Mainstreaming disability in water and sanitation programmes in Madziwa community (Shamva District, Zimbabwe): A Transformative Social Policy Perspective

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Abstract

The purpose of the study was to analyse the extent to which disability has been mainstreamed in water and sanitation programmes that were implemented by both state and non-state actors in Madziwa community under Shamva district in Zimbabwe. Enhancing the wellbeing of people living with disability in relation to water and sanitation was the overarching aim of the study. The researchers applied the Transformative Social Policy conceptual framework. This conceptual framework emphasises that social policy programmes and projects should be protective, preventive, promotive and transformative. Water and sanitation programmes are components of social policy in Zimbabwe. An analytical research design based primarily on qualitative research methods was applied. The researchers aimed to go beyond statistics on geographical and population coverage, which often shrouds the situated meanings and lived experiences of the often marginalised groups such as people living with disabilities. This focus inclined itself to qualitative data collection and analysis. The results of the study show that disability was never considered in designing and implementing water and sanitation programmes. There is need to design and implement disability-friendly water and sanitation programmes in Madziwa community and other parts of Zimbabwe to enhance the wellbeing of people living with disabilities.

Key words: potable, mainstreaming, sanitation, access, use, disability and policy

1.0Introduction

Access to and use of potable water and sanitation services are essential human needs worldwide. Each individual is entitled to access water and sanitation services regardless of age, sex, gender, race, ethnicity, class and other socioeconomic and political differentiations. However, it is apparent that most countries including developed countries are lagging behind in ensuring adequate potable water provision and sanitation services due to economic and political challenges. In addition, there has been increasing calls for inclusive and broad-based development with increasing emphasis on active participation of and benefits for people living with disabilities, the aged, women and children. This reorientation of development is reflected in social and economic policies of most countries.

National and international instruments have also been influenced by such reorientation. An example is the new Constitution of the Republic of Zimbabwe that has several provisions for people living with disabilities (Mugumbate and Nyoni, 2013). In addition, governmental and Non Governmental Organisations (NGOs) implemented several water and sanitation projects in many rural area of Zimbabwe. Madziwa community also benefited from such water and sanitation projects. However, to date no one has analysed the extent to which disability was mainstreamed in such projects, particularly in Madziwa community. Accordingly, there is no basis upon which future projects in and outside the water and sanitation sector can be designed and implemented to address the needs of people living with disability. This study addressed these issues.

1.1 Background

Water and sanitation programmes that are designed and implemented by both state and non state actors are components of social policies in Zimbabwe and other countries. The overall aim of social policies and their sub-programmes and projects is to enhance the wellbeing of various individuals and groups. The concept of mainstreaming has been in use in development studies for a long time. The United Nations Economic and Social Council (UN ECOSOC) (1997) cited in Miller and Albert (2006) with disability substituted for gender explains that:

'Mainstreaming a (disability) perspective is the process of assessing the implications for (disabled persons) of any planned action, including legislation, policies and programmes, an all areas and at all levels. It is a strategy for making (disabled people's) concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that (disabled and non disabled people) benefit equally and inequality is not perpetuated.'

This definition informs the analysis of water and sanitation programmes in Madziwa community.

Disability is ubiquitous and is as old as humanity. What vary are the conceptions of disability and family, community, international and international responses disability. Disability may be physical, cognitive, mental, neurological, sensory, emotional or developmental. In some cases a person may have multiple disabilities. The disability process starts with an impairment followed by handicap. In cases where a person fails to get assistance to compensate for the impairment, she or he becomes disabled. Using these concepts interchangeably is wrong.

National legislations and programmes and international instruments were put in place with the aim of improving the overall wellbeing of all people or specifically people with disabilities. At an international level, the Universal Declaration of Human Rights (UDHR) of 1948 and the International Convention on the Rights of People with Disabilities (ICRPD). The ICRPD was adopted by the United Nations General Assembly Resolution 61/106 on 13 December 2006 and entered into force on 3 May 2008 with the ratification of 20 states. The UDHR and ICRPD are vital instruments for people living with disabilities and those caring for people with disabilities although the former is a more general instrument on human rights.

According to the ICRPD, disability is a long term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder the full and effective participation of the affected persons in society on an equal basis with others. The ICRPD uses a social model of disability. Accordingly this instrument emphasises the role of society in making impaired individuals disabled. The society plays a crucial role in improving or decimating the wellbeing of people living with disabilities.

