Article

Addressing Drug Abuse Among Youth with Disabilities in Zimbabwe: An Inclusive Care Ethics Perspective

by

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Abstract

Drug and substance abuse is a challenge that knows no boundaries, impacting individuals and communities across the globe. Although drug abuse is recognized as a national crisis in the context of Zimbabwe, this paper argues that young persons with disabilities (YPWDs) are systematically sidelined in the national response to substance abuse. Yet in urban settings such as Harare, this constituency faces a heightened risk of drug abuse, which is exacerbated by the unique socio-economic challenges they face and social exclusion, as well as their limited access to inclusive support services. This study problematizes the critical and largely underexplored oversight of this group in national initiatives to address the drug pandemic. This oversight is reflected in the absence of references to YPWDs in Zimbabwe's Multisectoral Drug and Substance Abuse Plan (2024–2030), the lack of disability-disaggregated data in national surveys such as the Afrobarometer report on drug abuse of 2025, and the silence on substance abuse within the National Disability Policy of 2021 and the Persons with Disabilities Act of 2025. In this respect, the paper argues that if this oversight continues unabated, it risks undermining efforts to end the drug abuse pandemic without leaving the constituency of persons with disabilities behind. To address this problem, the paper engages an Inclusive Care Ethics approach. Thus, drawing on this framework, this paper emphasizes the significance of incorporating the key tenets of relational responsibility, attentiveness, competence, and contextual sensitivity (responsiveness) in developing inclusive support and response systems to the challenge of drug and substance abuse. By synthesizing current legislative frameworks with existing literature, the study identifies systemic gaps. It offers an illustrative application of Tronto's Inclusive Care Ethics framework to inform inclusive responses to the problem of drug abuse in Zimbabwe. Ultimately, it proposes actionable, community-rooted interventions to ensure that the fight against the drug pandemic does not leave persons with disabilities behind.

Keywords: drug abuse, young people living with disabilities, inclusive care ethics

Introduction

That drug abuse remains a significant public health concern globally, with young people constituting one of the most vulnerable groups, is beyond doubt. In Zimbabwe, the problem of drug abuse has intensified in recent years, affecting not only mainstream youth populations but also those with disabilities—a demographic often marginalized in both research and policy interventions. Existing evidence positions drug abuse as a society-wide crisis (Chirisa et al., 2021; Masunungure et al., 2025). Although the recognition of drug abuse as a society-wide problem is commendable, what remains problematic is the oversight of young persons with disabilities (hereafter YPWDs) in existing interventions. A critical analysis of Zimbabwe's Multisectoral Drug and Substance Abuse Plan (2024–2030), the Afrobarometer report on drug abuse (Masunungure et al., 2025), and other foundational instruments such as the National Disability Policy of 2021 and the Persons with Disabilities Act 3 of 2025 exposes this oversight. This oversight creates a dangerous illusion that YPWDs from the 15–35 years age group are not affected, thereby impeding a holistic approach to the drug abuse crisis. It is precisely this issue that constitutes the core problem of this paper. Therefore, the central contention is that the constituency of YPWDs is sidelined in the national fight against drug abuse, and rendered invisible in policy, data, and service provision, despite being equally affected. Furthermore, the paper argues that if this oversight continues unabated, it will not only perpetuate cycles of marginalization but also risk undermining national efforts to end drug abuse by leaving this significant constituency behind.

Fundamentally, the paper underscores the need for a paradigm shift by demonstrating how YPWDs constitute a uniquely vulnerable group in a largely vulnerable youth population. They face compounded risks for drug abuse owing to the disproportionate impact of poverty and social exclusion characterizing their everyday experiential realities. Beyond situating the oversight of disability as a problem, the paper locates the solution within the Inclusive Care Ethics approach. Thus, it articulates how the key tenets of Inclusive Care Ethics, which include relational responsibility, attentiveness, and responsiveness, provide a solid foundation for developing comprehensive interventions for the drug pandemic that accommodate YPWDs. Thus, the paper employs a qualitative research methodology

that synthesizes policy instruments and related reports on drug abuse with existing literature to assess current gaps in relation to the existential realities of YPWDs. In doing so, the paper seeks to contribute to a more holistic, ethical, and effective response to drug and substance abuse within Zimbabwe's urban context, which is also transferable across similar contexts across the African continent.

Beyond this introduction, the paper is structured as follows. The next section outlines the methodological approach. The subsequent section presents a detailed exposition of Tronto's Inclusive Care Ethics framework and articulates how this approach is used in the study. This is followed by a background discussion of drug abuse as a pandemic in urban Zimbabwe. The paper then problematizes the oversight of disability in current policy and literature before systematically applying the five pillars of Tronto's Inclusive Care Ethics framework to illustrate how current policies fail and how these failures can be addressed. Informed by these five pillars, the paper concludes with recommendations for policymakers, practitioners, and researchers.

