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Religion and Disability: Developing an Intervention Model for Persons with Disabilities

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Abstract

Persons with disabilities continue to be marginalised in many areas of life the world over. Religious communities routinely draw on the interpretive and moral authority of religion to shape how disability is understood and addressed, yet few scholars have proposed intervention models that translate these interpretations into structured institutional practice. This paper responds to that gap by developing an intervention model, the IEF, to guide religious institutions toward a structured and sustained response to disability rather than the ad hoc gestures of goodwill that currently predominate. The framework identifies three interdependent components—awareness and education, support systems, and empowerment—that religious institutions can use to organise their response to disability around persons with disabilities themselves rather than around institutional convenience. A qualitative research approach was adopted to examine perceptions of disability held by representatives of African traditional religion (ATR) and Christianity. An ethnographic, cultural-anthropology design was used to collect data from ten traditional healers and ten pastors in Zimbabwe, selected through purposive sampling. Data collected through semi-structured interviews were analysed thematically. The resulting model is intended to help both Christian and ATR institutions move from theoretical commitments to inclusion toward practices that preserve the dignity and self-worth of persons with disabilities.

Background and Theoretical Context

Accommodating and understanding disability in church and in society has never been straightforward. Religions differ widely in how they interpret disability, and these interpretations shape how persons with disabilities are perceived and treated within and beyond their communities. Masiga and Nkabala note that persons with disabilities in Africa continue to be perceived as objects of pity and abuse, a pattern they attribute to ignorance and harsh economic conditions. They cite killings of persons with albinism carried out in the false belief that burying a person with albinism's head in a building's foundation brings wealth.[1] Ndlovu similarly finds that persons with disabilities sit at the bottom of the social scale in terms of impoverishment, powerlessness, and exclusion, routinely denied amenities and privileges that others take for granted.[2] Such evidence points to the need for religion, which retains considerable moral authority in African communities, to be enlisted deliberately in raising awareness and developing structured interventions that promote the dignity of persons with disabilities, rather than being left to reproduce the stigma they have sometimes helped to entrench. Masiga and Nkabala further argue that stigma and discriminatory attitudes rooted in cultural practice can be challenged through biblical teaching[3], a claim this study revisits empirically in the thematic findings below.

The continent's legal and policy architecture reflects a formal commitment to inclusion that has not always translated into lived practice. Africa is a signatory to the African Charter on Human and Peoples 'Rights (1990) and the African Decade for Persons with Disabilities (1992), commitments reinforced globally by the Salamanca Statement (1994), the Dakar Framework for Action (2000), the Millennium Development Goals and, more recently, the Sustainable Development Goals and Zimbabwe's own Vision 2030. Domestically, Sections 22 and 83 of Zimbabwe's National Constitution (2013) obligate the state to ensure that persons with disabilities realise their full potential, access medical, psychological, and functional treatment, and are protected from exploitation and abuse. Section 22 specifically promotes their full inclusion and

[1] Masiga and Nkabala, 'The Biblical Discourse'.
[2] Ndlovu, 'African Beliefs'.
[3] Masiga and Nkabala, 'The Biblical Discourse'.

participation in society. This study takes that policy commitment as its point of departure: if disability inclusion is already established in law, the outstanding question is how religious institutions, as trusted and proximate community actors, can be organised to deliver on it in practice.

Two theoretical lenses inform the analysis. The first, theological anthropology, is the branch of theology concerned with the nature, purpose, and destiny of human beings, explored here through the doctrine of the *imago Dei*, the belief that human beings are made in the image of God. That doctrine has historically been interpreted in ways that exclude persons with disabilities, associating divine likeness with rationality, independence, or physical wholeness. Amos Yong's *Theology and Down Syndrome: Reimagining Disability in Late Modernity* challenged this reading directly, arguing that all individuals, including those with disabilities, are created in the image of God. Swinton extends this argument, observing that marginalisation is produced partly through language that reduces persons to their condition, and distinguishing 'inclusion', which he treats as a passive, programmatic gesture, from 'belonging', which requires persons with disabilities to be accepted, valued, and embraced as full participants in the life of a faith community.[4] For Swinton, personhood is rooted in relationship and divine recognition rather than intellectual capacity, which is why he calls on faith communities to build reciprocal relationships rather than deliver one-directional assistance. Swinton develops the same argument through Christ's command to 'love one another', framing the celebration of difference, rather than its correction, as the theological basis for inclusion. No society, on this account, is complete without persons with disabilities.[5]

