Living Conditions Among Persons with Disability Survey

KEY FINDINGS REPORT 2013

unicef

SWEDEN

Living Conditions Among Persons with Disability Survey

KEY FINDINGS REPORT

2013

unicef


rabbit

Table of Contents

Acknowledgements

The Ministry of Health and Child Care would like to thank the following institutions who were members of the Survey Technical Committee for their valuable contribution towards the success of the survey: Ministry of Public Service, Labour and Social Welfare; Ministry of Primary and Secondary Education; the Zimbabwe National Statistics Agency (ZimStat); the J. F. Kapnek Trust; UNICEF Zimbabwe and SINTEF Technology and Society, the consultants of the survey. The committee was influential in all the survey processes from questionnaire review through to report production.

The Ministry would also like to acknowledge the tireless effort of all the technical committee members, UNICEF experts and officers in the Ministry in all the survey processes and the development of this report.

We are particularly thankful to all the individuals, families and communities who unreservedly participated and cooperated with the survey personnel. This work would not have been possible without their dedicated participation.

Special commendation is extended to UNICEF for technical and financial support.

List of Acronyms

AIDS	Acquired Immuno Deficiency Syndrome
CCORE	Collaboration Centre for Operational Research and Evaluation
CHH	Case Household
CNHH	Control Household
DPO	Disabled Persons' Organisation
EA	Enumeration Area
HDDS	Household Dietary Diversity Score
HH	Household
HIV	Human Immunodeficiency Virus
ICF	International Classification of Functioning, Disability and Health
MDGs	Millennium Development Goals
MOHCC	Ministry Of Health and Child Care
NSDH	National Survey on Disability and Health
SAFOD	Southern Africa Federation of the Disabled
SES	Socio–Economic Status
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNCRC	United Nations Convention on the Rights of the Child
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNICEF	United Nations Children's Fund
WG6	Washington Group of Disability Statistics
WHO	World Health Organization
WHS	World Health Survey
ZimStat	Zimbabwe National Statistics Agency


Printi
It is the method of
transferring an
image from one
surface to
another.

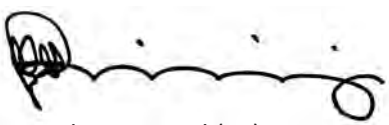
Preface

The report presents the key findings of a survey of a national representative sample of nearly 15 000 households. The survey on 'living conditions among persons with disability' was conducted by the Ministry of Health and Child Care in collaboration with ZimStat and Ministries of Primary and Secondary Education, Public Service, Labour and Social Welfare. The main objective of the survey was to produce evidence to guide the development of appropriate national policies, strategies and action plans, paying particular attention to specific needs of children and adults with disability.

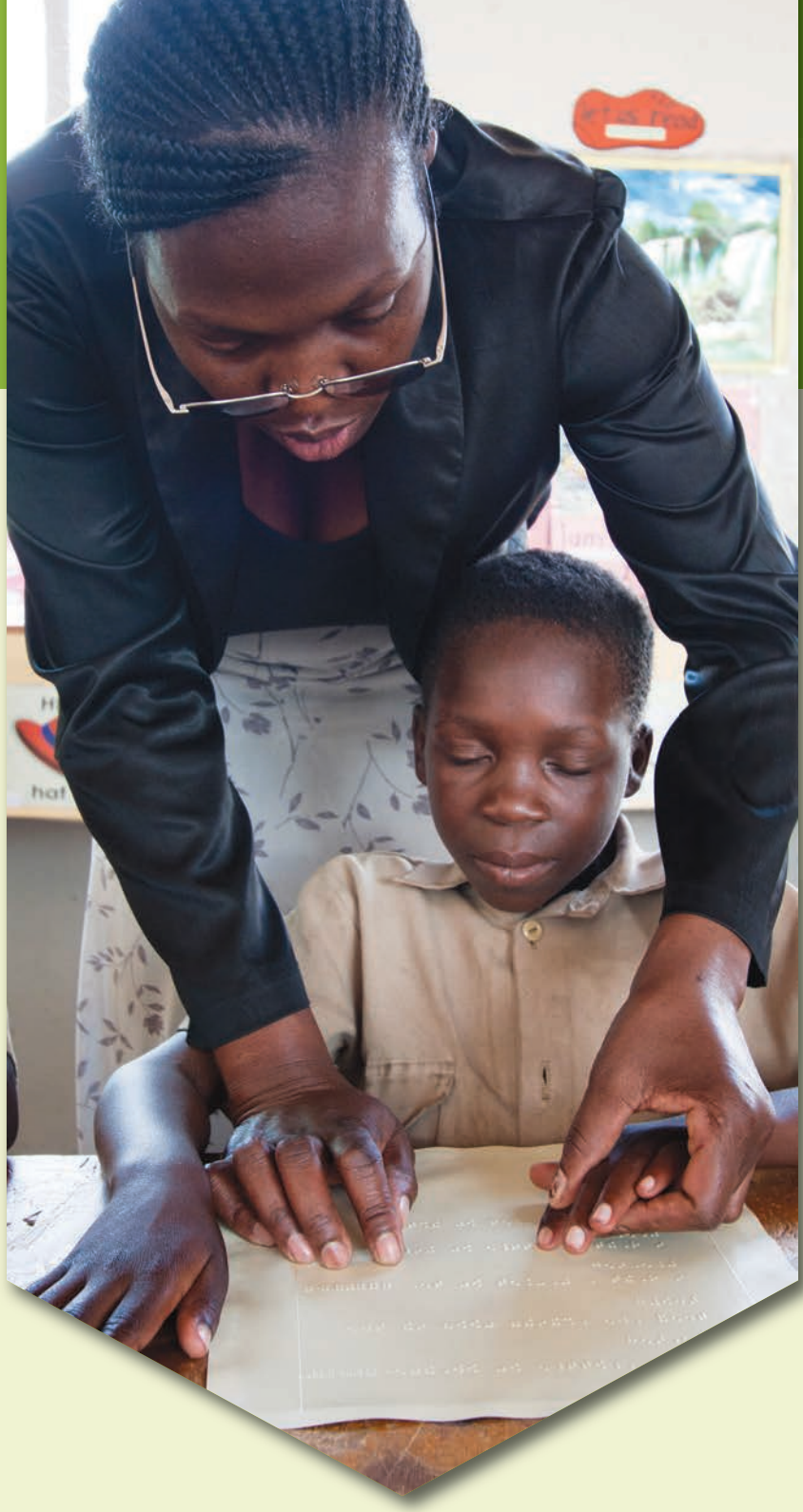
The survey was conducted from September to December 2013 and covered the 10 provinces of Zimbabwe. The key findings report provides information on disability profile, socio-demographic characteristics of the sampled households and individuals, as well as barriers faced by persons with disability in the physical environment, access to health, education and social amenities. The report also provides information on the most common and different types of conditions and impairments leading to disability in Zimbabwe and highlights the gaps in service provision to persons with disability.

We hope that the evidence in this report will provide the necessary direction for our country in the successful implementation of the WHO Action Plan "Better Health for Persons with Disabilities" which draws from the provisions and recommendations of the United Nations "Convention on the rights of the Child" (UNCRC), the United Nations "Convention on the Rights of Persons with Disabilities" (UNCRPD) and the World Disability Report (WHO 2011). As Ministry working together with our development partners, we have an obligation to remove any barriers to participation for persons with disability through investing sufficient resources and expertise towards increasing access to quality health, rehabilitation and assistive technologies or any other support that may be required to facilitate functionality and achievement of full potential for individuals with disability.

The objective of this report is to facilitate the timely dissemination and use of results from the 'Living Conditions Survey 'prior to the release of the final survey report that will contain detailed information on the survey findings. The comprehensive final report will be published in the second quarter of 2015.



Brigadier General (Dr) G. Gwinji
Secretary for Health and Child Care



1

Introduction

This report highlights the findings of the "Living Conditions among Persons with Disability" survey conducted by the MOHCC between September and December 2013 in the ten provinces of Zimbabwe. Surveys of this nature are designed to provide a comprehensive mapping of living conditions among persons with disability in view of identifying gaps in service provision and access to services for this segment of the population. In this survey disability was identified through a screening procedure based on WHO International Classification of Functioning, Disability and Health (ICF). According to the ICF, a person has a disability if, due to a health problem, s/he has difficulty seeing, hearing walking, with memory, self-care or language. The current survey assesses the prevalence of disability in Zimbabwe at 7%. Based on total population of 13 million this amounts to over 900 000 individuals.

The background to the Ministry's strong interest to generate statistical data on disability follows the recommendations of the World Disability Report and a key resolution on Disability adopted by the World Health Assembly in May 2013, which urges Member States to prioritize disability as a development and health issue. This also coincided with the global renewed focus and spotlight on people with disabilities by international organizations, including UNICEF which focused the 2013 edition of its Flagship Report State of the World Children (UNICEF 2013) on the barriers limiting children with disabilities in reaching their full potential.

Africa has prioritised disability issues evidence of which can be noted in its declaration on the Rights and Welfare of the African Child which culminated in the 'African Charter on the Rights and Welfare of the Child' of 1990 (which entered into force in 1999). Article 13 of the Charter provides for special protection measures for children with disabilities. Furthermore, the years 2000 to 2009 were declared as the African Decade of Persons with Disabilities, this was later extended to the second decade covering the years 2010 to 2019. Zimbabwe was the first country to come up with Disability specific legislation through the Disabled Persons Act Chapter 17.01 of 1992. It was nominated to host the first headquarters of the African Rehabilitation Institute. Since 2002 Zimbabwe has included a question on disability in the National population census. The survey provides a basis for

CHAPTER 1 Introduction

strengthening the already existing structures and to scale up service provision to persons with disabilities.

1.1 Survey Objectives

The aim of the survey was to develop the evidence base of living conditions among persons with disability in Zimbabwe. The specific objectives for the survey were to:

- determine the prevalence of disability in the country
- assess and document the degree of activity limitations and participation restrictions and societal activities for persons with disability
- ascertain the specific vulnerabilities that children with disability face in Zimbabwe
- establish the accessibility of health and social services for persons with disability in Zimbabwe
- generate data that guides the development of policies and strategies that ensure equity and opportunities for children and adults with disability

1.2 Background

Persons with disability are often marginalised and belong to the poorest segments of society. According to the World Disability Report (WHO 2011), an estimated 15% of the world's population lives with some form of disability. The majority of the persons with disability live in developing countries, very often without the optimal technical, medical or social support that could improve their quality of life. The report further highlighted the need for conducting research on disability as a means to generate knowledge that can be instrumental in breaking the disability – poverty cycle. In low-income countries, including Zimbabwe, there is inadequate information on disability, translating to limited information on which to base advocacy, policy development and effective resource mobilization and utilization.

Zimbabwe as a State Party to the United Nations Convention on the Rights of the Child (UNCRC), the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), the African Charter on Rights and Welfare of the Child and other conventions related to disability has reporting obligations to which this survey can contribute.

2

Sample and Survey Methodology

2.1 Sample Design

The sample for the Living Conditions survey in Zimbabwe (2013) was designed to provide estimates at national and provincial level. The sampling frame for the survey was based on the 2012 Zimbabwe Master Frame developed after the 2012 Population Census.

A two-stage stratified cluster sampling was applied, with Enumeration Areas (EAs) as the first sampling unit. Overall, the sample included 307 EAs in all the ten provinces of Zimbabwe. Households were the units for the second stage of sampling. A complete listing of households was carried out in each of the 307 selected EAs prior to interviewing. EA maps were provided from ZimStat and all private households were listed excluding institutional living facilities (e.g. army barracks, hospitals, police camps, and boarding schools). Within each selected EA 25 households with at least one person with disability were randomly selected and if there were less than 25 Case Households then all eligible households were selected and additional households to add up to 25 were obtained from extra EAs provided. The same number of households without a member with disability was selected to form the control group. Control individuals were identified in these households matched by age and sex to the individual with disability in the Case Households. In total, a representative sample of 7 684 Case Households and the same number of households without a member with disability was selected for data collection, making up a total sample of 15 368 households.

In households where the number of persons with disability was more than one, the questionnaire for persons with disability was administered to all individuals with disability.

2.2 Survey Tools

Four questionnaires were used for this survey. These were adapted from previous studies on living conditions carried out in the region and in particular a similar survey that was carried out in Zimbabwe in 2003. The questionnaires, including the operationalisation of disability, draw heavily on the International Classification of Functioning, Disability and Health (ICF).

The set of questionnaires applied in this survey comprised the following:

CHAPTER 2 Sample and Survey Methodology

I. Screening questionnaire for the listing process;

II. Household questionnaire;

III. Questionnaire for individuals with disability;

IV. Questionnaire for individual without disability.

1. The **screening questionnaire** included six questions based on the Washington Group of Disability Statistics (WG6) and was administered to all households in the selected geographical area (EAs). Households listed on the screening form were classified as either cases (households with at least one member with a disability) or controls (households without members with disabilities). The respondent was the head of the household or a knowledgeable adult member of the household.

The questions were designed to collect information, as shown in Table 2.1.

Table 2.1: Due to a health problem, any member of the household had difficulty with

	No	Some	A lot	Unable
seeing, even if wearing glasses	1	2	3	4
hearing, even if using a hearing aid	1	2	3	4
walking or climbing steps	1	2	3	4
remembering, concentrating, or both	1	2	3	4
self-care	1	2	3	4
communicating (understanding or being understood by others)	1	2	3	4

A member of the household was considered to have a disability (activity limitation or participation restriction) if the response to at least one of the above questions was 'some' (2), 'a lot' (3) or 'unable' (4).

In this survey an additional question was included to find out whether there were any members of the household with albinism.

2. The **household questionnaire** for both case and Control Households comprised 45 questions covering demographics, education and literacy, economic activities of household members, income and expenditure, housing conditions and household assets, transport and communication. The respondent was the head or a knowledgeable member of the household.

3. The **questionnaire for individuals with disability** comprised 55 questions covering the following domains: activity and participation, environmental factors, type of disability and cause, education, employment and income, services needed and received, accessibility in the home and environment, assistive technology and devices, health and general well-being, abuse and child functioning and disability. The respondent was the individual with disability or a proxy in the case of individuals limited by age or disability.

4. The **questionnaire for individuals without disability** comprised 21 questions covering the same domains as the questionnaire for individuals with disability, except for environment factors and disability specific questions. The respondent was the individual without disability or a proxy in the case of a young child.

The questionnaires were designed in English and translated to various local languages depending on enumeration areas (shona, Ndebele, kalanga, suthu, tonga).

2.3 Survey Activities

101 interviewers and 30 supervisors were identified. Due to the nature of the survey the majority of interviewers were MOHCC rehabilitation personnel. A particular feature of this survey was the involvement of persons with disability in all survey processes. Out of a total of 101 interviewers 20 were persons with disability.

(i) Pre-survey training

All interviewers and supervisors were trained for 9 days from 26 August to 3rd September 2013. The main purpose of the training was to familiarize the research teams on the methodology and instruments and general conduct of the research, including field procedures.

(ii) Data collection

Data collection took place from 6 September to 30 December 2013. The interviewers and supervisors were organized into 24 teams comprising one supervisor, 4 interviewers and a driver. The teams first visited all households within the boundaries of the specific EAs, interviewing the head of the household or a knowledgeable adult by using the screening questionnaire to identify households with at least one member with disability. These households were later re-visited to administer the household and the individual case questionnaires. A neighbouring household was selected as a control household and both the household and the individual control questionnaires were administered.

(iii) Data processing

Data entry took place from the 9th of October to the 31st of December 2013. 20 Data entry clerks completed a two day training at which they were introduced to the survey content, survey tools and data entry procedures. Statistical packages used for data entry and analysis were *EPI INFO 8* and *SPSS 20*. All questionnaires were edited for completeness and consistency and coded before data entry.

Weights were calculated on the basis of population size and sample per province, and the weights were calibrated down proportionally in such a manner that the number of observations was not affected, but that the relative proportions were retained.

2 Sample and Survey Methodology

2.4 Quality Control

The measures used to ensure high quality and consistent data included:

(i) ***pre-survey training:*** the training for survey teams was done at one central venue to ensure that all participating individuals had the same understanding of the survey objectives, key concepts, questionnaire content and field processes to ensure appropriate level technical capacity to collect quality data.

(ii) ***minimal delay between the training and the actual data collection:*** Data collection started immediately after training.

(iii) ***two levels of supervision (field and national):*** field supervisors moved with the teams, this ensured that supervision started from the onset of data collection and any detected errors were corrected on the spot. National supervisors comprising staff from ZimStat head office, senior officers from key line ministries, Survey Technical Committee members, SINTEF consultants and UNICEF provided technical support. A statistician from ZimStat guided sampling and related procedures throughout the conduct of the survey.

(iv) ***field and office editing of completed questionnaires:*** all interviewers were encouraged to check questionnaires before leaving a household. Field supervisors checked all the questionnaires in the field for accuracy and completeness and instructed interviewers to do necessary call backs. Office editors checked and coded all completed questionnaires for completeness and consistency before data entry. Identified errors were immediately communicated to the teams to take corrective action.

(v) ***an instruction manual*** was developed for the interviewers and supervisors as a reference tool to ensure consistency of information collected.

2.5 Sample Coverage

Table 2.2: Survey Implementation

Sample Frame		2012 Zimbabwe Master Sample		
Questionnaires		-Household listing and screening -Household questionnaire -Individual level disability questionnaire -Individual level control questionnaire		
Listing		September – October 2013		
Interviewer Training		26 August – 3 September 2013		
Fieldwork Data collection Mopping up exercise/Data verification		 6 September – 18 October 2013 20 October – 30 December 2013		
Data Entry		9 October – 31 December 2013		
Survey Sample		**Case**	**Control**	
Households	Sampled	7684	7684	15368
	Sample for final analysis	7505	7477	14982
Individuals	Sample for final analysis	7781	7493	15274

Table 2.3: Case and Control Households by province, final sample for analysis

Province	Case Households			Control Households			Total Households	
	N	% of HHs	(N individuals)	N	% of HHs	(N individuals)	N	%
Bulawayo	531	7.1	(484)	548	7.3	(504)	1079	72
Manicaland	1080	14.4	(1028)	1017	13.6	(1021)	2097	14.0
Mashonaland Central	697	9.3	(683)	628	8.4	(688)	1325	8.8
Mash East	768	10.2	(848)	783	10.5	(779)	1551	10.4
Mashonaland West	809	10.8	(954)	810	10.8	(803)	1619	10.8
Matabeleland North	405	5.4	(409)	395	5.3	(393)	800	5.3
Matabeleland South	342	4.6	(421)	353	4.7	(394)	695	4.6
Midlands	888	11.8	(974)	899	12.0	(865)	1787	11.9
Masvingo	785	10.5	(863)	826	11.0	(837)	1611	10.8
Harare	1200	16.0	(1280)	1218	16.3	(1208)	2418	16.1
Total	**7505**	**100.0**	**(7944)**	**7477**	**100.0**	**(7493)**	**14982**	**100.0**

() = individuals interviewed during the survey
** = the total percentage may be different from 100 due to rounding*

2 Sample and Survey Methodology

The survey is based on a representative sample of 15 368 households. Fifty percent (50%) of these households were Case Households and the remaining 50% were Control Households. Following quality control, the net household sample was reduced to 14982, of which 7 505 are Case and 7 477 Control Households.

The total sample for the individuals interviewed in the survey is 15437 of which 51.5% (7 944) are individuals with disability according to the WG6 scale and 48.5% (7 493) are controls. The total size of the sample N will vary in the different tables and graphs due to missing values and loss of data during matching of files.

