

**A community-based disability programme
for rural areas**



LIZEL PRETORIUS

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LIZÉL PRETORIUS

BA (SOCIAL WORK), MA (EMPLOYEE ASSISTANCE PROGRAMME)

PHILOSOPHIAE DOCTOR

in

SOCIAL WORK

in the

FACULTY OF HEALTH SCIENCES

at the

NORTH - WEST UNIVERSITY, POTCHEFSTROOM CAMPUS

Promoter: Dr A.G. Herbst

Co-Promoter: Dr C.C. Wessels

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PHILIPPIANS 4: 6 – 7:

*“DO NOT BE ANXIOUS ABOUT ANYTHING, BUT IN EVERYTHING, BY
PRAYER AND PETITION, WITH THANKSGIVING PRESENT YOUR
REQUESTS TO GOD. AND*

*THE PEACE OF GOD, WHICH TRANSCENDS ALL UNDERSTANDING,
WILL GUARD YOUR HEARTS AND YOUR MINDS IN CHRIST JESUS”*

FILIPPENSE 4:6 – 7:

*“WEES OOR NIKS BESORG NIE, MAAR LAAT JULLE BEGEERTES IN
ALLES DEUR GEBED EN SMEKING MET DANKSEGGING BEKEND WORD
BY GOD. EN DIE VREDE VAN GOD, WAT ALLE VERSTAND THE BOWE
GAAN, SAL JULLE HARTE EN JULLE SINNE BEWAAR IN
CHRISTUS JESUS.”*

TO:

*My loving grandparents, who both passed away
during this time*

SUMMARY

A community-based disability programme for rural areas

Keywords: poverty, health, disability, rural, community-based programme, empowerment.

This study was conducted in the Heuningvlei community in the Kgalagadi District Municipality in the Northern Cape Province. This study was part of the "Tshwaragano Project" with the general aim of empowering the disadvantaged communities in rural areas.

The **aim** of this research was to develop, implement and evaluate the effectiveness of a community-based disability programme for poverty stricken families in rural areas of the Northern Cape Province.

To achieve this aim, the following objectives needed to be attained:

- ☞ ***To study the interrelation between health, poverty and disability?*** This objective was achieved by means of a critical review and analysis of the relevant literature. It can therefore be concluded that the interrelation between health, poverty and disability is significant. Poverty makes people more vulnerable to disability and disability can lead to isolation, lack of support and lack of resources. Many people still remain ill-fed, ill-housed, under-educated and defenceless to preventable diseases.
- ☞ **To establish what the bio-psychosocial needs of the Heuningvlei community with regard to a community-based disability programme are?** The researcher also established a profile on the community members with disabilities in the Heuningvlei community. The study showed that the highest prevalence of disabilities involves physical disabilities, with hearing, blindness and mental impairments also represented. The causes of disabilities are mostly illness related causes, substance abuse and natural causes. All three aspects which could, on the whole be prevented through general health awareness and a healthier lifestyle. It was also palpable that crucial disability management- and support services lack in this rural area. Partnership working between government organizations and Non Government Organizations

(NGO's) seems a foreign affair and the community members with disabilities and their families an elapsed entity.

- ***To design and implement a community-based disability programme for rural areas.*** This programme was presented successfully over a stretch of five group sessions to ten community members with the aim to improve their knowledge regarding disability matters. They also received skills to start their own food garden. By means of this programme the members of the group also enhanced their social functioning and showed great interest in disability awareness and management.
- **To evaluate the effectiveness of this community-based disability programme in empowering community members with disabilities, their care-takers and the wider community to manage disability related matters in a poverty stricken area.** The evaluation by utilizing a focus group with the identified key role players in the community. The results obtained through this evaluation indicated that the programme had brought a significant change in the lives of the members. It can therefore be concluded that the programme was very successful and effective in the sense that members felt that there was a transition in their lives.

In summary it can be stated that proof has emerged from this research that a scientifically founded, well-planned community-based disability programme can undoubtedly be applied to improve the social functioning of poverty stricken rural families.

OPSOMMING

‘N gemeenskapsgebaseerde gestremdheidsprogram vir ’n landelike gebied.

Sleutelterme: armoede, gesondheid, gestremdheid, landelike gemeenskap, gemeenskapgebaseerde program, bemagtiging.

Die ondersoek is in die Heuningvlei-gemeenskap onderneem wat deel uitmaak van die Kgalagadi-distrik Munisipaliteit in die Noord-Kaap Provinsie. Die studie vorm deel van die “Tshwaragano Projek” met die doelstelling om gemeenskappe in landelike gebiede te bemagtig.

Die **doel** van hierdie studie was om die effektiwiteit van ’n gemeenskapgebaseerde gestremdheidsprogram vir gesinne in armoede in landelike gebiede in die Noord-Kaap Provinsie, te evalueer.

Om hierdie doel te bereik moes die volgende doelwitte behaal word:

- ☞ ***Om ondersoek in te stel na die verband tussen gesondheid, armoede en gestremdheid.*** Hierdie doelwit was bereik deur die kritiese navors en analiseer van relevante literatuur. Die gevolgtrekking kan gemaak word dat daar ’n verband bestaan tussen gesondheid, armoede en gestremdheid. Armoede maak mense meer kwetsbaar vir gestremdheid en gestremdheid kan lei tot isolasie, gebrek aan ondersteuning en aan hulpbronne. Heelwat mense bly steeds ondervoed, het gebrekkige behuising en min skoolopleiding en staan magteloos teenoor voorkombare siektes.
- ☞ ***Om vas te stel wat die bio-psigososiale behoeftes van die Heuningvlei-gemeenskap is ten opsigte van ’n gemeenskapgebaseerde gestremdheidsprograme.*** ’n Gemeenskapsprofiel is saamgestel uit die gemeenskapslede met gestremdhede. Die studie het aangetoon dat fisiese gestremdheid, wat doofheid, blindheid en verstandelike gestremdheid insluit, die meeste in hierdie gemeenskap voorkom. Die algemene oorsaak van die gestremdhede is siektes, dwelm- en drankmisbruik en natuurlike oorsake. Al drie kan voorkom word deur algemene gesondheidsbewuswording en ’n gesonder leefstyl. Dit was ook duidelik dat noodsaaklike

gestremdheidshanterings- en -ondersteuningsdienste in die landelike gebied kort kom. Vennootskap tussen die regeringsorganisasies en NGO's blyk 'n nie-bestaande verskynsel te wees en die gemeenskapslede met gestremdhede en hulle gesinne is vergete.

- ☞ ***Om 'n gemeenskapgebaseerde gestremdheidsprogram vir 'n landelike gebied te ontwikkel en te implementeer.*** Hierdie program is met sukses aan tien gemeenskapslede aangebied, deur middel van vyf groepsessies met die doel om hulle kennis aangaande gestremdheidsaspekte te verbeter. Hulle het ook die vaardighede ontvang om hulle eie groentetuin te begin. Deur hierdie program het die groep lede ook hulle sosiale vaardighede ontwikkel en het hulle opregte belangstelling getoon in bewusmaking en hantering van gestremdheid.
- ☞ ***Om die effektiwiteit van die gemeenskapgebaseerde gestremdheidsprogram om gemeenskapslede met gestremdheid, hulle versorgers en die breë gemeenskap se vermoëns om gestremdheidsaspekte in 'n arm gemeenskap te behartig.*** Die evaluasie is deur middel van 'n fokusgroepsessie met belangrike rolspelers in die gemeenskap uitgevoer. Die resultate wat deur die evaluasie behaal is, het aangedui dat die programme 'n aanmerklike verandering in die lewens van die gemeenskapslede tot gevolg gehad het. Dit kan dus saamgevat word dat die programme geslaagd en doeltreffend was deurdat die lede gevoel het dat 'n verandering in hulle lewens ingetree het.

Samevattend kan gestel word dat daar uit hierdie navorsing bewys gelewer is dat 'n wetenskaplik gefundeerde, goed beplande maatskaplike groepwerk-bemagtigingsprogram onteenseglik aangewend kan word om gesinne se psigososiale funksionering in landelike gebiede te verhoog.

FOREWORD

This manuscript is presented in article format in accordance with Rules A.11.5.3 and A.11.5.4 that are set out in the year book of the North-West University (Potchefstroom Campus) 2006. The context and technical requirements of the accredited professional journals *Social Work Practitioner-Researcher/Maatskaplike Werk Navorsers/Praktisyn*, *Social Work/Maatskaplike Werk* were used as basis to structure the articles.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	iii
SUMMARY.....	v
OPSOMMING	vii
FOREWORD.....	ix
TABLE OF CONTENTS	x
LIST OF APPENDIXES.....	xviii
LIST OF TABLES.....	xix
LIST OF FIGURES AND GRAPHIC PRESENTATIONS.....	xx
LIST OF ABBREVIATIONS	xxi
<u>SECTION A</u>	
ORIENTATION TO THE RESEARCH	1
1. INTRODUCTION	2
2. ORIENTATION AND PROBLEM STATEMENT	2
3. AIMS AND OBJECTIVES.....	7
3.1 Aim.....	7
3.2 Objectives	7
4. CENTRAL THEORETICAL ASSUMPTION	7
5. THEORETICAL PERSPECTIVE.....	7
6. DESCRIPTION OF CONCEPTS	8
7. RESEARCH METHODOLOGY.....	9
7.1 PRELIMINARY EXPLORATION	9
7.1.1 Analysis of the literature.....	9
7.1.2 The utilization of experts	10
7.1.3 The initial exploration study.....	10
7.2 Empirical investigation	11
7.2.1 Research design.....	11

7.2.2	Population.....	12
7.2.3	Data collection instruments.....	12
7.2.4	Procedures.....	12
7.2.5	Ethical aspects.....	13
7.2.6	Data-analysis.....	14
8.	RESEARCH LIMITATIONS.....	14
9.	CHOICE AND STRUCTURE OF THE RESEARCH REPORT.....	15
10.	BIBLIOGRAPHY.....	17
<u>SECTION B</u>	ARTICLES.....	21
	ARTICLE 1 THE INTERRELATION BETWEEN POVERTY, HEALTH AND DISABILITY IN A RURAL COMMUNITY.....	22
1.	INTRODUCTION.....	23
2.	PROBLEM STATEMENT.....	23
3.	AIM AND OBJECTIVE.....	25
3.1	AIM:.....	25
3.2	OBJECTIVE:.....	25
4.	ETHICAL ASPECTS.....	25
5.	RESEARCH METHODOLOGY.....	26
5.1	Phase 1 - Literature study.....	26
5.2	EMPIRICAL RESEARCH.....	27
5.2.1	Research model.....	27
5.2.2	Research design.....	28
5.2.3	Sampling and research participants.....	28
5.2.4	Data collection.....	29
5.2.5	Data analysis.....	29
6.	POVERTY, HEALTH AND DISABILITY IN CONTEXT OF THIS STUDY.....	29
6.1	POVERTY.....	29
6.1.1	Terminology.....	29

6.1.2	The bio-psychosocial aspects and implications of poverty	30
6.1.3	The impact of poverty on a rural community.....	30
6.1.4	Suggested strategies to deal with poverty in South Africa	31
6.2	HEALTH	32
6.2.1	Terminology	32
6.2.2	The bio-psychosocial aspects of health.....	32
6.2.3	Health in rural communities.....	34
6.3	DISABILITY	37
6.3.1	Terminology	37
6.3.2	Strategies to improve disability prevention and management.....	38
6.3.3	The bio-psychosocial aspects and implications of disability.....	39
6.3.4	Disability in rural communities.....	43
6.3.5	Suggested intervention with regard to disability.....	44
7.	MAINTANANCE OF THE RELATIONSHIP BETWEEN POVERTY, HEALTH AND DISABILITY.	45
7.1	SOCIAL FACTORS.....	46
7.2	EMOTIONAL FACTORS	46
7.3	PSYCHOLOGICAL FACTORS	47
7.4	ECONOMICAL FACTORS	48
7.5	PHYSICAL FACTORS	49
7.6	CULTURAL FACTORS	50
8.	CONCLUSIONS	51
9.	RECOMMENDATIONS	51
10.	BIBLIOGRAPHY	53
ARTICLE 2	DEVELOPING A COMMUNITY-BASED DISABILITY PROGRAMME: RESULTS OF A SITUATION-ANALYSIS IN A RURAL COMMUNITY	58
1.	INTRODUCTION	59
2.	PROBLEM STATEMENT	59

3.	AIM AND OBJECTIVE	60
3.1	AIM.....	60
3.2	OBJECTIVE	60
4.	RESEARCH METHODOLOGY.....	60
5.	ETHICAL ASPECTS.....	61
6.	SITUATION ANALYSIS.....	62
6.1	Terminology	62
6.1.1	Situation analysis	62
6.1.2	Needs assessment	63
6.1.3	Community profile	63
6.2	CONCEPTUALIZATION OF THE PROCESS.....	63
6.3	The motivation of the intervention process.....	64
7.	BIO-PSYCHOSOCIAL NEEDS OF PEOPLE WITH DISABILITIES.....	65
7.1	Biological needs.....	65
7.2	Psychological needs	66
7.3	Social needs	66
8.	COMMUNITY-BASED DISABILITY INTERVENTION IN A RURAL AREA	67
9.	RESULTS	68
9.1	Community profile	68
9.2	BIO-PSYCHOSOCIAL NEEDS WITH REGARD TO DISABILITY.....	76
9.3	INDIVIDUAL INTERVIEWS WITH EXPERTS IN THE COMMUNITY	82
9.3.1	Interview questions and main themes	83
10.	CONCLUSION.....	86
11.	RECOMMENDATIONS.....	86
12.	BIBLIOGRAPHY	89

ARTICLE 3	A COMMUNITY-BASED DISABILITY PROGRAMME FOR RURAL AREAS	94
1.	INTRODUCTION	95
2.	PROBLEM STATEMENT	96
3.	AIM AND OBJECTIVE	97
3.1	Aim.....	97
3.2	Objective	97
4.	RESEARCH METHODOLOGY	97
5.	ETHICAL ASPECTS	98
6.	RESEARCH RESULTS	98
6.1	COMMUNITY PROFILE.....	98
6.2	DISABILITY-SPECIFIC INFORMATION	99
7.	A COMMUNITY-BASED DISABILITY PROGRAMME FOR RURAL AREAS	100
7.1	DISABILITY INTERVENTION STRATEGIES, MODELS AND APPROACHES UNDERLYING THE PROGRAMME.....	100
7.1.1	The primary theory	100
7.1.2	Supporting theories	100
7.1.3	Intervention models.....	101
7.1.4	Levels of intervention	102
7.2	INTERVENTION STRATEGY SUMMARY.....	104
7.3	SUGGESTED PROGRAMME STRUCTURE.....	105
7.4	FACILITATING THE PROGRAMME.....	107
7.4.1	Group work	107
7.4.2	Practical sessions	107
7.4.3	Visual aids	108
7.4.4	Learning aids	108
8.	PROGRAMME COMPOSITION	108
9.	THE PROGRAMME (Appendix F)	108

10.	OPPORTUNITIES OF THE PROGRAMME	110
11.	RECOMMENDATIONS.....	111
12.	CONCLUSION.....	112
13.	BIBLIOGRAPHY	114
ARTICLE 4	THE EVALUATION OF A COMMUNITY BASED DISABILITY PROGRAMME FOR RURAL AREAS.....	117
1.	INTRODUCTION	118
2.	PROBLEM STATEMENT	118
3.	AIM AND OBJECTIVE	120
3.1	Aim.....	120
3.2	Objective	121
4.	RESEARCH METHODOLOGY.....	121
4.1	RESEARCH MODEL	121
4.1.1	Evaluation and advanced development.....	121
4.1.2	Dissemination	122
4.2	RESEARCH DESIGN	122
4.3	PARTICIPANTS	123
4.4	DATA COLLECTION.....	125
4.5	MEASURING INSTRUMENTS.....	126
4.6	RESEARCH PROCEDURE	127
4.7	DATA ANALYSIS	127
5.	ETHICAL ASPECTS.....	128
6.	THE NATURE OF THE EVALUATION PROCESS.....	129
7.	THE RESULTS	131
7.1	FACILITATION ASSESSMENT QUESTIONNAIRE.....	131
7.1.1	The assessment of the learning process.....	131
7.1.2	The assessment of the content of the programme	132
7.2	SUMMARY OF THE FOCUS GROUP PROCESS AND RESULTS	134

7.3	THE LINKS BETWEEN THE QUALITATIVE AND QUANTITATIVE RESULTS	137
7.3.1	Positive intervention	137
7.3.2	Expectations met	137
7.3.3	Ongoing support needed.....	137
7.3.4	Lack of service delivery.....	137
7.3.5	Lack of community resources.....	137
7.3.6	Home-based care and physical assistance	137
7.3.7	Disability awareness	138
8.	THE OPPORTUNITIES AND CHALLENGES OF THE PROGRAMME.....	138
8.1	THE OPPORTUNITIES OF THE COMMUNITY-BASED DISABILITY PROGRAMME.....	138
8.2	THE CHALLENGES OF THE COMMUNITY-BASED DISABILITY PROGRAMME.....	139
9.	RECOMMENDATIONS.....	140
10.	CONCLUSION.....	141
11.	BIBLIOGRAPHY	142
<u>SECTION C</u>	SUMMARY, CONCLUSIONS AND RECOMMENDATIONS.....	146
1.	INTRODUCTION	147
2.	SUMMARY OF THE MAIN ASPECTS OF THE RESEARCH PROCESS	147
3.	AIM AND OBJECTIVES OF THE STUDY	148
3.1	Aim.....	148
3.2	Objectives	148
4.	RESEARCH METHODOLOGY.....	148
4.1	LITERATURE STUDY.....	149
4.2	EMPIRICAL RESEARCH.....	150

5.	DISCUSSION AND INTERRELATION OF THE KEY CONCEPTS – POVERTY, HEALTH AND DISABILITY	152
6.	THE COMMUNITY-BASED DISABILITY PROGRAMME	153
7.	THE EVALUATION OF THE COMMUNITY-BASED DISABILITY PROGRAMME	154
8.	CONCLUSIONS	155
9.	TESTING THE CENTRAL THEORETICAL ASSUMPTION	156
10.	RECOMMENDATIONS	156
11.	CLOSING REMARKS	160
	THE HEUNINGVLEI COMMUNITY	161
12.	BIBLIOGRAPHY	163
<u>SECTION D</u>	APPENDIXES	166
<u>SECTION E</u>	CONSOLIDATED BIBLIOGRAPHY	272

LIST OF APPENDIXES

APPENDIX A: DISABILITY QUESTIONNAIRE: TSHWARAGANO PROJECT	167
APPENDIX B : QUESTIONS – INDIVIDUAL INTERVIEWS	170
APPENDIX C : FOCUS GROUP QUESTIONS	171
APPENDIX D : PERMISSION LETTER.....	175
APPENDIX E : HEUNINGVLEI CONSENT FORM.....	177
APPENDIX F : A COMMUNITY-BASED DISABILTIY PROGRAMME FOR RURAL AREAS.....	178
APPENDIX G: PRESENTER'S GUIDE	240
APPENDIX H: FACILATION AND ASSESSMENT SCALE	282
APPENDIX I : MAP OF HEUNINGVLEI.....	285

LIST OF TABLES

TABLE 1:	Summary of the research methodology.	11
TABLE 2:	Summary of the research methodology for this article	26
TABLE 3:	The potential impact of health problems and disability on a rural community.....	35
TABLE 4:	National health goals, objectives and indicators for disability management	38
TABLE 5:	Challenges for PWD in rural communities.....	43
TABLE 6:	Summary of the research methodology for phase 1.....	60
TABLE 7:	Participants' characteristics.....	69
TABLE 8:	Utilization of food gardens.....	73
TABLE 9:	Skills training required	76
TABLE 10:	Knowledge with regard to application for grants.....	80
TABLE 11:	Interview questions and main themes	83
TABLE 12:	Summary of the research methodology for this article	97
TABLE 13:	Representation of the intervention strategy.....	104
TABLE 14:	Action steps in compiling a community-based disability programme.....	105
TABLE 15:	Layout of the community-based disability programme	109
TABLE 16:	Summary of the research methodology for this article	121
TABLE 17:	Summary of the results of the focus group session.....	135
TABLE 18:	The research methodology for the study.....	149
TABLE 19:	The community-based disability programme.....	153

LIST OF FIGURES AND GRAPHIC PRESENTATIONS

FIGURE 1:	Scale of vulnerability of a person with a disability	41
FIGURE 2 :	The interrelation between poverty, health and disability.....	45
FIGURE 3:	The research process	64
FIGURE 4:	Circles of support	103
FIGURE 5:	Participants and data collection throughout this study.	125
Graphic presentation 1:	Housing distribution.....	71
Graphic presentation 2:	Water resources	72
Graphic presentation 3:	The distribution of cooking facilities.....	72
Graphic presentation 4:	Types and utilization of social security grants	74
Graphic presentation 5:	Perceived causes of poverty	75
Graphic presentation 6:	The prevalence of disabilities in the community	77
Graphic presentation 7:	The causes of disability	77
Graphic presentation 8:	The use of assistive devices (ADs) in the household	78
Graphic presentation 9:	Grant utilization	79
Graphic presentation 10:	Immunization knowledge	80
Graphical presentation 11:	Regular health check-ups	81
Graphic presentation 12:	Services required	81

LIST OF ABBREVIATIONS

NGO:	Non government organization
PWD:	People with disabilities
ISDM:	Integrated Service Delivery Model
HIV:	Human Immune Deficiency Virus
AIDS:	Acquired Immune Deficiency Syndrome
USA:	United States of America
SAPS:	South African Police Service
D & D model:	Design and Development model
RDP:	Reconstruction and Development Programme
GEAR:	Growth, Employment and Redistribution
INDS:	Integrated National Disability Strategy
STIs:	Sexually Transmitted Infections
UIF:	Unemployment Insurance Fund
ESS:	Education Support Services

SECTION A
ORIENTATION TO THE RESEARCH

1. INTRODUCTION

People with disabilities (PWD) in South Africa and even across the world have for centuries been isolated, discriminated against and hidden away in institutions. Patel (2005:174) defines disability as a physical or mental impairment that limits a person's capacity to perform one or more major life activities and states that quadriplegia, deafness and blindness are the most common disabilities in South Africa.