The second lens, the social model of disability, locates the origin of disability outside the individual, in the barriers that society erects. It stands in contrast to the moral model, which frames disability as sin or affliction, and the medical model, which frames it as a deficiency requiring clinical correction. The social model instead attributes disability to external barriers of discrimination, devaluation, and stigmatisation. It was developed specifically as a reaction

[4] Swinton, 'From Inclusion to Belonging'.
[5] Swinton, 'Disability, Vocation, and Prophetic Witness'.

against the tendency of the medical model to locate the 'problem' in the person with the impairment.

Because cultural and religious constructions of disability in African settings are deeply entangled, it is often difficult to separate how disability is constructed by culture from how it is constructed by Christianity or by African traditional religion (ATR); a study of one is necessarily a study of the other.[6] Together, theological anthropology and the social model give this study a way of reading the empirical findings below: the former explains why religious interpretation matters for the dignity of persons with disabilities, and the latter explains why the barriers persons with disabilities encounter in religious spaces are properly understood as socially produced, and therefore as amenable to structured, institutional intervention rather than individual charity alone.

Research Methodology

This study employs a qualitative research approach to explore religious perceptions of disability, an approach chosen because it allows for an in-depth examination of religious perspectives and the lived experiences of persons with disabilities that a quantitative design would not capture. An ethnographic, cultural-anthropology design was adopted. Sharma and Sarkar describe ethnographic research as concerned with the discovery and description of a culture or a group[7], which suits a study seeking to understand how two distinct religious traditions construct meaning around disability. Purposive sampling was applied to select a population of twenty participants, ten leaders of ATR and ten Christian pastors, all based in Zimbabwe. In-depth, semi-structured interviews were conducted with each participant, and the resulting data were subjected to thematic analysis, from which eight thematic areas emerged. These are reported below, followed by the intervention framework the study proposes in response to them.

[6] Amenyedzi, '"We are forgotten"'.
[7] Sharma and Sarkar, 'Ethnography Research'.

Findings and Intervention

Thematic Area 1: Religious Interpretation of Disability

The findings on religious interpretation reveal varied and sometimes contradictory perspectives. Some Christian participants believed that disability is part of God's creation; others believed it is congenital or acquired; still others attributed it to witchcraft or personal sin. A minority position holds that disability does not, in a theological sense, exist at all, since God does not specify what a 'full' person should look like.

One pastor said, 'as a pastor, I know that disability is caused by chromosomes.' Another pastor said, 'Christians believe there is witchcraft. According to the Bible, all are made in the image of God … only a disabled relative of mine used to say it is a "dysfunction" of something.'

ATR participants similarly attribute disability to witchcraft or to angry ancestral spirits requiring appeasement, though some hold simultaneously that disability is God's creation and that ATR can cure it. Read together, these views suggest that within ATR, disability is understood as externally caused rather than natural. One herbalist explained, 'according to ATR it appears as if people must appease ancestors so that disability does not recur.' In this framing, disability is treated as something that can, in principle, be eradicated. Another herbalist offered a more theologically layered account: 'a disabled person is a God's creation, we believe that it's God, but from ATR we think it's from outside.'

Sentiments held by ATR participants further indicate that disability is understood to entail a loss of function, capability, and cognitive capacity. One herbalist put it this way: '[they are] unable to do other things. We care and think for that person.' Statements of this kind reflect a paternalistic and, at points, negative attitude: able-bodied participants across both traditions tended to assume that persons with disabilities are incapable and dependent on the goodwill of others.

Thematic Area 2: Myths, Taboos and Prevalent Beliefs Regarding Disability

The most common myth reported by Christian participants is that disability results from witchcraft practised by, or a curse upon, the family of the person with a disability. ATR participants hold a parallel belief that disability results from witchcraft or from punishment by ancestors, alongside more specific taboos, for instance that laughing at a person with a disability may cause the person who laughs to bear a disabled child themselves. Another belief holds that persons who have suffered a stroke have been struck by *izulu laphansi* ('underground thunder'), and that traditional healers can treat the condition on that basis.