Methodological Considerations

In terms of methodology, this paper utilizes a Qualitative Desk Research approach and documentary analysis. The choice of this research design is fundamentally dictated by the study's primary research question: To what extent do contemporary Zimbabwe's national policy instruments, strategic intervention plans, and statistical datasets structurally recognize and address substance abuse among young persons with disabilities (YPWDs)? The issue of the oversight of YPWDs in the national response to substance abuse requires immediate conceptual analysis to inform implementation—a task for which desk-based policy analysis is optimally suited. Thus, to ground the study in the specific socio-political context of Zimbabwe, three primary categories of documents are systematically identified and analyzed. For peer-reviewed scholarship, a systematic search is executed across Google Scholar, PubMed, and African Journals OnLine (AJOL), utilizing combinations of Boolean operators (AND/OR) and keywords across four conceptual clusters: (1) target population ("young persons with disabilities", "YPWDs", "disabled youth"); (2) health crisis ("drug abuse", "substance misuse", "crystal meth", "addiction"); (3) geographic context ("Zimbabwe", "Harare") and (4) Inclusive Care Ethics ("Tronto"). This initial

database search yields 72 records. Accordingly, key national documents are purposively selected based on their direct relevance to disability rights and also issues of drug and substance abuse. These include the National Disability Policy (2021), the Persons with Disabilities Act (2025), and the Multisectoral Drug and Substance Abuse Plan (2024–2030). These documents are purposively selected because they represent the primary legal and statistical baseline guiding current national interventions. Access to these important documents is gained through official government publication platforms to ensure the authenticity and credibility of their provisions. The key search terms used on these platforms focus on structural mandates, using strings such as: "national drug plan", "substance abuse strategy", "disability policy", and "multisectoral action plan".

To triangulate findings and identify gaps in policy instruments and existing literature, the study incorporates insights from grey literature. A targeted search of grey literature is conducted across key organizational platforms, including the digital repositories of the Government of Zimbabwe (Ministry of Public Service, Labour and Social Welfare; Ministry of Health and Child Care), UNICEF Zimbabwe, and the Afrobarometer digital library. This tier of retrieval successfully integrates materials such as the *Afrobarometer Report on Drug Abuse (2025),* (Masunungure et al., 2025), which provides nationally representative data on public perceptions of drug abuse, and reports from international bodies specifically addressing issues that intersect with youth, disability, or substance use in Zimbabwe. Strict inclusion and exclusion criteria are applied to the combined search results. Documents are included if they were published between 2013 and 2026, directly address substance use or mental health frameworks, and govern public health or disability rights applicable to Zimbabwe. Following the removal of 10 duplicates and a strict process of title/abstract screening, a final analytical corpus of 51 primary sources was retained for complete evaluation.

The limitations of a desk-based conceptual study are significant and explicitly acknowledged here, especially the lack of primary empirical data from YPWDs themselves regarding their lived experiences of substance use, treatment access, and barriers to care. This paper identifies systemic gaps in existing policy and literature, and consequently lays the foundation for future empirical research

involving interviews with YPWDs, which is necessary to validate these findings. A thematic approach is adopted, with analytical themes drawn directly from the five pillars of the Inclusive Care Ethics framework to evaluate current policy architectures and inform inclusive interventions in Zimbabwe.

The Inclusive Care Ethics Framework

The Inclusive Care Ethics approach is rooted in the foundational principles that emphasize relational interdependence, empathy, attentiveness to vulnerability, and moral responsibility toward others (Engster, 2007; Tronto, 1993). The concept of the ethics of care has evolved substantially since its emergence in the 1980s (Hankivsky, 2004). First-generation theorists such as Gilligan (1982) articulated care ethics in response to perceived gender bias by focusing more on the moral development of women and highlighting the caregiving roles that have traditionally been linked to motherhood, nurturing, and emotional support (Held, 1993; Noddings, 1984; Ruddick, 1989, 1992). These foundational works established care as a legitimate moral orientation but remained primarily focused on interpersonal, often feminized, domains of caregiving. For instance, Noddings (1984) further developed this through the concept of natural caring as the ethical ideal, while Ruddick (1989) applied maternal thinking as a model for peace politics.

Conversely, second-generation theorists transformed care ethics into a robust political and social theory. Scholars such as Tronto (1993) broadened the concept, framing care not only as a moral obligation but also as a political and societal duty. Tronto described care as an essential human activity encompassing all efforts to sustain, restore, and enhance our bodies, relationships, and environments, creating an interconnected framework that sustains life (Tronto, 1993). Accordingly, Sevenhuijsen (1998) highlighted a central feature of Inclusive Care Ethics—the recognition that individuals exist within a web of unequal, interdependent, and interconnected relationships. Scholars such as Engster (2007) advanced care ethics as universally applicable, articulating three core capabilities: attentiveness, responsiveness, and respect. This paper operationalizes Tronto's (1993; 2013) five-phase model of care, which provides a granular analytical tool for evaluating policy responses. Thus, the analysis of literature and statistical and policy instruments is

structured around the concepts of *Attentiveness*, *Responsibility*, *Competence*, *Responsiveness*, and *Solidarity*. Each document is systematically evaluated to determine whether its strategic goals fulfill or neglect these specific dimensions of institutional care. This systematic thematic mapping ensures that the subsequent policy critique moves beyond superficial observation to offer an empirically grounded, conceptually driven evaluation of the policy gaps facing YPWDs in Zimbabwe.

