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Title

Models and case studies of managing disability in Zimbabwe: from Jiri to Mujaji

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Abstract

Zimbabwe has dealt with disability from various angles. The country has various institutions that deal with the medical aspects of disability. These institutions are complemented by the voluntary sector that also provides vocational training and other resources for persons with disabilities. Although the disability movement in Zimbabwe took root a long time ago, there is still a lot of work to be done before the movement accomplishes its task. Disability in Zimbabwe, like in many developing countries is a terrain filled with physiological, psychological, social, economic and political vicissitudes, attitudes and perceptions. In this light, it is that aspect of life not envied by many in society. As a result, persons with disabilities in Zimbabwe find themselves with a plethora of challenges stemming largely from their impairments and interactions with society. Disability is viewed from a variety of perspectives which have come to be known as models of disability. These are the charity model, the medical or personal tragedy model, the religious model as well as the social model to mention but a few. The choice of these models is entirely dependent on a society's understanding of the needs of persons with disability and its level of civilization. This article is geared towards articulating the extent of disability in Zimbabwe, starting with the theoretical issues surrounding disability. The article illustrates the models of disability through vivid examples of cases well known to Zimbabwean society. Finally, the article ends by examining the institutional framework within which disability is handled.

Key words

disability, impairment, Jairos Jiri, Elliot Mujaji, models of disability, social protection, Zimbabwe

Introduction

Zimbabwe has dealt with disability from various angles. The country has various institutions that deal with the medical aspects of disability. These institutions are complemented by the voluntary sector that also provides vocational training and other resources for persons with disabilities. Although the disability movement in Zimbabwe took root a long time ago, there is still a lot of work to be done before the movement accomplishes its task. Disability in Zimbabwe, like in many developing countries is a terrain filled with physiological, psychological, social, economic and political vicissitudes, attitudes and perceptions. In this light, it is that aspect of life not envied by many in society. As a result, persons with disabilities in Zimbabwe find themselves with a plethora of challenges stemming largely from their impairments and interactions with society. Disability is viewed from a variety of perspectives which have come to be known as models of disability. These are the charity model, the medical or personal tragedy model, the religious model as well as the social model to mention but a few. The choice of these models is entirely dependent on a society's understanding of the needs of persons with disability and its level of civilization. This article is geared towards articulating the extent of disability in Zimbabwe, starting with the theoretical issues surrounding disability. The article illustrates the models of disability through vivid examples of cases well known to Zimbabwean society. Finally, the article ends by examining the institutional framework within which disability is handled.

Disability: an overview

Defining disability

Disability is a highly contested concept varying in definition, understanding and interpretation within and across cultural boundaries (Mnsaka, 2012). The International Convention on the Rights of People with Disabilities (ICRPD) adopts a social model of disability, and defines disability as including:

> *…those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.*

On the other hand, the Disabled Persons Act Chapter 17:01 of 1992 defines a disabled person as:

> *a person with a physical, mental or sensory disability, including a visual, hearing or speech functional disability, which gives rise to physical, cultural or social barriers inhibiting 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 definitions 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.

Causes and prevalence of disability

Causes of disabilities may be categorized into four as follows:

- Traumatic e.g. due to injuries caused by accidents, burns, war or occupational hazards.
- Congenital e.g. related to birth defects.
- Genetical e.g. caused by inherited genes, although the prevalence is low.
- Unknown causes.

Disability statistics are a source of contention. The contention often emanates from what makes a disability. Globally, it is estimated that over one billion people live with some form of disability. According to WHO 15% of any given population has various forms of disabilities translating to over one billion people with disabilities in the world of whom 2-4% experience significant difficulties in functioning (WHO, 2011). Over 75% of people with disabilities are in developing countries. Further, WHO estimates show that there are over 1,8 million people with disabilities in Zimbabwe, which is about 15% of the total population (WHO, 2011). As shown by Choruma (2007) and Mtetwa (2012), prevalence of disability in Zimbabwe is contentious.

In Zimbabwe, the debate is not substantiated with adequate prevalence studies. The Government of Zimbabwe estimates that about 130 000 or 1% people live with disabilities (ref). This figure is contested by disability

organizations and people with disabilities themselves. The National Association of Societies for the Care of the Handicapped (NASCOH) argues that disability prevalence is over 10% of the population. This translates to 1 200 000 people.