2.6 Survey Limitations

The sample size was confined to the minimum level of households required to provide estimates at national and provincial levels.

3

Results

This chapter presents the results from the analysis of the household and individual level questionnaires for both case and Control Households. The information provided covers the survey population and household characteristics, the disability profile, education and literacy, employment and activity, health, environmental barriers, awareness and access to health and other social services, child functioning and disability, discrimination and abuse, assistive technology and availability of social amenities.

3.1 Survey Population and Household Characteristics

The survey revealed socio-demographic differences between case and Control Households and between males and females.Overall 67.3% of the households were in rural areas and 32.7% in urban areas. The average household size is 4.31 persons, with Case Households having more household members than households without persons living with a disability (4.48 and 4.15 respectively). The average number of persons with disability in Case Households is 1.17 with the large majority of screened households having one member with disability, 9.4% having two and a smaller proportion reporting more than two members with disability. Fifty one percent (51%) of the population is in the 0 – 20 years age group, with more individuals with disability (50.3%) than control individuals (49.7%) in this age group.

Results

CHAPTER 3

Table 3.1: Characteristics of Survey Population

	Case	Control	Total
Average household size	4.48	4.15	4.31
Mean number of members with disability in household	1.17	0.05	____
Percentage household -Urban	32.8	32.6	32.7
Percentage household -Rural	67.2	67.4	67.3
Percentage households headed by member with disability	46.2	-	46.2
Percentage of population Male	52.3	52.4	54.85
Percentage of population Female	47.7	47.6	45.15
Percentage of population children 0 – 4 years	10.5	12.3	11.1
Percentage of population children 5 – 10 years	16.4	14.9	15.7
Percentage of population 11 – 20 years	26.1	22.5	24.3
Percentage of population 60 years and above	11.2	8.3	9

Table 3.2: Average household size by province

	Case	Control
Bulawayo	4.05	3.69
Manicaland	4.42	4.03
Mashonaland Central	4.62	4.37
Mashonaland East	4.51	4.20
Mashonaland West	4.69	4.35
Matabeleland North	4.70	4.66
Matabeleland South	5.19	4.60
Midlands	4.36	4.04
Masvingo	4.33	3.99
Harare	4.49	4.16
Total	**4.48**	**4.15**

Age and sex distribution

Figure 3.1 below shows the distribution of sex by age groups for both case and control households. Households with members living with disability have a mean age of 17.7 years, whilst the corresponding figure for Control Households is 14.2 years. There are more males than females in both case and Control Households up to the age of 20 years. For the older age groups there are more females than males. Overall the average age of women (38.6) is higher than for men (36.9 years).

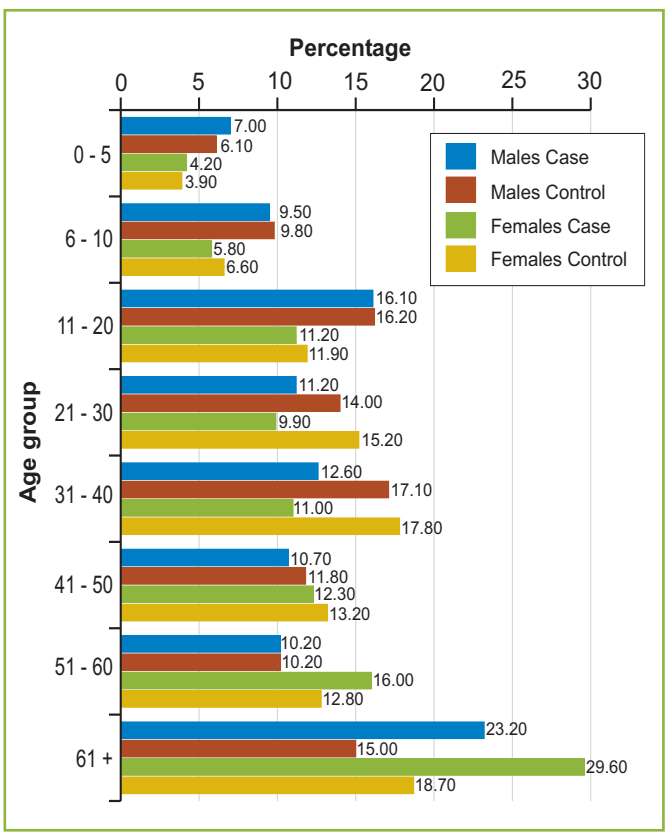


Figure 3.1: Age distribution by disability status and sex

Marital status of respondents

About half of the persons in the 15 years and older age group were married.

Figure 3.2 reveals that individuals with disability reported more often to be divorced or widowed.

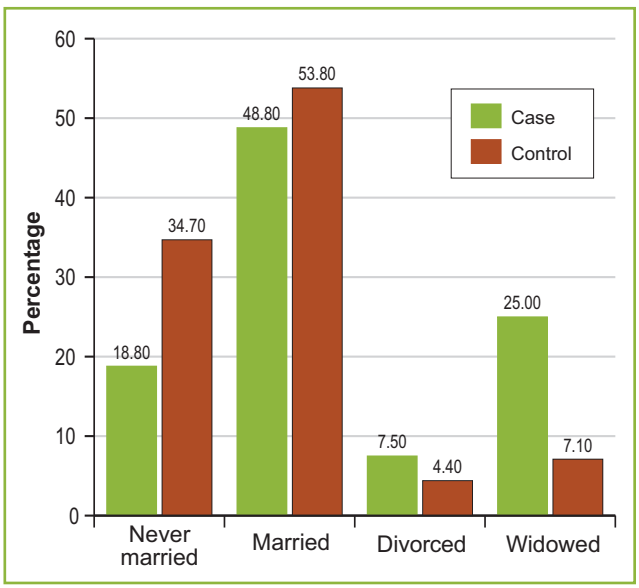


Figure 3.2: Marital status by disability status

CHAPTER 3 Results

Housing Conditions

There are small variations in housing conditions when comparing households with members with disability to those without. The housing situations covered include; building materials, tenure status, source of drinking water, source of energy for cooking and sanitation facilities.

The majority (70.9%) own the dwelling units they live in, but this is particularly prevalent in rural areas. Among Control Households, more people in the urban areas were renting their accommodation (51%) whilst more Case Households owned their houses (53%). Bricks are the most common material for walls and concrete or cement is the most common material for floors in both urban and rural areas and among case and Control Households.

Most common source of drinking water in urban areas is piped water, either inside or outside the house on premises. In the rural areas the most common source is borehole. A large majority of the rural households (94%) use wood as main source of energy for cooking while the majority of urban households use electricity.

Flush toilet system is used by the majority in the urban area (84% case and 85% control), although more than one in ten use pit latrine. In the rural areas the majority reported that they had no sanitation facility (39% case and 38% control). Details are given in Table 3.3.

Although there is no significant difference between case and Control Households on sanitation and drinking water facilities, actual access can be more difficult to persons with disability because of their physical limitations.

Table 3.3: Housing Conditions

Household Conditions	Case %	Control %
Accommodation/Tenure Status		
Rented	14.8	20.2
Owned	73.8	68.1
Rent free (not owned)	5.5	5.9
Provided by employer	5.4	4.5
Other	0.5	0.3
Source of energy for cooking		
Electricity	29.6	30.5
Paraffin	1.8	2.0
Gas	0.2	0.4
Wood	68.1	66.8
Coal/charcoal	0.1	0.1
Solar	0	0.1
Other	0.1	0.1
Source of drinking water		
Piped water inside	14.1	13.9
Piped water outdoors/on premises	12.4	12.9
Piped water outside premises	4.1	4.1
Public tap	3.4	3.5
Borehole	30.9	31.3
Protected well	13.4	13.8
Unprotected well	12.3	11.8
Other	9.5	8.7
Sanitation facility		
Flush toilet	31.8	32.3
Traditional pit	21.8	21.2
Ventilated pit	18.4	20.3
No facility	26.1	24.5
Other	1.8	1.6

CHAPTER 3 Results

3.2 Socio-Economic Status/Indicators

Four different indicators on Socio-Economic Status (SES) were applied in this survey: dependency ratio, possession scale, food availability and dietary diversity, availability and affordability of information.

SES is an economic and sociological combined total measure of a person's work experience and of an individual's or family's economic and social position in relation to others, based on income, education, and occupation. The respondents were asked questions that included; ownership of housing assets, food availability and dietary diversity in the households, access to information and income and expenses.

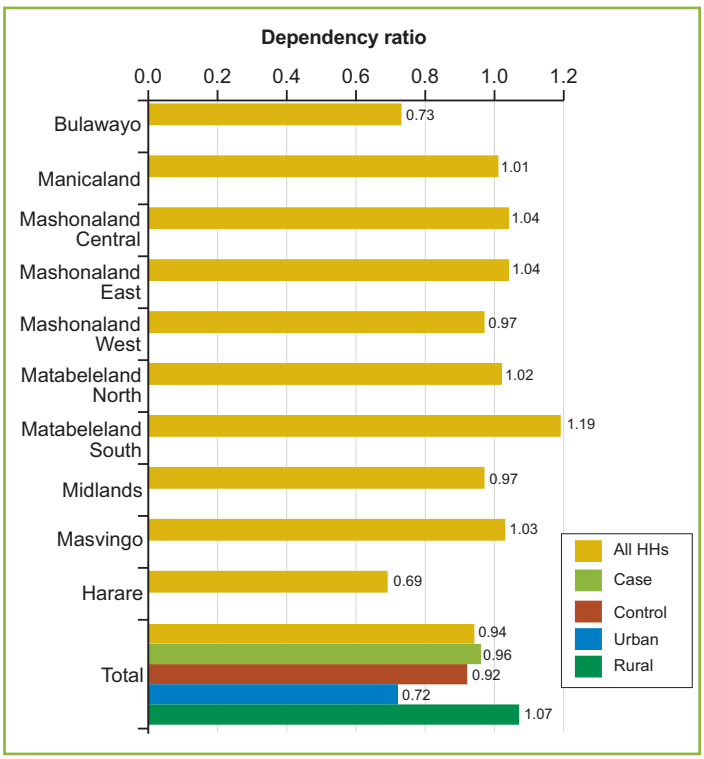


Figure 3.3: Dependency Ratio by province in the sample

Dependency Ratio

Dependency ratio is a measure of the portion of a population which is composed of dependents (people who are too young or too old to work). In this survey dependents were defined as those who were below 15 years or over 65 years, while the working age is defined by those aged 15 to 65 years. Figure 3.3 shows that Case Households have a slightly higher dependency ratio than Control Households; 0.96 and 0.93 respectively. The figure also presents the differences of dependency ratio between Case and Control Households by province.

Household assets (Possession scale)

Socio-economic status was measured by recording possessions of 26 different household items. For 17 of the 26 items in Table 3.4, fewer Case HHs report that they have or own the respective items. Overall this socio-economic indicator distinguishes clearly between the two household types, showing that Case HHs are worse off than Control HHs. The results further show that cell phones and bed(s) are the items households in this context most often confirm that they own, while washing machine, motor cycle and air conditioner are least common. Seventy-six percent Case Households and 82 % Control Households confirm that they own cellphones, 73% and 76% confirm owning at least one bed.

Table 3.4: Distribution of household items by household type (% confirming possession)

Household Item		Case HHs %	Control HHs %	Total N	Total %
1.	Radio	47.5	54.2	7476	50.9
2.	Hi – Fi/Music stereo	12.8	16.4	2092	14.6
3.	Television	38.0	41.6	5835	39.8
4.	DVD/VHS player	34.2	39.8	5412	37.0
5.	Cellphone	75.9	81.7	11605	78.8
6.	Telephone in the House	4.5	4.7	643	4.6
7.	Iron	51.7	54.4	7753	53.1
8.	Fan	10.5	12.7	1666	11.6
9.	Heater	6.7	7.5	1018	7.1
10.	Air conditioner	1.3	1.4	196	1.4
11.	Stove with gas or electricity	29.6	31.4	4428	30.5
12.	Stove with paraffin	18.6	21.5	2948	20.1
13.	Table and chairs	47.1	49.2	7028	48.1
14.	Refrigerator	22.6	22.9	3268	22.7
15.	Microwave	7.4	7.6	1062	7.5
16.	Electricity	32.0	33.1	4732	32.6
17.	Solar energy system	24.9	27.5	3924	26.2
18.	Generator	4.2	5.2	690	4.7
19.	Personal computer	4.1	5.1	671	4.6
20.	Bicycle	18.4	22.9	3085	20.7
21.	Motor cycle	1.3	1.3	186	1.3
22.	Private car	6.4	6.5	936	6.5
23.	Bed(s)	72.7	76.3	10945	74.5
24.	Live stock	36.4	38.3	5540	37.4
25.	Washing machine	1.1	1.3	174	1.2
26.	Satellite Dish	19.5	20.6	2867	20.0

CHAPTER 3 Results

Figure 3.4 below reveals that in all provinces, Case Households score lower on the SES indicator. Bearing in mind the above results on differences between household types, analysis was also weighted by household size, yielding slightly higher differences between households with and without members with disability. For instance, the total difference between mean values increased from 0.4 to 0.5.

The urban/rural difference in SES was, as expected, substantial with rural households scoring 4.5 and urban households 10.3. Separate analysis for the urban and rural samples will be included in the comprehensive report.

Food availability and dietary diversity

Food Availability

Information on food availability was obtained by asking 'If in the past 2 weeks there was an occasion when there was no food of any kind to eat in the household due to lack of resources'. Table 3.5 shows that while the large majority of households had not experienced being without food of any kind due to lack of resources during the two weeks preceding the survey ("No" or "Rarely"),around 10 % of all households reported such incidents,with 3.2 % stating that they had "Often" gone without food during the two weeks preceding the survey. More Case Households had been without food (12.1 %) in comparison to 9.1% in the Control Households.

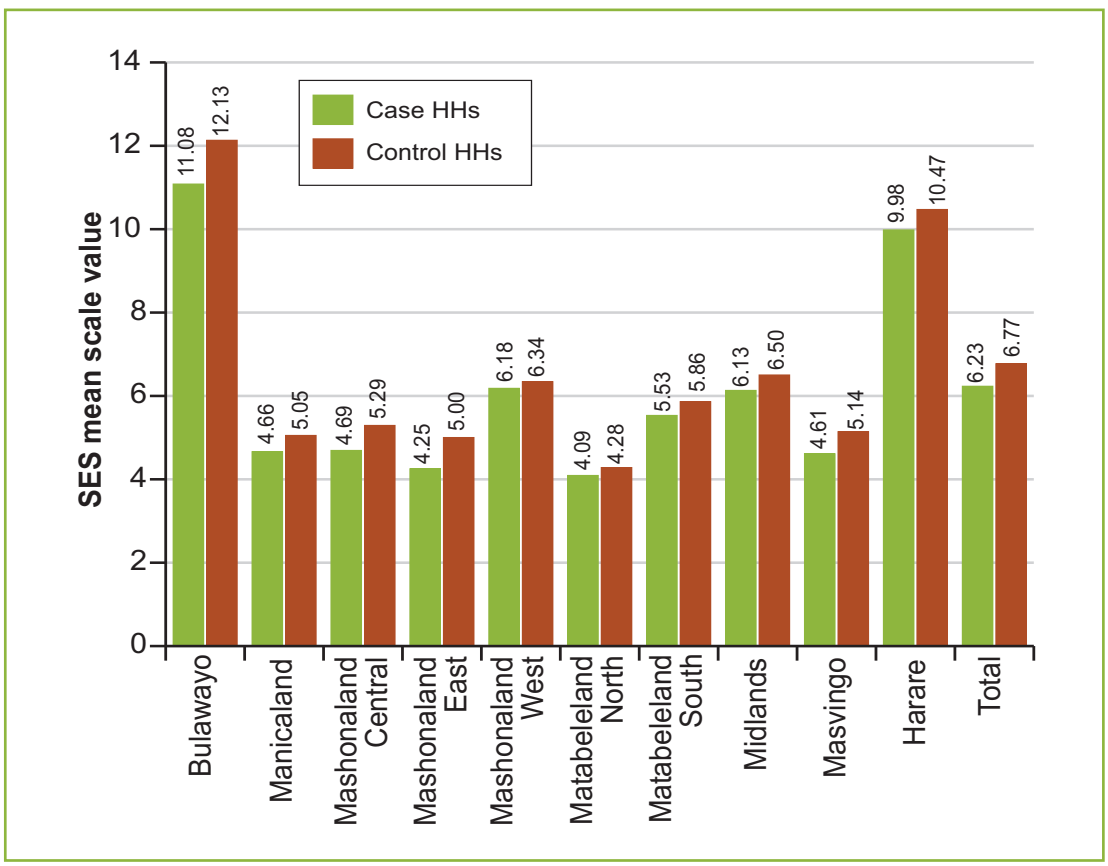


Figure 3.4: SES by Province and Household Type

Table 3.5: Food availability in household during past 2 weeks

No food to eat in household during the last two weeks	Case Households N = 4800	Control Households N = 4752
No	67.0	74.7
Rarely	20.8	16.2
Sometimes	8.6	6.4
Often	3.6	2.7

Dietary diversity by household type

Household dietary diversity was assessed by the Household Dietary Diversity Score (HDDS). The assessment was based on 12 different food groups consumed in the household in the past two weeks (preceding the survey) during the day and night. A sum score of 12 represent the highest food diversity. These food groups include: Cereals; Fish and sea food; Roots and tubers; Pulses/legumes/nuts; Vegetables; Milk and milk products; Fruits; Oil/ fats; Meat, poultry and offals; Sugar/honey; Eggs.

Overall, Case Households had lower dietary diversity compared to Control Households; 8.1 and 8.6 respectively. Figure 3.5 illustrates the distribution of HDDS between Case and Control Households. While the frequency of HHs with members living with disability is higher than Control HHs on the lower end of the graph (up to 9 food items), the trend is reversed on the high end (10 – 12 food items).

