

**Psychological wellbeing of adolescents with physical disabilities in Zimbabwean inclusive
community Settings**

by

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PRETORIA

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“I declare that the thesis, which I hereby submit for the degree of philosophiae doctor(Educational Psychology) at the University of Pretoria, is my work and has not previously been submitted by me for a degree at this or any other tertiary institution”.

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Date _____



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ABSTRACT

The purpose of this study was to explore the psychological wellbeing of adolescents with physical disabilities living in inclusive community settings in Zimbabwe. An inclusive community is one that aims to remove exclusionary practice within the community and promote community's systems that accept all people, regardless of their differences. A constructivist lived experience perspective underpinned this research, in which the researcher used multiple case studies to interact with the participants about their inclusion and psychological wellbeing as adolescents with physical disabilities. The 14 participants (nine males and five females) were purposively sampled. Data was collected through face-to-face interviews.

Four themes emerged from the inductive thematic analysis of data sources. It was found that participants in this study were involved in various inclusive community activities available within their communities. The study also found that parent, the government, the community and donor communities were working together towards improving the lives of adolescents with physical disabilities in the communities in which they live. These stakeholders assumed different roles, such as providing disability awareness education, vocational counselling, and inclusive infrastructure and resources. The study also found that the participants encountered environmental restrictions in choosing inclusion activities in which to participate in their communities.

The findings of this study have the potential to help the policy makers and researchers in inclusive communities to better understand the needs of adolescents with physical disabilities living in these communities. Furthermore, the current research has the potential to guide future research and develop future initiatives to improve the psychological wellbeing of adolescents with physical disabilities, thus improving their outcomes and quality of life.

Key words:

Adolescents, disabilities, Inclusion, Inclusive communities, psychological wellbeing, physical disabilities

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DEDICATION

I dedicate this thesis to my late mother Etah (02 /04/1919-31/10/2012) and my father Machina Denhere who sacrificed all they had towards my education. I also dedicate this work to my wife Erica Makicheni whose humaneness, love and dedication became pillars I leaned on when I could not toil on anymore. Your support spurred me on and gave me unceasing strength towards the goal. I also dedicate this thesis to my beloved children who grew up seeing a father who was ever away pursuing education. Thank you, Tafara Machina, for coming during the last hour of this journey and inspiring me to make a difference in my academic career. Last, but by no means least, I dedicate this thesis to all those adolescents with physical disabilities who generously shared their stories with the readers and me.

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First and foremost I would like to thank the institutions and the individuals that played key roles in enabling me to conduct this study and write this thesis. I would like to thank the Zimbabwean Ministry of Primary and Secondary Education for giving me the authority to carry out this study in its schools. You set the whirlwind in motion, and made it possible for it to traverse boundaries –I thank you.

I am equally greatly indebted to my employer, the Zimbabwe Open University, for the support I received in varied ways since the beginning of this journey.

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Lastly, thank you Isabel Claassen, for performing the language editing of my work with great care, wisdom and passion.

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ACRONYMS

AU African Union

UN United Nations

UNESCO United Nations Educational, Scientific and Cultural Organisation

WHO World Health Organization

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1. CHAPTER 1:

INTRODUCTION TO THE STUDY

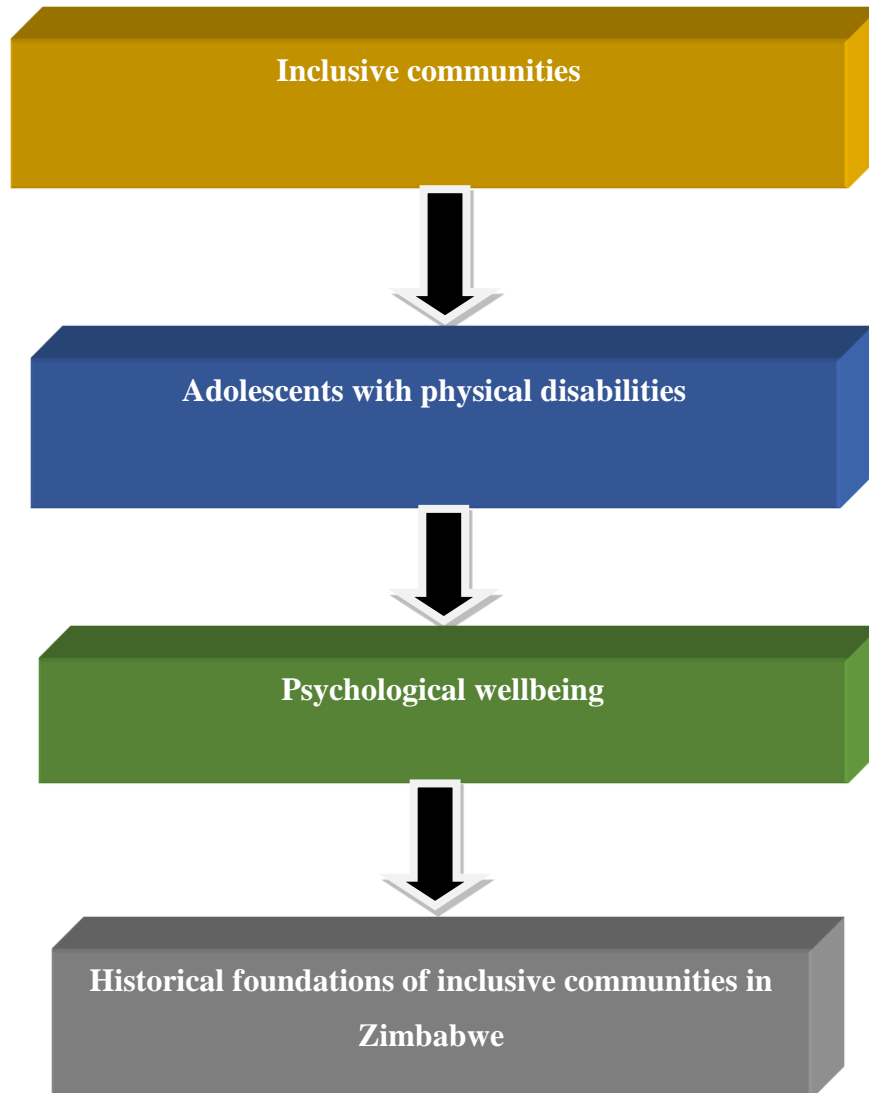


Figure 1.1: Chapter Map

1.1 Introduction

The purpose of this research was to explore the psychological wellbeing of adolescents with physical disabilities in inclusive community settings in the Mashonaland West province of Zimbabwe. For adolescents with physical disabilities, psychological wellbeing is important, as it is positively linked to self-acceptance (Leiblum, Koochaki, Rodenberg, Barton, & Rosen, 2006; Santtila et al., 2007); establishment of quality ties to others (Santosa, Öhman, Högberg, Stenlund, & Hakimi, 2011); as well as continued growth and development as a person (Gallicchio et al., 2007). Conversely, having a disability has a negative impact on psychological wellbeing and general happiness (Lewis et al., 2010; Sadovsky & Nusbaum, 2006). There is an interactive association between having a disability and poor psychological wellbeing (Basson, Rees, Wang, Montejo, & Incrocci, 2010). Physical disability is a bodily dysfunction that has negative consequences for health and psychological wellbeing.

This chapter introduces the concept of inclusive communities, physical disability and psychological wellbeing, and posit the rationale for exploring the psychological wellbeing of adolescents with physical disabilities in inclusive community settings in the Mashonaland West province of Zimbabwe. The chapter provides definitions of the concepts inclusive communities, adolescents with physical disabilities and psychological wellbeing; it touches on the historical foundations of inclusive communities in Zimbabwe and continues to provide a statement of the problem, the rationale of the study, the research objectives, research questions and a conclusion.

1.2 Inclusive communities

Inclusive communities are communities that put never-ending strategies to effectively address diversity in its communities (Mutamiswa & Chakuchichi, 2003). They facilitate the inclusion of people with and without disabilities, rather than expect individuals to fit into the existing arrangements (Chakuchichi & Mutamiswa, 2003; WHO, 2001). Inclusive communities are not

about the vulnerable members of the community but constitute a framework through which all community development can take place (Ainscow, 2003). Inclusive communities recognise that all community members, not only those who are vulnerable to marginalisation, require communities that are responsive to all aspects of community diversity (Ainscow, 2003). The core value of an inclusive community is acknowledging that people are different and that diversity should be valued (Chakuchichi, Chimedza & Chinze, 2003; Engelbrecht & Green, 2007). An inclusive community engages in both sustained and sustainable strategies that are designed to address the needs of its diverse people. It is a lifelong process as it is not possible to respond to the needs of all community members at the same time, and because individuals' needs continuously evolve and change as life progresses.

Inclusive communities are concerned with the identification and removal of barriers to community adjustment, development and participation (Ainscow, 2003). Inclusive communities have the potential to serve as the context for the creation of sustainable and free support systems and a means of communication adapted to meet the diverse needs of community members. Inclusion in community is about the presence, participation and achievement of all community members. Presence implies location, that is, where the individual is, and participation is concerned with the quality of his/her experience (Ainscow, 2003). Although inclusive communities are not uniquely designed for vulnerable populations, they have been adopted by most communities as a basic strategy to influence and enhance the psychological wellbeing of their people with disabilities. The next section contains a brief overview of adolescents with physical disabilities, the types, examples and signs of physical disability, followed by an introduction of the concept of psychological wellbeing.

1.3 Adolescents with physical disabilities

Adolescents are aged between 13 and 19 years of age and the physical disabilities that they experience are physical impairments that significantly limit their participation in the activities of

daily life (Harris, 2008; Tafangombe & Mutamiswa, 2009). Adolescents with physical disabilities have problems with moving their bones, joints and muscles. The particular group involved in the current study includes those with orthopaedic conditions, neurological defects, musculoskeletal impairments and those with health-related problems.

The causes and types of physical disabilities vary from one individual to the next (Chinze & Tambara, 2000). However, most physical disabilities (Mpofu et al., 2011) are congenital, meaning they are present at birth or before. Such physical disabilities could result from metabolic dysfunction, toxic reactions or radiation, among other things (Heward, 2003). Other physical disabilities, however, are acquired and are often the result of accidents, diseases, and pre- or post-natal complications (Heward, 2003). Physical disabilities exclude visual or auditory impairments, although some people with physical disabilities have these disabilities as secondary problems (Mpofu et al., 2012; Heward, 2003). People with physical disabilities may also have other disabilities such as mental impairment, or emotional, behavioural and communication disorders (Mpofu et al., 2012). Appendix I (pp: 163) provides a summary of physical disabilities that emerged from a study of the available literature.

1.4 Psychological wellbeing

Psychological wellbeing is a multifaceted concept (Kahneman & Krueger, 2006). It is generally believed that psychological wellbeing is made up of three distinguishable aspects (Dolan, Layard & Metcalfe, 2011; Kahneman & Deaton, 2010), namely evaluative, affective and eudemonic wellbeing. Evaluative wellbeing involves global assessments of how people evaluate their own lives or their satisfaction with life (Desmarais & Savoie, 2011, p. 14; Fredrikson, 2001). Affective or hedonic wellbeing involves measures of feelings such as happiness, sadness and enjoyment (Fredrikson, 2001).

Inclusive community affects the psychological wellbeing of its members differently. For example, there is a higher possibility that community members who are physically handicapped and live in inclusive communities will not report the same level of psychological wellbeing as their peers without disabilities. The greater the impairment (type of impairment), the more severely it will affect the psychological wellbeing of the affected individual, even if he/she lives in a community that practises inclusion. The next section provides a Levant background to the study and situates the concept of inclusion in Zimbabwe and psychological wellbeing of people with disabilities.

1.5 Background to the study

Zimbabwe is a country in Southern Africa. It has a population of approximately 13 million people comprising of eight major cultural-linguistic communities, namely Asians, Kalanga, Ndebele, Shangani, Shona, Tonga, Venda and whites (Mpofu et al., 2007; Zimbabwe Census, 2014). The Shona and Ndebele constitute the majority of the population (Mpofu et al., 2007; ZMSAT, 2013). Of the 13 million people in Zimbabwe, about 5 million are adolescents (ZIMSAT, 2013). If one applies the World Health Organization's (WHO) estimate that 0.2-1.5 percent of people worldwide have a physical disability (African Union Commission, 2010; WHO & World Bank, 2011), Zimbabwe is likely to have approximately 333 000 adolescents with physical disabilities.

The general quality of life for people with disabilities has shown some improvement over the last decade. This has been due largely to the involvement of these individuals with disabilities in various inclusive community strategies (Choruma, 2006). The adoption of inclusive community practices by many countries in Africa came as a result of international conventions and pressure from disability advocacy groups, mainly from international communities such as the United States of America and the United Kingdom (Chimhonyo et al., 2011). This has directly influenced most Zimbabwean adolescents with physical disabilities to move from disability group homes to living in more inclusive communities (Majoko, 2005; Makuyana, 2004; Mkandla & Matarutse, 2002). Those who remained behind in group homes are catered for by special institutions such as

Jairos Jiri, Daniko and residential rehabilitation hospitals that are scattered around the country (Hungwe, 2005; Mpfu & Shumba, 2012; Mpfu et al., 2012), as inclusion has its own limits (Hansen, 2012). Other adolescents with physical disabilities are kept indoors by their parents for various reasons, including attitude-related reasons (Choruma, 2006). An example of an attitude-related reason would be when family members consider their children with physical disabilities as incapable of socialising with others (Choruma, 2006; Mpfu, 2003). This is particularly true in the case of adolescents who experience disability comorbidity. Comorbidity in this case means having a physical disability coupled with mental illness and/or severe behaviour disorders (Heward, 2003). People with physical disabilities tend to be stigmatised by the communities in which they live, and most of these stigmas are attitude related. Although attitude-related stigmas against people with physical disabilities are found throughout the world, they tend to be especially high in developing countries (Mpfu et al, 2013).

The Zimbabwean Ministry of Public and Social Services has the primary responsibility for supporting communities in their inclusive community practice (Mpfu et al., 2007). It provides a wide range of inclusive community services (Mpfu et al., 2007) (e.g. counselling, disability advocacy, income-generating projects, assistive devices, education, etc.) that are consistent with the Jomtien World Declaration on Education of 1990 and the Salamanca World Conference on Special Needs Framework for Action 1994. The Jomtien World Declaration on Education provides guidelines for inclusive community practice. Inclusive community activities are designed to enhance the psychological wellbeing of adolescents with physical disabilities (Mpfu et al., 2007).

Zimbabwe is a member of both the United Nations (UN) and the African Union (AU). The country was once a model country for inclusive communities in Africa with a high-level disability advisor to the president, and progressive inclusive communities' legislation (Choruma, 2006). It was one of the first countries in Africa to adopt disability legislation in 1992 (UNCEF, 2005). The pro-inclusive laws were designed to encourage communities to facilitate the smooth integration of people with disabilities into mainstream society by enhancing their psychological wellbeing. Zimbabwe is also a signatory to a number of pro-inclusive community conventions such as the

Jomtien (Jomtien World Declaration on Education for All Report 1990) and the Salamanca Framework (Salamanca World Conference on Special Needs Education Framework for Action, 1994). The country also ratified the UN Convention on the Rights of Persons with Disabilities (UCRPD, 2016) and the Optional Protocol on 23 of September 2013. The UN Convention on the Rights of Persons with Disabilities and the Optional Protocol are still regarded as the cornerstone for inclusive community practice.

Zimbabwe currently has no specific legislation for inclusive community practice similar to the United States PL 91-142 (Mpofu et al., 2007, p. 443) or the UK's Equality Act of 2010 (Equality Act 2010). Nonetheless, it has several legislations (e.g. Social Welfare Assistance Act, 1998; Child Protection Act, 1999) and policy circulars (e.g. Secretary's Circular No. P36 of 1990; Education Secretary Circular No. 2 of 2000) whose intent are to support the existence of inclusive communities' (Mpofu et al., 2007). The legislations are also intended to address the psychological needs of Zimbabwe's citizens with physical disabilities (Choruma, 2006; UNICEF, 2005). For example, the Zimbabwean Education Act (1987) promotes universal education, regardless of disability. The Education Act of 1987, as amended in 1996 and 2006 respectively, states that every child has the right to access education at the nearest school. The law forbids discrimination by the imposition of onerous terms and conditions with regard to the admission of a student to any school on the grounds of race, tribe, and place of origin, national origin, political opinion, colour, creed or gender.

Despite the fact that Zimbabwe still needs to introduce specific legislation on inclusive education, a UNESCO (1996) study on inclusive community needs legislation regarded Zimbabwe's policies as some of the most comprehensive in Africa. The report noted that the policies included the following elements:

1.5.1 Early identification and intervention

Early identification and intervention of people with disabilities in Zimbabwe requires that existence of a disability be identified at the earliest possible time (Mpofu, 2003). This can be done through the following: general observation as in most cases with physical disabilities; x-rays; or the administration of standardised tests for salient disabilities such as learning disabilities, mental retardation, and sensorial impairments such as hearing and visual loss (Chimhonyo et al., 2012). These activities are aimed at identifying the individual's disabling conditions so as to provide appropriate community support. Different disabilities manifest themselves at different life stages (Mpofu et al., 2012). For example, some types of physical disabilities (e.g. arthrogyrosis, scoliosis, phocomelia, acheria, amelia, paraxial hememila) are identifiable at birth because they have physical markers, such as absence of hands and limbs, while other disabilities (e.g. hearing impairments, speech defects, learning disabilities, mental retardation) are identified later in life. Hence, the timeliness of early identification and intervention depends on the type of disability.

1.5.2 Development of local training facilities

This involves the construction of institutions that serve to address the needs of people with disabilities (Mutamiswa & Chakuchichi, 2003). Examples of such institutions include rehabilitation centres, colleges and universities where those who work with people with disabilities are trained, as well as adapted sports facilities.

1.5.3 Procurement of equipment

Through the buying of equipment individuals with disabilities are assisted to live the least restrictive life (Mutamiswa & Chakuchichi, 2003). Examples of such equipment include wheelchairs, rehabilitation equipment and other forms of assistive devices for various disabilities.

1.5.4 Provision of support and monitoring services

Effective support structures (formal and natural) are essential for making communities inclusive. Formal support refers to support coming from professionals such as doctors, teachers, physiotherapists, etc. Natural support comes from the community and is provided by peers, parents and other community members (Mpofu et al., 2012).

1.5.5 Assistance received from non-governmental organisations (NGOs)

Individuals with disabilities are referred to non-governmental organisations that operate in the country and target their assistance at people with disabilities (Mutamiswa & Chakuchichi, 2003). These non-NGOs supplement government efforts in meeting the day-to-day needs of people with disabilities, for example by providing vocational training, food, and shelter and employment opportunities for people with disabilities.

The UNESCO (1996) report also noted that Zimbabwean community structures are in support of inclusive community practices and that the local communities are engaged in serious awareness programmes that focus on and emphasise the creation of disability-friendly communities. Unfortunately the country faces a number of challenges that affect the implementation of its inclusive community activities. In the following section the historical foundations of inclusive communities in Zimbabwe are discussed in more detail.

1.6 Historical foundations of inclusive communities in Zimbabwe

Historically, inclusive communities in Zimbabwe were structured to contain the spread of institutionalised rehabilitation centres throughout the country (Mpofu, 2003) since centres such as special needs schools were demanding huge resources from the national budget (Mpofu & Shumba, 2012). The government could not sustain these costly overheads (e.g. low rehabilitation officer-client ratios, specialist counsellors, teachers and equipment) and opted to involve communities to manage the needs of some of their own people with mild to moderate disabilities (Mpofu, 2003; Majoko, 2005; Makuyana, 2004). Individuals with mild to moderate disabilities were considered not only capable of managing with little or no special services, but also educable and trainable in inclusive communities. Moreover, rehabilitation services in Zimbabwe were suspended because rehabilitation results were not deemed commensurate with the resources invested (Mpofu, 2003; Thomas & Loxley, 2007). Adolescents with physical disabilities were underachieving in academic and social areas, and this was considered the result of a lack of equitable spaces for integration and participation in special needs schools (Hungwe, 2005; Majoko, 2005; Makuyana, 2004; Mkandla & Matarutse, 2002; Mpofu & Shumba, 2012). Within inclusive communities, adolescents with physical disability tend to achieve higher or at least comparable to those with typical development (UNESCO, 2003). This finding may be supported by the fact that an inclusive community enables better integration, space and participation to people with disabilities by extending community citizenship rights to all (Choruma, 2006; UNESCO, 2003). Inclusive community is now seen as enacting citizenship rights among people with disabilities in Zimbabwe.

The Zimbabwean government also adopted inclusive community practice as the democratic right of adolescents with physical disabilities and their families (Chakuchichi et al., 2003). Therefore, inclusive education was adopted to curtail the marginalisation and exclusion of adolescents with physical disabilities in public places (Choruma, 2006; Thomas & Loxley, 2007). It is important to note at this juncture that it has never been a goal of the Zimbabwean government's special institutions to exclude people with physical disabilities from the activities of mainstream society.

Unfortunately, exclusion seems to be one of the unintended consequences when special institutions are used to enhance the psychological wellbeing of adolescents with physical disabilities. Thus, introducing inclusive community practice was an empowerment intervention method aimed at full community citizenship for people with disabilities (Hungwe, 2005; Majoko, 2005; Makuyana, 2004, Mkandla & Matarutse, 2002).

In adopting inclusive community practice, Zimbabwe subscribed to the social model of disability based on the proposition that it is only society and its institutions that are capable of removing the oppressive, discriminatory and disabling conditions (Mpofu & Thomas, 2010) of its people with disabilities. The social model of disability suggests that attention to the challenges of having a disability needs to be focused on the removal of obstacles to the participation of adolescents with disabilities in the day-to-day life of a society (Mpofu & Thomas, 2010), and on changing institutional regulations and attitudes that create and maintain exclusion (Mittler, 2005). In the context of community settings, the restructuring of schools and other social amenities and the creation of laws along inclusive lines are a reflection of the social model of disability.

The social model of disability has its shortcomings –one of them being the under emphasis of assessment and focus on social construction of disability, health and functioning. The under emphasis on assessment by proponents of the social model may result from regard of psychological methods as part and parcel to the medical model, which overlooks important and personal contextual factors (Peterson, Mpofu & Oakland, 2010). The problem statement of the study receives attention in the next section.

1.7 Problem statement

The Zimbabwean government adopted the policy of an inclusive community in 1997 as a measure to enhance the psychological wellbeing of adolescents with physical disabilities (Chakuchichi & Chimedza, 2003; Mutamiswa & Chakuchichi, 2003). However, its implementation has been

wrought with several challenges, some of which include the incompatibility of the programme with consumer cultures, and continued negative attitudes of community members without disabilities towards those with disabilities (Chidyausiku, 2000; Mpofu, 2003). The inclusive community's programmes that are being implemented in Zimbabwe and in other developing countries supports Western perspectives on disability. Western perspectives on disability generally differ from African perspectives as the latter are based on local cultures (Chakuchichi & Chimedza, 2003) and they operate from the broader attitudes of society (Mpofu, 2003). African societies as a rule view disability as a product of sin or a curse, and efforts to address challenges emanating from such causes must therefore be directed at the family and not the community level (Chakuchichi & Chimedza, 2003; Mpofu, 2003; Mpofu et al., 2012a; Mpofu et al., 2012b). This view is however not peculiar only to African cultures. It is also found in a wide range of religions, including those rooted in Western societies (Oliver, 1990). For example, from a Christian perspective the Bible makes numerous references to diseases and disabilities as punishment from God for immoral acts, and efforts to address these challenges include repenting and having faith in God (Deut. 27:27; John 5:14; Matt. 9:2).

Negative attitudes of community members without disabilities towards those with disabilities also compromise the successful implementation of inclusive communities' programmes as a measure to enhance the psychological wellbeing of adolescents with physical disabilities in Zimbabwe (Chidyausiku, 2000; Mpofu, 2003). Terms that are used by particular groups of persons to identify others (e.g. the disabled, the crippled, wheelchair-bound, mentally challenged, mad people, insane, etc.) determine and reflect their attitudes towards these people (Chakuchichi & Chimedza, 2003). This may also affect how people with disabilities perceive themselves. The terms that are used by wider society to describe persons with physical disabilities tend to be negative. This makes the implementation of inclusive community programmes problematic, as people with and without disabilities is supposed to work together as equal partners, yet there is a clear power imbalance (Choruma, 2006; UNICEF, 2005).

Zimbabwe currently has no legislation for inclusive communities (Choruma, 2006; Mpofu et al., 2007; UNICEF, 2005). The operation of inclusive communities in the country is governed by policies not laws. Zimbabwean inclusive policies are in form of circulars that give guidance in inclusive communities in Zimbabwe and are designed at department level. There are not laws by themselves. Examples of such policies are the Director Circular No 3 of 2001, guidelines on providing equal access to education for learners with disabilities (Chakuchichi & Mutamiswa, 2003). Laws on inclusive communities 'services are necessary for the funding and accountability of these programmes (Chakuchichi & Chimedza, 2000; Mutamiswa & Chakuchichi, 2003). In the absence of any mandatory order stipulating the services to be provided, there can be no meaningful inclusive communities' services for adolescents with physical disabilities in Zimbabwe. The absence of inclusive community laws in Zimbabwe demonstrates the fact that the country is not yet ready for the costs related to inclusive practices (Mpofu et al., 2012a; Mpofu et al., 2012b). In fact, according to Choruma (2006), Mpofu (2003) and UNICEF (2005), the country delegated the cost caring of people with physical disabilities to already poor communities. Inadequate policies on the funding of inclusive community activities are evidenced in the country's constitution. For example, Section 83 of the Zimbabwean Constitution, which deals with the Rights of Persons with Disabilities, limits the provision of services and resources by the state to people with disabilities (COPAC, 2013).

In terms of Section 83, the State and all its institutions and agencies of government can only assist persons with disabilities to achieve their full psychological needs and minimise the disadvantages that they suffer within the limits of the resources available to the State (COPAC, 20, 2013). Given that the country's resources are stretched, the notion that the provision of services to persons with disabilities should be subject to the availability of resources may reduce inclusive spaces for adolescents with physical disabilities in Zimbabwe. This study has therefore sought to determine the extent to which integration into an inclusive community enhances the psychological wellbeing of adolescents with physical disabilities – in spite of the myriad of challenges currently facing Zimbabwe. The next section presents the rationale of the study.

1.8 Rationale of the study

The purpose of this study was to explore how communities in Makonde Urban, the provincial capital of the Mashonaland West province of Zimbabwe, are implementing the principles of inclusivity to enhance the psychological wellbeing of adolescents with physical disabilities. Rehabilitation and health care practices for people with disabilities, such as the use of inclusive practices, are continually evolving. Those practices that focus on the use of community efforts in the psychological (re)habilitation of people with physical disabilities are likely to be preferred over time (Hobart, 2002). Social factors that influence psychological wellbeing will continue to receive attention, as will their interface with measures of physical function in everyday settings (World Health Organization, 2004).

The negative effects of using a ‘medical model’ in rehabilitation of people with disabilities have necessitated enormous effort to utilise communities to reduce the stigmatisation and labelling of people with disabilities (ILO, UNESCO & WHO, 2004). Despite these efforts, adolescents with physical disabilities are still stigmatised as incompetent people, and this is likely to affect their psychological wellbeing (Fox, Prilleltensky, & Austin, 2009). Thus, there is an undeniable need to address psychological issues when trying to rehabilitate people with disabilities. Inclusive communities are used as a means to enhance the psychological wellbeing and build the resilience of adolescents with physical disabilities (Mpofu et al., 2013). Resilience helps to develop competence in the face of adversities encountered by these adolescents and it is essential for the development of their psychological wellbeing (Buckner, Mezzacappa & Beardslee, 2003; Mpofu et al., 2013).

The use of inclusive communities as a strategy to influence psychological wellbeing in adolescents with physical disabilities also helps to integrate adolescents with physical disabilities into the mainstream community (ILO, UNESCO & WHO, 2004; UNESCO, 2005). This may result in more rewarding encounters and lead to psychological flourishing in areas such as life satisfaction

(WHO, 2001). The rationale for and intention of this study were therefore to explore the psychological wellbeing of adolescents with physical disabilities in inclusive community settings in the Mashonaland West province of Zimbabwe.

1.8 Research questions

1.8.1 Primary research question

The following was the key question examined in this study:

How do selected inclusive community strategies contribute to the overall wellbeing of adolescents with physical disabilities?

1.8.2 Secondary research questions

In order to provide an adequate answer to the study's primary research question, the following sub questions also had to be addressed:

- What strategies are available to integrate adolescents with physical disabilities into the community to enhance their psychological wellbeing?
- How are these strategies implemented within these communities?
- How do youths with physical disabilities choose between the available strategies?

1.9 Chapter outline and overview

Chapter 1

This chapter served as the introduction to the study and provided some background. As an entry point, the chapter introduced the concept of inclusive communities, physical disability, psychological wellbeing, and posited the rationale for exploring the extent of the psychological wellbeing of adolescents with physical disabilities in inclusive community settings in the Mashonaland West province of Zimbabwe. The chapter dealt with (1) inclusive communities ;(2) adolescents with physical disabilities ;(3) psychological wellbeing; (4) historical foundations of inclusive communities in Zimbabwe ; (5) statement of the problem;(6) the rationale of the study; and (7) the research questions.

Chapter 2

Chapter 2 presents the Systems Theory as the conceptual framework of the study. This is then followed by review of pertinent literature on the concept and structure of inclusive community's is reviewed. The researcher also provides literature on the social construction of disability and the psychological wellbeing of adolescents with physical disabilities in Zimbabwe. The chapter also discusses community strategies that are meant to enhance the inclusion of adolescents with physical disabilities in local communities.

Chapter 3

Chapter 3 treats the methodology followed and the research design of the study. The researcher indicates his choice of design and explains the sample and sample choice (i.e. multiple case studies), as well as contextualise each individual case within the study.

Chapter 4

Chapter 4 presents the results of the study. The researcher provides information on data analysis and interpretation, and shows his choice of strategies as well as how he used the thematic approach in analysis. He presents his results by themes, subthemes and categories and uses verbatim representation of participants' voices.

Chapter 5

Chapter 5 is the revisiting of literature that the researcher found compatible with the results of his study. He also provides a reflection of contrasting literature and indicates the silences encountered.

Chapter 6

Chapter 6 treats the presentation of results, and provides conclusions as well as implications of the study. In this final chapter, the study's research questions are used to guide the researcher's findings, recommendations and conclusions.

1.10 Conclusion

Chapter 1 introduced the study's aim, namely to explore the psychological wellbeing of adolescents with physical disabilities in inclusive community settings in the Mashonaland West province of Zimbabwe. Inclusive communities are communities that adapt their structures and procedures to facilitate the inclusion of people with disabilities, and they do not expect people with disabilities to fit into the existing arrangements. The use of inclusive communities as a measure for enhancing the psychological wellbeing of people with disabilities follows the global trends in

disability care and support. Psychological wellbeing is a multifaceted concept that is generally believed to consist of three distinguishable aspects evaluative, affective and eudemonic wellbeing. The general quality of life that people with disabilities in Zimbabwe enjoy has improved somewhat over the past decade due largely to their own involvement in various inclusive strategies in their community settings. The purpose of the current study was therefore to explore the psychological wellbeing of adolescents with physical disabilities in inclusive community settings in the Mashonaland West province of Zimbabwe.

2 CHAPTER 2: LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

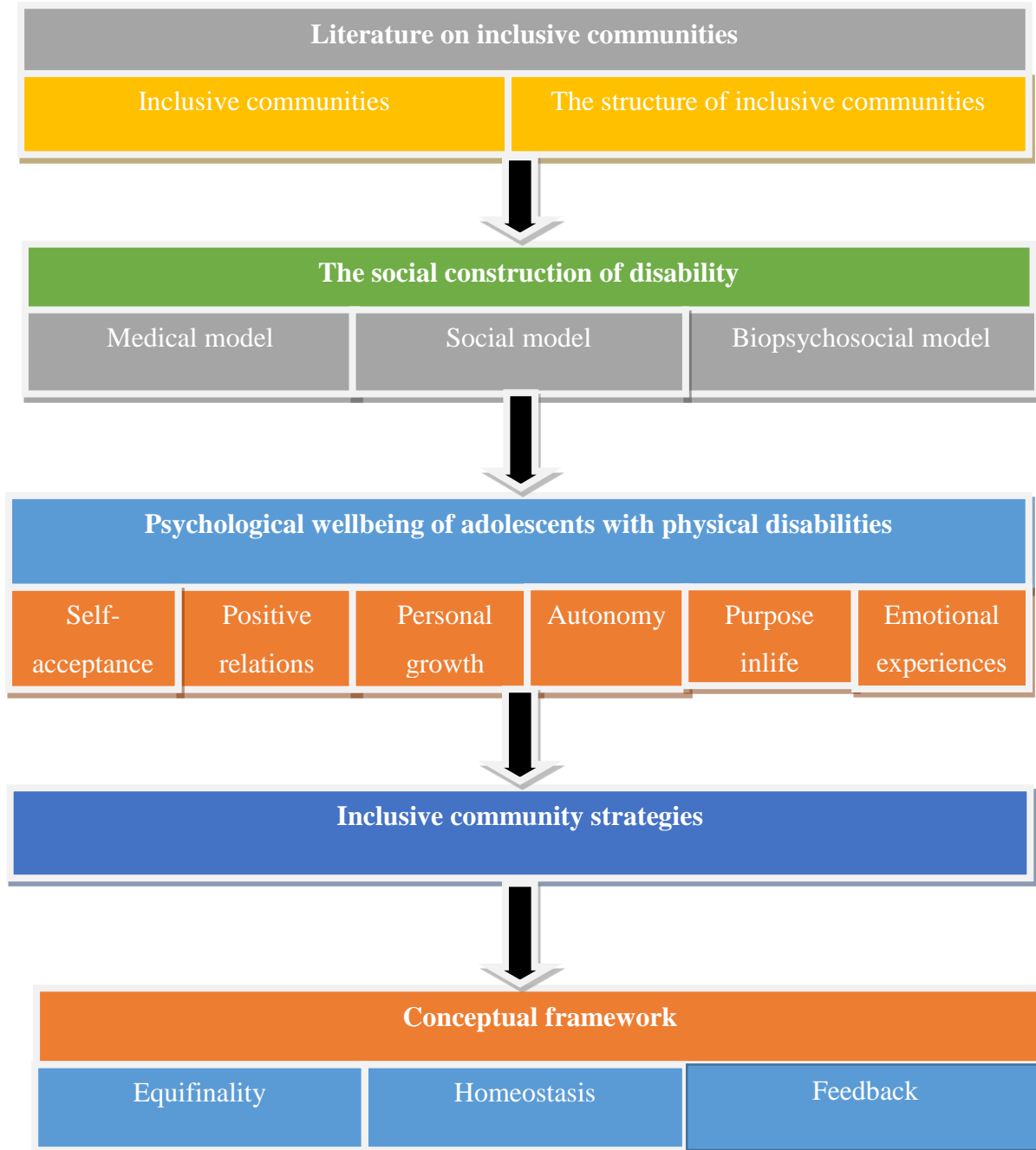


Figure 2.1: The Chapter Map

2.1 Introduction

The previous chapter highlighted that inclusive community's act as a community strategy to enhance the psychological wellbeing of people with disabilities within their own communities (Mpofu et al., 2012). According to Choruma (2006), WHO (2001), Mutamiswa and Chakuchichi (2003) the general quality of life for people with disabilities in Zimbabwe has shown some improvement over the last decade, largely due to these individuals' participation in various inclusive community activities (Chakuchichi et al., 2003). This chapter will explore some of the literature that focuses on the psychological wellbeing of adolescents with physical disabilities in inclusive community settings.

The concept of inclusive communities has been covered in detail in Chapter 1, so this chapter only provide the structure or organisation of an inclusive community in detail. A detailed discussion of the ICF models of disability, function and health will be provided. These are very important to the current study in that they give insight into treatment and care of people with physical disabilities in their communities, and how these disabilities interfere with their psychological wellbeing. They also provide core concepts in disability, health and functioning that are increasingly embracing community health services (WHO, 2001) and that are consistent with the (ICF) assessments methods (ICF& WHO, 20001). The goals of classification systems in community health describe qualities related to health status within the domains of functioning, which includes psychological wellbeing. These assist in designing intervention strategies at the community level, such as inclusive communities to maintain or enhance functioning, prevent loss of functioning, and enhance recovery and independence (Stucki et al., 2003). The essential focus of this thesis is the psychological wellbeing of adolescents with physical disabilities in inclusive community settings. Therefore, this chapter will go further in exploring literature on the psychological wellbeing of adolescents with physical disabilities, and how they experience life in inclusive communities. The last part of the literature exploration will focus on community strategies for the integration of adolescents with physical disabilities in mainstream communities. The following section presents the theoretical framework used by this study.

2.2 Theoretical framework

This study adopted the systems theory to explain the relationship between inclusive community strategies and the psychological wellbeing of adolescents with physical disabilities living in mainstream communities (Makore-Rukuni, 2003). The systems theory was adopted for two main reasons:

- It looks at an individual from a community point of view, which is consistent with the methodological philosophy of this study and inclusive community practices.
- It views disability from a social model perspective, which is in line with globally accepted trends of disability and health (Mpfu & Oakland, 2010; WHO, 2004).

The next section provides an overview of the systems theory.

2.2.1 Systems theory

Systems theory was proposed in the 1940s by the biologist Ludwig von Bertalanffy, and furthered by Ross Ashby (1950). Von Bertalanffy was both reacting against reductionism and attempting to revive the unity of science. He emphasised that real systems (Whitchurch & Constantine, 1993) are open to and interact with their environments, and that they can acquire qualitatively new properties through experiences, resulting in continual evolution (Whitchurch & Constantine, 1993). For instance, when viewing a village, one sees cattle, pens and fields that make up a village – not individual entities.

Another contribution of the system theory is that it is made up of subsystems and these constitute a hierarchical order of systems. For instance, the individual in a subsystem is made up of the nervous, digestive, respiratory and other systems. In turn, the individual is a subsystem of a larger

system: the nuclear family, the family subsystem of the extended family, and the extended family subsystem in the community, which is the supra-system of the subsystems and systems mentioned.

The different parts of the system are not to be viewed in isolation from each other. The best way to understand the parts is to look at them as functioning parts of the total system. If we applied to an inclusive community as system the implementers of inclusion, parents, individuals with disability, the donor community, and the government are the parts who influence each other as they interact.

In the next section, the focus is on the key concepts of systems theory and how they can be applied to understand the psychological wellbeing of adolescents with physical disabilities who live in inclusive community settings.

2.2.2 Systems Theory and its applicability to the psychological wellbeing of adolescents with physical disabilities living in inclusive community settings

This discussion of the key concepts of systems theory should lead the reader to understand what is going on in an individual with physical disabilities and will focus on the major components of systems theory: equifinality, homeostasis, hierarchy, boundaries, and feedback (Whitchurch & Constantine, 1993).

2.2.2.1 Equifinality

Equifinality when applied to systems theory refers to the ability of a system to arrive at the same destination from different paths or conditions. The concept explains that similar outcomes may stem from different early experiences (Guttman, 1991; Whitchurch & Constantine, 1993). The principle of equifinality explains that in any closed setting the final state is determined by the initial

state (Legg & Scher, 1996; Whitchurch & Constantine, 1993). In educational psychology, it refers to how different early experiences in life (e.g. having a disability, parental care) can lead to similar outcomes (e.g. poor participation in learning activities) (Guttman, 1991). In other words, there are many different early experiences that can lead to the same learning disorder (Bentovim & Kingston, 1991; Shora, 2004). In the context of this study, the concept of equifinality supports the use of various inclusive community strategies (education, sport, counselling, income-generating projects, and disability awareness activities) to achieve positive psychological wellbeing in adolescents with physical disabilities (Campbell, Draper & Crutchley, 1991). What it means then is that adolescents with physical disabilities need to be exposed to different subsystems in their communities simultaneously, e.g. sports clubs and the school, with a view to developing their psychological wellbeing (Campbell et al., 1991). These subsystems will expose them to different levels of power and different skills (Bentovim & Kingston, 1991; Shora, 2004). Participation in these various subsystems will assist adolescents with physical disabilities to learn by negotiating through different adverse environments, and this may assist them in developing enhanced levels of psychological wellbeing.