The striking similarity between Christian and ATR belief in this area can most plausibly be attributed to a shared cultural substrate: the two traditions, despite their theological differences, draw on the same underlying culture, and it is that culture, more than either religion's formal doctrine, that appears to shape how disability is understood.

Thematic Area 3: Biblical Passages that Shape Perspectives on Disability

Christian participants 'perceptions are shaped directly by biblical texts, while ATR participants 'perceptions are shaped primarily by ancestral guidance, though with an acknowledgement of God's presence. Two pastors independently identified John 9 as a familiar and formative scripture on disability, and one referenced the story of a crippled man seated at the temple gate, evidence that disability is treated within Christian teaching as a recurring feature of human existence rather than an aberration from it.

A traditional herbalist described being guided directly by ancestral spirits in the provision of herbal therapy: 'my ancestors show me and guide me how I can help the person, and that shapes my understanding.' Despite their different sources of authority, both traditions converge on a shared preference for care within the community over institutional referral. A participant from ATR said, 'we believe that no disabled person should be sent to a rehabilitation centre', a sentiment closely echoed by a Christian pastor.

Thematic Area 4: Common Beliefs Between Christianity and ATR

Both traditions maintain that disability can be caused by witchcraft or a curse, while simultaneously encouraging care and support for persons with disabilities, a tension the findings do not resolve so much as document. A herbalist offered a particularly candid account of this shared ground: 'In most cases we have common understanding that disability is a result of spirits. We only approach it differently.' Another participant went further: 'all of us struggle, Christians and non-Christians … ninety-nine per cent of our faith is informed by our culture.' A third herbalist added, 'in life in general, we are not different. The way Christians handle those with disabilities … we are the same,' a view echoed by another participant who stated plainly, 'we are the same in caring for the disabled, we usually help them.' Culture, rather than doctrine, again emerges as the more powerful determinant of how disability is understood and treated.

Thematic Area 5: Ways of Actively Including Persons with Disabilities

Evidence on the involvement of persons with disabilities in religious activity points, across both traditions, to a considerable gap between stated commitment and practice. A Christian pastor conceded, 'theoretically, we encourage members, but practically it does not exist.' Another was more blunt: 'we want to use them if they are there, we don't have them.' Both remarks indicate that inclusion in Christian settings, where it is discussed at all, tends to remain rhetorical.

ATR participants reported a more concrete pattern of inclusion: some persons with disabilities serve as traditional healers themselves and participate actively in ritual dance, where their spirits are reportedly regarded as unusually powerful. One herbalist confirmed, 'we have some who are traditional healers who are disabled,' and another added that persons with disabilities are 'usually' present during ritual dances. A further participant confirmed that persons with disabilities visit and consult ATR practitioners and are assisted with herbal therapy on each visit. This pattern suggests that persons with disabilities consult ATR practitioners considerably more often than they attend church, a finding with direct implications for how the intervention model below is targeted.

Thematic Area 6: Initiatives to Promote the Inclusion of Persons with Disabilities

Some initiatives were reported in both traditions, though inconsistently. A Christian pastor described appointing persons with disabilities to church leadership and gave the example of a blind congregant being given the opportunity to share through music during a church conference. Another participant, by contrast, stated flatly, 'there is nothing.' ATR participants reported that the needs of persons with disabilities are considered in training and in the procurement of herbal treatment, including a fee waiver for those unable to pay in full, since, as one participant explained, 'most of persons with disabilities do not work … so they pay whatever they can.' Persons with disabilities who possess an ancestral spirit are, according to another participant, actively trained to become traditional herbalists in their own right. Taken together, ATR practitioners appear to hold a keener and more consistent interest in including persons with disabilities than their Christian counterparts, though this inclusion is, as the next section shows, conditional rather than unconditional.

Thematic Area 7: Programmes to Address the Needs of Persons with Disabilities

Neither tradition reported dedicated, structured programmes for persons with disabilities. One pastor noted that the church has organs formally representing persons with disabilities but could not identify any specific needs those organs addressed in practice, adding 'we allow them to advocate for themselves.' ATR participants likewise reported no designated programme; whatever assistance persons with disabilities receive is left to individual compassion. In Zimbabwe more broadly responsibility for disability care has historically defaulted to government and non-governmental actors, a pattern this study links to the disengagement of communities, including religious communities, from disability care as a shared obligation. It is this gap, a policy commitment on paper, goodwill in principle, but no institutional mechanism in practice, that the intervention model developed in this paper is designed to close.