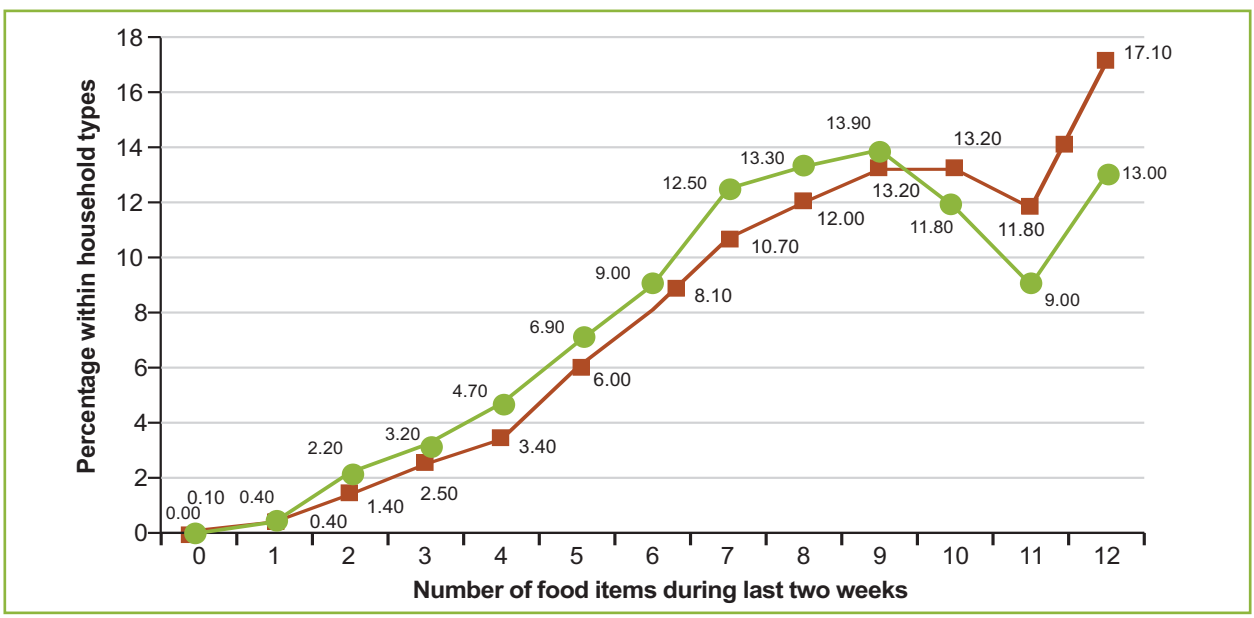
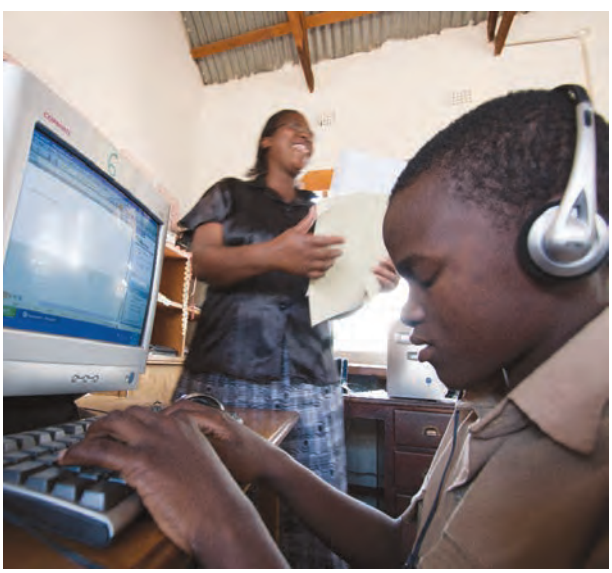


Figure 3.5: Dietary diversity by household type

CHAPTER 3 Results

Access to information

Access to information was applied as a fourth SES indicator. Two questions were asked; one on availability and another on affordability of six different sources of information. For all information items shown in Figure 3.6, there is a consistent pattern in that HHs with members living with disability report less ownership or regular use. Similarly, Control Households also report more often that they have no access or use. For all items except one (Library), the differences between the two household types are significant. The explanation for this phenomenon could be that libraries are part of a shared facility rather than an indicator of purchasing power in the households.



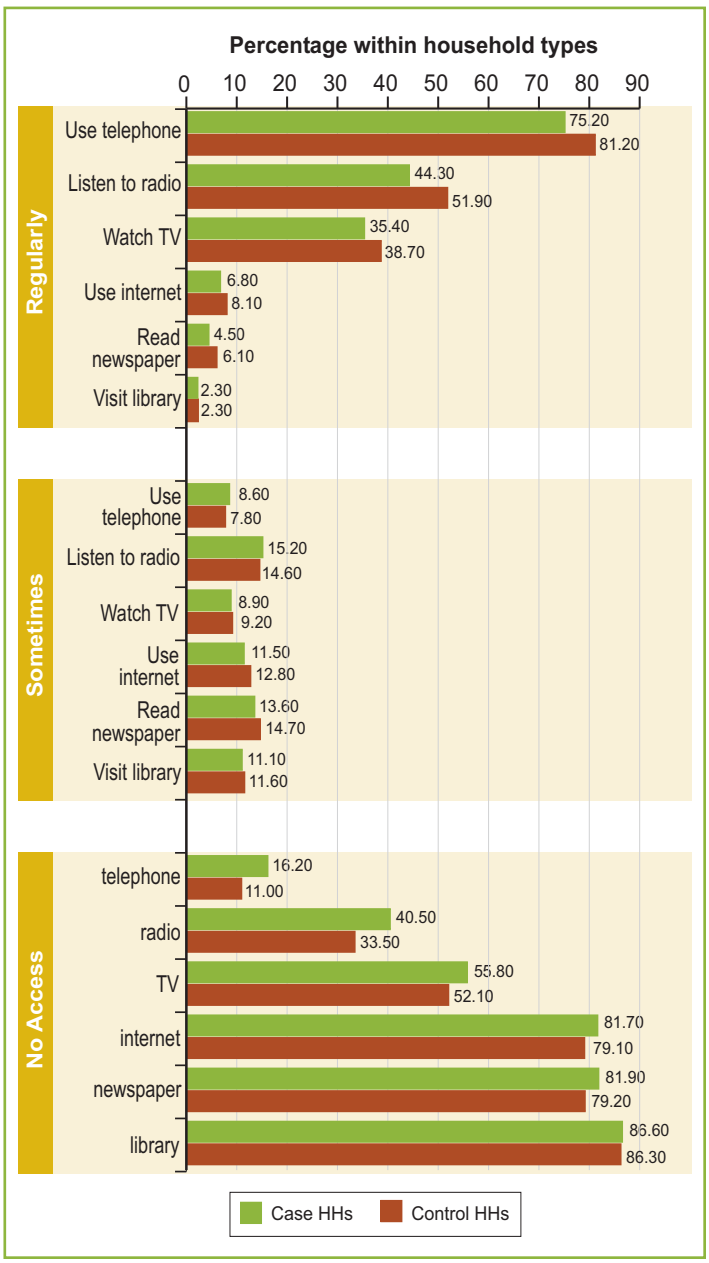


Figure 3.6: Access to information by household type

The information items were re-coded with 2 = own or regular use; 1 = have access; and 0 = no access. The six items were added together, producing an information scale with range 0 – 12.

Affordability of information

Affordability of the six information sources were measured by a simple question (Yes = affordable, No = Not affordable). Table 3.6 shows the proportion of those that answered 'yes'. The majority can afford telephone, about half (50%) can afford radio and more than 30% can afford TV. The internet and newspaper are mentioned as the least affordable items by both household types. More Control Households report that they can afford all the five different information sources.

Table 3.6: Affordability of information sources by household type

Information Source	Case Households	Control Households	Total
Telephone	64.4	73.1	68.8
Radio	45.5	52.8	49.1
TV	32.8	37.8	35.3
Internet/ Internet cafe	11.2	13.6	12.4
Newspaper	9.3	12.1	10.7

3.3 Income and Expenses

Household income

The survey collected information on the primary source of income for the households. The results show that the most common types of income are Subsistence farming, Wages, and Informal business. The urban/rural difference is pronounced in that for urban households the primary sources of income are Wages and Informal business (45.5% and 28%) respectively, while for rural households Subsistence farming (42.4%) is the most common. Control Households are somewhat higher on wage as primary source of income, otherwise there are minor differences between households with and without a member with disability. Table 3.7 below.

Table 3.7: Income and expenditure

Income Category	N	% Total	% Urban	% Rural	HH Case	HH Control
Wage	3858	26.3	45.5	16.0	23.1	29.4
Remittances	1000	6.8	7.3	6.6	7.9	5.7
Cash Cropping	435	3.0	0.6	4.2	2.9	3.0
Livestock Sales	97	0.7	0.3	0.9	0.9	0.4
Subsistence Farming	4151	28.3	1.8	42.4	28.4	28.1
Subsistence fishing	42	0.3	0.0	0.4	0.2	0.4
Formal Business	169	1.2	2.1	0.6	1.0	1.3
Informal Business	2734	18.6	28.1	13.6	18.3	19.0
Private Insurance/Pension	205	1.4	1.7	1.2	1.8	1.0
Workmen's compensation	61	0.4	0.6	0.3	0.5	0.3
Rent	282	1.9	4.6	0.5	2.7	1.1
Other	491	3.3	2.5	3.8	3.4	3.3
No income stated	933	6.4	3.7	7.8	7.4	5.4
Not stated	-	1.5	1.1	1.8	1.6	1.5

Results

CHAPTER 3

Household expenditure

An expense scale was used for ranking the different expenses in Figure 3.7. Respondents were asked to place each expense type on a scale of 1 to 5, where "1" = the least of the household income goes to and "5" = the most of household income goes to. If the household had no expense on a specific category, there was also a "None" answer category.

Food and beverages are highest ranked among the expense categories, with 58.6 % ranking this expense as either 4 or 5 on the ranking scale. This is followed by Education (42.5 %), Agricultural inputs (fertilizer, labor, etc.) (20.0 %), Clothing/footwear (13.4 %), and Medical care/health services and personal care (11.2 %). Comparing households with and without person(s) with disability revealed small and largely insignificant differences.

Among individuals who report "No income" (N = 936), only around 5 % have indicated expenses at all, and mostly these expenses are ranked low on the expense scale (1 – 5).

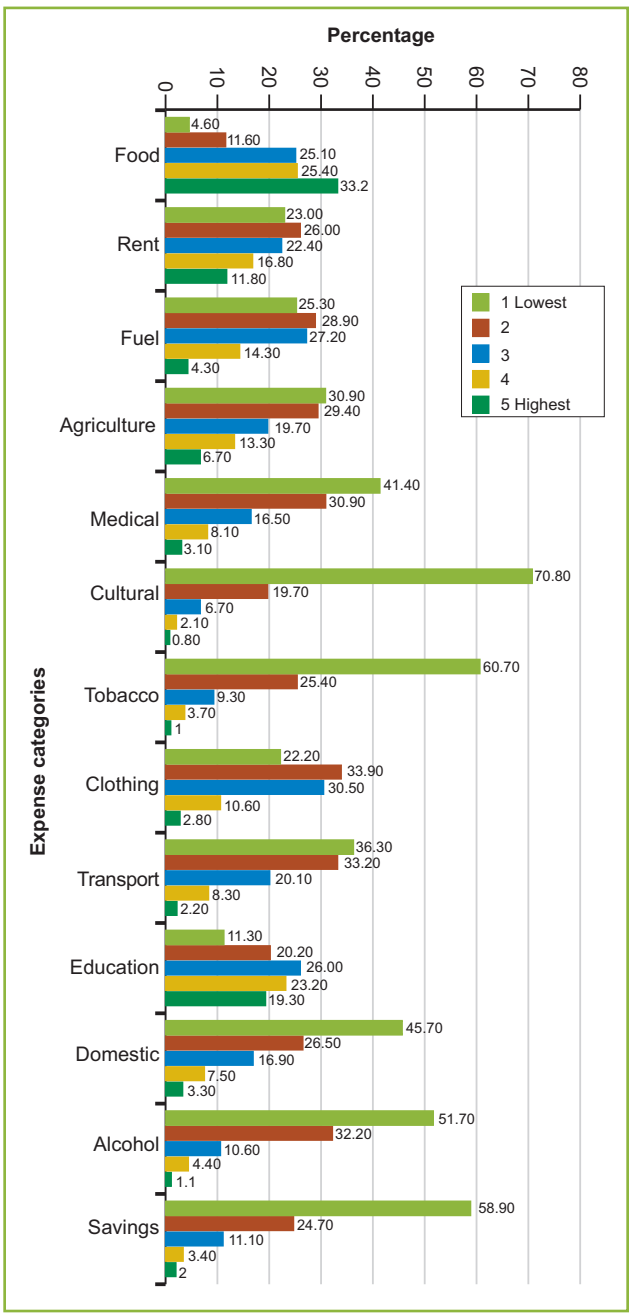


Figure 3.7: Ranking of expense categories

3.4 Disability Prevalence

Disability prevalence

Globally disability prevalence is on the increase. This has been attributed to the higher risk of disability in older persons as well as the global increase in chronic health conditions such as diabetes, cardivascular disease, cancer and mental health disorders among others.

According to the National Survey on Disability and Health (NSDH) 2013 the prevalence of disability in Zimbabwe is estimated to be 7%, this amounts to approximately 914 287 persons based on the total Zimbabwe population of 13 061 239 (Zimbabwe 2012 Population Census). Twenty-six percent (26.2%) of all screened households had at least one member

with disability. In case-households there was an average of 1.2 persons with a disability. The estimate from the current study is less than the global estimate by the World Health Organization, which suggest 2.9% are persons with severe disability and 12.4% have moderate disability in the global population.

Prevalence of albinism

A question on albinism was included in the screening questionnaire. A total of 179 households with at least one member with albinism were identified giving an estimated prevalence of 0.03%. This amounts to 3 900 individuals based on the 2012 population census results. The estimate is based on the assumption that there is only one person with albinism per household, this figure may therefore be an underestimate considering that albinism occurs within clusters and a household may have more than one member with albinism. This result is, however, higher than earlier estimates that prevalence of albinism in Zimbabwe and South Africa is approximately one in 4 000, which corresponds to 3 266 persons in Zimbabwe.

Impairment prevalence at household level

During the screening process the head of household was asked to indicate 'If, because of a health problem, any member of the household had difficulty' in the six activity domains based on the WG6 questions. Each question had four response options designed to capture the full range of activity limitations from mild to severe.The screening data, which is a mapping of all households in the entire enumeration areas, shows that almost 14 percent of the households have someone with vision problems; followed by mobility (12.6 %) and hearing difficulty (6.8%) and remembering as shown in Figure 3.8. In total, 26.2% of all households have at least one member with some difficulty, in the context of this survey these are classified as persons with disability.

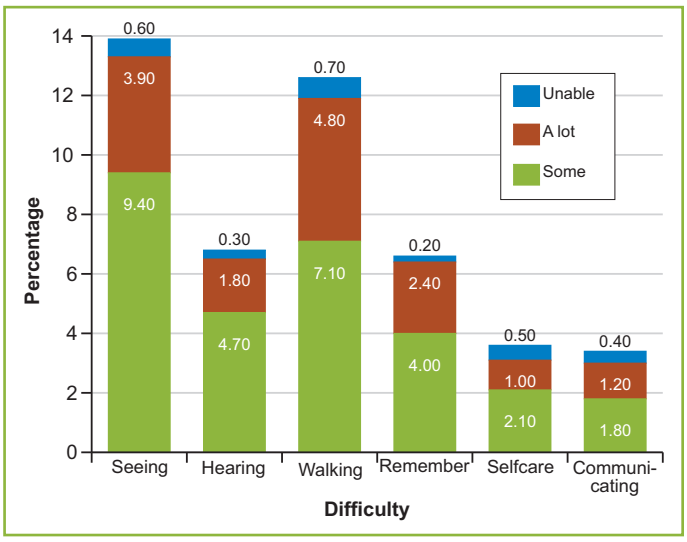


Figure 3.8: Screening of household members: anyone with activity problems?

Distribution of persons with disability in case households

As shown in Table 3.8 overleaf, the majority of the Case households have one person with disability as member, with 9.4 % having two persons and a small number reporting more than two. The figures concur quite well with results from the previous study in Zimbabwe. More rural households had one person with disability only as compared to urban households (89.5 % and 85.9 % respectively), and more urban households had two persons with disability (11.4 % and 8.3 % respectively).

CHAPTER 3 Results

Table 3.8: Number of persons with disability in households

Number of persons with disability in HH	Number of Households	% Total
1 person	6508	88.2
2 persons	694	9.4
3 persons	102	1.4
4 persons	33	0.4
5 persons or more	43	0.6

3.5 Disability Profile of sample

Figure 3.9 and 3.11 reveal that difficulties with walking and seeing are the most common types of impairments in the sample, followed by remembering, self-care, communicating and hearing. Sex differences are particularly pronounced with regards to seeing and walking impairment and more females in the sample report at least some problems. Among those who report the most serious problems (a lot of problems or unable to do), the most prevalent (among those who qualify as being a person with disability with the current definition) is walking impairment, followed by seeing, remembering, self-care, hearing and communicating. Of those who qualify as being persons with disability (at least "some problems" in one activity domain), 51.5 % have difficulty in one domain, 28.2 % have two difficulties, 12.7 % have three, 5.2 % have four, 1.8 % have five, and 0.6 % have reported difficulties within all six activity domains.

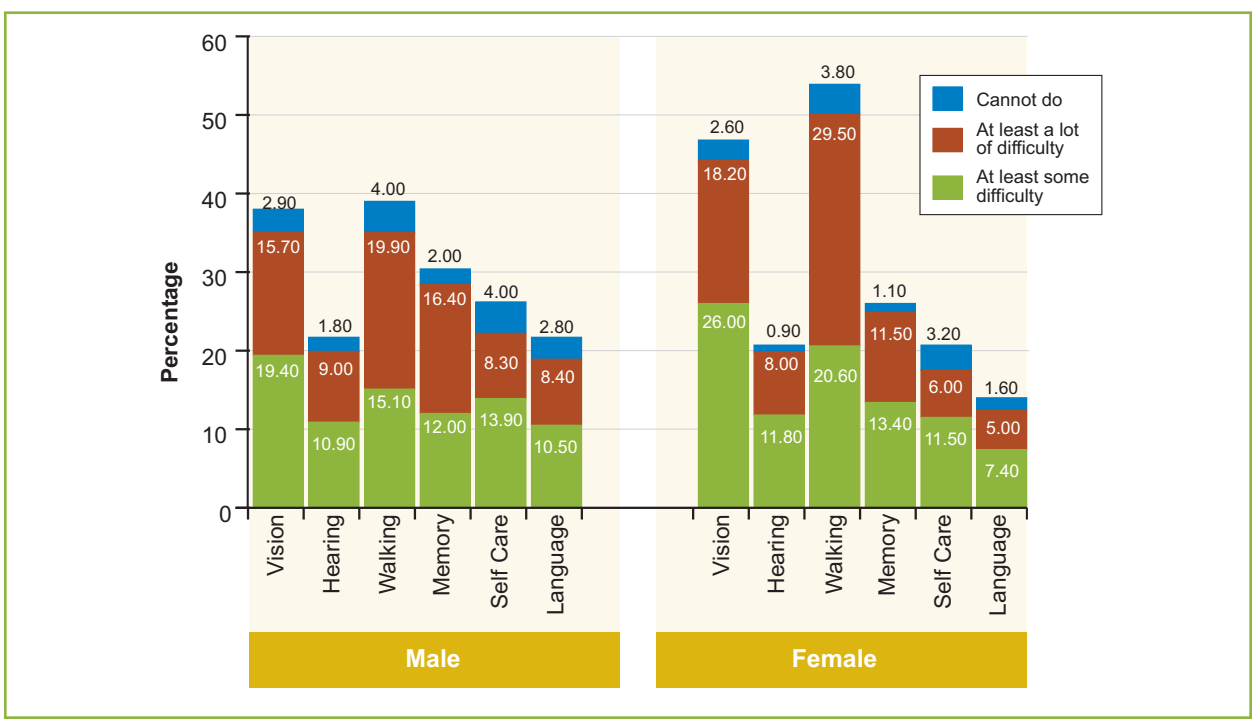


Figure 3.9: Disability profile of sample

Activity limitations by age and sex

Level of activity limitations drops with increasing age until age group 41 – 50, and increases with age after that. There is some variation between sexes, in that women in the two oldest and the youngest age group tend to report higher levels of activity limitations, whilst men report higher levels of activity limitations between 6 and 50 years. Ageing appears to have a major influence on disability trends, the disability prevalence among persons 60 years and older is high, and higher among women than men.

