

**Experiences of adults with physical disabilities at Kukura Neshungu Institute
in Marondera, Zimbabwe: A Social Work perspective**

By

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DISSERTATION

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DECLARATIONS

I, Everjoy Tatenda Mutema do hereby declare that the dissertation hereby submitted to the University of Limpopo, for the degree of Master of Social Work has not prior been submitted by me for a degree at this or any other institution; that it is my work in design and in implementation, and that all material contained herein has been accordingly acknowledged.

Everjoy Tatenda Mutema

SIGNATURE.....

DATE.....

DEDICATIONS

I dedicate this dissertation to my father, mother and younger sisters who have always supported me throughout the course of this degree. They were my pillar of strengths. The research is also dedicated to all persons living with different disabilities in Zimbabwe.

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I would like to acknowledge and thank the Almighty God for giving me wisdom, sight, direction and strengths throughout the compilation of this dissertation. May His Name forever be Glorified!

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ABSTRACT

Physically disabled adults encounter many constraints in the societies they live in, and are often prone to stigma and discrimination, social exclusion and negative perceptions. Rooted in the qualitative research approach, this study is informed by a sample of 20 adults with physical disabilities. It gathered data relating to experiences of adults with physical disabilities. Participants were identified using purposive and convenience sampling and took part in comprehensive face to face interviews. This data collection method provided a platform to elicit experiences of adults living with physical disabilities. Thematic content analysis was used to analyse data. The major findings that came out of the study included the main challenges faced by adults with physical disabilities, established the accessibility barriers, assessed how adults cope with health challenges, evaluated the cultural and traditional prejudices of adults with physical disabilities and assessed the stigma and discrimination that they face. From the participants' personal encounters and narratives, the study recommends assistance and support of physically disabled adults, implementation of awareness campaigns and donations to be specified according to their needs. More so, the study recommends extensively involving and consulting adults with physical disabilities in matters that directly or indirectly affects them and supervising and monitoring schools which accepts persons with disabilities.

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CHAPTER ONE

ORIENTATION AND BACKGROUND OF THE STUDY

1.1 INTRODUCTION

Persons with disabilities are some of the most disregarded groups in society. Poverty, exclusion and continuous struggle to be viewed as equal, cherished citizens often depicts their lives. The contribution of social work in terms of individuals with disabilities goes back virtually to the early stages of the profession (Stainton, Chenoweth & Bigby, 2010). A social worker is there to boost social justice. This involves being prepared to fight inequality in policies and practices, discrimination, prejudice, enhancing positive social change particularly for the advantage of the defenseless, feeble and underprivileged and inspire justice in prospects and access to resources, full involvement and empowerment of all (Mugumbate, Nyanguru, Nyoni, Maushe, Masuka, Chisvo & Ngwerume, 2014). The chapter will provide a general orientation and outline of the research. It contains the background to the study, the problem statement, aims and objectives, significance of the study, chapter outline as well as the conclusion of the chapter.

1.2 BACKGROUND

Experiences of the physically disabled adults have become rampant in this modern society, especially in the rural areas whereby the physically disabled persons struggle to maneuver in and out of their homes. The challenges they encounter affect their social, educational, religious, political and health life, among others. Mtetwa and Rugaranganda (2016) assessed that the condition of persons living with disabilities in Zimbabwe's bureaucratic structures is tremendously negligible. They further argued that there are virtually no persons with disabilities at the very apex of the administrative machinery such as judges and permanent secretaries.

According to Manatsa (2015), Zimbabwe was at one point observed as a typical country for disability rights in Africa and the whole world. The country was one of the first in Africa in 1992 to adopt disability related legislation through the promulgation

of the Disabled Persons Act (DPA), 1996). This was a huge growth bearing in mind that for years, persons with disabilities were burdened by lack of disability statutes. Besides the DPA, Zimbabwe has now incorporated other statutes such as the amended Zimbabwe Constitution (2013), which address disability in broad and specific terms. However, the effectiveness of these policies and legislations is still being questioned by Mtetwa and Ruparanganda (2016), Mugumbate and Nyoni (2013) and Manatsa (2015).

Mtetwa and Ruparanganda (2016) voiced that persons with disabilities need to be represented in all aspects of governance. They are of the view that individuals with infirmities are highly marginalised in every sphere of humanity, remain poorly represented in political structures and decision-making bodies, and have little control of decisions that directly or indirectly affect them. Mugumbate and Nyoni (2013) argue that due to limitations and shortcomings that are packed with being disabled, persons with disabilities cannot be on the same standing with their able-bodied counterparts.

The presentation of the (DPA) in 1992 widened the prospects of disability rights activism in Zimbabwe, with disability institutions backing prospects for persons with disabilities on an equal standing with their non-disabled individuals. Nevertheless, it is crucial to highlight that such activism did not profit greatly as the rights of people with disabilities were not officially acknowledged under the former Lancaster House Constitution (1979). It was only in 2005 that the Zimbabwean legislature perceived it necessary to revise section 23 of the Lancaster House Constitution to consist of disability as a standing upon which discrimination could be forbidden. This also forwards the argument that legislation that stands for persons with disabilities in Zimbabwe is highly outdated. However, the Constitution was still seen as weak even after this amendment. Manatsa (2015) confirms that this was due to the Constitution solely indicating physical disability as a ground upon which discrimination was proscribed, thereby not including other forms of disability articulated under Article 1 of the United Nations Convention on the Rights of People with Disabilities.

Choruma (2007) asserts that overseeing the growth prerequisites of individuals with disabilities or shying away from plans that directly profit them can be one of the

greatest intense systems of marginalisation that persons with disabilities can experience. People with disabilities remain mostly disregarded in their societies, and chiefly unnoticed in efforts by the global development community to enhance the wellbeing and standard of living for millions of the world's poor people. In Zimbabwe, they still have a state where a decent sum of disabled children are not going to school. They carry on to rely on others as they grow, hence becoming an economic drain on their communities, basically because they have been deprived of the chance to contribute.

It is from this background that the researcher explored experiences of adults with physical disabilities at Kukura Neshungu Institute in Dombotombo, Marondera, Zimbabwe. Kukura Neshungu Institute is a non-profit organisation which provides day care services and stimulation activities to persons with various disabilities. It is situated in a small town called Marondera in Mashonaland East Province in Zimbabwe.

1.3 RESEARCH PROBLEM

People living with impairments in Zimbabwe encounter bodily and environmental hurdles that deter their access to services or employment and inhibit them from enjoying their rights. They face hurdles in attending school classes, going for shopping, and visiting hospitals because of how indoor and outdoor facilities are designed and made. Public transportation, parks and footpaths may also be a challenge to access, inhibiting some individuals with disabilities from enjoying the most basic fundamentals of participation in social life. Hence, this study explores various experiences that adults with physical disabilities encounter in their day to day lives (Hanass, Regondi & Naidoo, 2013).

All aspects of the lives of persons with disabilities are affected by stigma and discrimination. In most cases, persons who are physically challenged face difficulties in attaining education compared to their able-bodied counterparts. This stems from inequitable happenings that have continually belittled the disabled. In a research carried out by Hanafin, Shevlin, Kenny and McNeela (2007), responses from their participants indicated that they encountered access difficulties at every level in their college life, especially physical access. Hanass, Regondi and Naidoo (2013) argue that persons with physical disabilities may only be able to access a portion of the

accommodation that persons without disabilities may have access to, which evidently depicts discrimination, a phenomenon at the centre of discussion of the social model of disability (Altman, 2010).

Munsaka and Charnley (2013) argue that adults with physical disabilities have limited access to the information of sexual reproduction and overall health information. In Zimbabwe they are mostly not familiar with family planning information and knowledge. They bear more children, contributing to their financial challenges in terms of looking after these children. Some health facilities are very far, and others are expensive (Baart & Taaka, 2017). There is no easy access of Braille material for the blind. Some persons with disabilities go through sexual and physical abuse. It would be too late to get appropriate and precise treatment when the abuse is actually discovered (Rugoho & Maphosa, 2015).

The life of the disabled in Zimbabwe has been made a nightmare by beliefs and practices of culture. Adding to being overlooked, they may be murdered at infant levels as they are considered a bad omen. Spouses who give birth to disabled children have separated or divorced by reason of such births. The husband either divorces the wife, or the woman leaves the house so that the father will take care of the child alone. Albinos are being slain for customary reasons in Tanzania (Choruma, 2007). The study seeks to explore experiences of adults with physical disabilities at Kukura Neshungu Institute.

1.4 ROLE OF THEORY IN THE STUDY

In conducting the study, the social model and the medical model were used. The social model voiced the society as the cause of disability. It sits on the platform that the environment is responsible for disabling the populace. In this study, the social model argued that persons are disabled by the environment they live in.

The medical approach was also meaningful in the context of this study as it viewed disability as a medical condition diagnosed by medical practitioners. The model is of the view that disability is solely on the individual and not on the environment.

1.4.1 THE SOCIAL MODEL

Shakespeare (2006) alluded to the fact that stimulated by the activism of the British disability movement in the 1960s and 1970s, the social model of disability was

established in response to restrictions of the medical model of disability. The social model developed from the intellectual and political fights of the Union of Physically Impaired Against Segregation (UPIAS). This network had been designed after Paul Hunt, a prior occupant of the Lee Court Cheshire Home, transcribed to The Guardian newspaper in 1971, recommending the formation of a consumer group of disabled inhabitants of institutions. Shakespeare (2006) further indicated that in founding the association and evolving its philosophy, Hunt operated in collaboration with Vic Finkelstein, a South African psychologist, who had come to Britain in 1968 after being banished for his anti-apartheid events. UPIAS was a minor, uncompromising group of people with disabilities, encouraged by Marxism, who rejected the liberal and reformist movements of more mainstream disability establishments such as the Disablement Income Group and the Disability Alliance. Rendering to their policy declaration (adopted December 1974), the goal of UPIAS was to substitute isolated amenities with prospects for persons with impairments to contribute wholly in society, to live autonomously, to take on productive work and to have complete charge over their own lives. From the aforesaid, it is clear that the social model of disability stems from way back.

The social model looks at the capability of the world to systematically persecute and victimise persons with disabilities and the destructive social attitudes experienced by disabled people in their lives. The society is thus seen as the main causal aspect in disabling people rather than their bodies and impairments. Altman (2010) highlights that the model is of the opinion that disability is the consequence of the public's failure to deliver sufficient and suitable resources and services. Hence, if any change must happen, it is the society which needs to undergo social change. Disability is observed in attitudinal terms as affected socially and not biologically. The social model of disability established that disability is triggered by the manner in which the society is systematised, rather than by an individual's impairment or difference. The study revealed that adults with disabilities are disabled not by their impairments but by the negative attitudes of the communities they live in, the stigma and discrimination that people hold towards persons with disabilities and by the cultural beliefs that demoralise people with disabilities. From the tenets of the social model of disability, the society and its environments have to go through social change in order to curb disability.

1.4.2 THE MEDICAL MODEL

The medical model of disability perceives disability as a predicament that is solely on the individual with disability. Retief and Letsosa (2018) argued that the crucial ideologies of the medical model of disability are that primarily, a person's impairment can be detected, cured, or at least rehabilitated, by contemporary treatment and or medical technology. Moreover, such mediations will be provided by well-informed professionals. According to Areheat (2008), the medical model of disability sees disability as an issue that is personal to the individual with a disability. The model depicts that the individual with a disability should personally seek a medical solution and that the society is not involved in the advent of the disability or its amelioration. People with physical disabilities in this study are seen as owning their disabilities and to seek themselves the solution thereof. This is the ideology that the medical model stands on.

The medical model has its roots in the biomedical view of [disability](#). The model stands on the ground that the detection of disability only happens on a person's physical body. The medical model of disability is the belief that the disability may diminish a person's quality of life, and the mandate is to ameliorate the problem through medical intervention (Crow, 2010). Managing or curing the disability is the central focus of this model. To add on to that, the medical model of disability says that the society only gets involved by devoting resources to health facilities that will assist in curing or managing the disability. The society gets involved according to the medical model by supporting the functioning of citizens living with disabilities so that they may also be afforded a considered normal life. Medical knowledge and experience is considered crucial in this instance. Disability is seen as a problem of the affected individual and not a case to worry anyone else. This model presumes that the challenges that come along with being disabled should be stomached with the person affected, and that if any change should be made, may be in terms of resources such as money, then the disabled individual should carry the burden and not disrupt or inconvenience the next person (Crow, 2010). Thus, people with physical disabilities in this study are also viewed as responsible for their impairments.

1.5 PURPOSE OF THE STUDY

1.5.1 AIM OF THE STUDY

The aim of the study was to explore experiences of adults with physical disabilities at Kukura Neshungu Institute.

1.5.2 OBJECTIVES OF THE STUDY

The objectives of the study were;

- To identify major challenges faced by adults with physical disabilities.
- To establish accessibility barriers faced by adults with physical disabilities in attaining education.
- To assess how adults with disabilities cope with health challenges.
- To evaluate cultural and traditional prejudices of adults with physical disabilities.
- To assess the stigma and discrimination faced by physically disabled adults.

1.6 SIGNIFICANCE OF THE STUDY

The study explored and pointed out chief problems and experiences that adults with physical disabilities are going through in their livelihood at Kukura Neshungu in Marondera, Zimbabwe. The research findings will help government departments in planning services for physically disabled adults. Professionals who work with adults with physical disabilities such as social workers, care givers, physiotherapists and occupational therapists will utilise the results and implement workshops and trainings that will help in drawing out intervention plans to help adults with physical disabilities. The information gathered will bring major progress to policies being made and amended as well as service providers, stakeholders, administrators, the public and donors who place a major role in the establishment of effective intervention strategies that will address the quandary of physically disabled adults who are at the centre of this research project. The study will also add knowledge of physically disabled adults as well as open doors for further studies in the field of disability.

1.7 ETHICAL CONSIDERATIONS

According to Blumberg, Cooper and Schindler (2005), ethics is a division of ideology that deals with the deeds of people and directs the standards of conduct of people

and relationships towards one another. Since disability is a sensitive and emotional issue, the researcher was obliged to conduct the research as guided by research rules, principles and ethics.

1.7.1 Permission to conduct the study

Considering the fact that the researcher was dealing with human subjects in her study, she was obliged to respect their rights, dignity, privacy as well as other sensitive issues. In order to conform to acceptable ethical standards, she cleared off official channels by formally requesting permission before embarking on the main study. Turfloop Research and Ethics Committee provided the permission to conduct the study that was applied for by the researcher. Subsequently, the researcher obtained an ethical clearance letter. The researcher also sought permission from the Managing Director at Kukura Neshungu Institute.

1.7.2 Confidentiality and Anonymity

The participants were guaranteed of confidentiality and anonymity by the researcher. Before embarking on the interviews, the researcher requested all her informants to allow her to record their responses. In maintaining confidentiality and hiding identity, the names of the participants were coded. The researcher used pseudo names in order to mask the identity of the informants involved in the study (De Vos, Strydom, Fouche & Delport, 2011).

1.7.3 Informed Consent and Voluntary Participation

Voluntary participation was plainly clarified to the respondents before they signed in their consent forms. The participants were at liberty to withdraw from the research at any point. Rubin and Babbie (2012) submit that informed consent is a vital issue that one has to bear in mind. The researcher explained the goal of the research to the respondents. This was done to give them a platform to make informed decisions. The researcher promised complete exposure of the results of the research to the participants, and were informed beforehand that taking part in the research project was voluntary. They were allowed to pull out from the research should the need arises. Babbie and Rubin (2011) note that voluntary participation refers to the readiness of a person to take part in the study, as no one should be coerced to participate. The participants' principle of self-determination was prioritised.

1.7.4 Do no harm

Emotional and psychological harm may happen as the respondents will be discussing sensitive issues affecting their lives. The researcher mobilised the availability of a social worker and a psychologist to assist if there was a need for counselling or any other service. Since she was aware of the cultural norms of her study arena, she made sure that words and language that seemed to be sensitive to religion, disability, age, marriage status or tribe were avoided. The application of informed consent and confidentiality also assisted in preserving the respondents from harm as they had the ultimate choice in participation.

1.7.5 Competence of the researcher

The researcher acquired the relevant expertise and knowledge of research through her undergraduate studies. The researcher was ethically indebted to make sure that she was skilled and adequately trained to commence the study (Babbie & Rubin, 2011).

1.7.6 Release and publication of results

A dissertation setup was made use of to issue the study results to the public (Akaranga & Makau, 2016). In all facets of academic inscription, researchers must stick to the correct conduct in directing and publicising their study findings (Blumberg et al, 2005). The research findings were also published in an accredited social sciences journal. Kukura Neshungu Institute was informed of the research findings.

1.8 DEFINING KEY CONCEPTS

1.8.1 Disability

According to the World Health Organization (2014), disability is the result of an impairment that may be physical, cognitive, mental, sensory, emotional, developmental or some blending of these. It may occur from the birth of an individual or be present during the lifetime of a person. This meaning of disability will be adopted in this study.

1.8.2 Physical disability

A physical disability as described by WHO (2014) is any condition or problem which makes it difficult for a person to carry out everyday activities without some degree of assistance or adaptation. People with physical impairments often use mobility aids

such as crutches, canes, walking frames, wheelchairs, orthotic appliances and artificial limbs to obtain mobility.

1.8.3 Adult

According to the Zimbabwean Disabled Persons Act (1996), an adult is an individual of 18 years of age and above. This definition is adopted in this study.

1.8.4 Main assumptions of the study

The main assumptions of the study are the myths that surround people living with disabilities. They are perceived as individuals who are useless and cannot amount to anything in life. More so, most people think that disability is contagious and are resistant to get in close contact or to be touched by a person with a disability. Disability in most societies' world wide is attached to witchcraft and bad omen in families or generations. With the data gathered from this study, such experiences were also proven to be happening around the globe even today.

1.9 STRUCTURE OF THE DISSERTATION

Chapter 1: Introduction

This chapter offers an outline of the term 'disability'. It illustrates the goal of the research, provides illumination and description of terms and sketches the essence of the research.

Chapter 2: Literature Review

This chapter explores literature available pertinent to physically disabled adults. It views the term 'disability' in-depth, exploring aspects like models, causes and experiences of adults with physical disabilities. Chapter 2 also looks at experiences of adults with disabilities from other contexts beyond Zimbabwe.

Chapter 3: Research Methodology

Chapter 3 presents the research methodology used in the research in detail. It covers aspects such as research design, sampling procedures, population and data collection tools, among others.

Chapter 4: Presentation and discussion of results

This chapter reports the main results from the information gathered and analysed in the study. It comprises data collected through the use of interviews from adults with physical disabilities at Kukura Neshungu Institute. The chapter responds to study questions put forward in chapter one.

Chapter 5: Conclusions and Recommendations

The aim of chapter 5 is to present recommendations based on the results presented in Chapter four. Recommendations will also be outlined based on the research results for future use in planning and delivering services to adults with disabilities.

1.10 CONCLUSION

In this chapter, an outline to the topic of the dissertation was firstly done by discussing the historical and cultural view of disability. A brief definition of disability from different models was given. The research topic, aims, objectives and significance of the study were laid down. Lastly, the structure of this dissertation was outlined. In the next chapter, literature review is presented.

CHAPTER TWO

THE SCOPE OF DISABILITY IN SOCIAL WORK

2.1 INTRODUCTION

Lang and Charowa (2007) noted that individuals living with disabilities are amongst the greatest marginalised, socially excluded and the underprivileged group in the Zimbabwean society. This chapter provides the contextual background of experiences of persons with physical disabilities. It assesses the present, issued writings concerning the physical, economic, political, social and religious state of physically disabled adults in Zimbabwe and other countries. The purpose of the literature review is to assimilate and simplify findings across components, actions, conclusions and situations in order to resolve a dispute within a field. An additional goal, according to Hedges and Cooper (2009), is to critically examine prior studies, recognise dominant matters or clarify a line of dispute within a field as well as to detect and articulate the applicable theoretical context of the research. Zhou (2015) highlighted that people with disabilities, regardless of the area in which they reside, are more likely to be jobless, uneducated, to carry less recognised education and have inequitable access to established support systems and social capital than their able-bodied counterparts.

2.2 DEFINITION AND CLASSIFICATION OF DISABILITY

Rugoho and Maphosa (2015) assert that there is no common approved classification of disability. The rights of people with disabilities cannot be fully definite without a proper description built on individual measures of disability as noted by Kauffman and Landrum (2009). In the past, disability was perceived as a medical condition with the problem positioned on the individual. The medical model was challenged by disability protesters who re-conceptualised disability as mainly a social phenomenon. The social model of disability draws a strong discrepancy between impairments and disability. The failure of society to recognise and accommodate difference disables people with impairments. The institutional and attitudinal barriers that the society presents towards adults with disabilities further disables them (Oliver, 2013). Disability therefore ascends from an intricate collaboration between health conditions

and the context in which they occur. Disability is a common word with some impairments getting worse or better in diverse settings.

Choruma (2007) stated that people with disabilities are typically considered burdens, live in lack and have no avenue for mandatory facilities such as health care, education, employment and vocational training, to name just a few. People of all genders with disabilities yearn to be effective in all areas of their lives in their societies. In first and third world countries, boosting more involved societies and job prospects for persons with disabilities needs enhanced access to education, career training related to the industry necessities and occupations suitable to their skills, interests and abilities, with editions as required. Several communities are also identifying the need to pull apart other blockades, making the environmental setting more reachable, and giving knowledge in diverse ways, and fighting attitudes and incorrect ideas concerning disabled people.