Thematic Area 8: Support and Resources Required to Serve Persons with Disabilities

Participants from both traditions identified training as the resource religious institutions most urgently require: one specifically named sign language training, while others called for broader training on disability, knowledge and care. Material resources, including clothing, food, and assistive technologies, were also identified as pressing needs.

ATR participants additionally called for government partnership toward self-sustaining projects. One participant raised the absence of identity documentation as a particularly acute obstacle, describing a relative with a disability who had no identity documents at all. Without such documentation, she noted, organisations can rarely provide assistance of any kind, a finding that echoes Ndlovu's observation that persons with disabilities are frequently denied access to the amenities and privileges available to others.[8]

[8] Ndlovu, 'African Beliefs'.

The Inclusive Empowerment Framework (IEF)

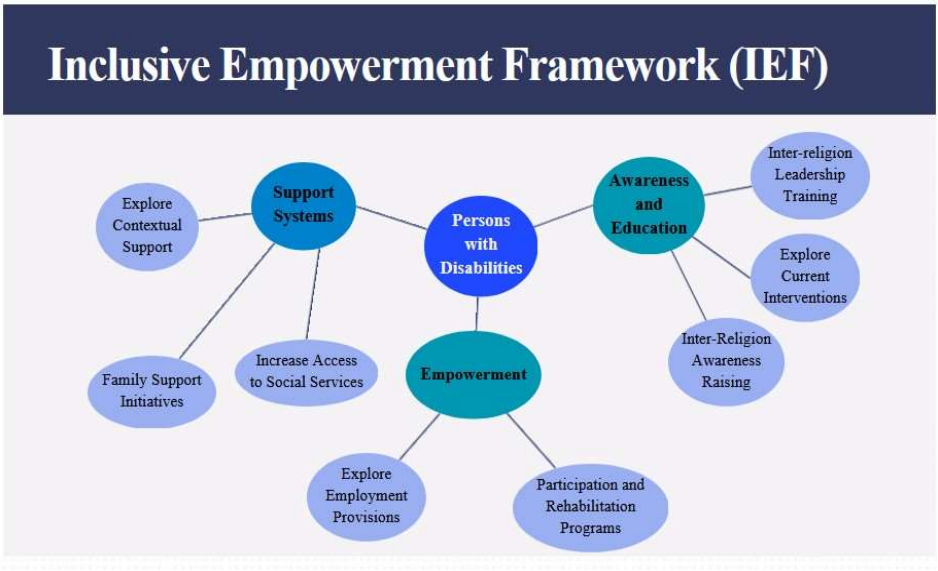


Figure 1: The Inclusive Empowerment Framework (IEF)

In view of these findings, this study proposes the Inclusive Empowerment Framework (IEF) as an appropriate model for intervention. The section develops the framework in detail: it situates the model within the broader conceptual-framework literature on disability inclusion, explains the structure of the diagram in Figure 1, and unpacks each of the model's three pillars and their constituent sub-elements in turn, grounding each in the thematic findings reported above.

Positioning the model

Conceptual frameworks for disability inclusion have proliferated across disciplines in recent years. Situating the IEF among them clarifies both its debts and its distinctive contribution. Several recent frameworks organise disability inclusion around a small number of interacting components in a way the IEF shares structurally: Sarancha and Fushtey proposes a 4P model of rights,

resources, partnerships and performance for inclusive education[9]; Mckenzie et al propose a four Ps curriculum framework of planning, practice, person-centredness and participation for learners with intellectual and developmental disabilities[10]; and Evangelista et al propose a dual-axis, four-quadrant framework mapping formal and informal, enabling and constraining mechanisms of workplace disability inclusion.[11] What these frameworks share with the IEF is a refusal to treat inclusion as a single variable; each breaks it down into interacting components that must be addressed together rather than traded off against one another. Where the IEF departs from this literature is in its centring device. Selisko et al and Simplican et al both build their respective frameworks around models of disability—medical, relational, social, and ecological—rather than around persons with disabilities as the organising node.[12] Theall et al similarly centre the learning environment rather than the individual.[13] Kumari et al, whose Disabled Older People's Empowerment Model draws, as this framework does, on empowerment theory and the social model of disability, comes closer, treating empowerment as a mediator between internal and external resources and specific wellbeing outcomes.[14] The IEF adapts this empowerment-theoretic logic to the religious institutional setting specifically, and takes the additional step of placing the person with a disability, rather than a mediating construct, literally at the visual and conceptual centre of the model, a choice further explained below.