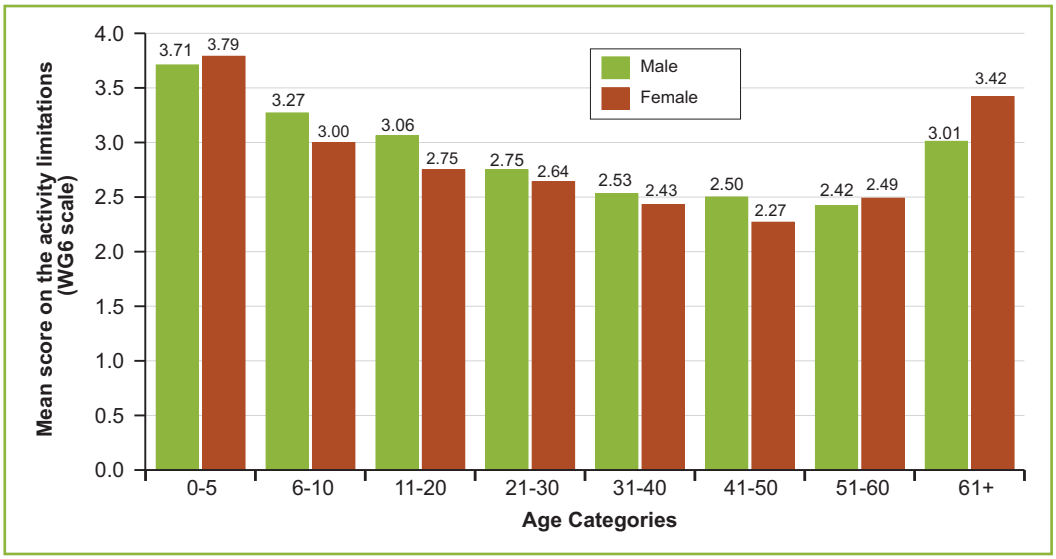


Figure 3.10: Activity Limitations by age and sex

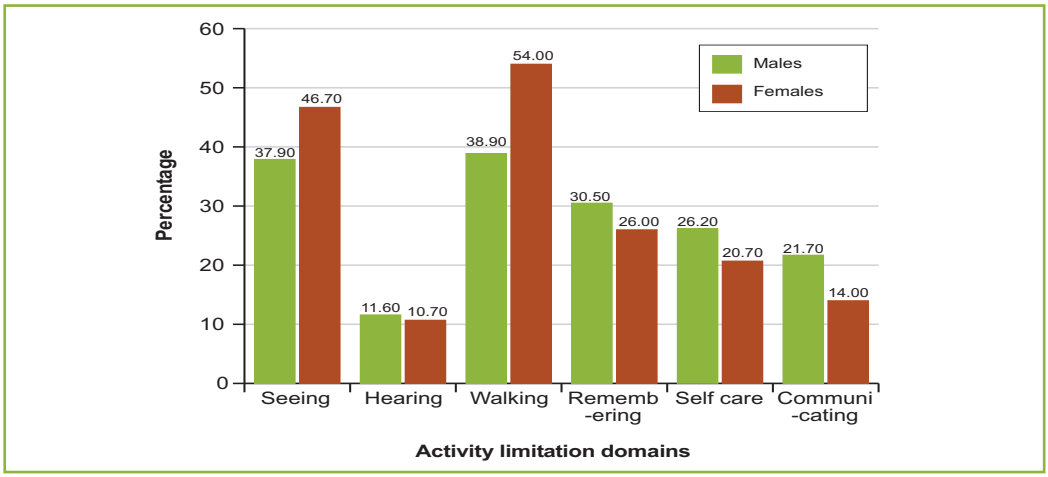


Figure 3.11: Activity limitations by sex

Results

CHAPTER 3

Disability Onset and Cause

Disability Onset

The survey results show that a large proportion of individuals with disability acquire their disability as children. Around 25% of individuals with disability acquire it at birth or before the age of 5 years. Approximately 45 % acquire disability before 20 years of age. While males seem to be more exposed to disability in the younger age groups, the results indicate a strong association between increasing age and disability among women as compared to men.

Results from the previous survey in Zimbabwe (2003) also established that children are exposed to disabling conditions while increasing age is also associated with disability.

Cause of disability

The major causes of disability reported were diseases, congenital/perinatal causes and accidents. The major types of accidents reported were road traffic accidents, falls and burns. More males experienced disability due to accidents and congenital/perinatal causes whilst females scored higher on disease as cause of disability.

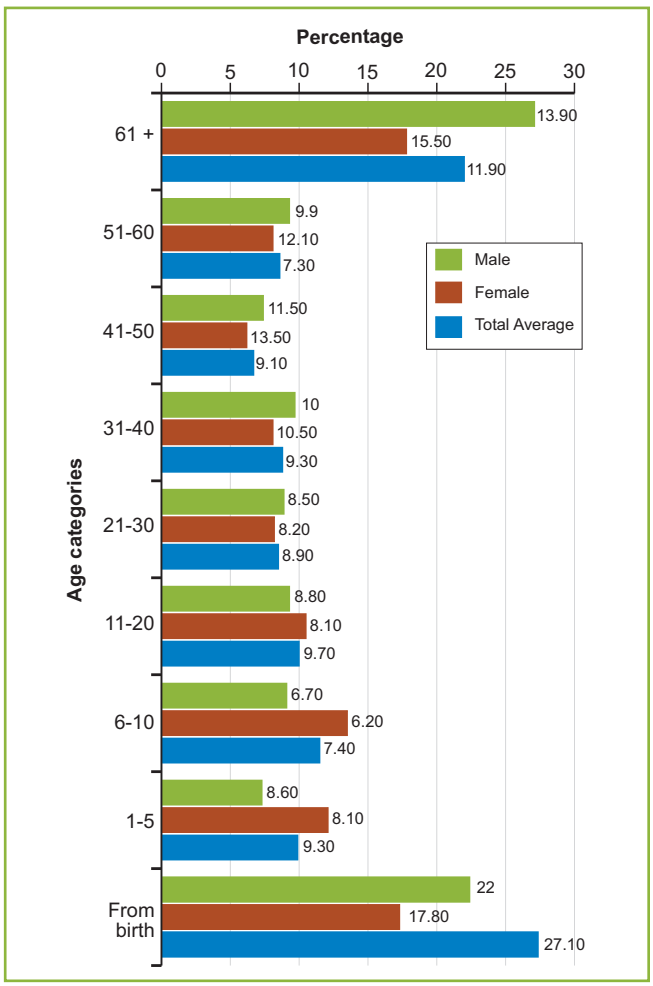


Figure 3.12: Disability onset by age and sex

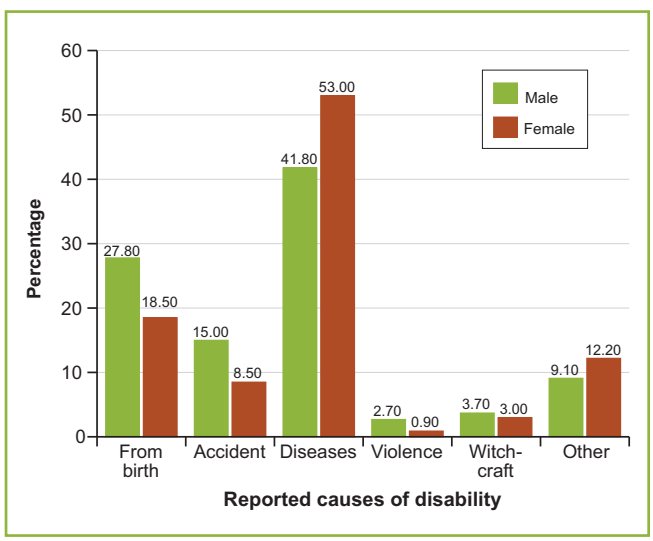


Figure 3.13: Self reported cause of disability by sex

Cause of disability – urban/rural

Respondents from the rural areas reported more often than those in urban areas that their disabilities were present from birth. For both urban and rural respondents, disease was reported to be the main cause.

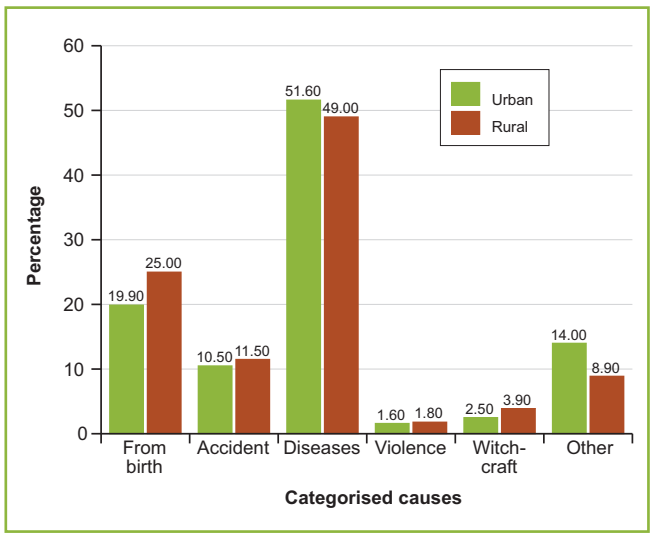


Figure 3.14: Self reported causes of disability by urban - rural

3.6 Education and Literacy

School attendance

Information on school attendance (ever attended any school, college or university) was collected from individuals aged 3 years and above. The responses were categorized into three age categories; 3 – 12; 13 – 18; 19 years and above. For all three age categories, the percentage of those who have ever received formal education among persons with disability was lower (84.2%) than among persons without disability (93.1%).

Analysis of school attendance among females and males aged 3 years and above show that more males were attending or had attended school, college or university than females (91.5% and 89.0%) for the control group. The same pattern is found among males and females with disability (87.3% and 81.4%).

Most common types of disability

All individuals with disability were asked to describe their disability and condition. The responses were classified into major disability categories. Figure 3.15 below shows that the most prevalent type of disability is Physical disability (31 %), followed by Visual impairment (26 %), Multiple disorders (13 %), Hearing impairment (12 %), Intellectual disability (8 %), and Mental illness (6 %). Totally blind and Totally deaf (2 % and 1 % respectively) increases the figures for Visual and Hearing impairment to 26% and 12% respectively.

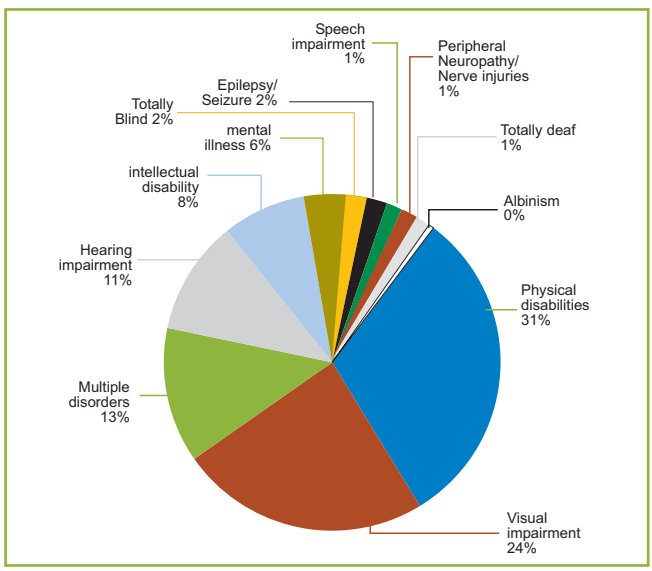


Figure 3.15: Disability types in the sample

CHAPTER 3 Results

Fewer females than males have ever attended formal education. The sex difference is small but significant for both case and control. An overall impression (Table 3.9) is that the large majority have attended formal education, but that there is a disability and sex gradient to the disadvantage of individuals with disability and females.

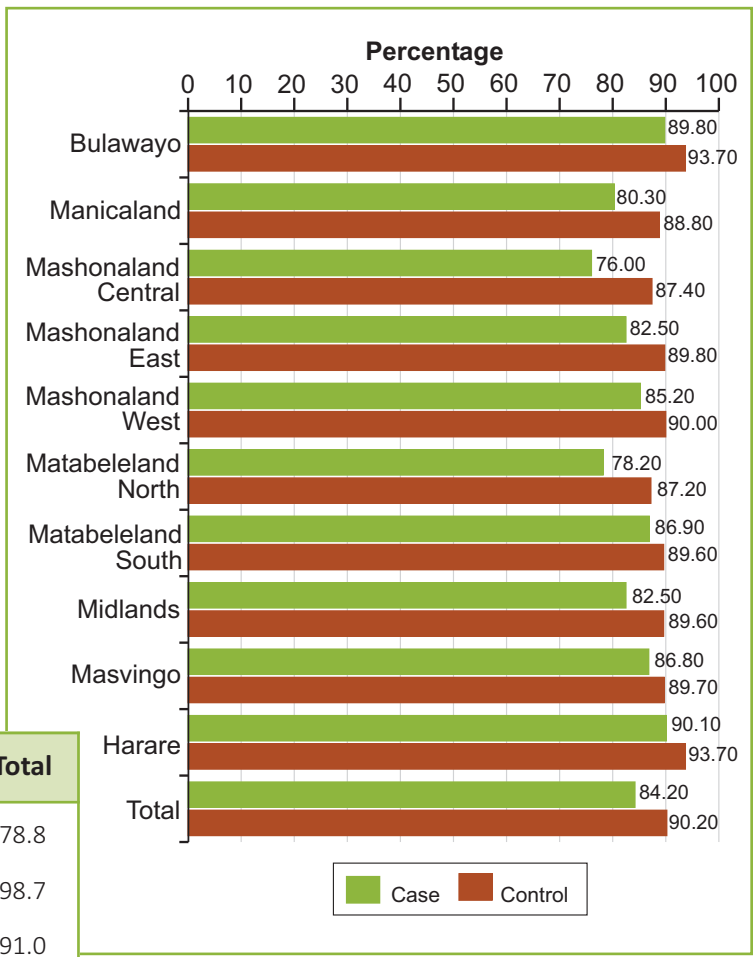


Figure 3.16: School attendance by disability status and province

Table 3.9: School attendance by sex and disability status

Age Group	Case	Control	Total
3– 12	76.5	79.2	78.8
13-18	95.9	99.1	98.7
19+	84.2	93.1	91.0
Sex			
Male	87.3	91.5	90.7
Female	81.4	89.0	87.5

School attendance: Formal education

Fewer individuals with disability have ever attended formal education. In all provinces there is a consistent difference between individuals with and without disability. The total difference between the two groups varies between 2.9% and 11.4 % in the different provinces. The smallest differences are found in Harare and Bulawayo. In total, 84.2% of individuals with disability have attended formal education, while the corresponding figure for individuals without disability is 90.2%.

Formal education by disability status/urban and rural

The urban – rural difference in school attendance is shown in Figure 3.17. Both in urban and rural areas, a higher proportion of individuals with disability do not or have not attended any formal education, and the Case – Control difference is substantially higher in rural areas. In urban areas, 93.9% of persons without disability and 92.5% of persons with disability have ever attended formal education, and the corresponding figures in rural areas are 90.0% and 83.6% respectively.

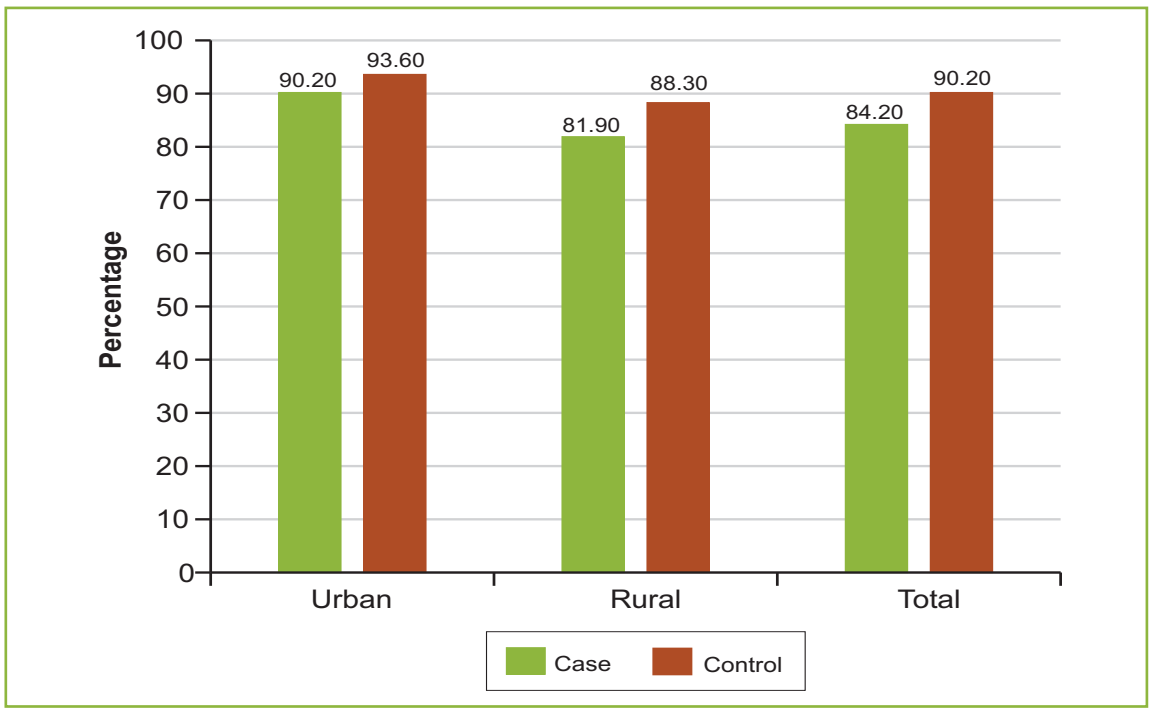


Figure 3.17: Ever attended formal education by urban/rural (3 + years)

Years of education by disability status and sex

Information on total number of years spent studying was reported by all those who had or were attending formal education. The results show that the average number of years of education among individuals with and without disability is 7.5 and 7.9 years respectively (see Table 3.18). The differencein total number of years is found among both males and females and there is a sex difference in that males tend to stay longer in school (8.7 years) than females (7.5 years).

Figure 3.18 indicates that many children/ students who enter formal education do not reach completed primary education (38.5%), with a marginal difference between individuals with and without disability. The major difference between the two groups is that more individuals with disability report completed

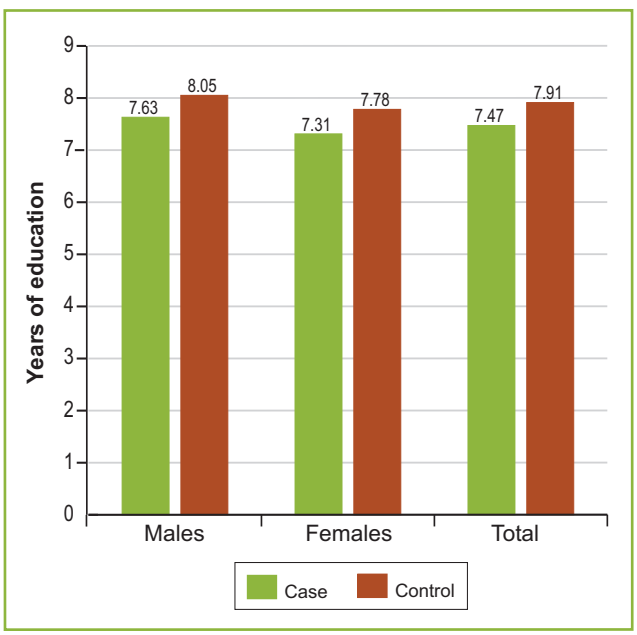


Figure 3.18: Years of education by disability status and sex

Results

CHAPTER 3

primary education as their highest level, while more control individuals report secondary education including completed Form 4 (A level). This indicates a disadvantage for individuals with disability in the transition to secondary school and to O-levels. While 14.6% of control individuals reach grade 7, the corresponding figure among individuals with disability is 19.0%.