Quality of life, physical, psychological and environmental well-being is a crucial consideration for professionals working with PWD. It is necessary to address discrimination and inequality in its many institutional and social forms. This includes changing the skewed distribution of resources and focussing of community development, equal opportunities and a non-discriminating society. Disability awareness requires the transformation, in terms of composition, culture and focus, distribution of resources, the development of social protection, maximising of human potential, self-reliance and participating in the decision-making processes and participating in skills training and the open labour market. Essential to this are social development programmes to promote understanding, tolerance, management skills and prevention. There is a need to focus on the ability and not the disability.

This specific research project focuses on PWD in the Heuningvlei community. The first aim of this study was to explore the interrelation between poverty, health and disability, and secondly, to assess the bio-psychosocial needs of the PWD in a rural and isolated area, and finally, to develop a community-based disability programme for poverty stricken families in a rural area.

2. ORIENTATION AND PROBLEM STATEMENT

This study was conducted in Heuningvlei community in the Kgalagadi District Municipality in the Northern Cape Province (see Annexure I for map of the area). It was part of the "Tshwaragano Project" with the general aim of developing and empowering the disadvantaged communities in rural areas. The Integrated Service Delivery Model (ISDM) (South Africa, 2008:28) provides a framework for this development process and relevant to this study specifically, is the description of the poverty reduction programmes. The Tshwaragano project specifically focuses on empowerment programmes to build the capacity of the poor people living in the Heuningvlei community in order to ultimately achieve self-reliance. Deep rural communities in South Africa are usually without important resources. The roads leading to Heuningvlei are in an appalling condition,

discouraging service providers to engage with these communities. Lack of service delivery, low levels of income, high unemployment and lack of education, training and development opportunities lead to a multi-dimensional poverty phenomenon that impinges the entire spectrum of human development.

The interrelation between poverty, health and disability is confirmed by Vorster, Wissing, Venter, Kruger, Malan, De Ridder, Veldman, Steyn, Margetts and MacIntyre (2000:505) who concluded that urbanization is associated with detrimental effects of health. It includes increases in infant mortality, fertility, infectious diseases and chronic diseases. Scales and Streeter (2004: 179, 181) link extreme poverty and threats to physical and mental health, which are the top social problems afflicting developing countries. Malnutrition, chronic hunger, ill health, lack of health care facilities and of knowledge lead to high levels of various illnesses, including Human Immune Deficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and disabilities. Green (2008:178) states that people are not only particularly vulnerable to poverty when they are unemployed, but the impact of poverty also increases vulnerability to ill health.

According to De Beer and Swanepoel (2000: xvii) the challenge is to assist the community members with disabilities in creating structures for themselves to operate within. These structures must be the results of development process in order to be sustainable. The ISDM (South Africa, 2008:10) provides key principles for this development approach.

Rothman (2003:226) states that the foundation for any community empowerment programme should be that of human dignity and respect in order to overcome oppression, exclusion and discrimination. Rothman, Erlich and Tropman (2001:5) mentions the aims of community intervention strategies as establishing new community services and programmes, facilitating collaboration among them and building the capacity of grassroots citizen groups to solve community problems.

The development of social welfare forms the grassroots of this research study and intervention strategy. Lund (2008:138) describes social development as follows:

“Overall development that has as its goal the improved well-being of people, rather than economic growth itself being the primary goal; that is decisively redistributive in addressing both poverty and inequality; that recognises the need for active state intervention; and that is participatory, giving voice to all interest groups, but especially to the poor and marginalised.”

According to Lombard (2008:161), the developmental approach to social welfare embraces socio-economic rights; therefore the cornerstone of all human intervention is the Bill of Rights of the Constitution of South Africa (South Africa, 1996) which enshrines the rights of all people in the country to human dignity, equality and freedom. Lombard (2008:160) states that from the perspective of socio-economic rights one of the challenges is to ensure that all South Africans have access to social services and social security benefits through community development.

The White Paper for Social Welfare (South Africa, 1997) mentions the following factors which contribute to impaired physical functioning: unhealthy lifestyles, failed medical services, accidents, violence, war, poverty, inadequate information and poor social and environmental conditions.

The South African Department of Social Development's ISDM towards improved social services (South Africa, 2008:12) aims to address this phenomenon through the development paradigm. This paradigm is build on the following key concepts: developing social protection, maximising human potential, self-reliance and participating in the decision-making processes in order to enhance the capacity of communities to respond to their own needs. The vehicle for this process should be empowerment programmes through the utilization of strength-based approaches by specifically focussing on vulnerable and oppressed people (Gathiram, 2008:255).

Sharkey (2000:10) argues that community work should therefore focus on all groups including vulnerable groups such as older people, disabled people, carers and people with HIV or AIDS. "In order to meet the goal of economic development, the developmental approach also recognises the need for infrastructure, service provision and social support to ensure the inclusivity of disabled persons in development efforts" (Gathiram, 2008: 250).

The Terminology Committee for Social Work (1995:12) defines community development as the process of enabling people to mobilise and manage forces and resources in a community by creating opportunities. Patel and Hochfeld (2008:195) discuss the developmental approach to social welfare as part of the White Paper for Social Welfare (South Africa, 1997). Lund (2008:137) suggests that the phenomenon be attended to. The ISDM (South Africa, 2008:16) states that community development should be of a dynamic, multi-sectoral and multidisciplinary nature and will focus on the following areas:

- ☞ Facilitation of the community development process.
- ☞ Development of people-driven and community-based programmes.
- ☞ Facilitation of capacity-building and economic empowerment programmes.

Guidelines for any community development programme or intervention is outlined by the South African Department of Social Development's ISDM towards improved social services (South Africa, 2008:12, 16, 18). Suggested programmes include youth development, socio-economic programmes, moral regeneration, woman empowerment programmes, poverty reduction programmes and integrated empowerment programmes. It provides a framework and guidelines for the development process relevant to this study. Mehra (1997:137) suggests the sustainable livelihood approach, which will improve people's economic status and well-being through empowerment and improvements in their own lives.

For purposes of this study community work, as defined by Weyers (2001:20), is the primary point of reference. Two practice models (development and education) are of particular importance in this study and it will be integrated with opinions of other authors. Weyers (2001: 118) defines community development as a method, programme or strategy of process to provide direction to the development process which will contribute to human growth, unlock human potential and empower people to take responsibility for their own as well as their community system's development. Motivating community members to take responsibility and ownership of a development programme could, according to Jason, Keys, Suarez-Balcazar, Taylor and Davis (2004:4, 12), be achieved through participation research approaches, which increases citizen power and voices. They provide general principles for implementing this approach.

Development, according to Scales and Streeter (2004:182) refers to the process whereby people engage in planned efforts to change their circumstances in order to advance their quality of life. De Beer and Swanepoel (2000: xviii) provide a guideline for sustainable development and advocate that the development process should enable capacity building through which human dignity is enhanced. They continue to promote partnership working with various role-players such as NGO's, government organizations, private organizations and volunteers. Monaheng (2000:127) suggests that all the role-players should co-ordinate their efforts in order to maximize the impact of their efforts and to avoid superfluous duplication. These efforts should be based on the "felt needs" of the community or people. This would imply that the people are the experts on their needs, abilities and assistance requirements.

Lund (2008:138) and Ross and Deverell (2004:286) describe community work as an opportunity to bring services and resources to a community, which might otherwise be geographically and economically inaccessible, with the overall aim to improve the well-being of people.

Hodapp (1998: 6) provides the vehicle to warrant growth and discuss the classical developmental approach, which should ultimately result in social inclusion, personal growth through social action and fostering co-operative activity. Jason et al. (2004:44) emphasize that the community members' experience and knowledge are crucial in the development process and a needs-based community programme. They also provide crucial guidelines for a community-based programme.

Karger, Iyiani and Shannon (2007:81) remind the reader of the importance of multiple strategies which involve engaging with the relevant decision makers, at the right time, at the right level as well as working through the power differentials, and especially empowering local communities to facilitate effective development. They continue by stressing the importance of participation of the community members in order to bring them into the empowerment process. Ross and Deverell (2004:296) emphasize the importance of including the relevant community leaders in a committee who will be responsible for the leadership of the intervention programme as well as the establishment of a community action group who will be responsible for the implementation of a community-based programme.

Until the latter part of the 1900s, PWD were seen as different and a burden to society (medical model of disability). Since the rise of the rights movement, this perspective has changed and disability-related issues are now seen as the obstacles society creates for PWD (social model of disability). PWD, however, still experience discrimination, isolation and social and environmental barriers. Development, prevention, education and empowerment form the framework for the guidelines for the intervention with PWD in the Heuningvlei community.

The afore-mentioned lead to the following research questions:

- What is the interrelation between poverty- health-, and disability?
- What are the bio-psychosocial needs of the Heuningvlei community with regard to a community-based disability programme?
- What should be included in a community-based disability programme for the Heuningvlei community?
- How effective was the implemented community-based disability programme?

3. AIMS AND OBJECTIVES

3.1 Aim

- ☞ To develop and evaluate a community-based disability programme for poverty stricken families in a rural area.

3.2 Objectives

- ☞ To explore the interrelation between poverty-, health-, and disability within a rural resource restricted community.
- ☞ To do a situation analysis in the Heuningvlei community to assist in the development of a community-based disability programme.
- ☞ To develop and implement a community-based disability programme.
- ☞ To evaluate the community-based disability programme.

4. CENTRAL THEORETICAL ASSUMPTION

A community-based disability programme can improve awareness, empowerment and support with regard to disability issues in a rural community.

5. THEORETICAL PERSPECTIVE

The following theoretical frameworks shaped the development of the community-based disability programme and were utilized during the literature study as well as during the implementation of the intervention programme.

- ☞ Empowering social work practice which promotes and utilizes human resources (Marti-Costa & Serrano-Garcia, 2001:267).
- ☞ The community development-, community education-, social- and relation models have been utilized (Weyers, 2001:148, Wilson, 2005:24, 240, The White Paper for Social Welfare, South Africa, 1997:6).
- ☞ The systems theory (Zastrow & Kirst-Ashman, 2007:12).
- ☞ The strengths theory (Long, Tice & Morrison, 2006:44).

6. DESCRIPTION OF CONCEPTS

The following descriptions of terms directed this study:

Community

The community is the territorial organization of people, goods, services and commitments. It is an important subsystem of the society, and one in which many locality-relevant functions are carried out (Rothman, Erlich & Tropman, 2001:10).

Community-based disability programme

For the purpose of this study community-based disability programme is defined by the researcher as a community-based programme that will focus on the challenges of people with disabilities through capacity building, functioning skills and social education. This programme will equip the community members with knowledge, insight and skills to prevent, manage and support disability-related issues in the Heuningvlei community.

Community development

The process which through consciousness-raising, promotes and utilizes human resources, leading to the empowerment of individuals and communities so that they can understand and solve their problems (Marti-Costa & Serrano-Garcia, 2001:267).

Disability

A physical or mental impairment that limits a person's capacity to perform one or more major life activities (Patel, 2005:174).

Health

The capability of people to fulfil certain roles and activities in the ideal state of physical-, social- and mental well-being (Laverack, 2005:19).

Poverty

Poverty can be defined as the inability to attain a minimal standard measured in terms of basic consumption need or the income required satisfying members of the family. Individuals, families and groups can be said to be in poverty when they lack the resources to obtain the types of diet, participate in the activities and have the living conditions and amenities which are customary or at least widely encouraged or approved in societies to which they belong (The White Paper for Social Welfare, South Africa, 1997).

7. RESEARCH METHODOLOGY

Research methodology, according to Fouché (2005:118), includes “a description of the specific techniques to be employed, the specific measuring instruments to be utilized and the specific series of activities to be conducted in making the measurements”. The research methodology of this study consisted of the preliminary exploration, the literature study, the utilization of experts, the initial exploration study and the empirical research.

7.1 PRELIMINARY EXPLORATION

The empirical investigation includes a preliminary exploration in order to gain a holistic view of the phenomenon. This process assists in the identification of obstacles at an early stage and thus provides the researcher with an opportunity to make the necessary adjustments and changes. Strydom (2000:43) provides some guidelines with regard to this investigation, namely:

- ∞ Analysis of literature
- ∞ The utilization of experts
- ∞ The initial exploration study
- ∞ An intensive study of the strategic aspects

In this study all four methods were utilized. The study included intensive research material which was gained from the literature study and local experts' opinions were utilized during the initial inquiries into the community's needs and challenges as well as during the evaluation phase of the project. An initial exploration study through the utilization of existing research materials, as well as an intensive study of the disability specific needs in the community, completed the process.

7.1.1 Analysis of the literature

According to Delport and Fouché (2005:261), the first step is to conduct a literature study in order to select an appropriate paradigm for the study. This paradigm can then be explored by consulting various resource materials such as relevant textbooks, journals, completed research projects and data bases.

A collection of local and international books, scientific journals, theses and previous research were consulted. Data bases utilized to identify applicable literature included EBSCO Host, Academic Search Premier, CINAHL, Emerald, Health Source: Nursing/Academic Edition, Master File Premier, MEDLINEA, ProQuest and PsycINFO.

7.1.2 The utilization of experts

The utilization of experts in this study contributed to the understanding of the practical and technical challenges of the project (Strydom, 2000:51). The researcher consulted with community experts, including the school principal, a member of the peace corps from the United States of America (USA), registered nurses, religious leaders, elderly community leaders, the Chief and his royal family members, members of the South African Police Service (SAPS) and a few community members with disabilities.

The researcher also consulted with a psychologist, social worker, nurse, multi-professional team co-ordinator (United-Kingdom) and a communications officer of the SAPS. Each person is an expert in his/her field and contributed to the understanding of the phenomenon.

7.1.3 The initial exploration study

The researcher has been working as a social worker for the Disability Team (Essex County Council) in the United Kingdom for several years. This involved the support and care of any person with a disability and their family. The researcher gained valuable information through various disability-related training courses as well as experience through direct contact with and assessment of the PWD and their families. Based on the systemic therapy principles, the inclusion of family members or caretakers of the person with a disability is crucial, since no person can function in isolation. Every human being is part of a system and a person with a disability is often dependent of these systems. Unger and Powel (1991:1) remind the reader that these support systems cannot fulfil their nurturing role without assistance. "Families require environments which support and strengthen their ability to serve as healthy, care-giving systems." Without support, research indicated that some carers felt that their own physical health had declined over the years due to the responsibilities, physical strains and stresses associated with care-giving (Schofield, Bloch, Herrman, Murphy, Nankervis & Singh, 1998:27).

Strydom (2000:51-52) explains that this initial exploration study and practical experiences are beneficial to the overall study. However, disability issues within the South African context, and indeed rural South Africa, is altogether a unique phenomenon. This has been explored through additional interviews with community members with disabilities in the Heuningvlei community as well as an in-depth literature study on the challenges, legislation and resources available to PWD in South Africa. Valuable information with regard to the challenges for PWD was also gained through work experience as Disability Co-ordinator in the SAPS.

7.2 Empirical investigation

The empirical investigation included the exploratory research design, the population and sample selection, data collection instruments, procedures and ethical aspects.




7.2.1 Research design

Both the exploratory and descriptive research designs were utilized including quantitative and qualitative methods (Delpont, 2005:159-191; Fouché, 2005:267-285). This combined methods approach contributed to the triangulation of data (Creswell, 2009:213) – a combination of qualitative and quantitative research methods, as described by Henn, Weinstein and Foard (2006:19). A further advantage of mixed methodology is that it offers more rigor, breadth and depth to any investigation.

The quantitative research design utilized for this study was the single-system design which is the ideal way to evaluate the effectiveness of treatment interventions (Strydom, 2005:145).

Table 1 provides an overview of the research methodology of the study as a whole.

TABLE 1: Summary of the research methodology.

<p>PHASE 1</p> 	<p>Literature study</p> <p>Conducting individual interviews with community expert and relevant role-players.</p> <p>Pilot testing the questionnaire with 2 community members.</p> <p>Survey: Doing a situation and needs analysis with community members with disabilities.</p>
<p>PHASE 2</p> 	<p>Pilot testing the programme with 3 community members.</p> <p>Programme implementation.</p>
<p>PHASE 3</p> 	<p>Pilot testing the interview schedule with 2 community members.</p> <p>Evaluating the programme through a focus group session with experts and local key role-players and the Facilitation Assessment Scale (FAS).</p> <p>Advanced development and dissemination.</p>

During this study the intervention research, the design and development (D&D) model was utilized as discussed by De Vos (2005a:394). In phase one of this study an in-depth literature study was conducted, which formed the basis of this study. Individual interviews (pre-programme implementation) with experts and significant role-players were utilized to establish the departing point of the intervention process. Questionnaires were utilized to do a situation and needs analysis in phase two. Phase three consisted of a focus group interview with key local community members (post-programme implementation). The focus group participants (significant role-players and key figures) were identified during phase one of the research project. This group was utilized to evaluate how effective the implemented programme was, as suggested by Rossi, Lipsey and Freeman (2005:7).

7.2.2 Population

The Heuningvlei community consists of approximately four thousand households. The Tshwaragano project had already selected a non-probability sample population of a total of two hundred and fifty-four households from the Heuningvlei community in the Kagisano Municipal district. Exploratory questionnaires were completed with this sample population utilized during this study with the aim of compiling a community profile. The sample population for disability-related issues were selected through the non-probability, snowball method (Strydom, 2005a:203).

7.2.3 Data collection instruments

- ☞ In this study, a disability specific questionnaire (Appendix A) with open and closed-ended questions was utilized in order to assess the bio-psycho-social needs of the PWD in the Heuningvlei community. Initial individual interview sessions (Appendix B) with key role-players in the community during the initial phase of the study as well as an evaluative focus group session (Appendix C), (with same key role-players utilized during the final phase of the study) were utilized to elicit data. The Facilitation and Assessment Scale (FAS) (Appendix H) was utilized to evaluate the community-based disability programme.

7.2.4 Procedures

- ☞ The researcher obtained permission from the Chief of Heuningvlei and his tribal council to conduct this research project in their village (Appendix D).
- ☞ The participants were prepared by explaining the nature and goal of the research.

- ∞ Confidentiality was emphasized and respected.
- ∞ A written consent form was signed by every participant in order to prove that all participation in this project takes place on a voluntary basis (Appendix E).
- ∞ Individual interviews were conducted with key role-players in the community.
- ∞ The questionnaires were pilot-tested.
- ∞ The disability questionnaires were distributed to each household in the sample population of the Heuningvlei community.
- ∞ The data was processed.
- ∞ A community-based disability programme (Appendix F) and a presenter's guide (Appendix G) was implemented.
- ∞ The impact of this programme was reviewed and evaluated through the FAS (Appendix H) and a focus group session with the local key role-players. (Appendix C).
- ∞ Research report was presented in written format.
- ∞ Written feedback to Chief Bareki and the Heuningvlei community.

7.2.5 Ethical aspects

Ethical permission has been granted by the Ethics Committee of the North-West University (Potchefstroom Campus) with ethical application number: 06k07, Tshwaragano Project. The necessary permission has also been attained from the Heuningvlei Chief. Henn et al. (2006:81) emphasizes that social research can harm an individual in different ways. Strydom (2005(b):59) states that informed consent is extremely important and that special attention should be given to people with lower status and less power than the researcher, as they may feel compelled to participate. The goal of the research project must be clear and transparent and the researcher must inform the respondents of the potential consequences of participating in the research. It was made clear to the participants that participation was voluntary and that they could withdraw from the study at any stage. Harrison and Wise (2005:20) suggest that the researcher should respect the participants' decisions and choices. With this in mind, the participants were informed about all aspects of the research project and written consent forms were signed in advance. Henn *et al.* (2006:67) discuss the reasons for written consent. All information was kept confidential and anonymous and all the respondents were informed of the results of the research project. Debriefing sessions were offered to the group members if needed.

7.2.6 Data-analysis

During the data-analysis the information gathered from both the qualitative and quantitative methods were brought together in order to gain a holistic picture of the results of the research project. The qualitative data obtained from the interviews and focus groups were analyzed by means of Tesch's approach to data analysis (Poggenpoel, 1998:343-344). Central themes were identified and categorized.

The quantitative data were analyzed and interpreted in consultation with the Statistical Consultation Services of the North-West University (Potchefstroom Campus). The overall results of the research project were interpreted and presented in graphic format.

8. RESEARCH LIMITATIONS

The following limitations were experienced during this research:

- ☞ A major challenge which was identified during the evaluation process is the lack of support and endorsement from Chief Bareki and his representatives. As part of the focus group interview session, certain key role-players/experts were invited to participate in the evaluation process. However, due to the lack of communication and involvement of the Chief and community leaders, a large group of community members requested to attend the interview session in order to understand the intervention process in their community.
- ☞ Another challenge identified is the lack of partnership working and community resources. The Department of Health, for example, could play a significant role through the promotion of primary health care services such as healthy nutrition, safe water supply, basic sanitation, maternal and child care, family planning, immunisation, prevention and control of endemic disease, chronic diseases and the prevention of disabilities. The Heuningvlei community does have local clinics, but these clinics are extremely under staffed and no doctor currently delivers any medical care in this area. The community members have to travel a great distance to the nearest hospital. The Department of Social Development's Social Worker has not visited this area in several years.
- ☞ The fourth challenge is access to disability grants. A small portion of the PWD in the Heuningvlei community does receive Disability grants, but a large portion of the PWD indicated that they are not aware of how/where/when to apply for this grant. They also indicated that no advisors/social workers are available to assist them with the application process.