Table 1 below defines each phase and illustrates how it applies to the intersecting needs of YPWDs with co-occurring substance misuse.

Table 1: Tronto's Five-Phase Model of Care Applied to YPWDs and Substance Use

Tronto's Phase of Care	**Definition/ Key Expectations**	**Application to YPWDs & Substance Use (Illustrative)/ Core Questions**
1. Caring About (Attentiveness) Tronto (1993)	The capability to recognize, understand, and interpret others' needs, uncovering subtle dimensions of vulnerability, dependency, and lived experience. Recognizing and identifying that someone has a need and requires attentiveness.	Institutional sectors and service providers must actively identify substance use risks among youths with disabilities, recognizing that cognitive, physical, or sensory communication barriers may mask signs of emotional distress or trauma. Does the Afrobarometer survey or Drug Plan notice that YPWDs might have unique risks and needs for substance use support?
2. Taking Care Of (Responsibility) Tronto (1993)	Accepting explicit moral and institutional ownership to address an identified need, rather than shifting accountability or abandoning the care-seeker. Accepting responsibility for addressing the identified need requires responsibility.	Relieving systemic fragmentation by ensuring that relevant social welfare, disability rights, and public health ministries assume collaborative responsibility rather than passing YPWDs between disconnected sectors. A dedicated coordination system is required. Whose job is it to provide sign language interpretation at a rehab center?
3. Caregiving (Competence) Tronto (1993)	Providing actual care through skilled, effective, and resource-backed action that genuinely and effectively satisfies the recipient's specific needs. This requires competence.	Delivering specialized harm-reduction, psychiatric support, and rehabilitation services within physically and cognitively accessible facilities, administered by staff cross-trained at the intersections of disability rights and addiction medicine. Are rehabilitation staff trained to work with youths with a psychosocial disability and a substance use disorder? Are facilities accessible?

Tronto's Phase of Care	**Definition/ Key Expectations**	**Application to YPWDs & Substance Use (Illustrative)/ Core Questions**
4. **Care Receiving (Responsiveness)** Tronto (1993)	Monitoring how care-receivers respond to interventions to ascertain if their needs are being met. This requires prioritizing the perspective and feedback of those receiving care.	Structuring screening, treatment protocols, and feedback mechanisms in highly flexible, accessible formats (e.g., adaptive communication tools) that adapt around the lived, experiential realities of YPWDs. Support is adjusted based on the individual's lived experience rather than predetermined program expectations. Are YPWDs asked if the support worked for them? Are their perspectives included in program design?
5. **Caring With (Solidarity)** Tronto (2013)	Treating care-receivers as moral equals, centering care in rights-based protection, anti-stigma, democratic participation, and structural fairness. Ensuring care is grounded in solidarity, justice, and democratic participation requires shared responsibility and structural fairness.	Including YPWDs with lived experience as active co-designers of national drug prevention strategies, while continuously eliminating underlying structural drivers like urban poverty, social exclusion, and institutional stigma. Is care co-designed with YPWDs? Does the policy address the systemic issues, such as poverty and stigma, that create their vulnerability?

To effectively operationalize the Inclusive Care Ethics framework for policy analysis, its five dimensions must be viewed as interconnected and highly dependent on each other. At the foundational level, if a state lacks Attentiveness and fails to recognize a marginalized group such as young people with disabilities (YPWDs) facing substance misuse in Zimbabwe, the entire ethical system collapses. Without this initial recognition, the state avoids taking official Responsibility, which structurally prevents the mobilization of resources and trained staff needed for competence. Consequently, public services remain inaccessible, silencing the Responsiveness of the care-receivers who are pushed out of the loop entirely. Ultimately, this entire process must be bound together by Solidarity (caring with) and respect; without it, top-down care degrades into paternalistic control or complete erasure. Applied to Zimbabwe's policy landscape, this five-part chain reaction demonstrates that the absolute silence regarding YPWDs facing substance misuse is not an isolated

administrative oversight but a compounding structural failure that dismantles the ethical integrity of the state's multi-sectoral response.