A total of 18% of individuals with disability reach Form 4, while the corresponding figure for control individuals is 25%. Figure 3.19 further indicates that relatively fewer children with disability attend pre-school. Marginal differences between the two groups (case/control) were found concerning number of years of education to reach Grade 7 or Form 4.

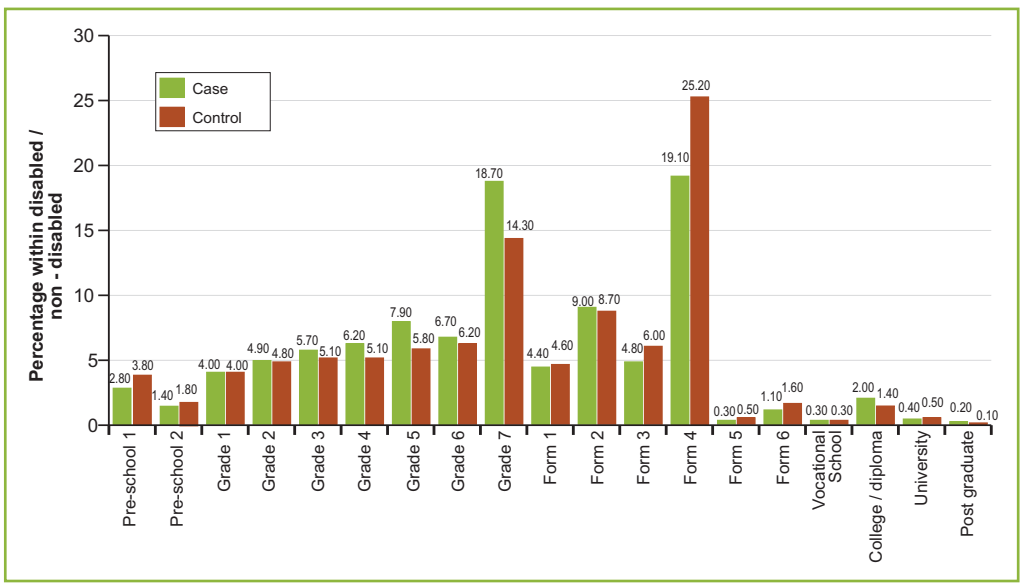


Figure 3.19: Highest level of education achieved by disability status

When the results are disaggregated by province, the overall difference between individuals with and without disability (among individuals who had ever attended formal education) is marginal except for Harare and Bulawayo.

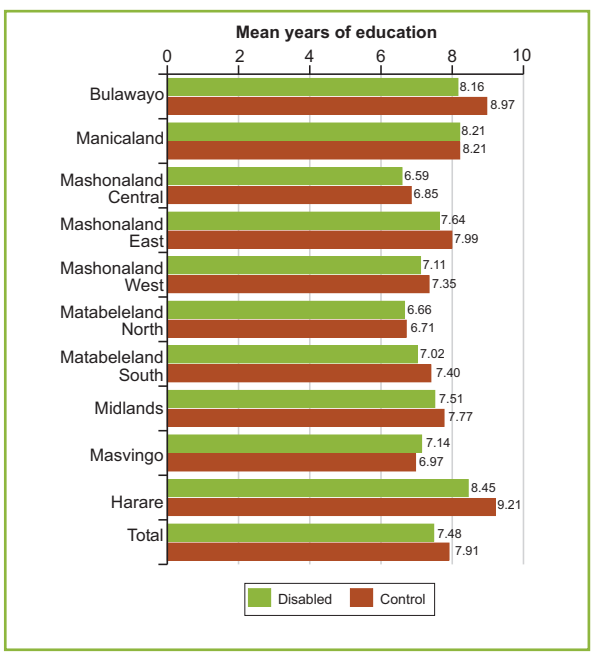


Figure 3.20: Mean years of education by disability status and province

3.6.1 Reasons for not attending school

Those that had never attended or had left school at some point were asked to give reasons for not attending and or discontinuing school. Table 3.10 below reveals that 8.4 % of urban and 16.0 % of rural persons with disability state that the disability was the reason for not attending school, implying less access for individuals with disability in rural areas. The second major implication of Table 3.10 is that, for the majority of children, lack of money is the major cause for not attending school. A third finding is that individuals with disability to a greater extent ascribe illness as a cause, which is realistic bearing in mind the co-morbidity of disability and other health problems.
As individuals with disability score higher on disability and illness as causes, there is a logical tendency in the data material that persons without disability score higher on the other alternatives. A total of 3 %, which in reality implies 6 % of the females, ascribe pregnancy as cause of non-attendance. Early pregnancy is thus a threat to education for girls in this context, in both urban and rural areas, and among both students with and without disability. A small number of control respondents have indicated "disability" as a cause for not attending school, which may indicate temporary disability or change in disability status over time.

Literacy

The question on literacy addresses the issue of an individual's ability to read and write in any language. The data recorded was based on the evaluation given by the head of the household or the main informer on behalf of every household member. The analysis include only data from household members aged 15 years old and above with complete data on age and literacy. Literacy among persons belonging to this age group was 92.9 % in the control group, and among persons with disability, it was 76.9 %.

Table 3.10: Main reasons for not attending school by disability status and urban/rural

Reason for not attending school	Person with disability		Person without disability	
	Urban	Rural	Urban	Rural
Not enough money	58.9	55.8	67.6	72.9
Failing/under achiever	9.0	5.5	13.7	7.3
Illness	8.9	8.2	1.5	1.7
Lack of interest	2.1	3.8	4.9	5.3
Because of disability	8.4	16.0	0.2	0.4
School not accessible	2.0	2.0	0.7	2.0
Pregnancy	3.9	1.1	4.4	3.2
Other	6.8	7.4	6.9	7.1

CHAPTER 3 Results

Literacy rate by sex and disability status. 15 years or older

Literacy among males is significantly higher than among females for both individuals with and without disability.

Table 3.11: Literacy rate by sex and disability status

	Case	Control
Male	81.9%	95.0%
Female	73.1%	91.0%
Total	**76.9%**	**92.9%**

Literacy by disability status and province

Literacy rate among individuals with disability is substantially lower than among individuals without disability, with the gap varying between 23 and 9 percentage points across the 10 provinces. There is also substantial variation between the different provinces, with the highest literacy rates for both groups (case and control) being recorded in Harare and Bulawayo, and the lowest in Mashonaland Central and Matabeleland North provinces.

3.7 Employment and Activity

The right to work is a fundamental right for all individuals. Its upholding further contributes to improvement in living conditions. In this survey, respondents in the economically active age group (15 to 65 years) were asked about their current employment status.

The tables and graphs below give the distribution of employment status among economically active persons aged 15 to 65 years old.

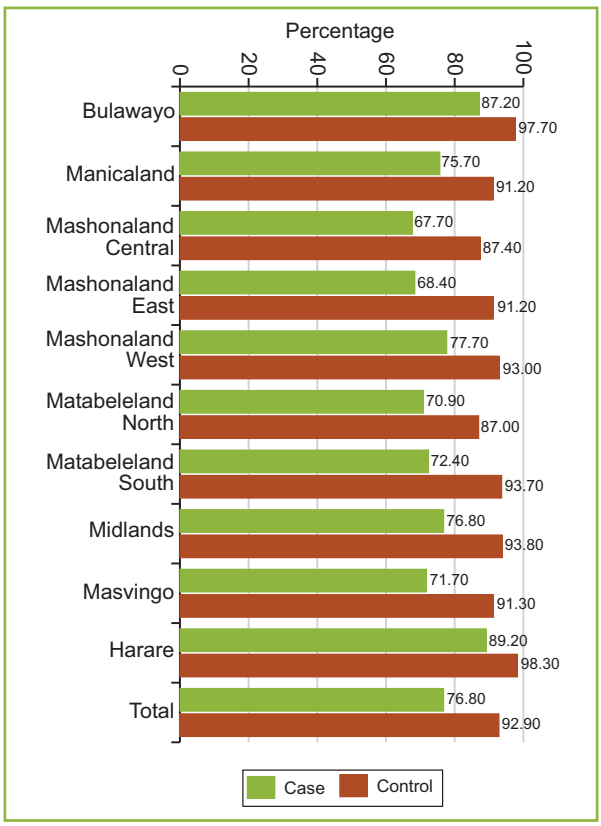


Figure 3.21: Highest level of education achieved by disability status

Activity by disability status

Table 3.12 below shows the distribution of employment status among economically active persons aged 15 to 65 years old.

The results reveal differences between individuals with and without disability; fewer individuals with disability report that they are in formal, paid employment; more controls are looking for work; the proportion of students is almost three times higher among controls as compared to individuals with disability; 6 times more individuals with disability (14.8%) than without disability (2.2%) report that they are retired, sick or too old to work. The results thus reveal that individuals with disability are less involved in formal employment and higher education as compared to individuals without disability.

Table 3.12: Activity by disability status

Activity	Activity Limitation		Percent
	Case	Control	Total
Homemaker	29.8%	28.0%	28.3%
Own account worker	21.1%	20.8%	20.8%
Looking for work/unemployed	10.5%	15.1%	14.5%
Student	5.1%	14.3%	12.9%
Paid employment	9.1%	11.3%	11.0%
Unpaid family worker	5.8%	6.0%	6.0%
Retired/sick/too old	14.8%	2.2%	4.0%
Other	2.9%	1.3%	1.6%
Employer	0.8%	1.0%	1.0%
Total	100.0%	100.0%	100.0%

Activity domains by activity limitations (15 – 65 years)

Comparing the different activity limitations (activity domains/disability types) with current activity status reveals primarily the same rank order of activity status items across activity limitation domains (disability types). There are some differences, where the most pronounced are that fewer individuals with memory, self-care or language difficulties are employed or homemaker, and more are retired, sick or too old to work.

Table 3.13: Activity domains by activity limitations (15 – 65 years)

Activity/Domain	Seeing N = 1853	Hearing N = 736	Walking N = 1909	Memory N = 985	Self-Care N = 678	Language N = 639
Homemaker	29.5	30.3	27.6	27.6	21.4	23.2
Own account worker	23.0	21.3	21.6	11.8	11.5	12.0
Looking for work/unemployed	9.6	10.2	9.0	11.9	11.1	11.6
Retired/Sick/too old	12.6	11.7	19.2	25.0	35.7	27.4
Student	5.7	7.5	2.3	5.1	3.7	5.6
Paid employment	12.1	9.1	7.5	4.0	3.4	4.0
Unpaid family worker	4.3	7.3	4.6	9.2	7.2	9.4
Employer	0.9	0.5	0.9	0.5	0.7	0.2
Other	2.3	2.0	3.4	5.0	5.3	6.7

CHAPTER 3 Results

Current work status

Table 3.14 below shows that fewer individuals with disability are currently working, or returning to work, and more individuals with disability state that they have been previously employed, and this difference is found also when analyzing men and women separately. Fewer females than males are currently working or have been previously employed, while more females are housewives/homemakers.

Table 3.14: Work status

Work Status	Case		Control	
	M	F	M	F
Yes, Currently working	21.2	10.9	35.5	16.8
Yes, returning to work	3.0	2.2	1.0	0.5
No, but previously employed	31.1	13.2	20.7	9.4
Never employed	43.2	56.5	40.5	52.8
Housewife/homemaker	1.5	17.0	2.3	20.6

Reasons for current unemployment

Individuals with disability are more often unemployed because of illness, and evidently because of disability. Individuals without disability are more often unemployed due to being retired, retrenched or discharged.

Table 3.15: Reasons for current unemployment

Reason	Case	Control
Retired	27.5	35.6
Retrenched	17.6	26.0
Discharged	4.8	7.5
Injury at work	3.2	1.2
Illness	16.6	4.1
Disability	12.2	0.3
Other	18.1	25.4

3.8 Burden of Disease

In both Case and Control Households, information was obtained on incidents of chronic illness or death in the household in the 12 months preceding the survey. Among individuals with disability, a total of 30.2% were reported to be or had been chronically ill during the last 12 months. The corresponding figure for controls was 7.2%. Table 3.16 details the type of illness reported and the distribution within the two groups. High blood pressure is common among individuals with disability while cancer, malaria and diarrhoea were commonly reported by individuals without disability.

Of the Control Households, 5.5% had experienced death of a household member within the past 12 months, whilst the proportion for Case Households was 6.8%.

Table 3.16: Type of illness during the last 12 months

Type of Illness	Individuals without disability (N = 3441)	Individuals with disability (N = 2220)
Cancer	9.6	2.7
TB	4.5	3.0
Malaria	12.8	4.1
Diarrhoea	8.4	3.9
Malnutrition	0.6	0.2
Measels	0.4	0.2
Pneumonia	4.4	2.7
Heart disease	2.3	3.1
High blood pressure	6.2	12.3
HIV/AIDS (related)	8.3	7.8
Other disease	42.6	59.8

Death in the household

The rank order of the position of the deceased household member is the same for Case and Control Households; mostly it was the spouse of the household head, parent of head/spouse, or grandchild of head/spouse. Spouse was reported more often by the Case Households, whereas the Control Households reported more often Parent or Grandchild of head/spouse.There was no age difference of the deceased person among the two household types (mean age 41.9 years).

The major cause of death was reported to be HIV/AIDS related (20.6 % and 19.7 % among Case and Control Households respectively), followed by "Other disease" (19.1 % in both household types), and TB (7.2 % and 7.1 % respectively). Cause of death varied marginally between the two household types. While the deceased person was reported to be a person with disability by 14.7 % of the households, the figures for Case and Control Households were 16.0 % and 12.8 % respectively.

Results

CHAPTER 3

Table 3.17: Deceased person's position in the household

Position in household	Case HHs (1655)	Control HHs (1249)
Head	8.8	6.5
Spouse	40.2	34.7
Son/daughter of head/spouse	0.9	1.3
Spouse of child	6.6	6.3
Grandchild of head/spouse	12.8	15.5
Parent of head/spouse	27.6	35.0
Other relative	2.5	0.6
Non-relative	0.4	0.0

3.9 Disability and Health

Disability is extremely diverse. While some health conditions associated with disability result in poor health and extensive health care needs, others do not. All people with disabilities have at least the same general health care needs as everyone else, and therefore need access to mainstream health care services. Article 25 of the UN Convention on the Rights of Persons with Disabilities (CRPD) reinforces the right of persons with disabilities to attain the highest standard of health care, without discrimination.

Table 3.18: Health conditions among individuals with/without disability during last 12 months

Health Conditions	Case		Control	
	N	%	N	%
Back or neck problem	615	9.5	394	6.6
Arthritis/rheumatism	1258	19.5	357	6.0
Stroke problem	1825	28.2	936	15.8
Developmental problem	393	6.1	127	2.1
Asthma/breathing problem	267	4.1	37	0.6
Cancer	1191	18.4	616	10.4
Mental retardation	141	2.2	35	0.6
Neurological disorder	210	3.3	51	0.9
Fracture or bone/joint injury	86	1.3	21	0.4
Heart problem	522	8.1	18	0.3
Kidney/bladder/renal problem	483	7.5	24	0.4
Misssing limb/amputee	107	1.7	11	0.2
Hypertension/HBP	718	11.1	144	2.4
Depression/anxiety/emotional	107	1.7	11	0.2
Diabetes	151	2.3	17	0.3

General health and Well being (WHODAS)

General health and well being were explored by applying the WHO-DAS II 12 questions, tapping anxiety and depression. The scale comprises 12 items:

For the past week have you –

- Been able to concentrate on what you are doing?
- Lost much sleep over worry
- Felt you were playing a useful part in things
- Felt capable of making decisions about things?
- Felt constantly under strain?
- Felt you couldn't overcome your difficulties?
- Been able to enjoy your normal day to day activities?
- Been able to face up to your problems?
- Been feeling unhappy and depressed?
- Been losing confidence in yourself?
- Been thinking of yourself as a worthless person?
- Been feeling reasonably happy all things considered?

All questions were responded to by a four-point scale, with increasing values indicating higher problems. The 12 items where thus added, yielding a Well-being scale with range from 12 to 48. Mean score 23.07. Higher values indicate more problems with depression and anxiety.

Table 3.19 reveals significant differences in that individuals without disability score substantially higher on well-being as compared to individuals with disability. This difference is valid in both rural and urban areas, whereas the overall differences between urban and rural, and between males and females, were marginal.

Table 3.19: Health and well-being by disability status

Health and Well-being scores (WHODAS)			
Disability Status	**Male**	**Female**	**Total**
Case	22.71	22.16	22.41
Control	27.88	27.07	27.43

Figure 3.22 illustrates both the differences in well-being between persons with and without disability for all age categories, and a general slight reduction in well-being with increased age.

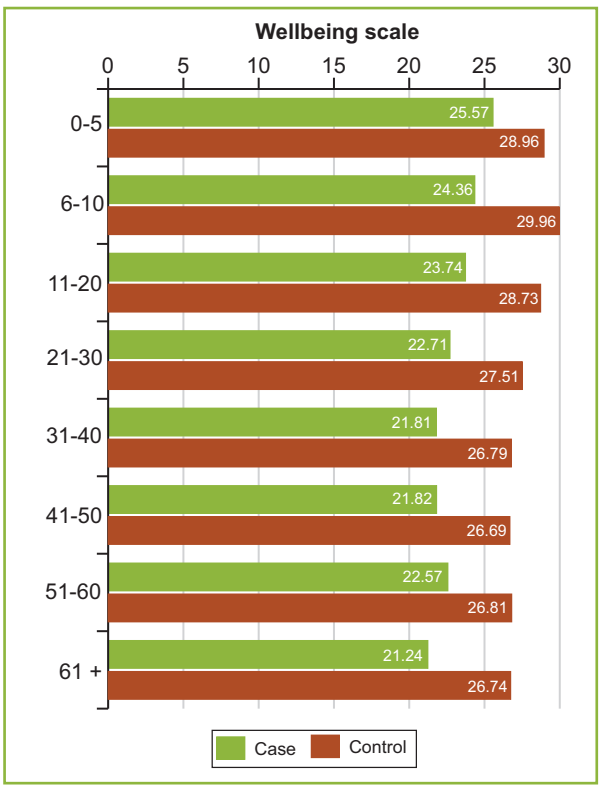


Figure 3.22: Well-being by disability status and age category

Results

CHAPTER 3

Physical health and disability

Figures 3.23 and 3.24 below show that, for both physical and mental health, individuals with disability score significantly lower than individuals without disability. Individuals with disability thus report lower general physical and mental health. It is however also a finding here that some individuals with disability report either good or very good on both physical and mental health.

