

BINDURA UNIVERSITY OF SCIENCE EDUCATION



FACULTY OF SCIENCE

DEPARTMENT OF SUSTAINABLE DEVELOPMENT

***ASSESSING THE IMPACT OF COMMUNITY-BASED INTERVENTION PROGRAMMES
ON PEOPLE LIVING WITH DISABILITIES IN WATERFALLS, HARARE SOUTH,
ZIMBABWE***

**A DISSERTATION SUBMITTED TO BINDURA UNIVERSITY IN PARTIAL
FULFILMENT OF THE REQUIREMENTS OF THE BACHELOR OF SCIENCE
HONOURS DEGREE IN DEVELOPMENT STUDIES**

BY

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APPROVAL FORM

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The Department of Board of Examiners is satisfied that this dissertation meets the requirements of examination. Therefore, I recommend Bindura University of Science Education to accept the study by Prisca Muchena in partial fulfilment of the requirements for the award of Bachelor of Science Degree in Development Studies (HBScDG).

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DECLARATION

I Prisca Muchena registration number (B221442B) declare that **“Assessing the impact of community-based intervention programmes on people living with disabilities in Waterfalls, Harare South, Zimbabwe”** is my work and all the sources I used or quoted have been properly indicated and acknowledged by means of complete references.

Signature 

Date: 21/05/2026

Supervisor's signature



Date: 19/08/26

DEDICATION

I dedicate this work to all individuals living with disabilities in Zimbabwe and the whole world, hoping that this study will contribute to better empowerment, equal opportunities and inclusion in communities.

ACKNOWLEDGEMENT

Firstly, I would like to acknowledge Almighty God for His protection, love, strength and guidance throughout my academic journey, without His overriding grace, I would not make it. I would also like to extend my special appreciation to my supervisor for the patience, valuable guidance and tireless commitments provided throughout my study. His support contributed to the completion of this research. I also thank all participants who participated in this study. Their willingness to share their experiences made this research possible. I would also like to thank my family for their support, love, support, encouragement, emotional support and prayers throughout my academic journey. Special thanks goes to my beloved mother for believing in me always, I appreciate her endless love, sacrifices and prayers throughout my studies. Lastly, I appreciate my friends and everyone who contributed directly or indirectly to this study.

ABSTRACT

This study assessed the impact of community-based intervention programmes on people living with disabilities in Waterfalls, Harare South, Zimbabwe. The research focused on identifying the types of community-based intervention programmes (CBIPs) for individuals with disabilities in Waterfalls, assessing the impact of CBIPs on social inclusion, empowerment and overall well-being. The study also focused on researching the strategies for strengthening inclusion of people with disabilities (PWDs) through CBIPs and proposing policy recommendations for improving the sustainability and implementation of CBIPs. The research was guided by the Social Model of Disability as the theoretical framework, which defines disability as caused by social and environmental barriers not person's impairments. The study used a qualitative research. Data were gathered through focus group discussions, semi-structured interviews, and observations and was collected from PWDs, caregivers, programme implementers or service providers and community member. The main community-based intervention programmes identified in Waterfalls found in by the study included therapeutic and rehabilitation services, vocational training, peer networks and support groups and sports and recreational activities. The study findings highlighted that these interventions improved confidence, self-advocacy, psychological well-being and community participation among PWDs. Positive changes in community attitudes towards disability was found in the study. However, different barriers continue to restrict participation in CBIPs. The barriers included poor road infrastructure, stigma, transport challenges, communication barriers, limited funding and cultural beliefs. The research results highlighted that despite the existence of some inclusive programmes, accessibility remains a primary challenge. The study recommends improving accessibility conditions, more awareness campaigns, and increase participation of PWDs involvement in planning and leadership, strengthening transport systems for PWDs, ensure sustainable funding through the support of the government and more income generating programme. In addition, the study recommends strong enforcement of disability law and inclusion policies to enhance sustainability of CBIPs for PWDs.

LIST OF ABBREVIATIONS AND ACRONYMS

CBID-	Community-Based Inclusive Development
CBIP-	Community-Based Intervention Programme
IDD-	Intellectual and Developmental Disability
NGOs-	Non-Governmental Organisations
PWDs-	People with Disabilities/ Persons with Disabilities
UN-	United Nations
UNCRPD-	United Nations Convention on the Rights of Persons with Disabilities
UNICEF-	United Nations Children's Fund
WHO-	World Health Organisation

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CHAPTER I

INTRODUCTION

1.1 Chapter introduction

This chapter presents an introduction of the study by outlining the essential components that form the foundation of the research. It begins by providing background information on the community-based intervention programmes and disability to help the reader understand the study context. The chapter then outlines the research problem, the study aim, the specific objectives and research questions that guide the investigation. In addition, this chapter highlights the importance of the study, defines the key terms used in the research, and describes how the dissertation is organised to guide the reader through its structure.

1.2 Study background

Disability is a complex and diverse condition that affects individuals across all societies. It includes sensory, intellectual, physical and mental health conditions that can limit an individual's activities and participation in daily life (Dunn et al., 2020). PWDs often face barriers to accessing education, employment, healthcare, and social services, which can hinder their full inclusion in society (Prasad, 2025). Besides the physical and social challenges, disability is often accompanied by stigma and discrimination, further limiting opportunities for personal development and social engagement. Addressing disability requires inclusive policies, supportive environments, and societal awareness to ensure that all people can participate fully and equally in their communities.

Disability is more widely seen as a global public health and human rights issue (Krahn, 2021). According to World Health Organisation (2025), an estimated one billion three hundred million (1.3 billion) individuals live with a type of disability, and the majority of them are in developing countries where access to important services is limited. According to Ayalew et al. (2020), PWDs continue to experience barriers to education, healthcare, employment and community participation, worsening social exclusion and poverty. Regardless of global frameworks like the United Nations Convention on the Rights of Persons with Disabilities (CRPD, 2006), progress

remains limited. The UN Disability and Development Report (2023), highlighted that 98% of Sustainable Development Goals (SDGs) indicators related to disability are off track, showing gaps in inclusive development. These challenges have demanded the introduction of community-based intervention programmes as strategies to enhance inclusion and improve the quality of life for PWDs. Rule et al. (2019), state that to deal with these challenges, the World Health Organisation introduced CBR programmes in the 1970s, later expanded to cover education, social inclusion, health, livelihood and empowerment. Disability is a significant global issue, affecting over 1.3 billion people, or about 16% of the world's population (World Health Organisation Eastern Mediterranean Region, 2024). This number is increasing as a result of factors like population aging and the increase in non-communicable diseases.

Disability affects a large portion of Africa's population, though accurate figures remain uncertain because of unreliable data collection and underreporting related to stigma and limited reporting systems. In South Africa, for instance, 3.3 million people (5.3% of the population) were found to be living with disabilities in 2022 (Statistics South Africa, 2024), though actual numbers may be higher. The rate is often higher in rural areas, among women, and in older populations, with women with disabilities facing increased gender-based discrimination and violence. Studies highlighted that persons with disabilities face continuous barriers, including exclusion from education, inadequate access to healthcare, limited livelihood opportunities, and social stigma that limits their participation in community life (Sarkar & Parween, 2021; Tinta et al., 2020; Tinta & Kolanisi, 2023). In response, the African Union adopted the protocol to support PWDs Africa, while countries such as Rwanda have advanced inclusive education policies with UNICEF support (Ferri, 2022; Joshi, 2023). Community-based intervention programmes across the continent also aim to strengthen empowerment and service provision. Overall, while notable initiatives are in place, disability continues to be a pressing challenge across the continent, demanding sustained attention and inclusive action.

In SADC, disability remains a serious concern, affecting millions and causing challenges to inclusive development, though regional data is limited. In South Africa, about 3.3 million people (5.3% of South African citizens) were reported as having disabilities in 2022, while nearly 29 million children in Eastern and Southern Africa face barriers to education, healthcare, and social inclusion due to stigma, inaccessible services and institutional care instead of being completely

included in society (Statistics South Africa, 2024). To address these issues, community-based programmes have been implemented across the region, aiming to support PWDs and improve access to basic services (Rule et al., 2019). Regional programmes like the SADC gender and development policy and inclusive development strategies support the integration of PWDs and promote equitable engagement in society (Kar et al., 2024) . Pasara (2022) agreed that despite these measures, progress on SDG indicators related to education, health, and employment for individuals with disabilities remains off track, showing the importance of sustained interventions and effective programme implementation across the region.

In Zimbabwe, according to Nanji and Olivier (2024) noted that the government, NGOs and religious organisations have been at the forefront of carrying out community-based interventions for individuals with disabilities. The CBIPs often include physiotherapy, occupational therapy, skills training, sports activities and psycho-social support aimed at improving the physical, social and economic well-being of PWDs (Saran et al., 2023). Regardless of these interventions, Ndhlovu and Mudzingwa (2022) agreed that PWDs in Zimbabwe continue to face stigma, discrimination and structural barriers that restrict their full participation in society.

The community in Waterfalls in Harare South provides an important context for understanding the effectiveness of such programmes. Being a semi-urban area, Waterfalls host different populations, including people with physical, sensory, intellectual and psycho-social disabilities who depend on both formal and informal support groups. Different community-based initiatives are in place, but their real impact on the daily lives and long-term development of PWDs remains poorly examined. Assessing these programmes provides useful insights into their successes, limitations and areas for improvement. Therefore, this study seeks to examine the effectiveness of community-based interventions on the lives of people living with disabilities in Waterfalls, Harare South, Zimbabwe. The findings are expected to contribute to the growing body of knowledge on disability and development, while also informing policymakers, practitioners and communities on how to strengthen inclusive community-based programmes for PWD.

1.3 Research problem statement

Although community-based intervention programmes have been introduced in Zimbabwe to promote rehabilitation, empowerment and inclusion of PWDs, the extent to which these

programmes improve the daily lives of people living with disabilities remains unclear, particularly within localised communities like Waterfalls, Harare South, Zimbabwe (Bongo et al., 2018a). In many cases, PWDs continue to experience poverty, unemployment, social exclusion and inadequate access to basic services regardless the existence of such initiatives (Hughes, 2013; Sarker, 2024; Sarkar & Parween, 2021) . In Waterfalls, Harare South, such programmes exists but there is limited evidence on whether they have significantly improved the quality of life and inclusion for individuals with disabilities. This lack of evidence limits the ability of policymakers, practitioners and community stakeholders to make informed decisions about how to strengthen and sustain inclusive disability interventions. Hence, the problem that this study aims to address is lack of understanding of the impact of community-based intervention programmes on the lives of people living with disabilities in Waterfalls, Harare South, Zimbabwe.

1.4 Aim

The aim of this study is to assess the impact of community-based intervention programmes on the lives of persons living with disabilities in Waterfalls, Harare South, Zimbabwe

1.5 Research objectives

The objectives of this study is:

- i. To identify the types of community-based intervention programmes available for people living with disabilities in Waterfalls, Harare South, Zimbabwe
- ii. To assess the impact of community-based intervention programmes on the social inclusion, empowerment and well-being of people with disabilities
- iii. To suggest strategies for strengthening the social inclusion of PWDs through community-based interventions
- iv. To propose policy recommendations for enhancing the implementation and sustainability of community-based intervention programmes for people living with disabilities

1.6 Research questions

- i. What types of community-based intervention programmes are available for people living with disabilities in Waterfalls, Harare South, Zimbabwe?

- ii. How do these programmes impact the social inclusion, empowerment and well-being of people with disabilities?
- iii. What strategies can be adopted to strengthen the social inclusion of people living with disabilities through community-based interventions?
- iv. What policy actions can be recommended to enhance the implementation and sustainability of community-based intervention programmes?

1.7 Data delimitation

This research is guided by specific boundaries that define its scope and focus. These delimitations were set to ensure that the study remained manageable, context-specific as well as relevant to the community under the investigation.

The study is geographically limited to Waterfalls, a semi-urban area in Harare South, Zimbabwe. The focus is specifically on selected neighbourhoods where community-based intervention activities are common. The neighbourhoods include Derbyshire, North Way, Retreat as well as Uplands. Focusing on these areas allows for detailed coverage of programmes operating in diverse socio-economic profiles, with varying levels of existing community support structures and allows for comparative analysis of CBIP effectiveness across different community contexts within Waterfalls.

Conceptually, the research focuses on the broad concept of individuals living with disabilities, covering all categories of disability. The decision was made because PWDs form a smaller percentage of the population compared to people without disabilities and limiting the study to only one category of disability would have limited the sample size and reduced participants. Therefore, the study adopts an inclusive conceptual approach to disability so that results can show diverse experiences across all groups of disability.

On the delimitation of interventions, the research was limited to CBIP implemented within Waterfalls, Harare South, Zimbabwe, targeting people living with disabilities. These interventions include educational, empowerment, sports and psycho-social programmes delivered at a

community level including those implemented through special schools and community oriented initiatives like disability education programmes and inclusive sports activities. This study excluded purely clinical or custodial interventions provided in hospitals or long-term residential rehabilitation facilities because they do not primarily highlight community participation and social inclusion. This boundary ensures that the study focuses on interventions that encourage empowerment, inclusion and active engagement of persons with disabilities within their communities.

The study was limited to adults aged 18 and above who are either PWDs, care givers and community leaders involved in CBIPs in Waterfalls. Children and minors were excluded due to ethical considerations and consent requirements.

1.8 Justification of the study

People living with disabilities often faces many barriers in accessing education, healthcare, employment and full participation in the community life. In Zimbabwe, in urban areas like Waterfalls in Harare South, community-based intervention programmes have been introduced to promote inclusion, empowerment and improved quality of life for people living with disabilities. Despite the existence of these initiatives, there is limited evidence on their actual effectiveness in addressing the economic and health-related or social challenges faced by this group. This study is justified because the results of this study will be of great importance to different stakeholders. For policy makers and government, the results will provide evidence-based insights that can inform disability-inclusive policies, resource allocation and strategies to strengthen community-based intervention programmes.

Additionally, for non-government organisations, it will highlight the best practices and gaps in disabilities. For local community and the families of people living with disabilities, the study will help in understanding how participation in community-based interventions programmes contribute to empowerment, social inclusion and improved quality of life. Lastly, this research will contribute to advocate for the rights and dignity of PWDs promoting inclusion and ensuring that interventions designed for them are effective and sustainable.

1.9 Definition of terms

Community-based intervention programmes (CBIPs) - Means multi-sectoral strategies that designed to promote human rights, social inclusion and promotion of equal opportunities for people with disabilities, their families and their communities with governmental and non-governmental services (Michelle Aldersey et al., 2023). This refers to organised, non-institutional initiatives that are designed to address the needs of people living with disabilities within the Waterfalls community. They are carried out within the community setting for example, community halls, schools, homes or churches as opposed to institutional settings. Community-based intervention programmes involve the active participation of community members, including PWDs and their families in their planning and management. The primary aim of CBIPs is to support inclusion, improve the quality of life and empower participants by addressing barriers in areas such as health, education, livelihoods and social participation (Blöse et al., 2021). Examples of community-based intervention programmes include vocational skill training, peer-support groups, disability rights awareness campaigns and community-led advocacy movements.

Disability- It is the outcome of the interaction between an individual's condition and the barriers created by society (Babik & Gardner, 2021). Therefore, disability is a complex issue showing the interaction between one's inherent physical, mental, intellectual or sensory impairments and the various societal and environmental barriers that hinder their full potential in society on an equal basis with others. This modern, social model understanding shifts the focus from a medical condition that needs to be fixed within the individual to the responsibility of the society to remove obstacles such as inaccessible buildings, discriminatory behaviours and exclusionary policies, thereby recognising that people are disabled not by their bodies but by a world that is not developed to accommodate them (Oliver, 2023).

People living with disabilities- PWDs are defined as individuals with long-term physical, intellectual, mental or sensory impairments that, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others (Jaiswal et al., 2020). Hence, disability is not solely a result of the condition of a person but as a result of environmental and societal barriers that hinder inclusion and equal participation.