A related, and equally relevant, body of work asks not how inclusion should be organised but what genuine participation, as distinct from mere presence, actually consists of. Ginis et al, reviewing conceptualisations of participation among persons with physical disabilities, find that most existing frameworks measure participation only in terms of roles performed and activities attended. They argue for a broader conceptualisation encompassing autonomy, belongingness, challenge, engagement, mastery, and meaning—dimensions

[9] Sarancha and Fushtey, 'Social Design'.
[10] Mckenzie et al, 'A Conceptual Framework'.
[11] Evangelista et al, 'Disability-inclusive HRM in practice'.
[12] Selisko et al, 'Models of Disability'; Simplican et al, 'Defining social inclusion'.
[13] Theall et al, 'Promoting Disability Inclusion'.
[14] Kumari et al, 'Pathways to Empowerment'.

that performance-based measures routinely miss.[15] This distinction matters directly for how the IEF should be read: thematic area 5 found that a blind congregant was permitted to share through music at a single church conference and that some persons with disabilities participate in ritual dance within ATR, instances of presence that, on Ginis et al's account, would not by themselves demonstrate meaningful participation unless they were also experienced by the participants as autonomous, belonging, and purposeful.

Suarez-Balcazar et al, reviewing five decades of community psychology research on disability, reach a related conclusion from a different angle, arguing that promoting empowerment and advocacy, supporting organisations and settings, and including persons with disabilities in knowledge production are recurring, mutually reinforcing themes across the field[16], themes that map, respectively, onto the empowerment, support systems, and awareness and education pillars developed below. Read alongside one another, this literature cautions against treating the IEF's three pillars as satisfied merely because a religious institution can point to an instance of each. The framework's indicators, discussed below, probe the quality and durability of participation, not only its occurrence.

Two further bodies of literature ground the model's specific components. Tyabashe-Phume and Kleintjes develop a conceptual framework for self-advocacy among people with intellectual disabilities built around personal development, a supportive environment, and improved participation opportunities[17], a structure that maps closely onto the awareness, support, and empowerment pillars developed below. Nanthambwe's work on religion and disability-inclusive development in sub-Saharan Africa argues that African churches, given their influential community position, are well placed to act as catalysts for disability inclusion once approached through a practical, rather than purely doctrinal, theology[18], a claim this study's findings substantiate empirically. Participants across both traditions in thematic areas 1 and 2

[15] Ginis et al, 'Broadening'.
[16] Suarez-Balcazar et al, 'Disability rights'.
[17] Tyabashe-Phume and Kleintjes, 'A Conceptual Framework'.
[18] Nanthambwe, 'Reimagining Inclusion'; Nanthambwe and Magezi, '"Leave no one behind"'.

showed that belief, not institutional capacity, is the more immediate obstacle to inclusion. Tagwirei documents a comparable gap between the Zimbabwean church's stated commitment to disability inclusion and the continued inaccessibility of its leadership and liturgical and infrastructural spaces[19], a gap this study's own thematic areas 5 and 7 reproduce almost exactly. Matumbu and Kutama, working within the Apostolic Faith Mission of Zimbabwe, likewise find that Pentecostal cosmology shapes which disabilities are accommodated and which are not[20], underscoring that theological interpretation, not simply resource scarcity, drives the exclusion that the IEF is designed to address.

