THE PROBLEMS OF PHYSICALLY DISABLED PERSONS IN THE MOLOPO REGION OF BOPHUTHATSWANA: IMPLICATIONS FOR SOCIAL POLICY

by

R. K. MALULEKA

A Dissertation submitted in Candidature
for the Degree of M. Soc. Sc.
in Social Work

University of Bophuthatswana December 1989

TABLE OF CONTENTS

PAGE

ACKNOWLEDGEMENTS i

LIST OF TABLES ii

LIST OF FIGURES iii

CHAPTER 1

1.1 Introduction 1
1.2 The Hypothesis 2
1.3 Aim of Study 3
1.4 Purpose of the Study 3
1.5 Definition of Concepts 6
1.6 Theoretical Framework 23

CHAPTER 2 DESCRIPTION OF THE MOLOPO REGION AS AN AREA WHERE THE PRESENT STUDY WAS UNDERTAKEN.

2.1 Topography 29
2.2 Demographics 29
2.3 Economic details 31
2.4 Urbanization in the Molopo region 36
2.5 Housing 37
2.6 Social Services 38

CHAPTER 3 METHODOLOGY

3.1 The Research Design 49
3.2 The Universe and the Sample 52
3.3 Constructing the Sampling Frame 54
3.4 Sampling 63
3.5 Fieldwork and Data Collection 65
3.6 The Interview Schedule 74
3.7 Data Analysis and Interpretation 75
3.8 Limitations of the Study 75

CHAPTER 4

4.1 THE PROBLEM OF DISABILITY

4.2 The Psychological Consequences of Cripplehood 80

4.3 The Social Consequences of Disability ... 82

4.4 Disability and Problems of Practical Daily Living 93

4.5 Education and Disability 98

4.6 Employment and Disability 103

4.7 Disability and Economic life 108

4.8 Social services that can be Rendered to Persons with Disability 109

CHAPTER 5 DISABILITY IN THE THIRD WORLD

5.1 The Concept Developing country 123

5.2 Theories of Underdevelopment 128

5.3 The Profile of Disability in Developing Countries 133

5.4 World-wide Prevalence Trends of Disability with Special Emphasis on the Third World 143

5.5 The Major Characteristics and Problems of Developing Countries with Special Reference to their Impact upon Persons with Disabilities 149

CHAPTER 6 REHABILITATION SERVICES FOR PHYSICALLY DISABLED PERSONS IN BOPHUTHATSWANA

6.1 Introduction 188

6.2 Social Work and Social Welfare Services in the Third World 189

6.3 The Welfare Structure of Bophuthatswana . 196

6.4 Social Work Services rendered to Physically Disabled Persons in Bophuthatswana with particular reference to the Molopo area 221
6.5 Service Categories 222

CHAPTER 7 FINDINGS AND CONCLUSIONS

7.1 Age Composition of Respondents 249
7.2 Sex Distribution of Respondents 251
7.3 Marital Statuts of Respondents 253
7.4 Functional Diagnosis 255
7.5 Educational Standards 261
7.6 Employment Position of Respondents 267
7.7 Income Sources 279
7.8 Accommodation Circumstances of Respondents 285
7.9 Care-related Problems of Respondents 291
7.10 Social Service Problems 298
7.11 Summary of the Findings and Conclusions .. 301

BIBLIOGRAPHY 310
APPENDIXES

ACKNOWLEDGEMENTS

I wish to acknowledge with gratitude a grant from the Research Committee of the University of Bophuthatswana, which in part covered the costs of my research study. In particular, I am deeply indebted to Professor Brumhilde Helm whose stimulating and inspiring guidance, sacrifice and cheerful encouragement made the whole of my study a possibility.

Sincere thanks are extended to Mary and Queen for their efficient typing and the consideration they both displayed in times of pressure.

Special thanks go to the Molopo Region Pension Officers, to headmen of villages, and to my respondents and their families. Their co-operation not only made my research possible, but also added to my enjoyment of it.

Special gratitude goes to my husband Edward Maluleka for his co-operation, encouragement, and love throughout my study. My children are thanked for their endurance during my times of immense preoccupation, especially in the latter stages of the work.

I am grateful to my colleague in the UNIBO Department of Social Work, Ms Geraldine Thekisho who constantly motivated me.

LIST OF TABLES

PAGE

1. Age distribution of the population in the Molopo region... 30

2. Income structure from employment in the Molopo region 36

3. Primary schooling facilities in the Molopo region vis-a-vis those of the whole country 39

4. Secondary schooling facilities in the Molopo region vis-a-vis those of the whole country 39

5. Teacher-pupil ratios in primary and secondary schools in the Molopo region 40

6. Literacy and Education levels in the Molopo region 41

7. Health resources in the Molopo region in 1986 43

8. A listing of Third World countries 126

9. Relationship between age and disability as indicated by Harries 141

10. Per Capita gross national products of selected countries for the year 1978 153

11. Infant Mortality rates in various countries 158

12. South African government structures within which education for various races is administered, together with the accompanying budget allocations for the years 1983/1984 ...162

13. Illiteracy rates by racial group in 1980 163

14. Special schooling facilities for Black disabled children within the international boundaries of South Africa i.e. including homelands 165

15. Educational levels of 57 physically handicapped persons of employable ages in the Ditsobotla region 168

16. Respondents classified by age in years 250

17. Respondents classified according to Marital Status 253

18. Respondents classified according to functional diagnosis.. 256

19. Respondents classified according to educational standards..... 261

20. Respondents classified by the major reasons given for not working 269

21. Respondents classified according to gainful occupation .. 274

22. Fifteen employed respondents in the informal sector classified according to job problems 276

23. Respondents classified according to income sources..... 279

24. Respondents classified according to problems experienced regarding income source 282

25. Respondents classified by functional group and according to the type of accommodation problem 287

26. Respondents classified according to the principal carers mentioned by them 292

27. Respondents classified according to major problems encountered in daily care 295

28. Respondents classified according to the major social service problem encountered 298

LIST OF FIGURES

PAGE

The Welfare Structure of Bophuthatswana 196

The Social Welfare Structures of South Africa 245

CHAPTER 1

1.1 INTRODUCTION

The problem addressed in this dissertation is of physically disabled persons who live in a deprived area. The deprived area here is a predominantly rural zone with a very small urban complex in a developing territory. It is basically an impoverished area. The area in question is the Molopo region of Bophuthatswana.

The area is regarded as being deprived because it lacks some physical and social resources that could be mobilised to enhance the lives of disabled persons within it.

Physical resources would include job opportunities, proper housing, schools, and communication systems. Social resources would include social services like health, special education, and social welfare.

Since the disabled, like all people, are heavily dependent upon their milieu for living, it means that those who live in an environment as deprived as the one considered here, are pervasively disadvantaged, i.e. disadvantaged over a wide spectrum of human life.

An aspect of environmental deprivation that I am primarily concerned with here is that of absent or undeveloped social services. Social services are basically established to meet people's needs. If absent or underdeveloped, needs are not met.

Professional social service providers are significant as far as enhancement of the lives of people is concerned. They deal

directly with citizens. They are in strategic positions to determine what needs are and duly to inform policy makers. In this way they are instrumental in influencing the creation of life-enhancing resources. Their absence or insufficiency in an area implies absence or inadequacy of social services. This means the needs of people in the particular milieu are either never attended to, or if they are then, they are inadequately addressed.

Such is the plight of disabled persons whose circumstances this dissertation surveys. They are largely unidentified and unreached by professionals, hence are unnoticed by leaders in power structures.

This study seeks to answer some questions about the nature of their situation.

1.2 THE HYPOTHESIS

This study is basically explorative, hence no hypothesis in the strict sense of the word can be formulated. Hypothesis formulation should be based on existing knowledge, and this is lacking in this instance.

Instead, the study will seek to answer the following questions:-

What is the societal context of physically disabled persons in the Molopo region like?

What are the problems experienced by them?
Are there any services that are being rendered to them?

If any, how effective, efficient, accessible, and complementary are they?

If there are no services, what can be done about it?

1.3 AIMS OF THE STUDY

The study aims to:-

1.3.1 Review literature on the phenomenon of disability.

1.3.2 Assess the manifestations of disablement in developing settings. Towards this end, causative factors and prevalence trends of disability in these settings will be examined, and also the major attributes of developing countries and their impact upon the situation of the disabled.

1.3.3 Study the Molopo region as the setting in which disablement will be examined.

1.3.4 Collect information from disabled persons themselves regarding the problems they encounter. Emphasis here is on the study subjects' perspectives.

1.3.5 Study the rehabilitation service system in the region.

1.3.6 Recommend social policies, plans, and programmes based upon the findings.

1.4 PURPOSE OF THE STUDY

This section examines who the anticipated users of the study data might be, and to what purpose(s) its findings might be put.

Usually, research is conducted primarily for two main groups, namely the sponsors and users of data. Sometimes these might not be the same. By way of example, the First and Second Carnegie Inquiries into poverty and development in Southern Africa in the 1930's and 1980's respectively, had different sponsor(s) and users. The former was an American tycoon, called Carnegie; the latter the South African Government.

Kearl (1976) suggested several users of research findings. First, policy makers who may want to know about development trends, the nature of particular social and economic problems, and the effectiveness of government programmes. Second, development planners and other change agents who may need demographic details and those of target areas. Third, international donors who frequently commission studies to evaluate programmes that they have sponsored, or simply to explore an area that is of interest to them. Fourth, pressure groups who may seek information to support their case for particular policy positions and actions. Fifth, citizen groups who may need data on population segments they are concerned with. Sixth, researchers, either in the investigator's own or related fields. Seventh, and finally, students to whom research may have instructional benefits (Kearl (1976)) in Bulmer & Warwick (1983:28).

This study is primarily aimed at policy makers, social work practitioners, and administrators in Bophuthatswana. Secondarily it is aimed at students and other researchers who may be interested in the field of disability, particularly rural disability.

None of the envisaged users sponsored the project. The University of Bophuthatswana was the sponsor in the sense that it provided me with some financial assistance towards the

costs of the research and provided supervision in my role as research student.

As mentioned already, the study is envisaged for policy makers, practitioners in the region, and administrators at the main office of the State Department of Health and Social Services. My assumption here is that policy makers do not have scientific data that may be used as the bases for formulating relevant policies, and in the allocation of resources to the disabled.

Where, social work practitioners and administrators are concerned, they might have observed some problems endured by sufferers, but they might not have been able to subject their observations to scientific investigations. Their observations could thus not have served as reliable bases for formulating relevant policies and plans. Data collected in this study, will, hopefully serve this purpose. In other words, the study might serve as a blueprint for social welfare planning.

This project, because of its potential utility, is classifiable as "applied research". Bailey (1982:21) says of this research type that it generates findings that can be applied to solve social problems of immediate concern. Its converse is the so-called "pure or basic research" which involves developing and testing theories and hypotheses that are intellectually interesting to the investigator and might thus have some application in future, but have no application to social problems in the present time (Bailey, Ibid).

Examples of pure research topics that can be drawn from this project might for instance include "Effects of Disablement upon Family Functioning"; "Attitudes of Rural People towards Disability and its Victims"; and "Reactions of Victims towards Traumatic disablement".

1.5 DEFINITION OF CONCEPTS

1.5.1 DISABILITY

The term disability which basically means "to be less able" or "to be disadvantaged in carrying out some activities of daily living" (Blaxter, 1976 is defined differently depending upon the user's purposes and orientation.

Blaxter (Ibid) has identified four different uses (definitions) of the term. These are the administrative, medical, and self-definitions, and disability as deviance (Blaxter, 1976:3-15).

Administrative definitions are used within the various social security Acts, and those that determine the allocation of work-related benefits.

Another group of users of administrative definitions would be educationists and administrators in education. A disabled person within this usage would be anyone who is incapable of learning in a normal or ordinary situation. People with severe physical handicaps, or intellectual, hearing, visual, neurological and learning disabilities (dyslexia) would fall within this definition.

Administrative definitions are generally based on medical assessments.

Medical definitions are assessments by a medical authority on the nature and extent of impairment and its resultant disability.

Within this definition would fall people who are not disfigured but whose medical conditions are such that they are handicapped in carrying out some functions (especially of an economic nature). Asthma, arthritis, tuberculosis, and cardiac sufferers would fall within this definition.

Self-definitions refer to a victim's subjective experience. His lowered self-esteem, damaged ego, the reality of his body being different and regarded by himself and others as such, his feelings of loneliness, rejection etc, are the results of his interaction with physical and social environments. This experience is so unique to him that it cannot be shared with other disabled, let alone the able-bodied.

Two overtly disabled persons, who, to an ordinary observer might seem to be experiencing the same problems, might in fact be living in diverse experiential worlds, for the simple reason that each one of them transacts with the outside world differently, as determined by his unique personality make-up, the social and physical supports available to him, the nature and degree of his handicap, and the culture of his group and his society. Implicit here are the idiosyncracies of disablement.

Perhaps Kathy Jagoe, a paraplegic, was making reference to this subjective dimension of disability when she addressed academics, professionals, and fellow disabled at a National Symposium on Disablement held in Bloemfontein in October 1986.

She stated that the able-bodied professionals who profess to serve the disabled lack experiential

insight into disability and disfiguration. Hence the services they render tend to satisfy professional aspirations rather than the needs of sufferers.

Jagoe's views are supported in the statements of some able-bodied authors. Scott, for instance, suggested that professionals working with victims of stigmatising conditions (poverty, disability, mental retardation, epilepsy) possess preconceived ideas on these conditions, and that these ideas are mainly derived from their learned theories. (In other words they are not experientially based). As a result, services rendered by them are primarily geared towards meeting their own expectations rather than the needs of those served.

Disability as deviance is the fourth and last definition by Blaxter.

This usage refers to the conception of disabled persons as a deviant group. Deviancy here means to be outside the "normal" range as determined by the able-bodied and also by the disabled themselves. And such abnormalcy is derived mainly from being in possession of some stigmatising condition.

Deviants are generally relegated inferior social status. They are also treated in preconceived ways which are basically negative. They are often rejected, socially isolated, and denied opportunities.

If such deviants are disabled, they play the "disabled" or "sick roles" as expected by the able-bodied. In fact, as Scott says, stigmatised persons are socialised into roles of deviants by the able-bodied, specifically

by professionals who purport to serve them. To quote him verbatim:

> "Some clients internalise these expectations into their self-concepts; others simply play the part their counselor expects them to play only because they want to matriculate through the programme as quickly and as efficiently as possible" (Scott in Boswell and Windgrove, 1984:110).

What Blaxter and Scott say is very much in order. How many of us would miss noticing a passing cripple? Why do we ogle a paraplegic struggling out of a driver's seat into his wheelchair? Or a woman with a heavy limp pushing a pram?

These and other examples indicate that society has created a little obscure corner of the world which it imagines to be solely for occupation by the disabled.

Now coming back to Blaxter's four definitions: One can work out varying prevalence figures of disablement according to each of them, i.e the able-bodied but medically ill persons, the disfigured but able-bodied, the able-bodied and non-disfigured who encounter learning problems, those who experience themselves as disabled, those who do not feel disabled but are labelled abnormal. If all are counted separately, a diversity of prevalence and incidence statistics would emerge.

In order to circumvent this probability, the researcher selected for study, from this spectrum of disabilities and their victims, people who are

impaired and disabled in a perceptible manner. More is to be said on this later on.

What the researcher has done so far is to describe disability from various perspectives without defining in precise terms what the concept is to be taken to mean in the present study.

In the section that follows, a definition of the concept will be given. To make it clearer, this will be done in relation to associated terms, namely, impairment and handicap.

1.5.2 IMPAIRMENT

'Impairment' refers to a loss, injury, or deformation of a physical organ or structure of the body. It can can be sensory, physical, mental and intellectual.

Sensory impairments have to do with loss or injury of the senses, leading to sensory disabilities (blindness, hearing pathology, speech defects). Physical impairments refer to removal of bodily organs or limbs of the body, either through trauma, or surgical intervention. They also refer to malformation of limbs or organs due to illness, accident, or congenital factors. Physical impairments lead to motor disabilities which include inability to walk, to sit, to grasp, to stand, etc.

Mental impairments lead to mental retardation and other forms of intellectual disabilities (including learning disabilities, inability to comprehend, etc).

UNIBO LIBRARY

Focus in this dissertation is on impairment of a physical and perceptible nature. Impairments of a sensory, mental, and intellectual nature will basically be excluded although, where necessary, reference to them will be made.

1.5.3 DISABILITY

The term disability refers to a functional limitation or restriction that results from impairment. Inability to see, to hear, or to speak as a result of sensory impairments; inability to walk or grasp caused by physical impairments; inability to comprehend as a result of intellectual and mental impairments; are typical examples of disabilities.

This dissertation focuses primarily upon people who suffer from moving disabilities, and those who may be disfigured but not disabled. The latter will include sufferers like dwarfs, and hunchbacks. These people are malformed but they retain their functional abilities. They are however included here because, in general, they are classified under the rubric of cripples or physically disabled persons.

The concepts disability and impairment, though closely related, do not always have a causal relationship. A person may be "impaired" in the sense of being malformed but may not suffer any functional restrictions. I have already cited the examples of dwarfs and hunchbacks. Similarly, a leg-amputee who is fitted with a prothesis (artificial limb) might suffer little or no motor restriction where for instance his job or hobby is concerned.

What functional limitation or restriction a victim may experience depends much upon the limb or organ that is impaired. For example, a woman who undergoes mastectomy will not suffer any functional loss (except of course if she is breast feeding), but she may be disfigured. She can however compensate for her loss by the use of a prothesis. On the other hand, a person who loses the use of both legs will suffer severe functional restrictions. Both will inevitably suffer social handicaps.

1.5.4 SOCIAL HANDICAP can be regarded as a behavioural consequence of disability since it affects a subject's capacity to play a personally acceptable role.

A blind person may not be able to drive; a deaf person to use a telephone or operate a switchboard; a leg-amputee fitted with an artificial leg may not be a ballet dancer or take part in athletics. Similarly a wheelchaired person may not be able to use public transport.

Social handicap emerges at the point at which an impaired and disabled person interacts with or (seeks to interact with) the social world outside himself. Some (but very few) impaired people who are also disabled suffer no social handicap. They develop compensating strengths which result in their being able to ignore the social disadvantages that afflict others similarly disabled who lack money, family support, education, and determination.

Franklin Roosevelt is a typical example. He was a paraplegic as a result of polio and yet was the

President of the United States of America for a period of 10 years. His political activities were apparently not curtailed by his disability; some might say they even gained from it.

Roosevelt and his kind are certainly not numerous. They are exceptional, since in general disablement tends to impair its victims in performing social roles.

Social handicap is thus an idiosyncratic experience that is determined by numerous factors, including the nature and degree of impairment and disability.

Handicaps are many and varied. The British Association of Social Workers' inventory of handicapping factors includes environmental (housing, transport, access to public buildings); societal (attitudes within society towards a given disability); availability of resources (e.g financial, aids to living, various support services); personality; family relationships; life style (e.g loss of a finger will be more handicapping to a violinist than to a singer). (Butrym and Horder, 1983:170).

A closely related concept to social handicap is social stigma. A stigma is a personal attribute that disqualifies someone from full social acceptance. By its nature it is socially and also personally less desirable. Erving Goffman describes a stigmatized person aptly as one with a 'spoiled identity'.

Goffman suggests three different types of stigma. First, there are the abominations of the physical deformities. Second, character disorders (mental

illness, imprisonment, a dependency on public welfare). Third, those that are associated with race, religion and colour. (Gokhale, International Social Work, Volume 28 of 1985, Pages 31-39). These various forms of stigma may not be mutually exclusive, but may combine in one person, making him doubly or triply stigmatised.

While physical handicap which may be sensory, physiological and mental,is a reality arising out of the hard facts of being impaired and disabled, social stigma is an imputation by normal people upon those they regard as 'imperfect' in one respect are 'imperfect' in all others. A blind man will be credited with less intelligence than he in fact possesses, etc.

Stigma has its origin in the model constructed by society of what is considered normal or perfect. Any person perceived to be deviating from this model invariably falls into a stigmatised category.

Stigma becomes obvious when disfigured persons are denied opportunities they may be capable of using despite their limitations. A leg amputee, for example, with a reasonable level of education might not be appointed to a job which he might be quite capable of performing.

The concepts impairment, disability, social handicap and social stigma, are the principal sources of problems encountered by disabled persons.

1.5.5 BOPHUTHATSWANA AND THE MOLOPO REGION

South Africa is divided into the so-called "white-designated areas" and "homelands," sometimes called Bantustans or National States.

The former comprise mainly the towns, larger metropolitan centres, and white farming areas.

The latter comprise the bulk of the rural and arid portions of the country. In fact, within the context of South Africa, the so-called rural areas are the "homelands". And they comprise the Third-World face of the country.

The political origin of "homelands" dates as far back as the 1950's when Dr Verwoerd, the then Prime Minister of South Africa, introduced the so-called 'Bantustan policy' and promulgated the Bantu Self-Government Act of 1959. Through this policy decision and the Act, all "Native Reserves" were consolidated into nine homelands, each representing a particular ethnic group (Mabetoa, 1982:18).

Today there are ten such territories. Four are "politically independent" of South Africa. The remaining six are still politically regarded as part of the Republic of South Africa, albeit they have their own administrative machinery.

The bulk of the African population of South Africa live in these areas. In fact, all Africans are regarded as the de jure and de facto citizens of "homelands".

In 1986 the Institute of Race Relations estimated that, of the 28 million Africans in the country, 22 million live in "homelands", leaving only 6 million in white areas, and a small percentage in white farming areas (The SAIRR Survey 1985 (1986:260). It is however important to ask what the SAIRR means by "live." Very many Africans might technically be said (in terms of law and policy) to "live" in homelands, but they spend most of their lives working in towns and cities.

As mentioned already, "homelands" comprise the rural and underdeveloped face of South Africa. Major characteristics of underdevelopment are found here. These include high birth rates, high rates of infant mortality and morbidity, low life expectancy rates, poor health, poor social and physical infrastructures and underdeveloped social services (See Chapter 4). All these are both effects and causes of poverty.

Poverty and underdevelopment within National States have been clearly documented in the reports of the Second Carnegie Inquiry into Poverty and Development in South Africa in 1982-1984.

This is not to say that National States do not have relatively urban and developed patches. They do have such, but these are proportionately small when compared with the vast underdeveloped rural hinterlands. In fact, the so-called towns within National States are nothing more than administrative centres, which can rightly be referred to as 'development towns'.

The present project was undertaken in one of these National States, namely, Bophuthatswana. This

territory consists of seven discontinuous land areas that are divided into twelve magisterial regions lying on the South African plateaux without direct access to the sea (see Appendix A). The total land area is 40,330 km (Chris Van Rensburg Publications (1977:26). The total estimated population is approximately 2,5 million Batswana.

The twelve regions that comprise the 'country' of Bophuthatswana adjoin the Transvaal, Orange Free State, the Cape Province, and the independent counry of Botswana.

Bophuthatswana has a predominantly agrarian economy. As the modernization theory of underdevelopment postulates, such economies predispose countries towards poverty. But Bophuthatswana has been spared this fate (of poverty, especially of an extensive nature) by the rich mineral deposits found in one of its regions, and also by the fact that some of its regions are adjacent to the larger metropolitan centres of South Africa.

Regions that lie far from the mine areas and the metropolitan centres are truly rural and under-developed.

The Molopo Region, the context of this study, is one of the twelve regions. It has a vast and underdeveloped zone which comprises approximately 67 villages, and a very small developed and urban patch in and around the capital (i.e. Mmabatho/Mafikeng).

The reader will note that emphasis in this discussion and in the whole dissertation is placed on the rural zone of the region. The reason is that the bulk of the

subjects studied (approximately 97%) were drawn from this zone.

In this dissertation, therefore, the Molopo region is potrayed as a deprived and underdeveloped area, without much reference to its smaller developed patch.

1.5.6 SOCIAL POLICY

Social policy is a very difficult term to define. This difficulty emanates from its ambiguous component terms, Social and Policy. It is my belief that splitting these key terms is the only way of simplifying the definition of the concept.

The term Social

The many interpretations and uses of the term make it difficult to conceptualise. Conyers recognised this difficulty and identified five uses of the term in his elaborate work on Social Planning.

What he mentions first is 'social' as associated with entertainment or leisure. Second, he sees 'social', as an antonym of individual, suggesting a group of people, and as associated with society and community. From this usage emerge concepts such as social good, social welfare, social benefit etc. Third, he mentions concern or involvement with people as opposed to things, for example, social relations, or interactions amongst people instead of things. Fourth, he views 'social' as an antonym of economic, e.g social development instead of economic development. Fifth, he speaks of 'social' as meaning something to which people have intrinsic rights (Conyers, 1986:5).

In this dissertation the term will be used as an adjective derived from the noun society, and will therefore come to mean 'having to do with life in society, and with intra-societal relationships amongst individuals, groups, and society as a whole' (Gil, 1973;13).

The term Policy

Gil defines policy as guiding principles or courses of action adopted and pursued by societies and governments as well as various groups or units within societies, such as political parties, other interest groups, business firms and corporations, labour unions and professional associations, formal and informal voluntary organizations, religious and ethnic groups, geographic entities, family and kinship groups, etc. He further suggests that individuals too may hold, promote, and pursue some specific policies.

Policies govern or are intended to govern specified domains of a society other than the one which they are primarily concerned with (Gil, 1973:12).

Pierce, like Gil, sees policy as a guiding principle which is more or less formalised and adhered to by all units of society from the smallest to the largest, the smallest being an individual, and largest the Goverment as a collective entity. In between there are family, small group, and organizational policies.

Pierce further suggests that policies set parameters on the behaviour of those who adhere to them. (Pierce, 1984).

If we combine the terms policy and society, a derivative "social policy" emerges. This refers basically to guiding principles or courses of action in dealing with society. Since the Government is the largest social unit that has the mandate to formulate guidelines or policies that have reference to the society as a whole, social policy then presupposes Government action.

But, as Hill points out, it is not necessarily the whole government as a collective unit that formulates social policies. It can also be groups and individuals with judiciary and legislative powers, and who are recognised by other societal members as having such authority to formulate societal policies. Hanekom for instance identifies the following policy-making bodies:-

> "Commissions of Inquiry;
> Departmental and Interdepartmental Committees;
> Staff units and domestic institutions;
> Select Committees
> The Cabinet (or members of the Cabinet);
> The Cabinet Committees;
> The Caucus"
> Hanekom (1985:21).

As mentioned already, social policies are guiding principles or courses of action. The next question then is: What is the aim of Social Policy?

Social policies, depending upon the aims of their formulators, can be geared to meeting social needs, to solving social problems, to allocating social resources (in the form of social services), or to

leading society in a particular direction. These diverse aims led Hill to caution that social policies should not always be regarded as being welfare-oriented, since they are decisions made by people and as such are rooted in values, ideologies, beliefs, and philosophies, which may not necessarily be in concert with the welfare of people (Hill, 1980:4). On this score, he critices authors like T.H. Marshall, Elizabeth Huttman, and David Gil for associating social policy with welfare.

I concur with Hill on this point because I know of social policies that are basically discriminatory and oppressive to some population sectors. Such are the South African social policies which are based on the ideology of apartheid, being very oppressive especially to the African population of that country.

For my present purposes, I however regard social policy as aiming at the welfare of people because I am, for now, concerned with providing for the well-being of a disadvantaged population sector. Social Policy will here be seen as aiming at allocating national resources to the benefit of the disabled, meaning solving their problems and meeting their needs of a social nature.

Such allocation of resources, solution to problems, and gratification of needs is to be done through established social services and rehabilitation programmes.

In rounding up the discussion I wish to adopt Burns's and Marshall's definitions of social policy since both are welfare-oriented.

UNIBO LIBRARY

Eveline Burns views social policy as "the organised efforts of society to meet identifiable personal needs of, or social problems presented by, groups or individuals (Gil, 1973:5).

T.H. Marshall states that social policy is "taken to refer to the policy of governments with regard to action having a direct impact on the welfare of the citizens, by providing them with services or income. The central core consists, therefore, of social insurance, public (or national) assistance, the health and welfare services, and housing policy". (Gil, Ibid: 6).

As far as this dissertation is concerned then, the Government of Bophuthatswana will be expected to formulate policies covering all aspects of the rehabilitation of physically disabled persons, since they are presently non-existent in the country.

Such policies will not only end up being decisions but also as products in the sense that they have to be codified into pieces of legislation, or policy documents such as the British call a "White Paper".

Such policy documents should spell out clearly the following:-

- a description of the people to be served (WHO)
- the programmes or services to be offered (WHAT)
- the service delivery networks (HOW).

The documents should thus answer the questions who gets what, and how. Finally, policies thus formulated should be implemented in the form of well-patterned rehabilitation programmes and social welfare services.

1.6 THEORETICAL FRAMEWORK

This study interlocks two theories, namely the life model, (ecological perspective) and the dependency theory of underdevelopment.

The basic tenet of the life model is the transactions between the person and the environment.

The person, with his inherent and acquired attributes of self-identity, competence, autonomy, and human relatedness, transacts with the environment. (Germain & Gitterman in Turner) (1986:364).

The environment is conceptualised as being both physical and social, the physical environment being the built world and the world of nature. The social environment is the human environment of other people at many levels of organization, ranging from a dyadic relationship to society itself. (Germain & Gitterman, Ibid).

Depending upon the unique combination of both environmental qualities and those of the person, such transaction may either be adaptive or maladaptive.

The dependency theory explains deprivation (underdevelopment) or affluence of some world countries as against others; of areas within countries; and amongst social groups within a country. Deprivation and affluence within the theoretical orientation are perceived to be in a dialectic relationship, meaning development (or affluence) of the one leads to underdevelopment (or poverty) of the other.

The theory further presupposes an existence of an exploitative relationship between the rich or advanced nations and the poor

or backward ones. (Or such a relationship between the rich and poor within countries, or that between urban elite and the rural poor.) The theory is discussed in detail in Chapter 5 of this dissertation.

The basic ideas of the dependency theory are applicable to this dissertation. "Homelands" are conceived to have been impoverished in a bid to enrich the white-designated areas or urban centres in South Africa. Within homelands themselves, rural villages are exploited to benefit development towns. The disabled are denied resources or allocated insufficient resources, because these are devoted mainly to serving the needs of the able-bodied. Therefore there is a need to formulate social policies that are intentionally redistributive.

An attempt will be made here to relate Germain and Gittermans' concepts of 'person and environment' to this study. In other words, what sort of person and environment are we looking at within the context of this study?

We are looking primarily at a person with physical limitations (instead of psychological qualities of self-identity, autonomy, competence, human relatedness as proposed by proponents of the theory) in transaction with the environment that is deprived. Being deprived here means lack of physical and social resources that may be crucial to enhancing living circumstances. Such resources as may be crucial include transport facilities and other communication systems, proper or adapted housing, plumbing and electricity, job opportunities, medical and health care services, social welfare services, general and special schooling facilities, and appropriate technology. All these are essential to rehabilitation of disabled persons, and also to their convenience.

Because of the dual flaws of the person and environment discussed here, problems of sufferers are exacerbated. In Germain and Gittermans' words, there is an absence of "goodness-of-fit" between the person and the environment.

NOTES

1. Bailey, K.D. (1982). Methods of Social Research (2nd ed). New York: The Free Press.

2. Butrym, Z. & Horder, J. (1983). Health, Doctors, and Social Workers. London & Boston : Routledge & Kegan Paul.

3. Conyers, D. (1986). Introduction to Social Planning in the Third World. Chichester & New York: Wiley & Sons.

4. Gil, D. (1973). Unravelling Social Policy. Cambridge, Massachusetts: Schenkman.

5. Goffman, E. (1965). Asylums. Essays on the Social Situations of Mental Patients and Other Inmates. New York: Doubleday & Co.

6. Gokhale, G.S. "Dynamics of Attitude Change". International Social Work 1985, Volume 28, Pages 31-39.

7. Germain, C.B. & Gitterman, A. "The Life Model Approach to Social Work Practice Revisited" in Turner, F.J. (ed) (1986). Social Work Treatment. Interlocking Theoretical Approaches (3rd ed). New York: The Free Press.

8. Cox, F.M. et al. (1987). Macro-Practice. Strategies of Community Organization (4th ed). Itasca, Illinois : F.E. Peacock.

9. Hill, M. (1980). Understanding Social Policy. Oxford : Blackwell & Robertson.

10. Huttman, E. (1980). Introduction to Social Policy. New York, London: McGraw-Hill Book Company.

11. Kearl (1976) cited by Bulmer, M. & Warwick, D.P. (1983). Social Research in Developing Countries. Surveys & Censuses in the Third World. Chichester & New York: Wiley & Sons.

12. Kahn, A.J. (1979). Theory & Practice of Social Planning. New York: Russell Sage Foundation.

13. Mabetoa, M.M. "A Comparison of Welfare Provision for African Children in South Africa with that for Children in Britain. M.A. Dissertation, Keele University, Great Britain, 1982.

14. Pierce, D. (1984). Policy for the Social Work Practitioner. New York: Longman.

15. Republic of Bophuthatswana. Chris Van Rensburg Publications, Johannesburg, 1977.

16. The South African Institute of Race Relations (SAIRR) 1985. Johannesburg, 1986.

17. Scott, R.A. "The Construction of Conceptions of Stigma by Professional Experts". in Boswell, D.M. & Windgrove, J.N. (ed) 1974. The Handicapped Person in the Community. A Reader & Sourcebook. London: Tavistock & the Open University Press.

18. Hanekom, S.X. (1985). Public Policy. Framework and Instrument For Action. Johannesburg: Macmillan.

CHAPTER 2

DESCRIPTION OF THE MOLOPO REGION AS AN AREA WHERE THE PRESENT STUDY WAS UNDERTAKEN

This Chapter discusses the area in which the study was undertaken, covering its historical emergence, and its physical, demographic, and economic profiles. In addition, some of its "Third-World" features such as escalating rates of urbanization, chronic unemployment, underdeveloped social services are touched upon.

The area in question, prior to the creation of the state of Bophuthatswana, was a rural part of South Africa situated in the North-Western Cape. When Bophuthatswana came into existence in the late 1960's the area was ceded to the new self-governing "homeland", and it became one of Bophuthatswana's regions. The territory remains predominantly rural and underdeveloped, but its degree of rurality has been moderated by the development efforts that have taken place in and around the town of Mafikeng. These have been accelerated after Bophuthatswana's independence in 1977, when the capital town of Mmabatho was created, contiguous with Mafikeng, the two making one conurbation. It became the focus of all development efforts, virtually to the neglect of all the villages that comprise the rural face of the region. The bulk of the subjects of the present study were drawn from these villages.

The rural-urban inequalities mentioned by Lipton as common in all developing countries also exist in the Molopo region (Lipton in Midgley, 1982:58), with the Mmabatho-Mafikeng areas as the centrefold of all development efforts. Some real life indication of this urban bias can be observed in the lack of resources and services (such as tarred roads, electricity supply, pure water supply, adequate sanitation, health services, education, and welfare services) in rural villages in the Molopo region.

Since in Third-World settings the above services and resources are publicly provided (through undeveloped social policies), coupled with the fact that there are no prospects for intervention by the private sector, such services will persistently be lacking or inadequate. As it is right now, environmental and individual deprivations are facts of life in the villages of the Molopo region, and are likely to remain so unless policy-makers have a dramatic change of heart, of which to date there has been no sign.

The neglect of rural development implied here has serious consequences for the disabled studied in this dissertation. For, in the final analysis, they are deprived of environmental supports that are essential to minimizing their physical handicaps.

A detailed discussion of the area follows.

2.1 Topography

The Molopo region consists of approximately 46,000 hectares of land. Much of the region can be said to be part of the Kalahari desert with its sandy surface. It ranges in elevation between 1 000-2 000 meters. The climate is suitable for livestock and (where water is available) for crop production.

2.2 Demographics

Population Size and Spatial Distribution

The population is approximately 170,000 (as by the 1985 Census records). Fifty five percent (55%) live in the town areas as a result of urban migration, which is estimated to be at the rate of 32% p.a. (quoted from the Report of the Conference on the Economic Development of the Molopo Region, drawn by the BNDC in 1987).

The rural population has been reduced by the process of urbanization. Official figures stand now at approximately 2,600 persons per village. Household sizes are relatively small, and official estimates are 4,76 persons per household, which is lower than the country's average of 5,23 (BNDC Report, 1987).

The bulk of the rural population is mainly comprised of the "economically unproductive" or the dependent sections (viz the aged, disabled, sick, and children). The economically productive i.e. the younger people, the able-bodied and the relatively skilled have emigrated to towns in search of employment.

Age Distribution

Like most developing areas, the Molopo region has a relatively high population growth rate, estimated to be about 8% p.a. (as in 1987), the tempo being higher in town areas as a result of migration.

The age distribution assumes the pattern indicated in Table 1.

TABLE 1

AGE DISTRIBUTION OF THE POPULATION IN THE MOLOPO REGION

Age in Years	Percent
0 - 14	41.0
15 - 64	55.0
65+	4.0
All age groups	100.0

Source: The Report of the Conference on the Economic Development of the Molopo Region, drawn by the BNDC in 1987.

Table 1 indicates more than two-fifths of the population under the age of 15, a fact which points to the high birth rates that characterise all developing nations. This reality causes high dependency patterns, which are estimated to be at the rate of 435 per 100 working persons in the Molopo region. (The BNDC Report of 1987).

The small proportion of the aged population (4%) indicated in Table 1 points to low life expectancy rates in the region. But recent findings by the Epidemiology Section of the Department of Health and Social Services (Bophuthatswana) show an increase in the age group 65 and over. This may be caused by various factors, amongst others the immigration of retirees from some parts of South Africa (especially migrant workers) and people resettled in the region. Improved health services, that prolong longevity, might also have contributed.

The Infant Mortality Rates

These are presumably high in the region, although no figures are available in support of this assumption.

2.3 Economic Details

2.3.1 Employing Sectors

As the Molopo region is predominantly agricultural, one would expect agricultural produce, and industries connected therewith, to dominate the economic scene. But, as in most Third World settings, agriculture is of a subsistence nature. It has no growth potential and there is no exportable surplus. As a result, it does not contribute to growth of the economy and the expansion of the labour market.

The major employer in the region is the Social and Community Services (in the public and quasi-public sectors). These account for 50% of employment in the region, with construction and wholesale and retail accounting for 14 and 13 percent respectively.

The Small Business Industry is also a significant feature of the economy of the region. Very little can be said about this relatively new development because of lack of details.

Lastly, domestic service is another informal sector employment. It is often disregarded in official documents, but ironically it is very significant as it absorbs the majority of the unskilled womenfolk.

Domestic Service as a type of employment is associated with somewhat exaggerated income inequalities common in some countries of the world. Midgley (1987:28) says that this employment institution has disappeared in developed nations as a result of narrowed disparities in income structures. In South Africa and in Bophuthatswana, the institution is still very much in vogue and is the major job provider. The Molopo region of Bophuthatswana is no exception. The rising black elite are the major employers of domestic helpers.

2.3.2 Employment - Unemployment Situation

Shortage of manufacturing industries accentuate urban unemployment while the predominance of subsistence farming accentuates rural unemployment. In both urban and rural sections of the region, unemployment is chronic and under-employment rife.

The Department of Economic Affairs (Bophuthatswana) indicated in 1987 that approximately 70% of the labour force in the region is

UNIBO LIBRARY

without jobs. The larger proportion of this percentage consists of the unskilled and the uneducated. The skilled and educated are absorbed by the growing public and quasi-public services. On this score, the Molopo region is in line with what prevails in most "homelands", as revealed in the findings of the Second Carnegie Commission.

The skilled manpower that is available in the region is significantly less than that which is needed.

This reality caused the Bophuthatswana Government to deploy expatriates to perform the many tasks occasioned by development. These (expatriates) are concentrated in Mmabatho, inducing in it a cosmopolitan outlook.

2.3.3 Income Sources

Simkins (1984:5) documented some income sources that he claimed are basic to all homelands in South Africa.

These are:

- transfer payments (old age pensions, blind person's pensions, disability grants, etc)

- remittances, notably from husbands to wives; from unmarried sons and daughters to parents; and from parents in support of children left with kin

- subsistence agricultural production and earnings of people employed within homelands.

The Molopo region is very much in line with convention as regards sources of income.

Transfer payments are the major sources of income. In Bophuthatswana's official records they are categorised as follows:

Type 0 Old Age Pensions
Type 1 - Blind Persons' Pensions
Type 4 - Disability Grants
Type 6 - Ex-soldiers (Veterans)
Type 8 - Leprosy Patients
The Social Pensions Act (18/1978)

According to the Social Pensions records of 1987, approximately 152,000 people received social security pensions of all categories country-wide. But the breakdown of figures by category and by region was not available. Presumably figures for social pension recipients are equally high in the Molopo region as seen from the massive agglomeration of people at pension pay-out centres. Incidentally, these were the centres the researcher used to trace my study subjects.

Remittances from migratory labour is another major source of income for homeland dwellers. The high incidence of cross-border movements of migrants and commuters between South Africa and "homelands" is a clear indication of the fact that migratory labour is the major source of income for homelands. The figures for migrants from all homelands into South Africa, for the year 1984, was estimated to be 1,2 million. Migrants accounted for 800,000, and frontier commuters about 447,000 (The Race Relations Survey 1985 (1986:145). Figures for Bophuthatswana in the same year were about 237,000 (privately communicated).

Recent figures show an increase in migratory labour. The 1986 December figures for the whole of Bophuthatswana were estimated

to be in the region of 261,368 (privately communicated information).

South African "homelands" are economically non-viable and as a result they lack the potential for economic growth that will enable them to absorb their rapidly increasing labour forces. Migrant employment will continue to be a significant aspect in the employment scenario.

Implicit in the migratory labour situation considered here is the interdependence of employment in South Africa and "homelands". This means that unemployment in South African cities spills over into homelands. Hence the chronic unemployment in the Molopo region should be viewed against the background of what prevails in the South African cities.

Subsistence agricultural production and employment within homelands are the last two in Simkin's categorization of income sources.

Subsistence agricultural production is an informal sector-economic activity, and cannot, therefore, be expected to make a good impact as a source of income for the Molopo inhabitants. Moreover, because of its very nature (use of primitive technology) it has little growth potential.

Employment, as a source of income in the Molopo region has already being discussed. For now the researcher needs to mention the income structure in the region. Table 2 gives details of the income structure. Notably this information is adopted from the Report drawn by the BNDC in 1987. And the information is not accurate.

TABLE 2

INCOME STRUCTURE

FROM EMPLOYMENT IN THE MOLOPO REGION

Income in Rands per month	Percentage of the total Population in employment
50 - 999	86.0
1000 - 1 999	6.0
2000 - 5 999	5.0
6000+	3.0
All Income Brackets	100.0

Source: Adapted from the Report on the Economic Development of the Molopo Region compiled by the Bophuthatswana National Development Corporation (BNDC) in 1987.

2.4 Urbanisation in the Molopo Region

The rate of urbanization in the region is estimated to be about 32% p.a. It assumes the form of migratory labour and the migration of children of school going ages into towns. The latter leave rural homes to live with relatives so that they are able to attend primary and secondary schools because they, are in short supply in their own areas. Whatever form it takes, migration deprives the rural sections of manpower potential for rural development.

In the Molopo region, urban migration has led to the rise of temporary homes called 'Meraka'. What happens here is that people move to town areas in search of jobs, but return to rural homes during some specific periods of the year (such as farming seasons or when they are on holiday) to check on their livestock and farms. In other words, to them the 'Meraka' are work and investment homes.

Urbanization in general has its inherent problems like the creation of squatter areas and unemployment. Squatter villages also exist in the region. To name a few: Dibate, Mothlabeng, Lonely Park, and Ramosadi. Some of my respondents were drawn from these villages.

Squatter areas in the region are characterised in general by poor living conditions, such as informal housing, communal water taps, lack of electricity supply, and generalised impoverishment. When one moves along the Mangope Highway in Mmabatho, the distinction between the urban elite and the urban poor is glaringly obvious. On the one side of the road one sees urban affluence reflected through modern housing structures, and on the other hand the rural urban poor, also obvious from the traditional or informal type of housing structures. Since housing is a work-related benefit, it means that those who live on the fringes of the town suffer from chronic unemployment or their employment carries insufficient financial remuneration to enable them to afford better homes.

2.5 Housing

As implied in the discussion above, modern type of homes are occupied mainly by the urban elite in Mmabatho and Mafikeng areas. But as one drifts further into the periphery, informal or traditional type of structures increase. These, by their very nature, reflect some degree of impoverishment prevailing amongst inhabitants.

This is however not to assume that 'traditional' or 'informal' homes exist exclusively in rural areas and in the fringes of towns, and *vice versa* for modern homes. This assumption would otherwise deny the existence of dual societies within the region. As a matter of fact, rich and poor co-exist in the Molopo area, and so do modern and trational homes.

In the rural hinterland the shopkeeper, the small-scale farmer with modern equipment, the tribal leader who owns a large homestead, represent the affluent according to local standards.

Rural dwelling structures, in addition to their sub-standard quality, lack logical arrangement. Houses are unnumbered. Even where they are, the numbering is not sequential, and streets are not named. Addresses are, as a result, non-specific. The difficulties the researcher encountered in tracing my respondents as mentioned in Chapter Three of this dissertation were related to this environmental reality.

2.6 Social Services (Education, Health and Welfare)

Social services (education, health, welfare) in Bophuthatswana fall within the domain of public policy. Privately provided services are found, albeit to a lesser extent.

These services have distinctive features. They are underdeveloped and urban-based. Their underdevelopment is related to country-wide poverty. Poor countries lack a good taxation base necessary to fund social policies. Bophuthatswana is no exception.

The urban bias in providing these services causes personnel and facilities to be concentrated more in town areas and less in rural areas. And as the World Bank suggests, this tendency is accentuated by the Government's fiscal and economic policies that favour urban development to a neglect of rural development. (World Bank in Midgely and Hardiman, 1982:183)

With this statement as a point of departure, the author proceeds to give details on the provision of social services in the Molopo region.

2.6.1 Education Services

Education resources in the region are in short supply, and are concentrated in urban areas where the powerful and elite live. The weaker and dependent rural inhabitants do not have access to such resources.

Tables 3, 4, and 5 indicate the position of schooling facilities in the Molopo region. Table 6 illustrates literacy and education levels.

TABLE 3

PRIMARY SCHOOLING FACILITIES IN THE MOLOPO REGION VIS-A-VIS THOSE OF THE WHOLE COUNTRY

Primary Schools

	Molopo	Countrywide	Molopo:Country proportion percent
Number of schools	65	96	7,25
" " teachers	851	353	9,90
" " classrooms	645	539	8,50
Total pupil enrolment in 1986	26 608	617	8,40

Source: Republic of Bophuthatswana, Department of Education Annual Report, 1986.

TABLE 4

SECONDARY SCHOOLING FACILITIES IN MOLOPO VIS-A-VIS THOSE OF THE WHOLE COUNTRY

	Molopo	Countrywide	Molopo: Country Proportion percent
Number of schools	24	365	6,5
Number of teachers	466	4628	8,8
Number of classrooms	31	3282	8,5
Pupil enrolments in 1986	13 434	141,553 149,815	8,36

Source: Republic of Bophuthatswana, Department of Education Annual Report 1986.

TABLE 5

TEACHER-PUPIL RATIOS IN PRIMARY AND SECONDARY SCHOOLS IN MOLOPO

School Type	Number of Teachers	Number of Pupils	Teacher-Pupil ratio
Primary	851	29 608	1:35
Secondary	406	13 434	1:33

Source: Annual Report, Department of Education, Bophuthatswana, (1986)

Tables 4 and 5 show that facilities for education in the Molopo region are proportionately smaller than those for the whole country. This finding suggests regional inequalities in the distribution of educational resources. But since these figures cannot be matched by those for other regions, as the latter are not available, it is hard to draw such conclusions from the two tables alone.

The teacher-pupil ratios indicated in Tables 4 and 5 are on the whole the average for Bophuthatswana as a whole, and counter the commonly held belief that teachers are in short supply in the region. But as Peil (in Bulmer & Warwick, (1983) suggests, official statistics in Third-World countries are always unreliable. There is also a chance here that these ratios may be inaccurate.

In fact, from the author's personal observation, facilities for schooling, including the proportion of teachers in relation to students, are insufficient. Real life evidence of this shortage could be discerned from the persistent rush for accommodation in primary and secondary schools in the beginning of each school year.

Shortage of schooling facilities, has a sequel in the low literacy levels prevalent amongst the people of the Molopo region. Table 6 illustrates these.

TABLE 6

LITERACY AND EDUCATION LEVELS IN THE MOLOPO REGION

Category	% of the population
No schooling	44,5
Primary schooling only	40,5
Secondary schooling only	14,3
Post-secondary schooling	00,7
All categories	100,0

Source: The Report on the Economic Development of the Molopo area drawn by the Bophuthatswana National Development copy 1987.

Figures in Table 6 indicate a high rate of illiteracy and semi-education prevalent amongst people in the region, since approximately 44,5% of the population never attended school, while those who dropped out at the primary level comprise a further 40,5% of the population. Less than one percent were educated beyond secondary school level. The high rates of illiteracy and semi-education in the Molopo region put it on par with many settings of the Third World.

Facilities for special education in the region are also in short supply, and this has been noted by the Second Education Commission of 1985/86.

There is only one Special School, namely that for the mentally retarded, in the whole region. Facilities for the other categories of disabilities (namely, the deaf, the dumb, the blind, and the physically handicapped) are found in regions other than the Molopo region. This means that persons with these disabilities who live in the Molopo region have no school facilities that take their disabilities into account. It can therefore be expected that the rate of illiteracy and semi-illiteracy will be high amongst them.

The distribution of educational resources in the Molopo region show an urban bias. Of all the 65 primary schools in the region, the majority are found in the town areas and within its 5 kilometer radius; the distribution of high school facilities show a similar tendency. Twenty of the 24 secondary schools are located in town areas and within villages adjacent to them. Like the World Bank (Hardiman & Midgley, 1982:80) suggests, Government policies in Third World countries reinforce this urban bias. This is also the case with the Bophuthatswana Government's policy regarding the provision of social services, including schooling facilities. The policy states that social services are rendered on a partnership basis with the community. This policy is not implemented impartially between rural and urban areas. In the latter, Government provides schools and facilities. But in the former, people are expected to build schools themselves, and the Government will assist them after their initial efforts. This is done under the guise of community development. This State-community partnership policy is inappropriate because it takes away Government responsibilities in areas where the need is great. Shortage of schools in rural villages of the Molopo region should be seen against these policy inadequacies.

2.6.2 Health Services

Health resources are reflected in Table 7

TABLE 7

HEALTH RESOURCES IN THE MOLOPO REGION IN 1986

Type of Health Resource	Private	State	All
Doctors	25a	19	44
Nurses	-		607a
Paramedics b	-	-	392a
Hospitals	1	1	2
Clinics	-	-	37c

Notes to Table 7.

a - approximate figures
b - including social workers
c - 24 clinics are mobile

The health resources listed in Table 7 are mainly concentrated in town areas, not in rural villages.

The Molopo region has two hospitals, one private and the other public.

Bophelong is a Government hospital and medical services are offered at a cost affordable by all. Above all, it is the largest hospital in the country to date, and sometimes serves as a specialist hospital for some rural hospitals in the regions, and also for the 13 rural clinics in the region.

UNIBO LIBRARY

Although the country's largest hospital, it lacks special technology, specialist personnel, and other facilities usually available in large hospitals. As a result, it relies heavily upon larger hospitals in South Africa, (particularly Baragwanath and GaRankuwa hospitals) for specialist technology and manpower.

Victoria Hospital was in the past mainly for whites, but has now been privatised and it is at present a relatively expensive clinic. It has no racial bar, but its costs are prohibitive for people such as those covered by my study.

Bophelong Hospital (as in 1986) had a total of 19 doctors who served 1082 patients' beds, making up a doctor-patient ratio of 1:56. These figures do not reflect the severity of the shortage of doctors, which is obvious from the daily masses of out-patients who crowd the hospital corridors.

In addition to doctors, there are 607 nurses and 392 paramedicals. Approximately 4 social workers are based within the hospital but also serve clients who are outside the hospital walls.

There are 13 static and 24 mobile clinics. The latter serve as substitutes for the former.

Almost all private doctors are located in towns.The principal determining factor in their choice of area is probably a reliable market for their services, found in towns but not in the country areas. Rural areas are characterized by extensive poverty. The poor cannot afford costs for private health and medical care. One may therefore conclude that it is not only fears of

professional isolation and lack of social and intellectual stimulation which drive personnel (including private doctors) away from the rural hinterland, as suggested by Spencer (1980:93). It is a combination of these factors and a lack of a market.

Spencer's suggestions could perhaps be valid for doctors, nurses, and social workers who are employed by the Government, who have no market to lose by being placed in rural areas.

In addition to private doctors, hospitals too are located within town areas: Bophelong is situated in Mafikeng. Within the same vicinity there are four (4) clinics, while the remaining nine (9) are distributed throughout the 67 villages in such a way that a cluster of villages are serviced by one clinic. This set-up implies that some villages have limited or no access to the facility. With transport facilities being so inadequate in rural villages, one can well imagine the scale of the problem. Complaints from some of the researcher's respondents about health facilities and services being inaccessible are justifiable. Moreover, in their case, physical handicaps combine with inadequate transport facilities to make health resources even more inaccessible.

Attempts to reach out to populations in rural villages are made in a service delivery pattern, similar to what Johnson (1980:86) refers to as the circuit-riding model. A team of health professionals (including social workers) from Bophelong Hospital visit rural areas on a scheduled arrangement. Their visiting point is normally a static clinic; or, where none exists, a local leader's

home, a church, or school. By way of preparing for visits, a visiting programme is supplied to the host so that the latter informs the consumer public about the visiting days. This arrangement has its own limitations, but it does bring the needed services to people.

2.6.3 Welfare Services

A full Chapter will be devoted to the discussion of social welfare services in the whole of Bophuthatswana, with particular reference to services for disabled persons. Here the author needs to mention that informal welfare activities, especially to disabled persons and other disadvantaged groups, are still in vogue among rural populations. Other traditional social structures still perform their traditional role of caring for the disabled, sick, and old persons. Institutional care is less acceptable, and moreover institutions do not exist in these areas. Even if they did exist, they are not regarded as wholly acceptable, since they entail a separation of the sufferer from his familiar home environment.

The intimate face-to-face relationships that Toennies refers to as "Gemeinschaft" (Milson, 1974:7) are still current amongst rural inhabitants, and are the bases upon which these informal welfare activities are laid.

"Gemeinschaft" however is no more an absolute quality. It has been modified by the modernizing forces that infiltrate the rural hinterland. Winds of social change are certainly blowing across these zones. And their sources are the developmental activities that take place in and around the capital town of Mmabatho.

NOTES

1. Bophuthatswana National Development Corporation Report on The Economic Development of the Molopo Area. 1987.

2. Bophuthatswana 1985 Census Records. Published by the Department of Economic Affairs, Statistics Division. 1986.

3. Hardiman, M. and Midgley, J. (1985) The Social Dimensions of Underdevelopment. Social Planning in the Third World. London: Wiley & Sons.

4. Report of the National Symposium on Disablement compiled by the Co-ordinating Committee : Year of Disabled Persons, 1987. Department of Health and Population Development: South Africa.

5. Willensky, H.L., & Lebeaux, C.N. (1958). Industrial Society and Social Welfare. New York: Russel Sage Foundation.

6. Simkins, C., (1984) What Has Been Happening to Income Distribution and Poverty in the Homelands? Carnegie Conference Paper, No.7. Cape Town.