- ☞ The fifth challenge is the lack of assistive devices (AD) and the lack of a medical practitioner to assess their disabilities during the application process.
- ☞ The sixth challenge is the lack of specialized schooling for PWD in this community.
- ☞ The seventh challenge is the lack of employment opportunities and the lack of skills training available.
- ☞ The eighth challenge is the lack of recreation activities in the community.

9. CHOICE AND STRUCTURE OF THE RESEARCH REPORT

The research results are presented in article format. The final report comprises the following sections:

SECTION A: *ORIENTATION AND METHODOLOGICAL OVERVIEW*

This section will cover the actuality of the research, aims and objectives, theoretical assumption, limitations of the research, the research design and procedure, definitions of key terms and presentation of the research results.

SECTION B: *THE JOURNAL ARTICLES*

Article 1

Provisional title: “The interrelation between poverty, health and disability in a rural community.”

Intended journal: Social Work/ Maatskaplike Werk

Article 2

Provisional title: “Developing a community-based disability programme: results of a situation-analysis in a rural community.”

Intended journal: The Social Work Practitioner-Researcher.

Article 3

Provisional title: “A community-based disability programme for rural areas.”

Intended journal: Social Work/ Maatskaplike Werk

Article 4

Provisional title: "The evaluation of a community-based disability programme for rural areas."

Intended journal: Social Work/ Maatskaplike Werk & The Social Work Practitioner-Researcher.

SECTION C: *CONCLUSIONS AND RECOMMENDATIONS*

SECTION D: *APPENDIXES*

SECTION E: *CONSOLIDATED BIBLIOGRAPHY*

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SECTION B
ARTICLES

L Pretorius is a PhD student in the Subject Group Social Work, School for Psychosocial Behavioural Sciences, at the North-West University (Potchefstroom Campus)

A.G. Herbst (PhD) is a Senior Lecturer in the Subject Group Social Work, School for Psychosocial Behavioural Sciences at the North-West University (Potchefstroom Campus)

C.C. Wessels (PhD) is a Senior Lecturer in the Subject Group Social Work, School for Psychosocial Behavioural Sciences at the North-West University (Potchefstroom Campus)

ARTICLE 1

**THE INTERRELATION BETWEEN POVERTY, HEALTH AND
DISABILITY IN A RURAL COMMUNITY**

ABSTRACT

This article focuses on the concept “disability” as social construct in poor rural communities and is explored through a comprehensive literature study. The aim of this article was to gain a holistic view with regard to the interrelation between poverty, health and disability. Poverty is a perturbing phenomenon with various psychosocial and economic implications for PWD (People with Disabilities) in a resource-restricted, rural community. Poverty implies the lack of basic resources and the ability to fulfil the most basic human needs. It also results in limited opportunities, choices and development. Disability, as a social construct and social oppression on the basis of physical and mental impairment limits a person’s capacity to perform major life activities. The impact of disability on a person includes discrimination, disadvantages, restrictions and exclusion. Health factors could be linked to the above-mentioned concepts on the basis that for PWD in poor rural communities to cope with a disease, illness or disability, they need to be strong, healthy, and resilient, with access to the necessary community, social and personal resources.

KEYWORDS:

∞ Poverty, health , disability, rural community, community-based intervention

1. INTRODUCTION

This study is part of the Tshwaragano community development project which was started in the Heuningvlei community in the Kgalagadi District Municipality in 2006 when Heuningvlei was still part of the North West Province. Since 2007, Heuningvlei was moved to the Northern Cape Province. (See Appendix J for map of the area.)

This community was founded by the son of the original Chief Bareki from Kwa-Zulu Natal. He was sent to this area to explore it. He found several small villages, but the people were terrified of the wild animals in this area. He was the only person who owned a gun and killed several of these wild animals. The people were so impressed with him, that he became the Chief of this area. He became Chief Bareki II. Today the Heuningvlei community consists of the following villages; Heuningvlei, Shalaneng, Tsilwane, Kome, Perth, Klein-Avon, Klein-Effel, Madibeng, Ganap, Loopeng (See Annexure 1 for a map of the area).

The Heuningvlei community consists of approximately four thousand households, with people living in absolute poverty. This community is extremely isolated and in desperate need of support and development programmes. Disability and poor health can be seen as some of the consequences of poverty in poor communities. In this article poverty, health and disability-related issues will be explored through a comprehensive literature study. This literature review forms the basis for further intervention in this community and explores disability as social construct in poor rural communities.

2. PROBLEM STATEMENT

Limited literature exists on the interrelation between poverty, health and disability, but the interrelation between these aspects is undisputed. Vorster, Wissing, Venter, Kruger, Kruger, Malan, De Ridder, Veldman, Steyn and Margetts (2000:505) studied the differences in physical, physiological and mental health of Africans in the North West Province and the results indicated major differences in the health and general well-being of people living in rural areas and people living in urban areas. People in rural areas were found to lack knowledge concerning safe sex and primary health care, foetal malnutrition, childhood stunting, inactivity and nutritional facts.

Poverty in South Africa is an alarming reality and the result of this phenomenon is that families struggle to survive in very difficult circumstances. A report on poverty reveals that 71% of the poor population in South Africa lives in rural communities with the minimum resources available for utilization (Msindisi, 2000:5; Wessels, 2003:61). Women and children, people with special needs (the elderly and PWD) and those living in rural areas,

are most at risk (South Africa, 1997) and are categorized by Smart (2003: 3) as vulnerable. Since 1994 the government has formulated various policies to address inequities. These policies focus on empowering previously disadvantaged groups, including women, children and PWD. These policies are contained in various policy documents such as the Reconstruction and Development Programme (RDP), Growth, Employment and Redistribution (GEAR) and the Integrated National Disability Strategy (INDS).

The focus of this research project is PWD as a disadvantaged group, residing in a rural community. The data collected in Census 2001 indicated that there were 2 255 982 people with various forms of disability in South Africa. This number constituted 5% of the total population enumerated in this census (South Africa, 2001: 9). About 53% of the households headed by PWD lived in permanent houses (house or brick structure. However, a significant proportion of households headed by PWD (22%) lived in traditional types of dwellings/ huts or structures made of traditional materials with only a few with access to piped water. The most disadvantaged households headed by PWD were those enumerated in Eastern Cape and KwaZulu-Natal, where only 42% and 49% respectively used electricity for lighting. The figures with regard to access to schooling indicate that the PWD were relatively disadvantaged compared to the rest of the population. The differences were more pronounced for PWD between ages 6 and 18 years, whereas in most cases the figures were, on average, 10% lower than those of non-disabled persons.

These statistics refer to related concerns which place PWD in the "vulnerable" client group. Vulnerable client groups of the community are, according to the ISDM (South Africa, 2008a:27), people infected with and affected by HIV or AIDS, people with disabilities and those who have special needs. Guidelines provided by the Policy on Disability (South Africa, 2008b:9) state that the Department of Health (DOH) will remain responsible for the provision of appropriate health care to PWD, but from a developmental social services approach, the DOH and the Department of Social Development (DSD) will have to work in close collaboration in providing identified services. Guidelines for the identified services are also provided.

Children living in rural areas or in informal settlements are the most vulnerable to disablement and HIV or AIDS, more so as facilities for early detection, diagnosis and support are inadequate. "Inadequate facilities inevitably lead to an increase in both the extent and the severity of disablement" (South Africa, 2008b:13, 14).

Blank and Burau (2004: x) argue that health care should be viewed in a broader social context and demonstrate its interdependence with factors such as economic inequalities,

environment and social services. They continue the discussion and state that health promotion and disease prevention should be tied to populations rather than to individuals, through income distribution, public services, housing, social conditions and the environment. The White Paper (South Africa, 1997:15) mentions the following factors which contribute to impaired physical functioning: unhealthy lifestyles, failed medical services, accidents, violence, war, poverty, inadequate information and poor social and environmental conditions. Due to the limitation with regard to these community resources for communities residing in poor and rural areas, community-based interventions are crucial.

Lombard (2008:154) points out that awareness with regard to general health, the causes of disabilities, government grants and resources needs to be increased. These factors will be included in the exploration of the interrelation between poverty, health and disability.

The afore-mentioned leads to the following research question:

- ☞ What is the interrelation between poverty, health and disability?

3. AIM AND OBJECTIVE

3.1 AIM:

- ☞ This article aims to explore the interrelation between poverty, health and disability within a rural, resource-restricted community.

3.2 OBJECTIVE:

- ☞ To explore and to establish the interrelation between poverty, health and disability as social constructs in a rural community.

4. ETHICAL ASPECTS

Ethical permission for this study was granted by the Ethics Committee of the North-West University (Potchefstroom Campus) with approval number 06k07, (Tshwaragano Project). The necessary permission has also been attained from the Heuningvlei Chief, Chief Bareki. Overall ethical aspects kept in mind during this study included that the goal of the research project must be clear and transparent and the researcher must inform the respondents of the potential consequences of participating in the research. It was made clear to the participants that participation is voluntary and that they could withdraw from


the study at any stage. With this in mind, the participants were informed with regard to all aspects of the research project and written consent forms were signed in advance (Henn, Weinstein and Foard, 2006:67). All information was kept confidential and anonymous. All the respondents will be informed of the results of the research project. The researcher is aware that many of the ethical issues raised are extremely complex and careful consideration of both context and principle is needed.

5. RESEARCH METHODOLOGY

The research methodology includes the description of the specific techniques, measuring instruments utilized as well as the specific series of activities conducted (Fouché 2005:118). In this article the method of investigation is a literature study.

Table 2 supplies an overview of how this model was applied for phase 1 in this study.

TABLE 2: Summary of the research methodology for this article

<p>PHASE 1</p> 	<p>Literature study</p>
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This article involves the literature study mentioned in Phase 1 and will be described in more detail.

5.1 Phase 1 - Literature study

The analysis of literature forms the foundation of this part of the study and will be the main focus of this article. A literature review assists the process of relating the research problem to the existing theory (Royse, 2004:40). According to Delport and Fouché (2005:261), the first step is to conduct a literature review in order to select an appropriate paradigm for the study. This paradigm can then be explored through the consultation of various resource materials such as relevant textbooks, journals, completed research projects and data bases. A collection of local and international books, scientific journals, and previous research were consulted.

5.2 EMPIRICAL RESEARCH

In this section the research model, design, the population and sample selection, data collection instruments, procedures and ethical aspects will be discussed briefly.

5.2.1 Research model

This study is based on the intervention research model (D & D model) (De Vos, 2005a: 394-407) consisting of three phases. The first part of phase one (literature study) was conducted during this part of the study.

5.2.1.1 Phase 1: Problem analysis and project planning

A social problem is a condition affecting a significant number of people in ways considered undesirable and about which something could be done through collective action (De Vos, 2005a:395-398). This phase comprises the following steps:

- ☞ Linking with an existing community research project which required a disability-related focus and intervention
- ☞ Gaining permission for this project from the local Chief of Heuningvlei and his tribal council to undertake research in the Village.
- ☞ Utilizing the existing research information in order to compile a community profile and an interview schedule.
- ☞ Identifying disability-specific concerns of the community members with disabilities and their caretakers through a disability-specific survey
- ☞ Testing the interview schedule with people not included in the sample to maximize the level of reliability and validity of the instrument.
- ☞ Analysing the identified problems presented by the community members
- ☞ Setting goals and objectives for the study

5.2.1.2 Information gathering and synthesis

In order to successfully address a social dilemma it is important to gain a holistic view of the phenomenon, including existing research and intervention projects, current community resources utilized and possible intervention models (De Vos, 2005a:398 – 400). The steps for this phase are as follows:

- Utilizing existing information sources and research materials
- Identifying possible social work models of intervention
- Identifying useful community resources and possible partnerships for this study

5.2.2 Research design

The research design can be described as the blueprint of the study which includes all aspects of the study from the conceptualization of the problem right through to the dissemination of findings (Babbie & Mouton, 2001:55; Grinnell, 2005:547). The single-system quantitative research design was utilized for this study and guidelines for this design are provided by Strydom (2005c:148). Both exploratory and descriptive qualitative designs were used.

The research approach for this study includes quantitative and qualitative methods (Delpont, 2005:159-191; Fouché, 2005:267-285). The Concurrent Triangulation approach as discussed by Creswell (2009:213) was utilized. Creswell (2008:7) describes the mixed methods approach as a process that involves collecting, analyzing and integrating quantitative and qualitative research in a single study. The purpose of utilizing this research design is to gain a more holistic understanding of a specific phenomenon/a.

5.2.3 Sampling and research participants

The research participants were members from the Heuningvlei community in the Kgalagadi District of the Northern Cape Province. Bless and Higson-Smith (2000:85) refer to the research participants as the population – as the set of elements the research focuses on and to which the obtained results should be generalized. A sample of respondents was selected from within this population. Sampling is the process of selecting observations (Rubin & Babbie, 2005:241). Existing data elicited through systematic sampling from a total of two hundred and thirty households from Heuningvlei village (thus one participant per household) were utilized in order to compile a community profile. This included every fifth household in the row/street. The first house in the row/street served as the starting point. Questionnaires were completed with this sample population and were utilized during this study with the aim of compiling a community profile.

In this particular study snowball sampling was utilized to gain disability-specific information from the community members with disabilities in the Heuningvlei community. A total of 150 respondents were selected, who completed disability-related questionnaires.

5.2.4 Data collection

In this study, a disability-specific questionnaire (Appendix A) with open and closed-ended questions was utilized in order to assess the bio-psychosocial needs of the PWD in the Heuningvlei community. This questionnaire was utilized to gain disability-specific information for this study. The main objectives were to establish the accessibility of social security grants (disability grant), the respondents' knowledge with regard to the importance of timely immunizations and health care in order to prevent disabilities and the utilization of the disability grant and assistive devices (AD's) in the community. The final question focused on the respondent's specific needs with regard to community resources, employment, skills development and social work intervention.

5.2.5 Data analysis

Data analysis was based on the content analysis and it was carried out by the Statistical Consultation Services the North-West University, Potchefstroom Campus.

6. POVERTY, HEALTH AND DISABILITY IN CONTEXT OF THIS STUDY

Poverty, health- and disability-related issues in a rural area need further exploration in order to gain a holistic view of the interrelation between the three constructs. In this section each construct will be discussed in terms of relevant terminology, bio-psychosocial aspects/implications, the impact on a rural community and suggested strategies to deal with the three constructs.

6.1 POVERTY

Poverty is a perturbing phenomenon with various bio-psychosocial and economical implications. Frank (2003:21) mentions that Africa is characterized by deep economic and social division, a rapidly changing environment, and a population that is under severe pressure due to poverty, crime, HIV and AIDS, amongst others.

6.1.1 Terminology

Poverty is defined as a condition in which people are inhibited from participation in society because of a serious lack of material and social resources. Poverty is defined in two categories, namely absolute and relative poverty. **Absolute poverty** refers to conditions that will not sustain physical life as individuals and families are not able to meet the

minimum needs of food and shelter. **Relative poverty** refers to the lack of resources to obtain the minimum standard for living conditions as set by a specific society or community (Pierson & Thomas, 2006:411).

6.1.2 The bio-psychosocial aspects and implications of poverty

Poverty means more than a lack of basic resources or the ability to fulfil the most basic human needs for shelter, warmth and food. It also results in the denial of opportunities, choices and development. Ellis and Freeman (2005:333) state that poverty in rural areas is largely due to the depletion of assets people rely on for their livelihood.

To understand the impact of poverty on South Africa and the people, it is important to view the impact on the country as a whole. "Poverty remains one of the greatest challenges facing Southern African countries" (Patel, 2005:51). She continues to describe the phenomenon and mentions that 70% of the population in Southern African countries live below the international poverty line of US\$2 per day. She also categorises children, PWD, woman, rural communities, youth and those that have been displaced, as "poor". Osei-Hwedie (2007:106) adds to the afore-mentioned by stating that many people still remain ill-fed, ill-housed, under-educated and defenceless to preventable diseases. Basupeng (2002:1) discusses the causes of poverty and Green (2008:177) states that poverty should be the main socio-economic concern to be addressed in South Africa.

6.1.3 The impact of poverty on a rural community

Scales and Streeter (2004:179) describe the impact of extreme poverty on a rural community by stating that poverty is a threat to physical and mental health - the top social problems afflicting developing countries. Malnutrition, chronic hunger, ill health and lack of health care facilities and knowledge lead to high levels of illnesses, including HIV and AIDS and disabilities. Blank and Burau (2004:201) state that people from poor communities often face more exposure to air pollution, poor water, ambient noise, sub-standard housing and overcrowding. Vorster, Venter, Wissing and Margetts (2005:488) state that low nutrient intakes are linked to higher levels of distress, anxiety, anger, hostility, depression, self-consciousness, impulsiveness and vulnerability.

Green (2008:178) emphasizes that poverty increases vulnerability to ill health. Chenga and Cronjé (2007: 144) discuss the "Family stress model" which focuses on the stresses of poverty. They mention some of these stresses on families and state that some women, in order to earn an income to feed themselves and their families, even take up sex work or offer their children to men in order to get continuous financial support. This may result in an increased risk for HIV and AIDS and other sexually transmitted infections (STIs). STIs

can lead to disabilities and HIV and AIDS are leaving many children without parents. Child- and/or grandparents are taking the caring responsibility for families, negatively impacting on the mental health of these families.

These changes have removed the traditional support systems that existed in the society, leading to an increase in moral degeneration, teenage pregnancies, HIV and AIDS occurrence, child neglect, child abuse, malnutrition and extreme poverty.

6.1.4 Suggested strategies to deal with poverty in South Africa

To address the growing poverty dilemma, the government has introduced social security programmes, known as social assistance. Social assistance consists mainly of social grants including maintenance, disability, foster care, single care and social pension grants. Vorster and De Waal (2008:235) discuss social security and the importance of the utilization thereof. Patel (2005:122) agrees with the importance of social security for reducing poverty and insuring the minimum standard of living for all people. The provision of social security ensures the protection of individuals who have been exposed to contingencies beyond their control. They are unable to utilize the available resources and they live below the acceptable standard of living.

Patel (2005:129, 137) discusses the current social assistance or social grants paid to older people (state old age pensions), PWD (disability grants), caregivers of children with disabilities (care dependency grants), persons with a physical or mental condition requiring regular attendance by another person (grants-in-aid), caregivers of children up to the age of 14 years (child support grants), foster children (foster care grants), war veterans (war veterans grant) and social relief of distress grants. She further discusses the unemployment insurance fund (UIF), which has been implemented in the event of temporary unemployment in the event of illness, maternity leave, adoption and termination of employment.

These grants provide support and care in the community, but are clearly not sufficient; the consequences of unemployment in South Africa are too overwhelming. A more comprehensive approach is needed to address unemployment, education, training and skills development and to reduce poverty and inequality. Patel (2005:147) suggests that social security and social policies should be complemented by a wider range of social and community development activities and should build on indigenous and informal systems of care. Martí-Costa and Serrano-García (2001:267) define community intervention and development as a community development process which empowers individuals and communities through awareness, promotion of fair and equal participation and utilization of resources to understand and solve their own problems.

With regard to his research in the Heuningvlei community, Motshedi (2009:40) states that it is concerning that almost the entire community are dependent of Social Security grants. Community-based intervention would provide the community members of the Heuningvlei community with the necessary access to information, social and moral support as well as prevention and management strategies.

6.2 HEALTH

According to Ross and Deverell (2004:4) a holistic approach should include aspects of social, human and behavioural sciences as it is devoted to understanding the psycho-social influences on how people stay healthy, why they become ill and how they respond when they do get ill.

6.2.1 Terminology

Laverack (2005:1, 19) defines health as a subjective concept and its interpretation as relative to the environment and culture in which people find themselves. However, he describes public health as an approach that aims to promote health, prevent disease, treat illnesses, prolong valued life, care for the infirm and provide accessible health services to all people. For purposes of this study, **health** can be defined in functional terms as the capability of people to fulfil certain roles and activities, rather than the absence of disease.

6.2.2 The bio-psychosocial aspects of health

According to Ross and Deverell (2004:4) the mono-causal model of disease and health has been replaced by a multi-causal or multi-factorial approach. This multi-factorial approach includes characteristics such as physique, metabolism, behaviour such as smoking, drug taking, unsafe sexual practices, personality, family structure, working environment, socio-economic status, education, diet and lifestyle as possible causes of illness, disease and disability.

6.2.2.1 Biological aspects

A very common ill health factor associated with disability is a stroke or cerebral vascular accident, which occurs when the blood supply to the brains cells is cut off. Ross and Deverell (2004:134) state that a stroke not only affects the physical aspects of a person's life, but could also have a dramatic effect on all areas of a person's life. Physical problems could include pain, nausea, loss of bowel and/or bladder control, hemianopia, agnosia, hemiplegia and apraxia.

Patel (2005:52) gives an example of the interconnectedness of health, illness, risky behaviour and coping mechanisms. She debates that diseases such as cholera, HIV and AIDS, malaria and tuberculosis are impacting negatively on the welfare of the people. Risky sexual behaviour could lead to several STIs, HIV and AIDS, unwanted pregnancies and even disabled children due to certain genetic disorders. Marlatt (1998:70) also describes some risk factors and mentions alcohol abuse as being interrelated to accidents, unsafe sexual behaviour, attempted suicide, liver disease, cardiovascular complications, stroke, cancer and neurological complications. All these long-term illnesses have the potential to lead to disabilities.

Riddell and Watson (2003:58) state that old age is often associated with the onset of impairment and ill health. Older people are no longer able to perform certain duties or tasks without assistance. Howes (2007:179) mentions that old age is accompanied by declining physical ability and health, the loss of a life partner, family and friends and changes in economic status. Investing in older people's health is crucial, although this transition period cannot be avoided.

One public health factor which is very important to point out is the significance of the lack of housing and poor bathing and hygienic facilities which puts people, particularly children, at serious health risk. Sub-standard housing is also closely related to house fires and accidents (Blank & Burau, 2004:195).