Disability process

There is often a misunderstanding of three words relating to disability. These are disability, impairment and handicap. The confusion surrounding these words is often seen in their use, verbally or in written form. At times they are used interchangeably, to mean the same thing. To clarify what these three words mean, it is crucial to clarify the disability process. These three elements make up the disability process. The process starts with impairment, followed by handicap and then disability (Oliver, 1996). At impairment level, a person loses a body part. Thus, loss of a physical body part becomes impairment. For example, in an accident, a limb may be lost. This results in an impaired person. Alternatively, a brain cell responsible for memory may be damaged. The loss of that cell becomes impairment (Oliver, 1996). Further in the process, a person whose limb is lost may be unable to work or walk. On another hand, a person whose brain cell responsible for memory is injured may also lose the memory function. Thus, loss of the function of walking, working or memorizing becomes a handicap (Choruma, 2007). If a handicapped person fails to get a wheelchair that can compensate loss of body part and loss of function, then the person becomes disabled. Or if a person with a wheelchair is unable to access a building because it has stairs then that person becomes disabled. In most cases, society can do something to avoid a disability (Reeve, 2004).

Models of disability

Disability is the quintessential post-modern concept, because it is so complex, so variable, so contingent, and so situated. It fits at the intersection of biology and society and of agency and structure. Disability cannot be reduced to a singular identity: it is a multiplicity, a plurality... (Shakespeare and Watson, 2001:19). These are paradigms explaining issues relating to disability. There is currently no single paradigm that can explain the causes, impact and management of disabilities. However, a number of approaches exist that provide explanations. When combined, these approaches enhance understanding of disability issues.

Traditional model

The first of these approaches is normally termed the traditional or religious model. According to Oliver (1996), this model sees disability from a religious or cultural perspective. In terms of causes, this view assumes disabilities are a form of punishment from ancestors or gods. In Christian faith, people with mental challenges are regarded as possessed by demons. Such beliefs often lead to ostracism, stigma and discrimination. This view of looking at disability has been discredited and discarded because of its focus on common sense. However, some communities still use this view.

Charity model

The charity model of disability, at times termed the deficit or tragic model, assumes that people with disabilities deserve pity, sympathy and that their plight can only be solved by philanthropists through charity or welfare. The medical model of disability focuses on rehabilitating the individual with a disability. It believes disabilities are caused by impairments hence the need for medical intervention to correct the disability. Medical sociology makes sense of 'chronic illness and disability' through the *social deviance* lens, while disability studies have *social oppression* as their analytical signature. (Thomas 2007:178).

Medical model

The other approach is normally termed the medical model. It is at times termed the individual or deficit model. It views disability as abnormality. It makes a distinction between abnormal body parts and functions. Most body parts and functions which are absent from the mainstream population are regarded as forming a disability. As remedies, persons with disabilities are expected to be cured or corrected to resemble characteristics of the main population in a given society.

Social model

The other model is the social model. It is widely used and it has gained a wider acceptance. The model contends that disability is caused by society. Proponents of this idea, mainly people with disabilities, believe that it is society that impairs and disables people with disabilities. Disability is social creation. They believe that to tackle disability, society should be the main focus. Society should prevent impairments and accept people with disabilities as part of diversity (Oliver, 1996). The social model views disability as a product of the social

organization (Reeve, 2004). It asserts that society 'disables' by placing barriers on people with disabilities (Mtetwa, 2012). It calls for social integration, altering the environment and social action.

Human rights based model
This model assumes that barriers created by society can only be removed by guaranteeing rights to people with disabilities. It argues that disability rights are human rights. It calls for opportunities and participation.

Economic model
This model sees disability as a result of marginalisation of people with disabilities in the economy. Exclusion and discrimination, as a result of stigma and competition in the economic sphere makes people with disabilities economically disadvantaged.

Political model
This model works hand in hand with the human rights model. It assumes that without political power, persons with disabilities will remain marginalised. It calls for political representation, formation of organisations of persons with disabilities and mainstreaming disability.

Affirmative model
This model is about people with disability defining themselves and the models they would prefer. It is about people with disability taking the lead in issues affecting their lives.