7. The South African Institute of Race Relations. Race Relations Survey 1985 Johannesburg: 1986.

8. Lancaster-Gaye,L. (1972) Personal Relationships, The Handicapped and the Community. Some European Thoughts and Solutions. London & Boston: Routledge and Kegan Paul.

9. Republic of Bophuthatswana. Department of Education Annual Report. 1986.

10. Spencer, I.W.F. (1980) Community Health, An Introductory Orientation for South African Students. Pietermaritzburg: Shuter & Shooter.

11. Bophuthatswana Department of Health and Social Welfare. Annual Report, 1985.

12. Johnson, H.W. (1980). Rural Human Services. A Book of Readings. Itasca, Illinois: Peacock.

13. Milson, I (1974): An Introduction to Community Work. London. Routledge & Kegan Paul.

CHAPTER 3

METHODOLOGY

This Chapter introduces the research design adopted for this study. Aspects of this design to be discussed include delineating the universe, constructing the sampling frame, sampling, and collecting and analysing the data. The study's limitations will also be discussed.

The reader is reminded that this study was undertaken in a Third-World setting, as described in Chapter 2; such contextual realities largely determined its course. Sometimes deviation from established principles and norms of research became unavoidable, especially because of the nature of the problem being addressed, and the environmental situation of study subjects.

3.1 THE RESEARCH DESIGN

A research design is a plan of how a study is to be conducted. It includes making decisions on the universe, the sample and sampling strategies, methods of collecting data from the selected sources, strategies for measuring, counting or classifying the data, and methods for analysing the data (Polansky, 1978:38). Simply stated, a research design is the entire process which begins with identification of a research problem and is concluded by analysis of the data relating to such a problem, and reporting upon the analysis.

If one peruses research literature, one is often struck by the many documented ways of categorizing research designs. Castle (1987) attempted to put together various designs and their users: Gay (1976) is reported to classify designs by purpose

and by method. When talking about purpose she differentiates between applied and basic research. When discussing method she identifies the historical, the descriptive, the correlational, and the causal aspects, and experimental methods.

Fox (1969) is reported to classify by method and came up with the historical approach, the survey approach, and the experimental approach.

Babbie (1979), unlike Gay & Fox, is said not to be classifying. Instead, he is said to be identifying the purposes of research (viz. exploration, description, explanation), and discusses sampling, measurement, and data collection techniques.

Wilson (1985) describes several typologies, including the basic-applied classification and discusses a set of types of nursing studies classified according to methods.

Polit & Hungler (1983) differentiate between experiments/quasi experiments and non-experimental approaches, and include survey and evaluation research, needs assessment, historical research, case studies, secondary analysis, and methodological research as additional types of research (Castle, 1987:58).

Polansky (1975:61-62) suggests a five-point typology of exploratory, descriptive, explanatory, panel (longitudinal) and experimental designs.

Polansky further suggests that these typologies are not absolute, but are points on a continuum in the sense that a particular study may begin by being exploratory and develop into descriptive after some substantial knowledge on the phenomenon studied, will have been gained. Still, a study might be somewhere in between two designs. For example, it might be an exploratory-descriptive study.

Grinnell's typology for Social Work research is a three-point one consisting of exploratory, descriptive, and explanatory designs. According to him, each one of these designs provides a different knowledge-level, the lowest being the one derived from exploratory designs, since at this level very little knowledge, or none at all, would be existing on the phenomenon under study. (Grinnell, 1987:227).

Amidst this array of designs how does one make a selection? Some authors suggest that a researcher should be guided by factors such as the problem at hand, subjects to be studied, and the level of knowledge existent on the problem under surveillance.

Similarly the problem at hand (rural disability), subjects to be studied (rurally-based cripples), and knowledge level (no basic empirical knowledge) led the researcher to select the exploratory design, although in due course the project will become descriptive, as it will describe the services and problems experienced by the respondents.

Very little, if any, empirical knowledge is available on the societal context of physically disabled persons in the Molopo region. Rural disability in Bophuthatswana and other National States has to the reseacher's knowledge been very little researched.

The first known study in Bophuthatswana is the one by Cornelje & Cornelje in Mareetsane Village in the Ditsobotla region in 1986 (details of the study are given in Chapters 4 & 5). This study was undertaken by physiotherapists whose primary aim was to seek out strategies for physical rehabilitation.

McLaren's study in Kwa-Zulu in 1986 was the first of its kind in the area. It had aims similar to those of Cornelje & Cornelje. The researcher was also a physiotherapist.

Majake's study in Lebowa in 1986 is also, to my knowledge, the first in that area. Hers was both sociological and social work-oriented since she examined community attitudes towards the disabled, and studied social services and their inadequacies.

These studies, although they differ in respect of focal areas and professional orientations, have one thing in common, namely that they represent significant pioneering efforts in a problem area that is largely unexplored. It is therefore hoped that they will introduce an epoch of research into rural disability.

As mentioned already, this study is exploratory and, like many others, it should form a basis for further studies some of which could be of a higher level. The researcher has identified here further topics for researching. To name a few: "Effects of Disability upon Employment", "Practical Daily Life Problems of Physically Disabled Persons in Deprived Settings", "housing needs for rurally-based disabled persons", "Social Policy for the Disabled in the Third World", "Interfaces between Environmental Deprivation and Disability".

3.2 THE UNIVERSE AND THE SAMPLE

The universe of this study consists of physically disabled and disfigured persons, or "cripples" as they are commonly, and sometimes perjoratively called.

Their deformities and disabilities are caused by amputation or deformation of limbs as a result of either surgical intervention, trauma, illness, or congenital factors.

Paraplegics, hemiplegics, quadriplegics, limb amputees, cerebral palsied persons, persons with abnormal gaits (the stepping gait, the Parkinson gait), osteriotic sufferers, dwarfs, and hunchbacks, are included in the study.

Reasons for isolating this subset from the comprehensive set of "the disabled" have included limited resources of time, manpower, and money available to me as the researcher.

The age range of persons in the universe is 16-70 years. It was assumed that such persons would be chronologically mature enough to be able to contribute meaningfully to the project by bringing in their perspectives on their problems. Younger persons presumably would still be in the care of adults, be it relatives or parents. Whatever perspectives they would bring forth would most likely reflect those of their carers.

In addition to the criterion of assumed maturity, there is also the legal and administrative definition of "adult" in South Africa and in Bophuthatswana. In both countries a person of age of 16 and over is considered an adult: he qualifies to possess an identity book, to enter the job market, and is eligible for certain social securities (especially disability grants) if he meets criteria laid down for such eligibility. He is also ineligible for the benefits and services that are specified for children. By way of example, Maintenance Grants given to parents and destitute children in terms of the Children's Act No.33 of 1960 (the now amended Child Care Act of 1983) are discontinued as soon as the children concerned attain the age of 16, irrespective of their circumstances.

Furthermore items on the interview schedule, such as questions on employment, housing, practical daily living, or family relationships, would be more meaningful and pertinent to the selected age category than they would be to younger age groups.

Having delineated the universe, the researcher's next step is to describe measures taken to construct the sampling frame.

3.3 CONSTRUCTING THE SAMPLING FRAME

A sampling frame, according to Murthy & Roy (Bulmer & Warwick, 1983:109), is an enumeration of all sampling units in a population or universe along with their identification particulars (addresses, location particulars, and boundaries).

These authors divide sampling frames into two broader categories, namely, list frames (e.g a list of factories, disabled persons, villages etc.) and area or map frames (e.g a village map showing boundaries of plots).

This study had two list sampling frames, namely villages and townships in the region (estimated to be about 70) and a list of disabled persons.

The list of villages was obtained from the now-dismantled State department of Lands and Rural Development, and that of townships from Municipal records.

The list of villages thus obtained was useful to a certain extent and useless in another. On the useful end it gave an idea of the numerical distribution of villages in the area, while on the useless one it failed to provide the researcher with much-needed details of households and their occupants. Had these particulars been available, the researcher would have had some indication of the geographical distribution of the would-be respondents.

Following the suggestion of Peil et al, that sampling frames may sometimes be constructed from official records (Peil et al, 1982), the researcher looked around for State departments that dealt in one way or the other with the disabled. These were those of Health and Social Welfare (welfare records), Internal Affairs (pension records), Economic Affairs - Statistics Division

UNIBO LIBRARY

(Census records). These records, as will be shown later, fell short of meeting the researcher's needs.

3.3.1 Welfare Records of the State Department of Health and Social Welfare

The Welfare Administration Division of this Department (Main Office) and social workers at the operational level are linked in serving the disabled.

Social Workers at agency operational levels in various regions receive demands for services directly from clients. These demands may be for services of a material or non-material nature. Most of these demands, particularly for material assistance, are forwarded to the Main Office in Mmabatho for further attention. This bureaucratic procedure is caused by an absence of decentralised planning in Bophuthatswana. Planning activities (programme development, resource allocation, staffing etc) are done at the Main Office or at the so-called societal or national level. No local (regional) level planning is done. And, as critics of national level planning say, it falls short of realistically meeting the needs of people, especially at "grass-roots". These critics include Conyers (1986), Lauffer (1978), Cox et al (1987).

The Main Office and social workers were visited in the expectation that they might be in possession of organized data on the disabled who had once requested their services or who were still receiving them. But, as it turned out to be, such data were not available.

Reasons for this unavailability are many but are based primarily on the fragmented and unco-ordinated

nature of services rendered to disabled persons by agency workers and those at the main office, including hospital and clinic-based rehabilitation personnel.

Seemingly, absence of a statistical unit in the Department of Health and Social Welfare exacerbated the inadequacies of documentation. Had it been present, such a unit could have served to collate all statistics relating to services rendered to disabled persons by various organizations at operational and administrative levels. Maintenance of a register of disabled persons would have been possible.

Absence of a data bank seems to be related to the wider problem of under-developed public services in Bophuthatswana. Presumably, this is a universal deficiency in all developing countries. Such a deficiency has been commented upon by some authors. Rimmer, for instance, speaking of difficulties in research in developing countries, said that "researchers would have to be remarkably insensitive to the problems of research if they did not at some stage question the accuracy and reliability of the official figures they use either as fundamental data or as a frame of reference", (Rimmer, in Peil et al, 1982:46).

In a similar way, records of the State Department of Health and Social Welfare were so inadequate that the researcher could not use them in constructing the sampling frame.

3.3.2 Pension Records of the State department of Health and Social Welfare

Difficulties of using these records for constructing the sampling frame were two-fold, namely, access to

records, and the varying definition of the concept "disabled person" as used in these records and as used by the researcher.

Established bureaucratic procedures for gaining access to official Government records are normally rigid. For instance, securing permission of the State Department Secretariat was the first and foremost pre-condition. For such a request for permission to be considered, the researcher was expected to obtain a supporting letter from her University supervisor. Such a letter should contain details such as the rationale for the study, the envisaged use, its nature, etc. Although the researcher's supervisor would have provided such a letter, the researcher foresaw a long time before it would be answered, and the answer might have raised further questions. The researcher adopted instead a strategy of getting round the bureaucratic jargon by using personal acquaintances she had made within the pension section during her days as a professional practitioner. In this way, she gained limited access to records.

The few files she managed to get hold of helped her to determine whether these were going to be useful or not for her purposes. The researcher looked at things such as the types of disability, and the addresses recorded in each file. She will comment later on the former, but at this juncture she needs to point out that addresses on the files were not complete. Only the name of village where the applicant lives was indicated. This might have been due to the fact that the villages are haphazardly arranged, so that streets are not named and houses not numbered. Specific addresses, such as in townships, are virtually impossible to give.

As for the definitions of the disabled as used on the records, they differed significantly from the one used by me. A disabled person for social security purposes is "anyone who has attained the age of sixteen, and is owing to physical and mental disability unfit to obtain from any service, employment, or profession, the means needed to enable him to provide adequately for his maintenance" (The Social Pensions Act, 18/1978, Bophuthatswana Government Gazette No. 55, Volume 7 of 16/1/78). This definition is wide enough to include epileptics, mental patients, the blind, the deaf and deaf-mutes, the cripples, and people who suffer from chronic or acute medical conditions (such as asthma, tuberculosis, hypertension, heart disease etc). All but one of these categories (viz. cripples) are excluded from my study.

Pension records, therefore, operated on a typology that varied considerably from mine. This typology is as follows:-

Type 0 - the elderly
Type 2 - the blind
Type 4 - the disabled
Type 6 - ex-soldiers
Type 8 - leprosy patients.

Type 4, 'the disabled', was the category similar to the one the researcher studied. But, as explained already, it included many other categories which she excluded from her definition. As a result, a prevalence figure she could have drawn from these records would certainly have been inappropriate for her purposes.

Pension records thus did not prove pertinent to her purpose in constructing a sampling frame.

3.3.3 Census Records of the Division of Statistics, Department of Economic Affairs

A census is a count of the total population. Bulmer and Warwick (1983:29) say of it that it is the most comprehensive type of a research exercise, and in terms of representativeness it is almost perfect

Censuses collect data on demographic, economic, and social variables. The researcher approached these records anticipating to get information on disabled persons, with particular reference to details such as categories, ages, location, or any details as would be pertinent to constructing the sampling frame.

Fortunately, the census records (of 1985 in particular) came closer to what the researcher wanted most. She derived useful details such as the prevalence figure of the disabled, their distribution by categories and by regions. But the snag was that the classification included those types of disabilities which she excluded from my study. These were the epileptics, the seriously and less seriously mentally ill, the blind, and the deaf and dumb.

The category "cripples", which also formed part of the classification used in the census, numbered about 629, if all age groups (0-70+) were counted. There were 561 in the age category (of 16-70) which is the category the researcher had decided upon, and this comprised her universe. But, useful as they were, these records did not in any way indicate where the 561 people were located within the region. Could this perhaps be an

error in recording? Certainly no, because the manner in which data are recorded is determined by the purposes of the user. Censuses are primarily conducted for Government policy makers and administrators, who tend to be more interested in trends than in specifics such as location of the people who are counted.

The next step was to invent ways of locating all or part of the 561 people. Or, in case the researcher failed in this venture, to draw up a new sampling frame from those that she would successfully trace. These ways became interviews with local or "grassroots" leaders, and visits to pension pay-out centres. As it were, these strategies would be dually purposeful, that is, for listing the study units and locating them.

3.3.4 Interviews with Local Leaders

Local leaders here refer to village-based authorities known in Bophuthatswana as headmen, ward leaders, or chiefs. Their authoritative positions presumably enable them to possess considerable knowledge of their communities. It was this presumption that made the researcher to approach them, anticipating that they might be helpful in identifying village-based cripples. But, as it turned out, her expectations were not met by them. The researcher speculate that the reasons for this are that they do not keep registers of their community members.

To say that all local leaders did not know their communities would however be an unfair generalization. Some of them know their communities in general, and in particular know disabled persons within such communities. Such leaders were so few that the researcher decided not to pursue this strategy any further. She then

turned to visiting pension pay-out centres as the alternative.

3.3.5 Visits to Pension Pay-Out Centres

Payment of pension benefits in Bophuthatswana is done on a scheduled basis at specific centres which may be churches, schools, or tribal offices. Details of dates and venues are usually indicated on a document called a pension itinerary (See Appendix B).

A particular centre usually serves more than one village, a factor which makes it possible for masses of people to congregate at a common point. The researcher visited these centres, assuming that disabled persons themselves, or otherwise their relatives, would be present to collect disability grants.

Before the researcher embarked upon the visits, she obtained a pension itinerary from the pension office (at a lower level). This initial contact with pension-paying officers enabled her to establish a working relationship that was to pay off later on, especially at the various pay centres.

As the researcher was no more a stranger to paying officers, it became easier for them to introduce her and her envisaged project to the masses. This turned out to have significant consequences as it led the people to associate her with paying officers, and hence with the Government.

As villagers in this region tend to be favourably disposed towards the Government, their co-operation was not hard to get. But this blessing was not without

disadvantages: It tended to raise expectations about the outcome of the project, because the Government and its extension staff are perceived (by villagers) to be the carriers of "manna from heaven". Presumably, this perception was brought forth by their previous experiences, which included the drought relief programme through which indigent people, country-wide, were supplied with food stuffs during the dry years of the early eighties.

In order to prevent expectations being raised on the anticipated outcome of the project, the researcher explained its purpose in explicit terms: To collect data that were to be used for future planning rather than for immediate implementation.

After introducing the project and its aim, disabled people were requested to submit names and addresses. Particulars of those who were at home, but whose relatives had come in their stead, were also obtained. Co-operation in this venture was good.

After visiting all pension pay-out centres, the researcher was able to list 245 potential subjects. But, as will be shown later, not all of them fitted her definition of study subjects.

A follow-up of some of them was made as part of the second pilot study to ascertain whether information given to her was accurate. The first pilot study was made at the initial stages of the project when she was testing the data collection apparatus.

3.4 SAMPLING

The listed 245 persons constituted the sampling frame. Constructing this sampling frame was among the most difficult phases of the research process, mainly because of the unknown locations of study units. Seemingly, sampling difficulty is not unique to Bophuthatswana, but is common in most Third- World settings. Observations of some authors are cited here in support of this notion.

Zarkovick in Bulmer & Warwick (1983:102) write about difficulties of sampling work in the Third World. Central to these difficulties, according to him, are insufficient (or complete lack of) resources (manpower, transportation, funds), inaccurate official statistics, and sizes of samples. In recognising the scale of the problem, the author concludes by saying that "designing sample surveys becomes more a study of limitations and their sampling implication than an exercise of principles and type of work leading to an optimum design in developing countries". (Zarkovick, in Bulmer & Warwick 1983:102).

Peil makes similar observations on difficulties inherent in sampling work in underdeveloped areas, but with particular reference to using some probability sampling procedures. She comments that" the standard approach to sampling suggests that random, stratified, or quota samples can be drawn by following certain principles. This assumes knowledge of the population being studied, which is often possible in developed countries where regular censuses of population, households, schools, and businesses provide detailed information on various aspects of society. But in many countries such statistics are rudimentary, out of date, or unavailable" (Peil in Bulmer & Warwick, 1983:79). To support her statement (of statistics being inadequate in some Third-World countries) she cites the example of the Nigerian 1980 population estimates which varied between 60-120 million.

The researcher tends to agree with Peil's observations on the difficulties in using certain types of samples, especially representative ones. But she also thinks that much depends upon subjects studied. For instance, if one were to study "married couples" one would encounter less difficulty in drawing representative samples because of the relative accessibility of subjects. In any household approached in an area, there is ample chance of meeting a married couple. But more difficulties are expected in studying rarer subjects such as the disabled. It is not uncommon for a location to have no disabled person at all.

Under such conditions, how would one use, say, stratified random sampling, cluster, or systematic sampling?

For reasons given above, probability sampling in this study was difficult to implement. Use of non-probability sampling became the inevitable alternative. Some authors, such as Williamson et al and Grinnell, consider the use of non-probability sampling justifiable in some instances, and for certain types of studies.

Williamson et al (1985:105) regard this type of sampling as being preferable for exploratory studies where focus is on the generation of theory and research ideas and also for observational and qualitative research studies.

Grinnell (1988:251) thinks along same lines. He states that non-probability sampling is also employable in exploratory studies where interest is primarily on obtaining unique data on research questions and where probability sampling would be costly.

For reasons similar to those expressed by these authors, non-probability sampling was appropriate for the current study. First, it is exploratory. Very little is known of the societal context of disabled persons in the Molopo region. As far as I know, they have never been studied. Second, probability sampling

would have been costly in terms of resources because of the logistical realities of the study.

The non-probability sampling technique selected for the current study is designated differently by various authors. Grinnell (Ibid:253) refers to it as "Availability sampling", Williamson et al (1985:105) as "Accidental or Incidental sampling", Bailey (1982:205) as "Convenience Sampling".

The principal consideration in this sampling technique is availability of the sample. The first available units are met and interviewed. In this study, the first of the 245 listed and traced persons were interviewed. These numbered 105, but only 60 of them fell within the researcher's definition of a study unit. As mentioned already, logistical realities made it difficult for the researcher to trace more than the number indicated above (105).

Had it not been for these difficulties and barriers, the researcher might have successfully traced the 245 listed persons. If these had fitted her definition of "disabled persons", it would mean that she would have interviewed the total universe, which is also possible, according to some authors. In such a case then the use of the term "sample" would have been inappropriate. As it is, the researcher believes that the way her respondents were actually selected does not justify the use of the term "sample". The reason is that the term has acquired a technical sense in social science literature where it generally indicates a selection from a universe according to some systematic method.

3.5 FIELDWORK AND DATA COLLECTION

Fieldwork in this project was a two-fold activity. First, there was listing of subjects at the six pay-out centres in the region. Second, listed persons were traced for purposes of interviewing.

UNIBO LIBRARY

Ideally, these activities could have been done simultaneously, but the tone or mood at pay-out centres rendered it too difficult. People were excited about pension money, and about meeting each other, and might have resented being interviewed on such an occasion. Under conditions of such extreme excitement and crowdiness could interviews, which need serenity, have been fruitful? Certainly no. Hence interviewing had to be held in abeyance until the time and the situation were appropriate.

Listing and tracing of would-be respondents covered a period of approximately 18-20 months, from January 1986 until August 1987. The first 12 months (January 1986 - December 1986) were devoted primarily to listing, while the remaining months (January 1987 - August 1987) were used for tracing and interviewing.

The reader should note that the two events (listing and interviewing) were not as mutually exclusive as they have been made out to be in the preceding statement because in between them the researcher did try to locate the listed persons, and interviewed some of them, to test the feasibility of her strategy.

For the once, she will dwell on two aspects of her field work viz. village entry and introduction to respondents. Later the interviewing process per se will be discussed.

3.5.1 Village entry

> Herschfield et al and Hurch-Cesar (Bulmer and Warwick, 1983:241) suggest that anyone who contemplates village entry at one stage or another should have a well-constructed plan. Such a plan should contain the following specifics:-
>
> (i) the order in which the interviewer is to contact the leaders

(ii) the type of leaders to be sought, for example, "chiefs, village headmen, elders, patrons, civic influentials, school teachers, priests, herbalists, shrine keepers, and major farmers"

(iii) instructions on how to identify prominent local leaders who occupy no readily identifiable formal leadership role, for example school principals.

In the researcher's opinion, a well-constructed plan would be a prerequisite for those whose experience with village work is limited or altogether lacking. Since the researcher did not fall into any of these categories, a scheme such as the one described by Herschfield et al was not necessary. It would otherwise have been useful to her if she had had assistants whose experience of village work was scanty.

Using her relevant experience, in each village she made first contact with the local leader, be it a headman or chief.

Experience taught her that village leaders have tremendous influence over villagers, and care should always be taken not to antagonize them. Should this happen, one might as well forget about getting the co-operation of villagers.

To those leaders with whom the researcher was having first contact (meaning those who were not present at pay-out centres), her first task was to introduce the nature and purpose of the study and the people to be involved. To those with whom she was having second or third contacts she reiterated the purposes of her visits, after which permission to enter the village was granted.

Some leaders were so enthusiastic as to give the researcher local guides. Where no guides were given, she would find hers among villagers. Where such was the case, the researcher observed mixed reactions to her overtures: Some were openly curious, others suspicious, and others enthusiastically helpful.

The curious ones would direct the researcher to the household and would also attempt to stay for the interview in order to get some piece of news. Those with suspicion would refuse to point out the wanted household, or would simply deny any knowledge of the would-be respondent and his family in case she was going to cause trouble, with which they did not want to be associated.

In some villages a group of villagers would follow the researcher to a sought-after household.

Behaviours such as the above were tolerated by the researcher because, given the stillness of the village atmosphere, arrival of a stranger becomes the significant event of the day.

Upon entry into the study subject's home, the researcher would greet first, and engage in small talk in line with their customary practices. Thereafter she introduced herself and her mission again. To respondents whom the researcher had met already at pension pay-out centres it was a question of reiterating her purpose. Some indicated that they had been anxiously waiting for her call. The stage was then set for an interview.

3.5.2 THE INTERVIEW (Data Collection)

Data was collected from respondents through structured

personal interviews. They are called structured because they involve the use of a schedule which will be described later on.

Personal interviews were preferred above telephone interviews and postal questionnaires because of the contextual realities of the study and the subjects. Respondents lived in an area with no telephones. The few who lived in townships where telephones existed did not themselves own telephones. Because of these factors, telephonic surveys for data collection were out of the question.

Postal questionnaires would have been equally inappropriate. First, postal services in villages are underdeveloped. For instance there are no post offices in villages. Villagers depend upon privately-owned postal bags, or those owned by schools or churches. Those who lived in townships were reachable through the post. But they were not numerous, and the researcher also had to consider the question of uniformity in what she was doing.

Second, the bulk of the people in her "sample" were not literate enough to be able to read and interpret posted questionnaires.

Third, respondents were not used to being surveyed. The only similar experience they were likely to have had might have been with population censuses, which by their very nature also involve personal interviews, not postal surveys. Had posted questionnaires been used, they would have brought forth a poor response rate.

Using personal interviews had the following advantages and disadvantages, based on Grinnell's ideas (Grinnell 1982, pages 255-261).

3.3.2.1 Advantages of Personal Interviews in the Present Study

(a) Personal interviews provided access to serendipitous information, and observation of non-verbal messages especially on issues respondents found difficulty in expressing verbally, such as questions on personal relationships.

(b) Structured interviews were appropriate in dealing with illiterate people like my study subjects. They had to be guided in their thinking, especially to condense their thoughts to fit into items on the schedule.

(c) Interviews are spontaneous and natural. They tend to create a natural situation for exchange of information. For people who are not used to the complexities of responding to the type of inquiry the researcher's interview schedule represented, the personal presence of the researcher was assuring.

(d) The flexibility contained in personal interviews allowed the researcher to probe and frame items or questions to suit respondents' characteristics such as age, sex, ethnic grouping, intelligence,

and experience. By way of illustration: The question of marital status is sensitive to some unmarried female disabled persons. Instead of asking directly if the respondent was married or not, one would simply ask where the husband was. A question thus framed presupposes marriage. She would then respond by saying, "No, I am not married".

(e) Personal interviews allowed a high response rate, as the researcher interviewed and recorded at the same time. This would have been unlikely if postal questionnaires were used.

3.3.2.2 Disadvantages of Personal Interviews in the Present Study

(a) Interviews necessitate the use of research assistants which could not be used in this study.

The researcher was constrained by limited resources and the logistics of her project from employing assistants. The drawing of the sampling frame, and listing and tracing of subjects, were the most difficult aspects of the project. Any assistant whose primary motive was monetary gain, other than, say, a gain in research experience, would never have endured the effort.

(b) Domestic factors tended to make the climate unfavourable to interviewing.

Perspectives derived from literature on interviewing dictate that quietness and privacy are the essentials for effective interviewing. These were difficult to maintain with the study subjects and their circumstances. Firstly, the presence of the researcher (especially in villages) attracted the attention of neighbours, friends, and relatives, thus casting a spotlight on the would-be respondent and his family. Although the researcher did manage to exclude all such would-be spectators or participants from the interview, their initial presence and curiosity were disruptive to the respondents' minds, especially to those who valued privacy.

But on the other hand there were some respondents who did not favour the idea of excluding from the interview their closest friends and relatives, with whom confidences were usually shared.

(c) Family members, particularly those who were involved in the practical daily care of the respondent, insisted on attending the interview. They argued, that whatever decisions were to be taken by the respondent, they would any way be affected. Their argument was valid. But their presence caused responses on some items (especially those that had reference to the respondent's

relationships with those who cared for him) to be distorted.

(d) On the other hand there were those who were not willing to take decisions without them being sanctioned by whomsoever they perceived to be the sanctioning authority (father, mother, uncle, brother etc). This tendency seemed to suggest that the much-acclaimed Euro-West principle of "self-determination" was very little, if ever, prioritized by the study subjects.

As a result, presence of relatives in some interviews became an inconvenience to be tolerated by the researcher.

(e) Respondents and families tended to turn research interviews into therapeutic ones. Issues of delayed responses to applications for pensions, their insufficiency, their fluctuating amounts, delayed repairs to appliances, were not interpreted in relation to the information-seeking purpose of the research. On the contrary, respondents thought the issues were being raised in order for the researcher to do something helpful about them. This difficulty was realistically dealt with by making referrals to appropriate offices.

It should be remembered that most villagers in the region seldom, if ever, had any access to social service providers, and did not know where to direct their problems. Misinterpreting the purpose of the interview was natural in such circumstances.

(f) Respondents were almost impossible to reach due to unreliable addresses in villages. Those who were based in townships were easily traceable because of specific addresses and the presence of named streets and numbered houses.

(g) Finally, Grinnell asserts that personal interviews make it possible for respondents' names and addresses to be known, and thus they do not guarantee anonymity. This was not an issue as far as present respondents were concerned, because most rural people do not in general value privacy. Indeed, the success of "community" depends upon shared thought, experience, and information.

3.6 THE INTERVIEW SCHEDULE

The schedule contained eleven main items, each of them having several sub-items

Questions were of the open and close-ended type. Although the questions were formulated in English, communication was in Setswana. (See Appendix C).

3.7 DATA ANALYSIS AND INTERPRETATION

Data were classified, analysed, and presented through frequency tables, and percentages.

3.8 LIMITATIONS OF THE STUDY

(a) The "sample" was heterogeneous. Although the study subjects were all classifiable under the rubric "cripples", this did not necessarily mean that they were a homogenous group. They varied in terms of degrees of impairment and disability. Their experiences of handicap therefore differed. Present findings cannot be claimed to apply to all cases.

(b) The "sample" was not representative, therefore the findings cannot be generalised to all physically disabled in the region, or to those in other regions in Bophuthatswana. (This is a general problem in social science research because of the uniqueness of each human being.)

(c) The methods of constructing the sampling frame and tracing the study subjects were laborious and relatively. unproductive, as only 60 out of 245 were successfully traced. Perhaps a community forum in each village would have been a better alternative. Admittedly therefore, this was more of a learning experience on the researcher side than application of the methodological principles of survey work.

(d) The study was costly in terms of money, largely because of the inaccessibility of study subjects. Addresses in most villages were very difficult to locate. Land marks such as "next to a large blue-gum tree", "next to a thatched

house", or "next to a school yard" had often to be used as leads to particular homesteads.

Such slender leads were often ineffective. There were many times when the researcher travelled kilometers without tracing a single homestead.

UNIBO LIBRARY

NOTES

1. Bulmer, M & Warwick, D.P. (1983) Social Research in Developing Countries. Surveys and Censuses in the Third World. Chichester & New York: Wiley & Sons.

2. Castle, M.R. (1987) Primer of Nursing Research. London: W.B. Saunders.

3. Conyers, D. (1986) Introduction to Social Planning in the Third World. Chichester & New York: Wiley & Sons.

4. Cox, F.M. et al. (1987) Macro-Practice. Strategies of Community Organization. (4th ed). Itasca, Illinois: F.E. Peacock.

5. Grinnell, R.M. (1988) Social Work Research and Evaluation. (3rd ed). Itasca, Illinois: F.E. Peacock.

6. Herschfield, A.F. et al. & Hursh-Cesar, G. "Fieldwork in Rural Areas" in Bulmer & Warwick (Ibid,1) Pages 241-252.

7. Lauffer, A. (1978) Social Planning at the Community Level. englewood Cliffs, New Jersey: Prentice-Hall.

8. McLaren, M. "Prevalence of Motor Impairment and Disability in a Rural Community in Kwa-Zulu". Unpublished.

9. Murthy, M.N. & Roy, A.S. "The Development of the Sample Design of the Indian National Sample Survey during its First 25 Rounds" in Bulmer & Warwick, (Ibid,1) Pages 109-123.

10. Peil, M. et al. (1982) Social Science Research Methods. An African Handbook. London : Hoddes & Stoughton.

11. Polansky, N. (1980). Social Work Research. Methods For the Helping Professions. Chicago & London : the University of Chicago Press.

12. Rimmer, D. "Official Statistics" in Peil et al (Ibid, 10).

13. The Social Pensions Act of Bophuthatswana. Act 18/1978. Government Gazette No. 55, Volume 7 of 16/6/1978.

14. Zarkovick, S.S. "Some Problems of Sampling Work in Underdeveloped Countries" in Bulmer & Warwick, (Ibid, 1) Pages 101-108.

CHAPTER 4

4.1 THE PROBLEM OF DISABILITY

Disability has inherent problems that can be classified as psychological, practical, social, and economic.

Psychological problems refer to the disruptive effects of a given condition upon the personality of the sufferer. His self-esteem is affected, which in turn make it hard for him to relate to others in the social environment.

Practical problems refer to the victim's difficulties of going about practical daily activities. This implies his inability to care for himself and to manage himself. This handicap is basically a functional limitation which disrupts the sufferer's relationship with the physical world. It is what Germain and Gitterman (1980) refer to as the absence of a "goodness-of-fit" between the victim and the physical environment.

Social problems emerge when the victim's social functioning is impaired, i.e. when the victim encounters difficulties in performing social roles as expected of him by society, and also if he fails to relate to others in the social world. In this way, some of his very significant life domains become seriously affected. In this dissertation these will include employment, education, and economic life.

Disability-related problems considered here are intricately related: Psychological problems affect the victim's relationship with others, mainly by affecting his communication with them. Practical problems have the same effect, because they make the victim heavily dependent upon others for daily care, and because he might fail to meet social role expectations. His economic

life is just one of the many areas of life that is disrupted by a combination of practical, psychological, and social problems that inhere in disablement. Upon closer examination, all these problems converge at the victim's social arena for the simple reason that he is a social being.

4.2 THE PSYCHOLOGICAL CONSEQUENCES OF CRIPPLEHOOD

Schoenberg & Carr (1970:120) assert that the psychological response to disablement is related to an abstraction called the 'body image' which they define as a "convenient abstraction referring to how one experiences, differentiates and conceives of and perceives his body and its parts and to the relationship of this experience to reactions accompanying loss or change in the body".

The body-image then is any person's conception of himself as an integrated psychological and physical whole. This conception can be lost through partial or complete loss of an organ or part of the body. The feelings of incompleteness commonly experienced by disabled persons is a natural response to disruption of the body image.

When and how does this body image develop? Schoenberg & Carr (Ibid) suggest that the process sets in during infancy and childhood through contact with objects in the environment. By these tactile experiences, the child begins to differentiate what is part of him and what is not. In other words, he develops a self-identity. These authors further suggest that this self-concept in babyhood is always neutral. It assumes a qualitative dimension (good or bad) as the child interacts with significant others in the environment, particularly the mother, father, and siblings, normally in that order. Through this interaction the child acquires social precepts,

attitudes, and affects towards his body-image (Schoenbeg and Carr Ibid:121). Depending upon other's reflections, the body parts may be conceived as good or bad, pleasing or repulsive, clean or dirty, loved or disliked.

The significance of parent-child interaction in molding a child's self-perception is obvious here. Should anything go wrong in the process, his self-image will be affected, and the effects may become internalised in his personality. The likely result will be a child with behaviour problems. Bentovim (in Boswell & Windgrove, 1974:10) seemingly recognises the significance of the parent-child relationship in the development of the self-concept of a child. He suggests that the mother-child interaction in particular is a fundamental determinant of other social relationships. The dynamics of the process, according to him, is the perception of a mother as an object of love and satisfaction by the child. If the mother reciprocates negatively (by being rejecting, punitive, grieving, or depressed) she is experienced as a frustrating and discomforting figure from whom the child turns away. This reaction, according to Bentovim, destroys the fundamental basis of social relationships and also affects the person's self-esteem.

In the light of the above exposition, the development of the body image is a concomitant process of physical development that sets in post-natally. Thus disfiguration (through any causes, including amputation and deformity), certainly has a devastating effect upon the victim's self-image. More so if it happens in adult life. Schoenberg & Carr (1970) suggest that the impact of disablement is less adverse if it occurs at birth, or before the age of 6 or 7. This, in my opinion, is because children of these ages, especially when they are congenitally disabled, know no other life except that of being disfigured and disabled. An adult on the other hand has his

pre-morbid life to compare with. One can therefore imagine the intensity of the impact of disablement upon the victim's ego.

In addition to the age of onset and its effect upon the psychological reaction to disablement, is the victim's perception of the utility or value of the lost organ. By way of an example, an athlete values his fully functioning legs because they are tied to his economic and social life -- economic life if his sporting activities were his source of livelihood, and social life if his social identity was tied to his sporting activity. Loss of legs will certainly adversely affect his style of life, and also his quality of life. Psychological breakdown may sometimes be the outcome of such a loss.

The reactions of people to the victim and his condition may engender in him feelings of inferiority or superiority as dictated by cultural precepts. In our own Western-oriented society, where the 'body-beautiful' is highly prized, victims of disability and disfiguration are made to feel like monstrosities. In Korea and Afghanistan, as Scott states, the disabled and the maimed are believed to possess unusual culturally-valued abilities for which they are accorded a special and superior status. (Scott in Boswell & Windgrove, 1974:108).

When a sufferer is made to feel inferior, he normally reacts by withdrawing into his psychological shell, and may assume the 'disabled role' or 'sick role'.

4.3 THE SOCIAL CONSEQUENCES OF DISABILITY

As mentioned already, disability interpenetrates the victim's social life and disrupts his relationship with the social world. Since people relate on the basis of role performance,

the sufferer, because of his social and physical handicaps, is very often prevented from performing roles as expected of him by society. Herein lie the roots of his poor social relationships.

Social relationships that are likely to be disrupted by disablement include those of the family (husband-wife; parent-child; and with extended relatives who share a common household), and those of the larger society.

The extent to which these relationships may be impaired is determined by numerous factors which include the degree and nature of disability and handicap, and the social and cultural values that determine society's attitudes towards sufferers.

4.3.1 Disability and Family Relationships

Family relationships normally suffer in the presence of a disabled member because of the physical and economic burden he imposes upon the family.

The practical daily care he requires from the family may be physically burdensome to them. His lost capability to earn a living may make him wholly or partially dependent upon the family for livelihood. Less affluent families are likely to feel the strain of maintenance. When this happens, the family becomes handicapped as a totally functioning unit. Blaxter (1976) refers to this process as 'handicapping the normals'. Family handicap is determined by variables such as the degree of disablement, physical and financial resources available to the family to care for a disabled member, family strength and unity, and available manpower.

A family that has to care for a severely disabled member (e.g a quadraplegic) would find it difficult if they lack money, technology, and supportive devices and family supports which may cushion the stresses and strains occasioned by such care.

I would imagine nuclear families who lack resources to be doubly handicapped, and extended families to be less so. Sufferers who live alone, or with people who lack the capability to care for them (for example those who live with children or the aged) will experience particular problems.

What then are the dynamics of these processes of disrupting family relationships? In other words what actually happens between the victim and his family that affects their mutual relationships?

DYNAMICS OF A MARITAL RELATIONSHIP

A husband-wife relationship is ideally a resource for meeting the needs of love, intimacy, and companionship. Disability, especially if it is traumatic and extreme, may interfere with this relationship in two basic ways. First, it affects sexual performance (especially in cases of paraplegia and quadraplegia). Second, it causes communication breakdown because of the victim's psychological reactions to loss. Third, it disrupts role performance.

Sexual malperformance results from damage to sexual organs or organs that relate to the functioning of reproductive organs. Since sex is a basic element of a marital relationship, one can imagine the pervasive effects of sexual disruption on a marriage.

A person who suddenly or insidiously becomes disabled normally suffers from extreme feelings of loss and bereavement. He becomes depressed and may withdraw into a psychological shell which cuts or makes communication between him and his spouse difficult. In this way a fundamental breakdown of the marital relationship may result. Battye (Boswell & Windgrove, 1984:94), in his chapter titled 'The Chatterley Syndrome', relates a story of a man who became traumatically paraplegic. Prior to his affliction, he enjoyed a close relationship with his wife, which changed in a drastic manner thereafter. His post-morbid personality was so bad that it put a lot of stress on the marriage. His wife reacted by falling in love with their house servant. The new relationship became so strong that both eloped.

In this case example, sudden disability thwarted the husband's ability to meet his wife's needs of love and intimacy. This reality caused a wide rift in their relationship which culminated in desertion.

Disruption in marital-role performance is another source of difficulties in a marriage. A disabled spouse forfeits some ability to carry out familial roles as prescribed by society, leading to a situation where the unafflicted spouse is over-burdened with role responsibilities. Some such roles likely to be affected are connected with breadwinning, home management, and discipline of children.

Naturally, when disablement strikes there have to be some adjustments in the performance of familial roles. Most probably there will be role reversals and new role assumptions. Husband-father roles are likely to be

exchanged with those of wife-mother.

These adjustments may not be smooth processes. Failure to assume or to adapt to new roles and their contingent demands is frequent. For example, a wife who has never functioned as breadwinner may find it difficult to take up employment as a means of performing this role. Marital stress may often result as she ventilates her frustrations within her marriage.

While it might be considered normal that disablement will disrupt marital harmony, much still depend upon factors such as the couple's level of maturity, their pre-morbid relationship, economic resources, and social supports available to them.

THE DYNAMICS OF PARENT-CHILD RELATIONSHIPS AND DISABILITY

Children build up certain perceptions about their parents which they integrate into parent images -- 'father image' and 'mother image'. These perceptions are based upon their daily interactions with parents.

A father image represents attributes of strength, audacity, authority, protection, independence, and instrumental functioning. When disability strikes, these attributes fade away, as no person can remain stoic in the face of disablement. A previously strong father might become helpless, dependent, and invalidated. This new image may be less acceptable to his children. They may react to it in a negative way. Should their reaction be negative, their relationship with the father will become strained since

he would still be expecting them to behave the same way as they did prior to his affliction. Similarly, the children would still expect him to perform his father role as he did previously (e.g role of provider). If their expectations are not met, they become disillusioned in the father as a capable person.

Focus so far has been on a parent's disablement and its impact upon his/her relationship to the children. What would be the effect of a disabled child on family relationships?

Some authors suggest that a disabled child in the family triggers off feelings of a negative nature. McKeith (in Boswell and Windgrove, 1984:129) states that parents react through either ambivalence, bereavement, or embarrassment to the birth of a deformed child. Greenway and Harvey (in Laura, 1980:27) emphasise denial. It is also possible for all these feelings to be combined, for they are not mutually exclusive.

Ambivalence, according to McKeith, stems from the need to protect a helpless child, and a simultaneous revulsion at its deformities. The resultant behaviour may be rejection or over-protection of such a child.

Bereavement, as the author further suggests, results from loss of an idealized baby with which parents fell in love in utero. Since their actual baby would be an unwanted present, they confront a shattering experience. They undergo an emotional turmoil, characteristically of grief and bereavement, which are related to the loss of a 'normal baby'. These feelings are very often communicated either overtly or covertly

UNIBO LIBRARY

to the infant. In whatever form, these feelings will impede formation of a sound parent-child relationship.

Feelings of embarrassment, according to McKeith (Ibid), result from parents' anticipated responses of other people to their misfortune. They react by withdrawing from social contacts.

Greenway and Harvey, as mentioned already, suggest that parents (and indeed the whole society) may react by denial which may either be obvious or subtle. Obvious denial may take any one or all of the following forms: a parent may refuse to take the baby home from hospital, or he may refuse to acknowledge the presence of such a baby in the home leaving the other parent to attend to it.

Denial can also take subtler forms. A parent may not adhere to the rules for bringing up a disabled child, such as in the case where he disregards special dietary requirements in favour of those not recommended for such a child. Second, denial can take the form of euphemism in the way people talk about disablement. Quite often we hear people say 'he is just a normal little boy' when it is obvious that this is not really the case. Third, the whole way in which the environment has been designed may reflect denial. The disabled are seldom catered for appropriately (Greenway & Harvey in Laura, Ibid).

Author wishes to add feelings of guilt to the above list of emotional responses. Parents, particularly mothers, may be obsessed with feelings of guilt which emanate from imagined or sometimes actual contribution to the

child's deformity. A mother may begin to question her behaviour, her eating habits, or general life style during pregnancy. Self blame often results.

Birth of an abnormal child may not only prevent formation of normal parent-child relationships, but may affect, in an adverse manner, parents' relationship, especially if it was strained already. Such a birth then becomes the 'straw that breaks the camel's back'.

On the other hand, a previously healthy relationship may suffer in the event of a crisis of this magnitude. At critical times like these, coping mechanisms of parents may break down. They may blame each other and fail to offer the necessary support. In this way considerable stress is put on their marriage.

4.3.2 DISABILITY AND SOCIETAL RELATIONSHIPS

The relationship between the able-bodied society and the disabled is largely determined by the former's perceptions of the latter.

If the disabled are perceived to be deviant or abnormal, they are likely to be socially isolated and denied opportunities for self-realization and self-aggrandizement. But where such perceptions are positive, sufferers will be socially integrated into the world of the able-bodied. From some literature reviews and from common knowledge, perceptions may however be both positive and negative, resulting in similar attitudinal dispositions. Negative perceptions tend to be predominant. It should also be noted that attitudes differ from society to society, community to

community, social group to social group, and person to person. It is thus difficult to make universally valid generalisations.

As Safilios-Rothschild (in Shurka, International Social Work, Vol. 27, No. 1, 1984) says, attitudes are culturally determined. Some cultures regard the disabled as monstrosities, while others accept them as persons with some deficiencies.

Scott (Ibid:109), quoting from the Human Relations Area Files, says some societies, viz. Tibet, Burma, and Turkey regard disabled as outcasts and lesser human beings. Others, such as Korea and Afghanistan, regarded them as possessing 'unusual culturally-valued abilities for which they are accorded a special and superior status'.

Mba (International Social Work, Vol. XXVI, No. 1, 1985) reported positive attitudes amongst Nigerians. Majake (1986) observed a combination of both negative and positive attitudes amongst rural communities in Lebowa.

Smith and Shurka maintain that the significant social attitudes are those of leaders because these determine to a greater extent availability of social programmes for the disabled.

Smith (in Laura, 1980:17) holds the view that societies have certain perceptions and conceptions of people with physical disabilities. When these are translated into social philosophies, they can give rise to social policies which seek to exclude opportunities for the disabled to function as people. It is people in power structures who decide to create or not to create

opportunities for the disabled. Through their authoritative positions they can decide to formulate policies and laws that create or withhold resources for the disabled. Hence their attitudes are crucial in rehabilitation.

Shurka (International Social Work Journal) also suggests that attitudes of political and professional leaders are particularly significant in determining availability or scarcity of rehabilitation programmes. Professionals may influence allocation of resources, but political leaders do the actual allocation.

Assumptions that positive attitudes of policy makers are the chief determinants of resources for rehabilitation may not be universally true, since there are some parameters to consider. These include availability of resources (manpower, money, facilities) and philosophical viewpoints of leaders on the nature and causes of social problems.

On the one hand policy makers might hold positive attitudes, but, given the lack of economic resources, they might not be able to translate them into social policies for the disabled. Social policies are publicly funded, and if a country is poor it lacks a good taxation base from which to fund public policies. Under such conditions services to the disadvantaged are likely not to be a priority. Hence such services, if they are ever provided, are likely to be inadequate or residual.

On the other hand, community attitudes could be negative but, paradoxically, programmes be adequate. This is possible where the disabled are sophisticated

enough to engage in social action and influence policy makers to devote resources to their needs. In certain societies policy makers sometimes adhere to the view that disabled people possess residual abilities which can be developed to put them on the road to economic independence. In this they see a possibility of relieving the Government of the burdensome responsibility of caring for disabled persons. Therefore economic resources that would otherwise be used for elaborate social policies and programmes could be diverted towards economic development.

Mali is a typical example here. Goussou (in Children in the Tropics 175/176, 1988) describes how the government of Mali, amidst its extensive poverty, has formulated appropriate policies towards the social promotion of disabled persons. These policies are implemented through elaborate programmes, structures within Government departments, organizations, and institutions. The formation of voluntary organizations to care for the disabled was also encouraged.

Seemingly, the Mali Government believe in exploiting residual abilities of the disabled to make them self-reliant economically, instead of providing dependency-producing social securities and services. It would seem that, in this example, the question of attitudes was far less significant than economic considerations. In other words, the policy was not primarily prompted by considering the rights of the disabled to develop their potential, but by the hope that they would not cost the nation money.

Researcher would also think that the vested interests of policy makers influence availability or scarcity of services for the disabled. Policy makers who have relatives or personal acquaintances within the disabled population are likely to be more willing to devote adequate resources to the rehabilitation of sufferers.

Perhaps what Johnson (1980) says about disadvantaged population sectors in developing countries being denied the attention of policy makers may be ascribed to the reason mentioned above: that they lack personal acquaintances within the ranks of those in power structures.

4.4 DISABILITY AND PROBLEMS OF PRACTICAL DAILY LIVING

A basic assumption here is that disabled persons encounter problems in their practical daily living. The nature and extent of these problems is influenced by variables such as the degree of disability and handicap, availability of technology, the physical setting (whether it is adapted or not) and availability of social supports.

Degree of Disability

Disabled persons, to a considerable extent, forfeit some ability to manage and care for themselves, although this depends upon the degree of disability and handicap. We would, for instance, expect a quadraplegic to be more disadvantaged than a leg-amputee.

Technology

A technical device, despite facilitating mobility, can impose further handicaps, especially if it is related to the living

or working situation. An example would be a wheelchair. Its particular design is such that it can be difficult to manoeuvre in any setting, particularly in those that are not adapted for its use.

Kahan, cited by Goldsmith (in Loring & Burn, 1978:40-41) gives a vivid account of contingent problems in using a wheelchair. He says that "a wheelchair decreases the user's height by 1/3 and his width doubles up. The construction of a wheelchair is such that the user is unable to get his body into close proximity with objects. To travel in a straight line he needs a path 3' 0" wide, and he needs almost 5' 0" of straight travel before he can negotiate a turn. Twenty-seven (27) square feet of clear area is needed to permit him to turn about".

Kahan's narrative demonstrates inherent problems of being wheelchaired, and these appear to prevail irrespective of situational realities. This puts victims in a dilemma of impaired mobility and the necessity of trying to overcome impairment by means of an equally handicapping appliance.

From the discussion above, practical daily living problems of some categories of disabled people are considerable, and technology is not a panacea.

Social Support

Disabled persons are largely dependent upon family supports for practical daily help and care. This is more so with those who are severely disabled and handicapped. We may therefore expect a chronically disabled person who lives alone to be more handicapped than the one who is in the care of family, such as a parent, spouse, or children.

But, as Blaxter (Ibid:56) suggests, it is not only availability of such carers that counts, but also their ability to accommodate the situation without strain. Should the family find it burdensome, there could be a tendency to take the strain out on the victim, leading to low quality care, or, in extreme cases, to abuse.

When this happens, alternative care should be considered. This may either be paid home help or institutional care. In the former, a sufferer enters into a contractual agreement with the carer regarding the exchange of a service for money, leading to the creation of mutual roles of employer-employee. Since a carer in this contractual arrangement is bound by his terms he is likely to endure, with relative ease, the strain of caring for the victim. A paid home helper all the same has an advantage over a family member because he has a choice of leaving in case the situation becomes intolerable, while families are morally and culturally bound to offer such care. Being under obligation they are likely to persist in the face of all adversities. Low quality care may however be the undesirable result. Cases where disabled people are left to die alone or subjected to abuses are not uncommon.

Where residential institutions are available, they could be used as alternatives to home-based care, provided that family tradition allows it, and the sufferer favours it. Sometimes sufferers are denied the choice, and end up in institutions.

A burning question with residential care is whether it is desirable or not. In other words, is it conducive to the welfare of inmates or not?

Let us examine Goffman's views on the character of institutional living. This author, in his study of the various social establishments (institutions) which he refers to as

'asylums', pointed out what he regarded as the evils of life within them. What he says would also be applicable to residential institutions for the disabled.

First, there is a basic split between inmates and staff. Inmates live in perpetual confinement while staff have contact with the world outside the institutions, as they usually operate on an eight-hour basis. Each group tends to conceive of the other in terms of "narrow hostile stereotypes". Inmates are perceived by staff to be bitter, secretive, and untrustworthy, while inmates see staff as mean, high-handed and condescending. As a result there is a perpetual rift between the server and the served.

Second, institutional living tends to make all aspects of lives of inmates to be conducted under same conditions, implying a life of monotony or of little variety.

Third, staff and inmates comprise mutually exclusive strata. Social mobility between the two strata is grossly restricted. And so is communication. Inmates are not allowed to communicate with staff other than in prescribed ways. Goffman suggests that sometimes even a tone of voice is altered deliberately to reinforce this stratification. Communication from staff is commonly in the form of instructions only.

In researcher's own observation, staff tend to talk about inmates instead of with them. They often talk of "cases" instead of persons with problems.

Fourth, Goffman states that work given to inmates lacks incentives. If there is incentive, it will not have the same structural significance it would otherwise have in the outside world.

It is to be remembered that work given within institutions is a prescribed routine meant to suit the policy, programmes, and goals of the management of the institution. It has little to do with the development of inmates or their individual interests. Gwynne & Miller (1974) hold the same view.

Other evils of institutional life include:-

1. Loss of identity and depersonalization because of categorization. "The paraplegic (or the hemiplegic) in such and such a room" are common references.

2. The impersonal atmosphere of the institution. This atmosphere lacks homeliness, and creates a perpetual feeling of homesickness amongst inmates.

3. Separation from families and familiar home environments is stressful to inmates. Piroquet (World Rehabilitation Fund, 1986:9) for example states that patients have been observed to exhibit psychologic disturbances after periods of long confinement in institutions.

4. Submission to routine rigid enough to be a complete disregard of the varying needs of inmates.

Given the negatives of both home-based care and institution-based care, one may wonder what the best type of care would be for persons with disabilities. Researcher prefers home-based care because it is capable of considerable improvement if sufficient environmental, physical, and social supports can be mobilised.

Disability-related problems considered so far are universal, but their manifestations may be determined by a variety of factors, particularly economic ones. Disabled people who are poor but

UNIBO LIBRARY

live in poor environments may be greatly disadvantaged, given the economic demands inherent in physical disability. The costs of rehabilitation aids, orthotics and prosthetics; architectural adaptations and supportive home devices, are very often beyond the reach of the majority of disabled persons. Hence some people see individual and environmental deprivation to be the significant factors in handicap.

Thus far researcher have discussed contingent and inherent problems of disablement in general. She now wish to relate these to some life domains that she regards as significant to all human beings. These domains include education, employment, and economic life.

Education in author's opinion is the means through which an average citizen can enhance his living circumstances, because of its potential influence on employability. Employment is the key to economic well-being for average citizens.

4.5 EDUCATION AND DISABILITY

Farrant (1980:18) defines education as the 'total process of human learning by which knowledge is imparted, faculties trained, and skills developed. It takes place in three forms namely formal, non-formal, and informal'.

Formal education is here used to denote basic or elementary schooling that aims at eliminating illiteracy and innumeracy, and that is given within conventional schools. This type of education equips the learner with reading and writing skills, which he in turn can transfer to a work-setting in the form of an ability to read and understand instructions. From this perspective then, basic education or formal schooling is a fundamental stage in the whole process of work preparation

(for all persons). It is also fundamental to those who are congenitally disabled or whose disability sets in early and in adult life.

Non-formal education according to Farrant (Ibid) is an organized activity that takes place outside the structure of the formal education system. Such education basically aims at meeting specific learning needs of particular groups of children, youths, and adults in the community, and encompasses a variety of activities such as skills-training, agricultural extension, health education, family planning, and functional literacy (Farrant, Ibid:19).

Non-formal education as used in this dissertation will refer to two categories of activities. First, it will refer to training activities that aim at preparing congenitally disabled persons for work, initiated normally after acquisition of elementary education (lasting approximately 13 years). Second, it will refer to work-rehabilitation that is normally offered to persons whose disablement sets in during their adult lives. Work rehabilitation considered here is geared towards either training cripples in new types of work commensurate with their limitations, or to orient them in jobs they held prior to disablement.