6.2.2.2 Psychosocial aspects

The psychosocial aspects of health firstly include the abilities and resources of individuals to deal with illness and other health-related issues, and secondly involve the psychological and social aspects that contribute to an individual's health. Health can therefore be interpreted as a subjective facet and a phenomenon one could cope with – a disease or illness providing one has the personal strength, resources and resilience. The coping model suggests that one can be healthy even if one is diseased or ill providing one has the personal strength and resilience to cope with life (Blank & Burau, 2004:52, 200).

The second aspect is the psychological, economical and social determinants of health. The economical determinants include lack of public transport, lack of resources, lack of education and social and physical barriers. This further contributes to the isolation and depression experienced by this group (South Africa, 1997:44). Blank and Burau (2004:200) also mention that people from lower economic backgrounds generally work and live in less healthy environments. This group faces more exposure to air pollution, poor water, ambient noise, sub-standard housing and overcrowding. They also mention culture as an important link to health. They state that often the culture of the lower classes

leads to multiple high-risk behaviour, which could lead to poor health. They mention smoking, alcohol and drug abuse, violence, obesity and poor diet. People with a higher income are able to afford medical resources; thus preventing serious and long-term illnesses and disabilities. Income is closely linked to employment. "Unemployment can influence health by reducing income level and standard level" (Blank & Burau, 2004:202). They also mention that unemployment is linked to lower self-esteem, psycho-social stress and mental ill health.

Psychological determinants include the onset of deafness due to old age. Ross and Deverell (2004:178) discuss the traumatic occurrence of profound deafness caused by deterioration and old age. The consequences are isolation, fatigue from effortful communication, anxiety and depression. Problems include voice problems, articulation errors, cognitive, emotional and social development adjustment problems and frustration.

Ross and Deverell (2004:134) also discuss the fact that communication problems could result in the loss of comprehension and impaired speech which could lead to emotional problems and could include anxiety, tearfulness, emotional overreaction, anger, frustration, hostility, aggression, irritability, hopelessness, withdrawal, rejection, lowered self-esteem and depression.

Based on the above-mentioned aspects of health, it is evident that any person with a disability in a poor, rural community is vulnerable and will benefit from intervention and support.

6.2.3 Health in rural communities

It is agreed that poverty, disability and health problems in a rural, poor community is a reality and a challenge for the South African government and Non-government organizations and a huge challenge for any community development worker. Poor health influences individuals, families and communities and the impact thereof is illustrated in Table 3.

TABLE 3: The potential impact of health problems and disability on a rural community

<p>Potential impact on the individual</p>	<ul style="list-style-type: none"> ☞ Low self-esteem ☞ Reduced well-being ☞ Lack of ability to perform one's daily tasks ☞ Stress, anger, depression & low self-esteem ☞ Increased malnutrition & starvation ☞ Loss of health status ☞ Loss of employment opportunities ☞ Loss of educational opportunities ☞ Forced migration ☞ Homelessness ☞ Crime ☞ Isolation & discrimination ☞ Vulnerability to HIV, AIDS & STIs ☞ Poverty
<p>Potential impact on families and households</p>	<ul style="list-style-type: none"> ☞ Lack of family support ☞ Lack of community/friends support ☞ Changes in family roles and responsibilities ☞ Lack of income ☞ Forced migration ☞ Demoralization, resentment & anger ☞ Long-term pathologies – depression, trauma ☞ Stress, low self-esteem and conflict ☞ Discrimination & isolation ☞ Lack of health care ☞ Vulnerability to crime & violence ☞ Lack of education ☞ Poverty ☞ Low literature levels

Potential impact on communities	<ul style="list-style-type: none"> ☞ Reduced labour ☞ Increased poverty ☞ Lack of infrastructure ☞ Inability to maintain infrastructure ☞ Loss of skills and knowledge ☞ Lack of education ☞ Elevated mortality ☞ Elevated morbidity ☞ Isolation & lack of social cohesion ☞ Inability to secure & manage resources ☞ Crime & violence ☞ Poverty
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Table 3 illustrates the potential impact of health problems and disability on a rural community. Each level of impact will be discussed in more detail (Richter, Manegold & Pather, 2004:9).

6.2.3.1 The impact of health problems on individuals living in a rural area

The potential impact of health problems on an individual living in a rural area is inevitable. Reduced well-being and lack of ability to perform one's daily tasks and responsibilities is a reality for an ill person. Survival in a rural community often depends on one's ability to attend to agriculture, fetching clean water, cleaning, washing and ability to work and earn money (Richter, Manegold & Pather, 2004: 9). An ill person is not able to work, travel to employment and education opportunities and care for himself/herself and his/her family, ultimately resulting in feelings of stress, anger, depression, low self-esteem, isolation and worthlessness. Lack of education and employment could also lead to people turning to sex work in order to feed themselves and their families. This increases a person's risk to HIV, AIDS and STIs. Based on these facts, it seems crucial for any community intervention to include self-management, stress relief and individual empowerment.

6.2.3.2 The impact of health problems on families and households in rural areas

The potential impact of health problems on a family or household includes aspects such as isolation, discrimination, lack of community members' support and social interaction. Vorster *et al.* (2000:505) concluded that people living in poverty, rural areas and densely populated areas are experiencing a high risk of disease associated with under nutrition. Lack of income and health care means that families might be forced to move closer to the cities or that the children are forced to leave school and seek employment. This in turn results in feelings of demoralization, resentment, anger, fear, stress and family conflict.

Unemployment and poverty leaves the door open for the family to deal with potential crime and violence. It is therefore crucial that the importance of family, friends and community support is taken into consideration when implementing a community intervention programme.

6.2.3.3 The impact of health problems on a rural community

Communities at large could also be affected by serious health problems and disabilities. Lack of education, employment opportunities, skilled labour as well as the strain on existing service delivery are huge challenges. Social cohesion (strength of community groups) is stretched to the extreme and normal, supportive partnerships go to the way side. The inability to secure and manage resources contributes to community conflict. Community awareness and support will be crucial during the intervention process.

6.3 DISABILITY

Patel (2005:174) discusses disability and states that it is a physical or mental impairment that limits a person's capacity to perform one or more major life activities and states that quadriplegia, deafness and blindness are the most common disabilities in South Africa. It is the inability of society to provide PWD with the necessary and needed assistance, resources and opportunities. The impact on PWD is discrimination, disadvantages, restrictions and exclusion.

6.3.1 Terminology

Olkin (1999:11) provides a comprehensive definition of disability. The term "disability" means, with respect to an individual –

- (A) A physical or mental impairment that substantially limits one or more of the major life activities of such an individual;
- (B) A record of such an impairment; or
- (C) Being regarded as having such impairment.

The term "physical or mental impairment" means:

- (1) Any physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs),

cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine; or

- (2) Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. Major life activities means functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.

Pierson and Thomas (2006:153) describe disability as social oppression on the basis of physical or mental impairment. The disability phenomenon for the purpose of this study includes physical, mental, hearing and sight disabilities.

6.3.2 Strategies to improve disability prevention and management

The Department of Health (South Africa, 2001:15) provides some guidelines for health intervention in South Africa with specific reference to indicators for disability management. These guidelines are summarized in Table 4.

TABLE 4: National health goals, objectives and indicators for disability management

GOAL	OBJECTIVE	INDICATOR
Prevent and control non-communicable chronic diseases (i.e. hypertension, chronic diseases years) of persons with hypertension diabetes, asthma	Improve quality of care to people with chronic diseases	Proportion of emergency admissions (<75 years) of persons with hypertension
Improve the quality of life of PWD	Increase accessibility of health services to PWD	Percentage of PWD who have accessed basic rehabilitation services

It is evident that a comprehensive care approach is needed in order to address the health situation in South Africa. Ross and Deverell (2004:6) maintain that health interventions can only be successfully implemented through a multidisciplinary approach. Each individual's skills and knowledge are utilized in order to achieve improved standards of care and to meet the bio-psychosocial needs of the community. *The goals of social*

development and public health should include the promotion of social and economic development, social justice, improving the quality of life and minimum standards of living and promoting human development and well-being (Patel, 2005:98).

6.3.3 The bio-psychosocial aspects and implications of disability

According to the Human Development Report 2007/2008 (United Nations, 2009), more than half a billion people worldwide are disabled as a result of mental, physical or sensory impairment. Approximately 80% of these PWD live in developing countries. During Statistics South Africa's Census 2001, a total of 2 255 982 persons reported that they had some form of disability that prevented them from full participation in life activities. This number constituted 5% of the total population (44 819 778) enumerated in the census. The African population reported the highest number of disabled people (1 854 376 or 5,2% out of a total of 35 416 166), followed by white (191 693 or 4,5%), coloured (168 678 or 4,2%) and Indian (41 235 or 3,7%) people. It was indicated that the Northern Cape had 46 973 PWD (Statistics South Africa, 2005:1).

6.3.3.1 Biological aspects

Biological aspects of disability refer to the physical prevalence of disabilities. Each type of disability has a unique impact on an individual's ability to perform certain activities. Hence it is of paramount importance to ascertain the prevalence of the various disabilities at national level and by population group, gender and age.

The prevalence of sight disability was highest (32%) followed by physical disability (30%), hearing (20%), emotional disability (16%), intellectual disability (12%) and lastly communication disability (7%). However, although the ranking of disabilities by gender is very similar to the above general ranking, a higher percentage of disabled males (31%) suffered from physical disabilities while 36% of disabled females suffered from problems related to sight. The main causes of disabilities are biological (born with it or due to the onset of age-related disabilities), environmental aspects (alcohol/drug abuse, accidents, attempted suicide) and health aspects (STIs, HIV, AIDS, polio etc.). A comparison of the demographic and socio-economic characteristics of disabled and non-PWD shows that PWD were on average older. This could be an indication that age-related disabilities are prominent occurrences (Statistics South Africa, 2005:21).

6.3.3.2 Psychosocial aspects

Approximately 30% of PWD had no education, but only 13% of the non-disabled population. All in this category. However, the most affected population group in this regard

were Africans. The findings with regard to access to basic services (housing, water and electricity for lighting) indicate that 53% of households headed by PWD lived in houses or brick structures – nearly the same as the percentage of households headed by non-PWD (56%). A significant proportion (37%) of households headed by PWD lived in traditional dwellings or huts and informal dwellings/ shacks. More or less 78% of households headed by PWD had access to piped water, compared to 85% of those headed by non-PWD. As far as electricity for lighting is concerned, 62% of households headed by PWD used this service. The above findings provide useful information on the prevalence of disability in the country. Apparently, PWD are disadvantaged as far as access to educational and employment opportunities are concerned. The profiles by type of disability underscore the need to have preventive and rehabilitation programmes that target the most affected groups (Statistics South Africa, 2005:8).

The exclusion experienced by PWD and their families is the result of a range of diverse demographic, economic and social factors. The key forms of exclusion responsible for their disadvantage are poverty, social isolation and the fact that a large number of them are unemployed. Leshilo (2004:iv) indicated that PWD in another community experienced feelings of isolation, rejection, marginalization and stigmatization.

These factors have a significant influence on how PWD view themselves and have an impact on how they integrate with society. Dominelli (2002:35) focuses on the role of identity in PWD. She firstly defines identity and states that the group an individual finds himself or herself in contributes to his or self-esteem and identity formation. Identity issues are therefore part and parcel of every human being. It defines one's self-esteem, self-worth and opinion of the world around one. For a person with a disability to achieve the desired lifestyle for themselves and their loved ones, they need to feel valued, supported and empowered to do so.

Figure 1 aims at summarizing the influence of disability on a person's identity (Olkin, 1999:13). This author refers to the effect of identity on a person with a disability and his/her vulnerability to stigma, prejudice and discrimination. Whitley and Kite (2006:7) define this discrimination as feeling different towards a certain group of people based on their membership to a specific group, and prejudice as a feeling, assumption or evaluation directed towards people of a certain group. This could lead to problems with identity forming which is illustrated in Figure 1.

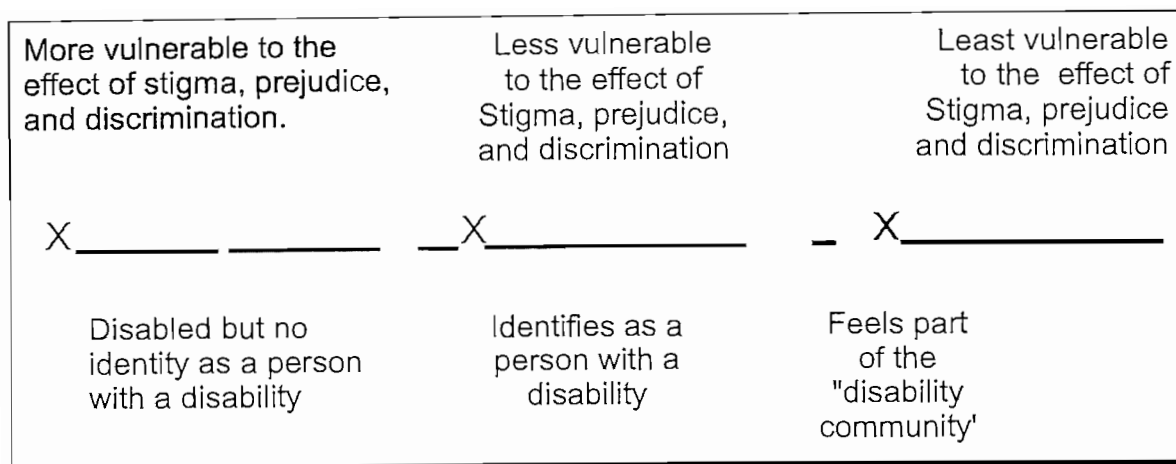


FIGURE 1: Scale of vulnerability of a person with a disability

The first group of PWD could be severely disabled, but do not see themselves as being disabled or part of the disability community. These people would be most vulnerable to the effects of stigmatization and discrimination.

The second group consists of people for whom their disability is part of the overall self-concept. This group is labelled the disability identity group. According to Olkin (1999:13), people in this group identify themselves as members of the non-disabled world and try to function and live as “normally” as possible. They tend to compare themselves to individuals who are not disabled and the vulnerability comes from trying to meet able-bodied standards despite their disability. The third group views themselves as PWD; they feel comfortable in the disability culture and are realistic about their abilities and limitations. They are the least vulnerable to stigma, prejudice and discrimination, because they function effectively as a person with a disability.

In addition to how a person with a disability views himself or herself, Wilson (2003:2) states that the major cause of emotional distress for disabled people is not only the actual physical impairment, but the effect the impairment has on their relationship with others and their ability to manage the environment. Whitley and Kite (2006:221) refer to self-esteem as people’s evaluation of their personal characteristics and behavioural patterns. Olkin (1999:61) points out that people form impressions of the person with a disability based on the presence of the disability. People have certain beliefs about disabilities and this contributes to people’s opinions of the person with a disability. Some of these beliefs include that disability causes suffering, that PWD are lazy, that they are cursed or that they are moody. People often avoid them, resulting in oppression, which is defined by Dominelli (2002:9) as interaction between people in a social arena; thus socially constructed through people’s actions with and behaviours towards other people. Oppression has an influence on all aspects of a person’s life, including the establishment

of a person's personality, coping mechanisms and attitude towards the self and others. If a person with a disability is oppressed and discriminated against, it not only affects the person with the disability, but many others in a circle of family and friends as well.

Ross and Deverell (2004:36) state that disabling conditions tend to evoke strong emotional reactions in the affected individual and his/her family. When a child, for example, is born with a disability, the parents might feel grief. The main stages of grief include feelings of denial, bargaining, guilt, depression, anger and acceptance. It is important to deal with all these feelings with the parents/family/friends, in order to achieve acceptance and psychological well-being. Family members may be supportive towards the person with a disability, but the possibility also exists that the family see the person with a disability as a "shame" or a threat to the position of the family in the community. This might result in a person with disability having limited support in the home environment. He/she might even be rejected and sent away to an institution. Parents with a child with a disability might not know what to expect, leading to uncertainty and lack of confidence in their role as parents. This relationship is characterized by unequal status and may not be mutually rewarding (Olkin, 1999:68). On the other hand, a person with a disability's independence options is limited. Employment options for PWD are significantly lower than for people without disabilities, resulting in dependence on the family members, marginalizing in society and discrimination (Statistics South Africa, 2005:29).

Another valuable aspect which should be discussed and does have a significant influence on the psychosocial aspects of disability is culture. Riddell and Watson (2003:1, 5) define culture as "...a 'signifying system' and a packet of signs, symbols, tools and beliefs". They further advocate that socially foremost cultures shape the way in which a person with a disability is viewed and accepted. In addition to identity and prejudice, aspects such as the community culture, social group and belief system intermingle to determine the response and support to the person with a disability. Rothman, Erlich and Tropman (2001:4) state that problems and systems are interconnected and that values and behaviours of individuals can undermine the common good of a society. Mkhize (2008:32) reminds us of the importance of utilizing not only classical psychological theories and intervention approaches, but to also include an African perspective within an African socio-psychological framework. The culture of the community plays an important role in how disability-related issues are viewed and should be taken into consideration during the development of a community-based disability programme.

Wilson (2003:7) explains that in the Western cultures there is a tendency to view a child's disability as the mother's responsibility or fault, whilst in many African cultures the child is viewed as a separate individual who is responsible for his or her own fate. In the East the

belief in reincarnation may explain why parents experience a disabled child as less traumatic and they even view themselves as especially chosen for this important role.

6.3.4 Disability in rural communities

Being disabled in a rural community brings along a long list of challenges presented in Table 5 (Richter, Manegold & Pather, 2004:9).

TABLE 5: Challenges for PWD in rural communities

<p>Potential impact on individuals</p>	<ul style="list-style-type: none"> ☞ Isolation, depression ☞ Lack of education opportunities ☞ Lack of employment opportunities ☞ Lack of medical resources ☞ Vulnerability to poverty-related illnesses
<p>Potential impact on families and households</p>	<ul style="list-style-type: none"> ☞ Isolation, discrimination ☞ Extra financial burden & Poverty ☞ Additional care and resources required ☞ Stress, depression
<p>Potential impact on communities</p>	<ul style="list-style-type: none"> ☞ Poverty ☞ Strained resources & lack of appropriate resources ☞ Reduced labour & loss of skilled workers ☞ Lack of external resource involvement

Table 5 illustrates the major difficulties experienced by PWD in rural communities. PWD are referred to as a vulnerable group of South African citizens who are facing daily internal- and external challenges. They are often dealing with acceptance of their disability themselves, discrimination from society, isolation and depression. Caring for a PWD can also be straining on the caretakers and family members, often resulting in the need for additional resources, finances and support. Disability matters are often placed on the back burner by society and communities due to the limited and ill-distributed resources available to the people of South Africa. However, relevant policies and procedures are available, but a major gap seems to exist between paper and reality.

The Policy on Disability (South Africa, 2008b:2) states that like all other citizens, PWD have both rights and responsibilities. The challenges for and responsibilities of PWD are evident in Table 4. They have to contribute to society and the development of the community, but are not always able to due to obstacles such as lack of transport, lack of ADs and lack of educational opportunities. They also need support and advice in order to maintain healthy and balanced psychosocial behaviour, but due to lack of resources, this is also not possible - aspects which clearly need addressing during community intervention.

6.3.5 Suggested intervention with regard to disability

When planning intervention with regard to disability it is necessary to investigate some models on disability. Olkin (1999:171) provides guidelines for the different models. The medical model embraces the perception that a disabled person should be 'repaired' or 'cured' in order to assist the person to function and look like the non-disabled majority. This model can be interrelated with the biological aspects of health and the prevention of disabilities. The social model aims to cure the environment and the social attitudes towards PWD. This model refers mainly to the social aspects of health. Olkin (1999:26) discusses the minority or social model and describes it as a problem that lies within the negative attitudes of people without disabilities, not with the person with a disability. Our society labels certain groups of people and this labelling process leads to discrimination and isolation. A study by Howes (2007:187) indicated that friends are more often important resources of intimacy, while relatives other than marital partners usually are not. It is therefore important to explore the needs of all the people involved with the person with disability/severe illness - not only the closest relatives. If a person is not adequately supported, these initial feelings could result in stress-related illnesses and even long-term depression.

The analytical model focuses on the possible effects physical differences and changes can have on the individual's psyche. This model focuses mainly on the psychological and spiritual aspects of health. Most importantly, it has been realized that indigenous knowledge often holds the key to effective community development, inspiring communities to value and use traditional ways of acquiring quality of life (Kamper: 2006:76). Practitioners who provide services to specific communities or groups such as the deaf community must be aware that traditional methods of educating and outreach to members used in the hearing community may not be effective in the deaf community. Consideration should be given to the unique cultural and linguistic needs of that specific community (Crowe, 2003:289).

In conclusion, disability has a major influence on any person's functioning and abilities. "Disability is of concern to all of us - no one is immune to the loss of ability that can accompany an accident, illness or old age" (Wilson, 2003:ix).

7. MAINTANANCE OF THE RELATIONSHIP BETWEEN POVERTY, HEALTH AND DISABILITY.

From the afore-mentioned paragraphs, poverty, health and disability were discussed as individual constructs and as interrelated social constructs. Cain and Howe (2008:127) agree with the idea of certain interrelations between poverty, health and disability. This interrelation is maintained by social factors, emotional factors, psychological factors, physical factors, economic factors, health factors and cultural factors. This interrelation is illustrated in Figure 2.