Reading the diagram

Figure 1 depicts the IEF as a hub-and-spoke diagram. At its centre sits a single node, persons with disabilities, rendered in a darker shade than any other node in the figure to signal its conceptual priority. Three larger nodes—awareness and education, support systems, and empowerment—are arranged around this centre and connected to it directly. These are the model's three pillars. Each pillar is, in turn, connected to a set of smaller satellite nodes representing its constituent sub-elements. Awareness and education branch into inter-religious leadership training, exploration of current interventions, and inter-religious awareness raising. Support systems branch into exploring contextual support, family support initiatives, and increasing access to social services. Empowerment branches into exploration of employment provisions and participation and rehabilitation programmes. No arrows or directional lines connect the three pillars to one another directly. Each connects only to the central node and to its own satellites. This is a deliberate design choice, not an oversight. A linear or sequential diagram, in which awareness fed into support which in turn fed into empowerment, would imply that a religious institution could complete one pillar before beginning the next. The hub-and-spoke structure instead implies that all three pillars act on the same centre simultaneously, and that the connection each pillar requires is not to the others but to the person with a disability that the model is organised around.

Placing persons with disabilities at the centre of the diagram, rather than at its edge as a beneficiary category, is the single most consequential design decision

[19] Tagwirei, 'Enabling Abilities'; Tagwirei, '(Dis)Abling church spaces'.
[20] Matumbu and Kutama, 'Exploring the Inclusivity Gap'.

in the model. It follows directly from the theological-anthropological argument developed in the background section above, most notably Swinton's distinction between 'inclusion' as something done to a category of people and 'belonging' as a relationship persons with disabilities are drawn into as full participants.[21] A diagram in which persons with disabilities appeared as one satellite node among several, attached to the support systems pillar, for example, would visually reproduce exactly the passive 'inclusion' Swinton criticises. Centring them signals that the model treats persons with disabilities as the point around which religious institutions organise support, education, and empowerment. Persons with disabilities are not passive recipients of programmes designed elsewhere without their input, a design principle the findings section shows is currently absent in practice. Thematic area 5 found that Christian inclusion efforts, where they exist, are designed and delivered without any apparent consultation of the persons with disabilities they are meant to serve.

Pillar 1: Awareness and Education

The first pillar responds directly to the confusion documented across the thematic findings. Christian and ATR participants offered starkly different, and at times internally inconsistent, explanations for the origin of disability, ranging from chromosomal causes to witchcraft to congenital difference and divine creation. Participants explicitly named training as the resource religious institutions most urgently require. As Figure 1 shows, awareness and education is unpacked in three sub-elements: inter-religious awareness raising, inter-religious leadership training, and exploration of current interventions.

Inter-religious awareness raising is positioned as the pillar's foundation because the findings show that misinformation directly shapes how persons with disabilities are treated. For example, the belief that laughing at a person with a disability will cause one to bear a disabled child, or that disability results from being struck by *izulu laphansi*. A structured awareness-raising component is intended to replace such beliefs with a disability-affirming understanding informed by the theological anthropology and social model perspectives discussed above, and to do so jointly across religious traditions rather than

[21] Swinton, 'From Inclusion to Belonging'.

within each in isolation, since thematic area 2 found that Christian and ATR myths about disability are strikingly, almost interchangeably, similar.

Inter-religious leadership training responds to the finding that Christianity and ATR, despite their theological differences, draw on the same underlying culture. Rather than training pastors and traditional healers separately, and so reproducing a division the findings suggest is largely artificial, the model proposes joint training, so that the striking similarity observed between the two traditions becomes a shared platform for reform rather than two uncoordinated, and potentially contradictory, efforts.

Exploration of current interventions commits religious leaders to auditing what, if anything, their institutions are already doing—an audit the findings suggest is overdue. The evidence indicates that existing efforts are largely rhetorical. One pastor described inclusion as something the church 'encourage[s] … but practically it does not exist'; another indicated the absence of any disability-specific programme, saying 'we allow them to advocate for themselves'. Building this audit into the model is intended to narrow the gap between the theological commitment to 'belonging'[22] and the largely rhetorical programming the study documents, a gap Tagwirei identifies as the central obstacle facing disability inclusion in Zimbabwean church spaces specifically.[23]

Pillar 2: Support Systems

The second pillar addresses the practical, everyday needs that participants raised largely unprompted. Chief among these was the near-total absence of identity documentation: one participant described caring for a relative with a disability who had no identity documents, an obstacle both Ndlovu and the participant herself identified as a major barrier to accessing social services[24]. As Figure 1 shows, support systems are unpacked into three sub-elements: increasing access to social services, exploring contextual support, and family support initiatives.