What then are the problems encountered by disabled persons in these two areas of education?

Problems encountered in Formal Education

Problems in this field are premised on physical handicaps, social handicaps, and the attitudes of able-bodied teachers and peers. Notably these problem sources are exaggerated in ordinary school settings.

Disabled persons, particularly those who are severely disabled, find it difficult to manoeuvre in school settings that are basically designed for able-bodied persons. Lack of appropriate structural adaptations tends to exacerbate mobility problems. But this also depends upon the degree of disability and handicap.

In addition, school programmes do not cater for the special needs of the disabled. For instance pupils who have a grasping disability cannot write or draw. And yet these are essential tasks in classroom learning.

Some extra-mural activities, by their very nature, are exclusive to some categories of disabled pupils. A pupil who uses calipers, for instance, cannot participate in school athletics.

Because of their disabilities pupil-sufferers can engage in some but not in most school programmes. They thus fail to adapt to 'normal' or mainstream schools.

A feasible alternative for them would be special schools. But these are generally in short supply or totally absent in some environments. Their inadequacy is another manifestation of a discriminatory attitude towards the disabled.

The second group of problems (in addition to physical and social handicaps) is the rejecting attitudes of teachers and peers.

Teachers, like all able-bodied persons, have their own idiosyncratic perceptions and attitudes towards disablement that make them react to victims in a characteristic manner, usually in a rejecting way. This is particularly so with teachers in ordinary schools since they are not trained to

deal with special needs of persons with disabilities.

Some studies have shown the rejecting behaviours of able-bodied teachers towards disabled pupils.

Branans (1972) (cited in Dovey & Graffam, 1987:95) studied responses of 150 disabled college students in which they were asked to name the two most negative experiences in their lives. Most of them are said to have reported "destruction of self-confidence, embarrassment and humiliation in front of the class, personality conflicts, and unfair evaluations".

Given experiences of this nature, one may as well ask if the much-acclaimed and so-called 'integrated schooling' is really desirable.

Is it not an unconscious way of denying disabled pupils education? Will it not be better for sufferers to be schooled in settings specifically designed for them, and where they are served by supportive staff who understand their special needs?

To the researcher it seems as though to force integrated schooling is a way of creating a precedence for school drop-out and poor performance on the part of disabled pupils. Both these processes ultimately lead to illiteracy and semi-education.
These two tend to exacerbate problems of sufferers, especially if they desire to enter institutions of further training which normally have some stipulated pre-entry requirements, the most important one being a certain standard of elementary schooling (mostly Standard 8, particularly in South Africa and homelands).

Should sufferers fail to meet this pre-entry requirement, the alternative would be to gain entry into handicraft centres, or any such centres as may be designed to accommodate their shortcomings.

Training to be received in such centres is not in any way a remedy because it is seldom, if ever, geared towards the labour market needs. Hence trainees from handicraft centres are seldom attractive to prospective employers. This is the reason why most of them, upon completion of a specific period of training, opt to get sheltered employment within the very same institution.

Problems encountered in Non-Formal Education

As mentioned already, non-formal education here refers to two types of activities: first, activities that aim at preparing congenitally disabled persons for work, usually initiated after acquisition of elementary education; and second, those that are normally referred to as "vocational rehabilitation". These basically aim to reorient the disabled in new jobs or jobs held in the pre-morbid period.

Problems that are generally encountered in the former area have already been indicated under 'formal education', and will not be repeated here.

The second field, viz vocational rehabilitation, can be expected to have minimal or no problems whatsoever, the reason being that it is basically geared towards persons with disabilities. Therefore the setting itself, the staff, facilities, and activities are appropriately designed to accommodate sufferers. A typical example of a centre of this nature would be the Medical Fitness for Work unit at the H F Verwoerd Hospital in Pretoria.

This facility combines a treatment centre, and a centre for assessment of work abilities and work preparation.

Formal testing, work simulation, job samples, and work trial are some of the techniques used here to meet the above objectives. (Shipman in Rehabilitation in South Africa, March, 184: 10-11).

Facilities of this nature are numerous. And are totally absent in most "homelands".

In Bophuthatswana for example, vocational rehabilitation is integrated in a programme known as occupational therapy commonly offered in most country's hospitals. These programmes are lacking in sophistication and cannot prepare patients for fruitful labour outside the treatment setting.

From what has been discussed above, deprivation in the area of schooling and training for the disabled largely influences their employability. It can therefore be expected that they confront insurmountable problems in the domain of employment.

4.6 EMPLOYMENT AND DISABILITY

Physical handicaps, social handicaps, attitudes of employers, absence of compensatory skills (due to lack of schooling and appropriate training), are central to problems encountered by sufferers in the domain of employment.

Physical handicaps may prevent a sufferer from performing the jobs that are available to him. But since handicap is an individual thing, determined by inter alia the degree of impairment and disability, we may expect some categories of disabled persons to be severely disadvantaged, some may possess residual abilities that enable them to perform some jobs but not others, while some may be completely bereft of such abilities. By way of examples, a paraplegic may not be able to work as a cleaner, but might do as a lift attendant; a hemiplegic might do clerical work but not menial tasks;

a leg-amputee might be able to be a typist but not be acceptable as a fashion model.

Implicit in these examples is the fact that, in many ways, choice of jobs for sufferers is limited. Hence efforts to widen the choices are essential. One such way would be to acquire compensatory skills of an economic nature. These might not prove to be the panacea for work problems, given the reality of negative employer attitudes. To a considerable extent, however, possession of compensatory skills does remedy the situation. A paraplegic skilled in one or more areas (e.g computer programming) will have better chances of employment, than his unskilled counterpart. His chances would even be better than his unskilled able-bodied counterpart.

It should not be forgotten though that ability to use such skills will depend upon the physical setting of the work place, i.e. whether it is adapted or not. This necessity in turn depends upon willingness of the prospective or actual employer to adapt the setting, and place the sufferer in a job commensurate with his abilities and skills.

In view of the realities outlined here, both prospective employability and actual employment of persons with disabilities depend upon a multiplicity of interacting factors. This in itself illustrates the pervasive effects of disablement upon employment.

Some world-wide studies are cited here in support.

Johnson and Johnson (Boswell & Windgrove 1984:356) surveyed employment positions of 50 paraplegics who had formerly received hospital treatment. The findings revealed that only 7/50 were working, and 33/50 were not. One out of seven (1/7)

in employment was back in his previous job. Two out of seven (2/7) were in sheltered employment.

The same authors in their report refer to other studies which also indicate the effects of disablement upon employment. One such study was by Robinson in 1970.

Robinson is reported to have made a follow-up of 188 quadruplegics discharged from certain hospitals in Scotland. Approximately 51,4% were unemployed, 44% in paid employment, and 7,4% were students.

Johnson & Johnson also cite studies carried out at the Institute of Rehabilitation Medicine, New York University Medical Centre on 131 quadrupplegics who were discharged from hospital treatment. These people were surveyed over a period of 5 years.

The findings revealed that after disablement 34% were employed, 47% were receiving higher education, while 19% were unemployed.

Two South African researchers, viz. Du Preez and Uys of the Institute of Personnel Management, University of Potchefstroom, studied various aspects of the employment situation of persons with disabilities (blind, deaf, epileptics, cripples etc.). Their data sources were a total of 512 business concerns in the larger metropolitan cities of South Africa. Their findings revealed amongst others that 56,86% as against 43,13% did not employ disabled persons. Within the total work force of 978,557 in the 512 business undertakings, only 2 348 members were disabled. This figure amounted to 0,24% of the total labour force.

Cornelje and Corneljes' study in the Mareetsane village in the Ditsobotla region of Bophuthatswana also demonstrated the pervasive effects of disablement upon work-opportunities. They

studied a sample of 124 physically handicapped persons, and singled out 57 from this sample of 124 for examining their employment situation. This was a category considered by them to be of employable ages (16-60).

Twenty percent (20% or 12/57) were working (but we are not given details of the type of jobs they were engaged in) and 80% or (45/57) were not working. The reasons for not working as cited by the 45 respondents were mainly handicap (in 70% of cases) age, mental state, and household circumstances (in 22% of cases). In 8% of the cases no reason was stated.

These studies reveal the universality of the impact of disability upon employment. I refer to universality because these studies span across First-World and Third-World settings, which differ in their socio-economic levels, leading to varying employment opportunities. This may mean that factors other than availability or scarcity of jobs in environments influence the work situation of victims. In my opinion such principal factors are attitudes of employers and employing agencies towards engaging persons with disabilities.

Employers, depending upon their particular beliefs, can enhance employability of sufferers in various ways. They may adapt work settings, minimise competition, place a sufferer in a section or in a job commensurate with his limitations and skills possessed by him, and also by being supportive so as to sustain his interest and motivation in his work.

But these are more of ideals than actualities. In the first place employers are seldom, if ever, willing to employ persons with disabilities for reasons to be mentioned later, including

the fact that some economic policies and ideologies entitle them the choice of employees. Reference is made here to the ideology of capitalism and its free market policy.

Reasons for reluctance to employ disabled persons are suggested in the Report of the National Symposium on Disablement, compiled by the Department of Population Development of South Africa in November 1987. They are quoted here as coming from an authoritative source although no direct evidence can be quoted in support of particular beliefs.

First, most employers believe that the work performance of disabled persons will not meet the required levels of output. Second, special adaptation costs may be thought not to be economically justifiable. Third, employers believe that the presence of a disabled person could affect the morale of other employees and harm business, especially if such a person is posted at a public place such as a counter or reception desk. Fourth, employers may believe that disabled persons are highly susceptible to industrial accidents.

These beliefs largely prevent or limit work opportunities for persons with disabilities, especially where no system of compulsory employment exists for them, as is the case in Bophuthatswana and South Africa. But compulsory employment may also not be an overall remedy especially where there are no resources, as is the case in South Africa.

Even where such resources are available in a relative sense, compulsory employment fails to bring forth the anticipated results. A case in point here is the British quota system of employing disabled persons, as stipulated in the Disabled Persons (Employment) Act of 1944.

4.7 DISABILITY AND ECONOMIC LIFE

Employment is for average citizens the means of livelihood. This is true of disabled persons too. Since they often confront insurmountable problems in the field of employment, which leave them either unemployed or under-employed, one may conclude that they are predisposed towards impoverishment.

Exceptions could be found in those who may have been compensated for their disablement depending upon the causes of such disablement and insurance protection previously held.

Some may be compensated through Industrial Injuries Compensation Schemes, Automobile Assurance schemes, some other personal assurance schemes available in the market, or as compensation received after legal suits where neglect by others, especially authorities, is found to have caused disabling injuries.

But otherwise the majority of the disabled subsist on social securities. These are by their residual nature insufficient, implying that beneficiaries will have to live in perpetual poverty.

The magnitude of problems that confront victims of disablement calls for well-organised social services. Such services, to be effective, must address all problem areas, including those that are not mentioned in this chapter.

An inventory of some of the essential services is given in the section that follows.

4.8 SOCIAL SERVICES THAT CAN BE RENDERED TO PERSONS WITH DISABILITIES

The multiplicity of problems that confront disabled persons, as explained in the foregoing discussion, calls for a configuration of social services that will address all dimensional aspects of the condition of disablement. These services must address social, psychological, economic, and practical problems.

An all-embracing term for this service-configuration is "rehabilitation". Rehabilitation as defined by Moyes (1981) as the "combined and co-ordinated use of medical, social, education, and vocational measures for training or retraining the individual to the highest possible level of functional ability".

He continues to say that "rehabilitation measures include medical care and treatment, therapeautic measures, training in self-care activities (such as mobility, communication, body care), technical aids (crutches, hearing aids), education, social counselling and assistance; and vocational training and placement designed to enable someone disabled to find suitable employment". (Moyes, Ibid).

From these two definitions it is clear that rehabilitation is a multi-disciplinary activity in which each professional discipline has its particular focus. Medicine, nursing, physiotherapy, and related para-medical professions focus on physical rehabilitation while counselling, social work, psychology, and psychiatry focus on the various forms of counselling (social, psychological etc.).

Since researcher professional orientation is Social Work, primary focus in this discussion will be on its contribution to the total process of rehabilitation.

SOCIAL WORK AND SOCIAL WELFARE SERVICES IN REHABILITATION

First and foremost the researcher need to mention the difference between Social Work and Social Welfare services as used here.

Social Work is basically a profession as it possesses all attributes of a profession. These are listed here.

(i) A defined purpose which is to 'enhance the social functioning of individuals, groups and communities'. Pincus and Minahan (1973) list seven functions of Social Work which may also be regarded as the objectives through which this function is realised.

(ii) A knowledge component which consists of assumptive and practice knowledge. The former describes the nature of man and society and their interactions. The latter explains the 'how' of social work intervention, i.e. it describes the technology (skills, techniques, methods) of social work treatment. Skidmore and Thackery (1982) refer to this category of knowledge as intervention theory.

Knowledge in Social Work is derived from related social sciences (sociology, anthropology, economics, psychology, psychiatry etc.)

(iii) A system of values that is peculiar to it. This value system guides a social worker as to how to conceive of people, on what the preferred outcomes of his interventions for people should be, and through which means these interventions should be done (Morales & Sheafor, 1983:200).

(iv) A community sanction, meaning on authoritative permission to exist. Sources of sanction include

agencies (governmental and voluntary) authorised by law; and the organized profession which sets forth educational and other requirements for practice, which can, in turn, sanction people to practise social work even if it is practised outside auspicing agencies (i.e private practice).

Social Welfare on the contrary is not a professional entity since it lacks the basic attributes of a profession discussed above. It is also conceived by some authors, Morales and Sheafor in particular, to be the context of Social Work, Social Work being the profession within it. But this viewpoint does not necessarily mean that related professions are excluded. To do this would be to compartmentalize complementary and supplementary professional activities that are supposed to be integrated.

Related professionals who are lay in the field of social work and also commonly excluded from the definition of social welfare workers are to all intents and purposes nevertheless contributors to welfare. The reason is that the services they render contribute to the well-being of other people. Thus professionals like physiotherapists, vocational counsellors, occupational therapists, nurses, doctors, and psychologists, are, as far as the researcher is concerned, welfare providers.

Perhaps their exclusion from the ambit of welfare is based upon the ambiguity which surrounds the definition of the concept 'Social Welfare' which is very often confused with 'Social Work'.

To sum up, all other rehabilitation professionals will be included in the definition of Social Welfare Workers, although emphasis will be more on Social Work services.

Social Workers, irrespective of the setting in which they operate, contribute in many ways to the rehabilitation of disabled persons. By this author means that rehabilitation social workers are not only those who are located in treatment settings or institutions. They include those who are placed at magistrate offices, Children's courts, etc, because in these settings they do render some services to disabled persons. Those in magistrates offices, especially within the context of Bophuthatswana, where no specialisation by function exists, offer counselling and tangible help, and determine eligibility for disability grants and rehabilitation aids.

A CLASSIFICATION OF SOCIAL WORK SERVICES THAT CAN BE OFFERED TO PERSONS WITH DISABILITIES

The reader should note that the discussion to follow is largely prescriptive because it does not describe particular services that exist. Instead it defines what services ought to be rendered to ameliorate problems inherent in disability.

Classification of social work services are many and varied. Morales and Sheafor, for instance classify them into 'Social provisions', 'Social services', and 'Social action' (Morales and Sheafor, Ibid:107-111).

Social provisions according to these two authors are cash and kind help. Social services are those that promote the social functioning of clients and include therapy, help, rehabilitation, and access services. Social action includes programmes that are informational and consciousness-raising or those that directly challenge the existing situation. (Morales & Sheafor, Ibid).

For the researcher's present purposes, I will use Helm's classification is used. This author classifies social work services according to

method and problem (Helm, 1962:15). For a start the author adopts her classification by method.

(a) Eleemosynary Methods

These methods are applied when the clients are given assistance in cash or kind. Social security, accommodation, technical aids, transport, recreation and food, would be classifiable under this method.

A Social Workers' main function here is provision of access to these services basically in two ways, i.e either by informing the client where and how such services can be obtained, or determining eligibility in cases where the client is unable to obtain such from the economic market (that is if a social market is to be used).

In what way do cash and kind services promote the goals of rehabilitation?

Some tangible goods provided in this service category are crucial to rehabilitation: rehabilitation aids, such as orthotics and prosthetics, are used as supplements or substitutes for lost or malfunctioning organ(s) of the body.

As mentioned above, eligibility criteria are important to dispensing cash and kind services. And these are directly related to policy issues of selectivism or universalism; residualism or institutionalism. Timms and Watson (1976) suggest that these policy issues are more pronounced when cash and kind services are to be dispensed with. A reason for this may perhaps be that this category of services involves direct expenditure of monetary resources.

These policy issues are explained further.

Selectivism and universalism

Selective services or benefits are given only to specific people who meet stipulated eligibility criteria. This implies that they are means-tested.

Contrary to selective benefits are the universal ones. These are given to all irrespective of need.

Several authors, such as Gil (1973), Gilbert & Specht (1973), and Titmuss (1983), cite one benefit, Assistance to Families with Dependent Children (AFDC) in the United States of America and the United Kingdom, as the typical example of a universally provided benefit.

Residualism and Institutionalism

A residual social policy is based on the principle that all persons are responsible for their own welfare. Only those that genuinely fail to provide for their own welfare within normal social institutions qualify for State assistance.

Within this policy stance, clients are conceived of as applicants for a service. Most social security systems of the world are residual because of their characteristic inadequacies, insufficiencies, and the cumbersome procedures one has to go through in applying for them.

In contra-distinction to residual policy is the so-called institutional (or developmental) policy. Here social welfare is seen as a first-line function of the Government, such that societal members qualify for

services irrespective of need. Clients here are referred to as claimants or consumers.

Institutional and universal types of social policies are common in the so-called welfare states. Britian and Sweden being amongst them. But most countries do have programmes that combine both selective and universal, residual and institutional social policies. One such programme is public education and health care in most countries of the Third and First Worlds.

(b) Counselling Methods

According to Helm (Ibid:15) these methods are employed when a social services agency offers its clients 'guidance, consultation, and advice'. Instead of clients being supplied with tangible goods, they are helped to help themselves. These methods include activities like counselling, assessment of problems, referral and access services, guidance and after care.

These services are given to disabled persons on the premise that their social functioning has been disrupted by disablement, and therefore their psychological and social needs must be addressed.

Policy issues, as mentioned above, are not so pronounced in this group of services since the expenditure of resources, especially finance, is not direct.

(c) Educative Methods

Helm (Ibid) suggests that these methods are employed "when the agency seeks to improve its client's condition

by education, generally, a more long-term process than counselling, and one in which larger and less intimately bonded groups are dealt with".

In the case of disabled persons, educative methods would include the two types of education broadly referred to as "vocational preparation and vocational rehabilitation" mentioned elsewhere in this chapter.

Vocational or work preparation involves preparation for a career initiated in early life stages through elementary education at the primary level, and proceeds to the secondary level where a choice of a career is made. This is followed by training in the selected field, then placement in a job trained for, and thereafter in-service training.

Vocational rehabilitation involves skill-training for a new job appropriate to the victims' abilities, or retraining in a job previously held (see previous discussion).

What then is the role of Social Work in these two areas of education and training?

Social Work may not be directly engaged in the practicalities of education, but may perform any one of the following related functions, as adapted from Pincus and Minahan's (1979) listing.

First, it may help in the creation of schooling facilities for the disabled. Second, it may link disabled persons with existing facilities for schooling and training. Third, it may facilitate interaction between these facilities and the disabled by influencing

and modifying their policies (for example, admission policies).

(d) Information Methods

These methods, denoted 'Social Action' by Cox et al (1987), and Morales & Sheafor (1983), are regarded by Helm (Ibid) to be seeking improvement, propaganda, information or publicity.

What actually happens through these methods is that people who share interest in the problem of disability, be it the disabled themselves, their relatives and families, and/or professionals organise themselves into a body or structure to engage in any action they deem appropriate. Such action may, for instance, be informal education through mass communication media, the content of such education being the promotion of social acceptance of persons with disabilities.

Activities by organisations such as Disabled People of South Africa (DPSA) fall into this category.

Similarly, the United Nations Project called the Decade of Disabled Persons (1981-1992), and President Botha's National Year of Disabled Persons (1986) in South Africa are also classifiable under social action or information methods.

These projects turned the world's spotlight on the disabled and their plight.

Social Workers engage in information dissemination through mass communication media addresses, workshops, and conferences and symposia, which focus on disability and its victims.

How then do informational activities promote rehabilitation?

As mentioned above, social attitudes, especially those of policy makers, are crucial to creating rehabilitation resources and programmes. Information methods (Social Action) can be used as strategies for changing attitudes into those that will cause policy makers to devote adequate resources to rehabilitation.

In the chapter that follows an attempt is made to relate the problem of disability to a developing setting. The basic idea here is to demonstrate the interfaces between poverty and disability.

NOTES

1. Bentovim, A. "Handicapped Pre-School Children and their Families: Effects on Child's Early Emotional Development" in Boswell, D. M. & Windgrove, J.N. (ed) 1974. The Handicapped Person in the Community. A Reader & Source Book. London : Tavistock and the Open University Press.

2. Blaxter, M. (1976). The Meaning of Disability. A Sociological Study of Impairment. London : Heinemann.

3. Battye, L. "The Chatterley Syndrome" in Boswell & Windgrove, Ibid.

4. Cox, F.M. et al (1987). Strategies of Community Organization. Macro-Practice. Itasca, Illinois : F.E. Peacock.

5. Dovey, K & Graffam, J. (1987). The Experience of Disability. Social Construction and Imposed Limitation. Victoria College, Burwood Campus, Australia.

6. Farrant, J.S. (1980). Principles & Practice of Education. Longman.

7. Germain, C.B. & Gitterman, A. (1980). The Life Model of Social Work Practice. New York: Columbia University Press.

8. Gil, D. (1973). Unravelling Social Policy. Cambridge, Massachusetts: Schenkman Publishers.

9. Gilbert, N. & Specht, H. (1986). Dimensions of Welfare Policy (2nd ed). Englewood Cliffs, New Jersey: Prentice Hall.

10. Goffman, E. (1965). Asylums: Essays on the Social Situations of Mental Patients and Other inmates. New York: Doubleday & Co.

11. Goussou, R. "Social Rehabilitation of the Physically Handicapped in Mali". Children in the Tropics, August 1989. International Children's Centre - Paris.

12. Greenway, P. & Harvey, D. "Reactions to Physical Handicap", in Laura, R.S. (1980). Problems of Handicap. Hong Kong: MacMillan, Pages 27-32.

13. Helm, B. (1962). Social Work in a South African City. University of Cape Town: Board of Sociological Research.

14. Johnson, H.W. (ed) (1980). Rural Human Services. A Book of Readings. Itasca, Illinois: F.E. Peacock Publishers.

15. Johnson, G.S. & Johnson, R.H. "Paraplegics in Scotland: a Survey of employment and facilities. in Boswell & Windgrove, Ibid. Pages 354-365.

16. Laura, L.S. (1980). Problems of Handicap. Hong Kong: MacMillan Company.

17. Loring, J. & Burn, G. (eds) (1978). Integration of Handicapped Children in Society. London, Henley & Boston: Routledge & Kegan Paul.

18. Mba, P.O. "Social Welfare Services for Disabled Children in Schools in Developing Countries". International Social Work, Volume 26, No. 1, 1985.

19. McKeith, R. "The Feelings and Behaviour of Parents of Handicapped Children" in Boswell & Windgrove Ibid, pp 127-129.

20. Mojake, M.C. "Attitudes of the Rural Community Towards the Disabled and the Availability of Support Systems in Rural Areas". 1986 unpublished. University of the North.

21. Morales, A. & Sheafor, B.W. (1983). Social Work. A Profession of Many Faces (3rd ed). London & Sydney: Allyn & Bacon.

22. Moyes, A. (1981). One in Ten. Disability and the Very Poor. Oxfam. Britain.

23. Miller, E.J. & Gwynne, G.V. (1974). A Life Apart. A Pilot Study of Residual Institutions for the Physically Handicapped and the Young Chronically Sick. London: Tavistock.

24. Pincus, A. & Minahan, A. (1979). Social Work Practice. Model & Method. Itasca, Illinios. F.E. Peacock Publishers.

25. Piroquet, A. (1986). "The Experience of Bacolod City". World Rehabilitation Fund, Monograph No. 26, 1986. Page 12.

26. Scott, R.A. "The Construction of Conceptions of Stigma by Professional Experts" in Boswell & Windgrove, Ibid pages 108-120.

27. Shipman, E. "The Functioning of a Medical Fitness for Work Unit". Rehabilitation in South Africa, March 1984, Vol. 28, No. 1, pages 8-14.

28. Schoenberg, B. & Carr, A.C. (1970). Loss and Grief. Psychological Management in Medical Practice. New York: Columbia University Press.

29. Shurka, E. "Attitudes towards Disability and Rehabilitation among Political and Professional Leaders in Israeli Development Towns". International Social Work Volume 27, No. 1 of 1984: Pages 35-42.

30. Skidmore, R.A. & Thackeray, M.G. (1982) (3d ed). Introduction to Social Work. New York: Appleton Century Crafts.

31. Smith, N. "Physical Handicap, Disability and Welfare" in Laura, L.S. Ibid. Pages 17-25.

32. Titmuss, R.M. (1983). Social Policy. An Introduction. Boston & Sydney: Allen & Unwin.

33. Timms, N. & Watson, D. (eds) (1976). Talking about Welfare. Readings in Philosophy and Social Policy. London & Boston: Routledge & Kegan Paul.

34. Report of the National Symposium on Disablement Compiled by the Co-ordinating Committee. Year of Disabled People, 1986. Department of Health and Population Development (RSA) November 1987.

35. Goldsmith, B. "Designing for Physically Handicapped Children - Are You on the Right Level, Mr Architect?" in Loring & Burn, Ibid pages 36-48.

CHAPTER 5

DISABILITY IN THE THIRD WORLD

The thesis of this Chapter is that there are some features of the Third World that exacerbate the problems of disability. These features are embedded in the massive poverty that predominates Third-World settings.

This poverty is reflected in the overall profile of disability -- its incidence, causes, and the living circumstances of disabled persons. These will be focal issues in this Chapter.

This Chapter will be presented in the following format. First, the researcher will introduce the concept of a developing society, including a listing of countries that fall within this category. Mention will also be made of those features characteristic of developing countries. Second, disability will be placed within the context of a developing society, since this is the theoretical basis of this dissertation. To this end, the causes and prevalence trends of disability will be given, and how the major features of developing countries impact upon the circumstances of disabled persons will be illustrated.

5.1 THE CONCEPT 'DEVELOPING COUNTRY'

The world today is classified into developed and developing countries. One of the bases of this classification is the size of the Gross National Product. The Gross National Product (GNP) according to Gil (1973:18) is a simple measure of the totality of goods and services produced by a society and divided by the

number of the country's inhabitants. Variables such as the population size will affect the distribution of income, hence influence the size of the GNP. It is for this reason, amongst others, that the GNP is not so reliable a measure of the poverty or wealth level of any country. For instance, two countries might have the same GNP. One might have a small number of fabulously wealthy elites, and a huge preponderance of persons who live at a starvation level, as was the case in India before the British Raj. The other might have a much more egalitarian distribution of income, with everybody managing to avoid abject poverty. In the first-named instance, the GNP, pushed up by the enormous wealth of the few, masks the fact of the great poverty of the many. In addition, corporate bodies, for the purposes of calculating a country's GNP, are counted as "individuals". This practice conceals individual or family economic positions.

Notwithstanding these limitations, the GNP is an internationally accepted measure of the economic position of a country. It also serves as the dividing line between the poor and rich countries of the world.

Countries that fall within the developing category are poor as measured by the sizes of their GNP's (See Table 10). Various terms are used to describe such countries. These include 'least developed', 'underdeveloped', 'developing', 'industrializing' 'the South' and the 'Third World'. The last descriptive term, Third World, came into vogue in the 1960's to refer to nonaligned countries which were previously colonised. These were the countries sought by super powers for trading and also for expansion of their economic and political ideologies (Mountioy, 1983). They therefore became the battle grounds for the so-called 'cold war' between the East and West. Vestiges of this struggle can still be seen in the political upheavals of countries such as Afhganistan, Angola, Mozambique, and Nicaragua.

Developing countries are said to be 141 in all, and are chiefly found in Asia, Africa, and Latin America. They occupy approximately 67% of the world's total land surface, and have approximately 70% of the world's population (Midgley, 1984:37). Table 8 is a listing of all developing countries as extracted from Goldthorpe (1984) who in turn quoted the World Bank's Development Report of 1982. This organisation excluded from its listing some 34 countries and territories with populations of less than one million, and also Taiwan. This is the reason why the list in Table 8 comprises only one hundred (100) instead of 141 countries.

TABLE 8

A LISTING OF THIRD WORLD COUNTRIES

SOURCE: GOLDTHORPE (1984)

Afghanistan	Ecuador	Laos	Ruanda
Albania	Egypt	Lebanon	Senegal
Algeria	El Salvador	Lesotho	Seirra-Leone
Angola	Ethiopia	Liberia	Singapore
Argentina	Ghana	Madagascar	Somalia
Bangladesh	Greece	Malawi	South Africa
Benin	Guatemala	Mali	Sierra-Leone
Bhujan	Guinea	Mauritania	South Korea
Brazil	Haiti	Mexico	South Yemen
Burma	Honduras	Mocambique	Sri-Lanka
Burundi	Hong Kong	Mongolia	Sudan
Cameroon	Iran	Morocco	Syria
Central Africa Republic	Iraq	Nepal	Tanzania
Chad	India	Nicaragua	Tobago
Chile	Indonesia	Niger	Togo
China	Israel	Nigeria	Trinidad
Colombia	Ivory Coast	Pakistan	Tunisia
Congo	Jamaica	Papua New-Guinea	
Costa Rica	Jordan	Panama	Turkey
Cuba	Kampuchea	Paraguay	Uganda
Dominican Republic	Kenya	Peru	Upper-Volta
	Komari	Phillipines	Uruguay
		Portugal	Venezuela
			Vietnam
			Yemen
			Yugoslavia

Bophuthatswana, although possessing the characteristics of the developing world, is excluded from the list. The reason is that its claim to sovereignty is not accepted by the international community, as it is regarded as an integral part of South Africa. However, in this dissertation, it will be regarded as an independent country with full sovereign powers. To a certain extent, it does meet the criteria which denote an independent country. These, according to Goldthorpe (1984), are 'a defined geopraphical area with a human population and a Government'.

The geographical area of Bophuthatswana consists of 12 discontinuous land areas divided into 19 Magisterial regions lying on the South African plateau. It has no direct access to the sea.

The twelve regions adjoin the Transvaal, Orange Free State, Cape Province and the independent country of Botswana. The total land area is 40,330 sq kilometers and its total estimated population, according to the 1980 census records, is 2,5 million.

Bophuthatswana has its own political government and is therefore not an administrative arm of South Africa. It is governed by an Executive President, a Cabinet, a National Assembly, twelve (12) Regional authorities, and seventy-six (76) tribal community authorities.

The National Assembly of Bophuthatswana is a sovereign authority which has full powers to pass laws for the running of the country.

Developing countries have some salient features which are characteristic to them and these are largely based in poverty. They include high infant mortality rates, high population growth rates and dependency burdens, low life expectancy rates, poor health, illiteracy, underdeveloped social services, escalating

rates of urban migration, and chronic levels of unemployment and underemployment. These problems will be discussed in detail later on. Preliminarily the theoretical orientations that explain existence of massive poverty and underdevelopment in developing countries are presented. Modernization and the Dependency Theories will be discussed.

5.2 THEORIES OF UNDERDEVELOPMENT

Basically there are, according to development literature, two theoretical perspectives that explain the low socio-economic development of Third-World countries, respectively known as the modernization and dependency theories.

The fundamental difference between the two theories is that the modernization theory, on the one hand, is ahistorical and apolitical, meaning that it does not see underdevelopment within the international context and history of development. The dependency theory, on the other hand, explain poverty and underdevelopment as resulting from structural inequalities between poor and rich countries, and between rich and poor within countries.

The modernization theory explains poverty as resulting from intrinsic incapabilities of poor countries to modernize and also in terms of their lack of pre-conditions for development. The dependency theory sees poverty in terms of socio-economic structures internationally and nationally. These theories are discussed in some detail below.

5.2.1 THE MODERNIZATION THEORY

Protagonists of this theory include all Anglo-Saxon social scientists like Lewis, Rostow, Goode, Hoselitz, Hagen, and Waterson (Midgley, 1984:57).

The basic premise of this theory is that lack of development is the fault of Third-World countries because of internal deficiencies. Such deficiencies include heavy reliance upon agrarian economy, primitive technology, lack of capital, and lack of modernizing values (Webster,1987).

The theory further suggests ways of modernizing which include injection of massive capital into their economies from abroad, creation of modern industries to minimise heavy reliance upon agrarian economy, and inculcation of inhabitants with modernizing values (Todaro, 1982).

These strategies are Euro-centred, and the theory tends to equate development with modernization, Westernization, and industrialization.

Strategies such as these, upon implementation, proved not to have the desired effect. Development was confined to the urban elite while the masses remained underdeveloped.

Some criticisms have been levelled against this theory. First, the theory is Euro-centric in that it views only one path to development, which is the Western path. The question now is whether, if any of the "backward" countries was to attain the highest level of development within its own frame of reference, would it, in the eyes of Euro-Westerners, still be regarded as underdeveloped?

Second, the theory is general and unspecific. It does not explain development and only describes one form of development.

Third, it is ahistorical and a-spatial in that it does not take account of the international context and history of development. It disregards international socio-economic interdependence.

Fourth, it is based on the idea that "modern" and "traditional" are mutually exclusive conditions and do not co-exist. It disregards dualism.

The modernisation theory has a residual effect on social policies. Social policies are extended to consumers only in times of need. The most likely to need them are those who, as a result of factors beyond their control, cannot provide for their own welfare. These include the disabled, sick, old, and children.

5.2.2 THE DEPENDENCY THEORY

The principal protagonists of the theory are from Third-World countries and include Furtado, Cardoso, Rodney, Amin and Frank (Midgley, 1984:58)

Gunder Frank is generally regarded as the founder of this school of thought. Basic tenets of his theory include:-

- the development of the First World leads to underdevelopment of the Third World

- Third-World poverty stems from its dependency on the West, or is due to external rather than internal factors

- Development does not diffuse but gets confined to a small urban elite

- The expropriation of economic surplus occurs through a chain of metropolis and satellites (Webster, 1985:19).

Frank's theory has the following implications. Firstly, poverty is explained in terms of socio-economic structures. Meaning Poverty is thus more of a political and economic artefact than an inherent deficiency of the poor themselves. Social policies should therefore be institutional and redistributive. Secondly, the theory does not separate development and underdevelopment, modern and traditional, rich and poor, as they are the opposite sides of each coin. In other words, it recognises the existence of dual societies (rich urban elite and poor masses). Thirdly, it advocates breaking of the chain of exploitation through socialist revolution and overthrow of the urban elite.

The dependency theory is criticised on the following grounds.

It seems to suggest that foreign investment is primarily exploitative, whereas it can, on the contrary, promote development and industrialization. A living example of this is the effect of economic sanctions on the economy of South Africa: as foreign companies withdraw their investments the economy takes a downward plunge. Evident of this is the escalating rate of unemployment which is so pervasive as to threaten the political and social order.

Furthermore, the theory shuns the existence of multi-national corporations in Third-World countries and regards them as the vanguards of the First World's economic exploitation.

Economic exploitation is said to happen at the level of trade, technology transfer, and monetary aid. In a way the theory is right here, the reasons being that Westerners are staunch capitalists and trade activities, according to their beliefs, should necessarily generate interest. But what is unfair in this case is when such interest rates disregard the economic position of trading partners. To cite an example: The Citizen newspaper of December 1988 quoted UNCEF's gruesome statistics of children who die every year in Cambodia while the country is preoccupied with repaying its foreign debts, which annually run into billions of dollars made up of the original loan plus interest.

Lastly, the dependency theory emphasises exploitation between First and Third-World countries to the neglect of such exploitation within Third-World Countries. This exists between the urban elites and the masses, between rural farmers and city merchants.

The dependency theory in my opinion is applicable to the situation of my study subjects. Firstly, the disabled are a powerless minority. As a result they suffer from discrimination in the allocation of resources. This means that their poverty is largely determined by the able-bodied society.

Second, they are inhabitants of "homelands", which are the rural face of South Africa. As the dependency theory suggests, rural dwellers are exploited by the urban population, with the intention of keeping them undeveloped. The exploitation of homeland dwellers is common knowledge, and it takes many forms, including the use of homeland dwellers as a source of cheap labour, by the merchants in South African cities.

Thirdly, the bulk of the study subjects are based in rural villages within a "homeland" of Bophuthatswana. These villages, in comparison with town areas, are deprived. They lack economic resources and the social services needed to enhance the living circumstances of inhabitants.

5.3 THE PROFILE OF DISABILITY IN DEVELOPING COUNTRIES

5.3.1 World-Wide Causes of Disability

While the causes of disability in both First and Third Worlds are basically the same, namely, illnesses, accidents (traffic, industrial, home) and congenital factors, the difference is that these causative factors are more affluence-related in the former and poverty-related in the latter. With this basic difference in mind, the causes of disability in the Third World are discussed. Notably this discussion will not be exclusive to categories of disability studied in this project, but will include almost all categories of disabilities.

5.3.2 Accidents

The World Health Organization (WHO) (in Moyes, 1981) indicated that approximately 75 million people world-wide are affected by accidents of all types.

In developing countries, industrial accidents are linked to agricultural work (cut limbs, falls, and from climbing trees), which is the work the majority of people do. Low safety standards at work places, ignorance about the operation of equipment, and inadequate protective equipment (open tractors and trailers) all combine to expose Third-World people to industrial injuries and disabilities.

Home accidents are linked to the impoverished condition of dwellings inhabited by Third-World people. Open fires used for cooking and lighting, falling walls and roofs generally made of cheaper materials, are amongst the hazards of these people in poor dwelling units.

Traffic accidents too are on the increase in response to the increasing rate of urbanization, which leads to a situation 'where man, vehicles, cycles, animals, share a carriage way' (Moyes, 1981).

In addition, the predominance of poor driving skills amongst Third-World people (owing to a vehicle still being a relatively foreign object) increases the chances of traffic accidents. This proposition is supported by statistics cited in a South African Broadcasting Corporation (SABC) programme broadcast some time in December 1988. The programme focussed on statistics of road accidents in some selected world countries, including South Africa. The United States of America (USA) was estimated to have one serious accident for every 100 million kilometers travelled. If one considers that this country is one of the highly industrialised countries of the world where the number of cars per unit of population is correspondingly high, then one needs to appreciate the degree of expertise in driving possessed by people in that country.

The situation of some Third-World countries, as represented by South Africa in that programme, was considered to have been alarming. South Africa was said to have the highest frequency of accidents in the world. But no accident rates per kilometer were given in support of this claim.

Evidence of this is however not hard to find. The frequently occuring 'mini-bus' or 'combi' 'taxi' deaths are classical illustrations. Unfortunately death and trauma statistics are not available, but all the same they are presumed to be very high.

5.3.3 Illnesses (Congenital and Environmental)

Disease patterns in Third-World settings are primarily related to poverty, hunger, and ignorance, singly or in combination. Malnutrition ranks high on the list of causes. The Food and Agricultural Organization (FAO) regarded malnutrition as the principal child-killer in the Third World (Mac Pherson, 1985:27). It is also a principal cause of disability. Malnutrition-related disabilities include Protein Energy Malnutrition (PEM), endemic goitre, xerophthalmia and nutritional anaemia (Wilson, 1983:21-22).

P.E.M. is a disorder that affects physical growth and growth of the brain, immunological competence, ability to cope with environmental infections, and the ability to heal wounds. P.E.M. leads to stunted growth and mental impairment of the sufferer.

Endemic goitre is a disorder associated with a deficiency of iodized salt especially amongst pregnant women. It leads to developmental abnormalities in the form of deaf-mutism and cretinism. It is said to prevail in Third-World Countries particularly India and Nepal (Wilson, 1983:24).

Xerophthalmia is a vitamin A deficiency that leads to blindness.

Nutritional anaemia is a disorder that is associated with low iron deficiency during pregnancy. It retards the physical and mental growth of the baby born of the afflicted mother.

5.3.4 Other Disabling Diseases (not Necessarily Linked to Malnutrition) but to Poverty and Ignorance.

Poliomyelitis or Infantile Paralysis

Polio is transmitted by a polio virus that enters the body through the intestine wall cells when someone swallows a bit of human faeces. When the virus invades the nerve cells in the base of the brain, or those which control muscle movement in the spinal cord, paralysis results (Moyes, 1981). Polio is said to affect approximately 1,5 million people, mostly in the Third World, because of the low levels of living, poor conditions of health, and lack of adequate primary health care facilities and programmes (immunizations in particular) (Moyes, Ibid).

Lathyrism is a disorder caused by eating toxic pulse. It is a crippling disorder that leads to paralysis of both legs. It is said to be common in the state of Madhya Pradesh in India, where an estimated 4% of the population may be affected (Wilson, 1983:21).

Tuberculosis affects approximately 50 million people mostly in the Third World because of the low quality of life and lack of health facilities. Wilson (1983:24) suggests that tuberculosis is a forgotten entity in almost all countries of the developed world.

Tuberculosis is cited amongst the disabling illnesses because it tends to handicap performance of some daily activities that are an integral part of living, with the result that some sufferers become eligible for social security benefits. But this depends primarily upon the degree of handicap imposed by this disease.

Leprosy affects approximately 20 million people, nearly 2/3 of whom are in Asia, and most of the rest in Africa (Moyes, 1981). Leprosy sufferers are disabled and stigmatised, and are often confined to institutions or "leprosy colonies", as they are often called.

Deafness affects about 10% of the population of some First-World Countries (in Australasia, Europe and North America). Estimates are believed to be higher in the Middle East, Africa, and South East Asia (Wilson, 1983:33).

Causes of deafness include congenital factors and illnesses (otitis media and meningitis), environmental factors (particularly prolonged exposure to noise), pollution, and nutritional deficiencies.

5.3.5 Disabling Illnesses Related to Poverty and Environmental Factors

Malaria is transmitted by the anopheles mosquito which infests the hot and humid equatorial and tropical zones. (Incidentally the bulk of the Third World falls within these zones.) Hence the high prevalence of malaria in equatorial and tropical countries.

Malaria is counted among the disabling illnesses because of its potential for brain damage, especially if the attack is extensive.

Bilharzia (schistosomiasis) is a disease of environmental poverty. It is found in stagnant waters or in flowing waters contaminated by excretion which finds its way into rivers and dams because of inadequate or complete absence of sanitation.

Bilharzia causes inflammation of the liver, intestinal veins, lungs, and bladder. In many sufferers it causes general weakness and debility that hampers work and activity. Only when the condition is severe is the sufferer classified as disabled.

This disease is estimated to be rife in some Third- World countries. For example 50% of the population of Egypt is estimated to be affected (Moyes, 1981).

River Blindness (Onchocerciasis)

This condition is caused by filarial round worms which penetrate the eye and live there for years, producing larvae inside the eye. These round worms are transmitted by a black fly.

River blindness is said to affect about 20 million people, mostly in the Upper Volta river basin in West Africa, and in Central and South America. About 500,000 of the affected 20 million are totally blind, and almost the same number is partially sighted. Wilson (1983:30)

5.3.6 Miscellaneous Causes of Disabilities

Pregnancy and Births

The high incidence of pregnancies and births in the Third World predisposes women and their offspring towards disabilities, because of the probability of pregnancy and birth-related disabilities.

According to Wilson (1983:18) approximately 20 million people are afflicted with disabilities linked to pregnancy and birth. These are more prevalent in developing countries where birth rates per annum are considerably higher.

Basic causes of pregnancy-related disabilities include malnutrition and severe anaemia, and diseases such as German Measles, influenza, and syphilis. Disabling birth injuries are caused by low quality midwifery and home-based births. Ntoane (1987) carried out a study of the homebased midwives commonly known as "Mmabotsetsi" in some villages in Bophuthatswana. She found the high prevalence of home-based delivery practice irrespective of the availability of primary health care centres (basically rural clinics) in villages.

Stroke and Hypertension

Hypertension is a risk factor for strokes, and it is said to be involved with 75% of first strokes. It accelerates arteriosclerosis which causes about 1,25 million heart attacks, and 650 000 heart attack deaths per year world-wide (Wilson, 1983:63).

Three main types of strokes are identifiable. These are cerebral thrombosis, cerebral embolism, and subarachnoid hemorrhage. All these three forms may cause disabilities and death. Hemiplegia is one disability caused by strokes and hypertension.

Strokes and hypertension are closely linked to life style, dietary habits, and stress. Amongst these factors, stress exists in equal proportions amongst the First and Third Worlds, although sources of stress may vary. Within the Third World, primary causes of stress are impoverishment and the adaptations to socio-economic changes incurred by urbanization and modernization. As people try to adapt to transitional forces, without the necessary adaptive devices, stress is experienced. This causes strokes and hypertension. This proposition may explain the high frequency of hemiplegia among my present study subjects.

The Age Factor

The incidence and degree of disability tend to increase with age. Meaning as age advances a person may lose some of the basic functions of the body. And also that disability that had been latent becomes manifest. The relationship between the prevalence of disability and age was illustrated in the report published by the British Office Population Census and Survey (Harries, 1970) quoted by Disler (1984:4 unpublished). Refer to Table 9 for details.

TABLE 9

RELATIONSHIP BETWEEN AGE

AND DISABILITY AS INDICATED BY HARRIES

Age in Years	Percentage of Population Found to be Disabled
Less than 16	0,5
16-64	1,0
65-74	7,0
75 and over	30,0
All age groups	38,5

Source: Adapted from Disler (unpublished, 1984:4).

This confirms the proposition that age influences, to a considerable extent, the prevalence of disability. This reality tends to confuse prevalence figures, in the sense that one might be dealing with cases of ageing instead of disability. The researcher also encountered this difficulty in my present project.

Age-related disabling illnesses include arthritis, multiple-sclerosis, general paresis, senility, cataract, dementia etc. Given that the average life expectancy rates in the countries of the First-World are higher (65+), and those of the Third-World are lower (approximately 40-50 years), age related disabilities will be more prevalent in the former than the latter. But Third-World countries are slowly catching up as they move along the path of socio-economic advancement. Improvement of their health services is also taking place.

Spasticity

A spastic is someone who is afflicted with cerebral palsy, which is a condition resulting from brain damage. Cerebral palsy causes permanent tautness of muscles, leading to a type of paralysis called "spasticity". (Moyes, 1981). Spasticity and Flaccidity, depending on their severity, may cause a wide range of disabilities.

Cerebral palsy is believed to occur with equal frequency in First- and Third-World countries, but no statistics are available in support of this belief.

War

As stated initially, Third-World countries are the battle-grounds for the East-West 'cold war'. On-going wars in countries like Afghanistan, Kampuchea, Angola, Namibia, Mocambique, and Lebanon are real evidence of the raging political and ideological warfare between countries of the Eastern and Western blocks.

In addition to international conflicts there are also civil wars and counter-revolutionary attacks which leave many people disabled. Sarah Jackson, of the Nicaraguan Health Fund, writing on the counter-revolutionary attacks in that country, stated that between 1981-1986 a further 3000 people have been disabled by wars (Aids for Living, August 1986, Vol.7, page 8).

Wars combine with natural and man-made disasters to increase disabilities. These include earthquakes, fires and floods. Sport is also a source of physical disability. Rugby in particular can lead to horrific injury. The World Health Organization (WHO) estimates that about 3 million people world-wide suffer from disabilities related to these factors (Moyes, 1981).

Poverty-related causes of disability that have been outlined so far are not exclusive to the Third World, but also prevail in the underdeveloped parts of the First World. They are highlighted in this discussion because they are more prominent in the developing countries and less so in the developed ones. Similarly, affluence-related disabilities do exist in the Third World, since dual societies are also found here. But, as Moyes (1981:5) says, 'the poor get the worst of both worlds' in that they are exposed to disabilities caused by both poverty and affluence. He further states that it will be difficult to keep disablement to 'one in ten' in the Third World.

5.4 WORLD-WIDE PREVALENCE TRENDS OF DISABILITY, WITH SPECIAL EMPHASIS ON THE THIRD WORLD

It is difficult to arrive at a universally valid figure for the incidence of disability world-wide because of the many and varying interpretations of the condition. One instance of this confusion is the four definitions mentioned by Blaxter (1976:1-18), namely administrative definitions, medical definitions, self-definitions and disability as deviance. The other stems from the related concepts to disability, namely impairment and handicap. A person maybe impaired but not disabled (a dwarf for instance). An impaired and disabled person will almost certainly suffer social handicaps. Some impaired persons might suffer social handicaps, but others might not. A patient who suffers from functional limitations (e.g. a cardiac sufferer) may not be stigmatized. Within this confusion, how does one arrive at an accurate prevalence figure that can be universally valid?

A further source of confusion is the relationship between age and disability. Persons who become disabled as a result of the ageing process may be difficult to classify under a disabled category.

All these difficulties cause variations in the prevalence figures of disabled persons internationally, nationally, and within various communities.

The World Health Organization (WHO), congnisant of these difficulties, worked out what came to be a universally accepted world wide prevalence figure of disability, which is approximately 450 million. This figure includes disabilities of all kinds, and it cuts across all definitions. Of the 450 million, 350 million are believed to be found in the Third-World (Moyes, 1981 and Wilson, 1983), i.e. more than three-quarters.

The observation that disability is more concentrated in developing countries has been made by several authors viz Piroquet (1986), (WHO) in Moyes 1981, Wilson (1983), Gear (1986), Mia (International Social Work Journal, 1985). Their observations relate to developing countries and rural zones within them.

Piroquet's observations were derived from his studies on the situation of disabled persons in the city of Bacolod in the Phillipines. He observed inter alia that there is a correlation between the dispersal pattern of the general population and that of the disabled, and that chances of disability increase correspondingly with an increase in population size. Since Third-World populations are larger, the numbers of the disabled are also large.

The World Health Organization stated that 7% to 10% of most countries' populations are disabled. That would mean about 8 million in Bangladesh and Nigeria, 12 million in Brazil, 14 million in Indonesia, and 64 million in India (Moyes, 1981:5).

Wilson (1983:1), in his studies on the causes and prevalence trends of disability world-wide, also observed that disability exists in higher proportions in the Third-World. He supports WHO's estimation of the world-wide figure of disability being 450 million. He adds that a third (1/3) of this figure are children, probably because of their vulnerability to hunger, ignorance, and poverty-related disabilities.

Professor Gear, addressing the Workshop on Rural Disability held at the University of Witwatersrand Medical School in November 1986, estimated that 80% of the population of South Africa live in rural areas (although the Department of Population Development in South Africa estimated the figure to be approximately 60% in 1989 in the T.V. 3 programme "Thlakangwaga" as broadcast on the 5th May 1989. South Africa's latest census data also do not bear Professor Gear out. It might be that Professor Gear used quite different criteria for what is considered rural than is South African census practice.

Gear further estimated the disabled population of South Africa to be 3 million, with 2,5 million living in the rural areas where he estimates 80% of the population live. Rural areas in South Africa are predominantly Bantustans, but include some white farming areas. Gear's observations actually imply the concentration of persons with disabilities in "homelands".

Mia (International Social Work, 1985), in her studies on disability and rehabilitation services in India, indicated that the 12 poorest countries of Asia contain approximately 200 million or 40% of the world's disabled population. He too supports the notion of the disabled being concentrated in developing settings.

What are prevalence trends in Bophuthatswana and the Molopo region like, since both are predominantly rural?

The 1985 Census Records estimated the population of persons suffering from disabilities of any kind to be approximately 11,291. Those in the category similar to the one studied in this dissertation numbered 7365.

The figure 11291 comprises about 0,42% of the total population of the country, which is approximately 2,5 million. This percentage is far below the 7-10% estimated by the World Health Organisation. For reasons to be explained later, this low percentage (0,42%) might not be accurate.

As with the rest of the world, regional variations in the distribution of disabled persons exist also in Bophuthatswana. These variations are determined by the dispersal pattern of the total population. The Odi region, for instance, is the most densely populated of all. It is said to have a correspondingly high number of persons with disabilities, viz 4232. This comprises 37,48% of the country's population of disabled persons. The Molopo region, whose population is smaller than that of the Odi region, has approximately 1647 or 14,59% (1985 Census Records).

As explained already, the Molopo region has approximately 1647 disabled persons of all categories. For the category similar to the one I studied, the figures are 7,62% or 561. The bulk of this figure is presumed to be concentrated in rural villages. Logistical problems within these areas make the disabled largely inaccessible.

The author have indicated earlier that possibly the 0,42% of disabled persons (as a proportion of the total population) may be inaccurate; it could be higher. Owing to factors such as what Peil (Bulmer & Warwick, 1983:73) refers to as inaccurate official

statistics common in developing countries, this figure for Bophuthatswana is probably too low. Difficulties of identifying and tracing the disabled might have led to the low percentage (0,42). Difficulties considered here were also observed by Piroquet in the Phillipines.

Piroquet in his studies on disability in Bacolod City made some observations regarding the situation of disabled persons. These observations include their inaccessibility due to geographical location, their distribution pattern being unknown, and their not being reached by professionals and voluntary welfare organizations. These observations are explained further and corollaries are drawn regarding the situation of those who live in this country.

First, the disabled in the Phillipines were found by Piroquet to be inaccessible because of "geographical impediments" that include poor road communications (especially in the rural zones), and their being spread over a wide geographical area.

The situation in Bophuthatswana is almost similar. This country has a vast rural hinterland made up largely of tribal villages. The majority of the disabled are presumed to be based there but there are no official documents to validate this presumption.

The second observation by Piroquet concerns the "uneven disabled population dispersal pattern" which may cause a locality to have a large number or only a few.

Bophuthatswana lacks an adequate data bank. Certain Government departments dealing in one way or the other with disabled persons do however keep some records. These are principally the Departments of Internal Affairs (Pensions Records) and of Economic Affairs (Census Records). These records were however found not to

have been useful enough in pinpointing the precise location of disabled persons. Census records have been useful in providing the sampling frame for this study , but of no use in locating disabled persons.

In the third place, Piroquet observed "manpower shortage", particularly shortage of rehabilitation personnel. Such shortage leaves the disabled unserved, or inadequately served.

The manpower situation in Bophuthatswana is equally grave. Rehabilitation personnel are in short supply, and the few available are based in towns. More will be said on this issue later.

The fourth observation concerned the "limited reach of voluntary organizations". Non-government organizations are important partners of Government agencies in the delivery of services in the disability-related field. Piroquet notes that these organizations seldom, if ever, extend their services to rural areas where the greater need is. The disabled in these areas are therefore often left out of the mainstream of service provision.

South African based voluntary organizations in the main adhere to the policy of not extending their services to "homelands", Bophuthatswana included. Their justification is that these areas are geographically and politically separate from South Africa. Bophuthatswana detoured around this problem (of lack of voluntary input) by formulating some legislative measures. These measures basically aim at encouraging the formation of voluntary bodies. Reference is made here to the Voluntary Associations Act, and the Social Welfare Development Fund Act, 21/1982.