Addressing Criticisms of Care Ethics and the Resonance with Ubuntu

Despite its significant contributions, care ethics has faced substantial criticism. Two counterarguments are particularly salient and require explicit engagement in this paper. First, questions have been raised as to whether care ethics, rooted in intimate, face-to-face relationships, can adequately address justice at institutional and global levels. Second, critics note the origins of care ethics in Western, predominantly North American, feminist thought, raising questions about its transferability to non-Western contexts. Such questions are critical because they speak directly to the relevance of the Inclusive Care Ethics framework in the context of this paper. The first counterargument is addressed through the application of Tronto's later work (2013), which explicitly extends care ethics to democratic institutions and policy systems. Thus, this paper applies the framework to national policy instruments, including the National Disability Policy (2021) and the Multisectoral Drug and Substance Abuse Plan (2024–2030), as sites of institutionalized responsibility, demonstrating that care ethics is not limited to interpersonal relationships but can guide macro-level policy evaluation. In this respect, therefore, the fundamental questions derived from the Tronto-anchored thematic matrix guiding this analysis become: First, do these national instruments demonstrate a foundational attentiveness to the unique intersectional vulnerabilities of YPWDs who are involved in substance abuse? Second, does the state assume explicit institutional responsibility for addressing these intersected needs? Third, are the strategic and financial allocations structurally competent to deliver accessible caregiving? Fourth, are the policy evaluation and intervention mechanisms genuinely responsive to the lived perspectives of YPWDs? And finally, are these strategic frameworks grounded in a democratic solidarity that respects youths with disabilities as moral equals?

The second criticism can be addressed by acknowledging that the relational ontology of care ethics resonates with the Ubuntu philosophy prevalent in Southern Africa. Ubuntu's emphasis on interdependence, community, and mutual responsibility provides a culturally resonant foundation for operationalizing care ethics in the

Zimbabwean context. Essentially, Ubuntu translates to humanness or personhood, as expressed in the fundamental idea that whatever happens to the individual happens to the whole group, and whatever happens to the whole group happens to the individual (Bowa, 2024; Mabovula, 2011; Matolino & Kwindingwi 2013). Therefore, at the core of this indigenous philosophy are virtues that celebrate mutual social responsibility, sharing, unselfishness, kindness, and consideration for others, among other ethical values (Bowa, 2024; Gwaravanda, 2021; Mabvurira, 2020; Mangena, 2016; Matolino & Kwindingwi 2013). As Bowa (2024) puts it, the primary objective of such virtues is the maintenance of social justice, equality, equity, cooperative living, and social harmony in communities. In this respect, therefore, the Inclusive Care Ethics approach offers a morally grounded path that not only resonates with the philosophy of Ubuntu but also ensures that recovery efforts are also tailored to the lived realities of YPWDs. Ultimately, this approach helps to reframe substance abuse among YPWDs, not as a personal failing but as a socially situated issue requiring collective responsibility.

Ultimately, a fundamental question arises from the foregoing discussion: Will an ethical framework originating in Western thought be effective in achieving meaningful and sustainable impact in the distinctly different cultural context of urban Zimbabwe? The answer lies in the profound resonance between the four principles of Inclusive Care Ethics and the core tenets of Ubuntu philosophy. Where Inclusive Care Ethics demands attentiveness to the marginalized, Ubuntu insists that our humanity is diminished when others are excluded or suffer. As Bowa (2024) demonstrates, Ubuntu embodies an ideology of social inclusiveness toward disability, which often finds expression through proverbs. Where care ethics calls for assuming responsibility within relational networks, Ubuntu grounds moral obligation in the understanding that individual flourishing is inseparable from collective well-being (Mabovula, 2011; Mangena, 2016; Matolino & Kwindingwi, 2013). Accordingly, where competence requires context-sensitive and culturally anchored interventions, Ubuntu provides the indigenous philosophical framework through which communities already understand mutual care and support (Gwaravanda, 2021; Mabovula, 2011; Matolino & Kwindingwi, 2013). And where responsiveness demands the active participation of care-receivers, Ubuntu’s emphasis on dialogue, consensus, and the inclusion of all voices in community decision-making offers a familiar and respected pathway for co-

designing services with YPWDs. As Bowa (2024) argues, from an Ubuntu perspective, there is no room for the outright exclusion of persons with disabilities.

Thus, the synergies between Inclusive Care Ethics and Ubuntu provide a powerful foundation to guide Zimbabwe's roadmap to addressing the social, economic, and psychological drivers of drug use within a framework of empathy, respect, and empowerment. This is what remains missing in current interventions, especially as they relate to the plight of YPWDs. Thus, by adopting Inclusive Care Ethics, Zimbabwe can begin to reverse the tide of the drug pandemic by transforming its urban health landscape into a site of inclusive healing and community accountability. Indeed, such an undertaking carries profound implications for social work practice in Zimbabwe, fundamentally reorienting care providers' roles, methods, and ethical commitments in addressing drug and substance abuse among YPWDs.

Setting the Scene: Drug and Substance Abuse as the New Pandemic in Zimbabwe's Urban Settings

The problem of drug abuse has risen exponentially in the context of Zimbabwe. Afrobarometer data confirms that 79% of Zimbabweans perceive drug and substance abuse as widespread in their communities, with urban residents (93%) significantly more likely to report this than their rural counterparts (70%) (Marandure et al., 2023). As Chirisa et al. (2021) put it, Zimbabwe is facing a growing public health emergency in the form of widespread drug and substance abuse, particularly among its youth population. This crisis, often described by health professionals and social commentators as Zimbabwe's "new pandemic" (Rusakaniko et al., 2021), has escalated rapidly due to the convergence of socio-economic instability, political turbulence, and institutional failure (Chidume & Mugambiwa, 2026). Substances such as marijuana (mbanje), crystal methamphetamine (mutoriro), codeine-based syrups, musombodia, and prescription pills are widely available in Harare's informal markets (Mushonga, 2022), and are increasingly accessible to youths regardless of socio-economic or disability status. So prevalent is this new pandemic among youths aged 15–35 that drug-related admissions to psychiatric institutions such as the Harare Central Psychiatric Hospital account for 80% of cases (Marandure et al., 2023). The surge in drug abuse among youths is attributed to several interlocking factors. In

urban areas such as Harare, deteriorating economic conditions marked by rising youth unemployment, informality, and deepening urban poverty exert immense psychological pressure on young people (Chidume & Mugambiwa, 2026; Muchacha, 2020).

