have a misconception that "disability" is a very specialist area. PRP partners recognized the fact that they needed to make a more concerted effort to include disabled people. However, it was openly acknowledged that this is by no means easy. One of the problems is that there are no outcome indicators have been developed, in any true sense, that analyses the extent to which disabled people have genuinely benefited from PRP programme activities. UNICEF are particularly aware of the problem and are very keen, in the medium-term, to work with other stakeholders in developing the meaningful, pertinent and quantifiable outcome indicators, which genuinely demonstrates the sustained, improvement in the quality of life of disabled people, following programme interventions. This is an important issue that will need to be addressed during a second phase of the programme.

PRP partners considered that it was possible to take some meaningful actions that will increase the probability of effectively incorporating disability into future activities. These include meaningful consultations with disabled people's organisations when designing and developing new initiatives during Phase II.

At the workshop that brought together DPOs in Bulawayo, some very interesting and pertinent comments were made regarding the involvement and inclusion of disabled people in PRP Phase I, and in development programmes more broadly. Many felt that their expertise and knowledge had largely been ignored, primarily because PRP partners and other NGOs did not consider that DPOs had the sufficient capacity to make a significant contribution to programme design, implementation and evaluation. A further concern was that, because DPOs in Zimbabwe are small and lack sufficient organisational capacity, they have been ineligible to apply for PRP Phase I funding of and in their own right. It was therefore felt that the international donor community such as DFID should be more flexible in their eligibility criteria for funding DPOs.

It was further stated that there needed to be greater dialogue between NGOs and DPOs, in order that each could further understand each other's role and perspectives. In summary, it was strongly felt that NGOs needed to change their mindset regarding disabled people. Rather than perceiving them as objects of pity and patronage, they should be seen as equal

partners within the development process, thereby using their skills and experience accordingly.

At the workshop for DPOs in Bulawayo, a number of recommendations were made with regard to how disability issues could be effectively incorporated into PRP Phase II. These will be addressed in the next section of the report.

4.3.1 PRP Phase II

DFID are now the process of drafting and developing Phase II of the PRP programme, scheduled to commence in April, 2008. This will be a five-year programme, with an estimated budget of £50 million. Although this is still at an embryonic planning stage, it is envisaged that the programme will have the following priorities:-

- improved food security
- social protection
- water and sanitation
- capacity building
- coordination
- communications and learning.

The overall strategic goal of the programme is to reduce extreme poverty in Zimbabwe, by preventing destitution, in concert with protecting and promoting the livelihoods of the poor and most vulnerable.

As was the case during Phase I, the programme activities will be implemented through civil society institutions, primarily INGOs and national NGOs. The underlying rationale for the programme is premised upon the belief that even under conditions of extreme vulnerability, as currently experienced within Zimbabwe, it is nevertheless possible and desirable to deliver well-targeted interventions that will have long-term, positive and sustainable impact upon the country. Due to the current political situation in Zimbabwe, it is envisaged that there will be no direct involvement and contact with the Government of Zimbabwe. There is also recognition within DFID to incorporate a strong disability component within the next phase.

4.4 General Observations regarding the Situation of Disabled People in Zimbabwe

By undertaking key informant interviews and focus group discussions in this scoping study, some very interesting observations were made regarding the more broader situation encountered by disabled people living in Zimbabwe

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at the present time. Despite the fact that these fall outside the strict parameters of DIFD's PRP programme, they are nevertheless instructive and complement the literature review above.

It is very apparent that disabled people in Zimbabwe constitute one of the most poor, socially excluded and marginalized groups within the country. This is compounded by deep-seated, systemic attitudinal, institutional and environmental barriers that militate against their ability to participate in mainstream society. It is widely assumed that disabled people are a "burden" upon their families. In a country where the vast majority of the population is unemployed, it is commonly assumed that, particularly in rural areas, that disabled people constitute an economic burden, are by definition unproductive, and therefore are a drain on the scarce financial resources that are available to vast majority of households. These perceptions are exasperated within rural areas, where the causes of disability are often attributed to sorcery and witchcraft.

Women with disabilities are particularly at risk and vulnerable, who are often subjected to sexual violence, harassment and even rape. Within Zimbabwe, the Disabled Women's Support Organisation provides invaluable support to women in such circumstances. It is one of the few DPOs that cater to the needs of all impairment groups.

4.4.1 The Disability Movement

At the outset, it is important to emphasize that Zimbabwe has produced some of the world's most finest and influential disabled people, who are rightly claim to have been the leaders and driving force of the international disability movement, spearheading the development and growth of DPOs throughout the developed and developing world. This can be partially attributed to the excellent educational system, which used to thrive within the country. At one time, Zimbabwe had one of the best education systems throughout sub-Saharan Africa.

Notwithstanding this, it is true to say that many DPOs remain small, predominantly catering for the needs of single impairment groups, such as those with hearing difficulties or who are visually impaired. Consequently, at the present time, there is no one single, nationally based DPO who has the sufficient organisational capacity to play a leading advocacy role in terms of disability policy development within the country. During the past four years, efforts have been made to establish a multi-impairment, national DPO - The Federation of Disabled Persons of Zimbabwe (FODPZ). However, this is a comparatively very young organisation, and only has been established during the past four years. The organisational capacity of FODPZ remains

weak. It is therefore questionable whether it is able to play a strategic role in PRP Phase II.

Zimbabwe also is host of the Southern African Federation of the Disabled (SAFOD), which is a regionally based DPO, with an operational presence within 10 countries. It is undoubtedly one of the most respected and well established DPOs in the world.

Within Zimbabwe, there is a national umbrella disability organisation, the National Association of Societies for the Care of the Handicapped (NASCOH), which comprises of 53 organisations of and for disabled people. Despite the fact that the organisation does some very good and useful work, its name is problematical, because it is deemed by many to be very patronising. Recently, it has undertaken a needs assessment of disabled people, funded by USAID. It has also undertaken research regarding the funding of disability grants and their relationship between gender and disability within Zimbabwe. Until comparatively recently, there have been relatively good relations between DPOs and service providers. However, with the formation of the National Federation of disabled persons in Zimbabwe, who aspire to become the nationally recognized voice of disabled people, these relationships have to some extent deteriorated.

4.4.2 The Role of the State

The Government of Zimbabwe was one of the first countries in the world to pass disability legislation. The Disabled Persons Act was enacted in 1994 and revised in 1996. The Disability Act specifies that it is an offence to prohibit or deny disabled persons of access to public premises, services and amenities. It is also an offence to discriminate against disabled persons in employment. It is silent on issues such as education, rehabilitation and provision of devices.

The priority that the Government of Zimbabwe places on disability seems to be contradictory. On the one hand, it is unclear to what extent that the Government of Zimbabwe, given the current political and economic climate, considers disability as a priority issue. In contrast with many African countries, the lead Government Department for disability issues, the Department of Social Welfare, in the Ministry of Public Service and Labour, is not located in the Office of the President. However, on the other hand, in recent months, the President of Zimbabwe has appointed an Advisor on disability issues. However, it is far from clear what are the priorities of this new post, and what coherent strategies will be implemented to raise the profile of disability issues. It is also unclear to what extent the Adviser has the confidence of the disability movement in effectively addressing disability issues.