Formulation of policies and Acts may not be the appropriate ameliorative measures, because there remains the task of implementing them, which may turn out to be awkward. Some of these tasks might include the formation of voluntary bodies and structures, and the formulation of responsive programmes. For as much as the people (especially professionals) may be willing to form organizations for example, the lack of resources (such as finance, manpower, and facilities) emerges as constraints. Organizations successfully formed against this background of deprivation tend to become either dormant or to function poorly. Regrettably, this is the position of the numerous organizations existent in Bophuthatswana.

5.5 THE MAJOR CHARACTERISTICS AND PROBLEMS OF DEVELOPING COUNTRIES WITH SPECIAL REFERENCE TO THEIR IMPACT UPON PERSONS WITH DISABILITIES

5.5.1 Poverty

Poverty is described by Ellis (1984:9) as the cause of a lack of welfare, rather than the lack of welfare itself or its consequences. The causes of poverty according to him are economic, social, political, and legal. These four basic dimensions yield four types of poverty, viz economic poverty, social poverty, political poverty, and legal poverty (Ellis, Ibid).

Economic poverty refers to a "lack of economic resources that can be deployed to increase the group's welfare". Broadly defined, economic resources here include financial, natural, human, and technological resources. Third-World countries are severely deprived of this category of resources, a fact which causes them to be underdeveloped and impoverished.

Social poverty, unlike economic poverty, refers more to utility instead of availability of resources. Social poverty is said to occur in three ways. First, some administrative, bureaucratic, and legal constraints may prevent the use of resources. An example given by Ellis (1984:10) is influx control in South Africa that prohibits migrant workers from living with their families in white-designated areas. (This control has, since the delivery of Ellis's Carnegie Paper, been abolished).

Second, it refers to a situation where there is a "lack of social networks and supportive structures that make productive use of opportunities possible." An example here would be the resettlement of Africans in economically deprived and unenviable 'homelands'.

Third, social poverty is manifested in Lewis's "Culture of Poverty" (Hardiman & Midgley, 1982). This concept mean that poor people possess some inherent attributes that predispose them towards poverty. These include indolence, passivity, stagnation, and a lack of ingenuity to manipulate the environment in order to generate wealth.

Where Political poverty is concerned, the degree of access to power structures that would enable people to influence the allocation of resources is in point. People who are denied political participation are inclined to be poor because they become victims of inequalities and inequities in the distribution of resources. The situation of South African blacks is a classical example here.

Legal poverty as defined by Lewis exists when a social group has no reasonable recourse to corrective procedures or no structural machinery to oppose the malfunctioning of

systems. An appropriate example would be the absence of advocacy structures in South Africa through which consumers of public services could appeal against their systems. I am thinking here in terms of structures like the Tribunals in Britain, and also "Ombudsman" offices. Although as Hill (1980:83) says these may fall short of being effective as they are often run by public servants, their existence in my opinion does make some difference in that the operation of public service systems is kept under surveillance.

The dimensions of poverty considered here culminate in economic poverty, which will now be discussed. Focus will be on its absolute and relative qualities, and its measures.

Three approaches to measuring poverty have been proposed in the relevant literature (McGrath, 1984:1) available to me.

First, absolute standards of living are determined through the poverty datum line (PDL). This is an income line representing a national minimum that would be necessary to obtain for a household a standard of living providing health and decency. The composition (number, age, and sex) of the household is allowed for. Food, clothing, housing and cleaning materials are included. If a household's earnings amount to <u>less</u> than the PDL, the household is in poverty. An advantage of the PDL as a measure of poverty is that it is <u>comparative</u>, and indicates by how much actual household income falls short of (or exceeds) the national amount that is based on objectively-based minimum allocations, according to that household's composition.

The second measure according to McGrath (Ibid) embraces the "behaviouristic concept of relative deprivation". This approach embodies both the "objective conditions of deprivation" and "subjective feelings". Objective deprivation is measured by assessing for example housing, income, employment, clothing, food etc. that is available. Subjective deprivation is determined by collecting views of persons who are perceived to be encountering objective deprivation.

Third, poverty is measured in terms of inequalities in the distribution of income, which are determined by looking at the relative size of the differences between the incomes of the lowest percentiles of the population and the incomes of the higher strata (McGrath, Ibid).

Per capita incomes are still considered as suitable empirical measures of poverty within and between countries. When per capita incomes are high, living standards should be correspondingly high, and vice versa.

Per capita incomes and gross national products are also used internationally as bases of classification into developing and developed countries. Table 10 presents per capita Gross National Incomes of various countries.

TABLE 10

PER CAPITA GROSS NATIONAL PRODUCT
OF SELECTED COUNTRIES FOR THE YEAR 1978

Country	Per Capita GNP in US Dollars
Switzerland	12 100
Sweden	10 200
USA	9 590
UK	5 030
USSR	3 700
Brazil	1 570
Taiwan	1 400
Mexico	1 290
Colombia	850
Nigeria	560
Phillipines	510
Kenya	330
China	230
India	180
Ethiopia	120
Bangladesh	90

SOURCE: TODARO 1981: 52

Table 10 tells us that Switzerland is the richest country in the list, and Bangladesh the poorest. But these conclusions should be viewed against the limitations of the gross national product as a reliable measure of the affluence or poverty level of countries. Its limitations as such a measure have been discussed at the beginning of this Chapter.

Poverty is the cardinal feature, as well as the principal problem, of developing countries. Other features (illiteracy, high infant mortality rates, low life expectancy rates, chronic levels of unemployment and underemployment, underdeveloped services, poor housing) are

expressions of poverty. They are also the causes and effects of poverty, a fact which illustrates a cyclical relationship between poverty and these conditions.

Poverty is massive in developing countries and it affects the majority. The disabled are amongst the poorest. Their poverty is rooted in environmental deprivation and their physical limitations. These combine to deny them access to life-enhancing resources, particularly employment. Poor environments lack jobs, and disability prevents its sufferers from taking up jobs that may be available to them. Poverty and disability are therefore closely related. The United States Census Bureau clearly demonstrated the interrelationship between poverty and disability, through its massive country-wide survey.

In 1976, this Bureau surveyed a total of 158 000 households with a view to assessing inter alia their income and education. Disability in the study was defined as a "chronic health condition preventing people from participating in a major activity appropriate to age". Using the Federal Poverty Datum Line as a cut-off point in the economically active age group of 18-64 years, 28,7% of poor people were found to be disabled in comparison with 11,8% among those who were not poor (Disler, 1984:5).

This study of the US Census Bureau demonstrated the cyclical relationship between poverty and disability. Poor people are prone to disablement (as indicated in my earlier discussion of the causes of disability). In turn, disabled people become impoverished due to loss of economic potential.

The cyclical relationship between poverty and disability leads us to conclude that disability should be concentrated in developing countries because of their massive poverty. Statistics quoted earlier on support this conclusion.

5.5.2 HIGH POPULATION GROWTH RATES, DEPENDENCY BURDENS, AND DISABILITY

High rates of population growth and dependency burdens are expressions of poverty and underdevelopment.

Poor people regard children as wealth and a potential investment for those periods of life marked by dependency such as old age, illness, chronicity, and disability. This thinking seems to be sustained by Third-World realities such as lack or inadequacy of organised supportive services, ineffective social policies, and insufficient social security systems. These realities are used by Third-World people as justification for having many children.

Todaro (1983:61) points out that in poor countries the educational level of women tends to be lower than that of men. Women of low educational standards pursue no interests outside their families. They preoccupy themselves with repeated births. It is not unusual for them to create production units within their homes. In this way the rates of births are kept high in underdeveloped countries.

Birth rates are estimated to be in the region of 35-40 per thousand in developing countries. They are half this figure in developed countries. (Todaro, Ibid:30). Such

population growth tendencies cause an imbalance in the distribution pattern of the world population. Poor countries contain 70% of the world's population as against 30% in the rich ones. This means that the majority of the world's people live in poverty.

Dependency burdens refer to the proportion of children under the age of 15, and that of people aged 65 and over, who are to be maintained by the labour force (Todaro, 198:67). Dependency burdens are said to be high in developing countries primarily due to high birth rates. In the more affluent countries improved medical and health services prolong longevity and such countries might experience a burden of too many old persons in proportion to the income-producing population.

High dependency burdens are a recipe for poverty because the labour force has to support proportionally twice as many children as it would in advanced countries.

What then are the implications of high population growth rates and dependency burdens on disability?

First, high birth rates increase chances of disability, since poor people lack the necessary knowledge and facilities to prevent disability at all levels, primary, secondary and tertiary.

At the primary level we encounter congenitally disabling illnesses, birth injuries, and childhood illnesses. At the secondary level we encounter a lack of facilities for corrective treatment that might stall or arrest further deterioration of the condition. At the tertiary level, we

encounter lack of facilities for rehabilitating those whose conditions are chronic already. The onset and progression of disability amongst poor people is largely an unfettered process. The high prevalence of disability amongst the poor, estimated to be 7-10% of the population, may be related to these factors. Moyes's (1981) assertion that disability is a 'disease of poverty' appears to be true.

Second, the disabled add to the unproductive and dependent masses. This means that the work force in the developing world is economically burdened with many children, and many disabled. Development theorists see this situation to be antithetical to development.

5.5.3 INFANT MORTALITY RATES AND DISABILITY

Infant mortality rates refer to the number of children who die before the first date of birth out of every thousand live births (Todaro, 1983:86). In developing countries they are said to be higher and average 155 as compared to 27 in the developed world. Table 11 lists infant mortality rates in various countries.

TABLE 11

INFANT MORTALITY RATES

IN VARIOUS COUNTRIES

COUNTRY	RATES PER 1000
Afghanistan	226
Central African Republic	190
Nigeria	157
Bangladesh	153
Pakistan	136
Tanzania	125
India	122
Kenya	119
Brazil	109
Phillipines	80
Uraguay	46
Taiwan	25
USA	14
Netherlands	10

Source: Todaro 1983: 44

Figures for Bophuthatswana, although not included in the above table, are high. In 1987 rates were 90 per thousand country-wide (privately communicated information). But recent surveys undertaken by the Department of Health and Social Welfare showed a marked decrease to 35-45 in some of the country's regions (viz Ditsobotla and Moretele). Improved primary health care services are believed to have influenced this decrease.

Infant mortality rates are an expression of poverty because of the main causes of infant deaths. Children in poor countries die of malnutrition, deprivation, and ignorance-related diseases which include Kwashiorkor, marasmus, diarrhoea, measles, and gastro-enteritis.

Congenitally disabled children and those who become disabled in early life are amongst those who die because of poverty-related childhood illnesses plus factors listed below.

First, parents lack the means and facilities to care for their disabled children, and are unable to meet their special needs. Raising a disabled child is to many such parents a taxing experience. Neglect and abuse often result, and death may occur.

Second, since children are perceived by poor parents to be the future providers of their social and economic care, disabled children are perceived to be lacking in this potential. Neglect with a view to causing death may be the resultant response.

Third, some cultural beliefs regard disabled persons as monstrosities. This tends, to encourage some parents to kill such children or to neglect them so that death occurs naturally.

Fourth, inadequacy of residential care facilities common in poor countries predisposes disabled children to adversities related to improper home-based care.

As congenitally and perinatally disabled children are amongst the many who die early in life, one would expect the population of disabled persons to be lower in developing countries. On the contrary this not so, due to an over-production of people who are circumstantially pre-disposed to disabilities.

5.5.4 LOW LIFE EXPECTANCY RATES

Low life expectancy rates denote the health status of countries, and also indicate the existence of poverty. Developing countries are said to have low life expectancy rates estimated to be 60 years or less in contrast to the 74 years in the developed ones (Todaro. 1983:114). This author claims that rates in developing countries are showing an upward trend because of improved health facilities.

Some studies carried out in the "homelands" of South Africa reveal dramatically low life expectancy rates. The Rand Afrikaanse University (RAU) research team reported by Harries (1984:8) revealed rates of about 55,3 years for girls, and 49,5 for boys at birth. For 5 year olds the figures were 59 and 55 respectively.

Poor people are susceptible to poverty-related illnesses and stresses coupled with the fact that they are unable to afford better medical and health care. Rich people on the other hand are susceptible to diseases of surfeit, but the knowledge and adequacy of medical and health care facilities possessed by them counter- balance the occurrence of diseases and increase their lifespan.

Disabled people are amongst the poorest in society. Their situation is compounded by their inability to afford to pay for special needs. This double-bind situation tends to shorten their lifespan considerably.

4.5.5 ILLITERACY

Illiteracy is deeply rooted in the underdevelopment of the educational system of a country. This underdevelopment may either be politically or economically determined. It is said to be politically motivated when education is used to subjugate the masses to maintain the status quo, as is the case of the education system for Africans in South Africa. When shortage of economic resources prevent the development of education, we are dealing with a purely economic problem.

Whatever the causative nature of the inadequacies, some social groups, predominantly the poor and powerless, will be deprived of education, leading to high illiteracy.

Illiteracy has been found to be widespread amongst Third-World peoples. Todaro (1983:128) estimated that 97% of people in the Third World are either illiterate or semi-illiterate as compared with 33% in the First World. Because of lack of supporting reference material from other Third-World countries, reference in this discussion will be made to the situation of South Africa and its national states only.

Several researchers auspiced by the Second Carnegie Inquiry revealed high rates of illiteracy amongst 'homelands' inhabitants. Moody & Golino (1984) observed these in GaZankulu and Venda; Muller and Tapscott (1984) in Transkei; and Ardington (1984) in Kwa-Zulu.

Independent studies by Jeppe (1980) and Molosankwe (1983) made similar observations in Bophuthatswana.

The low rates of literacy amongst "homeland" dwellers are related to politically motivated inadequacies in the education system for Africans in South Africa. Education was for decades administered in such a way that Africans remained largely uneducated.

Evidence of this maladministration is found in the many racially-based Government structures within which education is offered. The allocation of resources differed from one structure to the other. Table 12 gives a breakdown of education structures and their budget allocations for the year 1983/1984.

TABLE 12

SOUTH AFRICAN GOVERNMENT STRUCTURES WITHIN WHICH EDUCATION FOR VARIOUS RACES IS ADMINISTERED, TOGETHER WITH THE ACCOMPANYING BUDGET ALLOCATIONS FOR THE YEARS 1983/1984

Structures	Education Expenditure in million of Rands	Expenditure percent
Provinces (White Schools)	1 537	36,6
Department of National Education (mainly universities)	649	16,0
Department of Internal Affairs (Coloured Education)	497	12,5
Department of Internal Affairs (Indian Education)	248	6,5
Department of Education & Training (Africans in S.A. cities)	591	14,4
Non-Independent homelands	312	7,6
Other State Departments	259	6,4
Total	4 093	100.0

SOURCE: South African Race Relations (SAIRR) (1986:365).

The table above suggests that Whites (who are in the minority) enjoy an adequacy and sufficiency of resources, while the situation is different for other groups, particularly blacks.

Inequalities in resource allocation inevitably lead to disparities in literacy rates amongst the different racial groups. Pillay's findings are cited here in support of this claim.

TABLE 13

ILLITERACY RATES BY RACIAL GROUP IN 1980

Race	Number of Illiterates	Percentage
Africans	3,300,000	92,0
Coloureds	247,000	6,9
Indians	39,000	1,0
Whites	2,300	0,2
All Races	3,588,300	100,0

Source: Pillay, P.N. The Carnegie Conference Paper No.95 Page 26.

Figures in the Table above were said to exclude Venda, Transkei, and Bophuthatswana, which were politically independent then. Their exclusion certainly deflated the figures which could otherwise have been higher.

The figures in the preceding paragraph suggest that the able-bodied population may be deprived of education for political and economic reasons. In some countries, political factors take precedence over others, as in South

Africa. But whatever reasons there could be for denying education to the able-bodied population, they certainly affect the situation of the disabled. This may be due to any one or more of the following reasons.

Firstly, the disabled are a minority. They suffer deprivations common to racial, religious, ethnic, and other minorities. Amongst many of their deprivations is denial of educational opportunities on the ground that education, particularly in the developing world, is perceived as the means of improving employability. The disabled are considered to be lacking in economic potential. Logically therefore very few if any resources should be devoted to their education.

This line of thought is encouraged by the paucity of economic resources characteristic of the Third World. Therefore whatever resources there might be, should be invested wisely. Education for the disabled is not considered to be amongst the worthy investments.

These justifications result in the dire shortage of schooling facilities for the disabled in most countries of the Third World. Unfortunately, the author do not have sufficient supportive reference material from Third-World countries other than for South Africa and its national states.

Special schooling facilities in these territories are insufficient. Details in Table 14 support this claim.

TABLE 14

SPECIAL SCHOOLING FACILITIES FOR BLACK DISABLED CHILDREN WITHIN THE INTERNATIONAL BOUNDARIES OF SOUTH AFRICA (I.E INCLUDING HOMELANDS)

Disabled Category served	Number of Facilities
Blind Only	2
Crippled Only	10
Deaf Only	9
Mentally Retarded Only	25
Comprehensive Schools	16
All	62

Source: Pamphlet: "Adreslys: Spesiale Skole vir Swart Gestremendes": Department of Education and Training, 1987.

The 62 special schools indicated in the table above are distributed throughout South Africa.

Eighteen (18) are located within "homelands" and the remaining 44 in the so-called "White-designated" areas or cities. These facilities seem to be inequitably distributed in the sense that disabled persons are concentrated more in rural than in urban areas. In an ideal situation the concentration of these facilities should have been in "homelands". This is yet another instance of the urban bias in the provision of services and facilities, observed by the World Bank (Hardiman & Midgley 1982).

Special schooling facilities for Bophuthatswana are included in Table 14. Suffice to mention here that they are only four and one only addresses itself to more than

one disability, viz Kutloanong School for the Deaf and Dumb. Otherwise Tlamelang, Bartimea, and Ratlametswe address themselves to physically handicapped persons, blind persons, and mentally retarded persons, respectively.

Further evidence of their inadequacy is that they are based within four regions out of a total of twelve. There is at most one special school within each one of these four regions.

The Human Sciences Research Council (HRSC), in its findings on the educational provision of black disabled persons, confirms the shortage of schooling facilities for this population group. Their findings were reported in a Conference Report titled "Education for the Black Disabled". This was a combined report on conferences held in several venues in March 1987. The HSRC study revealed severe under-provision which is caused by several factors including lack of an adequate data bank on the disabled. Such a data bank would indicate details such as incidences, prevalence per category, location, and places of high concentration. Implicit here is the idea that disabled Blacks, especially in rural areas,are largely unidentified. Under conditions such as these ,it is difficult to formulate appropriate policies and initiate relevant services. The high prevalence of illiteracy amongst disabled people within some "homelands" is due to factors exposed by the HSRC. The situation in Bophuthatswana is cited here as an instance of what prevails in "homeland" areas. The findings of Cornelje and Cornelje will be used as an illustration. Initially it is necessary to indicate how the lack of special schooling facilities impacts upon the school lives of sufferers in case they be forced to enter mainstream schools.

Because of the quest for knowledge, and also the force of tradition, disabled pupils in areas where there are no special schools tend to enter mainstsream schools where they confront insurmountable problems related to the physical setting itself, the school programmes, and the attitudes of teachers and peers. The last-mentioned problem area will be expanded on because the researcher believes that, if teachers and peers could be supportive enough,the attendance of disabled students might be sustained in the face of all adversities. This is however presumably not true for the blind and the deaf, with whom this dissertation does not deal.

Able-bodied teachers have their own idiosyncratic attitudes towards disablement and its victims. When these are basically negative, they tend to reject and discriminate against disabled pupils. Brannans's study illustrated rejecting behaviour in teachers. He studied responses of 150 disabled college students in which they were asked to name the two most negative experiences in their lives. Most reported "destruction of self-confidence, embarrassment, humiliation in front of class, personality conflict, and unfair evaluation" (Brannans, 1972, cited by Dovey & Graffam, 1987:100).

Experiences of this nature naturally lead to high-drop out rates, and predisposes suffers towards semi-education and illiteracy. These are presumed to be high amongst the disabled. Unfortunately, the author does not have sufficient statistical data, especially from the developing world, to support my presumption. Hence I cite only those that were presented by Cornelje & Cornelje (1986, unpublished).

Cornelje & Cornelje studied a total of 124 physically handicapped persons living in the Ditsobotla region of Bophuthatswana. The study focussed on aspects of the lives of physically handicapped persons, including education. A sub-sample of fifty seven (57) persons, out of a sample of 124 were selected for examination of their education levels because the researchers considered them to be of employable ages (16-60 years). The findings are presented in Table 15.

TABLE 15

EDUCATIONAL LEVELS OF 57 PHYSICALLY HANDICAPPED PERSONS OF EMPLOYABLE AGES IN THE DITSOBOTLA REGION

High School Standard attained	Number of Persons	Percent
Never went to School	37	65,0
Standard 1-5	15	26,0
Standard 6-8	5	9,0
All	57	100,0

Source: Cornelje & Cornelje' (1986:18)

Table 15 shows that virtually two thirds (2/3) of the 57 persons studied had no education whatsoever, and that none of those who did have some education had gone beyond standard 8. One quarter had not gone beyond standard 5.

The findings reveal the existence of semi-education and illiteracy amongst the disabled in Bophuthatswana. Since Bophuthatswana shares much in common with other Third-World countries, speculation can be made about the situation in other developing settings in general.

5.5.6 POOR HOUSING STANDARDS AND DISABILITY

Poor housing standards are some of the "objective conditions of deprivation", meaning that they reflect poverty in an objective way. Poor people cannot afford proper homes mainly because of the established ways of acquiring homes.

In some ways, housing is largely a work-related benefit. Either an employee purchases a home with his earnings, or his employer provides it through one of the many housing schemes available in the market.

The majority of people in the Third World are however unable to afford proper homes by either means because of chronic unemployment and under-employment. As a result they erect shelters out of any readily available and affordable material. Wood, mud, stone, grass, and zinc are commonly used. This tendency was observed in South African "homelands" by several researchers involved in the "Second Carnegie Inquiry into Poverty and Development in Southern Africa". These researchers reported a predominance of poor housing structures in all the ten "homelands". The "wattle and daub" type was found to be common.

The hazards of shelters erected out of cheap material are well known. These include susceptibility to natural disasters, floods, hail, fires, and storms. When these disasters strike, death or serious injuries result and some of these traumas may be disabling.

The disabled in the Third World presumably swell the ranks of the unemployed and the under-employed. Employment is to most average citizens the only way to material welfare; without it people are confined to a life of poverty. They will therefore be unable to afford homes, particularly homes that suit their needs. However, author does not have reference material from other Third-World countries on housing for the disabled to support my assumption.

But if one considers the cost of housing, and especially that of adapting houses to suit the disabled, one can assume that because of their socio-economic position the majority of disabled persons in developing settings are unable to afford homes suited to their needs.

Such homes should have special architectural adaptations like widened door entrances, pavings, remote control devices, and special plumbing and electricity arrangements. But these are far-fetched dreams for the disabled in poor areas.

Deprivation in the area of housing is for the disabled both an individual and an environmental problem. Third-World countries are unable to provide proper homes as part of a social service to disabled persons. The disabled would for instance not be able to repay their part of the cost of such housing. In First-World countries, where the disabled are relatively well off, there exist "integrated" housing schemes which are also inhabited by the able-bodied community. These housing units are designed with special needs of disabled people in mind. Examples include the 'Het Dorp' in Holland, 'Knudsens Plads' in Denmark, the 'Haringey Home Scheme' in England and the 'Fokus Integrated Flats' in Sweden (Lancaster-Gaye, 1972 pp 11-52).

In the absence of housing schemes of this nature in Third-World countries, accommodation for some disabled persons is provided either in residential institutions or hostels. Such accommodation exists in South Africa and its "homelands".

Hostel accommodation is common in South Africa especially for whites. Examples of such hostels include the Phyllis Robertson Home in Pretoria. This is a residence-cum-workshop for adult disabled persons (Rehabilitation in South Africa, June 1986, page 20).

The Phyllis Robertson home is a project run under auspices of the Pretoria Association for the Care of Physically Disabled Persons, which was formerly the Pretoria Cripple Care Association.

The Vita-Nova Home in Springs, accommodating 48 adult disabled persons, is also a residence-cum-sheltered workshop, under the auspices of the Springs Association for the Care of Physically Disabled Persons. (Rehabilitation in South Africa, December 1985:17).

Accommodation for the disabled in Bophuthatswana is provided for in a few institutions. In addition, there are the 'Welfare Housing' units within communities. Their establishment was an attempt to provide "integrated" housing referred to above. Because of the generalised poverty of the country, however, 'Welfare' Housing units are disastrous projects. Their physical conditions would provoke disgust in people who regard safety, cleanliness, convenience, and comfort as basic attributes in any dwelling unit.

5.5.7 HIGH LEVELS OF UNEMPLOYMENT AND UNDER-EMPLOYMENT

Unemployment (meaning here a situation where a person is willing to work but cannot secure a job) and underemployment (meaning where a person works for fewer hours than would normally be required) are both expressions of poverty and underdevelopment. Both are intricately related to high population growth rates caused primarily by high birth rates and secondarily by urbanization.

High rates of birth increase population size which as Malthus would have said, then tends to outrun the resources of the earth. In a situation where the population increases and the economy remains stagnant, the result is an oversupply of the labour force in a shrinking job market.

Urban migration also causes a shrinking job market. The influx of people from the rural hinterland outstrips the number of jobs in the cities. As Mountjoy (1983) says, migrants exchange rural unemployment for urban unemployment.

Statistics on underemployment and unemployment in the developing countries of the world have been cited by various authors. Todaro (1983) estimated the figure for unemployment to have been 90 million, and that of underemployment 500 million in the early eighties. These will have increased by now, since there has been no significant reduction in population increase, and no signs of a boom in economies. Plummeting economies of both First and Third Worlds are national and international issues of concern today.

The Business Times supplement of the Sunday Times of the 28 November 1988 supplied figures for South Africa. This newspaper reported that 10,06% of the country's economically active population is without work. It was predicted that this figure would rise in response to the rapidly growing population, which is estimated to reach the 45 million mark by the year 2000.

This situation has implications for the "homelands" in South Africa. First, they comprise the rural face of South Africa. Population growth rates are high in rural areas. Second, their economies hinge on that of South Africa. Economic problems (unemployment in particular) that may prevail in South Africa spill over into "homelands".

The World Education Programme (WEP) and the International Labour Organization (ILO) cited by Leonor (1985) highlighted the prevalence of unemployment in some Third-World countries, namely, Phillipines, Tanzania, Egypt, and Indonesia.

Leonor himself observed a dimension of unemployment, "the unemployed school leavers" in some countries of the Third World. This phenomenon refers to Matric and secondary school leavers who cannot get jobs. Could this perhaps be due to the alleged inappropriateness of education provided in developing countries as decried by development theorists? Or due to the fact that people enter schools in large numbers, and upon graduating cannot find jobs?

Dr. Ghai, an economist and director of the United Nations Research Institute for Social Development, observed a similar phenomenon in Zimbabwe. In his article "Jobs for

Boys" which appeared in the Mafikeng Mail of the 12 December 1988, he reported that the problem of unemployed school leavers in that country is so pervasive that it threatens political and social order. He further cautions that the frustrated anger of youth is explosive by nature, and should be heeded.

Legotlo's studies revealed the problem of unemployed school leavers in Bophuthatswana. His findings were part of a dissertation submitted towards an M.A. degree. But a summary of his findings appeared in the New Bulletin, Mathlasedi, vol.No.6 (1987:15).

The observations by the authors, Leonor, Ghai, and Legotlo cited above, illustrate a close link between population increase and unemployment.

What then are the implications of this unemployment situation for persons with disabilities?

Disabled persons face daunting problems rooted in physical and social handicaps and stigma, which interfere with lack of jobs in their environment. The disabled generally lack marketable skills, often because of illiteracy. Their handicaps prevent them from performing jobs that may be available to them. Because of stigma employers are generally reluctant to employ them. The researcher regards the last reason to be significant in the sense that the supportive attitudes and actions of employers can minimize the effect of lack of skill and that of handicap. A willing employer would facilitate employment of a disabled worker amidst all adversities.

But since most employers, are reluctant to employ persons with disabilities, the need for employment grows.

These findings demonstrate that work opportunities for disabled persons in cities are not as good as might be expected and that they are capable of considerable expansion.

5.5.8 ESCALATING RATES OF URBANIZATION

Urbanization refers to the movement of people from predominantly rural and impoverished areas into towns and areas considered relatively affluent. According to Mountjoy (1983,102) it is both a national and international socio-economic phenomenon. Internal migration takes place when people move from rural areas into cities within the same country in search of better opportunities and jobs. As Mountjoy suggests, in the Third World migrants tend to be concentrated in large towns, mostly capitals, leading to the creation of Megacities. Examples of such cities include Mexico City in Mexico, Sao-Paulo in Brazil, Calcutta in India, Accra in Ghana (Mountjoy, Ibid), and perhaps the Pretoria - Johannesburg - Vereeniging complex in South Africa.

International migration involves the emigration of skilled people from poor (developing) countries to those of the developed world. When skilled people comprise the bulk of the emigrants, a process known as "international brain drain" is said to occur. This, according to development theorists, causes underdevelopment of the Third World.

International brain drain is a problem in most developing countries, and South Africa is no exception. The South African Broadcasting Corporation's TV 1 Programme illuminated the scale of the problem in South Africa. The Star newspaper of Friday, April 28 1989 did the same.

Within the boundaries of South Africa, rural-urban migration takes the form of the cross-border movements of labourers between South African cities and the "homelands". Figures for migrants and commuters run into millions. For instance, for the year 1984 the estimated figure was 1,3 million (Race Relations Survey 1985 1986:130). Within homelands, people move from rural villages into development towns.

Urbanization is said to be reaching alarming proportions in developing countries, because rural people are frustrated with farming life which is arduous and provides too poor a living. As a result, urbanization is used as an escape from poverty. Little do migrants realise that what they actually do is to exchange rural poverty for urban poverty. As they enter the cities, they are confronted by massive unemployment. Because they cannot get jobs, they face a life of further impoverishment.

What is the implication of migration (especially internal migration) for disabled persons?

First, those who move from rural areas are the productive able-bodied, the youth, and the young adults, whether skilled or unskilled. The disabled are amongst those who remain at home in the rural areas. This urban migration deprives them of social support.

Secondly, urban migration disrupts the extended type of family which is largely a primary resource for care for disadvantaged family members.

Third, areas migrated from are neglected in terms of development efforts. This means that departure of migrants leads to further underdevelopment of the rural areas. As a result those who remain find themselves as sojourners of deprived areas where services and resources do not reach them.

5.5.9 UNDERDEVELOPED SOCIAL SERVICES
(Education, Health and Welfare)

Social services in the Third World are characteristically urban-based. They are also inadequate. This inadequacy is part of the wider problem of underdevelopment and poverty. Economically poor countries lack a good taxation base to fund social programmes. Since social services are mostly paid for from public funds, poor governments cannot pay for enough of them. According to the World Bank, (in Hardiman and Midgley (1982:89) governments' fiscal and economic policies favour urban rather than rural development. So people in rural areas get the worst deal.

A further feature of services in Third World countries is their being prioritized according to their potential to contribute to economic development. Education and Health are thought to contribute to such economic development. Education provides skilled manpower and a healthy labour force (Conyers, 1986:71) Welfare services are regarded as the "odd man out". To be precise, they are perceived to be antithetical to development basically in two ways. On the

one hand they divert scarce resources to 'unproductive' people. On the other, they do not directly generate income. Hence policy-makers are less keen to devote resources to them.

That social welfare services are not economically remunerative may be an inaccurate assumption, because through social work intervention people become mentally and psychologically healthier. This usually enhances their productivity. A brief overview of social services (education and health) in developing countries is given here, while a full Chapter will be subsequently dedicated to welfare services.

5.5.10 EDUCATION

Formal education in the Third World is criticised for preparing people to take up urban rather than rural employment (Conyers, 1986:85). Todaro (1983:102) supports this criticism in saying that the education model in the Third World is an imported Euro-West concept which fails to meet the development needs of such countries. As a result its limitations facilitate the international brain drain, and encourage movement of people from the rural hinterland into cities.

Notwithstanding these criticisms, education is still regarded a national priority, and sizeable resources are devoted to it. Shortage of schooling facilities, high teacher-pupil ratios, poorly-trained teachers, high rates of illiteracy and extensive semi-education however, persist in most underdeveloped countries, because, even if improvement of education is accorded high priority in a development plan, results take long in coming and raising

educational levels throughout a society might take as long as three generations.

Amidst these difficulties, education for persons with disabilities should be given special attention, but seldom is. Aspects of education that are crucial to the disabled are vocational preparation and vocational rehabilitation. Both however presuppose elementary schooling. Where no such schooling is given, they will only direct the trainee to sheltered employment, which has inherent demerits. Gwynne and Miller (1974:149) list these disadvantages as lack of incentives such as good remuneration, opportunities to influence the management of the industry, and prospects for personal development. According to them, sheltered employment merely keeps employees occupied to avoid boredom, and nothing more.

5.8.11 HEALTH

Health services in the Third World are also a national priority. They too remain largely underdeveloped owing to lack of resources. Few hospitals, high doctor-patient ratios, poorly-equipped medical and health facilities, and shortage of personnel are some salient features.

Doctor-patient ratios are regarded as a matter of special concern. They are usually high, although variations in ratios exist amongst Third World countries. Africa is said to have between 20,000-40,000 patients per doctor. Nepal has 36,000 patients per doctor (McPherson, 1982:55). The figure for Bophuthatswana is said to be 20,000 patients per doctor (privately communicated).

In addition to their inadequacy, health services in the Third World are urban-based. Professionals and facilities are concentrated in towns. Private doctors tend to be unheard of in rural areas. Spencer (1980) says professionals are attracted to city areas by the opportunities for intellectual and social stimulation present there. Prospects for economic and professional advancement are added attractions in town areas.

The profile of health facilities in Bophuthatswana follows a similar trend: Health resources are inadequate and the available ones are town-based.

Manpower shortage is acute. In 1987 there were only 5 occupational therapists, 3 physiotherapists, 1 clinical psychologist, 93 doctors, 2649 nurses, 10 hospitals, and 145 static clinics countrywide (privately communicated.) These facilities are disproportionate to the country's 2,5 million population.

With such a background of health services, the disease patterns reflect poverty. Disabling diseases are common. Poliomyelitis, meningitis, measles, xerophthalmia are among those that cause serious disability.

Physical rehabilitation of the disabled in poor countries is hampered by shortage of staff and lack of appropriate technology. The latter calls for some explanation here.

By technology is meant rehabilitation aids (wheelchairs, walkers, crutches, orthotics, clogs, calipers, and orthopaedic shoes). Protheses, for substituting missing limbs or organs (artificial limbs, marble-eyes, false teeth etc.) are included (Moyes, 1981).

Such technological appliances have to be imported from advanced countries. They are therefore designed for conditions in those countries. As a result they are often unsuitable for developing settings with their rugged terrains. They are also expensive for the pockets of poor countries. In developed countries they are usually purchased in the economic market, while the social market is the major supplier in developing countries. To add to this, there are often complicated bureaucratic procedures involved in securing such devices.

In developed countries accessibility to technology is facilitated by the services provided in the so-called "Independent Living Centres". These are display and demonstration centres for sufferers and their families. In South Africa these are located in large metropolitan areas, viz Johannesburg, Cape Town, and Bloemfontein. (Rehabilitation in South Africa, September 1984, vol.28 No.3).

An account of attempts to indigenize technological appliances in India is given by Banerji & Banerji. These authors describe various aids made of cane and bamboo. These are said to be strong, elastic, pliable, light, and malleable, and are therefore ideal for contingent conditions in India. (Quoted from AHRTAG, "Aids for Living" No.7 of August, 1986).

Arleen Richman (Ahrtag, Ibid) gives a description of a type of wheelchair suitable for the rugged terrains of the Honduras. This wheelchair is called the ATI-Hotchkiss Wheelchair, named after its designer, one Hotchkiss, who was paraplegic.

In Nicaragua there is an organization of disabled persons called the Organization of Revolutionary Disabled People (Ernesto Che Guevara-ORD). This organization, which is composed basically of war-disabled people, produces locally designed aids (Ahrtag, in "Aids for Living" (August 1986).

Examples such as these reflect the growing need to localize technology for the convenience of the user. First-World technology in the Third World is costly, and hard to maintain; technicians to do maintenance work are in short supply. As a result, people go for longer periods without aids, and this seriously hampers their mobility.

NOTES

1. Ahrtag. Aids for Living. No.7, August, 1976.

2 Ardington, E (1984). Poverty and Development in a Rural Community in Kwa-Zulu. Carnegie Conference Paper No. 53b, Cape Town.

3. Blaxter, M. (1976). The Meaning of Disability. A Sociological Study of Impairment. London; Heinemann.

4. Bophuthatswana. Statistics Division of the Department of Economic Affairs: 1985 Census Report. Mafikeng.

5. Byrne, A, & Padfield, C.F. (1978) Social Services Made Simple. London; Howard & Wyndham.

6. Conyers, D. (1986). An Introduction to Social Planning in the Third World. Chichester & New York; Wiley & Sons.

7. Cornelje A, & Conrnelje, H. (1986 Unpublished). Rehabilitation in Ditsobotla. A survey done in Mareetsane, Gelukspan Hospital.

8. Disler, P. (1984). Poverty and Disability. Carnegie Conference Paper No. 186, Cape Town.

9. Dovey, K. & Graffam, J. (1987). The Experience of Disability. Social Construction and Imposed Limitation. Victoria College, Burwood Campus.

10. Ellis, G.F.R. (1984) The Dimensions of Poverty. Carnegie Conference Paper No. 4, Cape Town.

11. Gil, D. (1973) Unravelling Social Policy. Cambridge, Massachusetts; Schenkmann.

12. Ghai, D. "Jobs for Boys", Mafikeng Mail, 1 November 1988.

13 Goldthorpe, J.E. (2nd ed.) (1984). The Sociology of the Third World. Disparity and Development. Cambridge, University Press London: Oxford University Press.

14 Hardiman, M. & Midgley, J. (1982). The Social Dimensions of Development. Social Planning in the Third World. Chichester & New York: Wiley & Sons.

15. Harries, P. (1984) Aspects of Poverty in Gazankulu. Three Case Studies. Carnegie Conference Paper No.7 Cape Town.

16 Lancaster-Gaye, D (1972) Personal Relationships:The Handicapped and the Community. Some European Thoughts and Solutions. London & Boston: Routledge & Kegan Paul.

17. Lopes, H. & Tri, H.C. "The Poverty Trap: The Plight of Least Developed Countries." The UNESCO Courier. October 1981, pages 5-9.

18. Leonor, M.D. (ed.) (1985) Unemployment, Schooling, and Training in Developing Countries. London, Sydney, Dover: Croom Helm.

19. Jeppe, S. (1980) in Molosankwe,S.J. (1983). An Analysis of Some Contributory Factors to Malnutrition viz Unemployment, Poverty, and Overcrowding. B.A.(SW) Honours Extended Essay. Department of Social Work, University of Fort Hare, Alice.

20. MacPherson, S. (1985) Social Policy in the Third World. The Social Dilemmas of Underdevelopment. Brighton, Sussex: Wheatsheaf Books.

21. McGrath, M. (1984) The Determinants of Poverty : A Theoretical Analysis. Carnegie Conference Paper No.269, Cape Town.

22. Midgley, J. (1984) Social Security, Inequality,and the Third World. Chichester & New York: Wiley & Sons.

23 Miller, E.J. & Gwynne, G.V.,(1974) A Life Apart. A Pilot Study of Residential Institutions for the Physically Handicapped and Young Chronically Sick. London: Tavistock.

24. Mia, A. "Community Participation. The Needed Approach to Primary and Secondary Prevention of Disability and Rehabilitation of the Disabled in Rural Communities. International Social Work Vol.28, No.1, 1985.

25. Moody, E. & Golino, C. (1984). Area Study on Ganzankulu. Carnegie Conference Paper No. 252. Cape Town.

26. Moody, E. & Golino, C. (1984) Area Study on Venda. Carnegie Conference Paper No.251. Cape Town.

27. Moyes, A. (1981) One in Ten. Disability and the Very Poor. Oxford: Oxfam.

28. Mountjoy, A. (1983) (ed.) The Third World. Problems and Perspectives. London: MacMillan Press.

29. Molosankwe, S.J. (1983) Ibid.

30. Muller, N.D. & Tapscott, G.P.G. (1984). The Face of Rural Poverty in Transkei. Two Villages' Socio-Economic Profile. Carnegie Conference Paper, No. 46, Cape Town.

31. Pillay, P.N. (1984). The Development and Under-development of Education in South Africa. Carnegie Conference Paper No. 95, Cape Town.

32. Piroquet, D. "The Experience of Bacolod. Disability in the Phillipines". World Rehabilitation Fund, Volume 3, 1986.

33. Peil, M. "Situational Variables" in Bulmer, M. & Warwick, D.P. (eds.) (1983) Social Research in Developing Countries. Surveys & Censuses in the Third World. Chichester & New York: Wiley & Sons.

34. Rehabilitation in South Africa, December 1985 Volume 29 No. 4.

35. Rehabilitation in South Africa, June 1986, Volume. No.2.

36. Rehabilitation in South Africa, March 1984, Volume. 28 No. 1.

37. Rehabilitation in South Africa, September 1984, Volume. 28, No.3.

38. The South African Institute of Race Relations, (1986). Race Relations Survey 1985. Johannesburg.

39. The Report on Disability in South Africa. National Symposium on Disablement Vol 25, November 1987. Compiled by the Coordinating Committee. Year of Disabled People 1986. Department of National Health & Population Development.

40. S.A. Human Science Research Council. Conference Reports On "Education for the Black Disabled" held in Durban, Port Elizabeth, Pretoria, and Johannesburg in 1987.

41. The Republic of Bophuthatswana: Department of Health and Social Welfare. Annual Report 1985. Mafikeng.

42. Todaro, M.P. (1983) Economic Development in the Third World. New York: Longman.

43. Webster,A. (1984) Introduction to the Sociology of Development. London: MacMillan.

44. Wilson, J. (ed) (1983) Disability Prevention. The Global Challenge. Oxford, New York, Toronto: Oxford University Press.

45. Verslag van die Sub-Komitee. Opleiding en Indiensplasing Van die Gestremde Persoon, Book 2 1987.

46 The Citizen, Wednesday 12 November 1988.

47. The Sunday Times. Business Times Supplement 28.11.88

48. The Star, Friday 28 April 1989.

49. The T.V.3 Programme, "Thakangwaga".

50. Spencer, I.W.F. (1980) Community Health. An Introductory Orientation for South African Students. Pietermaritzburg; Shuter & Shooter.

CHAPTER 6

REHABILITATION SERVICES FOR PHYSICALLY DISABLED PERSONS IN BOPHUTHATSWANA

6.1 INTRODUCTION

This chapter basically describes Social Work and Social Welfare Services to disabled persons in the Molopo region. These services are seen as part of the total programme of medical, physical, and social rehabilitation, although emphasis here is on the latter.

Since the Molopo region is a developing one, social welfare and services, to the disabled in particular, are viewed against the background of underdevelopment and the Government's priorities. An attempt will be made to put Bophuthatswana and the region into a wider context. To this end, social work and welfare services in the developing world are discussed with reference to their nature, historical origin and present status in the eyes of politicians and the impact of this upon their condition. The attitudes of policy makers towards these services are highly likely to determine the allocation of resources to them.

Since Bophuthatswana is part of the developing world, an attempt will be made to relate general insights regarding development to the country. To this end a brief review of the history of social work and social welfare will be made. Current issues which include service delivery structures, policies, and the manpower profile will be examined too. Inadequacies and deficiencies in policies and structures will form the backdrop against which deficiencies in social provisions (to disabled in particular) are to be viewed. This is not to suggest that Social Workers in

the country do not contribute to service deficiencies. They do, to a considerable extent, because of their lack of motivation. They are as demotivated as to be almost inefficient.

But focus here is mainly on lack of resources rather than their inefficiencies.

6.2 Social Work and Social Welfare Services in the Third World

Social Work and Social Welfare services as practised today in the developing world are regarded as Euro-West and hence foreign, and therefore not pertinent to needs of these countries.

These criticisms are based on the fact that such services focus on problems associated with the structure of the population and mode of life in developed nations (Conyers, 1986: 9). Such problems include psychiatric illness,marriage breakdown,child neglect, neglect of the aged, problems of the disabled, etc. These are brought about by urbanization and westernization which have largely destroyed traditional social care structures.

The focus on the problem areas mentioned above tends to overlook the indigenous problems of developing countries which are rooted in underdevelopment and poverty. The researcher does not suggest that urban and affluence-related problems do not exist in developing countries, but that those that are poverty-related are more extensive in there. Social service disciplines are however prioritised according to their perceived impact upon the problem areas that have been named. As Conyers (1986: 41) says, education and health disciplines are regarded as national priorities since they are perceived (by politicians) to be dealing directly with problems of underdevelopment, viz. skilled manpower shortage, and poor health. Education services produce skilled manpower needed to perform developmental tasks; health services improve the health

status of the population and hence raise productivity in the labour force.

In these ways these services impact directly upon economic development which is the main concern of governments in developing countries. As a result there is a tendency to devote resources to educational and health services only and not to other social services for which there is a great need.

Social work and social welfare are for instance, perceived by politicians to be diverting scarce resources to disadvantaged individuals and groups (the aged, the disabled, widows, abandoned children, etc) who have very little, if any, economic potential. As a result, politicians are rarely prepared to allocate sufficient resources to these social service fields.

To overcome these problems of inferior status, social work must seek to move away from micro-practice towards macro-practice. The macro-practice perspective consists of Community Work (made up of community development, social action and social planning), and Policy and Administration (Cox, 1987:29).

The macro-approach implies interventions that transcend individuals, families, and groups, concentrating instead on environments , communities, organizations, and national entities (Cox, Ibid:35). Through this approach it is possible to pick up environmental forces that impinge on the welfare of people, which micro-practice does not do. Such forces may include extensive poverty and deprivation which may either be political (structural) or economic (the two are however inter-related). Macro-social work may be the means to enhance the profession's credibility in the eyes of politicians.

Do ideas expressed here mean abandonment of micro-practice? Certainly not, for the following reasons.

First, developing countries, as the name suggests, are not static, but are in a state of transition because of the forces of urbanization and modernization. These socio-economic phenomena have contingencies to be addressed through Euro-Western approaches, viz micro-practice.

Second, Third-world countries are not internally homogeneous. They comprise developed and underdeveloped, rural and urban zones, and also contain dual societies. But the underdeveloped and rural patches are extensive and comprise a bulky 70% of such countries (Todaro, 1983). Because of these realities there is a need for a type of social work that focuses dually on problems of poverty, underdevelopment, and rurality on the one hand, and those of affluence and urban life on the other. A complete elimination of the Western model of social work, as apparently suggested by some authors, is to me, unrealistic. The scales should rather be tipped more towards the indigenous model of social work which by its nature focuses on problems of poverty and underdevelopment.

How did this Euro-West model of social work find its way into the Third World?

It infiltrated the developing world as part of the cultural legacy of colonialism. Hardiman and Midgley (1982:40) say that social work was imported into the Third World to deal with problems of colonial capitals. "Welfare experts" from advanced countries were imported to offer services to town-based indigenous populations. This focus on urban rather than rural problems laid the foundation for urban (hence foreign) welfare work.

As problems multiplied and imported manpower could no longer cope, training of indigenous manpower became imperative. Coupled with what Heisler (1967) as cited by Hardiman & Midgley (Ibid) referred to as 'bulging caseloads and linguistic handicaps', this training became more pressing.

Training courses were, as a result, introduced in some advanced countries. Noted efforts were those of the London School of Economics in 1943. The school enrolled eight Nigerians, seven Ghanaians, two Sierra-Leons, one Zanzibari, and two students from the far East (Hardiman & Midgley, Ibid).

As one author puts it, these students were not to be taught how to practise indigenous welfare work, but to learn how the British system of social welfare work so that this could be transplanted into their own countries. In this way, the foundation for Euro-West training was laid and that of practice entrenched.

The current and predominant use of British and American books in both practice and training make foreign approaches hard to abandon. But, on the positive side, there is a growing awareness amongst both university trainers and practitioners to indigenize the profession. The profession however is still suffering some injustices, as it is not able to compete successfully for resources.

What then is its present status?

First, Social Work is considered to be somewhat irrelevant by Third-World governments. It is therefore not well catered for. Structures are inadequate, policies are residual and underdeveloped, and manpower is in short supply. Researcher does not have enough empirical evidence to substantiate her assertion, but do point to the fact that very often there is no state Ministry which is established solely for welfare. Welfare departments are commonly appendaged to other State departments. Conyers (1986) states that since policy makers in Third-World governments do not understand the exact role of the current model of social work in economic development, they tend to move it from one Ministry to the other. He says that in Zambia it used to be attached to that of Labour (as was the case before 1937 in South

Africa), then moved to that of Adult Education, and so on. The situation in Bophuthatswana is no different. There is no Ministry of Welfare, but it is instead a part of Health. Previously it used to be that of the Interior, now known as Internal Affairs.

An arrangement of this nature tends to make the needs of welfare subordinated to those of the spacing department. Evidence of this subordination in Bophuthatswana is the fact that the welfare structure is inadequate, and poorly equipped in its own right and also in comparison with that of Health. It lacks some organizational arrangements that are vital to welfare policy formulation. More will be said on this later on. Structural inadequacies considered here impact negatively upon the quality and quantity of social welfare services.

Second, policies are residual and emphasise individual and family responsibility in providing welfare. Benefits are also inadequate. All these point to small budgets. Midgley (1984: 131), in his essays on social security in developing countries, cited the findings of a study done by the United Nations in 1979 on the financing of social security in 31 countries of the Third-World. This study, as he reported, revealed that such governments spent less than 1% of their gross domestic products; and only 7 countries spent more than 2% of their national incomes on social security and social work services. Industrial countries were said to spend about 10% of their GNP's on these services.

Similarly, in Bophuthatswana welfare budgets are small. Exact figures proved to be unobtainable, but the meagre social security amounts payable in the country are enough evidence of this.

At present amounts for disability grants and old age pensions range between R195-R234 bimonthly. Amounts in South Africa are comparatively higher. Hence there is a desire on the part of ex-South Africans who now live in Bophuthatswana to retain their

South African pensions. Such people shuttle frequently across borders to collect their pensions.

Another evidence of residualism is the underlying philosophy of individual and community responsibility. This is capitalist ideology common in both developed and developing nations, especially of the Western block.

Some social welfare policies reflect this ideology clearly. By way of example the Bophuthatswana Social Welfare Development Fund Act 21/1982 provides financial assistance to persons, groups, or organizations who wish to offer welfare. Assistance proposed in this Act is intended to serve as an incentive to people to engage in formal welfare work and relieve the State of some of this responsibility. The Registration of Voluntary Welfare Organizations Act also has similar objectives as it proposes to give legitimation, and therefore the authority, to solicit public funds for welfare work. This policy has so far failed to stimulate voluntary action. This is evident in the absence of autonomous and fully-functioning welfare organizations. More will be said on this issue later.

Other policies illustrate clearly the underlying philosophy of individual responsibility for welfare. These include the Bophuthatswana National Provident Fund Act 19/1979, which administers the Unemployment Insurance benefits; The Bophuthatswana Workmen's Compensation Act, which provides for financial compensation to the industrially injured; and the Bophuthatswana Unemployment Insurance Fund Act 17/1978 which extends unemployment benefits to employees who have lost their jobs but are employable. Benefits that accrue from these policies are certainly much higher in value than those in the social assistance category. The reason is that they are work-related, and are based on the employee's own contribution, that of his employer, and partly that of the State.

The work ethic, and the philosophy of individual responsibility, are both obvious here.

While these policies exist in both poor and rich countries of the capitalist system, the governments' rationale for adopting them may differ. In advanced countries they are intended to encourage individual efforts in generating wealth. In poor countries it may be a combination of this and that of avoiding or limiting State responsibility in financing individual welfare in the face of scarcity of resources. It is common knowledge that poor countries lack a good taxation base to fund public policies. But, whatever justifications there could be for policies to be residual, the fact of the matter is that the benefits they administer are commonly inadequate by all standards.

As has been demonstrated in the foregoing discussion, social welfare and social work services in developing countries are not national priorities. Hence very limited resources are devoted to them. These realities also apply to Bophuthatswana. Present structural inadequacies and service deficiencies should be viewed against this background.

In the ensuing discussion, a description of the welfare structure of Bophuthatswana will be given, focussing mainly on its short-comings and inadequacies. These will form the background against which present service deficiencies are viewed.

6.3 THE WELFARE STRUCTURE OF BOPHUTHATSWANA

DIAGRAMATIC PRESENTATION

FIGURE 1

PROFESSIONAL WELFARE SERVICES BRANCH

Director

1 Assistant Secretary — 1 Assistant Secretary

SECTION Family Welfare Services	SECTION Specific Services	SECTION Planning and Development	SECTION Community Services
1 Chief Prof. Officer	1 Chief Prof. Officer	1 Chief Prof. Officer	1 Chief Prof. Officer
SUB-SECTION Administration	SUB-SECTION Care of the Aged and Physically Handicapped	SUB-SECTION Child and Family Welfare Services	SUB-SECTION Research and Publications	SUB-SECTION Development and training
1 Senior Clerk 2 Clerks Gr I 1 Clerk Gr II	1 Principal Social Worker	2 Principal Social Workers	3 Principal Social Workers	1 Principal Social Worker 2 Senior Social Workers	1 Principal Social Worker 2 Senior Social Workers

6.3.1 DESCRIPTION

6.3.1.1 THE MAIN OFFICE - WELFARE BRANCH

The Welfare Branch of the Main Office is headed by an Executive Director of Welfare Service since it has no Ministry of its own (being a relatively minor part of the Ministry of Health).

The Director has two Assistant Secretaries, one in charge of Family Welfare Services and Specific Services; the other in charge of Planning and Development, and Community Services. The positions of Director and of both Assistant Secretaries were at the time of writing vacant.

In addition to the Director and the Assistant Secretaries, there are four Chief Professional Officers, each heading a particular section. These sections are:-

The Family Welfare Services, which comprises the sub-sections of Care of the Aged and Physically Handicapped, and that of Child and Family Care.

The Specific Services which are primarily charged with offering specific services (e.g rehabilitation of substance abusers). It seems, however, that activities of this Section overlap with some of those for the Family Welfare Services. Absence of definite policy guidelines for the Section, which is commonplace amongst all Sections, could be the cause of these over-lappings and duplications.

The Planning and Development Section, comprising the sub-sections of Research and Publication, and Development.

The name itself indicates the primary charge of the section and its sub-sections: it is responsible for planning and organizing welfare

programmes. This is done in various ways, but in the main by analysing monthly returns from all the country's regional offices, and (ideally) designing programmes based on these returns. It is also responsible for staff development programmes. It should therefore be a live wire, but the irony is that it is severely short staffed.

This reality has a drastic effect on service organization and improvement.

Like all others, the Section is not replicated at regional levels, as will be shown later. This is indicative of the level at which social welfare planning is done in the country. Planning is done solely at national level. Throughout social work literature, planning at national level has been criticised for failing to meet needs of people at "grassroots."

Lauffer, in his criticism of societal-level planning, illustrated the advantages of local planning by stating that "the more local the locus of decision-making, the more likely that decisions are going to be relevant and responsive to local needs and interests." "Smaller is better" because it is close to home, more manageable, more personal, and probably less wasteful of resources. The greater also the diversity of local responses to locally felt needs, and the greater the freedom of choice. Getting the (big) Government "off our backs" restores responsibility to the individual and to

the local where it truly belongs." (Lauffer, as cited by Cox 1987).

Although Lauffer was making reference to the American situation, his assertions are applicable to Bophuthatswana.