[22] Swinton, 'From Inclusion to Belonging'.
[23] Tagwirei, '(Dis)Abling church spaces'.
[24] Ndlovu, 'African Beliefs'.

Increasing access to social services operationalises the constitutional obligations set out in Sections 22 and 83 of Zimbabwe's National Constitution (2013) at the level of the religious institutions, positioning churches and traditional healers as intermediaries who help members obtain the documentation and referrals that formal social services require, given that, as thematic area 8 shows, the absence of such documentation is currently the single greatest obstacle participants identified.

Exploring contextual support acknowledges that Christianity and ATR already provide informal forms of support—traditional herbal therapy in ATR, and informal pastoral care in Christianity—that the model seeks to formalise and resource rather than replace. These including the reduced fees some traditional healers extend to persons with disabilities who cannot pay in full. The pillar's function is therefore not to introduce support from nothing but to make existing, ad hoc supports systematic and sustainable.

Family support initiatives respond to the finding that the care of persons with disabilities in Zimbabwe has historically defaulted to government and non-governmental actors, a pattern the study links to communities becoming disengaged from disability care. The exact nature and extent of this disengagement is stated only in general terms in the original findings and would benefit from more precise specification in a future, larger study; nonetheless, embedding family support within the model is intended to relocate some of this responsibility back into the immediate community rather than leaving it to external actors alone.

Pillar 3: Empowerment

The third pillar shifts the model from awareness and support to agency. The findings show that where persons with disabilities are included in religious life at all, inclusion rarely extends beyond presence. Christian participation was described as largely symbolic, while ATR inclusion, though more visible in ritual practice, was reported as conditioned on the disabled person possessing an ancestral spirit rather than on capability or membership. As Figure 1 shows, empowerment is unpacked into two sub-elements: participation and rehabilitation programmes, and exploration of employment provisions.

Participation and rehabilitation programmes build on the few positive examples the study surfaced: a blind congregant given the opportunity to share through music during a church conference, and persons with disabilities who serve as traditional healers within ATR. It proposes that such inclusion become structured and expected rather than exceptional. This is consistent with Tyabashe-Phume and Kleintjes's finding that structured participation opportunities, not simply goodwill, are what convert nominal inclusion into genuine self-advocacy.[25]

Exploration of employment provisions responds to a gap the study observed: none of the eight thematic areas surfaced a religious initiative connecting persons with disabilities to livelihoods or income. This is inferred from the absence of employment-related findings in the data reported above rather than from a question that directly probed employment. The inference echoes Tinta and Kolanisi's finding that persons with disabilities in sheltered and community settings face compounding barriers to income-generating activity that require a dedicated, rather than incidental, intervention strategy[26], and Chumo et al's argument that social inclusion in employment specifically requires deliberate, targeted support rather than the by-product of broader inclusion efforts.[27]

Read together, the three pillars are conceived as interdependent rather than sequential. Reducing the circulation of harmful beliefs about disability without a corresponding support system or empowerment pathway would leave any resulting change in attitude unsupported in practice. Conversely, expanding access to services or employment without first addressing the awareness deficit documented in thematic areas 1 and 2 risks reproducing the same stigmatising assumptions within better-resourced programmes. It is this interdependence, rather than any single pillar in isolation, that the hub-and-spoke structure in Figure 1 is intended to convey. It is also, per the framework comparison above, what most clearly distinguishes the IEF from linear or stage-based models of disability inclusion elsewhere in the literature.

[25] Tyabashe-Phume and Kleintjes, 'A Conceptual Framework'.
[26] Tinta and Kolanisi, 'Overcoming barriers'.
[27] Chumo et al, 'Social Inclusion'.