Therefore, The extent to which disability is really prioritised by the Government of Zimbabwe is unclear. Moreover, the majority of key informants interviewed for this study considered that the Government of Zimbabwe does not have the capacity or the political will to implement effective policies and services in the field of disability.

The Government perceives disability as a non-threatening and non-political issue. Therefore, it welcomes the involvement of INGOs in the disability sector. This is somewhat ironic, considering that the international disability movement, which in the past has been spearheaded by some very prominent Zimbabwean disabled people, has a very strong, overt political agenda, which places a great deal of emphasis on human rights, non-discrimination, empowerment and choice.

Disabled people are entitled to receive some disability grants, but these are woefully inadequate to have any significant impact upon the lives of disabled people (Z\$8 000 for an adult and Z\$4 000 for children per month). Furthermore, there is a grossly inadequate and inefficient infrastructure for the administration of these grants. Due to the deteriorating economic situation it is becoming increasingly not worth disabled people to receive this grant. Micro finance for disabled people is available through the Ministries of Public Service, Labour and Social Welfare and Women's Affairs, Gender and Community Development. However, due to the rapid hyperinflation that is engulfing the economy, these loans are worthless.

In addition to the above initiatives the Government of Zimbabwe had established the National Disability Board (NDB) in accordance to provision of Section 4 of Act of Parliament entitled Disabled Persons Act 1701 of 1992. The Board comprises of the Director, ten members from organisations/associations that represent disabled people, three members from disability strategic Ministries, one member from the trade unions in Zimbabwe and one member from the association of employers in Zimbabwe. The Board in consultation with the responsible Minister can make co-options provided the membership of the board does not exceed twenty.

The NDB is under the Department of Social Welfare in the Ministry of Public Service, Labour and Social Welfare. According to the Act the Board should be serviced by a fully-fledged Secretariat, headed by a Director of Disability Affairs. However, since 1994 to date Social Welfare staff have been working on other responsibilities, to the detriment and neglect of disability issues.

Some major functions of the Board are:

- Formulate and develop measures and policies designed to achieve equal opportunities for people with disabilities by ensuring that they

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obtain education and employment. They also fully participate in other academic activities and are afforded full access to community social services;

- Prevent discrimination against people with disabilities by encouraging and putting into operation schemes and projects for employment or income generating projects for disabled people who are unable to secure employment elsewhere; and
- Issue adjustment orders in a bid to attain accessibility to buildings, information and services.

The Board established the Disability Fund in 2003 and 2006 and received funding from the national fiscal reserves. It also lobbied for the inclusion of disabled people in the Zimbabwean Constitution; Section 23:02 as a prohibited ground for discrimination. Children with disabilities are also benefiting from the Basic Education Assistance Module after the Board had successfully lobbied for their inclusion.

The Board is limited in its operations of mainstreaming disability issues because, all the work is being handled under one Ministry of Public Service, Labour and Social Welfare which is administratively responsible for the NDB. Therefore it is difficult to hold other Ministries accountable since they do not report to the Minister responsible for disability issues. The Board is invisible since it has got limited resources to implement its strategic plan.

4.5 Analysis of the Stepping Stool to Inclusion

Table 4.3 overleaf presents the analysis of the stepping stool to social inclusion, as applied within the Zimbabwean context. A full description of the methodology employed in this analysis can be found in Appendix E. As can be seen, despite the fact that Zimbabwe was one of the very first countries to enact disability discrimination legislation, the support provided by the state is grossly inadequate to meet the needs of disabled people within contemporary Zimbabwe. This situation can only be exasperated by the context of the current political and economic crisis that the country is now experiencing. In theory, disability grants are available, but these are meager when compared against the level of potential demand. Furthermore, the necessary infrastructure for the effective administration of these grants does not exist.

Despite the fact that the Government of Zimbabwe has indeed enacted disability legislation, disability issues, when compared with other competing economic and developmental challenges, remains a low priority. However, in recent months the President has appointed a special adviser on disability issues, but it remains very unclear what is his mandate, and what strategies

will be employed to raise the level of awareness with respect to disability within the country.

For all intents and purposes, the large majority of services available to disabled people are provided by international NGOs. However, those that are available are very limited with regard to geographical coverage. This is compounded by the fact that aids and appliances are in very short supply in comparison with the potential level of demand. Furthermore, those appliances that are available are prohibitably expensive for the vast majority of disabled people to benefit from them.

Disabled people's organisations, in common with many civil society institutions in Zimbabwe are small, and lack sufficient organisational capacity to lobby governmental and other organisations for sustained change and advancement of human rights. In recent years, attempts had been made to establish a national, multi-impairment DPO - the The Federation of Disabled Persons of Zimbabwe (FODPZ). However, this initiative had proven to be problematical, and it remains unclear regarding to what extent the organisation is truly representative of the views of all impairment groups. Within Zimbabwe, it is estimated that there are approximately 35 to 40 DPOs.

A comprehensive Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis of the support currently available to disabled people in Zimbabwe can be found in Appendix E of this Report.

This Section has primarily focused upon analyzing the systemic barriers that militate against the social inclusion of disabled people in Zimbabwe. Very practical guidance for the inclusion of disability issues into generic development programmes are made with a separate document entitled "Disability Guidelines for Inclusion", which was produced as a separate output of this consultancy.

It is worth emphasizing that the attitudinal, institutional and physical barriers to social inclusion be disabled people in Zimbabwe are by no means unique. Many studies conducted in other counties experiencing states of emergency document similar barriers encountered disabled people. A good example is the work undertaken by Corderio et. al., (2006), which analyses the inclusion of disabled people in humanitarian relief operations in the aftermath of the December 2004 Asian tsunami.

Table 4.3: Disability Scoping Study in Zimbabwe - Stepping Stool Analysis to Inclusion

Sector	Key roles and functions	Indicative assessment
THE STATE	<ul style="list-style-type: none"> • The rights of Disabled people are enshrined in the Constitution of Zimbabwe in 2005. It is therefore illegal to discriminate against disabled people. • The Disability Act was first enacted in 1994 and revised in 1996. The Act solely focused on health issues, and excluded education and employment. • The Mental Health Act and the Child Protection Act also make some reference to disability. • The Government has established a National Disability Board, whose mandate is to advice the Minister of Public Service, Labour and Social Welfare on disability issues. • In the last two months the President of Zimbabwe appointed a Disability Advisor but his role and mandate is not clear. • There are no published and agreed standards to monitor the implementation of the Disability Act. • Within the ZANU (PF) Politburo, there is a Senator with physical disability, who promotes disability issues. . • There is no evidence that suggest disability is included in mainstream public services, such as education, employment and health. 	<ul style="list-style-type: none"> • Despite having the Disability Act, there are no formal policies and implementation strategies that are in place to ensure the Act's enforcement. • The lead Ministry for disability issues is the Ministry of Public Service, Labour and Social Welfare. However, the coordination of disability policy is fragmented. This can be attributed to low priority given to disability issues and inputs from the Ministry of Education, Sport and Culture and the Ministry of Health and Child Welfare. • The Government of Zimbabwe provides funding for the National Disability Board but insufficient resources to ensure effective implementation of disability policies. The National Disability Board does consult with DPOs and Service Providers in Zimbabwe. However, this is cosmetic and tokenistic. • There is provision for micro finance loans by the Ministry of Women's Affairs, Gender and Community Development. These are Z\$100 million per each woman DPO at 50% interest per annual. This is a very favourable rate of interest in comparison with the market rate of 900% per annum. These loans are paid in cash and then distributed directly to women. Therefore these are effective because they can be spent immediately. • Grants are also provided by the Department of Social Welfare. However, these grants are grossly inadequate (Z\$8 000,00 for adults and Z\$4 000 for children). There is inadequate infrastructure for the administration of these grants. • The Ministry of Finance has a fund, which could be accessed by disabled people through the banks at an interest rate of 50 percent per annum. However, accessing these loans are extremely problematical because disable people do not have sufficient capacity to secure these loans.