The Mmabatho Main Office is the national level planning office. Planning takes the form of analysing monthly returns from regions, and designing welfare programmes based on data from these reports. But, unfortunately for this section, it, like the rest, lacks clear policy guidelines and adequate staff. It is therefore functioning poorly.

The last Section is titled Community Services. Although it too does not have a definite policy-guideline for its programmes, included in its list of functions is the sanctioning of applications for registration by Voluntary Welfare Organizations, in terms of existing legislation.

In the staff hierachy, the level below that of Assistant Secretary is that of Chief Professional Officer. There are four of these in all. Each one of them is accountable to an Assistant Secretary and each manages a specific subsection.
The administrative chain of communication as it exists now provides for each chief professional officer to be accountable to an assistant secretary who heads the Section.

The third level of staff in the hierachy is that of Principal Social Worker. There are eight in all.

The fourth (and lowest) level is that of Senior Social Worker, and there are four in all. Finally there are also a few clerical posts.

The main office staff establishment, as it exists on paper, consists of 19 professional positions and 4 clerical. But at the time of writing only 6 of all these posts were occupied. This situation indicates such severe personnel shortage that it is clear that the work of the Professional Welfare Services Branch of the Ministry cannot possibly be effectively carried out.

In addition to shortage of manpower, there is also absence of a Policy-Making Council. Researcher is referring here in particular to the Welfare (Policy) Council that exists within the welfare structure of South Africa. This Council's prescribed function is primarily to advise the Government in relation to:-

(a) "the general policy which should be followed to promote and ensure the social stability of the inhabitants of the Republic and to prevent social decline;"
(b) the measures generally necessary to combat or prevent social problems;
(c) the measures particularly necessary for stabilizing, protecting, or promoting family

or married life or the welfare of the aged or children or physically or mentally handicapped persons or other groups of the population;

(d) the measures which should be taken in order to improve social welfare services in the Republic;

(e) the rendering of social welfare services by welfare and other organizations and matters connected therewith;

(f) any research which should be undertaken in connection with any social problem;

(g) any social welfare matter referred to the Council by the Minister or about which the council deems it necessary or desirable to advise the Government; and to provide information and guidance to welfare organizations in connection with social welfare services [quoted from the Republic of South Africa National Welfare Act, 100/1978.]

There is no welfare Council within the welfare structure of Bophuthatswana. The functions that might be performed by it are presumably performed by the Welfare Branch. This implies that there is no formal organizational arrangement established primarily (perhaps exclusively) to execute the policy-making function. One may therefore assume that this vital function is done in piecemeal fashion by the Welfare Branch. Researcher's assumptions seem to be valid because at present there are no policy guidelines for the various Service Sections. By way of an example, there is no policy for services to disabled people.

An umbrella policy document is however to be in Departmental Circular No. 22/1981. (See Appendix A). The Circular basically explains the global welfare policy of the Government, its underlying philosophy, and its aims. It says nothing of the various service fields and the proposed service delivery structures. In this respect, amongst others, it differs significantly from the one of South Africa (See Appendix B).

Since the circular does not in any way indicate what implementation structures (or organizations) there should be, it follows that the policies of such structures will not be outlined. Guidelines for all service delivery structures should have been provided. For example, if there are policy guidelines for a section, they would have strategic as well as operational dimensions. The strategic dimension would spell out overall aims, philosophies, principles, and proposed programmes. The operational aspect would spell out staff programmes and the methodologies and technologies to be used.

When these policy details are non-existent, as with all Sections of the welfare structure of Bophuthatswana, how then are the day-to-day activities of staff to be governed?

In answering this question, the researcher would say that policies that govern the daily activities of social workers in Bophuthatswana were adopted from South Africa mainly through observation. Seldom, if ever, were they in written form.

At present there is no single policy document in all the country's agencies.

Since policies are made in a particular socio-economic and political context, (Meenaghan, T.M. & Washington 1980), the question should be asked how then are the South African policies going to be appropriate in Bophuthatswana, since the two countries differ politically and economically?

To illustrate the inappropriateness of some adopted policies, the researcher cites the social security benefit called the Maintenance Grant, provided in Bophuthatswana under the stipulations of the Children's Act 33/1960 of South Africa (now amended as the Child Care Act of 1983 but still used in its old form in Bophuthatswana).

The Maintenance Grant provides financial assistance to indigent parents with dependent children, and to such children themselves. It is something akin to the "Assistance For Families with Dependent Children" (AFDC) operative in the United Kingdom and United States of America.

The grant is selective and means-tested. It is payable to parents whose children are 16 years and below. This age criterion seems to be in line with certain labour policies of South Africa where the benefit was originally designed. A person is registrable as a labourer upon attaining the age of 16. He then qualifies to possess identity documents and enter the labour market. Such a person is, for all intents and

purposes, regarded an adult and is to be treated as such. According to the capitalist principles that underlie most social securities, every adult must fend for himself, unless he is rendered absolutely incapable by factors beyond his control, e.g age, disability, chronic illness, etc. It follows therefore that a beneficiary who turns 16 (in South Africa) automatically forfeits the benefit. This happens regardless of his socio-economic circumstances.

In the researcher's opinion, the age at which adult status is conferred upon a person in South Africa is determined in line with that Government's policy of maintaining its reserve of (black) cheap labour through various means.

First, a small proportion of african Children in South Africa and homelands actually do attend school, but will have long dropped out at the age of 16 such that they are barely literate Hence they register at this age as unskilled labourers.

Second, since there is no system of compulsory education for Africans in South Africa in contrast with Indians, Coloureds and Whites, it means there is no way of enforcing a black child to attend school or his parents to take him to school. The logical thing would be for youths under similar circumstances to seek employment, possibly of the unskilled type.

This whole principle of conferring adult status at age 16 has rippled through to many policy areas such as those of the welfare cluster. The eligibility criterion for Maintenance Grants (i.e below age 16) seemingly is in line with the broader policy. I would not say it is anomalous of South Africa to adopt age as a cut-off point in legislation, since this is to be found in all countries. What I regard as unacceptable is the particular age, in this case 16. If all things were equal children at this particular age should be encouraged to pursue education, instead of being encouraged to register as labourers.

As for Bophuthatswana, I would criticise it for the apparent blind adoption of this age-cut-off point, which seems to disregard the socio-economic realities of the inhabitants.

A Motswana child at age 16 is barely schooled to be able to get a good job. The reasons are firstly, that there is no compulsory system of education in Bophuthatswana. Had it been available there would have been a stipulated age for beginning school. Secondly, due to problems of deprivation Setswana children start school later than the normal ages of 5-6 years, so that at 16 most of them have barely made it to say, Standard Eight, which is regarded as a desirable Standard of education, and which is laid down as a pre-entry requirement in most country's institutions of further training. Third, poverty leads to slow development of the intellect. As a result most, children would at the age of 16 have barely benefited from schooling or achieved

sufficient years of schooling to be considered truly literate.

Thus what we normally have at this age is a barely educated, barely literate person who is expected to enter the labour market. Should the grant be discontinued at this age, how is he/she expected to finance him/herself? Hence this benefit falls short of performing its primary function.

Policies such as these could have been reformulated to suit the needs and circumstance of the Batswana, had there been a policy-formulating organization such as the Welfare Policy Council of South Africa. Its absence has far-reaching implications for the organization of services and the determination of relevant delivery structures.

Absence of appropriate local-level delivery structures, which will be discussed below is a sequel to non-existence of a Policy Council.

6.3.1.2 THE REGIONAL LEVEL STRUCTURE

Bophuthatswana is divided regionally into Health Wards. A Health Ward, according to the Health Act 12/1983, is an area designated by the Minister of Health and Social Welfare as the area to be served by one or more hospitals.

Presently, there are approximately 12 Wards which follow the Magisterial Divisions of the country. These Wards are served by hopitals. Where no hospital exists, there are health centres.

A hospital or health centre in any Ward functions as a local-level head office for health and welfare services. Such an office for the Molopo region is Bophelong hospital, and it will be used as an illustration of what happens within regions. (It is located in the area where my study was undertaken).

The administrative head of any Health Ward is the Medical Superintendent appointed by the Minister of Health and Welfare in terms of section (1) of the Health Act. Such an officer is charged with the organization and administration of the hospital, and of health services (including welfare services) even if this is not formally indicated in the Act.

The regional welfare division is embedded in the hospital or health centre structure although it has its own personnel establishment.

6.3.1.3 THE BOPHELONG WELFARE STRUCTURE

The staff establishment structure of Bophelong Hospital, as it exists on paper, consists of three levels which are vertically linked. At the top are the Principal Social Workers, of which there are three. The second level is the one of Senior Social Workers, of which these are eight.

Finally there are the Social Workers and Junior Social Workers, eleven in all.

If the regional structure replicated that of the Main Office, there could have been one or more posts of Chief Professional Officer(s). Or else they might have been four or more Principal Social Workers, each being in charge of a particular service section. Each Principal Social Worker could for instance have had a staff cohort that would be accountable to him. In other words, the proposition put forward here is simply a replication of the Main Office structure. A situaton of this nature would have permitted some measure of specialisation on the basis of functions, and also vertical as well as horizontal co-ordination of services. Various service fields, such as care of the disabled, might be rendered on a specific basis. But as the situation stands today, this is a remote possibility.

Structural deficiencies are compounded by severe staff shortage. At the time of writing, all the posts of Principal Social Workers at Bophelong, as they existed on paper, were vacant. This is common in most regional hospitals or health centres, thus creating a situation where a person of the position of Senior Social Worker heads the section. Where no person of the rank of senior is available, the so-called "accountable officer" exists in his/her stead. An "accountable officer" is by definition a person of a rank of social worker who is deployed to execute

functions that should be carried out by a senior person, either a Senior Social Worker or even a Principal Social Worker.

Because of high turnover and chronic shortage of staff in most country regions, most accountable officers are newly-qualified social workers with no, or very little relevant professional and administrative experience. This reality is a drawback in service efficiency. Even more than this the case where the prescribed functions of senior social workers or accountable officers are concerned. The administration of social welfare programmes, supervision of staff, compilation of monthly reports on programme activities, et al are complex enough not to be left in the care of officers with limited adminstrative experience.

But perhaps the redeeming factor here could be that the planning of welfare programmes is not amongst the defined duties of such officers, because planning is done at the Main Office. It is in this respect that the social service pattern of Bophuthatswana differs from that of South Africa.

In South Africa planning is decentralised. This has been achieved by dividing the country into welfare regions. A welfare region is a designated geographical area which consists of one or more magisterial districts. Each welfare region is administered by a Regional Welfare Board usually made up of 11-15 members who are appointed by the relevant Minister. (National Welfare Act 110/1978).

Regional Welfare Boards are community or local-level planning and co-ordinating bodies. Their prescribed functions include researching into local conditions and problems, designing programmes, and co-ordinating the various agencies existent in the respective welfare region.

What actually happens in South Africa is that research, planning, and implementation are all done at the local level, while in Bophuthatswana the research (seldom systematic scientific inquiry) is not. Data from such research is forwarded to head office where programmes are designed and returned back to regions for implementation. Disadvantages of this national level of planning have already been mentioned. What I need to mention here is only that the vested interests of national level planners inevitably cause some regions to be insufficiently catered for.

Another distinctive feature of social welfare services in Bophuthatswana is absence of effective mechanisms for community involvement in welfare provision. The adjective "effective" is operative here. Some organizational arrangements for community involvement do exist in regions. These are called Regional Health Authorities appointed in terms of the Health Act. These "grass-roots" organizations are supposed to report their welfare and health needs in particular Health Wards, and report to the hospital or health centre administration in a

special forum. Such a forum is the so-called Regional Health Meeting, which takes place monthly. But what happens here is that these "grass-roots" organizations report mainly on health needs, very often to the complete neglect of those of welfare. The reason might be that health needs tend to be universal, (e.g absence of a clinic in a village, absence of a water source etc.) while Social Welfare needs on the contrary tend to affect only certain people. By way of example, absence of day care centre for crippled children may be a need confined to a few community members. Hence welfare needs are normally given low priority by these "grass-roots" bodies. In general, welfare needs are over-shadowed by those of health.

A more appropriate arrangement would be one similar to that which exists in South Africa. Reference is made here to local Welfare Committees. Welfare Committees are "grass-roots" bodies appointed by Regional Welfare Boards for certain areas within each welfare region. They are therefore accountable to respective Welfare Boards. But their principal function is to advise the boards on social welfare needs in their areas of jurisdiction.

This makes it possible for needs of various client groups to be attended to including the disabled.

Because of the level at which they operate, welfare committees are presumably appropriate

structures for community involvement in welfare provision. In addition, they focus exclusively on social welfare issues, unlike the regional health authorities in Bophuthatswana.

This is yet another fundamental flaw in the social welfare delivery machinery in Bophuthatswana, with the inevitable consequence that disabled persons are not adequately served.

While the absence of policy councils, appropriate local level planning organizations, and formal community involvement organizations in Bophuthatswana have an indirect impact upon the services for the disabled, the absence of the so-called "Co-ordinating Committee" or its equivalent is more direct. The reason is that this is a statutory body in South Africa that caters solely for the disabled. Its existence makes it possible for the Government to be kept informed about the situation of disabled persons country-wide.

The Committee operates under the aegis of the "Common Affairs" Department of National Health and Population Development (see Figure 2). Its main function is to promote the interests of disabled people at national and regional levels, through formulation of a national policy on the care of disabled persons,and to devise strategies to meet their needs. (McKendrick, 1987:27).

The existence of this Committee makes it possible for clear policy guidelines for serving the

disabled in South Africa to exist. This policy declares the following:-

"Disability is combated and the quality of life of disabled people is promoted;

- with a view to self-realization and for the benefit of the community, a disabled person is trained and educated to his full potential

- the independent functioning of the disabled person is promoted

- equal opportunities for disabled people are pursued."
(Anderson, in Maatskaplike Werk Praktyk/ Social Work Practice: 2-88.)

The existence of the Committee and its policies may be said to have influenced the creation of the many facilities for rehabilitating the disabled in the RSA. The researcher thinks here thinking in terms of facilities such as Access College which is a business training institution that caters primarily for disabled persons. Rehabilitation in South Africa, September, 1984: 62-64).

A Wage Subsidy Scheme exists under the auspices of the Department of Manpower and Utilisation (RSA), which provides for subsidization of salaries of people of all races who, owing to their physical and mental handicaps and age, are unable to compete in the open labour market.

The subsidies are as follows:-

80% subsidy for the first 12 months
60% subsidy for the second 12 months
40% subsidy for the third 12 months.

Each subsidy falls off when the employee completes three years of employment with the same employer (Rehabilitation in South Africa, December 1981, pp 98-99). Presently the scheme employs approximately 2000 people.

Sheltered workshops and factories which are distributed among large centres in the country number thirteen in all. These workshops offer training and employment to people who are either physically or mentally handicapped to such an extent that they are unable to find and retain employment in the open job market.

Vocational rehabilitation centres, such as the "Medical Fitness For Work Unit", presumably owe their existence to activities of the Committee. This Unit, like many others, is attached to a large teaching and general hospital, namely the H F Verwoerd Hospital in Pretoria. (Rehabilitation in South Africa, March 1984:9). Here vocational training and retraining are offered to disabled persons as part of the total programme of medical and paramedical care.

Special schooling facilities in South Africa are many, presumably as a result of the Committee's influence. Such schools are generally attached

to hospitals so that formal education, and paramedical and medical services can constitute an integrated programme.

Presently there are about 62 special schools in South Africa for blacks. Approximately 18 of them are in the "homelands". These schools offer formal education at primary level. Facilities for secondary education are in short supply. There is at present only one such facility, viz. the Philadelphia Secondary School for Crippled and Blind Persons, located in Soshanguve near Pretoria. There remains a great need for post-primary schooling facilities in the RSA, let alone in the "homelands".

In addition to facilities mentioned above, there is also special legislation applying solely to disabled persons. This is the Disability Grants Act of 1968. Formulation of this formal policy might have also been influenced by the Co-ordinating Committee.

Such a Committee, or an equivalent, does not exist in Bophuthatswana. The absence leaves a wide gap in social provision for the disabled. By way of illustration, there is no special legislation or policy for disabled persons. The disabled are catered for formally and legally by the Social Pensions Act mentioned already. Informally under any policies that cater for indigent persons. These include maintenance grants, free medical care, and poor relief assistance. There are no administrative policies

to address the needs of the disabled. Special schooling facilities are in short supply. Presently there are only four country-wide, and one for each category of disabled. Three of them were inherited from South Africa when Bophuthatswana was created. The Bophuthatswana Government itself created only one such facility for mentally retarded pupils, viz. Retlametswe School for Mentally Retarded Pupils located in the Molopo region. Post-primary schooling facilities do not exist in the country.

At present there are only two sheltered workshops in Bophuthatswana. country-wide, One is Itireleng Workshop for the Blind in Ga Rankuwa and the other Itsoseng Handicraft Centre in Itsoseng. These institutions function as both workshops and training centres. Programmes offered include handicrafts, such as mat and weaving, sewing, knitting, welding and shoemaking. As far as the researcher has observed, these programmes are not geared towards the needs of the open labour market. As a result trainees find it difficult to get employment outside the institution. That is why, in most cases after training, they take up sheltered employment there. Those who do venture into communities very often encounter employment frustrations.

Apart from training that is offered in handicraft centres, there is also training offered as part of occupational therapy in hospitals. Handicrafts feature prominently in these settings.

There is nothing as sophisticated as the 'Medical Fitness For Work Unit' mentioned above.

The discussion so far has highlighted the fact that there are no statutory or quasi-statutory structures that, either through direct or indirect actions, cater for the disabled. Reference is made here to organizations like the Welfare Policy Council, Regional Welfare Boards, Local Welfare Communities, and the Co-ordinating Committee. Absence of such structures in Bophuthatswana means that at both community (grassroots) and national (Government) levels disabled people are not attended to. This reality is compounded by the non-existence of registered voluntary welfare organizations, that would fill the gaps where the Government falls short.

Voluntary Welfare Organizations and the Disabled

Voluntary Welfare Organizations grow out of functional communities, or communities of interest. What happens is that a group of people recognise an existence of a need, problem, or interest area that is common amongst them, and decide to join efforts in order to take appropriate action. In due course such a group develops a formal structure and grows into an organization. Organizational structures and policies are then created. The Government then gives recognition or legitimation through providing for registration under stipulated legislation. In South Africa such legislation is the National Welfare Act 100/1978, which provides for establishment of a South African Welfare Council, regional welfare boards, and welfare committees, in

addition to the registration of welfare organizations. An equivalent legislation in Bophuthatswana is called Bophuthatswana Registration of Voluntary Welfare Organizations Act.

Organization formation is not as straightforward as it is made to appear here. It is determined by a variety of variables which include the level of development and sophistication of the people, and availability of resources.

People of low socio-economic levels encounter difficulties in forming productive and fully functioning organizations since these are demanding in terms of skills (leadership, organizing, economic managing, political, bargaining etc). Political skills are essential to obtaining official sanction and finances from the Government. Economic skills are needed to solicit for finances from the wider community, and management skills are necessary to keep an organization running.

Recognition of these demands leads authors such as Swil (1984) to say that development should precede organization; and therefore community organization as an approach in social work should take place in sophisticated neighbourhoods, while community development is appropriate in under-developed areas.

Bophuthatswana is, by and large, a developing country with a proportionally smaller developed sector and a proportionally larger underdeveloped and unsophisticated sector. Hence people find it difficult to organise formally to cater for their welfare needs, especially the disabled who are amongst the deprived population sectors.

Instead, the researcher has observed that initiative for such organization comes from professionals, particularly social workers. But difficulties crop up with regard to the identity of people to be incorporated into membership. Social Workers more often, than not, choose elites rather than people affected by the problem or their relatives. Their exclusion from membership is justified by social workers on the ground that their socio-economic and educational positions are such that they cannot contribute meaningfully to the development of such an organization. Elites are selected on the basis that they are influential and have access to those in power structures. They might thus influence the allocation of resources and also legitimation. To some extent, these reasons are valid. But unfortunately human nature is such that people are much more likely to be enthusiastic about matters that affect them personally. As both social workers and elites are seldom, if ever, directly affected by the problems relevant to the intended organization (in this case disability) they tend to lack enthusiasm. In the final analysis, organizations thus formed function poorly to a point of dormancy. These probabilities cause such organisations to fail to develop a measure of autonomy that would enable them to employ professional social workers. Hence they fail in their envisaged role of complementing the Government in serving the disabled. Bophuthatswana has a few such organizations, listed below. While autonomous organizations exist in South Africa, their policies do not provide for extension of their activities into areas known as homelands", Bophuthatswana included. Hence the country at present does not have significant voluntary input into social welfare provision, and in particular to provisions for the disabled.

Following is a list of existing such organisations:

Boiketlong Cripple Care Association (Moretele region)
Ga-Rankuwa Cripple Care Association (Odi region)
Ditsobotla Association For the Care of Cripples (Ditsobotla region)
Molopo Association for the Care of Physically Handicapped Persons

VOLUNTARY WELFARE ORGANISATIONS IN SOUTH AFRICA

The situation in South Africa is different. First, the areas designated as South Africa have some characteristics of the First World. They are relatively more affluent and urbanised. They are therefore at a level suggested by some authors to be appropriate for community organizations.

A proliferation of registered autonomous welfare organizations in South Africa seem to confirm this suggestion. These organizations render specific services to selected population groups. Their designations generally denote the consumer-client served. Examples are Child Care Societies, Societies For the Care of Blind Persons, Aged Persons, Deaf Persons, Crippled Persons, Substance Abusers, etc.

Absence of voluntary input, statutory and quasi-statutory structures, relevant policies, and (above all) lack of concern by those in power structures culminate in a situation where disabled persons in Bophuthatswana are left out of the mainstream of social service provision. Most of them are unidentified and unreached. Those who are ever reached receive fragmented, piecemeal, and uncomprehensive services (meaning those that fail to address all problem areas). Such services are ineffective as they do not put the disabled en route to economic independence, which is what matters most in their deprived positions. The findings of this study, to be presented in the next Chapter, will reveal the problems from the perspective of sufferers themselves.

6.4 SOCIAL WORK SERVICES RENDERED TO PHYSICALLY DISABLED PERSONS IN BOPHUTHATSWANA WITH PARTICULAR REFERENCE TO THE MOLOPO AREA

As pointed out in Chapter Four, relevant services are those that address practical, psychological, social, and economic problems of disabled persons. Within the same Chapter, categories of such services were identified. These were counselling, education, information, and cash-and-kind services.

Current services rendered in the Molopo area are, as far as the researcher is concerned, far from meeting these criteria. They are inclined more towards cash-and-kind services to the partial (sometimes total) neglect of other service categories. In addition, they are charactistically ineffective, inefficient, fragmented, non-comprehensive, and inaccessible.

By "ineffective" services is meant such as do not bring any anticipated changes in the lives of disabled persons; "inefficient" services refers to those that are wasteful in the sense of costs outweighing benefits; "fragmented" means that services are discontinuous; "non-comprehensive" means services do not deal with multiple aspects of a problem; and "inaccessible" assumes services are available but inaccessible due to such barriers as location, psychological, or other costs, scheduling and so on. (Lauffer in Cox, 1987: 319. The extent to which services described here meet these deficiencies will be indicated.

The service deficiencies mentioned here, are rooted in the absence of appropriate policy guidelines and implementation structures. Organizational flaws of this magnitude cause social workers to operate without specific frameworks. Hence very often they implement policies of other public administration agencies (such as the Departments of Health, Education, Manpower and Utilization,

etc). Although, as Pierce (1984:29) says, "welfare is not the exclusive domain of social workers", policies of other Government Departments have welfare implications. All the same, it is important for social workers to conceive clearly what falls within their professional domain, otherwise it would mean complete loss of professional identity.

Realities considered here form the backdrop against which the following services and their deficiencies are viewed.

6.5 SERVICE CATEGORIES

6.5.1 Applications for Admission to Special Schools

Within this category of service, social workers implement some aspects of the education policy of Bophuthatswana.

The policy sets out to extend educational opportunities to all persons in the country irrespective of their origin, culture, religion, ethnic affiliation, and physical or mental states. In line with this policy special schools were created for people whose physical, sensory, or mental aberrations prevent them from using mainstream facilities. Presently these are four in all country-wide.

Educational programmes offered within special schools are the same as those for ordinary schools except that medical and paramedical services are integrated within the former.

Applications for admission to such a school is done on Form D.E 270 (Appendix K). This Form is completed by the applicant with the assistance of a social worker. A medical doctor completes a portion in order to certify as to the condition. The remaining portion is completed by a magistrate or a minister of religion. This Form is

supplemented by a psycho-social report compiled by a social worker. Such a report normally contains an appropriate recommendation. Additional documents such as birth certificates are also included. A collation of all documents is then forwarded to the Special Education Division of the Department of Education at the head office in Mmabatho. It is in this office where final assessment of the application is made. Should the application be favourably considered, arrangements for admission are made directly with the school. The Social Worker is informed only when the school is ready to take in the applicant so that he/she assists with final plans for placement.

As soon as the applicant is admitted, he passes from the "jurisdiction" of the community-based social worker into that of the special school. The former will serve only as a liaison between the family and the school.

Certain deficiencies are identifiable in the programme.

First, application procedures are cumbersome. Form D.E 270 is completed by four different people who operate on different schedules and are often located at different places. This may mean that at some stages of the application process the applicant may find himself shuttling between offices, knocking sometimes at "dead men's doors."

Second, absence of direct communication between the applicant and the school causes delays because of administrative inefficiency in some public service offices; such inefficiency must unfortunately always be reckoned with.

To circumvent possible inefficiency, applications ought to be directed straight to the school instead of via the head office. The latter should merely be informed for purposes of statistics.

Third, the current imbalance between demand and supply makes the facility relatively inaccessible. Only one such school in the whole country implies a persistent scramble for accommodation.

Waiting lists grow longer and longer. Applicants are known to have waited for two years and more before gaining admission. It has happened in some cases that applicants outgrow the stipulated ages of admission (6-10 yrs). (Privately communicated.)

Fourth, the location of the facility imposes geographical impediments. The school in question (Tlamelang School for Crippled Children) is located in the Ditsobotla region within the complex of Gelukspan hospital. This means applicants from the country's other regions have to leave their home environments when admitted to the school.

In all cases where the homes of children are far from the school, daily attendance from home is not possible. This means an inevitable removal of a disabled child from his family. The psychological effects of such separation are well-known. Hence many parents avoid using the facility. Instead, they opt either to keep the child from school, or use local mainstream schools. Those who opt for the latter are mainly ignorant about the magnitude of problems that await a disabled child in such schools (see Chapter Four). They are often surprised when the child drops out.

What Social Workers Could Do

Social workers should aim to enhance availability and accessibility of special school facilities. Their efforts should be based on elementary research. For instance, social workers should keep records of all applications and their

responses made within a particular time frame, say half-yearly or yearly. These should be supported by details of those who are on waiting lists, how many they are, how long they have been on such waiting lists, and possible reasons for the delay. Such data could be used to convince social planners of the need for expanded facilites. By so doing, social workers would be performing one of the functions peculiar to social work, namely, "linking people to resources" as Pincus and Minahan (1973) put it.

Administrative requirements that may be unfairly prohibitive in effect should also be dealt with. The researcher is referring specifically here to possession of Bophuthatswana citizenship rights as a requirement for all applicants. This is Government policy, however, with deep political roots, and intervention on this issue may be beyond the capabilities of individual social workers in agencies. It might perhaps be amenable to the efforts of a professional organization. This may mean that social workers countrywide, and as members of a professional association, should collect relevant data relating to the negative impacts of such a policy. These data should be presented to policy makers. However, this may prove to be an insurmountable task as priorities of politicians more often than not supersede welfare issues and concerns.

Geographical impediments can be dealt with by building a good data base to motivate for the establishment of community-based special schooling facilities. For instance, a record should be kept of the number of drop-outs, and the reasons for them as presented by pupils themselves and by school personnel. Such data should be coupled with a strong recommendation for creation of either special schooling establishments or special facilities within ordinary schools.

Social workers must also contribute to the establishment of post-primary special schools as these do not exist in Bophuthatswana. The one and only secondary school available to the physically disabled people of Bophuthatswana is Philadelphia School for Blind and Crippled Students in Soshanguve near Pretoria. The school is open to pupils of all ethnic affiliations, and this situation implies a probable scramble for accommodation.

6.5.2 Applications for Social Security Benefits

Social security refers to 'programmes of protection usually involving financial assistance provided to people by the State in order to protect them against the contingencies of life, eg blindness, disability, and old age'. (McKendrick, 1987: 25).

The International Labour Organization (ILO) identified two types of social security namely, Social Insurance and Social Assistance schemes. Social Insurance schemes are work-related benefits made available through the contributions of potential beneficiaries, their employers, and by the Government. Social assistance schemes are non-work-related, are financed through public taxation, and are subject to a test of means. (ILO in Midgley 1984:8).

Social insurance schemes in Bophuthatswana include the Bophuthatswana Provident Fund (BNPF), Workmen's Compensation Fund (WCF) and the Unemployment Insurance Fund (IUF). These benefits are regulated by specific legislation mentioned previously. They are relatively adequate since they are work-related.

Social assistance schemes in this country include Disability Grants (Type 4), Ex-soldiers Grants (Type 6), Blind Persons Pensions (Type 1) and Old Age Pensions (Type 0). All are regulated by the Bophuthatswana Social Pensions Act 18/1978.

In addition there are Maintenance Grants provided in accordance with section 89 of the Children's Act 33/1960 and Part IV of the Regulations. Disability and Maintenance Grants are relevant here.

6.5.3 Applications for Disability Grants

Social workers in this service function as access workers and mainly implement the social welfare policy of Income Maintenance.

The programme provides income to persons aged 16 years and over whose physical and/or mental state renders them incapable of earning a living through employment or any other means.

Benefits are residual, selective, and means-tested.

Application for benefits is done on a medical report Form Ts S.40(a) (Appendix F), which is completed by hospital doctors (there are no district surgeons in Bophuthatswana). A rating of disability is assigned the applicant according to percentages indicated on the form. A percentage score of 50-100% would mean the applicant is considered permanently disabled. Annual reviews are not necessary here. A percentage score of 40-49% would mean the applicant is considered temporarily disabled and annual reviews are imperative.

Amounts payable in respect of the grant range between R195-R234 bimonthly depending upon the test of means and degree of disability (permanent or temporary).

These amounts are by any standards inadequate. Heffernan suggests that welfare programmes and benefits in the United States of America are calculated on the basis of prevailing community standards, available resources, and what the community considers to be the basic needs. (Heffernan, 1979:27). Should a similar formula be used in Bophuthatswana, conceptions of what community standards and basic needs are, would be shown to be certainly different, and probably lower. But we must also not overlook prevailing Government attitudes towards State-provided welfare. As indicated already, welfare services in Bophuthatswana are not a national priority. Moreover, they are considered to be a public (economic) burden. If one considers amounts paid in the form of social grants, one would conclude that Gilbert and Specht's value-base of 'social adequacy' which means 'a concern for decent standards of living and spiritual well-being of beneficiaries' was never considered when these (grants) were calculated (Gilbert and Specht, 1986:5).

Bophuthatswana social security schemes are so inadequate as to be incapable of meeting their primary goal, namely, meeting the financial needs of beneficiaries. Most of them live in abject poverty as will be shown in the next Chapter when the findings of the study are summmarised. The means-test inherent in the grants prevents beneficiaries from engaging in any economic activities that are intended to supplement the grants. Beneficiaries who disregard this condition risk forfeiture of the grants.

The following deficiencies in the programme were identified by me as the researcher:

(a) Fragmentation

(i) There is no mechanism to monitor the movement of the medical reports from hospitals to the local office of the Department of Internal Affairs.

Some applicants do not send in medical reports until about a year has elapsed. By the time they are sent in, they are already a year old. When this happens the Main Office of the Department of Internal Affairs will no longer accept them. This is an instance of duplication of services as it may possibly involve a re-examination of the applicant to update the medical report. Enormous delays are caused in the processing of applications.

The deficiency would be remedied if all medical reports were to be sent to the local office of the Department of Internal Affairs via the hospital-based social worker. This is at present not possible as applicants are expected to present themselves personally to the office to have their fingerprints and other personal particulars taken down.

(ii) Medical reports and relevant documents pass through a number of offices to Head Office in Mmabatho. In this way they are likely to be subjected to bureaucratic inefficiencies. Very often applicants are told of authorising officers who are too preoccupied to attend to applications; or officers who are on vacation and have no substitutes; or, worse still, forms may be misplaced in offices.

Social workers have little or no control over the movement of application forms mainly because social pensions are administered in a State Department other than theirs. This in itself shows that welfare services in Bophuthatswana are fragmented. Had the situation been different, social work and welfare services would fall under one Government Ministry which would be designated appropriately as the 'Ministry of Social Welfare and Pensions' or something similar.

(b) Citizenship Requirement

Reference here is to possession of citizenship rights, either by birth or formal application of naturalisation. The latter is applicable to all persons of non-Tswana ethnic affiliation irrespective of their period of stay in the territory now defined as Bophuthatswana. All persons who apply for social pensions must possess these rights. This pre-condition has on many occassions proved to be a stumbling block since it is not easy to get citizenship rights granted.

(c) Cumbersome Scheduling and Method of Payments

All social pensions are paid bi-monthly, not monthly. Beneficiaries are therefore without income for a long period, and in practice do not manage to spread their meagre incomes over two months.

A system of payment whereby beneficiaries wait in long queues for the greater part of the day is inappropriate. Cases are known where some collapsed because of fatigue.

Social work intervention, especially the Social Action strategy, is necessary to deal with these deficiencies. Social action as a strategy for community work intervention tends to enhance consciousness of the problem, and there is a chance to trigger off prompt response from the envisaged target system.

In adopting this approach, social workers must help consumers to organise themselves for action. Such action must aim at remedying the present methods of payments, increasing pension amounts, and at reconsideration of the citizenship issue as a pre-condition for pensions.

But, however appropriate this action choice may be, it contains inherent risks for the social worker who may be perceived by people in political authority to be promoting political dissent. As Ferrinho suggests in his essays on 'principles that underlie community social work', a community social worker must "love him/herself." Loving oneself means self-preservation by refraining from engaging in actions that are potentially dangerous. (Ferrinho, 1981:21). A social worker who adheres to this principle will not engage in activities of a dangerous political nature, or any activity that will cause him to lose his job.

In addition, attitudes (of social pensioners) may also be sources of risk. "Grass-roots" people in Bophuthatswana regard the Government as a source of "manna from heaven", and presumably would be reluctant to engage in any action that may be perceived to be not in line with Government's expectations.

Furthermore, they seem to lack a level of sophistication enabling them to understand the rationale or philosophy behind provision of social security benefits. Most regard these as a special favour from the Government. Little do they realise that any State, being the supreme collective unit of society, has a responsiblity towards providing basic needs to people in accordance with social policies. They themselves, as the consumers, have a social right to shape these policies.

For the reasons mentioned, social pensioners are unlikely to engage in action perceived to be contrary to the expectations of policy makers. Social workers must therefore be perceptive enough to grasp with maximum accuracy the socio-political variables that are at stake. Realities considered here largely restrict action by social workers aimed at improving social security benefits.

6.5.4 Application for Maintenance Grants

A Maintenance Grant is a social security programme that provides financial assistance to indigent parents and their children aged 16 years and below. It is administered in terms of section 85 of the Children's Act 33/1960. Its value-basis seems to be the protection of children from the forces of deprivation and indigency. Maintenance Grants are corollary of the programme known as Assistance For Parents with Dependent Children (AFDC) available in the United States of America and the United Kingdom.

Maintenance grants are not exclusive to disabled persons; it is possible to qualify on the basis of indigency and destitution. The grant is selective and given to persons who

meet some, but not all, of the following criteria:-

(i) a parent who is employed but not earning enough to be able to provide adequately for his/her children and for himself or herself;

(ii) a parent who is a receipient of any social security scheme (eg a disability grant);

(iii) a widow/er who is indigent; and

(iv) a mother to whom the whereabouts of her husband or father of her children is unknown, and there is documentary evidence of his disappearance, eg a police report.

An initial step in the process of applying for the grant is drawing up of a psycho-social report by a social worker. The contents of this report will largely determine the applicant's eligibility. The report is supported by additional reports on Forms Ts.S 37 and Ts I. 128 (Appendix I and J respectively).

All documents, which should include birth or baptismal certificates of children under 16 years, their school reports, and wage certificates, are forwarded to the Welfare Branch in Mmabatho for final assessment. This assessment includes rejecting or approving the application and determining payment rates for both parents and children who qualify. Previous rates were approximately R24 per month per parent and R12 per month per child (privately communicated information). However these are considerably increased. I do not have the new rates.

Applications that are succcessful are sent to the local office of the Department of Internal Affairs for payments to be authorised. This office then informs the social worker of the outcome of the application. The latter in turn transmits the message to the applicant.

Deficiencies in the programme are found in some eligibility criteria, annual reviews, and insufficient amounts of pension money.

One of the conditions of qualifying for the grant is for female applicants to give proof of their husbands' or lovers' whereabouts. This is found to be embarrassing, and also may disqualify the applicant in cases where there is no adequate proof of the whereabouts of the father of her children. This pre-requirement is tied to the residual and selective nature of the programme.

Annual reviews of the grants are found by applicants as well as social workers to be cumbersome since they involve almost all procedures followed in making new applications. Procedurally, due dates for reviews are stipulated. Should an application be so delayed as to miss the due date, it is assumed by the Welfare Head Office to have been cancelled.

Payment is immediately stopped. Should the applicant still be interested in the grant, he/she must resume the application from scratch. This reality makes the grant an unreliable source of income.

Previous rates for the grant, namely R24 and R12 monthly for parent and child respectively, were insufficient as an income supplement.

Finally, the qualifying age of 16 years and below, often makes the benefit inaccessible. This aspect has been dealt with previously and will not be repeated here.

6.5.5 Applications for Admission to Residential Institutions for Chronically Ill Persons

Within this service category social workers implement social welfare policy.

Institutional care in Britain dates as far back as 1601 when the Poor Law was formulated. The law provided inter alia for care of the sick, disabled, aged, destitute children, or the "worthy poor" (as they were then called) in institutions then known as almshouses. This mode of care was known as "indoor relief" and it contrasted with another namely, "outdoor relief." The latter provided for welfare assistance outside institutional settings. (Friedlander, 1980).

These policies were adopted and modified in many countries over centuries until they assumed the present conventional forms of institution-based and community-based care.

Policies and programmes to be considered here were imported into South Africa as part of its colonial legacy. Bophuthatswana adopted them from South Africa when welfare services were transferred from the then Department of Bantu Administration and Development, in the late sixties and early seventies.

The Government of Bophuthatswana has since modified its policy and its programmes to suit the situation of the country by declaring a policy statement of de-institutionalization. This policy declares a preference

for home-based rather than institution-based care. In line with this policy, the Government refrains from creating any more institutions. Should this ever be done, it is to be a matter of absolute necessity. In addition, application procedures are made stricter, probably to serve as deterrent to institutionalization.

Presently (1989), the country has only six residential institutions, all of which were inherited from South Africa. These are, Herberg Institution for Chronically Physically Handicapped Persons in Gelukspan, Gelukspan Old Age Home, Pabalelo Place of Safety in Ga-Rankuwa, and three institutions in Thaba-Nchu, viz. the Boiketlong Old Age Home, the Poloko Sanatorium for Mentally Ill Persons, and the Barend van Rensburg Home for children-in-need-of-care and juvenile delinquents. Mooifontein Children's Home which was located in the Ditsobotla region, was phased out as a result of social welfare planning within the policy of de-institutionalization.

The policy stance that over-emphasizes home-based care is sometimes unrealistic as it disregards the socio-economic forces that operate accross the country. Bophuthatswana is in a state of transition. Forces of urbanization and modernization are actively destroying traditional social care structures of extended and nuclear families and the "Gemeinschaft" in communities. Migrant labour erodes potential care givers; able-bodied men and women, and the youth move away from rural areas to seek work. The aged, children, the disabled, and the sick are amongst those who remain. These categories are by their nature in need of care. Under circumstances such as these, should home-based care be the mode of social care?

The envisaged role of social workers here should aptly be social planning. They must observe social trends such as migrant labour, changes in family size and composition, people's attitudes towards home-based care, and its feasibility in the face of social changes. These observations will help determine policy directions.

As mentioned above, the policy of de-institutionalization largely affects application procedures to residential institutions. As an example, application procedures to Herberg Institution for Physically Handicapped Persons are explained.

The initial step in the application process is a medical examination and report on Form B.A. 1016 (Appendix G). The medical report form is completed by a hospital doctor who determines the nature and degree of disablility. A social worker, a magistrate, and the Secretary for Health and Social Welfare, complete other sections of the form. A reader will note some discrepancies in my statements and what appears on Form BA 1016, especially relating to the designations of some officials. The discrepancies are due to the fact that this form was adopted from the former Department of Bantu Administration and Development in South Africa, and is not yet re-designed for use in Bophuthatswana.

In addition to the medical report there should be a psycho-social report compiled by a social worker. Major contents of such a report are the applicant's home circumstances including an indication as to why institution-based care is necessary in the case. An appropriate recommendation is also looked for.

All documents referred to here are forwarded to Mmabatho Head Office (Welfare Branch) for consideration. It is again this

same office that makes arrangements for placement with the institution and the social worker in the institution would be duly informed.

A prolonged waiting period is normal. In some cases applicants are known to have waited for up to three years to be granted admission. This is caused by limited accommodation.

The programme has inherent deficiencies of inaccessibility. The nature of care given within institutions, also leaves much to be desired.

First, long waiting lists make the institution less accessible.

Second, application procedures are so cumbersome as to deter many from using the facility. For instance Form BA 1016 is completed by four different officers, which may mean that the applicant is sent from one office to the other. This is potentially delaying since the officers may not all be present when needed.

Additional delays are caused by the bureaucratic procedure of having to send applications through Head Office to the institution. Such applications are very often subjected to administrative inefficiencies common in public offices.

Third, the involvement of social workers in the service is not continuous. There is a period of interruption when all documents are forwarded to Head Office. The social workers involvement resumes when the officer-in-charge is informed of the outcome of the application, when he/she transmits the message to applicants.

Ideally, in the interim period (when the application is still pending), social workers should be offering some home-based services to the applicant and his family. The type of services to be offered would be based upon the outcome of investigations when the psycho-social report was initially drawn up. This service gap is caused by an absence of agency policy guidelines on serving the disabled.

Fourth, social workers in this service category omit important roles. The researcher particularly refers to the role of the statistician necessary in this type of service. Social workers should keep accurate statistics of pending cases (viz those who are on waiting lists), how long they have been on such lists, and projected chances of admission. These data should be used as the basis for advocating expanded residential facilities. But because of absence of clear agency policy this role is never carried out.

6.5.6 Applications to Itsoseng Handicraft Centre

Social workers in this service category are implementers of the labour policy of the Department of Manpower and Utilisation. The policy provides for the training and the sheltered employment of persons whose physical conditions prevent or limit their chances of being trained or employed in the open labour market. A setting of this nature in Bophuthatswana is the Itsoseng Handicraft Centre in the Ditsobotla region.

Adult literacy programmes, social work services, and medical care form part of the programme. In the main, handicrafts feature prominently. In addition, skills in woodwork, shoe mending, and welding are offered.

Applications for admission are made by clients themselves with the assistance of a social worker. Playing the role of access worker, the social worker compiles a social report on the applicant. This report, together with the medical report, is sent by the social worker directly to the Centre, contrary to the tradition of using the Head Office as a go-between.

The service is characterised by ineffectiveness, discontinuity, and inefficiency.

(a) The programme is ineffective in that it fails to attain its intended goals, the primary one being to equip trainees with economic skills. Low admission standards, and the type of programmes offered at the Centre, militate against these goals.

Paper credentials are not required as pre-entry requirements. Illiterates and semi-illiterates are admissible. This reality reflects upon the quality and quantity of training offered therein. This training seems not to be pertinent to needs of the open labour market.

(b) The service is discontinuous since there is no mechanism to link trainees with open labour markets. After training some venture into communities, either to seek employment or to establish home-based industries. Very often they confront insurmountable problems because of their limited marketability, scarcity of jobs in the environment, and lack of materials and equipment necessary to set up cottage industries. Those who choose to take up sheltered employment instead of venturing into communities seem to be better off.

(c) The programme is inefficient, in that it is wasteful. Upon visiting such a Centre one is often struck by stacks of products that seem to have been there for years. This is indicative of the fact that products are not readily marketable.

The costs that went into production, material and equipment expended, staff salaries, energy used, seem not to be recouped directly through the sale of products or indirectly through production of skilled manpower, which is one of the principal concerns of developing countries.

(d) However inadequate these centres may be, they are in short supply as seen from the long waiting lists. Seemingly, disabled people use them in the absence of better alternatives.

Existence of these programme deficiencies reflects society's limited concern for the position of disabled persons, and Bophuthatswana is no different. A caring society would give disabled persons equal opportunities for education and training in the form of technicons specially designed for use by them. In this way the disabled would acquire skills that are pertinent to open job markets, thus enhancing their employability.

What is the potential role of social workers in this service category?

First, social workers should make follow-ups of ex-trainees who ventured into communities to determine whether they are employed, unemployed or under-employed.

Second, employers' attitudes on employing disabled persons, especially those who were trained in handicraft centres, should be studied.

Third, study is needed of the perceptions of the training programme by the disabled themselves. Do they regard the training as relevant to their needs? Is it within their framework of expectations?

Fourth, programme instructors should be interviewed on their perception of the utility of the programme as a means of preparing for the open job market.

Data from these studies should be used as bases for arguing for changes in the current model of training. The target action-group here would be education and labour planners.

The model of training envisaged here would, amongst others, incorporate minimum education standards as pre-entry requirements and new training programmes that would be pertinent to the needs of the open labour market.

6.5.7 Application for Medical Appliances

In carrying out this function, social workers serve as implementers of health care policies. These policies, amongst others, extend free medical services to indigent persons, especially those who receive social security assistance, the disabled included. The service is selective.

Free medical assistance includes technological appliances, orthotics, prosthetics, rehabilitation aids eg (wheelchairs), and medical treatment.

Applications for technological appliances are made on Form Ts. I.86 (Appendix H). The Form is completed by various professionals. A doctor cetifies as to the condition; a social worker gives demographic details which inter alia, determine whether the applicant should pay or not (or, if need be, at what rate of payment); a physiotherapist also completes a portion of the form.

A duly completed form is sent to the Stores Department of a Regional Hospital or Health Care Centre, in this case, Bophelong Hospital. This Department then purchases the appliance from a contracted supplier chosen by the Government.

Programme Inadequacies

(a) Gilbert and Specht's "fragmentation" is applicable here in the sense that, while service providers are located in one place, they operate on different schedules (Gilbert and Specht, 1986).

Physiotherapists, social workers, and doctors have different work schedules and it happens very often that some, particularly social workers, are out for field visits. In this way they would be unavailable to applicants at a particular time.

(b) The programme is relatively inaccessible, especially to applicants who reside on the periphery of the area or in distant areas. Medical examinations are done in hospitals and never in village units. Paramedicals (physiotherapists) are also hospital-based. Applicants have to travel to hospital amidst transport inadequacies in villages.

(c) The service is discontinuous.

First, if the application made is for repairs, the applicant is never supplied with a substitute appliance for use in the interim period. This means that the applicant will be without an appliance for a prolonged period. This is compounded by scarcity of technicians to do repairs.

Second, there are no community-physiotherapy follow-ups on users of appliances. Sometimes appliances are ill-fitting and users fear to take them back to hospital as this would mean a prolonged wait again. In addition, appliances are abused and damaged because their uses are not monitored by professionals. Community-based services are more likely to lead to the design of appliances suitable for the community conditions.

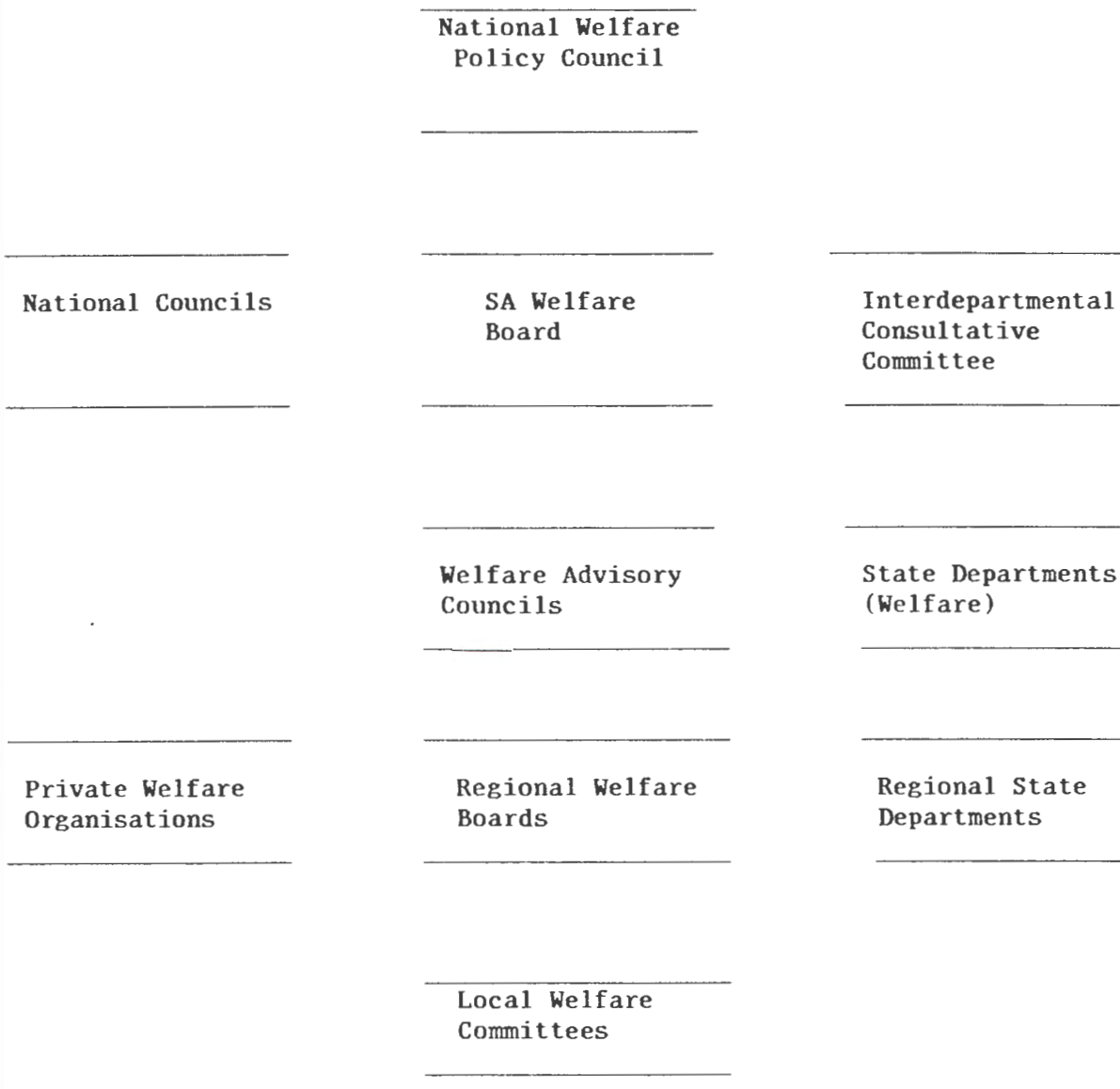
Social workers should function as social researchers here. They need to study the problems relating to the type of appliances supplied; problems regarding facilities for repairs as seen by users; procedures for applications, etc. Data from such studies would be used as bases for improving this aspect of physical rehabilitation.

As reflected throughout this discussion, absence of clear agency policy guidelines for serving the disabled account for the deficiencies mentioned. Absence of policy is in turn embedded in structural flaws of the State Department of Health and Social Welfare, residualism of the welfare system, and the low priority accorded the Social Work profession in Bophuthatswana.

These inadequacies inevitably impact negatively upon the services rendered to disabled persons.

FIGURE 2

SCHEMATIC PRESENTATION OF THE SOCIAL WELFARE STRUCTURES OF THE REPUBLIC OF SOUTH AFRICA



Source: Maatskaplikewerk - Praktyk/Social Work Practice 2/88.

NOTES

1. Anderson, W.W. "The Social Welfare Policy and Structuring of the Republic of South Africa." Maatskaplikewerk-Praktyk-Social Work Practice 2/88 Pages 15-17.

2. Bophuthatswana Social Welfare Development Fund Act No 21 of 1982. Government Gazette Vol 11 No 137 of 1982.

3. Bophuthatswana Health Act No 12 of 1983. Government Gazette Volume 12 no 153 of 1983.

4. Bophuthatswana National Provident Fund Act No 19 of 1979.

5. Bophuthatswana Unemployment Insurance Act No 17 of 1978. Government Gazette Volume 7 No 143 of 1978.

6. Bophuthatswana National Education Act No 2 of 1979. Government Gazette Volume 8 No 69 of 1979.

7. Bophuthatswana Social Pensions Act No 18 of 1978.

8. Bophuthatswana Department of Health and Social Welfare. Departmental Circular No 22 of 1981. Social Welfare Policy in Bophuthatswana. Dated 16 July 1981.

9. Conyers, D. (1986). An Introduction to Social Planning in the Third World. Chichester & New York: Wiley & Sons.

10. Cox, F M et al (ed) (1987) Strategies of Community Organization - Macro Practice 4th ed. Itasca, Illinois: Peacock Publishers.

11. Ferrinho, H (1981) Towards a Theory of Community Social Work: Cape Town, Wetton & Johannesburg: Juta.

12. Friedlander, W.A. (1982) Introduction to Social Welfare. Englewood Cliffs: Prentice Hall.

13. Gilbert, N & Specht, H (1986). Dimensions of Social Welfare Policy (2nd ed) New Jersey: Prentice Hall.

14. Hardiman, M & Midgley, J. (1982) The Social Dimensions of Development: Social Planning in the Third World. Chichester & New York: Wiley & Sons.

15. Heffernan, W.J. (1979) Introduction to Social Welfare Policy: Powers, Scarcity and Common Human Needs. Itasca, Illinois: F E Peacock Publishers.

16. McKendrick, B.W (ed) (1987). Introduction to Social Work in South Africa. Pinetown: Owen Burgess Publishers.

17. Meenaghan, T.M. & Washington, R.O. (1980) Social Policy and Social Welfare: Structure and Applications. New York & London: The Free Press.

18. Midgley, J (1984) Social Security: Inequality and the Third World. Chichester & New York: Wiley & Sons.

19. Pierce, D (1984) Policy for the Social Work Practitioner. London & New York: Longman.

20. Pincus, A & Minahan, A. (1973) Social Work Practice: Model and Method. Itasca, Illinois: F.E. Peacock.

21. Rehabilitation in South Africa. September 1984, Vol 28 No 3.

22. Rehabilitation in South Africa. December 1981, Vol 29 No 4.

23. Rehabilitation in South Africa. March 1984, Vol 28 No 1.

24. Republic of South Africa. Government Gazette Volume 161 No 6202. Department of Social Welfare and Pensions. Draft Regulations Under the National Welfare Act (Act 100/1978). Fund-Raising Act, (Act 107/1978), Social and Associated Workers Act, (Act 100/1978).

25. South African Federal Council for Rehabilitation of the Disabled Conference Report on "The Disabled are part of the Community" held in Johannesburg on the 4-6 November 1981.