Indigenous model
This model is about what is culturally relevant to the situation of people with disability. In the past, models taken from Europe or America have been forced on people with disability in developing countries, through a process called colonisation. Indigenisation is about valuing local ways of dealing with disability and doing awy with colonial ways.

Case studies from Zimbabwe showing use of different models

Jairos Jiri's charity model of disability and rehabilitation

The Founder of Jairos Jiri Association for the Disabled and Blind (JJADB), Jairos Jiri was born in Mutenyami Village of Bikita on 26 June 1921. His father, vaMutenyami was a Chief and his mother, vaMarufu was a daughter of Chief Mazimba of Gutu. He wished to be educated like at other children at nearby Silveria Mission but his dream was not achieved since his parents were poor. He worked in his family garden and reared poultry to get money for school fees but was only able to go up to standard 2 (Grade 2) at Gokomere Mission in 1937. He dropped out of mission school because of health challenges. At the age of 17 years, he went to Masvingo, then Fort Victoria, and worked as a garden boy for a year. He was poorly paid, so he left for Bulawayo with his brother Mazviyo trekking the railway line. Whilist in Bulawayo, he came face to face with urban poverty. Urban youth were destitute and disabled people begged in the streets. During World War II, injured soldiers in the Rhodesia African Rifles were rehabilitated in Bulawayo. Jiri was employed as a dishwasher at one of the rehabilitation centres. Whilst there, he leant about rehabilitation especially from white military medical officers.

Later, he was to use this knowledge to initiate an association for people with disabilities which opened its first training centre in 1951. The first association was supported by the Municipality of Bulawayo and people like Benjamin Burombo, Joshua Nkomo and Michael Mawema. He used his personal savings to initiate the association and to give handouts to people with disabilities, including ferrying them to hospital on his bicycle. Such kindness made his to become one of Zimbabwe's greatest philanthropists. His associations grew in number and he reached so many people. One of his centres in Bulawayo trained in music and dance, producing (Dr. Love), Paul Matavire , the late and great music composer and singer. Paul led the Jairos Jiri band and made it very popular.

He was recognized fairly. He had awards locally and abroad including Member of the British Empire (MBE) conferred by the Queen of England and Master of Arts Honorary Degree conferred by the University of Zimbabwe (then University of Rhodesia). He met Pope John Paul who presented him with a medal. He addressed conferences and toured several countries. After establishing 16 centres and after all this great work, on 12 November 1982, he passed on. When he died, the Government of Zimbabwe accorded him hero status and had it not been for his brother Ziwumbwa who preferred that he be buried at his rural home, he was supposed to be buried at the National

Heroes Acre. His funeral was attended by dignitaries from Zimbabwe and abroad, among them President Robert Mugabe.

The story of Mr. Jiri highlights that the charity model of disability is motivated by background and values. Mr. Jiri probably developed these values based on his personal tragedy. He lacked the basic things he required as a boy among these was education, health and income. He lived near a mission and the little education he obtained was from a mission school where he also learned about Christian values. But we can also not rule out that his immediate surroundings, his family and community espoused values of *ubuntu/unhu*. His father being a Chief and his mother being daughter of a Chief impacted on his values towards others. Zimbabwean chiefs are termed *vana chirera nherera* meaning those who look after orphans. He grew up in a community where helping others is valued. Poverty in Rhodesia necessitated Jiri to act against it. On another hand, his association with rehabilitation doctors was also instrumental in nurturing his kindness.

Whilst Mr. Jiri's work was charitable, he broadened the association to become developmental. This can be seen in empowerment which was achieved through training. He also ensured medical treatment for those who required it. For all this work, he was recognized and awarded. He received recognition as follows:

1. Zimbabweans recognised him as Baba, meaning respected father.
2. The Government of Zimbabwe honoured him by naming an award in his name, The Jairos Jiri Humanitarian Award given to people who contribute significantly to helping others.
3. He was honoured with the National Hero of Zimbabwe status.
4. International Symposium on Rehabilitation awarded in Kampala, Uganda in 1975.
5. Honours Degree in Masters of Arts by the then University of Rhodesia, now University of Zimbabwe.
6. Lions International Service Award in 1977
7. Humanitarian Award from the then Salisbury Union of Jewish Women in 1977.
8. Freedom of the City of Los Angeles in 1981.
9. Goodwill Industries International Award for Humanitarian and Rehabilitation Work in 1981.
10. Rotary International presented him with their International Year of Disabled Person Award for Africa which carries citation "Greatest Contribution to Rehabilitation in Africa - IYDP 1981".