Indeed, Harare, as Zimbabwe's capital and largest urban center, presents an acute case. High-density suburbs such as Mbare, Epworth, and Hatcliffe are characterized by entrenched poverty, high informality, and limited social infrastructure. Within this context of heightened social suffering, the plague of drug abuse emerges as a national crisis. As the new pandemic, the problem of drug abuse is also directly connected to corruption and drug trafficking from countries such as South Africa. Some among the youths have created an underworld industry through selling drugs. With the corruption at the border reaching unbearable levels, all kinds of drugs have flooded Zimbabwe's urban and rural settings. Increasing the exposure of the youths to substance abuse. The Zimbabwean government has come up with the Multisectoral Drug and Substance Abuse Plan (2024–2030), which clearly demonstrates how widespread the drug abuse problem has become, warranting targeted interventions. This strategic plan is an attempt by the government to come up with carefully measured approaches to end the drug pandemic before it causes unimaginable damage to society. It outlines a comprehensive strategic approach to address the escalating threat of drug and substance abuse to public health, economic growth, national security, and social stability in Zimbabwe. There is consistent evidence to the effect that if left unabated, drug addiction will negatively impact the overall human capital of the nation, leading to a decrease in productivity among the majority of individuals in communities (Chidume & Mugambiwa, 2026; Chikoko et al., 2019). Thus, Zimbabwe's Multisectoral Drug and Substance Abuse Plan (2024–2030) must be understood as a mechanism for reversing the current degeneration of society, particularly that of youths, owing to the drug pandemic.

The Oversight of Disability–Drug Abuse Nexus in Existing Literature and Policy Infrastructure: The Core Problem

Whilst it is commendable that Zimbabwe has a standardized plan to address the problem of drug abuse, the plan exhibits exclusionary tendencies in the context of

disability, which also manifest in existing literature. The prevailing discourse and national data on substance abuse in Zimbabwe remain heavily generalized, overlooking the specific vulnerabilities faced by YPWDs. As Mupedziswa (2018) notes, YPWDs are systematically marginalized across social services, and this marginalization is even more pronounced in the context of drug prevention and rehabilitation. Although various initiatives exist, many overlook the intersectionality of disability, drug abuse, and youth, excluding a marginalized group from effective care systems (Mtetwa & Muchacha, 2020). Similarly, Mupedziswa (2018) emphasizes that conventional one-size-fits-all models fail to address unique vulnerabilities like social isolation and poverty affecting YPWDs. This oversight is problematic in that it ignores the broad existential realities faced by persons with disabilities (hereafter PWDs). Bowa (2024) speaks to the existence of a disability–poverty nexus, which he characterizes as one of the most visible manifestations of a political economy of inequality. Accordingly, research demonstrates that PWDs experience very serious social exclusion and social suffering, which is nurtured and perpetuated by a predominantly negative and discriminatory attitudinal environment toward disability (Bowa, 2024). What this means is that PWDs generally face intersecting vulnerabilities, which are heightened in crisis times. This puts into perspective Bowa's (2024) argument that PWDs constitute a vulnerable group within a largely vulnerable country such as Zimbabwe. Building on Bowa's line of thinking, it is plausible to argue that the constituency of YPWDs is disproportionately affected by the problem of drug abuse.

In the context of the drug abuse pandemic, YPWDs remain mostly invisible, not only in the existing commentary but also in the tailored responses to the problem. Evidence suggests that YPWDs face double stigma, which contributes to chronic social isolation, internalized shame, and reduced self-worth, all of which increase susceptibility to substance abuse as a coping mechanism (Muchacha, 2020; Mupedziswa, 2018). In densely populated, high-density suburbs, where drug availability is rampant and peer influence is significant, the need to belong or gain social acceptance pushes YPWDs toward drug abuse. As the societal fabric that once provided support, such as extended family systems, continues to erode due to urbanization, poverty, and unemployment, many are left to fend for themselves emotionally and socially (Chikowore & Munemo, 2023; Mushonga, 2022).

Accordingly, the informal economy, although dominant, remains largely inaccessible to those with mobility or cognitive impairments. This economic marginalization leads to feelings of helplessness and diminished life prospects, making drug use a perceived form of escape from harsh realities (Chikowore & Munemo, 2023; Muchacha, 2020).