<p>DISABILITY SERVICES (e.g. rehabilitation, assistive devices, support services for disabled children, specialist vocational training, etc.)</p>	<ul style="list-style-type: none"> • There are a number of very good special schools being funded by International donors such as SIDA (Sweden and the Danish Government). • Leonard Cheshire International provides some residential accommodation and education programmes. • Motivation – UK provides training for spinal cord injured people and the provision of appropriate and affordable wheelchairs. 	<ul style="list-style-type: none"> • The scale of service provision is grossly inadequate to address needs and demand of the majority of disabled people in Zimbabwe. TEF's Disability Living Conditions Survey, children with disabilities are three times less likely to attend school than their able-bodied counterparts. • Services for those with mental health difficulties are especially inadequate, due to the unaffordability of the essential medication. Also, those with learning difficulties are do not received any services. • Due to the political situation in Zimbabwe, there is little coordination between Public Service providers and NGOs. • Very few disabled people have sufficient access to the basic service they need. • The political and economic situation in Zimbabwe seriously compromises the effective implementation of sustainable services. • The main barriers for accessing services are widespread negative attitudes regarding disability (especially in rural areas), inadequate physical infrastructure and inadequate financial resources. Also, the Government of Zimbabwe does not perceive disability as a priority in compassion with other Government initiatives.
<p>DISABLED PEOPLE'S ORGANISATIONS</p>	<ul style="list-style-type: none"> • Zimbabwe has been historically one of the strongest countries in establishing DPOs and disability activists throughout the world. • However, the majority of DPOs are small and lack sufficient organisational capacity to campaign on disability rights. • DPOs do engage with the National Disability Board. However, this is tokenistic. 	<ul style="list-style-type: none"> • There is national cross-cutting disability umbrella DPO in Zimbabwe – The Federation of Disabled Persons of Zimbabwe (FODPZ). It represents all impairment groups. • There are approximately 35 DPOs in Zimbabwe operating at national, provincial, district and local levels. • Many DPOs cater for the needs of single impairment groups, such as the hard of hearing and those with visual impairments. • There is little collaboration between DPOs with respect to lobbying and advocacy. • It is unclear to what extent DPOs comprehend what is really meant by a rights-based approach to disability. • Some DPOs run micro-credit programmes, which are funded by the State.

Section Five

Recommendations

5.1 Introduction

As has already been stated, the recommendations made within this report are based upon the assumption that Zimbabwe has relative political and economic stability for the next two years, and that intention to launch the second phase DFID's Protracted Relief Programme does in fact commence in April, 2008. Given the current political and economic instability that is currently engulfing Zimbabwe, it is readily acknowledged that this assumption, with the benefit of hindsight, may prove to be erroneous. Furthermore, these recommendations have been drafted in the light of the evidence gathered during the fieldwork for this study, attempting to take into account the multifaceted and sometimes diverging views of all the stakeholders that were consulted. Consequently, the recommendations delineated below and to be very practical in nature, which can be hopefully be implemented by DFID and PRP project partners.

As will be seen, the recommendations have been clustered into five distinct sub-categories. The rationale upon which they have been founded is presented at the end of each sub-category.

5.2 List of Recommendations

a) Mainstreaming disability issues in PRP Phase II

1. PRP partners should be encouraged to actively include disability issues and disabled people in their future programmes activities. This could be done by requiring applicants in calls for proposals to articulate how they will include disabled people in their activities.
2. All PRP partners should receive disability awareness training. This should be provided by representatives of DPOs.
3. That SAFOD and the African office of Motivation - UK be consulted regarding the most appropriate personnel to undertake this training.
4. That PRP partners intending to prioritise disabled people, as a key target beneficiaries with Phase II be encouraged to develop effective outcome indicators that demonstrate what positive impact project activities have had upon the lives of disabled people.
5. That Motivation – UK and Practical Action be encouraged to work collaboratively to develop inclusive solutions so that disabled people can access food distribution centres and water and sanitation projects.

6. That the beginning of PRP Phase II, a workshop/seminar is held for all PRP partners to develop meaningful outcome indicators for inclusion of disability issues within PRP Phase II project activities.

In order to address the apparent failure of PRP Phase I partners to effectively include disability within their programme of activities, it was felt necessary that during Phase II, that all potential partners should be encouraged to explicitly include disability when developing project proposals. For this to be more than just a cosmetic and tokenistic exercise, it was considered that all potential PRP Phase II partners to receive disability awareness training. Ideally, this should be conducted by disabled people, and preferably by a DPO based in Zimbabwe. In order to ensure some degree of transparency and objectivity, it was thought that initially SAFOD and Motivation UK, (a British NGO that is well respected and has worked extensively with DPOs in Zimbabwe), should be consulted regarding who would be the most appropriate personnel to undertake this training.

It was also considered necessary, at the beginning of Phase II, to develop incisive and meaningful project indicators that effectively assess the impact of programme activities upon the lives of disabled people. These should not exclusively focus upon output indicators, (from example, the number of disabled people receiving food aid), which provides a arguably blunt form of analysis. Rather, they should also and perhaps more importantly, focus on the development of outcome indicators, which analyses the enhancement of quality of life of disabled people. It is readily acknowledged that this is by no means a simple, unproblematic exercise, and will demand a great deal of conceptual analysis. However, in the long-term, this process could be very beneficial to ensuring that PRP Phase II programme activities are effective in targeting those who are most poor and vulnerable, not least disabled people. In the first instance, it may be advisable to ask UNICEF Zimbabwe if they would lead on this particular issue, given that they have already expressed an interest in working in this field. It is also recommended that during the first year of Phase II, a workshop is held to discuss project output and outcome indicators, thereby creating the opportunity for all project partners to form a common understanding of the nature and complexity of the issues involved.

b) Disability Advisors in PRP Phase II Management Structures

7. That three part-time Disability Advisors should be appointed to the Programme Management Team to advise on disability issues at strategic level. Three part-time Advisers are proposed instead of one full-time adviser to ensure that a range of impairments are represented

- and that no one DPO or group should be seen to be dominating. Three Advisers could also cover different geographical areas.
8. That SAFOD and other registered DPOs be consulted regarding the most appropriate personnel to be recruited as part-time disability advisors.
 9. That the Disability Advisors should be recruited through an open and transparent competitive tendering process.