The medical model: St Giles Rehabilitation Centre

St Giles is the most comprehensive and biggest rehabilitation centre in Zimbabwe. It specializes in rehabilitating stroke patients, accident victims and children. At its rehabilitation complex in Harare, it has a hospital for treatment of disability related ailments. It has a physiotherapy unit, occupational therapy unit, speech and language therapy unit and a social therapy unit. It runs a school for children with special needs. Although St Giles fuses all these functions, its main function is the medical functioning of the person with a disability.

Tracing mental health: the life of Rodwell Biggie Mhosva Marasha Tembo

Popularly known as Biggie Tembo, Mhosva Marasha was born on 30 September 1958 in Chinhoyi although give his date of birth as 31 October 1957. He was of the *tembo* (zebra) totem. Rodwell was his baptism name. He initially worked as a domestic worker for a white family. He rose to popularity through Jit and Chimurenga music. He worked with musicians like Cehpas Mashakada before he teamed up with colleagues like Kenny Chitsvatsva to form Bhundu Boys. The name Bhundu perhaps came from the fact that Mhosva was a *mujibha* or a bush boy as war collaborators were known during the liberation struggle. The Bhundu Boys topped charts in Zimbabwe with their songs like Simbimbino, Hatisitose, Tsvimbo dzemoto, Kuroja chete, Faka pressure and Chekudya chese. In 1984, he first toured the UK and got lucrative contracts. In 1986, he then immigrated to the UK together with his family. The climax of his career was probably when he curtain-raised for Madonna at Wembley to a 70 000 crowd. He toured more than 20 countries.

It is believed, fortune and fame overtook him. Some content that drugs became part of his life. Some argue that work stress affected him. He had disagreements with his Bhundu Boys band and his music promoters. In 1991, he dumped the group or was he dumped by the group but formed his own. His fortunes started falling. Stress developed to depression which was treated at a Bristol hospital in the UK. It then developed to psychosis as pressure mounted on him. He was deported together with his family, and his musical group refused him re-entry. In Zimbabwe, he received psychiatric treatment at Harare Hospital, but it did not help for long. It is assumed he also received traditional therapy especially in relation to the view that he did not know his real father. He believed

traditional methods would help him find his father and that his mental ill health was a result of his father looking for him.

Some Zimbabweans believed otherwise, advising him to get faith healing. He joined ZAOGA church, where he was promoted to become a pastor. He then started pastoral training. With his challenges not going, rather becoming huge, his mortgage home in Highfield repossessed by the bank, his mental health deteriorated. He was in and out of hospital. He was violent, even at church. All other means having failed to restore his life, Biggie committed suicide in a seclusion cell at Harare Mental Health Hospital on 30 July 1995, leaving behind a wife, four children and a music legacy. The story of Tembo gives an insight into how society views mental health as a disabling condition.

Preventing disability: Occupational health and safety at NSSA

Zimbabwe's National Social Security Authority (NSSA) is the arm of government responsible for social security. Social security refers to:

> *...public policy measures intended to protect an individual in life situations or conditions in which his or her livelihood and wellbeing may be threatened...based on the principle of solidarity and pooling of resources and risks. Social security involves making contributions from one's income whilst working and in good health.*

The contributions are saved for future during periods of injury, old age, retirement, invalidity, unemployment, death, sickness or otherwise.

NSSA has schemes that presently favour those who are formally employed. These schemes include the Pensions and Other Benefits Scheme and the Accident Prevention Workers Compensation Scheme (APWCS). These are mandatory schemes run by the National Social Security Authority (NSSA) under the NSSA Act Chapter 17:04 of 1989 and statutory instrument 393. NSSA schemes provide a fund (grant or pension) after retirement, provide a funeral grant, and provide spouse and survivors grants. Health and rehabilitation assistance is given to injured workers. NSSA has a department for occupational health responsible for preventing injuries through safety awareness and workplace inspections.