Mental health challenges are another significant yet under-acknowledged driver of drug abuse among YPWDs. According to Mtetwa and Muchacha (2020), YPWDs are at a higher risk of experiencing mental health issues such as depression, anxiety, post-traumatic stress, and social withdrawal, often resulting from chronic stigma, discrimination, and social isolation. The lack of accessible and inclusive mental health services exacerbates this vulnerability, leaving many young people without adequate psychological support. Due to the under-resourced mental health sector and limited culturally appropriate services, many young people resort to self-medication through drug use (Mtetwa & Muchacha, 2020). In this respect, Muchacha (2020) and Mutsaka (2021) argue that drug and substance abuse often become a way to cope with persistent emotional distress and unaddressed trauma. Thus, the intersection of disability and poor mental health, coupled with limited service provision, creates a dangerous cycle in which mental health struggles both fuel and are worsened by substance abuse. Moreover, inadequate institutional support and the absence of inclusive rehabilitation programs exacerbate the problem. Rehabilitation services are already scarce and underfunded across Zimbabwe (UNODC, 2022), but such services are often completely out of reach to YPWDs due to issues such as inaccessibility of facilities, lack of disability-informed staff training, and institutional stigma (Mtetwa & Muchacha, 2020). Zimbabwe's existing drug treatment and prevention efforts are not tailored to the unique circumstances of YPWDs. As a result, these youths are often excluded from policy conversations, outreach campaigns, and recovery programs, thereby reinforcing their marginalization (UNODC, 2022).

What is problematic is that existing initiatives overlook the disability–drug abuse nexus in Zimbabwe. Mtetwa and Muchacha (2020) express their deep concern over how various government and civil society initiatives that have been implemented to address drug and substance abuse seemingly overlook the intersectionality of

disability, drug abuse, and youth. This gives the impression that YPWDs are not affected by the drug abuse problem; however, existing evidence clearly indicates that urban centers such as Harare have witnessed a disturbing surge in drug and substance abuse among youths, including those with physical, sensory, intellectual, or psychosocial impairments (Chirisa et al., 2021). The scale of this oversight is starkly illustrated by the Afrobarometer report (Masunungure et al., 2025), which indicates that drug abuse is rampant among the youths but provides no disaggregated data on the disabled constituency. This oversight effectively renders their specific struggles with substance use statistically invisible. Without disability-aggregated data, it is impossible to not only ascertain the prevalence of substance use among YPWDs but also to identify their specific patterns of use, or to design targeted interventions.

The invisibility of disability also cascades through the entire policy and programming cycle. Foundational instruments such as the Multisectoral Drug and Substance Abuse Plan (2024–2030) represent Zimbabwe's primary strategic response to the drug crisis. Despite its comprehensive scope, the Plan contains no explicit reference to disability. Accordingly, policy instruments such as the National Disability Policy of 2021 and the Persons with Disabilities Act of 2025 contain no explicit reference to substance abuse, substance use disorders, or drug rehabilitation. This absence is striking given that both policy instruments were developed within a context of increased awareness of drug abuse as a significant public health issue that affects many communities in Zimbabwe. This perpetuates the invisibility of substance abuse as a health concern for PWDs and represents both a failure of legislative attentiveness and a direct contradiction of the principle of leaving no one behind that both instruments explicitly invoke.

What emerges from existing scholarly literature is a confirmation of the invisibility of YPWDs in the various initiatives aimed at addressing the public health crisis related to drug and substance abuse in Zimbabwe. In their scoping review protocol, Marandure et al. (2023) explicitly identify the absence of a national monitoring system for substance use in Zimbabwe, and note that most evidence cited is anecdotal in nature and heavily reliant on secondary sources. They further observe that reports of a substance use crisis in Zimbabwe are predominantly based on anecdotal evidence,

limiting the ability to gain an accurate picture of the situation (Marandure et al., 2023). Indeed, there are several gaps within the existing literature. This paper responds directly to these identified gaps by foregrounding the specific invisibility of YPWDs within this already limited evidence base, and proposing a framework through which current policy might be evaluated and adapted to make the challenges of YPWDs more visible.

Discussion: An Illustrative Application of the Inclusive Care Ethics Framework in Evaluating Policy Gaps

Having problematized the oversight of a disability lens and the exclusionary tendencies characterizing Zimbabwe's mainstream approaches to addressing the problem of drug abuse in the above analysis, this section enunciates how aspects of the Inclusive Care Ethics approach can be adopted and operationalized to provide a comprehensive solution. In essence, the unfolding analysis seeks to demonstrate how this oversight constitutes a fundamental violation of key principles of Inclusive Care Ethics, including attentiveness, responsibility, competence, responsiveness, and solidarity. From an Inclusive Care Ethics perspective, one can argue that what remains missing in existing interventions in Zimbabwe is an inclusive social ideology that recognizes the unique vulnerabilities of YPWDs in the context of the drug-induced public health emergency, which threatens the health and vitality of the entire population. Hence, the fundamental argument advanced here is that adopting an Inclusive Care Ethics approach offers a coherent, principled solution to this impasse. Operationalizing this framework in the context of the fight to end drug and substance abuse among youths in Zimbabwe provides both the ethical foundation and the practical architecture for ensuring that YPWDs are not merely added to existing services but that services are fundamentally transformed to be accessible and responsive to their needs. Therefore, the unfolding discussion applies this care ethics framework to Zimbabwe's drug response, demonstrating how its core principles can guide the development of genuinely inclusive interventions that honor the constitutional promise of leaving no one behind.