In an attempt to ensure that disability issues are effectively incorporated into PRP Phase II activities and that project partners gain a mature, well-grounded understanding of disability, it is recommended that three part-time Disability Advisers be appointed to the Project Management Team. The Advisers must have personal experience of living and working with an impairment. Their role will be to provide input, at a strategic level, into the overall management and development of the programme. It was considered necessary to appoint three part-time Disability Advisers, as opposed to one full-time position, in order to ensure that no one single DPO, nor any single impairment group has a monopoly in advising the Project Management Team. This strategy will also ensure that there is some geographical representation in the appointment of Disability Advisers. Again, in order to ensure transparency and openness, it is strongly recommended that these positions be recruited through an open competitive tendering process.

c) DPO Involvement in PRP Phase II

10. That a consortium of DPOs being encouraged to submit a joint project proposal during the PRP Phase II.
11. This consortium should be made up of at least five DPOs.
12. That the National Association of Non-Governmental Organisations (NANGO) be recruited to provide generic organisational capacity building and project management training to the Consortium. This could be financed through the British Embassy.
13. In addition individual DPOs should be encouraged to submit joint proposals with PRP partners, thereby facilitating the mainstreaming of disability issues with PRP Phase II core activities.

With a view to encourage the active involvement of DPOs in PRP Phase II, it is recommended that a consortium of at least five DPOs be invited to submit a joint funding proposal. Given that the vast majority of DPOs in Zimbabwe are very small and their current organisational capacity is limited, it was considered that no one single DPO, at this point in time, would have the sufficient wherewithal to make a successful application by themselves. However, if a consortium of DPOs was constituted with the explicit objective of making an application for a Phase II project, these inherent difficulties may

well be overcome. This approach also has the added advantage of encouraging DPOs to work together in a collaborative way, which in turn could act as a catalyst for other future collaborative ventures.

In order to facilitate this initiative, it is also recommended that some targeted organisational capacity building training be provided to members of the consortium, thereby increasing the likelihood of the submission of a successful proposal. This training could be provided by the National Association of Non-Governmental Organisations (NANGO), who has previous experience and proven track record in providing such training to other civil society institutions in Zimbabwe. The British Embassy in Zimbabwe has already indicated that they would be open to financing such a training initiative, if they were to be approached.

In addition, individual DPOs should be encouraged to make joint applications with other mainstream NGOs. This would have the advantage of facilitating the cross-fertilising of ideas and experiences between both parties. This approach would also further inculcate the ethos mainstreaming disability issues into generic development programmes.

d) Monitoring and Evaluation

14. That disability issues should be incorporated into the monitoring and evaluation frameworks for PRP Phase II.
15. That some funding should be allocated to enable DPOs to play a significant role in the monitoring and evaluation process.
16. A minimum of three DPOs be funded to undertake monitoring and evaluation activities or this could be undertaken by the disability advisers in the Management unit.
17. That SAFOD and the African office of Motivation – UK should be consulted regarding the appropriate DPOs to undertake monitoring and evaluation activities.
18. That these DPOs should be recruited through an open and transparent competitive tendering process.

If disability issues are to be effectively incorporated into PRP programme activities, it is essential that disabled people and DPOs are inherently involved in developing and implementing the monitoring and evaluation frameworks for the programme. Ideally, three DPOs should be involved in this process, again thereby ensuring that a cross-section of DPOs and impairment groups are involved in this process. It may be advisable to incorporate these functions into the role of the disability advisers described above. In order to achieve some degree of objectivity, it is considered necessary to consult SAFOD and Motivation UK regarding whom will be the most appropriate

DPOs carrying out these functions. It is also strongly recommended that open competitive tendering processes are adopted for these positions.

e) International Disability Day

19. That DFID Zimbabwe should host an event targeted at other donors to raise the profile of disability issues on the International Disability Day, which is 3rd December.

In order to ensure that disability issues are highlighted as a legitimate and important issue in the field of international development, it is recommended that DFID should host a seminar on international disability day (3rd December), specifically targeted at other bilateral and multilateral donor agencies. DFID is well placed to host such an event, given their previous work in this particular field.

Appendix A

Questionnaire sent to Mainstream Organisations

SECTION A – DETAILS OF ORGANISATION

1. Name of organisation: _____

2) Address & contact details

Tel: _____
-

E-mail: _____

3) Type of organisation

National NGO, International NGO UN Agency

Other Please specify

4) Please list the core activities of your organisation

5) Geographical coverage

Where does your organisation work? (Provinces, districts , village, ward)

SECTION B – Knowledge of disability

6) What do you understand by the term 'disability'? How would you define disability?

7) Does your organisation have any policy or guidelines on disability and the inclusion of disability in programmes?

8) What do you know about the situation of disabled people in Zimbabwe – from reading, experience of working in the country?

SECTION C: Disability and current activities

9) Does your organisation consider disability to be relevant to your work in Zimbabwe?

If yes, why?

If no, why?

10) Does your organisation incorporate disability issues into your current core activities?

If, yes, please describe in what way -----

11) Have you consulted with any Disabled People's Organisations or other organisations working on disability issues? If so, please give details

12) Has your organisation specifically allocated financial resources for including disability in your core activities? If Yes, give details

13) What difficulties and constraints hamper the effective inclusion of disability issues into your core activities?

14) What need to take place for these difficulties to be overcome?

i) Internally within the organisation?

ii) Within the broader development and policy-making context?

15) Does your organisation intend to incorporate disability issues into its future activities?

i) If yes, in what way?

ii) Have you consulted with disabled people's organisation regarding your future plans?

- iii) What challenges and difficulties have you encountered or anticipated in developing this?

SECTION D - DECLARATION

I consent to the content of this completed questionnaire being quoted in the final report of this study

Yes No

I consent to the name of my organisation being attributed to any quotation within the final report

Yes No

Signed

Position

Date

Appendix B

Questionnaire sent to Disabled People's Organisations

SECTION A – Details of Disabled Persons Organisation or Disability Organisation

1) Name of organisation'-----

2) Address: -----

-

Tel:-----

Email:-----

3) What type of organisation are you?

DPO Umbrella Organisation

DPO

Disability Organisation for Disabled Persons

Faith-based Organisation

NGO

4) Is your organisation registered with the Government? Yes or No

5) How long has your organisation been operating? (state years and months) -----

SECTION B – Details of activities

6) Which areas of the country do you work?
(Province, districts, village, ward)

7) What activities do you carry out to support disability issues and disabled people? For example: advocacy, provision of assistive devices, income generation projects etc.

8) What are your sources of funding? For example

1. Membership fees
2. Government grants (which ministries?)
3. Local donors (please specify)
4. International donors (please specify)
5. Other (specify)

SECTION C – Working with others

9). Do you work with any other organisations in support of your programmes? If yes, please give details.

10). What has been your experience of working with these other organisations?

11) How is your organisation involved?

SECTION D – Working with mainstream organisations

12) Are you aware of any development and assistance programmes being offered in the areas where your organisation works? Please give details:

13) If yes in Q12, are disabled people benefiting from these programmes? Explain

14) If No in Q12 what is the reason for disabled people not benefiting from the programmes?

.....

15) What needs to be done to ensure better inclusion of disabled people in development and assistance programmes?

16) How best can mainstream organisations work with disabled people?

17) Do you have any further comments? Can you suggest other organisations who should be consulted?

.....

Thank you

Respondent's name: Date:.....

Position:.....