The next component of systems theory is homeostasis.

2.2.2.2 Homeostasis

Homeostasis is the tendency of a system toward maintenance of a relatively stable internal environment through a series of interacting processes (Friedman, 1991). Homeostasis, also referred to as a system's "equilibrium," is the tendency of a system to interact in ways that maintain its balance or state of equilibrium (Legg & Scher, 1996; Whitchurch & Constantine, 1993). This concept in the context of this study suggests that all members in a human living system (with or without disabilities) tend to follow organised ways of behaving towards one another (Bentovim & Kingston 1991; Shora, 2004). A preferred pattern for relating to one another evolves over time. As the needs of an inclusive community's system change, a healthy system will also work towards changing its preferred patterns of behaving (Campbell et al., 1991). For instance, a current trend

in inclusive communities involves the use of preferred terms to refer to people with disabilities (ICF, 2001; WHO, 2001). A healthy inclusive community system will work to develop positive terms for referring to its people with disabilities. However, sometimes these preferred patterns of behaviour do not fit the needs for the psychosocial growth of its members and a crisis develops (Bentovim & Kingston, 1991; Shora, 2004).

Another example of a homeostatic situation in a disability context is using time out procedures for an adolescent with a physical disability who exhibits behaviour disorders that interfere with his/her psychological wellbeing. In this situation, the community may attempt to interrupt this pattern of restriction and help the adolescent's family to search for more age-appropriate alternatives. This action will not only modify preferred patterns of interaction but also contribute to changing the system (Legg & Scher, 1996; Whitchurch & Constantine, 1993).

The next important aspect of systems theory involves feedback.

2.2.2.3 Feedback

Feedback (Campbell et al., 1991) is the process by which the input of each community member leads to a more complex, systems-oriented output. The output of the community system is thus no longer individually determined and analysed. The concept of feedback in the context of this study assumes that the poor psychological wellbeing in adolescents with physical disabilities is caused not by a breakdown in the intrapsychic machinery, but by the failure of the community systems to operate properly (Guttman, 1991). There are both negative and positive feedbacks. Negative feedback is an attempt that is made to correct a system in trouble and to re-establish its previous state of equilibrium. This becomes relevant to those with an acquired physical disability, for example when an adolescent who acquired a physical disability as a result of an accident at work must be re-employed in order to re-establish harmony at the workplace. In this case, negative feedback is used to keep the status quo or maintain homeostasis. Positive feedback, on the other

hand, forces someone into new ways of behaving by making old behaviour patterns unattainable. It is often used to counteract negative feedback.

In the context of this study, systems theory views a community as an inclusive entity that is made up of people with different abilities rather than of the characteristics of each part, such as people with specific abilities and disabilities. It focuses on how the community functions inclusively, instead of on the problems of individuals in the community. Systems theory does not view the psychological wellbeing of adolescents with physical disabilities as the problem of their condition, but rather as the symptom of a problem in the community as a whole (Guttman, 1991). It suggests that the elimination of behaviour problems such as negative and low psychological wellbeing (as is the case with most adolescents with physical disabilities), is only attainable by changing the structure of the community rather than by trying to change the behaviour problem directly (Loreman et al., 2005). Thus the systems theory, like the social model of disability, emphasises the role of the community in addressing the psychological needs of people with physical disabilities (Fox et al., 2009).

Until relatively recently, the psychological rehabilitation of adolescents with physical disabilities has been viewed to comprise of associations between two individuals – such as the parent and the individual with a physical disability – independent of any other relationships within the community (Fox et al., 2009; Makore-Rukuni & Maunganidze, 2001). However, an inclusive community system asserts that relationships among community members are interdependent and that the community is more than the sum of its individual members (Makore-Rukuni & Maunganidze, 2001). Individuals exert influence on community members and are in turn influenced by other community members and by the contexts in which all community members interact (Mpofu, 2003). Relationships are thus described as a ‘system’, operating so that all members are affected in some way by experiences of any one individual in the system, in much the same way that a machine’s function ‘emerges’ from the mutually dependent actions of its various parts (Makore-Rukuni & Maunganidze, 2001).

In the next section my attention moves to the structure of inclusive communities.

2.3 The structure of Inclusive communities

As the concept of inclusive communities has been dealt with in detail in Chapter 1, in this section the researcher contextualises the structure of the inclusive community as being made up of four equal players: a formal support system, a natural support system, adolescents with physical disabilities, and the philanthropic community. These four players must work as a team by sharing notes on points of interest (Engelbrecht, 2007). The roles of each of these groups in an inclusive community setting will be discussed next.

2.3.1 Formal support system

A formal support system involves support that is government funded via the general community (Chakuchichi et al., 2003; Chakuchichi & Mutamiswa, 2003). Some of the formal support systems include qualified teachers, para-professionals, doctors and physiotherapists, as well as appropriate curriculum materials and technological assistive device systems (Chakuchichi et al., 2003; Chakuchichi & Mutamiswa, 2003).

2.3.2 Natural support system

A natural support system involves that help which is obtained naturally at home. This support is obtained from the parents, siblings and friends of an adolescent with physical disabilities. In most African communities the majority of members in the natural support systems are functionally illiterate and vulnerable, but they contribute vital information about their children. Natural support systems usually provide information on the strengths and challenges, the likes and dislikes, and the developmental history of a child with physical disabilities. They provide reports (both written

and nonverbal), notes and homework diaries to other stakeholders in the system (Chakuchichi et al., 2003; Chakuchichi & Mutamiswa, 2003). At collaboration level, parents create a physical environment and emotional space for performing various inclusive community activities such as school tasks (Engelbrecht, 2007). They also attend meetings, both formal and informal, and engage with teachers and other staff members. Parents also provide classroom aides; assist in maintaining classrooms, and help to raise funds for the school. They are also useful in inclusive community policy formulation by being active in disability advocacy meetings (Mckenzie & Loebenstein, 2007).

2.3.3 Adolescents with physical disabilities

Adolescents with physical disabilities are also major players in any inclusive community activity. Like their parents they may be functionally illiterate and vulnerable, but they are able to contribute vital information about their own condition (Chakuchichi et al., 2003; Chakuchichi & Mutamiswa, 2003), their abilities and weaknesses, their likes and dislikes, and their developmental history. They can provide written and nonverbal report or notes, do homework, and take part in inclusive community tasks (Mckenzie & Loebenstein, 2007). At the collaboration level, adolescents with physical disabilities cooperate and participate in various inclusive community activities (Engelbrecht, 2007). As their parents, these adolescents are also able to attend formal and informal meetings at school, and engage with staff members. Although they are young, they are useful in inclusive community policy formulation because they are active in disability advocacy meetings, they take part in demonstrations and they attend stakeholder conferences (Chakuchichi et al., 2003; Chakuchichi & Mutamiswa, 2003).

2.3.4 The philanthropic community

The philanthropic community is the donor community (Ndawi, 2000). In most cases the donor assists the government in funding inclusive community programmes and provides training to both

natural and formal support players in inclusive communities. In some cases donors run the programmes themselves under the supervision of the government (Ndawi, 2000).

The next section provides a discussion on the social construction of disability and its models. These disabilities models have been included in this study for specific reasons:

- They serve as the backbone to how societies construct the concept of disability.
- They assist communities' in designing strategies that focus on the treatment and care of people with disabilities.
- They serve as a foundation for the theoretical framework (systems theory) and philosophical view (phenomenological philosophy) of this study.

The current study's theoretical and philosophical position tries to give meaning to the psychological wellbeing of adolescents with physical disabilities in inclusive communities as perceived by the adolescents living with the physical disabilities themselves. Their life experiences and explanations are largely influenced by the disability models that are common in their communities.

2.4 The social construction of disability

Disability is a contested concept (Encyclopaedia Britannica, 2009). The term is associated with widely varied meanings and definitions (Mpofu, Hawkins, Bishop, Cherema, Ntinda & Moswela, 2010, p. 36). The central disagreement in modern debates on disability centres on how we should view the presence of a disability (Barnes, 2009). As noted by Marks (1999, p. 139), "Language is not a transparent referential system...it does not refer straightforwardly and objectively to objects in the external world". Meanwhile, Castrodale and Crooks (2010, p. 89) succinctly capture varied meanings and definitions of disability via the phrase, 'geographies of disability', as definitions

tend to be contextual. As part of the human explanatory repertoire, people use attitudinal judgments (Krahé & Altwasser, 2006) and develop explanatory systems in order to explain disability from different geographical locations.

In this study the researcher adopts the ICF models of disability. The study adopted the ICF models of disability because it is widely embraced in rehabilitation and community health care services and it is therefore presented here as the international standard for assessing disability, functioning and health. The ICF disability models fall within the discourse of this thesis, they influence the researcher's belief system and assist him to explain the psychological wellbeing of adolescents with physical disabilities who live in inclusive community settings (Mpofu, et al, 2010).

The ICF defines disability as an umbrella term for impairments, activity limitations and participation restrictions. Functional limitation occurs as a result of the interaction between an individual (with a health condition) and the individual's contextual factors (environmental and personal factors) (WHO, 2001). Impairments (according to ICF) are manifestations of dysfunction in the body structures or functions that represent a deviation from the general and acceptable population standards of functioning. Disability then refers to the outcome or result of a complex relationship between an individual's health condition and personal factors, and of the external factors that represent the circumstances in which the individual lives (WHO, 2001).

In the next section literature is reviewed on ICF models of disabilities, namely the medical model, social model and the biopsychosocial model (WHO, 2001). These three models relate to the construct of disability, health and functioning (ICF, 2001).

2.4.1 Medical model on disabilities

The focus of the medical model is on the impairment and hence on the physical or biological condition of people with disabilities (Peterson, et al. 2010). Moreover, the medical model views physical disability as a condition that can be—and more importantly, ought to be – repaired, after which the individual may be rehabilitated and returned to “normal life”, or as close to it as possible (WHO, 2001). In other words, the medical model treats a person with a physical disability as a person with an illness such as measles (De Kleijn-De Vrankrijker, 2003). Consequently, the medical model calls for a person with a physical disability to act as a sick person or a patient that is expected to act in or assume the “sick role”.

The medical model constitutes a plausibility structure (a set of policies and procedures) whose implicit premise, as it defines the privileges and the obligations of the sick role, unobtrusively controls and oppresses persons with impairments, and renders people with physical disabilities disabled and dehumanised (WHO, 2001). It cancels the (impaired) person’s obligation to take charge of his/her own affairs. Indeed it encourages them to accept their dependency under the sick role as normative for the duration of the impairments (ICF, 2001). In short, the sick role works to deprive an impaired person of autonomy and the control of his/her own affairs, which is the defining mark of human personhood (WHO, 2001).

It is this background of perceiving persons with physical disabilities as helpless, dependent victims in need of professional assistance and care that has caused inclusion movements to advocate for the adoption of inclusive community strategies as a measure to enhance the psychological wellbeing of adolescents with physical disabilities (Mpofo, et al. 2010). The inclusion movement is the movement to secure equal opportunities and equal rights for people with disabilities (UN, 2006). The specific goals and demands of the inclusion movement are accessibility and safety in transportation; architecture and the physical environment; equal opportunities in independent living; employment; education and housing; and freedom from abuse, neglect and the violation of

patients' rights. Effective civil rights legislation is sought in order to secure these opportunities and rights (Leonardi, et al. 2006).

2.4.2 Social model of disability

Inclusion movements challenged the medical model and proposed to replace it with the social model as proper model for understanding disability (Leonardi, et al. 2006). The medical model was viewed as oppressive and a major source of the exclusion of people with disabilities from mainstream society (WHO, 2001). It was considered part of the problem and not the solution, and therefore the inclusion movements came up with a new model to replace it (Leonard et al., 2006). The social model was designed to be liberating, not oppressive, and a basis for inclusion, not marginalisation. According to the social model, disability is not a tolerable, necessary result of an individual's impairment, but something created primarily by the attitude of society (Hurst, 2003). It is society's response to an impairment that disables a person, not the impairment itself (Hansen, 2004). Moreover, such a societal response brings with it the injustice of an unwarranted denial of the autonomy of a person with impairment (Olkin & Pledger, 2003). Moreover, if – as the disability rights movement contends – disability is a social oppression, then disabled people should be seen as the collective victims of society rather than as individual victims of circumstance (Olkin & Pledger, 2003). If disability is a result of society-induced oppression, societal actions such as the passing of appropriate laws would be called for to facilitate the elimination or at least the reduction of that oppression. It was important, then, for the inclusion movement to offer a new definition and a new model of disability.

The new model as indicated above was based on two premises:

- 1) Social conditions, and not the impaired person, convert impairment into a disability.
- 2) The focus of efforts on behalf of those with a so-called disability should be rooted in respect for their personhood, that is, in their ability and right to make their own,

autonomous decisions as to how they live with their ‘disability’, and not in the impairment per se (Smart, 2005).

In other words, it is not the “welfare of the handicapped” that is at issue, but “the human rights of people with disabilities” (WHO, 2001). The first premise of the social model is that disability is both a social construction and a social creation. Disability is constructed, individually and collectively, as a consequence of views held by people without a disability and it is expressed both in hostile social attitudes and in the stigmatisation of those with a so-called disability in interpersonal encounters or primary relationships (Mpofu, 2003; WHO, 2001). However, disability is also a social creation in that it is a consequence of the laws, policies and institutionalised practices of society that are evident in the restrictions faced by those with (Mpofu, 2003).

The premise that inclusion is a human right emanating from the social model resulted in the expansion of rights for adolescents with physical disabilities (Smart, 2005). The history of segregation and inhuman treatment of people with disabilities resulted in the realisation that to segregate on the basis of disability was inherently unequal and unconstitutional (Dakar World Educating Forum, 2002). Advocates for people with disabilities pushed for their expanded rights by challenging the practice of exclusion. Human rights issues for people with disabilities ultimately found centre stage in the United Nations and Organisation of African Union (now African Union) and have resulted in the promulgation of legislation on the rights of persons with disabilities (Chakuchichi et al., 2003). The organisations of the AU and the UN have been the catalysts that have spurred on inclusion to become the only humane way of treating those who are exceptional the world over.

2.4.3 Biopsychosocial model of disability

The biopsychosocial model of disability is a health care and disability model. It incorporates useful aspects of both the medical and social models (Petersen & Rosenthal, 2005), and combines diagnostic information (medical and psychosociological) with psychosocial aspects of life (e.g. resilience) (Elliot Kurylo & Rivera, 2002). The model gives equal consideration to all factors that have an impact on health and functioning. The biopsychosocial perspective is consistent with contemporary inclusive community activities, processes and practice (Frank & Elliot, 2000), and the biopsychosocial model does not discount either the medical or social perspective but integrates them into a contemporary conceptualisation of disability, health and functioning.

Disabilities exist in several forms or types. Examples include multiple disabilities, emotional and behavioural disorders, learning disabilities, cognitive disabilities, visual disabilities, hearing disabilities and physical disabilities. The different types and signs of physical disabilities were covered in Chapter 1 and the next section provides evidence from the available literature on the state of the psychological wellbeing of adolescents with physical disabilities.

2.5 Psychological wellbeing of adolescents with physical disabilities

Although adolescents with physical disabilities report the lowest psychological wellbeing in many countries (Campen & Santvoort, 2012) the gap in psychological wellbeing compared with people without disabilities is smaller in some countries than others (Huppert et al., 2009). The level of psychological wellbeing of adolescents in developed countries is much higher compared to those in developing nations (Helliwell, 2008). This is possibly due to the fact that developed countries have comprehensive policies designed to improve the psychological wellbeing of their citizens while most developing countries do not. In cases where comprehensive policies are present in developing countries, the implementation is often hindered by lack of resources (Campen & Santvoort, 2012; Frey & Stutzer, 2002).

However, inequality in psychological wellbeing among people with disabilities exists in both developed and developing countries (Campen & Santvoort, 2012). Levels of psychological wellbeing differ between adolescents with physical disabilities as a result of variables other than policies, such as severity of disability, socio-demographic background and social participation (Huppert et al., 2009). However, literature on the psychological wellbeing of people with physical disabilities (e.g. Campen & Santvoort, 2012; Diener et al., 2009; Dunn & Elliott, 2005; Frey & Stutzer, 2002) suggests that a physical disability affects people with physical disabilities in a number of ways.

In the next section, more literature is presented on how physical disabilities interfere with six attributes of psychological wellbeing that are of interest to the study.

2.5.1 Self-Acceptance

The disabling condition, with which many adolescents live, causes them to react to it differently, which affects their psychological wellbeing. Disability identity and consciousness in adolescents with physical disabilities and their environment may mediate responses to disability (De Kleijn-De Vrankrijker, 2003; Dunn & Elliott, 2005). For instance, if an adolescent believed a disability to lead to negative social connectedness, he/she might react with social withdrawal or diminished participation. This would result in reduced social participation and, potentially, a lower sense of wellbeing (Gill, 2001). However, this might not be true in all cases. Some adolescents may take into account their disability, but reframe their social situation and choose to engage in activities that are rewarding, (Fox et al., 2009). It is to be noted that former trains of thought believed that adolescents with physical disabilities viewed their disability as tragic and as an individual deficit (Dunn & Elliott, 2005). This view came as a result of the medical model which viewed people with disabilities as people who should come to terms with their disability, and grieve and mourn their lost limbs, abilities and lost looks, and help them to adjust to their lost body image (Fox et

al., 2009). The medical model viewed physical disability as a problem inherent in individuals that could be ‘cured’ or at least contained (Fox et al., 2009; ICF, 2001; WHO, 2001).

This tragic and deficit view of physical disability from a medically oriented community brings with it self-isolation, powerlessness, poverty and low social status, which subsequently lead to poor psychological wellbeing (Gill, 2001). This view is also negatively reinforced by attitudes from most communities towards adolescents with physical disabilities that embrace differences rather than similarities (Bedini, 2000). The more visible the difference, the more discrediting an environment it creates in the eyes of the observer and the more disruptions it can cause to social acceptance (Mpfu, 2003). This particular view allows for adolescents with physical disabilities to be discriminated against and to be stigmatised (Mpfu et al., 2012). Community members who are exposed to adolescents with physical disabilities tend to be more anxious, uncertain and uncomfortable in their interaction with them than with those without physical disabilities (Mpfu, 2003). This leads to the isolation of adolescents with disabilities and causes poor self-acceptance among people with disabilities as they succumb to the negative effects of having a physical disability, such as their inability to cope with or adjust to perceived problems (Diener & Ryan, 2009).

2.5.2 Personal growth

In addition to problems related to negative self-attitude, some adolescents with physical disabilities such as cerebral palsy and spina bifida display inappropriate cognitive developmental and maturational levels (Heward, 2003). They also have problems with cognitive processes (Chinze & Tambara, 2000; Heward, 2003). These problems emanate from brain injuries, inherited genetic disorders, congenital disorders or illnesses that affect the muscles, brain or nerves (Heward, 2003). When an individual’s cognitive abilities are reduced, as in a traumatic brain injury and cerebral palsy, they tend to have difficulties in actualising themselves and realising their potential, which is central to perspectives on personal growth (Ryff, et al. 2006). Such a circumstance then affects those individuals’ abilities in confronting new challenges or tasks at different periods in life.

Continued personal growth, according to this study, is viewed as an attribute of psychological wellbeing and is lacking in a good number of adolescents with physical disabilities that are related to nerve or brain injury (Gwitima & Sibanda, 2000).

2.5.3 Positive relations with others

By virtue of their limited mobility, adolescents with physical disabilities cannot easily meet with other people, unlike their peers who can travel at will from one point to another to meet friends (Chakuchichi & Mutamiswa, 2003). Most adolescents with physical disabilities hardly ever meet their peers (with or without disabilities), except if they are institutionalised (Chimedza & Sithole, 2000). This puts them at risk of not developing healthy and positive relations with others, which is another attribute of psychological wellbeing (Mpofu, et al. 2013). Positive relations with others assist individuals in developing deeper and more lasting friendships and more complete identification with others (Mpofu et al., 2012). Some types of disabilities, such as cerebral palsy, also present speech disorders and reduce social behavioural functioning as they affect brain and social abilities. Once speech is retarded, communication disorders take precedence in the person (Heward, 2003), and this then becomes one of the developmental consequences of individuals with physical disabilities that can lead to the poor development of positive relations with others (Heward, 2003).

2.5.4 Autonomy

In most countries, adolescents with physical disabilities face numerous environmental barriers that can discourage them from having meaningful interactions with their environment (UN, 2006). Most environments create limitations for people with disabilities and make participation in everyday activities very difficult for them (Buckner et al., 2003). When they cannot enter buildings, ride local transport or talk with service providers, young people with disabilities are losing out on opportunities to learn and participate (Lyubomirsky & Layuos, 2013). Environmental

barriers also include negative attitudes against adolescents with disabilities from the wider society (Loreman, Deppeler & Harvey, 2005). This limitation interferes with their ability to choose or create environments suitable to their mental conditions (Mpofu & Oakland, 2010). It reduces their participation in the communities in which they live and contributes to retardation immaturity (Buckner et al., 2003). Well-developed environmental mastery is an indicator of the existence of good psychological wellbeing (Lyubomirsky & Layuos, 2013).

2.5.5 Purpose inlife

Purpose inlife refers to “having beliefs that there is a purpose and meaning to life” (Doyle, Moffatt & Corlett, 1994, pp: 89). People who felt that their life has meaning experience a substantially higher sense of wellbeing and physical health (Ryff, 1989). Many people gain a great deal of psychological benefit from understanding what their lives are about and how they fit into the world around them. Those people who have a sense of meaning and purpose in their life feel– in general– happier, as well as more satisfied on a daily level. They also feel less depressed or anxious, and are less likely to engage in risky behaviours (Ryff, 1989; Ryff et al., 2006). People who experience allow sense of purpose inlife usually display hardly any goals or aims in life; they lack a sense of direction, do not see the purpose of past life, and have no outlook or beliefs that give life meaning (Arnold & Chapman, 1992).

Researches on disabilities and purpose inlife (Dolan et al., 2011; Kahneman & Deaton, 2010; Mpofu, 2003) shows that people with disabilities tend to develop positive indicators of purpose inlife if they are living in inclusive communities. The assumption, then, is that in such an environment people with disabilities would compare themselves to peers without disabilities as similar to themselves. The environment is believed to enhance purpose inlife for people with disabilities by minimising upward self-comparisons, which may escalate personal dissatisfaction (Dolan et al., 2011; Mpofu, 2003).

Inclusion has unfortunately been practised in most African countries without putting into place adequate materials and legislation to enhance the success of persons with disabilities (Dolan et al., 2011; Kahneman & Deaton, 2010; Mpofu, 2003). Poorly planned and implemented inclusive communities programmes may cause more harm than good, both to persons with and to persons without disabilities. More often than not, poorly resourced inclusive community programmes set up people with disabilities for public failure, which may reinforce the negative stereotypes about them. An example includes having a person who uses a wheelchair to attend a school where there are no curbs or ramps to facilitate mobility in and out of the classroom. The person is forced to require assistance in being lifted into and out of the classroom with someone else's help each time. Such an unimaginative allocation of learning spaces sets the wheelchair person up for failure every day by imposing the condition of dependency on him/her, and therefore, limits his/her independence (Kahneman & Deaton, 2010; Mpofu, 2003). This dependency makes the person feel helpless and susceptible to experiencing a lack of sense of purpose in life (Doyle et al., 1994; Dolan et al., 2011; Kahneman & Deaton, 2010; Mpofu, 2003).

Most adolescents with physical disabilities want to operate on equal footing with their peers without disabilities. However, they will unfortunately have difficulty in attaining these goals due to various environment-related restrictions within their communities (Mpofu, 2003). This then makes them develop a poor sense of purpose in life, as well as an attitude of waiting to receive assistance from people without disabilities. Having a purpose in life would not only make them productive and creative, but also help them to achieve emotional integration in later life and become a lot more autonomous (Arnold & Chapman, 1992).

2.5.6 Emotional experiences

Adolescents with physical disabilities tend to experience emotional problems such as fear, disappointment and depression as a result of a lack of effective rehabilitation services. Neurosurgery would be an example of a rehabilitation service that may appear ineffective in adolescents with physical disabilities. Such a service may be designed to assist the carers and/or

family members of the person living with a neurological-related disability, such as a spinal cord injury (Simmons et al., 2000). For example, fear of what the result will be following the surgery is a common reaction of many adolescents with physical disabilities, especially those who acquired adult onset disabilities such as multiple sclerosis, spinal-cord damage and traumatic brain injury. Adolescents with such disabilities may experience a significant disruption of self-value (Mpofu & Harley, 2006). Similarly, people with acquired physical disabilities face challenges in aligning their personal values in ways that are relevant to community participation. According to Venes (2009), adolescents who receive neurosurgery rehabilitation services must also receive psychoeducation. Psychoeducation offers pre-knowledge to adolescents with physical disabilities when going for neurosurgery rehabilitation services to prepare them for possible psychological difficulties as a result of surgery.

As some adolescents do not receive psychoeducation following the operation, fear of developing those potential psychological difficulties induces psychological weakness immediately following the surgery (Venes, 2009). Some individuals may feel uncomfortable in the presence of others for a period of time. The period of time it would take to diminish these fears would depend on whether the individual received psychoeducation (Murro, 2006). Disappointment and disillusionment are often felt towards medical professionals who fail to provide adequate education about the possible difficulties of epilepsy (for example), and who do not give the necessary counselling both prior to and following a surgery (Simmons et al., 2000). Depression often results from the realisation that the elective surgery was not able to fully control the problem, and that the (unanticipated) regular taking of physical disability-related medication (e.g. anti-epileptic drugs) must recommence (Murro, 2006; Simmons et al., 2000).

Murro (2006) presented a personal reflection of a Zimbabwean adolescent, Tinofa, living with a physical disability in a mainstream community. Tinofa is not his real name and it was used for the purpose of illustration and anonymity.

Tinofa experienced adult onset epileptic seizures (AOES). AOES is a neurological condition that adversely affects the day-to-day functioning of an adolescent living with the condition. It is classified under physical disability. The term onset refers to the time or age at which the seizures began (Murro, 2006). Tinofa's case demonstrates some of the bad experiences people with disabilities encounter in their lives. In his case, he experienced negative emotions, including fear and frustration.

At the age of 14, Tinofa began to unknowingly experience adult onset epileptic seizures (AOES). It was not until December of 1990 that his friend, who had witnessed the onset on several occasions, brought the experience of seizure activity to his attention. Although he had been experiencing a number of complex partial seizures at least a few times a month for a period of about one year, his friend appeared not bothered. After talking to his friend he started experiencing negative emotions, including fear, frustration, and jealousy.

At 16 years of age, following a long list of neurological testing, it was suggested by Tinofa's neurologist that he should undergo an intracarotid sodium amobarbital procedure (ISAP), commonly identified as the WADA test. The WADA test is the injection of sodium amobarbital into one of the femoral arteries, resulting in the shutting down of any language and/or memory function in the other hemisphere of the brain. This allowed the medical team to evaluate the level of cognitive function in the other hemisphere. Following the examination of both hemispheres, it could be determined to what extent these functions would be impeded as a result of neurosurgery. In Tinofa's case, it was recommended that a partial temporary lobectomy (PTL) be performed. This is an elective surgical procedure where a portion of the temporary lobe; the hippocampus, is removed. This form of neurosurgery is conducted to remove lesions on the temporary lobe that cause seizure activity.

Tinofa and his parents regarded the physical and neuropsychological effects of the elective surgery. Several questions caused him considerable anxiety. He was not sure whether the operation would leave him with significant brain damage or cause him to become more embarrassed when

in general society. The fear of the unknown, mostly due to lack of psychoeducation of the potential effects that may result from the operation, influenced his emotional reaction as to whether or not to proceed with the operation. The confusion influenced him not to have the elective surgery at that time. He also experienced low subjective wellbeing (SWB). He started thinking that people in his social network were judging him in relation to his experience of epilepsy and he reacted by withdrawing from most environment she had previously enjoyed. He dropped out from school, church, and other social gatherings.

For a period of about three years he took every possible anti-epileptic medication available at that time, combining up to three medications at higher than recommended doses. However, the frequency of seizures increased to as many as seven per week. A neurologist suggested that he undergo a second PTL to reduce the seizure activity. It was at this time he chose to go ahead with the procedure, believing there was a chance of a positivity impact on his quality of life. Tinofa subsequently underwent a number of operations following an increase in the regularity of seizure activity. The operations threatened his short-term memory as a result of several tempers with his hippocampus. After realising this, Tinofa resolved to study more about epilepsy, the difficulties of this condition, and its effect on his health and subjective wellbeing. Tinofa's decision confirmed the earlier position on experiences of persons with disabilities, namely that having a disability also presents opportunities for personal growth and development.

The above experience of a Zimbabwean adolescent with epilepsy provides anecdotal evidence of an adolescent whose physical disability put him at a higher risk of rejection and isolation by peers in his community (Schachater, 2007) than peers without disabilities.

The next section presents literature from research on some of the efforts made by various communities' to integrate adolescents with physical disabilities and to enhance their psychological wellbeing.

2.6 Research on community strategies to enhance psychological wellbeing

Several studies (Bradshaw & Keung, 2011; Cluttebuck & Novie, 2003; Maunganidze & Kasayira, 2002; Mpofu & Shumba, 2012) indicate that community strategies are being used to enhance the psychological wellbeing of adolescents with physical disabilities in Zimbabwe and the world over.

A study done in Zimbabwe and relevant to strategies that can be used to develop inclusive environments was done by Maunganidze and Kasayira (2002). Maunganidze and Kasayira's (2002) study focused on the attitudes of Zimbabwean Secondary mainstream teachers towards students with physical disabilities. The study found that Zimbabwean teachers were willing to teach students with physical disabilities and were aware of the idea that education could be used as a strategy to build social inclusion by helping reduce inequalities and encourage contributions of all community members.

The effective use of education as a pro-inclusive strategy was also found in a survey carried out by Cluttebuck and Novie (2003) in Alberta. The survey was performed to get the voices of 150 inclusive community stakeholders on how education can best be used to support changes that are necessary to eliminate discrimination in communities. The use of education as an instrument to enhance the psychological wellbeing of adolescents with physical disabilities was also found to be not significantly effective in promoting their self-esteem, personal relations with others, personal development and autonomy.

The provision of locally assistive devices to adolescents with a physical disability is also a strategy that is designed to create a smooth integration of people with physical disabilities into their communities, at little cost. Community-manufactured devices are usually not expensive, as they are made from resources found within the communities themselves. Bradshaw and Keung (2011) conducted a study in the United Kingdom on the influence of the provision of locally designed assistive devices (e.g. wheelchairs, artificial arms, prosthesis, etc.) as an inclusive community

strategy to enhance the psychological wellbeing of adolescents with physical disabilities between the age of 13 and 15. The study was self-reporting in nature. Participants reported about their levels of happiness and self-esteem following continued assistive devices support services spanning from 1994 to 2008. The study found that the overall happiness scores increased significantly over this period of time (especially for girls), and that happiness was significantly higher in 2008 than in all the previous years, except for 2007. The authors noted that it was difficult to draw clear conclusions about the causes of this improvement, but there was some evidence that it could be linked to improved relationships with friends as a result of an increase in mobility and less dependence. The study also reported a reduction in depression and anxiety among respondents.

Mpofu (2002) carried out a similar study related to the creation of an inclusive environment at the community level as a means to enhance the psychological wellbeing of adolescents with physical disabilities in Zimbabwe. He investigated community efforts at meeting the provisions of inclusive education in Zimbabwe and found that the provision of assistive devices such as wheelchairs, crutches and other prosthesis equipment was vital for unconditional acceptance of people with physical disabilities. Assistive devices were found to be very effective in enhancing functional aptitude among individuals with physical disabilities (Mpofu, 2002).

The provision of counselling services to people with disability is one of the many strategies available for various communities the world over. People with disabilities need counselling services to enable them to live positively with their condition. Mnkadla and Matarutse (2002) carried out a study on the effectiveness of Zimbabwean school counselling services in enhancing social acceptance of people with physical disabilities in inclusive education settings. Mnkadla and Matarutse (2002) found that the provision of counselling services was the cornerstone for any successful inclusive community. They also found that counselling was necessary both for people with and without disabilities, so that they could know their strengths and limitations and accept each other as equal partners.

The importance of counselling services as a necessary tool for unconditional acceptance of people with physical disabilities was also reflected in research conducted in Australia by Smart and

Sanson (2008). They carried out a longitudinal study on the effectiveness of counselling services as an inclusive strategy to enhance the psychological wellbeing of Australian adolescents with physical disabilities and found that Australian adolescents who received some form of counselling at the community level had a positive temperament style and less disability-related behaviour problems (Smart & Sanson, 2008).

The use of income-generating projects as a measure to enhance the psychological wellbeing of people with physical disabilities was also investigated by Mpofu and Shumba (2013) in the Makonde District of the Mashonaland West province of Zimbabwe. The study used survey methods to assess community engagement of people with disabilities in entrepreneurship programmes and how these programmes enhance the quality of life of these people. Questionnaires and interviews were used to solicit relevant information from 137 persons with various disabilities (46 physically impaired, 24 visually impaired, 20 hearing impaired, 15 intellectually impaired, 10 with emotional disorders and 22 with other health-related conditions) from a rural district in Zimbabwe. Respondents who happened to be people with disabilities were selected purposively from the Makonde district. Quantitative data was analysed using bar graphs and tables, while qualitative data was analysed using themes. The respondents acknowledged that entrepreneurial activities in their communities were vital for their quality of life as these activities made them live autonomous lives. However, they also reported that they were being shunned by entrepreneurial peers without disabilities, and this had a negative effect on the way some of their colleagues with disabilities viewed their disability. The respondents reported that some of their colleagues were viewing themselves as incompetent because of poor performance and the stigma attached to their entrepreneurial activities. Mpofu and Shumba's (2013) findings also confirm the practice of entrepreneurship as an inclusive community activity in Moldova.

Moldova uses entrepreneurship as a community activity to enhance the psychological wellbeing of its people with disabilities. The MATRA project –self-employment support for visually impaired people – sought to enable people with visual impairments to integrate into economic life by launching a business through assistance offered by the Business Support Program Moldova

2009. It is part of a wider initiative funded by the Netherlands' Ministry of Foreign Affairs and aimed at supporting countries in south and southeast Europe (Badza & Tafangombe, 2009).

Disability awareness programmes were also found to develop self-acceptance and social acceptance among adolescents with physical disabilities in Vietnam. In a research-based report on the Development of a Community-Based Rehabilitation Program in Vietnam, presented by Associazione Italiana Amici di Raoul Follereau (AIFO) and Vietnam Rehabilitation Association (VINAREHA, 2000), disability awareness was found as an activity that could be used to increase the integration and acceptance of children with disabilities, both inside and outside their immediate environment. The study found that Vietnamese adolescents with disabilities reached their full potential with adequate support of family, community and friends. These support systems were particularly important in the case of a child with a disability who was reliant on others to provide different types of assistance. Support was received from the family and community through activities that raised disability awareness. Adolescents with physical disabilities in Vietnam were also found to be playing a key role in mobilising the community to be more closely involved in their lives and education.

Disability awareness programmes, as a tool to enhance the psychological wellbeing of adolescents with disabilities, were also found to be effective in a study carried out by Werner (2013) in Jerusalem, Israel. The purpose of Werner's (2013) study was to find out whether (or not) the use of laws as a disability advocacy or awareness activity would enhance the autonomy of people with disabilities. The study focused on the use of Article 12 of the United Nations Convention on the Rights of People with Disabilities (CRPD) in Jerusalem. The CRPD stresses the right of individuals with disabilities to legal capacity on an equal basis with others. To achieve the basic human right of autonomy, individuals (those with the disabilities) must, according to the CRPD, be able to practise decision-making, that is, to make their own decisions and communicate these decisions to others. Supported decision-making approaches may aid individuals with disabilities in achieving this right. The question remains whether the implementation of the CRPD did indeed

translate into opportunities for autonomous and supported decision-making among individuals with disabilities.

In order to examine this question, a systematic review of bibliographic databases since 2008, when the CRPD came into force, was conducted to map the current state of decision-making among individuals with disabilities in Jerusalem, Israel. Twenty-seven manuscripts were reviewed with most focusing on decision-making within the fields of residential settings, health care, and sexuality-related decisions. The review showed that the implementation of the CPDR was effective in developing decision-making in people with disabilities

The next chapter addresses the study's methodology.

3 CHAPTER 3: METHODOLOGY

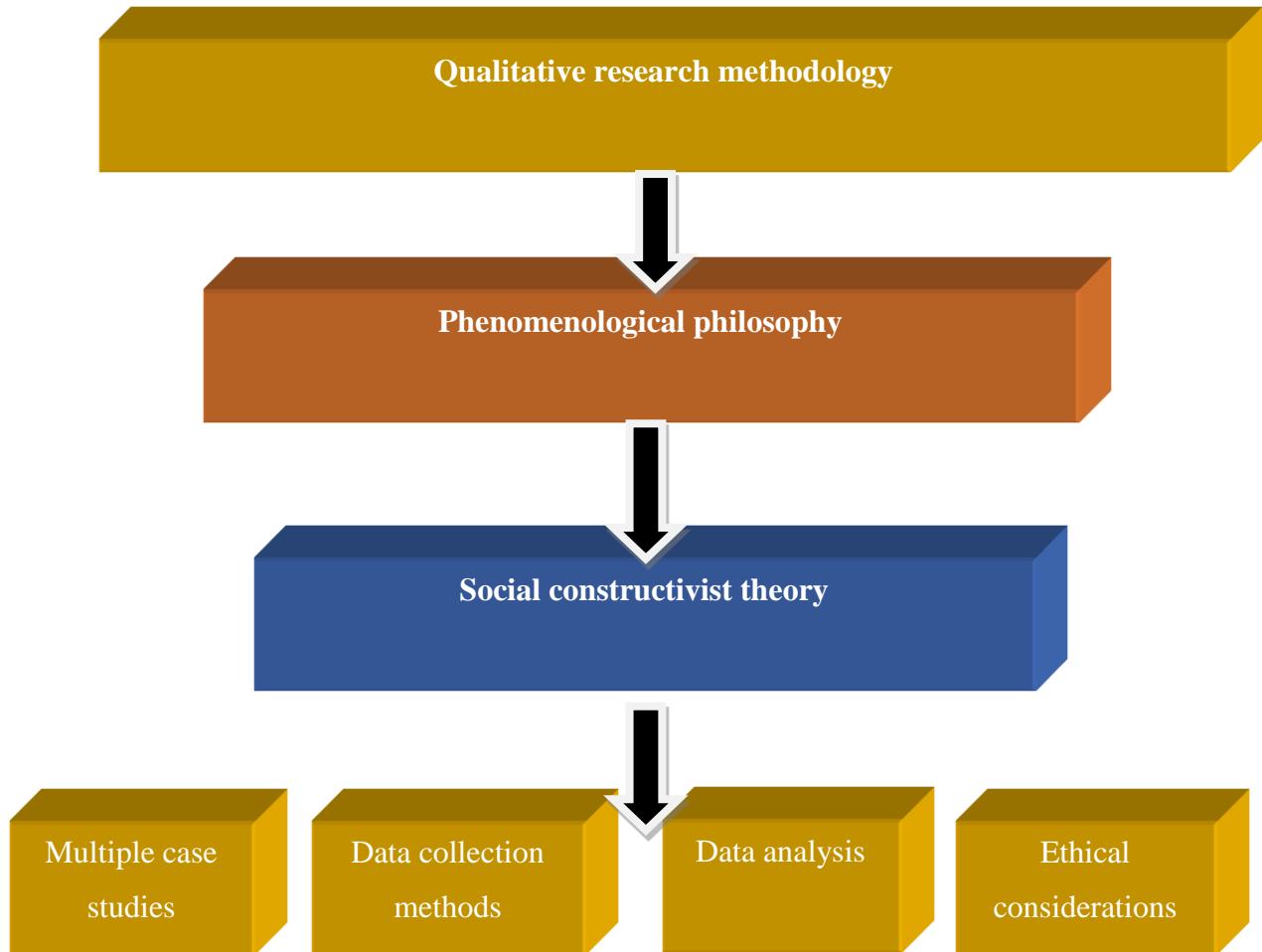


Figure 3.1: The Chapter Map

3.1 Introduction

The study used qualitative research methodology to explore the influence of an inclusive community strategy on the psychological wellbeing of adolescent with physical disabilities in Zimbabwe. The study used the social constructivist lenses to explore the influence of inclusive community strategy on psychological wellbeing of adolescence with physical disabilities in Zimbabwe focusing on the following research questions:

- 1) How do selected inclusive community strategies contribute to the overall wellbeing of adolescents with physical disabilities?
- 2) What strategies are available to integrate adolescents with physical disabilities into the community to enhance their psychological well-being?
- 3) How are these strategies implemented within the communities?
- 4) How do youths with physical disabilities choose between the strategies available?