1.10 Organisation of the study

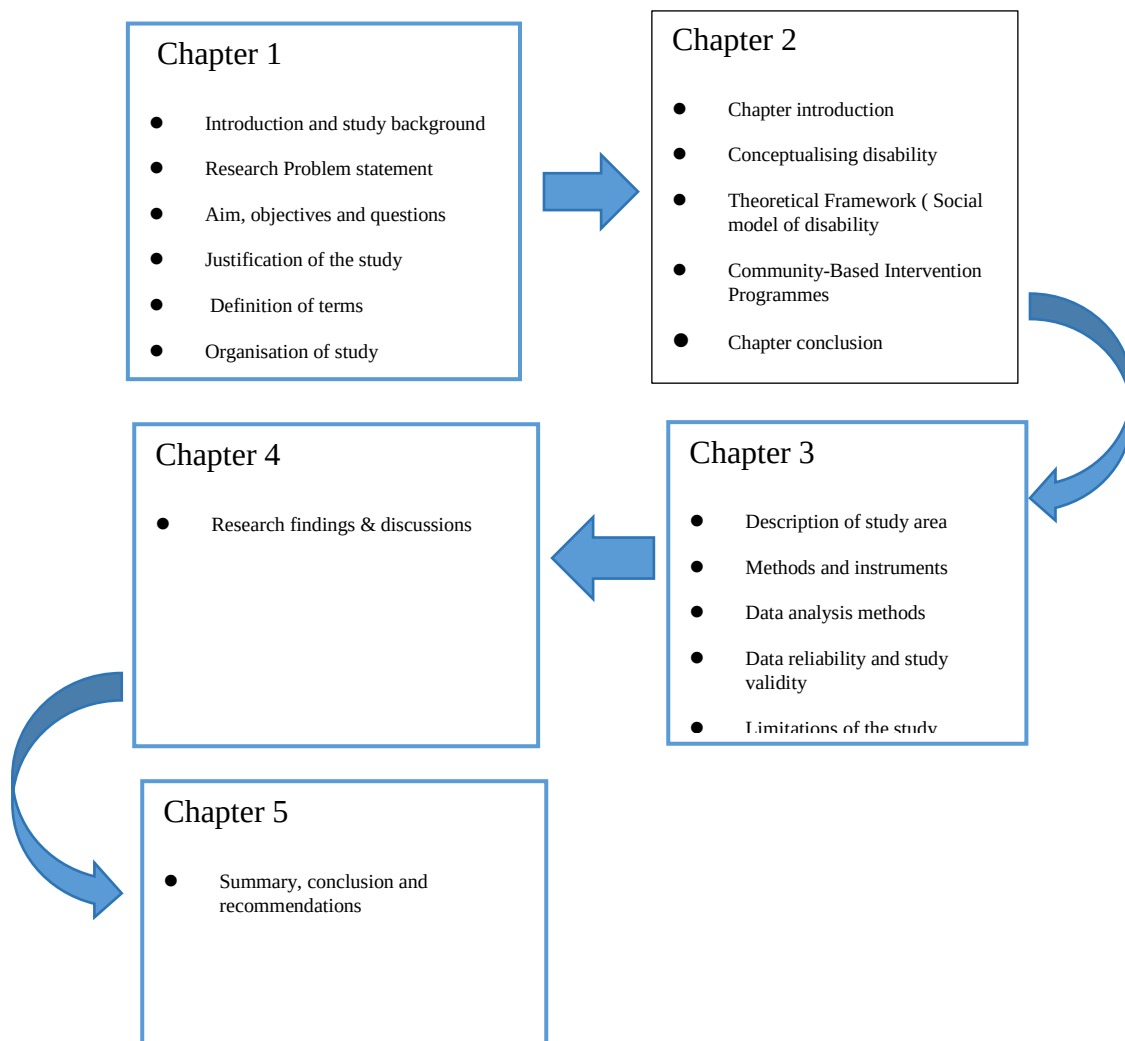


Figure 1.1 shows the organisation of the study

This study is made up of five chapters, each addressing specific aspects of the research topic. The first chapter introduces the study, describing the background, research problem statement, study aim and objectives, research questions, justification of the study, definition of terms, organisation of the study and chapter conclusion. Chapter 2 presents a review of relevant literature, discussing key concepts, theoretical frameworks and previous research related to community-based intervention programmes and their impact on people living with disabilities. Chapter 3 details the

research methodology, including description of the study area, methods, data collection instruments, target population sample size and sampling techniques, data analysis methods, data reliability and study validity as well as limitations of the study. The fourth chapter presents the research findings and analysis, providing interpretations in line with the study objectives. The final chapter offers the summary, conclusions and recommendations based on the study findings.

1.11 Conclusion

Chapter one has introduced the study by presenting the background of the study, problem statement, aim, research objectives and research questions. The justification of the study and definition of key terms. This chapter has laid the foundation for the research, providing a foundation for the chapters that follows.

CHAPTER II

LITERATURE REVIEW

2.1 Chapter introduction

This chapter presents a detailed review of existing literature related to community-based intervention programmes and their impact on the lives of people living with disabilities. It examines theoretical frameworks of disability, key concepts, and previous research findings that inform the understanding of disability inclusion and community development. The review critically examines global, regional, and local experiences, identifying successes and challenges in implementing community-based intervention programmes. It also identifies gaps in the existing knowledge, particularly within the context of Waterfalls, Harare South, Zimbabwe, which this study aims to address.

2.2 Theoretical framework:

2.2.1 The social model of disability

This research is grounded in the Social Model of Disability, a theoretical approach that reshaped global understanding of disability from a charitable or medical issue to one focused on human rights, equality, and social inclusion (Oliver, 2023). This theory was developed in 1976 by scholars and activists specifically the Union of the Physically Impaired Against Segregation (UPIAS), as social interpretation of disability, emphasising that disability is a limitation of activity as a result of economic, political and cultural norms that fail to consider individuals with impairments and exclude them from active engagement (Koutsoklenis & Adam, 2024a). The name ‘Social Model of Disability’ was coined and expanded latter by Mike Oliver in 1983 (Adam & Koutsoklenis, 2023). This model argues that disability is not primarily caused by an individual’s condition, but rather from social, attitudinal, and environmental barriers that limit participation (Oliver, 2023). Therefore, it shows that the problem is not within an individual, but in the failure of the community to accommodate diversity and ensure accessibility.

In this study, the Social Model of Disability is applicable as it provides a helpful lens for assessing how community intervention programmes address barriers faced by people living with disabilities in Waterfalls, Harare South, Zimbabwe (Proehl, 2001). The study uses this theory to examine

whether the community-based initiatives enhance participation, reduce social exclusion and promote accessibility (Oliver, 2023). The Social Model of Disability guides the study to assess how the community-based interventions contribute to more inclusive community development (Chaka et al., 2021a).

2.3 Conceptual framework

The concepts discussed in this section are drawn from the Social Model of Disability, which serves as the theoretical foundation of the study. Guided by this theoretical view, the study adopts concepts that explain how community-based intervention programmes can address disabling barriers and promote positive results for PWDs at the community level. These concepts include accessibility, societal and environmental barriers, participation, social inclusion and empowerment.

2.3.1 Accessibility

Accessibility is a central concept within the Social Model of Disability and refers to the extent to which physical environments, services, and information are designed to be usable by all community members, including PWDs (Oliver & Barnes, 2012). The model emphasises that inaccessible environments, rather than impairments, create exclusion and dependency. Community-based intervention programmes often seek to improve accessibility by adapting infrastructure, facilitating access to services, and promoting inclusive community planning (Chawa et al., 2021). In this study, accessibility refers to the availability and usability of community facilities, services, and intervention programmes for PWDs in Waterfalls, Harare South.

2.3.2 Participation

Participation is a key principle of the Social Model of Disability and refers to the active involvement of persons with disabilities in social, economic, and civic activities (Owen, 2008). Exclusion from participation is regarded as a form of social oppression that reinforces inequality and marginalisation. Community-based intervention programmes promote participation by involving individuals with disabilities in programme activities, decision-making processes, and community initiatives (Hasan et al., 2024). In this study, participation refers to the extent to which

individuals with disabilities in Waterfalls, Harare South are actively involved in community activities and development processes.

2.3.3 Societal and environmental barriers

Societal and environmental barriers are viewed as the primary factors that disable individuals with impairments (Oliver, 1996). These barriers include inaccessible physical infrastructure, exclusionary institutional arrangements, and negative social attitudes that restrict participation in community life. Schneider (2012), argue that such barriers systematically marginalise PWDs and limit their opportunities for inclusion and empowerment. In the context of community-based intervention programmes, addressing societal and environmental barriers involves modifying physical spaces, improving access to services, and challenging discriminatory practices at the community level (Tinta & Kolanisi, 2023). In this study, societal and environmental barriers refer to the physical, institutional, and behavioural obstacles experienced by individuals with disabilities in Waterfalls, Harare South.

2.3.4 Social Inclusion

Social inclusion, within the study's theoretical view, means including persons with disabilities into mainstream community life by removing structural, social, and attitudinal barriers (Shakespeare, 2013). Inclusion is achieved when individuals are recognised as equal in the community with full access to opportunities, relationships, and resources (Jones, 2010; Saran et al., 2021). Community-based intervention programmes seek to promote social inclusion by encouraging acceptance, reducing stigma, and strengthening social networks within communities (Chawa et al., 2021). In this study, social inclusion means the level to which individuals with disabilities in Waterfalls, Harare South experience acceptance, belonging, and meaningful engagement in community life.

2.3.5 Empowerment

Empowerment is a foundational concept of the Social Model of Disability, emphasising self-determination, autonomy, and control over decisions affecting one's life (Oliver, 1990). The model rejects approaches that portray persons with disabilities as passive recipients of care and instead views them as active participants capable of shaping their social and economic conditions (Schneider, 2012). Within this view, empowerment is achieved through the removal of social, institutional, and attitudinal barriers that limit choice and participation (Tinta et al., 2020).

Community-based intervention programmes are therefore seen as important strategy for promoting empowerment by supporting participation, advocacy, and local-level engagement (Giummarra et al., 2022). In this study, empowerment refers to the level to which individuals with disabilities in Waterfalls, Harare South are able to make decisions, show their views, and exercise greater control over aspects of their lives because of participation in community-based intervention programmes.

2.4 Conceptualising disability

Understanding disability is important to this study because it defines the population on whom community-based intervention programmes (CBIPs) aim to benefit. Disability covers a range of conditions like physical, sensory, intellectual and psycho-social conditions and the environmental and attitudinal challenges that hinder full participation (Carr, 2023). The definition of disability has a major influence on the design, delivery and evaluation of CBIPs. For example, programmes based on medical assumptions often focus on treatment and rehabilitation, while those informed by social or rights-based perspectives focus on empowerment and the removal of barriers (Goering, 2015). Hence, this section reviews how disability has been understood in the existing literature and policy. It examines key definitions and models of disability, outlines the main disability types, and highlights global and regional frameworks that shape contemporary understanding of inclusion. Defining these concepts provides a foundation for analysing the importance and effectiveness of CBIPs in improving the lives of PWDs in Waterfalls, Harare South, Zimbabwe.

2.4.1 Definition and scope of disability

Disability is a complex and debated dynamic, with no single globally accepted definition. It is influenced by medical, social, cultural, and legal factors that shape how societies understand and handle differences. According to World Health Organisation (2021), disability arises from the interaction between individuals with health conditions and the contextual barriers that limit their participation in community. This definition shows a transition from seeing disability just as an individual problem to viewing it as caused by both personal and environmental factors. Traditionally, the medical model of disability viewed disability as a problem or condition located within the individual, often requiring treatment, cure, or rehabilitation (Zaks, 2024). This approach improved clinical care and rehabilitation but has been condemned for promoting dependency and

neglecting the social and environmental barriers that limit participation (Zaks, 2024). People with disabilities were often viewed as passive recipients of care instead of active participants in their communities.

In response to limitations of the medical model of disability, the social model of disability developed in the 1970s and 1980s by individuals with disabilities as a reaction to the medical model, then term was coined by Mike Oliver in the year 1983, highlighting that disability is not solely caused by individual conditions rather by societal barriers, including inaccessible infrastructure, discriminatory policies, and negative attitudes (Hendren, 2020). This approach prepositions disability as a social concept and supports rights-based and inclusion-oriented approaches, emphasising the removal of barriers and full participation (Lawson & Beckett, 2021). The biopsychosocial model, formalised in the WHO's International Classification of Functioning, Disability and Health , integrates the medical and social perspectives (Hickson & Worrall, 2001). It views disability as the outcome of the complex interaction between a person's health condition, individual characteristics, and environmental and social factors, providing a framework for developing community-based interventions that address both personal and environmental factors of participation and well-being.

The rights-based understanding of disability, mentioned in the United Nations Convention on the Rights of Persons with Disabilities (CRPD) adopted in 2006, further expands on this idea by describing PWDs as individuals who have long-term physical, mental, intellectual, or sensory impairments which, in interaction with various barriers, may limit their full and effective participation in society on an equal basis with others (Ashalatha et al., 2024). This approach highlights dignity, freedom, and equality, shaping global and regional policy frameworks, including Zimbabwe's National Disability Policy (2021), which aligns with the CRPD and promotes accessibility, inclusive education, and social support (Ndhlovu & Mudzingwa, 2022b). Together, these frameworks reflect a thorough understanding of disability as a complex and socially created phenomenon, due to the interaction among individual conditions and environmental, social, and behavioural barriers (Putri & Marsa, 2025). For this study, this conceptualisation provides the foundation for analysing how community-based intervention programmes impact social inclusion, empowerment, and well-being among PWDs in Waterfalls, Harare South, Zimbabwe.

Therefore, this dissertation views disability according to the social model of disability. The reason is that this model focuses on how environmental, social and attitudinal barriers restrict participation, which aligns directly with the study's aim (Campbell & Oliver, 2013). By highlighting the removal of barriers and promotion of inclusion, the social model provides the most suitable framework for analysing the effectiveness of these CBIPs (Koutsoklenis & Adam, 2024). On the other hand, this study also acknowledges viewpoints from ability studies which view people with disabilities as persons with different abilities showing the difference in human functioning as well as challenging fixed ideas of what is considered normal by the society (Harpur, 2012; Dolmage, 2014; Wolbring, 2008).

2.4.2 Types of disabilities

Disabilities manifest in diverse forms, reflecting a broad range of physical, sensory, intellectual, psycho-social, and multiple impairments. The World Health Organisation (2021) explains that these categories are not rigid medical classifications but rather functional descriptions of how individuals experience limitations in interaction with physical, social, and attitudinal environments. Weber et al. (2023) concurred that understanding the different types of disabilities is essential for the design and implementation of inclusive CBIPs as each category presents unique needs, challenges, and opportunities for participation and empowerment.

Physical or mobility disabilities refer to conditions that affect an individual's movement, coordination, or physical functioning (Bonner, 2023). Individuals with physical disabilities often face barriers related to inaccessible infrastructure, limited transport options, and inadequate rehabilitation services, which restrict participation in social and economic life. The WHO emphasises that accessible environments such as ramps, adaptive devices, and inclusive transport systems are critical to ensuring equality and independence for persons with physical disabilities (World Health Organisation, 2021). These insights emphasise the need to create inclusive physical and social environments that enable individuals with mobility challenges to live independently and engage fully in society.

Sensory disabilities include visual and hearing conditions that limit a one's ability to see or hear (Kelly et al., 2025). Visual conditions range from partial sight to total blindness, while hearing impairments may include mild, moderate, or severe hearing loss. According to the Global Report on Assistive Technology of 2022, more than 2.5 billion individuals worldwide need one or more

assistive products such as eyeglasses, hearing aids, or mobility devices yet access remains limited in developing countries (World Health Organisation Regional Office for the Eastern Mediterranean, 2022). The absence of accessible information formats, sign language interpretation, and inclusive communication systems worsens exclusion for people with sensory disabilities, particularly in education and employment sectors.

Intellectual and developmental disabilities (IDD) are defined by limitations in intellectual functioning and adaptive behaviour, including conditions such as Down syndrome and autism spectrum disorders (Pinals et al., 2022). These disabilities often affect communication, independent living skills and learning. The individuals with IDD face persistent barriers to vocational training, employment opportunities and education largely because of stigma and inadequate support systems (Heron et al., 2020). Snapp et al. (2020) agreed that community-based programmes that provide early intervention, inclusive education, and family support are therefore essential to improve quality of life for persons with IDD.

Multiple disabilities refer to situations in which an individual experiences two or more co-existing impairments such as a combination of physical and intellectual disabilities (Rensfeldt Flink et al., 2021). This shows the importance of developing tailored and strong inclusive support programmes that meet the diverse and overlapping needs of persons with multiple disabilities, promoting their complete inclusion and equal engagement in all areas of life as noted by Maes et al. (2020).