International instruments may influence national programmes and legislations and vice versa. At a national level, Zimbabwe enacted the Disabled Persons Act in 1992. This Act seems to borrow much from the ICRPD's social model. Chapter 17:01 of the Disabled Persons Act of 1992 defines a disabled person as:

> ...a person with a physical, mental or sensory disability, including a visual, hearing or speech functional disability, which gives rise to physical, cultural or social barriers inhibiting him from participating at an equal level with other members of society in activities, undertakings or fields of employment that are open to other members of society.

Choruma (2007) and Mtetwa (2012) explain state that national and global statistics of disability are contested. WaterAid (2010: 1) points out that globally one in every six people is likely to have some form of impairment. The greatest proportion of people with disabilities is in developing countries, constituting 75% of the world's people living with disabilities. The 2011 World Health Organisation and World Bank Report states that globally, people in excess of one billion have some kind of impairment. Such impairments may develop to disability. In addition, 2 to 4 percent of the 15 percent of any given population who have different forms of disability experience difficulties in human capability functioning.

Zimbabwe is not an exception in contestations on the prevalence of disability. According to the Government of Zimbabwe, merely 1% (130 000) of Zimbabwe's population are living with disabilities (Mtetwa, 2011). In 2011, the World Health Organisation estimated that 15% of the people in Zimbabwe have disabilities. At that time this constituted 1.8 million of Zimbabwe's population. In 2013, the National Association of Societies for the Care of the Handicapped (NASCOH) estimated that 10% of Zimbabwe's population are living with disabilities. However, statistical contestations were not the focus of the study but how well disability has been mainstreamed in water and sanitation programmes in Madziwa community for the transformation of their wellbeing.

1.2 Conceptual Framework

The researchers applied Transformative Social Policy as the conceptual framework for the study. The premise of this conceptual framework is the need to return to a wider vision of social policy. Transformative social policy depicts a shift from mono-tasking to multi-tasking of social policy. The multiple tasks of social policy that are acknowledged by this conceptual framework are production, reproduction, redistribution, protection and nation building/social cohesion (Mkandawire, 2006: 1; Adesina, 2007). Social policy that has a transformative agenda works in tandem with economic policy in the pursuit of national socio-economic goals. In addition, it enhances innovation through its effects on human capital and skill formation, and its capacity to alleviate risk and uncertainty (Mkandawire, 2007). Such social policies have protective, preventive, promotive and transformative measures (Devereux and Sabates-Wheeler, 2004). Water and sanitation programmes are part of a national health policy and may have some or all of these functions for the target groups.

The conceptual framework is composed of transformative social policy norms, functions, instruments and outcomes. Transformative social policy uses broader and diverse instruments as well as funding and delivery mechanisms to positively and expansively change people's lives. The Republic of Zimbabwe Health Policy is an example of such social policies. The multiple levels of transformation include social institutions, norms and social relation; broad-based economic and social development. A diagrammatic representation of the conceptual framework is shown below.

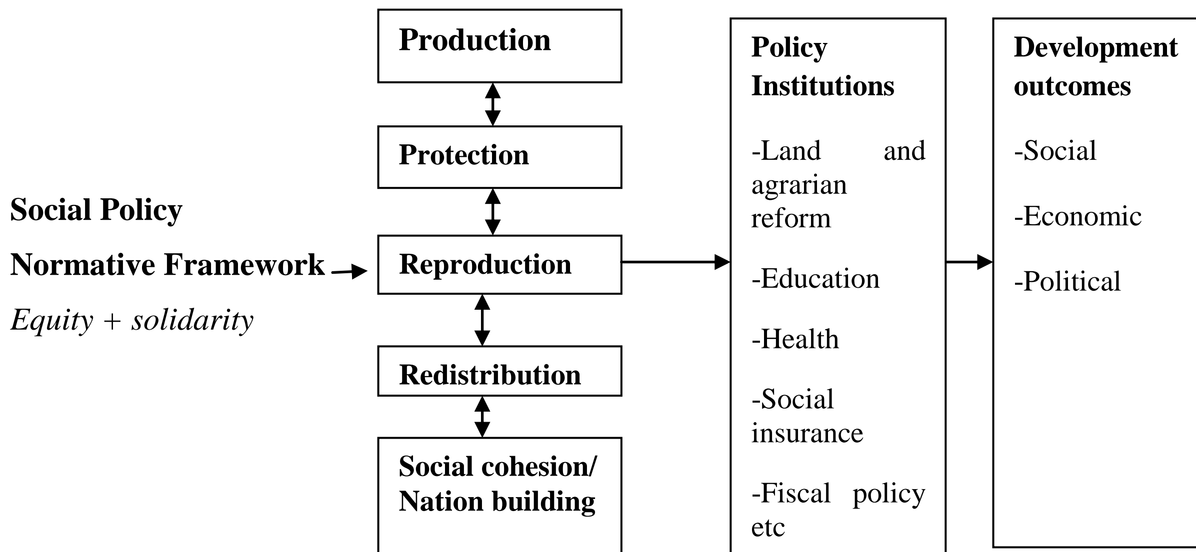

Figure 1: Components of a Transformative Social Policy Conceptual Framework

Source: Adesina (2011).