Chapter 3 presents the research methodology thus the paradigm, design and methods.

3.2 The research paradigm

The paradigm for this study, namely the phenomenological paradigm (Lincoln & Guba, 2000), is a collection of logically related assumptions, concepts or propositions that orient thinking and research (Creswell, 2009; Lincoln & Guba, 2000). Creswell (2009) defined a paradigm as the philosophical intent or motivation for undertaking a study. Paradigms represent a world view that defines, for the researcher, the nature of the ‘world’, the individual’s place in it (Jacobs & Manzini, 2000; Kincheloe, 2008) and the range of possible relationships to that world and the its principles. (Bisman & Highfield, 2013; Lincoln & Guba, 2000). They serve as basic beliefs in the sense that they must be accepted simply on faith (however well argued); there is no way to establish their

ultimate truths (Burr, 2003). Research paradigms also serve as the lenses or organising principles by which reality is interpreted (Friedrick, 2008; Nieuwenhuys, 2009). They enable the researcher to tell a coherent ‘story’ by depicting a world that is meaningful and functional but culturally subjective (Jacobs & Manzini, 2000; Kincheloe, 2008). Research paradigms are discrete and culturally based (Schwandt, 2003), and they are influenced by the researcher’s background, such as his/her profession and cultural orientation (Bisman & Highfield, 2013). In the context of this study, my choice of study methodology (phenomenological-qualitative) was grounded in social constructivism.

The phenomenological paradigm originated as an attempt by the social constructivist theorists to come to terms with the nature of reality (Lincoln & Guba, 2000) and it has its roots in the field of sociology (Schwandt, 2003). Social constructivism is about how human beings engage with the world and how they make sense of it, based on their historical and social perspectives (Starks & Brown Trinidad, 2007). It assumes that the basic generation of meaning is always of a social nature and that it arises from interaction with a human community (Starks & Brown Trinidad, 2007). The major assumptions of the social constructivist theory discussed above are in alignment with the paradigm of this study, namely the phenomenological philosophy. Social constructivists and phenomenologists point to the fact that truths are accessible through inner subjectivity, and that the person is integral to the environment (Starks & Brown Trinidad, 2007).

Phenomenology is one of the many paradigms in the field of social sciences that are meant to discover new social knowledge (Goulding, 2005; Starks & Brown Trinidad, 2007). Phenomenology has its roots in the philosophical work of the German philosopher Edmund Husserl (1913–1931) (Goulding, 2005) and was later refined by Clark Moustakas (Creswell, 2007). Phenomenology is premised on the belief that most basic human truths are accessible only through inner subjectivity, and that the person is integral to the environment. It is more descriptive than prescriptive, as it relies more on individual’s narration of his/her own experience with the environment (Goulding, 2005).

Phenomenology is mainly concerned with the study of lived experience and how it is experienced (Giorgi, 2009). Lived experience is the starting point and end point of phenomenology research (Giorgi, 2009; Hopkins, 2006). According to Sokolowski (2000) phenomenology is a certain awareness one has of the experience while living through or performing it. Phenomenology fits well with the goal of the present study, namely to investigate the experiences of adolescents with disabilities regarding their psychological wellbeing in inclusive community settings or those typical of others who are non-disabled. A phenomenological approach was used to harvest their personal or lived experiences more than would alternative approaches.

Kuhn (1970) strongly believed that a phenomenological approach makes it possible to obtain insights into the essential structures and relationships of these phenomena on the basis of a careful study of real-life examples supplied by experience or imagination. Some phenomenologists such as Tasson (2012), Zahavi (2006) stress the need for studying the ways in which the phenomena appear in object-directed or “intentional” consciousness. The use of phenomenology and the social constructivist position in this qualitative research helped me to achieve the goal of my inquiry as the study sought to provide an adequate description of the influence of inclusive community strategies on the psychological wellbeing of adolescents with physical disabilities in the Makonde Urban district of Mashonaland West (Cohen et al., 2000).

3.3 Research design

This study made use of a multiple case study as its research design (Lincoln & Guba, 2000). A multiple case study research design refers to a research approach that facilitates the exploration of a phenomenon within its context, using a variety of data sources (Cohen et al., 2000; Lincoln & Guba, 2000). This ensures that the issue is not explored through one lens, but rather a variety of lenses, which allows for multiple facets of the phenomenon to be revealed and understood (Eatough & Finlay, 2012).

The multiple case study research design was chosen for this study because it enabled the researcher to provide a rich and vivid description of the influence of inclusive community strategies on the psychological wellbeing of adolescents with physical disabilities (Cohen et al., 2000; Lincoln & Guba, 2000; Patton, 2002). Information that was obtained from individual adolescents with physical disabilities in this regard was treated as real-life experiences of the participants, hence making conclusions relevant to the phenomenon under study. “Case studies are also easily understood by a wide audience (including non-academics) as they are frequently written in everyday, non-professional language” (Kaputa & Munemo, 2013, pp. 132; Moustakas, 1990; Patton, 2002). This strength makes the information obtained through case studies ready for use by service providers and other research stakeholders such as the research participants themselves (Cohen & Manion, 2001).

Like any other research design, multiple case study research has its own weaknesses. One of the weaknesses is that results may not be generalizable except where other readers/researchers recognise their application (Keyton, 2001; Punch 2005). However this limitation did not have a negative effect on the quality of the current study as it did not attempt to address the issue of generalisability. Instead, it aimed at providing a ‘thick’ description or address particularities, rather than to provide ‘typical’ accounts or generalizable findings.

Another limitation of a case study is that it is not easily open to cross-checking, hence it may be selective, biased, personal and subjective (Kaputa & Munemo, 2013; Muchengetwa, 2012; Patton, 2002; Starks & Brown Trinidad, 2007). Multiple case studies are also prone to problems of observer bias despite attempts to address reflexivity (Lincoln & Guba, 1985; Moustakas, 1990; Kaputa & Munemo, 2013; Muchengetwa, 2012; Patton, 2002). Reflexivity and author positionality were used to minimise the effects of cross-checking and problems of observer bias in this study by always being aware of how the researcher’s own experiences, attitudes and values affect the research process (Breuer & Roth, 2003).

3.4 Study setting

Participants were drawn from Makonde Urban which is the provincial capital of the Mashonaland West province (ZIMSAT 2012). It is a medium-sized town with an estimated population of 350 adolescents with physical disabilities (ZIMSAT, 2014). The town is fundamentally agrarian (ZIMSAT, 2015) and its few industries closed long ago, following the implementation of indigenisation policies by the Zimbabwean government. The collapse of industries and poor performance of the agrarian sector in Zimbabwe contributed to poor social services for people with disabilities as the country is running on a stringent budget (Mpofu, 2003). Institutionalised social services for people with disabilities such as special schools and rehabilitation centres were closed as they demanded huge resources from the national budget (Mpofu, 2003). The government could not sustain their costly overheads (e.g. lower rehabilitation officer-client ratios, specialist counsellors, teachers and equipment) and hence opted to involve communities to manage the needs of some of its people with disabilities (Mpofu, 2003; Mpofu, 2012). Communities such as Makonde Urban were called in to take care of those with mild to moderate disabilities (Chakuchichi & Mutamiswa, 2003; Mpofu, 2012). The Zimbabwean government encouraged these communities to be inclusive and designed never-ending strategies to effectively address diversity in these communities by identifying and removing barriers to community adjustment, development and participation (Chakuchichi & Mutamiswa, 2003). The remaining sections of this chapter will look at the sample, the research process and instruments, the researcher's role, data collection methods, data analysis, methodological norms and ethical considerations.

3.5 Methods

Open-ended interviews (Baxter & Jacke, 2008; Scholz & Tietje, 2002) were used in this study to collect data on the influence of inclusive community strategies on the psychological wellbeing of adolescents with physical disabilities in Makonde Urban in Zimbabwe. By using interviews, the study aimed to obtain rich descriptive data to understand how adolescents with physical disabilities

construct their views and experience (Cohen, Manion & Morrison, 2001; Keyton, 2001; Kaputa & Munemo, 2013; Muchengetwa, 2012; Punch, 2005) of an inclusive community as a strategy meant to enhance their psychological wellbeing.

The use of interviews in this study also provided greater depth of knowledge than in the case of other methods of data collection (Cohen et al., 2001; Kaputa & Munemo, 2013; Muchengetwa, 2012). The interviews probed for more specific answers (Thomas, 2011) and questions were repeated when a response indicated that the participant had misunderstood a question (Cohen et al., 2001; Kaputa & Munemo, 2013). More difficult questions were handled with ease through the use of clarifying probes or questions. Through the use of interviews the researcher was also able to assess the non-verbal behaviour of participants for contextualising their verbal responses (Muchengetwa, 2012). The use of interviews enabled him to ask sensitive questions (Charmaz, 2000; Goulding, 2005; Lincoln & Guba, 2000), for instance, terms that were friendly towards participants, without compromising the focus of the study (Goulding, 2005; Lincoln & Guba, 2003; Mpofu et al., 2013; Mpofu, 2003).

Although the use of interviews in this study presented many advantages, much time was also consumed on the part of the researcher (Liamputtong, 2009; Muchengetwa, 2012). This was caused by participants who took a long time to open up and divulge the required information (Kaputa & Munemo, 2013; Patton, 2002). Some participants spent more time discussing information that was not relevant to the study and may not have been willing to be reminded of issues under discussion more often (Cohen et al., 2001; Kaputa & Munemo, 2013). The researcher ended up using a small and manageable number of participants (n=14) to ensure credible data (Creswell, 2007; Creswell, 2009).

The study used open-ended interviews to solicit information on the psychological wellbeing of adolescents with physical disabilities in inclusive community settings in Makonde Urban, Zimbabwe. The individual interviews were conducted using an interview schedule (see Appendix II). The questions were designed to explore the relationship between people with disabilities living

in an inclusive community and the development of their psychological wellbeing. Each interview lasted for about 60 minutes and followed an interview schedule (see appendix III). The interviews were conducted in schools during participants' spare time and at places convenient to the participants. Participants did not incur any transport costs by participating in this study. There were no risks to participants as a result of taking part in the study. The participants were given the option not to take part in the study if you wish so and to withdraw from the study at any point without penalty or obligation.

This study also used funnelling, probing and story-telling as interview techniques (Creswell, 2007; Yin, 2003; Kaputa & Muchengetwa, 2012). Funnelling involves starting with general questions and then moving on to more specific questions (Kaputa & Muchengetwa, 2012). Probing is achieved by asking questions that elicit more detail or clarification (Creswell, 2007; Yin, 2003), while story-telling involves asking questions that encourage the participant to tell a story about his/her experience (Scholz & Tietje, 2002). Participants' stories provided rich descriptions of the concepts being explored and allowed the researcher to understand and conceptualise the experiences of the participants (Liamputtong, 2009).

3.6 Sample

The sample used for this study consisted of 14 adolescents (nine males and five females) with physical disabilities that were living in the inclusive communities of Makonde Urban. This purposively selected sample was able to yield credible data for the purposes of this phenomenological study. The sample of 14 purposively selected cases was able to achieve data saturation (Cohen, Kahn, & Steeves, 2000; Creswell, 2007). To be included in this study the adolescents had to have been staying in Makonde Urban either intermittently or continuously for at least two months. The study investigated the psychological wellbeing of adolescents with physical disabilities in inclusive community settings as the activities in these communities are designed for people who have mild to moderate degrees of disability (Chinze & Tambara, 2000).

Therefore those with severe disabilities were not considered in this study and there was no need to seek the consent of legal guardians for participants who were older than sixteen years old (Beskow et al., 2004; Makore-Rukuni, 2003). People with mild to moderate disabilities are considered competent to make their own decisions (Chinze & Tambara, 2003; Mpofu, 2003; Mpofu et al., 2012).

The sampling method used is sometimes considered a type of purposive sampling (Starks & Brown Trinidad, 2007). Characteristics to be displayed by participants in this study involved their sex, age, type of disability and level of education (see Table 3.1 on inclusion and exclusion criteria and Table 3.2 on the demographic data of the participants). The names used in Table 3.2 are pseudonyms so as to protect the identity and confidentiality of the research participants.

Table 3.1 Inclusion and exclusion criteria for participants

Inclusion criteria	Exclusion criteria
Between 13 years and 19 years of age	Below 13 years and above 20
Having a physical disability (amputation, myelodysplasia, cerebral palsy, head injury, spinal cord injury, neuromuscular disorder, health related)	Having other disabilities other than a physical disability
Having lived in an inclusive community in Makonde Urban – either intermittently or continuously for at least two months	Living in a rehabilitation institutions such as hospitals and special schools
Must speak Shona (conversational or better)	Being a visitor with a physical disability in Makonde Urban

Table 3.2 Demographic data of the participants

Participant's pseudo name	Sex	Age in years	Type of physical disability	Educational level
Kevie	Male	18	Cerebral palsy	Voc Tech
Langton	Male	13	Neuromuscular disorder	Grade 4
Nyarai	Female	15	Myelodysplasia	Grade 5
Witness	Male	15	Neuromuscular disorder	Grade 6
Walter	Male	14	Spinal cord injury	Grade 4
Try	Female	14	HIV	Grade 7
Nyarie	Female	14	Myelodysplasia	Grade 6
Dimingu	Female	15	Epilepsy	Grade 6
Dzanhasi	Male	19	Cerebral palsy	Grade 7
Kombo	Female	13	Polio	Grade 6
Dagie	Male	19	Cerebral palsy	Grade 5
Jeff	Male	15	Traumatic brain injury	Grade 6
Chiwaridzo	Male	19	Myelodysplasia	University
Jinye	Male	16	Hemimelia	Grade 5

3.7 The research process

The research process began in January 2012 and recruitment took place in two short steps. The first step of recruitment took only one day and involved visiting the Makonde District Social Welfare Office, which happens to be the custodian of records for all people with disabilities living in the district. The aim of the visit was to extract information of adolescents with disabilities living in Makonde Urban and the biographic data needed by the study (sex, age, type of physical disability, and level of education). This information was used to select the sample of final participants in this study.

The second step involved the actual recruitment of the study's participants. Since prospective participants were visited in their homes, the recruitment process took about four days. Makonde Urban is a medium-sized town that could easily be covered by the researcher in a single day, even when using public transport. However, four days were used to allow for enough time spending talking with the would-be research participants.

3.8 Researcher's role

The role of the researcher was that of a reflective mirror for participants to articulate and own their social constructions. Furthermore, he provided pre-interview counselling to prepare participants for any unexpected effects of the interview (Kaputa & Muchengetwa, 2012). This was done to minimise risks such as embarrassment, anger, and frustration that may result from participating in this study and to enhance the potential benefits of this study to the greatest extent possible. He also sought to establish rapport with the participants and strived towards maintaining it (Cohen & Morrison, 2006) by being courteous and respectful throughout the interviewing process (Kaputa & Muchengetwa, 2012). He encouraged participants to give their honest opinion (Thomas, 2011) on the influence of inclusive community strategies in enhancing their psychological wellbeing. He furthermore tried to be objective (Cohen & Morrison, 2006) and avoided introducing his own

views (Baxter & Jacke, 2008) or experiences (Creswell, 2009) so as not to influence the participants' responses (Baxter & Jacke, 2008). He avoided putting words into respondents' mouths by allowing free expression and letting them say what they wanted to say (Keyton, 2001; Punch, 2005). The researcher also tried to be a good listener throughout the process (Munemo, Kaputa & Muchengetwa, 2012) and avoided reacting to what participants said –he showed neither disapproval nor approval, and he did not show surprise, etc. (Baxter & Jacke, 2008). The audiotaped and handwritten notes that were generated for data analysis (Creswell, 2007; Creswell, 2009) also served as his field notes (Makore-Rukuni, 2003).

3.9 Data analysis

The data obtained from this study was analysed using the thematic content analysis approach (Grbich, 2010), which involves an interpretive process in which data is systematically searched for patterns to provide an illuminating description of the phenomenon (Chenail, 2012; Smith & Firth, 2011; Smith & Firth, 2011). Thematic content analysis results in the development of meaningful themes without explicitly generating theory (Gale, Heath, Cameron & Rashid, 2013). It also provides rich insights into complex phenomena (Gale, Heath, Cameron & Rashid, 2013) and expands on or tests an existing theory (Smith & Firth, 2011).

The entry point of the data analysis was to become familiarised with information obtained from the interviews (Grbich, 2010). The researcher did this by immersing himself in the research data by reading it line by line repeatedly (Chenail, 2012). This was done to obtain a sense of the descriptive information (Creswell, 2003; 2006; 2009) supplied by the study participants on the influence that inclusive communities' strategies had on their psychological wellbeing (Chenail, 2012; Hirsch & Sharon, 2005). From this immersed reading the researcher developed codes and categories (Elizabeth et al., 2014) by considering each line, phrase or paragraph of the transcripts in an attempt to summarise what adolescents with physical disabilities living in Makonde Urban were describing (Elizabeth et al., 2014; Smith & Firth, 2011). Coding is the process of defining

and categorising the data (Charmaz, 2000). An experienced external coder was asked to review the data to verify the trustworthiness of the coded data (Charmaz, 2006; Gale et al., 2013).

Coding (meanings derived from a statement) was used to compare the data category by category as part of the conceptualisation of processes (Charmaz, 2006). Coding assisted to reveal or explicate the relationships between the categories being identified (Charmaz, 2006). The researcher also used the constant comparative method (Turner, Kim & Andersen, 2013) to verify the emerging categories and concepts. Data coding included generating categories of the dataset that have a recurring pattern (Strauss & Corbin, 1998) and the researcher used these to manage the data as research themes (Turner et al., 2013). He subsequently used the themes to write the study report and did this by summarising and synthesising the themes derived from the interview data, by producing a story (Creswell, 2003), and by comparing the results to the study's research questions and the existing literature on the study subject (Creswell, 2003; 2012).

3.10 Data Validity and Reliability

This study was guided by norms or standard procedures common in qualitative research. The importance of credibility and trustworthiness was emphasised and attention was also given to transferability, reflexivity and author positionality, as well as member checking.

3.10.1 Credibility

Credibility refers to the extent to which the findings accurately describe reality, thus representing a true picture (Guba, 1981). Guba (1981) describe credibility as taking into account the complexity of the study and addressing the particulars that “are not easily explained”. Furthermore, for the research study to be useful, the work should be credible and use well-established research methods (Patton, 2002). Credibility depends on the richness of the information gathered and on the

analytical abilities of the researcher. There must also be an element of confidence and truth in the findings of the study (Lincoln & Guba, 1985; Patton, 2002).

To obtain credibility the study made use of member checking. Member checking –also known as informant feedback (Tinggaard, 2008) or participant validation (Byrre, 2001) – was used as a technique to help improve the accuracy, credibility, validity (Cohen & Crabtree, 2006) and transferability of the study (Creswell, 2007). To address the issue of member checking all participants were asked if they would like to receive feedback about the study (Cohen & Crabtree, 2006). Providing feedback would serve three purposes:

- First, it served as a way to give something back to the participants (Cohen & Crabtree, 2006). Being members of a vulnerable community, participants may have wanted to know if their experiences were unique, and the feedback gave them the opportunity to relate to others and feel less ‘alone’ in their journey (Byrre, 2001; Rubin & Babbie, 2008).
- Secondly, feedback allowed adolescents with physical disabilities see the results of their time and effort (Creswell, 2007).
- Thirdly, feedback strengthened the validity of my research as it allowed participant checking to take place (Harper & Cole, 2012; Carlson, 2010).

Only few additions to the missed information were made by the participants.

3.10.2 Trustworthiness

Trustworthiness is one of several techniques inherent in qualitative research and it helps to preserve the integrity of the research; specifically, the constant comparative method, purposeful sampling, saturation and reflexivity (Glaser, 1998). The constant comparative method was used to allow the theory to be modified as new codes and categories emerged, thereby verifying the

analysis. The use of purposeful sampling made sure that the participants had experience of the phenomenon being investigated and allowed the emerging analysis to be checked and verified by subsequent participants (Cutcliffe, 2000; Morse, 2007). Saturation allowed for replication and validation of the data (Morse, 2007), although reflexivity was used to examine biases in data, and justify decisions (Dey, 2007; Mruck & Mey, 2007). Finally, two other procedures were used to preserve quality in this research, namely participant checking and triangulation (Tuckett, 2005).

3.10.3 Transferability

The issue of transferability is also very important in qualitative research (Teddie & Tashakkori, 2009). To obtain transferability in this study, the researcher connected the empirical findings of the inquiry at hand to those of other cases and theories, and explained how the new evidence enhanced the understanding of the data from this study (Bourke, 2014). Adequate comparisons between empirical findings and previous theoretical contributions led to acceptable conclusions (Gilgun, 2010; Koskinen et al., 2005), and this avoided a situation where this study claimed to have discovered something already demonstrated in other studies.

3.10.4 Reflexivity and author positionality

The issues of reflexivity and author positionality are further important aspects of qualitative research (Bourke, 2014). Reflexivity was used to strengthen the trustworthiness of the research process (Bourke, 2014). As the researcher was aware of the influence he might have on the research process by *inter alia* correcting answers from the research participants (Gilgun, 2010; Bourke, 2014), reflexivity and author positionality were included in this study. Reflexivity was used to minimise this influence by the researcher's being constantly aware of how his own experiences, attitudes and values could affect the research process (Breuer & Roth, 2003). For example the researcher would be patient enough for the participants to give his or her opinion rather than to complete the sentence for the participant.

Being a professional who is very active in disability advocacy in Zimbabwe (including advocacy on inclusive communities, disability and its effects on the psychological wellbeing of adolescents with physical disabilities), this unique knowledge assisted the researcher in data collection (Breuer & Roth, 2003). Reflexivity allowed him to step out of this identity (academic and advocacy of disability rights) so that bias could be minimised (Corbin & Strauss, 2008). During the research process the researcher closely examined his own experiences, decisions and interpretations by not interfering with the participant's responses (Dwyer & Buckle, 2009). This 'reflexive stance' informed how he conducted the research, interacted with the participants (Corbin & Strauss, 2008; Dwyer & Buckle, 2009), and represented the participants' experiences (Breuer & Roth, 2003).

3.11 Ethical considerations

This study was guided by principles that provided a generalised framework of how research must be conducted. Before collecting any data in this study, the researcher applied for permission to the Faculty Ethics Committee of the University of Pretoria to carry out the study. Such permission was granted (see **Appendix XVI**). Throughout this study he emphasised rules that are rational, objective, universal and impartial, and he also addressed the following ethical considerations to serve as the study's methodological norms.

3.11.1 Informed consent and voluntary participation.

Informed consent and voluntary participation constituted major ethical considerations in this study. The research participants were given all relevant information about the risks or harm that could arise if they participated in the research (Woodson & Karim, 2005). To the greatest extent possible, the study minimised risks and enhanced potential benefits (Smith & Firth, 2011), such that the risks to participants were proportionate to the possible benefits to individual participants or to society in general (Emanuel, Wendler & Grady, 2000; APA, 2002; Lou & Okello, 2000).

Participants were also be allowed to pull out of the study at any point (should they have wished to) without any penalties (Loue & Okello, 2000). Since this study made use of adolescents – in other words participants whose ages are below 16 –their asset to participate in the study was sought both from them and their consent from their parents (Beskow et al., 2004; Makore-Rukuni, 2003). The legal age of majority in Zimbabwe is 16 years old (COPAC, 2014). An assent statement was part and parcel of the research instruments.

3.11.2 Protection from harm

The study ensured that respondents were not exposed to any undue physical or psychological harm. Harm could be embarrassment, anger, intimidation, physical or emotional stress, low self-esteem (Woodsong & Karim, 2005), exacerbation of stress, delay of treatment, sleep deprivation, loss of respect from others, negative labelling, invasion of privacy, damage of personal dignity (Beskow et al., 2004; Makore-Rukuni, 2003), loss of employment, and civil or criminal liability (Code of Ethics, 2010; Emanuel et al., 2000). To provide adequate protection to all participants, the researcher provided counselling before and after this study to cushion the respondents against any possible negative effects of their participation in this study. Serious attempts were made to be honest (Beskow et al., 2004; Makore-Rukuni, 2003), respectful and sympathetic towards all the participants. In addition, if by any chance participants required debriefing after an interview, the researcher provided this and made referrals whenever possible (Beskow et al., 2004; Makore-Rukuni, 2003). Debriefing used in this study included thanking the participants for taking part in the study, explain what the goal of the study was, how they were involved in the study and what was found from their responses.

3.11.3 Confidentiality and privacy

The study also protected the identities of the participants by not recording their names or locations in the study (APA, 2002; Emanuel et al., 2000; Loue & Okello, 2000). The confidentiality of their

disclosures was guaranteed and consent had to be obtained for the release of personal information (Beskow et al., 2004; Makore-Rukuni, 2003). However, in this study the guardians of participants under the age of 16 were allowed the right to observe the interviews or to request the transcripts of interviews (Loue & Okello, 2000; Irvine, 2010). Parents were only allowed to observe the interviews or view the transcripts if they requested it (Loue & Okello, 2000; Irvine, 2010). Participants were informed that their guardians might hear the comments made during the interview (Cohen, Manion & Morrison, 2001), and this allowed the participants to freely choose what they wanted to discuss during the interviews (Irvine, 2010). The information and responses shared by respondents during the study were also kept private by presenting them anonymously in the study's results (Makore-Rukuni, 2003).

3.12 Conclusion

The use of a qualitative research methodology, phenomenological philosophy, constructivist research paradigm, multiple case study research design and interviews facilitated an understanding of the psychological wellbeing of adolescents with physical disabilities in inclusive community settings. This study used 14 adolescents with physical disabilities living in Makonde Urban as research subjects. The adolescents participated in face-to-face interviews. A thematic approach was used to analyse the qualitative data that was collected on the psychological wellbeing of adolescents with physical disabilities in inclusive community settings.

Data presentation, analysis and interpretation will be done in the next chapter.

4 CHAPTER 4: RESULTS

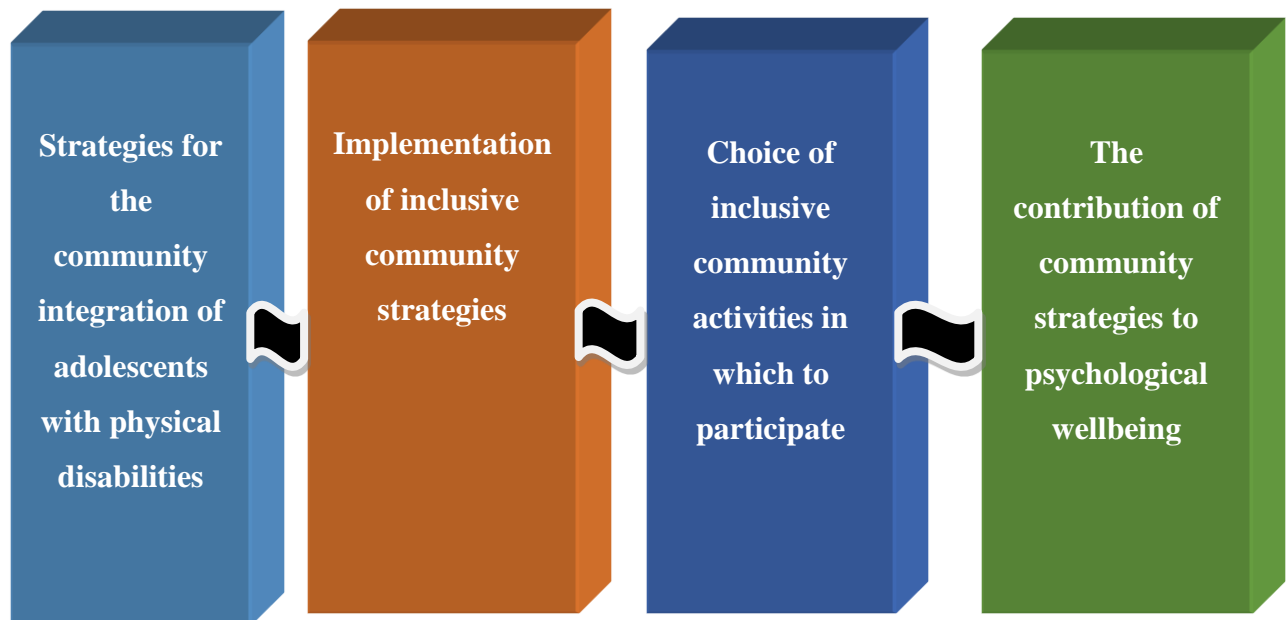


Figure 4.1: Thematic results

4.1 Introduction

The previous chapter discussed how the phenomenological-constructivist research paradigm was utilised to frame this study, and how the multiple case study approach was used for the collection of data in Makonde Urban. Chapter 4 now presents the main results of the study to address the following issues of the research:

- types of activity for inclusiveness of adolescents with physical disabilities in Makonde Urban;
- implementers of community strategies for social inclusiveness;
- personal factors and choices for community activities to participate, and
- Community-environmental influences for integration and psychological wellbeing.

4.2 Thematic results

This section presents the results obtained from the multiple case studies and uses the interview narratives of how adolescents with physical disabilities experienced inclusion. The study results are presented according to four major themes, with elaboration by subtheme, category and subcategory:

- Strategies for the community integration of adolescents with physical disabilities
- Implementation of inclusive community strategies
- Choice of inclusive community activities in which to participate

- Contribution of inclusive community strategies to the psychological wellbeing of adolescents with physical disabilities

In the presentation of themes, the voices of participants are interwoven in response to the study's research questions.

Themes and categories in this study were formulated following the thematic content approach of Creswell (2003; 2009; 2012) in the generation of themes in qualitative research data analysis. In this study, the thematic content approach assisted in the search for patterns that provided an illuminating description of the influence of inclusive community strategies on the psychological wellbeing of the participants (Turner et al., 2013). These patterns led to the formulation of themes (Charmaz, 2006), subthemes, categories and subcategories (Bazelet & Jackson, 2013).

This chapter presents the verbatim responses of participants and pseudonyms were used in their narratives to protect the identity and confidentiality of the participants. Their responses comprise the evidence gathered for the study. See appendix VII (pp: 195) for schematic presentation of themes, subthemes, categories and subcategories that emerged from this study.

4.3 Theme 1: Strategies for the community integration of adolescents with physical disabilities

The essence, and therefore the results of this theme in relation to strategies for the community integration of adolescents with physical disabilities, centred on available strategies for the community integration of adolescents with physical disabilities. One subtheme that emerged from this theme involved inclusion activities in which adolescents with physical disabilities could participate. This subtheme was supported by the following categories: learning-oriented activities; sport as a rehabilitation measure; self-care as a daily living skill; selling as training for independent living (vending); and gardening as a life skill (see appendix VII, pp: 195).

4.3.1 Subtheme 1.1 Participation of adolescents with physical disabilities in inclusion activities

The participants in this study (adolescents with physical disabilities) indicated that they were involved in five major inclusion activities available in their communities. Under this subtheme are firstly stated the experiences of adolescents with physical disabilities, and the verbatim extracts from the participants' responses are used as supporting evidence. See appendix V (pp: 175) lists the inclusion and exclusion criterion for Theme 1.

4.3.1.1 Learning-oriented activities

Learning-oriented activities were identified as a category of major community strategies meant to integrate adolescents with physical disabilities into the community of Makonde Urban. The category was supported by subcategories, formal and informal learning. The category and its subcategories were extracted from the narratives of this study's participants. Next the verbatim narratives of the participants on learning-oriented activities are presented by subcategory.

4.3.1.1.1 Formal learning

All (n=14) participants in this study indicated that their communities were engaging them in formal learning at school. In respect of formal learning activities participants reported as follows:

“I learn at school. At school I learn so many things, I learn to read and write. I also do a lot of art, drawing, knitting, and do a lot of moulding. My teacher also teaches me music. He also

teaches me the correct use of toilets and how to play well with others”Kevie (cerebral palsy, 18 years, male) (1, 1:1-4).

Engagement in learning at school was an interesting activity for Kevie, as he went on to say, *“I enjoy learning all subjects. Learning is good”* (1, 1:5). Langton, another participant, said:

“I go to school to learn so many things. My teacher every day encourages me to participate when in class. Besides that he usually takes us around the school yard picking papers viewing the school and other activities going on at school. During sports he takes us to watch sports at school or other sites around the school. We also do a lot of PE at our school but with Miss Suzan. I don’t know where she comes from. I like the way she teaches me PE. We do PE twice per week” Langton (neuromuscular disorder, 13 years, male) (2, 6:181-186).

Langton specifically stated that he enjoyed physical education (PE) at school by saying, *“I like P.E”* (2.6.187).

Nyarai (limb deficiency, 15 years, female) also had this to say:

“I go to school to learn. Besides learning reading and writing, my teacher teaches me how to recite poems. I present these poems at parents and prize giving days. I am also active in school drama” (3, 17:493-494).

Nyarai confirmed that she was happy with her achievements in school drama by saying, *“I am very good in drama. I was given prizes for being the best actor in our drama and good poems on so many occasions at our school”* (3, 17:494-495). Another participant had this to say on formal learning-oriented activities:

*“I go to school to learn. My teacher always teaches me how to play well with others. She always makes sure that I am not isolated in class and encourages me to ask her and others when I miss what she will be teaching. In most cases when I don’t finish my work she gives me the work as homework. Besides learning how to read and write, my teacher always helps me to manage my health condition. I have epilepsy. She discourages me to sit on sharp objects or big stones”*Dimingu (epilepsy, 15 years, female) (8, 36:1044-1049).

However, Dimingu said her health condition was preventing her from fully enjoying some of the school’s learning-oriented activities, *“My condition prevents me from taking leading roles in learning activities that are physical in nature, for example, PE”* (8, 36:1050-1051).

Another participant remarked:

*“I do a lot of learning at home. My parents teach me my homework and help me doing my other work which I would have failed to complete at school. They also teach me new work which we will do at school. Besides teaching me schoolwork time and again they also help me with training to move using parallel bars they constructed at home. In addition to this my young brothers and sisters also teaches me various games at home such as ball throwing and catching, correct handling and use of food utensils”*Witness (neuromuscular disorder, 15 years, male)(12,56:1062-1070).

4.3.1.1.2 Informal learning

The participants in this study also indicated that their communities engaged them in informal learning. In respect of informal learning activities, one of the participants, Try (HIV, 14 years, female) reported as follows:

“I learn so many things at home. My parents always teach me about how to take care of myself in the face of my health condition. They teach me a lot about the importance of taking my drugs in time and daily. In addition to this, they always teach me how to socialise with others at home and school” (13, 61, 1079-1082).

Walter (spinal cord injury, 14 years male) also added:

“I learn a lot of things from my community. Most of the things I learn in my community are about doing good things to others. When saying others I mean my colleagues. I get this type of education from my colleagues. The other experience or learning I am getting from the community is to respect elders. We learn about this at church. I go to Methodist” (10, 46:1033-1038).

Kombo (polio, 13 years, female) said:

“I learn various community rules from members of the community, such as my friends and community elders. I am always being reminded that if you do evil things such as stealing, saying bad about others, you will go to jail. This teaching is good. I don’t want to go to jail. I also learn from the community that fighting others is bad” (11, 51,301-305).

Chiwaridzo (cerebral palsy, 19 years, male) remarked:

“As a university student I interact with so many people. This interaction brings with it a lot of experiences. Through these experiences I learn so many life issues that are very helpful for my survival as an adolescent living with a physical disability. All I can say, is I am involved in continuous learning from my community” (6, 26:1428-1431).

4.3.1.2 Sport as a rehabilitation measure

Taking part in sport was another activity that the participants in this study identified as an inclusive physical activity provided by their communities (see appendix VII, pp: 195). Sport as a rehabilitation measure was also considered as a category in this study after being consistently identified by 93% (13 out of 14) of the study's participants. This category considered only experiences that reflected actual engagement in sport as a rehabilitation measure by adolescents with physical disabilities. Sport as a rehabilitation measure was supported by three subcategories, namely competitive sport (percussion, traditional dance, soccer, wheelchair tennis); leisure activity (computer games, street games, pebbles), and fitness activities (walking). The following subsection contains the narrative expressions of participants in respect of these three subcategories.

4.3.1.2.1 Competitive sport

Five participants of the 13 who said they were taking part in sport as an inclusive community activity indicated that they were doing this at competition level. Chiwaridzo (myelodysplasia, 19 years, male) said:

“I play wheelchair tennis. I am a tennis captain at our university. I am also a wheelchair tennis captain for the provincial paralympics team. I also featured in last year’s national paralympics team selection. Besides paralympics I am a non-playing captain for our mainstream lawn tennis team. Although I am just one year old at this university and playing wheelchair tennis, our team has won several medals under my captaincy”(6.26:728-731).

Witness (neuromuscular disorder, 15 years, male) remarked:

“I play soccer. I am a player in our school paralympics. Last year we played four schools. We did not win all the games but we also won some two of them. I am a keeper. Besides playing soccer I play drums in the school percussion band” (12, 56:1624-1625).

Another participant, Jinye (hemimelia, 16 years, male) said:

“I play chess for my school’s team not the paralympics team only but the school team. I am good at chess I have won several medals at district level, when playing other schools. I have travelled a lot playing chess. I learn chess from my computer. I play better than my teachers and they cannot teach me chess; thus why I learn it from the computer” (7, 31:868-870).

4.3.1.2.2 Leisure activity

Five participants in this study also indicated that they took part in sport as a leisure activity. Walter (spinal cord injury, 14 years, male) said:

“I play street games such as soccer, one touch and hide and seek.....these games are nice and quite interesting to me because they make me relax after school” (10, 46:1228-1230).

Another participant, Dzanhasi (cerebral palsy, 19 years, male) added:

“I play ball games with my friends at home after school and during weekends. We play ball games like “rakaraka”we also play nhodo (pebbles) at home” (8, 36:1296-1297).

Jinye (hemimelia, 16 years, male) said:

“Although I play chess at school for competition I also play it at home on my laptop during my leisure time. I also play it on my cell phone with other players of my age from other towns and countries. When I am not reading or watching TV, chess takes most of my spare time at home” (7, 32:896-896).

4.3.1.2.3 Fitness activities

Two of the 13 participants indicated that they were engaged in sport as a measure to maintain their physical fitness. Kevie (cerebral palsy, 18 years, male) said:

“I usually spend my sporting time at school walking around the school yard exercising my muscles. My health condition requires me to do some exercises to remain fit” (1, 1:18-19).

Langton (neuromuscular disorder, 13 years, male) agreed:

“At school I do PE with my teacher Miss Suzan, I do it as learning and also as sport to keep me strong. At home my parents also make sure I do exercises to keep myself fit. I used to go to the hospital for the exercises, but since last year we started doing them at our home” (2, 6:174-176).

Although 93% of the participants indicated that they were highly active in sport, one of the participants, Dimingu (epilepsy, 15 years, female), indicated that her health condition was preventing her from taking part in physical activities such as sport. She said:

“I don’t do any sporting both at home and school because my mother told me that you have poor health and if you play games you will collapse and die”(8,36:1044-1046).

4.3.1.3 Self-care as a daily living skill

Self-care was one of the community strategies that were identified as a physical activity in which five of the participants of this study were taking part with their families. Only experiences that reflected the engagement of adolescents with physical disabilities in activities orientated towards self-care were considered in this category. The five participants identified the self-care activities in which they were engaged at home. The following subcategories emerged as a result of these activities, namely: washing and bathing; sweeping and bedding; and cooking.

