THE INTERNATIONAL JOURNAL OF HUMANITIES & SOCIAL STUDIES

Challenges of Community-Based Rehabilitation as an Empowerment Tool for Rural People with Disabilities in Umguza District, Zimbabwe

Duduzile Nkomo
Lecturer, Department of Education and Training,
Baisago University, Botswana
Buyisani Dube
Lecturer, Department of Educational Leadership and Management,
School of Graduate Studies Research, Baisago University, Botswana
Bolatumi Oyegoke
Dean, Department of Education, Baisago University, Botswana

Abstract:
The purpose of this study was to establish challenges that stakeholders face in implementing community-based rehabilitation for people with disabilities in one rural district of Zimbabwe. This was dependent on the realisation that there are notable disparities in the quality of life led by people with disabilities who reside in rural areas as compared to their counterparts in urban settings. An inclusive society that imparts independent living skills to all its members using locally available resources is desirable. This study employed the qualitative research design. Convenient sampling was used to select 1 ward councilor, 5 village heads, and 5 village health workers. Purposive sampling was used to select 32 caregivers (parents/guardians) and 20 persons with mild to moderate disabilities to participate in the study. Focus Group Discussions (FDGs) were conducted with caregivers and persons with disabilities. Face-to-face interviews were carried out with the village heads, village health workers, and the ward councilor. Data were analysed thematically. The findings of the study were that caregivers assumed greater responsibility for empowering and serving the needs of individuals with disabilities than other stakeholders. The study recommends that community-based rehabilitation programmes should be intensified in rural areas by utilising locally available resources and indigenous expertise to improve the functionality of people with disabilities within their settings.

Keywords: *Community-based rehabilitation, disability, empowerment, tool, people with disabilities*

1. Introduction

The education, care, treatment, and observation of rights of Persons with Disabilities (PWDs) worldwide have largely been influenced by society's stereotypes, beliefs, and perceptions (Munyi, 2012). In the past decades, such persons were generally viewed as sub-human and, therefore, considered incapable of benefiting from the availed education system or contributing to the socio-economic development of any society. In nomadic tribes, (PWDs) were considered useless because they could not contribute to food gathering or the wealth of the tribe (Burnett, 2013). The Greeks sought rational explanations for disability with insufficient medical science. They reached such conclusions as epilepsy is a disturbance of the mind and that people who are deaf cannot learn without verbal communication (Davis, 2006). Some early Christians brought a gentler approach, focusing on sympathy and pity towards (PWDs). However, sympathy and pity led to condescension and paternalism, resulting in a general loss of autonomy. As the attraction to supernaturalism increased during the Middle Ages, Christians became fearful of (PWDs) and ridiculed them (Shreve, 2011). This ridicule often turned to persecution and 'impurity' transformed into a vision of disability as a manifestation of evil. In some societies and tribes, they were hidden, segregated, discriminated against, or even killed. Concurrent to this, Hardman, Drew, and Egan (1999) posit that people who were perceived as different were vulnerable to practices such as infanticide, slavery, physical abuse, and abandonment.

This maltreatment continued until the period of the renaissance, which brought new strides in medical science and treatment for people with disabilities. During this time, the 'charity model' and 'medical model' began determining attitudes towards disability. Education was gradually made available to affected individuals for the first time in recorded western history. An enlightened approach to social norms and dreams for a better future seemed to encourage active participation of (PWDs) in their communities (Wheatley, 2010).

The charity model led to the promotion of institutionalisation during the renaissance period as a method of doing 'what is best' for those with disabilities. From the Renaissance through World War II, society believed that PWDs might be

educated in 'special' segregated programmes or schools, often far from populated areas (Shreve, 2011). While institution-based rehabilitation had its notable positive contributions to the development of PWDs, the proponents of inclusivity have criticised them for isolating PWDs from their natural ecological environment and, in some cases, giving them a distorted view of their niche in society (Simplican, Leader, Kosciulek & Leahy, 2015). They also deprive the other units of society, such as the family, the village, and the school, of the chance to contribute to developing a person with a disability. Therefore, the advent of inclusion of marginalised groups in all spheres of life has gradually influenced the adoption of community-based rehabilitation (CBR) in many parts of the world.