Appendix C

List of Key Informants Interviewed During Fieldwork

1. Tom Barret – Head of DFID - Zimbabwe
2. Philippa Thomas – DFID – Social Development Officer -
3. Joanne Manda – DFID – Deputy Programme Manager
4. Erica Keogh – TLC Coordinator
5. Ernest Mupinga - Practical Action Regional Director
6. Farai Mukuta – NASCOH Director
7. Lovemore Rambiyawo – NASCOH Information Officer
8. Godfrey Mittie – Care Deputy Chief of Party for Community-based
Natural Resource 9. Management and Sustainable Agriculture
10. Shepherd Murahwi – CAFOD Programme Support Officer, HIV and AIDS
Livelihoods Programme, Zimbabwe
11. Joshua T Malinga – Senator and Deputy Secretary of the ZANU (PF)
Politburo for the Disabled and Disadvantaged people
12. Phillip Barclay - British Embassy Second Secretary – Political and Projects
13. Roeland Monosch – UNICEF Country Programme Coordinator
14. Jose Bergua – UNICEF Child Protection
15. Dr Felix Muchemwa Disability issues Advisor to the President
16. George consultant working of the targeting guidelines for NGOs
17. Susan consultants working of the targeting guidelines for NGOs
18. RESCU management
19. Annie Malinga –Vice Chairperson of the Federation of the Disabled
Persons of Zimbabwe (FODPZ)
20. Rosewater Alice Mudarikwa, National Disability Board Chairperson
(Fact Sheet)

Appendix D

List of Organisations Participating in Focus Group Discussions

a) Disabled People's Organisations Workshop – Rainbow Hotel, Bulawayo, 13th July, 2007

Catholic Relief Service
Chronicle
Disabled Persons Institute Foundation
Dabani Trust
Federation Of Disabled Persons of Zimbabwe
Local Rehabilitation Workshop (LOREWO)
KING George VI
Matebeleland Aids Council
Muscular Dystrophy Association of Zimbabwe
Ministry of Health and Child Welfare
National Council of Disabled Persons of Zimbabwe
National Foundation of the Disabled Persons
OXFAM (Great Britain)
Pan – African Federation Of the Disabled
Quadriplegics and Paraplegics Association of Zimbabwe
Southern African Federation Of the Disabled
Save the Children – UK
Zimbabwe Association of the Visually Handicapped
Zimbabwe Sport Association for People with Disabilities.
Zimbabwe Women with Disability in Development

b) Non-Governmental Organisations Workshop – Miekles Hotel, Harare, 15th July, 2007

African Rehabilitation Institute
CARE
Catholic Relief Services
Clarity Global Inc
Farm Community Trust of Zimbabwe
Department For International Development
Disabled Women's Support Organisation
Food and Agriculture Organisation
Joint initiative Mercy Child Welfare
Min of Women's Affairs, Gender and Community Development
National Council Corps
Ministry of Education Sport and Culture.
Ministry of Health and Child Welfare
Musasa Project

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National Council of Disabled Persons of Zimbabwe
National Association for the Care Of the Handicapped.
Practical Action
Quadriplegics and Paraplegics Association of Zimbabwe
Save the Children – UK
Spinal Injuries Association of Zimbabwe
Technical and Learning Coordinating Unit
United Nations Children's Fund
Women's Coalition of Zimbabwe
Zimbabwe Association of the Visually Handicapped
Zimbabwe National Association for the Deaf
Zimbabwe Women Resource Centre and Network.

Appendix E

SWOT Analysis of Support for Disabled People in Zimbabwe

DISABILITY SCOPPING STUDY IN ZIMBABWE: SWOT ANALYSIS				
Sector	Strengths	Weaknesses	Opportunities	Threats
The State	<ul style="list-style-type: none"> The Government of Zimbabwe was one of the first countries in the world to pass disability legislation. The Disabled Person Act was enacted in 1994 and revised in 1996. The Disability Act specifies that it is an offence to prohibit or deny disabled persons of access to public premises, services and amenities. It is also an offence to discriminate against disabled persons in employment. The Ministry of Public Service, Labour and Social Welfare is dealing with the issues of disability. In this Ministry, there is a Director for Social Welfare. The National Disability Board's mandate is to formulate and develop policies for people with disabilities. The Government on a 	<ul style="list-style-type: none"> There are no published and agreed standards to monitor the implementation of the Disability Act. The Minister has more power on disability issues than the disabled persons themselves as they are just appointed by him. The Disability Act of 1996 in Zimbabwe is silent on issues such as education, rehabilitation and provision of devices. There is no Employment Equity Act, Social Assistance Act, Skills Development Act and Skills Development Levy Act designed specifically designed for people with disabilities, in the country. In the Government of Zimbabwe there is no Members of Parliament with disabilities or one who has a higher position in government such as Permanent Secretary or Director. All issues of 	<ul style="list-style-type: none"> The PRP Partners are willing to work with Government disability issues. The Government of Zimbabwe should make use of well- educated disabled people to address issues of disability. The Government of Zimbabwe can make use of DPOs in policy and decision making process. Government of Zimbabwe could take advantage of the platforms that it interacts with other Governments i.e. SADC, AU and UN to learn of the policies regarding disability being adopted by other governments; With the signing of the UN Convention on Disability, the Government of Zimbabwe will be able to source for funding for disability issues. 	<ul style="list-style-type: none"> The political and economic situation in Zimbabwe seriously compromises the effective implementation of sustainable services. The political volatility in the Zimbabwe might repulse the NGOs/INGOs who are willing to work for the improvement of living standards of the people with disability in the country. The economic instability in the country might result in people with disability living standards deteriorating, and many of them failing to acquire basic education, health and rehabilitation. Also the Government of Zimbabwe might fail completely to continue giving grants to the people with disability.

DISABILITY SCOPPING STUDY IN ZIMBABWE: SWOT ANALYSIS				
Sector	Strengths	Weaknesses	Opportunities	Threats
	<p>small scale, through the Department of Social Welfare and the Ministry of Health and Child Welfare provide persons with disabilities with devices.</p> <ul style="list-style-type: none"> • The Ministry of Women's Affairs, Gender and Community Development has come up with programmes for women with disabilities. • The President of Zimbabwe has appointed one Senator with a disability. • The President of Zimbabwe had appointed a Disability Advisor to the President • The Government of Zimbabwe is a signatory to all the key legally binding United Nations human rights treaties • The rights of Disabled people are enshrined in the Constitution of Zimbabwe in 2005. • The Government has established a National Disability Board, whose mandate is to advise the Minister of Public Service, Labour and Social 	<p>disability are being dealt with by able-bodied. The disabled people suffer exclusion from the formal political process.</p> <ul style="list-style-type: none"> • Most of the government and public buildings if not all are inaccessible • The Government of Zimbabwe had not signed the UN Convention on Disability Rights • The educational system of higher learning has by now, not yet mainstream disability studies in their systems. Also, the University of Zimbabwe seems to be the only institute of Higher learning with a developed Disability Resource Centre and other institutes are at their initial stages, with others failing to have one. • There is no evidence that suggest disability is included in mainstream public services, such as education, employment and health. • Disabled people are entitled to receive a disability grant. The grant 	<ul style="list-style-type: none"> • If the Government of Zimbabwe is to implement good governance, then there are many opportunities of funding of many programmes including disability. 	