In Zimbabwe, the National Disability Policy (2021) adopts a broad categorisation that includes physical, sensory, intellectual and multiple disabilities, in line with the United Nations Convention on the Rights of Persons with Disabilities (CRPD, 2006), estimated that roughly nine percent of the national population. According to the Zimbabwe Population and Housing Census, approximately 1.6 percent of the population aged five years and above, which amounts to 206 447 persons have some form of disability, with mobility, vision, and hearing impairments being the most common (Zimbabwe National Statistics Agency(zimstats), 2022). In urban communities such as Waterfalls, Harare South, infrastructural inaccessibility, limited rehabilitation centres, and ongoing negative attitudes continue to marginalise PWDs. Recognising the diversity of disability types is therefore key to assessing how community-based intervention programmes impact inclusion, empowerment, and overall well-being among persons with disabilities in Zimbabwe.

2.5 Community-based intervention programmes

CBIPs are based on the belief that people thrive best when services and support are provided within their own communities rather than through institutional care (Bongo et al., 2018b). They aim to promote empowerment, participation, and independence by using locally available resources and encouraging cooperation among community members, families, local authorities, and organisations of persons with disabilities through community-led service delivery, diverse stakeholder collaboration and community participation (University of California, Davis et al., 2022). This community-centred strategy improves the sustainability of initiatives by ensuring they are in harmony with local strengths and cultural backgrounds.

Within the context of disability, community-based intervention programmes address a range of needs such as rehabilitation, education, livelihood, social integration, and empowerment (Hunt et al., 2022). One of the most broadly recognised models under this approach is Community-Based Rehabilitation (CBR), introduced by the World Health Organisation (WHO) in the late 1970s (World Health Organisation, 2010a). CBR was initially developed to enhance access to basic rehabilitation services for persons with disabilities in developing countries (Butura et al., 2024). This was achieved through training of community health workers, community outreach programmes and community rehabilitation support interventions (Pasara, 2022). Over time, its scope expanded to include multiple development components like education, health, livelihood, social participation, and empowerment as outlined in the WHO CBR Matrix (World Health Organisation, 2010b). Although CBR remains a cornerstone of disability-focused interventions, many community-based programmes go beyond rehabilitation to include awareness campaigns, income-generating projects, inclusive education initiatives, and advocacy for disability rights. Grills and Varghese (2019) agreed that these broader intervention programmes aim to reduce social exclusion and enhance participation of PWDs in everyday community life.

Globally, community-based intervention programmes have shown positive impacts such as improved access to services, increased school enrolment among children with disabilities, enhanced self-reliance, and reduced stigma (Hepperlen et al., 2021). In Zimbabwe, such initiatives have been implemented by both government and non-governmental actors. The Ministry of Public Service, Labour and Social Welfare, together with organisations like Leonard Cheshire Disability Zimbabwe, Jairos Jiri and L'Arche Zimbabwe, has supported community programmes focusing

on vocational training, empowerment, and advocacy for the rights of PWDs (Musekiwa et al., 2025). Overall, community-based intervention programmes provide a practical framework for achieving disability inclusion and sustainable development (Bachfischer et al., 2023). By focusing on participation, capacity building, and the use of community resources, they help create environments where persons with disabilities can contribute meaningfully to social and economic life.

Community-based intervention programmes play a crucial role in promoting the inclusion, empowerment, and overall well-being of persons with disabilities (Chawa et al., 2021). These programmes are designed to address not only physical rehabilitation needs but also the social, economic, and psychological barriers that prevent full participation in community life (Tinta et al., 2020). By placing PWDs at the centre of development, community-based programmes align with rights-based and participatory approaches that emphasise equality, self-determination, and local ownership as also noted by Hasan et al. (2024).

One key role of community-based intervention programmes is to enhance access to important services such as health care, assistive devices, and rehabilitation. Many persons with disabilities in low-income settings face challenges to accessing formal health systems due to cost, distance, or stigma (Clemente et al., 2022). Jackson and Dhirendra Singh, (2024) concurred that community-based approaches bridge this gap by bringing services closer to where people live and by training community volunteers and health workers to provide basic support. Secondly, these programmes contribute to education and skill development (Saran et al., 2023b). They often facilitate inclusive education by raising awareness among teachers and parents, supporting school accessibility, and providing learning aids. For adults with disabilities, community-based interventions often offer vocational training and livelihood opportunities, enabling them to contribute economically to their households and communities (Mudde et al., 2025). Hence, community-based intervention programmes are crucial in promoting inclusion, empowerment and sustainable development for individuals with disabilities specifically in resource-limited settings.

Another critical role is in social inclusion and empowerment (Saran et al., 2021). Community-based intervention programmes encourage PWDs to take part in decision-making processes, local governance structures, and community activities (Chawa et al., 2021b). This helps to challenge negative attitudes and reduce stigma and discrimination. Through peer support groups and

advocacy training, persons with disabilities gain confidence and a stronger shared voice to claim their rights.

The impact of community-based intervention programmes has been widely documented across various contexts. Studies have shown improvements in physical functioning, increased self-esteem, and better social participation among beneficiaries (Umunnah et al., 2023) and (Uchenwoke et al., 2023). For instance, World Health Organisation (2010) noted that community-based rehabilitation programmes enhance community awareness and facilitate the social integration of persons with disabilities. In Zimbabwe, organisations such as Leonard Cheshire Disability Zimbabwe and Jairos Jiri Association have reported improved livelihood outcomes and self-reliance among individuals who participated in their community programmes (United Nations Office for Disaster Risk Reduction (UNDRR), 2025). A review of the success of these initiatives is the goal of this study.

2.5.1 Global community-based initiatives

Community-based intervention initiatives have been implemented globally to enhance inclusion, participation, and access to services for PWDs (Ghebre et al., 2026). These initiatives emphasise that communities are central in identifying needs, reducing barriers, and supporting individuals, complementing formal services (Ghebre et al., 2026). One of the most influential examples is the CBR strategy developed by the WHO in the 1980s (Grills & Varghese, 2019). The CBR framework has advanced from a medical-centred service delivery system to a multi-sector and rights-based development (Rule et al., 2019). The framework is now structured around the CBR Matrix, which focuses on health, social inclusion, education, livelihood and empowerment (Van Pletzen et al., 2021). These five key pillars work as a systematic guide for interventions designed for reducing poverty as well as equalising the opportunities of individuals with disabilities in their communities (Wolbring & Deloria, 2024). The CBR framework has been adopted in countries such as India, Nepal, Tanzania, and Indonesia (Kumar et al., 2012; Nugraha et al., 2021; Vaughan & Thapa, 2023). The Mobility India in collaboration with Christian Blind Mission (CBM), through the CBID project, has assisted individuals living with physical disabilities by offering home-based physiotherapy as well as assistive devices like wheelchairs (Khasnabis et al., 2010; Nugraha et al., 2021). Research indicates that access to these assistive devices like prosthetics (artificial body parts) and wheelchairs act as a foundation for economic participation,

thereby reducing caregiver burden and enabling people with disabilities to engage in livelihoods (Shankar et al., 2020; Hwang et al., 2025). This helped PWDs by allowing children to attend local schools and adults to start small business directly improving livelihoods.

In addition, organisations such as Special Olympics develop and provide important community-based programmes for individuals with IDs (Diz et al., 2024; Heenan & Sumner, 2025; Ponce-Alcala et al., 2025). Their ‘Health Athletes’ programme offers free health screenings, health education and nutrition advice in community settings (Ponce-Alcala et al., 2025). In South Africa, this programme has helped identify undiagnosed dental and vision problems in athletes ensuring they receive treatment that was previously not available for them. For example, a screening conducted at Tshegofatsong Special School in Mamelodi, Pretoria screened 198 athletes, helping to identify health needs and raise awareness about proper healthcare for people with intellectual disabilities in the community (Dladla, n.d). Moreover, the Opening Eyes programme of Special Olympics, in partnership with Optometry Giving Sight and local universities, provides vision screenings and training for people with intellectual disabilities in Ghana, the USA and Kenya. In Kenya, 2,149 athletes were screened and 364 received glasses. In the USA 1,763 athletes were screened and 1,008 received prescription glasses. In Ghana, 51 athletes were screened, with seven receiving follow-up care for potential vision loss, and local eye care students and practitioners were trained to ensure long term healthcare capacity (Special Olympics, n.d). These interventions have helped individuals with intellectual disabilities by offering vision and health screening ensuring better health as well as having access to trained healthcare system.

The global recognition of disability rights is led by legal frameworks. Global legal frameworks such as the UNCRPD of 2006 have further encouraged community-based interventions by promoting local participation, inclusive education, accessibility, and advocacy (Pacific Disability Forum, 2025; United Nations Department of Economic and Social Affairs, 2024). According to the United Nations Department of Economic and Social Affairs (2024), the CRPD highlights the importance of ensuring that individuals with disabilities can participate fully in the communities as well as having access to important services like healthcare, employment and education. As emphasised in the Global Disability Inclusion Report (UNICEF, 2022), countries like Kenya, Brazil, South Africa, and the Philippines have implemented CRPD-inspired programmes, including peer-support groups, awareness campaigns, and disability committees. According to V.

Catama et al. (2024), in the Philippines, the ‘Parent support network’ has helped families of children living with disabilities by educating them advocacy skills. This has led communities to build more accessible ramps in local markets and public parks. In high-income countries such as Canada, Australia, and the United Kingdom, community initiatives also focus on inclusive planning, accessible infrastructure, and advocacy networks (Fish et al., 2025; Yan et al., 2025). This is exemplified by the ‘Accessible UK’ scheme which uses community volunteers to map accessible transport routes, helping persons with disabilities navigate without fear of barriers (Local Government Association, 2024). In Kenya, the ‘Access to All’ programme also aligns with the CRPD, offering accessible infrastructure and public transport, which has improved employment and enabled greater mobility for individuals with disabilities (National Council for Persons with Disabilities, 2023).

In addition to CRPD, the 2030 Agenda for Sustainable Development (SDGs), guides global efforts to improve the lives of people living with disabilities and provides global recognition by demanding that no one is left behind, specifically goal 10 and 11 calling for the reduction of inequality and creation of accessible cities (United Nations, 2024). The SDGs encourage governments to promote inclusive communities and provide individuals with disabilities access to important services. In Tanzania, the Disability Inclusion Action plan, guided by SDGs, has improved access to healthcare and vocational skill training in Mbeya and Morogoro, increasing employment for individuals with disabilities and reducing stigma (UNFPA Tanzania, 2025; World Health Organisation, 2025). The Salamanca statement of 1994 remains an important international recognition of the right to inclusive education within communities (UNESCO, 2024). For example, in South Africa, the inclusive education programme in some regions, like Durban and Cape Town, has integrated children with disabilities successfully into regular schools with adequate support like assistive technologies and special education teachers, showing the principles of the Salamanca Statement (South Africa Department of Social Development, 2025). The global frameworks guide community-based initiatives in the whole world, encouraging community ownership as well as full active participation of individuals living with disabilities in the development of all programmes that improve their well-being and inclusion (Warfield et al., 2022). In summary, global evidence shows that effective community-based interventions depend on active engagement of communities and people with disabilities themselves. Despite existing global efforts, the impact and sustainability of local initiatives in areas like Waterfalls, Harare South, remain poorly recorded.

2.5.2 Regional community-based interventions

In the SADC, community-based intervention programmes (CBIPs) have been applied to promote inclusion, participation, and social well-being for people living with disabilities (Pasara, 2022). These programmes aim to respond to local needs by actively involving community members, families, and local organisations in planning and delivering services (Castillo et al., 2019). Regional CBIPs include initiatives such as skills development, livelihood support, inclusive education programmes, peer-support groups, and awareness campaigns implemented through community partnerships, capacity building programmes and community mobilisation (Butura et al., 2024; Pasara, 2022). By responding to social and environmental barriers, these interventions aim to enhance participation, reduce stigma, and strengthen community support networks (Virendrakumar et al., 2026). Ghebre et al. (2026) and Van Pletzen et al. (2021b), state that countries such as South Africa, Zambia, Botswana, and Tanzania provide examples of programmes that integrate health, education, and social support components to improve the overall quality of life for people with disabilities.

For example, the government-supported community programmes in Botswana operate through district rehabilitation services as well as community-based workers who provide support like connections to social welfare services, outreach services which include occupational and physiotherapy, assistive devices directly to households rather than centralised hospital care (Guyen et al., 2022; Lorenzo et al., 2015). The study by Van Pletzen et al. (2021b), carried out in Gaborone and neighbouring districts, highlights that community-based workers help young persons living with disabilities to access skills training, government livelihood schemes and small business activities. These initiatives also connect families with trained caregivers and social grants in daily living support, ensuring that services are available at the community level. This study shows how these workers link families to social protection services, also promoting disability inclusion at a local level, though they face challenges like limited resources and lack of coordination.

Similarly, in Zambia, community-based interventions support children with disabilities through programmes like Zambia Enhanced Community-Based Rehabilitation Response Project (ZECREP), part of the Breaking Down Barriers (BDB) programme, which adopts a community-based strategy that addresses health, education, livelihoods, social participation and empowerment (Banlanjo et al., 2025). Community members are also trained to identify and refer individuals with

disabilities, conduct assessments as well as community awareness campaigns which help in reducing stigma and link families to social protection (Banlanjo et al., 2025). The recent research shows that community-level support, including home visits, caregiver training as well as access to essential services like education and healthcare improves children's functioning, increases caregiver knowledge as well as participation in everyday activities (Ghebre et al., 2026). These efforts demonstrate how organised community support in Zambia reduces stigma, promotes inclusion, and improves the overall well-being of children with disabilities.

In addition to the above examples of local based interventions in SADC, organisations like Childreach Tanzania offer programmes for people with disabilities that connect health services like physiotherapy and surgeries with education support, including supply of learning materials and teacher training. As noted by Mtemi Philip and Kumburu (2023), Childreach has been helpful in addressing language barriers for students with hearing impairments through interventions like sign language training as well as workshops for both teachers and students. These efforts are in line with the Tanzanian Ministry of Education, Science and Technology (MoEST), which aims to improve educational outcomes through the provision of hearing aids and creating sign language clubs to promote interaction between students with and without hearing impairments (Mtemi Philip & Kumburu, 2023). Moreover, Leighton et al. (2023), found that community-based caregiver training in Tanzania rural can greatly improve children's development, further supporting community-based initiatives like those run by Childreach.

In Malawi also, the Malawi Council for Disability Affairs (MACODA) founded by the Persons with Disability Act of 2024, implements community-based programmes in many districts like Mzimba, Mangochi and Lilongwe (Malawi Council for Disability Affairs, 2025). In line with WHO CBID guidelines, these interventions help parents, support groups and community volunteers to improve access to inclusive education and healthcare (Elder & Migliarini, 2025; World Health Organisation, 2010). In South Africa, organisations like Blind SA provide community-based assistance to people with visual impairments by providing services like Braille training, mobility education, orientation and educational scholarships. Rural programmes, including disability community gardens have improved economic participation and social connections, particularly in districts like the Eastern Cape and Limpopo (Tigere & Moyo, 2022).

The SADC Protocols provide a regional policy framework that encourages member states to adopt inclusive, participatory, and rights-based community interventions (Ntinda et al., 2018). Within this framework, CBIPs focus on promoting accessibility, community awareness, and advocacy for the rights of PWDs (Ntinda et al., 2018). Experiences from the SADC region indicate that the success of community-based intervention programmes relies on collaboration between governments, civil society organisations, and local communities, ensuring interventions are context-specific and culturally appropriate (M’kumbuzi & Myezwa, 2017). Overall, regional initiatives provide important understanding into how community-based approaches can support the empowerment, social inclusion, and well-being of persons living with disabilities. Despite these lessons, there is lack of in-depth studies providing an impact assessment of specific, local interventions in areas like Waterfalls, Harare South, Zimbabwe.

2.5.3 Community-based intervention initiatives in Zimbabwe

In Zimbabwe, community-based intervention programmes (CBIPs) have been increasingly used to promote inclusion, empowerment, and participation for people living with disabilities (Kudzotsa et al., 2025). These community-based programmes aim to address both social and environmental barriers that restrict access to essential services, including education, healthcare, livelihood opportunities, and social support (Bongo et al., 2018b). Guided by the National Disability Policy (2021) and aligned with the SADC Protocols, CBIPs in Zimbabwe emphasise community involvement, participatory planning, and rights-based approaches (United Nations Department of Economic and Social Affairs, 2025; United Nations Department of Economic and Social Affairs, 2025). The local non-governmental organisations (NGOs), faith-based organisations, and government agencies collaborate to deliver initiatives that provide skills training, awareness campaigns, peer-support networks, and inclusive education programmes across various communities (Mbaimbai, 2025). According to Mapulanga et al., (2024), this was achieved through diverse stakeholder partnerships, community advocacy interventions and community training.