1.2.1 Social Policy, its Aims and Actors Involved

Transformative Social Policy cannot be understood without basic understanding of social policy. Social policy is a diverse field with a long history, marked by various conceptual, theoretical and practical approaches. This variety emanates from the increasing number of contributors to this fascinating field. Of importance to the objectives of the study are Adesina (2009; 2010), Mkandawire (2011), Devereux and Sabatier-Wheeler (2004), Alcock, May and Wright (2012), Baldock, Mitton, Manning and Vickerstaff (2007) and Titmuss (1974). These experts bring out the contestations in mapping out social policy, its roles and the actors involved.

Despite the definitional contestations surrounding social policy, Adesina (2009: 38) draws readers, against a long backdrop of emphasising only the role of the state, to the view that social policy are "the collective public efforts aimed at affecting and protecting the social wellbeing of people within a given territory." One would discern two vital aspects of social policy from this definition. The first aspect is the view of collective public effort. The implication of this view is that social policy is much broader than what the state does. For example, the provision of potable water, health education and health promotion are done by both state and non state actors in Madziwa community and other parts of Zimbabwe. Secondly, and in response to the 'old order view', social policy is far more than just guaranteeing minimum levels of social wellbeing. On the basis of these two views, Adesina

(2009) refines and focuses social policy on publicly-considered and guaranteed access to social goods and services. In the context of this study, these may include access to adequate water and healthy environment. For Adesina (2009; 2010), social policy can be residual, palliative or transformative.

Adesina (2011) also points out that in addition to explaining what social policy is or is not, one should also consider who does social policy. Both the state and voluntary agencies are essential in social policy. However, conventional wisdom is aptly narrow and only emphasises the role of the state in social provisioning. In addition, conventional wisdom tends to be more often concerned with *ex post* vulnerability. This practice is under increasing attack by social policy practitioners who are vying for new directions for social policy. For example, the possible impact of water and sanitation programmes on the lives of the people living with disabilities should be understood before the implementation of the programmes.

An attempt to understand social policy can also be extended to Alcock, May and Wright (2012), whose view is that social policy refers to the activities of policy making and the inter-disciplinary academic study of such actions. Alcock et.al (2012) summarises social policy as a practice of welfare. Baldock, Mitton, Manning and Vickerstaff (2007: 11) explains that social policy involves both formal and informal conception, and implementation of measures that ensure that citizens have safe, fulfilling and healthy lives. It involves institutional mechanisms for deliberate provisioning such as the state, market, family, community and voluntary organisations. The study of social policy therefore becomes a study of how to deliver wellbeing to people in a given society. Water and sanitation programmes and reforms are examples of such social policies.

Mkandawire (2011) explains that social policy is concerned with four key aspects. These are "the redistributive effects of economic policy; the protection of people from the vagaries of the market and changing circumstances of age; the enhancement of the productive potential of members of society; and the reconciliation of the burden of reproduction with that of other tasks." These aspects of social policy are yet to be comprehensively studied in relation to water and sanitation in Zimbabwe.

Two vital concerns of the discipline of social policy emerge in the work of Titmuss (1974). The first component is the meaning of social policy and the second one is the purpose of social policy. These could be summarised in the two questions: What is social policy? Whose social policy? Social

policies are the means and ends that lead to change. Such change could be on practices, behaviour, ownership and systems. According to Titmuss (1974), there are many definitions of social policy, just as there are several authorities on social policy. However, despite the definitional plurality, three areas of overlap can be discerned. Firstly, social policies have a beneficent objective. Secondly, social policies are based on the public belief that they can effect change. Thirdly, all social policies are problem oriented. For example, reforms to water and sanitation may be introduced to address access and use problems for people living with disabilities. A cross cutting theme in the work of all authorities on social policy is enhancing and transforming wellbeing.

2.0 Methodology

Flick (2006), Punch (2005), Creswell (2012) and Creswell and Plano-Clark (2007), are among the key scholars on research methodology. The components of the methodology used in the study are explained below.