DISABILITY SCOPPING STUDY IN ZIMBABWE: SWOT ANALYSIS				
Sector	Strengths	Weaknesses	Opportunities	Threats
	<p>Welfare on disability issues.</p> <ul style="list-style-type: none"> The Ministry of Finance has a fund, which could be accessed by disabled people through the banks at an interest rate of 50 percent per annum. 	<p>is far too small (Z\$8 000,0 for an adult and Z\$4 000,00 for children per month), to have any significant impact on the lives of disabled people. Due to the deteriorating economic situation it is becoming increasingly not worth disabled people to receive this grant.</p> <ul style="list-style-type: none"> The government does not have the capacity or the political will to implement effective policies and services in the field of disability. The National Disability Board does consult with DPOs and Service Providers in Zimbabwe. Educational level of disabled people in Zimbabwe, in comparison with their able-bodied counterparts remains very low. Many do not complete primary education. The government has not come up with a favourable strategy so that, at list the majority of people with disability access these loans since 		

DISABILITY SCOPPING STUDY IN ZIMBABWE: SWOT ANALYSIS				
Sector	Strengths	Weaknesses	Opportunities	Threats
		<p>most of the disabled people do not have sufficient capacity to secure these loans</p>		
INGOs/NGOs	<ul style="list-style-type: none"> The NGOs/INGOs are well funded and have adequate resources i.e. vehicles The majority of INGOs/NGOs are well established and are capable of campaigning on disability rights. Most of the INGOs/NGOs have programmes that cover rural and urban areas the could potentially incorporate a disability component 	<ul style="list-style-type: none"> All the NGOs that responded admitted that they have never consulted with any DPOs or other organisations working on disability issues and they have not allocated financial resources for the inclusion of disability in their core activities. Disability issues are not being funded since priorities of the government, NGOs and other local donors are on fighting HIV and AIDS. Most of the NGOs and other organisations are not aware of disability issues. The majority of PRP partners do not comprehend, in any sophisticated manner disability issues. 	<ul style="list-style-type: none"> They were willing and happy to include disability in their work and they have admitted that they need assistance in the PRP Phase II. It was agreed at the two workshops, that there is need to have a disability technical person to work with the NGOs under the PRP Phase II. Also at the NGO workshop in Harare, all NGOs enormously agreed that there is need for a technical advisor on disability issues to be housed at the TCL. People with Disability are not seen as a threat to the Government of Zimbabwe, hence any organisation which want to work with disabled people are permitted by the government. 	<ul style="list-style-type: none"> The selection criteria of people meant to benefit from the aids and services from the PRPs tends to be political, hence jeopardising those who are suppose to benefit.

DISABILITY SCOPPING STUDY IN ZIMBABWE: SWOT ANALYSIS				
Sector	Strengths	Weaknesses	Opportunities	Threats
DPOs	<ul style="list-style-type: none"> • Zimbabwe has been historically one of the most strongest countries in establishing DPOs and disability activists throughout the world • DPOs do engage with the National Disability Board. • There is national crosscutting a disability umbrella DPO in Zimbabwe – The Federation of Disabled Persons of Zimbabwe (FODPZ). It represents all impairment groups • There are approximately 35 DPOs in Zimbabwe operating at national, provincial, district and local levels. 	<ul style="list-style-type: none"> • The majority of DPOs are small and lack sufficient organisational capacity to campaign on disability rights. • The majority of DPOs are populated by and cater for needs of single impairment groups, such as those with hearing impairments and the visual impaired. • Most of the DPOs are urban based without much activities being undertaken in rural areas. • The membership of DPOs in Zimbabwe seems to be operated by mostly indigenous Zimbabweans, without any form of representation from white disabled people. • There is little collaboration between DPOs with respect to lobbying and advocacy. 	<ul style="list-style-type: none"> • The NGOs/INGOs are prepared to work with the DPOs and to incorporate disability issues in their core activities. • The President of Zimbabwe appointed a Disability Advisor and the DPOs could take this appointment as an opportunity to lobby their concerns with the government. 	<ul style="list-style-type: none"> • The political and economic situation in Zimbabwe seriously compromises the effective implementation of sustainable services. • Within the ZANU (PF) Politburo, there is a Senator with physical disability, who is not respected by the disability movement.

Appendix F

Disability Scoping Study Terms of Reference

Summary

Disability and poverty are linked and mutually reinforcing. Disabled people are amongst the poorest and most vulnerable people in Zimbabwe (Zimbabwe Living Conditions Survey.) Stigma and discrimination means that often disabled people are almost invisible and this excluded from programmes of assistance in Zimbabwe.

DFID's Protracted Relief Programme (PRP) provides a range of assistance to enhance food security and support the livelihoods of the poorest and most vulnerable people in Zimbabwe. The programme currently reaches approximately 1.5 million Zimbabweans in mainly rural but some urban areas. However, the latest annual review of the PRP notes that disabled people were almost invisible within the programme.

DFID is currently in the process of designing a second phase of the PRP and is anxious to ensure greater involvement of disabled people in the future in the programme. Therefore a Disability Scoping Study is planned to provide an overview of the current situation of disabled people in Zimbabwe; to map organizations providing support to disabled people and to identify strategies to facilitate greater involvement of disabled people in a second phase of the PRP.

Objectives of the Scoping Study

This study will:

- Provide an overview and assessment of the current situation of disabled people in Zimbabwe
- Map channels of support on disability in Zimbabwe
- Identify strategies to facilitate greater involvement of disabled people in PRP 2

Scope of work

In particular this study will:

- Provide an overview and assessment of the current situation of disabled people in Zimbabwe
 - indicate the scale and prevalence of disability using existing data sources (eg: Census, Demographic Household Survey etc)
 - assess perceptions and attitudes towards disability
 - provide an overview of the role of the state, disability services and disabled people's organizations (DPOs) in Zimbabwe using as the tool of analysis the 'Stepping Stool to Inclusion' (see Annex)
- Map channels of support on disability in Zimbabwe
 - Map organizations for and of disabled people providing support and services to disabled people
 - Map current sources of donor funds for disability in Zimbabwe
- Identify strategies to facilitate greater involvement of disabled people in PRP 2
 - assess current attitudes amongst existing PRP partners towards disability and the inclusion of disabled people in the PRP
 - identify opportunities for linkages between PRP partners and DPOs and potential entry points

- identify opportunities to make the process of competitive proposal selection more open to disabled people and their organizations
- develop draft guidelines on the inclusion of disabled people

Methodology

This study will provide an overview and rapid assessment of disability issues in Zimbabwe. Research techniques will include the following:

- o Desk review of literature
 - Disability specific research (eg: Sinteff Living Conditions Survey, UNICEF/FAO Research on living conditions and situation of disabled children etc)
 - DFID publications on disability and related topics (eg: Disability, Poverty & Development; Realising Human Rights for Poor People, Social Exclusion Policy, selected outputs from the Disability KAR programme etc)
 - PRP related (Annual Review 2006; Community Dynamics and Coping Strategies, Joint Initiative Baseline Survey etc)
- o Key informant interviews
 - Organisations of and for disabled people
 - PRP partners
 - DFID staff
 - Disabled people
- o Focus group discussions with disabled people
- o Stakeholder workshop

Outputs

- Inception report outlining how the consultants will undertake the mission
- Stakeholder workshop
- 4 Reports
 - 1) Summary Report (maximum 20 pages) outlining key findings and recommendations
 - 2) Situation Analysis of disability in Zimbabwe
 - 3) Mapping of support for disability in Zimbabwe
 - 4) Guidelines on the inclusion of disabled people