26. Swil, I. (1982) Community Work: Theory and Case Studies: A Primer. Cape Town. Creda Press.

CHAPTER 7

The findings and recommendations discussed in this chapter are based upon demographic data and data concerning the problems experienced by the sixty physically disabled persons whom this study covers.

In presenting the findings use is made of frequency tables and percentages.

7.1 AGE COMPOSITION OF RESPONDENTS

The age span of 16-70 years was selected for study for several reasons. First, the information sought would be obtainable from adults rather than from children. An adult within the context of Bophuthatswana is legally defined as a person aged 16 and over. Such a person is authorized to engage in activities and contractual dealings defined for adults. He may for example, acquire an identity book or enter the labour force (Refer to Chapter 6). Second, since interest in this study is primarily on problems experienced by disabled persons themselves rather than their carers and relatives, adults were more appropriate to include than children. Third, many items in the interview schedule would hardly be applicable to the very young or the very old. Items on "employment" and "accommodation" would be examples.

The age distribution of respondents is indicated in Table 16 below.

TABLE 16

RESPONDENTS CLASSIFIED BY AGE IN YEARS

AGE GROUP	NUMBER	PERCENTAGE
16-20	4	06,7
21-25	13	21,7
26-30	7	11,7
31-35	4	06,7
36-40	3	05,0
41-45	7	11,6
46-50	6	10,0
51-55	6	10,0
56-60	5	08,3
61-65	2	03,3
66-70	3	05,0
A11	60	100,0

The distribution in the table above is skewed towards younger age groups with the highest frequency (21,7%) being in the 21-25 category followed by the 26-30 and 41-45 categories. The smallest numbers were in the age categories 61 and above.

This finding contrasts with those of the British Office Population Census and Survey (cited by Harries, and quoted by Disler (1984:4) and cited in Chapter 5 page 138 of this dissertation); and those of the Bophuthatswana 1985 census records, in that these attest to the correlation between the incidence of disability and increasing age. While such a correlation could be true in general (because bodily organs and senses lose functions with advancing age), in this particular study factors other than age played a dominant role. These factors are based on the environment. They include poverty-related diseases (such as poliomyelitis common in developing settings), stress-related diseases (such as hypertension and strokes which cause hemiplegia, common in areas that undergo transition from rurality to urbanism), industrial accidents, related to jobs done by many for example construction

work current in the area, farm work and mining), and automobile accidents (caused by poor road conditions, an imbalance between traffic volume and size of road networks, poorly skilled drivers, animal-drawn vehicles still forming part of the road traffic, and unfenced roads allowing free passage of stray animals). These factors singly or in combination lead to high possibility of paralysing injuries.

Those who become disabled as a result of factors such as those listed above are to be found chiefly in the younger age groups. These younger interviewees had some expectations about the outcome and purpose of the study. For example, they expected to gain in some tangible way, like being helped with jobs or with applications for pensions. The older folks would be beyond these needs. They for instance, would have long secured their pensions. They would thus feel they have already obtained their due from the Government (which was in this study usually perceived by respondents to be represented by the researcher). The younger interviewees were still battling with administrative pre-conditions for getting pensions. Because of their need for help, they tended to give more definite and accurate leads to their homes at pay-point centres. This made them easier to trace.

7.2 SEX DISTRIBUTION

A preponderance of males over females was found in the study (60% as against 40%). This finding is supported by data in the 1985 census which indicated a total of 561 cripples in the Molopo region, of whom 318 were males and 243 females.

The present finding can be explained in terms of males being more exposed to disabling agents because of their established social role expectations. The role of breadwinner for instance, demands of them to provide the means of livelihood for their families. In pursuit of such means they engage in work activities of a wide

variety, some of which are fraught with disabling agents. Males in the area studied tend to engage in the more menial types of jobs owing to their lack of skills and education. These job categories include construction work, mining, heavy duty driving, and farm work etc. Injuries sustained in these job categories are often disabling or even fatal.

Women on the contrary, find themselves in the more protective home environments because of their roles as housewives and mothers. Disabling agents here are certainly present, but are in general, less serious. There are however also those women who head families (which is unfortunately on the increase nowadays) and perform the role of breadwinners. The work predominantly done by such women especially those in the area under study, is domestic service. Exposure to disabling agents in this service sector is less than that in the job categories that apply to males.

In addition to job categories as sources of disablement, there is also the environment itself. Men in the rural area studied either commute between job and home (often long distances) or migrate to the cities. City life has its own contingencies such as crime, violence, and automobile accidents which are potentially disabling. The stress of city life, which may also be occasioned by unemployment, lack of proper accommodation, poor health and lack of support systems (in the form of spouses, children and relatives left behind) compounds the list of potentially disabling agents. Southern Africa's system of migrant labour takes mainly men from rural homes to urban jobs. Hence the present study found a significant number of males crippled by industrial and automobile accidents, violence and stress. To quote a few examples, two were paralysed by stab wounds, five crippled in car accidents (as drivers or passengers), three were injured in mining or construction work, fourteen were crippled by hypertensive strokes leading to hemiplegia.

The above-mentioned causes of crippling are to be found more often in city environments than in rural ones. Not only are they less frequent in rural areas but their variability is narrower. Farming labour which is what most people engage in in rural areas, seems to be the principal source of disabling injuries (more to be said on this issue later on).

7.3 MARITAL STATUS OF RESPONDENTS

The variable of marital status was included in the study because of the pervasive impact of disablement upon personal relationships. Table 17 below indicates the marital status of interviewees.

TABLE 17

RESPONDENTS CLASSIFIED ACCORDING TO MARITAL STATUS

MARITAL STATUS	NUMBER	PERCENTAGE
Married	11	18,3
Single (never married)	37	61,7
Divorced	4	06,7
Separated	7	11,6
Widowed	1	01,7
All	60	100,0

Table 17 indicates that the majority, approximately 80% were found not to be married when the study was done. This figure was made up of those who never married, the divorced, the separated, and the widowed.

This finding indicates the pervasive effect of disablement upon formation and maintenance of marital relationships. Factors that underlie the disruption of relationships were detailed in Chapter 4, pages 82-85. These included the physical, economic, and emotional burden imposed by a disabled spouse, and the disruption

of role performance. A case example in support of these assumptions was cited in the same chapter, page 84. It should be remembered that the categories of disablement covered in this study are markedly perceptible, which render the sufferers physically unattractive. Their deformities deprive them of the crucial attribute of physical beauty which is often basic to love relationships especially in the Western society which developing people emulate so much. Disabled persons deprived of this attribute, frequently encounter insurmountable difficulties in having love partners.

Study of the traditions and mores of the Batswana however, would suggest their disability is not necessarily a bar to marriage. Schapera (1984:40) for instance states that marriage according to the setswana tradition is an arranged affair between family-groups. He defines a family-group as "being made up of different households living side by side and acknowledging a common 'elder'. Such a group usually consists of 20-50 persons. It consists basically of families whose men are all descended agnatically from a common grandfather or great grand father by whose name the group is commonly known; the 'elder' is always the man senior to the rest in line of descent".

This force of tradition would give every Motswana boy or girl chances of getting married, sometimes even notwithstanding any physical imperfections each one may have. Yet, as is evident from the findings, the chances of marriage do indeed seem to have eluded about 62% of the respondents. The most probable reason is that modernizing changes have impacted strongly upon tradition. People seem to be no longer bound by traditional practices which amongst others dictate to them the choice of a marriage partner. People now tend to follow their desires and needs. These realities certainly deprive sufferers of chances of marriage.

Had the system of extended families still existed in its original

form, it would have sustained a marriage between an able-bodied partner and a disabled one, or between two disabled partners. But the system has been weakened as a result of urbanization. People feel the imposed strain by the physical and economic burden of caring for a disabled partner. Divorces and separations, where one partner is disabled are common.

Absence of professional marital therapy and counselling services in the area from which the bulk of study units were drawn, seems to disadvantage sufferers further in the domain of marriage.

From the evidence gathered in this study, marriage is greatly desired by the disabled. During interviews some respondents overtly expressed their needs for love unions. One respondent asked me to get a wife for him because he was lonely. Another bitterly narrated her experiences of being deserted by her lover after disablement. Another respondent, in answering a question on marital status, questioned in turn "Do you think there is any person who could love a grossly deformed person like me?" These statements reflect the despair felt by persons bereft of love relationships.

7.4 FUNCTIONAL DIAGNOSIS

Subjects were categorized according to their functional conditions. Each one of these conditions had several sub-categories. The basis of classification adopted produced four distinct groups of functional conditions, i.e. paralysis, amputation, deformation and muscle tautness.

Emphasis in this categorisation is on homogeneity of respondents. By this the researcher means that each one of the sub-categories imposes a differential handicap upon its victims depending upon its intensity. A quadruplegic, for instance, would be more handicapped than a hemiplegic. Emphasis in this dissertation is

not on idiosyncracies, but on the overall or universal problems encountered by physically disabled persons as a distinct social group in a deprived environment.

Table 18 lists the respondents according to functional diagnosis.

TABLE 18

RESPONDENTS CLASSIFIED ACCORDING TO FUNCTIONAL DIAGNOSIS (N=60)

PARALYSIS SUB-CATEGORY	NUMBER
Paraplegia	9
Hemiplegia	14
Quadriplegia	8
Monoplegia	3
Sub Total	34 or 56,6%
AMPUTATION SUB-CATEGORY	NUMBER
Above-knee (both legs)	1
Above-knee (unilateral)	8
Arm (unilateral)	4
Sub Total	13 or 21,7%
DEFORMATION SUB-CATEGORY	NUMBER
Bow-legged	4
Osteriotic	3
Hunch-backed	2
Dwarfed	1
Sub Total	10 or 16,7%
MUSCLE TAUTNESS SUB-CATEGORY	NUMBER
Cerebral palsied	2
Parkinson gait	1
Sub Total	3 or 5%

Table 18 tells us that paralysis and amputation affect 56,67% and 21,7% of the persons covered by the study.

7.4.1 Paralysis and Amputation

Paralysis and amputation can be expected to prevail in environments such as the one studied here. As mentioned in chapter 2, the region is in a state of transition, moving away from rurality to urbanism. The rural-urban dichotomy is becoming a thing of the past. It is being replaced by a rural-urban continuum. This means that some areas will be relatively more rural, others more urban. We can expect affluence and poverty-related pathologies to occur, with incidence variability being determined by each area's position on the continuum.

Given the background of the area, one might infer that paralysing agents and those of amputation are environmentally-based.

Paralysis, which affects more than half of study units, is caused by congenital factors, illness and accidents. Paralysing diseases common in transitional areas such as this one, are stroke-cum-hypertension and poliomyelitis. Etiological factors of strokes in hypertension and stroke may include, amongst others, the stresses associated with socio-economic change occuring in the Molopo area. These changes demand of people to make certain social and psychological adaptations which are stressful. This stress is in turn manifested in psychosomatic conditions of stroke and hypertension which may deteriorate to hemiplegia. About one quarter (23,3%) of respondents were so affected. hypertension is very common in the area. The Bophelong Hospital records support this. They show that as many as 120 people are treated on each clinic

day. Clinics are held three times a week. These figures obviously exclude those who visit private doctors, making the incidence in the area probably higher than what the hospital records show.

Poliomyelitis is another common crippling ailment in the area. It seems to be prevalent in the peripheral sectors of the region. These are areas seldom reached by professional medical services. The researcher knows of areas where neither static nor mobile clinics are provided for. Essential immunization services against diseases such as poliomyelitis are absent. In addition to the absence of prophylactic medicine, there are also exaggerated beliefs in traditional medicine and witchcraft. People tend to believe that poliomyelitis is caused by witchcraft, hence they are ignorant of the fact that it can be medically prevented. In some families one finds repeated attacks of poliomyelitis among two or more family members. With adequate health services such crippling diseases could be kept in check or completely eliminated. From the researcher's observation poliomyelitis is not common in town areas.

Accidents, both industrial and automobile, are yet other causes of paralysis in the area. Industrial accidents are related to construction work going on in the urban centres. Falling off buildings, or injuries by building equipment are common. Some of these accidents are paralysing.

In the rural areas accidents are related principally to farm labour. People are moving away from primitive farming practices. Modern farming methods are being the innovation introduced by AGRICOR (Agricultural Cooperation). Accidents are frequent when people are not

well conversant with operations of new farming equipment. This is coupled with low safety standards of such equipment. Open tractors and trailers are typical of unsafe equipment.

Statistics of automobile accidents are not available, but the incidence is believed to be high. Pre-conditions for traffic accidents in the area include poorly skilled drivers, and the phenomenal increase in the number of cars which is not complemented by commensurate expansion of road networks, leading to a situation of traffic congestion. Roads are unfenced, causing stray animals to be a perpetual danger on the roads. Animal-drawn vehicles are part of the traffic adding to inconsistent driving patterns. Injuries sustained in car accidents are often crippling. Some cause paralysis, others cause accidental or surgical amputation.

Although automobile accidents tend to be commoner in urban areas, they are not unknown in rural ones. Poor road conditions (e.g. untarred roads), coupled with poor driving skills are principal causes of crippling accidents.

The high number of amputees and paraplegics amongst study subjects is likely to be related to the "disabling agents in the environment although other agents, notably disease, may cause paraplegia or necessitate amputations. There are also those who are crippled in South African cities where they work as migrants. After disablement they return home to Bophuthatswana to be cared for by relatives, thus adding to the total number of disabled people in Bophuthatswana.

7.4.2 Deformation

Deformation affected approximately 17% of respondents. Malformed limbs are basically inherited, but may also be caused by illness or trauma. Because of either complete lack or insufficiency of primary health care services, preventable deformation nevertheless occurs. Researcher is thinking here in particular of absence of genetic counselling services. These services make it possible for latent disability to be intercepted, in this way preventing the possibility of deformed births. With the high rates of births in the area as mentioned in Chapter 2 and 5, the numbers of malformed children are also likely to be large.

Muscle-tautness was found to be less common amongst study subjects. It affected only 5%. Conditions of muscle-stiffness found among respondents are cerebral palsy and the Parkinson gait. Cerebral palsy, as indicated in Chapter 5, is caused by brain damage. Brain damage may occur at birth or parentally due to disease or trauma. Birth-related brain damage can be expected to be common in the area because of unhygenic home-based deliveries commonly done in the area (Refer to Chapter 5).

Although paralysis, amputation, and deformation (in that order) emerged as significant causes of disablement amongst respondents (perhaps because of environmental factors), the role of methodological procedures adopted in the study must not be overlooked. The distribution of the disabling conditions and their order of occurrence as indicated in Table 18 may have been a chance event. Further studies would be needed if the true picture is to be revealed.

7.5 EDUCATIONAL STANDARDS

The educational levels of respondents were inquired into, in part as a yardstick of their socio-economic levels. A person's level of education largely influences his socio-economic position because of its intimate link with employment. Especially for "average" people, the paper qualifications they possess are instrumental in securing them better jobs. Educational standards of respondents are indicated in Table 19.

TABLE 19

RESPONDENTS CLASSIFIED ACCORDING TO EDUCATIONAL STANDARDS.

HIGHEST STANDARD PASSED	NUMBER	PERCENTAGE
Not even Standard A	32	53,3
Standard A-B	9	15,0
Standard 1-2	5	08,4
Standard 3-4	8	13,3
Standard 5-6	5	08,3
Standard 7-8	1	01,7
All	60	100,0

Table 19 tells us that 53,3% i.e. more than half of the respondents had not even attained Standard A. They had either never been to school, or had dropped out before completing the first school standard.

Approximately 37% (comprising 22 respondents) had not attained Standard 4. Ten percent (comprising 6 respondents) had attained an educational level between Standards 5 and 8.

The high level of illiteracy amongst the study units is particularly striking. Since reading and writing skills within the context of Bophuthatswana are only taught formally in the classroom, little or no exposure to elementary schooling means partial literacy or complete illiteracy. Emphasis in Bophuthatswana is on formal education.

The 37% who had less than Standard 4 are best regarded as semi-literate. The researcher cannot assume with with certainty that the six years of schooling (Standard A to Standard 4) enabled them to acquire a reasonable level of basic literacy. The United Nations as cited by Graaff & Lawrence (1986:38) suggests this to be about 5 years. Beeby (1976:16) suggests 4 years. He further says that much depends upon the quality of teaching and opportunities to practise learned skills. Both the conditions suggested by Beeby are lacking in the situation of persons in my study. It is the researcher's belief that, unless post-school life almost daily reinforces the literacy skills gained at school, these skills are eventually lost even if more than four years of schooling were received.

As has been indicated in Chapter 2, respondents were drawn from an environment deprived of educational facilities. Such deprivation was the legacy of maladministration of the education system by the Government of South Africa prior to the independence of Bophuthatswana in 1977, and of course genuine lack of resources in the country of Bophuthatswana, because of its underdevelopment. In the same Chapter the researcher has also indicated that the situation of educational deprivation is worse in rural areas because of the Government's biased distribution of resources between rural and urban sectors, to the detriment of the former. The result of a combination of these factors is high rates of illiteracy in the area. In Chapter 2 the researcher has pointed out that approximately 44,5% of the

area's population has never attended school, while those who dropped out at the primary level of schooling comprised a further 40,5% (Refer to Chapter 2 page 40).

Under conditions such as these the situation of the disabled is extremely difficult in that they are a minority and suffer discrimination in the provision of opportunities. By way of illustration, they do not have special schooling facilities in the Molopo region. The one and only available school for them is the Tlamelang School for Cripples situated in a different region, viz Ditsobotla. Its geographical location and admission policies makes it largely inaccessible to the disabled based in the Molopo area (See Chapter 6 on details concerning these issues).

Lacking special schooling facilities, the disabled in the area studied venture into mainstream schools. There their physical handicap, the school programmes and the attitudes of teachers and peers all militate against their continued attendance and their progress. In addition there is also the reluctance on the part of parents to educate disabled children. Illiteracy or semi-education are the ultimate results. Hence low levels of education and literacy amongst the study subjects. The reader should however note that illiteracy in the area is not only confined to disabled persons. The able-bodied are affected. Amongst my study units there were those who were disabled during their adult years, but they had, while physically normal, never had opportunity to attend school.

In addition to environmental factors that prevent the disabled from attending school, there are also the negative attitudes of parents towards educating their disabled children. The following appear to be the chief reasons for parental reluctance:-

(1) Parents, particularly in poor areas, regard the ultimate value-goal of education to be employment, especially

"white-collar employment". This notion seems to be reinforced by presence of 'local elites' (usually teachers and nurses within communities). These 'elites' inspire parents to educate their children with a view to opening better job prospects for them.

Disabled children, in the researcher's observation, are perceived by their parents to be virtually unemployable. Educating them for work is considered a futile exercise implying that the more intangible benefits of education are not valued. Such benefits include what Ferrinho (1980) refers to as the "ability to integrate into the fast-moving world", and what Bruner (1977) refers to as the "acquired ability to interpret real life situations and events in terms of learned ideas". To such parents the principal consideration is the acquisition of economic skills. Since disabled children are perceived to be incapable of implementing learned skills, denying them education is found justifiable by the parents.

(2) Another reason, closely allied to the above, is the perception of children by poor parents as future investments and social care providers during parental years of dependency such as old age and disablement. Such perceptions seem to be rooted in the lack of formal social care structures in their immediate environment and also their lack of personal social security schemes. Disabled children are regarded by their parents to be lacking in both economic and social care potential. Parents are therefore not prepared to invest in their education.

(3) Some parents in poor areas (Molopo included) believe that care of disadvantaged persons (the blind, the aged, disabled) is the responsibility of the Government. This belief is common in all ill-informed communities who know very little about the policy that controls government sponsored welfare benefits. By way of illustration, the researcher has observed a tendency amongst some parents of disabled children to ask for material assistance from welfare agencies, on behalf of their disabled children even if they can truly afford to do without such. Such parents normally refuse to educate their children, arguing that after all at age 16 he/she will qualify for a State disability pension, which will be his basic income source.

(4) The direct costs of education, viz school fees, books, uniforms and other occasional contributions such as tribal school levies and travel costs, generally prevent parents, (especially the poor) from educating their children. Disabled children are worse off because in their case there are additional costs occasioned by special needs (such as motor appliances, special transport and medical costs). Parents then weigh current financial obligations related to educating disabled children with the ultimate benefits of such efforts, which are not immediately obvious. Keeping disabled children out of school becomes the preferred option.

(5) Overprotection might also be a motive. Parents sometimes fear that their disabled children will be rebuked and maltreated by teachers and peers in ordinary schools. To curtail this possibility they do not take them to school, and they sometimes even 'detain' such children within protective home environments.

(6) Fear of embarrassment should also be mentioned. Having a disabled child can be an embarrassing experience in some cultures, especially where disablement is perceived to be a curse, or the result of an act of witchcraft. In communities where such beliefs prevail, parents withdraw themselves and their deformed child from social contacts, in the process denying him/her education. From the author's observations, feelings of embarrassment change to those of tolerance at about age 16 when the child becomes eligible for a disability grant. At this stage he becomes a social utility to the family because of the income he brings in.

(7) Some ignorant parents associate physical handicaps with intellectual handicaps. They therefore believe that a disabled child is not able to benefit from learning opportunities.

Absence of Special Schools in the Immediate Environment

Where special schools are not provided for within the living area of disabled children, the alternative is to use mainstream schools. Unfortunately here they confront insurmountable problems emanating from their physical condition and from teachers' attitudes [Refer to Chapter 4 for details on these issues]. In my opinion teachers' attitudes are crucial. Their direction will determine the school attendance and enrolment patterns of afflicted children. If they are accepting, they will tend to minimise the adverse impact of physical handicaps, hence sustain a sufferer's school attendance. But, as indicated in Chapter 4, teachers are very often culprits. A case example is cited here in support of this assertion.

'Thabo', aged 12, was crippled by poliomyelitis. The researcher met him during fieldwork. Nevertheless, he managed to attend his school regularly as his mobility was enhanced by use of calipers, orthopaedic shoes, and crutches.

At the time of encounter he was about to abandon his schooling alleging that his school teacher and principal persistently nagged him to leave the school and enter schools "appropriate for people of your kind". 'Thabo' felt they were not going to allow him to remain where he was.

7.6 EMPLOYMENT POSITION OF RESPONDENTS

An analysis of the societal context of disabled persons would be incomplete if it excluded the domain of employment. Work is for average citizens the means to enhance living standards. It is particularly crucial to sufferers because of its potential to intercept the intricacies of a combination of poverty and disablement, especially if such work is skilled.

In this section, the researcher will examine some aspects of the work situation of respondents, viz, their current employment status, job problems encountered by the few in employment, and the viewpoints of the rest on their unemployed state.

7.6.1 Employment Status of Respondents

Seventy three percent (or 44) were not working at the time of study, with only 27% or (16) in employment.

This finding supports the proposition made in Chapter 4 about the pervasive impact of disablement upon the employability of the disabled.

Studies quoted there by Robinson, Johnson and & Johnson, Du Preez & Uys, and Cornelje' & Cornelje' (see Chapter 4 pages 103-104) demonstrate the negative impact of disablement upon employment. Du Preez and Uys' study in particular added another dimension: even where jobs are relatively sufficient, and disabled persons therein are relatively skilled and educated employment is still not easily accessible to them. Attitudes of the employing community seem to be the obstacle.

In the case of the respondents in this study, environmental realities (particularly scarcity of jobs in their immediate milieux) and lack of marketable skills combined with factors mentioned above to combat their employment possibilities.

As has been mentioned in Chapter 2 and 5, the Molopo region is underdeveloped. There is an immense scarcity of jobs. This is in part due to imbalance between economic growth and population growth. The increase in population size outruns economic growth, with unemployment as the result. Such unemployment is particularly manifest in rural areas (see Chapter 5).

The Molopo region is no exception. Figures cited in Chapter 2 show that 70% of the economically active population is without jobs. The remaining 30% is absorbed in the few existing employment sectors, the largest being the growing public and semi-public sectors. It is estimated that this sector absorbs about 50% of the population (See Chapter 2).

The job categories available in the area can accommodate basically three types of labour:

(i) the able-bodied and skilled to do the skilled developmental tasks in both the private and public sectors:

(ii) the able-bodied but unskilled to do menial jobs especially in construction work going on in the area; and

(iii) the skilled but disabled (to be elaborated upon later).

People in this study do not fit into any of the above-mentioned categories. They are doubtly disadvantaged by physical limitations and lack of skills. Had they been able-bodied but unskilled they would have been able to do any jobs that demand physical exertion. Had they been skilled but disabled, they might have done light, skilled jobs, within their limitations.

One major emphasis of this study is the respondents' perspectives on their problems and situations. They were therefore asked how they viewed their unemployment.

Reasons given by respondents for their not working are indicated in Table 20.

TABLE 20

RESPONDENTS CLASSIFIED BY THE MAJOR REASON GIVEN FOR NOT WORKING

REASONS	NUMBER	PERCENTAGE
Disability itself	23	52,27
Unavailability of jobs	17	38,64
Family influence	4	09,09
All	44	100,00

Response categories indicated in the table above were constructed from grouping the answers given on questions relating to their work positions. Respondents were asked to mention the reason they regarded as the major one. The answers are analysed here.

The Disability Itself

According to Table 20, 52,3% considered their disablement as the major factor preventing them from working. These respondents included:

- those who defined themselves to be unemployable and possibly refrained from seeking jobs

- those who lost their jobs after injuries

- those who considered their deformities to be as truly unacceptable as to repel prospective employers

- those who considered themselves the rightful claimants of State welfare benefits, hence did not think they needed to work
- those who claimed to have searched for jobs, but could not find any.

The responses suggest that physical handicaps, social handicaps, and employers' attitudes were the major impending factors. As has already been said, these factors are universally applicable to the disabled, in varying settings. But, in the case of the subjects of this study, they are compounded by scarcity of jobs in the environment and by lack of marketable skills in the subjects themselves.

Unavailability of Jobs

About two-fifths (38,6%) blamed their unemployed state on lack of jobs in their living milieux. As far as the present study units are concerned what they experienced as unavailability of jobs probably arose from a combination of three reality factors, i.e. a genuine absence of job opportunities, the irrelevance of such skills as they might posses to the needs of the labour market, and the unwillingness of the employing community to take on persons with disabilities.

Absence of job opportunities in the environment has already been explained. Theoretical explanations concerning employers' reluctance to employ persons with disabilities were given in Chapter 4. The researcher needs only mention here that she has not been able to test this theory within this study. It is therefore a potential area for further study. The third factor here concerns the nature of skills possessed by the majority of respondents. Respondents possess rudimentary skills in handicrafts. These are obtained in the Country's handicraft centres, particularly the Itsoseng Handicraft Centre which caters primarily for physically disabled persons. As will be explained later, the skills acquired there do not seem appropriate to the needs of the open job market because trainees find difficulty in securing jobs outside the training centres.

Family Influence

Less than a tenth (9,1%) of the respondents alleged that their families prevented them from working. This group was either ignorant of other prohibitive factors (like attitudes of employers, scarcity of jobs in the area,

physical handicaps, and their own lack of skills), or alternatively were cognizant of these factors but regarded them as less important. They perceived the principal problem to be the restraint by their families. These were the minimally disabled. The reader is reminded that subjects studied here suffered from varying degrees of handicap. Some had residual abilities that could be tapped and applied, while others had far less.

The question to be asked here is why would families discourage a disabled member from working?

There are certain perceptions held by family members regarding the employment of a disabled relative.

First, disabled persons are regarded to be best suited for household chores such as animal herding or caring for children and the aged. The able-bodied family members are expected to go out to work in cities. As for open market employment, it seems to be regarded to be beyond the capabilities of the physically impaired. Second, families fear that sufferers would forfeit part or the whole of the State pension should they engage in any form of remunerative activities especially if these are discovered by pension authorities. Such fear is related to the residual nature of State pensions brought to the attention of applicants during the application process. Keeping a sufferer away from employment is a way of safeguarding the pension, since in many families it is the only source of stable and regular income. Third, families in poor environments consider street begging to be the better way of earning a living, especially for deformed persons who are more likely to attract the sympathy of the public. Very often they post a disabled person at a street corner. Disabled beggars are a common sight in shopping

complexes in Mafikeng and Mmabatho. In the past they used to be embarrassed to authorities, that an inter-departmental organisation was set up to deal with the problem. This organization was, however, not successful in its mission. Causes of this failure were on the one hand, the resistance from beggars themselves and their apparent lack of fear of action from authorities. On the other, the donating public, predominantly the Indian business community in Mafikeng, helped to sustain the begging activities. While authorities defined begging as a problem the donating community saw it differently, as a religious obligation.

The factors outlined here (viz disability, shortage of jobs, lack of skills, and family influence) singly or in a combination militated against employment of the disabled. Absence of official policy regarding such employment tends to aggravate matters.

While the overwhelming majority of research subjects were unemployed, a minority, viz. 26,7%, were working. Their occupations are shown in Table 21.

TABLE 21

RESPONDENTS CLASSIFIED ACCORDING TO GAINFUL OCCUPATION

TYPES OF EDUCATION	NUMBER	PERCENTAGE
Switchboard operating	1	1,7
Show-repairing	4	6.7
Handweaving	5	8,3
Handknitting	2	3,3
Sewing	1	1,7
Livestock herding	2	3,3
Seasonal farm work	1	1,7
No occupation	44	73,3
All	60	100

Table 21 indicates that gainfully employed respondents were basically involved in handicrafts, reflecting a narrow range of skills possessed by them. Such skills are in Bophuthatswana taught at Handicraft Centres. They are basically rudimentary, and researcher believes they can even be claimed by untrained people. Some respondents admitted they did not undergo any training for their skills, but developed them through interest.

In Chapter 4 the researcher mentions that training in Handicraft Centres is basically geared to the circumstances of disabled persons, who in most cases are without the formal educational standards which generally are the pre-entry requirements in mainstream educational centres. In this respect Handcraft centres differ fundamentally from the country's Manpower Centres and Technicons which have Standard 8 and 10 respectively as pre-conditions for entry. Obviously therefore, trainees

of handicraft Centres are not prepared for the open job market. Most of them resort to home-based production activities, which are by their nature not economically viable.

Training offered in Handicraft Centres seems to reflect the attitudes of education planners and manpower planners regarding the employment of disabled persons. Intervention should be geared towards redirecting these attitudes. A complete overhaul of the present training system is necessary so as to effect a change in the employment potential of disabled persons in the country.

7.6.2 Job Problems of Respondents

As mentioned in paragraph 7.6.1, 16 respondents were in some form of employment at the time of study. Only one (1) was in the formal sector, as a switchboard operator employed by a semi-public agency. Apart from two cattle herders and one seasonal farmworker the rest were in self-employment as home-based producers. All except the switchboard operator may however be regarded as working in the informal sector. Table 22 indicates their problems, while problems of the only one in the formal sector are briefly mentioned first.

This respondent complained of boredom and absence of variety in his job. He worked as a receptionist and switchboard operator. The nature of the job combined with his paraplegia are naturally confining. Hence boredom and routine are experienced as the major job-related problems.

TABLE 22

FIFTEEN EMPLOYED RESPONDENTS IN THE INFORMAL SECTOR CLASSIFIED ACCORDING TO JOB PROBLEMS

PROBLEM EXPRESSED	NUMBER
Income irregular	4
Lack of raw material & equipment	2
No market for finished products	1
No proper workplace in dwelling	1
Customers do not pay for services	2
Industry time consuming and financial returns poor	5
All	15

Respondents were asked to name the problem they regarded most important. These problems are discussed below.

7.6.2.1 Industry is Time Consuming

One third complained of the cumbersome nature of their production which has poor financial returns. Handwork is basically a labour-intensive undertaking and has very little income-generating potential, especially in the region in which the research subjects were living. This is compounded by other problems also mentioned in the Table above [viz lack of raw materials and lack of markets for finished products]. One respondent indicated that it took him approximately two or more months to complete an article. Some indicated that products are seldom completed owing to lack of raw materials, and perhaps lack of enthusiasm also. Most people would lose interest in what often turned out to be a futile task.

7.6.2.2 Income is Irregular

Four respondents complained that the income from their production activities was irregular. This problem is inherent in home-based and labour-intensive production, especially when carried out by deprived persons in a deprived environment. Human flaws (illness, indolence, lack of enthusiasm) do cause some days to be without production, thus reducing income. Even if items are produced on a regular basis, it is not a guarantee that they will be bought (particularly the type produced by present research subjects). Hand products very often face competition from machine products. In these modern times of technology, people are more likely to be fascinated by fashionable machine-products. Populations in rural environments share similar interests in fashionable machine products. Handicrafts would therefore be more attractive to tourists seeking souvenirs or gifts, or to support and promote community development. Others may also buy to show sympathy with the disabled seller. All these imply that the seller should be somewhat near a town centre. Most respondents claimed they do their sales within their living environments, a fact which severely limits their sales opportunities.

7.6.2.3 Lack of Raw Material and Equipment

Two respondents complained of having difficulty in obtaining raw materials and production tools. This problem arises because production activities do not generate finances essential to maintain the enterprise. When this happens there will be no

money to replace the needed raw material. This problem is entangled with the economic unavailability of their activities.

7.6.2.4. Lack of Market for Finished Products

Though mentioned by only one respondent, researcher considers this problem significant because it is also encountered by Handicraft Centres themselves, making obvious the gap between the needs of the buying community and the production activities of the Centres. Trainees of such Centres inevitably inherit the problem.

That products of Handicraft Centres are not really needed within the community becomes evident when one visits such Centres. One finds stocks and stocks of finished products that seem to have layed there for years, instead of being sold. In the researcher's opinion Handicraft Centres are 'economic white elephants'. They neither generate the much-needed income nor produce the much-needed skilled manpower in the country. For purposes of economic progress there has to be a thorough assessment of Handicraft Centres and their activities by education and manpower planners in the country.

7.6.2.5 One respondent complained of this. Even if stated by only one respondent, researcher regards this as significant because it implicates existence of problems of accommodation (to be discussed later). Preliminarily she wishes to mention that people studied here mainly live in traditional dwelling units characterized by insufficient accommodation

for living, let alone for working. During fieldwork the researcher observed some of them working under trees because of lack of working space within homes.

In summary, the problems discussed here imply that the present employment activities of respondents do not provide satisfactory sources of income. Appropriate employment opportunities should be made a priority by social planners.

7.7 INCOME SOURCES

Questions on income sources were included in the interview schedule as an indication of the socio-economic positions of the research subjects. Findings are tabulated in Tables 23 and 24.

TABLE 23

RESPONDENTS CLASSIFIED ACCORDING TO INCOME SOURCES

SOURCE	NUMBER	PERCENTAGE
Wages from employer	1	01,67
Earnings from self-employment	7	11,67
State Pension only	30	50,00
Self-employment & State Pension	9	15,00
Workmen's Compensation benefits	2	03,33
Support by relatives	11	18,33
All	60	100,00

Table 23 indicates that half (50%) subsisted on social pensions, i.e. disability grants for females aged below 60 and males aged below 65. Disability grants are converted into old age pensions when the respective ages of 60 and 65 are reached.

That the majority subsisted on State Pensions is due to the fact that they did not have any form of personal insurance to safeguard themselves against the contingencies of life such as disability or old age. As the researcher mentioned in Chapter 6 social security is divided into so called social assistance and social insurance schemes. The former is state-sponsored and is given to selected persons. The latter is a work-related or occupational benefit basically accessible to persons who hold certain types of jobs, i.e. jobs that enable their holders to afford monthly premiums. As mentioned previously present research subjects had mostly never been in the type of employment that permitted membership of personal social insurance schemes. Hence they were catered for under the social assistance scheme disability grants, or old age pensions. In addition there were those who were crippled in automobile accidents. Owing to lack of recourse to legal aid they did not claim against the Motor Vehicle Assurance Funds. In both cases, (i.e. lack of personal insurance schemes and lack of recourse to legal aid to claim against the MVA), the respondents suffered. This is the plight facing the majority of able-bodied people in the area, i.e. that when disablement strikes, many have recourse only to State Social Pensions. By way of illustration, according to the records of the Department of Internal Affairs - Pension Division, there were in 1987 altogether 158,000 beneficiaries country-wide in Bophuthatswana. This figure is almost certainly too low. Poor official records are common in developing countries (as mentioned in Chapter 3). In addition, at any one time there would be applicants still battling with administrative pre-requirements (such as citizenship documents, appropriate identity books etc. see Chapter 6).

In addition to the 50% of respondents who had no source of income except a State Pension, a further 15% claimed to have subsisted on a State Pension, plus the proceeds of self-employment. In fact there might have been more in this category, since 16

respondents out of 60 were working (see Table 22). Pensioners might have withheld information relating to supplementary economic activities for fear of forfeiting their pensions.

Eighteen percent (18%) claimed they subsisted on support by relatives. Presumably, this group had difficulty in securing social pensions, the principal income source for so many of the disabled. Administrative pre-qualifications for pensions include citizenship rights, possession of appropriate identity books, and regular payment of tribal levies for those resident in tribal villages. In addition there is also the question of appropriate medical ratings indicating the degree of disablement (Refer to Chapter 6 on these issues). These pre-qualifications limit the awards of State pensions, and the 18% considered here might have been caught up in the bureaucratic machinery, leaving support by relatives as their only means of livelihood. About one-eighth (11,7%) cited self-employment to be their sole income source. Self employment here would basically be home-based craft industries. Problems inherent in this job type were detailed in paragraph 7.6.2.

Two respondents cited benefits from the Workmen's Compensation Fund to have been their only source of income. These were the two who sustained crippling injuries in mining accidents. Workmen's benefits in Bophuthatswana are administered under the Workmen's Compensation Act. Beneficiaries of this Fund are automatically disqualified from receiving other State Pensions. Amount payable under the Fund were in general more adequate than State Pensions. They ranged between R220-R230 monthly at the time of study. Recipients did not complain about the amounts they were receiving.

In general, though, respondents were dissatisfied with their low level of income. Respondents were asked to name the most important ground for such dissatisfaction. Their answers are indicated in Table 24 below.

TABLE 24

RESPONDENTS CLASSIFIED ACCORDING TO PROBLEMS EXPERIENCED REGARDING INCOME SOURCE

A. Wages from Employer (one=1) The only respondent in this category had no specific complaints. B. Wages from Self-Employment Only (seven=7)		1,7%
PROBLEM EXPRESSED	NUMBER	
Income irregular Income shared with too many others	3 4	
Sub Total	7	11.7%
C. State Pensions (Thirty=30) Benefits insufficient Amounts fluctuate Benefits not paid monthly Payment procedures cumbersome Payments not readily accessible Benefits shared with too many others	 8 4 7 4 1 6	
Sub Total	30	50%
D. Workmen's Compensation Funds (Two=2) Payment procedures cumbersome	 2	
Sub Total	2	3,3%
E. Support by Relatives (Eleven=11) No money for personal needs Cannot get pension	 8 3	
Sub Total	11	18,3%
F. Self-Employment plus State Pensions (Nine=9) Incomes insufficient Fear of losing pensions	 3 6	
Sub Total	9	15,0%
ALL	60	100%

The findings in Table 24 are discussed. Notably not all problems expressed regarding income sources will be discussed. Only those with high scores viz, State Pensions and Support by relatives will be discussed.

Problems Related to Social Pensions

The expressed problems about State Pensions as an income source may be classified into six types. These are discussed.

Benefits are Insufficient

Eight out of 30 beneficiaries complained of pensions being insufficient to meet their material needs. As indicated in Chapter 6, social pensions are a residual benefit hence characteristically inadequate. Above all, lack of economic resources in the country is responsible for the small amounts payable. To alleviate this problem will not be easy because of the fundamental policy of residualism and because of economic insufficiencies.

Pensions are Paid bi-monthly Instead of Monthly

Seven out of 30 complained that they found it difficult to stretch their meagre benefits over two months.

Bi-monthly payments seem to have been adopted to lessen administrative tasks. But unfortunately payment procedures better suit distributors than recipients. This is yet another manifestation of the residual nature of social pensions.

Social workers ought to function more often as social researchers. Dissatisfactions of the beneficiaries urgently call for nation-wide investigation. Data thus collected could be used to effect changes in payment procedures.

Pensions are Shared with too Many Others

Six out of 30 mentioned this problem. Respondents share homes with others, including members of their extended families. Often the pension is the only source of regular income in the household because family members are unemployed. Should there be working members, they are migrants in cities who seldom come home or send money for support of their dependents.

Payment Methods Regarded as Cumbersome

Refer to Chapter 3 and the detailed discussion of pension payment procedures followed in Bophuthatswana.

Payment of all State Pensions is done at selected points. Such points can be a school, church, or a tribal authority office. Normally a single paypoint serves two or more villages. As a result, on each pay day there is often a large agglomeration of recipients of all pension types (the aged, blind persons, war veterans, etc.). A queue system, or a first come first served method is used. A struggle for first positions forms part of the picture. As a result people leave their homes as early as possible just to be among the first to receive benefits. Meanwhile, pension officers normally arrive at such paypoints after 9.00 a.m. as they have to obtain cash from banks which normally do not open before this time. Prolonged waits are inevitable. Cases are known where pensioners collapse because of fatigue and exposure.

Environmental realities and the circumstances of pension recipients make alternative methods of payment (i.e. those used in town areas) to be impossible or difficult to implement. These include payments through banks and post offices. These facilities are not available in the immediate milieux of most respondents in this study. The few who live in town areas can

also not be paid through post offices and banks in consideration of uniformity in payment procedures. Hence present methods, albeit regarded cumbersome by recipients, will for sometime remain.

Inaccessible Paypoints

The pension paypoint system used has already been described. Its form implies that respondents will experience differential accessibility. Those who are distantly located will certainly confront serious problems of access, remediable only through adequate transport facilities. These are in turn out of reach for folks such as those studied here.

Amounts Fluctuate

Four out of 30 expressed this problem. Pension officers explained that this is a rare problem, attributable only to minor administrative errors.

Support by Relatives as an Income Source Problem

Eleven respondents were solely dependent upon relatives. As mentioned, this group includes those who do not as yet receive pensions because of one reason or another, including failure to meet pre-qualifying conditions. It presumably also includes some who have been told they cannot qualify. These people encounter insurmountable problems as they have to be supported by people who, themselves, lack stable sources of income. The scale of their problems is hard to contemplate, and the remedy equally so.

7.8 ACCOMMODATION CIRCUMSTANCES OF RESPONDENTS

Shelter is a crucial area of human need. Its quality largely reflects the socio-economic level of its occupants. It is included in the study as a probable area of need to persons such as those studied here.

7.8.1 Lack of Adaptation

Table 25 indicates lack of adaptations in homes occupied by respondents to be the major problem. It was expressed by one third across all disabilities, the highest proportion being in the paralysis category. The reason may perhaps be that within the paralysed group there are those whose degree of handicap is so great as to render them immobile. To make their practical daily lives in any sense convenient the homes must be adapted.

The second highest scores with regard to needs for adoptions was found in the amputation category. Within this group too we do find those whose handicap is so serious as to render them immobile. An instance would be someone who lost both legs through amputation.

7.8.2 Overcrowding

Overcrowding as a problem was expressed by 35% of persons across all disabilities, the majority being in the paralysis category. This may be because of their being severely handicapped and thus easily stifled in small spaces.

Overcrowding in essence refers to available space relative to the number of occupants. Setswana households are normally large, because the household is the basic domestic grouping. A household according to Schapera (1984:39) consists of a man with his wife or wives, and their married children. It may include one or more married sons, brothers, or even daughters with their respective families. Each household has its own compound, consisting of one or more huts and granaries situated

within a courtyard surrounded by a reed fence, a wooded palisade, or a low earthen wall.

Communal cohabitation is evident from the traditional arrangement described by Schapera. Although 'civilising' influences and the impact of the South African Government's policies of resettlement have considerably altered this traditional pattern of home occupancy, its residues can still be discerned in the form of extended family settings existent amongst some town and rurally-based families. Overcrowding is basically caused by the household arrangement and the fact that many do not have the means to build larger homes.

7.8.3 No Own Homes

Approximately 17% of the respondents in all categories of disablement expressed their wish to own homes, i.e. the wish to disengage from the bonds of communal living. Realisation of their wishes is remote. Their deprived state, combined with physical handicaps, would be major obstacles. Respondents cannot afford their own homes, especially homes that are adapted to enhance their practical independent daily living. They are bound by necessity to live with relatives. In addition, it is part of the traditional customs of the Batswana to care for their dependent family members (viz the aged, sick, disabled,children) within their homes. This cultural practice is reinforced by absence of residential institutions in their environment. Traditional practice has led to the Government's policy of deinstitutionalization and that of partnership between the family, community, and Government in caring for the needy. This policy works better in theory than in practice. Furthermore, disabled persons, particularly of pensionable

ages, are regarded as social utilities because they bring pension benefits normally shared among family members. Therefore families try to keep them within homes. Finally, there are those who do not consider any alternative to sharing dwellings. These include those who are unable to manage by themselves and those whose disablement is congenital or acquired in early childhood. Because they grew up in a situation of sharing a dwelling with relatives they do not think of any alternative

Only 13,33% claimed not to have any accommodation problems. There were two groups of them. First, there were those who did not want to reveal their problems to me as the researcher, particularly owing to the presence of their carers during the interview. Second, there were those who had been disabled in early life, and had never been on their own. They had therefore never developed a sense of independent living.

Homes that are not adapted to their needs represent the major problem experienced by respondents. Adaptations are basically costly and perhaps possible only in homes of above average standards. Unfortunately such homes are far beyond the means of people such as those studied here, basically owing to the established ways of acquiring homes. A home is for average citizens an occupational benefit. It can either be provided by the employer through one of the many subsidization schemes available on the market, or linked to a salary or any means available to the purchaser. People in my study however have no such means because of lack of jobs and poverty. Hence they are unable to afford homes convenient enough to accommodate their limitations. The majority inhabit traditional dwelling units of the 'wattle and daub' type. These are dwellings also occupied by the able-bodied persons with

whom respondents commonly share (Refer to Chapter 2 for detailed discussion of housing standards in the rural areas of the Molopo region).

Saying that poor housing is an environmental reality may perhaps be an overgeneralization that discounts the existence of dual societies. Even in deprived environments we do find both rich and poor co-existing. The rich (in relative terms) would include the local business persons, the tribal leader, the locally-based public servant, the teacher, the community nurse, etc. These are the people who can afford decent homes (albeit by local standards) perhaps as an occupational benefit or through financial means available to them. But the policies of home financing institutions very often militate against them. These policies prevent the financing of homes when the buyer dos not own the land on which the home is to be built. Tribal authorities are sole owners of the land. People's rights extend only in so far as building upon or lending out such land, but not to ownership. Selling or renting of tribal land is prohibited by tribal law (Schapera, Ibid : 20). These policies prevent even the working class group, who might otherwise own decent homes as an occupational benefit, from doing so. Hence in the area studied decent homes are unknown.

7.9 CARE-RELATED PROBLEMS

7.9.1 Respondents were asked to mention the persons who were primarily charged with caring for them on a regular basis. Their responses are given in Table 26.

TABLE 26

RESPONDENTS CLASSIFIED ACCORDING TO THE PRINCIPAL CARERS MENTIONED BY THEM

CASES	NUMBER	PERCENTAGE
Spouse	6	10,0
Parent	13	21,7
Child (daughter/son)	8	13,3
Extended relatives (uncle, grandparent,niece, nephew, son/daughter-in-law	17	28,3
Self	11	18,3
Paid home help	1	01,7
Others (neighbours and friends)	4	06,7
ALL	60	100,0

Table 26 indicates that more respondents (viz 28,3) were cared for by "extended relatives " than by other category of carer. This finding illustrates the predominance of the household as the basic social care structure within the culture of the Batswana, and the extended nature of the household unit. But, as already mentioned, the extended family unit is slowly disappearing in the face of urbanising influences,both in rural and in urban communities. Within urban communities it takes two forms. One is where the youth leave rural homes to live with relatives in town so as to attend schools, since these are scarce in their own communities. The other is where migrant workers live with relatives.

Just over one-fifth (21,7%) claimed they were cared for by their parents in accordance with the Setswana culture. Culturally, a person, irrespective of age or marital status, is always considered to be a child in the eyes of his/her parents. Parents tend to wield great influence in the "child's"life. In the case of the disabled, there is even more justification for this. The

tendency on the part of the disabled to be cared for by their parents is a facet of family-based care for disadvantaged family members commonly practiced by the Batswana. Within such a system of care the mother tends to feature prominently, perhaps due to her traditional social role.

Approximately eighteen percent (18,3%) claimed they cared for themselves. This group included mainly those who lived alone, and those whose handicap was relatively so small as to enable them nevertheless to care and manage for themselves daily and practically.

Approximately thirteen percent (13,3%) were cared for by their own children either daughters or sons. Traditionally, children are responsible for caring for their parents especially during those periods of life marked by dependency, for example illness, old age, disablement (Refer to 7.5.1 for a detailed discussion on this aspect of care).

A small number, 06,7% said they were cared for by neighbours and friends. From my observation, informal support systems offered help of an informal type, but did not include practical daily care. Such informal helping activities include things like getting water from pumps, help with purchase of groceries, or tangible help like giving a cup of sugar, some mealie meal, or anything that is needed. Observations suggest that neighbourly helping activities are common in the area studied, for two basic reasons. First, the community is closely-knit, because most of them have some form of relationship, either by blood or affinity, with one another. These relationships are intimately tied to the household as the basic social organisation. A tribe is very often an extension of an extended family system. Second, some communities were resettled in the Molopo region from areas in south Africa. They thus share a common background, which makes them a closely-bonded community in the resettled area. Informal

help therefore has become a way of recognising the common or shared origin. Such help is extended to all who share this background irrespective of physical attributes.

The researcher observed during fieldwork that disabled persons, particularly in the rural part of the Molopo region, are not socially isolated. They seem to have a wide circle of social contacts. When she called, most of them were found at neighbours' or friends' homes. They were known by their local, and perhaps endearing, names. This observation seems to negate the common belief that the disabled are generally socially isolated and shunned. But, as I indicated in Chapter 4, attitudes towards the disabled differ from person to person, from social group to social group, from community to community, and from one society to another. More indepth studies ought to be carried out to determine what the latent attitudes of the Molopo community towards the disabled are, particularly in the face of social change.

From the foregoing discussion, families (both nuclear and extended) are principal sources of social care. Institutional or paid home help is virtually unknown.

7.9.2 Respondents were also questioned about the problems related to their practical daily care. Responses to this open-ended questions were grouped, and seven problem categories emerged. These are detailed in Table 27.

TABLE 27

RESPONDENTS CLASSIFIED ACCORDING TO MAJOR PROBLEMS ENCOUNTERED IN DAILY CARE

PROBLEM	NUMBER	PERCENTAGE
Carer monopolises pension money	6	10,0
Care offered in not constant	12	20,0
Burdened with child care	3	05,0
Personal (material) needs not met	11	18,3
Cannot get financial support from father of children	1	01,7
Need home help	5	08,3
No problems	22	36,7
ALL	60	100,0

Respondents were asked to name the problem they considered as the chief one encountered in daily care. Their responses were then grouped. By way of illustration, a problem "care offered is not constant" included complaints like carer is not always around because he/she is working, alone most of the time, remain with young children for the greater part of the day, carer socialises too much.

Table 27 tells us that more than one-third (36,7%) claimed to have no problems regarding their care. This group basically included those who lived alone, and those who did not feel at liberty to express themselves because of the presence of family members, particularly their principal carers during the interview. (Refer to Chapter 3 on details regarding the interview settings in some respondents' homes). Owing to

characteristics of the setting, some respondents could not speak freely of sensitive matters such as the quality of care and of personal relationships. A third group here was comprised of those who genuinely did not have any problems. Inter alia through observing non-verbal clues during interviews I was able to distinguish between the three groups.

Twenty percent (20%) complained that care offered was not constant. Amongst this group were those who were extensively handicapped, needing regular and constant care, and those whose carers were mostly away because of work or some other reason.

Approximately eighteen percent (18,3%) complained that their carers did not meet their material needs. The majority within this group were found not to have any medical appliances. They blamed this on alleged neglect by their principal carers. While neglect may have been wholly or partly the cause, other factors too were significant. These included cumbersome application procedures in securing state-sponsored appliances, and also shortage of finances within the Government, rendering Government-sponsored appliances scarce. One elderly female respondent bitterly narrated her family's persistent failure to secure a wheelchair for her over a period of about four years. An investigation into the matter revealed that the Department of Health and Social Welfare had temporarily suspended the purchase of medical appliances because of shortage of funds. This case example show how little community know about the impoverished state of their (third world) Government.

Ten percent (10%) mentioned as main problem the alleged misuse of their pension money by principal carers. Principal carers had access to such money basically in two ways. First, he/she might have been granted "power of Attorney" by the beneficiary, i.e. in such case the authority to collect pension benefits from

distributors on behalf of the beneficiary. This is done in particular where the beneficiary is severely handicapped, or too old to be able to collect and administer the pension himself. In cases where use of the pension is the problem, the authorised person is also charged with the responsibility of administering the pension on behalf of the rightful beneficiary. Human-nature being what it is, such monies are sometimes misused or used in such a way that the owner does not have any control over them. Some respondents complained in the presence of their carers that they had never seen or touched their pension moneys. They also claimed not to be aware of the pension amounts.

Approximately 8% claimed that they needed home help. This group included those who lived alone, or lived with old persons or else very young children. Many people in the villages commute daily to town for work or work as migrants. The disabled are amongst those who remain at home. Ironically, they are left in the company of those who need help themselves because of age or youth. In many cases, the disabled are charged with care of children or the aged. The researcher encountered three cases of hemiplegics who said they were caring for aged relatives and young children while other family members were away at work.

Problems encountered by disabled persons in the Molopo region regarding their care call for professionals to implement the Government's policy of deinstitutionalization with caution. In fact, social planners need to observe social trends such as changes in the family (or the basic social care structure) occasioned by processes of modernization and urbanization. Such observations would help to determine whether it is possible for community-based care satisfactorily to replace institution-based care, or whether some combination of the two will be needed. If so, the relationship between the two types of care also requires study.

7.10 SOCIAL SERVICE PROBLEMS

Respondents were asked about their problems that needed intervention from formal social service providers. Again, they were asked to mention one problem that they considered to be the chief. Responses were grouped into categories indicated in Table 28.

TABLE 28

RESPONDENTS CLASSIFIED ACCORDING TO THE MAJOR SOCIAL SERVICE PROBLEM ENCOUNTERED

PROBLEM	NUMBER	PERCENTAGE
Difficulty in getting medical appliances	11	18,3
Need repairs to medical appliances	13	21,7
No transport to medical centres	8	13,3
Difficulty in getting pensions	11	18,3
Help in admission to institutions (special schools, handicraft centres, etc.	9	15,0
Maintenance from father of children	1	01,7
Need food rations	5	08,3
Wish for marriage	2	03,4
ALL	60	100,0

Table 28 indicates the need for repairs to be done to appliances as the problem more often cited than any one other. As mentioned in Chapter 6, there are no follow-up services into communities to supervise the use of medical appliances supplied through the hospital. Very often appliances are ill-fitting, or they are

worn out, and users do not take them into hospital for repairs for fear that they will spend sometime without the appliances, since such repairs take a long time to be done. Hence most of the respondents complained of worn out appliances.

Delays in repair of appliances is a universal problem, as indicated in Chapter 5. The reason is that these technologies are imported from the First-World. Technicians to do repairs on such imported appliances are in short supply. Implicit here is the need for indigenous appliances. Some countries India, for instance, have already made significant inventions in this regard through the use of locally available material of cane and bamboo to make appliances. (See Chapter 5 pages 179-180 in connection with these issues.)

An equal number of respondents (18,3%) reported difficulty in obtaining medical supplies and difficulties connected with pensions as their principal problem.