2.1.1 Research Design

The researchers applied an analytical research design based primarily on qualitative research methods. This design was chosen because the researchers sought to analyse the situation and level of mainstreaming of the people the people living with disabilities in water and sanitation programmes. The researchers aimed to go beyond statistics on geographical and population coverage, which often shrouds the situated meanings and lived experiences of the often marginalised groups such as people living with disabilities. This focus inclined itself to qualitative data collection and analysis.

2.1.2 Population and Sampling Techniques

All the residents of Madziwa community were the general population for the study. People living with disabilities and the key informants on water and sanitation services provision were the essential participants of the study. The eighteen years and above (18+) age group were sampled because they had attained the legal age of majority. Getting consent from people in this age category is legally easier. The villages and the general residents of these villages were selected randomly while the people living with disabilities were selected using purposive sampling methods.

2.1.3 Types of Data and Data Sources

The researchers were mainly concerned with qualitative data. These were in primary, secondary or documentary forms. Qualitative data that were based on descriptions and observations were gathered. Focus Group Discussions (FGDs), in-depth interviews and participant observation were used to gather primary data. The researchers reviewed literature on disability, water and sanitation; and the Republic of Zimbabwe National Water Policy, Health Policy and Disabled Persons Act of 1992 to gather secondary and documentary data respectively.

2.1.4 Data Collection Methods

FGDs, in-depth interviews and participant observation were applied concurrently.

(i) Focus Group Discussions (FGDs)

The researchers conducted twelve (12) FGDs. Eight FGDs were done with the people living with disabilities and four with the general members of the community. The villages and the general members were randomly selected while those living with disabilities were purposively sampled. FGDs created a platform for the emergence of key issues and debates on mainstreaming of disability in water and sanitation. Small groups of eight to ten (8-10) participants were appropriate for easier management. Demographic uniformity or near uniformity was prioritised for 'uniform' or near uniform group dynamics. Stratified views were sought through including participants of different age groups and sex either separately or simultaneously. In-depth interviews and participant observation were used to explore the key issues that emerged from the FGDs.

(ii) In-depth interviews

In-depth interviews were conducted with the key informants on disability, water and sanitation. Key informants were drawn from people living with disabilities and their representatives, traditional leaders, local health, water and sanitation officials and heads or representatives of private organisations or NGOs.

(iii) Participant Observation

The researchers used the following phases of observation: selection of the site or aspects, general definition of what is to be observed, descriptive observations, focused observations, selective observations and documentation of observation. However, these phases were flexible.

2.1.5 Ethical Considerations

The researchers carried out ethical data gathering and analysis based on informed consent, voluntary participation, avoidance of harm, protection of privacy and providing feedback to the participants.

3.0 Results and Discussion

The results of study are divided into two categories. These are water and sanitation services. The discussion takes the definition of mainstreaming provided in the background to the study as its foundation for analysing mainstreaming of disability in water and sanitation services.

(i) Water

Generally, the availability of potable water drawn from boreholes and protected wells is high in across the district. The Government of Zimbabwe (GoZ) through the District Development Fund (DDF) sunk many boreholes in the community. Moreover, international non-governmental organisations such World Vision complemented the government in borehole drilling and maintenance and in providing materials for the constriction of protected wells.

Very few exceptional cases where few community members may draw unprotected water from rivers for household use were identified. Adequacy of water for human consumption is good for people living with disabilities and the whole community. However, mere availability of water in the community may not translate into easier access and use by all individuals and groups in the community. A key consideration in the study was the how well the needs, concerns and experiences of people living with disabilities were integrated in the design, implementation and evaluation of water and sanitation programmes in Madziwa community. Scarcity in a context of plenty may mark the lives of people living with disabilities especially the physically disabled and other vulnerable groups.

Distance to the water point

The study revealed three key gaps in water programmes by both the state and non-state actors. Firstly, the distance to the water point is greater for some people living with disabilities. This group is constituted by those who could not dig and construct protected wells on their own or could not hire labour to do it on their behalf. However, given that the incidence of poverty is high amongst the people living with disabilities as compared to the general population, most of the people living with disabilities could not hire labour for digging and constructing protected wells.

Both the government and NGOs merely provided construction materials without following up on those who have special needs in constructing protected wells or accessing boreholes. This was a gap in the design and implementation of water programmes because putting disability in mainstream development was not considered. Most of those people living with disabilities who do not have protected wells at their homesteads rely on water from neighbours' protected wells or nearby boreholes. Disability was never a consideration when designing protected wells and abstraction technology.