Knight (2012) is of the view that individuals with disabilities are most likely to be poverty-stricken, and the conditions that come along with poverty increases the risk of disability, hence becoming a two-way relationship. As matter of fact, poverty reduction will be effected by addressing disability. Extreme poverty is inevitable due to challenges such as lack or no access to education, stigma and discrimination in the market place, limited access to credit facilities, infrastructural problems and the point that most people with disabilities are from poor homes. Persons with disabilities face major challenges due to the fact that organisations which are mostly development oriented are not directly associated with individuals with disabilities or their issues. Consequently, they may not appreciate the degree to which persons with disabilities and their relations are excluded, disadvantaged and sidelined within a brutal poverty disability cycle (Knight, 2012).

Due to gender and impairment, females with disabilities experience a double discrimination. The outcomes of deficits and impairments are mainly grave for women, who exposed to cultural, economic and social drawbacks, which inhibit their access to, for instance, employment, education, health care and vocational training. More so, if they are mentally or physically disabled, the probabilities of overpowering their disablement are weakened, which makes it very challenging for them to participate in community life (Plummer & Findley, 2012). People of all genders,

whether male or female, want to be effective members of society. It is imperative to promote more inclusive societies, increase the availability of the necessary education, engage in career training relevant to labour market requirements and needs for persons with disabilities in both first world and third world countries. Various societies are also identifying the necessity to destroy other hurdles, making the physical setting accessible, offering knowledge in many setups, and fighting attitudes and mistaken ideas about individuals with disabilities.

2.3 TYPES OF DISABILITIES

There are different types, forms, severity and nature of disabilities. Some disabilities occur before or during birth, whilst others occur during the course of life due to factors such as war, accidents and malnutrition, among others.

2.3.1 Physical disability

An individual's mobility is affected when he or she has a physical disability. Assistance with mobility using some sort of equipment is needed for persons with physical disabilities. This also involves people who cannot walk due to how their body is shaped, and need alterations to allow them to contribute in society. Many people easily identify persons with physical disabilities who are paraplegic or quadriplegic. Paraplegia occurs due to injury on the backbone underneath the neck, whereas quadriplegia injures the bone found in the neck (Crow, 2008). Variable degrees of loss of limb and further movement may be a product of either condition. Forms of physical disability like cerebral palsy, polio and some genetic conditions can result in failure for a person to walk. Additional forms of physical disabilities include hemiplegia, multiple sclerosis, missing limbs, polio and dystrophy, among others. Physical disability is commonly characterised by a part of an individual's physical functioning, either their movement, stamina or dexterity, which be affected. Persons living with physical disabilities are generally specialists in their own necessities and will comprehend the in-depth of their disability (Crow, 2008)

This study is inclusive of adults who are paraplegic and hemiplegic. Abbasi and Fardkhani (2014) described two types of paraplegia. Falls and road accidents mostly causes traumatic paraplegia. Part of the participants in this study experienced traumatic accidents that perpetrated disability in their lives. On the other hand, non-traumatic paraplegia has numerous causes, which include spinal cord vascular

illness, infection, cancer, vertebral injury and intervertebral disc illness. This study as well involves adults who became disabled because of extreme illnesses.

According to Cioni, Sgandurra, Muzzini, Paolicelli and Ferrari (2010), hemiplegia is a state that disturbs a single side of the body. It can be right or left hemiplegia, depending on which side is affected. Damage to parts of the brain that are in control of mobility causes hemiplegia. When it happens before, during or after birth, it is termed congenital hemiplegia, while acquired hemiplegia usually happens later in childhood due to sickness or injury. In general, damage to the left side of the brain will cause a right hemiplegia, whilst damage to the right side a left hemiplegia. This study comprises of adults with disabilities who are hemiplegic, implying that their left or right side is dysfunctional.

2.3.2 Intellectual disability / Learning disability

Katz and Lazcano-Ponce (2008) argued that intellectual disability is an ailment that is characterised by the existence of partial or dysfunctional mental growth, primarily defined by the weakening of major attributes on each phase of development and that contributes to the general level of acumen, such as language, cognitive, socialisation and motor functions. In this variance, adaptation to the surroundings is mostly hindered. Maina (2016) furthered this by saying that individuals with an intellectual, cognitive or learning disability have a lowered ability to learn chores or to make sense of information. Persons with learning disabilities face challenges to verbalise what they know or take in information. Challenges in reading, writing, reading or mathematics are a result of learning disability. Three to 10 percent of the population comprises of affected people with attention deficit disorder and learning disabilities. As students, people with these disabilities are often intelligent, creative and productive. An individual with a learning disability may have substantial restrictions in the abilities required to work and live in the society, including complications with communication, looking after themselves, social skills, safety and personal direction.

According to Bray (2003), most people with an intellectual disability are not aware of it. Some parents do not inform their children and live their lives as if their children do not have any learning problems. Parents do not inform them because they do

not want to upset their children's feelings. He further said that if individuals with a learning disability are not aware of it, it might be difficult for them to learn to be responsible and accountable adults.

2.3.3 Mental disability

Maina (2016) further argued that mental disability can occur at any time in a person's life, and that it is difficult to detect with natural eyes. Mental disabilities are mostly not understood in the community, and the attitudes of people may be grounded on prejudice and myth. For instance, people with schizophrenia are described to be mostly violent. Mental disabilities can include depression, stress related illnesses, bipolar disorder, schizophrenia and anxiety. Depression is the most known non-psychotic mental ailment. Psychosis is described as a disorder that involves the loss of contact with reality. Mental illness comprises of a number of illnesses that disturb the brain or mind. These disorders, which include bipolar disorder, depression, schizophrenia, bipolar disorder, personality disorders and anxiety inhibit the way an individual feels, acts and thinks.

Loss of concentration due to sometimes medication affects a person with a mental health condition. Individuals with a mental disability require the same support and understanding shown to persons with a physical disability. A mental illness is not an illness for which any person should be blamed. Persons with mental disabilities are prone to a risk of drug use and other dangerous substances. This makes a cure more difficult, hence the efficient handling of alcohol and other drug use is essential. People with mental illnesses are at high risk of suicide, especially right after the illness has been diagnosed and the person is released from hospital or from any place considered safe. Misconceptions, myths, negative stereotypes and attitudes surround mental disabilities as well as their families and carers (Price, 2011).

From the above discussion on mental disability, it can be noted that people living with mental disability are more prone to abuse. People can shout or scream at them whenever they portray the traits of the disability. As it is difficult to detect with natural eyes, it is easier for people living with a mental disability to be abused.

2.3.4 Neurological disabilities

An injury to the nervous system that perpetrates losing some mental or physical functions cause neurological disabilities. An individual's ability to manipulate or move things or the way they express themselves or act is affected by a neurological disability. Neurological disabilities commonly affect the way people process information and think. The spine and the brain are the parts of the body most closely connected with neurology. This disability may also be a result of grave infections, loss of oxygen to the brain and heart attacks (Crow, 2008). A person's functioning, abilities and participation are highly affected by neurological disabilities. WHO (2006) stated that rehabilitation should begin immediately after the detection of a neurological condition, and should put the main focus on the community rehabilitation perspective. The type of provision of resources and services is mainly reliant on the individual's health care system. As a result, there are no commonly arranged principles currently in place concerning the delivery of rehabilitation and related services. Rehabilitation is regularly entirely related with well-informed and coordinated multidisciplinary efforts by expert rehabilitation services. Although access to these specialised inpatient or outpatient services are at the centre of effective rehabilitation, a necessity also exists for rehabilitation service provision, from the critical contexts through the hospital and the society, often by professionals in health not experts in rehabilitation but operating closely with rehabilitation professionals. It is imperative to know that therapy efforts in the community can be provided by specialists outside the health division, ideally in partnership with rehabilitation professionals.

Rehabilitation services are less or unavailable in many developing countries for persons with disabilities attributable to neurological illnesses or other reasons. This entails that many people with disabilities will rely entirely on other people, in most cases family members, for assistance with daily activities. This state propels poverty (WHO, 2006). Disadvantaged societies all over the world are affected by a number of disabilities and, in turn, persons with disabilities become more susceptible to poverty because of limited resources such as social care, rehabilitation services and health care. Once rehabilitation services are accessible, the absence of human resources significantly confines the allocation of knowledge from specialised centres

to district and community set ups. The ideology of rehabilitation stresses patient edification and self-management and is appropriate for a number of neurological conditions. The ground for effective neurorehabilitation is the deep comprehension and comprehensive measurement of functioning and the utilisation of efficient interventions, intervention programmes and services. The optimal functioning of individuals with neurological disabilities has been boosted by numerous intervention programmes, rehabilitation programmes and services.

Without the support of individuals, families and communities, it is immensely difficult to go through life for persons living with neurological disabilities. The social model of disability discusses this in depth as it portrays the importance of togetherness and unity in assisting people with disabilities.

2.4 MODELS OF DISABILITY

Naidoo (2010) describes disability models as tools for defining impairment and for enabling a foundation upon which government and society can formulate plans for meeting the needs of people with disabilities. Naidoo (2010) further illustrates that these models of disability are mostly perceived with doubt as it is alleged that they do not represent the real world, are often incomplete and encourage narrow thinking, and seldom offer comprehensive direction for action. Nevertheless, Buntinx and Schalock (2010) emphasise that the models are a beneficial context in which to accomplish understanding of disability matters, and of the perception held by those forming and applying the models. People should then not view these models as a series of exclusive alternatives with one greater in substituting previous sets. Their growth and fame offer us with a continuum on shifting social attitudes to disability and where they are at a specific time. They complement each other in providing attention to other dimensions within the analysis and conceptualisation of disability and impairment. Naidoo (2010) further elaborates that these models transform as society changes. Though the models of disability do have strengths as well as shortcomings in their descriptions, they are necessary to understanding the concept of disability.

2.4.1 THE SOCIAL MODEL OF DISABILITY

The social model originated in response to the critique of the medical model of disability. Juxtaposed with the medical model of disability, the social model argues that disability is defined as a social concept, a form of multi-faceted social oppression distinguished from the physiological view of impairment (Areheart, 2008). In this framework, being disabled depends upon deviation from society's structure of corporeal normality. Furthermore, the experience of being an individual with a disability comprises mainly of encounters with the many hurdles established by the physical, institutional and attitudinal society that hinders full participation in mainstream life. The main idea of the social model is that the experience of disability is not inherent or unavoidable provided by a certain medical condition; instead it depends upon the particular social background in which one exists and functions. Upon theorising that the principal drawbacks related with disability are social structures and practices, the claim that society has some accountability to remedy the disadvantage must follow naturally. Therefore, while the medical model facilitates medical resolutions to adjust the individual to fit society, the social model concentrates on changing the social environment to fit individuals (Areheart, 2008)

It has produced a caucus of academic writing, principally inscribed by academics and activists who themselves have disabilities and is the total antithesis to the medical model (Lang, 2009). Disability is thus situated in the broader, peripheral environment, and is not justifiable as a result of a person's cognitive and or physical deficiencies. The model unearths the need for disability to be addressed at all levels, including the social, economic and political levels. It must be prioritised when drafting plans and making decisions.

Lang (2009) unearthed that common to all variants of the social model is the belief that, on the ground, disablement and disability are socio-political constructions. It is therefore the unfriendly physical environment, in combination with the negative social attitudes that people with disabilities encounter, which result in the systematic oppression, exclusion, discrimination and oppression of people with disabilities. The way in which disability is commonly viewed has a deep influence upon the way in which stakeholders are considered by policy makers, organisations for people with

disabilities and non-governmental organisations alike to have a legitimate role in determining how resources are disseminated.

Anastasiou and Kauffman (2013) are of the view that disability is eradicated once social challenges to the reintegration of persons with physical impairments are removed. The society, environment, social roles, attitudes and perceptions of people in the communities need to change. Consequently, in concentrating on the way in which disability is socially twisted, the social model gives precedence to the importance of empowerment, politics, choice and citizenship. Moreover, disability is the outcome of society's failure to offer satisfactory and suitable services. Accordingly, the needs of people with disabilities are not sufficiently accounted for within the modern social order of society. It is viewed in attitudinal terms as a socio-cultural and not a biological construct (Lang, 2009).

However, on the other hand, Bruce and Kauffman (2011) are not certain if it would be possible to eliminate disabilities by shifting only the socio-political context because the contradiction between disability and impairment is methodological; it is not ontological. The titles given to mental or physical conditions do not form disabilities or change disabilities into abilities (Kavale, Kauffman, Bachmeier & LeFever, 2008). People living with disabilities have been succumbed to numerous social attitudes that are oppressive throughout history, which involved anxiety, fear, distrust, pity, horror, patronising behaviour and overprotection. Such harsh attitudes, joined with an unwelcoming physical environment namely inaccessible buildings and insufficient transport systems, are considered to be the actual issues of disability. It is thus maintained that persons with disabilities live within a disabling world.

The social model is mostly criticised because of its persistence that disability can only be addressed through action to shift society, and does not recognise the real impact that peoples' impairments can have on their lives. Focusing only on the larger society may risk children's impairments being unrecognised or poorly comprehended so that children might not get the individual devotion that might make their lives better.

2.4.2 THE MEDICAL MODEL

Areheart (2008) stated that the medical model perceives disability as something that is wrong with an individual's mind or body. In other words, an individual is the locus

of disability. Comprehended as a biological trait, disability leaves the person with a disability in need of medical help to eradicate the effects of the disability. The medical model of disability perceives people with disabilities as incapable and overly dependent. Consequently, given the understanding of disability as one's problem, proper assistance is understood either as rehabilitation efforts to empower the individual to overcome the effects of disability, or medical efforts to find a cure for the individual with a disability. Either way, the emphasis is on the individual and how he or she can overcome the disability. In simple terms, devotion to the medical model inspires the view that disability rights are important, akin to some form of charity for biological losers. In short, a person's disability is viewed as an individual's personal calamity that has nothing to do with the society. From this standpoint, Areheart (2008) held the view that the medical model has the ability to fragment the disability community by emphasising the person's physiological traits that differentiate persons with disabilities, rather than the common societal impediments that bring them together.

For instance, this model might propose that an individual with a disability is suffering from a disease, illness, injury or genetic defect that would ideally be cured and treated. Presented with such views often makes people want to help fixing the challenge by using surgery, drugs or other methods of intervention. These views may also make people want to assist by averting transmission of the problem to other generations maybe by sponsoring involvements such as contraception or sterilisation. The medical model is described to make assumptions. Such a challenge may be grievous for the young person to make sound decisions about their lives. The young person's mind or body is the problem. They are likely to require experts to take care of them or if the challenge will not be fixed, they can never be on the same level with other young people (Areheart, 2008).

The medical model is criticised for viewing the impairment as the most crucial aspect of the individual, suggesting that the individual is stranded to do anything about this. This model of disability is explained to be deterministic as it proposes that a particular problem will always entail that a person cannot be equal. As a result, this may decrease the life opportunities and options of a young person. The model also indicates that the young person is simply a passive receiver of treatment. Lastly, the

medical model is basically disablist as it defines all things in terms of an able-bodied norm, instead of accepting a viewpoint from the young person with a disability.

In a nutshell, Shakespeare and Watson (2001) illustrated that the argument on wellbeing convincingly demonstrates the variance between the medical and social models of disability. The medical model of disability is akin to a system of conservative antiwelfare ideology, which pinpoints the challenge in the person. This philosophy is essentially proved through claims that the person just needs to stop being lazy or just get employed. On the same note, when people individualise disability, as do welfare conservatives, they overlook the prospect that disability is a group challenge (Areheart, 2008). Conversely, the social model of disability moves the point of responsibility for the problems that people with disabilities face from the individuals themselves to their inhospitable environments. Fascinatingly, the medical opinion of disability stands in plain contrast to how other methods of discrimination are typically viewed. For instance, the massive majority of people stand on the ground that the challenges besetting racial minorities, women and homosexuals stem not from these groups' physiological inferiority, but from societal discrimination. Discrimination against these groups is considered illogical by many; rare efforts to defend discrimination against any of these groups as acceptable (Burchardt, 2004). Yet most people appear to perceive discrimination against people with disabilities as rational, the effect of their own bodies' deficits and distinct from other forms of discrimination. The consequence is that even people who avoid other systems of discrimination may be apt to justify disability discrimination.

Nevertheless, seeing disability through a sociological eye positions it as a prejudice that is different from other forms of discrimination in type but not degree. Many people are normally accustomed with what it means for a person to be exposed to the discriminatory aspects of culture (Choruma, 2007). Thus, comprehending disability discrimination as another type of socially constructed bias, such as race based, or sex based discrimination, which makes it more probable that people will back disability rights. In this study, disability discrimination is the product of a society that is resistant to include and accommodate disabled individuals. Commonly known statements and images about disability have strengthened widespread stereotypes and formed imprecise assumptions about what it means to be disabled. Apart from this, the media's dissemination of a medicalised picture of disability has had

undesirable results in the areas of education, health care, unemployment, self-esteem and social policy.

2.4.3 THE RELIGIOUS OR MORAL MODEL

Pardeck and Murphy (2012) are of the view that the religious or moral model of disability is the oldest model of disability and is found in a number of religious cultures, including the Judeo-Christian tradition. This disability regards disability as a form of punishment from God for wrong doings, or particular sins that would have been committed by the person. Retief and Letsosa (2018) provide an in-depth explanation of the moral and or religious model of disability as they indicate that most people, if not all of them, are of the belief that disabilities are a result of lack of adherence to social morals and religious principles that warn against committing or participating in certain behaviours. Moreover, in explaining further this model, some beliefs are founded upon the assumption that disabilities are the result of punishment from an almighty being. Additionally, the belief is that the penalty is for an act or acts of disobedience against dominant moral or religious decrees. McClure (2007) reveals how the religious model has had an incredible effect on most preaching directly or indirectly associating deafness, blindness, mental illness, lameness or other forms of disability with human sin, evil or disobedience. The sins committed by parents and ancestors are also considered as a probable cause of disability and not just the individual's sins. Expounding on the undesirable impression of this model on the person with disability and his or her family, Rimmerman (2013) stresses the possible damaging consequences of such a perception, arguing that it may result in entire families being omitted from social contribution in their local communities.

The religious or moral model is also based on the idea that disabilities are a test of peoples' faith. Niemann (2005) provides a concise account of the beginning of disability as a test of faith. In essence, individuals and families are specifically picked by God to have a disability and are offered a chance to redeem themselves through their resilience, piety and endurance. Individuals are chosen by God or a higher being or power to receive an impairment not as a punishment for wrongdoing or sins, but to communicate and reveal that the individual has a special calling or purpose to fulfill (Niemann, 2005). Although religious and or the moral model of disability is no longer as dominant as it was in the past, the common ideology defining the model is

still regularly met in the way people rationalise when confronted with a disability or illness (Henderson & Bryan, 2011; Rimmerman, 2013). More so, there are some cultures where the religious model of disability is still the main view (Dunn, 2015), particularly societies dominated by magical or religious ways of thinking. In those societies, adults with disabilities are frequently brutally marginalised, even facing the possibility of desertion or in worst cases, death (Anderson, 2013). Niemann (2005) pointed out the undesirable effect of the religious model of disability on religious image, be it congenital or acquired. Many theologies have previously described disabilities to be a curse, one mostly connected with shame onto an individual or family.

2.4.4 THE CHARITY MODEL

The charity model relates to the view that persons with disabilities should be pitied as they are considered to be victims of circumstances. Duyan (2007) affirms this as he explained that the charity model views persons with disabilities as victims of their impairment. Their condition is catastrophic, and they are in anguish. Able-bodied people should thus help persons with disabilities in any way possible, as they require special institutions and special services because they are different (Duyan, 2007). In contrast with the religious or moral model of disability, which is highly negative of people with disabilities, the charity model seeks to act to the profit of persons with disabilities, inspiring kind treatment of persons with disabilities. The charity model is viewed in a very negative light by many people in the disability community. It is mostly understood as presenting persons with disabilities as helpless, miserable and reliant on other people for protection and care, adding to the conservation of destructive stereotypes and misconceptions about them (Seale, 2006).

2.5 CAUSES OF PHYSICAL DISABILITIES IN INDIA

According to Kumar, Roy and Kar (2012), disability is a significant public health challenge more especially in developing countries such as India. The challenge is perceived to increase in future due to growth in trend of non-communicable diseases and a shift in age structure with an increase in life expectancy. The matters are diverse in developed and developing countries, and rehabilitation actions should be targeted bearing in mind the needs of individuals with disabilities with community participation. A large number of people in India live in rural areas whereby

availability, accessibility and utilisation of rehabilitation services and their effectiveness are the chief issues at the core of being considered. Research on the burden of disability, suitable intervention tactics and their execution to the current situation in India is a big challenge (Kumar, Roy & Kar, 2012).

According to Srivastava and Kumar (2015), analysis of the sources of disability from a bio-centric or medical position seems to highlight disease, hereditary and birth defects over environmental and systemic factors. Limited access to essential services and resources as well as genetic factors can cause a person to become disabled. For instance, prior to birth it can be taking drugs, improper medication, poor nutrition, smoking cigarettes, mental or physical trauma; during birth it can be complicated delivery or premature birth; after birth it can be lack of vaccination, infections, toxic substances, malnutrition or trauma. There are other aspects responsible for disability in India such as poverty, malnutrition, wars, crime and traffic hazards (Srivastava & Kumar, 2015).

2.6 CAUSES OF PHYSICAL DISABILITIES IN KENYA

The reasons for disabilities in Kenya are as varied as the conditions caused (Kiarie, 2014). A damaged central nervous system is a major cause of physical impairments that may affect movement. Damage to the brain and or the spinal cord from trauma, infections, tumors and autoimmune disorders, among other causes, may result in a myriad of physically disabling conditions such as cerebral palsy. While some physical disabilities are congenital, other causes of physical impairments include motor vehicle, water and diving accidents, gunshot wounds, injuries sustained from sports such as boxing, skiing, football, child abuse, poisonings or toxins, diseases such as polio and measles, premature birth, infectious diseases, the Human-Immuno deficiency virus (HIV), genetic disabilities, seizures, hydrocephaly and asthma (Nelson & Chang, 2008).