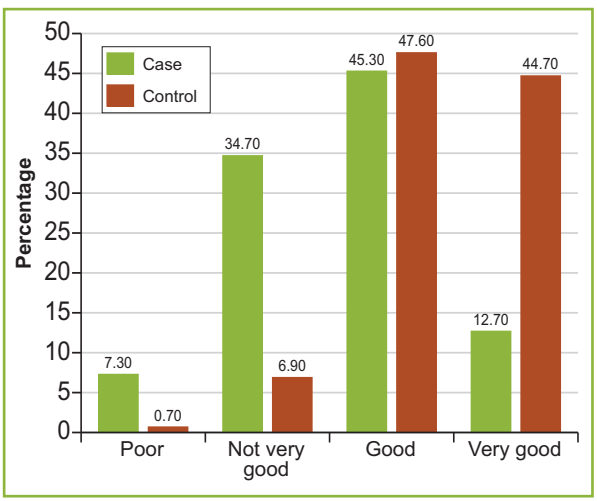


Figure 3.23: Physical health and disability by status

Mental Health and disability

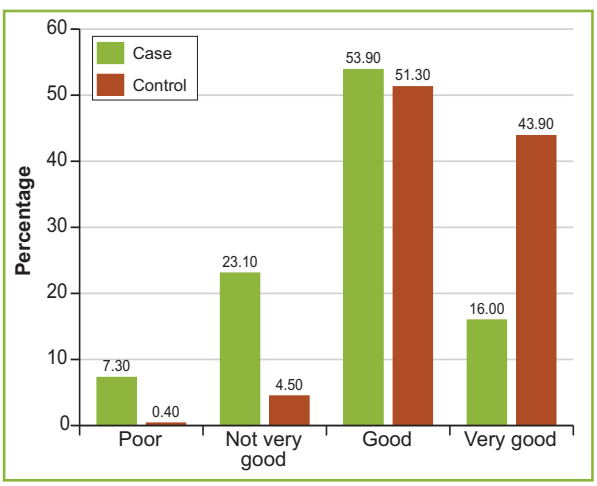


Figure 3.24: Mental health and disability by status

Knowledge and understanding about common diseases

The survey collected information on knowledge and understanding about HIV and AIDS, STIs, Diabetes, TB and Cancer among individuals with and without disability.

As shown in Table 3.20 below, for all five diseases, individuals without disability report more knowledge than individuals with disability. Sex difference is significant for four of the diseases (except STI), with a tendency for women to report more knowledge than men.

Table 3.20: Knowledge about some common diseases

Have you any knowledge about...?	Case		Control	
	M	F	M	F
HIV and AIDS	72.6	76.9	83.0	85.0
STI	64.1	64.5	72.5	72.6
Diabetes	54.6	58.2	58.9	62.2
TB	63.6	66.5	72.1	73.3
Cancer	54.5	58.0	59.4	61.9

Major sources of informationon on common diseases

For all five diseases, the respondents mainly get their information from a health clinic. Close to two thirds report health clinic as the main source, and there are marginal or small differences between individuals with and without disability. School, family, radio/TV, and friends follow after health clinic, but these sources are stated as most important by around one in ten or less. Differences between the two groups are found in that individuals with disability tend to report friends and family more often than individuals without disability, and the other way around for schools.

Table 3.21: Major Sources of Information on HIV and AIDS, STI, Diabetes, TB and Cancer

Source of Information	HIV and AIDS		STI		Diabetes		TB		Cancer	
	Case	Control	Case	Control	Case	Control	Case	Control	Case	Control
Health Clinic	64.3	63.0	65.0	64.2	61.2	56.8	63.0	59.7	60.5	56.9
School	10.2	14.8	8.8	12.7	6.9	10.7	8.0	12.1	7.0	10.1
Radio/TV	7.3	7.1	7.2	6.9	7.7	8.9	7.3	8.5	9.7	11.0
Family	6.7	4.8	6.8	4.1	10.2	10.1	10.0	7.9	9.7	7.9
Friends	5.3	4.4	6.1	5.8	7.5	7.4	5.6	5.4	6.7	6.8
Work place	1.9	2.2	2.1	2.2	1.6	2.0	1.6	2.0	1.4	1.9
Doctor	1.5	1.1	1.5	1.2	2.2	1.5	1.6	1.2	2.2	1.9
Magazines/newspapers	0.8	1.1	0.9	1.2	1.1	1.4	0.9	1.2	1.0	1.7
Posters and pamphlets	0.6	0.6	0.6	0.6	0.5	0.7	1.1	1.3	0.5	1.0
Other	1.3	0.9	1.2	1.0	1.1	0.6	0.8	0.7	1.3	0.9

Understanding and obtaining information on common diseases

More individuals with disability report that they have problems in understanding and obtaining information about the five diseases. Approximately one in ten state that obtaining and understanding information is a problem. The difference between individuals with and without disability is small, around 1 – 2 %, but the pattern is consistent and significant across the five diseases. Sex difference in understanding/obtaining information is significant for Cancer only, where more females report that they have problems.

Table 3.22: Problems in understanding about HIV and AIDS, STI, Diabetes, TB and Cancer

Any problems in understanding...	Case		Control	
	M	F	M	F
HIV and AIDS	9.7	10.1	8.4	7.6
STI	8.4	9.0	7.4	7.1
Diabetes	9.3	10.0	8.8	8.9
TB	9.1	9.7	8.1	7.4
Cancer	9.6	12.3	8.8	9.6

Experience of disease

Table 3.23 below shows that individuals with disability tend to report more often than individuals without disability that they have/have suffered from the five diseases. The most pronounced difference concerns HIV where twice as many individuals with disability report that they have/have had the disease (10.2 % and 5.0 %, males and females combined)(HIV, STI, Diabetes, TB and Cancer). More females than males report that they have/have had HIV, while more males than females report STI.

Table 3.23: Have you ever had this disease...

Have you ever had this disease...	Case		Control	
	M	F	M	F
HIV and AIDS	8.9	11.2	3.9	6.0
STI	5.8	4.7	4.4	2.9
Diabetes	3.9	5,0	2.2	1.9
TB	5.9	5.1	2.8	3.1
Cancer	2.1	2.6	1.4	1.1

Results

CHAPTER 3

3.10 Environmental Barriers

The concept that the environment can be a co-factor contributing to disability has provided the impetus for broadening the scope of scientific inquiries on disability. In this new paradigm, disabilities are considered to be the result of interactions among personal, biomedical and functional limitations, and environmental barriers to participation. In this survey, the magnitude of different environmental barriers was measured by means of a 12 item scale.

Experienced environmental barriers among individuals with disability in the last 12 months

As shown in Table 3.24 below, the natural environment stands out as most often perceived as a barrier by the respondents. This is followed by other aspects of surroundings, availability of information, and not getting help at home. Sex differences are further found for Transport and Policies and rules of organisations and business. Government programs and policies were perceived as less problematic. The differences between males and females do not appear to be systematic to the advantage/disadvantage of either men or women. Comparing urban and rural, the results show a consistent pattern in that rural respondents perceive and experience more barriers than their urban counterparts in all assessed areas except for one item, 'Government programs and policies'.

Table 3.24: Experienced environmental barriers among individuals with disability in the last 12 months

Environmental Barrier		Daily		Weekly		Monthly		Less than monthly		Never	
	N	M	F	M	F	M	F	M	F	M	F
Transport	6252	10.2	10.6	4.7	4.1	11.8	14.0	11.2	13.0	62.1	58.3
Natural environment	6300	21.7	19.3	5.3	5.4	8.7	9.6	16.3	19.8	50.4	43.6
Other surroundings	6273	12.2	12.1	3.9	4.1	5.7	5.5	7.6	8.8	70.6	69.4
Availability of Information	5825	11.1	10.8	3.9	3.1	6.4	7,2	8.4	9.5	70.1	69.5
Availability of health care	6299	7.8	7.2	3.8	3.5	16.5	17.1	12.0	11.6	59.9	60.6
Could not get help at home	6262	10.6	10.8	5.0	5.5	6.3	7.3	10.7	13.2	67.3	63.2
Could not get help at work/school	2779	9.7	9.3	4.8	4.6	6.3	5.9	9.1	9.1	70.1	71.1
Attitudes at home	6144	8.6	7.1	2.7	2.8	4.5	3.8	7.1	8.3	77.2	77.9
Attitudes at school/work	2962	10.2	9.3	4.1	3.1	5.3	4.2	7.4	6.6	73.0	76.8
Prejudice/discrimination	6140	10.1	7.2	3.7	3.0	5.1	4.6	10.3	8.7	70.7	76.5
Policies and rules of organisations	4992	3.5	2.3	1.2	1.0	4.4	3.3	8.5	8.0	82.5	85.4
Goverment programmes and policies	5459	5.0	4.1	1.4	0.9	4.6	4.1	8.2	7.5	80.8	83.5

Environmental barriers by disability status and sex

An environmental barrier scale was constructed by adding the 12 items (value 0-4) together. Figure 3.25 below shows differences in mean values on the Environmental barrier scale between males and females. The case/control difference is however substantial in that individuals with disability score significantly higher on the environmental barrier scale, an indication that they face more environmental barriers than those without disabilities. The difference between males and females is marginal.

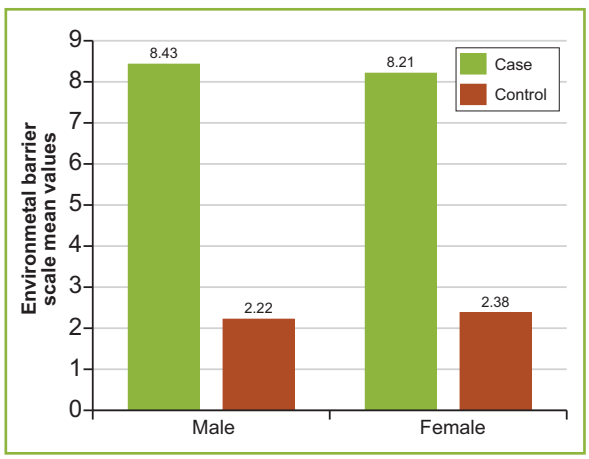


Figure 3.25: Environmental barriers by case/control and sex

Environmental barriers by province and urban/rural

Figure 3.26 shows that there are more environmental barriers experienced by individuals residing in rural as compared to urban areas. This trend was observed in 7 of the provinces, while two provinces, Mashonaland East and Harare, reported more environmental barriers in the urban setting. Bulawayo had no rural sample.

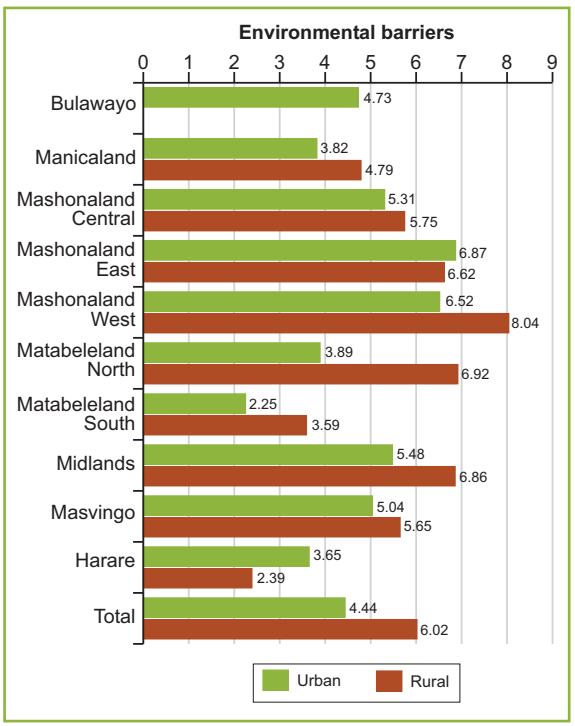


Figure 3.26: Environmental barriers by province and urban/rural

3.11 Access to Social Services

Health services, health information and traditional healers were received by most individuals with disability. On the other hand the most noticeable shortcomings with regards to service provision for those who were aware of the existence of the service and needed the service were welfare services, legal assistance, vocational training services.

CHAPTER 3 Results

Table 3.25: Access to Social Services

Type of Service	Needed	Aware	Received	Gap[1]
Medical Rehabilitation	40.1	42.7	19.2	52.7
Assistive devices	38.7	49.5	14.1	63.6
Educational services	34.5	47.9	26.2	24.1
Vocational Rehabilitation	17.6	31.5	5.0	71.6
Counselling for persons with disability	25.9	34.3	12.0	53.7
Counselling for parents	25.5	35.4	13.4	47.5
Welfare services	37.0	55.2	9.7	73.8
Health services	83.9	88.8	77.5	7.8
Health information	65.8	72.9	60.5	8.0
Traditional Healer	38.3	73.2	35.3	7.8
Legal advice	8.3	39.1	3.8	54.2

Gap[1] = 100% - percentage of those who needed a service and who actually received it

3.12 Assistive Technology

Among individuals with disability, 14.4 % reported that they were using an assistive device. The highest proportion of users was in the urban areas. The results also reveal that, those who use assistive devices score lower than non-users on socioeconomic status (SES); they have more severe disability; report higher level of environmental barriers; have a later onset of disability and they score low on the well-being scale– but on the other hand they report lower service gaps and more years of education.

Although the whole spectrum of assistive technology use was assessed, it was assistive devices for information and personal mobility that were mostly in use. In urban areas, there is a fairly even distribution between the two, while devices for personal mobility are used more by those residing in rural areas.

Types of devices

The most common type of devices in use are mobility aids (70%). The second major type, are devices used by individuals with visual problems.

Table 3.26: Percentage of persons with disability that were using assistive devices

Activity limitation	Confirm use		Number with activity limitations
	%	n	
Seeing	18.3	571	3125
Hearing	8.9	139	1568
Walking	21.9	745	3402
Remembering	8.3	167	2016
Self-care	17.0	286	1681
Communicating	7.3	64	1294
Total	**14.4**	**1045**	**7302**

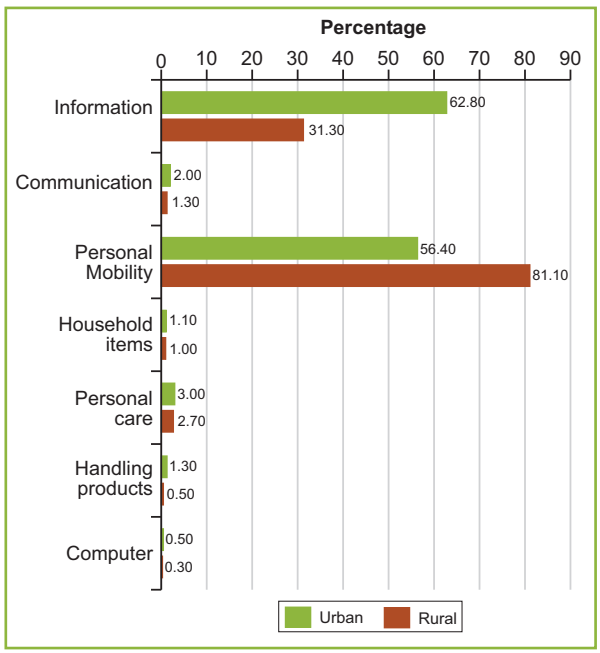


Figure 3.27: Type of assistive device by urban/rural

Functional status of assistive device

The majority (57.9%) stated that their devices were in good working condition, as illustrated in Figure 3.28.

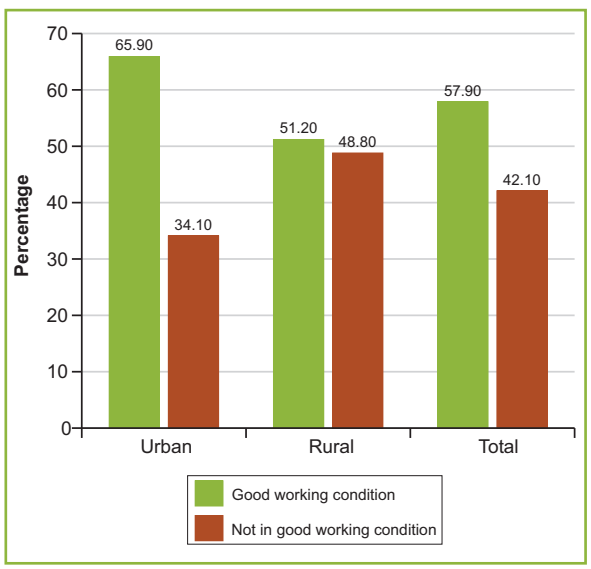


Figure 3.28: Working condition of assistive device

Maintenance of device

Figure 3.29 shows that most assistive devices are maintained by the users, family or they are not maintained.

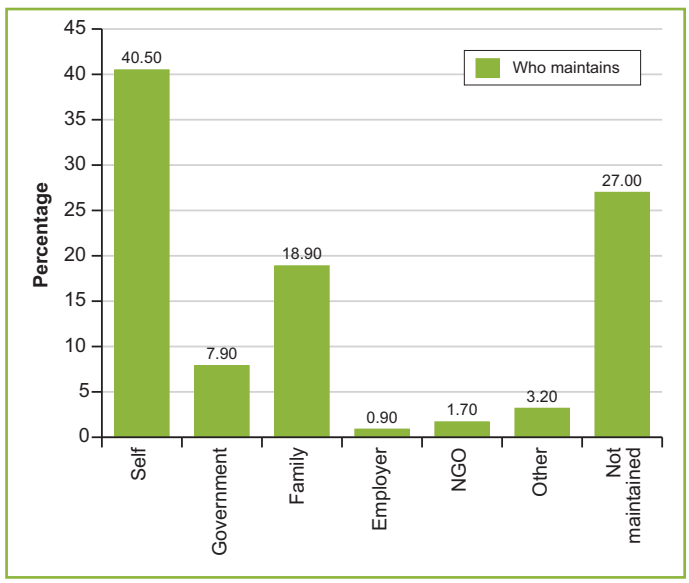


Figure 3.29: Maintenance of assistive devices

Provision of assistive devices

The major providers of assistive devices reported were the private sector and Government.

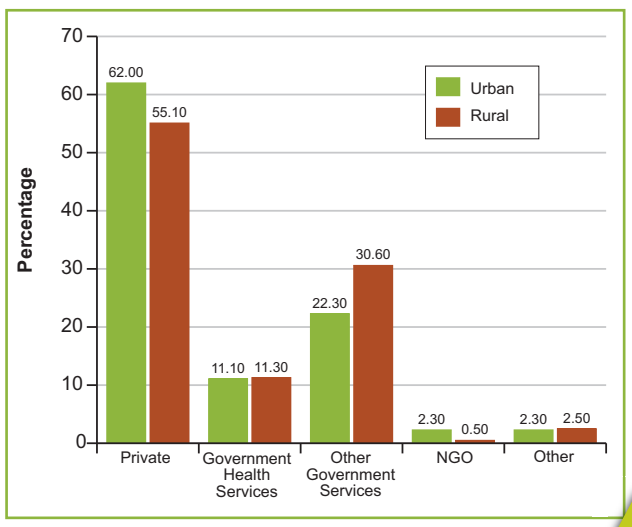


Figure 3.30: Source of assistive device

Results

CHAPTER 3

Information and training

The majority (about 50%) reported that they received information and training about the device and how to use it. About 30% reported that they had not received any information or training on their device.

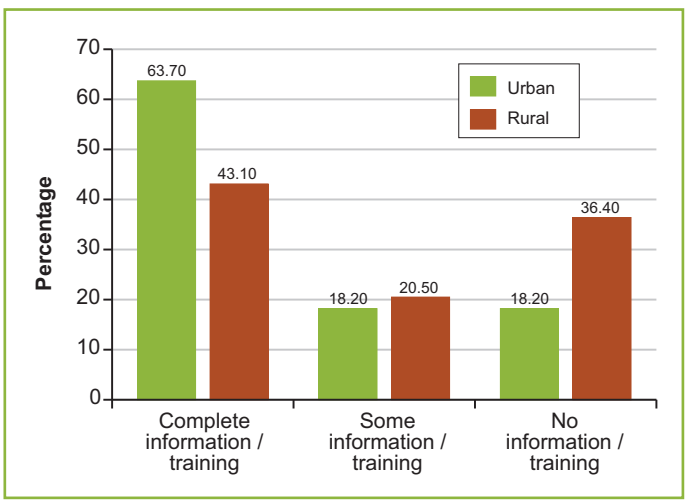


Figure 3.31: Information and training on use

Satisfaction with assistive devices

About 60% users were satisfied with their assistive device. Further analysis showed that users with high SES were less content than those with lower SES scores. Older persons were less content than younger users.