CBR attempts to restore or maximise the full potential and functions of PWDs, in their natural environment, that is, the family and the community (Mannan & Turnbull, 2007). Inclusion into the community is concurrent with the rehabilitation process and not subsequent to it. Ong'golo (2000) supports the idea of programmes for PWDs being carried out in their immediate environment and emphasises that CBR seeks to empower people with disabilities, their families, and communities regardless of cast, colour, creed, religion, gender, age, type and cause of disability through raising awareness, promoting inclusion, reducing poverty, eliminating stigma, meeting basic needs and facilitating access to health, education and livelihood opportunities. Some factors that need to be considered if CBR programmes are to be successful in any society include:

- Social mobilisation,
- Awareness raising,
- Training of various stakeholders, including people with disabilities, needs analysis, implementation, monitoring, and evaluation (Mannan & Turnbull, 2007)

2. Background

In the Zimbabwean context, the administration of CBR programmes is dependent on international and national legal frameworks and policies. The Standard Rules on Equalising Opportunities for PWDs was adopted at the UN General Assembly in 1993. According to this document, the term 'equalisation of opportunities' means the process through which the various systems of society and the environment, such as services, activities, information, and documentation, are made available to all, particularly to persons with disabilities.

The Salamanca Statement, issued in 1994, promoted the provision of Special education needs for children living with disabilities and paved the way for implementing CBR with the support of the Joint Position Paper. In 2006, the Convention on the Rights of Persons with Disabilities was ratified, clearing the path for promoting and protecting the rights of PWDs.

Some of the national policies that sustain CBR programmes include:

- The Education Act of 1987, as amended in 1996 and 2006,
- The Disabled Persons Act (1992) which specifies, amongst other issues, that communities should encourage and secure the establishment of vocational rehabilitation centres, social employment centres, and other institutions and services for the welfare and rehabilitation of disabled persons, and
- The Constitution of Zimbabwe Act No. 20 of 2013

CBR programmes are basically administered by:

- The Government,
- World Health Organisation (WHO),
- International Labour Organisation (ILO), and
- The voluntary sector (WHO, 2010)

The central thrust of the government through the Ministry of Health and Child Welfare is training rehabilitation assistants to work at district hospitals and providing a referral chain, as needed, from community or village level workers to central hospitals and national rehabilitation centres. Much rehabilitation must occur at home, in local clinics, or in district hospitals. At the same time, Non-Governmental Organisations (NGOs), such as the Zimbabwe Red Cross society, Cheshire Foundation, Zimcare Trust, Jairos Jiri Association, and the National Council of Disabled Persons of Zimbabwe (NCDPZ), have begun to develop various CBR and outreach programmes in different parts of the country, working, where possible, in conjunction with rehabilitation assistants and community rehabilitation workers (Lang, 2007).

According to the Zimbabwe Population Census (2013), approximately 3,50,000 PWDs were identified. This is a figure which equates to 2.9% of the national population. Further validations by the Poverty Assessment Study Survey (PASS) 2003 revealed that rural areas had a slightly higher prevalence of PWDs than urban ones. Concurrent to this, Lang (2011) observes that while CBR programmes have been fairly conducted in some urban areas of Zimbabwe, most of these projects have died a natural death in most rural communities, and the Umguza District of Matabeleland North is not an exception.

In this region, most persons with various disabilities do not possess prerequisite skills that facilitate self-dependence. Therefore, they totally rely on their caregivers for survival. They hardly attend school, and those who somehow manage to complete their primary level, fail to proceed to secondary education. Their level of contribution to community development is very limited or considered insignificant.