The major causes of disabilities are congenial problems that affect a child in the womb of the mother. These problems result in abnormal formation of the limbs and other parts of the body, leading to situations such as club foot and other such conditions. Other congenial disabilities in the child can be caused by factors such as medicines, smoking or alcohol taken by the mother during pregnancy (Monk & Wee, 2008). Many disabilities are right from childhood due to diseases like polio that can

affect the child in its early age. Another cause of disability can be due to lack of a balanced diet and insufficiency of certain minerals and vitamins in the body. In order to avoid disability, the child should be well fed to grow into a healthy adult without deformities. A large number of people have been disabled from different accidents. Apart from road accidents, there are accidents that happen at home such as fire accidents, poisoning and industrial accidents. Despite the cause of the disability, physically disabled persons experience a lot of challenges in securing employment.

2.7 CAUSES OF PHYSICAL DISABILITIES IN ZIMBABWE

Mpofu, Sefotho and Maree (2017) hold that what causes disabilities and their different types vary from one person to the next. However, most physical disabilities are congenital, denoting that they are present at birth or before (Mpofu, Ukasoanya, Mupawose, Harley, Charema & Ntinda, 2011). These physical disabilities can emanate from metabolic dysfunctions and radiation or toxic reactions, among other things. Other physical disabilities in Zimbabwe are acquired and are mostly a result of illnesses, accidents and pre- or post-natal complications (Heward, 2003).

Choruma (2007) identified the overall reasons for disability in Zimbabwe as primarily diabetes, birth complications, wars, traffic accidents and preventable diseases such as measles, polio and tuberculosis. Malnutrition of a pregnant mother causes hindrances in growth of a fetus, malformations and poor brain development. Cataracts and glaucoma were identified as major reasons for sight challenges in Zimbabwe. More causes of disability included otitis media, meningitis and maternal rubella. Pregnant mothers who are HIV positive are often sick and pose a high risk of bearing children with diverse disabilities.

According to Choruma (2007), numerous myths exist in Zimbabwe pertaining to the causes of disability. It is associated with maternal promiscuity, witchcraft, bad omen and punishment of wrong doings. Disability is viewed as a curse in the country based on the culture followed by the people. The culture in Zimbabwe is still to look at disability as a curse. In general, there is restricted social acceptance of persons with disabilities by their families, mainly their fathers, paternal relatives and the societies they live in. Giving birth to a disabled child is regarded as taboo and that it will bring a bad spirit to the family. The fathers to the children with disabilities put all the blame on the mothers.

2.8 EXPERIENCES OF ADULTS WITH PHYSICAL DISABILITIES

Health professionals and other generalist doctors need more education about disability problems to bring effective service delivery to persons with disabilities. Numerous barricades limit care, as well as transportation, physical access, funding, confines in professionals' information and attitudes, communication gaps, and health systems failures, which make the lives of adults with physical disabilities a nightmare (Morrison, George & Mosqueda, 2008).

2.8.1 EXPERIENCES OF ADULTS WITH PHYSICAL DISABILITIES IN INDIA

Menon, Parish and Rose (2014) argue that between 4 to 8 percent of the population in India consists of persons with disabilities as shown by empirical evidence from 2007 regardless of differing estimates. This however, is estimated to be 40-90 million total number of people. The authors further revealed that persons with disabilities in India are exposed to numerous deprivations and slim opportunities in many areas of their lives. They are most likely to be in poverty as it has been found that families with persons with disabilities are 25 percent less likely to report having sufficient meals per year; more likely to have members who are uneducated and young children not attending school; and have lesser employment rates and limited awareness of entitlements and services available by law for individuals with disabilities. Surprisingly, these households or families are more represented among the poor and socially marginalised. The encounters of persons with disabilities are in sharp contrast to the point that certain government departments in India such as the education department have been perceived as advanced in their distribution of opportunities to children with typical needs.

Amongst the group of families that consists of members with disabilities, those with female individuals with disabilities have per capita expenditures that are higher than households with male individuals with disabilities. This is striking in view of the reality that disability is less likely to discriminate by gender, and therefore there is a slim reason to believe that impairments afflicting men are more severe than those afflicting women. According to Thomas (2005), disability in India is largely caused by poverty. Persons with disabilities in India form part of the poorest, mostly reside in the peripheral rural areas, many are disabled at birth or even before school going age, and are mostly illiterate and jobless. Moreover, Cuong and Mont (2011) state

that a family which has a parent who is disabled, the children without disabilities have lower opportunities of attaining primary, let alone secondary education. Part of this is credited to the point that in such families, the child's time replaces parental time in generating money and household production.

Srivastava and Kumar (2015) opined that throughout history, persons with disabilities have been oppressed, marginalised and stigmatised in almost all parts of the societies. They constitute a segment of the population which is most unserved and grossly deserted. Persons with disabilities are the most deprived of basic needs, and have been educationally, economically and socially disadvantaged; therefore, have been customarily deprived of their right to identity, growth and self-assertion. This oppression is more evident in matters of education, employment, physical access and education (Srivastava & Kumar, 2015).

The government of India has taken the accountability of making accessible good environment to guarantee the total participation of individuals with disabilities. As a result, it has introduced a number of schemes, welfare programmes, vocational and economic rehabilitation, concessions and facilities for education purposes. The compensation of tuition fee in respect of children with physical and mental disabilities of the Central Government employee has been enhanced and reduced accordingly per month. The system of integrated education for children with disabilities under the scheme handicapped children is to be enrolled in the normal school system (Srivastava & Kumar, 2015). All the needed assistance is provided to various countries or education of children with disabilities suffering from certain minor handicaps in public schools with the assistance of incentives, qualified trained teachers and the necessary aids. In monetary support to individuals with disabilities, the National Handicapped Finance and Development Corporation (NHFDC), a section under the Ministry of Social Justice and Empowerment, Government of India, endorses infrastructure development structures directly, leading to the generation of income. This entity offers self-employment prospects to people with disabilities by giving them loans at very low rates of interest.

2.8.2 EXPERIENCES OF ADULTS WITH PHYSICAL DISABILITIES IN KENYA

Ingstad and Grut (2007) highlighted that as in most developing countries, persons with disabilities in Kenya are sidelined, and experience challenges as a

consequence of their disability. Many of them have no access to health, education, rehabilitation and employment. It is evaluated that 10 percent of the total populace in Kenya has some sort of handicap. They are exceedingly dominant among poor people; around 80 percent of them live underneath the destitution line and are regularly unemployed. Interest in monetary life is sought by huge numbers of them to win a living, add to the support of their families, and to improve self-satisfaction and self-regard. Employment opportunities offer individuals with disabilities a chance to be perceived as contributing individuals from their group (Maina, 2016).

Work has been distinguished as a basic requirement for people with incapacities, given that it is a fundamental segment of the nature of grown-up life. However, persons with disabilities are depicted to be the most powerless gathering in the general public. They are frequently under-taught, unexperienced, jobless and in extreme poverty. They confront numerous hindrances in their battle for uniformity. Despite the fact that men and women with inabilities are liable to separation in light of their incapacities, women are at a further detriment due to the joined segregation in view of their sex and handicap. Truly, these people have not had level with chances to seek after business and have experienced segregation and disgrace in the work environment. Maina (2016) alludes to the fact that since 2008, work misfortune for people with disabilities in Kenya has far surpassed that for people without disabilities.

Regardless of a scope of arrangements and intercessions, there are still various imperatives confronting individuals with incapacities entering work in Kenya. These range from an absence of reasonable business; constrained desires of families and managers and absence of contacts to secure jobs (Mugo, 2010). Most persons with disabilities are faced with various problems in accessing opportunities for employment in the formal sector, specifically in Private and Public Civil Service. Some of the challenges that they experience are negative attitudes by employers or work mates, unfriendly infrastructures, lack of working aids or technical aids and insensitive office buildings. Other challenges include unequal employing and advancement benchmarks, unsatisfactory access to preparing and requalification, inadequate access to credit and other profitable assets, unsatisfactory wage for equivalent work and word related isolation. Once in a while they take part in financial basic leadership.

The rate of people who are unemployed among people with disabilities in Kenya is higher compared to the rate of people without disabilities. In spite of all the government agencies and non-governmental organisations dedicated to persons with disability, there still remains a high rate of unemployment and inactivity among the working-age individuals from 18-60 years of age. Furthermore, working people with disability tend to be underpaid and have fewer opportunities for upward movement. The World Health Organization (2011) sheds light on development versus disability by unearthing that disability is an issue of development. Due to its bidirectional connection to poverty, disability may propel the risk of poverty, and poverty may propel the risk of disability. A growing body of pragmatic evidence from across sectors of the world highlights that persons with disabilities and their families are more likely to experience social and economic disadvantage than those without disability. The commencement of disability may lead to the deteriorating of social and economic functioning, and subsequent poverty through numerous avenues, including the adverse impact on employment, education, and increased expenditures related to disability and earnings. In light of the mentioned encounters of adults with physical disabilities in Kenya, Ingstad and Grut (2007) opined that there is a necessity to come up with the means to empower people with disabilities, decrease their poverty levels, and make them self-reliant and able to contribute in national advancement. On education, they further indicated that persons with disabilities encounter specific trials in training and education. Many people with disabilities are deprived of admission to basic education and numeracy skills.

2.8.3 EXPERIENCES OF ADULTS WITH PHYSICAL DISABILITIES IN ZIMBABWE

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) (2006) follow decades of work to shift attitudes and approaches to people with disabilities. It brings to another dimension the movement from viewing individuals with disabilities as objects of medical treatment, objects of charity and social protection towards seeing people with disabilities as individuals with rights, who have the capability to claim those rights, and to make choices for their lives based on their free and informed consent as well as being active members of society. CRPD is envisioned as a human rights tool with a clear social change dimension. It adopts a wide range classification of individuals with disabilities, and re-confirms that all

people with all types of disabilities must embrace all the human rights and fundamental freedoms. It explains and qualifies how all groups of rights apply to individuals with disabilities and detects parts where reworkings have to be made for people with disabilities to effectually exercise their rights and parts, where these rights have been dishonoured, and where fortification of rights must be strengthened.

The commitment of the international community to the advancement of the rights of people with disabilities and their involvement in society and development is intensely entrenched in the goals of the United Nations, as stated in its Charter preamble, which denotes the fundamental human rights, the dignity and value of a human being and the promotion of improved standards of life in greater liberty. It was not, however, until the implementation of the Convention on the Rights of Persons with Disabilities and its Optional Protocol in 2006 that the explicit challenges experiencing individuals with disabilities in comprehending their human rights were addressed using an international legal instrument. With the implementation of the Convention and its swift endorsement by many Member States, the international community is now in possession of a solid international normative framework on disability. However, a significant implementation gap remains (Manatsa, 2015).

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) (2006) argues that international teamwork plays a vital role in the promotion and protection of the rights of people with disabilities. In the preamble of the Convention, for instance, States parties denote the fact that most individuals with disabilities live in settings of deficiency, and realise the significance of international collaboration for refining the existing conditions of people with disabilities in each country, especially in countries which are still developing.

In the same respect, the African Union and its agencies as well as States Parties to the African Charter have pioneered numerous efforts towards certifying the rights of individuals with disabilities. Article 2 of the African Charter stipulates that the drive of its Protocol is to encourage, guard and guarantee the complete and equal enjoyment of all human and people's rights by all individuals with disabilities, and to guarantee respect for their inherent dignity. Amongst its principles that the Charter stands on are ensuring respect for and protection of the integral dignity, privacy and individual independence, including self-determination to make one's own choices, and

liberation of persons; non-discrimination; complete and effective participation and inclusion in society; respect of diversity and acceptance of people with disabilities as part of human diversity and humanity; fairness of opportunity; and availability and reasonable accommodation. On the other hand, the Southern African Development Community (SADC) protocols is geared to certify that individuals with disabilities have all the access to essential human rights through their active participation policy advancement and execution in Southern Africa (Manatsa, 2015).

In Zimbabwe however, individuals with disabilities are recognised in the National objectives stipulated in Section 22 of the Constitution of Zimbabwe 2013, which stipulates that the State and all institutions and agencies of government at each level should recognise the rights of people with mental or physical disabilities, precisely their right to be treated with respect and dignity; the State and all institutions and agencies of government at each level must, within the limits of resources accessible to them, help people with mental or physical disabilities to accomplish their full potential and to minimise the shortcomings suffered by them.

Mugumbate and Nyoni (2013) argue that the International Convention on the Rights of People with Disabilities (ICRPD) makes use of the social model of disability, and perceives disability as long-term intellectual or sensory, mental and physical impairments which, in interaction with various blockades, may inhibit the complete and effective participation of the affected persons in society on an equal footing with others. The perception by ICRPD puts emphasis on the role society plays in making impaired individuals disabled. This focus has also influenced the way Zimbabwe conceptualises disability. One of Zimbabwe's pieces of legislation, the Disabled Persons Act Chapter 17:01 of 1992, defines a disabled person as an individual with a physical, mental or sensory disability, including a visual, hearing or speech functional disability, which gives rise to physical, cultural or social blocks hindering him from participating at an equal level with other members of society in activities, undertakings or fields of employment that are open to other members of society. The views by ICRPD and the Government of Zimbabwe indicate that disabilities appear in various forms. They may be physical, cognitive, mental, neurological, sensory, emotional or developmental; at times a person may have multiple disabilities.

However, despite dictates of the Constitution of Zimbabwe 2013, the lawful provisions for individuals with disabilities are insufficient for their rights to be enjoyed in full. People with disabilities in Zimbabwe are still defenseless to social exclusion and discrimination; unavailability of services and support in health, education and others; inadequate care and support; unemployment and lack of great opportunities; limited access to information and communication; and patronage, which has motivated the researcher to go in-depth to explore experiences of adults with physical disabilities in Zimbabwe.

Edmos (2017) highlighted that social diversity, though a valued element of all democratic and advanced societies, is posing a dilemma to individuals with disabilities in Zimbabwe. This social group is being excluded from the economic, political and social avenues of power. This perception is further supported by Lang and Charowa (2007), who opine that persons with disabilities are met with a large number of attitudinal, environmental and institutional barriers that militate against their effective inclusion with the Zimbabwean society. It is a well-known in Zimbabwe that people with disabilities are inactive and economically unproductive, and thus constitute a burden upon society. However, Edmos (2017) opined that individuals with disabilities in Zimbabwe and the world over have ambitions and desires similar to those of persons without disabilities. They have similar rights as others to belong to a society free from discrimination and prejudice, a society of equal chances and social justice. However, an examination of the political, economic, social and administrative structures of Zimbabwean society illustrates that institutional discrimination is a major source of segregation and discrimination experienced by persons with disabilities (Edmos, 2017). The National Association of Societies for the Care of the Handicapped (NASCOH, 2011) reported that individuals with disabilities are still being observed from a medical and welfare context, which sees them as sick, different from their peers without disabilities, and in need of care (Mugumbate & Nyoni, 2013). This observation is supported by WHO (2011), which states that this often leads to neglect. Another study by NASCOH showed that only two percent of persons with disabilities had jobs in the public sector, and less than seven percent of individuals with disabilities in Zimbabwe were in formal employment.

Mtetwa and Ruparanganda (2016) believe that bureaucratic representation has become more topical, especially in the 21st century with emphasis placed on a

rights-based approach to governance. Various previously marginalised groups, including women and minority ethnic groups, now firmly believe that unless and until they become visible within various decision-making structures, it is likely that such decisions might not reflect their aspirations. The slogan “nothing about us without us” is fast gaining visibility among persons with disabilities in Zimbabwe.

The education of persons with disabilities is a basis for concern in Zimbabwe (Lang & Charowa, 2007). There is a huge inconsistency between policy, intentions and real practice. For many years now, there has been a lot of underrepresentation and inadequate guidance for people with disabilities on where and what is in place for them. There is also too much lip service in contrast to practice on the education of persons with disabilities. Some of the obstacles in the education of people with disabilities are being perpetuated by latent attitudes, and are also a consequence of social constructions from societal beliefs and norms, which can be corrected if issues are raised through advocacy (Lang & Charowa, 2007). Education for scholars with disabilities in Zimbabwe has experienced a huge revolution since 1980. The inclusion of pupils with disabilities has not been prioritised in Zimbabwe. For instance, the Education Act (1987) that was modified more than six times now is quiet about the schooling of scholars with disabilities. However, even with this lack of seriousness in Zimbabwe’s judicial system, pupils with disabilities have always faced barriers to access higher and tertiary education in Zimbabwe (Lang & Charowa, 2007).

Rugoho and Maphosa (2017) have illustrated that women with disabilities in Zimbabwe encounter several problems in accessing sexual and reproductive health. The Zimbabwean culture still view women with disabilities as not sexually active. The government has also failed to endorse policies that ease access to sexual and reproductive facilities by women with disabilities. The United Nations Convention on the Rights of Persons with Disabilities, (UNCRPD) which became part of international law, specifies that governments should ensure access to sexual reproductive health to individuals with disabilities (United Nations, 2007). Global studies prove that women with disabilities still face a plethora of challenges in accessing sexual and reproductive health services (Boezaart, 2012). Institutionalised discrimination, segregation and labelling of women with disabilities is still going on undiminished (Rugoho & Siziba, 2014). Violations of the sexual and reproductive

rights of women with disabilities have been overlooked in developed and developing nations. Governments and development partners, particularly in developing countries, have not succeeded to provide reasonable and available sexual and reproductive health facilities in Zimbabwe (Rugoho & Maphosa, 2017). Women with disabilities are still regarded as individuals who cannot take part in sexual and reproductive events. Undesirable attitudes towards sexual and reproductive rights of women with disabilities still occur. Women with disabilities are still alleged as non-sexual or as not having the capability to engage in sexual activities (Chikumbu, 2014). That they are viewed as wrecked items has made their predicament remain on the sideline of policymakers (Choruma, 2007).

Women with disabilities are more disposed to sexual abuse and oppression because they are measured to be weak and hence easy targets (Shuttleworth, 2007). The sexual rights of women with disabilities are compromised by aspects such as harmful attitudes of family and society, and harsh religious and cultural practices (Rugoho & Maphosa, 2015). The undesirable attitudes also cascade to health providers and medical staff (Bath, 2008; Burgen, 2010). Zimbabwe still faces problems in the delivery of sexual and reproductive health services. In an effort to address problems in sexual and reproductive health, the National Reproductive Health Policy of Zimbabwe (2006) was established by the Government of Zimbabwe. However, the sexual and reproductive needs of women with disabilities were not mentioned in the policy. As stated by Choruma (2007), the desires of individuals with disabilities, including women with disabilities, still remain an overlooked issue. Persons with disabilities continue to be treated as citizens who are not important (Rugoho & Siziba, 2014). Women with disabilities face challenges in getting sexual and reproductive health services. It is from this background that the research sought to understand experiences of adults with physical disabilities in Kukura Neshungu Institute.

WHO (2013) and Groce, Izutsu, Reier, Rinehart and Temple (2009) conclude that women with disabilities require larger access to sexual and reproductive health services than people without disabilities. Groce et al. (2009) found sufficient evidence to conclude that women with disabilities are three times more likely to be sufferers of sexual, emotional and physical abuse. With all that convincing signals, governments have not articulated policies to increase access to sexual and

reproductive health for women with disabilities (Groce & Trasi, 2004). Studies done by Job (2004) and Prilleltensky (2004) revealed that adolescents with disabilities are not provided the platform to be schooled about sexual and reproductive health in comparison with their peers because teachers, parents and counsellors fear to discuss sexual and reproductive health with them because they are perceived to be non-sexual. As such, they miss out on basic vocabulary to describe changes in their bodies (Groce, Yousafzai & Maas, 2007; WHO, 2009). Deaf women and women with physical disabilities face the same challenges (WHO, 2009). The development of literature in Braille and other formats is still a challenge in developing countries. Roberts (2006) states that deaf women are usually not given appropriate information owing to problems in conversing in sign language. Fedorowicz (2006), Heyederick (2006), Wilson and Monaghan (2006) and Groce et al. (2007) also observe that there is few knowledge existing for deaf women in the area of sexual and reproductive health. Medical staff in developing countries are usually not skilled in sign language and often find it hard to communicate with deaf women when they visit health centres (Margellos-Anast, Estarziau & Kaufman, 2006).

In Zimbabwe, sexual and reproductive health matters came to the attention in 2006 when the government formulated the National Reproductive Health Policy. The policy offers services such as maternal health, family planning, treatment for sexually transmitted diseases, including HIV and AIDS and adolescent reproductive health. Surprisingly, the policy offered few involvements towards women with disabilities. One of the main reasons for this oversight is that disability matters are still observed as charity issues; hence, funding for sexual reproductive health of women with disabilities is still a challenge (Kabzems & Chimedza, 2002). Very few studies have been done in Zimbabwe on sexual and reproductive health among women with disabilities; hence, very little is known about the problems they face in accessing sexual and reproductive health. Much research on sexual and reproductive health has focused on youth and people with HIV and AIDS (Wilcher & Cates, 2009). In Uganda, also a developing country, some policy frameworks have been in place to include and mainstream disability issues across sectors (Khumalo, 2008; Lang, 2009). In Zimbabwe, a number of non-government organisations such as Leonard Cheshire Disability Zimbabwe, Disability, HIV and AIDS Trust and Deaf Zimbabwe Trust are working with women with disabilities to help them access sexual

and reproductive health. However, they are limited to advocacy and awareness-raising issues.

2.9 CONCLUSION

The literature review above has shed light on the experiences of adults with physical disabilities not just in Zimbabwe, but in other countries such as India and Kenya. Models of disability that explain and describe the phenomenon of disability from various angles have also been included. Chapter three will discuss the research methodology.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The chapter deals with methods of research that were applied in carrying out this study. It includes discussions such as the research design used in the study, the tool for data collection, the sampling procedures and methods, the ethical considerations applied as well as the interview guide. The data analysis technique used in the study is also discussed.