Zimbabwean CBIPs have been implemented in both urban and rural settings, with programmes targeting social inclusion, livelihood development, advocacy, and empowerment for people with disabilities (Bongo et al., 2018a). For example, initiatives by NGOs such as ZimAble Trust, L’Arche Zimbabwe and Disabled Children’s Action Group focus on community awareness, vocational training, and support groups to strengthen social connections and improve participation

for people with disabilities (Baranauskienė et al., 2011). These community programmes demonstrate that active engagement of families, local leaders, and community members is crucial for overcoming stigma, promoting accessibility, and ensuring the sustainability of interventions, although challenges related to resource dependency continue (Bongo et al., 2018b). The combination of policy frameworks with community action shows the country's effort to support inclusive development that addresses both individual and societal barriers.

At the local level, in communities such as Waterfalls, Harare South, CBIPs have aimed to provide specific support to people living with disabilities within the neighbourhood setting (United Nations Department of Economic and Social Affairs, 2024). Programmes in Waterfalls include community awareness campaigns to reduce stigma, skills development workshops, peer-support groups, and initiatives to improve access to basic services including healthcare and education (Chambers & Varoglu, 2023). Local NGOs, community-based organisations, and government agencies work together to ensure these interventions are participatory and culturally appropriate. Tofani et al. (2021) concur that such localised intervention programmes illustrate the practical application of national policies and regional frameworks, highlighting how community-based initiatives can improve empowerment, inclusion, and overall quality of life for PWDs in specific urban settings. Despite the existence of these important programmes, the current literature lacks comprehensive studies that thoroughly assess their actual impacts on the lives of people with disabilities.

2.6 Challenges facing community-based intervention programmes

Although community-based intervention programmes have contributed significantly to bettering the lives of PWDs, several challenges continue to hinder their effectiveness and sustainability. One of the most persistent challenges is the lack of adequate funding and resources (Nkomo et al., 2022). Many programmes rely mainly on donor support or short-term project grants, making it difficult to sustain activities such as training, follow-ups, and the provision of assistive devices once funding ends (Trani et al., 2022). Limited financial resources also restrict the recruitment of qualified staff and the expansion of services to remote or underserved areas.

Another major constraint is the shortage of trained personnel and weak institutional capacity (Naicker et al., 2019). In many communities, there are few specialists in rehabilitation, occupational therapy, or special education, leaving much of the work to community volunteers

who often lack technical training. This affects the quality and stability of services provided. Furthermore, Durmus Senyapar (2025), agreed that poor coordination among stakeholders, including government agencies, local authorities, and non-governmental organisations often leads to duplication of efforts or fragmented service delivery, which reduces programme impact.

Social and cultural barriers also pose significant challenges to the success of community-based interventions (Foday & Sidikie, 2023). In many societies, negative attitudes, stigma, and false beliefs about disability continue, resulting in discrimination and exclusion of PWDs from community activities (Breffka et al., 2023; Dube et al., 2021; Geetha & Dineshan, 2024). These attitudes can discourage participation in the programme and weaken community support. Additionally, Leighton et al. (2023) agreed that although Zimbabwe has enacted progressive policies such as the Disabled Persons Act (1992) and the National Disability Policy (2021), implementation at the local level remains limited due to insufficient monitoring, funding, and enforcement.

Lastly, environmental and infrastructural barriers such as inaccessible buildings, poor transport systems, and the unavailability of assistive devices further limit the participation of persons with disabilities in community-based initiatives (Jost et al., 2022). Addressing these problems requires greater policy commitment, capacity building, and inclusive planning to ensure that community-based intervention programmes achieve their intended goals of empowerment and social inclusion for PWDs.

2.7 Conclusion

This chapter reviewed both theoretical and empirical studies on disability and community-based intervention initiatives, emphasising the Social Model of Disability and the historical development of community-based methods. It explored various frameworks at the global, regional, and national levels and outlined the main roles, effects, and difficulties associated with these programmes. The review highlighted a lack of research concerning the local-level impact in Waterfalls, Harare South, which this study aims to achieve.

CHAPTER III

RESEARCH METHODOLOGY

3.1 Chapter introduction

This chapter presents a summary of the study area and maps, research approaches used, data collection tools, the target population, sample size and selection methods, data interpretation methods, data consistency, as well as research validity and the limitations of the study.

3.2 Description of the study area

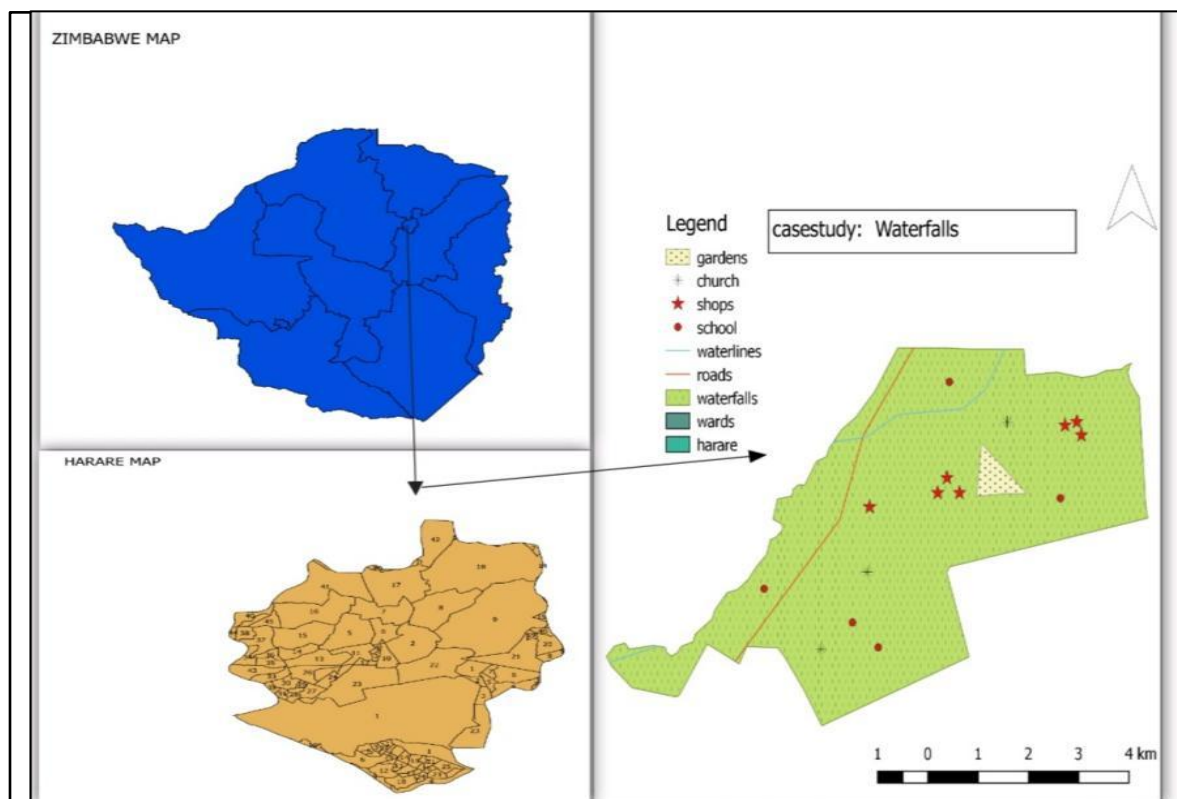


Figure 3.1 Study area map showing (a) Zimbabwe (b) Harare Province and (c) Waterfalls.
[Source: author]

Waterfalls is a large, low-density housing and commercial suburb located in the southern part of Harare, Zimbabwe (City of Harare, n.d.). The research area is part of Harare Ward 23 in the Harare South District and is bordered by neighbouring areas like Highfield, Glen Norah and Mbare (Open Council, 2024). According to ZIMSTATS (unpublished data), Harare Ward 23 has an estimated

population of 65349 and 0.3% of them are living with disabilities. The suburb's mixed land use and socio-economic variety make it a perfect location for community-based study, especially studies focused on investigating involvement, accessibility, and social progress for people with disabilities. Waterfalls is composed of several unique neighbourhoods, including Derbyshire, Grobbie Park, Houghton Park, Induna Park, Midlands, Mainway Meadows, Malvern, Parkton, Uplands, and Shortstone (City of Harare, n.d.). According to Propertybook (2023), each surrounding has different housing distributions, service access, and social characteristics, indicating the overall urban diversity of Harare South.

In economic terms, Waterfalls presents a mix of land uses that include residential, commercial, and light manufacturing zones (Propertybook, 2023). This variety supports diverse livelihoods, varying from formal jobs in local businesses to non-formal economic activities in surrounding areas. Waterfalls contains significant commercial centres like the Zindoga Shopping Centre act as social and economic hubs for the community (Propertybook, 2023). While Waterfalls has relatively improved infrastructure compared to surrounding high-density areas, it still experiences issues related to service delivery, the presence of squatter settlements and limited accessibility for persons with disabilities, as according to the petition submitted by residents in Waterfalls (Waterfalls Residents, 2025). From a development viewpoint, the area is an outstanding setting for assessing community-based intervention programmes (CBIPs). The combination of formal and informal settlements, distinct access to social services, and variations in household income levels allows for investigating how community-led initiatives function in varied urban contexts. Gaining insights into the impacts of these programmes in Waterfalls can provide important viewpoints on inclusive community development and service delivery that is responsive to the needs of PWDs in peri-urban settings within Zimbabwe.

3.3 Research design

This study used a case study research design with descriptive elements to investigate the impacts of community-based intervention programmes on persons with disabilities in Waterfalls, Harare South, Zimbabwe. The qualitative approach was considered suitable for providing detailed insights into participants' lived experiences and perceptions of community-based interventions. The use of multiple data collection methods, supported by secondary sources, led to the credibility and comprehensiveness of the research results.

3.4 Research methods

This section describes the research methods used in the study, detailing the procedures used to collect and analyse data on community-based intervention programmes for PWDs in Waterfalls, Harare South, Zimbabwe. The methods were selected to ensure the systematic generation of rich and credible qualitative data from relevant participants and sources. The section further explains the data collection techniques, sampling procedures, and data analysis processes used to address the study objectives.

3.4.1 Focus group discussions (FGDs)

FDGs were conducted first, as they provided a platform for collective interaction and sharing of ideas among participants before separate interviews were carried out. This arrangement helped the researcher to gain a summary of essential community issues and repeated themes, which later informed the design and refinement of interview questions. Four FGDs were conducted, each consisting of seven participants. This number was selected on purpose to ensure a controllable group discussion while allowing enough variety of views. The choice of the number participated was as recommended by Krueger and Casey (2015), who suggested that 6-10 participants per group and 3-5 groups are often sufficient to achieve data saturation while promoting rich interaction and capturing different views. The discussions were classified into two groups to reduce power imbalances and promote open participation. Two of the groups were made up only of individuals with disabilities, allowing them to share their life experiences freely. The remaining two groups included guardians or assistants and local officials or community leaders living in Waterfalls. Groups were organised to ensure variety in gender, age, and type of disability.

Participants were selected using purposive selection, focusing on people with direct experience in CBIPs and disability-related activities. The criterion for selection was based on relevance and experience with the subject matter, as recommended by (Midzi et al., 2024; Patton, 2015), who emphasise selecting participants who can provide rich, detailed, and meaningful data. Groups included a mix of male and female participants, with slightly more females (typically four females and three males per group) to reflect the higher proportion of women in caregiving and disability-related roles. Participants were chosen purposively for their direct experience and information-rich perspectives on community-based intervention programmes (CBIPs). This approach also ensured

that gendered dimensions of disability experiences were captured, recognising that women and men may face different barriers to participation and engagement.

3.4.2 Semi-structured interviews

After the FGDs, semi-structured interviews were carried out with picked key participants to examine emerging topics in greater depth. The 15 participants, including primary respondents and key informants were purposively selected and interviewed, representing different participant groups, consisting of 5 individuals with disabilities (3 females, 2 males), 3 caregivers, 3 community representatives, and 4 programme implementers or agents from organisations of persons with disabilities (OPDs). The semi-structured interview guide was used to maintain focus while allowing flexibility for participants to explain on their experiences and perspectives. The selection criterion reflected that used for FGD participants were chosen based on their involvement, expertise, or lived experience with CBIPs in the Waterfalls area. As noted by Palinkas et al. (2015), purposive selection of information-rich cases is important in qualitative research to obtain detailed insights rather than generalisable data.

The number of interviews was guided by data saturation principle, as according to Guest et al. (2006), who note that saturation in qualitative interviews is often achieved within the first 12 interviews, with additional interviews giving limited new information. Interviews were conducted in accessible and comfortable community settings, each lasting approximately 30–40 minutes, according to Patton (2015), who explains that qualitative interviews should be long enough to allow participants to share detailed experiences while remaining manageable, minimising participant fatigue, and respectful of the time of participants. Gender representation was guided by relevance and availability rather than strict numerical balance, with slightly more female participants showing the higher involvement of women in caregiving and disability-related community activities. This enabled the research to note potential gender related differences in access to and benefits from CBIPs, understanding that men and women may face different participation barriers.

3.4.3 Observations

Observation was used as an additional method to confirm and enhance data collected from discussions and interviews. The research employed non-participant observation, as according to

Creswell & Poth (2018), who concur that non-participant observation allows the researcher to systematically observe interactions, behaviours and settings without directly influencing actions of persons living with disabilities, caregivers, as well as community leaders. This method allowed the researcher to observe behavioural and environmental elements that could not have been clearly stated by interviewees and those who participated in focus group discussions. To address ethical concerns related to the vulnerability of PWDs the researcher asked for permission from all observed people, ensured privacy and the observation process did not cause any distress or interfere with their support. Observation focused on aspects like accessibility of physical infrastructure, ways of participation, involvement during community functions, and interactions between programme implementers and people with disabilities.

Thorough field observations were recorded to document observed behaviours, settings, and contextual factors applicable to the study objectives, as noted by Patton (2015), who highlighted that systematic observation and detailed field recording enhance depth and contextual understanding in qualitative research. The observational data offered more evidence to support and triangulate findings from interviews and FGDs, as noted by Denzin (2012), who identifies triangulation as a strategy for enhancing credibility by comparing data from multiple sources. Observations were accompanied by photographs, such as vocational sessions (taken only with clear written permissions to keep organisational information safe) to provide visual evidence of inclusion practices within community settings.

A purposive sampling approach was applied to choose participants like people with different disabilities, CBIP coordinators and caregivers who have relevant experience and engagement with CBIPs in Waterfalls, ensuring that the data reflected knowledgeable opinions and real-life experiences.

3.5 Data collection instruments

To achieve the research, aim and objectives, various qualitative data gathering tools were used to collect thorough and context-specific understandings about community-based intervention programmes (CBIPs) and their impacts on the lives of PWDs in Waterfalls, Harare South, Zimbabwe. The key instruments included a FGD guide and interview guide. Semi-structured interviews were carried out with key participants like community leaders, programme

implementers, and representatives from institutions for individuals with disabilities. This technique allowed for adaptable questioning while ensuring compliance to study goals, specifically in identifying available CBIPs and assessing their impact in promoting well-being, inclusion and empowerment.

3.5.1 Focus group discussion guide

A FGD guide was designed to enable organised yet open discussions among participants. The guide included a list of subject-related questions formulated to encourage discussion and explore participants' common experiences concerning the accessibility, impact, and inclusiveness of CBIPs. Questions included areas such as community views toward disability, accessibility of initiatives, engagement levels, empowerment results, and barriers. The FGD guide was separated into theme-based categories relating to the research objectives, ensuring uniformity across all group discussions as noted by Krueger and Casey (2015), who argue that organising focus group questions into theme-based sections promotes uniformity across groups while allowing systematic comparison of responses. The guide was first pre-tested with a small group to ensure clarity, it fits with the local culture and relevance of questions as highlighted by Creswell and Poth (2018), who note that pre-testing qualitative data collection instruments improves question relevance, enhances clarity and credibility of the research process. Adjustments were made before full implementation to enhance reliability. This tool was important for gathering collective insights and showing common trends in community views.

3.5.2 Semi-structured interview guide

The semi-structured interview guide was developed to collect detailed individual data from key informants, including persons with disabilities, caregivers, community leaders, and programme implementers. The guide combined structured, open-ended, and probing questions to allow flexibility while ensuring all interviews remained aligned with the research objectives, according to Kallio et al. (2016). A well-designed semi-structured interview guide helps ensure comprehensive coverage of important research areas while making possible for participants to explain their experiences in detail freely (Kallio et al., 2016). The questions covered participants' experiences with CBIPs, including their effectiveness, inclusiveness, and impact on empowerment and well-being. Each question was linked to a specific research objective, ensuring detailed data coverage. The instrument was developed following the guidelines of Creswell and Poth (2018),

emphasising open-ended questioning and researcher neutrality. Pre-testing was conducted as noted by Buschle et al. (2020), as to confirm clarity and sensitivity of questions, particularly when addressing personal or disability-related issues.