Consultants Profiles

It is anticipated that this study will be carried out by a team of two consultants:

Lead Researcher

- international / regional disability expert
- extensive experience in conducting disability research using the social model
- experience of international NGOs
- organizational development and capacity building
- knowledge of Southern Africa and Zimbabwe in particular
- knowledge of DFID, policies and procedures

Local Researcher

- disability activist and researcher
- Shona speaker, Ndebele desirable
- experience of working with international NGOs

Timeframe

Activity	Completed by
ToRs finalised	April 2007
Consultants identified	April 2007
Field work in Zimbabwe	Early July
Draft report	End of July

Background

Zimbabwe, in recent years, has experienced severe economic decline, social turbulence and drought, resulting in much increased levels of poverty and vulnerability. Life expectancy has dropped sharply to 34 years for women and 37 years for men. Recent figures for HIV show a reviewed rate of 21.6%, a fall from the previous figures of close to 25%. This decline reflects, in part, the high death toll as a result of having one of the lowest treatment rates in the world. 1.8 million Zimbabweans living with HIV and AIDS and more than 3,200 people die every week of AIDS-related causes. AIDS accounts for some 75 per cent of all patients in hospital beds. Inflation currently stands at nearly 1600%. Unemployment is estimated to be over 80%. The combination of rapidly rising prices and reduced unemployment has meant that most Zimbabweans now struggle to meet their basic needs.

Disabled people are over represented amongst the poor and experience poverty more sharply than non-disabled people. Public services, such as health and education are under extreme strain. School drop out rates are rising in response to increasing school fees. Similarly in the health sector, fees and charges represent a significant barrier to access. Doctors, nurses and teachers have all recently been on strike over low pay and conditions. Inflation has undermined the value of state social assistance. The monthly disability allowance is now insufficient to buy a loaf of bread. Similarly government grants for assistive devices are difficult and lengthy to obtain and when finally received are no longer sufficient to cover the cost of the device. Costs on public transport are also rising rapidly.

Donor assistance to Zimbabwe has declined sharply. As well as the quantity of aid there are concerns about the quality of aid and whether aid modalities are appropriate for tackling chronic poverty. A large proportion of donor aid is channelled to short-term, humanitarian assistance. DFID is exploring longer term and more predictable support to the poorest and most vulnerable through multi-year funding. Social protection is seen as one way to respond to Zimbabwe's protracted relief situation and to bridge the gap between short-term humanitarian responses and longer and more sustainable developmental support.

DFID's Protracted Relief Programme (PRP) provides a range of assistance to enhance food security and support the livelihoods of the poorest and most vulnerable people in Zimbabwe. The programme began in 2004 and the current phase will end in July 2007. The programme currently reaches approximately 1.5 million Zimbabweans in mainly rural but some urban areas. Interventions include agricultural inputs (seed, fertiliser, small livestock); training on agricultural techniques such as conservation farming, water and sanitation, home-based care; low input gardens, savings and loans and food vouchers. However, recent evaluations of the programme have noted that disabled people are almost completely invisible in the programme (2006 Annual Review). A second phase of the PRP is currently being designed and DFID is eager to identify ways to ensure better inclusion of disabled people in the PRP in the future.

Approximately 70% of DFID's budget is channelled through civil society either directly or via a UN body to implement programmes. Increasingly allocations to civil society are done on the basis of a competitive call for proposals which inevitably favours organisations with strong capacity such as large international NGOs. It is essential to consider how this

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process can be made more friendly to smaller and local civil society groups, such as disabled people's organisations, in the design of PRP 2. There may be lessons from the process adopted for the UNICEF Programme of Support for Orphans and Vulnerable Children.

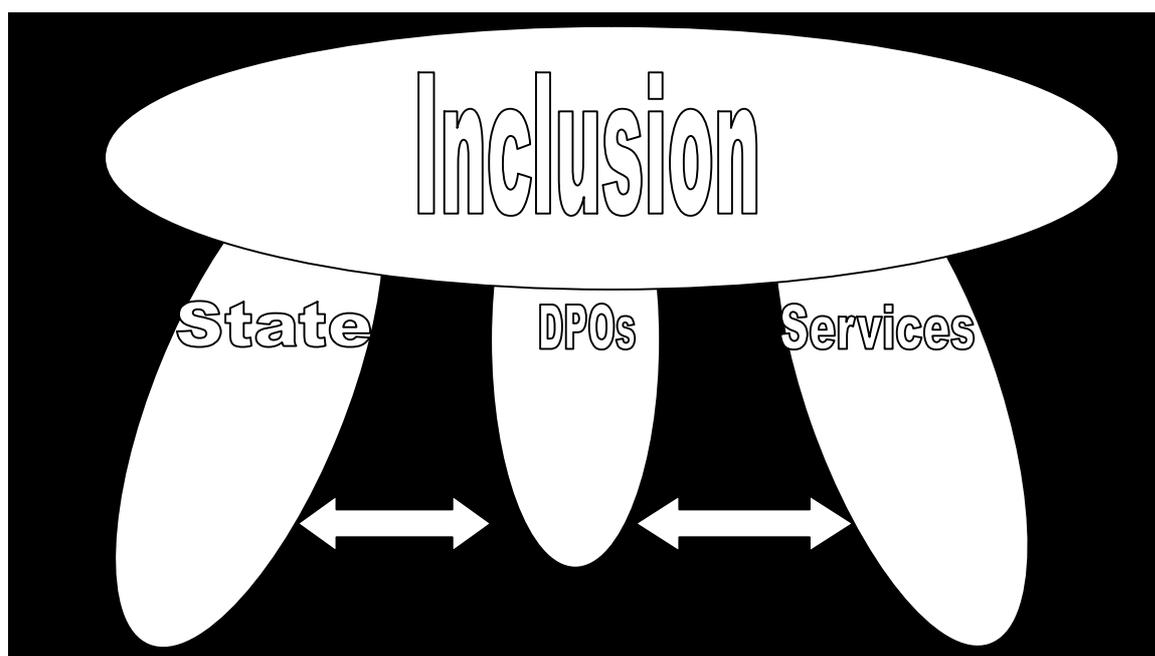
ANNEX 1

EQUALITY OF RIGHTS AND OPPORTUNITIES FOR DISABLED PEOPLE: THE STEPPING STOOL TO INCLUSION

Disability is increasingly being acknowledged as a human rights issue. Indeed, members of the disability movement see disability rights as the last liberation struggle. The new UN Convention of the rights of disabled people was adopted in January 2007, and many countries have passed their own domestic disability rights laws. Some of the most comprehensive disability legislation exists in developing countries, such as South Africa.

However, translating rights on paper into real improvements for the lives of disabled citizens is much harder. If organisations, such as DFID are to effectively enable such a transformation, it is necessary to have a basic understanding of the foundations of inclusion to achieve equality of rights and opportunities for disabled people in a society. Presented below is a simple tool to assist this.

THE STEPPING STOOL TO INCLUSION TOOL



Aim:

The tool aims to capture and present in a simple visual format the basic components and their inter-relationships needed to support the inclusion of disabled people to realise their equality of rights and opportunities.