Rajasekar, Philominathan and Chinnathambi (2006) are of the opinion that research methodology is a systematic means to solve a problem and a science of learning how research is to be done. They add that basically, the measures taken by researchers as they explain, describe and predict phenomena is termed research methodology. Research methodology is further elaborated as the study of various ways by which information or facts are gained. Its mandate is to provide the ultimate plan of research. When choosing one methodology instead of the other, importance is mainly placed on making a suitable and effective choice bearing in mind the kind of information that the researcher is looking for (Rubin & Babbie, 2011). The choosing of methodology was immensely affected by the subject and the goals of the research, the theories that were to be applied in the study as well the personal judgement of the researcher.

3.2 RESEARCH METHODOLOGY

3.2.1 RESEARCH APPROACH

The research adopted a qualitative approach, which allows flexibility to report on a wider range of issues. With this perspective, the qualitative approach is applicable to this study as it enabled the researcher to report on the encounters with adults with physical disabilities at Kukura Neshungu Institute. Denzin and Lincoln (2005) share the same sentiments by saying that qualitative research is a contextual event which puts the observer directly in the world. It therefore includes interpreting the natural world. This means that qualitative researchers study different phenomena in their natural state with the aim of making sense of what is happening, or interpret issues

based on the meanings people attach to them. Qualitative research accordingly stresses the importance of qualities of entities and meanings and processes that are not scientifically measured or examined (Denzin & Lincoln, 2005).

In agreement with Denzin and Lincoln (2005), Judge, Thoresen, Bono and Patton (2001) describe qualitative research as a method that uses a natural approach to comprehend aspects in their context, that is, in their real world. More so, the researcher does not in any way manipulate the phenomena of interest. It is the type of research that births results not arrived at by ways of statistical measures or any other means of quantification; but it is the type of research that produces results from the stand point of the real world where matters unfold naturally. Silverman (2016) illustrated that the goal of qualitative research is to offer the researcher a clear picture of the target audience, by making use of culture or face to face engagement with the people or subjects under study. This means that in the qualitative research, the researcher becomes a tool of collecting data, and findings may differ largely depending on the person who conducts the research. Promoting better understanding and increasing knowledge of the human state or condition is the main mandate of qualitative research. Different from quantitative research which has, as its basis, gathering facts about human behaviour that will lead to confirmation and extension of theories, qualitative research emphasises the enhanced comprehension of human experience and behaviour. From this perspective, the researcher sought understanding of the issues encountered by adults with physical disabilities at Kukura Neshungu Institute through interaction with them with the use of face to face interviews, which provided a platform for observations, follow-up questions, probing and even a close-range analysis of the emotional state of participants as they related their encounters as adults with physical disabilities.

Qualitative inquiry is based on making use of numerous data gathering ways, especially the views of the participants. It applies an inductive approach to analysing data, deducing its knowledge from the mass of details which comprise of the data base. The strong point of qualitative approaches, according to Silverman (2016), is their generation of rich and detailed information that leave the respondents' perspective intact, and provides a framework of the phenomena being studied. The major drawbacks of data collection in qualitative approach are that it is time consuming and labour intensive. Using qualitative inquiry, the researcher managed

to gather rich and detailed data about the experiences of adults with physical disabilities.

3.2.2 RESEARCH DESIGN

The study adopted an exploratory approach which was deemed useful for this study as it addresses a subject that has a high level of ignorance and uncertainty (Hanisch, 2007) and the encounters of adults with disabilities which are hardly understood. The major objective of exploratory research is to recognise the limitations of the setting in which the challenges, prospects or circumstances of interest are likely to exist, and to find prominent features or variables that might be found and be of importance to the study. Thus, the major purpose of the study was to explore experiences of adults with physical disabilities from all spheres of their lives such as economically, socially, culturally and educationally with the mandate to unearth in-depth, issues involved with being an adult with a physical disability. Hence, the researcher's choice to adopt qualitative design.

MacMillan and Schumacher (2001) describe a research design as a strategy for picking subjects, research locations, and data collection measures to answer the research questions. They further indicate that the purpose of a comprehensive research design is to deliver outcomes that are judged to be credible. For Blanche, Durrheim, Blanche and Painter (2006), a research design is a calculated outline for action that aids as a link between research questions and implementation or the execution of the research strategy. Thus, the research design can be described as a blueprint for collection, measurement and analysis of data. In simpler terms, the research design enunciates what data is essential, what approaches are going to be utilised to collect and analyse data, and how all of this is going to respond to the research question. Creswell and Inquiry (2007) are of the view that the research design procedure commences with philosophical assumptions that the researchers make when deciding to engage in a study. Researchers convey their own world interpretations, standards or sets of theories to the research project. These inform the manner and writing of the study.

The study adopted the multiple case study design. According to Gustafsson (2017), evidence gathered from a multiple case study is solid and dependable and the writer can illuminate if the findings from the results are valuable or not. The researcher

opted for a multiple case study in order to obtain a more in depth understanding of disability. Through the use of this design, rich information that was very crucial to the study was yielded from the research as supported by Heale and Twycross (2008). Multiple case study design also permits a broader discovery of theoretical evolution and research questions. When ideas are more strongly rooted in different empirical evidence, this type of case study then produces a more substantial theory. The decision was informed by the fact that the investigator is able to analyse the information within each state and through different situations. The researcher studies several cases to comprehend likenesses and variances between the cases, and thus can provide the literature with significant impacts from its variances and likenesses (Gustafsson, 2017). The multiple case study design enables the researcher to collect rich information on experiences of adults with physical disabilities.

3.2.3 POPULATION

Target population means all the members who meet the particular standard stated for a research enquiry (Alvi, 2016). Rubin and Babbie (2011) are of the view that population is a collective or total of all the objects, subjects or members that adapt to a set of stipulations. On the other side, Harnlon and Larget (2011) share the view that population is all the individuals or units of interest in a particular study. In this research, the population was all adults with physical disabilities at Kukura Neshungu Institute. The researcher was assisted by the Managing Director of Kukura Neshungu to identify adults with physical disabilities through the institution's admission register.

3.2.4 SAMPLING METHODS

Sampling

Abrams (2010) voiced that sampling is a foundation of research integrity in all methods of social science, which is an integral part of all research designs. A sample can be described as a group of fairly small quantities of people chosen from population for inquiry purpose. Members of a sample are identified as participants. The researcher selected 20 adults with physical disabilities at Kukura Neshungu Institute which constituted of 13 females and 7 males. Alvi (2016) further explained that the process through which a sample is extracted from population is known as sampling. With this sentiment in mind, the researcher selected a sample of 20 adults

with physical disabilities at Kukura Neshungu from the population of the whole institution. Alvi (2016) argues that in an inquiry, it is impossible to evaluate each part of population hence a set of people smaller in quantity than the population is chosen for the assessment. Grounded on data obtained from the sample, the interpretations are drawn for the population. The further the sample is representative of the population, the greater the correctness of the interpretations and the better the findings are generalisable. In this study, the sample represented the population as it was adults who had physical disabilities; hence they managed to portray experiences of adults with physical disabilities.

A sample is said to be representative when the features of elements chosen are the same to that of the total target population. The findings are described to be generalisable when the results from the sample are correspondingly true for the entire target population. The sampling process may meet the challenge of methodical errors and sampling partialities (Alvi, 2016).

Sampling procedure

Alvi (2016) stated that sampling comprises of two types, namely, probability sampling and non-probability sampling. In probability sampling each member of the population has a recognised non-zero probability of being involved in the sample. A form of haphazard selection is utilised. The probabilities can be allocated to each element of the population accurately. Such procedures need population to be precisely well-defined. These procedures cannot be made use of for the population that is too general a category existing almost all over in the world. Non-probability sampling is also termed judgment or non-random sampling. Each unit of population does not get the same chance of participation in the study and no random selection is made. The choosing of the sample is made on the basis of subjective judgment of the inquirer. These procedures do not need population to be exactly defined. Examples of non-probability sampling include purposive sampling and convenience sampling.

The researcher applied the non-probability sampling techniques in the study by utilising purposive sampling and convenience sampling. The Management of Kukura Neshungu Institute was approached in order to get the relevant respondents of the study. With the permission of the Managing Director, the researcher and the

Managing Director utilised the admission register for the centre to select all adults with physical disabilities who were 18 years of age and above.

Purposive sampling

Purposive sampling denotes the approach in which the researcher exercises his or her ruling about who will offer the best perception on the phenomenon of interest, and then deliberately requests those precise perspectives into the research (Abrams, 2010). Purposive sampling was found relevant in the study to explore experiences of adults with physical disabilities at Kukura Neshungu as they were able to shed light on the subject under study.

Etikan, Musa and Alkassim (2016) shared that data assembly is critical in research, as the data is intended to contribute to an improved comprehension of a theoretical context. It thus turns out to be imperious in such a way that selecting the way of obtaining information and from whom the information will be gathered be done with comprehensive judgment, particularly since no quantity of analysis can make up for inappropriately collected data. The purposive sampling technique, also known as judgment sampling, is the deliberate choosing of a respondent due to the abilities he or she possesses. From this perspective, the researcher chose physically disabled adults as the relevant sample to explore experiences that they encounter in their day to day lives. Etikan, Musa and Alkassim (2016) further argued that purposive sampling is a non-random procedure that does not require underlying theories or a group of participants. In simple terms, the investigator chooses what needs to be known and sets out to find people who can and are willing to offer information by the knowledge or experience they have concerning information needed in the study. Purposive sampling is classically used in qualitative research to find and select information-rich cases for the most suitable use of existing resources. This includes the identification and assortment of individuals or groups of individuals that are skillful and knowledgeable about a phenomenon of interest; hence the choice of adults with physical disabilities to unearth the encounters that they face. Apart from knowledge, skill and the importance of accessibility and readiness to participate; the capability of participants to communicate experiences and thoughts in an eloquent, open, and insightful manner is very essential when collecting data. Thus, the researcher made use of informed consent forms, and applied the ethic of voluntary

participation that the respondents participated out of their own choice, availability and willingness.

Convenience sampling

In convenience sampling, the researcher chooses subjects that are more willingly accessible (Sedgwick, 2013; Farrokhi & Hamidabad, 2012). Alvi (2016) shared the same sentiments as he stated that the researcher involves those respondents who are easy or convenient to approach. In this study, the researcher used Kukura Neshungu Institute, an organisation with an easily accessible sample of adults with physical disabilities as it already caters for persons with disabilities hence convenience sampling was applied.

3.2.5 STUDY AREA

The study area was Dombotombo area in Marondera, a place that is located in Mashonaland East Province in Zimbabwe. Marondera has a population of 116 985 comprising of 58 030 females and 58 955 males. Persons between 15 to 64 years of age make up 63 974 (Zimbabwe National Statistics Population Census, 2012). However, the disability population is unknown. The climate in Marondera is moderate and warm. The summers have a substantial rainfall, whereas the winters have very slight rainfalls with the average annual temperature of 16.7 °C and about 902 mm of precipitation falls annually.

Marondera began in 1890 as a rest house on the way from Salisbury, now Harare to Umtali, now Mutare. It was initially known as Marandella's Kraal, tarnished from Marondera, chief of the ruling VaRozvi people. This shifted to Marandellas. The Shona resistance was later destroyed in 1896. The town was then moved 6 km north to the Salisbury Beira railway line. It was only a village in 1913, but a town in 1943. During the South African Boer War it was utilised by the British as a construction area for military events into the Transvaal, and in [World War II](#), it was a shelter for exiled Poles.



Figure 1: Map of Zimbabwe showing Marondera (Dombotombo) Study area

3.2.6 DATA COLLECTION

Interviews were used as tools of collecting data in the study. According to Cohen (2006), an interview is a treasured technique for discovering the structure and negotiation of meanings in natural settings. Berg (2007) expounded on that by illustrating that the value of an interview is not only because it builds a holistic snapshot, examines words, reports thorough opinions of informers, but also because it permits interviewees to express themselves in their own voice and to express their perceptions and feelings. The investigator gave the respondents a chance to reveal their experiences in their own voice and understanding. She expressed a non-judgemental attitude throughout the data collection. She was interested in own descriptions by adults with physical disabilities of their experiences and opinions (Maguire, 2017). Alshenqeet (2014) added more insight, arguing that interviews are collaborative, and as a result, can press full, clearer responses and probe into any upcoming topics. Therefore, an interview is anticipated to expand the scope of understanding phenomena under investigation as it is a more naturalistic and a less

structured tool of collecting data. Thus, the researcher probed on responses that needed clarity to get a clearer understanding of interviewees' world. Through the interchange of interaction granted by interviews, issues that emerged were able to be clearly described and explored. With the aim of the research being to explore experiences of adults with physical disabilities, interviews provided the platform for in-depth capturing of information critical to the subject under study. The researcher used structured interviews which enabled her to stay focused on the goals of the study (Alshenqeet, 2014).

3.2.7 DATA ANALYSIS

Thematic Analysis is a kind of qualitative analysis used to analyse categorisations and existing themes or frameworks that communicate to the data. It demonstrates the data in great detail, and deals with different subjects via interpretations (Alhojailan, 2012). Thematic Analysis is classified as the most suitable in any study that seeks to discover issues using interpretations. It gives an orderly element to data analysis. It enables the researcher to compare an analysis of the frequency of a theme with one of the whole contents. This confers accuracy and intricacy, and enhances the whole meaning of the research. Qualitative research needs understanding in gathering varied aspects of data. Thematic Analysis gives a prospect to understand the potential of any issue more extensively (Marks & Yardley 2004). Padgett (2016) argues that data analysis is a method of establishing order, structure and meaning to the mass of collected data. As Nowell, Norris, White and Moules (2017) argue, the lack of focus on laborious and pertinent thematic analysis has repercussions in terms of the trustworthiness of the research process.

The researcher initially analysed the data manually by first translating it from its original recordings and then engaged in a process of transferring it from Shona to English. The data was then coded. Marks and Yardley (2004) hold that codes established for ideas or themes are then applied or connected to raw data as summary markers for future analysis, which may consist of matching the relative regularities of themes or subjects within a data set, observing code co-occurrence, or graphically displaying code relationships. The researcher applied the coding system in order to identify key issues and meanings. Maguire and Delahunt (2017) have emphasised that thematic analysis is the procedure of classifying patterns or themes within qualitative data. The researcher did so by making use of the coding system.

Basically, the researcher adopted Braun and Clarke's (2006) framework of doing thematic analysis, which involves becoming familiar with the data. In this phase, the researcher read and re-read the transcripts whilst also jotting down first impressions and making notes. Secondly, generating initial codes. At this stage, the researcher organised data in a meaningful and systematic way. Coding was applied, and helped in reducing masses of information into small portions of meaning (Braun & Clarke, 2006). The researcher coded each section of data that was important, or caught something fascinating about the research question. Thirdly, searching for themes. In this stage, the researcher scrutinised the codes, and some of them plainly fitted into a theme (Maguire & Delahunt, 2017). Fourthly, reviewing themes. In this stage, the researcher modified and developed the preliminary themes that were identified in step three, gathering together data that was relevant to each theme. The researcher studied the data linked with each theme and measured whether the data really reinforced it (Maguire & Delahunt, 2017). Fifthly, theme definition. This stage is the last modification of themes. The researcher identified the essence of what each theme was about. The last phase is write-up, which entails the end-point of research as a journal article or dissertation (Braun & Clarke, 2006).

The researcher also made use of the Nvivo software to analyse data. She reckoned that using both systems to analyse data will minimise a great deal of errors. Maguire and Delahunt (2017) stated that the Nvivo software is very useful, especially with large amounts of data associated with qualitative research. With many issues and factors that were raised from exploring the experiences of adults with physical disabilities and the numerous data thereof, the researcher adopted the Nvivo software as well in analysing the data.

Thus, the researcher was able to recognise the themes and outlined factors and issues that were pertinent in the study about experiences of adults with physical disabilities at Kukura Neshungu Institute. Clarke and Braun (2013) raised a crucial insight as they argued that a common drawback is to use key interview questions as themes. Consequently, this reflects the point that the information has been summarised and organised rather than analysed. Maguire and Delahunt (2017) further expounded on that by saying that analysis shifts beyond relating what is spoken to concentrate on interpreting and clarifying it. Thus, the researcher was able

to identify the themes, that is, she did not solely focus on the interview questions, but recurring issues raised in the data collected.

3.3 QUALITY CRITERIA

Quality criteria are about the means that are devised in research to ensure the validity of the results. Quality can be ensured through four basic forms, which are dependability, conformability, credibility and transferability (Cameron, 2011).

3.3.1 Dependability

Dependability refers to the steadiness of data over time and under diverse conditions. Thus, it is vital to mention the principles and criteria used to choose respondents and detail the participants' key features so that the transferability of the outcomes to other settings can be evaluated (Elo, Kaariainen, Kanste, Polkki, Utriainen & Kaingas, 2014). The researcher ensured dependability by describing the research methodology adopted in this research in full. The tool for collecting data which was interviews and the type of sample used will make it possible to produce the same results if the study had to be repeated. Moreover, Korstjens and Moser (2018) are of the view that the researcher should describe the research steps that were adopted from the onset of the research project, the progress of the study and the reporting of findings. The accounts of the study path were kept during the course of the study.

3.3.2 Conformability

Polit and Beck (2012) assert that conformability refers to objectivity, and implies that the information precisely signifies the data given by the respondents, and that explanations of those data are not devised by the inquirer. The findings must mirror the respondents' voice and settings of the inquiry, and not the researcher's prejudices, drives or viewpoints. The researcher ensured conformability by keeping the original transcribed responses of the participants (Graneheim & Lundman, 2004).

3.3.3 Credibility

Credibility is defined as the sureness that can be employed in the verity of the research outcomes (Macnee & McCabe, 2008). Graneheim and Lundman (2004) hold that credibility establishes whether or not the research results signify credible data drawn from the respondents' original data, and is a correct clarification of the

participants' original views. The researcher ensured credibility by making use of interviews as a tool of collecting information which afforded the platform to get authentic responses by observing the participants' verbal and non-verbal cues. More so, the purposive sampling adopted by the researcher ensured that the relevant participants gave credible information to the study. In fact, they provided first-hand information of their experiences. Further, credibility was ensured through prolonged engagement using follow-up questions with participants and persistent observations (Korstjens & Moser, 2018).

3.3.4 Transferability

Transferability entails the degree to which the results can be moved to other settings or groups (Polit & Beck, 2012). The researcher ensured transferability by providing a thick description and detailed information of the study to allow comparisons to be made, relating not just the behaviour and experiences, but their setting as well, in a way that these behaviour and experiences make more sense to an outsider (Korstjens & Moser, 2018).

3.4 ETHICAL CONSIDERATIONS

Steffen (2016) stated that moral questions rise at each phase of the study process, from final design, through fieldwork and analysis to the broadcasting of the research findings. She defined ethics as morals and how people ought to live their lives. Dolly, Moore and Vallejo (2017) posited that qualitative research, particularly studies in educational settings, regularly brings up questions of morals because the study design comprises of human subjects, some of whom are under age. In this study, the researcher applied ethical considerations as she was dealing with human subjects who were adults with physical disabilities. Since disability is a very sensitive issue, the researcher was also obliged to utilise ethical considerations in the study.

3.4.1 Permission to conduct the study

The researcher required permission to conduct the study from Turfloop Research Ethics Committee (TREC), which was obtained as an ethical clearance letter. Further, permission was also obtained from the management of Kukura Neshungu Institute.

3.4.2 Informed Consent and Voluntary Participation

Shahnazarian, Hagemann, Aburto and Rose (2013) argued that voluntary informed consent is not only a requirement for an individual's participation in research, but also an intended arrangement to contribute in research. It is not simply a system that is signed but a procedure in which the subject has an understanding of the study and its implications. Informed consent is crucial before registering respondents. It must be acquired for all types of studies about human subjects. Gaining consent encompasses telling subjects about their rights, the goal of the research, the measures to be undertaken, and the probable threats and profits of contribution. Subjects must participate willingly in the study. Informed consent is defined in moral codes and guidelines for research in human subjects. The aim of informed consent procedure is to offer appropriate information so that respondents can make knowledgeable choices about whether or not to participate in the study. Informed consent forms must be inscribed in a language that is understandable to participants. It must decrease the likelihood of duress or unnecessary influence, and subjects must be given adequate time to think about participation. The researcher designed the informed consent form in a language that the participants could understand, and the aim of the study was clearly explained thereon.

Babbie and Rubie (2011) explained voluntary participation as the preparedness of an individual to take part in research, as no one should be coerced to do so. Vanclay, Baines and Taylor (2013) shared the same sentiments, arguing that participation must be intentional and participants should not be subject to any force or danger for not participating. The researcher explained that the research was about experiences of adults with physical disabilities. She also clarified the probable risks of the study such as emotional breakdown and gave participants ample time to read through informed consent forms and to sign them out of their free will.

3.4.3 Confidentiality and Anonymity

Anonymity and confidentiality of participants is fundamental to ethical research practice in social research. Every effort will be made to guarantee that the information offered by participants cannot be drawn back to them in accounts, presentations and other forms of broadcasting. Researchers use pennames as the

principal method to preserve anonymity and confidentiality of the participants (Crow & Wiles, 2008)

The researcher used pseudonyms in the study as participants voiced that they were not comfortable with their real names being revealed in the study. They gave reasons for not disclosing personal and sensitive issues about their experiences as adults living with physical disabilities.

3.4.4 Do no harm

It is essential that no injury must come to participants as an outcome of their contribution in the research. This means not only that participants must not be exposed to discomfort or risk in the development of the research, but also that there must be no hostile consequences to a person as an effect of their participation. At the very least, the researcher must do their best to protect participants from any injury and to certify under the norm of informed consent that the participants are fully appraised of all potential risks from participation. Sometimes contribution in social research will necessarily cause a participant to return to personal issues, bringing about emotional grief. Here, the researcher's responsibility is to guarantee that the research interaction does not end until there is some resolve of the emotional distress that has risen, and that there is recourse to follow up support or therapy (Vanclay, Baines & Taylor, 2013).