4.3.1.3.1 Washing and bathing

One of the participants, Try (HIV, 14 years, female), suggested that she was actively engaged in some form of washing as an inclusive activity at her home. She said the following:

“At home I wash my plates after eating food. I make sure they are clean. I also wash other plates used by my siblings, including those used by my parents. I use soap or dish washer to do the washing. After washing the plates I always make sure that I live the dish clothes clean as well, because my mother always inspect my washing”(13,61:1647-1650).

Bathing was identified twice as a major community strategy to enhance the psychological wellbeing of adolescents in this study. One of the participants, Chiwaridzo (myelodysplasia, 19 years, male), had the following to say about bathing:

“One of my major strength in self-care section is I always keep myself clean. I do that by taking bath twice every day especially when it is hot or when we are having sports. People talk a lot about those who are not friendly to water, worse with those of my ages and at the university. It will be made worse especially when you have a disability like me. In short I am saying I take bath every day” (6, 31:899-901).

4.3.1.3.2 Sweeping and bedding

Nyarie (congenital limb deficiency, 14 years, female) suggested that her daily routine involved sweeping and doing some bedding at her home. She said:

“At home I sweep in my room, my brothers room, dining room, lounge, kitchen and the veranda. After sweeping these rooms I do the bedding for my room and brother’s room. I also dust the sofas and kitchen tables. After doing all that, my mother at times clean the rooms further by applying cobra. But I usually put cobra in my room. This work is tiresome but I like it” (4, 16:448-452).

Try (HIV, 14 years, female) stated the following:

“Like any other girls when you are at home you are taught how to sweep and do the bedding. The two activities are specifically designed for girls no matter how your condition is. I do the two at home very effectively” (13, 61:1830-1832).

Another study participant, Witness (neuromuscular disorder, 15 years, male), had this to say about sweeping:

“Every day I wake up early in the morning and sweep my bedroom. I share bedroom with my young brother. At times the young brother does the sweeping. After sweeping I make our bed. My young brother is too little to do that but I have to train him sweeping and bedding” (12, 56:1624-1626).

4.3.1.3.3 Cooking

On cooking, Dimingu (epilepsy, 15 years, female) said:

“I help with several household chores at home but I am mostly involved in cooking. I can cook sadza, vegetables, meat, rice and so many things including groundnuts. I only make sure that I don’t burn the food I am cooking. My mother does not like that” (8, 36:1008-1010).

She added, *“I do the cooking most of the time during the weekend and I only stop cooking when I am tired. My health condition does not allow me to cook throughout the day.”* Dimingu (epilepsy, 15 years, female) (8, 36:1012-1015).

4.3.1.4 Selling as training for independent living

Three participants in this study indicated that they were engaged in some form of selling activities in their communities. They all indicated that they were involved in only one subcategory of selling, which was vending.

4.3.1.4.1 Vending

On vending as an activity, Try (HIV, female, 14years) said:

“At times I go with my mother to the farmers market. At the famers market we buy bananas, tomatoes, onions, groundnuts and other farming products. We then take these items to the local bus terminus and repack them into small units and resell them. We make money by selling these things. I usually go together with my mother during weekends or when schools are closed. At times I am left alone at the bus terminus doing the selling” (13, 61:1708-1712).

Try, went on to remark, *“I enjoy selling”* (13, 61:1172). Dzanhasi (cerebral palsy, 19 years, male) agreed and said, *“I also sell at our market. I sell so many things”* (9, 42:1177).

4.3.1.5 Gardening as a life skill

Three of the participants in this study indicated that they were also doing gardening as an inclusion activity aimed at training for independent living. For this category, only experiences that reflected engagement in gardening activities by adolescents with physical disabilities were accepted. Those experiences that did not reflect engagement in gardening-orientated activities by the adolescents with physical disabilities were rejected.

4.3.1.5.1 Home gardening

One of the participants who stated that he was engaged in home gardening was Kombo (polio, 13 years, female). With regard to gardening, Kombo said:

“I do a little bit of gardening at home during the weekends and over the holiday. My mother told me that the garden is mine. We have a very big garden. The other side has flowers, plants, herbs and the bigger side has vegetables. We also have some strawberries. What I do in our garden is I water it using a horse pipe. I also maintain the flower beds and pots by putting back lost soil and stones” (11, 52:1456-1460).

She went on to say how she felt about gardening: *“I enjoy gardening, I love our garden when it is hot we sleep under tree shades in our garden. My mother sells vegetables from our garden and we get money” (11, 52:1461-1463).*

Another participant, Langton (neuromuscular disorder, 13 years, male) said:

“At home I do some gardening. I usually assist my father to make vegetable beds every Saturday during school term. During the holidays and mid-week I work in the garden with my mother. We have sections for maize and another section for vegetables” (2.7:231-234).

He also said, *“I enjoy it (gardening) quite well. I tell you this is the truth I love it very well (smiling)” (2.7:234).*

4.3.1.5.2 School gardening

One of the participants of this study, Nyarie (congenital limb deficiency, 14 years, female), indicated that she was highly involved in gardening at school. Nyarie said:

“I do gardening at school. I have my school bed which is one meter by one meter. This time my bed has some vegetables. They are not all that good because we have water problems in our garden” (3, 17:493-495).

Nyarie went on to suggest that she would like to have more than one garden bed as others, but her teacher was restricting her to one because of her disability. She restated the teacher’s sentiments about participation in gardening when she said:

“Activities such as gardening are reserved for boys at my school and those without disabilities at school. I have one bed because I have one hand. My teacher feels that I cannot water more than one bed even using a hose pipe” (3, 17:496-499).

4.4 Theme 2: Implementation of inclusive community strategies

This section presents the results relating to Theme 2, which is the implementation of inclusive community strategies. One subtheme emerged from this theme, namely stakeholders’ efforts to successfully implement inclusion strategies. The subtheme is supported by four categories: Disability awareness education; vocational counselling; provision of inclusive infrastructure; and resources. Appendix VII (PP: 195) presents Theme 2, its subtheme, categories and subcategories.

4.4.1 Subtheme 2.1: Stakeholders' efforts at the successful implementation of inclusive communities

Participants in this study who were adolescents with physical disabilities indicated that several stakeholders were working hand-in-hand with them to make their lives as least restrictive as possible in the communities where they live. They indicated that different stakeholders were taking on a variety of roles such as providing to them (adolescents with physical disabilities) disability awareness education, vocational counselling, inclusive infrastructure and resources. These types of community efforts are discussed as the categories of Subtheme 2.1 (see appendix VI, pp: 193). Appendix VII (pp: 195) present the exclusion and inclusion criteria of this subtheme.

4.4.1.1 Disability awareness education

The participants explained that they were being taken through disability awareness-related education by their communities. They explained that this was done both at home and at school. These two environmental contexts identified by the participants were thus considered the subcategories of the category on disability awareness education.

4.4.1.1.1 Disability education at home

According to this study, disability awareness education at home was mostly carried out by the parents of the participants. One of the participants, Kevie (cerebral palsy, 18 years, male), had this to say on the issue:

“My parents usually take me out for walk around our suburb; they will be walking and will be moving in my wheelchair. They take me to various places some easy and smooth but others difficult to move with my wheelchair. At times they also take me to play small games with other

youths with or without disabilities. After each day outing, they ask me to explain how I felt and experience the outing and my condition” (1, 2:33-37).

Witness (neuromuscular disorder, 15 years, male) said the following:

“My mother always teaches me about living with a disability. She always explains my condition that I live with a disability but that does not mean I am not like others, for example my friends. She always explains that people who see disability in me are bad people and I should ignore them or report them to my teacher if they say something bad on me. Sometime last term I reported John and the teacher punished him” (12, 57:1653-1658).

4.4.1.1.2 Disability education at school

With regard to the disability awareness education programmes at school, one of the participants, Langton (neuromuscular disorder, 13 years, male), said:

“At our school we hold a disability day. On this day people with disabilities and those without disabilities are invited to show their work to others. Our work is then displayed together with those of other students without disabilities. We recite poems on what we are able and not able to do as children with disabilities. I enjoy this day very much. The school is doing something good to us as children with disabilities” (2, 7:210-215).

Another participant, Kombo (polio, 13 years, female), had the following to say on education related to disability awareness at school:

“My teachers always talk to me in areas where I am good at and those that I need help. My teachers and parents at times bring people who come and give me tests; after that they will talk to me on my results and say I should do this and that work. At times this is done after we write tests in our class with others” (11, 52:1579-181).

4.4.1.2 Vocational counselling

Four participants in this study indicated that their communities were training them to be vocationally competent by taking them through vocational counselling. These participants said that they were being taught how to apply for jobs as well as other vocational skills competences.

4.4.1.2.1 Job application and interviews

On job application and interviews, Dingu (epilepsy, 15 years, female) made the following remark:

“At school we are taught several issues around getting jobs. We are taught how to write letters looking for job, what to do during interviews and where to look for jobs. I was taught you look for jobs from advertisements and you then write for a job you think you can do, you then apply for job at a company and you must clearly write what type of job you want. If called for interviews my teacher told me that you have to go in time and nicely dressed. In the interview you must speak without fear and avoid taking managers’ things such as pens and papers. My teacher always tells us that one of his former deaf students took the pen out and the manager got angry and did not give him job because of that” (8, 37:1081-1089).

Dzanhasi (cerebral palsy, 19 years, male) added:

“At school we are taught how to look for jobs from industries and notice boards in town. My teacher always says most companies no longer put advertisements in newspapers but on company notice boards”(9,41:1232-1234).

4.4.1.2.2 Vocational skills competence

On the subject of vocational skills competence, Kevie (cerebral palsy, 18 years, male), said the following:

“I did my grade seven last year at this school but I am still at this primary school. This time I am not learning grade seven materials, but learning carpentry. After this I will get a job as a carpenter and make money. If I don’t get the job in industries I will do it alone at our home and get money. I like carpentry” (1, 2:66-70).

Dagie (cerebral palsy, 19 years, male) also said:

“I am being taught to do so many jobs after school. Right now I am learning poultry. I am being taught how to keep chicks and how to sell them on market and realise profits” (14, 67:19961-19962).

4.4.1.3 Inclusive infrastructure and resources

Some of the study participants indicated that their communities were quite active in providing inclusive infrastructure and resources that make their lives in an inclusive community less

restrictive. The adolescents also indicated that they were getting resources for inclusivity from their parents, the government, and philanthropists. The three sources that were indicated served as subcategories under the category 'inclusive infrastructure and resources.

4.4.1.3.1 Resources from parents

Most of the participants indicated that their parents were responsible for paying their school fees. Kombo (polio, 13 years, female) clearly said:

“My school fees are paid by my father, He always pay it before schools open. Besides fees he also buys me exercise books, pens, ruler, satchels, lunch boxes, crayons, pencil and others. He also gives me money for civics day” (11, 57:1566-1568).

Kevie (cerebral palsy, 18 years, male) had this to say:

“The government used to pay my fees few years ago but it is now broke. My mother has taken over. She is paying everything and the Head is no longer sending me home for non-payment of fees” (1, 2:71-72).

4.4.1.3.2 Resources from government

Other participants in this study said that the government was paying for their school fees. Try (HIV, 14years, female) said the following:

“My fees are paid by the government. My parents are not paying anything. The government is paying through DAC (District AIDS Committee). DAC is also responsible for my learning materials including school uniforms” (13, 62:1820-1823).

DAC is a governmental agency that looks after the welfare of people living with HIV and AIDS. Dagie (cerebral palsy, 19 years, male) had a similar answer: *“My fees are paid by BEAM”* (14, 67,211). The Basic Education Assistance Model (BEAM) is a government fee assisting programme that targets learners from disadvantaged communities.

4.4.1.3.3 Resources from philanthropists

Three of the participants in this study indicated that well-wishers were paying their fees and were responsible for their learning materials. These participants were Jinye (hemimelia, 16 years, male), Witness (neuromuscular disorder, 15 years, male), and Nyarai (limb deficiency, 15 years, female). Jinye said the following:

“My fees are being paid by the Catholic sisters. The Catholic sisters are also responsible for all my learning needs, including school uniforms, my transport to and from school” (7, 33:933-935).

Nyarai (limb deficiency, 15 years, female) said:

“There is someone who is not my parents and is paying my fees. I don’t know her name and where she comes from but that person is the one who is paying for my fees and responsible for learning needs” (4, 18:541-543).

4.4.1.3.4 Resources from the community

Participants in this study also indicated that their communities were taking serious effort to make their physical environment as least restrictive as possible. They said their communities were helping them increase their independence through assistive devices and adapting the physical environment to suit the needs of persons with a disability.

4.4.1.3.4.1 Adaptive schools

Almost all the participants in this study indicated that their schools were accessible to them. Jeff (traumatic brain injury, 15 years, male) said, “*At my school, our classes have ramps. We also have paths that I move freely with my wheelchair*” (5, 23:546-547). Dagie (cerebral palsy, 19 years, male) also said, “*At my school our toilets are built nicely. I can use them without problems from my wheelchair*” (14, 67:122) and Walter (spinal cord injury, 14 years, male) added that “*the doors at my school are very good. I can open them from my wheelchair. The handles are so low that I can reach them with easy. They doors are also very light that I can push and pull them*” (10, 48:1440-1441).

4.4.1.3.4.2 Assistive devices

On assistive devices, one of the participants, Nyarie (congenital limb deficiency, 14 years, female), said, “*I was given the wheelchair I am using by Social Welfare,*” (4, 13:33) and Jeff (traumatic brain injury, 15 years, male) said, “*I was given this wheelchair by Social Welfare, but I also have my own wheelchair at home*” (5, 23:671-671). Social Welfare is a department within the Zimbabwean government that takes care of the social needs of special populations within the country. The participants also mentioned that their wheelchairs were being serviced by the government. Nyarie (congenital limb deficiency, 14 years, female) said, “*My parents take my wheelchair to the hospital after every two months for repairing,*”(4,17:558-559) and Jeff

(traumatic brain injury, 15 years, male)said, “*The Social Welfare people come to our home to put oils and other things on my wheel chair time and again*”(5,23:672-673).

4.5 Theme 3: Choice of inclusive community activities to participate in.

In this section, the results related to Theme 3 ‘Choice of inclusive community activities in which to participate’ are presented. One subtheme emerged from this theme, namely participation of adolescents with physical disabilities in inclusion activities. Theme 3 is supported by three categories: choice of activities at home; choice of activities at school; and choice of activities in the community. Appendix VII (pp: 195) is a schematic presentation of Theme 3 along with the subtheme and categories that support it.

4.5.1 Participation of adolescents with physical disabilities in inclusion activities

In this section results are presented relating to Subtheme 3.1: ‘Participation of adolescents with physical disabilities in inclusion activities’. Appendix V (pp: 175) present the inclusion and exclusion criteria for the subtheme.

Twelve of this study’s participants indicated that environmental factors restricted them in choosing the inclusion activities in which they wanted to participate. These serious environmental restrictions occurred in the following contexts, which then served as subthemes: the home, the school, and the community. The results on how these contexts were said to be interfering with the selection of inclusive activities by adolescents with physical disabilities are discussed next.

4.5.1.1 *Choice of activities at home*

Most participants indicated that their selection of inclusive community activities in which to participate was limited by the fact that they were facing social and environmental limitations at home. They indicated that their parents and significant others were acting as regulators about the activities in which they could participate. The following statements are verbatim narrations by the adolescents on the limits of their choices regarding inclusion activities to partake in at home.

Dimingu (epilepsy, 15 years, female), said:

“I have limited control on inclusive community activities to do at home because of my health conditions. Most of these activities are so physical, e.g. games, writing, etc. I easily get tired and fear that I can collapse and die. If my health was permitting, I would choose activities to do. At present all my activities are determined by my mother” (8, 38:1140-1145).

Dimingu also stated that:

“All my activities are controlled by my parents they always remind me of my health condition, that I am not fit, hence can't do other things. They believe I am sick and weak. This makes me withdraw from many activities at home and only takes those that are allowed by my parents” (8, 38:1146-1150).

Another participant, Try (HIV, 14years, female), said:

“What I do at home is determined by my parents. Their choices on activities to participate also includes what I do even at school and when playing with others. I don’t just choose things to do without consulting my parents” (13, 63:1890-1892).

Witness (neuromuscular disorder, 15, male) had the following to say with regard to his home environment and choices:

“Although my parents try as much as possible to make me socialise with other people, they select people I should mix up with. They don’t allow me to choose friends at will. They approve them. Even at home they are very watchful on my moves, like if we have visitors they don’t want me to play around them. They try as much as possible to keep me away. They only allow me around visitors if the visitors themselves have a child with a disability” (12, 58:1740-1747).

4.5.1.2 Choice of activities at school

Some of the participants in this study indicated that their freedom to choose inclusive community activities in which to participate was limited by the physical environment at school. They indicated that some of the school’s physical environments were not easy to negotiate and that the social environment at those schools also posed participation restrictions.

On the school environment and his choice of activities, Langton (neuromuscular disorder, 13years, male) said the following:

“My school environment affects my choices to participate in various inclusive community activities at school level. For example, some of the school places are not readily accessible for people with my condition. The sporting grounds are difficult to move” (2, 8:260-264).

Walter (spinal cord injury, 14 years, male) had this to say on his choice of activities at school:

“My choice to participate in inclusive community activities is facing a lot of problems such as attitudes of my colleagues without disabilities towards me at school. My colleagues’ attitudes are so negative. They side-line me in so many activities and qualify me to the lesser entertaining ones. You will end up avoiding taking part in some of the activities you may want to take part in. Just imagine some of them may not be willing to sit close to me watching a game, say soccer or netball. They don’t just feel comfortable for no reason. They believe my disability is contagious – I don’t know. What I end up doing is to go home or play alone or with my colleagues who has a disability” (10, 47:1510-1521).

Dimingu (epilepsy, 15 years, female) had a similar remark to make:

“My colleagues at school were told by their parents that epilepsy is contagious. They don’t want to socialise with me; they feel that they can get it from me if I’m under attack” (8, 39:1168-1170).

4.5.1.3 *Choice of activities in the community*

Physical and social environments in the community were also identified as posing limitations to the choices that adolescents with physical disabilities have. The participants indicated that the physical and social environments within their communities were restrictive in some cases. Kevie (cerebral palsy, 18 years, male) had the following to say about how such environments were posing limitations to his personal choice as an adolescent with a physical disability:

“I have challenges with the physical environment. Our roads are not all tarred and some have serious potholes. They present me with challenges when I want to move from point A to Point B. This will result me not attending some of the community functions I might want to attend. Some of the buildings in our town are not accessible by wheelchairs. This limits me visiting other places when I want to play with others. It also affects me visiting other places like schools and clinics” (1, 4:120-127).

Dagie (cerebral palsy, 19 years, male) said this on the impact that community limitations have on his personal choice:

“Most of the problems I get at school are transferred to my friends in our community. You find out that you may want to play with A, B, C but they may not be willing to play with you. They will tell you that their parents don’t allow that. They actually say bad words to refer to me in many cases. I am called “chirema” (the crippled). You find out even if you want to play with them you may not be comfortable and you end up withdrawing from activities of your choice. Just imagine the other day we were playing soccer. I was playing for team A; we were supposed to be 7 aside, our team was allowed to play with 8 because they felt that I was not an extra person” (14, 68:2040-2050).

4.6 Theme 4: The contribution of community strategies to psychological wellbeing

This section presents the study results relating to Theme 4: the contribution of community strategies to psychological wellbeing. Appendix VII (pp: 195) presents Theme 4 with the subtheme, categories and subcategories that support it. One subtheme emerged, namely inclusion and the psychological wellbeing of adolescents with physical disabilities. The subtheme is supported by the following categories:

- 4.1.1 Autonomy and choice (supported by subcategories 4.1.1.1 Formal learning, autonomy and choice; 4.1.1.2 Informal learning, autonomy and choice);
- 4.2.1 Purpose in life (supported by subcategories 4.2.1.1 Formal learning and purpose in life; 4.2.1.2 Informal learning and purpose in life);
- 4.3.1 Positive relation (supported by subcategories 4.3.1.1 Formal learning and positive relations with others; 4.3.1.2 Informal learning and positive relations with others);
- 4.4.1 Personal growth and self-acceptance (supported by subcategories 4.4.1.1 Formal learning and personal growth and self-acceptance; 4.4.1.2 Informal learning and personal growth and self-acceptance).

Participants in this study expressed their feelings on how their participation in inclusive community activities was contributing to their psychological wellbeing. Results from this theme focused on how inclusive community strategies contributed to the overall wellbeing of adolescents with physical disabilities and were presented according to the four major attributes of psychological wellbeing that were of interest to the study. These were autonomy and choice, purpose in life, positive relations with others, and personal growth and self-acceptance. The major attributes served as the subtheme categories.

4.6.1 *Autonomy and choice in life*

Most participants in this study indicated that their participation in inclusive community activities promoted their autonomy and choice. On the latter subject, the participants indicated that they were gaining some level of autonomy through their involvement in formal and informal learning. These two forms of learning are presented below as subcategories.

4.6.1.1 *Formal learning, autonomy and choice*

Most participants in this study indicated that their exposure to formal learning in their communities was helping them and developed their ability to practise autonomy and choice. Chiwaridzo (myelodysplasia, 19 years, male) had this to say on formal learning and autonomy:

“Because I am making progress at my university, I have a feeling that I am being empowered. This empowerment is giving me some feelings of self-rule and choice. Look here, I selected subjects to take at Advanced level alone. I also selected to take Accounting at the costs of so many other programmes in the Faculty of Commerce. I am also thinking of specialising in banking. This choice is coming all as a result of learning” (6, 31:930-935).

Another participant, Jinye (hemimelia, 16 years, male), remarked:

“Through learning using computers I feel I am being equipped with abilities to make choices. When learning games such as chess it’s all about making the correct move. If you move wrongly you are defeated, so learning makes me develop, making right choices not only in the game of chess, but in life” (7, 33:990-993).

However, Nyarai (limb deficiency, 15 years, female) had a different view of how learning was influencing her autonomy and choice. She said:

“Learning, be either at home or school, was not doing enough to enhance my feeling of control over my choices. Most of the materials I learn, I do in my life is controlled by my parents and teachers, my brothers, sisters and even friends. I am always told this is what I can do and I can’t do” (3, 13:390-393).

Reiterating this position, Dimingu (epilepsy, 15 years, female) also remarked:

“I don’t have a lot of choice in my life; my health condition is giving me limitations. Imagine I cannot even write a lot of school work or play with others for a long time, because I easily get tired even if I want to” (8,38:1140-1143).

4.6.1.2 Informal learning, autonomy and choice

Some participants in this study also indicated that the community was engaging them in various informal learning activities that were social and civic in nature. They suggested that this was very helpful and boosted their psychological wellbeing. Jeff (traumatic brain injury, 15 years, male) had this to say on this issue:

“Through play, my social needs are addressed at group level. People need to be happy some time and this is only possible when they have choices around them and if their choices are recognised by the significant others they share time with. In my case, we always have visitors who come to our school and ask us about our needs. We give them our needs they address some but most of them are ignored. However we would have given out our choices” (5, 23:690-698).

Nyarai (limb deficiency, 15 years, female) also said:

“The fact that I do not have my left leg – it controls me in choosing what I want to do in my community as long as it requires the use of the missing leg. What I am saying here is, my disability affects my choice” (3, 14:420-422).

Dimingu (epilepsy, 15 years, female) also stated:

“I am not developing any choice; the choice is determined by my health. I have epilepsy; it attacks me without notice and because of that you cannot just do anything you want. My choice is limited” (8, 39:1170-1172).

4.6.2 Purpose in life

Some of the participants in this study suggested that as a result of the greater community engaging them in formal and informal learning, they were coming to realise that they have roles to play in life, like all other adolescents in their communities.

4.6.2.1 Formal learning and purpose in life

On formal learning and purpose in life, one of the participants, Chiwaridzo (myelodysplasia, 19 years, male) said:

“I am really satisfied with the progress I have made in my life. I have been doing well more than what other people of my age without disabilities do. It’s an achievement to be at a

university considering that I have a disability. I am satisfied and have no problems in as far as knowledge is concerned” (6, 29:870-873).

Walter (spinal cord injury, 14 years, male) had a different view on learning. He said:

“The learning I am getting is unsatisfactory. I am being taught things that are not of much benefit to my life. I want to be a truck driver. I admire my uncle who drives a truck. Instead of being taught maths, English and others which takes a lot of time to be employed, they must teach me driving” (10,49:1470-1473).

Jinye (hemimelia, 16 years, male) had a similar view:

“I was going to be satisfied with my life if I was learning carpentry. The learning I am getting both at school will never give me the life I want to live. I want to be a carpenter” (7, 34:1120-1122).

4.6.2.2 Informal learning and purpose in life

Kombo (polio, 13 years, female) had the following to say on informal learning and purpose in life:

“When I participate in social issues with my peers with and without disabilities I get happy. I also get happy when I am consulted over my life” (11, 54: 1666-1567).

Another participant, Try (HIV, 14years, female), said:

“I learn more of my condition at home from my parents, others who live with HIV like me. These people are very important. They have made me understand my condition and that I can live a normal life like any other person living without HIV. They have made me understand that I am a person like any other person in my community. They have made me know that what is important is to take my tablets only and I live on” (13, 64:1856-1860).

4.6.3 Positive relations with others

Some of the adolescents in this study indicated that their participation in formal and informal community learning activities helped them to a great extent to develop good relationships with their peers.

4.6.3.1 Formal learning and positive relations with others

On formal learning and positive relations with others, one of the participants, Langton (neuromuscular disorder, 13years, male), said:

“As learners we are always a family, be it at school or home. For example at our school I have friends, I belong to group C, I am in grade 4; we wear a blue uniform the whole school. When we are at sports we support one team, our school, and if we win, we all get happy. If we lose, we all get sad” (2, 9:261-268).

Participant Try (HIV, 14years, female), said:

“When we learn we are always in groups, be it at home or school. At my home our parents teaches us good manners. If we behave well as a family they become happy. If one of us does something bad, our parents get angry. They teach us how to do well before visitors and where ever we are. We also help each other by telling ourselves to do well as people belonging to our family” (13, 65:1885-1888).

4.6.3.2 Informal learning and positive relations with others

On informal learning and positive relations with others, Kevie (cerebral palsy, 18 years, male) said:

“My involvement in so many issues with my friends and being consulted on issues around my disabilities makes me feel that I belong to the same group as others without disabilities in my community”(1.5:145-147).

Kombo (polio, 13 years, female) held a similar view about informal learning and positive relations:

“I have learnt to respect my friends through playing with them in my community. Of course we learn it at school at assemblies, social studies and Religious studies, but we do it out of school. You see that you are doing it well mostly when you are not in class” (11, 55:2595-1597).

4.6.4 Personal growth and self-acceptance

Participants in this study suggested that their participation in inclusive community activities enhanced their personal growth and self-acceptance. These activities were also cultivated through formal and informal learning.

4.6.4.1 Formal learning, personal growth and self-acceptance

On the subject of personal growth and self-acceptance, Chiwaridzo (myelodysplasia, 19 years, male) said:

“Because of being engaged in learning I feel I am growing well. I can now do a number of things by myself. I can read, write and am adding value to myself. Very soon I will be an accountant” (6, 30:900-903).

On that same subject, Langton (neuromuscular disorder, 13 years, male) said:

“Going to school makes me learn so many things. Learning so many things, this shows that I am growing. Look I was once in grade one but I am now in grade four. I have changed so many teachers and all my teachers are saying: well, you are growing well. Look I am now able to do so many things alone at home, things that I was not able to do before because of my condition. I am now seeing that I am not disabled. I am growing up” (2, 10:300-305).

4.6.4.2 Informal learning, personal growth and self-acceptance

On informal learning and personal growth and self-acceptance, participant Try (HIV, 14 years, female) said:

“Sport is assisting me growing all-round. It helps me to socialise well with others although it is painful when you lose. But it helps me a lot. My participation in sport makes me feel that I am being recognised at school as a person who is not disabled but abled” (12, 65:1885-1888).

Jinye (hemimelia, 16 years, male) said:

“In chess you win, lose or draw. These are the results awaiting any chess player so when I win like in most of my cases, you feel that you are someone great, someone big and your supports will value more. At my school if I win or lose, my Head always see well in me. I will be put in front of other students on the assembly and the students will be asked to clap hands and cheer for my results. Besides that if I win at school level, win again with other schools, that movement from one stage to another makes me feel growing in my sport” (7, 35:1015).

4.7 Conclusion

The results of this study revealed that several inclusive community activities were available that could potentially facilitate the integration of people with disabilities into mainstream community. The participants also pointed out that they were engaged in different activities and were happy to be part of the greater community. However, they all admitted that they were not fully involved in the selection of the activities in which to participate, and that they were mostly told what to participate in. The choice of activities those were available to the majority was simply given to them. Only two participants reported that they had full choice and say in the activities in which they participated.

Most of the participants also confirmed that their parents and the government were the major players in the inclusive communities in which they were engaged. Only three mentioned other external funders that made it possible for them to participate in inclusive activities in their community. The participants confirmed that their participation in inclusive community activities was helping them and enhanced their psychological wellbeing. These results suggest that inclusive community strategies can be used to influence the psychological wellbeing of adolescents with physical disabilities in Zimbabwe.

The next chapter provides a discussion of the results.

5 CHAPTER 5: DISCUSSION OF RESULTS

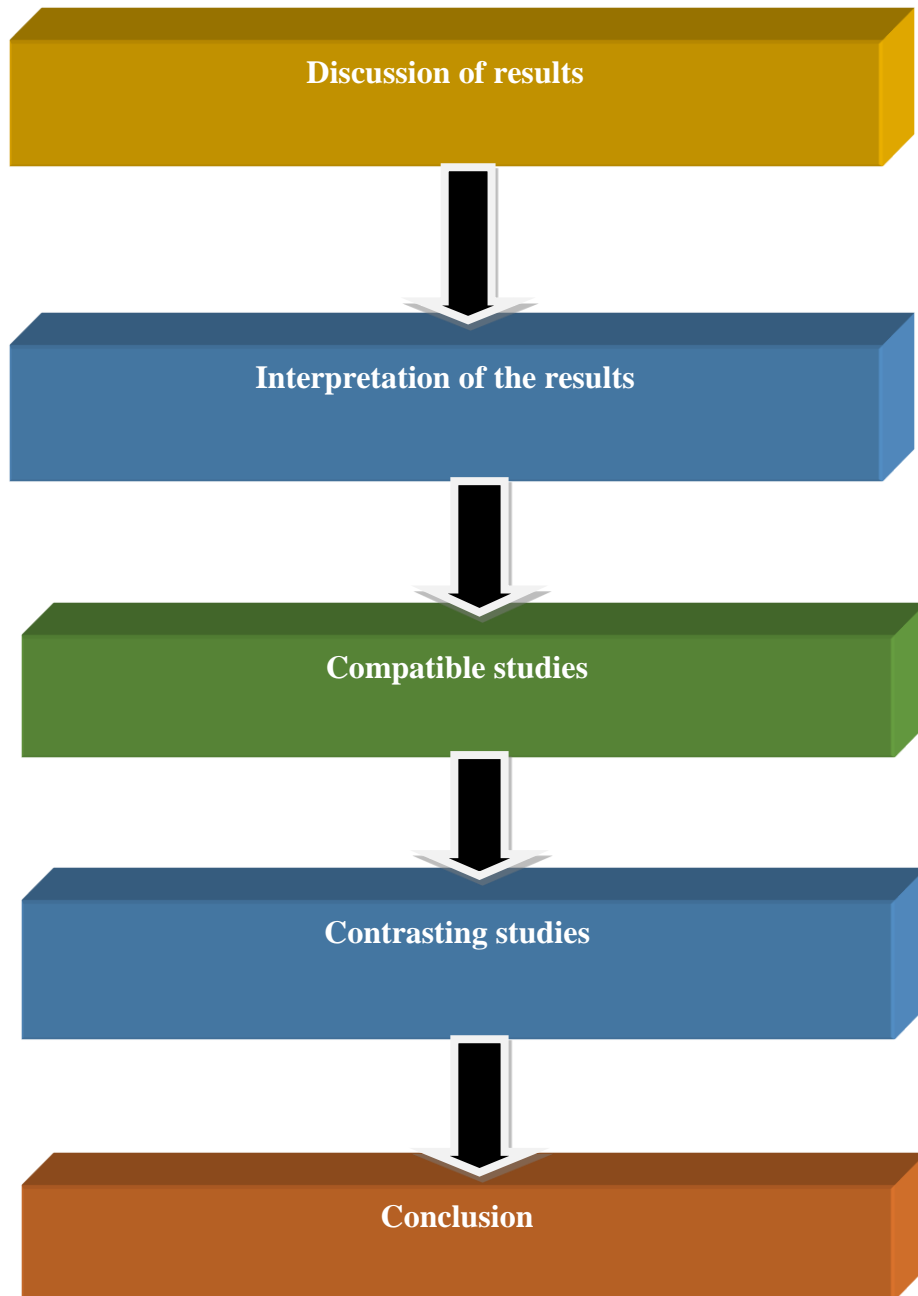


Figure 5.1: Chapter Map

5.1 Introduction

Chapter 4 presented the results of this study on the psychological wellbeing of adolescents with physical disabilities in inclusive community settings. In Chapter 5 the results are related to existing literature. Firstly the results of the study are stated. Secondly the meaning of the results is explained, as well as why the findings are important. Thirdly follows a review of the literature that is aligned with the results that emerged from this study, whereas review of the literature that contradicts the results of this inquiry concludes this chapter. Throughout this process the researcher demonstrates how the results of the study reflect relationships with existing literature as far as answering the research questions posed in Chapter 1 is concerned. The next section presents discussion on literature that is in support of the study results.

5.2 Literature that is compatible with strategies for the community integration of adolescents with physical disabilities

Information on appendix VIII validates the results on the psychological wellbeing of adolescents with physical disabilities in inclusive community settings as presented in Chapter 4. The information is sketched according to categories that emerged under Subtheme 1.1 'Participation of adolescents with physical disabilities in inclusion activities'. The researcher engages in discussions of the theme and its categories in précis form.

As in other studies such as Hungwe (2005), Majoko (2005), Makuyana (2004), Mkandla and Matarutse (2002), Mpofu and Shumba (2012), it was found that, according to the participants in this study, adolescents with physical disabilities in Makonde Urban were being exposed to some form of inclusion activities that were designed to integrate them into their communities. The participants indicated that they were engaged in learning, rehabilitative sport, training of self-care skills, selling and gardening activities. The study results are next presented following each and

every strategy identified by the participants. Immediately after the strategies, reference is made to studies that reached similar findings on strategies for the community integration of adolescents with physical disabilities. This method of presenting discussion is consistent with the theoretical framework of my study the systems theory. To begin with, learning-oriented activities are discussed as one of the identified strategies for community integration of adolescents with physical disabilities.

5.2. 1 Learning-oriented activities

This study revealed that all participants in this study were engaged in learning as a community activity to integrate them into the mainstream community. Learning refers to a process that helps an individual to acquire a wealth of knowledge by studying particular subject matters or experiencing life lessons that provide an understanding of something (Merriam Webster Dictionary, 2016). Learning requires instruction of some sort from an individual or from literature (Mpofu, 2003; Mpofu et al., 2012). The most common forms of learning result from years of schooling, which incorporates the study of a variety of subjects (Merriam Webster Dictionary, 2016). The most common type of learning to which people with disabilities are exposed in a mainstream school class is called inclusive learning (Chakuchichi et al., 2003). Inclusive learning occurs when all learners with diverse abilities are included in all those aspects of schooling that other children are able to access and enjoy (Loreman et al., 2005).

The UN defines inclusive learning as a “dynamic approach of responding positively to pupil diversity and seeing individual differences not as a problem, but as an opportunity to enrich learning” (UN, 2008, pp: 86). The UN (UN, 2008; UNESCO, 2005) also views inclusive education as a holistic approach towards the development of learners with disabilities and as a means to take care of their individual and societal needs. It fosters an attitude of unqualified acceptance and supports the growth of learners with disabilities at all levels of learning in the community (Loreman et al., 2005). Inclusive learning involves regular schools and classrooms genuinely adapting and changing to meet the needs of all children, as well as celebrating and cherishing

differences (Mpofu, 2003; Mpofu et al., 2012). The concept of inclusive learning ascribes to the notion that education is a basic human right (Oakes, 1992).

The current study produced results that corroborate the findings of a large proportion of previous work in the fields of inclusion, disability, education and community integration. There is much literature that validates inclusion education as a leading strategy for the successful community adjustment by people with physical disabilities. The essence of Theme 1 centres on promoting the participation of people with physical disabilities in their communities (Brownsberger & Hibbard, 2010; Mpofu & Oakland, 2010) by creating environments that are not restrictive to community participation (Prince et al., 2010) and by encouraging adolescents with physical disabilities to be as active as their peers without disabilities (Mpofu & Oakland, 2010). The promotion of community participation through the use of inclusive learning in the lives of adolescents with physical disabilities suggests that many adolescents who live in non-inclusive communities are living in restrictive environments that present them with barriers to successful community adjustment and integration (Prince et al., 2010).

The results obtained from this study indicate that learning-oriented activities are being used as an inclusive community strategy for the successful integration of adolescents with physical disabilities. This is consistent with literature on inclusive community practices in most developing countries (Badza & Tafangombe, 2009). Most developing countries view disability from the social model perspective (Chimhonyo et al., 2011), which proposes that disability is a social construct. As impairment, it manifests in a given context in society. In and of itself it is not problematic, but societal attitudes and barriers (Petersen, Mpofu & Oakland, 2010) posit that the issue of inequalities among citizens must be addressed at community level (Chimhonyo et al., 2011). The use of learning-oriented activities is one means of addressing issues of inequality (Badza & Tafangombe, 2009; Chimhonyo et al., 2011).

Most developing countries adopted the use of learning-oriented activities as a community strategy to integrate people with disabilities in mainstream communities. They did this mainly for the following reasons (Mpofu, 2003):

- The countries needed to contain the spread of special schools in their education systems, as these were becoming highly expensive and unaffordable for their economies (Chimhonyo et al., 2011; Mpofu, 2003).
- Special education schools in these countries were not seen as not giving desired learning space for participation by learners with disabilities (Mpofu, 2003; Thomas & Loxley, 2007), as children with disabilities were underachieving due to lack of equitable spaces (Hungwe, 2005; Majoko, 2005; Makuyana, 2004; Mkandla & Matarutse, 2002; Mpofu & Shumba, 2012).
- Rights-based influences affected services in developing countries and inclusive learning is now seen as enacting citizenship rights (Majoko, 2005). Most developed countries are signatories to pro-inclusive international conventions, such as the CRPD (UN, 2006). The CRPD encourage participating members to practise inclusion so as to achieve psychological wellbeing status of its people with disabilities higher than or comparable to the atypical ones (UN, 2000). Countries in Southern Africa that adopted inclusive learning as a measure to address the psychological wellbeing of people with disabilities as a result of the Salamanca Statement are Botswana (Dart, 2009), Uganda, Zambia, Kenya and Malawi (Badza & Tafangombe, 2009).

Botswana's National Development Plan (Government of Botswana, 2003) has an objective "to develop special education as an integral part of the regular education system to promote inclusive practices". This is a change from the country's 1994 Revised National Policy on Education (RNPE). The RNPE (Government of Botswana, 1994) and the National Commission on Education (Government of Botswana, 1993) were recognising special needs as in special classes and integration centres only. The RNPE introduced change in language to promote inclusive practices. Like Botswana, Uganda also adopted the policy of inclusive education in the wake of the Salamanca Statement (1994). However the country had various policies that were pro-inclusive well before the Salamanca Statement of 1994. Examples of such policies are the Government

White Paper on Education of 1992, the Constitution of the Republic of Uganda (1996) and the Universal Primary Education (UPE) (1997). The Ugandan government made its official commitment to the inclusion of children with disabilities in 2005 (ICEVI, 2005).