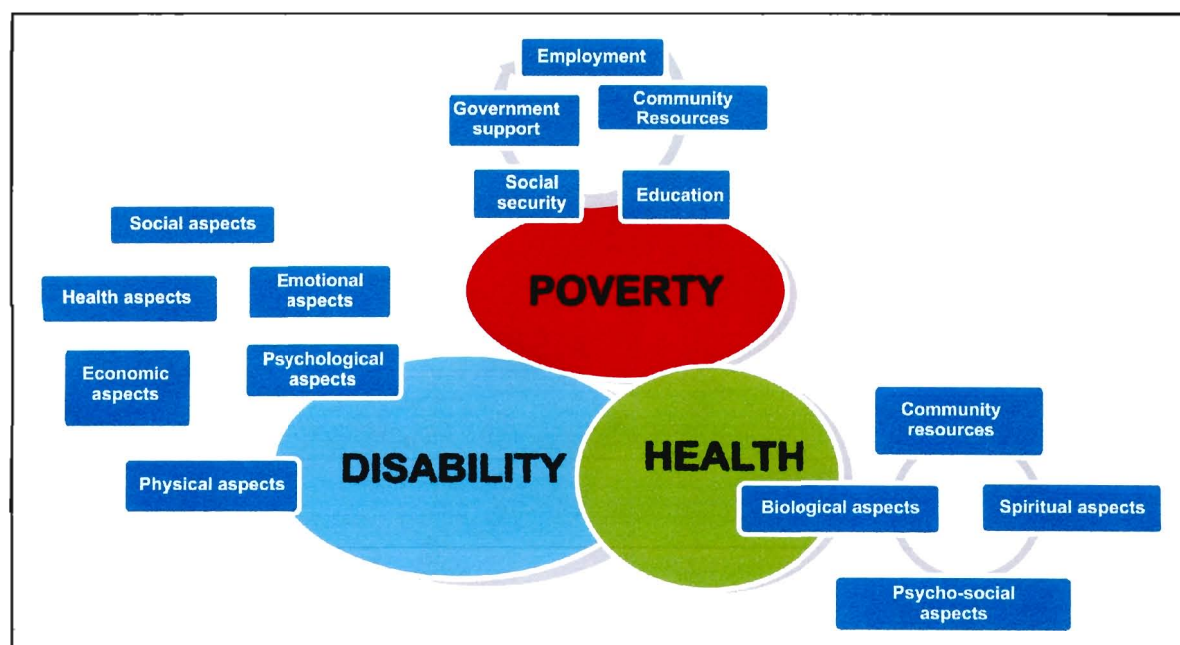


FIGURE 2: The interrelation between poverty, health and disability

Figure 2 illustrates that poverty; health and disability are discussed as three different social constructs which are interrelated with one another. These three arenas are supported by several aspects. Poverty could result in poor health and poor health could contribute to poverty. Poverty and poor health are also two aspects which hold major complications for a person with a disability. With this regard and for the purpose of this study the disability aspects will be discussed in more detail.

7.1 SOCIAL FACTORS

Rothman (2003:137) points out that human beings are social beings. The social world we live in provides meaning in our lives. When one is not able to participate in the social world, one is not able to benefit from the social interaction. Watson (2002:35) states that social interaction constitutes virtually the whole of human activity. He continues to discuss the role of stigma and the fact that a person's appearance could place him or her in a certain negative category or 'social identity'.

A study by Kim and Fox (2006:476, 481) indicate the following social factors that may influence a person with disabilities:

- ☞ Employment status
- ☞ Social adjustment
- ☞ Family relationships
- ☞ Access to health care
- ☞ Emotional support
- ☞ Financial support
- ☞ Involvement in the disability and non-disability communities

Social support such as family, neighbours and friends are therefore a crucial factor in the wellness contribution process between poverty, health and disability. Kim and Fox (2006:481) confirm this train of thought and state that relationships with others, such as family, friends, health care providers, and the disability communities or support groups, have a significant impact on health. Relationships with others are considered part of the social environment and are also one of the personal domains within the concept of health. Emotional and financial support from significant others give participants strength to deal with their disabilities. Involvement in disability communities or support groups offers opportunities to share a common understanding of experiences in relation to the environment as well as a chance to share specific strategies for living independently.

7.2 EMOTIONAL FACTORS

The emotional factors are very closely linked to the social factors. Kim and Fox (2006:476) mention that a positive attitude towards life, feeling happy and feeling independent may contribute to health. Unfortunately PWD, especially children with disabilities, are often unable to defend themselves, are often alone at home and are

undervalued by those around them. This makes them particularly vulnerable to physical, sexual and emotional abuse. Children with disabilities are also less likely than their siblings to attend school, to go on outings, to experience situations where they have to solve problems or to contribute to household chores. As a result, they grow to be disempowered adults, unable to make decisions, solve problems or take initiative. This, in return, contributes to high unemployment figures amongst adults with disabilities

Another theory as discussed by Whitley and Kite (2006:317) is the relative deprivation theory. This theory is based on the perception that people become negative and dissatisfied about certain circumstances in their lives. This feeling of dissatisfaction is relative and could be based on a comparison of something they used to have to what they think they ought to have. Prejudice is closely related to this perception as people respond to these feelings of deprivation. They blame other groups for causing their need and they therefore dislike this group or person. Family members/caregivers of a person with disability carry additional emotional, social and financial stress. If the family/caregivers are already less privileged, the person with the disability could be blamed and treated in an ill manner due to feelings of anger, resentment and frustration. This concept is also referred to as scape-goating. Scapegoating is fuelled by the frustration-aggression-displacement theory, which holds that frustration causes aggression. This may result in the abuse of a "scapegoat".

7.3 PSYCHOLOGICAL FACTORS

Physical and mental disabilities occasionally lead to severe lack of energy and the inability to fully participate in daily activities, causing stress and stress-related illnesses. According to Watson (2003:201), stress is a sense of distress arising because of pressures experienced in certain social or economic circumstances that render the sufferer emotionally and sometimes physically incapable of continuing to behave in the ways expected of them in those circumstances. Added stress can lead to depression and depression can lead to other related problems such as alcohol abuse, family violence and even suicide. PWD should therefore be considered a vulnerable group, one which does require additional support.

Kim and Fox (2006:483) state that negative social attitudes still isolate PWD from society and make them feel depressed. Therefore external oppression becomes internalized and impacts negatively on people's emotions. The social domain represents the importance participants placed on having good relationships, including those with family and friends. The spiritual domain was described in terms of having strong faith and having a relationship with God. All factors under the personal and environmental levels affect each

other. In order to enhance health for PWD, it is important to realize that individuals with disabilities are not inherently unhealthy or ill and that disability and health can coexist. A paradigm shift towards a holistic health view would offer a perspective of PWD as whole people, rather than one focusing on their impairments.

7.4 ECONOMICAL FACTORS

The Disabled Children Action Group (2001:1) estimated that 98% of mothers of children with disabilities living in rural areas are unemployed, semi-literate or functionally illiterate single women. Large numbers of PWD live in areas where the infrastructure for the provision of basic services is at its weakest. Hence a relatively low percentage of disabled people have access to piped water, electricity and inside toilet facilities. They continue to discuss that more than 80% of black children with disabilities live in extreme poverty in inhospitable environments. They have very poor access to appropriate health care facilities and early childhood development opportunities. When born into families of poor socio-economic backgrounds, such children frequently grow up believing that their disabilities are an economic and social curse and burden on their families. As a result, they often perceive themselves to be worthless (Disabled Children Action Group, 2001). According to Ross and Deverell (2004:7) there is a clear interrelation between social class and health. In essence treatment is mainly reserved for people who can afford it. Green (2008:178) states that people are not only particularly vulnerable to poverty when they are unemployed, but the impact of poverty also increases vulnerability to ill health. Patel (2005:53, 54) states that health issues form an important part of social development as they are directly related to human resource and community development.

Poverty further limits a person with disability's opportunities to participate in general community activities as well as his/her opportunities to access resources and health care. Limited health care to community members in return cause several long-term illnesses and even disabilities. Poverty and lack of resources in especially rural communities are also a leading cause of illnesses and disabilities. Marlatt (1998:x) supports this view and states that it is well known that lifestyle factors such as tobacco, diet, alcohol abuse and sedentary lifestyle are leading causes of diseases. She continues to discuss the health risks of poverty on a community and states that behavioural choices are the source of more than half of all preventable deaths and disabilities in the United States. Chenga and Cronjé (2007:146) focus on the fact that 80% of the South African population are living in tin shacks (poorly constructed corrugated sheds) and that poor housing conditions may lead to illness and disabilities.

It is critical to note that disability does not only affect the disabled individual. In addition, the birth of a disabled child, or the occurrence of disability in a family often places heavy demands on family morale, thrusting it deeper into poverty. This not only means that there is a higher proportion of disabled people among the very poor, but also that there is an increase in families living at the poverty level as a result of disability. This phenomenon seriously hinders the development process (South Africa, 1997:30).

Being disabled in a poverty-stricken society or community complicates the phenomena of survival and equal opportunities. Olkin (1999:47) continues to discuss the importance of social citizenship and the right not to be poor or not to live in fear of poverty. PWD should therefore have the same standard of living and lifestyle as everyone else.

7.5 PHYSICAL FACTORS

Research undertaken by Kim and Fox (2006:476) clearly indicated that instead of focusing on their impairment itself, the participants stated that health was not solely connected to medical issues. They indicated that biological/physical, mental/emotional, social and spiritual health matters interact with one another and should all form part of a holistic approach to managing health-related matters in the development of a community-based disability programme.

Pavlou (2008:124) supports the importance of good health and states that overweight and obesity are associated with several life-threatening diseases. Desmond and Boyce (2006:203) suggest that research results have shown that despite media warnings on the risks of smoking, a quarter of the adults in South Africa smoke at least sometimes.

People need to be assisted in improving their quality of daily life. Medical interventions could control the symptoms, but resources such as home-based carers play a crucial role in this education process. A process which is, according to Desmond and Boyce (2006:212), associated with better health, such as increased knowledge, is associated with health-benefiting behaviours. A lack of timely and appropriate medical care has contributed significantly to an increase in preventable secondary and tertiary disabilities. Appropriate, accessible and affordable health services at primary, secondary and tertiary level are essential to the equalisation of opportunities for PWD.

Walker (2004:168) indicates that the lack of resources and the low up-take of preventive mental health services could result in minor problems developing into major mental health problems. He provides statistics and states that over 90% of recidivist delinquents had a conduct disorder as children. Forty percent of seven to eight-year olds with an untreated conduct disorder became recidivist delinquents as teenagers. Preventive measures such

as assessment of children, providing the appropriate medication and even assisting a patient to correctly administer medication in the long term, could prevent serious mental health problems from developing. Equipping educational institutions to assist with the identification of such behaviour could also aid assessment, diagnosis and treatment of mental health disorders.

Another important aspect to discuss is the prevention of chronic diseases through health management. Tapsell and Probst (2008:94) state that the importance of nutrition in the prevention of chronic disease has been recognized and that in developing countries, nutrition-related problems such as obesity, diabetes and heart disease, are a major problem.

Based on these discussions it is clear that awareness and investment in health matters would prevent certain disabilities, mental illnesses and disfunctioning within a community. A comprehensive community-based disability programme is needed to meet the multi-facet poverty-health-disability phenomenon.

7.6 CULTURAL FACTORS

Culture within any specific nation, race, gender or population is important. Disability culture within a specific group of disabilities is also vital to be kept in mind. Crowe (2003:289) states that practitioners who provide services to the deaf community must be aware that traditional methods of educating and reaching out to members used in the hearing community may not be effective in the deaf community. Consideration should be given to the unique cultural and linguistic needs of the deaf community.

This community programme will be based in a traditional African community; therefore African traditions are very important aspects to take into consideration. Understanding the cultural functioning within a community will contribute to the understanding of the community's needs, functioning, beliefs as well as the identification of aspects such as the locus of control (motivational aspects). Sigogo and Modipa (2008:317-334) provide detailed intervention strategies for South African communities, including guidelines for African community intervention. Ross and Deverell (2004:25) point out that different cultures mean different views. An overall principle in the African culture is the Ubuntu concept that means "humanness". It is a holistic approach to life and places emphasis on unity and the incorporation of all parts. Ubuntu principles are humanity, compassion, generosity and hospitality, being open to the needs, interests and general welfare of others, sharing, mutual aid, caring for others, interdependence, solidarity, reciprocity and social harmony (Osei-Hwedie, 2007:107).

8. CONCLUSIONS

Poverty is a perturbing phenomenon with various psychosocial and economical implications. There is a strong relationship between poverty, health and disability. Poverty makes people more vulnerable to disability and disability can lead to isolation, lack of support and lack of resources. Many people still remain ill-fed, ill-housed, under-educated and defenceless to preventable diseases. There is interconnectedness between health, illness, risky behaviour and coping mechanisms. Diseases such as cholera, HIV and AIDS, malaria and tuberculosis are impacting negatively on the welfare of the people. Risk factors include alcohol abuse as being interrelated to accidents, unsafe sexual behaviour, attempted suicide, liver disease, cardiovascular complications, stroke, cancer and neurological complications.

Factors contributing to impaired physical functioning are unhealthy lifestyle, failed medical services, accidents, violence, war, poverty, inadequate information and poor social and environmental conditions. The promotion of a healthy lifestyle in the home, at school and in the community is important. A continued improvement in health services should include timely immunization, early identification of impairments and appropriate intervention, appropriate health care instruction, family planning, genetic information and counselling, as well as the monitoring of all potentially disabling diseases.

It is evident that information and education play a pivotal role in the prevention and management of a disabled person in a poverty stricken community. By obtaining more information with regard to disability-related issues the community members would be empowered to prevent certain disabilities from occurring and assist members of the community to support PWD in a more effective manner.

9. RECOMMENDATIONS

The South African Department of Social Development's Integrated Service Delivery Model (ISDM) towards improved social services forms the guideline of this community-based disability programme. It is therefore recommended that integrated service delivery should be the benchmark in order to relieve poverty, ensure inclusion for PWD and result in sustainable development.

The interrelation between poverty, health and disability has been explored and significant influences have been identified. The result of poverty is that a large number of people live in rural areas in traditional type dwellings/structures. Only a few have access to clean piped water and other basic health living necessities with vulnerability to ill health and

disablement as results. Healthy living and prevention of disabilities should relieve the burden on the limited resources, services and support in rural communities.

A community-based disability awareness, prevention and management programme could be beneficial to a rural community.

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ARTICLE 2

DEVELOPING A COMMUNITY-BASED DISABILITY PROGRAMME: RESULTS OF A SITUATION-ANALYSIS IN A RURAL COMMUNITY

ABSTRACT:

This article focuses on the prevalence of disabilities in the Heuningvlei community in the Northern Cape Province of South Africa. The Heuningvlei community is isolated. Based on the principles of inclusion, fair and equal treatment and access to resources, the research question was formulated: what are the bio-psycho-social needs of the Heuningvlei community with regard to a community-based disability programme? The research includes the exploration of the community profile and a comprehensive assessment of the bio-psycho-social needs of the community members with disabilities with regard to a community-based disability programme.

Results indicated that the prevention of disabilities in rural areas is the most effective way to reduce the burden on the limited resources in the community. It is important to create awareness with regard to disability issues in the community whilst keeping the local culture in mind. The mobilization of resources and service delivery should be paramount. It is possible to meet the bio-psycho-social needs of the community members with disabilities through a community-based disability programme.

KEYWORDS:

∞ **Bio-psycho-social needs, disabilities, needs assessment, situation analysis, community-based disability programme**

1. INTRODUCTION

This research project forms part of the Tshwaragano community development project which was started in the Heuningvlei community in the Kagisano Municipal district in 2006.

The Heuningvlei community comprises the following villages; Heuningvlei, Shalaneng, Tsilwane, Kome, Perth, Klein-Avon, Klein-Effel, Madibeng, Ganap, Loopeng. The focus of this article is to do a situation analysis of the Heuningvlei community. This will include a community profile and a needs analysis of the community members with disabilities. The results will be used to develop a community-based disability programme.

2. PROBLEM STATEMENT

The Tshwaragano project in the Northern Cape Province specifically focuses on empowerment programmes to build the capacity of the poor people living in the Heuningvlei community in order to ultimately achieve self-reliance. Lombard (2008:121) states that South Africa has accepted the challenge, as set by the United Nations, to alleviate poverty by the year 2015.

Heuningvlei is a deep rural community in South Africa, trapped in poverty and struggling to cope with limited resources. The Heuningvlei community consists of approximately four thousand households living in poverty. The roads leading to Heuningvlei are in an appalling condition, prohibiting service providers to engage with these communities. Poor service delivery, low levels of income, high unemployment and a lack of education, training and development opportunities lead to a multi-dimensional poverty phenomenon that impinges the entire spectrum of human development. Thin (2002:17) describes this as a social issue and an economic phenomenon.

This community is severely isolated and excluded. The concept of social exclusion or isolation has its origins, according to Walker (2004:164), in France in the 1970s where the idea of citizenship and social cohesion highlighted the plight of 'Les exclus' who were relegated to the margins of society. Therefore any social policy or development program should aim to advance social inclusion and health care enabling all citizens, including people with disabilities, to enjoy the opportunities in life.

Based on the principles of inclusion, fair and equal treatment and access to resources, the following question was formulated, based on the above description of the research problem:

- ☞ What are the bio-psychosocial needs of the Heuningvlei community with regard to a community-based disability programme?

3. AIM AND OBJECTIVE

The following aim and objective form the foundation for this specific article.

3.1 AIM

- ☞ To do a situation analysis in the Heuningvlei community to assist in the development of a community-based disability programme.


3.2 OBJECTIVE

- ☞ To compile a community profile and to determine the bio-psychosocial needs of the community members with disabilities through a comprehensive survey.

4. RESEARCH METHODOLOGY

- ☞ The research methodology for this part of the study is summarized in Table 6.

TABLE 6: Summary of the research methodology for phase 1

<p>PHASE 1</p> 	<p>Conducting individual interviews 5 with community expert and relevant role-players.</p> <p>Pilot testing the questionnaire with 2 community members.</p> <p>Survey: Doing a situation and needs analysis with community members with disabilities.</p>
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This article will focus specifically on the second part of phase 1 which includes individual interviews with the relevant community experts as well as the survey and needs analysis. The descriptive and exploratory research design was utilized including quantitative and qualitative methods (Delpont, 2005:159-191; Fouché, 2005:267-285). The qualitative method of investigation included individual interviews (pre-programme implementation) with experts and significant role-players in order to establish the departing point of the intervention process. As part of the single-system design, as described by Strydom

(2005c:145), the quantitative methods included questionnaires to do a situation analysis, including a community profile and analysis of the bio-psychosocial needs of the community. Van Wyk and Phutiagae (2003:47) discuss the importance of knowing the community and their needs through the development of a community profile, when departing on a community development project. The experts in the Heuningvlei community included registered nurses, religious leaders, elderly people, community leaders, the Chief and a few community members with disabilities. Information was gathered by means of individual interviews, utilizing a standard interview schedule.

The Tshwaragano project has already selected a non-probability sample population of a total of two hundred and fifty four households from the Heuningvlei community in the Kagisano Municipal district. Exploratory questionnaires were completed with this sample population and utilized during this study to compile a community profile. The sample population for the disability-related issues were selected through the non-probability, snowball method (Strydom, 2005a:203). In order to gain a holistic view with regard to disability-specific issues, a combination of qualitative and quantitative research methods as described by Henn, Weinstein and Foard (2006:19) were utilized. Disability-specific questionnaires were also utilized during phase one of the study.

The quantitative data were analyzed and interpreted in consultation with the Statistical Consultation Services of the North-West University (Potchefstroom Campus). The overall results of the research project were interpreted and presented in graphic format.

5. ETHICAL ASPECTS

Ethical permission for this study has been granted by the Ethics Committee of the North-West University (Potchefstroom Campus). Ethical application number: 06k07. Tshwaragano Project. The necessary permission has also been attained from the Heuningvlei Chief, Chief Bareki.

Overall ethical aspects kept in mind during this study included that the goal of the research project had to be clear and transparent and the researcher had to inform the respondents of the potential consequences of participating in the research (Strydom, 2005b:59). It was made clear to the participants that participation was voluntary and that it is their right to withdraw from the study at any stage (Banks, 1995:13). With this in mind the participants were informed with regard to all aspects of the research project and written consent forms were signed in advance (Henn *et al.*, 2006:67). All information was confidential and anonymous, as suggested by Etemad (1995:824).

6. SITUATION ANALYSIS

This article will explore the profile of the Heuningvlei community, with specific reference to people with disabilities (PWD) and the bio-psychosocial needs of the Heuningvlei community with regard to a community-based disability programme. A number of terms need clarification before the bio-psychosocial needs can be discussed in detail.

6.1 Terminology

The terminologies which will be described include *situation analysis*, *needs assessment* and *community profile*.

6.1.1 Situation analysis

The Heuningvlei community is marginalized and in order to compile a community's state of affairs, Weyers (2001:69) suggests that the research process should start with a situation analysis. This will include the context in which services will be rendered (compile a community profile and analyse the socio-economic and political context within which the services will be rendered), identifying the needs and expectations of the community members as well as the main role-players and their expectations and thirdly to compare the results of the first two steps with the main characteristics of the potential practice models.

The World Health Organization (2009:11) provides the following description of a situation analysis: "The study of a situation which may require improvement." This begins with a definition of the problem and an assessment or measurement of its extent, severity, causes, and impact on the community. An appraisal is launched concerning interaction between the system and its environment, and the process or performance is ultimately evaluated.

Jason, Keys, Suarez-Balcazar, Taylor and Davis (2004:41) define this situation analysis' main goal as being to determine the specific community's holistic phenomena and the impact thereof. Smart (2003:54) suggests that the results of this situation analysis will contribute to community mobilisation. Laverack (2005:8) describes the situation analysis and development process as the 'bottom-up' programme approach. The approach is a process during which the community members identify their own problems and communicate these to the top structures or decision makers. The situation analysis in this study explored the bio-psychosocial needs of the community members with disabilities within the bigger field of the community profile of the Heuningvlei community. It is evident that the situation analysis includes a needs analysis of the community members with

disabilities and their caretakers. Hence the situation analysis in this study implies a community profile and a needs assessment.