3.5.3 Observation guide

An observation guide served as an additional instrument to document the researcher's direct observations during field visits and CBIP-related community activities. This tool ensured systematic recording of non-verbal and environmental aspects that complemented data from interviews and FGDs. The key items in the observation checklist included accessibility of physical environments (e.g., ramps, seating, and signage), interaction between programme implementers and persons with disabilities, participation levels during meetings or activities as well as indicators of inclusion, respect, and empowerment. The use of an observation checklist ensured that observations could be collected reliably and systematically as stated by Patton (2015). He highlights that well designed observation instruments guide researchers in collecting detailed field data for later analysis. Each of these instruments was well designed to be line with the study objectives (Nuryanto et al., 2025). These include to identify existing community-based intervention programmes, assess their contribution on the lives of PWDs, suggest strategies for strengthening social inclusion and propose policy recommendations for enhancing the implementation and sustainability of CBIPs.

3.6 Target population, sample size, and sampling techniques

The target population for this research comprised of persons and groups directly involved in or impacted by CBIPs in Waterfalls, Harare South, Zimbabwe. This included individuals with disabilities, assistants, community leaders, programme implementers, and representatives from organisations of people with disabilities (OPDs). These groups were chosen because they have relevant experiences and understandings regarding the implementation, accessibility, and impact of CBIPs within the research area, as according to Elfil & Negida (2016) and Ishtiaq (2019). They highlight that the target population in the study must consist of people who are directly involved, share relevant characteristics or conditions, are affected by, or knowledgeable about the phenomenon under investigation.

3.6.1 Inclusion and exclusion criteria

Inclusion criteria: participants had to be above 18 years due to ethical considerations and practical consent, resident or employed in Waterfalls (or actively engaged with CBIPs in Waterfalls), and have direct experience of or responsibility for CBIPs (beneficiaries, caregivers, implementers, OPD representatives or community leaders). For PWD participants the research included a range of impairment types (physical, sensory, intellectual) to capture diverse experiences. Whilst, exclusion criteria people under 18 years, those without personal experience of CBIPs in the research area, and occasional respondents (not resident or engaged in Waterfalls) were dismissed, as selecting participants with relevant experience is important for qualitative research (Patton, 2015; Ishtiaq, 2019), and age criteria follows ethical guidance for adult participation (Weltgesundheitsorganisation, 2011; *WHO Tool for Benchmarking Ethics Oversight of Health-Related Research Involving Human Participants*, 2023).

3.6.2 Sample size (rationale and composition).

Table 3.1 shows the distribution of study participants by data collection methods

Data collection method	Planned number	Notes
Focus group discussions	28	4 FGD of 7 participants each. 2 groups of PWDs, 2 groups of caregivers, and community leaders
Semi-structured interviews	15	5 PWDs, 4 from the NGO of PWDs, 3 caregivers, and 3 community representatives
Total	43	Planned sample size

This qualitative study used a total selection of about 43 participants, chosen to achieve enough depth and diversity of viewpoints while remaining manageable for detailed, repetitive analysis, as concurred by Creswell and Poth (2018), who state that qualitative studies select sample sizes that are adequate to ensure a range of perspectives and depth while still being feasible for thorough examination. The planned distribution was focus group discussions (FGDs): 4 FGDs $\times$ 7 participants (average), 28 participants in line with the recommendations of Krueger and Casey (2015) that FGDs must include 6-12 participants representing relevant subgroups. Two groups of

PWDs, while the remaining two groups included caregivers and community leaders. Each FGD included a slight female majority and this composition was intentional, as women are more generally involved in disability related roles within communities and their experiences were crucial in understanding the impact and implementation of CBIPs.

Semi-structured interviews were done with 15 participants who selected purposively to provide expert and managerial insight, as advised by Creswell and Poth (2018) and Patton (2015), who highlight purposive sampling to target information-rich participants. Persons with disabilities (individual, in-depth cases): 5 (recommended gender split: 3 female, 2 male to reflect gender based experience), 4 programme implementers / NGO staff, 3 community representatives and 3 caregivers, following the guidance of Patton (2015), that diversity in participant characteristics improves credibility and richness of qualitative data. Some interview participants were expected to be selected from among focus group discussion participants according to their potential to provide more detailed perspectives into issues arising during discussions. The researcher got this approach from Cyr (2016), who notes that FGDs can act as a screening instrument for identifying participants with rich information with strong or unique views.

Given the descriptive and qualitative nature of the study, non-probability sampling methods were used. Specifically, purposive sampling was used to purposely select participants who could provide rich and detailed information related to the research objectives as according to Creswell and Poth (2018), who highlight that purposive sampling enables researchers to intentionally identify information-rich cases with direct experience of the case under study. This method made sure that only individuals with direct knowledge or experience of disability-related community interventions were included.

Snowball sampling was also used to improve the range and depth of perspectives. First participants were asked to refer other potential participants who fitted the inclusion criteria, particularly among persons with disabilities and caregivers who were involved in or benefited from CBIPs, as explained by Naderifar et al. (2017), who describe that snowball sampling is a purposeful qualitative method used to access specific population subgroups that may be difficult to identify through formal sampling frames. Moreover, Kirchherr and Charles (2018) agreed that snowball sampling is particularly important for improving sample diversity by making use of participant

networks to connect with individuals who have useful lived experiences that may otherwise not be noticed.

The actual sample size was decided based on the concept of data saturation, this occurs when no new information or themes come from additional data collection, as according to Fusch and Ness (2015) and Saunders et al. (2018), who highlight that qualitative data collection continues until no new information, codes, or themes appear for adequate and richness of perspectives.

3.7 Data analysis methods

Data collected using FDGs and semi-structured interviews were tested through thematic analysis, a method suitable for qualitative research aimed at finding, organising and identifying patterns of meaning within the data as described by Braun and Clarke (2006). This was also confirmed by Ahmed et al. (2025), who show that thematic analysis is a flexible qualitative method that finds, analyse as well interprets key themes in the data, ensuring methodological trustworthiness. This method enabled the researcher to carefully examine participants' views and experiences related to the impact of CBIPs on PWDs in Waterfalls, Harare South.

The analysis process included several key stages, which include data familiarisation, coding, topic development, and interpretation (Braun & Clarke, 2006; Creswell & Poth, 2018). First, every audio-recorded interview and focus group discussions were documented in the same words (verbatim) and carefully read to achieve a complete understanding of the content. Following, open coding was used to tag meaningful sections of text, recording participants' statements applicable to the study objectives. Matched codes were then grouped into sub-themes that indicated ongoing ideas and patterns, such as types of CBIPs, extents of social inclusion, empowerment results, and challenges faced by individuals with disabilities (Creswell & Poth, 2018; Fusch & Ness, 2015).

Lastly, the developing themes were compared and mixed with insights from secondary sources to enhance the accuracy and credibility of findings (Nowell et al., 2017). The analysis results were presented narratively and thematically and narratively, strengthened by clear quotations from participants in order to demonstrate key points and maintain the originality of their views as advised by Braun and Clarke (2006) and Creswell and Poth, (2018), who highlight the use of participants' own words to support analytic claims and enhance credibility in qualitative research.

3.8 Data reliability and study validity

In qualitative research, ensuring trustworthiness and validity was important to enhance the credibility and trustworthiness of the findings. Unlike quantitative studies which emphasise statistical measures of reliability and validity, this qualitative research used different strategies to ensure the accuracy and credibility of the findings (validity) and the uniformity and stability of the data collection and analysis processes (reliability) of the research process and results.

3.8.1 Data reliability

In this study, data reliability means the consistency and dependability of the data collection and analysis procedures (Creswell & Poth, 2018; Saunders et al., 2018). To achieve reliability, the researcher maintained clear and transparent processes, ensuring that the study could be traced and repeated by other scholars following the same steps (Enworo, 2023; Steltenpohl et al., 2023). The same FDG and interview guides were used across all participants to ensure uniformity in questioning and data gathering, as according to Kallio et al. (2016), who emphasise uniform use of guides.

Furthermore, the study used data triangulation to gather information from many sources (Fusch et al., 2018). Methodological triangulation was used through the application of different methods, such as semi-structured interviews, focus group discussions (FGDs), and observations (Carter et al., 2014). This allowed the researcher to cross-check findings from one method with another, according to Marlina et al. (2024). For instance, difficulties related to physical accessibility observed were compared with participants' personal experiences in interviews. Moreover, source triangulation was also applied by collecting insights from various stakeholder groups, including people with disabilities, caregivers, community leaders, and programme implementers (Meydan & Akkaş, 2024; Sarker & Adil Khan, 2024; Torkar et al., 2023). Comparing and contrasting these views provided a thorough and balanced view of the impact of CBIPs and increased the dependability of the findings. This cross-verification of information enhanced the consistency of the findings (Donkoh, 2023). In addition, a detailed audit trail was maintained through field notes, audio recordings, and verbatim notes, providing a thorough record of all collection and analysis of data activities (Nowell et al., 2017). Peer discussion sessions with academic supervisors and colleagues further improved reliability by minimising researcher bias and making sure that

interpretations remained based in the participants' views rather than the researcher's beliefs as concurred by Creswell and Poth (2018), who advocate peer briefing.

3.8.2 Study validity

In qualitative research, validity relates to the credibility, transferability, dependability, and confirmability of the findings (Creswell & Poth, 2018; Kakar et al., 2023). To enhance credibility, the researcher spent sufficient time engaging with participants to develop trust and to gain a deeper understanding of their lived experiences (Nowell et al., 2017). Member checking was also conducted by allowing participants to check and confirm the correctness of their documented statements and interpretations, ensuring that their voices were genuinely represented, as according to Birt et al. (2016) and Creswell and Poth (2018), who highlight the importance of member checking.

Transferability was strengthened by providing detailed descriptions of the study context, Waterfalls, Harare South and of participants' experiences (Ahmed, 2024 & Ahmed, Mohammed, Nashwan, Ibrahim, Abdalla, M. Ameen, et al., 2025). This allows readers to judge the applicability of the findings to other settings with similar characteristics. Dependability was enhanced through a systematic and transparent approach to data management and analysis, ensuring that all research procedures were well-documented and could be followed by other researchers wishing to repeat the study (Nowell et al., 2017). Confirmability was achieved through researcher self-reflection, where a personal notebook was maintained throughout the study to record personal biases, assumptions, and key decisions (Berger, 2015). This ensured that the findings came out from participants' views rather than from the influence of the researcher.

Additionally, the study was guided by the Social Model of Disability, which provided a clear theoretical framework for interpreting the data and linking findings to the research objectives (Oliver, 1996; Shakespeare, 2013). This framework enhanced the accuracy of the study by ensuring that data interpretation was similar, meaningful, and grounded in an established theoretical perspective as according to Creswell and Poth (2018), who highlight theory guided interpretation.

Through these mixed strategies, the study achieved a high level of research quality, ensuring that the results are credible, dependable, and reflective of the lived realities of people with disabilities and their participation in community-based intervention programmes in Waterfalls, Harare South.

3.9 Limitations of the study

Although this study used thorough qualitative methods to ensure credible and reliable results, certain limitations were unavoidable due to the nature and scope of the study. Seeing these limitations shows the researcher's serious reflection and transparency. The following challenges were identified, along with the ways used to reduce their potential impact on the study's results.

Large geographic scope -The study area, Waterfalls in Harare South, is large and includes various types of residential areas with different socio-economic conditions. The size of the suburb made it challenging to include every neighbourhood, which could have limited the thoroughness of the findings. To mitigate this, four residential areas were selected to represent different socio-economic activities, allowing for a diverse and representative understanding of the impact of CBIPs on the lives of PWDs.

Small, purposeful sample- The relatively small sample size and purposive/snowball sampling approach may have excluded some perspectives, especially from marginalised or less talkative participants. To mitigate this, triangulation was used by collecting data through many sources and methods, including semi-structured interviews, focus group discussions (FGDs), and observations. This ensured a broader range of views and cross-verified information to strengthen the dependability of the findings.

Potential researcher bias- Qualitative research is strongly based on the researcher's interpretation, which could introduce personal bias or influence data collection and analysis. To reduce bias, the researcher engaged in self-reflection, keeping a reflective journal to record personal ideas and decisions. In addition, peer debriefing sessions with academic supervisors and member checking with participants were carried out to ensure interpretations were based on participants' real experiences.

3.10 Chapter conclusion

This chapter covered the study methodology for the research, including the description of the study area, the qualitative design, study area, sampling methods, and data collection methods. Strategies to ensure data reliability and study validity, such as triangulation, member checking, thick description, reflexivity, and the use of the Social Model of Disability, were discussed. The study's limitations and the measures taken to mitigate them were also highlighted.

CHAPTER IV

RESEARCH FINDINGS AND DISCUSSION

4.1 Chapter introduction

This chapter provides and discusses the study results. These findings were collected through focus group discussions, interviews and observations. Thematic analysis was used to identify main or repeated themes in all data sources. The results of this study were presented and examined according to the objectives of the study.

4.2 Participants' background information

4.2.1 Interview participants' distribution by gender

Table 4.1 Gender distribution of interview participants

Category	Frequency	Percentage (%)
Female	7	58
Male	5	42
Total	12	100

The table indicates the total interview participants, the majority of the sample were females compared male as females were more willing to participate than males. Although at first the study aimed to interview 15 participants, data saturation was reached after the 12th participant. The participants included persons with disabilities, caregivers, programme implementers which included occupational and physio therapists, representative from OPDs and community member.

4.2.2 Interview participants by educational level

Table 4.2 Educational level of participants

Level	Frequency	Percentage %
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Ordinary	7	58
Advanced	-	-
Tertiary	5	42
Total	12	100

The table shows the highest level of education which was completed by interview participants. The majority of interviewees had finished secondary ordinary level and minority of participants had reached tertiary education. There were no interview participants whose highest educational level was primary level. This was so because all interview participants were 18 years and above. Information relating to minors and those with ID was given by their caregivers or parents.

4.2.3 FDGs

The FDGs included 2 groups of people with diverse disabilities, one of caregivers and parents and programme implementers or service providers. The age group of all participants was 18-45, because the research followed the ethical guidance for adult participation (*WHO Tool for Benchmarking Ethics Oversight of Health-Related Research Involving Human Participants*, 2023). Moreover, individuals in their 40s were much willing to participate than the older age groups especially those in their 50s.

4.3 Presentation and discussion of results

The presentation and discussion of the study results was done according to themes and sub-themes that were identified from the data. The results are based on the data collected through FGDs, interviews and observation. The views of the participants are also presented and analysed according to research objectives.

Table 4.3 Research themes and sub themes

Theme	Sub-theme
1. Types of community-based intervention programmes for PWDs in Waterfalls	1.1 Vocational training and economic empowerment 1.2 Rehabilitation and therapeutic services 1.3 Social, sports and recreational programmes

	1.4 Support groups, peer networks and awareness Rights-based and awareness programmes
2. Impacts of community-based intervention programmes on social inclusion, empowerment and well-being	2.1 Self-advocacy and empowerment 2.2 Community participation and social inclusion 2.3 Psychological well-being 2.4 Barriers to access and participation
3.Strategies for strengthening social inclusion through community-based intervention programmes	3.1 Environmental and physical accessibility 3.2 Stigma reduction and attitudinal change 3.3Inclusion programme planning
4 Policy recommendations for community-based intervention programmes	4.1 Sustainable funding 4.2 Participation and community ownership in governance 4.3 Disability legislation and enforcement

The table shows that there are various CBIPs for PWDs in Waterfalls and they focus mainly on inclusion, well-being and empowerment through different activities and support services. The results highlights that the benefit of these intervention programmes their full potential is limited by ongoing barriers such as stigma.

4. 4 Types of community-based intervention programmes in Waterfalls, Harare South

The participants from interviews identified different CBIPs that support individuals with disabilities in Waterfalls. The intervention programmes mentioned included vocational training, educational support, physiotherapy, occupational therapy, awareness campaigns, support groups, rehabilitation services, government social welfare support, and counselling services. Participants explained that these intervention programmes are mainly offered by churches, OPDs and other NGOs organisations.