The use of inclusive learning as an inclusive community strategy to integrate adolescents with physical disabilities at community level is in harmony not only with Africa and the developing countries, but also with most European countries and the USA (Badza & Tafangombe, 2009). The current trend in the European Union (EU) and its candidate countries is to develop a policy toward the inclusion of pupils with special needs in mainstream schools (Badza & Tafangombe, 2009; Mavundukure & Tembani, 2003). EU countries are divided into two categories according to their policies on inclusion. The first category (one-track) approach includes countries that develop policy and practices geared towards the inclusion of all pupils in mainstream education (Badza & Tafangombe, 2009). A wide range of services focusing on the mainstream school supports this (Badza & Tafangombe, 2009). The approach was adopted in Spain, Greece, Italy, Portugal, Sweden, Iceland, Norway and Cyprus. The countries belonging to the second category (multi-track approach) have a multiplicity of approaches towards inclusion (Thomas & Loxley, 2007). They offer a variety of services between the two systems (i.e. mainstream and special needs education systems). Denmark, France, Ireland, Luxembourg, Australia, Finland, the United Kingdom, Latvia, Liechtenstein, the Czech Republic, Estonia, Lithuania, Poland, Slovakia and Slovenia belong to this category.

The United States of America is another country that has adopted inclusive education as a measure to integrate adolescents with physical disabilities in its mainstream communities (Barnes & Mercer, 2003; Gibson & Blandford, 2005). The adoption of inclusive education by the USA and other Western countries came as a result of advocacy from the pro-inclusive pressure groups of 1975 (Barnes & Mercer, 2003). This advocacy led to the creation of the pro-inclusive Education Act (PL94-142). The Act demanded better treatment for those with special needs. The federal government also passed two pro-inclusive education laws, namely the Individual with Disabilities Act 1990 and the Americans with Disabilities Act 1990 (Heward, 2003). These three USA

legislations influenced the formulation of the Salamanca Statement in 1994 (Barnes & Mercer, 2003). According to Hardman and others (1999) about 95% of students with disabilities in the USA attended regular schools at the time. The National Association of State Boards on Education (NASSBE) in the USA encouraged communities to provide appropriate and adequate education for its people with disabilities (Heward, 2003).

The current study made use of adolescents with physical disabilities who were in schools, only because the subjects were easy to locate. The type of subject (school-going adolescents with physical disabilities) enhanced the probability of them picking learning as an inclusive community activity available to them. Future research should include involving adolescents with physical disabilities who are not in schools and try to find out if they were also exposed to learning opportunities in their communities, as well as the type of learning activities they were involved in outside school. Future studies also need to explore the extent to which these learning activities that are available for adolescents with physical disabilities living in inclusive communities really assist with their successful integration into mainstream communities. The next section contains a discussion on sport as a rehabilitation measure, which was one of the identified community strategies designed to integrate adolescents with physical disabilities into mainstream communities.

5.2.2 Sport as a rehabilitation measure

Results from this study also indicated that most participants are engaged in a variety of sports activities as a community effort to integrate them into the mainstream community. Sport is generally understood to include physical activities that go beyond competitive sports (Kanhukamwe & Madondo, 2003; Mpofo et al., 2013). Incorporated into the definition of ‘sport’ are all forms of physical activity that contribute to physical fitness, mental wellbeing and social interaction (Zvomuya et al., 2000). These include activities such as play; recreation; organised, casual or competitive sport; and indigenous sports or games (United Nations Inter-agency Taskforce on Sport for Development and Peace, 2016). The current study established that some

participants are engaged in mainstream sport while others take part in adapted sport. Adapted sport refers to sport modified or created to meet the unique needs of individuals with disabilities (Zvomuya et al., 2000). Adapted sport is conducted in integrated settings in which individuals with disabilities interact with those without disabilities (Kanhukamwe & Madondo, 2003; Mpofo et al., 2013). Based on this definition, for example, tennis is a regular sport and wheelchair tennis would be considered an adapted sport because it uses assistive devices (wheelchair). The term adapted sport is preferred to “disability sport” because it stimulates and encourages participation and excellence in a variety of settings (Kanhukamwe & Madondo, 2003). Adapted sport aims to provide personal development and the self-actualisation of people with disabilities and it benefits society as a whole (Kanhukamwe & Madondo, 2003).

The use of adapted sport as a measure to integrate people with physical disabilities in mainstream communities in Zimbabwe is derived from its African Union membership. Sports and recreation for people with physical disabilities are enshrined in the African Charter for Human Rights. Article 13 of the African Charter for Human Rights (2005) deals with handicapped children and it states that:

“Every child who has a mental or physical disability shall have the right to special measures of protection in keeping with his physical and moral needs under conditions which promote active participation in the community.”

The Directors’ Circular No P7 of 2005 of the Zimbabwean Ministry of Primary and Secondary Education encourages schools to adopt adapted sport in its curriculum. Directors’ Circular No P7 of 2005 provides guidelines for the inclusion of all learners with disabilities in all school competitions, according to which a category should be set up in all competitions and special prizes, is awarded for competitors with a diversity of disabilities. The necessary adjustments /modifications must also be made to the requirements of the competitions for children with disabilities so that they can participate fully, while their special needs are taken into consideration (Zimbabwean Ministry of Primary and Secondary Education, Directors’ Circular No P7 of 2005).

This study produced results that are consistent with the practicing of sport by people with a disability in most Western countries. Sport is used as a strategy to integrate people with physical disabilities in mainstream communities in Canada, the USA and Australia (Zvomuya et al., 2000). Evidence to this effect is seen in the countries' sports legislations and policies that are inclusive in nature. In Australia sport is used as a measure to integrate people with physical disabilities in mainstream communities and to enhance the psychological wellbeing of its people with disabilities. Under Australian laws such as the Disability Services Act of 1986, the Disability Discrimination Act of 1992 and National Disability Insurance Scheme Act of 2013, people of all abilities are encouraged to have access to sport and physical activity opportunities. The Disability Services Act of 1986 defines persons with disabilities as individuals who live with physical, sensory, intellectual, psychiatric, and/or other health-related impairments. The key message from the above Australian laws on sport is as follows:

- Disability should not exclude someone from participation in appropriate sports and physical activity.
- Organisations dedicated to policy, advocacy and programme delivery to persons with disability must have an established role within the sport sector.
- Stakeholder organisations must use needs-based and inclusive strategies to engage persons with disability, encouraging them to be physically active.

South Africa is another country that promotes the use of sport as a measure to integrate people with physical disabilities in mainstream communities. White Paper 6 expects each school to have some inclusive extramural activities involving sport (South Africa, Department of Basic Education, 2000). This requirement is meant to accommodate learners from different backgrounds. It acknowledges the broader view of the importance of sport, namely that sport enhances social interaction and the development of friendship between diverse learner populations, which is fundamental for inclusive interdependence among the diversity of individuals. The next section discusses another inclusive community activity that was identified by participants in this study.

The study found that communities also used training in self-care as a daily living skill as a strategy to integrate adolescents with physical disabilities into their communities.

5.2.3 Self-care as a daily living skill

Results from the study narratives indicate that adolescents with physical disabilities in Makonde Urban were engaged in self-care skills training as a community strategy to integrate them into their mainstream communities. Self-care skills are the skills used to complete the many tasks demanded in a normal day (Chakuchichi & Magama, 2003; Chakuchichi & Mutamiswa, 2003; Davis et al., 1998). They include skills for dressing, eating, toileting, bathing and many more (Chakuchichi & Magama, 2003; Davis et al., 1998).

Health professionals often use a person's ability or inability to perform self-care skills as a measurement of their functional status, particularly in regard to people with disabilities (Davis et al., 1998). Younger adolescents with disabilities often require help from adults and peers without disabilities to perform self-care skills, as they have not yet developed the skills that are necessary to perform the tasks independently (Chakuchichi & Magama, 2003). One subject that remains to be explored on the use of self-care skills training as a community strategy to enhance psychological wellbeing is to find out the relationship between functional mobility (dressing, eating, toileting, bathing) and psychological wellbeing. In the next three paragraphs reference is provided to studies that examined the use of self-care skills training as a measure to integrate people with physical disabilities in mainstream communities and to enhance their psychological wellbeing.

The use of self-care training as a measure to integrate adolescents with physical disabilities in their mainstream community is not peculiar only to Zimbabwean communities. Every year, approximately 400 persons per 100 000 in populations over the age of 45 years develop a first stroke in the United States, Europe and Australia (Centers for Disease Control, 2000; Hendricks, vanLimbeek, Geurts, Zwarts, 2002). Stroke is the most frequent cause of adult-onset disability among people in the range of 40-50 years old age (Centers for Disease Control, 2000). The

likelihood of improvement after stroke varies with the nature and severity of the initial deficit. Approximately 35% of survivors with initial paralysis of the leg do not regain useful function, and 20 to 25% of all survivors are unable to walk without full training in self-care skills (Hendricks et al., 2002).

Patients who survive a stroke almost always have less physical disability by the end of the first three months (Kwakkel, Kollen, van der Grond & Prevo, 2003). People who no longer require assistance at that point may still be unable to use the affected hand, or walk at speeds and distances that permit activities outside the home, or live alone (Samsa, & Matchar, 2004). Quality of life tends to be higher among patients with better self-care training than among those with worse functioning (Binkofski & Seitz, 2004). Results on the effectiveness of self-care training in the United States, Europe and Australia encourage the adoption of self-care training as both as a primary health care activity and an inclusion community activity targeting people with stroke in these countries.

Self-care training as a measure to enhance the psychological wellbeing of people with disabilities is also used on people with low back pain in most Western countries. Low back pain (LBP) is a common and disabling disorder in Western society. The management of LBP comprises a range of different intervention strategies including surgery and drug therapy, but the most popular one is self-care training (Rubinstein et al., 2010). Next, a discussion follows on the use of selling as training for independent living and as a measure to integrate adolescents with physical disabilities in mainstream communities, thereby enhancing their psychological wellbeing.

5.2.4 Selling as training for independent living

Results from the study narratives indicated that some adolescents with physical disabilities are engaged in some form of selling or vending activities in their communities. Selling activities refer to “the art of exploring, creating and delivering value to satisfy the needs of a target market”

(Kotler, 2016, p: 16). Ability to sell is a very important skill to people with disabilities. It develops entrepreneurship skills, among both people with and without disabilities, in order to promote economic independence (Mpofu & Shumba, 2010). Entrepreneurship is the ability and willingness to develop, organise and manage a business, along with any of its risks, in order to make a profit (Mpofu & Shumba, 2013). The most obvious example of entrepreneurship is the starting of a new business. With training, education and support, individuals especially those with a disability can become active members of the national economy.

Entrepreneurship is gaining increasing recognition in both developing and developed countries (Muzari, 2011). Participation by people with disabilities in this 21st century activity will improve their lives and make the Millennium Development Goal of reducing poverty by 50% in 2018 attainable by most developing countries. People with disabilities and their families need entrepreneurship skills to be empowered and take care of their needs in every sphere of their lives (Muzari, 2011). This implies that they must play a key role that will require participation to a greater extent in various economic processes in their communities, such as taking part in entrepreneurship activities (David, 2004).

Entrepreneurship as a measure to integrate youths with disabilities into their mainstream communities is also pursued in a number of countries, for example in the USA individuals with disabilities are guaranteed the right to a free and appropriate education, under the IDEA. Once a student is determined eligible, special education services are provided based on an Individualised Education Program (Hardman et al., 1999). The IDEA supports students with entrepreneurial activities by ensuring access to entrepreneurial education opportunities; participation in business-related clubs. The WIA, which was passed in 1998, mandates that states and localities use a centralised service delivery structure, known as the One-Stop Center system, to provide federally funded employment and training services (Department of Labor, 2016). The One-Stop delivery system provides an array of employment services for everyone, including individuals with disabilities. Slovakia also uses entrepreneurship to empower persons with a disability by means of

a project called ‘Pre Podnikanie’, an entrepreneurship activity that is targeting deaf entrepreneurs with disabilities throughout Slovakia (Badza & Tafangombe, 2013).

The results from the study in hand, namely that engagement in some form of selling activity assists in integrating adolescents with physical disabilities in their communities’ were based solely on the responses of the study subjects who were adolescents with physical disabilities and mainly in primary schools. Future research on the use of selling or vending as a measure to integrate people with physical disabilities should include adults with physical disabilities to verify to what extent these selling skills training would assist in integrating people with physical disabilities at post school level. This could be done by checking the participation of people with physical disabilities in entrepreneurship activities in their communities. The next section provides reference to studies that also investigated the use of gardening as a living life skill as well as a measure to integrating people with physical disabilities in mainstream communities. The use of training to develop gardening as a life skill was the last activity identified by participants in this study and will be discussed next.

5.2.5 Gardening as a living life skill

The results show that some of the adolescents with physical disabilities who took part in this study are involved in gardening as part of a community effort to integrate them into mainstream society. Gardening activities are those activities that focus on laying out and taking care of a plot or ground devoted partially or wholly to the growing of plants such as flowers, herbs or vegetables (Synge, 2016). Gardening skills are agriculture-based vocational skills that are very important to people with disabilities, as these skills are needed for their livelihoods and economic independence as they grow into adults (Chakuchichi & Mutamiswa, 2003).

The use of gardening as a community effort to integrate people with physical disabilities in mainstream community is part of vocational skills training. The International Labour Organisation

(ILO) (1981) defines vocational rehabilitation as part of a continuous and coordinated process of rehabilitation that involves the provision of vocational services such as vocational training and selective placement to enable people with disabilities to secure and/or return to employment. For decades, the ILO has promoted the equal treatment and equal opportunity of people with disabilities, including in respect of skills development and employability programmes (ILO, 1981). With the adoption and remarkable ratification rate of the UN Convention on the Rights of Persons with Disabilities, the right of disabled persons to training and employment is gaining renewed attention. Most developing countries are amending laws to guarantee these rights and are turning to their training systems at community level to ensure that people with disabilities can participate (ILO, 1981). Examples of ILO advocacy for equal treatment and equal opportunity for disabled persons include the first standard directly related to disability (ILO, 2004). In 1955, the recommendation concerning Vocational Rehabilitation of the Disabled, No. 99 stated, “Whenever possible, disabled persons should receive training with and under the same conditions as non-disabled persons”. Today, words like inclusion or mainstreaming capture this important concept that was articulated by the ILO in 1955. In 1983, the Convention concerning Vocational Rehabilitation and Employment (Disabled Persons) called for a policy on vocational rehabilitation (i.e. career guidance, training and placement) and employment “based on the principle of equal opportunity”(ILO, 2004, pp:38).The accompanying recommendation, No.168, specifically stated that “vocational training (and related services) for persons with disabilities should be the same as those for the general population whenever possible and be used with any necessary adaptations” (ILO, 2004, pp:39). The aim of vocational training is to help persons with disabilities in their physical and psychological adjustment to social and economic demands. It also helps to promote effective measures for the prevention of disability and for the rehabilitation of disabled persons (ILO, 2004).

Vocational skill training for people with disabilities is offered in both developed and developing countries. Japan is an example of a developed country that uses vocational skills training as a community effort to integrate its youth with disabilities. The Japan National Institute of Vocational Rehabilitation (NIVR) provides vocational rehabilitation services to adolescents with disabilities (The Japan National Institute of Vocational Rehabilitation, 2016). The NIVR develops policies for

the vocational rehabilitation of persons with disabilities and improves employment support techniques at Local Vocational Centres for Persons with Disabilities, as well as at Employment and Life Support Centres for Persons with Disabilities, hospitals, and special needs schools (Boelting et al., 2013). The NIVR conducts research-based analysis on the current situation of persons with disabilities in inclusive settings and trends in the development of disability-related measures. In Poland, the Invalids' Cooperative Movement provides socio-vocational services to 2 million youths with physical and mental disabilities (The Japan National Institute of Vocational Rehabilitation, 2016). The Polish state supports the cooperatives through tax reduction and tax exemptions.

As in the case of selling as training for independent living, the researcher proposes further studies to explore how livelihoods skills (gardening) can assist in the enhancement of community integration of adolescents living in low resource-income countries like Zimbabwe. Further studies may also explore the level of integration that can be brought about by offering personal agricultural-based skills training to people with physical disabilities. This could also be done (as in the case of selling) by checking the participation of people with physical disabilities in the agricultural economies of their communities.

The study results, which suggest that adolescents with physical disabilities in Makonde Urban were actually exposed to some form of inclusion activity that was designed to integrate them into their mainstream community, is very importance to various inclusive communities and researchers in community initiative projects. It adds up to addition of existing literature on a wide range of contemporary and traditional therapeutic approaches that may be employed in the integration of adolescents with physical disabilities at community level. It provides empirical evidence and empowers individuals with physical and other disabilities to make positive improvements in their lifestyle and physical self-care, as they encourage them to take part in various inclusive activities that may be available in their communities. The following section is devoted to a discussion of the results, following the identified inclusion activities.

5.3 Literature that is compatible with the implementation of inclusive community strategies

Appendix VII (pp: 195) also presents the main results of the study and literature, and validates the results as presented in Chapter 4. The information is sketched according to categories that emerged under Subtheme 2.1 ‘Implementation of inclusive community strategies’. The categories depict trends in existing knowledge that illuminate the results in this study. These categories are discussed next, based on the researcher’s reflections and selection of central themes, which are presented in précis form.

Results from this study indicated that some form of community effort is going into the implementation of inclusive community activities designed to enhance the psychological wellbeing of adolescents with physical disabilities in Makonde Urban. Community engagement is essential for meaningful inclusion to occur (Chakuchichi & Magama, 2003). The current study indicated that different players play different roles in the implementation of inclusive community strategies in the area under study. Major implementers cited by the participants were the parents, the government and philanthropists and they helped mainly in providing disability awareness education, vocational counselling and inclusive infrastructure and resources.

The involvement of people with disabilities, parents and community members working with local resources and through local organisations, is the key element of inclusive community practice (Judd, 2003; Mpofu et al., 2011; Ndawi, 2000). Hardman and others (1999) claim that successful inclusion programmes must have both formal and natural support systems. These systems are indispensable to inclusion, they complement each other and they act as inclusion implementers. Formal support systems are those that are funded and provided by the government through the general community setting. Some of the formal support systems include teachers, appropriate curriculum material and technological assistive devices. This multi-disciplinary team becomes stakeholders in inclusive practice. They define the problem, plan treatment or intervention, plan

education and future placement, and provide support for the family, both practical and emotional (McCarthy, 1984). Core members of inclusion stakeholders may include social workers, physiotherapists, occupational therapists, teachers, parents, rehabilitation engineers, psychologists, speech therapists, etc.

5.3.1 Parents as stakeholders in inclusive community activities

The participants in this study identified their parents as major implementers of inclusive community activities. Parents are considered natural supporters of inclusive community activities (Chakuchichi & Magama, 2003). Natural support usually involves other nonprofessional people, such as the individual's family and peers, who are critical for the successful implementation of inclusive community practices. According to Chakuchichi and Magama, (2003), natural support brings individuals with disabilities closer to friends and learning partners rather than isolating them. Natural support systems, especially parents, are pivotal in the psychosocial development of adolescents with physical disabilities.

This study's findings that parents are very active in inclusion an activity in their communities is consistent with inclusive community practices the world over. The UK Education Act of 1981 and its subsequent amendments have made a major contribution to raising the status of parents in the whole process of assessment and intervention for their children in inclusive community settings (Heward, 2003). For example, parents have statutory rights to contribute to the assessment, to seek independent advice, and to have access to independent parent support and parent partnership schemes (UK Education Act, 1981). The USA Public Law94-142, the Education for All Handicapped Children Act and the Individuals with Disabilities Act 1990also encourage parents of children with disabilities to be active in all-inclusive community activities available for their children (Department of Education, 2016). These laws urge parents to create least restrictive environments for maximum participation of their children in mainstream society. In addition to the creation of least restricted environments, the laws encourage parents to participate in decision-making processes regarding inclusive community services for their children (Department of

Education, 2016). Among other laws that encourage parents of children with disabilities to be active in inclusion processes of their children are the Chinese's Regulations on the Education of Persons with Disabilities, 1994, and Regulations on the Employment of People with Disabilities, 2008 (Chinese Government, 2008). All these laws and policies are seen as complementary to the Salamanca Statement of 1994, which encourages member countries to enhance the participation of key populations in all activities of society.

5.3.2 Philanthropists as stakeholders in inclusive community activities

Participants in the current study also indicated that philanthropists are helping them in their community activities. Although the concept of Philanthropism is consistent with charity model of disability which is not in line with CRPD the perspective is still available in most communities in developing countries (Ndawi, 2000). Well-wishers such as churches and non- governmental organisations are still active in most developing countries. Philanthropists are people who hold religious-philanthropist philosophies that are characterised by acts of patronage, sympathy, compassion, humanity, benevolence and charity (Chakuchichi & Kaputa, 2002). These people belong to the donor community (Chakuchichi & Kaputa, 2002). The philanthropist perspective towards disability concludes that people with disabilities are blessings from God who are incapable of sin; hence they deserve charity (Garwood, 2000; Hartley, Ojwang, Baguwemu, Ddamulira & Chavuta, 2005). Such a perspective promotes the human and compassionate treatment of people with disabilities (Chakuchichi & Kaputa, 2002; Garwood, 2000) and according to Chakuchichi and Kaputa (2002), this view has been in existence since the sixth century in the Jewish, Islamic and Christian world.

There results of the present study indicate that the donor community is active in the implementation of inclusive community practices in Makonde Urban. This trend is consistent most inclusive communities' activities in Africa and other developing countries. They are funded by international donor agencies, and without these funds, the inclusiveness programmes would lack the necessary resources and be not sustainable (Hartley et al., 2005). A number of illustrative cases can be

considered from across sub-Saharan Africa. Inclusive community programmes in Tanzania are funded by the Anglican missionaries in Tanzania (Zindi, 1997) International donor agencies such as CIDA, SIDA, UNESCO and DANIDA are similarly helping in the implementation of inclusive community activities in Malawi, Uganda, Kenya, Zambia and Botswana. The Leonard Cheshire Disability trust is also active in the promotion of inclusive community activities, both in Africa and the UK (LCD, 2013; 2016).

5.3.3 The government as stakeholder in inclusive community activities

The study in hand revealed that the Zimbabwean government is also active in promoting inclusive activities in the community. In inclusive community practice, the government acts as a formal support player. As discussed earlier, formal support stakeholders provide funding through the general community setting (Chakuchichi & Magama, 2003). The government provides formal support systems that include teachers, appropriate curriculum material and technological assistive devices. The government also monitors activities of donor communities in inclusive community practice.

The involvement of governments in inclusive community activities is true not only of Zimbabwean communities, but it is the trend all over the world. The monitoring of inclusive community activity by itself, according to the Salamanca Statement and Framework on Special Needs Education, rests with national governments (UNESCO, 1994). The United Nations declaration on the promotion of inclusive government's state that the promotion and implementation of inclusive communities is governments' business. Governments in Western countries such as the UK, Canada, Norway, Sweden, and Denmark play a supervision role and the major implementers are the local authorities.

5.3.4 The community as stakeholders in inclusive community activities

The study also found that communities are playing a major role in the implementation of inclusive activities and that they are helping their adolescents with physical disabilities by making their

physical environment as unrestrictive as possible. The involvement of community members who administer local resources is the key element to successful inclusive community activities. Inclusive community programmes attempt to maximise the full potential and functions of people with disabilities within their community (Ndawi, 2000). The community furthermore plays a pivotal role in changing the negative attitudes of its members towards people with disabilities. It also helps to modify environments such as roads to make them accessible for people with disabilities (Chakuchichi & Magama, 2003).

Involving the community as a stakeholder in inclusive community practices is also common practice in African countries like Ethiopia, Kenya and Uganda. Inclusive community programmes in Ethiopia provide a wide range of training activities to people with disabilities and their communities (Ndawi, 2000). For instance, community members without disabilities in Ethiopia have been trained in the maintenance of orthopaedic appliances and workshops (Ojwang & Hartley, 2001). Inclusive community activities in Kenya aim at increasing the participation of persons with disabilities in normal community activities by offering them vocational training skills (Ojwang & Hartley, 2001). In Uganda, community leaders have been trained in various disability topics, including the prevention, assessment and care of people with disabilities (Ojwang & Hartley, 2001). The use of local authorities by Western governments (i.e. the UK, Canada, Norway, Sweden and Denmark) in the supervision of inclusive community activities in their countries indicates the important role that communities play in inclusive community activities (Chakuchichi & Mutamiswa, 2003).

The fact that some form of community efforts made in the implementation of inclusive community activities designed to enhance the psychological wellbeing of adolescents with physical disabilities in Makonde Urban, serves as a pointer as to what community members themselves can do to assist persons with disabilities to integrate smoothly into the greater community – with little or no challenge. An example of such a pointer includes the identification of specific roles for different inclusive community stakeholders, thereby avoiding the duplication of roles among inclusion stakeholders. The results may also help the concerned stakeholders to look for other options that

are likely to add value to inclusive community programmes, such as forming collaborations. Literature on stakeholder ship in inclusive communities, e.g. by Chakuchichi and Mutamiswa (2003), Ndawi (2000), and Ojwangand Hartley, (2001) suggests that community programmes usually work well if there is proper collaboration. In the next section follows a discussion on literature that was compatible with the choice of specific inclusive community activities for participation by adolescents with physical disabilities.

5.4 Literature that is compatible with the choice of inclusive community activities for participation by adolescents with physical disabilities

Information on appendix VIII presents the main results of the study and literature, and validates the results on choice of inclusive community activities to participate in by adolescents with physical disabilities as presented in Chapter 4. The information is given according to categories that emerged under Subtheme 3.1. The categories again depict trends in existing knowledge that illuminate the results in this study. These categories are discussed next, based on the researcher's reflections and selection of central themes, which are presented in précis form.

This study revealed that adolescents with physical disabilities in Makonde Urban are facing environmental restrictions to choose inclusion activities in which to participate. Environmental restrictions involve physical conditions (due to the natural environment and human-made changes to the environment) or social conditions range from the immediate to the more general environment (Peterson et al., 2010). These factors are qualified as either facilitating or hindering the selection of inclusive activities for participation by adolescents with physical disabilities (Loreman et al., 2005). The participants indicated that they face serious environmental restrictions that limit their choice of inclusive activities in which to participate at home, at school or in the community.

The concept of practising choice is very important in communities that practise inclusion as a strategy to integrate people with disabilities into mainstream communities. Its importance is seen in its inclusion in the laws and policies of various countries. The right to choice is a very important right for all people – with or without disabilities. The availability of choices among persons with disabilities by context as found in this study is discussed next.

5.4.1 Choice of activities as school

The results of this study indicated that participants are not given the choice to select inclusive community activities in which they want to participate and that they are also facing physical environment limitations, even at school. They indicated that the school curriculum is not easy to negotiate and is posing participation restrictions. A restrictive curriculum is a general education curriculum with no support services (Peterson et al., 2010). This type of curriculum does not address the real learning needs of the learners with disabilities and learners are required to adapt to the curriculum, instead of the curriculum adapting to the needs of the learners (Peterson et al., 2010). A restrictive physical environment as discussed earlier in this chapter is a natural environment that was subjected to human-made changes (Peterson et al., 2010) and that hinders the free selection of inclusive activities for participation by adolescents with physical disabilities (Loreman et al., 2005). For successful implementation of inclusion at school level, the curriculum and the physical environment must be as unrestrictive as possible. Learners must make their own choice of activities to participate in at school.

The result that adolescents with physical disabilities are not given a choice in selecting a curriculum that suits their needs is true not only in Makonde Urban. Studies on curriculum compatibility among learners with disabilities conducted by Mowes (2002) among school principals reported that the Zambian curriculum was not making provision for children's different levels of ability. They found that the curriculum was not designed for learners with diverse needs. The researchers recommended that the Zambian curriculum should be inclusive and give learners the freedom to choose things that are compatible with their needs (Mowes, 2002).

Others studies carried out in Zimbabwe also reflected limited choice in curriculum matters for people with disabilities in Zimbabwean mainstream schools. Examples of such studies include those of Makuyana (2004), Mtetwa (2004) and Zingoni (2004). The studies revealed that the Zimbabwean mainstream curriculum was not easily accessible to students with disabilities. The contributing reasons included over-enrolment of students in classrooms; severe strain on teaching resources and the inadequate preparation of teachers to teach students with disabilities in their classrooms.

Adolescents with physical disabilities living in Makonde Urban were also found to be facing physical environment-related limitations to their choice making in schools. They indicated that in as much as they would like to choose inclusive activities in which to participate, some of the physical environments at their schools and social amenities were too restrictive.

5.4.2 Choice of activities at home

This study revealed that adolescents with physical disabilities are facing social-related restrictions on choice, even in their homes. They reported that their parents were determining the types of activities that they wanted them to do, and the types of friends they are supposed to play with. They said their parents are overprotective because of their conditions. This finding is consistent with literature on parental reactions to disabilities. Most parents believe that a disability is a chronic illness. This belief causes them to become protective of their family member with a disability (Makore-Rukuni, 2000). Mirfin-Veitch (2003), notes that most parents who have children with disabilities usually have a vision for their child's future. With this vision, however, come some dilemmas in as far as the self-determination of their children with disabilities are concerned (Makore-Rukuni, 2000). Parents may, on the one hand, want to create opportunities for the young person while, on the other, seek to ensure his/her safety by making decisions for him/her. They may also want to ensure that the young person has a separate and fulfilling social life, while

wanting to decide who the young person should play with. The idea of being protective of a family member with a disability is common to people of many cultures (Mirfin-Veitch, 2003; Nwoye, 2008).

Mirfin-Veitch (2003) also performed studies in Melbourne to determine the level of choice given to people with disabilities at family level. They found that laws in Australia are user friendly to people with disabilities at family level, but on the ground most parents of people with disabilities are very influential in determining the type of social activities in which their children are supposed to engage.

5.4.3 Choice of activities in the community

The current study results shows that people with disabilities were deprived of self-determination in choosing inclusive community activities – even at community level. Restrictions in choosing inclusive community activities for participation were also found to be present – even in community institutions such as hospitals. These results are consistent with those of Emerson and Hatton (1994) in their studies in the UK. They reviewed 46 studies of the resettlement of people with disabilities from hospitals and reported that only 12 of these had examined the opportunities available to exercise choice. Carlson and Wilson (1996), in a study of menstrual management, found that people who required on-going support with daily living tasks (common to people with physical disabilities) and those with very limited verbal communication (e.g. those with severe cerebral palsy) were unable to express their opinions and preferences and therefore had to rely on substitute decision makers.

In another institutions-related study conducted in Zimbabwe on the Zimbabwe patients’ charter of rights (Effects on health care access by people with disabilities living with HIV and AIDS), Mpofu and Shumba (2012) found that most people with disabilities in the country were not given the opportunity to state their health problems when they visited doctors and their “substitute decision makers’ were responsible for making health-related decisions, including when to go to the clinic.

The study also found that the substitute decision makers (who in most cases happened to be legal guardians) are the ones who talk to the doctors about the health conditions of their charge, thus breaching their right to confidentiality. People with disabilities are stereotyped as incompetent patients and unable to represent or articulate their health care needs, hence needing someone to explain their condition to the physician (Chireshe, Rutondoki & Ojwang, 2010). The promotion of confidentiality rights in the context of health and disability is an imperative of justice to overcome existing forms of discrimination and intolerance (United Nations, 2006).

Mpofu (2003) highlights the important distinction between legal competence and functional competence, arguing that physical capacity should not be the sole criterion for determining a person's competence in decision-making, since the individual may be competent in making some decisions but not in others. Mpofu (2003) cites evidence showing that people with mild to moderate physical disabilities can make meaningful choices even though these may be restricted to physical activities in the immediate environment. Indeed, there is growing evidence that students with mild to moderate physical disabilities do have preferences and can be taught to express them (Parsons, Reid, Reynolds & Bumgarner, 1990).

On the issue of social barriers and choice, the findings of this study indicated that the participants are facing socially related barriers to making their own choices about participation in inclusive activities available in their communities. These results are consistent with those of Auslander and Gold (1999) on choices available for people with disabilities in their communities. Auslander and Gold (1999) conducted a study on availability of choices among people with disabilities and found that people with disabilities are not given enough choice to choose what they want to do in life. The study also found that they are not even given choices with regard to self-representation. Persons with disabilities are denied the right to communication and self-representation in that there is still a wide use of language that is disrespectful of persons with disabilities by the scientific community, general public and the media (Auslander & Gold, 1999). For example, they are still referred to as the disabled and the crippled, in spite of the preferred terms of 'persons with disabilities' (Mpofu, 2003; Sandieson, 1988). The term "disabled person" is disrespectful of

persons with disabilities because it masks a disability-related difference as the priority over personhood (Auslander & Gold, 1999; Mpofu, 2003) and cannot stand to be a choice of identity for people with disabilities.

The study revealed that the participants' choice to participate in various inclusive community activities in their communities is also facing limitations as a result of negative attitudes towards them from the community. These results are consistent with those found by Mpofu, Thomas and Thompson (1996) in their study on the culture of shared experiences and meanings of the disability experience among people with disabilities in Zimbabwe. Mpofu and others (1996) found that, similar to racial or cultural minorities, people with disabilities have been and are under pressure to interpret their cultural experiences as a pathological form. For instance, persons with disabilities are perceived as ill, not socially competent or worth socialising with, and they are treated as commodities for charitable organisations. The severity of these negative attitudes from the greater community is mediated, in part, by the type of disability (Auslander & Gold, 1999). The more visible the disability the more severe the negative attitudes of the observer. This negative attitude causes people with physical disabilities to withdraw from the greater community activities in which they may have been willing to participate (Kennedy & Haring, 1993).

The above results are also consistent with many studies on attitudes of people without disabilities towards those with disabilities in Zimbabwe (e.g. Hungwe, 2005; Majoko, 2005; Maungainidze & Kasayira, 2002; Mpofu, 2004). All these studies concur that negative attitudes from Zimbabwean societies cause restrictions in the choice of people with disabilities to participate in inclusive community activities. Fewer of these studies have considered how the attitudes of individuals with disabilities towards themselves affect their choices in selecting inclusive activities for participation. Examples of the few studies done in Zimbabwe include those by Mpofu (2003), Peters (2001) and Zingoni (2004). The results of these studies indicated that most individuals with disabilities mirrored the community attitudes towards them, as their attitudes towards themselves and these mirrored positions were also presenting restrictions to their choice of inclusive communities' activities in which to participate.

The results that adolescents with physical disabilities in Makonde Urban face environmental restrictions to choose inclusion activities for participation are very important to various stakeholders in inclusive practices. It provides information on the actual environmental barriers that affect self-determination among adolescents with physical disabilities living in inclusive communities. This knowledge will assist community members to attend to environments that pose restrictions for the community participation of adolescents with physical disabilities. The results also serve as pointers to researchers on areas that need to be investigated so as to improve the quality of life for people with disabilities. The next section presents a discussion on literature that is compatible with the contribution of community strategies to the psychological wellbeing of people with disabilities.

5.5 Literature that is compatible with the contribution of community strategies to psychological wellbeing

This section focuses on how participants felt that their participation in inclusive community activities was influencing their psychological wellbeing. Appendix VIII (pp: 197) presents the major results of the study and literature that validate the results on the contribution of community strategies to the psychological wellbeing as presented in Chapter 4. The information is listed according to categories that emerged under Subtheme 4.1, ‘Inclusion and psychological wellbeing of adolescents with physical disabilities’. The categories depict trends in existing knowledge that illuminate the results of this study. The researcher engages in discussions of the categories, provides his reflections and selects central themes, which are presented in précis form.

The participants in this study indicated that their participation in inclusive communities is very helpful for the development of their psychological wellbeing. Literature on the psychological wellbeing of people with physical disabilities (Desmarais & Savoie, 2011; Fredrikson, 2001) suggests that a physical disability affects the psychological wellbeing of people with physical

disabilities in a number of ways. Discussions in this section will focus on how participating adolescents with physical disabilities in this study felt about the influence of inclusive community activities on their psychological wellbeing. The focus is on the four major attributes of psychological wellbeing that were of interest to the study, namely Autonomy and choice, Purpose in life, Positive relations with others and Personal growth and self-acceptance.

5.5.1 Autonomy and choice

The results of this study indicate that the participants believed that their participation in inclusive community activities contributed to the development of their autonomy and choice. Autonomy and choice as discussed in Chapter 2 involve displaying qualities such as self-determination, independence, and the regulation of behaviour from within (Desmarais & Savoie, 2011; Fredrikson, 2001). Adolescents with physical disabilities who are self-actualised are described as showing autonomous functioning and resistance to enculturation (Luhmann et al., 2012). They are also described as having a good internal locus of evaluation, that is, they do not need to look at others for approval, but evaluate themselves by personal standards (Fredrikson, 2001). Individuation here is seen to involve a deliverance from convention, in which the person no longer clings to the collective fears, beliefs and laws of the masses.

These results on self-determination contradict the earlier finding of this study on whether the study participants were exercising their right to choose inclusive activities to participate in their community. However, they are consistent with findings from Gabre (2000) and Gabre, Martinsson and Gahnberg (2002), who assert that less restrictive living arrangements for people with disabilities (like living in inclusive communities) lead to the increased prevalence of feelings of autonomy. Gabre (2000) and Gabre et al. (2002) explain that these are positive results, because they mean that people with disabilities come to look more like ordinary people.

5.5.2 Purpose in life

The results from the current study also indicate that participation in inclusive community activities by adolescents with physical disabilities in Makonde Urban is contributing to the development of their sense of purpose in life. Purpose in life refers to having beliefs that convince adolescents with physical disabilities that there is purpose in and meaning to life (Dolan et al., 2011; Kahneman & Deaton, 2010). Adolescents with physical disabilities are also expected to have a variety of changing purposes or goals in life, such as being productive and creative, or achieving emotional integration later in life.

This study's results are similar to those found by Nygren, Aléx, Jonsén, Gustafson, Norberg and Lundman (2005). Their study found that people with disabilities who live in inclusive community settings develop high scores of perceived purpose in life Test, and the Self-Transcendence Scale. King et al. (2003) also did a qualitative study on the nature of resilience in people with chronic disabilities. Fifteen people with disabilities identified the factors that helped or hindered them at major turning points, as well as the triggers and resolutions to these turning points. Turning points were emotionally compelling experiences and realisations that involved meaning acquired through the routes of belonging, doing, or understanding the self or the world. The major protective factors were social support, traits such as perseverance and determination, and spiritual beliefs (King et al., 2003). Three new protective processes were identified: replacing a loss with a gain (transcending); recognising new things about oneself (self-understanding); and making decisions about relinquishing something in life (accommodating). The results of King et al. (2003) show that protective factors, processes, and ways in which people with disabilities draw sense and meaning in life, have important implications for inclusive community practices.

Albrecht and Devlieger (1999) built on analysis of the interviews revealed that for both those who reported that they had a good and those who said they had poor purpose in life, purpose in life was dependent on finding a balance between body, mind and spirit in the self, and on establishing and maintaining a harmonious set of relationships within the person's social context and external

environment. This suggests that living in an inclusive setting was very influential in the perceived quality of purpose in life among people with disabilities.

5.5.3 Positive relations with others

Participation in inclusive community activities by adolescents with physical disabilities in Makonde Urban contributed to the development of their positive relations with others. A positive relation with others is the “ability to love and it is a central component of mental health” (Diener et al., 2002, pp: 80). Adolescents with physical disabilities who are self-actualised are described as having strong feelings of empathy and affection for all human beings. They are further described as being capable of greater love, deeper friendship and more complete identification with others (Diener et al., 2002). Relating to others with warmth is posed as a criterion of maturity. Adult development stage theorists (Freud, Erickson) support this view by emphasising the achievement of close unions with others and guidance and direction of others as criteria of maturity.