As the study revealed and reflected on the participants' individual matters, bringing about the possibility of emotive anguish, the researcher mobilised external resources such as a social worker and a psychologist from Marondera General Hospital to assist participants who needed counselling. Furthermore, as the researcher was conscious of the cultural norms of her study field, she ensured that words and language that are complex to conviction, disability, age, marital status or tribe were avoided.

3.5 CONCLUSION

In conclusion, this chapter discussed the research methodology that was used in the study about experiences of adults with physical disabilities. The qualitative design was adopted in this study with interviews as tools for data collection. A sample of 20 participants was selected, which constituted of both males and females. Chapter 4 will present and discuss the findings of the study.

CHAPTER 4

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

The chapter involves the discussion of the research findings and their interpretations. The qualitative approach enabled the discussion of issues faced by physically disabled adults. This report aims to show more insight into experiences of disabled adults. Face to face interviews were done with a sample of 20 people with physical disabilities. This enabled individuals to explain and to give meaning to their experiences as adults living with physical disabilities. As disability is a sensitive issue, a local psychologist and a social worker from Marondera Hospital were present during the face to face interviews to provide services such as counselling to participants where the need arose. The researcher made use of a spacious office at Kukura Neshungu Institute so that the respondents would not feel intimidated by the closeness between them and the researcher. The researcher portrayed a nonjudgmental attitude towards the research participants as they responded. The demographic characteristics of the participants are described fully in this chapter with the use of tables, graphs and pie charts. The themes and sub-themes that emerged in the study are tabulated.

4.2 DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS

The table showing the demographic characteristics of participants below highlights the pseudonyms, sex, age, type of disability and the marital status of the participants. The sex of the respondents is both male and female, which depicts that disability affects all genders. The ages of the participants ranged from 20 years to 51 years. The disability of research participants ranged from paraplegic, hemiplegic and the partially blind. For confidentiality purposes, real names of participants were replaced by pseudonyms in this study.

Pseudonym	Sex	Age	Disability	Marital
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				status
Adult 1	F	23	Partially blind	Single
Adult 2	M	30	Paraplegia	Single
Adult 3	F	20	Hemiplegia	Single
Adult 4	M	45	Paraplegia	Married
Adult 5	M	38	Paraplegia	Married
Adult 6	F	27	Hemiplegia	Single
Adult 7	M	29	Partially blind	Single
Adult 8	F	32	Hemiplegia	Single
Adult 9	F	35	Paraplegia	Divorced
Adult 10	M	43	Paraplegia	Married
Adult 11	F	51	Paraplegia	Divorced
Adult 12	M	26	Hemiplegia	Single
Adult 13	F	32	Hemiplegia	Married
Adult 14	F	21	Paraplegia	Single
Adult 15	F	38	Paraplegia	Single
Adult 16	F	34	Paraplegia	Single
Adult 17	F	30	Hemiplegia	Single
Adult 18	F	24	Paraplegia	Single
Adult 19	F	39	Paraplegia	Single
Adult 20	M	41	Hemiplegia	Divorced

Table 1: The demographic characteristics of participants

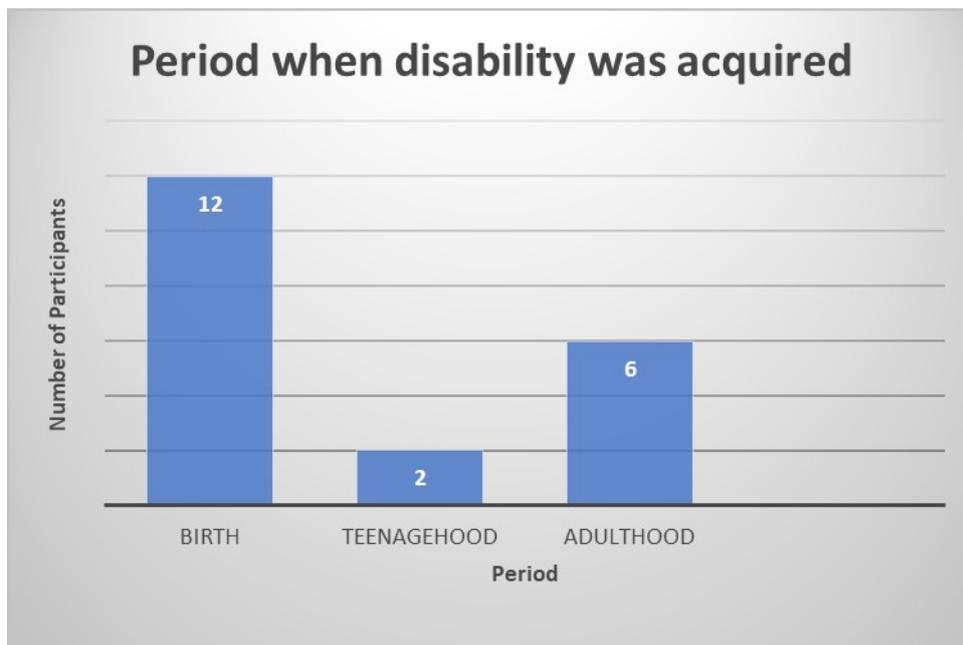
4.2.1 Educational level of participants

Grade	Total Number
Tertiary education	2
Secondary level	8
Primary level	10

Table 2: The table is showing the educational level of participants

Due to accessibility barriers in terms of the education sector in Zimbabwe, only two participants managed to reach tertiary education. However, both of them did not finish their studies. Eight participants reached secondary level and 10 participants ended at primary education. The educational levels of participants elaborate more of the accessibility barriers in the educational sector as a large number of them could not manage to finish their primary education. Parents tend to faint at an earlier phase when poised with the barriers that their children face in their early years of education (Mpfu & Molosiwa, 2017). These demographics are further supported by the stigma and discrimination that accompany persons with disabilities as described in-depth in this chapter from the participants' voice.

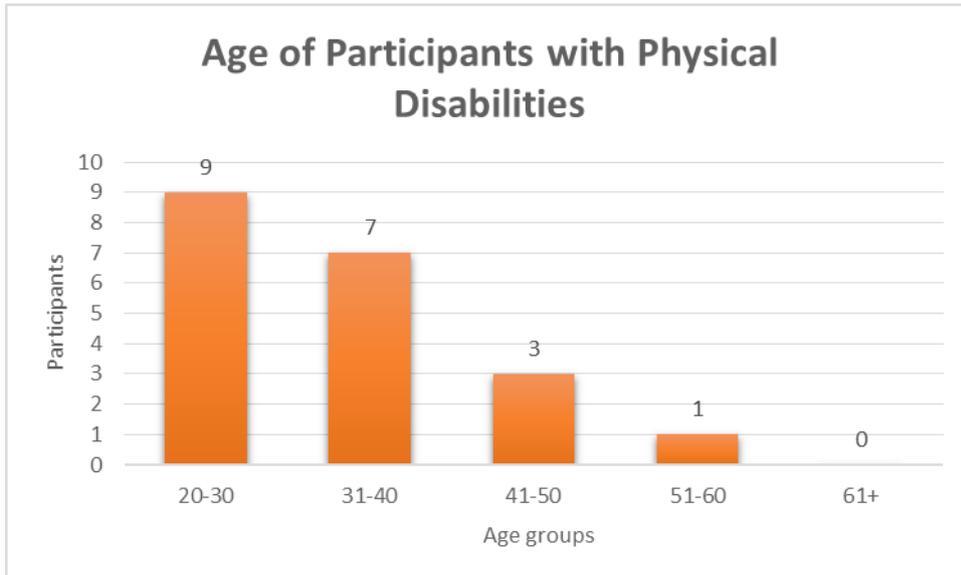
4.2.2 Period when disability was acquired by participants



Graph 1: The graph shows the period in which participants acquired the physical disabilities

From the graph above, 12 adults with physical disabilities acquired it from birth, 2 adults acquired disability in their teenage years and 6 acquired it when they were already adults. Most adults acquired disability at birth due to bad omen, witchcraft and evil spirits. Disability acquired at birth is the most common (Zhou, 2016). Disability acquired during teenage years are due to severe illnesses and accidents.

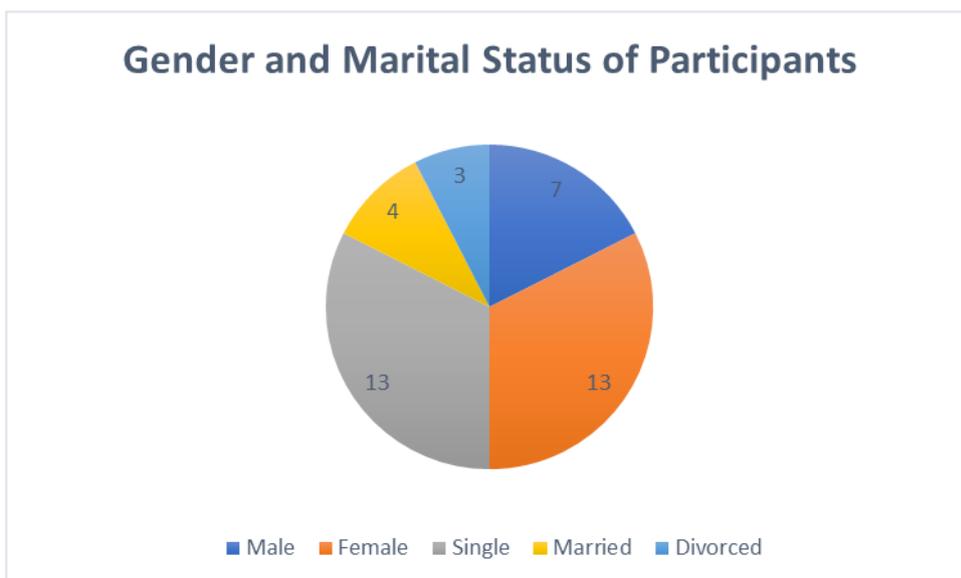
4.2.3 Age of Participants



Graph 2: The graph shows the age of respondents who took part in the study

The graph presents the age groups of participants, highlighting that there were 9 participants in the 20-30 years age group, 7 in the 31-40, 3 in the 41-50 years age group, one in the 51-60 years age group and there was none in 61 and above age group. The 20 – 30 years age group contains a large number of people with physical disabilities who were born already disabled. Participants from 31 years and above became disabled due to accidents or severe stress that caused stroke.

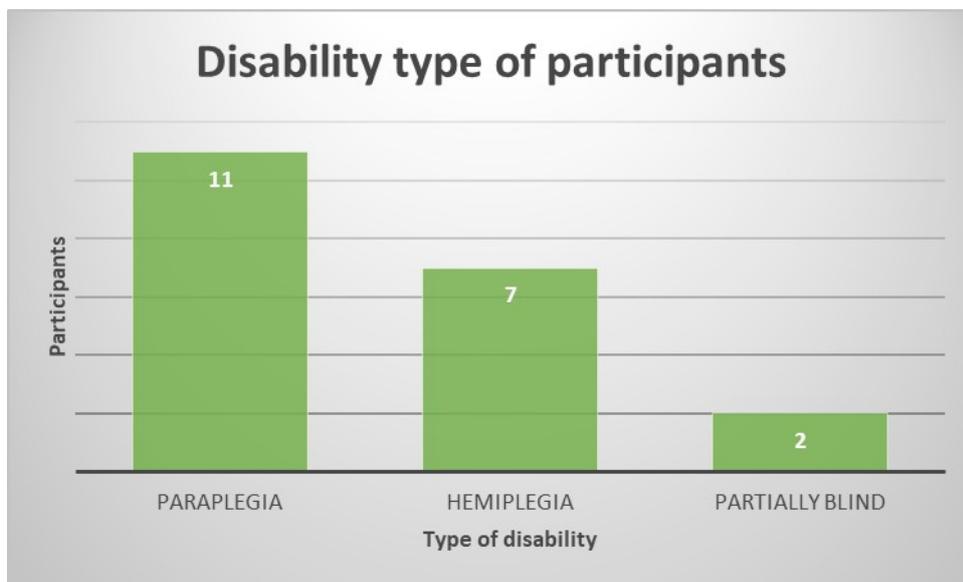
4.2.4 Gender and Marital status of participants



Pie chart 1: The pie chart presents the gender and marital status of 20 respondents who took part in the study

From the pie chart, 13 females and 7 males participated in the study, bringing the total to 20 participants. Of the 20 participants, 13 are single, 4 are married and 3 are divorced. 13 people are single due to the marriageability that is questioned by families and communities at large as revealed in this study. Persons with disabilities are not considered marriageable as people assume that they will not be able to perform their roles (Enns, 2008). This also explains the few numbers of participants who are actually married.

4.2.5 Disability type of participants



Graph 3: The graph presents the type of disability of participants

The graph above highlights that of the 20 participants who took part in the study, 11 are paraplegic, 7 are hemiplegic and 2 are partially blind. Paraplegia is a condition in mobility or sensory function of the lower parts. It is mainly caused by the injury of the spinal cord or an inherited disorder that affects the brain fundamentals of the spinal cord. Most people who are paraplegic are wheelchair users (Abbasi & Fardkhani, 2012). In this study, all participants with paraplegia are wheelchair users. Hemiplegia is an ailment that disturbs one side of the body. There is a left or right hemiplegia, depending on the side that is affected. Hemiplegia is mostly triggered by damage to the brain that controls mobility of the trunk, limbs and face. Accidents as well as strokes cause most participants to be paraplegic and to use wheelchairs.

4.3 THEMES AND SUB THEMES THAT EMERGED IN THE STUDY

The purpose of the study was to explore experiences of adults with physical disabilities. In conjunction with the aim of the study, qualitative design yielded rich responses from the participants, who shed light on their experiences as physically disabled adults living with disabilities. In line with the goal of the research, a relevant sample of 20 adults with different physical disabilities was utilised. Various themes which have their own sub themes emerged from the data collected by the researcher. These themes and sub themes are tabulated below.

THEMES	SUB THEMES
1. Social stigma and discrimination	<ul style="list-style-type: none"> ▪ Families' perceptions towards adults with physical disabilities ▪ Marriageability ▪ Donors' perceptions towards physically disabled adults ▪ Community's perspective towards adults with physical disabilities
2. Accessibility barriers	<ul style="list-style-type: none"> ▪ Educational barriers ▪ Transportation barriers ▪ Health barriers
3. Traditional medicine	
4. Western medicine	
5. Cultural beliefs towards disability	<ul style="list-style-type: none"> ▪ Families' beliefs on the causes of disability ▪ The community's beliefs on the causes of disability ▪ Individuals' beliefs on the causes of disability ▪ Families' beliefs about a cure of a disability
6. Attitude towards adults with disabilities	<ul style="list-style-type: none"> ▪ Community's attitude towards physically disabled adults
7. Activities done at Kukura Neshungu Institute	<ul style="list-style-type: none"> ▪ Gardening

Seven major themes were identified from the data collected by the researcher. Each theme has sub themes coming along with it. The first two themes generally portray personal experiences of adults with disabilities in their everyday lives. The last theme concentrates on experiences of disabled adults in relation to some of the activities that they do at Kukura Neshungu Institute. The themes and sub themes reveal their encounters with families, communities, culture and service providers such as schools, clinics, hospitals and the transport sector.

4.4 THEME: SOCIAL STIGMA AND DISCRIMINATION

From the participants' responses with regards to major challenges that they face as adults with physical disabilities, they identified social stigma and discrimination as some of them. Three main ideas arose from this theme, which are families' perceptions, donors' perceptions and community's perceptions towards adults with physical disabilities. These will be presented below as sub themes.

4.4.1 Sub-theme: Family perceptions towards physically disabled adults.

The responses of the participants indicated that family members have different perceptions in terms of how adults with disabilities ought to be treated which are contrary to how they themselves want to be treated. Though few members of their families are supportive, the participants reported that many of them portray stigma and discrimination towards adults with disabilities.

Adult 13 married female echoed the following sentiment:

- *“Amai vangu uye nedzimwe hama kwandakaroorwa vanofunga kuti handigoni kuchengetedza mhuri yangu nokuti ini ndiri chirema. Vanoramba vachindikurudzira kuti ndiunze vana vangu kuGutu, iyo inzvimbo yekumaruwa kwavari kugara iye zvino. Vanofunga kuti handigone kutarisira vana vangu zvakaenzana nokuti ndiri muwiricheya. Izvi zvinondigumbusa kwazvo nokuti ndinoziva kuti ndinokwanisa kutarisira vana vangu. Ndiamai verudzii vanokundikana kutarisira vana vavo”?*

“My mother in law and other relatives where I am married think that I cannot take care of my family because I am physically challenged. They keep pushing me to bring my children to Gutu, which is a rural area where they are

currently residing. They perceive that I cannot take care of my children sufficiently because I am in a wheelchair. This really makes me very angry because I know I can take care of my children. What kind of a mother fails to take care of her own offspring”?

In collaboration with the above, Adult 4 who is a married male argued as follows:

- *“Vana vangu vanofunga kuti nekuda kwekuti ini ndine chirwere chekurwadziwa handigone kuvabatsira. Vanoziva kuti sababa vavo ini handidi ivo vachitevera shure kwangu vachandibatsira nekunhonga zvinhu zvinenge zvadonha pasi kana kutakura zvinhu zvakapoteredza imba. Ndichiri kuda kuva baba vanobatsira uye kubatwa saizvozvi kunyanya kubva kuvana vangu”.*

“My own children think that just because I’m paraplegic I am unable to help them. They know that as their father I don’t like them tailing around me helping me with things such as picking staff from the ground or packing things around the house. I still want to be useful and be treated as such, especially by my own children.”

Adult 11, a divorced single mother argued that her eighteen-year-old daughter does not have respect for her. She just goes out for parties with friends without seeking her permission. If she tries to discipline her daughter, discuss how things ought to run in their house, she bangs the door and leaves.

The findings of the study point out that the attitudes of specific family members are critical in the general wellbeing and health of adults with physical disabilities. Family perceptions towards adults with disabilities were amongst the major challenges that they face. Participants indicated that they need to be respected and viewed as normal human beings who can adequately perform their duties. Disability is perceived differently by various people grounded on their socio-economic status. Idres and Ilyas (2012) held the view that historically, individuals with disabilities have been confronted with not only mental or physical impediments of their disability, but also with social stigma and discrimination. The findings also established that despite disability, persons still yearn to be perceived and treated as useful in society. Fathers still want their families to view them as men who are able to perform their fatherly

roles and activities that are considered manly despite their disability. Despite their disability, mothers expect respect and obedience from their own children. From the participants' responses, the researcher extracted that adults with disabilities also have a need to be respected in their respective families.

4.4.2 Sub-theme: Marriageability

Three participants pointed out how their extended families regard them as people who do not deserve to be married due to their disability. The participants felt that these views were very discouraging as they are perceived as useless.

The findings revealed that some relatives are resistant to get married. This implies that they would not be able to fulfil their obligations and tasks as wives and mothers because they are wheelchair-bound. In laws are doubtful whether their daughters with disabilities will be able to bear children. Participants argued that their parents are asked questions of child-bearing during lobola payments. The findings also established that families advice adults with physical disabilities not to marry, but to spend their time in doors as people will expect a lot of responsibilities from them if they marry. This is supported by the sentiments from Adult 10, a married male:

“My parents whispered in my ear during lobola negotiations if my wife to be will be able to bear children as she was also paraplegic”

Adult 1, a partially blind single woman indicated that her grandparents always pass sentiments that they hope she will find someone who will marry her despite the fact that she has to use her hands to sense what she has touched and to draw documents closer to her eyes for her to be able to read. To the grandparents, this means that the participant's disability might disqualify her from getting married, let alone finding a good man.

These sentiments are actually supported by Enns (2008), who alluded to the fact that a disabled woman is frequently not considered suitable for marriage by her family. They mostly cannot fulfil the common roles in the field and at home. From these views, the researcher assessed that the society has different misconceptions towards persons with disabilities. The findings elaborated that nuclear families and extended families are questionable about the marriageability of women in the sense of whether or not they will be able to manage the roles of being wives and mothers.

According to the findings, people with disabilities, especially women, are not fit to be married.

4.4.3 Sub-theme: Donors' perceptions towards physically disabled adults

Participants conveyed how donors view adults with disabilities as objects of pity. The respondents forwarded their complaints of how donors perceive them as people who are incapable of achieving anything substantial in their lives like their able-bodied counterparts.

Adult 9, a divorced female reported that well-wishers who once came at the organisation with donations alluded that "How can this woman achieve anything in life when she cannot even push herself well in a wheelchair. Shame, that will be her kind of life."

Participants also described that they are not happy with some of the resources they are given by donors. According to them, it makes them feel as if they are children who cannot rationalise on their own. Participants particularly described donated items such as colouring books, puzzles and toys as the major resources that they are not fond of. They said to them, it conveys a message of inability, incapability and being labelled as children.

The findings illustrated that adults at Kukura Neshungu Institute are not fond of some of the donations distributed at the organisation, such as colouring books, toys and puzzles. The issues stemmed from the donations that are being given to adults with disabilities. They proclaimed that they are too old to be seen colouring and doing puzzles. To them, it means they are being undermined by reason of their disabilities and being perceived as people who cannot engage in anything profitable with their lives. The findings are in line with Seale (2006), who is of the view that the charity model explains that persons with disabilities are seen as stranded, miserable and dependent on other people for maintenance and safety, contributing to the conservation stereotypes and misunderstandings about disabled persons. The charity model does not consider disabled peoples' knowledge and experience as necessarily valuable and essential.