Attentiveness

The first foundational principle that can be adopted is attentiveness. Inclusive Care Ethics emphasizes the importance of recognizing and valuing the diverse needs and experiences of individuals, particularly those who are marginalized (Pollack et al., 2023). In the context of the drug pandemic, the principle of attentiveness problematizes the lack of disaggregated data in mainstream initiatives. For example, the Afrobarometer report (Masunungure et al., 2025) demonstrates attentiveness to the general youth population by reporting that 79% of Zimbabweans see drug abuse as widespread. However, it demonstrates a critical failure of attentiveness to YPWDs by providing no disability-disaggregated data. Similarly, the Multisectoral Drug and Substance Abuse Plan (2024–2030) is inattentive to disability, containing zero explicit references to YPWDs. The National Disability Policy (2021) and Persons with Disabilities Act (2025) are equally inattentive to substance abuse as a health concern for PWDs. This absence of recognition is not a neutral oversight; it actively signals that the needs of YPWDs are not a legitimate object of concern. This violates the core demand of Inclusive Care Ethics, which mandates that we must first learn to see a vulnerability before we can address it (Hankivsky, 2004). The application of this principle, therefore, mandates an explicit acknowledgement of the unique psychological and social challenges faced by YPWDs in all surveys and reports on drug abuse in Zimbabwe. As Hankivsky (2004) theorizes, we must move away from impersonal and inflexible policies that ignore lived realities. Fundamentally, this is the kind of ethical shift that is needed in the programming of interventions in response to the drug pandemic.

Responsibility

The second key pillar is that of responsibility, which underscores the importance of assuming the burden of meeting identified needs. The absence of explicit references in Zimbabwe's Multisectoral Drug and Substance Abuse Plan (2024–2030) constitutes a violation of this very principle as there is no indication of the government's intention to acknowledge and address related challenges as they manifest in the lived experiences of YPWDs. For instance, when a deaf or hard-of-hearing youth in Mbare cannot access substance use prevention education in Sign Language, whose responsibility is this? The disability sector can argue that

substance use falls outside its mandate; the drug control sector can argue that sign language interpretation is a disability accommodation outside its expertise. This diffusion of responsibility means that no one assumes the burden of ensuring accessible and inclusive services. The ministries tasked with disability inclusion and those managing public health operate in silos, passing vulnerable individuals back and forth across institutional cracks. This means the burden of taking care of YPWDs affected by drug abuse currently lies exclusively with their families.

In this respect, the concept of a web of interdependent relationships as expressed by Sevenhuijsen (1998) becomes useful. At the core of the care ethics paradigm is relationality—the recognition that human lives are fundamentally interconnected and that care responsibilities emerge from these relationships (Tronto, 2013). This relational responsibility bridges the gap in policy frameworks that prioritize institutional support for drug addicts while undervaluing the role of endogenous care systems, which include family. Drawing on Pollack et al.'s (2023) characterization, responsibility thus involves bridging the gap between endogenous support, including families and exogenous support from formal institutional networks. Therefore, responsibility in the context of drug abuse means ensuring that the burden of care does not fall solely on families already stretched by the disability–poverty nexus in Zimbabwe.

Competence

Competence, as a third key pillar in Inclusive Care Ethics, requires that care be provided effectively. Earlier discussions exposed how rehabilitation centers are already scarce and underfunded across Zimbabwe (Mtetwa & Muchacha, 2020; UNODC, 2022), thereby undermining the effectiveness of care providers. This state of affairs violates the principle of competence. Indeed, a rehabilitation facility without wheelchair-accessible entrances, without staff trained in sign language, and without information in accessible formats cannot provide competent care to YPWDs. This problem can be addressed by adopting the principle of competence as enunciated in the broader framework of Inclusive Care Ethics. The application of this principle will foster a fundamental reorientation of how competence is understood and operationalized, especially when dealing with the most vulnerable members within

communities. It is a moral imperative to provide care that actually works for YPWDs in the context of the drug pandemic. To achieve this, there is a need for retraining care providers to engage in empathetic, non-stigmatizing practices, and to embed care within community structures. This retraining will capacitate care providers to address both the substance use among YPWDs and the underlying psychological wounds that fuel it. Currently, the absence of disability competence training across Zimbabwe's drug treatment workforce represents a systemic failure of the caregiving phase.