The results that living in an inclusive community enhances the development of positive relations with others is consistent with research findings on a related study done by Magiati, Dockrell, and Logotheti (2002). Magiati, Dockrell, and Logotheti (2002) conducted study on young children’s understanding of disabilities: the influence of development, context, and cognition in this Greece study investigated children’s representations of different disabilities. Altogether 79 Greek children with disabilities and between 8–9 and 10–11 years old, living in inclusive settings, were used in the study to see if they were selecting friends based on individual differences such as disabilities. Children from an urban school as well as from rural communities were used in the study. Responses to the attitude scale provided generally positive views of inclusion (Magiati, Dockrell, & Logotheti, 2002). However, children were less positive about activities that might directly reflect upon themselves. Children had the greatest understanding of sensory and physical disabilities and indicated that living in inclusive communities was helping them to have positive relations with peers with and without disabilities, without problems. In another study, Campbell, Gilmore and Cuskelly (2003) examined the use of inclusion to influence the development of

psychological wellbeing among people with and without disabilities. These researchers also found that living in inclusive setting had a strong influence on the development of psychological wellbeing in people (even those without disabilities), as it was found to contribute to the ability to have meaningful relations with others (Campbell et al., 2003).

5.5.4 Personal growth and self-acceptance

The current study found that participation in inclusive community activities by adolescents with physical disabilities in Makonde Urban greatly contributed to the development of their feeling of personal growth and self-acceptance. Personal growth involves not just optimal cognitive functioning, but continued cognitive function among adolescents with physical disabilities, and successfully confronting new challenges or tasks at different periods of life (Dolan et al., 2011; Kahneman & Deaton, 2010). Self-acceptance refers to a central feature of mental health, as well as a characteristic of self-actualisation and optimal functioning and maturity (Kahneman & Krueger, 2006). Thus, when adolescents with physical disabilities hold positive attitudes towards themselves, this emerges as a central characteristic of psychological wellbeing.

A study conducted by Mott et al. (2009) confirms that being engaged in physical activities at community level is associated with an improvement in personal growth, self-acceptance and quality of life (QOL) among those with multiple sclerosis (MS). In their study, Mott et al. (2009) examined variables that might account for the relationship between physical activity, personal growth and self-acceptance living with multiple sclerosis. The researchers found that people who were living with multiple sclerosis and who were more physically active at community level indicated lower levels of disability as well as higher levels of personal growth and self-acceptance, and they were able to manage their disabilities. In turn, those who were not active in inclusive physical activity programmes reported higher levels of depression, anxiety, fatigue and lower levels of quality of life.

Antle (2002) performed a study to find to what extent inclusive communities help in developing perceptions of self-worth among young people with physical disabilities in Ontario, Canada. Significant correlations were found between the participants' perceptions of self-worth and living in an inclusive community. Regression analysis revealed that perceived social support from the community was a stronger predictor of self-worth than diagnosis (onset of disability).

Another study to determine the influence of inclusion on the body image concerns of people with physical disabilities was carried out in Melbourne by Taleporos and McCabe (2002). Data was gathered through individual interviews during which participants responded to a set of predetermined open-ended questions. The study found that bodily impairment had a negative influence on the participants' psychological experiences, feelings and attitudes toward their own bodies. The impact of feedback from the inclusive environment was highlighted, and there was evidence suggesting that individuals gradually adjust to their different bodies and increasingly accept their disabilities over time.

The finding that participation in inclusive communities by adolescents with physical disabilities is helpful for the development of their psychological wellbeing is likely to add to the body of knowledge in the field of psychological wellbeing. Psychology of wellbeing theory, research and practice is devoted to understanding the biopsychosocial and behavioural factors leading to enhanced wellbeing, optimal emotional processing and the prevention of psychological dysfunction. Research that examines the mechanisms underlying the relationships between lifestyle factors, positive psychology interventions, emotion processes and wellbeing among people with disabilities adds value to the field of psychology, as most research studies have put emphasis on the atypical populations. An exciting feature in this area must include the exploration of mechanisms that offer insight into the processes that underlie psychological wellbeing in people with disabilities.

5.6 Literature that is contradictory to the results of the study

True qualitative research is not a one-sided story. The social construction of reality encompasses all sides of the story and displays phenomena being studied as a kaleidoscope. This section presents a synoptic review of the literature that represents alternative sides to that which emerged from the literature compatible with the results of this study. The researcher embraced contradiction as revelation of a different view to how he perceived the reality of his study and next provides literature that is contradictory evidence to the results of his study.

5.6.1 Contradicting evidence to strategies for the community integration of adolescents with physical disabilities

Whereas in some instances (UNESCO,2005;2004) (as discussed in 5.2.1) it was found that adolescents with physical disabilities were being constructively engaged in various community activities intended to integrate them into mainstream communities, other studies found low participation by adolescents with physical disabilities in some of the identified community activities. Some communities preferred the use of institutions and integration centres as a measure to integrate its adolescents with physical disabilities. One reason for these opposing results could be the level of industrialisation among communities. Some developed countries such as Australians pride themselves on the welfare of their citizens, hence they operate with several and well-funded disability homes to promote community participation of their citizens with disabilities (Australian Bureau of Statistics, 2003). On the other hand, developing countries such as those in Sub-Saharan Africa delegate the welfare of their citizens to communities, largely because the governments cannot adequately address the needs of their citizens with disabilities (Chakuchichi & Mutamiswa, 2003). Evidence is seen from their policies which are not pro-inclusive practices. An example of such a policy is the Constitution of Zimbabwe. Section 83 of the Zimbabwean Constitution on the Rights of Persons with Disabilities limits the provision of services and resources by the state to people with disabilities (Zimbabwean Constitution Amendment No. 20,

2013). Under this section, the State and all its institutions and agencies of government at every level can only assist persons with disabilities to achieve their full psychological needs and minimise the disadvantages suffered by them – within the limits of the resources available to the state (Zimbabwean Constitution Amendment No. 20, 2013). This neglect by the state leaves adolescents with physical disability in the hands of their community and such arrangement can be misconstrued as inclusive community practice. Innovative and feasible inclusive policies and funding seem necessary to address inclusive community activities.

In appendix IX (pp: 200) is literature evidence that contradicts the results as presented in the previous section of this study. In terms of Subtheme 1.1 ‘Participation of adolescents with physical disabilities in inclusion activities’: the following categories are reviewed: learning-oriented activities; sport as a rehabilitation measure; self-care as a daily living skill; selling as training for independent living; and gardening as a life skill.

As is obvious from the discussion in Section 5.2.1, literature that contradicts the results on strategies for the community integration of adolescents with physical disabilities is scarce. However, some studies (e.g., Wiegerink, Roebroek, Bender, Stam & Cohen-Kettenis, 2010) provide evidence showing that some communities in the world are not doing enough to integrate their adolescents with physical disabilities into mainstream communities. Through practice they exclude or give them the watered-down version of inclusion (UNESCO, 2009). In the context of the current study, it is possible that misconceptions about disability may perpetuate exclusion and isolation (Mpofu et al., 2012). Communities react variously to disabilities depending on their economies and cultural orientation (Mpofu, 2003). The next section provides contradictory evidence to communities’ activities identified by the participant in this study. Learning-oriented activities are presented first as one of the identified strategies for community integration of adolescents with physical disabilities.

5.6.1.1 *Learning-oriented activities*

Results from this study indicate that inclusive communities in Makonde Urban are making use of education as one of the strategies for the community integration of adolescents with physical disabilities. This result is contradictory to literature on disability and education. Literature on education and disability indicates that “the majority of children with disabilities in developing countries are currently out of school, while many of those enrolled are not learning” (UNESCO, 2009, p. 405). Available data, mostly focused on literacy, indicates that children with disabilities do far poorer in the educational arena than their counterparts without disabilities. For example, UNESCO, the World Blind Union and others estimate the literacy rate for children with disabilities as less than one percent (Groce, 1999), compared to an estimate of about 15% for people with disabilities as a whole (Heward, 2003; WHO, 2005).

In terms of school enrolment, UNESCO suggests that only two percent of children with disabilities are in school. To support the above assertion, there have been claims that most African communities hide children with disabilities from social agencies such as schools. However; these allegations have received serious criticism from many African scholars, e.g. Mpfu (2003), Ndawi (2000) and Ingstad (1995). These scholars claim that the allegations are made by persons from outside the communities in which children with disabilities live and that they are often mistaken. However, the same authors did not dispute the fact that there is low school attendance among children with disabilities in most African communities. What they dispute, is that these children are hidden from school.

A SINTEF study conducted in 2003 (SINTEF, 2003a; 2003b) indicated that 32% of people with disabilities in Zimbabwe have had no schooling, 36% had some primary schooling, and 32% had some education beyond primary school level. Mpfu (2003), Ndawi (2000) and SINTEF (2003a; 2003b) attributed poor school attendance to a number of issues that include poverty, unfriendly learning environments and others. The SINTEF (2003a) and SINTEF (2003b) respondents confirmed that challenges to access education for most people with disabilities started right at

family level. They reported that they were facing negative attitudes from family members. These attitudes are mainly reflected in the view that sending children with disabilities to school is a waste of time, as it is often believed that people with disabilities are not able to learn. These findings in education are part of a larger picture of discrimination based on disability that pervades the lives of children with disabilities in their communities.

5.6.1.2 Sport as a rehabilitation measure

Results from this study that indicate that adolescents with physical disabilities living in Makonde Urban were actively engaged in various sports activities as a community effort to integrate them into the mainstream community, also contradict the findings from research done by Choruma (2006) in Zimbabwe. Choruma (2006) acknowledges that although there are a variety of sports activities in which people with disabilities in Zimbabwe can participate, there are also serious obstacles to their participation in such activities. The participants in Choruma's (2006) survey identified the following as barriers to their participation in sport: lack of trained personnel; lack of equipment; lack of sponsorship; lack of venues. Existing venues that are not accessible to people with disabilities, negative attitudes from people without disabilities and the fact that few teams are available, lead to poor organisation of sport and recreation facilities. Further contradicting evidence comes from the Australian Bureau of Statistics in 2003 and 2009 when the Bureau conducted research to ascertain the level of sport uptake by people with disabilities in the country. The Australian Disability Services Act of 1986, the Disability Discrimination Act of 1992 and the National Disability Insurance Scheme Act of 2013 all encourage people of all abilities are having access to sport and physical activity opportunities. In addition, the country makes available adequate resources to stimulate sport participation by people with disabilities. Results from the two surveys done by the Australian Bureau of Statistics (2003; 2009) however indicate that the participation of adolescents with physical disabilities in mainstream sports activities is still low. The overall sport participation rate among adults (i.e. persons aged 15 years and older) with a disability was 25% in 2003 and 24% in 2009. This compares to an overall participation rate among able-bodied adults of 64%. Within the able-bodied population, the participation rate in sport over

the same period was highest for ages 15-17 years (74%) and declined with age to 48% for people over the age of 65 years (Australian Bureau of Statistics, 2003; 2009).

5.6.1.3 Self-care as a daily living skill

The current study could not find evidence that contradicts its finding that self-care skills training is necessary for community integration of adolescents with physical disabilities. Researchers such as Chimonyo et al. (2015), Alwell and Cobb (2009), Davis et al. (1998) and Mechling, Gast and Seid (2009) acknowledge that communities are training their people with disabilities to master self-care skills. The training is done both at home and in community institutions such as hospitals. Research should further investigate the effectiveness of each of these centres of training in equipping adolescents with physical disabilities with functional skills.

5.6.1.4 Selling as training for independent living

This study could find only one source that contradicts its finding that selling as training for independent living can be used to integrate adolescents with physical disabilities into their mainstream communities. However, there was also a salient indication in this study that training in the craft of selling to enhance independent living skills was offered to adolescents with disabilities at family level, and training at that level alone can obviously not constitute a community strategy. However, since the family is a unit in a community, the study's findings cannot be ignored for that reason.

The findings that inclusive communities in Makonde Urban were using entrepreneurship skills training (such as selling) as training for independent living and as a strategy to integrate adolescents with physical disabilities contradicts a study by Mpofu and Shumba (2012) in the same district. Their study investigated the level of engagement of people with disabilities in

entrepreneurship activities in rural communities of Makonde in Zimbabwe and found that several entrepreneurial activities in rural Zimbabwe targeting youths were being funded by the government and NGOs (Mpofu & Shumba, 2012). Examples of entrepreneurial activities in rural Zimbabwe included household furniture manufacturing (timber sawing, carpentry workshops for manufacturing chairs), non-chemical agricultural input activities, clothing and food manufacturing. However, respondents who were adolescents with disabilities indicated that most of these entrepreneurial activities were meant for community members in general and were not tailored to meet their disabling conditions. The results from Mpofu and Shumba's (2012) study confirm exclusionary practices associated with Zimbabwean empowerment activities such as entrepreneurship. Exclusion is also inconsistent with the acknowledgement of diversity and the promotion of integration of people with disabilities into mainstream communities'.

5.6.1.5 Gardening as a life skill / training for independent living

The study's results that adolescents with physical disabilities are involved in gardening as a community effort to integrate them into mainstream society is contradictory to research on disability and agriculture conducted by the Leonard Cheshire Disability Trust (LCD, 2010) in Kenya. However, there is an indication that training of gardening as a life skill for adolescents with disabilities also occurred at family level (as in the case of selling as training for independent living), and again that level of participation cannot constitute a community strategy. According to LCD (2010) there is a growing awareness that agriculture in urban areas has significant implications for income generation, food security and nutrition— particularly among the urban poor. Persons with disabilities have been notably absent from these activities. The LCD study also found a number of barriers to, and opportunities for, inclusion of people with disabilities in agricultural-based life skills activities in Kenya. Persons with disabilities apparently received little or no instruction or support in respect of agricultural activities, and without adaptations, some impairment may limit their ability to use agricultural techniques. However, such adaptations can cost time and money, and prejudice against persons with disabilities may limit their ability to sell produce or food.

5.6.2 Contradicting evidence regarding the implementation of inclusive community strategies

In his engagement with literature the researcher found none that contradicts his finding on the implementation of inclusive community strategies. The available literature indicated that different players are playing different roles in the implementation of inclusive community activities in the area under study. The literature also nominates parents (Heward, 2003; UNESCO, 2013), the government (Chakuchichi & Magama, 2003; Department of Education, 2016; The Chinese Government, 2008; UK Education Act, 1981), the community, and philanthropists (Hartley et al., 2005; LCD 2016; Zindi, 1997) as agencies that work towards creating least restrictive environments for adolescents with physical disabilities living in inclusive communities (Chakuchichi & Kaputa, 2002; Chakuchichi & Magama, 2003).

5.6.3 Contradicting evidence regarding the choice of inclusive community activities in which to participate

Information on appendix IX (pp: 207) presents contrasting evidence on the literature dealing with adolescents' choice of inclusive community activities in which to participate, as presented in Chapter 4. The subtheme 'Choice of inclusive community activities in which to participate' is supported by the following categories: Choice of activities at home; Choice of activities at school; and Choice of activities in the community. These categories are discussed next, based on the researcher's reflections and selection of central themes, which are presented in précis form.

Choice of activities at school

Although curriculum issues were found to place limitations on self-determination of inclusive activities for participation in schools in Zimbabwe and other sub-Saharan countries, research done in Europe and the USA indicates that learners with disabilities in these countries have a wide variety of choice regarding what they want to learn (Funk, 1987). Most developed countries such as the USA, UK and others have legally defined processes of determining a curriculum for learners with disabilities. For example, the USA PL 94-142 and PL 101-476 make the following processes mandatory for curriculum determination:

- Step 1: Determine the learners' current level of skills and behaviour.
- Step 2: Determine the learners' interest and experiences. (This stage does not exist in the education systems of most developing countries.)
- Step 3: Determine the learners' family backgrounds, cultures, traditions and norms.
- Step 4: Determine children's styles of learning and activity preferences.

The findings of the current study result also contradict inclusive education practice in the USA, where children with disabilities have unlimited access to the curriculum of their choice (Alper, Martin & Wehmeyer, 2002), as a result of the provision of the 1997 amendments to IDEA. The latter mandated individualised education programmes of students with disabilities to include giving children with disabilities a choice in selecting material to learn from the general curriculum. The intent of this Act was to ensure that students with disabilities are held to high expectations, receive a challenging curriculum, and are included in the accountability mechanisms being created for all students. This provision of unlimited choice in their curriculum has seen a considerable improvement in performance of students with disabilities within a year throughout the US (Mores, 1998). One variable that remains unknown, and that may affect the success of the mandates, is the opinion of teachers about this policy direction.

5.6.3.1 Choice of activities at home

In contrast to the results from this study that the participants were having a lot of barriers to choice and control at school activities to study participants, young people with disabilities were found to have unlimited choices about internet-related things in the UK. They were found able to act on the opportunity to make decisions and choices without significant interference from family members (Cahill & Hollier, 2009). In an evaluation of the Livewire Online Community for young people living with chronic illness or a disability, Cahill and Hollier, (2009) found that young people with disabilities were having freedom to make decisions on the Internet more than when seeking authority from their family members.

5.6.3.2 Choice of activities in the community

On the issue of social barriers and choice, the results from this study indicated that participants were facing socially related barriers when trying to make a choice about participation in inclusive activities available in their communities. These results are contradictory to a number of studies conducted on disability and self-determination, such as that of Antaki, Finlay and Walton (2009) on Choices for People with Intellectual Disabilities: Official Discourse and Everyday Practice in United Kingdom. In this study, Antaki and others (2009) found that people with disabilities were given a choice to express their preference, but with a bit of control for institutional reasons. In this case, adolescents with physical disabilities may request to make use of a toilet. The authors explained such scenario as choice can be given to accept someone preferences but the same preferences can be rejected when it seems if is inconsistent with acceptable norms.

Church and Marston (2010) conducted study on accessibility for people on a landscape of surfaces, barriers, and travel modes and found that most adolescents with physical disabilities were now having unlimited access to community institutions in most developed countries. They argued that this access was helping those with physical disabilities to gain access to their places of preference.

However, Church and Marston (2010) believed that there was still room for improvement to promote make the environment more accessible to people with physical disabilities.

In their study, Wehmeyer, Kelchner and Richards (1996) found that people with disabilities had some level of self-determination; which was determined by their level of disability and the context. They found that those living in institutions were governed by institutional regulations and appeared to have relatively few opportunities to make choices and decisions or assume control over their lives. Along the same lines, one would then conclude that adolescents with physical disabilities living in inclusive communities practice choice, given that they have mild to moderate disabilities and they live in an inclusive community. The participants in Wehmeyer, Kelchner and Richards (1996) indicated that they were practising their choices in Self-care, Family care management, Social and vocational activities and Recreation and leisure.

Another research conducted by Wolffet al. (2004) indicated that children with disabilities in the USA were having unlimited choice in dental services and health infrastructure in the country was generally user-friendly to people with physical disabilities (Wolffet al., 2004). Although much of the literature consulted in this study pointed towards the improvement of choice in accessing services offered by community institutions, findings on attitude-related barriers to nonprofessional services remained consistent in this study. People without disabilities are still not willing to accept those with physical disabilities as equal partners and this tends to reduce self-determination in people with disabilities. The next section presents contradicting literature on the contribution of community strategies to the psychological wellbeing of adolescents with physical disabilities.

5.6.4 Contradicting evidence on the contribution of community strategies to the psychological wellbeing of adolescents with physical disabilities

This section presents contradicting evidence on how participation in inclusive community activities can influence development of psychological wellbeing of adolescents with physical

disabilities. Appendix IX (pp: 2007) presents the main results of the study and lists the literature that contradicts the results on the contribution of community strategies to the psychological wellbeing as presented in Chapter 4. The information is sketched according to categories that emerged under Subtheme 4.1 ‘Inclusion and psychological wellbeing of adolescents with physical disabilities’. These categories are discussed next, based on the researcher’s reflections and selection of central themes, which are presented in précis form.

The participants in this study indicated that their participation in inclusive communities was very helpful for the development of their psychological wellbeing. However, other scholars such as Hall and McGregor (2000), Heward (2003), Mishna (2003), Mpofu (2003) and Mpofu and Harley (2000) have different views that are in contradiction to this study’s finding, namely that participating in inclusive community activities assists in the development of psychological wellbeing in adolescents with physical disabilities. The discussion below follows from the current study and focuses on the four major attributes of psychological wellbeing that were of interest to the participants: Autonomy and choice; Purpose in life; Positive relations with others; and Personal growth and self-acceptance.

5.6.4.1 Autonomy and choice

The results of this study, which indicate that participating in inclusive community strategies assists in enhancing the autonomy and choice of adolescents with physical disabilities, are contradictory to a small number of research studies done on autonomy and choice in people with disabilities. The few available contradicting literatures suggest that very few people with disabilities living in inclusive communities ‘enjoy self-determination. Examples of such literature include that of Emerson and Hatton (1994) who reviewed studies on the resettlement of people with disabilities from hospitals in the UK who found that people who require ongoing support with daily living tasks (common to people with physical disabilities) and have very limited verbal communication (e.g. those with severe cerebral palsy), are ‘unable to express their opinions and preferences and therefore rely on substitute decision makers’ (p.42). Another example of lack of self-determination

among people with disabilities includes a study carried out in Zimbabwe by Mpofu and Shumba (2012) on the Zimbabwean patients' Charter of Rights: Effects on health care access by people with disabilities living with HIV and AIDS. Mpofu and Shumba (2012) found that most people with disabilities in the country are not given an opportunity to state their health problems when they visit doctors. Instead, their 'substitute decision makers' were responsible for making decisions, including about when to go to the clinic. People with disabilities are being stereotyped as incompetent patients and unable to represent or articulate their own health care needs.

Researchers like Auslander and Gold (1999) also found that people with disabilities are facing limitations with regard to choice and autonomy, because of various social barriers existing in their communities. Mpofu (2003) also found that social barriers are interfering with autonomy and choice among people with disabilities who live in inclusive communities. Other studies conducted in Zimbabwe, e.g. by Hungwe (2005), Majoko (2005), Maungainidze and Kasayira (2002), all confirmed that people with disabilities in Zimbabwean inclusive communities had low levels of self-determination.

5.6.4.2 Purpose inlife

Although this study found that participating in inclusive community activities by adolescents with physical disabilities in Makonde Urban contributes to the development of their sense of purpose inlife, other scholars such as Albrecht and Devlieger (1999) believe it is just blissful feeling of purpose inlife. Albrecht and Devlieger (1999) built on the work of Sol Levine to examine this disability paradox: The paradox involves the apparent contradiction of people with serious and persistent disabilities living in inclusive communities reporting that they have a good purpose in life. Analysis of Albrecht and Devlieger (1999) interviews revealed that some of the participants indicated that they were not looking up to a better future. Another instance that suggests that living in an inclusive community does not contribute to the development of a sense of purpose in life is an interview with LeRoy Tolbert, conducted by Mpofu (2003). When asked to explain his condition, his life in an inclusive community and whether he was having a purpose inlife, LeRoy

Tolbert responded that “a label is a label is a label”. He used the word ‘label’ three times in order to emphasise that no matter what communities try to do, he was still disabled and still faced limitations in his life.

Another contrasting result was found in the study by Viemerö and Krause (1998) on the quality of life among individuals with severe physical disabilities living in inclusive communities in Finland and Sweden. The researchers found that the quality of life for people with disabilities in the two countries had improved greatly during the last two decades, partly as a result of well-planned intervention programmes such as the inclusive community. However, some individuals with physical disabilities in these two countries indicated that they did not cope well in their everyday life, no matter how long they have had the disability and lived in inclusive communities (Viemerö & Krause, 1998). They reported having low levels of purpose in life, although it was anticipated that those individuals would adjust well, regardless of the degree of their physical impairment. Viemerö and Krause (1998) revealed that satisfaction with one’s life situation is a function of the handicapped person’s occupation or meaningful occupational activities, social integration and sense of the meaning of life. Furthermore, the length of time since the onset of the disability was an important factor that affected the person’s feeling of satisfaction.

5.6.4.3 Positive relations with others

The results of the current study that participation in inclusive community activities by adolescents with physical disabilities contributes to their development of positive relations with others are also contradictory to literature on disability and personal relations with others. Having good personal relations with others is an indicator of developed psychological wellbeing. The development of good and positive relations with others is centred on social acceptance of people with disabilities and is very important for the successful adjustment and integration of such people (Heward, 2003; Mporu & Harley, 2000; Wehmeyer & Metzler, 1995). Positive relations with others also play an important role in facilitating their social and moral development (Albrecht & Devlieger, 1999). Nonetheless, literature on disability and personal relations with others suggests that people with

disabilities tend to be less well accepted by the majority in some societies (Hayashi & May, 2011; Ndawi, 2000). The rejection of groups with minority status is described in terms of stigmatisation (Lazowski et al., 2012). According to Mpofu and Harley (2000), those sharing the mainstream cultural values stigmatise persons whom they perceive to possess attributes that are deemed deeply discrediting (Barg, Armstrong, Hetz & Latimer, 2010). They are considered as less than fully human (Corrigan & Watson, 2002; Martz, 2004). These attributes could be visible as disability, skin colour, race, or geographical or cultural value. However, the more visible the attribute – like physical disability, the more stigma it attracts for the observer, and the greater disruption it can cause to social relations, or to personal relations with others (Mpofu, 2003).

Research by scholars like Hall and McGregor (2000), Mishna (2003) and Nowwicki, (2002) also contradicts this study finding, namely that participating in inclusive community activities by adolescents with physical disabilities contributes to the development of their positive relations with others. These authors found that people with disabilities in most communities not only experience difficulty in socially interacting with peers, but also that most of them choose social isolation, while others appear to be rejected by peers (Hall & McGregor, 2000; Mishna, 2003; Nowwicki, 2002). Their rejection by peers without disabilities was found to cause distress or anxiety in their relations with others (Mishna, 2003). Some adolescents with disabilities were also found to displaying an increase in acting-out behaviours, anger and loss of control (Nowwicki, 2002). Some resorted to living in a fantasy world or took out their anger on siblings at home (Hall & McGregor, 2000). The worst scenario may include health problems, increased vulnerability to psychopathology, physical aggression and lowered academic performance for those in school. According to Hall and McGregor (2000), Mishna (2003) and Nowwicki (2002), the occurrence of problem behaviours could further significantly disadvantage an adolescent with a physical disability in all settings of the community.

5.6.4.4 Personal growth and self-acceptance

The finding that participation in inclusive community activities by adolescents with physical disabilities contributes to the development of their feelings of personal growth and self-acceptance is also contradictory to literature on inclusion and self-acceptance. The available literature in this regard, e.g. Heward(2003), Mpofo and Harley (2000) and Mpofo (2003), suggests that persons without disabilities deny people with disabilities the right to representation through the use of language that is disrespectful of persons with disabilities. The scientific community, the general public and the press are guilty of this charge in most developing communities. The accusation points to the fact that persons with disabilities are not easily accepted by the greater community (Mpofo& Harley, 2000). In most cases these countries may not be having legislation and policies that foster the element of inclusion. In such scenarios people with disabilities feel unwanted by the greater community and tend to develop an individual disability identity (Mpofo et al., 2009). This individual disability identity refers to spontaneous self-description as having a disability or not being able bodied (Heward, 2003). It also refers to a consciousness of minority status in persons with disabilities. Persons with disabilities who spontaneously self-identify as having a disability, or of being non-abled, have a high level of individual disability identity or disability consciousness (Mpofo& Harley, 2000). Individuals with a high disability consciousness may be sensitive to disability-related prejudice and discrimination (low self-acceptance), and to the devaluation of their disability-related experiences. They are also more likely able to approve discrimination of a related difference (Martz, 2004).

Research on perceived social acceptance of people with disabilities by Faibsch (1995) illustrates the significance of insiders' views on social perceptions of people with disabilities. The study investigated perceived or self-reported social acceptance in 16 adolescents with physical disabilities attending ordinary primary schools and Faibsch (1995) reported lower perceived self-reported social acceptance in these children. Since the study furthermore reported that the participants considered themselves as being socially harassed and discriminated against, Faibish's study is an important contribution to the insider perspectives of disability. The failure to consider

outsider perspectives in this study is a significant limitation because both persons with and without disabilities constitute the social and environmental context of the social environment.

A study by Elfstro et al. (2003) on linkages between coping and psychological outcome, such as self-acceptance in the spinal cord injury patients and living in mainstream communities, also found that participating in inclusive community activities by adolescents with physical disabilities does not contribute to the development of their feeling of personal growth and self-acceptance. In this study Elfstro et al. (2003) found that people with spinal cord injuries displayed low levels of personal growth and self-acceptance. They apparently tended to report more helplessness and intrusion, while the newly patients additionally reported more social reliance. Because the initial period after lesion might include stressors that seem overwhelming to the individual, it may be a natural coping strategy to rely on others (Elfstro et al., 2003).

5.7 Conclusion

This chapter reviewed literature that is compatible with the results of this study, as well as literature that contradicts its results. In agreement with other researchers it was found that participants in this study –adolescents with physical disabilities – were engaged in various inclusive activities in their communities. Parents, the government, the community and the donor community emerged as major stakeholders in inclusive activities going on in their communities. However, the perception of restrictions to the self-determination of adolescents with physical disabilities to participate in inclusive activities seems to continue from home to school and into the community. The environmentally and socially restrictive conditions in their communities presented restrictions to their participation in inclusive community activities and resulted in their withdrawal from activities in which they might have wanted to take part. Although participants in the current study indicated that they were facing environmental and social restrictions to participation in inclusive activities available in their communities, they indicated that even the minimum exposure they were having

was assisting them to enhance their autonomy and choice, purpose in life, positive relations with others, and personal growth and self-acceptance.

**6 CHAPTER 6:
SUMMARY OF FINDINGS, CONCLUSIONS
LIMITATIONS AND RECOMMENDATIONS OF THE STUDY**

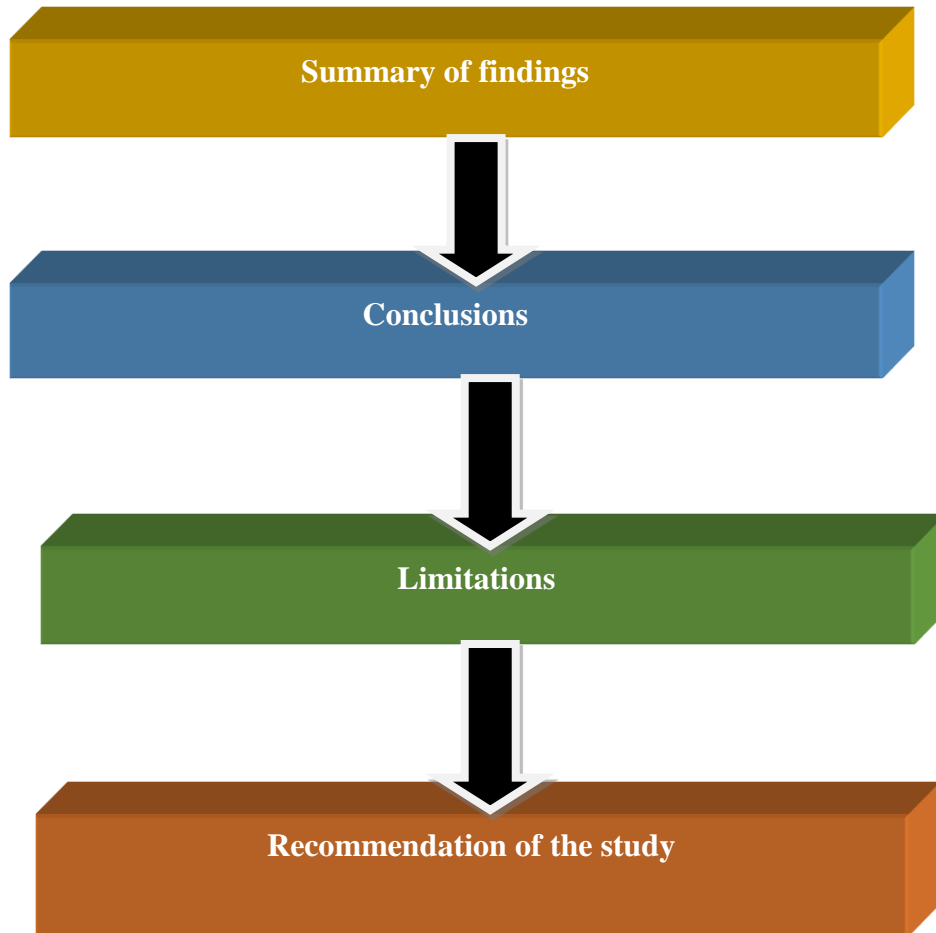


Figure 6.1: Chapter Map

6.1 Summary of findings

Chapter 5 presented a discussion of this study's results regarding the psychological wellbeing of adolescents with physical disabilities living in inclusive community settings. In this chapter the researcher presents his findings guided by the research questions as stated in Section 1.9.

6.2 Findings from the study's primary research question

How do selected inclusive community strategies contribute to the overall wellbeing of adolescents with physical disabilities?

In this study, experiences of adolescents with physical disabilities living in inclusive community settings seem to suggest that their participation in selected inclusive community strategies contribute to their overall wellbeing. The narratives of the study suggest that the participants felt that their participation in inclusive community activities was contributing to the development of their autonomy and choice. They felt that as a result of participating in the available inclusive community activities, their self-determination, independence, and regulation of behaviour from within were being enhanced. They also suggested that they were further developing their sense of purpose in life, as they now came to believe that there is purpose in and meaning to life, regardless of having disabilities.

The participants furthermore indicated that their participation in inclusive community activities was contributing to the development of their positive relations with others. Their narratives indicated that they were having strong feelings of empathy and affection for all human beings and described themselves as capable of showing greater love, deeper friendship and more complete identification with others. The study narratives also indicated that participation in inclusive community activities by adolescents with physical disabilities contributed to the development of

their feelings of personal growth and self-acceptance. They suggested that they were now having enhanced optimal cognitive functioning and continued cognitive function. They felt that they were now able to confront new challenges or tasks at different periods of life successfully. The narratives also indicated that they managed to self-actualise and hold positive attitudes towards themselves.

6.2.1 Secondary research question 1

What strategies are available to integrate adolescents with physical disabilities into the community to enhance their psychological wellbeing?

In this study, experiences of adolescents with physical disabilities regarding strategies that are available to integrate them into the community to enhance their psychological wellbeing seem to signify that several inclusive community activities are available for this purpose. The participants identified the following as some of the activities available for their integration into their communities, namely learning, sport as a rehabilitation measure, self-care as a daily living skill, selling as training for independent living, and gardening as a life skill. Adolescents with physical disabilities therefore had opportunities to explore various physical activities in their communities that were designed to integrate them into mainstream society and enhance their psychological wellbeing. As in other countries with emerging and developing economies, inclusive activities designed for people with disabilities are often reinforced by legislation and policies. These activities assist adolescents with physical disabilities to explore their environments and help them enhance their psychological functioning.

6.2.2 Secondary research question 2

How are these strategies implemented within these communities?

The study found that different players were playing different roles in the implementation of inclusive community strategies in Makonde Urban. The major implementers of these strategies were the parents, the government and philanthropists. The implementers were cited mainly as helping to provide disability awareness education, vocational counselling and inclusive infrastructure and resources. Involvement of communities in implementing inclusive activities for adolescents with physical disabilities succeeds in reaching more adolescents with physical disabilities, especially in the African context. African settings tend to prize a sense of community. Many special populations exist in African cultural heritage settings and services should be tailored to the specific needs of these special groups; this is particularly important for their psychological wellbeing. Services models that are likely to work for them are those that occur in groups and are recognised and included in societal, organisation and service-delivery resources.

The involvement of various stakeholders in inclusive community activities also provides cost-effective integrative models of intervention for people with disabilities, as most of the support services (e.g. parents, family members, peers) are found locally. However, the process of collaboration and the effectiveness of these teams need to be addressed adequately. The use of communities to implement inclusive strategies also assists in reducing stigma and discrimination against adolescents with physical disabilities within their communities. This helps them to actively participate in community activities and to develop “normal behaviour” patterns, develop healthy attitudes towards other people and establish friendships.

6.2.3 Secondary research question 3

How do youths with physical disabilities choose between the available strategies?

The findings from this study indicated that adolescents with physical disabilities in Makonde Urban were facing environmental restrictions to choose inclusion activities in which to participate. This seems to suggest that adolescents with physical disabilities are channelled to participate in particular activities based on other people's choices. These people's choices may not adequately address the needs of its intended clients, who happen to be adolescents with physical disabilities. The study findings suggest that the significant others who choose activities for participation by adolescents with physical disabilities operate from the perspective of the medical model of disability. They view disability as a personal aspect and believe any intervention in the condition should focus on diagnosis and treatment. This then gives the legal guardians an obligation to choose the specific inclusive activities to be performed by their relative with a physical disability, based on his/her particular type of disability. Some of these activities (according to the narratives of the study participants) may not be of actual interest to the participants.

An example of an activity cited as not relevant to the needs of some of the study participants was academic learning. School programmes for inclusive learning were found to have limited relevance in preparing adolescents with physical disabilities to address their life needs. The narratives suggested that an inclusive learning curriculum relegated the study participants to watered-down learning activities, which are usually less important for the development of their psychological wellbeing. The narratives furthermore suggested that the adolescents with physical disabilities in this study were much more interested in vocational skills training activities. They felt that these would help them get employment or establish some form of income in their lives.

In the next section some of the novel findings from this study are presented. These findings are neither supporting nor contradictory to the literature available on disability and inclusion, but despite the fact that they were unexpected, they are useful to the body of knowledge on disability inclusion and psychological wellbeing. They serve as possible areas that need further research into the psychological wellbeing of adolescents with physical disabilities in inclusive community settings.

6.3 Novel results from the study

During the period of data collection, the researcher noticed that most of his participants faced numerous challenges such as with regard to mobility, language and speech problems, fatigue and even seriously ill health. Some showed signs of depression and anxiety that resulted from their isolation from peers, while others experienced serious school delays (i.e. an 18-year-old doing Grade 3). Indications were that they were having low psychological wellbeing, based on the fact that, in his opinion, most of them did not look happy (Diener, 2000) and showed no indications of life satisfaction (Diener & Lucas, 1999; Lucas & Fujita, 2000).

Based on his interviews with participants, the researcher had to conclude that participation in inclusive community activities such as learning, disability-related sport, vending, and gardening made youths with physical disabilities feel autonomous, have positive relations with the self, have a purpose in life and develop self-acceptance. His expected findings were hypothesised to show some level of correlation between the results of the study narratives and directly observed wellbeing status of the individual participants. For example, he did not expect someone who was sickly, immobile and living in isolation from peers to report high levels of psychological wellbeing. However, this was the case with the study participants. Most of them displayed signs of anxiety, depression and some illness, and confirmed that they were not wanted by the mainstream community, but nevertheless all reported high levels of psychological wellbeing!

These findings may suggest that an environmental condition that they explained as a limitation in their exercise of self-determination has nothing to do with the development of psychological wellbeing. This novel finding from the current study may suggest that adolescents with physical disabilities in Makonde Urban perhaps do not have a correct understanding of the concept of psychological wellbeing. If they understand the concept of psychological wellbeing correctly as implying happiness and life satisfaction (Lucas & Fujita, 2000), their self-assessment of their psychological wellbeing is based on a short-term assessment. There is a possibility that if these same participants were asked to rate their lives over a longer period like six months, different outcomes would have resulted.

6.4 Conclusion

This study sought to explore how communities in the Mashonaland West province of Zimbabwe are implementing the principles of inclusivity to enhance the psychological wellbeing of their adolescents with physical disabilities. It identified learning, sport as a rehabilitation measure, self-care as a daily living skill, selling (vending) as training for independent living, and gardening as a life skill as some of the community strategies designed to integrate these adolescents into mainstream communities. It also identified parents, the government, the community and donor communities as different stakeholders who assume different roles, such as providing disability awareness education, vocational counselling and inclusive infrastructure and resources. The narratives emerging from interviews furthermore showed that adolescents with physical disabilities living in inclusive community settings were experiencing environmental restrictions in their choice of inclusion activities in which to participate at home, at school and in the community. Of particular importance was the finding that the adolescents with physical disabilities were facing physical and social restrictions in choosing inclusive community activities for participation. Equally important was the recognition of the positive influence of their narratives of redemption and positive resolution. Although the participants had limited free choice due to environmental and social restrictions, they considered their participation in the available inclusive communities as very helpful for the development of their psychological wellbeing.

The study in hand provided not only significant and important support, but also extended previous research that applied both the social and biopsychosocial models on disability to enhance the psychological wellbeing of people with physical disabilities by identifying inter- and intrapersonal factors that affect their psychological wellbeing. It also elucidated a unique lived experience insight into the entire implementation of inclusion for people with physical disabilities– from the identification of types of inclusive community activities, stakeholder inputs, choice of inclusive activities, and the lived feelings on the use of inclusive community strategies to enhance psychological wellbeing.