Towards implementation

A conceptual framework of this kind is of limited use to a religious institution unless it can be operationalised. In practical terms, the model implies a phased entry point rather than the simultaneous rollout its diagram might otherwise suggest. Given that thematic area 8 identifies training as the most urgently requested resource, joint inter-religious training under pillar 1 is the most immediately actionable starting point, since it requires no new infrastructure, funding stream, or partnership arrangement. It only requires the willingness of religious leaders to be trained together. Support systems and empowerment, by contrast, are more resource-dependent. Increasing access to social services presupposes the documentation-assistance pathway described above, while employment provisions presuppose partnerships with government or non-governmental actors that lie substantially outside any single religious institution's control. A realistic implementation sequence would therefore begin with awareness and education, use the resulting shift in leadership understanding to motivate the resourcing of support systems, and treat empowerment, and employment provision specifically, as a longer-horizon goal pursued in partnership with external actors rather than delivered by religious institutions alone. Indicators of progress might include the proportion of participating religious leaders who have completed joint training, the number of members assisted in obtaining identity documentation through the institution, and the number of persons with disabilities occupying non-symbolic leadership or service roles within the institution. Consistent with Ginis et al's caution, a crude count of participation instances would not be sufficient on its own[28]; any indicator set adopted would need to be paired with a qualitative check, such as brief follow-up interviews with the persons with disabilities involved on whether the resulting participation was experienced as autonomous and meaningful rather than merely permitted.

Given how the findings describe the current division of labour, responsibility for implementation cannot rest with religious institutions alone. Thematic area 7 found that the state and non-governmental organisations have historically absorbed responsibility for disability care by default, a pattern this study reads as communities, including religious communities, disengaging from an

[28] Ginis et al, 'Broadening'.

obligation rather than the state stepping in to fill a genuine capacity gap. The model does not propose reversing that division outright; rather, it proposes that religious institutions take primary ownership of pillar 1, retain a coordinating role in pillar 2 while drawing on existing government and non-governmental documentation and social-service infrastructure, and act as a referral and advocacy partner rather than the primary provider for pillar 3 where formal employment programmes typically sit outside any individual church's or traditional healer's practical reach. This division of labour is consistent with Nanthambwe's argument that African churches are best positioned to act as catalysts and advocates for disability-inclusive development, rather than as its sole delivery mechanism, working through their standing in the community to mobilise other actors rather than substituting for them.[29]

Conclusion

This study set out to understand how ATR and Christianity in Zimbabwe interpret disability, and to translate that understanding into a structured model religious institutions can use to organise their response to it. On the first question, the findings show that both religions hold ambivalent and, at points, internally inconsistent perspectives: some participants regard disability as part of God's creation, others as congenital or acquired, and still others as a curse or punishment originating with ancestral spirits. A further, smaller group denied that disability exists as a meaningful theological category at all. Despite their doctrinal differences, Christianity and ATR arrive at strikingly similar beliefs, a convergence the findings attribute to a shared cultural substrate rather than to any direct theological borrowing between the two traditions. Perspectives specific to Christianity are shaped substantially by biblical passages such as John 9, while ATR's understanding is shaped by practices guided by ancestral spirits.

The two traditions differ more in application than in belief. Christianity engages persons with disabilities only minimally in practice, while ATR involves them, albeit conditionally, in rituals and ceremonies and, in some cases, as practitioners in their own right. Both traditions 'willingness to include persons

[29] Nanthambwe, 'Reimagining Inclusion'.

with disabilities is, on the evidence gathered here, weaker than either claims. ATR's inclusion is constrained by the requirement that the person with a disability possess an ancestral spirit, while Christian institutions remain broadly reluctant to include persons with disabilities in programmes or activities beyond token gestures. Neither tradition reported a specific programme designed to meet the needs of persons with disabilities. Whatever support exists is sporadic, and largely through individual compassion rather than institutional commitment.

Taken together, these findings point toward the same conclusion from several directions: both religions require training that builds knowledge of disability and improves communication with persons with disabilities. Persons with disabilities themselves require documentation to access social services and assistive technologies that neither tradition is currently positioned to provide on its own. The IEF developed in this paper is a proposed answer to that need. It does not claim to resolve the theological disagreements documented in the findings, nor does it assume those disagreements must be resolved before institutional practice can improve. Its contribution is narrower and more practical, offering religious institutions in Zimbabwe and elsewhere a structure through which existing goodwill can be converted into sustained, coordinated, and person-centred practice. Future research should prioritise piloting the framework's three pillars within a small number of religious institutions, using the implementation indicators outlined above, to establish whether the model changes institutional practice and not merely institutional rhetoric.

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