4.4.4 Sub-theme: Community's perceptions towards adults with disabilities

Participants showed emotional pain as they described how persons with disabilities are viewed and treated by the very communities they live in. They identified community's perceptions towards physically disabled adults as some of the major challenges that they encounter. Adult 1 echoed that:

- *“Ndave ndiine zviitiko zvakaipa nevanhu kunyanya pandinopinda munzvimbo dzepaguru dzakadai sedzimba dzezvitoro. Nokuda kwemaziso angu asinganatsooni ndinoomerwa kuti ndione zvakajeka zviduku zviduku zvinyorwa pazvinhu saka naizvozvo kunyanya ndinofanira kubata chigadzirwa uye kutarisa zvakanyanya kana kukotama pamusoro peheferi kuti ndiongorore mutengo wakanyorwa. Vanhu vaizonzwira tsitsi ini, vamwe vaizoreva mazwi anokuvadza akadai se 'kunyadziswa' uye kungondipfuura. Uye vamwe muzviitiko zviduku vanomira vaondiudza mutengo wakanyorwa asi kazhinji ndinonzwa tsitsi mukutaura kwavo kwezwi uye mufambiro.”*
(single, 23 year old female)

“I have had bad experiences with people, especially when I go to public places such as shopping malls. Because of my poor eyesight, I struggle to clearly see the small lettered prices on items. Hence mostly I have to grab the product and look closely or bend over the shelf to check the price at a very close range. People would pity me, some would utter hurtful words such as 'shame' and just pass me by. And some in very minor cases would stop and tell me the written price but mostly I sense pity in their tone of voice and behaviour.”

In revealing the community's perceptions of adults with physical disabilities, Adult 7, a single male explained that he was at a taxi rank with his walking stick. Two women jumped to grab his stick and sat him on a seat. He revealed that the women just assumed that he needed help without asking him first.

The study also found that businesses which are pioneered by adults with disabilities are not supported. Participants described being demotivated and demoralised by most community members who said that they should just go home and rest as they assumed that persons with disabilities would not manage running successful businesses. Participants complained of community members who conclude that

adults with disabilities cannot run a successful business due to the disability. The study further found that participants are viewed by the society as draining and not worthy of any special attention. They are marginalised and isolated. As described by the respondents, this is stressful and emotionally straining.

Enn (2008) supports the sentiments of the above respondents that physically disabled adults are viewed as objects of pity. The understanding of the society is that people with disabilities are ill, helpless and require to be taken care of. The experiences of disabled persons are buttressed by social attitudes that strengthen their inactiveness and dependency. In this regard, the charity model claims that persons with disabilities are sufferers of situations who should be sympathised with (Retief & Letsosa, 2018). The study observed that disability often leads to rejection and isolation. This can be exacerbated by communities' attitudes perceiving adults with disabilities as abnormal, and as people who cannot perform functions as able-bodied people. They are perceived as sick, stranded and persons who need care.

4.5 THEME: ACCESSIBILITY BARRIERS

Amongst the major challenges faced by adults with physical disabilities are accessibility barriers. They ranged from education, transportation and health. Educational, transportation and health barriers are presented below as sub themes.

4.5.1 Sub-theme: Educational barriers

Participants mostly complained about the ramps which do not adhere to the proper design of wheelchair ramps in terms of the size and gradient. In areas where ramps are available, they reported that they are either too steep or too narrow for a wheelchair to move freely.

Adult 18 stated that, "I struggle to go to the local supermarkets and salon due to the fact that my wheelchair cannot climb the steep ramps. I always request for assistance when I arrive there." (single, 24 year old female).

On educational barriers, Adult 3, a single female explained that there are very steep ramps in the school that he used to attend to in such a way that at most times, the wheelchair will drive itself backwards. He further said that there are no ramps in some areas in the school. Furthermore, participants revealed finding it hard to find a

suitable school with facilities which can cater for their unique and special needs. The local high schools that they have been to for enrolment do not have ramps for their wheelchairs to move around. The classroom facilities and major offices around the school are built with staircases, hence it was a major setback in terms of accessibility to enrol with such schools. Many participants indicated that they resorted to dropping out of school. The partially blind participants illustrated that they struggled with study material for their courses as the material was not brailled to meet their unique needs.

These views are backed by Chiwandire and Vincent (2017), who stated that poorly designed physical settings exclude individuals with disabilities from contributing in mainstream society. Lack of brailled material was raised as a major concern that impedes the smooth studying of academic material. Chiwandire and Vincent (2017) affirmed this perspective by elaborating that lack of braille resources deter and restrict participation among people with disabilities in the school sector.

4.5.2 Sub-theme: Transportation barriers

Participants reported that they are unable to find employment, health care and education because of transport barriers. The design of public transport made it impossible for a wheelchair to enter, let alone to fit inside taxis and buses. Participants also reported giving up on schooling at Marondera High School due to lack of transport designed for disable persons. Families cannot afford to buy a private car, hence they opted for Kukura Neshungu Institute, which is closer to their homes where they can be accompanied daily on foot. The findings also revealed that participants were missing interview appointments because of lack of suitable public transport for persons with disabilities. Adult 10 described how he actually lost a job opportunity due to transportation related barriers. More so, the participant revealed that the company could not do an interview with him telephonically; thus he ended up losing an opportunity to get the job.

Participants argued that transport for the public in Zimbabwe is unsafe or accessible to them as persons who are living with disabilities, and has robbed them the right to live autonomous lives. They reported being locked in at home or just at the institution because there is no suitable transport for them to make choices of where they want to travel or visit. Transport barriers were described to be frustrating by participants.

“It is very unfair to us as people living with disabilities and using assistive devices such as wheelchairs. We have a right to access any place including public transport because we also have important places to go to daily”. (married, 43 year old male)

The findings portrayed that transport barriers make it difficult for adults with disabilities to move from one point to another. Unsafe and inaccessible transport is described as one of the explanations persons with disabilities are disadvantaged in Zimbabwe. Bascom and Christensen (2017) confirm these findings as he described that access to transportation is crucial for gaining employment, healthcare, social interaction and health care. People who face problems in gaining access are described as transportation disadvantaged, and involve individuals of lesser socioeconomic status, aging persons, and people with disabilities. The study established that many adults with disabilities feel that the level of their access to transportation has inhibited their social life. The responses indicated that adults with physical disabilities who use wheelchairs faced transportation related exclusion. The majority of participants had to miss important appointments due to transport accessibility barriers. As supported by Bascom and Christensen (2017), many adults with physical disabilities felt that their social life was disadvantaged by their level of access to transportation.

4.5.3 Sub-theme: Health barriers

When asked about how they cope with health challenges, most respondents mentioned the use of third parties assisting them to cope. In clinics where ramps are available, participants emphasised that they are not properly designed, hence they would still need other people for assistance. Adult 17, a single female stated that every time she goes to the clinic, she is accompanied by her brother so that he can help her balance the wheelchair up and down the steep and narrow ramps. Here is what she said:

“I am very lucky to have a brother with a kind heart who accompanies me to the clinic on every check-up. I don’t know how I was going to climb those steep ramps”

Places where medication is collected in hospitals and clinics were reported to have staircases. The participants described having to use third parties such as family members or neighbours to help them to lift their wheelchairs. Participants view

themselves in such instances as being burdens to their families and neighbours. Adult 1 also described asking people sitting next to her to confirm if she was given the correct medication as indicated in her prescription. She said that the prescription was written in too small letters for her to read.

Hanass, Regondi and Naidoo (2013) affirm these findings, arguing that the way in which indoor and outdoor facilities are structured can prevent individuals with disabilities from going to hospitals, clinics, schools and shopping centres, and getting access to police services and maintaining jobs. Places of recreation such as parks, footpaths and public transportation may also be unreachable, hindering some individuals with disabilities from embracing the most essential fundamentals of participation in social life.

4.6 THEME: TRADITIONAL MEDICINE

Twelve participants stated that they relied on traditional help to cope with the physical pain, stress and frustrations that come with being an adult with a physical disability. One participant described how her back gives her a problem a lot because it was largely strained due to an accident that she had. Whenever she finds it difficult to cope with the pain, her family mixes herbs that they were given by a traditional healer. Though she stated that she does not entirely get well, she did say that she does get better.

The findings established that participants develop sores as a result of always sitting on the wheelchair. This is caused by the pressure and friction of sitting in one position. In order to cope with this, they indicated that they use muti given to them by a sangoma. The muti, according to the participants, dries up the sores for a while.

Adult 12, a single male mentioned that his parents and some of their extended relatives brew beer and slaughter cows to appease the ancestors. He described it to be a way of guarding against evil spirits who might worsen his hemiplegic condition. Adult 12 mentioned that, "It is our culture to please the ancestors by brewing beer so that I am preserved at all times and for my hemiplegia not to get worse"

The study established that relatives who also happen to be traditional healers prepare herbs for adults with disabilities to rub on their bodies in the morning and in the evening in order to lessen the bone marrow pains. Others are given chains to

wrap around their waists by traditional healers. This is done as protection against further attacks that may worsen the disability or cause death.

The study revealed that participants cope with the pains and emotional strains of disability through traditional means. Bunning, Gona, Newton and Hartley (2017) confirm these findings as they explained that people seek traditional help to cope with health challenges as they believe the disability to have happened due to supernatural forces, unexplained events, evil spirits and curses from family members.

4.7 THEME: WESTERN MEDICINE

Some participants described how they rely on western medicine, that is, medication that they are given at clinics and hospitals to cope with health constraints. They indicated that the consistent use of the medication prescribed by their doctors has helped them cope with physical pain. Adult 4 actually revealed that he simply follows instructions he is given at the hospital and take pills regularly. In this way, he said he finds it relieving the pain on his spinal cord.

The study found that participants are given a change of medication if their current medication is no longer effective. This finding elaborates the participants' belief in western medication. One participant said the following:

- *“Ndinovimba kuti vana chiremba vanoziwa basa ravo. Mishonga yavo inondibatsira zvikuru.”* (single, 30 year old male).

“I believe the doctors know what they are doing. I trust the medications I am given, and I find them useful.”

The participants had no doubt that the medication made them whole. Others indicated that they make use of psychologists to vent out their fears and stress to a total stranger. Participants explained that the services of psychologists help them to cope as adults living with physical infirmities. The outcomes of the study show that participants are able to cope with health challenges using what they termed western medicine. They argued that it has been working for them by simply following what the doctors would have prescribed and instructed.

4.8 THEME: CULTURAL BELIEFS TOWARDS DISABILITY

The participants discussed different cultural beliefs that people have towards adults with physical disabilities. On this theme, four sub-themes emerged, which are families' beliefs on the causes of disability, the community's beliefs on the causes of disability, individual's beliefs on the causes of disability and the families' beliefs about a cure of disabilities.

4.8.1 Sub-theme: Families' beliefs on the causes of disability

Participants voiced out both constructive and deconstructive beliefs that families hold towards the causes of disability. Adult 9 mentioned that she was born with limbs that cannot walk. She grew up hearing from the relatives from her father's side that her late mother was being punished by God as she used to be a prostitute whilst growing up, hence her disability. The participant stated that her mother was using prostitution as a means of getting money as she was an orphan and had no one to help her make ends meet.

The study also unearthed families who believe that disability is due to generational curses. They believe that it is a bad omen that attacks their families. Others attach disability to witchcraft and punishment for wrong doings, such as extra marital affairs by their parents. However, participants stated that some of their families were of the view that disability is a consequence of natural causes and the will of God.

Ndlovu (2016) agrees with the findings of the study, arguing that some African beliefs promote the stigmatisation and marginalisation of people with disabilities through exclusion and depiction of them as objects of pity or ridicule, and as victims of evil forces. He went on to state that other African philosophies instil constructive and compassionate ethical and moral teaching aimed at shielding and empowering those living with disabilities by portraying them as full human beings who have similar rights, responsibilities and duties as normal persons.

4.8.2 Sub-theme: The community's beliefs about the causes of disability

The respondents argued that the communities they live in believe that they were bewitched and that God was punishing them or their parents for sins. Terrible road accidents were attached to witchcraft or bad spirits circulating in families. In support of this a married, 45 year old male said:

- *“Ndakapinda mutsaona yakaipa zvikuru mugore ra2017, vandinogarisana navo vanoti ndakaroiwa. Hapana anoziva kuti tsaona yacho yakakonzereswa nei. Kana ini handitozive kuti chii chakanyatsoitika. Ndinongorangira ruzha rwakaitwa nemavhiri emota.”*

“I had a terrible car accident in 2017 and my neighbours and community members attach that accident to witchcraft. No one could establish how the accident happened. Even myself I don't really recall what happened, everything happened so fast. I only remember hearing huge noises of the screeching of the tyres.

The findings established that community members do not want to associate themselves with houses where persons with disabilities live. The participants revealed that communities are of the view that they are cursed; hence they do not even want to step their feet in the yard where a person with a disability lives lest they also bear children who are disabled.

The findings of the study agree with Zhou's (2016) study that there are cultural beliefs that view disability as a consequence of witchcraft, penalty of sins committed in the past or bad luck to the household; and that individuals with physical disabilities are face a number of difficulties in their day to day lives due to cultural beliefs concerning disabilities in their communities.

4.8.3 Sub-theme: Individual's beliefs about the causes of their disabilities

Participants voiced out different opinions about the beliefs that they carry towards what caused their disabilities. Their responses ranged from natural causes, witchcraft, accidents and diseases. Adult 10, a married man stated that he knows what put him in a wheelchair. He indicated that he was drunk driving one night because of a lot of stress and pressure at work, and then had a terrible accident. He had important presentations to prepare for investors who were coming from neighbouring countries. He described that all he remembers is waking up in intensive care unit and was told that he would not be able to walk again.

According to the participants, witchcraft, diseases, curses and the will of God were major causes of their disabilities. Other participants attributed disability and poverty in their families to generational curses. The participants ascribed their disabilities to various reasons according to their own understanding and beliefs. These outcomes

connect with a research done in Kenya, where respondents described the causes of their disability as illnesses, accidents, natural causes, witchcraft, aging and traditional causes (Monk & Wee, 2008).

4.8.4 Sub-theme: Families beliefs about a cure of a disability

Participants mentioned various descriptions about their families' beliefs towards a cure of disabilities. Some participants highlighted that they have adopted those beliefs to cope with health challenges that they face as adults living with physical disabilities. They identified religious, medical and traditional beliefs towards a cure of disabilities.

Adult 11 elaborated that her and her family believes that medical practitioners will come up with cure of paralysis so that she will be able to properly walk again. She stated that, "I strongly believe that my answer of recovery will come from medical practitioners; experiments are happening daily. Surely one day, God will hear us". She further indicated that they are putting their hopes on medical advancement to find a cure. Beliefs in prophetic ministries were also mentioned by the participants. They talked of seeing people come out of wheelchairs on televised sermons. Some participants revealed that they are actually seeking donations to visit those esteemed men of God in neighbouring countries.

However, other families put their faith for the cure of disability on traditional healers. Families seek for information of the best traditional healers in Zimbabwe. They are willing to pay the price for their disabled members to find a cure. The unwavering beliefs of families in traditional healers stemmed from the fact that these healers, according to the families, were able to identify the root cause of the disability. To the families, if the traditional healers can identify the source of the problem, then they can successfully effect a solution.

Other participants purported that their families did not believe in finding a cure for disability as they awarded the disability to God's will. They stated that no man or medication can help them unless God decides it. The disability was also attributed to natural causes, hence participants indicated that there is no reason of finding a cure. It happened by nature.

Participants described families' beliefs about the cure of their disabilities ranging from medical, traditional and religious means. Dillenburger, McKerr and Ireland (2014) agree with these findings, arguing that families look for a cure for disability for the sake of their loved ones. They spend a lot of money either on Western or African medicine for their members to get completely healed.

4.9 THEME: ATTITUDES TOWARDS ADULTS WITH PHYSICAL DISABILITIES

Attitudes towards adults with physical disabilities ranged from positive and negative ones. Participants highlighted attitudes from their communities and the people that surround them.

4.9.1 Sub-theme: Communities attitude towards adults with physical disabilities

Participants were of the view that the communities that they are from disable them even more due to their negative attitudes and lack of support. The participants revealed that they are viewed as contagious, hence people would not want to associate themselves with them because they are disabled. They described the communities' attitude towards persons with disabilities as one of the aspects that reveal stigma and discrimination.

For instance, the participants indicated that when they are doing shopping in public places, they would literally see people change the till points that they will be using to the next ones. Others would be distancing themselves, not wanting their bodies to come in contact by mistake with persons with disabilities. Other participants reported of fellow students not wanting to sit next to them because they were warned by their fathers and mothers that disability is contagious.

Here is an experience described by Adult 18, a single female:

- *“Vanhu havadi kutenga madomasi kana hanyanisi yandinenge ndabata vachiti mweya wakaipa unokonzeresa hurema hunozobatirira pavari.”*

“If I go to the market to buy tomatoes and onions, people would not want to choose the ones I would have touched or come in contact with and not buy them. They believe disability is caused by an evil spirit, hence they suppose if they come in contact with anything, I would have touched or used, disability will also rub on to them”.

Barnes and Mercer (2010) complements the findings of the study, arguing that persons with disabilities are viewed as contagious by communities, which makes people not want to associate themselves with them. Society usually perceives the disabled as “less than human”. This means that they are not hurt the way other individuals do. They do not have the same prerequisites, needs or state of mind and thus are not eligible to equal rights and respect as individuals living without disabilities. As a matter of fact, the child or adult with disability is oppressed and secluded and their households are often demonised and marginalised. To conclude, the individual is often observed as an object which may be mistreated or even demoralised. Hence, what is a biological discrepancy or challenge turns into an undesirable social construct. Barnes and Mercer (2010) affirm the findings of the study.

4.10 THEME: DAILY ACTIVITIES

The participants highlighted some of the major challenges that they face as adults with physical disabilities in relation to daily activities that they do at Kukura Neshungu Institute. They raised challenges that they face in relation to gardening activities. It is discussed below as a sub theme:

4.10.1 Sub-theme: Gardening

Participants raised issues and complaints about beds that they use for gardening as well as the tools. Adults with disabilities who use wheelchairs indicated that the vegetable beds are too low for them. Some are too high, hence they have to bend or stretch too much, and end up straining their backs. They also stated that some of the garden tools that they use are too heavy in terms of strengths of their arms.

The participants described having a challenge of back aches. This happens whenever they come back from gardening. They stated that the garden beds are too low for them and they strain themselves further by bending too much. Other participants revealed that there is no sufficient space in between the rows of the beds for the wheelchair to move freely from one vegetable bed to the next.

Garden tools were also mentioned as too heavy for adults with physical disabilities. The participants indicated that the garden tools that they use were not designed for

persons with disabilities. In coping with the use of heavy garden tools, the participants described using both hands to balance tools such as garden forks because they are too heavy for one hand. From this standpoint, the participants suggested that the organisation needs to take their unique body measurements so that the garden beds can be designed to suit their varied needs.

Turner and Henryks (2012) agree with the findings of the study, and highlights that the health of persons with disabilities is a major consideration when we bear in mind the benefits of community gardens. From the participants' responses, it was clear that their health is of paramount importance when considering the establishment of gardens for them to work on.

4.11 CONCLUSION

The chapter presented the outcomes of the research according to the direct responses of the study participants. The chapter revealed experiences of adults with physical disabilities at Kukura Neshungu Institute. Chapter 5 will highlight the recommendations as well the conclusions of the study.

CHAPTER 5

SUMMARY OF FINDINGS,

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The aim of the chapter was to give an overview of the study, which explored experiences of adults with physical disabilities at Kukura Neshungu Institute in Marondera, Zimbabwe. This chapter also discussed conclusions drawn from the findings of the study. Recommendations and areas which need further research were also discussed. The chapter explained in what way the research reached the aim and objectives of the study. It is in this chapter that the researcher also revealed how the objectives were realised by stressing the chief outcomes of the study.

5.2 RE-STATEMENT OF THE PROBLEM

Individuals with disabilities face bodily, environmental and social obstacles that impede their access to amenities or work opportunities and avert them from relishing their liberties. The structure and assembly of indoor and outdoor facilities can prevent them from going to school and hospitals, shopping, gaining access to police services and finding or keeping jobs. Recreational facilities such as footpaths, parks and public transportation may also be inaccessible, preventing some individuals with disabilities from enjoying the most basic fundamentals of participation in social life. Hence, this study explores various experiences that adults with physical disabilities encounter in their day to day lives (Hanass, Regondi & Naidoo, 2013).

Stigma and discrimination is evident in virtually all facets of the lives of individuals with disabilities. In most cases, they face difficulties in attaining education compared to their able-bodied counterparts. This stems from prejudiced practices that have mostly looked down upon the disabled. In a research carried out by Hanafin, Shevlin, Kenny and McNeela (2007), responses from participants indicated that they encountered access difficulties at every level in their college life, especially physical access. Hanass, Regondi and Naidoo (2013) argue that persons with physical disabilities may only be able to access a portion of the accommodation that individuals without disabilities may access, which evidently depicts discrimination a phenomenon at the centre discussion of the social model of disability (Altman, 2010).

Munsaka and Charnley (2013) argue that physically disabled adults have slim access to sexual and reproductive learning and general health materials. They usually lack family planning information and access. Thus, they have many children, who they must look after in spite of their financial challenges. Some clinics are not

easily reachable, and others are very expensive (Baart & Taaka, 2017). There are no readily accessible resources in Braille for the blind. Some disabled individuals suffer sexual and physical abuse. When the abuse gets to be discovered, it would be too late to access the appropriate intervention and cure (Rugoho & Maphosa, 2015).

Cultural practices and beliefs have also played a major part in making the life of the disabled terrifying. Apart from being rejected, they may be slayed at infant level as they are considered a bad omen. Spouses who bear children with disabilities have separated or divorced because of such births. Either the husband divorces the wife, or the woman forsakes home leaving the child with the father. In Tanzania albinos are being slaughtered for rituals (Choruma, 2007). As a result, the study explores experiences of adults with physical disabilities at Kukura Neshungu Institute.