4.4.1 Vocational training and economic empowerment

Participants mentioned vocational training as a major type of CBIPs, with them stating skills-based interventions like tailoring or sewing, carpentry, educational support, baking, and gardening. Participants also mentioned that these programmes are largely led by L'Arche Zimbabwe, Mentally and Physically Handicapped Development and Counselling Trust (MEPHDECT), and Jairos Jiri Waterfalls Centre. These organisations were noted for improving economic independence for persons with disabilities in Waterfalls, Harare South, Zimbabwe.

During interviews, a male participant with disability (cerebral palsy) said: *“Daily life is better because I can sew and make some money rather than waiting for handout”*

Another male participant with disability from interviews (deaf) also shared how these interventions positively change his life: *“I am happier, knowing that I can make furniture gives me a purpose I did not have before”*

A male caregiver in in interviews again cement the importance of vocational training and economic empowerment from his experience with his son with intellectual disability and some speech difficulties said:

My son gained gardening skills and is working at L'Arche Zimbabwe, and having his salary monthly. As a parent seeing him included, happy and proud of himself has been one of the biggest positive change in our lives

Another male participant with disability during interview said: *“I have a vocational certificate in Carpentry, it was done through a community intervention programme that used visual manuals”*

A female participant with disability said the following during interviews: *“Yes, there are vocational workshops like the tailoring one I am in”*

Findings from focus group discussion 2 also highlight vocational training. FDG 3 of caregivers and parents added the type of vocational training offered by CBIPs in Waterfalls which included baking, sewing, and woodworking. During observations, the researcher saw PWDs in Carpentry workshop doing woodwork and the garden project.



Figure 4.1 PWDs doing woodwork in Waterfalls under CBIPs

The figure demonstrate PWDs participating in carpentry in Waterfalls. This shows the contribution vocational training interventions in preparing PWDs with practical skill that may enhance independence, economic empowerment and other income generation opportunities.



Figure 4.2 Garden project by PWDs observed by the researcher in Waterfalls

The image shows a garden project at L'Arche Zimbabwe in Waterfalls. They grow vegetables. A greenhouse is behind the vegetables showing in white colour and it contained cucumbers and tomatoes. The garden project shows how vocational programmes are supporting gardening and greenhouse agricultural skills among PWDs, which may lead to food security, income generating and independence.

These findings connects with the Social Theory of Disability's idea that disability is caused by social and structural barriers, rather than person's impairment (Oliver, 2023). The findings also agree with what reviewed literature identified as important role of community-based intervention programmes offering skill development and education allowing adults with disabilities to contribute economically to their homes and communities (Mudde et al., 2025; Saran et al., 2023) By offering vocational opportunities, community-based intervention programmes effectively remove one of the barriers, thus economic exclusion by enabling persons with disabilities to contribute in their communities in a useful ways.

4.4.2 Rehabilitation and therapeutic services

Therapy services appeared as the most mentioned type of community-based intervention programmes in Waterfalls. Organisations such as MEPHDECT, Jairos Jiri Children's Centre and L'Arche Zimbabwe were found as main service providers of counselling services, occupational therapy, and physiotherapy. These services are provided both home-based and centre-based approaches.

During interviews, participant A, who was an occupational therapist explained the range of therapeutic intervention as:

My role in community-based intervention programmes in Waterfalls is to make sure that whatever activities that PWDs do on day to day basis are meaningful and also increasing the sense of participation within the given activities that they do and also to make sure that the activities will bring good overall health and well-being that ultimately increase good quality of life

A programme implementer and representative from organisations with PWDs with more than twenty (20) years working with CBIPs mentioned therapeutic services such as counselling, physio and occupational therapy during interviews.

Participant C, a parent and primary caregiver during interview also said: *"It always depends with the type of help needed; we go to L'Arche Zimbabwe Centres for physiotherapy"*

Similarly, interview participant B, mentioned the scope of therapy services, highlighting that CBR sessions were aimed at mobility training, daily living skills, and home adaptations. Additionally, participant K, a representative from organisations of PWDs and programme implementer supported the availability of CBR outreach programmes including counselling and caregiver support groups. During observations, the researcher also observed Therapy Centres with occupational and physiotherapy materials like corner seats, therapy mats, sensory positioning chairs, swings, foam rollers, sensory material and balance, and climbing equipment. She also observed parents with children with developmental delays being taught how to do exercises on their children under CBIPs. These materials seemed to support therapy sessions for rehab and physical support for PWDs.



Figure 4.3 Shows parents doing physio to their children in Waterfalls

The image shows parents and caregivers of children with disabilities with therapists doing physiotherapy sessions in Waterfalls under CBIPs. This shows how these interventions support rehabilitation by including professionals and caregivers in improving mobility, physical functionality and overall well-being.



Figure 4.4 Therapy centre in Waterfalls

The figure 4.4 shows therapy room used for therapy services in Waterfalls. The researcher observed that the room is equipped with therapy materials such as cornerseats designed to support rehabilitation and physiotherapy activities for PWDs.

These findings are similar with WHO's 2010 CBR guidelines which highlight the importance of rehabilitation in community-based approaches to disability inclusion. The community outreach approach in the findings matches with what Bongo et al. (2018), noted as CBR strategies for enhancing quality of life in Zimbabwean communities, reached through home-based support and community outreach instead of centralised institutional care.

4.4.3 Social, sports and recreational programmes

The research findings identified social, sports and recreational activities as a third type of community-based intervention programmes. Special Olympics Zimbabwe was regularly stated sports programme in Waterfalls and other community events. Participants from FDG 1 confirmed that Special Olympics Zimbabwe coaches in Waterfalls were mainly people with disabilities themselves showing peer leadership within these interventions. Some participants also mentions

that organisations such as L'Arche Zimbabwe do sports for people with and without disabilities also.

A Waterfalls resident said: *“PWDs engage in different programmes like sports and community events where some sing, dance and some as MCs”*

Participant A gave explanation on how social participation leads to multidimensional gains to PWDs:

Their network system expands in that there is opportunity for them to interact with different people outside their disability community and their health tends to be uplifted in the sense that there is social component, mental component as they interact with others on a shared social perspective

Another female caregiver participant supported the idea that there are local sports programmes in Waterfalls for PWDs although she did not engage in them. She said: *“Yes, there are other programmes but I’m not very sure about how they operate, I got to know them when they are invited to events hosted by L'Arche Zimbabwe, such as Special Olympics”*

The findings from FGDs also highlight sports as intervention programs for PWDs in Waterfalls. Participants from FGD 2 also mentioned the existence of sports. The researcher saw sports training for individuals with intellectual disabilities at L'Arche Zimbabwe during field observations.



Figure 4.5 football training of PWDs in Waterfalls

The image show people with ID participating in soccer training sessions as part of CBIPs in Waterfalls. This highlights efforts to promote teamwork, physical activity among PWDs through sports-based rehabilitation services.

The findings relates to what was revealed in chapter 2, where Special Olympics' Health Athletes programme as an design that combines sports with health promotion, offering free screenings, social inclusion and encouraging social participation of people with intellectual disabilities (Diz et al., 2024).

4.4.4 Support groups, peer networks and awareness

Another type of CBIPs mentioned within all data sources included caregiver support groups, awareness campaigns, peer networks and disability rights education. Participants indicated that organisations such as Jairos Jiri Waterfalls Children's Centre, L'Arche Zimbabwe and

MEPHDECT implemented outreach programmes and workshops to educate both PWDs and the community about disability rights.

During interview one caregiver said that:

“There are local support groups where as parents and caregivers share challenges and reduce isolation associated with full time caregiving”

During interview another parent/ caregiver also said:

Hongu tine mapoka ekutsigirana sana amai tichipanana pfungwa nemazano pakuchengeta misha, mapurojekiti angatipa mari akaita sekupfuya huku pamwe nekurima mavheji kuti tisazoshandise vana vedu kupemha (Yes, we have support groups where mothers share tips and ideas on homecare and income-generating projects such as poultry and gardening so that we do not use our children to beg)

A female participant with disability said: *“Yes, there are vocational workshops like the tailoring one I am in”*

A Waterfalls resident participant noted: *“Yes, I see people from L’Arche Zimbabwe doing home visits, vocational training skills, and sports”*

Participants from FGD 1 of persons with disabilities also stated educational support, therapy services, and food donations specifically for families with persons with severe disabilities. PWDs who participated in FGD 2 also added the community-based intervention programmes including counselling and rehabilitation, social and emotional support, counselling, and awareness campaigns. Other additional programmes from FDG 3 of caregivers and 4 of service providers/programme implementers included sports activities, outreach programmes and vocational training such as sewing, gardening, and baking. The findings relate with those in chapter 2 considering the SADC literature which highlighted that regional community-based intervention programmes include peer-support groups and awareness campaigns (Butura et al., 2024).

4.5 Impact of CBIPs on social inclusion, empowerment and well-being of PWDs

The second objective assessed the impact of local intervention programmes on social inclusion, well-being and empowerment of PWDs in Waterfalls, Harare South, Zimbabwe. This theme

produced the most detailed findings in all data sources with participants continuously indicating both positive impacts and ongoing challenges. The following sub-themes were identified:

4.5.1 Self-advocacy and empowerment

The findings show that CBIPs in Waterfalls have contributed to the empowerment of PWDs, especially in areas like self-advocacy, decision making, and economic independence. Peer support groups, vocational training interventions, rights education were mentioned as the key contributors of empowerment.

During interviews, a female participant with disability said: *“Yes, I’m more confident. When you have a skill like sewing that I have, the community start to see you as a tailor not just a cripple”*

Another female participant with disability also mentioned the similar idea of being empowered: *“Yes, earning my own money for my rentals, airtime and hair changed my self-worth”*

A male caregiver participant E mentioned the same point on empowerment of his son during interviews: *“My son gained garden skills and is currently working at L’Arche Zimbabwe and having his own salary monthly”*

FDG participants with disabilities mentioned that they gained skills which led to their empowerment from CBIPs. Participants from FDG 1 said: *“Yes, we gained skills such as sewing and communication, we feel more confidence in ourselves”*

Participants from FDG 2 added: *“Yes, we gained confidence, vocational and life skills, improved self-esteem and teamwork skills”*

This sub-theme addresses the concept of empowerment as described in literature review, indicating autonomy, self-determination, and control over choices affecting individual’s life (Giummarra et al., 2022; Oliver, 1990). The findings also is also in line with the reviewed literature, which highlighted improvements in social participation and self-esteem among beneficiaries of CBIPs (Uchenwoke et al., 2023; Umunnah et al., 2023). In literature review, Schneider (2012) and Tinta et al. (2020) argue that empowerment is attained through removal of institutional and social barriers, which these intervention are clearly starting to achieve in Waterfalls

4.5.2 Community participation and social inclusion

Improved social inclusion appeared in all data sources. The findings show that before their involvement in community-based intervention programmes, individuals with disabilities in Waterfalls had faced serious isolation and social exclusion. Participants mentioned that this was caused by serious stigma, overprotective families and lack of inclusive spaces. Participants shows CBIPs helped to reduce this pattern.

During interviews, an occupational therapist mentioned a marked change in how persons with disabilities presented themselves:

Back then you would see that they would bundle up, they would not want to open up because they feel that they are being marginalised, and stigmatised. Now that these activities are now coming in, they are now affording opportunities for people to interact. PWDs also engage in some of the things that are regarded to be done mostly by able bodied people

During interviews, female caregiver participant D also mentioned great change brought by CBIPs on community's beliefs or views towards disability, she mentioned comments they often received before interventions: *"Chimwana ichochi ndicho chinoita kuti mabhizinesi avo ashande nekubudirira, vanoshandisa mwana kuwana mari"* (This child is what makes their business work and succeed, They use their child for money rituals)

She further explained the reduction of myths such as the idea that cerebral palsy is related to ngozi (avenging spirits), or witchcraft is fading because of CBIPs. Participants from FGD 3 of caregivers brought the same point of reduced use of hurt words: *"Yes, some community members are now accepting, supporting and speak kind words not word like chirema (disabled)"*

This is exactly what was reviewed in chapter 2, the Social Model of Disability identified this as the major challenge. The theory concurred that it is societies' inability to accommodate diversity not one's impairments that leads to disability (Oliver, 2023).

FDG 2 participants supported this sense of inclusion, mentioning: *"Yes, we feel accepted, supported and included. We no longer feel isolated"*

During observations, the researcher observed that PWDs are included in different activities, in organisations they are participating in sectors like kitchen and facilitating activities. This finding

clearly supports the Social Model of Disability as it was reviewed in chapter 2 that disability is not as a result of person's impairment but by restricting social environments (Oliver, 2023). Community-based intervention programmes in Waterfalls work as important tools for removing those environments, similar to what Chawa et al. (2021) explained as community-based approach to promote social inclusion by reducing stigma and encouraging acceptance.

4.5.3 Psychological well-being

Participants reported important improvements in quality life and psychological well-being after engagement with CBIPs. Drawing from the principles of occupational therapy, during interviews, participant A, noted important improvements in psycho-social presentation of PWDs:

So by the virtue of being given opportunity to engage in these activities, I have seen that when it comes to psycho-social component of how PWDs present themselves, I have seen massive improvements and changes.

He further mentioned the reductions in secondary challenges among individuals with disabilities who regularly engage in meaningful activities: *"With regards to physical attributes, I have seen that there is reduction of secondary complications that also rise with disability"*

Participant C, who's a primary caregiver explained the change in her son in relation to both social and psychological dimensions of well-being: *"My son become more confident, happier, and more social after joining CBIPs. He now enjoys interacting with others and participating in activities rather than staying alone isolated."*

This sub-theme clearly connects to literature review's discussion of well-being outcomes of community-based intervention programmes, which indicated that CBIPs improve participants' physical, social, and psychological functioning (Tofani et al., 2021; Umunnah et al., 2023).

4.5.4 Barriers to participation

Despite the benefits above, the findings show significant barriers to access and participate in CBIPs which were mentioned consistently in all data sources. These barriers included financial, structural, cultural and communicative in nature.

Transport and physical infrastructure appeared as the most consistently cited barrier. During interviews, participant with disability, who uses a wheelchair explained the inaccessibility of

transport. He said that *“Programmes are physically accessible (ramps) but getting to them is a problem. If you do not have or own a private car, using kombis is not easy to us all. Access is a maybe never a definitely.”*

During interviews, participant C, who have a child with disability said that

Sometimes I cannot attend weekly sessions to specialised centres because of transport costs, my son is now a grown up boy. I cannot carry him on my back to bus stop. Falling to attend every therapy sessions slows down the progress

Participant D, who is a parent and caregiver explained the physical and financial burden of transporting a child with CP during interviews, *“Our roads are full of potholes, making wheelchairs a nightmare to push. Most programmes are accessed by either foot or paying much for a private car because kombis sometimes refuse to take us.”*

She further described the problems they face as parents of children with disabilities when using public transport that, *“Chero tikawana makombi zvinenge zvakaoma kupinda nemwana ane hurema, vamwe vanobva vadzika kana kuchinja pekugara”* (Even if we get kombis, it will be difficult to board with a child with disability, others end up getting off or changing their seats)

During observations the researcher observed poor road infrastructure, which confirmed what participant D said during interviews about potholes and pushing wheelchairs.



Figure 4.6 the poor state of the Malvern Road observed by the researcher during observations in Waterfalls

The image shows a road in Waterfalls with potholes, showing poor infrastructure. These barriers may make it hard for PWDs access intervention programmes, specifically those using wheelchairs.

Stigma and cultural barriers were equally mentioned. Participant A, during interviews, explained the extent of cultural stigma as a barrier to access CBIPs:

Deeply rooted in cultural attitudes and stigmatised, like in African context in which they say disability is attributed due to witchcraft or where they view disability as incapable from a Medical model perspective leading to social exclusion and overprotection by family at times.

Another aspect of barriers is communication exclusion which was raised by an interview participant who was deaf. He said that, “Without an interpreter provided by programme organisers, I am just watching people’s lips move. My role is often being a silent participant”

He further said that, “Access for me is not ramps, it is about language. If there is no interpreter, I’m physically there but mentally excluded”

FDG 1 participant added that it is not easy to participant in CBIPs, *“It is not easy to participate if there is no sign language interpreter, the deaf will be just sitting”*

Beyond financial and other barriers, service providers also mentioned inconsistent caregiver dedication as a primary challenge they are facing that is affecting the potential of CBIPs to deliver their best. During interviews, participant K, the representative from organisation with PWDs and programme implementer said that:

One of the challenges is that therapy continues at home but some caregivers struggle to follow the routines and exercises taught during therapy outreach sessions. As service providers and therapists, we sometimes revisit families or their nearest centres after two-three weeks and notice little or no progress happened because at home, programme was not followed consistently

This sub-theme clearly confirms what was identified as ongoing challenges that CBIPs are facing in literature review, including negative cultural attitudes, limited financial resources, and the absence of communication formats (Foday & Sidikie, 2023; Jost et al., 2022). These barriers are also in line with what was reviewed in Chapter 2 as accessibility concept that it is inaccessible environments that create exclusion and dependency not impairments (Chawa et al., 2021; Oliver & Barnes, 2012). The results are also comparable to those reviewed in chapter two regarding the importance of caregiver engagement in sustaining CBIPs especially in therapeutic progress. Ghebre et al. (2026), argue that local-level support such as home visits and caregiver training greatly improve the daily participation and functionality of PWDs. This clearly means that when such home-based commitment does not happen, the benefits made during structured interventions are more likely slowed.