6.1.2 Needs assessment

Needs assessment is “the systematic appraisal to identify problems and potential solutions, measure relevant community characteristics, analyse consumer perceptions of problems and goals, evaluate existing resources and determine whether the needs of a particular group are being met by current programmes and services” (Terminology Committee for Social Work, 2005:41).

The community members would know what intervention would be possible with the existing internal resources, knowledge, skills and talents. The priority needs and outside capacity or resources should then be decided on. These identified needs then form the blueprint for the community development programme.

6.1.3 Community profile

The concept *community profile* is the ordered data on a community such as its origin and development, demographic data and tendencies, the nature of social institutions, availability of and accessibility to resources, incidence and range of social problems as well as the potential of people, which are used for developing and implementing social welfare programmes and programmes for community development (Terminology Committee for Social Work, 2005:12).

6.2 CONCEPTUALIZATION OF THE PROCESS

The conceptualization of the process is illustrated in Figure 3.

profile. Systematic sampling was used to elicit data from a total of two hundred and thirty households from Heuningvlei village; thus one participant per household. Every fifth household in the row/street was included. The first house in the row/street served as the starting point. This part of the research project provides demographic-related information and the participants' characteristics are illustrated in Table 7.

TABLE 7: Participants' characteristics

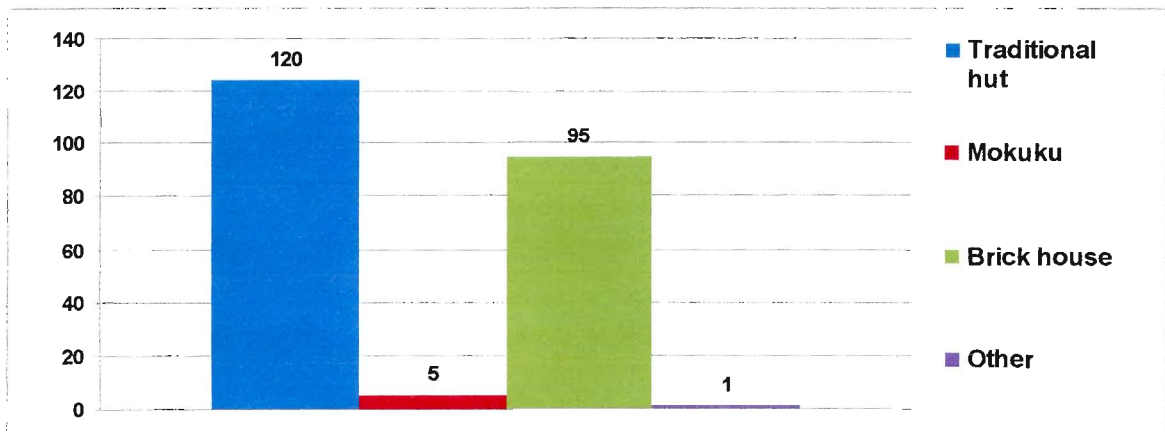
ITEM	CATEGORY	FREQUENCY	PERCENTAGE
<i>Gender</i>	Male	49	23,68
	Female	180	78,60
Frequency missing = 1			
N229			
<i>Age</i>	21- 30	44	19,21
	31-40	50	21,83
	41-50	63	27,51
Frequency missing = 1			
N229			
	51-60	43	18,78
	Above 60	29	12,78
<i>Qualification</i>	None	59	26,22
	Primary, GR 1-7	98	43,56
	Secondary, Gr. 8,9,10	36	16,00
	Secondary Gr. 11 & 12	32	14,22
	TOTAL	225	100,00
Frequency missing = 5			
N = 225			
<i>Marital Status</i>	Married	54	23,68
	Never Married	111	48,68
	Divorced	8	3,51
	Widowed	30	13,16
	Separated	5	2,19
	Living together	20	8,77
Frequency missing = 2			
N = 228			
N=230			

The majority of the respondents, namely 180 (78.60%) of the 230 respondents, were women. According to personal discussions with members of the community most of the men in this village have left to seek employment opportunities in bigger cities. Some men return home on an irregular basis, leaving the woman to take care of the household, child and elderly care. This leaves the family vulnerable to poverty and crime.

Based on a previous study in the Heuningvlei community Motshedi (2009:76) indicated that 49 (21.40%) of men were herding their livestock during the day and would come back by the evening.

The ages of the community members varied from between 21 to 30 years old to over 60 years old. The two highest groups, between 31 and 40, and 41 and 50 years of age represented the largest part of the community. These are the groups that should be participating in the open labour market, but they are mostly unemployed.

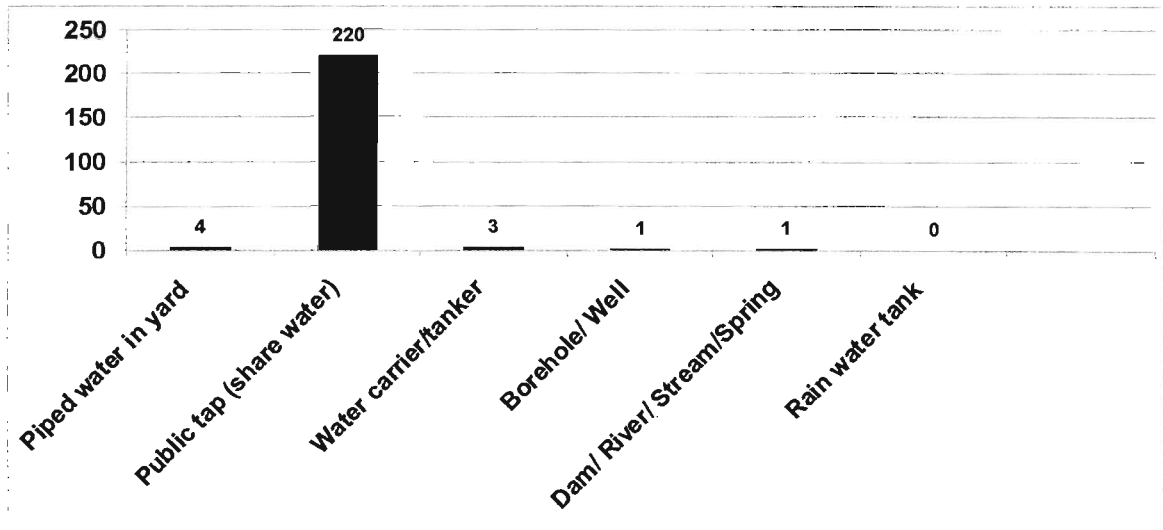
To the question on marital status, 54 (23.68%) of the respondents indicated that they are married and 111 (48,68%) that they were never married. The majority of people in this community are single and therefore do not necessarily have access to family relationships which encourage good health practices. According to Blank and Burau (2004:196, 203), economic deprivation, social disorganisation, personal alienation and isolation has a major negative impact on people's health. They continue to discuss the importance family plays in the integration of health-promoting routines into daily life. The family environment provides an individual with a social setting that is critical to health and psychological and physical development. It seems that most respondents have low levels of education. 59 respondents have no qualifications. The qualification level of a community is closely linked to poor education, unemployment, poverty, violence and crime. May, Woolard and Klassen (2000:36) argue that 'a better education at the individual level offers the possibility of a better income and at the aggregated level; a better-educated population leads to higher economic growth'. Green (2008:178) states that people are not only particularly vulnerable to poverty when they are unemployed, but the impact of poverty also increases vulnerability to ill health.



Not answered = 9 N=230

GRAPHIC PRESENTATION 1: HOUSING DISTRIBUTION

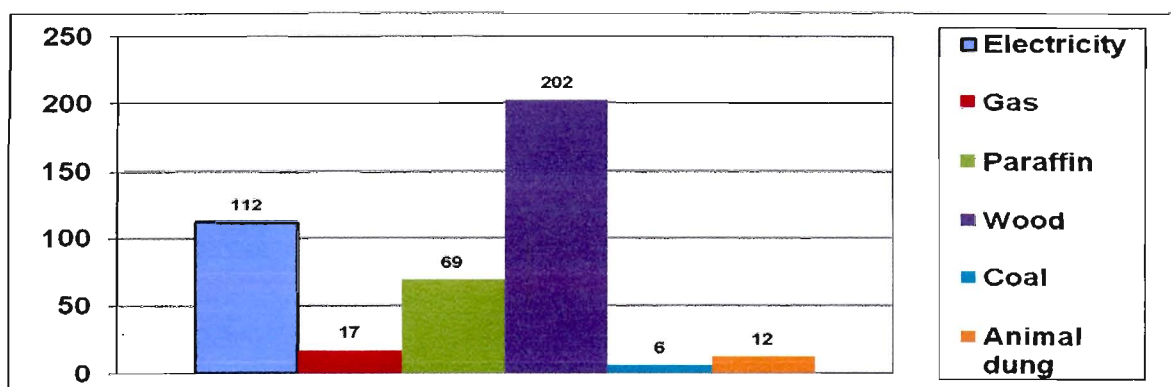
The type of housing the community members occupy has a significant influence on illness, health and the occurrence of disabilities in a community. The majority of respondents, 120 (52.17%) occupy traditional huts. 95 (41.30%) of the respondents live in a brick house, 5 (2.17%) respondents live in a traditional type dwelling (mokuku), 1 (0.43) of the respondents indicated other type of housing and 9 (3.91%) did not answer the question. Blank and Burau (2004:195) state that lack of housing seriously puts people, particularly children, at risk of poor health. The lack of adequate bathing and hygienic facilities leads to respiratory tract infections, trauma and skin-related illnesses. They continue to discuss the risks related to poor housing, such as house fires and increased accidents, damp and cold living conditions and improperly ventilated accommodation which is related to heat-related health problems. Another aspect to take into consideration with inappropriate housing is, according to Strydom and Tlhojane (2008:40), overcrowding, which could have a negative impact on the physical, psychological and social functioning of the family. The government attempts to address the poverty phenomenon through various policies, poverty alleviation programmes and including subsidised housing units (Strydom & Tlhojane, 2008:34). Gathiram (2005:123), however, indicates that despite these efforts, the government has not addressed the poverty phenomenon successfully.



Not answered = 1 N=230

GRAPHIC PRESENTATION 2: WATER RESOURCES

The majority of the respondents, 220 (95.65%) utilized the shared public tap in the community. 3 (1.30%) respondents indicated that they utilize a water carrier or tanker. 1 (0.43%) respondent indicated utilizing a borehole or well, 1 (0.43%) indicated dam or river water and only 4 (1.74%) respondents had access to piped water in the yard and one respondent had a borehole or a well. 1 (0.43%) respondent did not answer the question. This indicates that the majority of participants do not have running water and therefore do not have access to modern sanitation. This situation is described by Tempelhoff (2006:5) who states that 15 million people in South Africa do not have access to modern sanitation. Potgieter (1998:67) reports that 80% of the world's diseases and sicknesses, for instance cholera, diarrhoea and typhus, result from poor water supply and insufficiency or non-existence of sanitation facilities.



N=230

GRAPHIC PRESENTATION 3: THE DISTRIBUTION OF COOKING FACILITIES

In this case, the respondents could mark more than one option in this question. In Heuningvlei, only 112 (49.34%) of the respondents use electricity for cooking. 17 (4.07%) respondents use gas, 69 (16.51%) use paraffin, 6 (1.44%) use coal and 12(2.87%) use animal dung for cooking. 202 (48.33%) of the respondents indicated that they make use of wood to cook, although they have electricity, because of the financial burden of buying electricity.

The result of this is the depletion of natural resources and several concerns with regard to appropriate nutrition, food storage, hygiene and preparation of safe and healthy cooking. The Department manages an integrated nutrition programme, as well as a programme for the prevention of mother to child transmission of HIV (Frank, 2005:17).

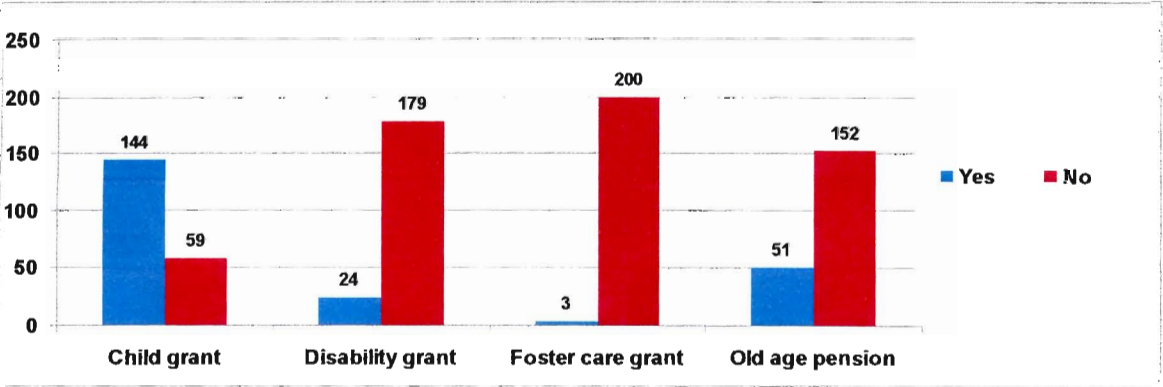
TABLE 8: Utilization of food gardens

	Yes		No	
	<i>f</i>	%	<i>f</i>	%
<i>Do you have a food garden?</i>	30	13.33	195	86.67

Frequency missing = 5

N =230

This table indicates that the majority of respondents, 195 (86.67) in the Heuningvlei community do not utilize food gardens. Only 30 (13.33%) of the respondents have food gardens. The lack of provision of water hinders the utilization of food gardens; therefore the community members do not benefit from important nutritious home-grown fruit and vegetables. Rossi, Lipsey and Freeman (2005:7) refer to a study with pregnant women, lactating mothers and children who were provided with a higher intake of protein and nutritious foods and supplements. Benefits included aspects such as gains in physical growth and increases in cognitive functioning. Uys and Cameron (2008:169) state that community food gardens have made a significant contribution to the nutritional status of many families in rural communities all over South Africa.

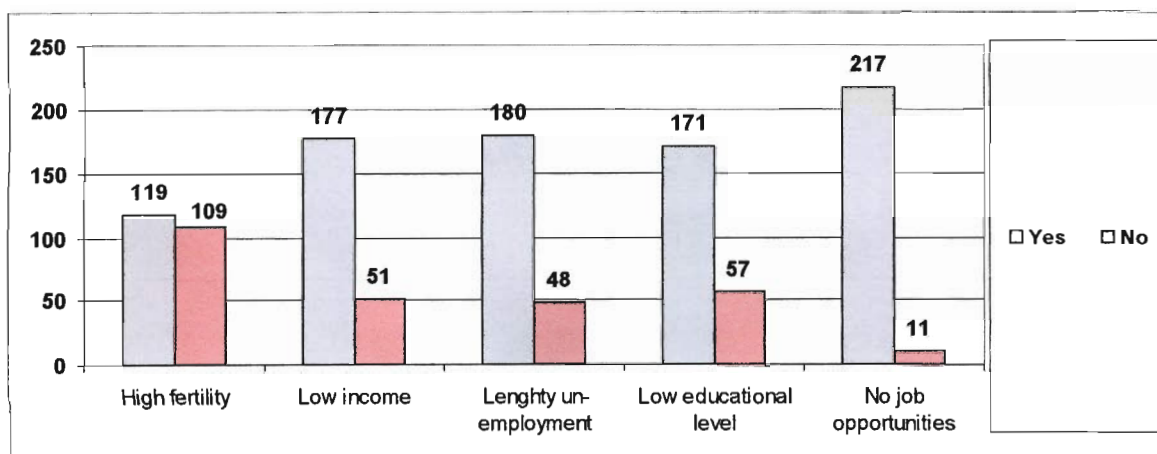


Not answered = 27 N= 230

GRAPHIC PRESENTATION 4: TYPES AND UTILIZATION OF SOCIAL SECURITY GRANTS

The main source of income of these households is social assistance grants from government. Some of the respondents receive more than one type of grant. 144 (70.9%) of these grants is Child Support Grants, 24 (11.8%) is Disability Grants, 3 (1.35%) is Foster Care Grants and 51 (25.1%) is Old Age Grants. The amounts of the grants paid out for the year 2006 are Old Age Grant R820, Disability Grant R820, Child Support Grant R190 and Foster Care Grant R580. The majority of households utilize these social security grants to sustain the entire household. It is clear that the community members of Heuningvlei will not be able to survive at this stage without this income. The exploration of the utilization of specific grants indicated that the child-care grant is utilized most and the foster-care grant is utilized least. The Department of Social Development (South Africa, 2006b:2) announced that an investigation into the possibilities of creating opportunities for social grant beneficiaries and the unemployed should be a key focus in order to meet the Millennium Development Goals by 2015. Merely receiving grants from the Government

alone is not enough. Growth and development in any rural and poor community is essential.



Not answered = 2 N=230

GRAPHIC PRESENTATION 5: PERCEIVED CAUSES OF POVERTY

Unemployment and limited job opportunities are perceived to be the major causes of poverty by 217 (95.2%) of the respondents. Blank and Burau (2004:202) state that unemployment can influence health by reducing income level and standard of living, lower self-esteem, cause significant psychological stress which is linked to higher levels of physical and mental ill health. They continue to discuss the consequences, which include suicide, self-harm and alcohol and drug abuse. 171 (75%) of the respondents said a low level of education was one of the causes of poverty. 180 (78.9%) respondents indicated lengthy un-employment, 177 (77.6%) respondents indicated low income and 199 (87.3%) respondents indicated the high fertility rate as causes of poverty in their community. According to the United Nations (1999:9), there is a very strong correlation between the level of education and standard of living. The attainment of a minimum education level improves a person's skills and capacity to enter the employment market, ultimately fighting the poverty circle. Scales and Streeter (2004:179) describe extreme poverty and threats to physical and mental health as the top social problems afflicting developing countries. Malnutrition, chronic hunger, ill health, lack of health care facilities and knowledge leads to high levels of various illnesses, HIV or AIDS and even disabilities.

TABLE 9: Skills training required

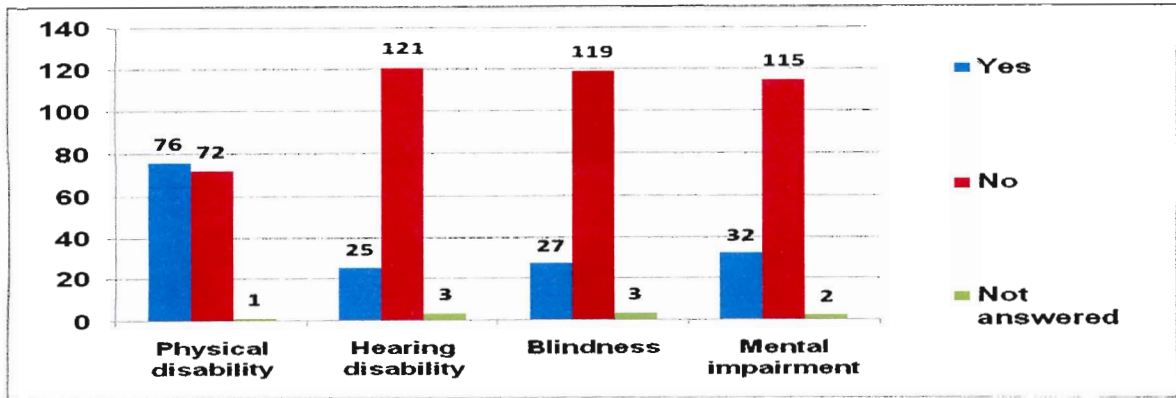
Which skills do you need training in?	Yes		No	
	<i>f</i>	%	<i>f</i>	%
Conflict skills	153	69.55	67	30.45
Communication skills	162	73.64	58	26.36
Bargaining skills	138	62.73	82	37.27
Parenthood skills	155	70.78	64	29.22
Frequency missing =10				

N= 230

According to table 9, communication skills as indicated by 162 (73.64%) of the respondents, parenting skills as indicated by 155 (70.78%) of the respondents and conflict management skills as indicated by 153 (69.55%) of the respondents are the most essential and requisite skills for the Heuningvlei community members. Laverack (2005:4) indicates that in order for any individual to feel confident to deal with his/her difficulties and further to assist other community members, it is important to assist the person to obtain skills, which can instil greater sense of self-confidence. Skills training is therefore essential during any community development programme. Midgley (1995:59) states that human development should be a key focus of social development, which in turn is again vital to economic development.

9.2 BIO-PSYCHOSOCIAL NEEDS WITH REGARD TO DISABILITY

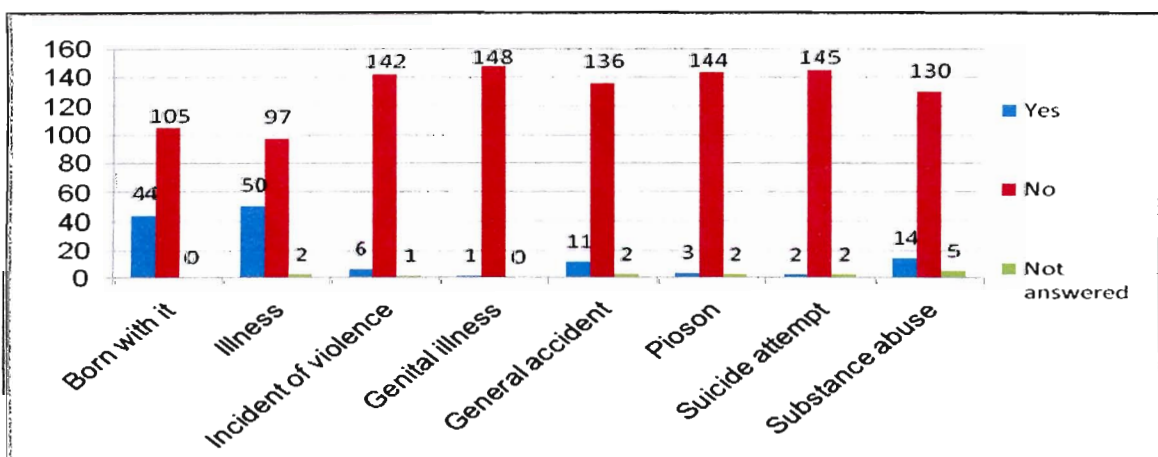
The information utilized for this specific section of the research was gathered by using disability-specific questionnaires. The snowball method resulted in 149 Heuningvlei community members with disabilities being interviewed.