3. Statement of the Problem

Throughout the history of mankind, people with disabilities have attracted attention and controversy with regard to the assistance they need and the contribution they render to community development. Cultural stereotypes, beliefs, and perceptions in vast communities have determined how these people are viewed, treated, and given the latitude to function

like their counterparts without disabilities. In the Zimbabwean context, strides to ensure the immediate environment of people with disabilities is reframed to allow them to achieve their full potential and functions have been taken up by the WHO, ILO, and NGOs, inclusive Red Cross, Zimcare Trust, and Jairos Jiri Society (PASS, 2003). This has been evidenced through the conduct of community-based rehabilitation programmes, which have, however, been more successful in urban areas than in most rural communities. Amongst the areas that have been negatively affected is ward 7 of the Umguza district.

In this setting, people living with disabilities have limited intra and inter-personal skills. They hardly attend primary school, and those who do, fail to proceed to secondary education. Those who do not attend school have limited vocational skills to facilitate their employability and mostly rely on their caregivers for survival throughout their lives. This scenario raises questions on the factors that hinder the empowerment of people with disabilities through community-based rehabilitation.

4. Purpose of the Study

The purpose of the study was to examine the challenges faced by stakeholders in implementing CBR to empower people with disabilities. The study also sought to recommend strategies that rural community leaders and members can adopt to enhance the full inclusion of PWDs in various societal settings.

5. Research Questions

This study was guided by the following research questions:

- What empowerment skills are needed by people that live with disabilities?
- What challenges are stakeholders facing in the conduct of CBR as a measure of empowering rural PWDs?

6. Theoretical Context

The social capital theory underpins the study as a derivation from the social model of disability. The theory is built on a social network of trust, reciprocity, participation, and social connections in community life. It advocates for community development through civic participation in ways that foster friendships, a culture of learning, social inclusion, and independent life. The goal is to bring about positive change in the community through practices, services, and programmes that enhance the mutually inclusive involvement of members (Bates & Davis, 2004). This framework is critical to CBR, which strives to achieve community development, social inclusion, independent life, community mobilization, and the dissemination of knowledge and skills to people living with disabilities.

7. Methodology

7.1. Research Design

This study employed the qualitative research design. The strength of this design rests on its ability to allow the researcher to be intimate with the research context in ways that foster access to rich, in-depth information.

7.2. Research Methodology

Focus Group Discussions (FDGs) were conducted with 32 caregivers and 20 persons with mild to moderate disabilities. Of the 20 individuals, 10 had physical challenges, 3 had mental challenges, 3 had hearing impairment, 3 had visual impairment, and 1 individual displayed albinism. Face-to-face interviews were carried out with 5 village heads, 5 village health workers, and 1 ward councilor. These were visited on appointments at their homesteads to solicit information for the study. The interviews bordered on the challenges of participants with regard to CBR activities, the kind of assistance that people with disabilities required, and strategies that needed to be adopted to develop CBR programmes.

7.3. Sampling

Convenient and purposive samplings were used to select the participants for the study. Convenient sampling was used to select the word councilor, 5 village health workers, and 5 village heads. Purposive sampling was used to choose 32 caregivers and 20 persons with disabilities.

8. Data Analysis

Data were analysed thematically. This involved subjecting the collected qualitative data to patterns and themes that emerged from the analysis process. This entails familiarisation with the transcribed data, coding data, developing themes in relation to the coded information, naming themes, and producing a report of analysis (Braum & Clarke, 2006). The value of thematic analysis lies in its ability to resist simple classification of data in order to establish meaning and reliable results (Sandelowski, 2010; Vaismoradi, Turumen & Bondas, 2013).