Responsiveness

Inclusive Care Ethics also embodies a fourth pillar—responsiveness—which underscores the importance of a participatory approach that not only respects the autonomy of care receivers but also enhances their sense of agency and responsibility. Current policy processes violate this principle entirely. Evidence suggests that Zimbabwe's Multisectoral Drug and Substance Abuse Plan (2024–2030) was developed through multi-stakeholder consultative processes involving numerous government ministries, development partners, and community leaders. However, organizations representing persons with disabilities were notably absent from these consultations. From a care ethics perspective, ignoring a population in data collection means refusing to see their pain, which fundamentally undermines the core pillar of responsiveness. Thus, the exclusion of YPWDs from policy development processes related to drug abuse profoundly undermines the responsiveness of such policies to their unique challenges. Without mechanisms for care receivers to indicate whether their needs are met, policies remain unresponsive and potentially harmful. Thus, through this principle, Inclusive Care Ethics offers a framework for creating policies that are not only ethical but also effective and empowering (Kittay & Feder, 2003). In this respect, adopting responsiveness means that YPWDs are not passive recipients of care designed by others but active agents in shaping and designing interventions for drug prevention and rehabilitation that genuinely accommodate the lived realities.

Solidarity

The final phase—solidarity—requires that care be grounded in solidarity, justice, and democratic participation. This phase addresses the structural and systemic dimensions of care. The absence of disability perspectives from drug policy development represents a failure of democratic participation and solidarity. This failure can be explained and understood in two critical respects. First, neither the Multisectoral Drug and Substance Abuse Plan nor the National Disability Policy addresses the systemic drivers of vulnerability for YPWDs, including the disability–poverty nexus, chronic social exclusion, and discriminatory attitudes, which Bowa (2024) explicitly exposes. Second, there is no mechanism for co-designing services with YPWDs themselves. The principle of solidarity would require that policies explicitly address structural barriers that create the conditions under which YPWDs become vulnerable to substance abuse in the first place. It would also require that YPWDs participate as equal partners in policy design, not merely as consulted stakeholders.

Concluding Reflections and Recommendations

This paper engaged Tronto's Inclusive Care Ethics framework to problematize the systemic oversight of YPWDs within Zimbabwe's national response to the escalating drug and substance abuse pandemic. Through a qualitative analysis of foundational instruments, including the Multisectoral Drug and Substance Abuse Plan (2024–2030), the National Disability Policy (2021), and the Persons with Disabilities Act (2025), the study revealed a critical gap that limits the effectiveness of these instruments in addressing drug abuse among YPWDs. The key findings emerging from this analysis reveal that despite the high prevalence of drug abuse in urban centers like Harare, YPWDs remain statistically and legislatively invisible, excluded from disaggregated data in major reports on drug abuse such as the Afrobarometer (2025**) (**Masunungure et al., 2025) and sidelined in policy design. The central argument remains that this invisibility creates a dangerous illusion of immunity among YPWDs, which fails to account for their heightened vulnerability driven by the disability–poverty nexus, social isolation, and unaddressed mental health trauma, among other factors. Thus, the paper demonstrated that YPWDs constitute a uniquely vulnerable group facing compounded risks that heighten their susceptibility

to substance abuse as a coping mechanism. Against this backdrop, the paper positioned the Inclusive Care Ethics framework as the most viable solution to this oversight impasse. It demonstrated how Tronto's five pillars of care, which include attentiveness, responsibility, competence, responsiveness, and solidarity, can be operationalized to transform Zimbabwe's drug abuse interventions from exclusionary, one-size-fits-all models into context-sensitive systems. In this respect, the paper also underscored the importance of building synergies between Inclusive Care Ethics pillars and Ubuntu philosophy with the view to developing culturally resonant interventions for drug prevention and rehabilitation that genuinely address the unique challenges faced by YPWDs.

Based on Tronto's model of Inclusive Care Ethics, the paper makes three key recommendations. First, for policymakers, there is an urgent need to mandate the disaggregation of all substance use data by disability status in national surveys such as the Afrobarometer. The Multisectoral Drug and Substance Abuse Plan (2024-2030) must be revised to include explicit provisions that address the specific needs of YPWDs, including accessible prevention materials, rehabilitation facilities, and treatment protocols. Second, practitioners, social workers, and healthcare providers must be trained in disability-inclusive practice, ensuring that rehabilitation facilities provide services in accessible formats such as Sign Language and Braille. Practitioners should adopt an Ubuntu-informed care approach that recognizes collective responsibility for the well-being of YPWDs. This includes developing community-based interventions that work with families and peer networks rather than relying solely on institutional models that are often inaccessible. Finally, for researchers, there is a critical need for primary empirical research that engages directly with YPWDs to document their lived recovery pathways and barriers to care. Additionally, participatory action research that centralizes the voices of YPWDs in designing and evaluating drug interventions is urgently needed. Through these recommendations, this paper ultimately makes a three-pronged contribution. It fills a critical literary gap by foregrounding the disability–drug abuse nexus. It also makes a theoretical contribution by aligning Western care ethics with the indigenous knowledge systems, such as the philosophy of Ubuntu, thereby demonstrating the cultural resonance of the framework. Lastly, it provides a policy architecture for fostering genuine inclusion, offering a practical tool for evaluating and redesigning

drug policies to ensure that the fight against the drug pandemic does not leave persons with disabilities behind.

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