The findings of this study should allow policy makers and researchers to better understand the needs of adolescents with physical disabilities who live in inclusive communities. Furthermore, this research will hopefully guide future research and the development of future initiatives to improve the psychological wellbeing of adolescents with physical disabilities – thus improving their outcomes and quality of life.

6.5 Limitations

Like all other research this study also had its limitations. One limitation of this study is that its research sample was culturally homogeneous. The majority of participants in this study were adolescents with physical disabilities in primary school education (93%). As such, they may represent only a restricted range of social experiences and therefore the findings may not accurately represent the experiences of those from culturally and linguistically diverse backgrounds (Baum, 2003). For instance, an adolescent with a physical disability at secondary school level, or at university level, or from a non-Shona-speaking Western culture may hold a different opinion on inclusive community activities and feelings, which may have implications for how he/she responds or chooses communities strategies in which to participate. Socio-economic status may have also been of significant influence. Presumably, adolescents with physical disabilities from middle-class

backgrounds have the financial ability to seek and explore a greater variety of inclusive community activities available in their communities than those from low-income classes. Research that includes participants from diverse socio-economic levels would clarify the role of social class in choices and participation in inclusive community activities.

The methodology used by this study also posed some limitations. The qualitative methodology, phenomenological research design, the social constructivist paradigm and the multiple case study design allowed for some data contours to be emphasised more than others (Mayoux, 2006). For instance, the data collected was mediated by the researcher's ability to ask questions and explore participant responses that allowed participants to thoroughly articulate their thoughts and conceptualisations of inclusive community activities and psychological wellbeing. The impact of this limitation was minimised by the phenomenological focus on lived experience, allowing for the adolescents with experience of physical disability to guide data analysis. While the in-depth interview technique used in the study provided insight about the psychological wellbeing of adolescents with physical disabilities in inclusive community settings, other methods may have also been useful, such as observation methods. The latter would involve frequent observation and recording of the events and experiences in participants' daily lives over a period of time, which may have allowed for more accurate or in-depth exploration of the psychological wellbeing of adolescents with physical disabilities in inclusive community settings (Bolger, Davis & Rafaeli, 2003).

Another limitation related to the methodology of this study was the use of multiple case studies, as the results from multiple case studies are not generalizable to other situations due to issues of validity and reliability (Gray, 2009). From early on it was the researcher's intention to co-construct the meaning of experiences that adolescents with physical disabilities had in inclusive communities. He worked together with them and let their voices be heard along with his. Their representation at various levels offset the weakness of the case study approach as the multiple case studies provided a more pluralistic approach (Danieli & Woodhams, 2005). In other words, the researcher acknowledged the weaknesses of a case study approach, which he subsequently

remedied by using multiple cases (Flick, 2009). However he was aware that participants could possibly have influence done another as they belonged to associations that collaborated on many disability programmes.

Due to the specific nature of the case under study, purposive sampling was used to choose participants who could be good informants (Flick, 2009). The researcher was assisted by district officials from the Ministries of Primary and Secondary Education, as well as the Ministry of Child and Social Welfare to locate prospective participants. He had to acknowledge that while the officials tried to look for best informants for the case, elements of bias could have been involved. To address this possible bias, the researcher insisted to be given possibilities of two or more possible participants to select from, before he made the final choice guided by the maximum variation selection criteria (Flick, 2009).

6.6 Recommendations of the study

Based on the complex nature of inclusion, disability, psychological wellbeing and public policy, several recommendations could be made for populations with similar characteristics as the one covered by this study. This section is therefore structured based on recommendations for research, public policy, training and practice.

6.6.1 Recommendations for research

This research in hand highlights the need for further research on inclusion, disability and psychological wellbeing. While inclusive community activities, the implementation of inclusion strategies and selection of inclusive communities to participate, and their influence on the psychological wellbeing of adolescents with physical disabilities were discussed in this study, further research is needed to fully understand the impact of the barriers to inclusion – such as a

negative attitude towards adolescents with disabilities living in inclusive communities and other environmental factors that affect their psychological wellbeing.

Future research could also investigate why adolescents with physical disabilities feel that their participation in inclusive community activities that they have not freely chosen, gives them a sense of enhanced psychological wellbeing. This may give some indication of the level of understanding of the concept of psychological wellbeing among adolescents with physical disabilities.

Research that compares the influence of inclusive community strategies on the psychological wellbeing of adolescents from different classes, e.g. urban, rural, primary, secondary, tertiary, etc., may identify contributors to the enhancement of perceived psychological wellbeing in adolescents with physical disabilities. Discourse analysis that investigates the relationship between inclusion and psychological wellbeing of adolescents with disabilities could lead to the improved implementation of inclusion. Such studies could also guide public campaigns on inclusive communities and help to improve community participation by non-dominant subcultures, such as adolescents with physical disabilities.

6.6.2 Recommendations for public policy

The study findings suggesting that most participants were engaged in learning as an inclusive community activity are consistent with global practice on inclusion, education and disability. This suggests the existence of global policies that encourage learning of people with disabilities in their communities, such as in the Zimbabwean Constitution, legislation and policies. However, this finding may also suggest that adolescents with physical disabilities in Makonde Urban were offered watered-down learning activities. Besides being exposed to mediocre teaching and learning, they were participating in activities that were not of their own choice, which creates the possibility that these activities were not be suitable for their needs. Based on these findings, the development is recommended of inclusive policies that encourage the participation of non-

dominant cultures – such as people with disabilities – in designing community activities that are designed for their personal development.

In order to combat the stigma and discrimination that lead to the enfeeblement of inclusive activities for participation by people with disabilities, it is recommended that public policy be used to transform attitudes and organisational cultures that impede potential inclusive practices. Policy is recommended to provide inclusion guidelines for the successful implementation of inclusive communities. An inclusive policy framework should also be developed to monitor and evaluate the implementation of inclusion at community level and encourage compliance among stakeholders. Such policy should target specific populations as the different groups have different needs. The current problem with the provision of services to people with disabilities in Zimbabwe is that these services are provided in terms of the general laws of the country, such as the Education Act of 1987. Without specific policies, it will not be possible to make budgetary provisions or seek donations for that particular group.

6.6.3 Recommendations for training and practice

The hampering of inclusive community activities for adolescents with physical disabilities may also suggest skills deficits among service providers, which impede the access to participation in inclusive community activities by adolescents with physical disabilities. Strong support is recommended for advocacy to ensure that the necessary policy, legislation and management are provided to meet the training needs of people with disabilities. While training needs may vary according to individual needs, some generic training programmes should be developed to address the community needs of people with disabilities, such as education and self-care skills. The researcher also recommends that appeals be made to non-governmental agencies, organisations for and of people with disabilities, as well as communities, to provide funding for skills training to people with disabilities, as a lack of resources has caused the government alone to fail in providing such training. The government has since cautioned itself through the Constitution that it can only provide funding subject to the availability of resources.

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APRENDIX 1

Summary of types of physical disabilities in the literature

Type of physical disability	Example	Signs
Neurological impairments (Chakuchichi & Magama, 2001; Chimhonyo et al., 2011; Mutsvanga et al., 2007)	Spastic (Chakuchichi & Magama, 2001; Chimhonyo et al., 2011; Heward, 2003; Kaputa et al., 2010; Mutsvanga et al., 2007)	Muscles stiffness; Muscles spasticity; Muscle co-contraction; Muscle hyper tonicity; Depressed inhibition (Chakuchichi & Magama, 2001; Chimhonyo et al., 2011; Heward, 2003; Kaputa et al., 2010; Mutsvanga et al., 2007)
	Athetoid (Chakuchichi & Magama, 2001; Chimhonyo et al., 2011; Heward, 2003; Kaputa et al., 2010; Mutsvanga et al., 2007)	Interference of voluntary motion; Extraneous motion causing misdirection; Grimacing (frowning); Lurching (staggering) or moving unsteadily; Drooling (saliva drooling from mouth; Superior gaze paresis; Partial inability to move (Chakuchichi & Magama, 2001; Chimhonyo et al., 2011; Heward, 2003; Kaputa et al., 2010; Mutsvanga et al., 2007)
	Ataxic (Chakuchichi & Magama, 2001; Chimhonyo et al., 2011; Gearheart, Weishahn & Gearheart, 1992; Heward, 2003; Kaputa et al., 2010; Mutsvanga et al., 2007)	Equilibrium disturbance (balance disturbance); Depressed motion awareness (movement problems); Direction sense disturbance (interference of sense of direction) (Chakuchichi & Magama, 2001; Chimhonyo et al., 2011; Gearheart et al., 1992; Hardman, Drew & Egan, 1987; Heward, 2003; McCarthy, 1984; Kaputa et al., 2010; Mutsvanga et al., 2007; Wener, 1987)

Musculoskeletal (Chakuchichi & Magama 2001; Chimhonyo et al., 2011; Mutsvanga et al., 2007)	Arthrogryposis	Shift curved joints, Fixed joints, Arms and legs which do not bend (Hallahan & Kauffman, 1994)
	Scoliosis (Chimhonyo et al., 2011; Chakuchichi & Magama, 2001; Heward & Orlansky, 1996; Kaputa et al., 2010)	Structural curves; Loss of normal flexibility; Tumours; Pelvic deformity; Abnormal posture (Chimhonyo et al., 2011; Chakuchichi & Magama, 2001; Heward & Orlansky, 1996; Kaputa et al., 2010)
	Osteogenesis Imperfecta (Chakuchichi & Magama, 2001; Chimhonyo et al., 2011; Mutsvanga et al., 2007)	Deformity; Dwarfism; Hearing loss; Bones of the lower and upper limbs that break easily (Chakuchichi & Magama, 2001; Chimhonyo et al., 2011; Heward, 2003; Kaputa et al., 2010; Mutsvanga et al., 2007)
	Amputation	Loss of some part of the body due to accident or infection (Mutsvanga et al., 2007; Kaputa et al., 2010)
	Head injury	Injury to the head as a result of accident or infection (Kaputa et al., 2010; Mutsvanga et al., 2007)

APPENDIX II

Interview Guide

My name is Jabulani Mpofu. I am a student at the University of Pretoria studying towards a PhD degree programme.

I am carrying out a study on the psychological wellbeing of adolescents with physical disabilities in inclusive community settings in the Mashonaland West province of Zimbabwe. You have been nominated to take part in this interview by virtue of being an adolescent with a physical disability living within these inclusive communities. I will be taking notes and audio-taping our discussion. The notes and audio-tape will be used for the purpose of this study only and will not be made available to any other person or to organisations not involved in this study. Feel free to talk to me. We will use a number as your identity for anonymity and confidentiality reasons. Please remember that there is neither right nor wrong answers in this discussion. Your participation in this discussion is entirely voluntary. If you wish to withdraw from this discussion, you are free to do so at any point without penalty.

I would like you to respond to these few questions based on your experiences and feelings of living in an inclusive community. Our discussion will focus on inclusive activities available in your community, how you have chosen them, and how they affect your autonomy, environmental mastery, personal growth, positive relations with others, purpose in life and self-acceptance. We can now start.

Please tick in the appropriate box:

Section A: Bio data

Gender: Male Female

Type of physical disability:

Amputation Myelodysplasia

Cerebral palsy Head injury

Spinal cord injuries Neuromuscular Disorder
 Heath-related Other's (Specify):

Age of Onset: Congenital Acquired

Issue	Proposed questions	Proposed follow-up questions	Probes
What strategies are available to integrate adolescents with physical disabilities into the community to enhance their psychological wellbeing?	Please tell me more about the inclusive activities available for you in your community?	What is your reaction to these activities?	Tell me more about how they are being done.
How are these strategies implemented within the community?	How are inclusive community activities in your area being implemented?	Explain agencies by activities.	Tell me more
Choosing inclusive community activities	How do you choose to participate in the inclusive community activities available for you in your area?	How does participating in these inclusive community activities make you feel?	Tell me more
How do selected inclusive community strategies contribute to the overall wellbeing of adolescents with physical disabilities?			
Issue	Proposed questions	Proposed follow-up questions	Probes

Autonomy	How does participating in inclusive activities increase your autonomy?	What autonomous-related issues are there in these inclusive community activities?	Explain further.
Environmental mastery	Do inclusive community activities make you feel in control of and able to act within the environment?	What happens in inclusive community activities that you feel promotes your mastery of the environment?	Explain further giving examples.
Personal growth	Do you believe that inclusive community activities help you to have a sense of continued development and self-improvement?	How do you come to that conclusion?	Go on.
Positive relations with others	Can you tell me whether inclusive community activities assist you in having satisfying and trusting relationships with other people?	What kind of satisfying and trusting relationship are they?	Really?
Purpose in life	To what extent does engagement in inclusive community activities influence people's beliefs about the meaning of life?	How does this happen?	Sure?

Self-acceptance	Can you briefly describe yourself?	What do you wish about others on the issues of self-acceptance?	Explain further.
How do selected inclusive community strategies contribute to the overall wellbeing of adolescents with physical disabilities?	Do you have any suggestions on how best community needs for adolescents with physical disabilities can be accommodated in inclusive community activities?	What do you wish to see done?	Explain further.

Thank you very much. I really appreciate your participation in this study.

APPENDIX III

Interview schedule

Interview/ Case	Interview Date	Time	Area	Number of interviewees and /type of interview	Total minutes
1. Kevie	26 January 2016	08 :00-09 00	Gadzema	1 face to face case interview	60 minutes
2. Langton	26 January 2016	10:03-11:30	Gadzema	1 face to face case interview	60 minutes
3. Nyarai	26 January 2016	12:00-13 :00	Gadzema	1 face to face case interview	60 minutes
4. Nyarie	26 January 2016	14:00-15:00	Gadzema	1 face to face case interview	60 minutes
5. Jeff	27 January 2016	08 :00-09 00	Mupata	1 face to face case interview	60 minutes
6. Chiwaridzo	27 January 2016	10:00-11:30	Mupata	1 face to face case interview	60 minutes
7. Jinye	27 January 2016	12:00-13 :00	Mupata	1 face to face interviews	60 minutes
8. Dimingu	27 January 2016	14:00-15:00	Cold Stream	1 face to face case interviews	60 minutes
9. Dzanhasi	28 January 2016	08 :00-09 00	Cold Stream	1 face to face case interviews	60 minutes
10. Walter	28 January 2016	10:03-11:30	Ruvimbo	1 face to face case interviews	60 minutes
11. Kombo	28 January 2016	12:00-13 :00	Ruvimbo	1 face to face case interviews	60 minutes
12. Witness	28 January 2016	14:00-15:00	Mzari	1 face to face case interviews	60 minutes
13. Try	29 January 2016	08 :00-09 00	Orange Grove	1 face to face case interviews	60 minutes
14. Daggie	29 January 2016	10:03-11:30	Rivers Side	1 face to face case interviews	60 minutes
Total	4 Days			14 interviews	14 hours

APPENDIX IV

Example of verbatim transcription

Interview: Chiwaridzo

Interviewer: J. Mpofo

Date: 27 January 2016: Time: 10:00-11:30

Place: Mupata

Aim: Collect information on Psychological wellbeing of adolescents with physical disabilities living in an inclusive setting

Interview number and Bio data	Issue	Transcription	Key issues from verbatim
Chiwaridzo (Myelodysplasia , 19 years, male) added Congenital Age 19 University	Researcher: What community strategies /activities are available to integrate you as an adolescents with physical disabilities into the community to enhance your psychological wellbeing	Participant Response: As a university student I interact with so many people . This interaction brings with it a lot of experiences . Through these experiences I learn so many life issues that are very helpful for my survival as an adolescent living with a physical disability. All I can say is I am involved in continuous learning from my community . I play wheelchair tennis . I am a tennis captain at our university. I am also a wheelchair tennis captain for the provincial Paralympics team. I also featured	Interact with community Getting life experiences from community learning from community lays tennis (Sport) Captains provincial team

		<p>in last year's national Paralympics team selection. Besides Paralympics I am a non-playing captain for our mainstream lawn tennis team. Although I am one year old at the university and playing wheelchair tennis our team has won several medals under my captaincy.</p> <p>One of my major strength in self-care sections I always keep myself clean. I do that by taking bath twice every day especially when it is hot or when we are having sports. People talk a lot about those who are not friendly to water, worse with those of my ages and at the university. It will be made worse especially when you have a disability like me. In short I am saying I take bath every day.</p>	<p>Involved in mainstream tennis</p> <p>Involved in competitive tennis</p> <p>Engaged in self-care activities</p> <p>Bathes every day</p>
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	<p>Researcher: How are these activities/strategies implemented within in your community?</p>	<p>Participant Response: My parents are responsible for my learning. I am receiving no help from any agency to participate in greater community activities. My parents are paying for my fees, Playing wheel chair tennis is my own initiative</p>	<p>Parents responsible for learning No agencies involved Parents pays fees Tennis participation participant driven</p>
	<p>Researcher: Do you have options to choose inclusive community activities to partake in your community.</p>	<p>Participant Response: I chose what I want to do because I am an adult and an academic. I enjoy my education although I am meeting a number of mobility challenges from moving from one lecture room to another</p>	<p>Have choice Physical Environment is creating mobility challenges</p>
<p>Researcher: How do selected inclusive community strategies contribute to the following aspects of overall wellbeing to you as an adolescent with physical disabilities?</p>			
<p>Issue</p>	<p>Transcription</p>		

<p>Researcher: How does it help in developing autonomy</p>	<p>Participant Response: Because I am making progress at my university I have a feeling that I am being empowered. This empowerment is giving me some feelings of self-rule and choice. Look here I selected subjects to take at Advanced level alone. I also selected to take accounting at the costs of so many other programmes in the faculty of commerce. I am also thinking of specialising in banking. This choice is coming all as a result of learning.</p>	<p>Empowered through learning</p> <p>Has sense of self rule</p> <p>Chooses subjects to learn</p>
<p>Researcher: How does it help in developing Environmental Mastery</p>	<p>Participant Response: I have control over some social environments but have challenges in physical environments. Some of them are not easily accessible to the type of my disability and some are not negotiable as fast as I wish. This is mostly true at my college</p>	<p>Limited control of social environments</p> <p>Physical environments are restrictive</p>
<p>Researcher: How does contribute to Personal Growth</p>	<p>Participant Response: I am developing cognitively. You can see that. It's obvious being at a university is personal growth</p>	<p>Developing cognitively through learning</p>
<p>Researcher: How does contribute to Positive Relations with Others</p>	<p>Participant Response: I have several friends including girlfriends (laughing). I mix well with them.</p>	<p>Mixes well with friends</p>
<p>Researcher: How does contribute to Purpose in Life</p>	<p>I am really satisfied with the progress I have made in my life. I have been doing well more than what other people of my age without disabilities do. It's an achievement to be at a</p>	<p>Satisfied with life</p>

	<p>university considering that I have a disability. I am satisfied and have no problems in as far as knowledge is concerned.</p>	
<p>Researcher: How does contribute to Self-Acceptance</p>	<p>Participant Response: The fact that I engage well with others gives me a sense that I'm like any other person I don't feel the disability in me or any sense of being rejected by community. Actually I don't believe disability is giving me any life limitations</p>	<p>Feels the same as those without disabilities Self-accepting Feels not rejected Not disabled</p>
<p>Do you think we have left anything you would like to add?</p>	<p>Participant Response: I just want to encourage people with physical disabilities to try to fit in this greater community in as much as they can to minimise the effects of having a disability such as dependency, isolation poverty and etc.</p>	<p>Minimise disability effects</p>

APPENDIX V

Themes, subthemes and categories that emerged from an in-depth review of the Transcriptions

Theme 1: strategies for the community integration of adolescents with physical disabilities				
Subtheme	Categories	Sub categories	Inclusion criteria	Exclusion criteria
Inclusion activities to participate for adolescents with physical disabilities			Any phrases, sentences or words that reflects experiences that reflects engagement in inclusion activities by adolescents with physical disabilities	Any phrases, sentences or words that do not make reference to experiences that reflects engagement in inclusion activities by adolescents with physical disabilities
	Learning oriented activities	Formal learning	<p><i>“I learn at school. At school I learn so many things, I learn to read and write. I also do a lot of art, drawing, knitting, and do a lot of moulding. My teacher also teaches me music. He also teaches me the correct use of toilets and how to play well with others” (Kevie Cerebral palsy, 18 years, male) (1, 1:1-4).</i></p> <p><i>“I go to school to learn so many things. My teacher every day encourages me to participate when in class. Besides that he usually takes us around the school yard picking papers viewing the school and other activities going on at school. During sports he takes us to watch sports at school or other sites</i></p>	

		<p><i>around the school. We also do a lot of PE at our school but with Miss Suzan. I don't know where she comes from. I like the way she teaches me PE. We do PE twice per week” (Langton, Neuromuscular disorder, 13 years, male) (2, 6:181-186).</i></p> <p><i>“I go to school to learn. Besides learning reading and writing my teacher teaches me how to recite poems. I present these poems at parents and prize giving days. I am also active in school drama.”... “I am very good in drama. I was given prizes for being the best actor in our drama and good poems on so many occasions at our school”. (Nyarai, Limb deficiency, 15 years, female)(3, 17:493-494).</i></p> <p><i>“I go to school to learn. My teacher always teaches me how to play well with others. She always makes sure that I am not isolated in class and encourages me to ask her and others when I miss what she will be teaching. In most cases when I don't finish my work she gives me the work as homework. Besides learning how to read and write my teacher always helps me to manage my health condition. I have epilepsy. She discourages me to sit on sharp objects or big stones” (Dimingu, Epilepsy, 15 years, female) (8, 36:1044-1049).</i></p>	
		<p>In-formal learning</p>	<p><i>“I do a lot of learning at home. My parents teach me my homework and help me doing my other work which I would have failed to compete at school. They also teach me new work which we will do at school. Besides teaching me school work time and</i></p>

			<p><i>again they also help me with training to move using parallel bars they constructed at home. In addition to this my young brothers and sisters also teaches me various games at home such as ball throwing and catching correct handling and use of food utensils” (Witness, Neuromuscular disorder, 15 years, male)(12,56:1062-1070).</i></p> <p><i>“I learn so many things at home. My parents always teach me about how to take care of myself in the face of my health condition. They teach me a lot about the importance of taking my drugs in time and daily. In addition to this they always teach me how to socialise with others at home and school” (Try, HIV, 14 years, female)(13, 61, 1079-1082).</i></p> <p><i>“I learn a lot of things from my community. Most of the things I learn in my community are about doing good things to others. When saying others I mean my colleagues. I get this type of education from my colleagues. The other experience or learning I am getting from the community is to respect elders. We learn about this at church. I go to Methodist” (Walter, spinal cord injury, 14 years male) (10, 46:1033-1038).</i></p> <p><i>I learn various community rules from members of the community such as my friends and community elders. I am always being reminded that if you do evil things such as stealing, saying bad about others you will go to hail. This teaching is good. I don’t want to go to hail. I also learn from the community</i></p>
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			<p><i>that fighting others is bad” (Kombo, polio, 13 years, female) (11, 51,301-305).</i></p> <p><i>“As a university student I interact with so many people. This interaction brings with it a lot of experiences. Through these experiences I learn so many life issues that are very helpful for my survival as an adolescent living with a physical disability. All I can say is I am involved in continuous learning from my community” (Chiwariidzo, Cerebral palsy, 19 years, male) (6, 26:1428-1431).</i></p>
	<p>Sporting as a rehabilitation measure</p>	<p>Competitive sport</p>	<p><i>“I play wheelchair tennis. I am a tennis captain at our university. I am also a wheelchair tennis captain for the provincial Paralympics team. I also featured in last year’s national Paralympics team selection. Besides Paralympics I am a non-playing captain for our mainstream lawn tennis team. Although I am one year old at the university and playing wheelchair tennis our team has won several medals under my captaincy” (Chiwariidzo, Myelodysplasia, 19 years, male)(6.26:728-731).</i></p> <p><i>“I play soccer. I am a player in our school Paralympics. Last year we played four schools. We did not win all the games but we also won some two of them. I am a keeper. Besides playing soccer I play drums in the school percussion band” (Witness, Neuromuscular disorder, 15 years, male) (12, 56:1624-1625).</i></p> <p><i>“I play chess for my schools team not the Paralympics team only but the school team. I am</i></p>

			<p><i>good at chess I have won several medals at district level, when playing other schools. I have travelled a lot playing chess. I learn chess from my computer. I play better than my teachers and they cannot teach me chess thus why I learn it from the computer”</i> (Jinye, Hemimelia, 16 years, male) (7, 31:868-870).</p>
		Leisure activity	<p><i>“I play street games such as soccer, one touch and hide and seek.....these games are nice and quite interesting to me because they make me relax after school”</i> (Walter, Spinal cord injury, 14 years, male) (10, 46:1228-1230).</p> <p><i>“I play ball games with my friends at home after school and during weekends. We play ball games like “rakaraka”we also play nhodo (pebbles) at home”</i> (Dzanhasi, Cerebral palsy, 19 years, male) (8, 36:1296-1297).</p> <p><i>“Although I play chess at school for completion I also play it at home on my laptop during my leisure time. I also play it on my cell phone with other players of my age from other towns and countries. When I am not reading or watching TV chess takes most of my spare time at home”</i>(Jinye, Hemimelia, 16 years, male)(7, 32:896-896).</p>
		Fitness sport	<p><i>“I usually spend my sporting time at school walking around the school yard exercising my muscles. My health condition requires me to do some exercises to remain fit”</i> (Kevie, Cerebral palsy, 18 years, male) (1, 1:18-19).</p>

			<p><i>“At school I do PE with my teacher Miss Suzan, I do it as learning and also as sport to keep me strong. At home my parents also make sure I do exercises to keep myself fit. I used to go to the hospital for the exercises but since last year we started doing them at our home” (Langton, Neuromuscular disorder, 13 years, male) (2, 6:174-176).</i></p> <p><i>“I don’t do any sporting both at home and school because my mother told me that you have poor health and if you play games you will collapse and die” (Dimingu, Epilepsy, 15 years, female)(8,36:1044-1046).</i></p>
	<p>Self-care as a daily living skill</p>	<p>Washing and bathing</p>	<p><i>“At home I wash my plates after eating food. I make sure they are clean. I also wash other plates used by my siblings including those used by my parents. I use soap or dish washer to do the washing after washing the plates I always make sure that I live the dish clothes clean as well because my mother always inspect my washing” (Try, HIV, 14 years, female)(13,61:1647-1650).</i></p> <p><i>“One of my major strength in self-care section is I always keep myself clean. I do that by taking bath twice every day especially when it is hot or when we are having sports. People talk a lot about those who are not friendly to water, worse with those of my ages and at the university. It will be made worse especially when you have a disability like me. In short I am saying I take bath every day”</i></p>

			<p>(Chiwaridzo, Myelodysplasia, 19 years, male) (6, 31:899-901).</p> <p><i>“I bath myself every day. During weekends I also make sure that I bath my young sisters two of them. I want to see them smart every time”</i> (Try, HIV, 14 years, female) (13.61:1769-1770).</p>
		Bedding and sweeping	<p><i>“At home I sweep in my room, my brothers room, dining room, lounge, kitchen and the veranda. After sweeping these rooms I do the bedding for my room and brother’s room. I also dust the sofas and kitchen tables. After doing all that my mother at times clean the rooms further by applying cobra. But I usually put cobra in my room. This work is tiresome but I like i.”</i> (Nyarie, Congenital limb deficiency, 14 years, female)(4, 16:448-452).</p> <p><i>“Like any other girls when you are at home you are taught how to sweep and do the bedding. The two activities are specifically designed for girls no matter how your condition is. I do the two at home very effectively”</i> (Try, HIV, 15 years, female) (13, 61:1830-1832).</p> <p><i>“Every day I wake up early in the morning and sweep my bedroom. I share bedroom with my young brother. At times the young brother does the sweeping. After sweeping I make our bed. My young brother is too little to do that but I have to train him sweeping and bedding”</i> (Witness, Neuromuscular disorder, 15 years, male) (12, 56:1624-1626).</p>

		Cooking	<p><i>“I help with several household chores at home but I am mostly involved in cooking. I can cook sadza, vegetables, meat, rice and so many things including groundnuts. I only make sure that I don’t burn the food I am cooking. My mother’s does not like that”</i></p> <p>(Dimingu, Epilepsy, 15 years, female) (8, 36:1008-1010).</p>
	Selling as training for independent living	Vending	<p><i>“At times I go with my mother to the farmers market. At the famers market we buy, bananas, tomatoes, onions, groundnuts and other farming products. We then take these items to the local bus terminus and repack them into small units and resell them. We make money by selling these things. I usually go together with my mother during weekends or when schools are closed. At times I am left alone at the bus terminus doing the selling”</i></p> <p>(Try, Health related, female, 13 years) (13, 61:1708-1712).</p>
	Gardening as a life skill	Home gardening	<p><i>“I do a little bit of gardening at home during the weekends and over the holiday. My mother told me that the garden is mine. We have a very big garden. The other side has flowers, plants, herbs and the bigger side has vegetables. We also have some strawberries. What I do in our garden is I water it using a horse pipe. I also maintain the flower beds and pots by putting back lost soil and stones”</i></p> <p>(Kombo Polio, 13 years, female) (11, 52:1456-1460).</p> <p><i>“At home I do some gardening. I usually assist my father to make vegetable beds every Saturday during</i></p>

		<p><i>school term. During the holidays and mid-week I work in the garden with my mother. We have sections for maize and another section for vegetables” (Langton Neuromuscular disorder, 13 years, male) (2.7:231-234).</i></p> <p>He also said <i>“I enjoy it (gardening) quite well. I tell you this is the truth I love it very well (smiling)” (Langton, Neuromuscular disorder, 13 years, male) (2.7:234).</i></p>
	School gardening	<p><i>“I do gardening at school. I have my school bed which is one meter by one meter. This time my bed has some vegetables. They are not all that good because we have water problems in our garden.....</i></p> <p><i>“Activities such as gardening are reserved for boys at my school and those without disabilities at school. I have one bed because I have one hand my teacher feels that I cannot water more than one bed even using a hose pipe”(Nyarie, Congenital limb deficiency, 14 years, female)(3, 17:496-499).</i></p>

Theme 2: Implementation of inclusive community strategies

Subtheme	Categories	Sub categories	Inclusion criteria	Exclusion criteria
Stakeholders’ efforts for the successful implementation			Any phrases, sentences or words that reflects stakeholders’ efforts for the	Any phrases, sentences or words that do not make reference to stakeholders’ efforts for the successful

tion of inclusion			successful implementation of inclusion	implementation of
	Disability awareness education	Disability education at home	<p>Examples of participants' responses</p> <p><i>My parents usually take me out for walk around our suburb they will be walking and will be moving in my wheelchair. They take me to various places some easy and smooth but others difficult to move with my wheelchair. At times they also take me to play small games with other youths with or without disabilities. After each day outing they asks me to explain how I felt and experience the outing and my condition” (Kevie, Cerebral palsy, 18 years, male) (1, 2:33-37).</i></p> <p><i>My mother always teaches me about living with a disability. She always explains my condition that I live with a disability but that does not mean I am not like others for example my friends. She always explain that people who see disability in me are bad people and I should ignore them or report them to my teacher if they say something bad on me. Sometime last term I reported John and the teacher punished him” (Witness, Neuromuscular disorder, 15 years, male) (12, 57:1653-1658).</i></p>	
		Disability education at school	<p><i>“At our school we hold a disability day. On this day people with disabilities and those without disabilities are invited to show their work to others. Our work is then displayed together with those of other students without disabilities. We recite poems on what we are able and not able to do as children</i></p>	

			<p><i>with disabilities. I enjoy this day very much. The school is doing something good to us as children with disabilities.” Langton (Neuromuscular disorder, 13 years, male),</i></p> <p><i>“My teachers always talk to me in areas where I am good at and those that I need help. My teachers and parents at times bring people who come and give me tests after that they will talk to me on my results and say I should do this and that work. At times this is done after we write tests in our class with others”(Kombo, Polio, 13 years, female) (2, 7:210-215)</i></p>
	Vocational Counseling	Job application and interviews	<p><i>“At school we are taught several issues around getting jobs. We are taught how to write letters looking for job, what to do during interviews and where to look for jobs. I was taught you look for jobs from advertisements and you then write for a job you think you can do, You then you apply for job at a company and you must clearly write what type of job you want. If called for interviews my teacher told me that you have to go in time and nicely dressed. In the interview you must speak without fear and avoid taking managers things such as pens and papers. My teacher always tells us that one of his former deaf students took the pen out and the manager got angry and did not give him job because of that”(Dimingu, Epilepsy, 15 years, female)(8, 37:1081-1089).</i></p>

			<p><i>“At school we are taught how to look for jobs from industries and notice boards in town. My teacher always says most companies no longer put advertisements in newspapers but on company notice boards”</i>(Dzanhasi, Cerebral palsy, 19 years, male)(9,41:1232-1234).</p>
		<p>Vocational skills competence</p>	<p><i>“I did my grade seven last year at this school but I am still at this primary school. This time I am not learning grade seven materials, but learning carpentry. After this I will get a job as a carpenter and make money. If I don’t get the job in industries I will do it alone at our home and get money. I like carpentry”</i> (Kevie, Cerebral palsy, 18 years, male)(1, 2:66-70).</p> <p><i>“I am being taught to do so many jobs after school. Right now I am learning poultry. I am being taught how to keep chicks and how to sell them on market and realise profits”</i> (Dagie, Cerebral palsy, 19 years, male) (14, 67:1961-1962).</p>
	<p>Inclusive infrastructure and resources</p>	<p>Resources from the parents</p>	<p><i>“My school fees are paid by my father, He always pay it before schools open. Besides fees he also buys me exercise books, pens, ruler, satchels, lunch boxes, crayons, pencil and others. He also gives me money for civics day”</i> (Kevie, Cerebral palsy, 18 years, male) (11, 57:1566-1568).</p> <p><i>“The government used to pay my fees few years ago but it is now broke. My mother has taken over. She is paying everything and the Head is no longer</i></p>

			<p><i>sending me home for non-payment of fees” (Kombo, Polio, 13 years, female) (1, 2:71-72).</i></p>
		<p>Resources from the government</p>	<p><i>“My fees are paid by the government. My parents are not paying anything. The government is paying through DAC (District AIDS Committee) DAC is also responsible for my learning materials including school uniforms” (Try, HIV, 15 years, female) (13, 62:1820-1823).</i></p> <p><i>“My fees are paid by BEAM” (Dagie, Cerebral palsy, 19 years, male) (13, 62:1820-1823).</i></p>
		<p>Resources from the philanthropists</p>	<p><i>“My fees are being paid by the Catholic sisters. The Catholic sisters are also responsible for all my learning needs including school uniforms my transport to and from school” (Jinye, Hemimelia, 16 years, male) (7, 33:933-935).</i></p> <p><i>“There is someone who is not my parents and is paying my fees. I don’t know her name and where she comes from but that person is the one who is paying for my fees and responsible for learning needs” (Nyarai, Limb deficiency, 15 years, female) (4, 18:541-543).</i></p>
		<p>Resources from community</p>	<p><i>“At my school, our classes have ramps. We also have paths that I move freely with my wheelchair” (Jeff, Traumatic brain injury, 15 years, male) (5, 23:546-547).</i></p> <p><i>“At my school our toilets are built nicely. I can use them without problems from my wheelchair” (Dagie, Cerebral palsy, 19 years, male) (14, 67:122).</i></p>

		<p><i>“The doors at my school are very good. I can open them from my wheelchair. The handles are so low that I can reach them with easy. They doors are also very light that I can push and pull them”</i> (Walter, Spinal cord injury, 14 years, male) (10, 48:1440-1441).</p> <p><i>“I was given the wheelchair I am using by Social Welfare”</i> (Nyarie, congenital limb deficiency, 14 years, female) (4, 13:33).</p> <p><i>“I was given this wheelchair by Social Welfare, but I also have my own wheelchair at home”</i> (Jeff, traumatic brain injury, 15 years, male) (5, 23:671-671).</p> <p><i>“My parents take my wheelchair to the hospital after every two months for repairing”</i> (Nyarie, congenital limb deficiency, 14 years, female)”(4,17:558-559).</p> <p><i>“The Social welfare people come to our home to put oils and other things on my wheel chair time and again”</i> (Jeff, traumatic brain injury, 15 years, male) (5, 23:672-673).</p>
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Theme 3: Choice of inclusive community activities to participate in

Subtheme	Categories	Inclusion criteria	Exclusion criteria
Choice in participation of adolescents with physical		Any phrases, sentences or words that reflects information on choice in participation of adolescents with physical disabilities in inclusion	Any phrases, sentences or words that do not make reference to choice in participation of

disabilities in inclusion			adolescents with physical disabilities in inclusion
	<p>Choice of activities at home</p>	<p><i>“I have limited control on inclusive community activities to do at home because of my health conditions. Most of these activities are so physical e.g. games, writing etc. I easily get tired and fear that I can collapse and die. If my health was permitting I would choose activities to do. At present all my activities are determined by my mother” (Dimingu, Epilepsy, 15 years, female) (8, 38:1140-1145).</i></p> <p><i>“What I do at home is determined by my parents. Their choices on activities to participate also includes what I do even at school and when playing with others. I don’t just choose things to do without consulting my parents” (Try, HIV, 15 years, female) (13, 63:1890-1892).</i></p> <p><i>“Although my parents try as much as possible to make me socialise with other people they select people I should mix up with. They don’t allow me to choose friends at will. They approve them. Even at home they are very watchful on my moves like if we have visitors they don’t want me to play around them. They try as much as possible to keep me away. They only allow me around visitors if the visitors themselves have a child with a disability” (Witness, Neuromuscular disorders, 15, male) (12, 58:1740-1747).</i></p> <p><i>“All my activities are controlled by my parents they always remind me of my health condition that I am not fit hence can’t do other things. They believe I am sick and weak. This makes me withdraw from many activities at home and only takes those that</i></p>	

		<i>are allowed by my parents” (Dimingu, Epilepsy, 15 years, female) (8, 38:1146-1150).</i>
	Choice of activities at school	<p><i>“My school environment affects my choices to participate in various inclusive community activities at school level. For example some of the school places are not readily accessible for people with my condition. The sporting grounds are difficult to move.” Langton (neuromuscular disorders, 14 years, male) (2, 8:260-264).</i></p> <p><i>“My choice to participate in inclusive community activities is facing a lot of problems such as attitudes of my colleagues without disabilities towards me at school. My colleagues’ attitudes are so negative. They side-line me in so many activities and qualify me to the lesser entertaining ones. You will end up avoiding taking part in some of the activities you may want to take part in. Just imagine some of them may not be willing to sit close to me watching a game say soccer or netball. They don’t just feel comfortable for no reason. They believe my disability is contagious I don’t know. What I end up doing is to go home or pay alone or with my colleagues who has a disability.”(Walter, Spinal cord injury, 14 years, male)(10, 47:1510-1521).</i></p> <p><i>“My colleagues’ at school were told by their parents that epilepsy is contagious. They don’t want to socialise with me they feel that they can get it from me if I’m under attack” (Dimingu, Epilepsy, 15 years, female) (8, 39:1168-1170).</i></p>
	Choice of activities in community	<i>“I have challenges with the physical environment. Our roads are not all tarred and some have serious potholes. They present me with challenges when I want to move from point A to Point B. This will result me not attending some of the community functions I might want to attend. Some of the buildings in our town are not</i>

		<p><i>accessible by wheelchairs. This limits me visiting other places when I want to play with others. It also affects me visiting other places like schools and clinics” (Kevie, Cerebral palsy, 18 years, male) (1, 4:120-127).</i></p> <p><i>“Most of the problems I get at school are transferred to my friends in our community. You find out that you may want to play with A, B, C but they may not be willing to play with you. They will tell you that their parents don’t allow that. They actually say bad words to refer to me in many cases. I am called “chirema” (the crippled). You find out even if you want to play with them you may not be comfortable and you end up withdrawing from activities of your choice. Just imagine the other day we were playing soccer. I was playing for team A; we were supposed to be 7 aside our team was allowed to play with 8 because they felt that I was not an extra person” (Dagie, Cerebral palsy, 19 years, male)(14, 68:2040-2050).</i></p>
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Theme 4: The contribution community strategies to the psychological well being