9. Findings

The report on the findings of the study ensued as informed by the purpose of the study and the research questions. Participants of the study were given codes which were then used to protect their anonymity as an ethical principle. These were crafted as follows:

- Caregivers= CG,
- Ward Councilor= WC,

- Village Heads= VH,
- Village Health Workers= VHW, and
- People with Disabilities= PWD

9.1. Theme 1: Empowerment Skills That Are Needed by People with Disabilities

The findings of the study revealed that the form of rehabilitation for people with disabilities that was availed inward 7was training in simple daily living skills like eating and bathing, and this was mainly the responsibility of the caregivers only. Furthermore, all groups of participants were aware that people with disabilities have general needs that apply to all of them but have specific ones that are related to age, the type, and the severity of a disability. In elaborating on the general needs, they affirmed through the following sentiments:

Persons with disabilities need to be trained in independent living skills, although this should basically be the role of caregivers who spend most of the time with the affected persons (VH)

Children with disabilities need to be sent to neighbourhood schools and be given education and training (CG)

People with disabilities and people who are out of school need to be trained in vocational skills to take care of and provide for themselves whenever they can (CG)

These individuals need to be counseled so that they can cope with their conditions (VHW)

Individuals living with disabilities primatised the need to be afforded space where they can establish friendships which is usually a rich platform for acceptance and social inclusion

9.2. Theme 2: Specific Needs of People with Disabilities

The specific needs of people with identified disabilities, emphasised by the participants in relation to this study, are indicated in the table below.

Specific needs relate to people living with defined types of disabilities. The study revealed that people with physical disabilities require assistive devices, which include wheelchairs, crutches, and walkers, to enhance mobility. Physical infrastructure also has to be modified or set up to suit the disabilities of individuals. The buildings need ramps and automatic doors to facilitate ease of movement of physically challenged people. Physiotherapy can also be done to increase the flexibility of those bodily parts that may have been affected at the onset of a disability.

Individuals with mental disabilities need training in inter and intrapersonal skills. They should be capacitated to communicate effectively within themselves and make decisions arising from personal reflection and debate. This has the power to create confidence, self-esteem, and assertiveness in individuals. Inter-personal skills need to be cultivated to allow individuals to interact with others in the communities in which they live. This aids socialisation and the formation of a collective spirit within the large social environment. This communication is possible because most people with disabilities still enjoy the power of voice and non-verbal skills.

Hearing impairments demand that individuals should be supported with hearing devices, trained in sign language and exposed to speech therapy. However, it may be essential that the sign language availed to them possess a wider or universal acceptance to increase the sphere of their communicative space. This can even be extended beyond their local communities.

People with visual disabilities require canes, training in orientation, and mobility. The normal remedy is to provide them with spectacles that suit their individual levels of visual impairments. However, braille machines can also be used in cases of total loss of vision. This may enhance mobility and participation in community activities projects.

Albinism, on the other hand, shares the need to provide spectacles to visually impaired people. In addition, this group requires protective lotion to protect their skin from sunburns.

9.3. Theme 3: Challenges of Community-based Rehabilitation

The results of the study also revealed that community members lacked knowledge of training-specific skills like sign language, mobility and orientation, and intra-personal skills for specific groups of people with disabilities. The village health workers regularly gave moral support to caregivers but could not offer advice on managing certain conditions. One of them said:

We sometimes visit the homes of people with disabilities to give moral support. However, we have minimal contribution and advice on managing certain conditions (VHW).

The built infrastructure at home and school was indicated to be insufficient to measure up to the desire to provide a rights-based, barrier-free, and inclusive environment to people with disabilities. The schools, for example, need to be provided with facilities and services to cater to individuals with different types of disabilities such as hearing, speech, visual and physical impairments. The views hereunder emerged from the participants:

My son, who uses a wheelchair, struggles to use our toilet facility at home. I used to comfortably help him when he was young, but now that he is a grown-up boy, the situation seems abusive to both of us (CG).

The results of the study also indicated that community members had limited knowledge to identify the qualities of environmental resources that could be considered in improvising materials for PWDs. However, in situations where this was not a challenge, they had inadequate skills in changing the identified raw materials into functional assistive devices. The study further gathered that, in this ward, the views and opinions of PWDs were not effectively considered in issues that concerned them or the development of the entire community.