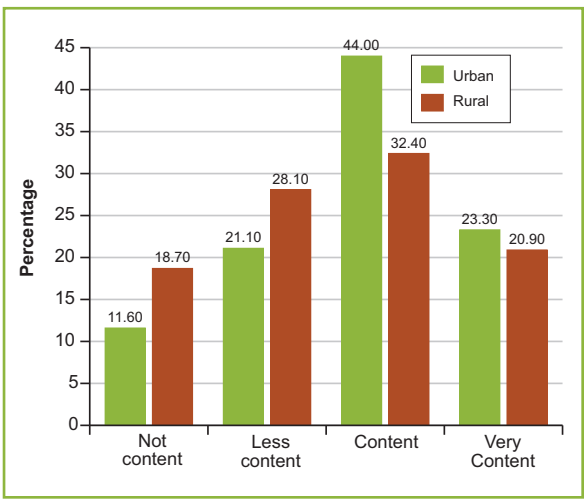


Figure 3.32: Satisfaction with assistive device

3.13 Availability and Accessibility of Services and Facilities

Full participation in the basic units of society, family, social groups and community is the essence of human experience. The right to equality of opportunity for such participation is set forth in the Universal Declaration of Human Rights and should apply to all people, including those with disabilities. In reality, however, persons with disability are often denied the opportunities of full participation in the activities of the socio-cultural system of which they are a part. This deprivation comes about through physical and social barriers that sometimes have evolved from ignorance, indifference and fear.

Accessibility in own home

A question was asked about accessibility in the respondent's own home. By accessibility was meant that one can get into the rooms easily and use the facility most of the time. The rooms in the home included kitchen, bedroom, living room, dining room, toilet and bathroom. Those who did not have the different rooms or facilities where they live, were excluded from the respective question. As shown in Table 3.27 below, accessibility to different rooms was not considered as problematic by the majority of respondents (95%).

Although the proportion of individuals who report accessibility problems may appear small, actual access into and inside buildings/facilities can be more difficult to a larger proportion of persons with disabilities due to their limitations.

Table 3.27: Accessibility in own home

	Accessible	N
Kitchen	94.6%	7448
Bedroom	95.4%	7571
Living room	94.5%	4634
Dining room	94.4%	3940
Toilet	93.1%	6086
Bathroom	93.9%	5905

Access to social amenities

In order to assess access to social amenities the following question was asked: **"Now let's look at various places you might go to. Think of getting in and out of the places, and tell me for each place whether it is generally accessible to you or not".**

A list comprising fourteen common public places was read out to the respondent who then indicated whether the place was accessible, not acceccible, not available or not applicable to their situation. Figure 3.33 below show that for all services and public places, a substantial proportion of the respondents regard them as not applicable or available. Availability ranges from 18% (workplace) to 94.6% (primary health care). In themselves, these high figures indicate substantial availability problems for many of the important facilities and services. Further analyses revealed as expected that this is largely a rural problem.

When excluding those who reported that the different services were not available (or not applicable), we remain with 6.4 % to 16.2 % not accessible for the different places/services. Banks and post office come out with high figures (i.e. low relative accessibility), while the lowest score (i.e. high relative accessibility) is found for schools and places of worship.

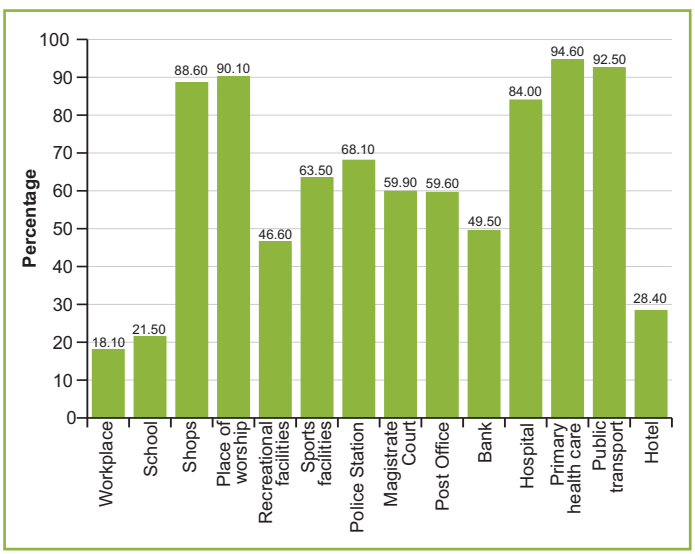


Figure 3.33: Availability of facilities and services

CHAPTER 3 Results

Accessibility to services and facilities

Figure 3.34 shows accessibility to different services and facilities among urban and rural respondents with disability, excluding those who reported that the services and facilities were not available. The urban/rural difference is significant for most of the facilities/services, and there is a consistent pattern with higher levels of accessibility in urban areas.

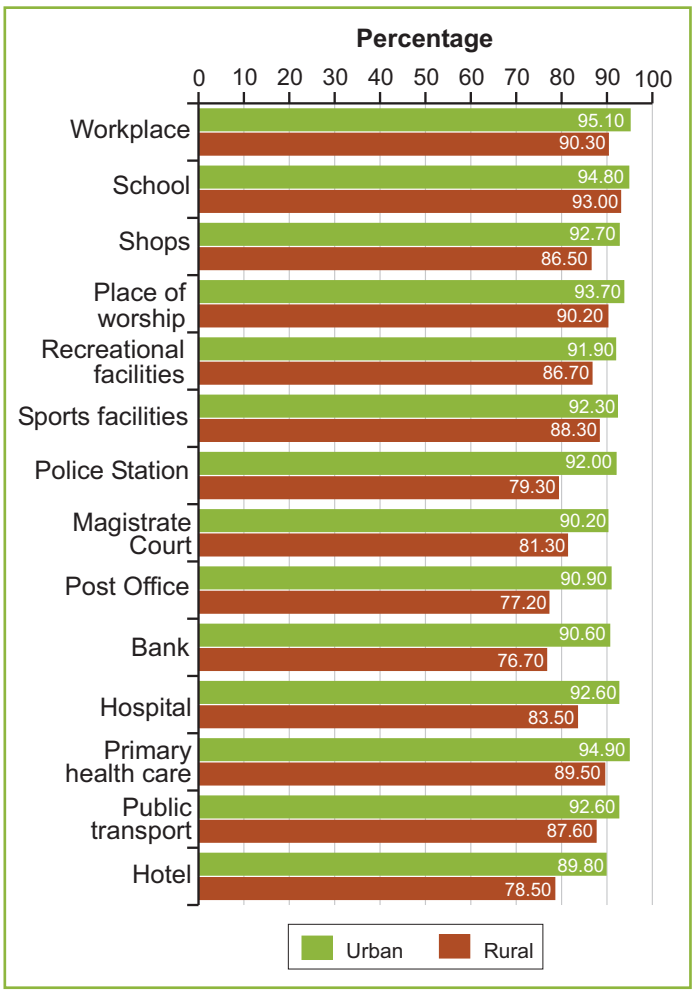


Figure 3.34: Accessibility to services and facilities by urban/rural

3.14 Family and Social Life (involvement in family, social life and marriage/ relationships)

Persons with and without disabilities were asked questions relating to their involvement in family and social life, whether they required assistance from family members and if they received any help, whether they were satisfied with the assistance.

Help received from other persons in household

Respondents mostly confirm that they receive help from household/family members as emotional support, Finances, Transport, Studying, Shopping and Cooking, and least for Eating/feeding, Toileting, Bathing and Dressing. Sex differences were found for the following activity items: More males tended to receive assistance for dressing, bathing, and studying, while more females tended to receive assistance for moving around, finances, and transport. Urban-rural differences were also found, and more help is reported among rural respondents, the exception being Emotional support where urban respondents reported higher levels.

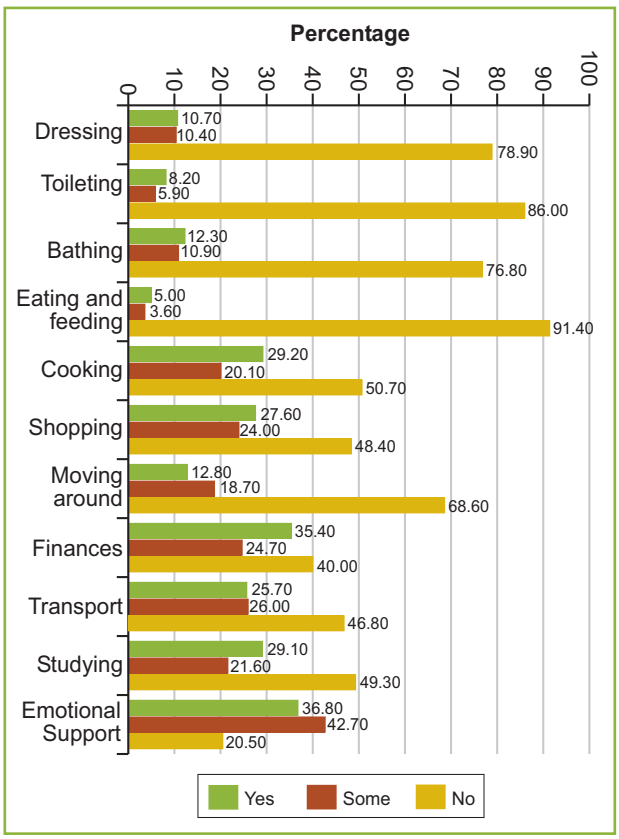


Figure 3.35: Help from other persons in the household

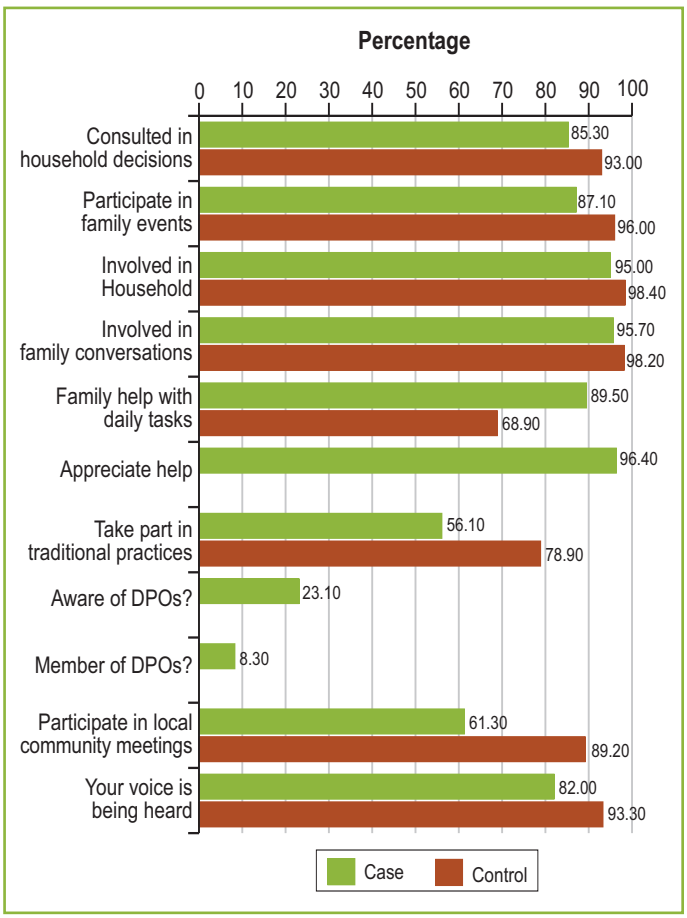


Figure 3.36: Involvement in family and social life by disability status (15 years +)

Involvement in family life

Normally persons without disability are generally more involved on all single indicators, except receiving help in daily life, but some of the differences between the two groups are relatively small as shown in figure 3.36. Particularly large differences are found for Participation in local community meetings and gatherings, and taking part in traditional practices. Some of the questions were only responded to by individuals with disability. Awareness of disabled people's organisations (DPOs) was very low (23.1 %) and as few as 8.3 % stated that they were members of a DPO. On the positive side, the large majority appreciated the help they got from their families.

Decision making

Individuals with disability report to a lesser extent than individuals without disability that they make important decisions about their lives. Even though the majority in both groups respond "Always" or "Sometimes", as many as 26.1 % of individuals with disability never make important decisions in their lives, compared to 12.6 % among individuals without disability. Individuals with disability are thus less involved in important decision making. Further analyses revealed sex differences in that males are more involved in decision making in both groups.

CHAPTER 3 Results

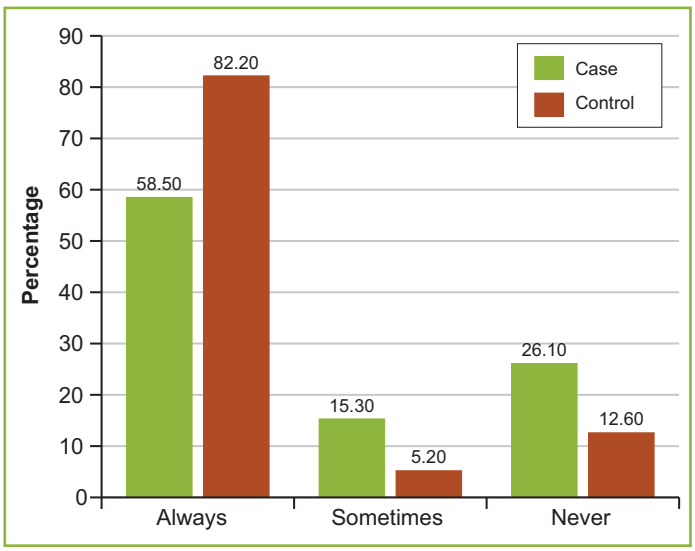


Figure 3.37: Decision making by case/control (Do you make important decisions in your life?)

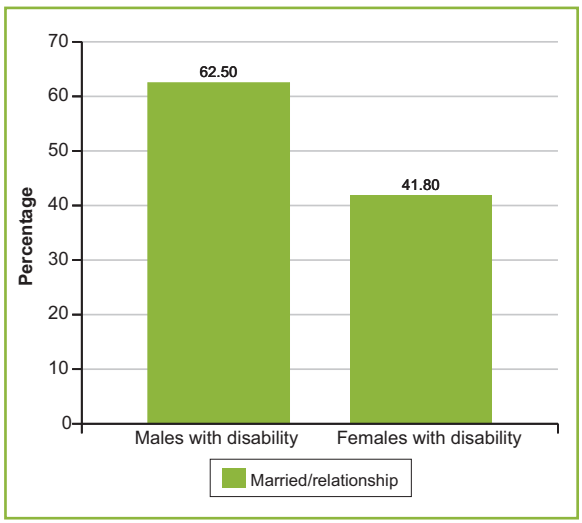


Figure 3.38: Marital status by sex, individuals with disability (=> 15 years)

Marital status by sex, individuals with disability

Figure 3.38 below shows that more than six out of ten males with disability state that they are married or in a relationship, while the corresponding figure for women with disability is about four out of ten.

Disability status of spouse

Among individuals with disability who were 15 years or older and confirmed being married or in a relationship, more females had spouses that are also persons with disability.

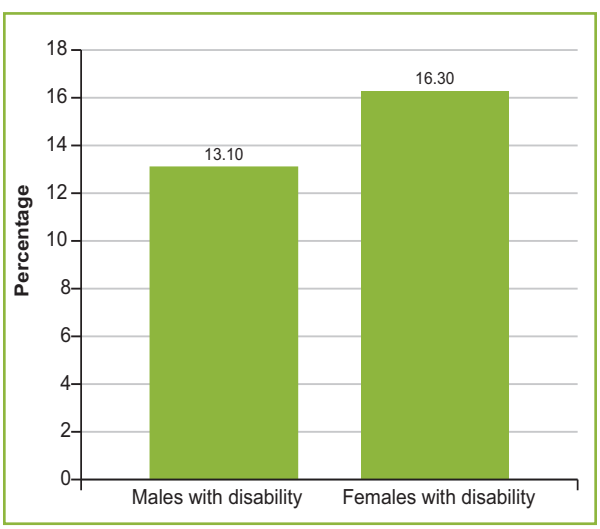


Figure 3.39: Does your spouse have a disability?

Do you have children?

Respondents who stated that they were married or in a relationship were asked whether they had any children. The figure below shows that substantially more females with disability (84%) state that they have children than men (71.0 %).

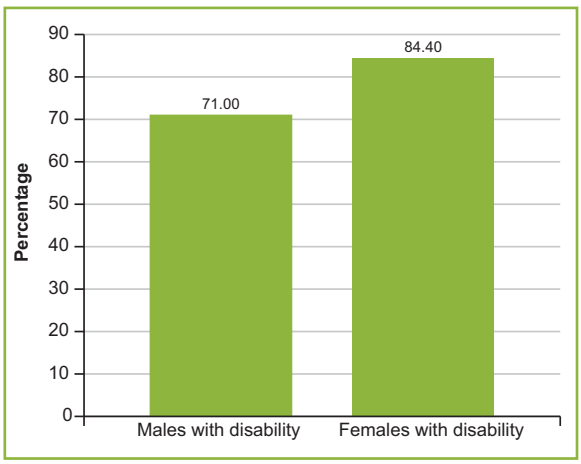


Figure 3.40: Do you have children?

3.15 Discrimination and Abuse

The survey reveals that more men than women experience discrimination in public places. A relatively high rate of discrimination within the family and society was also reported.

Males report higher levels of violence and discrimination due to their disability as compared to females. More than one in five (22.1%) of males with disability have experienced being beaten or scolded due to their disability. Males also report experiencing discrimination in relation to public services more than females. The data in Table 3.28 below show that the results from the 2003 and the 2013 surveys confirm the same level of abuse and discrimination, although the results indicate higher levels of violence and lower levels of discrimination against individuals with disability in 2013.

Table 3.28: Personal experience of being discriminated or abused (% yes)

Question: Have you ever...	N	2013		2003	
	2013	Male	Female	Male	Female
...been beaten or scolded because of your disability?	6178	22.1	16.2	17.5	13.8
...been beaten or scolded by any family member or relative because of your disability?	6244	13.4	10.8	12.0	8.0
...experienced being discriminated in any public service?	6226	8.0	5.9	12.3	11.8

Results

CHAPTER 3

Discrimination and abuse and severity of disability

Those who reported being beaten, scolded or discriminated also scored high on the activity limitation (WG6) scale. This result is an indication that severity of disability is positively associated with being abused or discriminated against.

Refusal of access to education

Refusal of access to education due to disability is highest for Regular primary school with 6.6 % and 6.8 % refusal rate for males and females respectively, followed by Secondary school with 5.5 % and 4.5 %. The differences between male and female respondents are not significant. A sex difference was however found in that more females state that the question is "not applicable", which can be an indication of sex difference in access to school in general. Those who responded "Not applicable" have been excluded from the analysis.