N=149

GRAPHIC PRESENTATION 6: THE PREVALENCE OF DISABILITIES IN THE COMMUNITY

Patel (2005:174) defines disability as a physical or mental impairment that limits a person's capacity to perform one or more major life activities and states that quadriplegia, deafness and blindness are the most common disabilities in South Africa. Most respondents indicated having more than one disability. The highest prevalence of disabilities in the Heuningvlei community involves physical disabilities (cerebral palsy, traumatic brain injuries, paralysis and speech impairments) as indicated by 76 (51.0%) of the respondents. Hearing disabilities were indicated by 25 (16.8%) of the respondents and sight disabilities as indicated by 27 (18.1%) of the respondents are the lowest incidence, but are closely related. These two disabilities were reported to be most frequently found between the elderly of the respondents, thus being age-related disabilities. Mental impairments are substantially high as indicated by 32 (21.5%) of the respondents and seem to be the least visible in the community with little or no support services available to these respondents.

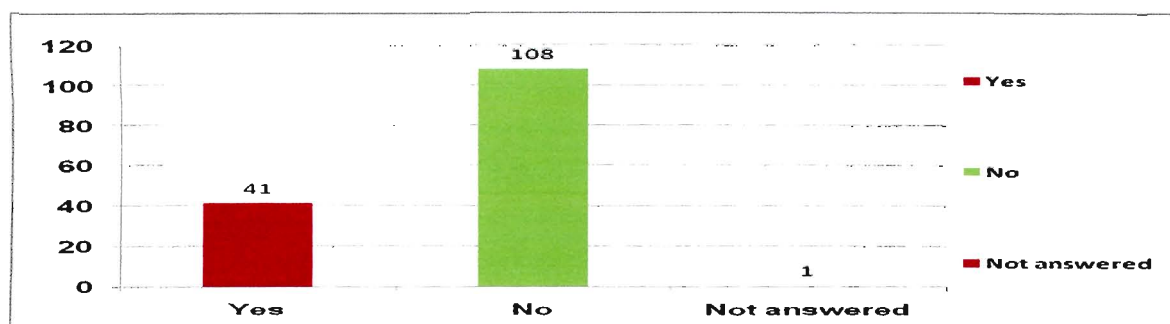


N=149

GRAPHIC PRESENTATION 7: THE CAUSES OF DISABILITY

Overall the data suggests that the leading causes of disabilities are illness-related as indicated by 50 (34.0%) of the respondents, natural causes were indicated by 44 (29.5%) respondents. The prevalence of disabilities is thus closely linked to the health status of the community members. Blank and Burau (2004:201) state that low-income families are more likely to have preventable hospitalisation-related illnesses and disabilities. These illnesses are not always treated due to a lack of transport, lack of financial resources and lack of knowledge, resulting in serious illnesses and disabilities. Risky individual behaviour includes smoking and alcohol abuse. Blank and Burau (2004:193,196) state that smoking and alcohol is a significant threat to a person's health. They continue to discuss the causes of illness and state that a fully preventable cause of illness and ultimately disabilities is violence. Violence is often tied to alcohol and drug abuse, firearm-related injuries, family-related violence, child abuse, spousal abuse and elder abuse. Desmond and Boyce (2006:201) support this view and state that health-related problems, linked to alcohol consumption such as cirrhosis and associative incidents, such as violence and car accidents.

The lowest prevalence of causes of disabilities is genital illness as indicated by 1 (0.7%) respondent, suicide as indicated by 2 (1.4%), poison as indicated by 3 (2.0%) and general accidents were indicated by 11 (7.5%), but it still indicates that a need exists for information and training focusing on HIV, AIDS and STIs in order to prevent disabilities from genital illnesses and even mother- to- child transmissions. This could be addressed by empowering the community members to be aware of their rights and to demand government intervention, social security and other resources in order to address stress and depression. The occurrence of poison being a cause of disabilities indicates the need for health and safety awareness in the home environment.

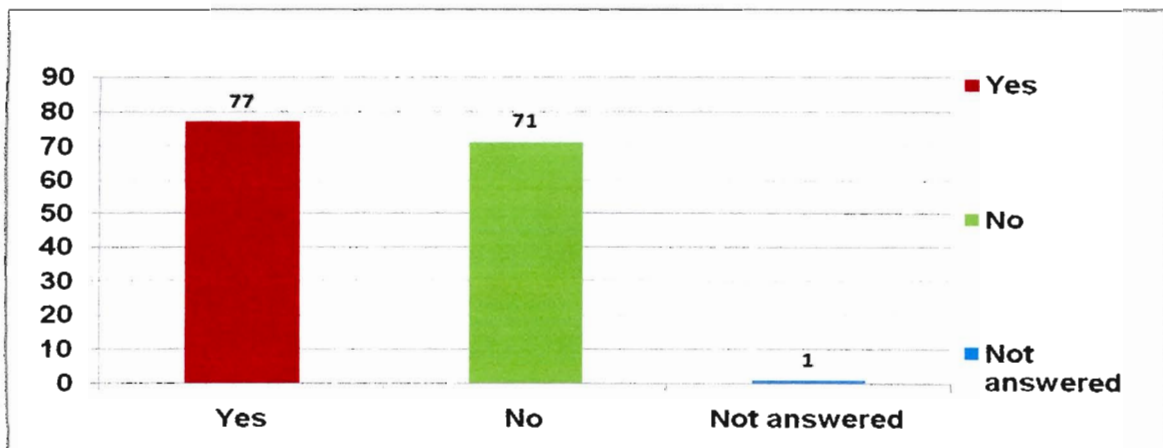


N=149

GRAPHIC PRESENTATION 8: THE USE OF ASSISTIVE DEVICES (ADS) IN THE HOUSEHOLD

The majority of the respondents, namely 108 (72.48%), do not utilize assistive devices and are in urgent need of such devices. Some of the respondents indicated that they do

utilize assistive devices 41 (27.52%). One respondent (0.67%) did not answer the question. This occurrence could indicate two reasons why a community member with a disability does not have assistive devices. Firstly they might not be aware of the application process and requirements for application for these devices or secondly they might not have access to a medical practitioner who would be able to assess their disability and provide a medical report (as requested as part of the application process). Both reasons indicate a need for awareness and information distribution in the community. Assistive/rehabilitation technology enables individuals with disabilities to participate on equal terms. If people with disabilities are to access their rights and responsibilities and participate in society as equal citizens, they must have access to appropriate and affordable assistive devices. Assistive devices can enhance mobility, communication and daily living circumstances of a person with a disability (Ross and Deverell 2004:157).



N=149

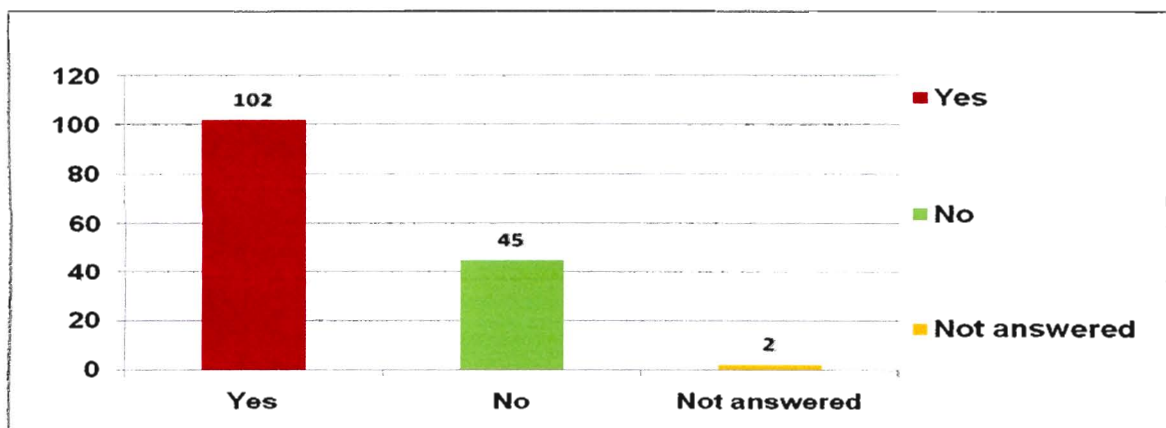
GRAPHIC PRESENTATION 9: GRANT UTILIZATION

Most respondents 77 (52.03%) indicated that they do utilize disability support grants, but a distressing 71 (47.97%) respondents with disabilities indicated that they do not receive any disability support grant. One (0.67%) respondent did not answer the question. This result could once again indicate that the respondents might not be aware of the application process and requirements for application for a disability grant or they might not have access to a medical practitioner who would be able to assess their disability and provide a medical report (as requested as part of the application process). This result clearly indicates the need for social work assistance, guidance and support in the community.

TABLE 10: Knowledge with regard to application for grants

	Yes	No	Not answered
Grant application:	100	48	1
How and when			
Frequency missing = 1			
N = 149			

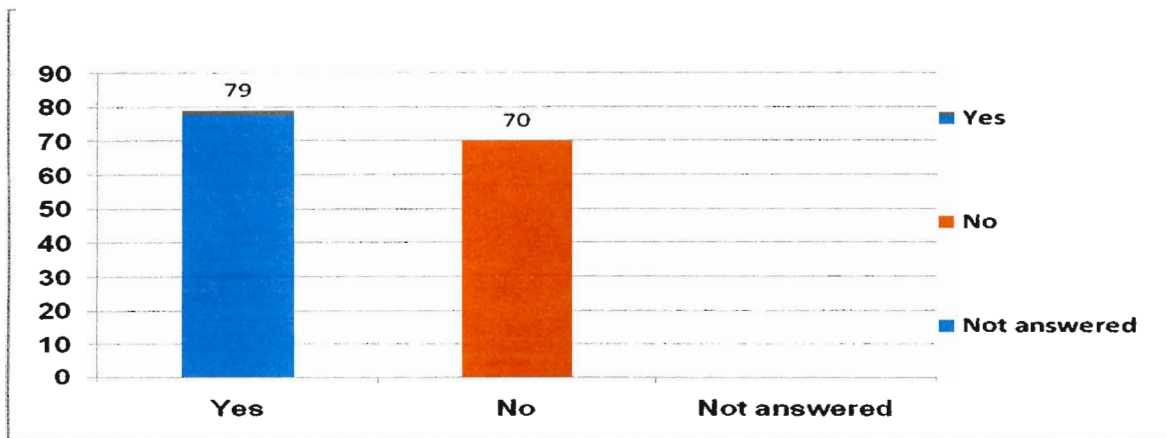
This table indicates that 100 (67.11%) respondents are aware of how, when and where to access social security grants, but 48 (32.4%) respondents indicated that they did not obtain this information and are not aware of the application process. 1 (0.67%) respondent did not answer the question. This confirms the need for social work intervention in this community.



N=149

GRAPHIC PRESENTATION 10: IMMUNIZATION KNOWLEDGE

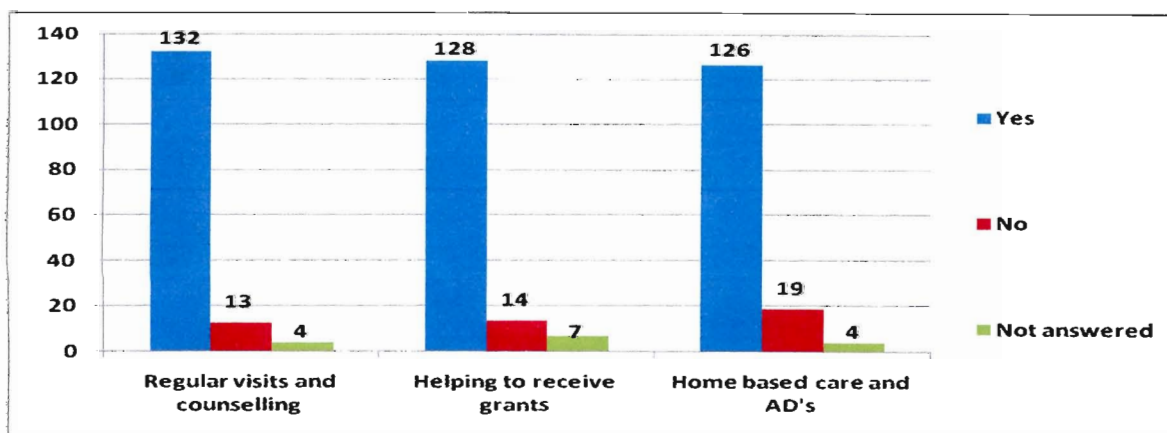
The majority 102 (68.46%) of the community members are aware of the importance of and guidelines with regard to immunizations. However, 45 (30.20%) of the respondents indicated that they are not aware of the immunization requirements and that they do not take their children for the necessary immunizations. 2 (1.34%) of the respondents did not answer this question. These results indicate a need for education and training regarding this matter.



N= 149

GRAPHICAL PRESENTATION 11: REGULAR HEALTH CHECK-UPS

The majority of respondents 79 (53.02%) also do have regular health check-ups, but a significant segment of the respondents 70 (46.98%) do not have regular health check-ups. To enable the community members to maintain a healthier lifestyle, Laverack (2005:47) suggests that the individuals should be assisted to gain power through knowledge, ultimately resulting in healthier lifestyle choices. Regular health check-ups could prevent certain diseases, serious health consequences and disabilities. Ross and Deverell (2004:286) concur, and state that prevention, control and treatment of common diseases and injuries are crucial to prevent long-term consequences.



N= 149

GRAPHIC PRESENTATION 12: SERVICES REQUIRED

This chart clearly indicates the needs of the Heuningvlei community members with disabilities. 132 (91.0%) of the respondents indicated that they need assistance through regular social work visits, counselling and support. These services should include assistance with applications for social security grants and assistive devices as well as home-based care. 128 (90.1%) of the respondents indicated that they need assistance with access and application for grants and 126 (86.9%) of the respondents indicated that

they need home-based care and ADs. Laverack (2005:75) states that certain groups or communities often exist on the margins of a society from where they can become excluded from the access to health, education and other community services. These marginalized groups include the elderly, the mentally ill and people of a low socio-economic status. Community care is the help and support given to individuals, for example children, people with disabilities and older people in non-residential settings by an informal, a quasi-formal or a formal helper (Terminology Committee for Social Work, 2005:11). They also have a desire to learn additional skills and to participate in other community development projects. Midgley (1995:16) confirms that the development approach can ensure integration into society and it could contribute to development and the well-being of the poor.

Home-based care seems to be a major need in the community and South Africa (2006a:4) recommends that all home-based care projects should also cater for orphaned, HIV affected and other vulnerable children (Smart, 2003:54). Ross and Deverell (2004:287) provide guidelines for the roles of the healthcare professionals during community development projects.

Support services should also include the immediate and extended family members as Fraser, Nelson and Rivard (1999:47) indicated that mental health studies have shown that family-centred intervention and support both reduces symptoms and lowers the risk of hospitalization.

9.3 INDIVIDUAL INTERVIEWS WITH EXPERTS IN THE COMMUNITY

Individual interviews with, five experts, were conducted with local community members to gain a holistic view on the current situation in Heuningvlei, the existing resources and available support to the community members with disabilities. The participants for these interviews were entirely selected on the judgement of the researcher (purposive sampling). The participants were likely to be knowledgeable regarding disability issues and concerns in the community and would therefore provide the most relevant information for this study. Interviews were conducted with local experts including the school principal, a member of the Peace Corps (United States of America), registered nurses from the clinics, religious leaders, community leaders, the Chief and his royal family circle members, members of the SAPS and a few community members. All the information gathered were analyzed according to Tesch's data analysis approach.

9.3.1 Interview questions and main themes

The initial interviews with key role-players in the Heuningvlei community were based on the following questions. The main themes from these interviews are also presented in table 11.

TABLE 11: Interview questions and main themes

QUESTION 1 NAME A FEW SERVICES YOU THINK THE PEOPLE WITH DISABILITIES IN YOUR COMMUNITY NEED?	
MAIN THEMES:	
∞	Help with accessing disability grants
∞	Social work counselling
∞	Assistive devices such as wheelchairs, crutches and hearing aids
∞	Specialized schooling
∞	Protection
∞	Government housing assistance
∞	Transport
∞	Jobs
DIRECT QUOTES:	
∞	“There used to be home-based care for the disabled and HIV people, but the man left with the money and no-one is getting paid to do the work”.
∞	“There is no special schooling for my child”.
∞	“They are very isolated, they need some social events”.
∞	“I am desperate to do something, any skills training is needed”.
LINK WITH LITERATURE:	
∞	Cochran (1991:64) states: “freedom to grow, through schooling, work, and leisure activities, will lead in turn to the social network connections that form the basis of healthy, productive communities”.

QUESTION 2

WHAT DO YOU THINK ARE THE PHYSICAL NEEDS OF THE PEOPLE WITH DISABILITIES

MAIN THEMES:

- ∞ Transport to the clinic, church and shops
- ∞ Comfortable and adapted housing
- ∞ Support to the caretakers

DIRECT QUOTES:

- ∞ "I need home-based care. I live close to the clinic, but am not able to get my high blood medication. A home-based carer could get it for me".
- ∞ "Physical handling training for the caretakers. I look after my mother, who had a stroke and I am not sure if I am handling her correctly".
- ∞ "We are poor, we need money for food".

LINK WITH LITERATURE:

- ∞ Weissbourd (1991: 73) states that families who receive support are empowered to advocate on their own behalf.

QUESTION 3

WHAT INFORMATION/EDUCATION SHOULD A COMMUNITY-BASED DISABILITY PROGRAMME INCLUDE FOR YOUR SPECIFIC COMMUNITY?

MAIN THEMES:

- ∞ Healthy living & healthy food – including the advantages of a vegetable garden
- ∞ Hygiene
- ∞ Anti-natal advise
- ∞ Physical homecare advice for caretakers
- ∞ The consequences of alcohol and drug misuse
- ∞ Social security grant applications
- ∞ Conflict management skills
- ∞ Bargaining skills
- ∞ Parenting skills
- ∞ Communication skills
- ∞ Causes of disabilities

DIRECT QUOTES:

- ∞ “One of the biggest needs in this community is information on ancestry and the disabilities that result from it”.
- ∞ “Information on timely immunizations.
- ∞ We struggle to get the mothers to bring the babies for their injections”.
- ∞ “We want to be part of the community, but transport and wheelchair facilities do not exist”.

LINK WITH LITERATURE:

- ∞ Weissbourd (1999:72) states that the most effective approach to families emanates from a perspective of health and well-being and the capacity of parent to raise their children effectively is influenced by their own development.

QUESTION 4

DO YOU THINK YOUR COMMUNITY MEMBERS ARE AWARE OF THE NEEDS, EXPECTATIONS AND DREAMS OF PEOPLE WITH DISABILITIES?

MAIN THEMES:

- ∞ Isolation
- ∞ Discrimination
- ∞ Marginalization

DIRECT QUOTES:

- ∞ “No, we don’t have the resources to transport them, provide special education or assist them to take part in any church service/ other events”.
- ∞ “Yes, I know that they want something to do. To learn some skills”.
- ∞ No, many people think that they are cursed
- ∞ No, people think the parents are being punished for their sins and the family is isolated

LINK WITH LITERATURE:

- ∞ Dunst, Trivette and Thompson (1991:25) state that mobilizing and utilizing informal support systems as sources of resources decrease the likelihood of dependency on professional and formal human service systems.

Based on the answers received from the individual interviews it seems that the people with disabilities in the Heuningvlei community do need support and services, including counselling, advocating, specialized schooling, employment opportunities and a fair

chance to live independently. The isolation of the community leads to lack of transport, learning and development opportunities. A community-based disability programme should include an array of disability prevention, -awareness and –management information in order to meet the assessed needs.

10. CONCLUSION

The objective of this article was to compile a community profile and to determine the biopsychosocial needs of the community members with disabilities through a comprehensive survey. During this study it was evident that the inhabitants of the Heuningvlei community were very poor and isolated. They were struggling to survive with the minimum resources, unable to afford electricity or water for a food garden. Women represented the majority of the community as the men have migrated to seek employment. The general level of education was low and income and living conditions poor (no running water or modern sanitation). The majority of the respondents were living in poor, improperly ventilated, cold and damp housing conditions. Research has indicated that this could have a negative impact on the physical, psychological and social functioning of an individual.

Social security grants were the main source of income and unemployment reported as the main cause of poverty. Extreme poverty, malnutrition, chronic hunger, ill health, lack of healthcare facilities and lack of knowledge all lead to chronic diseases and disabilities.

The disability-related study showed that the highest prevalence of disabilities involved physical disabilities (cerebral palsy, traumatic brain injuries, paralysis and speech impairments) with hearing, blindness and mental impairments also represented. The hearing and blindness disabilities were separately assessed because the researcher wanted to distinguish between physical disabilities related to old age and physical disabilities caused naturally or by other health problems.

The causes of disabilities are mostly illness, substance abuse or natural. All three aspects could, on the whole, be prevented through general health awareness and a healthier lifestyle. It was also palpable that crucial disability management- and support services lack in this rural area. Partnership-working between government organizations and NGOs seems a foreign affair and the community members with disabilities and their families an elapsed entity.

11. RECOMMENDATIONS

Community-based social intervention is not a static phenomenon, since needs of the community members may change. Different problems may present themselves at a later

stage and other unforeseen obstacles are to be expected during the development, implementation and evaluation of this programme. Flexibility and change will need to be integrated into this study. The community-based disability programme will aim to meet as many of the assessed needs, to prevent the occurrence of disabilities and to manage disability-related issues more effectively.