10. Discussion

The district ward in which the study was conducted relied solely on caregivers for managing and empowering people with various disabilities. These displayed a capacity to give training in self-help skills. However, they were not able to equip these individuals with vocational skills that would further enhance employability and self-sustenance later on in life. According to the Disabled Persons Act (1992), communities have a mandate to avail their members of vocational skills training programmes that are needed in employment settings. In other words, equipping PWDs with life skills should be the responsibility of not only families but all community members. Burnet (2013) observes that if training people with disabilities in vocational skills has to be successful, asset-based assessment must be done before training. Asset-based assessment is the overall evaluation of the person to identify his or her strengths (Davis, 2006). With the availability of diagnosed strengths, PWDs can be trained in vocational skills that they have the capacity to acquire.

Community members must be aware of the basic needs of PWDs in order to assist them appropriately. This involves the general needs of people with disabilities and the ones that are specific to a particular disability or its severity. Lebrum (2002) observes that while people with total loss of vision might need mobility and orientation skills, those who are deaf will wish to use sign language or augmentative and alternative communication. The limited awareness of community members of some of the needs of people with specific disabilities compromises the delivery of CBR. The village health workers who had a mandate in this community to monitor the health and upkeep of community members also could not give satisfactory advice on managing some disability conditions. This contributes to the challenge of CBR. Therefore, all community members need to gain basic skills in managing and accommodating PWDs within communities.

The built facilities like toilets, which were found not to be user-friendly, especially for those with physical challenges in most homes and schools, were indicative of a gap in the drive for effective CBR. Caregivers assisted people with disabilities to access this service more often than expected. In this regard, Munyi (2012) emphasises that public places and utilities should include provisions for accessibility by all people, inclusive of those with physical challenges.

Community members need to acquire skills to use the local resources to provide materials for people with disabilities. They need to improvise and take advantage of their local resources to help people living with disabilities lead independent lives. Raw materials like trees, metals, or rubber that could be used to produce functional assistive devices like wheelchairs, long canes, and hearing aids, amongst others, could be identified and engineered. The Disabled Persons Act (1992) emphasises that PWDs should be provided with orthopedic appliances and other equipment to enhance their functionality.

Inclusive principles require that the views and contributions of people with disabilities should be considered in the community. This is contrary to the findings of this study which revealed that their views and opinions were not sought in the process of making decisions that pertained to their development or that of the entire community. According to Disability services (2012), communities must maximise opportunities for people with a disability to make decisions in all aspects of their lives, specifically those related to their self-directed support. Opening up the space for the voice of people with disabilities to be heard promotes intra and inter-group relations, which is vital for successful community-based rehabilitation.

11. Conclusion

The study concludes that while CBR has a positive impact on the total development of PWDs, a number of crucial factors need to be considered before and during its implementation. For instance, in any setting, whether urban or rural, the responsible authority has to make sure that all community members are aware of what CBR means in relation to improving the quality of life of people living with disabilities. In this regard, they should also be sensitive to their unique and significant roles in all the activities conducted in the community. In addition, the material resources found in any community needs to be assessed for their suitability to verify those that can be used for improvising functional assistive devices. Above all, the perceptions or opinions of people with disabilities should be sought to conduct any CBR programme successfully. These assist in gaining knowledge of their preferences and eventually respecting their fundamental rights as human beings.

12. Recommendations

Based on the findings and conclusion drawn from the study, it is recommended that:

- The Government, Non-Governmental Organisations, and other interested stakeholders should conduct disability awareness campaigns and workshops aimed at:
  - Sensitizing the communities about the specific needs of people with various disabilities
  - Equipping community members with skills of early identification of disability and management
  - Conscientising communities to develop community-based programmes that match their members with various disabilities
- Through the Ministry of Labour and Social welfare, the Government of Zimbabwe should facilitate the intensifying of asset-based counseling, guidance, and therapy leading to vocational training for rural people with disabilities
- Leadership of rural local authorities should make use of resource persons to identify locally available resources that could be used to improvise functional assistive devices for use by PWDs
- The Government of Zimbabwe should consider allocating sufficient funds to improve the physical infrastructure in public places of rural areas to make them accessible to all individuals, including those who are physically challenged and wheelchair-bound