The barriers mentioned here interact and strengthen each other increasing to make participation difficult for PWDs in Waterfalls. The case of centres with ramps that is still not accessible because of poor roads and discrimination in public transport shows that accessibility is a systematic challenge not just building's characteristics. If communication barriers, cultural attitudes and transport funding are not addressed together, CBIPs in Waterfalls may continue to exclude those who need support the most.

4.6 Strategies for strengthening social inclusion through CBIPs

The third study objective aimed to indicate strategies strengthening the social inclusion of PWDs through CBIPs. Participants provided practical, experience-based suggestions that align with the conceptual framework discussed in chapter 2, which identified participation, accessibility, and empowerment as important pillars of effective CBIPs (Chawa et al., 2021; Oliver & Barnes, 2012). From this theme, three sub-themes developed.

4.6.1 Environmental and physical accessibility

Environmental and physical accessibility was the most commonly mentioned strategy in all data sources. Participants suggested the need for disability-friendly transport, accessible programmes venues, road infrastructure, and home-based outreach that brings services to persons with disabilities instead of requiring them to go to centralised locations.

During interviews, participant C, a caregiver, suggested practical transport interventions, *“Specialised transport, squeezing a wheelchair into a kombi is a nightmare, it is also expensive and some drivers do not want to wait too”*

She further suggested a technology-based solutions when there is rains or muddy roads, *“Programmes should use WhatsApp groups to keep everyone when the weather makes the toads impossible to use”*

Interview participant A, indicated a crucial point of accessibility of PWDs to physical environments and information:

Physical environments must be made accessible to ensure that community spaces, public buildings and transport systems are adopted to accommodate people with diverse disabilities. This include installing ramps, accessible toilets and clear signage, ensure information is available in formats such as braille, sign language and audios for those with sensory impairments

FDG 1 participants highlighted the need for accessible venues. This suggestions are according to the WHO CBR guidelines in literature review, which stand for accessible environments as important in ensuring independence and equality for individuals with physical disabilities (World Health Organisation, 2010). In addition, this suggestion clearly aligns with the concept of

accessibility discussed in chapter 2, which refers to how physical environments, information and services are developed to be used by all members in the community (Oliver & Barnes, 2012). Chapter 2 also identified environmental and infrastructural barriers which includes inaccessible buildings, lack of assistive devices, and poor transport as factors that limit participation people with disabilities in CBIPs (Jost et al., 2022; Tinta & Kolanisi, 2023)

4.6.2 Stigma reduction and attitudinal change

Attitudinal change and sustained community education campaigns were suggested in all data sources as an important strategy to strengthen social inclusion. Participants advised churches to actively challenge narratives on disability which are grounded on witchcraft beliefs.

During interviews, occupational therapist, participant A, suggested:

Changing community attitudes through ongoing awareness and sensitisation campaigns that educate the public or the community about disability rights that challenge harmful stereotypes and that promote a culture of inclusion and respect

FDG 1 participants with disability suggested that community members must treat PWDs with respect because they also feel, think and get hurt. FDG 4's participants also mentioned removal of stigma, promotion of inclusion and respect rights.

This suggestion is based on the chapter 2 which identified societal and environmental barriers such as cultural stigma and negative social attitudes as the main challenge to inclusion that must be addressed by CBIPs (Foday & Sidikie, 2023; Oliver, 1996; Schneider, 2012). Literature review further confirmed that community-based intervention programmes in Zimbabwe included awareness campaigns to minimise stigma as recorded part of CBIPs (Bongo et al., 2018).

4.6.3 Inclusive programme design

Participants in all data sources suggested for a need to completely redesign community-based intervention programmes to ensure that individuals with disabilities are not only beneficiaries of programmes but are also active in planning, leadership, and monitors of the services that serve them.

During interviews, participant D, caregiver said:

“Instead of us parents and experts deciding what is best for PWDs, the programmes should be developed by individuals with disabilities. I would love to see adults with disabilities in leadership, when our children see a person in a wheelchair leading a meeting teaching craft, they realise they are also part of the community not guests”

Participant D further indicate the need for disability specialised programmes not focusing on programmes that only support one disability in the name of disability inclusion:

Stop the blanket approach, most projects here treat all disability the same but my daughter with CP has different needs with the one who’s deaf. Interventions need to be specialised, they must not throw us in one group of disability and call it inclusion

This suggestion clearly reflects the empowerment concept reviewed in chapter 2, which highlights self-determination and control over choices affecting individual’s life and clearly rejects ways that portray PWDs as passive recipients of care (Oliver, 1990 ; Schneider, 2012). Literature reviewed in chapter 2 further explain community engagement as involving PWDs in decision making processes, community governance and programme activities as a key role of effective community-based intervention programmes (Chawa et al., 2021; Hasan et al., 2024)

4.7 Policy recommendations

The last objective aimed to propose recommendations for improving the delivery and continuity of CBIPs for persons with disabilities in Waterfalls and other areas. The three sub-themes were developed from the data, each focusing on the identified gap that clearly connects to challenges mentioned in literature review of Zimbabwean community-based intervention programmes, SADC context and national disability policy structure.

4.7.1 Sustainable funding

Over-reliance on donor support and unsustainable funding were mentioned in all data sources as the serious threat to sustainability of community-based intervention programmes.

Interview participant A, recommended the need to address funding and resource mobilisation urgently. He suggested:

Sustainability must be built into every programme from the beginning, this requires securing diverse and reliable resources through partnerships with the government, local businesses and donor organisations, while also establishing a dedicated community fund to reduce dependency on any single source of finance

He explained further, " *Waterfalls would also do partnerships with local businesses, international donor organisations and government departments to secure consistence and long-term financing of these programmes* "

Participant B recommended the same during interview. She said that, "*The programmes would secure government budget lines not just donor funds that can be cut unexpectedly*"

During interviews, caregiver participant C argued and recommended that programmes would fund themselves. She said that, "*Programmes must do small income-generating projects to supports groups so they do not rely completely on donors.*"

Participants from FDG 2 and 3 recommended government support and more funding in order to enhance the implementation of CBIPs. The results clearly confirm what literature review identified as one of the most ongoing challenges that CBIPs is facing in Zimbabwe. While these interventions show positive impacts, challenges linked to dependency on external sources continue, with many projects depending mainly on short-term grants or donor support that make it hard to support activities when funding ends (Bongo et al., 2018; Nkomo et al., 2022).

4.7.2 Participation and community ownership in governance

Community ownership and participation is another recommendation which is closely connected to ongoing challenges.

During interviews, participant A said:

CBIPs must strengthen the planning and coordination of activities by establishing a disability inclusive community made up of service providers, local leaders and individuals with disabilities themselves. This would ensure that programmes are designed based on the real need and priorities of those they are intended to serve rather than assumptions made on their behalf.

This highlight that current interventions are usually based on their behalf. Participants from FDGs are of the same view. FDG 3 participants noted limited participation that, *“Yes, PWDs organise meetings, contribute ideas and opportunities are still limited”*

The research findings indicate that CBIPs in Waterfalls are mostly led by NGOs, with limited engagement of PWDs in processes decision making processes. Literature review shows that effective community-based intervention programmes should be inclusive and empower individuals with disabilities in operational or leadership structures (Hasan et al., 2024; Oliver, 1990)

4.7.3 Disability legislation and enforcement

Participants mentioned a gap between existing disability laws in Zimbabwe and what really happens in practice at local level in Waterfalls. Laws exist but there is weak enforcement. The findings clearly connect with chapter two.

Participant A highlight the need for stronger systems:

Stronger policies and bylaws should be put in place to institutionalise disability inclusion making it permanent feature of community rather than a one-off project. Regular monitoring and evaluation feedback would ensure that initiatives remain relevant and responsive to the needs every time.

Participant F further recommended that policies must enforce accessibility compulsory. He said that *“Make accessibility, must be a mandate. Some business must not be given licence unless they have a ramp.”*

Participant G in interviews and FGD 3 participants emphasise sign language interpretation to be made a legal requirement in all community programme budgets: *“Make sign language interpreters a mandate in every project budget. No signer, no Deaf participation.”*

The literature reviewed in the second chapter confirmed that despite Zimbabwe has strong national policies including Disabled Persons Act (1992) and National Disability Policy of 2021, implementation remains weak because of poor monitoring, weak enforcement systems and poor funding (Foday & Sidikie, 2023).

4.8 Chapter conclusion

This chapter discussed the research findings and discussions using thematic analysis. Four themes were developed each aligning with the study objectives.

CHAPTER V

SUMMURY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Chapter introduction

This chapter presents the summary of important findings of the research. It provides the meaning of those results in linked to the objectives of the study, theoretical framework, and existing literature reviewed in the second chapter. The chapter also includes researcher's conclusions and recommendations.

5.2 Summary of findings

The research results were arranged under four themes that matched the four objectives. The data was gathered from four FGDs, each group with seven participants, twelve interviews and observations, in Waterfalls, Harare South, Zimbabwe.

5.2.1 Types of community-based intervention programmes available for PWDs in Waterfalls

The study identified various CBIPs exists in Waterfalls, provided mainly through MEPHDECT, L'Arche Zimbabwe and Jairos Jiri. Four types of intervention programmes were identified. The first one is therapeutic services and rehabilitation services which includes counselling, occupational therapy, physiotherapy, assistive devices, and home-based outreach. The second type of CBIPs is vocational training and empowerment programmes which covers areas such as baking, sewing, gardening, and carpentry. The other category of CBIPs identified is social and recreational activities which includes sports activities specifically implemented by Special Olympics Zimbabwe, community events and dance groups. The last one is awareness and rights-based programmes such as caregiver support groups, peer support groups, disability rights education and community awareness.

5.2.2 Impacts of CBIPs on social inclusion, empowerment and well-being

The research identified that CBIPs in Waterfalls have produced valuable positive change in three aspects. IN terms of community participation and social inclusion, participants noted a visible shift from isolation and hidden to active community participation. Persons with disabilities who used to stay home due to lack of opportunities and stigma were now interacting with neighbours,

participating in community events and sports. On empowerment and self-advocacy, participants noted improved confidence, self-worth, and economic independence. In addition, vocational training made many PWDs to earn income and reduce dependency on charity or family. In terms of quality life and psychological well-being, caregivers and service providers noticed better social functioning, reductions in secondary health complications linked to inactivity, reduced anxiety, and improvements in happiness. Peer support engagement built public courage, with some individuals participating in events or facilitating activities.

However, the research identified barriers to access and participate. Poor road infrastructure, transport difficulties and kombis refusing to carry wheelchair users were the widely referenced as the most barriers. Financial limitations prevented regular attendance, causing lack of therapeutic progress. Cultural stigma based on witchcraft narratives and other myths like disabilities being caused by avenging spirit, causing some families to completely hide children with disabilities, keeping them beyond the reach of community-based intervention programmes. Family overprotection caused by shame made isolation worse. The research also identified that hearing-impaired and deaf are facing communication exclusion due to limited sign language interpretation leading to physical attendance while mentally excluded.

5.2.3 Strategies for strengthening social inclusion through CBIPs

On physical and environmental accessibility, participants suggested for road infrastructure improvements, specialised transports services, and home-based outreaches. On stigma reduction and attitudinal change, participants suggested more education campaigns to challenge witchcraft narratives and disability stigma. Churches were specifically noted as the most powerful platform for attitude change. On inclusive programme planning, participants suggested that PWDs must be shifted from beneficiaries to active co-planners and leadership of interventions in the community, being of the view that programmes designed without input of PWDs often missed the real needs and fail to support themselves after external support ended.

5.2.4 Policy recommendations for CBIPs

On sustainable funding, participants in all data sources mentioned donor dependency as the most threat to sustainability of CBIPs, suggesting income-generating projects, partnerships with local businesses and international donors, community ownership of assets, and government budget lines

for disability inclusion. On community ownership and participation in governance, participants suggested the creation of disability-inclusive committees including local leaders, PWDs themselves and service providers, arguing that the only route to real programme sustainability is community ownership. On disability legislation and rights enforcement, participants recommended that existing laws should be enforced at the community level, interpretation of sign language to be included in all budget of programmes, and accessibility to be licensing requirement for every business.

5.3 Interpretation of findings

The results of this study are interpreted within the theoretical framework of the study. The Social Model of Disability locates the factors leading to disability in the society's failure to accommodate diversity not in one's impairment (Koutsoklenis & Adam, 2024; Oliver, 2023)

5.3.1 CBIPs are partially reducing disabling environments

The positive results mentioned in theme 2 such as empowerment, social participation, shift of community attitudes and social participation shows that CBIPs in Waterfalls are contributing to breaking down of social and attitudinal barriers highlighted by the Social Model as the main cause of exclusion of PWDs (Oliver, 2023). The change from isolation to participation, consistently highlighted by participants in all data sources in not a medical result but a social outcome, resulting from creation of inclusive environments and opportunities that was missing.

However, the barriers mentioned in chapter 4 shows that the disabling environments are not fully broken down. Road infrastructure, transport systems, family attitudes, cultural beliefs and communication systems all can continue as to work as barriers that excludes individuals with disabilities from benefiting from community-based intervention programmes.

5.3.2 Empowerment is still incomplete

Although this study shows notable progress in empowerment including economic independence, increased confidence, and individual advocacy, these gains are not fully achieved. As described in chapter two, based on the work of Oliver (2023), true empowerment requires control over choices that affect one's life and self-determination. However, the results shows that PWDs in Waterfalls continue to be excluded from design of the programmes meant to support them. They are included

as beneficiaries but do not engage in decision making processes. They complete vocational training but they lack capital required to convert their skills into income for example having sewing skill but no machines.

5.3.3 Sustainability as the primary challenge

Sustainability is mentioned as the major problem facing community-based intervention programmes in Waterfalls. The current donor dependent and non-governmental organisations model make programmes vulnerable to funding changes and limits their long-term survival. Participants suggest a shift towards community ownership, where community generate resources and persons with disabilities take part of governance as the sustainable approach. This connects with the existing literature in chapter 2, which shows that minimising donor dependence and including programmes within community structures enhances sustainability.

5.3.4 Communication exclusion as an ignored part of inclusion

The exclusion of the deaf and hearing impaired mentioned in this study reflects the part of disability exclusion that is limited in Zimbabwean community-based intervention programmes in chapter two. Though the Social Model of Disability argue about disabling environments, is well established in relation to physical accessibility, the research findings extend that argument to communication or information accessibility, indicating the environments made exclusively for the deaf and hearing impaired is just as effectively as buildings without ramps disable those with wheelchairs. The results that the deaf participants attend programmes physically while mentally excluded challenges the main understanding of inclusion as physically presence and calls for a more advanced understanding of what real inclusion needs in terms communication.

5.4 Conclusions

The following conclusions are drawn in relation to study objectives basing on the findings and their interpretations

5.4.1 Types of CBIPs available in Waterfalls

The study concludes that there are several community-based intervention programmes in Waterfalls including vocational training, therapeutic services, awareness and rights-based programmes and social, sports and recreational activities. These programmes are offered through

some dedicated non-governmental organisations such as Jairos Jiri Waterfalls Centre, L’Arche Zimbabwe, MEPHDECT and Special Olympics Zimbabwe, whose shared efforts are valuable assets for disability community in Waterfalls. However, limited funding and other barriers limit access and make it based on location instead of the need. The researcher concludes that while the basis of inclusive CBIPs systems exists in Waterfalls, it is still weak, uneven and not accessible to the most disadvantaged PWDs.

5.4.2 Impact on social inclusion, empowerment and well-being

The research concludes that community-based intervention programmes are making a meaningful and genuine difference to the lives of the PWDs they reach. There is evidence of improved economic empowerment, social participation, psychological well-being and change in community attitudes mentioned by many participants in all data sources. However, these positive changes are still limited. Most benefits are experienced by PWDs who are already connected to CBIPs while the isolated are left out. The barriers of cultural stigma, communication exclusion, transport and finances are not minor challenges but key components of disabling environments that hinder CBIPs from reaching their full potential. The researcher concludes that community interventions for PWDs in Waterfalls have made positive change, but ongoing challenges are limiting them from reaching full potential.