Difficulties in getting medical appliances or supplies inhere in the cumbersome administrative procedures followed in obtaining State-sponsored appliances, and deficiencies in the whole programme of administering these appliances as mentioned in Chapter 6, pages 241-243. In addition there is also the question of the appliance being a residual benefit, with all the problems common to residual services.

Those who reported difficulties in getting pensions include persons who failed to meet established pre-qualifying requirements. The first of such requirements is the approved disablement rating that is determined by hospital doctors. These ratings range between 50-100 for temporarily and permanently disabled persons respectively. A second requirement is citizenship documents and a third, officially approved identity documents, meaning "Bophuthatswana Book of Life". A fourth,

requirement is proof of having paid tribal levies in the case of those who reside in tribal villages. (Refer to Chapter 6 on details regarding the pre-requirements).

Often, these pre-qualifying requirements in effect prove prohibitory. Many needy and deserving applicants are denied access to social pensions because of these requirements. In this study these included the 18% who depended upon maintenance by relatives as indicated in Table 23. The expectation that help might be forthcoming in applications for pensions seems in several cases to have prompted enthusiasm to respond to the research project.

Fifteen percent (15%) of respondents claimed they needed assistance in getting admission to State institutions, chief of which were the Gelukspan Institution for chronically Disabled Persons, Tlamelang School for Cripples, and Itsoseng Handicraft Centre. Difficulties in getting access to these institutions were discussed in Chapter 6. Such difficulties centred around admission policies, cumbersome application procedures and deficiencies in the access services rendered by professionals (Refer to Chapter 6 for more details).

Eight percent (8%) claimed they needed assistance in getting food rations. Food rations are an in-kind type of assistance given to the destitute. The majority of community members seemed to be aware of this assistance. Moreover it had been given on numerous occasions. The researcher gives a few examples. There was the drought relief aid scheme introduced by the Government during the years of drought in the early eighties. Food parcels were given to local people defined as needy. The disabled and aged were amongst the recipients.' There was also the donations from the so called President's X-mas Fund. These donations consist of food parcels given to the needy at Christmas. The major sponsors

are the public. In early 1988, after disastrous floods, similar relief was offered to victims. With these prior experiences of donations, some respondents expected the researcher to be another bearer of "manna" from the Government. Several therefore asked for such tangible help.

The above discussion shows that most respondents expressed needs of a material nature. Only an insignificant number (approximately 3%) mentioned need for help with problems of an emotional nature. These wanted to be helped in obtaining a spouse. Presumably, they believed marriage would solve all other problems.

7.11 SUMMARY OF THE FINDINGS AND CONCLUSIONS

This section attempts to bring together the most important aspects of the findings of this study. It discusses implications for social policy formulation, and any other relevant conclusion. Seeing that the findings relate to a wide spectrum of the life domains of disabled persons, central issues only in each problem area will be highlighted and recommendations made in regard to them.

All-in-all, findings show that the disabled people studied are disadvantaged in wide-ranging ways. Objective criteria of such deprivation include low literacy rates, unemployable states, lack of proper accommodation, care-related problems that are contingent upon disablement, and lack of economically viable sources of income. In some, respondents were caught up in the intricacies of individual and environmental poverty. Hence effective intervention needs to be at the social planning level, involving formulation of appropriate social policies. This implies also far-reaching changes in the present social service provision.

7.11.1 FINDINGS AND CONCLUSIONS RELATING TO SOCIAL SERVICES

Social services rendered to disabled persons in the region are largely deficient. This deficiency is rooted in problems of under-development and in the Government's prioritization in the allocation of resources to various social service disciplines. Those disciplines that are privileged are those that are perceived by policy makers as contributing directly to economic development which is the primary concern of Third-World governments. Social work unfortunately is not included in the priority list. This is its reality in Bophuthatswana. It culminates in absence of vital structures essential to serving the population in general and the particular one under study, viz the disabled. Absence of structures in turn implies that no relevant policies are being formulated to serve the disabled population. Absence of structures also implies continued shortage of personnel. This is the current state of services to the disabled in the Molopo region.

Realistic intervention should be directed to creation of relevant structures. The researcher suggests the following in consideration of the socio-economic and political realities of Bophuthatswana, although basic ideas are derived from structures existing in South Africa.

(a) Policy-making structure is needed, be it a Council, Board, or whatever. This organization should exist at Head Office level. Its basic charge should be

the formulation of welfare policies to address the needs of all client groups including the disabled. The activities of this envisaged organization should be the formulation of major policies which will logically lead to establishment of appropriate implementation structures. Amongst these structures should be those that exclusively serve the disabled. Staff cohorts that serve disabled persons specifically are needed, because effective services to the disabled require both expertise and experience, and without a stable body of personnel such services are even more difficult to achieve.

An Inter-departmental Committee, something akin to that which exists in South Africa, is needed. The South African Committee is established along the lines of the racially-based welfare departments, an example that would be contrary to Bophuthatswana's Constitution for it to follow. The Committee envisaged will co-ordinate activities of all Government departments that deal in any way whatever with disabled persons, e.g. Department of Education, Department of Manpower and Utilisation, Department of Internal Affairs, Department of Health and Social Welfare, and Department of Population Development. A Committee of this nature would have in its organization a central statistical division where a register of all disabled persons is kept. Such a register does not exist at present. The Committee will also conduct research concerning disablement, rendering planning data. Such data are missing at present. More elaborate structures than those suggested here would be beyond the means of the Government of Bophuthatswana.

Voluntary input should also be encouraged although difficulties in establishing such input inhere in underdevelopment. Nevertheless despite its under-development, resources do exist in Bophuthatswana that can be tapped to finance voluntary organizations. For instance, there is the Social Welfare Development Fund which is under-utilised. Funds might also be solicited from various donor organisations. It is for social workers and other community workers to tap these resources to expand and enhance the functioning of existent voluntary organisations.

7.11.2 FINDINGS AND CONCLUSIONS ON PERSONAL DATA

Common disabling factors have been identified as poverty-related illnesses, automobile accidents, industrial accidents, stress, and hypertension. All are potentially preventable. Hence intervention strategies should basically be preventive. It will be cheaper for the country to prevent than cure disablement, or to try to deal with problems of disabled persons in view of the manpower, organisational and resource implications. Bophuthatswana ought to follow the example of Mali. Mali is one of the poorest countries of the world but has established structures and strategies for preventing and also dealing with disability amidst its shortage of resources. Its Government is engaged in keeping the numbers of the disabled, who are potential tax consumers, at a minimum level.

What prevention strategies can be adopted? Informal education, primary health care, and health education would be suitable prevention strategies. Informal education on occupational safety should be extended to employers and employees. For lack of safety standards is the major source of disabling injuries in industries.

Primary health care, which involves administration of prophylactic medicines, should be prioritized. Health education should be increased so as to conscientise people (especially those in deprived areas) about ways of preventing disablement. Actual primary prevention services like genetic counselling are imperative if Bophuthatswana is to control the growth of its disabled population.

An area that is more difficult to deal with through prevention is that of automobile accidents, which claim many victims. Informal education on defensive driving is given regularly by the traffic department of Bophuthatswana. But irrespective of these efforts accidents rate escalates. Perhaps what need to be done is to help many victims of automobile accidents to have recourse to legal assistance so that they are able to claim under the Motor Vehicle Assurance Scheme. Benefits thus claimed will help victims to have means of livelihood. This will reduce dependency on social pensions.

7.11.3 FINDINGS AND CONCLUSIONS ON EDUCATIONAL STANDARDS

The educational standards of the respondents were particularly low, and there is no reason to believe that they might be higher in other regions of Bophuthatswana. The researcher found a high degree of illiteracy and semi-illiteracy. At best, respondents were semi-educated. Factors arising from physical handicaps themselves combine with social handicaps, environmental deprivation (particularly shortage of special and mainstream schools), and reluctance on the part of parents to educate their disabled children, to deprive sufferers of education. Particularly important is the lack of educational facilities in the living milieux of respondents. Where such facilities are in short supply even for the able-bodied, the potentiality that the disabled should be illiterate persons is great.

Lack of education impacts adversely upon the employability of the disabled in that they lack marketable skills. Acquisition of skills is a long-term process, initiated at the primary level of schooling, and proceeding through to secondary or tertiary level where career choices are made. Such choices must then be followed by training in selected careers. The disabled in my study did not even achieve the fundamental stage of the process of vocational preparation.

In accordance with the theoretical framework adopted in this study, viz the life model, strategies in the educational field should focus dually on the environment and the individual. Environmentally, the Government should formulate policies which aim at expanding educational opportunities to disabled persons. One such policy might be compulsory education for all including the disabled up to standard eight or ten which are essential to opening up further training opportunities. (It should be remembered that disablement often strikes in adulthood, so general education is essential, not only education for disabled children.) Dillman (Rehabilitation in South Africa, September 1981) (editorial note) however points out that the lack of resources in South Africa makes compulsory education for all its citizens difficult to implement. If Dillman is right, universal compulsory education would be altogether impossible to implement in Bophuthatswana, whose insufficiency of resources is greater than South Africa's. Nevertheless, The researcher remains strongly of the opinion that compulsory education will minimise the number of illiterate disabled. One way of implementing this policy of compulsory education might involve joint efforts of community-based social workers and nurses in tracking down disabled children within communities to ensure that they enrol in a suitable training institution when they reach school-going age.

Intervention outside the social policy arena should include community education activities to eliminate those factors that at present prevent the disabled

from making use of such schooling facilities as are available.

Attitudes of mainstream school teachers should be addressed, as should the unwillingness of parents to educate their disabled children. Disabled children themselves should be educated about realities inherent in ordinary school settings which are designed to accommodate able-bodied pupils. Knowledge thus gained might help disabled pupils develop a philosophical stance that will aid them in tolerating school-related problems. Teachers too, as part of the school-social milieux, should be trained to deal with special needs of disabled pupils so they become instrumental in sustaining the pupil's school attendance. All of this will take money, time, and human organization. Without such steps, however the social situation of the disabled cannot be improved, and the costs of their present circumstances, both visible and invisible are much higher than is apparently realized.

7.11.4 FINDINGS AND CONCLUSIONS REGARDING EMPLOYMENT

The majority of the respondents were unemployed at the time of study. Reasons for this were found in the interfaces between the persons studied and the environment. The person is unskilled and lacks physical abilities to do any job that may be available to him. The environment lacks jobs; employers as part of the environment are not prepared to employ disabled people, and families somehow do not encourage even the minimally

disabled to work for reasons already stated. Amidst this multiplicity of interacting factors choice of a point of intervention is difficult to make. But, in line with the theoretical framework of this study, intervention should be directed towards both person and environment. Intervention at the environmental level (especially that which is directed towards creation of jobs) is an enormous task. Absence of job opportunities is a reality that is intricately interwoven with the economy, the polity, and their policies. Only in mythical thinking can job opportunities be created without considering the socio-economic contexts. Effective intervention must be realistic. It must therefore aim at making disabled and disadvantaged persons capable of competing for the jobs that are actually available in the area. Education and skill training would be the appropriate strategies, but the skills to be imparted would certainly be not the ones currently taught them.

The researcher emphasizes education and skill acquisition although studies done by some researchers, in particular Du Preez and Uys (cited earlier on) have revealed that, even where jobs are relatively sufficient and the disabled have the skills to do them, they still encounter employment problems (probably due to attitudes of the employing community). Given the environment where Du Preez and Uys's study was done, such problems are possible. The environment from which my study subjects were drawn however is different. The Molopo region is at this point in time still far off the stage in development where there is no

shortage of skilled labour. Therefore the disabled, if skilled, would have ample chances of getting jobs.

Training of the disabled for jobs, should thereafter be complemented by enactment of compulsory employment of disabled persons, such as is to be found in most developed countries, where a specified minimum proportion of the labour force must be recruited from among disabled persons.

Emphasis so far has been on preparing disabled children of school-going age for employment. The researcher now turns to the adult disabled who have already passed the age for primary and secondary schooling. To this group, adult literacy classes would be appropriate. Adult literacy classes here refers to informal education geared to improving the skills presently held by the adult pupils. It is not literacy teaching that is conventionlly known to help the learner acquire writing and reading skills. The adult disabled have long passed the stage appropriate to elementary education.

Informal education activities considered here would teach the disabled to sharpen their skills. By way of illustration, a shoe-maker would be taught about various kinds of leathers and the right type of products that could be made out of such. In addition, the adult disabled should be taught about

producing products needed in their communities. The researcher knows of a group of disabled persons in one region of the country who produce coffins out of local material. This project is successful since coffins are needed in most areas. The Molopo-based cripples can also be taught to produce motor appliances from locally available material . Crutches and walking sticks could be amongst such locally-produced aids.

7.11.5 FINDINGS AND CONCLUSIONS ON ACCOMMODATION PROBLEMS

Homes inhabited by the respondents are far from convenient enough to minimise their handicaps. They are structurally unadapted, overcrowded, and are owned by people other than the sufferers themselves. Yet, the disabled need homes of an above-average standard to accommodate their limitations. What is often regarded by disabled city dwellers as basic, such as home devices and architectural adaptations are unknown in traditional dwelling units. Thus housing is by and large an area of great need for the disabled in this study.

Intervention by means of social policies would in this matter be a difficult task, since the Government of Bophuthatswana does not have a declared policy regarding providing homes either to rural people or to disabled persons in communities both urban and rural. Rural dwellers are worse off since they live on tribal land. The Government does not provide homes on such land; its housing

schemes are confined to trust or municipal lands. This policy is also followed by institutions that offer housing finance. This is the reason why even those people in tribal areas who are in good employment are not helped in acquiring proper homes.

The most appropriate form of intervention would be to adopt the Community Work approach called Locality Development. Projects should aim at home improvement or neighbourhood improvement. Rural inhabitants should be helped to improve their homes within their own means. Structural adaptations could be done by using locally- available material. A good deal of organization, of the "grass-roots" kind, would however be involved, and this takes time. New ideas are often difficult to assimilate.

The remaining problem area, viz the social service-related problems, can be remedied by improvements in the social service structures and operations as have already been mentioned.

As for care-related problems, they are contingent upon home-based care. They are often manifestations of the burden imposed by the presence of a disabled person within a family. No social policies can be formulated to deal effectively with the problem. But through informal education activities better care for home-based cripples, could be encouraged.

Social policy recommendations put forward here are long term plans. They could ameliorate the situation of sufferers in the rather distant future, but not immediately. For immediate needs, social services currently rendered need to be improved. All that this would amount to is to 'paper over the cracks', and with very little paper at that. Short-term amelioration should however never be neglected in favour of long term strategies. Both are essential for man's life is short, and people are suffering in the here-and-now. It is better to light a small candle than to sit cursing the darkness. If one candle burns, others may be lighted from it.

NOTES

1. Beeby, C.E. (1976). The Quality of Education in Developing Countries. Cambridge & London: Harvard University Press.

2. Bruner, J.S. (1977). The Process of Education. Cambridge & London: Harvard University Press.

3. Dillman, J.H. "Vooroordeel Teenoor Gestremde Werkers" (Editorial note) in Rehabilitation in South Africa, September 1981, Vol.25 p.3.

4. Ferrinho, H.F. (1980) Towards A Theory of Community Development. Cape Town, Welton & Johannesburg: Juta & Company Limited.

5. Graaff, Johan F. de V. & Lawrence, M.L. (1986). Rural Parents and School Enrolment Patterns in Two Regions of Bophuthatswana. Education, Research Division. University of Bophuthatswana.

6. Schapera, I. (1984). The Tswana. KPI in association with International African Institute. Britain.

BIBLIOGRAPHY

1. Ahrtag. Aids For Living. No.7, August 1976.

2. Anderson, W W. "The Social Welfare Policy and Structures of the Republic of South Africa." Maatskaplikewerk - Practyk/Social Work Practice 2/88.

3. Ardington, E. (1984). Poverty and Development in a Rural Community in Kwa-Zulu. Carnegie Conference Paper No. 536, Cape Town.

4. Bailey, K.D. (1982) Methods of Social Research (2nd ed) New York: The Free Press.

5. Battye, L. "The Chatterley Syndrome" in Boswell, D.M. & Windgrove,
J.N. (eds.) (1974). The Handicapped Person in the Community. A Reader & Sourcebook. London: Tavistock & The Open University Press.

6. Beeby, C.E. (1976). The Quality of Education in Developing Countries. Cambridge & London: Harvard University Press.

7. Bentovim, A. "Handicapped Pre-School Children and their Families: Effects on Child's Early Emotional Development" in Boswell and Wingrove, Ibid.

8. Blaxter, M. (1976). The Meaning of Disability. A Sociological Study of Impairment. London: Heinemann.

9. Bruner, J.S. (1977). The Process of Education. Cambridge & London: Harvard University Press.

10. Bophuthatswana Department of Health and Social Welfare. Departmental Circular No. 22 of 1981. Social Welfare Policy in Bophuthatswana. Dated 16 July 1981.

11. Bophuthatswana Department of Health and Social Welfare. Annual Report, 1985.

12. Bophuthatswana Health Act No.12 of 1983. Government Gazette Volume 12 No. 153 of 1983.

13. Bophuthatswana Social Welfare Development Fund Act No.21 of 1982. Government Gazette Volume II No. 137 of 1982.

14. Bophuthatswana National Provident Fund Act No.19 of 1979.

15. Bophuthatswana National Education Act No.2 of 1979. Government Gazette Volume 8 No. 69 of 1979.

16. Bophuthatswana Unemployment Insurance Act No.17 of 1978. Government Gazette. Volume 7 No. 143 of 1978.

17. Bophuthatswana 1985 Census Records. Published by the Department of Economic Affairs, Statistics Division, 1986.

18. Boswell, D.M. & Windgrove, J.N. (eds.) 1974. The Handicapped Person in the Community. A Reader & Source Book. London: Tavistock and Open University Press.

19. Bulmer, M. & Warwick, D.P. (1983). Social Research in Developing Countries. Surveys and Censuses in the Third World. Chichester & New York: Wiley & Sons.

20. Butrym, Z. & Horder, J. (1983). Health, Doctors, and Social Workers. London & Boston: Routledge & Kegan Paul.

21. Byrne, A. & Padfield, C.F. (1978). Social Services Made Simple. London: Howard & Wyndham.

22. Castle, M.R. (1987). Primer of Nursing Research. London: W.B. Saunders.

23. Cornelje, A. & Cornelje, H. (1986 unpublished). Rehabilitation in Ditsobotla. A Survey done in Mareetsane. Gelukspan Hospital.

24. Conyers, D. (1986). An Introduction to Social Planning in the Third World. Chichester & New York: Wiley & Sons.

25. Cox, F.M. et al (1987). Macro-Practice. Strategies of Community Organization (4th ed). Itasca, Illinois: F.E. Peacock.

26. Dillman, J.H. "Vooroordeel Teenoor Gestremde Werkers" (editorial note) in Rehabilitation in South Africa, September 1981, Volume 25 No.3.

27. Disler, P. (1984). Poverty and Disability. Carnegie Conference Paper No. 186, Cape Town.

28. Dovey, K. & Graffam, J. (1987). The Experience of Disability Social Construction and Imposed Limitation. Victoria College, Burwood Campus.

29. Ellis, G.F.E. (1984). The Dimensions of Poverty. Carnegie Conference Paper No.4, Cape Town.

30. Farrant, J.S. (1980). Principles & Practice of Education. Longman.

31. Ferrinho, H. (1981). Towards a Theory of Community Social Work. Cape Town, Wetton & Johannesburg: Juta & Company Limited.

32. Ferrinho, H. (1980). Towards a Theory of Community Development. Cape Town, Wetton & Johannesburg: Juta & Company Limited.

33. Freidlander, W.A. (1982). Introduction to Social Welfare. Englewood Cliffs: Prentice Hall.

34. Germain, C.B. & Gitterman, A. "The Life Model Approach to Social Work Practice Revisited" in Turner, F.J. (ed) (1986). Social Work Treatment. Interlocking Theoretical Approaches (3rd ed) New York: The Free Press.

35. Germain, C.B. & Gitterman, A. (1980). The Life Model of Social Work Practice. New York: Columbia University Press.

36. Gil, D (1973). Unravelling Social Policy. Cambridge, Massachusetts: Schenkman.

37. Gilbert, N. & Specht, H. (1986). Dimensions of Social Welfare Policy (2nd ed). New Jersey: Prentice Hall.

38. Ghai, D. "Jobs for Boys". Mafikeng Mail, 1 November 1988.

39. Goffman, E. (1965). Asylums. Essays on the Social Situations of Mental Patients and Other Inmates. New York: Doubleday & Co.

40. Goldsmith, B. "Designing for Physically Handicapped Children - Are you on the Right Level, Mr Architect?" in Loring, J & Burn, G (eds) (1975). Integration of Handicapped Children in Society. London, Henley & Boston: Routledge & Kegan Paul.

41. Gokhale, G.S. "Dynamics of Attitude Change". International Social Work 1986, Volume 28.

42. Goldthorpe, J.E. (2nd ed) (1984). The Sociology of the Third World. Disparity and Development. Cambridge: University Press. London: Oxford University Press.

43. Graaff, Johan F. de V. & Lawrence, M.L. (1986). Rural Parents and School Enrolment Patterns in Two Regions of Bophuthatswana. Education Research Monograph No.6. Institute of Education, Research Division. University of Bophuthatswana.

44. Greenway, P. & Harvey, D. "Reactions to Physical Handicap" in Laura, R.S. (1980). Problems of Handicap. Hong Kong: McMillan.

45. Grinnell, R.M. (1988). Social Work Research and Evaluation (3rd ed). Itasca, Illinois: F.E. Peacock.

46. Goussou, R. "Social Rehabilitation of the Physically Handicapped in Mali". Children in the Tropics, August 1989. International Childrens' Centre, Paris.

47. Hanekom, S.X. (1985). Public Policy. Framework and Instrument for Action. Johannesburg: McMillan.

48. Hardiman, M. & Midgley, J. (1982). The Social Dimensions of Development. Social Planning in the Third World. Chichester & New York: Wiley & Sons.

49. Harries, P. (1984). Aspects of Poverty in Gazankulu. Three Case Studies. Carnegie Conference Paper No.7, Cape Town.

50. Hefferman, W.J. (1979). Introduction to Social Welfare Policy. Power, Scarcity and Common Human Needs. Itasca, Illinois: F E Peacock Publishers.

51. Helm, B. (1962). Social Work in a South African City. University of Cape Town: Board of Sociological Research.

52. Herschfield, A.F. et al & Hursh-Cesar, G. "Fieldwork in Rural Areas" in Bulmer and Warwick, Ibid.

53. Hill, M. (1980). Understanding Social Policy. Oxford: Blackwell & Robertson.

54. Huttman, E. (1980). Introduction to Social Policy. New York, London: Mc Graw-Hill Book Company.

55. Jeppe, S. (1980) in Molosankwe, S.J. (1983). An Analysis of Some Contributory Factors to Malnutrition viz Unemployment, Poverty and Overcrowding. B.A. (SW) Honours Extended Essay. Department of Social Work, University of Fort Hare, Alice.

56. Johnson, G.S. & Johnson, R.H. "Paraplegies in Scotland: A Survey of Employment and Facilities" in Boswell and Windgrove, Ibid.

57. Johnson, H.W. (eds.) (1980). Rural Human Services. A Book of Readings. Itasca, Illinois: F.E. Peacock Publishers.

58. Kahn, A.J. (1979). Theory & Practice of Social Planning. New York: Russell Sage Foundation.

59. Lancaster-Gaye, D. (1972). Personal Relationships: The Handicapped and the Community. Some European Thoughts and Solutions. London & Boston: Routledge & Kegan Paul.

60. Lauffers, A. (1978) Social Planning at the Community Level. Englewood Cliffs, New Jersey: Prentice Hall.

61. Laura, L.S. (1980). Problems of Handicap Hong Kong: McMillan Company.

62. Leonor, M.D. (1985). Unemployment, Schooling, and Training in Developing Countries. London, Sydney, Dover: Croom helm.

63. Lopes, H. & Tri, H.C. "The Poverty Trap: The Plight of Least Developed Countries". The Unesco Courier. October 1981.

64. Loring, J. & Burn, G. (eds) (1978). Integration of Handicapped Children in Society. London, Henley & Boston: Routledge & Kegan Paul.

65. Mabetoa, M.M. (1982). "A Comparison of Welfare Provision for African Children in South Africa with that for Children in Britain. M.A. Dissertation, Keele University, Great Britain.

66. MacPherson, S. (1985) Social Policy in the Third World. The Social Dilemmas of Underdevelopment. Brighton, Sussex: Wheatsheaf Books.

67. Mba, P.O. "Social Welfare Services for Disabled Children in Schools in Developing Countries". International Social Work, Volume 26, No.1, 1985.

68. McGrath, M. (1984). The Determinants of Poverty: A Theoretical Analysis. Carnegie Conference Paper No. 269, Cape Town.

69. McLaren, M. (1986) "Prevalence of Motor Impairment and Disability in a Rural Community in Kwa-Zulu" (Unpublished).

70. McKeith, R. "The Feelings and Behaviour of Parents of Handicapped Children" in Boswell & Windgrove Ibid.

71. McKendrick, B.W. (ed.) (1987). Introduction to Social Work in South Africa. Pinetown: Owen Burgess Publishers.

72. Meenaghan, T.M. & Washington, R.O. (1980). Social Policy and Social Welfare: Structure and Applications. New York & London: The Free Press.

73. Mia, A. "Community Participation. The Needed Approach to Primary and Secondary Prevention of Disability and Rehabilitation of the Disabled in Rural Communities." International Social Work. Volume 28 No.1, 1985.

74. Midgley, J. (1984). Social Security, Inequality and the Third World. Chichester & New York: Wiley & Sons.

75. Miller, E.J. & Gwynne, G.V. (1974). A Life Apart. A Pilot Study of Residential Institutions for the Physically Handicapped and Young Chronically Sick. London: Tavistock.

76. Milson, I. (1974). An Introduction to Community Work. London: Routledge & Kegan Paul.

77. Mojake, M.C. (1986) "Attitudes of the Rural Community towards the Disabled and the Availability of Support Systems in Rural Areas" (Unpublished). University of the North.

78. Molosankwe, S.J. (1983). An Analysis of Some Contributory Factors to Malnutrition viz. Unemployment, Poverty and Overcrowding. B.A. (SW) Honours Extended Essay. Department of Social Work, University of Fort Hare, Alice.

79. Moody, E. & Golino, C. (1984). Area Study on Venda. Carnegie Conference Paper No.251, Cape Town.

80. Moody, E. & Golino, C. (1984). Area Stduy on Gazankulu. Carnegie Conference Paper No. 252, Cape Town.

81. Morales, A. & Sheafor, B.W. (1983). Social Work. A Profession of Many Faces (3rd ed.). London & Sydney: Allyn & Bacon.

82. Mountjoy, A. (1983) (ed.). The Third World. Problems and Perspectives. London: McMillan press.

83. Moyes, A. (1981). One in Ten. Disability and the Very Poor. Oxfam. Britain.

84. Muller, N.D. & Tapscott, G.P.G. (1984). The Face of Rural Poverty in Transkei. Two Villages' Socio-Economic Profile. Carnegie Conference Paper No. 46, Cape Town.

85. Murthy, M.N. & Roy, A.S. "The Development of the Sample Design of the Indian National Sample Survey during its First 25 Rounds" in Bulmer & Warwick, Ibid.

86. Peil, M. "Situational Variables" in Bulmer & Warwick, Ibid.

87. Peil, M. et al. (1982). Social Science Research Methods. An African Handbook. London: Hoddes & Stoughton.

88. Pillay, P.N. (1984). The Development and Under-development of Education in South Africa. Carnegie Conference Paper No.95, Cape Town.

89. Pincus, A. & Minahan, A. (1973). Social Work Practice. Model & Method. Itasca, Illinois: F.E. Peacock.

90. Piroquet, A. (1986). "Community-Based Rehabilitation Services". "The Experience of Bacolod City". World Rehabilitation Fund. Monograph No.26 of 1986.

91. Polansky, N. (1980). Social Work Research. Methods for the Helping Professions. Chicago & London: The University of Chicago Press.

92. Rehabilitation in South Africa. September 1984, Volume 28 No.3.

93. Rehabilitation in South Africa. December 1981, Volume 29 No.4.

94. Rehabilitation in South Africa. March 1984, Volume 28 No.1.

95. Rehabilitation in South Africa. December 1985, Volume 29 No.4.

95. Rehabilitation in South Africa. June 1986, Volume 27 No.2.

96. Rehabilitation in South Africa. March 1984, Volume 28 No.1.

97. Rehabilitation in South Africa. September 1984, Volume 28 No.3.

98. Republic of Bophuthatswana. Department of Education Annual Report 1986.

99. Republic of Bophuthatswana. Chris Van Rensburg Publishers. Johannesburg, 1986.

100. Republic of South Africa. Government Gazette. Volume 161 No. 6202. Department of Social Welfare and Pensions. Draft Regulations Under the National Welfare Act (Act 100/1978), Fund Raising Act (Act 107/1978), Social & Asociated Workers Act (Act 100/1978).

101. Report of the National Symposium on Disablement. Compiled by the Co-ordinating Committee. Year of Disabled People 1986. Department of Health and Population Development (RSA), November 1987.

102. Schapera, I. (1984). The Tswana. K.P.I in Association with International African Institute, Britain.

103. Schoenberg, B. & Carr, A.C. (1970). Loss and Grief. Psychological Management in Medical Practice. New York: Columbia University Press.

104. Shipman, E. "The Functioning of a Medical Fitness for Work Unit" in Rehabilitation in South Africa. March 1984, Volume 28, No.1.

105. Shurka, E. "Attitudes Towards Disability and Rehabilitation Among Political and Professional Leaders in Israeli Development Towns". International Social Work. Volume 27, No.1 of 1984.

106. Simkins, C. (1984). What Has Been Happening to Income Distribution and Poverty in the Homelands? Carnegie Conference Paper, No.7, Cape Town.

107. Skidmore, R.A. & Thackeray, M.G. (1982) (3rd ed). Introduction to Social Work. New York: Appleton Century Crafts.

108. Smith, N. "Physical Handicap, Disability and Welfare" in Laura Ibid.

109. Spencer, I.W.F. (1980). Community Health. An Introductory Orientation for South African Students. Pietermaritzburg: Shuter & Shooter.

110. South African Institute of Race Relations (1986). Race Relations Survey 1985. Johannesburg.

111. South African Human Science Research Council. Conference Reports on "Education for the Black Disabled" held in Durban, Port Elizabeth, Pretoria and Johannesburg in 1987.

112. South African Federal Council for Rehabilitation of the Disabled. Conference Report on "The Disabled are part of the Community", held in Johannesburg on the 4-6 November 1981.

113. Swil, I. (1982). Community Work. Theory and Case Studies: A Primer. Cape Town: Creda Press.

114. The Citizen, Wednesday 12 November 1988.

115. The Sunday Times Business Times Supplement, 28 November 1988.

116. The Social Pensions Act of Bophuthatswana. Act 18/1978. Government Gazette No. 55 Volume 7 of 16 June 1978.

117. The Star, Friday 28 April 1989.

118. The T.V. 3 Programme, "Thakangwaga".

119. The Unesco Courier, October 1981.

120. Timms, N. & Watson, D. (eds.) (1976). Talking About Welfare. Readings in Philosophy and Social Policy. London & Boston: Routledge & Kegan Paul.

121. Titmuss, R.M. (1983). Social Policy. An Introduction. Boston & Sydney: Allen & Unwin.

122. Todaro, M.P. 91983). Economic Development in the Third World. New York: Longman.

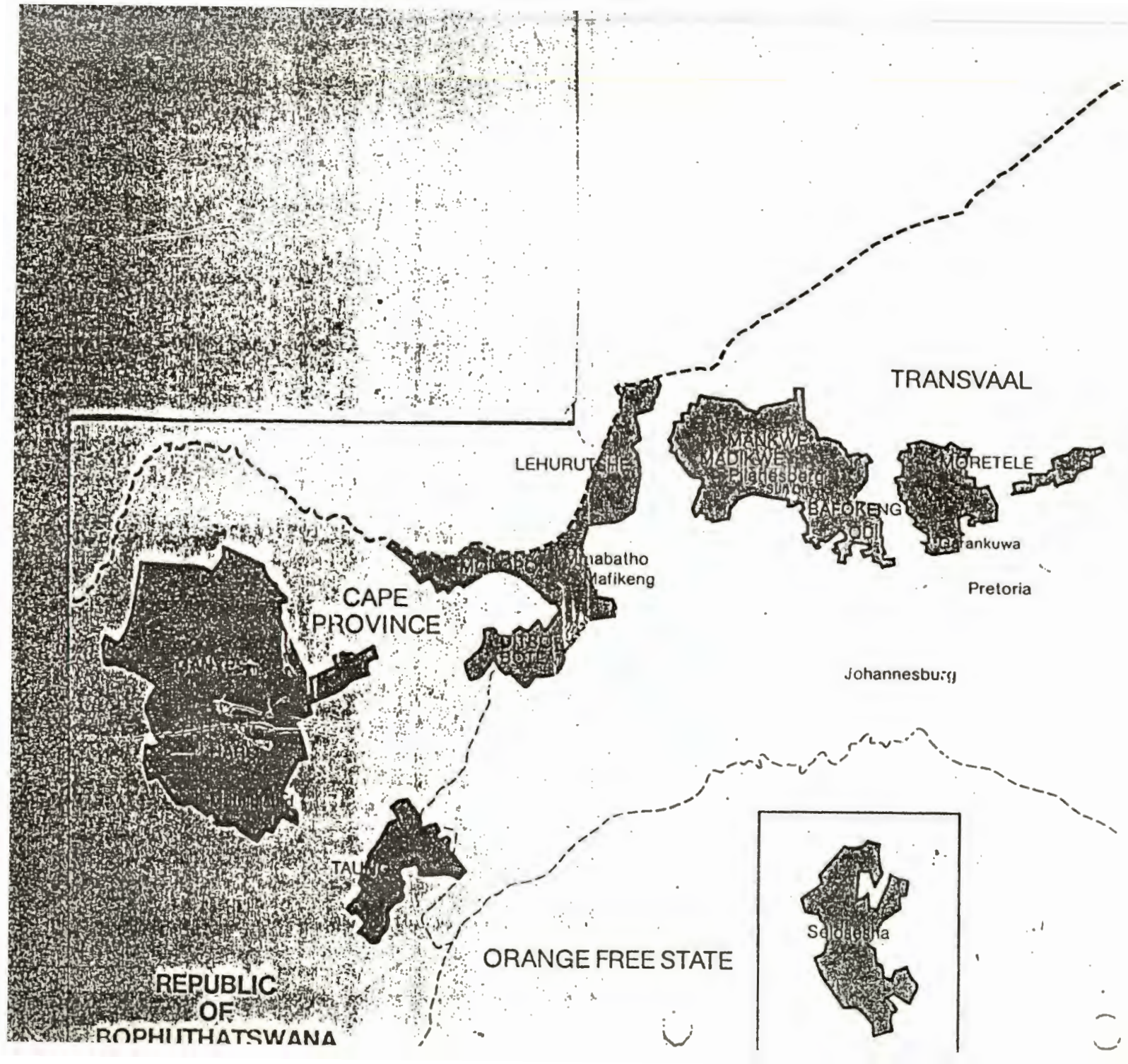
123. Webster, A. (1984). Introduction to the Sociology of Development. London: Mc Millan.

124. Willensky, H.L. & Lebeaux, C.N. (1958). Industrial Society and Social Welfare. New York: Russel Sage Foundation.

125. Wilson, J (ed.) (1983). Disability Prevention. The Global Challenge. Oxford, New York, Toronto: Oxford University Press.

126. Verslag Vam die Sub - Komitee. Opleiding en Indiensplasing van die Gestremde Persoon, Book 2 1987.

127. Zarkovick, S.S. "Some Problems of Sampling Work in Underdeveloped Countries" in Bulmer & Warwick, Ibid.


TRANSVAAL
LEHURUTSHE
MANKWE
MADIKWE
Pilanesberg
BAFOKENG
MORETELE
Mmabatho
Mafikeng
CAPE
PROVINCE
Pretoria
Johannesburg
ORANGE FREE STATE
REPUBLIC
OF
BOPHUTHATSWANA

APPENDIX 'A'

APPENDIX B

REPUBLIC OF BOPHUTHATSWANA

1989 ITENERARY. PAYMENTS OF SOCIAL PENSIONS.

MOLOPO REGION

PAY POINT G.1	PAY POINT G.2	JAN.	MARCH	MAY	JULY	SEPT.	NOV.
Montshiwa Magokgwane	Botshabelo Ikopeleng Mlga	9	6	8	10	11	6
Matlhanyane Matshepe Dithokong	Mareetsane	10	7	9	11	12	7
Montshiwa Stad	Lomanyaneng	11	8	10	12	13	8
Moshawane Lobageng Matlodlng	Mabule Masamane Tshidllamolomo	12	9	11	13	14	9
Kolkol Magogwe Roolgrond	Masutlhe Modimola	13	10	15	14	15	10
Mokgobistad	Makgori Logageng Loporung	16	13	16	17	18	13
Tsetse Signal Hill	Ramosadi	17	14	17	18	19	14
Disaneng	Tshunyane Vryhof Madibe	18	15	18	19	20	15
Tontonyane Moletsamongwe Kobe	Lekoko Lokaleng Tlapeng MOGOSANE	19	16	19	20	21	16

ADMINISRATOR MOLOPO.

APPENDIX C

THE INTERVIEW SCHEDULE

PROBLEMS OF PHYSICALLY DISABLED PERSONS IN THE MOLOPO REGION OF BOPHUTHATSWANA.

SURVEY - 1986

UNIVERSITY OF BOPHUTHATSWANA:
DEPARTMENT OF SOCIAL WORK

1. PERSONAL DATA

Make crosses in the relevant blocks.

1.1 AGE

16-20	☐
21-25	☐
26-30	☐
31-35	☐
36-40	☐
41-45	☐
46-50	☐
51-55	☐
56-60	☐
61-65	☐
66-70	☐

1.2 SEX

Male	☐
Female	☐

1.3 MARITAL STATUS

Married	
Single/never married	
Divorced	
Separated	
Widowed	

1.4 FUNCTIONAL DIAGNOSIS

1.4.1 Paralysis

Paraplegia	
Hemiplegia	
Quadruplegia	
Monoplegia	
Others	

1.4.2 Amputation

Above-knee (bilateral)	
Above-knee (unilateral)	
Arm (unilateral)	
Arm (bilateral)	
Finger	
Toe	
Foot	
Other	

1.4.3 Deformation

Bow-legged	☐
Osteriotic	☐
Hunchbacked	☐
Dwarfed	☐
Other	☐

1.4.4 Muscle tautness

Cerebral palsied	☐
Parkinsons gait	☐
Other	☐

2. PROBLEM AREAS

Make crosses in the relevant blocks

2.1 Educational Standards

Less than Standard A	☐
Standard A-B	☐
Standard 1-2	☐
Standard 3-4	☐
Standard 5-6	☐
Standard 7-8	☐
Standard 9-10	☐
Standard 10+	☐

2.2 Employment Status

Are you presently employed?

Yes ☐

No ☐

If NO state reasons you consider to have been major in causing your unemployment.

_____

_____

_____

_____

If YES state nature of employment.

Switchboard operating ☐

Shoe-repairing ☐

Hand weaving ☐

Hand knitting ☐

Sewing ☐

Woodwork ☐

Livestock herding ☐

Steelwork ☐

Seasonal Farm work ☐

Domestic work ☐

Other ☐

2.3 Job Problems

Do you have problems in your job?

YES ☐

NO ☐

If YES, mention a problem you regard as major concerning your job.

_____

_____

_____

_____

2.4 Income Sources

2.4.1 Source of Income

- Wages from employer ☐
- Wages from self-employment ☐
- State pensions ☐
- Self-employment and state pensions ☐
- Workmen's compensation benefits ☐
- Support by relatives ☐
- Other (specify) ☐

2.4.2 Do you have specific money problems regarding your income source?

YES ☐

NO ☐

If YES state one major problem

Wages from employer:_____

_____

_____

_____

Wages from self-employment: _____

_____

_____

_____

State Pensions: _____

_____

_____

Self employment and State pensions: _____

_____

_____

Workmen's Compensation benefits: _____

_____

_____

_____

Support by relatives: _____

_____

_____

_____

Other: _____

_____

_____

_____

2.5 Housing

(Problems to be classified according to functional group).

2.5.1 Do you have accommodation problems?

YES ☐

NO ☐

2.5.2 If YES, state one major problem.

Paralysis: _____

_____

_____

Amputation: _____

_____

_____

Deformation: _____

_____

_____

Muscle tautness: _____

_____

_____

_____

2.6 Care-Related Problems

2.6.1 Mention person(s) acting as principal carer(s):

Spouse ☐

Parent ☐

Child (daughter/son) ☐

Extended relative (uncle, grandparents,aunt, niece, nephew, daughter-in-law,etc) ☐

Myself ☐

Paid-home-help ☐

Other (specify) ☐

2.6.2 Do you have problems related to your care?

YES ☐

NO ☐

2.6.3 If YES, state one major problem:

_____

_____

_____

2.7 Social Service Problems

2.7.1 State one major problem regarding social services.

Difficulty in getting medical appliances	
Difficulty in getting transport to medical centres	
Difficulty in getting pensions	
Difficulty in getting citizenship documents	
Difficulty in getting identity book	
Difficulty in getting admission to Handicraft Centres	
Difficulty in getting admission to Institutions	
Difficulty in getting admission to special schools	
Help in getting a spouse	
Difficulty in getting maintenance from husband/lover.	
Need food rations	
No problems	
Other (specify)	

APPENDIX D

Ref: 12/10/P and 2/9/1

Enq: S.P. MOLEFE.

Tel: 2069 x 827

DEPARTMENT OF HEALTH
AND SOCIAL WELFARE
PRIVATE BAG X 2068
MAFIKENG
8670

16 JULY 1981

Executive Council For Information
Head Office Personnel
Regional Hospital Superintendents

DEPARTMENTAL CIRCULAR No. 22 OF 1981.
SOCIAL WELFARE POLICY IN BOPHUTHATSWANA.

1. PREAMBLE.

Bophuthatswana as a sovereign independent country which accepts the principles of democracy and as a developing country should adopt a welfare policy which recognises the rights of individuals to contribute to the life of the community. The welfare policy should strife to create structures which would make provision for measures which could stimulate the development and systematic planning of welfare services throughout this country.

The principle of self - help and mutual help is embedded in the traditions and customs of the Tswana people. This fact is confirmed in the findings of the commission of Inquiry into Social Welfare Services in Bophuthatswana. The Commission found that a considerable amount of mutual-help and self-help existed in both the urban and the rural areas, and that apart from the work of formal welfare organisations, there were a very large number of small informal organisations in which people on a voluntary basis give help to those in need of it in their own immediate neighbourhood. It is thus essential that the social welfare policy adopted should be in line with the culture of the people to make it possible for their efforts to be properly harnessed so that maximum benefit can be derived from the services offered.

2. UNDERLYING PHILOSOPHY.

The philosophy underlying the social welfare policy in Bophuthatswana is to direct increasingly the planning and co-ordination of welfare services back to the communities where the needs exist. It has been realised that welfare work is most succesful when its planning and execution centres around the community. The object is increasingly to involve people in welfare work within their own communities.

2/....

This philosophy strengthens the qualities of participation co-operation and self-direction in communities. Thus a considerable degree of autonomy should be given to communities and local welfare bodies to decide matters at the local level according to local needs, since they are in an especially favourable position not only to gauge the community's welfare needs, but also to assist, in gauging and influencing the community's feelings and opinions concerning the provision of welfare services. A large amount of Social maldevelopment or ill-health is preventable, hence prevention must enjoy priority as a component of a comprehensive strategy. To this end, institutionalisation is de-emphasised both for cure and rehabilitation. Preventive action, by its very nature, is a community based decentralised process.

3. AIMS.

The welfare policy of Bophuthatswana should be geared towards achieving the aims mentioned hereunder:-

3.1. To secure and maintain an adequate factual basis for sound planning and action.
3.2. To initiate, develop and modify welfare programmes and services in consultation with communities in the interest of securing a better adjustment between resources and needs.
3.3. To improve standards of social work and to increase the effectiveness of individual agencies.
3.4. To improve and facilitate interrelationships, and to promote co-ordination between organisations, groups and individuals concerned with social welfare programmes and services.
3.5. To develop a better public understanding of welfare problems and needs, and social work objectives,, programmes and methods.
3.6. To encourage and develop public support of and public participation in Social Welfare activities.
3.7. To encourage private enterpreurship in welfare work, co-ordinate the activities of private organisations and co-ordinate government with private services.
3.8. To be generally national minded in outlook, whilst not neglecting individual problems. "National" pre-supposes interdepartmental interdependence in the whole government service.

4. RECOMMENDED WELFARE POLICY.

The following is an outline of the welfare policy. This policy should be evaluated periodically and adapted to meet changing circumstances.
4.1. The greatest possible use should be made of voluntary effort and voluntary activity in the welfare system of Bophuthatswana. An atmosphere should be created in which volunteer and private activity will flourish.
4.2. Those elements in the existing system which obstruct and discourage voluntary activity, for instance the adoption of a complicated system of registering voluntary organisations, should be removed.

3/.....

4.3. The scarce resources of the State (Manpower) should be largely devoted to make voluntary activity more effective by co-ordinating such activity. This could be done by providing professional guidance to volunteers. Hence Social Workers should be accessible to the community for purposes of general help and guidance.

4.4. In order to uphold the principle of community participation and self-direction it is essential that the welfare system of Bophuthatswana, be highly decentralised to give each local area an opportunity to make its own decisions regarding priorities. A start has already been made in this regard, with the establishment of Regional Health Authorities in the the various districts.

4.5. Subject to certain conditions the government may grant financial assistance to voluntary organisations in order to enable the latter to provide more effective services.

4.6. Specific policies should be developed concerning services rendered to different groups and classes of people such as the physically handicapped, aged, alcoholics, children, ex-prisoners and drug addicts. These policies can only be formulated after evaluating services provided in the past for these different groups and determining more effective ways of improving these services. It should however be mentioned that these services should be offered on a partnership basis between the state, voluntary and private organisations.

4.7. While it is accepted that the existence of institutions may be unavoidable in specific instances it is suggested that the minimum possible use should be made of institutions. The object of the latter should wherever possible be to rehabilitate their inmates to a level where they can rejoin the community as rapidly as possible. Children's Homes should be temporary refuges where children can be kept pending adoption or placement in foster care or return to the custody of parents. Similarly institutions for handicapped should be training institutions aimed at putting the handicapped back into the community. Institutions as such must enjoy a broad definition which includes private houses of responsible citizens.

4.8. The major functions of the welfare section of the Department of Health and Social Welfare should be to ensure that as far as possible , the health and welfare needs of the people in Bophuthatswana are adequately met. The Department should plan, co-ordinate and evaluate services. Volunteers should be guided in order to improve the quality of their contributions to community life. Prevention must be stressed, rather than cure.

One of the major responsibilities of the Department of Health and Social Welfare is also to render statutory welfare services such as probation services and the control and administration of institutions.

4/.....

-such as children's Homes Places of Safety, Youth Camps and Old Age Homes.

4.9. As and when the need arises the Department of Health and Social Welfare should co-operate and collaborate with other independent states in order to share knowledge and expertise.

The Department should also be familiar with current trends in the Social Welfare field.

4.10. The existing Acts which regulate the provision of Welfare Services, and were inherited from the Republic of South Africa should be revised in order to ensure that their provisions suit the conditions prevailing in Bophuthatswana, for instance the registration of welfare organisations as outlined in the National Welfare Act. of 1965 should be simplified, to make it possible to recognise indigeneous organisations without subjecting them to cumber some procedures which greatly discourage voluntary effort.

5. CONCLUSION.

It is apparent from the above policy directive that community participation is the cornerstone of the welfare policy in Bophuthatswana. It is the intention of this policy to exploit the inherent potential of community members for the good of the entire community. In order to achieve the stated aims there should be full co-operation between the government and the various communities in Bophuthatswana and the principles of democracy should be upheld.

SECRETARY FOR HEALTH AND SOCIAL WELFARE.

MINISTER OF HEALTH AND SOCIAL WELFARE.

/jm

nde diens te verleen.

n organisasies nie vrywilligers g nie, kan baie mense swaarkry yd waarin die land finansiele me en werkloosheid ervaar. Vry- rs behoort by direkte dienste te word, wat belangstelling sal eer met die doel om *ontvangers* ransiers* te verander.

gesinsorganisasie moet die pro- vir vrywilligers as deel van die program van die organisasie word. Vrywilligers beteken nie vendig minder werk in die aan- tadium nie, maar dit sal uitein- delik 'n aanvullende diens aan die gesin beteken.

Tienderjarige vrywilligers is al met vrug gebruik in diens aan jong kinders. Volwassenes kan gebruik word by fisies en emosioneel gedepriveerde kinders. Ouer vrywilligers kan steun verleen aan gesinne in nood. Die betrokken- heid van vrywilligers kan help om hulle eie afhanklikheid te verminder.

Dit is nie maklik om programme vir vrywilligers te implementeer nie en een van die moeilikste aspekte is die definiëring van die aard van die diens.

Waar daar 'n gebrek aan kennis by vrywilligers bestaan, behoort program- me opleiding in te sluit.

Oriëntering van nuwe vrywilligers behoort te begin deur 'n bewusmaking van die vrywilliger ten opsigte van die organisasies.

Opleiding kan spesifieke take insluit en só bydra dat die vrywilliger sy plek in die organisasie verstaan. In op- leiding kan die vrywilliger leer hoe om van supervisie gebruik te maak.

A W Keen
Lecturer
Department of Social Work
University of Natal

The Social Welfare Policy and Structures of the Republic of South Africa

n 18 April the Minister of National Health and Population Develop- ment, Dr W A van Niekerk, an- ced a new social welfare policy structures for the Republic of h Africa.

concept Policy

policy document of this nature, le normally attach various mean- or expectations to its contents. his reason the writer considered it most importance to familiarise the er with the concept under discus- . Khan in his book "Theory and tice of social planning (1969)" on e 130, defines policy as follows: icies are general guides to future sionmaking that are intended to be those decisions so as to maxi- e their contribution to the goals of enterprise. Policies are the instru- nts by which goals are achieved". s is exactly what the policy docu- nt is intended to do i.e. to spell out eral guides to future decision- cing as well as the creation of chanisms in order to achieve the set ls.

licy declarations

the document the Government ain repeated its responsibility for prevention of social or physical ffering on the part of any of its izens. Where there is suffering, the vernment in collaboration with the vate welfare sector, will collectively end to the situation. The Govern- nt has also taken the initiative and responsibilty to purposefully and actively promote community develop- ment.

The *principles* underlying the social welfare policy are the following:

- People have the ability to develop.
- The individual is primarily respon- sible for his own welfare.
- The family is a natural and fun- damental social unit and should be protected.
- A healthy community life is con- ducive to the general welfare of the members of a community.
- Co-operation between the Govern- ment sector and the private sector is preferable and essential.
- The Government has an umbrella responsibility towards all inhabi- tants of this country.

The *objectives* of the social welfare policy are the following:

- To create a climate within which it will be possible for the individual to achieve the highest level of de- velopment by his own efforts.
- To prevent and combat social problems and dysfunctions and to promote social stabilty.
- To promote the social functioning of individuals, families and com- munities.
- To support persons in need of care.
- To co-ordinate social welfare pro- grammes at all levels.
- To integrate social welfare pro- grammes with the general social, constitutional, economic and physical-spatial programmes and regional developmental structures.
- To develop and maintain norms and standards for social welfare services.
- To conduct or have conducted on a continuous basis research into social welfare.

As *private welfare organisations* have since the beginning of this cen- tury played an exceptional role in the performance and advancement of welfare services in this country, their continued contribution in partnership with the State is again confirmed in the document. In this regard the much appreciated involvement of the com- munity in welfare services usually takes place through voluntary organisations. Furthermore, certain fields of service have for decades traditionally been the sole responsibility of private or voluntary welfare organisations. In an effort to further maintain and promote private intiative, the policy document again commits itself to State support especially by means of subsidisation. In other words, the fear that the State may withdraw its financial support from private welfare organisations as a result of their policy of privatisation, is totally unfounded and uncalled for. Referring to the question of privatisa- tion, the Minister during his media statement on 18 April 1988, expressed himself as follows: "Although I am of the opinion that welfare services in their present form are already fully privatised, it may be necessary to establish a clearer definition of the

various roles and functions of the private and public sectors."

In the document a definite distinction is made between the following *fields of service*, each with its own particular policy guide-line:

Married life, family and child care:

- Marriage is the foundation of family and community life and should therefore be protected and promoted.
- Children are socialised and cared for as far as possible within the family context.
- Family means and family size are reconciled.

The welfare of the aged:

- The aged person, with or without the assistance of the State or private welfare organisations, must maintain his independence within the community for as long as possible.
- It is expected from the individual himself to make provision for his retirement during his economically active life.
- The aged person's potential is used to the advantage of the economy for as long as possible.

The welfare of disabled people:

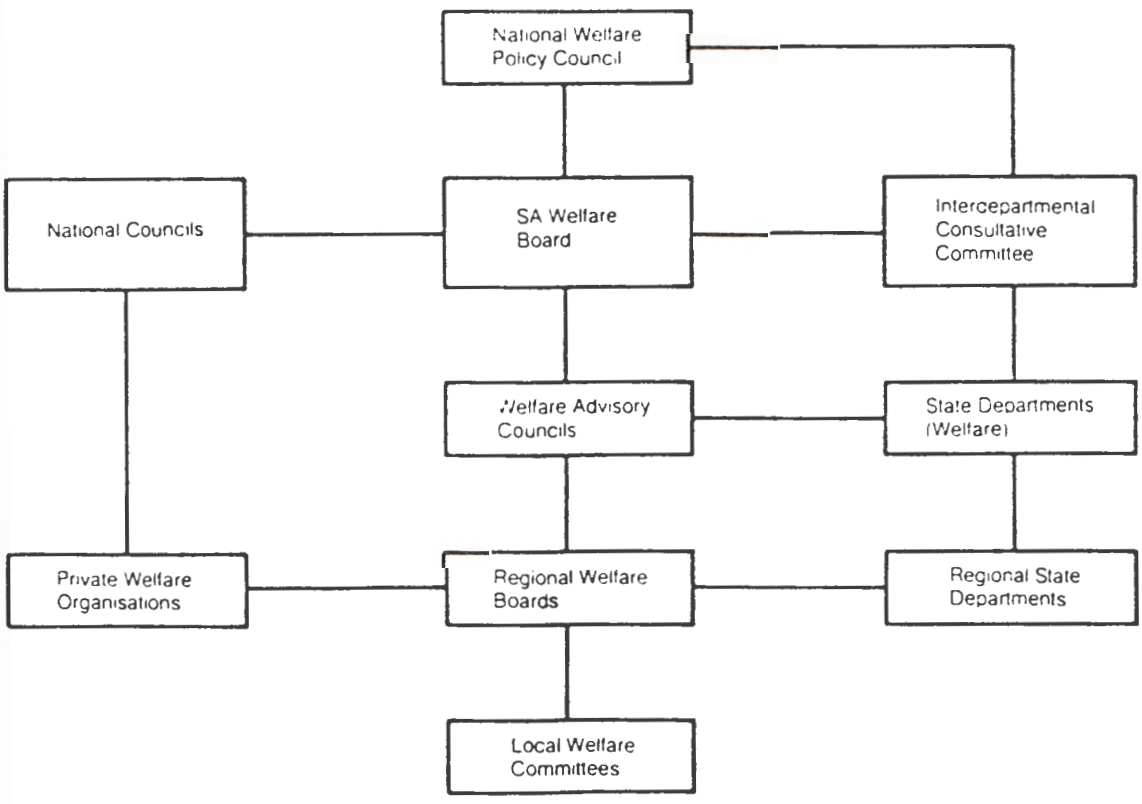
- Disability is combated and the quality of life of disabled people is promoted.
- With a view to self-realisation and for the benefit of the community the disabled person is trained and educated to his full potential.
- The independent functioning of the disabled person is promoted.
- Equal opportunities for disabled people are pursued.