Use

The tool can be *used* to:

- Provide a basic assessment of the status of disability issues within a country
- Identify the areas where interventions are likely to be the most enabling and thus effective

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Explanation

There are *three essential components* necessary to support the process of inclusion. They are:

- The state
- Disability services
- Disabled people’s organisations (DPOs)

Each component has distinct roles and functions (outlined in the table below).

These components can be visualised as the three supporting legs of the Stepping Stool to Inclusion.

The components must be in equilibrium and interact with each other in mutually supportive and reinforcing ways, otherwise the Stepping Stool to Inclusion will be unbalanced or the legs may splay outwards causing the stool to collapse.

The strength of each component or ‘leg’ in a country can be assessed by finding the answers to few simple questions (see table below). Then the Stepping Stool to Inclusion can be drawn to visually represent the basic status of disability issues within a country.

The role of a donor like DFID is to design and implement interventions that will:

- strengthen weaker components
- facilitate the key components (state, disability services and DPOs) to interact with each other in mutually supportive ways
- ensure balance and equilibrium between the key components

As a minimum, the donor actions should avoid anything that further unbalances the Stepping Stool to Inclusion.

Table: roles and functions of the key components (*cont. next page*)

STATE	Key roles and functions	Sample indicative assessment questions
STATE	<ul style="list-style-type: none"> • Define rights and entitlements through legislative and policy framework • Set standards and monitor implementation • Provide resources as much as the economic development of the country permits • Ensure that mainstream services, particularly health and education, are accessible to disabled people 	<ul style="list-style-type: none"> • Is there any disability rights legislation? Are there any policies addressing disability issues? • Which ministry or ministries take responsibility for disability issues? Is disability recognised as a cross-cutting issue? • Do the ministries of health and education have any policies or plans on disability? • What resources does the state provide to ensure implementation of any disability legislation, policies and plans? • Are there any mechanisms in place to monitor and enforce the rights of disabled people and their entitlements? • Does the state engage with

		disability service providers and DPOs? If so, in what ways? Does the state take on any responsibility for coordination?
DISABILITY SERVICES (e.g. rehabilitation, assistive devices, support services for disabled children, specialist vocational training, etc.)	<ul style="list-style-type: none"> • Reduce the impact of impairments • Enable disabled people to access their rights • Services can be provided by the state, international and local NGOs, DPOs 	<ul style="list-style-type: none"> • What services are available? Are there any major services gaps? (e.g.: mental health services, services for the hearing impaired) • Who are the main service providers? The state? Civil society? Combination of the two? Do service providers cooperate with each other? • Broadly what proportion of disabled people have access to the basic services they need? Nearly all? Most? Very few? • How sustainable are the existing services? • What are the main barriers preventing access to services? • What is the quality of existing services? Are there any standards? If so, are they monitored? • Are services well coordinated? Is there a good geographical spread?
DISABLED PEOPLE'S ORGANISATIONS	<ul style="list-style-type: none"> • Represent disabled people • Advocate and lobby for disability rights • Ensure that the state and service providers are responsive to the needs and rights of disabled people 	<ul style="list-style-type: none"> • Is there a national, cross-disability, umbrella DPO? • Are there national DPOs representing people with different impairments? • Are there DPOs at provincial, district and local levels? • Do DPOs have a rights-based approach to disability? • How united or divided are DPOs? • In what ways do DPOs engage with the state and service providers?

Using the 'Stepping Stool to Inclusion' tool: Example of Cambodia

Cambodia has probably one of the highest rates of disability in the world. The Asian Development Bank estimates approximately 10-15% of the population are disabled. Cambodia remains a heavily mined country. The problem of landmines has attracted considerable support for disability services but INGO service providers are now finding the funding climate more challenging.

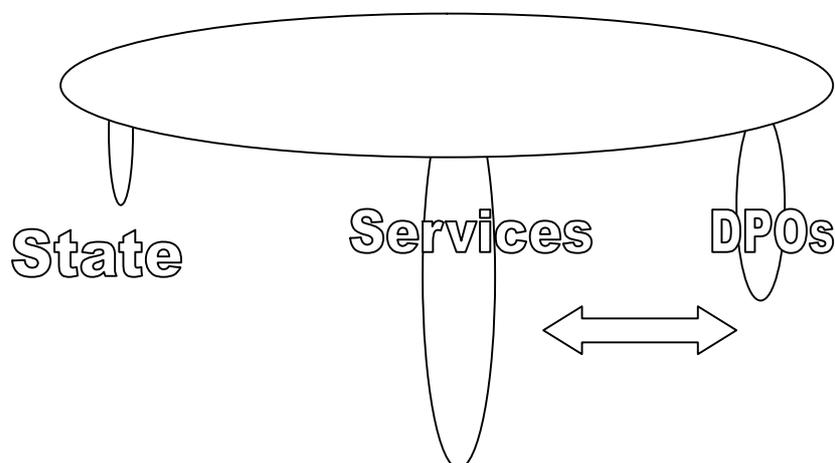
The characteristics of Cambodia's state, disability services and DPOs as the three key components of the stool are described in the table on the next page.

STATE	DISABILITY SERVICES	DISABLED PEOPLE'S ORGANISATIONS
- Disability is responsibility of	- All services provided by	- National cross-disability

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<p>Ministry of Social Welfare, very low capacity and poorly resourced.</p> <ul style="list-style-type: none"> - Government formed partnership with INGOs to establish a semi-autonomous, national advisory and coordinating body on disability, the Disability Action Council (DAC) in 1997. Effectively the Government has devolved responsibility for disability to DAC. - DAC effective coordination - Draft disability legislation developed but not enacted. Government given its support to Biwako Framework , an extension of the Asia Pacific Decade of Disabled People - Inclusion = vision of Ministry of Education. Inclusive Education (IE) Programme in 95 schools, 9 provinces but IE not integrated into national EFA plans - Government support to disability very limited: use of Ministry of Social Welfare buildings for rehabilitation centres, electricity supplied and modest contribution towards subsistence costs for people undergoing medical rehabilitation. - Pension system for veterans, but site of significant corruption. 	<p>NGOs, sustainability questionable</p> <ul style="list-style-type: none"> - Well coordinated, fair range and geographical spread - Limited mental health and services for hearing impaired, over-emphasis on physical impairments - Sector isolated from mainstream 	<p>organisation, Cambodia Disabled Person's Organisation (CDPO), but weak and undergoing reform</p> <ul style="list-style-type: none"> - Association of Blind Cambodians - No national deaf organisation - DPOs have rights based focus, growing grass-root network - Confusion of roles between CDPO and DAC
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Cambodia's Stepping Stool looks something like this:



The key areas for intervention lie in:

- strengthening the state to resume more responsibility for disability issues
- supporting the capacity building of DPOs so that they can lobby for their rights and hold the state to account²

Conclusion

The Stepping Stool to Inclusion is a basic tool. It is to be used to provide a snapshot assessment of the status of disability issues in a country. The information needed to draw a country's 'Stepping Stool' can be gathered very rapidly. Clearly much more detailed information needs to be gathered before designing specific interventions and programmes to address disability issues. As a point of principle, disability organisations, and especially DPOs as the representatives of disabled people, should be consulted.

² For a detailed discussion of disability issues in Cambodia, see Thomas, P (2005) 'Poverty Reduction and Development in Cambodia: Enabling Disabled People to Play a Role.' www.disabilitykar.net

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