The APWCS receives contributions from the employer and has the following disability related objectives:

- Providing financial relief to a person injured at work and their families.
- Create awareness and promote health and safety at workplace.
- Promote health and safety legislation and policy.
- Providing rehabilitation services to those who are injured at work to avoid disablement. This is mainly done at NSSA's Workers Compensation Rehabilitation Centre in Bulawayo.

The scheme does not cover government employees, domestic workers and these in the informal sector. Each employer contributes according to the risk factor of their industry. All contributions go to the Workers Compensation and Insurance Fund (WCIF) administered by NSSA. The WCIF provides the following benefits:

- Periodical payments to compensate for earnings lost.
- Medical costs covering transport, drugs, hospital stay and artificial appliances.
- Lump sum payment if disability is less than 30%. This includes a children's allowance for children below 19 years of age.
- Pension is given for employees with permanent disablement of over 30%. This includes allowances for children below 19 years and those still in education below 25 years.

Combining disability models: the work of the Epilepsy Support Foundation

The Epilepsy Support Foundation has a centre in Hatfield Harare. At the Centre, they specialize in promoting epilepsy education. This is based on the principles of its founder, Nicholas George, who lived with epilepsy for over 40 years. The main principle is that epilepsy is a social condition characterized by recurrent seizures. George argued that seizures have a biological origin but to manage the effects of seizures, awareness has to be promoted. For several years, the ESF promoted this philosophy but later realized that awareness without medical treatment

is inadequate. They then started working with the Ministry of Health to promote treatment but challenges like limited medical personnel and limited anti-epilepsy medicines resulted in most people not getting adequate medical care. As a result, the ESF initiated its own clinic to compliment government efforts. At the clinic, they have nurses, visiting doctors and more importantly diagnostic services like the encephalography (EEG).

Overcoming disability: The story of Elliot Mujaji

Elliot Mujaji was injured at work at Shabanie Mine at the age of 30. Before he was injured, he had qualified to compete at the 1998 Commonwealth Games. He was injured as a result of an electrical fault. He sustained severe burns and stayed for two months in a comma. He subsequently lost the lower half of his right hand which had to be amputated. This limited him physically. After recovering, he resumed training in athletics which he did well to prove to society that disability does not mean inability. He became a professional athlete, winning several trophies at home. His greatest moment was when he won gold at the Paralympics. The Paralympics were held during summer in Sydney and he won the first ever gold medal for Zimbabwe having sprinted the fastest in the 100 metres category. He was also Number 1 in the 200 metres sprint but was disqualified for encroaching into another line. His other 100m gold medal was at the 2004 Summer Paralympics in Athens. He competed during the Beijing Paralympics in 2008 and London Paralympics in 2012 but did not get any gold medals. He became a hero and had dinner hosted by President Mugabe at State House. From 2000-2006, he was awarded the Sportsman of the Year with a disability at the Annual National Sports Awards. What he had to say:

> *More disabled people should be seen in sport than on the streets. There are great benefits for the talented. The games can be a source of living. I had nothing when I started, but now I am a proud owner of various assets.*

Some options for managing disability

Income options for persons with disabilities

One of the challenges affecting people with disabilities in Zimbabwe is the availability of income. There are basically three ways an adult person can get income in Zimbabwe. The first one is through working in home-based agriculture as peasant farmers. Income is obtained from the fields through cultivation of crops or through gardens where vegetables are mainly grown. For people with disabilities, this is often a challenge. The second way to get an income is to get formally employed in the public service or in industry. There are various opportunities and, therefore, people with disabilities can choose from a variety of job types. However, whilst options are available, being employed depends on the decision of some other person or a committee. Owners of companies or prospective bosses may decide to hire a person or not. In other cases, selection committees hold that decision. The third option for people with disabilities to get income is through participation in the informal market. This involves production of goods for sale, reselling or providing services. It is easy to enter buying and or quit as no certificate is demanded. In most cases, however, people with disabilities do not qualify to get income because of their impairments. Participation in the three modes of getting an income is also limited by discrimination and labour market exclusion. In Zimbabwe, if one fails to get an income due to any of these modes, they may qualify for government social assistance. This currently gives about $20 a month. It is paid through the Department of Social Services. Other assistance may include support with assistive devices, payment of hospital bills, payment of rent or transport. In most cases though, this support is inadequate. At times, non-government organizations, churches, companies and individuals give handouts to people with disabilities and support developmental projects. Often, the support is limited and short lived. As a response, some people with disabilities have resorted to begging to get an income. Begging is done in the streets, in homes, institutions, buses or trains.