- Local authorities should mobilise community members to partake in the building of infrastructure that caters to the needs of people with disabilities
- Community leaders should urge their members to create an environment that encourages the active participation of people with disabilities in making decisions that pertain to their needs and development
- Through the rural community leadership, the Government of Zimbabwe should periodically monitor and evaluate the administration of available CBR programmes

13. References

i. Bates, P., & Davis, F. A. (2004). Social Capital, Social Inclusion and Services for People with Learning Disabilities. *Disability and Society***,** 19(3): 195-207.
ii. Braum, V., & Clarke, V. (2006). Using Thematic Analysis in Psychology. *Qualitative Research in Psychology***,** 3: 77-101.
iii. Burnett, E. (2013). *Our World Story: The Tales, Traditions and Turning Points of the Past and the Regional Challenges of Toda**y**.* Create Space, London.
iv. Constitution of Zimbabwe, (2013). Harare: Government Printers.
v. Convention on the Rights of People with Disabilities, (2006). London: The Stationery Office Limited.
vi. Davis, L.J. (2006). *The Disability Studies Reader.* New York: Routledge.
vii. Disabled Persons Act, (1996). Harare: Government Printers.
viii. Disability Services. (2012). *Value for Money and Policy Review and Disability Services in Ireland.* Dublin: Department of Health.
ix. Education Act, (2006). Harare: Government Printers.
x. Hardman, M.L., Drew, C.J., & Egan, M.W. (1999). *Human Exceptionality: School, Community, and Family.* Boston, Houghton.
xi. Lang, R. (2011).Community-Based Rehabilitation and Health Professional Practice: Developmental Opportunities and Challenges in the Global North and South. *Disability and Rehabilitation***,** 33(2):165-173.
xii. Lebrum, J. (2007). *Community-Based Rehabilitation (CBR) for People with Disabilities in Nepal.* Nepal: Handicap International, Kathmandu.
xiii. Mannan, H., & Turnbull, A.P. (2007). A Review of Community-Based Rehabilitation Evaluations: Quality of Life as an Outcome Measure for Future Evaluations. *Asia Pacific Disability Rehabilitation Journal,* 18(1): 29-46.
xiv. Munyi, C.W. (2012). Past and Present Perceptions towards Disability: A Historical Perspective. *Disability Studies Quarterly***,** 32(2): 1- 15.
xv. Ong'olo, G. (2000). *The Empowerment of the Visually Impaired in Africa. Conference on Mobility and Rehabilitation***.** Uganda: UNISE.
xvi. Poverty Assessment Study Survey. (2013). Harare: Government Printers.
xvii. Salamanca Statement on Principles, Policy, and Practices on Special Needs Education, (1994). UNESCO
xviii. Sandelowski, M. (2010). What's in a Name? Qualitative Description Revisited. *Research in Nursing and Health***,** 33: 77-84.
xix. Shreve, M. (2011). *The Independent Living Movement: History and Philosophy to Implementation and Practice.* Chicago, Routledge.
xx. Simplican, S.C., Leadre, G., Kosciulek, J. & Leahy, M. (2015).Research in Developmental Disabilities. *Research in Developmental Disabilities***,** 38: 18-29.
xxi. Standard Rules on the Equalization of Opportunities for People with Disabilities, (2003).UNESCO
xxii. Vaismorandi, M., Turunen, H. & Bondas, T. (2013). Content Analysis and Thematic Analysis: Implications for Conducting a Qualitative Descriptive Survey. *Nursing and Health Science***,** 15: 398-405.
xxiii. Wheatley, E. (2010). *Stumbling Blocks before the Blind: Medieval Constructions of a Disability***.** Michigan: The University of Michigan Press.
xxiv. World Health Organisation, (2010).Towards Community-Based Inclusive Development. Matla: WHO Press.
xxv. Zimbabwe Population Census, (2012). Harare: Government Printers.