5.3 RE-STATEMENT OF THE AIM OF THE STUDY

The aim of the study was to explore experiences of adults with physical disabilities at Kukura Neshungu Institute.

5.4 SUMMARY OF THE MAJOR FINDINGS OF THE STUDY AS PER EACH OBJECTIVE

Objective 1: To identify major challenges faced by adults with physical disabilities

The major challenges faced by physical disabled adults were successfully identified. They were discussed in section 2.8.3 of chapter 2 under literature review. Furthermore, the participants described the major challenges that they face as adults living with physical disabilities. The 20 participants who formed part of the study identified challenges that they face in their daily lives outside Kukura Neshungu Institute as well as the ones they face at the Centre. They highlighted issues that they considered as pressing. Amongst the challenges were stigma and discrimination, accessibility barriers and cultural constraints. In this way, the objective to identify the major challenges faced by adults with physical disabilities was met.

Objective 2: To establish the accessibility barriers faced by adults with physical disabilities in attaining education

The study established accessibility obstacles met by adults with physical disabilities in attaining education, hence the objective was met. Chapter 2 elaborated that The Education Act 1987 of Zimbabwe includes the right of persons with disabilities to attain education. However, through the face to face interviews done in this study, it is clear that the Act is mostly effective on paper and not much in practice. The participants argued that failing to enroll in higher education is due to the education environment that is inaccessible to them. In addition, negative attitudes and discrimination in the education sector were also discussed.

Objective 3: To assess how adults with disabilities cope with health challenges

The study managed to examine how adults with disabilities cope with health challenges. Hence, the objective to assess how adults with disabilities cope with health challenges was achieved. Research participants described their reliance on traditional and western medicine as a means of coping with health challenges. Both traditional and western ways were described as useful. Apart from this, the participants identified local clinics and hospitals as some of the places without wheelchair accessibility. Presented with this barrier, the participants stated that they would make use of third parties such as family members or neighbours to assist them to move wheelchairs in times of checkups and medical visitations. The participants depend on family members and at times neighbours and friends as a means to cope with health challenges.

Objective 4: To evaluate the cultural and traditional prejudices of adults with physical disabilities

The cultural and traditional prejudices that adults with physical disabilities encounter were identified and evaluated, hence this objective was met. The participants explained their families' beliefs about the causes of disability, the communities' beliefs about the causes of disability, their own beliefs of the causes of disability and the families' beliefs about the cure of disabilities. Hence through their sentiments and descriptions, cultural and traditional prejudices towards disability were unfolded.

Objective 5: To assess the stigma and discrimination faced by physically disabled adults

The research participants described during the face to face interviews how they encounter stigma and discrimination in their lives due to their disability. The findings revealed that adults with disabilities are viewed as inadequate and not good enough to do the same things that are also done with people that are considered normal. The participants described how they face discrimination in areas such as education, business and in their communities. Thus, the objective to assess the stigma and discrimination faced by physically disabled adults was successfully met.

5.5 CONCLUSIONS AS PER EACH FINDING OF THE STUDY

The study successfully explored experiences of adults with physical disabilities at Kukura Neshungu Institute. The face to face interviews revealed in-depth what it is to be physically disabled as an adult. Grounded on the study results, the researcher concludes that experiences of adults with physical disabilities are mostly undesirable and hinder them from having a fulfilling social life. However, with the necessary interventions and awareness, these undesirable experiences can be turned around to work in the best interests of adults with physical disabilities. A number of findings were discussed in the study. These findings revealed the overall experiences of adults with physical disabilities at Kukura Neshungu Institute. The conclusions of the study as per each finding are discussed in detail below.

5.5.1 Social stigma and discrimination

Social stigma and discrimination were found to impede the lives of adults with physical disabilities at Kukura Neshungu Institute. This affects their social, economic and educational life. The communities that the adults with physical disabilities are from lack awareness and knowledge of how persons with disabilities are also able to lead productive lives despite their disability. Not only are the communities that surround adults with disabilities ill-informed about disabilities, even their close families. Hence from this standpoint, micro and macro interventions are needed for effective change to prevail.

5.5.2 Accessibility barriers

The social model of disability postulates that persons with disabilities are only disabled in the absence of resources that make them to function effectively. For instance, a wheelchair user is considered disabled only when there are no ramps for the wheelchair. From this perspective, participants described accessibility barriers to

their education attainment, transport access and health due to lack or inadequate resources. How transport barriers hinder the lives of adults with disabilities in Zimbabwe has been described in-depth.

Despite successive government efforts since the country obtained independence in Zimbabwe in 1980 to offer discrimination security to individuals living with disabilities and to make sure that they are not exposed to discrimination under any life activity, persons living with disabilities are still encountering barriers when they try to use public transportation systems. The rights of persons with disabilities are specified in the Disabled Persons Act 1996. Though sturdy and favourable in formulations, it has a slight, if any effect on the ground. The researcher discovered that there are educational institutions that do describe that they accommodate persons with disabilities on their premises as well as systems. But that will not be the situation on the ground. The facilities and the school community itself will be disability unfriendly, thereby acting as a major hindrance for adults with disabilities to pursue and realise their dreams.

5.5.3 Coping mechanisms of health challenges

Participants revealed their coping mechanisms of health challenges from different standpoints. Others stated that they trust in traditional practices and traditional medication in coping with the pain, frustrations and stress that come with being an adult with a physical disability. Others argued that they bank on western medication prescribed and provided for by medical practitioners. These opposing traits were a result of participants' varied beliefs, practices and upbringing.

5.5.4 Cultural beliefs

There are cultural practices that perpetrate emotional abuse as adults with disabilities are often told that they are bewitched, cursed, or carry a bad omen or unlucky. They tread through life with these damaging perceptions of who their

families, communities even themselves say they are. The cultural beliefs of participants and their experiences as a result of different cultures and practices stemmed from their families' beliefs about the causes of disability, adults with disabilities' beliefs about the roots of their disability as well as the families' beliefs about the cure of disability. From the participants' responses that they gave during the interviews, their experiences with culture and tradition as adults with physical disabilities were realised.

5.5.5 Attitudes towards adults with disabilities

The attitudes that physically disabled adults encounter from external forces were found to be mostly negative. Parents with disabilities would also want to be respected by their children, but some participants reported otherwise. The communities at large also have a lot of misgivings when it comes to treating adults with physical disabilities.

5.5.6 Gardening activity

Participants described the challenges they face on one of the activities they do at the centre, which is gardening. They described how the garden beds and the tools are not disability friendly. The respondents stated that the garden beds are either too high or too low for them and the tools are too heavy for them to handle.

5.6 FROM EACH CONCLUSION, THE RESEARCHER RECOMMENDS THE FOLLOWING:

5.7 Social stigma and discrimination

On the conclusion of social stigma and discrimination, the following recommendations were formulated.

5.7.1 Assistance and Support

The social stigma, discrimination and negative attitudes encroached on adults with physical disabilities at Kukura Neshungu Institute need to be thwarted by assistance and support from the very same sources where they are stemming from, that is, family members that surround them as well as communities in which they live. Individuals with disabilities require support and care to attain a decent livelihood and so as to contribute completely in every aspect of life like any other citizen. For most adults with disabilities, help and care are essentials in society. The lack of adequate sustenance services can cause persons with disabilities to be extremely reliant on family members, and can inhibit both the person with disability and family members from becoming economically sustained and socially included. Assistance and support are also a way of preserving dignity of physically disabled adults as well as empowering one's independence and social inclusion. Rectifying the effects of discrimination and segregation is going to be essential if persons with physical disabilities are to enjoy their rights and get the same prospects.

5.7.2 Extensively involving and consulting adults with physical disabilities

Physically disabled adults need to be involved and consulted on involvements that target them and in other overall issues. Adults with disabilities need to be supported in every venture they embark on in their communities such as starting a business. Well reputable and successful adults with disabilities need to take part in sensitisation programmes so that the belief that adults with disabilities are useless and insignificant will weaken. This will also assist adults with disabilities themselves who require constructive role models. Access costs need to form part of programme budgets to certify that individuals with disabilities are not omitted on the grounds of their impairment.

5.7.3 Specifying the donations needed for adults with physical disabilities

The participants mentioned something on how they do not welcome some of the donations they are given. From this finding, specifying the donations needed for adults with physical disabilities was recommended.

From the interviews conducted with adults with physical disabilities, information was revealed of how they are not thrilled with some of the donations that are distributed at the organisation. The Institute may engage in creating a website whereby they specify the resources that they need from donors that adults with physical disabilities need to enhance their functioning. The management of the institution may also come together with adults with disabilities to discuss the resources that they need and how they will assist or build them. They can also tap into investigating individual talents and gifts of adults with disabilities at Kukura Neshungu Institute, which may further inform them of the services and resources to introduce and embark on at the centre.

5.8 Accessibility barriers

On accessibility barriers that included education, transportation and health barriers, the following recommendations were formulated:

5.8.1 Supervision and monitoring of schools which accept persons with disabilities

The Department of Education in Zimbabwe nationally and locally needs to work in partnership with other government departments to check and follow up if the schools which accept persons with disabilities are really fit to accommodate them in terms of the necessary resources and services adequate for them. If not, funds need to be distributed for appropriate renovations and establishments that suit persons with disabilities.

5.8.2 Transport for persons with physical disabilities

Local government departments and other stakeholders and role players need to advocate for the availability of specific vehicles designed for persons with physical disabilities. Buses and taxis can be bought with built in ramps for wheelchair users. With that being put into effect, adults with disabilities can obtain self-sufficiency and independence in every sphere of their lives.

5.8.3 Garden beds to be made with body specifications of adults with disabilities

The management of Kukura Neshungu Institute can collaborate with builders to make garden beds and paths for adults with disabilities according to the size of the

wheelchairs, height of the adult and level of ability to perform. For those with strenuous backs, their beds can be made a little bit higher so that they avoid bending a lot. Gardening equipment and tools can be modified to suit adults with disabilities. Gardens can also be landscaped so that the garden beds are easily accessible and safe.

5.9 Cultural beliefs and Attitudes towards adults with physical disabilities

On cultural beliefs that impede the effective living of adults with physical disabilities and the negative attitudes that they face, the following recommendations were formulated:

5.9.1 Awareness

An important aspect is that any plan that tries to shift the perceptions regarding disability must be established considering ethnic and traditional prejudices of disabilities. From this perspective, social workers, in association with other stakeholders, must be involved in this venture. Information educational campaigns should address solid traditional opinions that persons with disabilities have bad omen, are unlucky, are bewitched and cursed. However, this ought to be handled without disregarding beliefs from tradition so that it is reinforced in all areas. Education and health programmes need to frame the idea of disability in a constructive way that echoes with people's cultural beliefs and traditional values. Awareness of disability ought to be effected in every societal endeavour.

5.9.2 Mobilising support groups

The study established that adults with disabilities reside inside philosophies that have harmful discernments and opinions of disability. It is of paramount importance to broaden counselling programmes and social groups for persons with disabilities to assist them to cope. Numerous traditional insights concerning disabilities acknowledged in the study have a part of humiliation and guiltiness. Several people note impairment as a chastisement for wrong doings, leaving persons living with disabilities stigmatised and rejected. These insights can make it hard for individuals with disabilities and their households to cultivate constructive self-confidence and self-esteem, hence the need for these targeted support programmes.

5.10 Further study

This study can be more developed by either being presented at conferences for Social Sciences, and may also be published in recommended journals as a way of disseminating findings and knowledge. In summary, the study of adults with disabilities leaves more room to be studied from a different angle that can still bring insight and development towards persons living with disabilities.

6. REFERENCES

Abbasi, F., & Fardkhani, S. K. (2014). Paraplegia caused by infectious agents; etiology, diagnosis and management. In *Topics in Paraplegia*. IntechOpen.

- Abrams, L. S. (2010). Sampling hard to reach populations in qualitative research: The case of incarcerated youth. *Qualitative Social Work*, 9(4), 536-550.
- Aiden, H., & McCarthy, A. (2014). Current attitudes towards disabled people. *Scope*, UK. *Forskel ADHD-døv: 0,522 (< 0, 0001) Forskel kørestol-døv: 0,541 (< 0, 0001)*.
- Akaranga, S. I., & Makau, B. K. (2016). The hermeneutics of education management information systems for Kitinga Primary School in Mwingi Central-Kenya. *Journal of Education and Practice*, 7(35), 36-40.
- Alhojailan, M. I. (2012). Thematic analysis: A critical review of its process and evaluation. *West East Journal of Social Sciences*, 1(1), 39-47.
- Alshenqeeti, H. (2014). Interviewing as a data collection method: A critical review. *English Linguistics Research*, 3(1), 39.
- Altman, B.M. (2010). *Disability definitions, models, classification schemes, and applications*. In *Handbook of Disability Studies*, Albrecht GL., Seelman K.D., & Bury M (eds). California: Sage.
- Alvi, M. (2016). *A manual for selecting sampling techniques in research*.
- Anastasiou, D., & Kauffman, J. M. (2013). The social model of disability: Dichotomy between impairment and disability. *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine* 38 (4), 441-459).
- Anderson, D. W. (2013). *Reaching out and bringing In: Ministry to and with persons with disabilities*. WestBowPress.
- Areheart, B. A. (2008). When disability isn't just right: the entrenchment of the medical model of disability and the goldilocks dilemma. *Ind. LJ*, 83, 181.
- Baart, J., & Taaka, F. (2017). Barriers to healthcare services for people with disabilities in developing countries: A literature review. *Disability, CBR & Inclusive Development*, 28(4), 26-40.
- Barnes, C., & Mercer, G. (2010). *Exploring disability*. Polity.

- Bascom, G. W., & Christensen, K. M. (2017). The impacts of limited transportation access on persons with disabilities' social participation. *Journal of Transport & Health*, 7, 227-234.
- Bath A.P, (2008). Health informatics: Current issues and challenges. *Journal of Information Science*, 34(4), 502–518.
- Berg, B. L. (2007). Chapter 5: Focus group Interviewing. I: Berg, Bruce L. *Qualitative research methods for the social sciences*.
- Blanche, M. T., Blanche, M. J. T., Durrheim, K., & Painter, D. (Eds.). (2006). *Research in practice: Applied methods for the social sciences*. Juta and Company Ltd.
- Blumberg, B. F., Cooper, D. R., & Schindler, P. S. (2005). Survey research. *Business Research Methods*, 243-276.
- Boezaart, T. (2012). Protecting the reproductive rights of children and young adults with disabilities: The roles and responsibilities of the family, the state and judicial decision-making. *Emory International Law Review* 26, 69–85.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.
- Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage.
- Bray, A. (2003). *Definitions of intellectual disability: review of the literature prepared for the national advisory committee on health and disability to inform its project on services from adults with an intellectual disability*. National Advisory Committee of Health and Disability, Donald Bealey Institute.
- Bruce, S. M., Kauffman, J. M., & Hallahan, D. P. (2011). Severe and multiple disabilities. *Handbook of special education*, 291-303.
- Bryan, W. V., & Henderson, G. (2011). *Psychosocial aspects of disability*. Springfield: Charles C.
- Bryman, A., & Bell, E. (2015). *Business research methods*. Oxford University Press, USA.

- Bunning, K., Gona, J. K., Newton, C. R., & Hartley, S. (2017). The perception of disability by community groups: Stories of local understanding, beliefs and challenges in a rural part of Kenya. *PloS one*, 12(8), e0182214.
- Buntinx, W. H., & Schalock, R. L. (2010). Models of disability, quality of life, and individualized supports: Implications for professional practice in intellectual disability. *Journal of Policy and Practice in Intellectual Disabilities*, 7(4), 283-294.
- Burchardt, T. (2004). Capabilities and disability: The capabilities framework and the social model of disability. *Disability & society*, 19(7), 735-751.
- Burgen, B. (2010). Women with cognitive impairment and unplanned or unwanted pregnancy: A 2-year audit of women contacting the pregnancy advisory service. *Australian Social Work*, 63(1), 18.
- Cameron, R. (2011). Mixed methods in business and management: A call to the 'first generation'. *Journal of Management & Organisation*, 17(2), 245-267.
- Castillo-Montoya, M. (2016). Preparing for interview research: The interview protocol refinement framework. *The Qualitative Report*, 21(5), 811-831.
- Chataika, T. (2009). Inclusion of disabled students in higher education in Zimbabwe. In *Cross-Cultural Perspectives on Policy and Practice* (pp. 130-145). Routledge.
- Chidindi, E. (2010). *Disability and disadvantage: the educational access and participation for students with disabilities* (Master's thesis).
- Chikumbu, M. (2014). Challenges faced by disabled youth in sexual relationships. Unpublished thesis, Connect, Zimbabwe.
- Chiwandire, D., & Vincent, L. (2017). Wheelchair users, access and exclusion in South African higher education. *African Journal of Disability (Online)*, 6, 1-9.
- Choruma, T. (2007). *The forgotten tribe: People with disabilities in Zimbabwe*. CIIR.
- Cioni, G., Sgandurra, G., Muzzini, S., Paolicelli, P. B., & Ferrari, A. (2010). Forms of hemiplegia. In *The Spastic Forms of Cerebral Palsy* (pp. 331-356). Springer, Milano.
- Cohen, D., & Crabtree, B. (2006). *Qualitative research guidelines project*.

- Creswell, J. W. (2009). *Mapping the field of mixed methods research*. Sage
- Creswell, J. W. (2013). *Steps in conducting a scholarly mixed methods study*. Sage
- Creswell, J. W., & Inquiry, Q. (2007). *Research design: choosing among five approaches*.
- Crow, G., & Wiles, R. (2008). *Managing anonymity and confidentiality in social research: The case of visual data in community research*.
- Crow, K. L. (2008). Four types of disabilities: Their impact on online learning. *TechTrends*, 52(1), 51-55.
- Crow, L. (2010). Including all our lives: renewing the social model of disability. In exploring the divide: illness and disability, Barnes, C., & Mercer, G (eds). *The Disability Press*. Leeds.
- Cuskelly, M. (2006). Parents of adults with an intellectual disability. *Family Matters*, (74), 20.
- De Vos, A. S., & Strydom, H. (2011). Intervention research. *Research at grass roots: for the social sciences and human service professions*, 4, 473-490.
- De Vos, A. S., Delport, C. S. L., Fouché, C. B., & Strydom, H. (2011). *Research at grass roots: A primer for the social science and human professions*.
- Deepak, S., Kumar, J., Ramasamy, P., & Griffo, G. (2014). An emancipatory research on CBR and the barriers faced by persons with disabilities. *Disability and Rehabilitation*, 36(18), 1502-1507.
- Denzin, N. K., & Lincoln, Y. S. (2005). *The Sage handbook of qualitative research*. Sage Publications Ltd.
- Denzin, N. K., & Lincoln, Y. S. (2008). *Introduction: The discipline and practice of qualitative research*.
- Dillenburger, K., McKerr, L., & Ireland, N. (2014). Echoes of the future: Adults with disabilities living at home with their parents. *J. Neurol. Clin. Neurosci*, 1, 1-10.
- Disabled Persons Act. (1996). Retrieved on <http://www.parlzim.gov.zw/acts-list/disabled-persons-act-17-01>
- Dooly, M., Moore, E., & Vallejo, C. (2017). *Research ethics: Research-publishing. net*.

- Dunn, D. S. (2015). *Academy of rehabilitation psychology series*.
- Duyan, V., & Centre of Excellence Defence Against Terrorism. (2007). The community effects of disabled sports. *NATO SECURITY THROUGH SCIENCE SERIES E HUMAN AND SOCIETAL DYNAMICS*, 31, 70.
- Edmos, M. (2017). Policy dimensions of exclusion: Disability as charity and not right in Zimbabwe. *The Indian Journal of Social Work*, 72(3), 381-398.
- Eide, A., & Ingstad, B. (2017). *Disability and poverty: A global challenge*. Policy Press.
- Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). *Qualitative content analysis: A focus on trustworthiness*. *SAGE open*, 4(1).
- Enns, H. (2008). *The role of organisations of disabled people. A Disabled Peoples' International Discussion Paper, Sweden, Independent Living Institute*.
- Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics*, 5(1), 1-4.
- Farrokhi, F., & Mahmoudi-Hamidabad, A. (2012). Rethinking Convenience Sampling: Defining Quality Criteria. *Theory & Practice in Language Studies*, 2(4).
- Fedorowicz, S.C. (2006). 'HIV/AIDS and the deaf community', *Deaf Worlds-International Journal of Deaf Studies* 22(1), 197–221.
- Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, 24(2), 105-112.
- Groce N., Izutsu T., Reier S., Rinehart W. & Temple, B. (2009). *Promoting sexual and reproductive health for persons with disabilities*, WHO/UNFPA guidance note, World Health Organization and United Nation Population Fund, Geneva.
- Groce N.E. & Trasi R. (2004). 'Rape of individuals with disability: AIDS and the folk belief of virgin cleansing', *The Lancet* 363, 1663–1664.

- Groce N.E., Yousafzai A.K. & Maas V.D. (2007). HIV/AIDS and disability: Differences in HIV/AIDS knowledge between deaf and hearing people in Nigeria. *Disability and Rehabilitation*, 26(5), 367–371.
- Gupta, V. B. (2011). How Hindus cope with disability. *Journal of Religion, Disability & Health*, 15(1), 72-78.
- Gustafsson, J. (2017). Single case studies vs. multiple case studies: A comparative study.
- Hanafin, J., Shevlin, M., Kenny, M., & Mc Neela, E. (2007). Including young people with disabilities: Assessment challenges in higher education. *Higher Education*, 54(3), 435-448.
- Hanass-Hancock, J., Regondi, I., & Naidoo, K. (2013). Disability and HIV: what drives this relationship in Eastern and Southern Africa?: original paper. *African Journal of Disability*, 2(1), 1-6.
- Hanisch, H. (2007). *Frontiers of justice. Disability, nationality, species membership*.
- Hanlon, B., & Larget, B. (2011). Samples and populations. *Article: Department of Statistics*, 1-21.
- Heale, R., & Twycross, A. (2018). *What is a case study?*
- Hedges, L. V., & Cooper, H. (2009). *Research synthesis as a scientific process. The handbook of research synthesis and meta-analysis*, 1.
- Hendricks, A. (2007). UN Convention on the rights of persons with disabilities. *Eur. J. Health L.*, 14, 273.
- Heward, W. L. (2003). Ten faulty notions about teaching and learning that hinder the effectiveness of special education. *The Journal of Special Education*, 36(4), 186-205.
- Heyederick, I. (2006). HIV/AIDS and deafness in flanders. *Deaf Worlds: International Journal of Deaf Studies* 22(1), 194–196.
- Hunter, D. J., & Eckstein, F. (2009). Exercise and osteoarthritis. *Journal of Anatomy*, 214(2), 197-207.