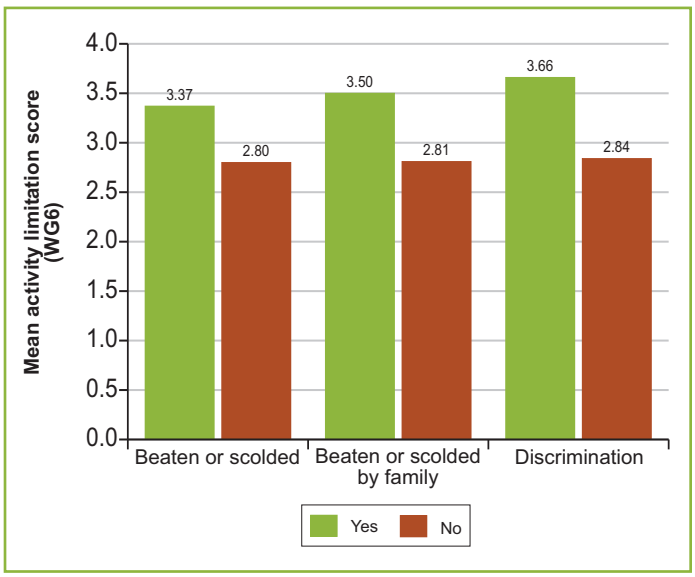


Figure 3.41: Severity of disability (WG6) by abuse and discrimination

3.16 Physical and Sexual Abuse

All individuals with and without disability aged 18 years and above were asked whether they had experienced any physical and/or sexual abuse as a child before they attained the age of 18 years.

Table 3.29: Have you ever been refused entry into a school because of your disability?

	Regular Preschool		Regular Primary		Regular Secondary		Special School		Special Class		University	
	M	F	M	F	M	F	M	F	M	F	M	F
Yes	3.1	3.8	6.6	6.8	5.5	4.5	1.4	0.4	0.2	0	0.1	0.1
No	96.9	96.2	93.4	93.2	94.5	95.5	98.6	99.6	16.5	12.2	16.7	15.0

Physical and sexual abuse by disability status and sex

Figure 3.42 below shows that individuals with disability are more exposed than individuals without disability to physical abuse. Males are more exposed to physical abuse than females, who on the other hand are more exposed to sexual abuse than males. Individuals with disability are more exposed to sexual abuse than individuals without disability.

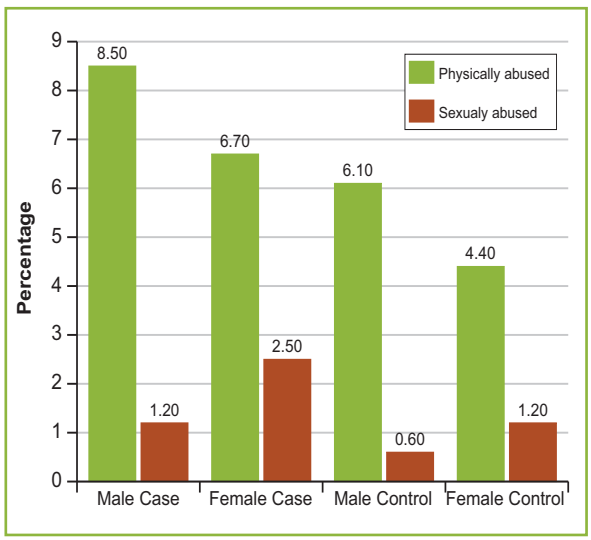


Figure 3.42: Physical and sexual abuse by disability status (%)

Physical and sexual abuse by age

As shown in Figure 3.43, self-reported physical abuse increases slightly over the years, which indicates that most physical abuse occurs during childhood and early adolescence. Sexual abuse tends to reduce with age, indicating firstly that most of such experiences happen during childhood, but also that either there is an increase during later years but that sexual abuse tends to be under reported with increasing age.

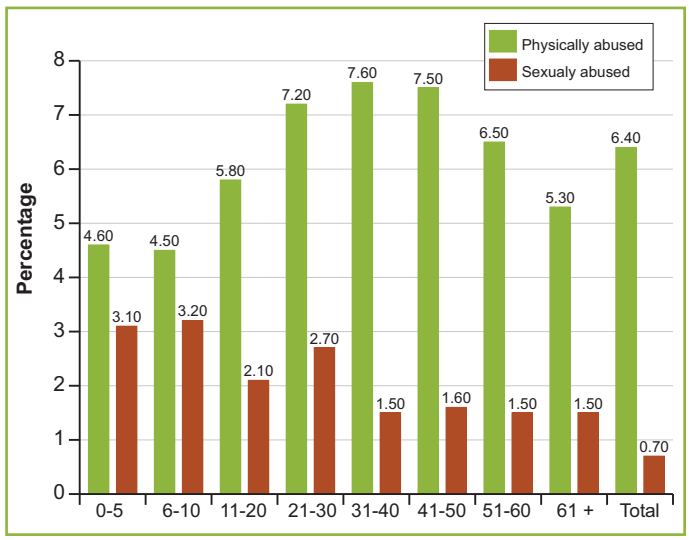


Figure 3.43: Physical and sexual abuse by age category

3.17 Child Functioning and Disability

Assessing disability among children has often been done by applying the same measurement instruments as for the adult population. There are several reasons why measuring disability among children is different from measuring among adults: i) Children are in a process of development and transition – not all of the 6 domains in the WG Short set are applicable to young children, ii) Child development does not follow a fixed schedule – there is natural variation in the attainment of functional skills, iii) Disability measurement often takes place through the filter of a parent or other adult. Washington Group on Disability Statistics and UNICEF have developed a Survey Module on Child Functioning that is intended to be used as a component of national population surveys or as supplement to surveys on specific topics of interest (health, education, etc.). The WG6/UNICEF Module on Child Functioning and Disability is designed to be delivered to a proxy

Results

CHAPTER 3

respondent (parent, guardian or primary caregiver) and is suitable for children/ adolescents 2 to 17 years of age inclusive. It is designed for age relevant questions for two specific age clusters: 2-4 years of age and 5-17 years of age.

The childhood questionnaire module is currently in the cognitive testing phase. Permission was granted to use the module in this survey as a trial.

Activity limitation by age

The questions on the child module were developed for specific age segments and represent a further development of the WG 6 questions. Distribution of activity limitations within the specific age ranges are shown in figure 3.44. Table 3.30 summarizes the information on an activity specific level. It reveals that child disability is much more complex than we could have revealed by using the "original" WG6 questions only. Questions related to behavior and intellectual development are particularly relevant to children since they capture better the limitations children with disability and their families struggle with and need to cope with in their daily life. Limitations related to limited sensory or mobility functioning are less prevalent and mobility equally prevalent in these age groups than the "softer" aspects of intellectual, mental and behavioral functioning, It is further worth noting that sex differences are small, largely marginal and only barely significant for three of the questions.

Table 3.30: Magnitude of activity limitations by activity domain

Activity Domain	Age Range	% At Least Some Problem
Seeing	2 – 17	15-20%
Hearing	2 - 17	27-30%
Walking	2– 4	45%
	5-17	34%
Self care	5 - 17	32%
Playing with toys	2 – 5	36%
Playing with other children	2 – 12	33%
Learning difficulty	2-3 (3 – 17)	50%
Understanding and being understood	3-17	42-45%
	2-4	34-42%
Remembering	5-17	47%
Doing things with other children	13-17	42%
Controlling behavior	5-17	30%
Completing a task	5-17	42%
Accepting change	5-17	33%
Getting along with others	5-17	39%

Figure 3.44 demonstrates that when combining the different levels of activity limitations ("some problems", "a lot of problems" and "cannot do"), it is difficulty walking, self-care and understanding other people that are most prevalent. Playing with toys, learning new things and remembering also come out quite high, while seeing and hearing with glasses/hearing aids and learning names on common objects are least prevalent. This result confirms that the whole range of difficulties included in the WG/UNICEF Child Module are relevant for children with disabilities and should be taken into account instead of isolating medical, health and rehabilitation services to one particular difficulty. We regard this as an important message both to the policy and the practice level.

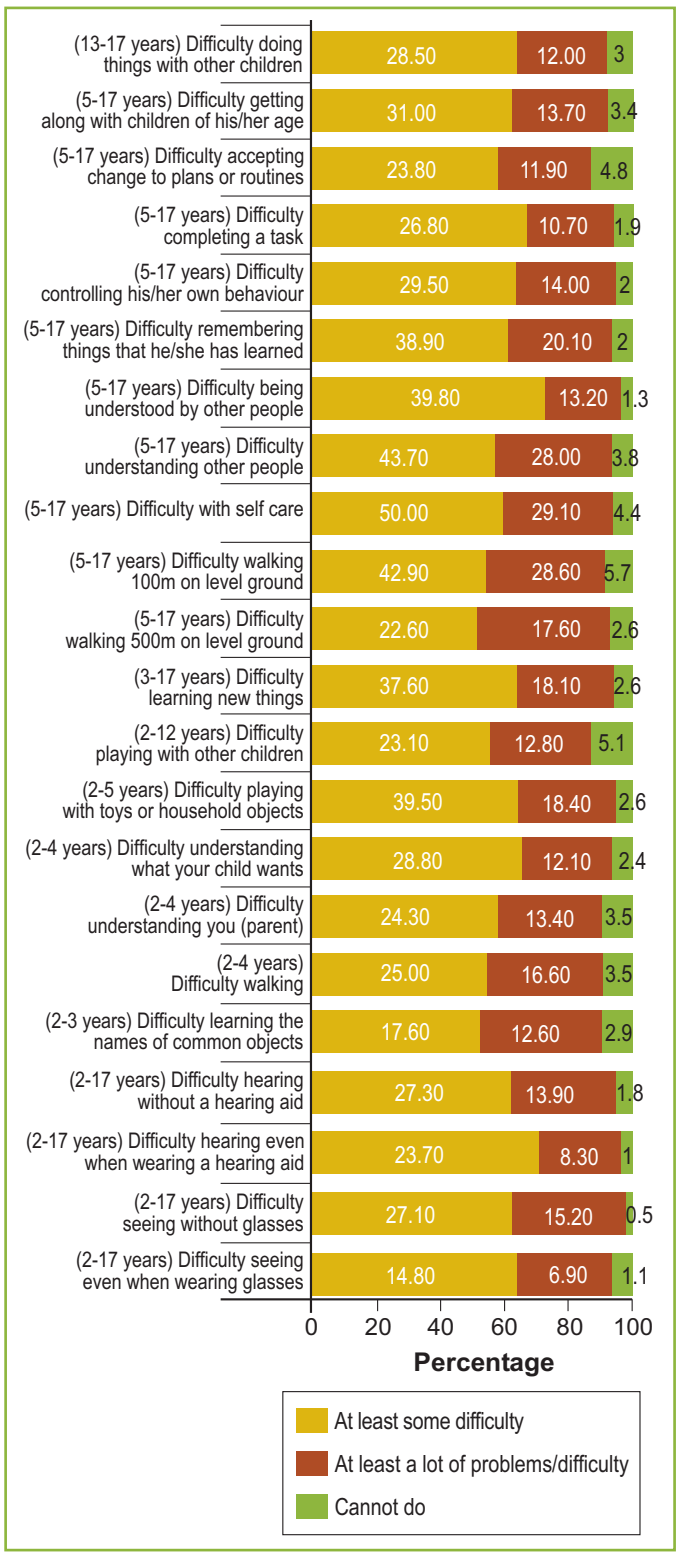


Figure 3.44: Distribution of activity limitations within appropriate age ranges

Annex 1

Households and Enumeration Areas (EAs) by Province, estimated sample

PROVINCE	Total number of households[1]	Total number of individuals[1]	EAs in sample	Sample HHs: Case/Control	Sample – indviduals in HHs		Total ind.
					Case	Control	
BULAWAYO	223741	653337	22	531/548	1510	1383	2893
MANICALAND	405235	1752698	40	1080/1017	4297	3638	7935
MASH CENTRAL	277653	1152520	28	697/628	3045	2377	5422
MASH EAST	333574	1344955	33	768/783	3110	2699	5809
MASH WEST	335148	1501656	33	809/810	3364	3062	6426
MAT NORTH	156156	749017	16	405/395	1732	1683	3415
MAT SOUTH	149498	683893	15	342/353	1667	1533	3200
MIDLANDS	363260	1614941	36	888/899	3531	3079	6610
MASVINGO	341850	1485090	34	785/826	3209	3055	6264
HARARE	501838	2123132	50	1200/1218	5117	4538	9655
TOTAL	**3087953**	**13061239**	**307**	**7505/7477**	**30582**	**27047**	**57629**

[1] ***Source:*** *ZimStats 2013*

Survey Technical Committee

Ministry of Health and Child Care (MOHCC)

Ministry of Public Service, Labour and Social Welfare

Ministry of Primary and Secondary Education

Zimbabwe National Statistics Agency (ZimStat)

United Nations Children's Fund (UNICEF)

J F Kapnek Trust

Definition of Terms

Activity limitation	difficulty encountered by an individual in executing a task or action
Assistive devices	are tools, products or equipment that are used by persons with disability or injury to perform desired tasks or activities such as mobility, communication, seeing etc
Case household	a household identified during the survey as having at least one member with a disability
Control household	a household without a member with disability
Current environment	where the individual spends most of their time (home, school, work); for children, where the child go to school, live or play
Dependency Ratio	age-population ratio of those considered dependent (people who are too young or too old to work, under 15 and over 65) and those considered in the labour force (people aged between 15 and 65)
Disability	activity limitation and participation restriction due to a health problem
Environmental barriers	obstacles that limit persons (with disabilities) from fully participating in social, school and workplace activities, includes access to services, organizational policies and programmes
Impairment	a condition that causes or likely to cause loss or limited anatomical, physiological or psychological function
Participation restriction	problems experienced by an individual regarding involvement in life situations
Socioeconomic status	an economic and sociological combined total measure of a person's work experience and of an individual's or family's economic and social position in relation to others, based on income, education and occupation.

SUMMARY TABLE OF KEY INDICATORS

Indicator	Case	Control	Average
Marital Status %			
Never married	18.80	34.70	26.80
Married/relationship	48.80	53.80	51.50
Divorced or separated	7.50	4.40	6.00
Widowed	25.00	7.10	16.10
Housing Conditions %			
In rented accommodation	14.8	20.2	17.5
In owned property	73.8	68.1	70.95
In tied accommodation (provided by employer)	5.4	4.5	4.95
Using electricity as main source of energy for cooking	29.6	30.5	30.05
Using Gas as main source of energy for cooking	0.2	0.4	0.3
Using wood as main source of energy for cooking	68.1	66.8	67.45
Water and Sanitation % Households			
Safe water for drinking (piped water, borehole + protected well)	78.30	79.50	78.90
Unsafe water for drinking	13.40	13.80	
Flush toilet	31.8	32.3	32.05
Traditional pit	21.8	21.2	21.5
Ventilated pit	18.4	20.3	19.35
No toilet facility	26.1	24.5	25.3
Dietary Diversity Score	**8.10**	**8.60**	**8.35**
SES Mean Scale Value	**6.23**	**6.77**	
Access to and Affordability of Information %			
Household can afford a phone	64.40	73.10	68.80
Household can afford a radio	45.5	52.8	49.1
Household can afford a TV	32.8	37.8	35.3
Primary Source of Income %			
Wage as primary source of income	23.1	29.4	26.3
Subsistence Farming as primary source of income	28.4	28.1	28.3
Informal Business as primary source of income	18.3	19	18.6
Private Insurance/Pension as primary source of income	1.80	1	1.4
Worker's compensation as primary source of income	0.5	0.3	0.4
Education and literacy %			
Literacy rate of total sample	76.90	92.90	84.90
School attendance %			
Access to formal education: age group 3 - 12 years	76.5	79.2	78.8
Access to formal education: age group 13 - 18 years	95.9	99.1	98.7
Access to formal education: age group 19+ years	84.2	93.1	91

Indicator	Case	Control	Average
School attendance % continued...			
Access to formal education (overall)	84.2	90.2	87.2
School attendance – years spent at school	7.5	7.9	7.7
Highest level of education achieved (Grade 7)	18.7	14.3	16.5
Highest level of education achieved (Form 4)	19.1	25.2	22.2
Reasons for not attending school (those that have never attended or discontinued school)			
Inadequate financial resources	57.35	70.25	63.8
Under achievement	7.25	10.5	8.875
Illness	8.55	1.6	5.075
Lack of interest in school work	2.95	5.1	4.025
Disability related	12.2	0.3	6.25
School not accessible	2	1.35	1.675
Pregnancy related	2.5	3.8	3.15
Employment status among economically aged persons aged 15 - 65 years %			
Persons aged 15 - 65 years in employment	16.05	26.15	21.1
Persons aged 15 - 65 years not working but previously employed	22.15	15.05	18.6
Persons aged 15 - 65 years who have never been employed	49.85	46.05	47.95
Housewife/homemaker	9.25	11.45	10.35
Reasons for current Unemployment % (those not in employment)			
Retirement	27.5	35.6	31.55
Retrenchment	17.6	26	21.8
Dismissal from work	4.8	7.5	6.15
Injury at work	3.2	1.2	2.2
Illness	16.6	4.1	10.35
Disability related	12.2	0.3	6.25
Burden of disease (morbidity and mortality) %			
Chronically ill in household last 12 months	30.2	7.2	18.7
Death in household in the last 12 months	6.8	5.5	6.15
Deceased person with disability	14.7		
HIV and AIDS related deaths	20.6	19.7	20.15
Health and well being %			
Anxiety and Depression (Health and well being scores – WHO-DAS)	22.41	27.43	24.92
Physical health (persons reporting good Physical health)	58	92.3	75.15
Mental health (persons reporting good mental health)	69.9	95.2	82.55
Knowledge and understanding about common diseases %			
Information and knowlegde about HIV and AIDS	74.75	84	79.38
Information and knowledge about STI	64.3	72.55	68.42
Information and knowledge about Diabetes	56.4	0.55	28.48
Information and knowledge about TB	65.05	72.7	68.88
Information and knowledge about Cancer	56.25	60.65	58.45

Indicator	Case	Control	Average
HIV and AIDS %			
Health facility source of information on HIV and AIDS	64.3	63	63.45
Persons reporting that they have HIV and AIDS	10.2	5	7.6
Experienced environmental barriers			
Environmental barrier score(persons with and without disability)	8.32	2.3	5.31
Physical and sexual abuse %			
Physical abuse before 18 years	7.6	5.25	6.4
Sexual abuse before 18 years	1.85	0.9	1.38
Age at onset of disability %			
Disability prevalent at birth	27.10		
Before 5 years	25.00		
Before 20 years	53.50		
After 60 years	11.9		
Reported cause of disability			
Congenital/perinatal causes	23.15		
Accidents	11.75		
Disease	47.4		
Violence	1.8		
Witchcraft	3.35		
Major disability types in the sample of persons with disability %			
Physical disability	31.00		
Visual impairment	26.00		
Multiple disorders	13.00		
Hearing impairment	12.00		
Intellectual disability	8.00		
Mental illness	6.00		
Access to social services %			
Persons with disability not receiving required medical rehabilitation	52.7		
Persons with disability not receiving required assistive devices	63.6		
Persons with disability not receiving required educational services	24.1		
Persons with disability not receiving required vocational rehabilitation	71.6		
Persons with disability not receiving required counselling services	53.7		
Persons with disability not receiving required welfare services	73.8		
Persons with disability not receiving required legal services	54.2		
Assistive devices %			
Functional assistive devices	57.9		
Information and training on assistive device	50		
Satisfaction with assistive device	60		