Design of water points

Both the boreholes and protected wells were not designed to be used by people living with physical disabilities. For example, the hand pumps are not accessible by those on wheel chairs. The abstraction technology at boreholes and protected wells is not user-friendly. The laundry areas that were constructed at boreholes are slippery, too low or too high for most people living with physical disabilities. Disability was never a consideration when designing water points and laundry areas.

Print and audio manuals on disability

Lack of mainstreaming disability in water goes beyond distance to water points and design of water points. There is no existence of print and audio manuals on disability in general and disability and water services yet the incidence of disability is high in the community. An information gap exists on disability and water programmes.

Inclusive decision making

There was consensus among the people living with disabilities that they were not consulted on water and sanitation programmes. This creates a gap in the relevance and usefulness of water and sanitation programmes to those living with disabilities.

(ii) Sanitation

Lack of a disability perspective was also noted in sanitation programmes probably because water and sanitation programmes go hand in hand. Weaknesses and omissions in one are most likely to be experienced in the other. Four areas of lack of a disability perspective in sanitation emerged. These are briefly explained below

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Provision of latrines

Toilets are an important component of a sanitary environment. Household latrines are important for improving health and enhancing personal dignity. The provision of materials for the construction of latrines as an end in itself meant that most of the people living with physical disabilities without family or community support could not have a toilet on their homestead. A programme that was hitherto assumed to be comprehensive had exclusionary tendencies.

Research generated latrines

A second gap that clearly indicates the absence of a disability perspective in sanitation is the lack of research-generated latrine solutions. Latrines that were constructed before and after the programmes do not show any consideration for the physically disabled. For example, all the latrines surveyed do not have movable toilet seats, toilet seats with raised blocks or protruding bricks or iron bars for support when entering or exiting the latrines. These are serious gaps that hindering the wellbeing of people living with disabilities in relation to sanitation.

Broad-based consultative decision making

The active participation of all groups in any community is important in creating meaningful projects and programmes. Active participation through broad-based consultation is a vital component of mainstreaming. The gaps in water and sanitation programmes show that the people living with physical disabilities were not consulted. Alternatively, their concerns and suggestions were disregarded at the design and implementation stages. A recurring concern is social stigma emanating from perceptions on disability. High levels of stigma imply that family and community support for people living with disabilities is low. In addition, inclusion in water and sanitation programmes is low.

Sanitation manuals

A striking gap is the lack of print and audio manuals on disability in general and disability and water services. A serious information gap exists on disability and sanitation. Misunderstandings and misconceptions become rife in such cases hence the exclusion of people living with disabilities.

4.0 Recommendations

Four recommendations emerge from the discussion. These are getting started in understanding the situation of people with disabilities, developing institutional approaches to mainstreaming disability, establishing institutional commitment and vision and applying inclusive practices as a long term

vision in water and sanitation and other areas of development. These recommendations are interdependent.

4.1 Getting started in understanding the situation of people with disabilities

There is urgent need for all development practitioners to learn about disability and try new ideas and practice on mainstreaming disability in water and sanitation. This may entail situation analysis, pilot projects and advocacy briefings and position papers for the inclusion of people with disabilities in mainstream development.

4.2 Developing institutional approaches to inclusion and mainstreaming of disability

Institutional approaches to inclusion and mainstreaming should be developed by both the state and non state actors in water and sanitation and other areas of development either individually or collaboratively. Key aspects include road mapping (strategic planning), advocacy activities, development of training materials and provision of guidance and advice on mainstreaming disability, piloting and finally developing water and sanitation programmes with a disability perspective.

4.3 Establishing institutional commitment and practice

The first two recommendations and any other activities on mainstreaming disability in water and sanitation can only be functional with institutional commitment and practice. Mainstreaming disability should be viewed as a norm in all water and sanitation projects and programmes. This stage may entail induction of staff and the communities, capacity building, providing inclusive designs, consultation procedures and networking and collaboration on mainstreaming disability.

4.4 Mainstreaming disability in water and sanitation programmes as a long term vision

Living with disability should be practiced as a long term vision of improving the wellbeing of people living with disabilities in relation to water and sanitation and all other areas of development. Disability perspectives should be prioritised in all practices and procedures.

5.0 Conclusion:

The study shows that the water and sanitation programmes that were designed and implemented by both state and non-state actors in Madziwa community do not have a disability perspective. The people living with disabilities are not benefiting from mainstream development programmes such as water and sanitation programmes due to non prioritisation of disability in baseline surveys, general and specific consultations, design and implementation of development projects and programmes. However, this problem is not restricted to Zimbabwe. No country in the world has genuinely

achieved equitable and inclusive water and sanitation provision. More work has to be by both the state and non state actors in putting disability at the core of mainstream development.

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