5.4.3 Strategies for strengthening social inclusion

The study concludes that strengthening inclusion through community-based intervention programmes needs action in three connected areas. Firstly, physical accessibility must be improved through road infrastructure and better transport. Programme design must involve PWDs as co-planners and leaders rather than beneficiaries only. Lastly, there is need to change community attitudes towards disability through continuous awareness even in churches, because all these three areas depend and support each other for sustainable impact.

5.5 Recommendations

The study concludes that even though Zimbabwe’s National Disability Policy 2021 and CRPD commitments are progressive, there is major gap between what the policy says and is being practice in Waterfalls. It highlights that enforcement of disability rights, sustainable funding, and meaningful participation of PWDs in governance are crucial. Without strengthening local policy

action and addressing donor dependency, CBIPs will remain effective at individual level but weak and unsustainable at policy level.

Basing on research findings, the following recommendations are given to different stakeholders:

5.5.1 Recommendations to CBIPs and NGOs

- Make sign language interpretation a must in all CBIPs
- Develop persons with disabilities inclusive governance structures for all interventions, positioning individuals with disabilities as decision-makers and co-designers rather than passive beneficiaries
- Strengthen vocational training by including capital to start an income business after having a skill, microfinance access
- Design programmes that are disability-specific that serve different needs, not a holistic approach
- Create disability budget lines to support CBIPs, at local government level

5.5.2 Recommendations to Zimbabwean government

- Amend legislation to make sign language a mandate not option in all publicly funded programmes
- Develop a child to young adult transition framework to support young individuals with disabilities into employment and livelihoods after CBIPs
- Increase investments in CBIPs, including community health workers' training for sustainable home-based support
- Encourage churches and community leaders to use their platforms to promote disability inclusion

5.5.3 Recommendations to community leaders and faith-based groups

- Church leaders should use their influence and platforms to challenge harmful cultural beliefs, disability stigma and replace spiritual punishment and witchcraft narratives with messages of acceptance, respect, dignity and social model view of disability not a curse that requires prayer

- Churches should open their buildings for these activities especially mid-week days than closing them yet venues are limited
- Church and neighbours should treat as equal community members in all community life

5.6 Chapter conclusion

The presented the summary of findings, interpretation of findings, conclusions and recommendations of the study.

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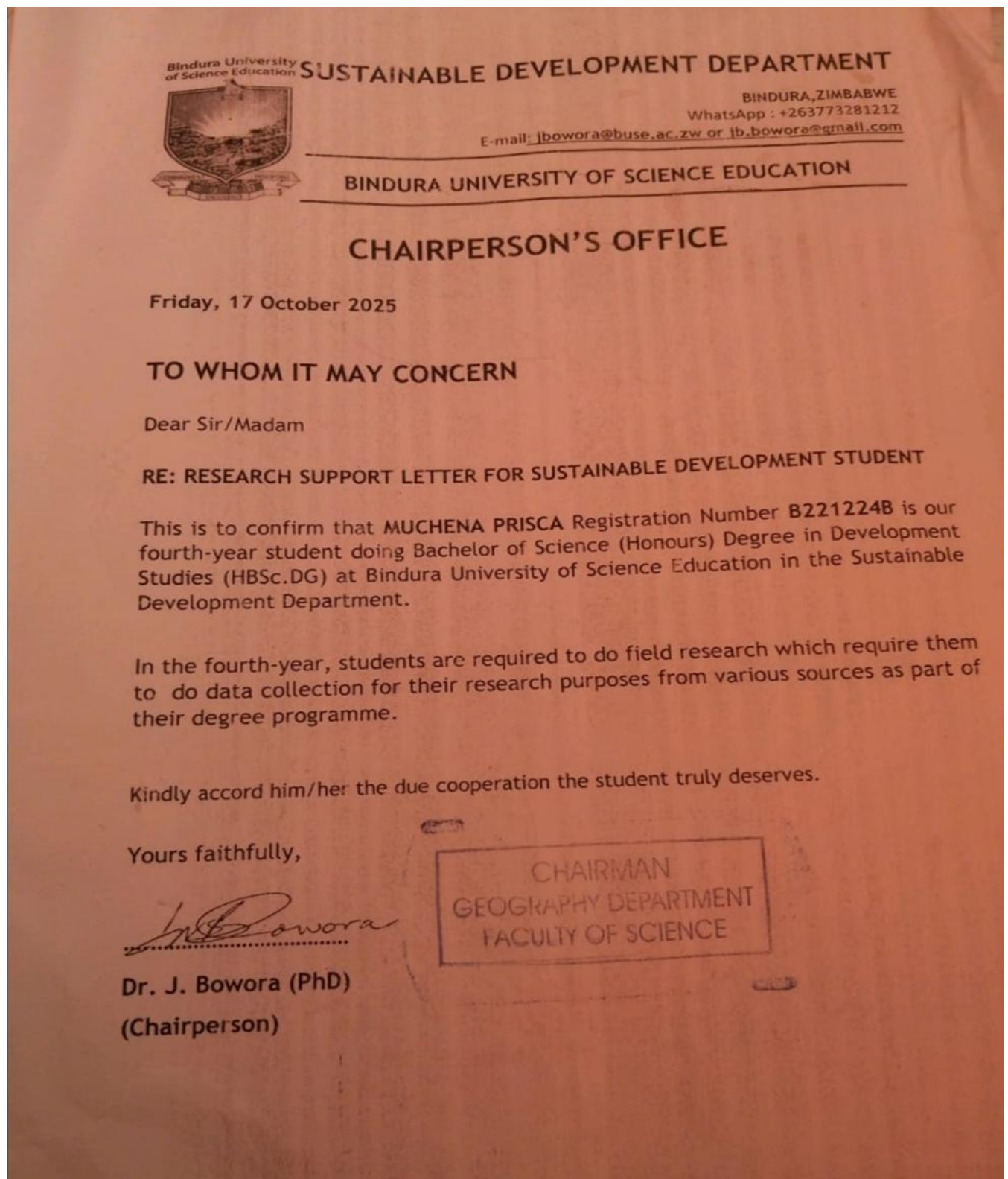
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Appendix A: Bindura University of Science Education approval letter to conduct the research



Appendix B: Approval letter from Department of Social Development to conduct research

Official communications should
Not be addressed to individuals

Telephone: Harare 790872/7
Telegrams "SECLAB"
Private Bag 7707/7750



MINISTRY OF PUBLIC SERVICE, LABOUR AND SOCIAL
WELFARE
Compensation House

Cnr/4
Fourth Street and Central Avenue
HARARE

ZIMBABWE

17 March 2026
Prisca Muchena (B221224B)
Bindura university of Science Education

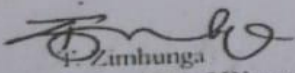
**REF:LETTER OF APROVAL TO CONDUCT RESEARCH STUDY TITLED
"ASSESSNG THE IMPACT OF COMMUNITY-BASED INTERVENTION
PROGRAMMES ON THE LIVES OF PEOPLE LIVING WITH DISABILITIES IN
WATERFALLS, HARARE SOUTH, ZIMBABWE"**

Receipt of your letter with the above mentioned matter is acknowledge.

Please be advised that permission is he is hereby granted for you to carry out your research titled assessing the impact of community-based intervention programmes on the lives of people living with disabilities in waterfalls, Harare south, Zimbabwe".

Permission is granted **"STRICTLY"** on condition that the research is for academic purposes only in pursuit of Bachelor of Science Honours Degree in Development Studies. The data collected should not be shared on third (3rd) part.

You are requested to submit a copy of your final research document to the Department of Social Development upon completion as your research has a bearing on the Department's mandate.


P. Zimhunga
Acting Chief Director Social Development and Labour Administration
MINISTRY OF PUBLIC SERVICE, LABOUR AND SOCIAL WELFARE

MINISTRY OF PUBLIC SERVICE, LABOUR
AND SOCIAL WELFARE
SOCIAL WELFARE REGISTRY
17 MAR 2026
P.O. BOX CY 429, CAUSEWAY
ZIMBABWE TEL 0742-790721/4

Appendix C: Zimstats unpublished data

Harare urban disability prevalence by ward, 2022 Population and Housing Census

Harare urban	Disability prevalence (%)	Population
Ward 1	0.4	357863
Ward 2	0.3	30229
Ward 3	0.5	20511
Ward 4	0.2	11699
Ward 5	0.2	16641
Ward 6	0.3	15101
Ward 7	0.3	25905
Ward 8	0.5	14279
Ward 9	0.3	49505
Ward 10	0.3	17941
Ward 11	0.4	18898
Ward 12	0.5	20294
Ward 13	0.3	23467
Ward 14	0.4	36061
Ward 15	0.3	65608
Ward 16	0.3	56597
Ward 17	0.2	18486
Ward 18	0.4	28929
Ward 19	0.3	17405
Ward 20	0.4	24291
Ward 21	0.3	22799
Ward 22	0.3	44606
Ward 23	0.3	65349
Ward 24	0.5	26473
Ward 25	0.2	26005
Ward 26	0.5	31100

Ward 27	0.4	33506
Ward 28	0.4	27934
Ward 29	0.4	11101
Ward 30	0.4	48995
Ward 31	0.3	19656
Ward 32	0.4	34802
Ward 33	0.3	56754
Ward 34	0.5	21471
Ward 35	0.4	19568
Ward 36	0.4	12966
Ward 37	0.3	69039
Ward 38	0.3	31201
Ward 39	0.4	19795
Ward 40	0.3	71617
Ward 41	0.3	55482
Ward 42	0.4	69234
Ward 43	0.3	89287
Ward 44	0.3	27463
Ward 45	0.5	30478
Ward 46	0.5	13208

[Data source: Zimstats unpublished data]

Appendix D: Focus group discussion (FGD) guide

Introduction

My name is Prisca Muchena. I'm a Development Studies student at Bindura University of Science Education. I'm researching '*Assessing the impact of community-based intervention programmes on the lives of people living with Disabilities in Waterfalls, Harare South, Zimbabwe*' as part of my studies. I'm going to use group discussion results for academic purposes only, and your information will be kept confidential. No answers will be considered right or wrong during our discussions. If there are questions you may need to ask in connection with this study, feel free to phone me on 071 182 1786, or email me on priscamuchena0@gmail.com.

A) Participant background information

1. What is your gender?
2. What is your age group? (18-22, 23-27, or 28-32)
3. How long have you been living in Waterfalls?
4. What is your role in the community?

B) Community-based intervention programmes

1. What projects, groups, or activities in Waterfalls support PWDs?
2. What type of help do these activities or groups provide for people with disabilities?
3. Who runs or organise the project or activities that support PWDs in Waterfalls?
4. Where do PWDs usually go to get this help?
5. Are there any other activities or programmes we have not talked about?

C) Impacts of CBIPs on the lives of PWDs

1. Do activities or programmes for PWDs help them feel part of this community?
2. Do PWDs gain knowledge, confidence, or skills because of these programmes?
3. Do PWDs take part in leading or organising any community activities?

4. Is it easy for PWDs to participate in community activities?
5. What makes it difficult for PWDs to participate in the community?
6. Have you noticed any change in the way the community treats PWDs?
7. What challenges make it difficult for community activities for PWDs to work well?
8. Is there anything else about how these programmes have affected or helped PWDs that we have not discussed you would like to say?

D) Improving participation for PWDs

1. What makes it hard for PWDs to feel that they are fully included in Waterfalls?
2. Are there situations where PWDs are left out community activities?
3. What has assisted PWDs to feel more included in Waterfalls?
4. What changes do you think can be done to make community activities more welcoming for PWDs?
5. How can the following members better support or help PWDs to be part of communal life?
 - a) Community members
 - b) Family
 - c) neighbours
6. Given a chance to improve community activities meant to support PWDs, what would you do in a different way?

E) Policy recommendations for CBIPs

1. What do you think is helping these community activities to be effective in Waterfalls?
2. What challenges make it hard for community activities to reach their full potential or work properly?
3. What makes it hard for these activities to continue for a long period?
4. What type of support is needed for these programmes to improve and continue?

5. What roles do you think the following should play in improving the sustainability of community activities for PWDs?

- a) NGOs
- b) Private sector
- c) Church organisations
- d) Members of the community

6. Is there any other advice you would suggest to support the community activities?

Appendix E: Semi-structured interview guide

Self-Introduction

I'm Prisca Muchena, a part 4.2 student at Bindura University of Science Education. I am studying Development Studies. I'm researching "*Assessing the impact of community-based intervention programmes on the lives of people living with disabilities*". I am assuring you that all shared information will be treated with respect and confidentiality. To ensure your privacy, we will use made-up names instead of use your real names. Your participation is voluntary and you have the right to withdraw at any time without penalty. The data collected will be used for academic purposes only. If there are questions you may need to ask in connection with this study, feel free to phone me on 071 182 1786, or email me on priscamuchena0@gmail.com.

A) Participant background information

1. Can you describe your role or engagement with community activities for PWDs in Waterfalls?
2. How long have you been involved in these community activities for PWDs?
3. Who are you participating as?
4. If you feel comfortable sharing, can you describe your condition? (PWDs)
5. What is the condition of a person or people you assist? (Caregivers)
6. How often do you interact with the local support activities for PWDs?
7. What is the highest level of education you have finished?
8. What is your age group? (For example 18-22, 23-27, 28-32)

B) Community-based intervention programmes

1. Are there any projects, groups or activities in Waterfalls that help individuals living with disabilities?
2. What type of help do PWDs often receive in Waterfalls?
3. Which groups or organisations in Waterfalls work with PWDs?
4. Where do PWDs usually go when they need any support or help in Waterfalls?

5. Are there any other programmes or community activities that support PWDs that we may have not talked about?

C) Impacts of CBIPs on PWDs

1. Do you think community activities or programmes in Waterfalls help PWDs feel part of the community?

2. What do PWDs gain from these activities or programmes?

3. Do PWDs participate in community events or activities because of these initiatives?

4. How do individuals with disabilities participate in these programmes?

5. Is it easy for individuals with disabilities to access these programmes in the community? How?

6. Have you noticed any change or improvement caused by any of the programmes on the daily lives or happiness of PWDs in any way?

7. Have you seen any positive change in how PWDs interact with other people since these activities started?

8. Have you noticed any change towards disability in community views or relationships as a result of these community support activities?

9. What challenges hinder the effectiveness of community activities that help PWDs in Waterfalls?

10. How do these challenges affect the participation of people with disabilities?

11. Are there any other ways these activities have made life better for PWDs that we may have not talked about?

D) Strategies for improving inclusion for PWDs

1. What do you think can be done to help PWDs feel more involved in community life?

2. What type of support or help do you think PWDs still need in Waterfalls?

3. Do you have any idea on how community activities or projects could improve the life for PWDs better?

E) Policy recommendations for CBIPs

1. What do you think can be done to make community activities for PWDs in Waterfalls work better?
2. What can be done to ensure these initiatives continue for a long period?
3. What gaps or limitations make it hard for these community support activities to continue or work well?
4. What advice would you give to the following on how to support PWDs better?
 - a) NGOs
 - b) Private sector
 - c) Church organisations
 - d) Members of the community

Appendix F: Observation guide

A) Types of community-based intervention programmes

1. Are the programmes targeting PWDs?
2. What type of intervention or activities are taking place?
3. Which groups or organisations are participating?
4. Location where these interventions take place

B) Inclusion of people with disabilities

1. Whether PWDs are present
2. The level of participation of PWDs
3. How PWDs interact with others?
4. How do programme facilitators and PWDs interact?
5. How do community members interact with PWDs during activities?
6. Any evidence of cooperation, exclusion/inclusion, respect?

C) Well-being and empowerment indicators

1. Do PWDs appear comfortable, confident and supported?
2. Are PWDs engaged in productive activities, including skill development?
3. Any notable signs that the CBIPs contribute to independence?
4. Are people with disabilities aware of their rights?

D) Accessibility

1. Availability of assistive devices
2. Physical accessibility

E) Barriers

1. Challenges to full participation

2. Whether the venues are accessible to people with disabilities
3. Are methods of communication inclusive?
4. Any other difficulties faced by PWDs

New additional field notes

Appendix G: Similarity report summary

Prisca Muchena

B221224B PRISCA MUCHENA DG 400 FINAL

 Final Project

Document Details

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