Subtheme	Categories	Sub categories	Inclusion criteria	Exclusion criteria
Inclusion and psychological wellbeing of adolescents with			Any phrases, sentences or words that reflects inclusion and psychological wellbeing of adolescents with physical disabilities	Any phrases, sentences or words that do not make reference to inclusion and psychological wellbeing of adolescents with physical disabilities
			Examples of participants’ responses	

<p>physical disabilities</p>	<p>Autonomy and choice in life</p>	<p>Formal learning and autonomy and choice</p>	<p><i>“Because I am making progress at my university I have a feeling that I am being empowered. This empowerment is giving me some feelings of self-rule and choice. Look here I selected subjects to take at Advanced level alone. I also selected to take accounting at the costs of so many other programmes in the faculty of commerce. I am also thinking of specialising in banking. This choice is coming all as a result of learning.” Chiwaridzo (myelodysplasia, 19 years, male) (6, 31:930-935).</i></p> <p><i>“Through learning using computers I feel I am being equipped with abilities to make choices. When learning games such as chess it’s all about making the correct move. If you move wrongly you are defeated so learning makes me develop making right choices not only in the game of chess but in life” (Jinye, Hemimelia, 16 years, male)(7, 33:990-993).</i></p> <p><i>“Learning, be either at home or school, was not doing enough to enhance my feeling of control over my choices. Most of the materials I learn, I do in my life is controlled by my parents and teachers my brothers, sisters and even friends. I am always told this is what I can do and I can’t do” (Nyarai, Limb deficiency, 15 years, female).</i></p> <p><i>“I don’t have a lot of choice in my life my health condition is giving me limitations. Imagine I cannot even write a lot of school work or play with others for a long time because I easily get tired</i></p>
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			<p><i>even if I want to”(Dimingu (epilepsy, 15 years, female)(3, 13:390-393).</i></p>
		<p>In-formal learning and Autonomy and choice</p>	<p><i>“Through play my social needs are addressed at group level. People need to be happy some time and this is only possible when they have choices around them and if their choices are recognised by the significant others they share time with. In my case we always have visitors who come to our school and ask us about our needs. We give them some of our needs are addressed but most of them are not. However we would have given out our choices”</i> (Jeff, Traumatic brain injury, 15 years, male) (5, 23:690-698).</p> <p><i>“The fact that I do not have my left leg it controls me in choosing what I want to do in my community as long as it requires the use of the missing leg. What I am saying here is my disability affects my choice”</i> (Nyarai, Limb deficiency, 15 years, female) (3, 14:420-422).</p> <p><i>“I am not developing any choice; the choice is determined by my health. I have epilepsy it attacks me without notice and because of that you cannot just do anything you want my choice is limited”</i> (Dimingu, Epilepsy, 15 years, female) (8, 39:1170-1172).</p>
	<p>Purpose of life</p>	<p>Formal learning and</p>	<p><i>“I am really satisfied with the progress I have made in my life. I have been doing well more than what other people of my age without disabilities do. It’s an achievement to be at a university considering</i></p>

		<p>Purpose of life</p>	<p><i>that I have a disability. I am satisfied and have no problems in as far as knowledge is concerned” (Chiwaridzo, Myelodysplasia, 19 years, male) (6, 29:870-873).</i></p> <p><i>“The learning I am getting is unsatisfactory. I am being taught things that are not of much benefit to my life. I want to be a truck driver. I admire my uncle who drives a truck. Instead of being taught math’s English and others which takes a lot of time to be employed they must teach me driving.”(Walter, Spinal cord injury, 14 years, male) (10, 49:1470-1473).</i></p> <p><i>“I was going to be satisfied with my life if I was learning carpentry. The learning I am getting both at school will never give me the life I want to live. I want to be a carpenter” (Jinye, Hemimelia, 16 years, male)(7, 34:1120-1122).</i></p>
		<p>In-formal learning and purpose inlife</p>	<p><i>“When I participate in social issues with my peers with and without disabilities I get happy. I also get happy when I am consulted over my life” (Kombo, Polio, 13 years, female) (11, 54: 1666-1567).</i></p> <p><i>“I learn more of my condition at home from my parents, others who live with HIV like me. These people are very important. They have made me understand my condition and that I can live a normal life like any other person living without HIV. They have made me understand that I am a person like any other person in my community. They have made me know that what is important is to take my</i></p>

			<p>tablets only and I live on” (Try (HIV, 15 years, female) (13, 64:1856-1860).</p>
	Positive relations with others	Formal learning and positive relations with others	<p>“As learners we are always a family be it at school or home. For example at our school I have friends, I belong to group C, I am in grade 4 we wear a blue uniform the whole school. When we are at sports we support one team our school and if we win we all get happy if we lose we all get sad” (Langton, Neuromuscular disorders, 14 years, male)(2, 9:261-268).</p> <p>“When we learn we are always in groups be it at home or school. At my home our parents teaches us good manners. If we behave well as a family they become happy. If one of us do something bad our parents gets angry. They teach us how to do well before visitors and where ever we are. We also help each other by telling ourselves to do well as people belonging to our family” (Try, HIV, 15 years, female) (13, 65:1885-1888).</p>
		In-formal learning and positive relations with others	<p>“My involvement in so many issues with my friends and being consulted on issues around my disabilities makes me feel that I belong to the same group as others without disabilities in my community” (Kevie, Cerebral palsy, 18 years, male)(1.5:145-147).</p> <p>“I have learnt to respect my friends through playing with them in my community. Of course we learn it at school at assemblies, social studies and Religious studies but we do it out of school. You see that you</p>

			<p><i>are doing it well mostly when you are not in class”</i> (Kombo Polio, 13 years, female) (11, 55:2595-1597).</p>
	Personal growth and self-acceptance	Formal learning and personal growth and self-acceptance	<p><i>“Because of being engaged in learning I feel I am growing well. I can now do a number of things by myself. I can read, write and am adding value to myself very soon I will be an accountant”</i> (Chiwariidzo, Myelodysplasia, 19 years, male) (6, 30:900-903).</p> <p><i>“Going to school makes me learn so many things. Learning so many things this shows that I am growing. Look I was once in grade one but I am now in grade four. I have changed so many teachers and all my teachers are saying well you are growing well. Look I am now able to do so many things alone at home things that I was not able to do before because of my condition. I am now seeing that I am not disabled. I am growing up”</i> (Langton, Neuromuscular disorder, 13 years, male) (2, 10:300-305).</p>
		In formal learning and personal growth and self-acceptance	<p><i>“Sport is assisting me growing all-round. It helps me to socialise well with others although it is painful when you lose. But it helps me a lot. My participation in sport makes me feel that I am being recognised at school as a person who is not disabled but abled”</i> (Try, HIV, 14 years, female) (12, 65:1885-1888).</p> <p><i>“In chess you win, lose or draw. These are the results awaiting any chess player so when I win like</i></p>

			<p><i>in most of my cases you fell that you are someone great, someone big and your supports will value more. At my school if I win or lose my head always see well in me. I will be put in front of other students on the assembly and the students will be asked to clap hands and cheer for my results. Besides that if I win at school, level. Win again with other schools that movement from one stage to another makes me feel growing in my sport” (Jinye, Hemimelia, 16 years, male) (7, 35:1015).</i></p>
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APPENDIX VI

Phase two: list of concepts from raw data developed into themes, sub themes and categories

Theme	Sub theme	Significant	Number of appearing
Strategies for the community integration of adolescents with physical disabilities Inclusion activities to participate for adolescents with physical disabilities	Inclusion activities to participate for adolescents with physical disabilities	Learning oriented activities	14
		Sporting as a rehabilitation measure	8
		Self-care as a daily living skill	5
		Selling as training for independent living	5
		Gardening as a life skill	2
Theme	Sub theme	Categories	Number of appearing
Implementation of inclusive community strategies	Stakeholders' efforts for the successful implementation of inclusion	Disability awareness education	10
		Vocational Counseling	8
		Inclusive infrastructure and resources	14
Theme	Sub theme	Categories	Number of appearing
		Choice of activities as school	8

Choice of inclusive community activities to participate in	Participation of adolescents with physical disabilities in inclusion activities	Choice of activities at school	9
		Choice of activities in communities	10
Theme	Sub theme	Categories	Number of appearing
The contribution of community strategies to the psychological wellbeing	Inclusion and psychological wellbeing of adolescents with physical	Autonomy and choice	9
		Purpose of life	10
		Positive relations with others	13
		Personal growth and self-acceptance	7

APPENDIX VII

Schematic presentation of themes, subthemes, categories and subcategories

THEME 1				
Strategies for the community integration of adolescents with physical disabilities				
Subtheme 1.1				
Participation of adolescents with physical disabilities in inclusion activities				
Categories				
1.1.1 Learning-oriented activities	1.1.2 Sport as a rehabilitation measure	1.1.3 Self-cares as a daily living skill	1.1.4 Selling as training for independent living	1.1.5 Gardening as a life skill
Subcategories				
1.1.1.1 Formal learning	1.1.2.1 Competitive sport	1.1.3.1 Washing and bathing	1.1.4.1 Vending	1.1.5.1 Home gardening
1.1.2 In-formal learning	1.2.2 Fitness sport	1.3.2 Bedding and sweeping		1.1.5.2 School gardening
	1.2.3 Leisure activity	1.3.3 Cooking		
THEME 2				
Implementation of inclusive community strategies				
Subtheme 2.1				
Stakeholders' efforts at the successful implementation of inclusion				
Categories				

2.1.1 Disability awareness education	2.2.1 Vocational Counseling	2.3.1 Inclusive infrastructure and resources
Subcategories		
2.1.1.1 Disability education at home	2.2.1.1 Job application and interviews	2.3.1.1 Resources from parents
2.1.1.2 Disability education at school	2.2.1.2 Vocational competence skills	2.3.1.2 Resources from government
		2.3.1.3 Resources from philanthropists
		2.3.1.4 Resources from the community
THEME 3		
Choice of inclusive community activities in which to participate		
Subtheme 3.1		
Participation of adolescents with physical disabilities in inclusion activities		
Categories		
3.1.1 Choice of activities at home	3.1.2 Choice of activities to participate at school	3.1.3 Choice of activities in the community
THEME 4		
Contribution of inclusive community strategies to the psychological wellbeing of adolescents with physical disabilities		
Subtheme 4.1		
Inclusion and psychological wellbeing of adolescents with physical disabilities		
Categories		

4.1.1 Autonomy and choice	4.1.2. Purpose in life	4.1.3 Positive relations with others	4.1.4 Personal growth and self-acceptance
Subcategories			
4.1.1.1 Formal learning and autonomy and choice	4.1.2.1 Formal learning and Purpose in life	4.1.3.1 Formal learning and positive relations with others	4.1.4.1 Formal learning and personal growth and self-acceptance
4.1.1.2 Informal learning and autonomy and choice	4.1.2.2 Informal learning and purpose in life	4.1.3.2 Informal learning and positive relations with others	4.1.4.2 Informal learning and personal growth and self-acceptance

APPENDIX VIII

Supporting evidence on the contribution of community strategies to the psychological wellbeing of adolescents with physical disabilities

Strategies for the community integration of adolescents with physical disabilities

Subtheme 1.1	Participation of adolescents with physical disabilities in inclusion activities		
	Salient concepts	Representative literature	Interpretive discussion
Categories	Trends in existing knowledge	Author and year	Central themes
Learning-oriented activities	Formal learning and informal learning	Loerman & Deppeler (2001); Loerman et al. (2005); Oakes (1992); UNESCO (2005)	Well participated Well understood
Sport as a rehabilitation measure	Competitive sport Fitness sport Leisure activity	Kanhukamwe & Madondo (2003); Mpofo et al. (2010); Zvomunya et al. (2000)	Well participated Some adapted to suit participants
Self-care as a daily living skill	Washing and bathing Bedding and sweeping Cooking	Chakuchichi & Mutamiswa(2003); Davis et al. (1998)	Well participated Handicap presents limitation
Selling as training for independent living	Vending	Kotler & Armstrong (2016)	Informally done by few Its inclusive role not understood

Gardening as a life skill	Home gardening School gardening	Chakuchichi & Mutamiswa (2003)	Only done by few. Its inclusive role not understood
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Implementation of inclusive community strategies

Subtheme 2.1	Stakeholders' efforts at the successful implementation of inclusion		
	Salient concepts	Representative literature	Interpretive discussion
Categories	Trends in existing knowledge	Author and year	Central themes
Disability awareness education	Disability education at home Disability education at school	Hardman et al. (1999) Heward (2003)	Fair participation. Phenomenon still to be understood
Vocational counselling	Job application and interviews Vocational competence skills	Chakuchichi & Magama (2003) Mpofu & Thomas (2000)	Done by few Concept well understood
Inclusive infrastructure and resources	Resources from parents Resources from government Resources from philanthropists	Davis et al. (1998)	Well understood Still incorporates externals

Choice of inclusive community activities in which to participate

Subtheme 1.1	Participation of adolescents with physical disabilities in inclusion activities		
Categories	Salient concepts	Representative literature	Interpretive discussion

Choice of activities at home	Attitudes and stigma	Peterson, Mpofu & Oakland (2010)	Limited choice
Choice of activities at school	Attitudes and stigma	Loerman et al. (2005), Jorgenson (1992)	No choice is granted
Choice of activities in the community	Environmental barriers Attitudes and stigma	Guess, Benson, & Siegel-Causey (1985); Peterson, Mpofu & Oakland (2010)	Limited choice

The contribution of community strategies to the psychological wellbeing

Subtheme 1.1		Participation of adolescents with physical disabilities in inclusion activities	
Categories	Salient concepts	Representative literature	Interpretive discussion
Autonomy and choice	Formal learning, autonomy and choice Informal learning, autonomy and choice	Desmarais & Savoie (2011),	Very limited Feelings and practice are misconstrued
Purpose in life	Formal learning and purpose in life Informal learning and purpose in life	Desmarais & Savoie (2011), Fredrikson (2001); Kahneman & Deaton (2010)	Existing
Positive relations with others	Formal learning and positive relations with others.	Luhmann et al. (2012) Diener et al. (2002)	Faces restrictions

	Informal learning and positive relations with others		
Personal growth and self-acceptance	Formal learning, personal growth and self-acceptance Informal learning, personal growth and self-acceptance	Fredrikson (2001)	Existing

APPENDIX IX

Contradicting evidence on the contribution of community strategies to the psychological wellbeing of adolescents with physical disabilities

Strategies for the community integration of adolescents with physical disabilities

Subtheme 1.1	Participation of adolescents with physical disabilities in inclusion activities		
	Salient concepts	Representative literature	Interpretive discussion
Categories	Trends in existing knowledge	Author and year	Central themes
Learning-oriented activities	Formal learning and informal learning given very late Special schools are still prevalent Watered-down curriculum	Abosi (2016); Choruma (2006); Mpofu et al., (2007); Engelbrecht & Green (2007); Soudien (2007); Abosi (1996)	No formal policies Not a priority Poorly funded No trained staff
Sport as a rehabilitation measure	Sport for the disabled	Zvomunya et al. (2000); Kanhukamwe & Madondo (2003); Choruma (2005)	Charity-funded
Self-care as a daily living skill	Family-based	Davis et al. (1998); Chakuchichi & Mutamiswa (2003)	Offered in rehabilitation institutions

Selling as training for independent living	Not offered in public institutions	Kotler & Armstrong (2016)	Offered in rehabilitation institutions Considered as child labour in public schools Not necessary; will survive on charity
Gardening as a life skill	Not offered in public institutions	LCD (2016)	Considered as child labour in public schools

Choice of inclusive community activities in which to participate

Subtheme 1.1		Participation of adolescents with physical disabilities in inclusion activities	
Categories	Salient concepts	Representative literature	Interpretive discussion
Choice of activities at home	Fairly given	Cahill & Hollier (2009)	Limited choice
Choice of activities at school	Provided through legislation and policies	Department of Education (2016); Funk (1987); IDEA Act (1997); Mores (1998)	Mandatorily given
Choice of activities in the community	Environmental barriers reduced in many developed countries Professional services provide unlimited choices	Antaki, Finlay & Walton (2009); Church & Marston (2010); Wehmeyer, Kelchner & Richards (1996); Wolff, Waldman, Milano & Perlman (2004)	Available to commercial entities

Community strategies to the psychological wellbeing of adolescents with physical disabilities

Subtheme 1.1		Participation of adolescents with physical disabilities in inclusion activities	
Categories	Salient concepts	Representative literature	Interpretive discussion
Autonomy and choice	Formal learning, autonomy and choice Informal learning, autonomy and choice	Emerson & Hatton (1994); Mpofu & Shumba (2012); Wehmeyer & Metzler (1995)	No choice at all Choice controlled by institutions
Purpose in life	Formal learning and purpose in life In-formal learning and purpose in life	Albrecht & Devlieger (1999); Mpofu (2003)	Low levels of purpose in life
Positive relations with others	Formal learning and positive relations with others Informal learning and positive relations with others	Hall & McGregor (2000); Mishna (2003)	Low levels of positive relations with others Stigmatised Discriminated against
Personal growth and self-acceptance	Formal learning, personal growth and self-acceptance Informal learning, personal growth and self-acceptance	Mpofu & Harley (2000); Heward (2003); Mpofu (2003)	Low level of personal growth and self-acceptance Carries disability identity

APPENDIX X

Consent letter to the Provincial Social Welfare Officer



11 November 2015

The Provincial Social Welfare Officer
Ministry of Public Service and Social Welfare
Mashonaland West Region
Chinhoyi
Zimbabwe

Dear Sir/Madam

I am a lecturer with Zimbabwe Open University and a doctoral student at the University of Pretoria (South Africa) and am hereby seeking your permission to carry out a research study in Makonde Urban. The study is part of my doctoral programme requirement and is supervised by Dr Maximus Monaheng Sefotho and Professor Kobus Maree of the University of Pretoria.

My research topic focuses on the psychological wellbeing of adolescents with physical disabilities in inclusive community settings. The Zimbabwean government adopted the policy of inclusion in 1997 as a measure to enhance the psychological wellbeing of adolescents with physical disabilities (Chakuchichi & Chimedza, 2003). However, its implementation has been wrought with several challenges, one of which has been the continued negative attitude of community members without

disabilities towards those with disabilities (Chidyausiku, 2000; Mpofu, 2003). This study seeks to use multi case study approach to elicit information from 14 adolescents (7 males, 7 females) with physical disabilities to investigate the psychological wellbeing of adolescents with physical disabilities in inclusive community settings in Mashonaland West province of Zimbabwe. Qualitative methods of data analysis will be used to analyse the data collected.

The findings of this study are likely to yield important information on the status of the psychological wellbeing of adolescents with physical disabilities in Zimbabwean mainstream communities. Any observed information could inform the Zimbabwean Public Service and Social Welfare policies on enhancing the psychological wellbeing for both adolescents with and without disabilities.

Participation of individuals in the study will be on voluntary basis. Altogether 14 participants will take part in interviews of which neither will take more than 60 minutes. Interviews will be conducted in schools during participants' spare time and those out of schools will be visited at home or places convenient to them. No transport costs will be incurred by the participants in this study. There are no risks to the adolescents with physical disabilities as a result of taking part in the study. Pre and Post Interview counselling will be provided to interviewed participants as a measure to reduce unanticipated effects of their interview participation. Participants will be given the option not to take part in the study if they wish not to and to withdraw from the study at any point during the study. You are also free to withdraw consent for any (or all) adolescents with physical disabilities in this study –without penalty or obligation.

Information collected in this study will be used solely for the purpose of this study. It will not be made available to any persons or organisations not involved in this study. All data will be kept secure in my office at the Zimbabwe Open University Mashonaland West Regional Centre and will also be placed in the open access repository at the University of Pretoria. A summary of the study's findings will be made available to you on conclusion of the study. The findings will not present results targeting individuals, but will combine all the participating participants.

If you agree to have adolescents with physical disabilities take part in the study, kindly sign the consent form below. Your letter of consent (as below) shall be shared with the Public Service and Social Welfare officers in line with the established Ministry of Public Service and Social Welfare policy on access to vulnerable people in Zimbabwean communities. Should you require further clarification pertaining to any aspect of this study, feel free to contact me or my supervisors at the addresses listed below.

Yours sincerely



Jabulani Mpofu

Zimbabwe Open University

Faculty of Applied Social Sciences

Department of Disability Studies
and Special Needs

P.O. Box 285

Chinhoyi

Tel +263 6724050

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E-mail: jabumpofuh@gmail.com

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Yes, I _____,

give permission for adolescents with physical disabilities in Mashonaland West province to take part in the study on the psychological wellbeing of adolescents with physical disabilities in inclusive community settings. I understand that the interviews will be conducted in schools during participants' spare time and those out of schools will be visited at home or places convenient to them. No transport costs will be incurred by the participants in this study. I also understand that I may withdraw consent for any (or all) adolescents with physical disabilities to take part in the study, without penalty or obligation.

Provincial Social Welfare Officer: _____ Date: _____

Mashonaland West Region

APPENDIX XI

Consent letter to the Provincial Education Director



11 November 2015

The Provincial Education Director

Ministry of Primary and Secondary Education

Mashonaland West Region

Chinhoyi

Zimbabwe

Dear Sir

I am a lecturer with Zimbabwe Open University and a doctoral student at the University of Pretoria (South Africa) and am hereby seeking your permission to carry out a research study in Makonde Urban. The study is part of my doctoral programme requirement and is supervised by Dr Maximus Monaheng Sefotho and Professor Kobus Maree of the University of Pretoria.

My research topic focuses on the psychological wellbeing of adolescents with physical disabilities in inclusive community settings. The Zimbabwean government adopted the policy of inclusion in 1997 as a measure to enhance the psychological wellbeing of adolescents with physical disabilities (Chakuchichi & Chimedza, 2003). However, its implementation has been wrought with several challenges, one of which has been the continued negative attitude of community members without disabilities towards those with disabilities (Chidyausiku, 2000; Mpofu, 2003). This study seeks to use multi case study approach to elicit information from 14 adolescents (7 males, 7 females) with

physical disabilities to investigate the psychological wellbeing of adolescents with physical disabilities in inclusive community settings in Mashonaland West province of Zimbabwe. Qualitative methods of data analysis will be used to analyse the data collected.

The findings of this study are likely to yield important information on the status of the psychological wellbeing of adolescents with physical disabilities in Zimbabwean mainstream communities. Any observed information could inform the Zimbabwean Public Service and Social Welfare policies on enhancing the psychological wellbeing for both adolescents with and without disabilities.

Participation of individuals in the study will be on voluntary basis. Altogether 14 participants will take part in interviews of which neither will take more than 60 minutes. Interviews will be conducted in schools during participants' spare time and those out of schools will be visited at home or places convenient to them. No transport costs will be incurred by the participants in this study. There are no risks to the adolescents with physical disabilities as a result of taking part in the study. Pre and Post Interview counselling will be provided to interviewed participants as a measure to reduce unanticipated effects of their interview participation. Participants will be given the option not to take part in the study if they wish not to and to withdraw from the study at any point during the study. You are also free to withdraw consent for any (or all) adolescents with physical disabilities in this study –without penalty or obligation.

Information collected in this study will be used solely for the purpose of this study. It will not be made available to any persons or organisations not involved in this study. All data will be kept secure in my office at the Zimbabwe Open University Mashonaland West Regional Centre and will also be placed in the open access repository at the University of Pretoria. A summary of the study's findings will be made available to you on conclusion of the study. The findings will not present results targeting individuals, but will combine all the participating participants.

If you agree to have adolescents with physical disabilities take part in the study, kindly sign the consent form below. Your letter of consent (as below) shall be shared with the Public Service and Social Welfare officers in line with the established Ministry of Public Service and Social Welfare policy on access to vulnerable people in Zimbabwean communities. Should you require further clarification pertaining to any aspect of this study, feel free to contact me or my supervisors at the addresses listed below.

Yours sincerely



Jabulani Mpfu

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Prof Kobus Maree

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Cell+27 823325065

kobus.maree@up.ac.za



Yes, I _____,

give permission for adolescents with physical disabilities in Mashonaland West province to take part in the study on the psychological wellbeing of adolescents with physical disabilities in inclusive community settings. I understand that the interviews will be conducted in schools during participants' spare time and those out of schools will be visited at home or places convenient to them. No transport costs will be incurred by the participants in this study. I also understand that I may withdraw consent for any (or all) adolescents with physical disabilities to take part in the study, without penalty or obligation.

Provincial Education Director

Mashonaland West Region

Ministry of Primary and Secondary Education

Date

APPENDIX XII

Consent letter to Parent/Legal guardian



11 November 2015

Dear Parent/Guardian

I am Jabulani Mpofu, a lecturer with Zimbabwe Open University and a doctoral student at the University of Pretoria (South Africa) and am hereby seeking your permission to have your child, who is a minor and has a physical disability, to take part in my study on the psychological wellbeing of adolescents with physical disabilities in inclusive community settings. The study is part of my doctoral programme requirement and is supervised by Dr Maximus Monaheng Sefotho and Prof Kobus Maree of the University of Pretoria.

My research topic focuses on the psychological wellbeing of adolescents with physical disabilities in inclusive community settings. The Zimbabwean government adopted the policy of inclusion in 1997 as a measure to enhance the psychological wellbeing of adolescents with physical disabilities (Chakuchichi & Chimedza, 2003). However, its implementation has been wrought with several challenges, one of which has been the continued negative attitude of community members without disabilities towards those with disabilities (Chidyausiku, 2000; Mpofu, 2003). This study seeks to use multi case study approach to elicit information from 14 adolescents (7 males, 7 females) with physical disabilities to investigate the psychological wellbeing of adolescents with physical disabilities in inclusive community settings in Mashonaland West province of Zimbabwe. Qualitative methods of data analysis will be used to analyse the data collected.

The findings of this study are likely to yield important information on the status of psychological wellbeing of adolescents with physical disabilities in Zimbabwean mainstream communities. Any observed information could inform the Zimbabwean Public Service and Social Welfare policies on enhancing the psychological wellbeing for both adolescents with and without disabilities.

Participation of individuals in the study will be on a voluntary basis. Altogether 14 participants will take part in interviews, of which neither will take more than 60 minutes. Interviews will be conducted in schools during participants' spare time and those out of school will be visited at home or at a place convenient to them. No transport costs will be incurred by the participants in this study. There are no risks to the adolescents with physical disabilities as a result of taking part in the study. Participants will be given the option not to take part in the study if they wish not to and to withdraw from the study at any point during the study. You are also free to withdraw consent for your child to take part in this study, without penalty or obligation.

Information collected in this study will be used solely for the purpose of this study. It will not be made available to any persons or organisations not involved in this study. All data will be kept secure in my office at the Zimbabwe Open University Mashonaland West Regional Centre and will also be placed in the open access repository at the University of Pretoria. A summary of the study's findings will be made available to you on conclusion of the study. The findings will not present results targeting individuals but will combine all the participating participants.

If you agree to have your child take part in the study, kindly sign the consent form below. Your letter of consent (as below) shall be shared with the Public Service and Social Welfare officers in line with the established Ministry of Public Service and Social Welfare policy on access to vulnerable people in Zimbabwean communities. Should you require further clarification pertaining to any aspect of this study, feel free to contact me or my supervisors at the addresses listed below.

Yours sincerely

Jabulani Mpofu

Zimbabwe Open University

Faculty of Applied Social Sciences

Department of Disability Studies
and Special Needs

P.O.Box 285

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maximus.sefotho@up.ac.za

Prof Kobus Maree

University of Pretoria

Faculty of Education

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kobus.maree@up.ac.za



I, _____ (name), the parent/legal guardian,
give permission for my child _____ who is a minor aged _____
to take part in the study on the psychological wellbeing of adolescents with physical disabilities in
inclusive community settings. I understand that the interviews will be conducted in schools during
respondents' and participants' spare time and those out of school will be visited at home or at a
place convenient to them. No transport costs will be incurred by the participants in this study. I
also understand that I may withdraw consent for my child to take part in the study without penalty
or obligation.

_____	_____
Parent/ Legal Guardian's Signature (or Mark)	Date
_____	-----
Witness Signature (or Mark when orally consented)	Date

APPENDIX XIII

Assent letter to minor participants



11 November 2015

Dear Participant

I am Jabulani Mpofu from the Zimbabwe Open University and a student at the University of Pretoria (South Africa) and I am inviting you to participate in my research study. The study is part of my degree programme, and is supervised by Dr Maximus Monaheng Sefotho and Prof Kobus Maree of the University of Pretoria.

My research topic focuses on the psychological wellbeing of adolescents with physical disabilities in inclusive community settings. The Zimbabwean government adopted the policy of inclusion in 1997 as a measure to enhance the psychological wellbeing of adolescents with physical disabilities (Chakuchichi & Chimedza, 2003). However, its implementation has been wrought with several challenges, one of which has been the continued negative attitude of community members without disabilities towards those with disabilities (Chidyausiku, 2000; Mpofu, 2003). This study seeks to use multi case study approach to elicit information from 14 adolescents (7 males, 7 females) with physical disabilities to investigate the psychological wellbeing of adolescents with physical disabilities in inclusive community settings in Mashonaland West province of Zimbabwe. Qualitative methods of data analysis will be used to analyse the data collected.

The results of this study are likely to yield important information on the status of the psychological wellbeing of adolescents with physical disabilities in Zimbabwean mainstream communities. Any

observed information could inform the Zimbabwean Public Service and Social Welfare policies on enhancing the psychological wellbeing for both adolescents with and without disabilities.

Your participation in this study will be on a voluntary basis. Respondents will be required to complete a questionnaire and participants will take part in interviews, of which neither will take more than 60 minutes. Completion of questionnaires and interviews will be conducted in school during your spare time and, if out of school, you will be visited at your home or at a place convenient to you. You will not incur any transport costs by participating in this study. There are no risks to you as a result of taking part in the study. You will be given the option not to take part in the study if you wish so and to withdraw from the study at any point, without penalty or obligation.

Information collected in this study will be used solely for the purpose of this study. It will not be made available to any persons or organisations not involved in this study. All data will be kept secure in my office at the Zimbabwe Open University Mashonaland West Regional Centre and it will also be placed in the open access repository at the University of Pretoria. A summary of the study's findings will be made available to you on conclusion of the study. The findings will not present results targeting individuals, but will combine all the participating participants.

If you agree to take part in the study, kindly sign the assent form below. Your letter of assent (as below) shall be shared with the Ministries of Primary and Secondary Education and the Public Service and Social District officers in line with the established Ministry of Public Service and Social Welfare policy on access to vulnerable people in Zimbabwean communities.

Should you require further clarification pertaining to any aspect of this study, feel free to contact me or my supervisor at the addresses listed below.

Yours sincerely



Jabulani Mpofo

Zimbabwe Open University

Faculty of Applied Social Sciences

Department of Disability Studies

And Special Needs

P.O.Box 285

Chinhoyi

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Cell +263 773 949 240

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maximus.sefotho@up.ac.za

Prof Kobus Maree

University of Pretoria

Faculty of Education

Dept. of Educational

Psychology

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kobus.maree@up.ac.za



My name is _____ and I am _____ years old. I have agreed to take part in the study on the psychological wellbeing of adolescents with physical disabilities in inclusive community settings. I understand that the interviews will be conducted in school during my spare time and, if out of school, I will be visited at home or at a place convenient to me. I will not incur any transport costs by participating in this study. I also understand that I may withdraw my assent to take part in the study without penalty or obligation.

Participant's Signature (or Mark)

Date

Witness's Signature (or Mark when orally assented)

Date

APPENDIX XIV

Consent letter to participants



11 November 2015

Dear Participant

I am Jabulani Mpofu from the Zimbabwe Open University and a student at the University of Pretoria (South Africa) and I am inviting you to participate in my research study. The study is part of my degree programme and is supervised by Dr Maximus Monaheng Sefotho and Prof Kobus Maree of the University of Pretoria.

My research topic focuses on the psychological wellbeing of adolescents with physical disabilities in inclusive community settings. The Zimbabwean government adopted the policy of inclusion in 1997 as a measure to enhance the psychological wellbeing of adolescents with physical disabilities (Chakuchichi & Chimedza, 2003). However, its implementation has been wrought with several challenges, one of which has been the continued negative attitude of community members without disabilities towards those with disabilities (Chidyausiku, 2000; Mpofu, 2003). This study seeks to use multi case study approach to elicit information from 14 adolescents (7 males, 7 females) with physical disabilities to investigate the psychological wellbeing of adolescents with physical disabilities in inclusive community settings in Mashonaland West province of Zimbabwe. Qualitative methods of data analysis will be used to analyse the data collected.

The results of this study are likely to yield important information on the status of the psychological wellbeing of adolescents with physical disabilities in Zimbabwean mainstream communities. Any

observed information could inform the Zimbabwean Public Service and Social Welfare policies on enhancing the psychological wellbeing for both adolescents with and without disabilities.

Your participation in this study will be on a voluntary basis. Participants will take part in interviews of which neither will take more than 60 minutes. Interviews will be conducted in school during your spare time and, if out of school, you will be visited at your home or at a place convenient to you. You will not incur any transport costs by participating in this study. There are no risks to you as a result of taking part in the study. You will be given the option not to take part in the study if you wish so and to withdraw from the study at any point without penalty or obligation.

Information collected in this study will be used solely for the purpose of this study. It will not be made available to any persons or organisations not involved in this study. All data will be kept secure in my office at the Zimbabwe Open University Mashonaland West Regional Centre and it will also be placed in the open access repository at the University of Pretoria. A summary of the study's findings will be made available to you on conclusion of the study. The findings will not present results targeting individuals but will combine all the participating participants.

If you agree to take part in the study, kindly sign the consent form below. Your letter of assent (as below) shall be shared with the Public Service and Social District officers in line with the established Ministry of Public Service and Social Welfare policy on access to vulnerable people in Zimbabwean communities.

Should you require further clarification pertaining to any aspect of this study, feel free to contact me or my supervisor at the addresses listed below.

Yours sincerely

U P U

Jabulani Mpofo	Dr Maximus Monaheng Sefotho	Prof Kobus Maree
Zimbabwe Open University	University of Pretoria	University of Pretoria
Faculty of Applied Social Sciences	Faculty of Education	Faculty of Education
Department of Disability Studies And Special Needs	Dept. of Educational Psychology	Dept. of Educational Psychology
P.O.Box 285	Pretoria 0002	Pretoria 0002
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Cell +263 773 949 240	Cell +27 72 6380868	Cell+27 823325065
E-mail: jabumpofuh@gmail.com	maximus.sefotho@up.ac.za	kobus.maree@up.ac.za



My name is _____ and I have agreed to take part in the study on the psychological wellbeing of adolescents with physical disabilities in inclusive community settings. I understand that the interviews will be conducted in school during my spare time and, if out of school, I will be visited at home or at a place convenient to me. I will not incur any transport costs by participating in this study. I also understand that I may withdraw my consent to take part in the study without penalty or obligation.

Participant's Signature (or Mark)

Date

Witness's Signature (or Mark when orally consented)

Date

APPENDIX XV

*All communications should be
addressed to
"The Provincial Education Director"
Telephone: 067-23083/4/5
Fax: 067-23320*



Ministry of Primary and Secondary
Education
Mashonaland West Province
P.O Box 328
CHINHOYI

26 May 2015

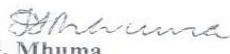
Mr Mpfu Jabulani
Zimbabwe Open University
Faculty of Applied Social Sciences
Department of Disability Studies and Special Needs

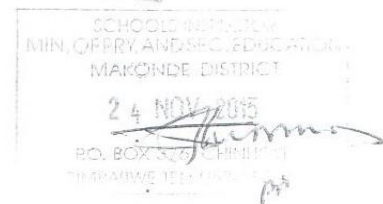
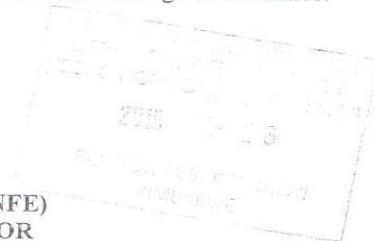
**AUTHORITY TO CARRY OUT A RESEARCH STUDY IN URBAN SCHOOLS:
MAKONDE DISTRICT.**

Reference is made to your letter dated 26 May 2015 on the above subject.

Permission is hereby granted for you to undertake research in urban schools in Makonde District on your topic focusing on the contribution of inclusive strategies on the psychological well being of adolescents with physical disabilities.

You are advised to visit the District Education Officer for Makonde District before visiting schools in his area and to submit a copy of your research findings to this office.


G. Mhuma
Deputy Provincial Education Director (SECNFE)
For: PROVINCIAL EDUCATION DIRECTOR
MASHONALAND WEST PROVINCE





Yes, I Marencane A, give permission for adolescents with physical disabilities in Makonde Urban to take part in the study on the contribution of inclusive community strategies to their psychological well being. I understand that I may withdraw consent for any (or all) adolescents with physical disabilities to take part in the study without penalty or obligation.

Provincial Social Welfare Officer

Mashonaland West Region

PROVINCIAL SOCIAL SERVICES
OFFICE
MASHONALAND WEST
26 MAR 2019
P BAG 7504, GLENVIEW
ZIMBABWE Tel: 021 911 1016

Date

APPENDIX XVII



Faculty of Education

Fakulteit Opvoedkunde
Lefapha la Thuto

Ethics Committee
25 January 2016

Dear Mr Mpfu,

REFERENCE: EP 15/04/01

Your application was considered by the Faculty of Education Ethics Committee and the final decision of the Ethics Committee is:

Your application is approved.

This letter serves as notification that you may continue with your fieldwork. Should any changes to the study occur after approval was given, it is your responsibility to notify the Ethics Committee immediately.

Please note that you have to fulfil the conditions specified in this letter from the Faculty of Education Research Ethics Committee. The conditions include;

- 1) *The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment (Section E) for approval by the Committee.*
 - *Any amendments to this approved protocol need to be submitted to the Ethics Committee for review prior to data collection. Non-compliance implies that the Committee's approval is null and void.*
 - *Final data collection protocols and supporting evidence (e.g.: questionnaires, interview schedules, observation schedules) have to be submitted to the Ethics Committee before they are used for data collection.*
- 2) *The researcher should please note that this decision covers the entire research process, until completion of the study report, and not only the days that data will be collected.*
- 3) *Should your research be conducted in schools, please note that you have to submit proof of how you adhered to the Department of Basic Education (DBE) policy for research.*
- 4) *The Ethics Committee of the Faculty of Education does not accept any liability for research misconduct, of whatsoever nature, committed by the researcher(s) in the implementation of the approved protocol.*

Please note that this is **not a clearance certificate**.

Upon completion of your research you need to submit the following documentation to the Ethics Committee:

- **Integrated Declarations Form (Form D08),**
- **Initial Ethics Approval letter and,**
- **Approval of Title.**

On receipt of the above-mentioned documents you will be issued a clearance certificate. Please quote the reference number: EP 15/04/01 in any communication with the Ethics Committee.

Best wishes,



Prof Liesel Ebersöhn
Chair: Ethics Committee
Faculty of Education

APPENDIX XVIII



Mashonaland West Region
Chinhoyi Public Service Training Centre
P.O.BOX 285
Chinhoyi
Tel +263 67 24050/26106/29345/7
Fax: +263 67 27520

To whom it my concern

This letter serves to confirm that I reviewed 14 narrative transcripts on the psychological wellbeing of adolescents living in inclusive communities collected in Makonde Urban by Mr. Jabulani Mpofu. The narratives were collected from adolescents with physical disabilities. This process was done on request from Mr. Jabulani Mpofu to enhance data trustworthiness in this research.

Thank

Yours faithfully

A handwritten signature in blue ink is written over a rectangular official stamp. The stamp contains the text: 'PERSONAL EMPLOYEE', 'ZIMBABWE OPEN UNIVERSITY', 'MASHONALAND WEST REGION', and the date '14 AUG 2018'. Below the signature, the name 'Dr P. Chiridza' is printed, followed by the address 'PO BOX 285, CHINHOYI' and the telephone number 'TEL (0263) 24050/26106'.