- Idrees, B., & Ilyas, R. (2012). Discrimination and stigmatization of physically disabled student in a general educational environment in Pakistan: A case study. *Academic Research International*, 2(2), 622.
- Ingstad, B., & Grut, L. (2007). *See me, and do not forget me: People with disabilities in Kenya*. World Bank.
- Job, J. (2004). Factors involved in the ineffective dissemination of sexuality information to individuals who are deaf or hard of hearing. *American Annals of Deaf* 149(3), 264–273.
- Jones, G. E. (1997). Advancement opportunity issues for persons with disabilities. *Human Resource Management Review*, 7(1), 55-76.
- Judge, T. A., Thoresen, C. J., Bono, J. E., & Patton, G. K. (2001). The job satisfaction–job performance relationship: A qualitative and quantitative review. *Psychological Bulletin*, 127(3), 376.
- Kabzems V. & Chimedza R. (2002). Development assistance: Disability and education in Southern Africa. *Disability and Society* 17(2), 147–157.
- Katz, G., & Lazcano-Ponce, E. (2008). Intellectual disability: definition, etiological factors, classification, diagnosis, treatment and prognosis. *Salud Pública de México*, 50, 132-141.
- Kauffman, J. M., & Landrum, T. J. (2009). Politics, civil rights, and disproportional identification of students with emotional and behavioral disorders. *Exceptionality*, 17(4), 177-188.
- Kavale, K. A., Kauffman, J. M., Bachmeier, R. J., & LeFever, G. B. (2008). Response-to-intervention: Separating the rhetoric of self-congratulation from the reality of specific learning disability identification. *Learning Disability Quarterly*, 31(3), 135-150.
- Khumalo, B. (2008). *Introduction on comparative study on adapted physical activity: Overview of the development of adapted physical activity in Zimbabwe*, viewed 23 June 2010, from <http://www.erasmusmundus.be/comparative/Zimbabwe.pdf>.

- Kiarie, M. W. (2014). Educating students with physical disabilities in Kenya: progress and promises. *International Journal of Educational Studies*, 1(2), 109-118.
- Knight, J. (2012). *Poverty and disability*.
- Korstjens, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice*, 24(1), 120-124.
- Kumar, S. G., Roy, G., & Kar, S. S. (2012). Disability and rehabilitation services in India: Issues and challenges. *Journal of Family Medicine and Primary Care*, 1(1), 69.
- Kvale, S. (2008). *Doing interviews*. Sage.
- Lancaster House Constitution. (1979). Retrieved from http://sas-space.sas.ac.uk/5847/5/1979_Lancaster_House_Agreement.pdf.
- Lang, R. (2009). The United Nations Convention on the right and dignities for persons with disability: A panacea for ending disability discrimination? ALTER', *European Journal of Disability Research*3, 266–285.
- Lang, R., & Charowa, G. (2007). *DFID scoping study: Disability issues in Zimbabwe*. London: DFID. London, 263-286.
- Leung, L. (2015). Validity, reliability, and generalizability in qualitative research. *Journal of Family Medicine and Primary Care*, 4(3), 324.
- MacMillan, J. H., & Schumacher, S. (2001). *Descriptive statistics. Research in education: A conceptual introduction*, 204-236.
- Macnee, C. L., & McCabe, S. (2008). *Understanding nursing research: Using research in evidence-based practice*. Lippincott Williams & Wilkins.
- Maguire, M., & Delahunt, B. (2017). Doing a thematic analysis: A practical, step-by-step guide for learning and teaching scholars. *AISHE-J: The All Ireland Journal of Teaching and Learning in Higher Education*, 9(3).
- Maina, D. K. (2016). *Citizen centric evaluation of accessibility of ICT services for persons with disability: A case study of Huduma Centres in Kenya*.

- Majiet, S. (2013). *Disabled women must stand up': exploring the leadership experiences of disabled women in disabled people's organisations in Zimbabwe* (Doctoral dissertation, University of Cape Town).
- Manatsa, P. (2015). *Are disability laws in Zimbabwe compatible with the provisions of the United Nations Convention on the Rights of Persons with Disabilities (CRPD)?*
- Margellos-Anast H., Estarziau M. & Kaufman G. (2006). Cardiovascular disease knowledge among culturally Deaf patients in Chicago. *Preventive Medicine* 42, 235–239.
- Marks, D. F., & Yardley, L. (Eds.). (2004). *Research methods for clinical and health psychology*. Sage.
- McClure, J. S. (2007). *Preaching words: 144 key terms in homiletics*. Westminster John Knox Press.
- Mead, R. (2017). *Statistical methods in agriculture and experimental biology*. Chapman and Hall/CRC.
- Menon, N., Parish, S. L., & Rose, R. A. (2014). The “state” of persons with disabilities in India. *Journal of Human Development and Capabilities*, 15(4), 391-412.
- Monk, J., & Wee, J. (2008). Factors shaping attitudes towards physical disability and availability of rehabilitative support systems for disabled persons in rural Kenya. *Asia Pacific Disability and Rehabilitation Journal*, 19(1), 93-113.
- Mont, D., & Cuong, N. V. (2011). Disability and poverty in Vietnam. *The World Bank Economic Review*, 25(2), 323-359.
- Mont, D., & Cuong, N. V. (2011). Disability and poverty in Vietnam. *The World Bank Economic Review*, 25(2), 323-359.
- Morrison, E. H., George, V., & Mosqueda, L. (2008). *Primary care for adults with physical disabilities: perceptions from consumer and provider focus groups*.
- Mpofu, E., Ukasoanya, G., Mupawose, A., Harley, D.A., Charema, J., & Ntinda, K. (2011). Counselling people with disabilities. In: E. Mpofu (Ed.), *Counselling People of African Ancestry* (pp. 187 – 195). Cambridge: Cambridge University

- Mpofu, J., & Molosiwa, S. (2017). Disability and Inclusive Education in Zimbabwe. In *Inclusive Education in African Contexts* (pp. 49-63). Brill Sense.
- Mpofu, J., Sefotho, M. M., & Maree, J. G. (2017). Psychological well-being of adolescents with physical disabilities in Zimbabwean inclusive community settings: An exploratory study. *African Journal of Disability (Online)*, 6, 1-7.
- Mtetwa, E. (2012). The dilemma of Social Difference: Disability and institutional discrimination in Zimbabwe. *Australian Journal of Human Rights*, 18(1), 169-184.
- Mtetwa, E., & Ruparanganda, W. (2016). Disability and the quest for bureaucratic representation in Zimbabwe. *The Indian Journal of Social Work*, 77(1), 39-52.
- Mugo, K. J., Oranga, J., & Singal, N. (2010). Testing youth transitions in Kenya: Are young people with disabilities falling through the cracks. *RECOUP Working Paper34: http://recoup.Educ.cam.Ac.uk/publications/WP34_MUGO_ORANGA_SINGAL_final.Pdf*.
- Mugumbate, J., & Nyoni, C. (2013). Disability in Zimbabwe under the new constitution: Demands and gains of people with disabilities. *Southern*, 178.
- Mugumbate, J., Nyanguru, A., Nyoni, C., Maushe, F., Masuka, T., Chisvo, D. J. & Ngwerume, E. T. (2014). *Promoting social work for Zimbabwe's development*.
- Munsaka, E., & Charnley, H. (2013). We do not have chiefs who are disabled': disability, development and culture in a continuing complex emergency. *Disability & Society*, 28(6), 756-769.
- Murphy, N., & Christian, B. (2007). Disability in children and young adults: the unintended consequences. *Archives of Pediatrics & Adolescent Medicine*, 161(10), 930-932.
- Naidoo, A. (2010). *Students with disabilities' perceptions and experiences of the Disability Unit at the University of KwaZulu-Natal, Howard College Campus* (Doctoral dissertation, University of KwaZulu-Natal, Durban).
- NASCOH. (2009). *Disability in Zimbabwe, National Association of the care of the handicapped*.
- Ndlovu, H. L. (2016). African beliefs concerning people with disabilities: implications for theological education. *Journal of Disability & Religion*, 20(1-2), 29-39.

- Nelson, K. B., & Chang, T. (2008). Is cerebral palsy preventable? *Current Opinion in Neurology*, 21(2), 129-135.
- Neuendorf, K. A. (2016). *The content analysis guidebook*. Sage.
- Niemann, S. (2005). Persons with disabilities. *Religious and spiritual issues in counseling: Applications across diverse populations*, 105-134.
- Noble, H., & Smith, J. (2015). Issues of validity and reliability in qualitative research. *Evidence-Based Nursing*, ebnurs-2015.
- Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, 16(1).
- Oliver, M. (2013). The social model of disability: Thirty years on. *Disability & Society*, 28(7), 1024-1026.
- Oliver, M. (2017). Defining impairment and disability. *Disability and Equality Law*, 3.
- Pardeck, J. A., & Murphy, J. W. (2012). An analysis of the Americans with Disabilities Act (ADA) in the twenty-first century. In *Disability issues for social workers and human services professionals in the twenty-first century* (pp. 141-172). Routledge.
- Plummer, S. B., & Findley, P. A. (2012). Women with disabilities' experience with physical and sexual abuse: review of the literature and implications for the field. *Trauma, Violence & Abuse*, 13(1), 15-29.
- Polit, D. F., & Beck, C. T. (2012). Designing and conducting quantitative studies to generate evidence for nursing. *Nursing Research*, 226.
- Poverty Assessment Study (2003). Retrieved from http://www.chronicpoverty.org/uploads/publication_files/kinsey_poverty_dynamics_zimbabwe.pdf
- Price, M. (2011). *Mad at school: Rhetorics of mental disability and academic life*. University of Michigan Press.

- Prilleltensky, O. (2004). *Motherhood and disability: Children and choices*. New York: Palgrave Macmillan.
- Rajasekar, S., Philominathan, P., & Chinnathambi, V. (2006). *Research methodology*. 1–53.
- Retief, M., & Letšosa, R. (2018). Models of disability: A brief overview. *HTS Teologiese Studies/Theological Studies*, 74(1).
- Rimmerman, A. (2013). *Social inclusion of people with disabilities: National and international perspectives*. Cambridge University Press.
- Roberts, G.S. (2006). Sexuality and HIV/AIDS education among deaf and hard of hearing students. *Deaf Worlds*, 22(1), 111–139.
- Rubin, A., & Babbie, E. R. (2011). Qualitative research: General principles. *Research Methods for Social Work*, 436-455.
- Rubin, A., & Babbie, E. R. (2012). *Essential research methods*. Cengage Learning.
- Rugoho T. & Maphosa F. (2015). 'Gender-based violence amongst women with disabilities: A case study of Mwenezi district, Zimbabwe', *Gender Questions* 6(13), 12–27.
- Rugoho T. & Siziba B. (2014). 'Rejected people: Beggars with disabilities in the City of Harare, Zimbabwe', *Developing Country Studies* 4(26), 51–56s.
- Rugoho, T., & Maphosa, F. (2017). Challenges faced by women with disabilities in accessing sexual and reproductive health in Zimbabwe: The case of Chitungwiza town. *African Journal of Disability (Online)*, 6, 1-8.
- Seale, J. (2006). *Disability, technology and e-learning: challenging conceptions*.
- Seale, J. (2006). *E-learning and disability in higher education: Accessibility research and practice*. Routledge.
- Sedgwick, P. (2013). Convenience sampling. *Bmj*, 347(f6304), f6304.
- Shahnazarian, D., Hagemann, J., Aburto, M., & Rose, S. (2013). Informed consent in human subjects research. *Office for the Protection of Research Subjects (OPRS)*,

University of Southern California. Retrieved from [oprs. Usc.edu/files/2013/04/Informed-Consent-Booklet-4.4](https://oprs.usc.edu/files/2013/04/Informed-Consent-Booklet-4.4), 13.

Shakespeare, T. (2006). The social model of disability. *The Disability Studies Reader*, 2, 197-204.

Shakespeare, T., & Watson, N. (2001). The social model of disability: an outdated ideology? In *Exploring theories and expanding methodologies: Where we are and where we need to go* (pp. 9-28). Emerald Group Publishing Limited.

Shuttleworth, R. P. (2007). Disability and sexuality: Toward a constructionist focus on access and the inclusion of disabled people in the sexual rights movement. *Sexual Inequalities and Social Justice*, 174-207.

Silverman, D. (Ed.). (2016). *Qualitative research*. Sage.

Srivastava, P., & Kumar, P. (2015). Disability, its issues and challenges: psychosocial and legal aspects in Indian scenario. *Delhi Psychiatry Journal*, 18(1), 195-205.

Stainton, T., Chenoweth, L., & Bigby, C. (2010). *Social work and disability: An uneasy relationship*.

Steffen, E. (2016). Ethical considerations in qualitative research. *Analysing Qualitative Data in Psychology*, 31-44.

Strydom, H., & Delpont, C. S. L. (2011). Sampling and pilot study in qualitative research. *Research at grass roots: for the social sciences and human service professions*, 4, 390-396.

The Education Act (1987). Retrieved from <https://zimlil.org/zw/legislation/num-act/1987/5/Education%20Act%20%5BChapter%2025-04%5D.pdf>.

The Mental Health Act. (1996). Retrieved from http://www.health.wa.gov.au/mhareview/resources/legislation/wa_mental_health_act_1996.pdf.

The Social Welfare Assistance Act. (1988). Retrieved from <http://www.parlzim.gov.zw/acts-list/social-welfare-assistance-act-17-06>.

- The State Service Act. (1971). Retrieved from <http://www.parlzim.gov.zw/acts-list/state-service-pensions-act-16-06>.
- The United Nations Convention on the Rights of Persons with Disabilities. (2006). Retrieved from https://www.un.org/disabilities/documents/convention/convention_accessible_pdf.pdf
- The War Victims Compensation Act. (1980). Retrieved from http://www.parlzim.gov.zw/actslist/download/702_e5cd736849f60ab83605d3a9cde3cf54
- Thomas, P. (2005). Disability, poverty and the millennium development goals: Relevance, challenges and opportunities for DFID. *GLADNET Collection*, 256.
- Tracy, S. J. (2010). Qualitative quality: Eight “big-tent” criteria for excellent qualitative research. *Qualitative Inquiry*, 16(10), 837-851.
- Turner, B., & Henryks, J. (2012). *A study of the demand for community gardens and their benefits for the ACT community*. University of Canberra.
- United Nations (UN). (2007). ‘Convention on the Rights of Persons with Disabilities GA Res 61/106 UN Doc A/RES/61/106 (24 January 2007) and Optional Protocol to the Convention on 1815 the Rights of Persons with Disabilities GA Res 61/106 UN DocA/RES/61/106’, UN, New York.
- Vanclay, F., Baines, J. T., & Taylor, C. N. (2013). Principles for ethical research involving humans: ethical professional practice in impact assessment Part I. *Impact Assessment and Project Appraisal*, 31(4), 243-253.
- Wells, T., Hogan, D. P., & Sandefur, G. D. (2003). What happens after the high school years among young persons with disabilities? *Social Forces*, 82(2), 803-832.
- WHO. (2014). *World Disability Report*, World Health Organization, Geneva. Retrieved from <http://www.who.org/world-disability-report>.
- WHO. (2017). *World Disability Report*, World Health Organization, Geneva. Retrieved from <http://www.who.int/gho/publications/world-health-statistics/2017/en/>

- Wilcher R. & Cates W. (2009). 'Reproductive choices for women with HIV', *Bulletin of the World Health Organization* 87, 833–839. <https://doi.org/10.2471/BLT.08.059360> [PMC free article] [PubMed].
- Wilson A. & Monaghan L. (2006). HIV/AIDS and the deaf community. *International Journal of Deaf Studies* 22(1), 1–10.
- World Health Organization. (2013). Retrieved from https://www.who.int/gho/publications/world_health_statistics/2013/en/
- World Health Organization (WHO). (2004). *Reproductive health strategy, to accelerate progress towards the attainment of international development goals and targets*, WHO, Geneva. [PubMed].
- World Health Organization (WHO). (2006). *Neurological Disorders, Public health challenges*, WHO, Geneva.
- World Health Organization (WHO). (2009). *Promoting sexual and reproductive health persons with disabilities WHO/UNFPA guidance note*, WHO, Geneva.
- World Health Organization (WHO). (2011). *International classification of functioning, disability and health (ICF)*, WHO, Geneva.
- Yardley, L., & Marks, D. F. (2004). Introduction to research methods in clinical and health psychology. *Research Methods for Clinical and Health Psychology*, 1-20.
- Zhou. (2015). Mutations in DCPS and EDC3 in autosomal recessive intellectual disability indicate a crucial role for mRNA decapping in neurodevelopment. *Human Molecular Genetics*, 24(11), 3172-3180.
- Zhou, M. C. (2016). *The cultural beliefs of people with physical disabilities in a community rehabilitation centre in Oniipa Namibia* (Doctoral dissertation, University of Pretoria).
- Zimbabwe Constitution. (2013). Retrieved from https://www.constituteproject.org/constitution/Zimbabwe_2013.pdf
- Zimbabwe Population Census. (2012). Retrieved from http://www.zimstat.co.zw/sites/default/files/img/National_Report.pdf

ANNEXURE A: INTERVIEW GUIDE

Research Topic: Experiences of adults with physical disabilities at Kukura Neshungu Institute in Marondera, Zimbabwe: A social work perspective

INTRODUCTION

My name is Everjoy Tatenda Mutema, a Master's Degree in Social Work student at the University of Limpopo in South Africa. I am conducting a research that intends to explore experiences of adults with physical disabilities. Your participation in this study will be kept confidential, and your names and addresses will not be included in the study. Information that will be gathered from this study will only be used for academic purposes. I would like to apologise in advance for any questions that might cause you discomfort and emotional stress. However, your contributions will be highly appreciated.

NHEURI

Zita rangu ndiEverjoy Tatenda Mutema, mudzidzi weDhigirii reSocial Work paYunivhesiti yeLimpopo muSouth Africa. Ndiri kuita tsvakurudzo inotarisira kuongorora zvakaikika kune vanhu vakuru vane hurema hwepanyama. Kupindira kwako muchidzidzo ichi kuchachengetedzwa chakavanzika, uye mazita ako neateri hazvizobatanidzwi muchidzidzo. Ruzivo ruchaunganidzwa kubva muchidzidzo ichi ruchashandiswa chete pakudzidza. Ndinoda kukumbira ruregerero mberi kwemibvunzo chero ipi zvingakuita kuti ukanganisike uye kushungurudzika mupfungwa. Zvisinei, zvipo zvako zvinotendwa zvikuru.

QUESTIONS

1. What are the major challenges you can identify in your life as a person with a physical disability? Ndeapi matambudziko makuru aunogona kuziva muupenyu hwako semunhu ane urema hwepanyama?
2. Will you please identify accessibility barriers that you encounter in accessing education? Ndapota chinyatsotsanangura kuti iwe unokwanisa sei kubata nematambudziko ezvidzidzo semunhu mukuru ane hurema hwepanyama?
3. How do you manage to cope with health challenges whilst physically disabled? Unokwanisa sei kurarama nematambudziko ehutano?

4. What are your experiences with culture and tradition as a person who is physically disabled? Ndezvipi zviitiko zvako nemitsika uye netsika semunhu akaremara mumuviri?
5. What aspects can be identified as revealing stigma and discrimination towards adults with disabilities? Ndezvipi zvaungataure zvinoratidza rusaruro pavanhu vane hurema?

ANNEXURE B

STUDENT NUMBER: 201113807

CONSENT FORM FOR PARTICIPATION IN THE STUDY

DECLARATION OF CONSENT

I, the participant, out of my free will, hereby agree to voluntarily participate in this research study. This study is aimed at exploring experiences of adults with physical disabilities at Kukura Neshungu Institute in Marondera, Zimbabwe. The purpose and the procedures of the study have been explained to me. I understand that I am not bound to participate in the study and that it is my right to withdraw from this study should I feel uncomfortable. I understand that my responses will be kept confidential.

The research might bring back painful memories. However, the researcher has made arrangement with the local psychologist and social worker at Marondera General Hospital should the need arise. By putting my signature and date on this consent form, I declare that I agree to take part in the interview.

Name of Participant:	Researcher (as witness).....
Signature.....	Signature.....
Date.....	Date.....



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TURFLOOP RESEARCH ETHICS COMMITTEE
ETHICS CLEARANCE CERTIFICATE

MEETING: 06 March 2019

TREC/36/2019: PG

PROJECT NUMBER:

PROJECT:

Title: Experiences of adults with physical disabilities at Kukura Neshungu Institute in Marondera, Zimbabwe: A social work perspective.

Researcher: ET Mutema

Supervisor: Prof JC Makhubele

Co-Supervisor/s: N/A

School: Social Sciences

Department: Masters in Social Work

CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: REC-0310111-031

Note:

- i) This Ethics Clearance Certificate will be valid for one (1) year, as from the abovementioned date. Application for annual renewal (or annual review) need to be received by TREC one month before lapse of this period.
- ii) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee, together with the Application for Amendment form.
- iii) PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

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