Institutional options

Creating institutions to manage disability is one option that has been used in Zimbabwe. Various institutions deal with disabilities in Zimbabwe. There are several ways to classify institutions. These can be categorised according to the government relationship, level of operation, type of disability or membership.

- Government relationship: institutions can be government, government related or non-government examples include the Department of Social Welfare, the Disability Board or the Rehabilitation Department within the Ministry of Health and Child Welfare. The president has a special advisor on disability and rehabilitation;
- Level of operation: institutions can operate at grassroots/community level, national level, regional level, international level;

- Type of disability: institutions may be classified according to their focus or type of disability they deal e.g. human rights or relief;
- Membership: organisations for people with disabilities e.g. NASCOH and organisations of people with disabilities e.g. Disabled Women Support Organisation (DWSO).

Legal options

There are legal issues relating to disability. Some of these include defining what disability is and also protecting the rights of people with disabilities. In Zimbabwe, the main legal instrument is the Disabled Person Act. It seeks to promote the rights of people with disabilities. The Labour Act seeks to protect the rights of people with disabilities in the labour market. The Mental Health Act seeks to achieve basically two things. Protect society from harm caused by violent mentally ill patients and to protect people with mental illnesses from harming themselves e.g. through suicide.

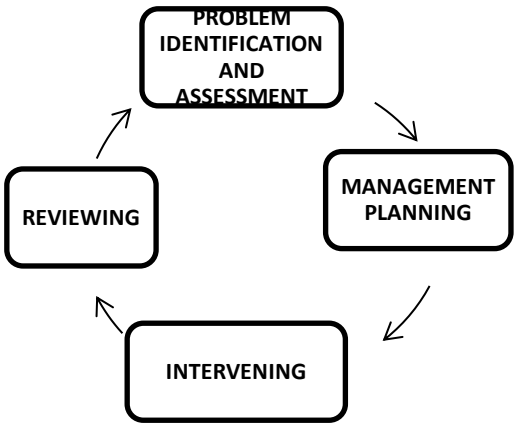
Professionals training option

Disability Studies is growing as a field. In Zimbabwe the Zimbabwe Open University pioneered disability studies with a Diploma in Disability Studies. Social work training does not cover disability studies per se, but covers principles and practice of rehabilitation. This has been the trend at the three Schools of Social Work in Zimbabwe, i.e. the University of Zimbabwe, Bindura University and Women's University. Marondera Hospital hosts Zimbabwe's School of Rehabilitation. At this institution, training in occupational therapy, speech and language therapy and physiotherapy is offered. Ingustheni in Bulawayo is the specialist institution for training in Psychiatry.

Social therapy

Social therapy is a method of managing disability based on person, group and community centered approaches. At the personal level, interventions like counselling are provided. At group level, group therapy activities are provided as a form of activity rehabilitation. At community level, there is community awareness, lobbying and other techniques. This process can be illustrated graphically as shown below:

The social therapy process



Social therapy process starts with problem identification and assessment. This is followed by planning for intervention. After a plan to manage the problem has been made, it is implemented. This is followed by assessment of the results of the intervention and further plans are designed. This is a cycle.

Conclusion

Disability is a cause for concern not only because of the physical limitations it presents, but according to Mittan (2012) and Kleinman & Hall-Clifford (2009), also because of the social issues like exclusion surrounding it. In support of Mittan's position, the United Nations, through its Standard Rules on the Equalisation of Opportunities for Persons with Disabilities, notes that exclusion contributes to a poor quality of life for people with disabilities. This view, accepted by the Government of Zimbabwe, is also supported by disability activists, amongst them Handicap International (HI), Inclusion International (II) together with National Council for Disabled Persons (NCDPZ) and National Association of Societies of the Care of People with Handicaps (NASCOH) at local level.

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