Prevention of alcohol and drug abuse as well as treatment and rehabilitation services:

- A healthy and positive lifestyle is promoted.
- Alcohol and drug abuse and dependence are combated.
- Alcohol and drug dependents are treated and rehabilitated as far as possible within a family and community context.
- Alcohol and drugs are dangerous substances that should be controlled.

To coincide with the new welfare policy, the Minister also annouced the National Plan to Prevent and Combat Alcohol and Drug Abuse in South Africa. Action in this regard became an absolute necessity because of the magnitude of and upward trend in the illicit production of, demand for and traffic in narcotic drugs and psychotropic substances as well as the escalation in alcohol abuse. As a countermeasure for a life controlled by drugs, the objective of the Plan is to create an environment in which a constructive lifestyle can be maintained, based on healthy values, self-actualisation and responsibility.

Schematic Presentation of the Social Welfare Structures



prevention and corrective
s:

introduction of preventive
asures.
promotion of services to
enders and their dependants or
ilies before and after senten-
g.
promotion of rehabilitation
hin the community and in penal
itutions.
extension of appropriate after-
e and parole services.
extension of services for the
ims of crime.

al care:

policy of the Government that
uals and communities should
plish self-sufficiency by their
forts. Help from the Government
only be considered to supple-
the existing means of a needy
or family to maintain an accept-
andard of living.

l welfare structures

ffort to purposefully and effec-
accomplish the preconceived
goals, a mechanism has been
ished in which both the State
ne private welfare sector can
pate.

grass-root level, existing *local
lfare committees* will be
engthened whereas new com-
ttees according to need will be
tablished. The activities of these
mmittees are amongst others to
ntify social problems and needs
their specific areas of operation,
d to plan and prepare welfare
ogrammes to meet these needs.

e task of *regional welfare boards*
similar to those of the local
lfare committees, except that
y serve and co-ordinate the
erests of a broader region.
e newly established *welfare ad-
ory councils* in collaboration
th local and regional welfare
ards are responsible for meas-
es to ensure the social stability of
different population groups on
al to national level.
e *South African Welfare Council*
outhpiece of the private sector)
d the *Interdepartmental Con-
ltative Committee on Social Wel-
re Matters* (mouthpiece of State
partments responsible for wel-
re matters) are separately and jointly responsible for the welfare of all population groups country-wide.

— Finally an umbrella *National Welfare Policy Council*, consisting of all ministers responsible for social welfare and provincial administrators, is established to attend to policy and welfare matters of general interest concerning all population groups on a national level.

Effective and adequate channels of communication exist between the mentioned structures. Furthermore, in an effort to enhance communication and to ensure thorough preparation, provision has been made for the establishment of working committees at all levels according to need.

Dynamic nature of the policy

From the foregoing it is evident that the social welfare policy is not a unique event or action but a dynamic process. For this reason no sensitive or important decisions regarding social welfare matters were taken. All matters of importance have been referred to the relevant structures for joint investigation and decisionmaking by both the private and public sectors. Included in these matters are amongst others the financing of social welfare services, the social security system, the implementation of Employee Assistance Programmes, rationalisation of legislation and the more effective utilization of voluntary workers.

The policy also makes provision for the arrangement of a national social welfare conference to be held early in 1989. The goal of the conference will be to discuss and plan an adequate and acceptable welfare system for the future.

National Family Programme

Finally, the inclusion of the National Family Programme in the present welfare policy is of special interest. This comprehensive and detailed programme has been referred to a special working committee on married and family life under the auspices of the South African Welfare Council for its implementation.

Concluding remarks

In conclusion it is necessary to briefly emphasise some of the more significant features of the social welfare policy:

Firstly, the shift in emphasis in the country's social welfare policy and programmes from care and remedy to prevention and development, is repeatedly emphasised in the policy document.

Secondly, the policy document has again reiterated the principle of partnership in welfare delivery between the private and public sectors. Both these sectors have an important role to play and should therefore supplement each other. To demonstrate the Government's sincere intentions in this regard, sufficient mechanisms have been created for collective decisionmaking; important policy issues have been postponed in order to give the private sector sufficient opportunity to partake in the formulation of such matters; and the proposed national welfare conference will give all interested parties the opportunity to prepare an adequate welfare system for the future.

Thirdly, in conjunction with the previous remark, the policy declaration must be seen as a dynamic process which can be adapted on a continuous basis to suit changing needs.

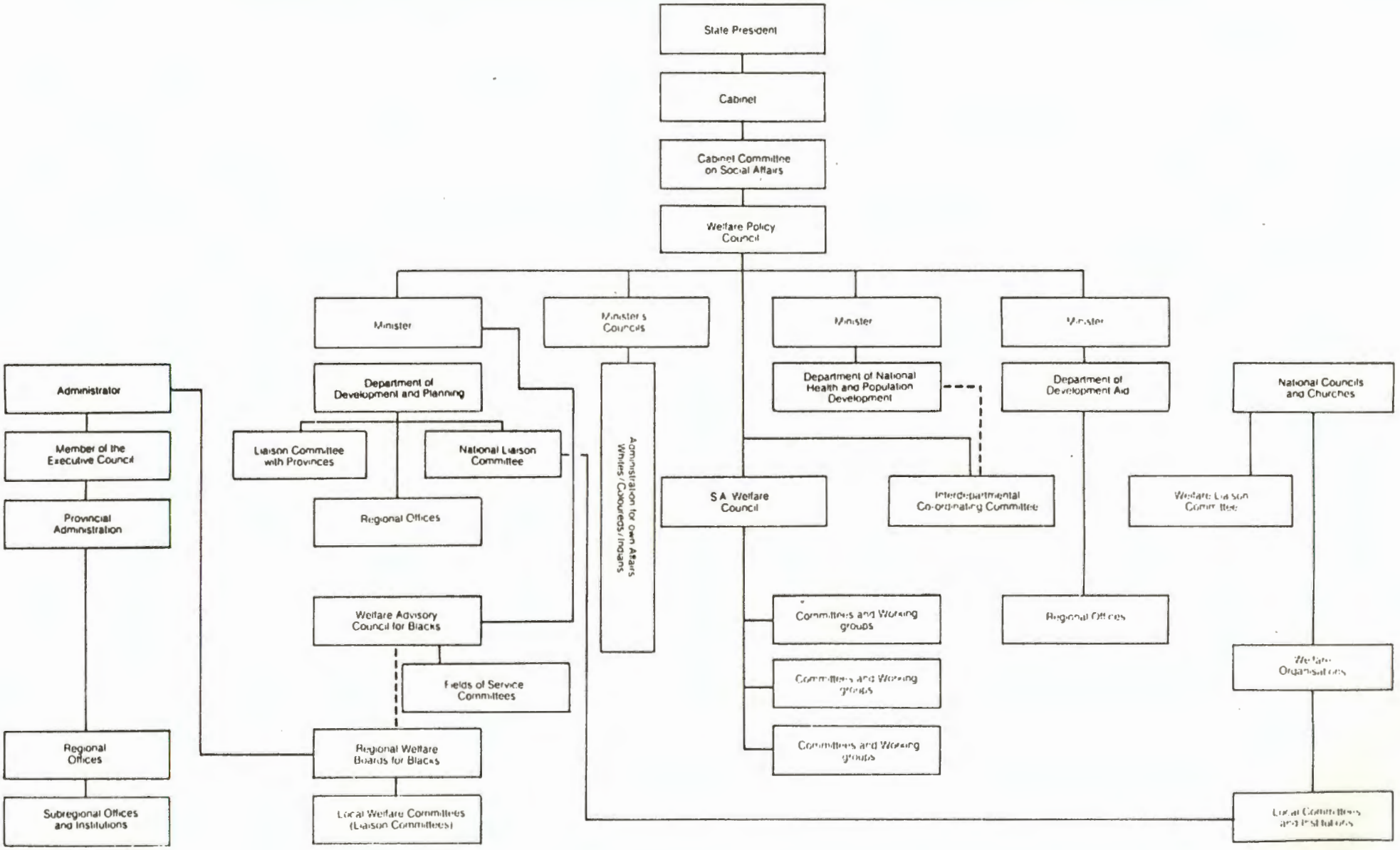
Fourthly, although a certain measure of differentiation is for obvious reasons again applied within the welfare structure, it is the intention of the responsible authorities to significantly synchronise and co-ordinate welfare actions in such a manner that the autonomy of any population group, the private sector and the State will not unnecessarily be affected.

Filthly, it is obvious that the Government's policy of privatisation will definitely not in any way be detrimental to the maintenance and advancement of the private welfare initiatives. Coupled with the principles of privatisation, it will however be necessary for the entire welfare community to safeguard the country of becoming a welfare state.

Finally, I wish to appeal to all dedicated social and voluntary workers to unconditionally accept the challenges set out in the policy document and to collectively work towards a better South Africa.

Dr W W Anderson
Chief Director: Social Welfare
Department of National Health and Population Development.

The Social Welfare Structures of the Republic of South Africa



Social Welfare Structures of the Republic of South Africa

n the RSA involvement of the community in the rendering of social welfare services takes place through oluntary organisations and churches. hus the role and place of welfare ganisations are protected on local, gional and national level. State deartments and adminstrations carry ut certain functions through their strict, regional and head offices.

Forums where the State and private tiative come together to identify cial problems and needs and to plan d co-ordinate services, play an portant role. Social workers should ke cognisance of the approval by the abinet of the following welfare ructures:

ocal welfare committees

hese committees, also known as aison committees are established ong non-statutory lines according to e needs of local communities and in -operation with regional welfare oards.

egional welfare boards

egional welfare boards for Black ommunities are established by the dministrators of the four provincial overnments in terms of the National elfare Act,1978. The nomination ollege for the composition of regional elfare boards is now extended to inude local authorities. The regional elfare boards are, where possible, set up to correspond with the development regions.

Welfare advisory councils

According to the structure approved by the Cabinet, the Minister of Constitutional Develpment and Planning may now establish a welfare advisory council for Blacks. Representatives of regional welfare boards and specialists in the fields of service will be appointed on the council. Experts on welfare matters for Blacks therefore have a formal structure on national level to enhance social welfare services.

The South African Welfare Council

In future the South African Welfare Council will be composed *inter alia* of representatives of welfare advisory councils. The interest of all population groups will be served by the council on a national level and it advises the National Welfare Policy Council.

The National Welfare Policy Council

An important development in the welfare field is the establishment of a National Welfare Policy Council consisting of all ministers responsible for social welfare services. This council will attend to policy and welfare matters of general interest concerning all population groups and it will be served by the South African Welfare Council and the Interdepartmental Consultative Committee on Social Welfare Matters. The latter is a co-ordinating committee being composed of representatives of State departments responsible for welfare matters.

Provision has been made for more effective channels of communication between these structures and for the establishment of working committees. The latter giving opportunity to many more social workers and other specialists to make contributions in enhancing social welfare services to all in the RSA.

Finally the existence of the National Liaison Committee should be mentioned. Representatives of the different national councils serving Black communities, the four provincial governments and the Departments of Development Aid and Development Planning serve on this committee. It is a non-statutory body and is an excellent example of a sound relationship between the government and private initiative. Apart from co-ordinating services, the committee also attends to problems in the welfare field and to the stimulation and development of services.

Mr J T J Wolmarans
The Director: Social Development
Department of Development Planning

BOOK REVIEW

arriage and Family Life in South frica: Research Priorities A.F. Steyn, .G. Strijdom, S. Viljoen & F.J. Bosman ditors), Pretoria: Human Sciences esearch Council, 1987

This publication was prepared under e auspices of the Human Sciences esearch Council's Co-operative rogramme on Marriage and Family fe. This co-operative programme has nce been upgraded to a national search programme.

The contents of the book is the final sult of two workshops held in 1985, overing seven themes on marriage d family life. Each contributor to the workshops was given the assignment to justify the necessity for research on the particular theme, to describe the most important research recently done in South Africa on that theme, and to point out neglected areas which should receive attention in future research projects.

The seven themes covered were the following: family structures and support systems, premarital and extramarital sex and cohabitation, family relationships, violence within the family, the family and divorce, the family and family law, and finally, preparation for family life, family enrichment, family counselling and available services.

Since such a tremendously wide range of subjects was covered, this reviewer will attend briefly to only one of the papers delivered at the workshops, which is reported as Chapter 3 of the book, entitled "Family structure and support systems in Black communities" by S.V. Nzimande.

Prof. Nzimande introduces his subject by arguing convincingly that it is unnecessary to consider family structure and support systems in terms of the different Black ethnic groups. There is sufficient reason to identify certain common patterns in all Black communities. His subject is treated

APPENDIX F

Ts. S 40

PEGELO YA BONGAKA
MEDICAL REPORT
GENEESKUNDIGE VERSLAG

GA DINEO TSA BOGOLE
(Go akarediwa bolwetse ba lehuba le difofu)

FOR DISABILITY GRANTS
(Which includes Tuberculosis sufferers and the blind)

VIR ONGESKIKTHEIDSTOELAE
(Sluit teringlyers en blindes in)

Kgatiso ya kgonojwe
Right thumb print
Regterduim-afdruk

Nomoretlhaolo
Identity number
Identiteitsnommer
.....

NGAKA YA SETEREKE,
THE DISTRICT SURGEON,
DIE DISTRIKSGENEESHEER,

.....

.....

Leina: Name: Naam:	Bogolo: Age: Ouderdom:
Letlha la bofelo la go dira: Date last employed: Datum laas gewerk:	Mofuta wa tiro ya bofelo: Nature of last employment: Aard van laaste werk:

Tsweetswee tlatsa karolo e e tshwailweng "Pegelo ya Bongaka" mme e romelwe go:
Kindly complete the section marked "Medical Report" and return it to:
Geliewe die gedeelte gemerk "Geneeskundige Verslag" in te vul en te stuur aan:

.....

.....

PEGELO YA BONGAKA/MEDICAL REPORT/GENEESKUNDIGE VERSLAG (Ka ditlhakakgolo/In block letters/In drukskrif)

1. Dintlha tsa bolwetse: Fa mokopi a sa tshwanelwe ke tetlo ya bofofu, mme, legale a tshwanelwa ke tetlo ya neo ya bogole, go tshwanetse ga
History of complaints: Should the applicant not qualify for the grant to the blind, but for a disability grant, the report should be completed
Geskiedenis van kwale: Indien die aansoeker nie kwalifiseer vir 'n toelaag vir blindes nie, maar wel vir 'n ongeskiktheidstoelaag moet die tladiwa jalo mo pegelong
accordingly
verslag dienooreenkomstig ingevul word .....

.....

.....

.....

2. Botlhatlhobi jwa Tšliniki: Bolela dintlha tsotlhe tsa bogole
Clinical diagnosis: Furnish full details of the disabilities
Kliniese diagnose: Verstrek volledige besonderhede van die ongeskikthede .....

.....

.....

3. Maemo le lobaka lwa bogole:
Degree and duration of disability:
Graad en duur van ongeskiktheid:

A o siametse mmaraka wa di-tiro tshekelela Suitable for openlabour market Geskik vir ope arbeidsmark	Ee Yes/Ja	Nnyaa No/Nee
A o siametse tiro e e botlhofo Suitable for light work Geskik vir ligte werk	Ee Yes/Ja	Nnyaa No/Nee

Peresente (%) ya bogole:
Percentage (%) disabled:
Persentasie (%) ongeskik:

Bogole jwa sebakanyana go fitlha:
Temporarily disabled until:
Tydelik ongeskik tot .....19.....

Bogole jwa leruri
Permanently disabled
Permanent ongeskik ☐

4. Tshekatsheko gape:
Review:
Hersiening:

Go sekwasekwa gape go a tlhokega?
Is review necessary?
Is hersiening nodig?

Ee Yes/Ja	Kgwedi Month/Maand	Ngwaga Year/Jaar
Nyaa No/Nee		

5. Kalafo ya ngaka:
Medical treatment:
Geneeskundige behandeling:

(a) A go ka tokofatsa bogole?
Will it cure or improve the disabilities?
Sal dit die gebreke genees of verbeter?

Ee Yes/Ja	Nnyaa No/Nee

(b) Fa go le jalo, go atlagenisiwa kalafo efe?
If so, what treatment is recommended?
Indien wel, watter behandeling word aanbeveel? .....

.....

.....

(c) Go dirilwe dithulaganyo di fe mo lebakeng le?
What arrangements have been made in this regard?
Watter reëlings is in die verband getref? .....

.....

.....

(d) Go ntshiwa ga molwetsi mo bookelong/bothibelelong ke ka ntlha ya
The patient's discharge from the hospital/institution is due to his/her
Die ontslag van die pasiënt uit die hospitaal/inrigting is te wyte aan sy/haar

Maitsholomabe Misconduct Wangedrag	Ngwegile Desertion Drosting

.....
Ngaka ya Setereke/Motlhankedi wa Bongaka
District Surgeon/Medical Officer

.....
Letlha/Date/Datum

APPENDIX H

Ts. I. 86

REPABOLEKI YA BOPHUTHATSWANA

REPUBLIEK VAN BOPHUTHATSWANA

REPUBLIC OF BOPHUTHATSWANA

LEFAPHA LA BOITEKANELO LE KATLAATLELOLOAGO
DEPARTMENT OF HEALTH AND SOCIAL WELFARE

KOPO YA DITHUSO TSA BONGAKA
APPLICATION FOR MEDICAL AIDS

INSTRUCTION

Diforomo tsotlhe tsa dikopo di tshwanetse go tladiwa ka tshwanelo le go romelwa ka sebedi.
All application forms must be duly completed.

1. Dintlha tsa moabelwa-thuso (k.g. Motho yo o batlelwang thuso):—
Particulars of Beneficiary (i.e. person for whom aid is required):—

(a) Leina ka botlalo
Full name .....

(b) Aterese
Address .....

(c) Mofuta wa thuso ya bongaka e e batlwang (Neela dintlha j.k. leoto la logong)
Type of medical aid sought (Give particulars, e.g. peg leg or articulated leg) .....

(d) A mokopi o tshwerwe ke bolwetsi jwa go swa mototwane
Does the applicant suffer from epileptic fits? (Answer "Yes" or "No") .....

(e) Bogolo
Age .....

(f) Bong
Sex .....

(g) Setshaba
Nationality .....

(h) Tiro
Vocation .....

(i) Borutegi
Educational qualification .....

.....

(k) Tiro ya jaanong
Present occupation .....

Maemo a tshelete (diteng tsa 2, 3, 4 & 6 di tshwanetese go tladi wa mabapi le moabelwa thuso kgotsa fa moabelwa-thuso a ikaegile ka semolao mo mokoping mabapi le mokopi:—

Financial position (paras. 2, 3, 4 and 5 must be completed in respect of the beneficiary or if the beneficiary is legally dependent on the applicant in respect of the applicant):—

2. (a) Letseno la kgwedi Monthly Income		
(i) Tefo kgotsa tuelo (go akaretsa tetlo ya go tshela) Wage or salary (including cost of living allowance)		
(ii) Mogatsa, motsadi kgotsa ngwana (bana) Spouse, parent or child(ren)		
(iii) Balosika bangwe Other relatives		
(iv) Mabotara kgotsa bahiri Boarders or lodgers		
(v) Dithoto tse di tlhomameng Fixed properties		
(iv) Diphensene tsa Mmuso kgotsa dikabelo (totobatsa palelo fa go lebaneng) Govt. pensions or grants (specify disability where applicable)		
(vii) Motswedi mengwe (totobatsa) Other sources (specify)		
(viii) A mokopi le kgotsa mogatse o amogela bonno le kgotsa dijo tse di sa duelwang, fa go le jalo Is applicant and/or spouse in receipt of free board and/or lodging, if so, from whom		
GOTLHE TOTAL		
(b) Tlhotlhwa ya letlotlo Value of Assets		
Thoto e e sutang, thoto e e sa suteng, diruiwa, dikuno, diinsorense, tshupa tlotlo ya poloko, tse dingwe Movable property, immovable property, livestock, crops, insurances, savings account, other (specify)		
.....		
GOTLHE TOTAL		
(c) Melato Liabilities		
Rente, bonno, tsalo ya ditlamo, dikelo le makgetho, meputso ya insorense (totobatsa) Rent, board, interest on bonds, rates and taxes, insurance premiums (specify)		
tse dingwe (totobatsa) Other (specify)		
GOTLHE TOTAL		

3. Palo ya batho ba ba ikaegileng ka moabelwa-thuso kgotsa palo ya batho ba ba ikaegileng ka mokopi fa yo o boletsweng morago a le boikarabelo mo moabelweng-thuso:—
Number of persons depending on beneficiary or number of persons dependent on applicant if the latter is responsible for the beneficiary:—

Leina Name	Botsalano Relationship	Letseno Income	Letseno gotswa metsweding mengwe Income from other sources
(a) Bagolo Adults			
(b) Bana Children			

4. Bokana jo mokopi kgotsa balosika lwa gagwe ba tla bo ntshetsang ditshenyegelo tsa thuso ya bongaka
Amount applicant or his/her relatives will contribute toward the cost of the medical aid .....

5. Dintlha tsa batho ba ba tlamegang go neela thuso go moabelwa-thuso (Maina a bana ba ba dirang ba ba leng ka fa tlase ga dinwaga di le 21 a tshwanetse go tlhagisiwa):—
Particulars of persons legally bound to give assistance to beneficiary (Names of working children under 21 years must be furnished):—

Leina Name	Botsalano Relationship	Tiro Vocation	Lotseno Income	Letlotlo le lengwe Other assets

6. Setifikeiti sa mokopi
Nna
I, ...

Applicant's Certificate
ke bolela gore tshedimosetso e e neetsweng mo kopong e e nepagetse. Ke lemoga gore Mmuso ga o tlamege go fa thuso e e batliwang le gore ka nako ngwe le ngwe a ka fetola kgotsa wa realise that the State is not obliged to grant assistance or relief sought and that it at any time may modify or withdraw the gogela morago thuso e e neilweng.
.....declare that the information given in this application is correct. I assistance or relief granted.

Tshaeno kgotsa letshwao la monwana la mokopi
Signature or fingerprint of applicant .....

Letlha
Date .....

7. Dintlha tsa mokopi (k.g. motho yo o dirang kopo mabapi le moabelwa-thuso, fa yo o kailweng a sa kgone):—
Particulars of applicant (.i.e. the person who applies in respect of the beneficiary, if the latter is not capable):—

(a) Leina ka botlalo
Full name .....

(b) Botsalano
Relationship .....

8. Dintlha tsa bongaka (di tladiwe ke ngaka)
Medical particulars (to be completed by a medical practitioner)

A.—DITOKOLOLO TSA MAITIRELO
A.—ARTIFICIAL LIMBS

(1) Letlha la kgaolo
Date of amputation .....

(2) Lebaka la kgaolo
Reason for amputation .....

(3) Letlhakore (tokololo ya mmele) la kgaolo
Site (body limb) of amputation .....

(4) Boleele jwa kutu ya logong
Length of stump .....

(5) A sekhumpu se siame go ka tsenngwa ka setlamakanyo maitirelo? Fa gole jalo tlhagisa thadiso ya sekhumpu o lebisitse ka thamalalo nama kgotsa bophokgophokgo—
Is stump ready to be fitted with a prosthesis? If so, a description of the stump should be furnished with particular reference to—
(a) Nama kgotsa bophokgophokgo
Fleshiness or oedema .....
(b) Motsamao k.g. tekanyo ya menego tlhisi le tioso
Mobility, i.e. degree of flexion, extension, adduction and abduction .....
(c) Dipadi, ga di kgomarela gore a di sephara kgotsa di dintsi
Scars, if adherent, whether broad or multiple .....
(d) Gala
Neuroma .....
(e) Tlhagala kgotsa bolwetsi jwa dikgotswane fa bo le teng
Ulcer or vascular disease, if present .....

(6) Fa kgaolo e bakilwe ke daebitisi, netefatsa fa maemo a le ka fa tlase ga taelo ka isolini
If amputation was due to diabetes, ascertain whether condition is under control with insulin .....

B.—DIDIRISWA TSA BONGAKA JWA BOGOLE LE KALAFO KALAFO KA KWA NTLE GA DITOKOLOLO LE DITILO 1 DIKOKA

B.—ORTHOPALDIC AND SURGICAL APPLIANCES (EXCLUDING LIMBS) AND INVALID CHAIRS

(1) Se ke go netefatsa gore nna, yo o saeneng ka fa tluse ke tlhobile molwetsi le gore o tshwerwe ke
This is to certify that I, the undersigned have examined the patient and that he/she suffers from .....

(2) Dintlha ka botlalo tsa sedirisiwa sa bongaka se se tla theliswa
Full details of medical appliance to be supplied. .....

(3) Tsholo e e latelang e neetswe
The following treatment has been given .....

.....

(4) Palelo e ka se tlhabololwe ketsholo ya karo nngwe gape go
The disability cannot be improved by further operative treatment because .....

.....

To what extent will the applicant's health be improved by the use of this appliance, will it make him/her fit to do suitable work, if so, what type of work? .....

.....

I hereby certify that this medical aid is prescribed solely for the purpose of replacing a permanently impaired function, and is not required for treatment.

Letlha
Date .....

Signature and designation .....

(7) Fa kgaolo e bakilwe ke daebitisi kgotsa. Bolwetsi jwa Buerger-leoto le tla kgona go rwala sediriswa, sa maitirelo
If amputation is due to diabetes or Buerger's disease, will stump stand up to wearing an artificial appliance .....

(8) Maemo a tokololo e nngwe
Condition of other limb .....

SETIFIKEITE BONGAKA
MEDICAL CERTIFICATE

Ke tlisa fano gore ke tlhatlhobile moabelwa-thuso mme ke bolela gore thuso ya bongaka e a tlhokega
I hereby certify that I have examined the beneficiary and declare that the medical aid is necessary

Letlha
Date .....

Tshaeno le inakeno
Signature and description .....

(9) Dithuso tsa bongaka tsa pele (e tladiwe ke batlhankedi ba ba batlisisang:—
Previous medical aids (to be completed by investigating officers):—

A.—TOKOLOLO YA MAITIRELO KGOTSA SEDIRISWA SA BONGAKA JWA BOGOLE

A.—ARTIFICIAL LIMB OR ORTHOPAEDIC/SURGICAL APPLIANCE

(1) A mokopi o kile a nna le tokololo ya maitirela kgotsa sedirisiwa sa bongaka jwa bogole se sele?
Has applicant previously had an artificial limb or other orthopaedic/surgical appliance? .....

(2) Fa go ntse jalo e thelesitswe ke mang?
If so, by whom supplied? .....

(3) Fa go dumeletswe ke lefapha le tsweetswe neela nomore tshupetso
If authorised by this Department, please state reference number
.....

(4) A thuso ya bongaka e kgologolo e ka baakanngwa?
Can the old medical aid be repaired? .....

(5) Bolela gore a mokopi o ne a amogela pusetso go tswa motsweding mongwe mme o supe mabaka a katso. Fa mokopia gobaletse mo tirong, go tshwanetse go, nelefediwa gore a o amogetse ditokoldo tse pedi tsa maitirelo jaaka karolo ya pusetso ya gagwe. Fa go na le topo ya pusetso e e latelang, se se tshwanetse go kaiwe.
State whether the applicant received compensation from any source and indicate the terms of the award. If the applicant was injured on duty, it should be ascertained whether he/she has already received two artificial limbs as part of his/her compensation. If there is a claim for compensation pending, this should also be mentioned .....
.....
.....

(6) Thuso ya bongaka e tla thelesidwa ke
The medicial aid will be supplied by .....
tshenyegelo e e lekonyeditsweng ya
at an estimated cost of R .....according to
go ya ka dinopolo tse di palagontsweng.
attached quotations.

B.—MENO A MAITIRELO
B.—ARTIFICIAL DENTURES

(1) Leino la bofelo le mokopi le somotswe ka dia
Applicant's last tooth was extracted on .....19.....
and altogether .....teeth were extracted on that date.

(2) O ne a theleswa ka meno lobaka lo ha kae morago ga moo?
How long thereafter was he/she supplied with dentures?

(3) A tlhinitswe ke mang?
By whom supplied? .....

(4) A duetswe ke mang?
By whom paid? .....
Fa go rebotse lefapha le, naya nomoro-tshupetso
If authorised by this Department please furnish reference number
.....

(5) Meno a simolotse leng go tlhoka go ka baakanngwa, le go ka fa tlase ga mabaka afe?
When and under what circumstances did denture(s) become unserviceable? .....

(6) A meno a ka baakanngwa, fa go le jalo, ka bokae?
Can dentures be repaired, and if so, at what cost? .....
.....
If the applicant is in receipt of a disability grant, state nature of the disability and in what respect the supply of denture(s) at State expense, will benefit his/her health, or improve his/her chances on the labour market .....
.....

Is patient suffering from any gastro-intestinal disorders?
If so, the district surgeon's certificate if possible, to indicate diagnosis, prognosis as well as duration of treatment given, should be attached.

Letlha
Date .....

Tshaeno le inakemo
Signature and designation .....

10. Dithagiso dingwe
Other remarks .....

11. Tshedimosetso ya tlaleteso (ka botlalo):—
Additional information (details):—

A thuso ya bongaka—
Will the medical aid—

(a) bo tla kgontsha moabelwa-thuso go ka thapiwa mo tirong?
qualify the beneficiary for the labour market? .....

(b) botla tokafatsa boitekanelo jwa moabelwa-thuso?
improve the beneficiary's health? .....
A thuso ya bongaka e tlhokego fele ke maikemisetso a go emistsa tiro ya — leruri e e senyegileng?
Is the medical aid solely for the purpose of replacing a permanently impaired function? .....
A thuso ya bongaka e tla fokosa kalafo?
Will the medical aid eliminate treatment? .....

SETIFIKEITE SA MOOKAMEDI WA KOKELO KGOTSA MOTLHANKEDE WA KATLAATLELO
MEDICAL SUPERINTENDENT OR WELFARE OFFICER'S CERTIFICATE

Ke tlisa fano gore morago ga dipatlisiso tse di tshwanetseng ke kgotsofetse gore mokopi ke motlhoki mo bokaong mme ka maikemisetso a kwalotiko ya boitekanelo ya No. ya 5 ya 1950, ke atlanegisa ka tshwanelo gore kopo e newe.
I hereby certify that after due investigations, I am satisfied that the applicant is an indigent within the meaning and for the purposes of Health Circular No. 5 of 1950. I accordingly recommend that the application be granted.

Date ..... Signature and designation .....

REPABOLIKI YA BOPHUTHATSWANA

Ts. S. 37

APPENDIX I

REPUBIC OF BOPHUTHATSWANA REPUBLIEK VAN BOPHUTHATSWANA

Nr. Tsh.: Kantoro ya Setereke
Ref. Nos.: District Office _____

Kantoro Kgolo
Head Office _____

KOPO YA
APPLICATION FOR

***(a) Neo ya Tlamelo/Maintenance grant**

***(b) Neo ya Motsadi wa Mofatlhosi/Foster parent grant**

***(c) Tshekatsheko-gape ya Tlamelo/Neo ya Motsadi wa Mofatlhosi/Review of maintenance/foster parent grant**

***Tlosa se se sa lebanang/Delete whichever is not applicable.**

(Go ya ka karolwana 89 ya Molao wa Bana, 1960 (Molao Nr. 33 wa 1960) le karolo VI ya Melawana.)
(In accordance with section 89 of the Children's Act, 1960 (Act No. 33 of 1960), and part VI of the Regulations.)

Letlha la go amogelwa ke motlhankedi wa setereke Date of receipt by district officer	Ga tiriso ya kantorokgolo For use by head offcie	
Setempe sa Letlha Date Stamp	Kopo e Netefaditswe Application checked	Letlha la go amogelwa ke kantorokgolo Date of receipt by head office **Setempe sa Letlha** **Date Stamp**

Nna, mosaenitlase (maina ka botlalo)
I, the undersigned (full name) _____

monna/mosadi _____ setso _____ dingwaga, nomoretlhaolo
male/female ethnic group _____ years, identity number

yo nnang kwa _____
residing at _____

fano ke kopa neo ya tlamelo/motsadi wa mofatlhosi mabapi le (ba)ngwana ba/yo ba/o boletsweng fa tlase ba/yo ba/o nnang leruri le nna; ke netefatsa fano gore tshedimosetso e e neilweng mo foromong e ke nnete e bile e nepagetse go ya ka kitso ya me e e tletseng mme e bile ke ikemisetsa go bega phetogo nngwe le nngwe mabapi le maemo a me mo kantorong e.

hereby apply for a maintenance/foster parent grant in respect of the undermentioned child(ren) permanently residing with me; I hereby certify that the information given in this form is true and correct to the best of my knowledge, and that I undertake to report any change in my circumstances to this office.

1. DINTLHA MABAPI LE BANA BA GAGO/LONA (GO AKARETSWA BASIRILETSWA) BA FATLHOSWA, BA BA KA FA TLASE GA DINGWAGA TSE SOME THATARO
PARTICULARS OF CHILDREN (INCLUDING WARDS) OR FOSTER CHILDREN, UNDER 16 YEARS.

Maina le sefane Full name and surname	Letlha la botsalo Date of birth	Kwa sekolong (fa go se jalo, faa mabaka) At school (if not, gve reasons)
(i)		
(ii)		
(iii)		
(iv)		
(v)		
(vi)		
(vii)		

2. DINTLHA TSA BATSADI BA BAFATLHOSI
PARTICULARS OF FOSTER PARENTS

(i) Kamano le (ba)ngwana
Relationship to child(ren) _____

(ii) Lotseno lwa kgwedi di tlhakantswe
Combined monthly income: R _____

(iii) A o amogela thuso ya Mmuso? Ee/Nyaa. Fa go le jalo nopola, dinomore tsa tshupetso

3. DINTLHA TSA BATSADI/MOTSADI-KA-NYALO/BATLAANS
PARTICULARS OF PARENTS/STEP-PARENTS/GUARDIMEDI

(i) Kemo ya nyalo. Nnyetswe/Kgope/Motlholagadi/ Moswagadi/Tlhadilwe/Ngalogile
Marital state: Married/Single/Widow/Widower/ Divorced/Deserted .....

(ii) Dingwaga tsa mogatsa
Age of spouse .....

(iii) A wena le mogatso lo nna mo ntlong e le nngwe? Ee/Nnyaa
Do you and your spouse live in the same house? Yes/No

(iv) A le nna jaaka monna le/kgotsa mosadi le motho yo mongwe? Ee/Nnyaa
Do you live as man and/or wife with another person? Yes/No

(v) Ke eng rraagwe (ba)ngwana a sa mo/ba tlamele? Faa mabaka
Why cannot the father of the child(ren) support him/her/them? Give reasons .....

.....

.....

(vi) Diphensene le dithuso tse o di amogelang le/kgotsa Phensene ya Bogolo/Phensene ya Bofofu/Neo ya Bogolo/Neo ya Masole a Pele/Neo ya Lepero:
Pensions or grants paid to you and/or your spouse: Old Age Pension/Blind Person's Pension/Disability Grant/Grant to Ex-soldiers/Leprosy Grant:

R_____ ka kgwedi — (Di)nomoretshu petso per month — Reference number(s) .....

(vii) Maina le diaterese tsa bathapi:
Names and addresses of employers:

(a) Mokopi
Applicant .....

.....

.....

(b) Mogatsa
Spouse .....

.....

.....

(viii) Mohuta wa tiro
Type of employment:

(a) Mokopi
Applicant .....

(b) Mogatsa
Spouse .....

4. LOTSENO/INCOME

(a) Thoto e e sa suteng ya mokopi/mogatsa
Fixed property of applicant/spouse

(i) Palo la dikamore
Number of rooms .....

(ii) A mokopi o nna mo setsheng? Ee/Nnyaa
Does applicant occupy the property? Yes/No

(iii) Peotlhotlhwa
Valuation: R.....

(iv) Tlamelelo le tsalo e e duelwang k.k.
Bond: R_____ and interest payable: R_____ p.m.

(v) Tlhotlhwa e e sa betelelwang
Unencumbered value: R_____

(vi) Rente ya setsha le ditefo: k.k.
Stand-rent and rates payable R_____ p.m.

(vii) Palo ya dikamore tse di hirilweng
Number of rooms let .....

(viii) Rente e e amogelwang k.k.
Rent received: R_____ p.m.

(b) Setsha se se hirisitsweng/Leased property

(i) Rente k.k.
Rent: R_____ p.m.

(ii) Rente e e amogelwang go tswa go khiriso-nnyane k.k.
Rent received from sub-lease: R_____ p.m.

(c) Dikamogelo/Earnings

(i) Dikamogelo k.k.: Mokopi ; Mogatsa
Earnings p.m.: Applicant R_____; Spouse R_____

(ii) Fa o le mo tirong e e tlhomameng a wena/moga tso o amogela mophako le/kgotsa
If in full-time employment do you/your spouse receive rations and/or quarters? _____

(iii) Madi a dijo le marobalo a a amogetsweng maba pi le bana ba lona
Monthly board and lodging i.r.o. own children: R_____

(iv) Madi a dijo le marobalo a a amogetsweng maba pi le (palo) ya batsholwa
Monthly board and lodging received i.r.o. _____ (number) of boarders: R_____

(v) Lotseno lo longwe ka kgwedi (jk. kgwebo ya ga go: Mogatsa
Over monthly income (e.g. own business): R_____ Spouse R_____

(vi) Dineo kgotsa diphensene tse di amogetsweng go bathapi ba pele: Mokopi ; Mogatsa
Monthly grants or pensions received from previous employers' applicant R_____; Spouse R_____

(go tlogetswe ba ba boletsweng mo temaneng ya 3(vi) fa godimo)
(excluding those mentioned in paragraph 3(vi) above)

(vii) Tsalo ya kgwedi ya e e amogetsweng mo ditsadisong tsa
Monthly interest of R_____ received on investments of R_____

(viii) Lotseno longwe le longwe
Any other income (give particulars) _____

_____

_____

_____

Tshaeno/Kgatiso ya kgonojwe
Signature/Right thumb-print

Basupi/Wtnesses:

(i) _____ Felo/Place _____

(ii) _____ Letlha/Date _____

(Ditemana 5, 6 le 7 ga tiriso yo Lefapha fela/Paragraphs 5, 6 and 7 for Departmental use only.)

5. SETIFIKEITI/CERTIFICATE

Nna, mosaenitlase, ke tiisa gore ka bonna ke sekasekile ko po ya
I, the undersigned, certify that I have personally examined the application of _____

_____, gore mokopi le mogatse ba tlhagile fa pele ga me,
_____, that the applicant and his/her spouse have appeared before me, and that

(i) mokopi o nna mo kgaolong ya Magiseterata wa
the applicant resides within the Magisterial district of _____

(ii) maiteko a dirilwe a go busetsa balapa nageng ya bona ya botsalo;
efforts have been made to repatriate the family;

(iii) ke kgotsafalela diteng tsa setifikeite sa dituelo
I am satisfied with the contents of the wage certificates;

(iv) Ke kgotsofetse gore mokopi o tshwanelwa ke neo ya ka kgwedi jaaka go kaeletswe mo
Molaong wa Bana 1960 (Molao Nr. 33 wa 1960)
I am convinced that the applicant qualifies for a grant of R_____ per month as prescribed in the
Children's Act, 1960 (Act No. 33 of 1960);

(v) Ke kgotsofetse gore mo kgatlhegong ya (ba)ngwana neo o tshwanetse go duelwa mme e bo e laolwe ke
I am convinced that in the interest of the child (ren) the grant should be paid to and administered by

_____

(vi) ditlhokego tsa Molao le Melawana e e thaetsw eng mo go ona e ne ya elwa tlhoko
the requiremnts of the Act, and the Regulations framed thereunder, have been observed

Felo/Place _____ _____

Motlhankedi wa Moreboledi
Letlha/Date _____ Authorising Officer

---

6. DIPATLISISO TSA NEO YA MOTSADI/MOTLAMEDI/ASESSMENT OF PARENT/GUARDIAN GRANT

A. Dintlha tsa thoto e e tlhomameng/Particulars of fixed property:

(i) Bonno: Diphesente tse 3 tsa ; Diphesente tse 5 tsa
Occupancy: 3 per cent of R_____; 5 per cent of R_____

Gotlhe/Totaal R_____

(ii) Rente e e amogetsweng — temana 4(a)(viii)
Rent received — para. 4(a)(viii) R_____

(iii) Tlositswe ditefo/makgetho/rente ya setsa e e duetsweng
— temana 4(a) (vi)
Less rates/taxes and stand-rent paid — para 4(a)(vi) R_____

(iv) Lotseno lo lo lekanyediwang R_____

B. Dintlha mabapi le thoto e e hirisitsweng/Particulars of leased property

(i) Rente ya kgwedi le kgwedi e e amogetsweng go khiriso-nnyana — temana 4(b)(ii)
Monthly rent received from sub-lease — para. 4(b)(ii) R_____

(ii) Rente ya kgwedi le kgwedi e e duetsweng
Monthly rent paid — para. 4(b)(i) R_____

(iii) Lotseno lo lo lekanyediwang
Assessable income R_____

C. DIKAMOGELO/EARNINGS (para. 4(c))

(i) Lotseno lotlhe
Total income R_____

(ii) Tlogetswe ditloso tse di dumelesegang
Less admissible deductions R_____

(iii) Lotseno lo lo lekanyediwang
Assessable income R_____

(iv) Halofo e le nngwe go mogatsa mongwe le mongwe
One-half to each spouse R_____

(v) Palo ya bana ba ba ka fa tlase ga dingwaga di le 16
Number of children 16 years and under _____

(vi) Setlhopha sa lotseno (tema. 17 ya ditaelo)
Income group (paragraph 17 of manual) R_____ to R_____

(vii) Neo go motsadi
Grant to parent R_____

(viii) (Di)Kokomana
Grant to child(ren) R_____

(ix) Madi a tlaleletso
Additional amount R_____

(x) Palogotlhe ya lelapa
Total to family R_____

(xi) E duetswe go tswa
Payable from

(xii) Letlha la tshekatsheko-gape
Review date

Lefelo/Place _____ _____
Motlhankedi wa Bothati
Letlha/Date _____ Authorising Officer

7. TEKANYETSO YA NEO YA MOTSADI WA MOFATLHOSI/ASSESSMENT OF FOSTER PARENT GRANT:

(a) Palo ya bana ba fatlhoswang, dingwaga di le 16 le kwa tlase
Number of foster children, 16 years and under _____

(b) Neo e e duelwang mabapi le _____ bana ba ba fatlhoswang
Grant payable in respect of _____ foster children, R_____

(c) Neo e duelwa go tswa go
Grant payable from _____

(d) Letlha la tshekatsheko-gape
Review date _____

Lefelo/Place _____ _____
Motlhankedi wa Bothati
Letlha/Date _____ Authorising Officer

Munabatho Books & Printers

APPENDIX K

D.O./D.E. 270
Verw. No:- L/3
Ref. No :-

DEPARTEMENT VAN ONDERWYS
DEPARTMENT OF EDUCATION

Aansoek om toelating tot n goedgekeurde spesiale skool.
Application for admission to an approved special school.

Naam van skool wat leerling wil bywoon:
Name of school which pupil desires to attend:

A. BESONDERHEDE VAN LEERLING:
PARTICULARS OF PUPIL:

	Van Surname	Naam Name
1. Volle naam, van eerste: Full name, surname first:		

2. (a) Datum van geboorte:
Date of birth:

(b) Geskatte ouderdom indien geboortedatum onbekend
Estimated age if date of birth is not known:

3. Geslag:
Sex:

Manlik Male:	Vroulik Female:

4. Etniese groep:
Ethnic group :

Huistaal
Home language:

5. (a) Het die kind reeds enige skool bygewoon?
Has the child already attended any school?

JA YES	NEE NO

(b) Indien ja, meld standerd geslaag?
If so, mention standard passed?

(c) Naam van skool bygewoon?
Name of school attended?

6. Getal broers en susters van die applikant:
Number of brothers and sisters of the applicant:

7. Hoeveel van die broers/susters is ook:
How many of the brothers/sisters is also:

(a) doof
deaf

(b) blind
blind

(c) epilepties
epileptic

(d) anders gestremd (spesifiseer)
otherwise handicapped (specify)

2/....

8. Het die vader of moeder ook dieselfde gebrek? / Has the father or mother the same defect? | JA / YES | NEE / NO |

9. Is die kind selfstandig ten opsigte van:
Is the child independant in respect of:

(a) eet / eating | JA / YES | NEE / NO |

(b) aan- en uittrek / dressing | JA / YES | NEE / NO |

(c) was en bad / washing | JA / YES | NEE / NO |

(d) toilet gewoontes / toilet habits | JA / YES | NEE / NO |

10. Naaste Spoorwegstasie of Spoorwegbushalte:
Nearest Railway Station or Railway Bus Stop:

B. BESONDERHEDE VAN OUERS OF VOOG:
PARTICULARS OF PARENTS OR GUARDIAN:

1. (a) Volle naam van vader (as hy leef):
Full name of father (if still alive):

Persoonsnommer:
Identity Number:

(c) Volle naam van voog as ouers oorlede is:
Full name of gurdian if parents are deceased:

Persoonsnommer:
Identity Number:

2. Adres van ouers/voog:
Address of Parents/Guardian:

3. Kerkverband:
Church parents belong to:

4. Besonderhede omtrent ander kinders in die gesin:
Particulars about other children in the household:

Name / Names	Oud/Age	Verdienste Earnings

Name / Names	Oud/Age	Verdienste Earnings

5. (a) Aard van Ouer se werk:
Nature of Parent's Work:

6. (b) Naam en adres van Werkgewer:
Name and Address of Employer:

(c) Totale jaarlikse inkomste uit salaris en/of ander bronne:
Total annual income from salary and/or any other sources:

R BRONNE:
SOURCES:

(d) Aard van ander kinkomste (besigheid, boerdery, ens.) :
Other sources of income (e.g. business, farming, etc.):

(e) Besonderhede van enige vaste eiendom wat u besit:
Particulars of any fixed property you may own:

(f) Getalle en waarde van vee wat u besit:
Numbers and value of any livestock you own:

Beskrywing : Description:	R

(g) Hoeveel huishuur betaal u per maand?
How much house rent do you pay per month? R

(h) Besonderhede omtrent enige skulde:
Particulars about any debts: R

VERKLARING DEUR OUER/VOOG

Ek verklaar plegtig dat ek die inligting in hierdie vorm verstrek het en dat dit na my beste wete waar en juis is.

1. DECLARATION BY PARENT/GUARDIAN

I solemnly declare that I supplied the information in this form and that to the best of my knowledge it is correct and true.

4/.....

Verder belowe ek en verbind ek my om nie die kind ten opsigte van wie hierdie aansoek gedoen word en vir wie geldelike hulp en/of ander vergunnings gemagtig mag word, sonder die toestemming van die Departement van . . -onderwys uit die inrigting te neem nie.

2. Furthermore I promise and undertake not to remove the child in whose respect this application is made and for whom financial aid and/or other concessions may be authorised, from the institution without the consent of the Department of Education.

Hiermee verleen ek as ouer/voog my volle toestemming dat hierdie kind enige operasie mag ondergaan s soos deur 'n geneesheer aanbeveel word.

3. I give my full consent to any operation performed on this child if advised by a medical doctor.

Ek verleen hiermee die reg aan die skoolhoof om hospitaalvorms vir toestemming tot operasies, namens my te onderteken.

4. I also authorise the principal this school to sign the hospital's permission forms for operations on this child on my behalf.

Hiermee gee ek ook my toestemming dat hierdie kind in 'n skoolvoertuig vervoer mag word en ek of my eksekuteurs sal geen eise teen die skool of Departement van onderwys stel in geval van ongelukke waarin die kind beseer of beskadig word nie.

5. I also hereby agree that this child may be conveyed in a Departmental or School vehicle, at his or her own risk and that the said Department of Education any officers of this school will not be held responsible for any losses or damage suffered by this child in any road accident.

HANDTEKENING VAN VADER, MOEDER, OF WETTIGE VOOG

SIGNATURE OF FATHER, MOTHER OR LEGAL GUARDIAN

DATUM DATE

Getuie :
Witnesses:

Adres:
Address:

Adres:
Address:

...../5

D. SERTIFIKAAT DEUR PLASSLIKE LANDROS OF LERAAR
CERTIFICATE BY LOCAL MAGISTRATE OR MINSTER OF RELIGION:

Ek, die ondergetekende, verklaar dat vir sover ek weet en kon vasstel die inligting deur die applikant verstrek, betroubaar en juis is. Ek beveel aan dat :

I the undersigned, certify that to the best of my knowledge and go, far as I could ascertain the information furnished by the applicant is reliable and true. I recommend that:

Toelating goedgekeur/afgekeur word
Admission be approved/not approved

LANDROS/LERAAR/MAGISTRATE/MINISTER

DATUM , DATE

ADRES:
ADDRESS:

E. MEDIESE VERSLAG OOR KIND SO VOLLEDIG MOONTLIK, ASSEBLIEF

MEDICAL REPORT ON CHILD IN THE FULLEST POSSIBLE DETAIL PLEASE

1. Is die longe gesond?/Are the lings healthy? JA YES / NEE NO

2. Is die geluide, puntstoot, ritme van die hart normal? Are the sounds, impulse, rhythm of the heart normal? JA YES / NEE NO

3. Is hy/sy blykbaar vry van besmetlike en aansteeklike siektes/ Is he/she apparently free form infections and contageous diseases ? JA YES / NEE NO

4. Is die kind na u oordeel verstandelik normaal? Do you consider the child normal mentally ? JA YES / NEE NO

5. (a) Is die tande gesond ? / Are the teeth sound ? JA YES / NEE NO

(b) So nie, het hulle onmiddellike aandag nodig ? If not, do they require immediate attention? JA YES / NEE NO

6. Kind se gewig/Weight of child ____ KG.

7. Is hy/sy na u mening ondervoed? / Is he/she in your opinion underfed — JA YES / NEE NO

8. Het die kind 'n breuk / Is there any hernia ? — JA YES / NEE NO

9. Is die mangels of adennoide enigsins aangetas? / Are the tonsils or adenoids-affected in any way? — JA YES / NEE NO

10. Is daar enige tekens van sifilis? / Are there any signs of syphilis? — JA YES / NEE NO

11. Ontvang hy/sy enige behandeling? / Is he/she under any medical treatment? — JA YES / NEE NO

Indien wel, waarvoor? / If so, what for?

12. Het hy/sy enige-LIGGAAMSGEBREK? / Is there any PHYSICAL DEFECT? — JA YES / NEE NO

Indien wel: / If so:

		Ruggraattering: / T.B. Spine:	
Serebraleverlamming: / Cerebral Palsy		Muskulêre distrofie: / Muscular dystrophy:	
Post Polio		Klompvoet: / Club feet:	
Post encephalitis:		Hemiplegie: / Hemiplegia:	
Post meningitis:		Paraplegie: / Paraplegia:	
Spina bifida:		Amputasie: / Amputation:	

Anders: / Others:

Kan die kind loop? / Can the child walk? — JA YES / NEE NO

Indien wel: / If so: — Goed / Well; Medium Reasonably; Swak / Weakly

Dra die kind loopysters: / Does the child wear calipers: — JA YES / NEE NO

3. Ly die kind aan EPILEPTIESE AANVALLE? / Does he/she suffer EPILEPTIC FITS?

JA YES	NEE NO

Indien wel:
If so:

Grand mal: | Petit mal: | Gekontroleer / Controlled | JA YES | NEE NO

4. Is daar 'n GESIGSGEBREK? / Is there a DEFECT IN VISION?
Indien wel: / If so:

(a)

Totaal: Totally:	Gedeeltelik: Partially:

(b) Indien gedeeltelik, mate van gesig (Snellen) / if partially, degree of sight (Snellen)
Regs: Right:
Links: Left:

(c) Is hy/sy blind gebore? Was he/she born blind? JA YES | NEE NO

(d) Indien nie op watter ouderdom het hy/sy blind geword?
If not, at what age did he/she become blind?

(e) Oorsaak van blindheid: / Cause of blindness:

(f) Is daar ooit aan die oë geopereer? / Have the eyes ever been operated on? JA YES | NEE NO

(g) Indien wel, (i) deur wie? / If so, whom by?

(ii) wanneer? / when?

(iii) waar? / where?

(h) Beskou u die toestand as: / Do you consider the condition to be:

Permanent: / Permanent:	Staties: / Static:	Progressief: / Progressing:

(i) Is hy/sy 'n albino?/ Is he/she an albino? JA YES | NEE NO

5. Is daar 'n GEHOORGEBREK? / Is there a DEFECT IN HEARING? JA YES | NEE NO

Indien wel:- / If so :-

(a)

Totaal: Totally:	Gedeeltelik: Partially:

(b) Indien gedeeltelik, op watter afstand kan hy/sy normale spraak hoor en verstaan?
If partially, at what distance can he/she hear and understand normal speech?

(c) ~~Is hy/sy doof geboore?~~ / Was he/she born deaf?

JA YES	NEE NO

(d) Indien nie, op watter ouderdom het hy/sy doof geword?
If not, at what age did he/she become deaf?

(e) Oorsaak van doofheid:
Cause of deafness:

(f) Is daar ooit aan die oor of net agter die oor geopereer?
Has he/she ever had any operation on the ear or directly behind the ear?

JA YES	NEE NO

(g) Indien wel, (i) deur wie?
If so, by whom?

(ii) Wanneer?
When?

(iii) Waar?
Where?

(h) Beskou u die toestand as:
Do you consider the condition to be:

Permanent / Permanent	Staties: / Static	Progressief / Progressing

(i) Ly hy/sy aan lopende ore?
Does he/she suffer from discharging ears?

JA YES	NEE NO

16. Is daar 'n SPRAAKGEBREK? Is there a DEFECT IN SPEECH

JA YES	NEE NO

Indien wel:
If so:

Erg: Bad:	Medium Reasonably	Lig: Mild:

17. Beskou u die applikant as verstandelik normaal?
Do you consider the applicant mentally normal?

JA YES	NEE NO

18. Beskou u die applikant as 'n geskikte kandidaat vir 'n spesiale skool?
Do you consider the applicant a suitable candidate for a special school?

JA YES	NEE NO

19. Enige ander opmerkings:
Any other relevant remarks:

HANDTEKENING EN KWALIFIKASIE VAN MEDIESE PRAKTISYN Adres:
SIGNATURE AND QUALIFICATIONS OF MEDICAL PRACTITIONER Address:

DATUM: DATE:

...\8

T L A M E L A N G .

SCHOOL FOR THE CRIPPLED.

PERMISSION FOR OPERATIONS ON PUPILS.

I, ...(parent,guardian) hereby agree that .....may be operated and given whatever treatment may be necessary , if advised by a medical doctor. I authorise the doctor to act as he may deem it necessary. I also authorise the principal of this school , Tlamelang, to sign the hospital's permission forms (for operations) on my behalf.

.....
DATE

.....
Signature
(Father, mother, guardia)

ADDRESS: .....

.....

.....

Witnesses :

1. .....

2. .....