- ☞ The community profile indicated that the people from the Heuningvlei community are struggling with limited resources and income. The lack of resources should play a major role in the planning process for community intervention. It therefore makes sense to restrict the dependency on these limited resources to prevent exhaustion thereof. The encouragement of healthy living and the prevention of disabilities in this community could reach this goal.
- ☞ It was also indicated that only a few community members had food gardens. Fresh fruit and vegetables could be beneficial to the community members' health and prevent serious illnesses and disabilities.
- ☞ The food garden could also provide the PWD with healthy food and improve their immune systems.
- ☞ The main sources of income for these households are social security grants. The most effective way of reducing the burden of increasing numbers of people becoming disabled and draining the social security system (disability grant) is to prevent the occurrence of disabilities in rural areas. Training included requirement for specific grant applications, application process and general application requirements.
- ☞ Unemployment is a major obstacle.
- ☞ Skills training would be beneficial to the community members with disabilities but marketing the products and selling it is a major challenge in rural areas.
- ☞ It is important to take the community's language and culture requirement into consideration.
- ☞ Several physical disabilities are due to ill health, high blood pressure, substance abuse, and bad eating habits. Healthy living advice should be included in the programme.
- ☞ The majority of PWD does not utilize ADs, but would like to. Assistance with the application for ADs could be covered in the programme, but the responsible role-player (Department of Social Development) in the community should be motivated to assist the PWD.

- ☞ Services required included regular visits and counselling, help to receive grants and ADs as well as home-based care support. These services should be provided by the relevant role-players, including the Department of Social Development, Department of Health, SASSA, Department of Housing, Department of Education, Office of the Premier, NGOs and disability-specific organizations.
- ☞ Community members with disabilities are often isolated and discriminated against; therefore community awareness and support is paramount.
- ☞ The families/caretakers of the people with disabilities are in need of psycho-social support, advice and physical care support. Disability-trained home-based carers could assist the family members.
- ☞ A support group for people with disabilities could meet the assessed psycho-social needs of the participants.
- ☞ Education Support Services (ESS) ought to be available to all learners with disabilities. Education for people with disabilities, their family, friends and other significant role-players in a community should include aspects such as independent living, independent travelling and life skills.

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ARTICLE 3
A COMMUNITY-BASED DISABILITY PROGRAMME FOR RURAL
AREAS

ABSTRACT

This article aims to develop a community-based disability programme based on a situation analysis in order to support and empower poverty-stricken rural families in the Heuningvlei community, in the Northern Cape Province of South Africa, with skills, knowledge and insight into disability issues. It includes the exploration of the intervention theories, models, approaches and principles underlying the programme as well as the possible impact of this programme on micro-, meso- and macro levels.

The programme was developed in response to the findings of the community profile, the disability needs assessment survey, the individual interviews conducted and the literature studies with regard to the study reported here.

KEYWORDS:

Disability management, community empowerment, people with disabilities, rural community, community-based intervention

1. INTRODUCTION

This research project forms part of the Tshwaragano community development project, which was started in the Heuningvlei Village in the Kagisano Municipal district in 2006. The Heuningvlei community comprises the following villages; Heuningvlei, Shalaneng, Tsilwane, Kome, Perth, Klein-Avon, Klein-Effel, Madibeng, Ganap, Loopeng. The Tshwaragano project in the Northern Cape Province specifically focuses on empowerment programmes to build the capacity of the poor people living in the Heuningvlei community in order to ultimately achieve self-reliance.

Jason, Keys, Suarez-Balcazar, Taylor and Davis (2004:44) state that community residents are the primary stakeholders in changing community behaviour. The community members' experiences and knowledge are crucial in order to develop a co-learning process and needs-based community programme. They continue to discuss the importance of health promotion as part of the community development programme and states that optimal development of competence pathways requires an integrated approach involving families and community resources on micro, meso and macro level

Based on the above guidelines, disability-specific research conducted in this community, by means of comprehensive needs assessment clearly indicated the need for knowledge, skills and coping mechanisms related to disability matters. This article will focus on the veracity of the obstacles in this community, linking it with the development and presentation of the community-based disability programme.

Poverty, health and disability are closely linked and through essential research procedures it has been established that a community-based disability programme could meet the needs of the community members with disabilities as well as their caretakers. The rationale of this community-based disability intervention programme is to address disability-related issues in a rural community through proper management, increased awareness, the development of support systems and an improved understanding of disability-related issues. Overall the motivation for this programme is to empower community members with disabilities, significant role-players and the community members to successfully take ownership of a sustainable intervention programme. This process would then enable capacity building through which human dignity is enhanced and structures are created within which it can operate.

2. PROBLEM STATEMENT

This deep rural community in South Africa is mired by limited resources. The roads leading to Heuningvlei are in appalling conditions, discouraging service providers to engage with these communities. Lack of service delivery, low levels of income, high unemployment and lack of education, training and development opportunities lead to a multi-dimensional poverty phenomenon that impinges on the entire spectrum of human development.

Unemployment and related obstacles are major crises and have a direct impact on the entire community's functioning. Roberts (2006:103,108) states that food insecurity and malnutrition has been on the increase resulting in children's development and growth being disproportionately affected. He continues to describe typical problems in rural areas such as malnutrition, lack of food gardens, safe water utilization, and sanitation which all have a negative impact on the well-being of people. In addition to these facts, Chenga and Cronje (2007:145) describe poverty as one of the main causes of loss of self-esteem, alcoholism, family violence and family disorganisation. To promote psycho-social and physical well-being and prevent certain disabilities, the consequences of these concerns should be brought to the attention of the community members. Contributing factors to the prevalence of disabilities in the Heuningvlei community have been identified during this study and the community-based disability programme aims to address these needs.

Desmond and Boyce (2006:200) state that health is a key component of people's well-being and that it is vitally important that people gain knowledge and have control over aspects such as healthy eating habits, exercise, smoking, drinking, drug abuse and risky sexual behaviour. Pretorius, Terblanché and Tshiwula (2007:117) support this view and state that violence is a contributor to vulnerability to mental health problems. According to Ross and Deverell (2004:4), other challenges are prejudice and social stigma, isolation, lack of access to support networks and resources for an independent daily existence, lack of access to infrastructure, services, communication, transport, opportunities, resources, education, technical aids, etc that allow them independence and promote their dignity, self-sufficiency and responsibility.

South Africa (2008a:2) states that the goal of people-centred development espoused by the department will be attained through increased participation by people with disabilities as consumers of government services.

The question as to exactly how and where they could play a role in the process will be one of the issues to be addressed through the following research question:

- ∞ What should be included in a community-based disability programme for the Heuningvlei community?

3. AIM AND OBJECTIVE

The following aim forms the foundation for this specific article.

3.1 Aim

- ∞ To implement the community-based disability programme for the Heuningvlei community.

3.2 Objective

- ∞ To develop and implement a community-based disability programme based on the situation analysis.


4. RESEARCH METHODOLOGY

The research methodology for this article is explained by De Vos (2005a:368) as follows:

“When we are asked, or feel compelled, to design and develop (and eventually evaluate) a new intervention, we are conducting intervention research”.

The research methodology for this study is visually portrayed in Table 12.

TABLE 12: Summary of the research methodology for this article

<p><u>PHASE 2</u></p> 	<p>Pilot testing the programme with community members</p> <p>Programme implementation</p>
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This article is representative of phase 2 of the summary. The programme was pilot-tested by three community members before it was implemented with the group participants. This provided the researcher with the opportunity to test the relevance of the programme as well as the methods of presentation. It was clear that an interpreter would be crucial to ensure successful implementation and sustainability of the programme. The programme was implemented and evaluated after approximately six months. Phase three consists of

the evaluation by focus group participants. The focus group participants (significant role-players and key figures) were identified during phase one of the research project. Rossi, Lipsey and Freeman (2005:7) suggest that the focus groups' purpose is to evaluate the programme's efficiency.

5. ETHICAL ASPECTS

Ethical permission for this study has been granted by the Ethics Committee of the North-West University (Potchefstroom Campus). Ethical application number: 06k07. Tshwaragano Project. The necessary permission has also been attained from the Heuningvlei Chief.

Ethical guidelines are important aspects in social sciences. Strydom (2005a:56-67) suggests that the researcher should demonstrate ethical responsibility towards those who participate in the research project and secondly towards the discipline of science. Overall ethical aspects kept in mind during this study were that the goal of the research project was clear and transparent. The researcher informed the respondents of the potential consequences of participating in the research. It was made clear to the participants that participation was voluntary and that they were able to withdraw from the study at any stage. With this in mind the participants were informed with regard to all aspects of the research project and written consent forms were signed in advance. Henn, Weinstein and Foard (2006:67) discuss the reasons for written consent. All information will be kept confidential and anonymous as suggested by Kartell and Chabilall (2005:215). All the respondents will be informed of the results of the research project. The researcher is aware that many of the ethical issues that have been raised are extremely complex and careful consideration of both context and principle is needed.

6. RESEARCH RESULTS

The results of the research conducted in the Heuningvlei community, which forms the foundation of this community-based disability programme, have been presented in Article 2. The information presented in this article is a summary of the results and aims to provide a focus for the programme development. The results are as follows:

6.1 COMMUNITY PROFILE

The first part of the research project was to utilize the information gathered from a previous study in the Heuningvlei community in the Northern Cape Province in order to compile a community profile for a more holistic approach. The results could be

summarized as follows: It was clear that the Heuningvlei community members are extremely poor; women, who were also the main breadwinner of the households, represented the majority of the community. It is interesting that the respondents were between 31 to 50 years of age and that the general level of education was grade 7. Accommodation is poor and the majority of the community utilize a public water tap for general household use. Their cooking facilities are of a low standard and they are not generating an income or providing healthy food for themselves and their families through the utilization of food gardens.

Unemployment and barely any job opportunities are perceived as the major causes of poverty and a foremost need for these community members is advice and assistance in applying for social security grants. Communication skills, parenting skills and conflict management skills are the most essential and requisite skills for the Heuningvlei community members.

6.2 DISABILITY-SPECIFIC INFORMATION

The second part of this research project was to focus specifically on disability-related information in this community. The highest prevalence of disabilities as indicated by 25 (15.63%) of the respondents include hearing impairments, 27 (16.88%) of the respondents indicated blindness, 32 (20.00%) indicated mental impairments and 76 (47.50%) indicated physical disabilities (cerebral palsy, traumatic brain injuries, paralysis and speech impairments). The biggest causes of disabilities in this community are illness-related and natural causes. Risky individual behaviour includes smoking and alcohol abuse. Some of the respondents, 41 (27.52%), with disabilities do utilize assistive devices (ADs), but a major group with disabilities, 108 (72.48%), are still in need of advice and support in order to secure devices for themselves.

Most respondents, 77 (52.03%), indicated that they do utilize disability support grants, but a distressing 71 (47.97%) respondents with disabilities indicated that they do not receive any disability support grant. They also indicated that they need support and advice in order to access disability grants. The majority of the respondents are also aware of the importance of immunization at the appropriate age, but some respondents still indicated that they are not aware of the immunization requirements and that they do not take their children for the necessary immunizations.

The community members indicated that they need assistance by means of regular social work visits, counselling and support. These services should include assistance with applications for social security grants and assistive devices as well as home-based care.

Some of the Heuningvlei community members are well informed about their rights and responsibilities, but they clearly still need a large amount of assistance and advice. The community-based disability programme will aim to meet all the assessed needs, to prevent the occurrence of disabilities and to manage disability-related issues more effectively.

7. A COMMUNITY-BASED DISABILITY PROGRAMME FOR RURAL AREAS

The intervention programme for the Heuningvlei community is a first community-based disability programme. The background, framework and intervention strategies included in the programme will be discussed in this article.

7.1 DISABILITY INTERVENTION STRATEGIES, MODELS AND APPROACHES UNDERLYING THE PROGRAMME

The development of a community-based disability programme for rural communities is based on a process which promotes and utilizes human resources through consciousness-raising and empowerment (Martí-Costa and Serrano-García, 2001:267), empowering social work practice and is supported by various intervention strategies, models and approaches. An empowering practice approaches all activities from a solution-seeking perspective and follows an organized process and actions (Du Bois & Miley, 2008:193).

7.1.1 The primary theory

The primary theory for this study is the systems theory. Zastrow and Kirst-Ashman (2007:12) explain the systems theory as concepts of interactions and relationships, dynamically involved with one another, among various systems such as families, groups, organizations and the community. The Heuningvlei communities' systems will include the individual with a disability, the environment system, the family system and the broader community system.

7.1.2 Supporting theories

The strengths theory and the empowerment theory support this strategy successfully. Laverack (2005:97) continues to advocate that empowerment is crucial during the independence process of any person or community that wishes to take control of his/her

life. Long, Tice and Morrison (2006:44) explain relationship between the strengths theory and the empowerment theory. They state that the empowerment theory focuses on the ability of people to gain control and power over their lives. This involves identifying and building on both personal and social dimensions of power in order for people and communities to gain power to affect change. To gain power, these systems need to utilize their resources and strengths as pointed out by the strengths perspective. Zastrow and Kirst-Ashman (2007:6) support the empowerment and strengths theories, as focussing on strengths provides the basis for empowerment. Individual strengths can include problem-solving, decision-making, advocating and creative thinking. Group strengths are embedded in the support group principles where people with similar problems, issues or obstacles come together to provide each other with support, information and resource suggestions (Ratele, 2006:2).

7.1.3 Intervention models

The overall intervention models for this study were community development, community education, social and the relation models. Weyers (2001:148) describes the community development model's focus on community members themselves resolving concrete problems, satisfying concrete needs and learning practical skills in order to develop their own community. He continues to describe the community education model's 'core business' to eliminate the disempowering effect of ignorance by improving the literacy and skills levels of the communities. Wilson (2005:24, 240) suggests utilizing the relational model which points out the link between the experiences, both internal and external, of individuals who perceive themselves as disabled and the effects disability can have on the non-disabled. This model focuses on the struggle against dependency and the stages by which disabled people achieve separate identity and positive self-image.

The White Paper for Social Welfare (South Africa, 1997:6) describes another pertinent and prevailing model. The social model of disability, which suggests that discrimination is fundamental to the way society thinks and operates. This model is based on the belief that the circumstances of people with disabilities and the discrimination they face are socially created phenomena and have little to do with the impairments of disabled people. The disability rights movement believes, therefore, that the 'cure' to the 'problem' of disability lies in restructuring society. Promoting social integration and fair integration is one of the fundamental principles of the social model to addressing disability.

7.1.4 Levels of intervention

The following figure will provide the guidelines for the intervention, namely Circles of Support, as illustrated by Smart (2003:43), which includes awareness and support at three levels, namely; micro, meso and macro.

The overall aim of the micro-intervention strategy is to ensure the general well-being of all community members with disabilities, and McGillivray (2007:3) provides a definition of what a holistic well-being approach should include, namely social welfare, well-living, utility, life satisfaction, prosperity, needs fulfilment, development, empowerment, capability expansion, poverty, human poverty and happiness. Patel (2005:217) mentions micro-intervention as the vehicle to address the development of skills such as relationship-building, effective communication, growth, socialisation, education and skills-building opportunities.

The second level, meso-level is based on the second circle of support as suggested by Smart (2003:43). Patel (2005:217) suggests that networking, working in teams, mobilizing, implementing and evaluating collaborative partnerships to achieve universal goals and to aid social change should be the main ingredients to this level. Programmes should focus on aspects such as decision-making, managing conflict, anti-discriminatory practice and development of practical skills. This level of intervention therefore includes help and assistance to the community members with disabilities through the formation of circles of support (support groups). Rothman (2003:206) states that people with disabilities experience a great loss of self-esteem due to isolation, stigmatization and oppression. It is therefore important to utilize the empowerment model where the client is the primary source of action and change, but the second circle of support will be crucial in order to achieve empowerment.

The third and most comprehensive level is the macro-intervention level. Long et al. (2006:3, 136) explain that macro-intervention in social work involves the ability to look at and to intervene in the big picture through the collaboration with larger systems in the socio-economic environment. It is ideal to focus on minority groups which can develop social support systems to help mitigate problems. Smart (2003:43) supports this view and states that the third circle (macro-intervention) should involve resources in the broader society such as youth (groups such as LOVE LIFE), church groups, NGOs, local businesses, local leaders, home-based care organizations, teachers, social workers, SAPS, Department of Social Development and other local authorities. Patel (2005:217) calls community, societal and global action, such as social policy and planning, and macro-intervention and suggests that it should include the mobilization of a broad range of people in solving their own problems through accord strategies and community-building

initiatives. This would also include advocacy intervention which involves the mobilization of people to take action against iniquitous social situations, to equally distribute power and resources and to bring about necessary transformations. The circles of support are illustrated in figure 4.

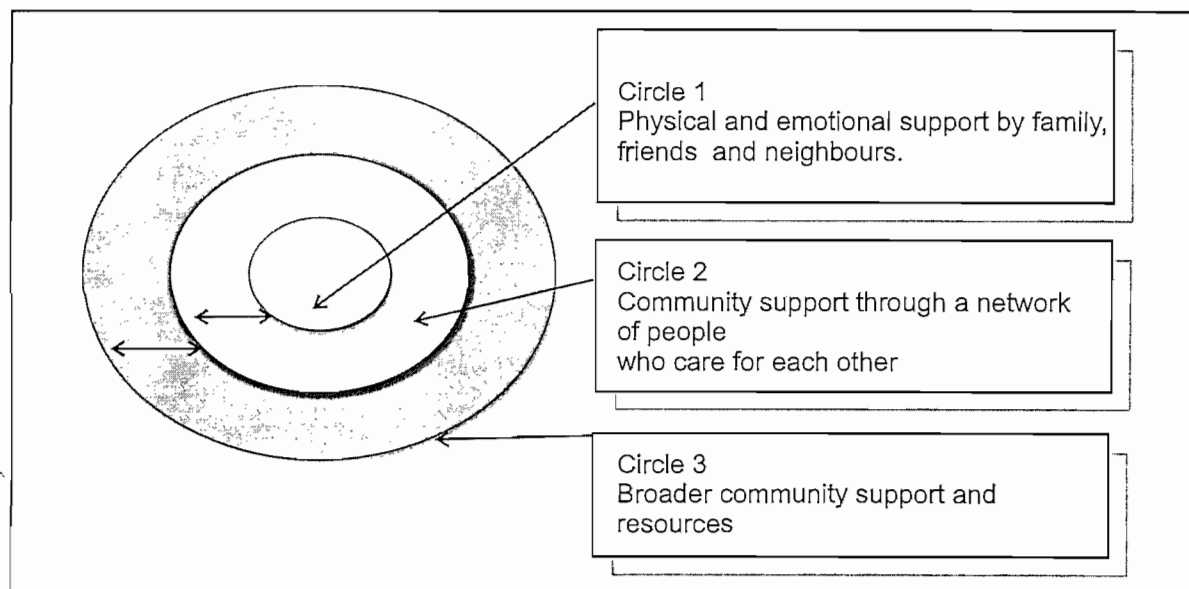


FIGURE 4: Circles of support

The first circle consists of family, neighbours and friends. Support in this circle could include physical care and assistance as well as emotional support and advice. The second circle includes help from the community through the formation of a Circle of Support Group. The aim of this group is to develop a network of people who care for and work with the members of the community. The third circle involves resources in the broader society such as youth and church groups, NGOs, local businesses, local leaders, home-based care organizations, teachers, social workers, SAPS, Department of Social Development and other local authorities.

The advantage of utilizing Smart's circle of support concept is that this programme is being approached in a holistic manner. As mentioned previously, the client group for this study is the community members with disabilities, and within this realm, Condeluci (1991:4) reminds the reader that all people with disabilities need to achieve the same goals as the people without disabilities. He mentions a safe place to live, meaningful things to do; intimacy, recreation and rejuvenation are important aspects which should form part of their lives. This approach assists individuals with disabilities to gain power and self-confidence which will lead to better participation and control in their lives. It will improve inclusion, resource mobilization and empowerment of the community.

The intervention for this community will mainly focus on the enhancement and empowerment of individuals in the community with disabilities at macro level. Intervention will be based on the guidelines provided by South Africa (2006b:13) which focuses on the provision of integrated developmental social services, i.e. security, welfare and community development, to people with disabilities.

7.2 INTERVENTION STRATEGY SUMMARY

The intervention strategy is summarized with a combination of a framework provided by Rothman (2003:463) and Wilson (2005:59) and is illustrated in Table 13.

TABLE 13: Representation of the intervention strategy

TARGET POPULATION	GENERAL PROBLEM	SPECIFIC PROBLEMS	INTERVENTION STRATEGY ON THE 3 LEVELS
People with disabilities In rural settings – Needs assessed by means of disability-specific questionnaire	Isolation and Discrimination	1. Lack of government services. 2. Lack of local services 3. Lack of community involvement 4. Lack of education	MACRO: COMMUNITY AWARENESS, COMMUNITY INVOLVEMENT, RESOURCE MOBILIZATION, DISABILITY PREVENTION, CREATION OF ORGANIZATIONAL SUPPORT STRUCTURES, LINKS TO EXTERNAL RESOURCES, ADVOCATE FOR THE RIGHTS OF THE COMMUNITY THROUGH SOCIAL AND POLITICAL ACTION
	Limited resources and support	5. Lack of social contact 6. Lack of support 7. Lack of health management 8. Lack of hygiene and healthy living 9. Lack of provision of ADs.	MESO: PWD SUPPORT GROUPS, FAMILY/CARER SUPPORT, DISABILITY LINK WORKER PROBLEM ASSESSMENT SKILLS DEVELOP LEADERSHIP SKILLS
	Stagnation, lack of development, education and training opportunities	10. Feelings of isolation, depression and worthlessness 11. Lack of counselling services 12. Lack of religious support	MICRO: INDIVIDUAL EMPOWERMENT PARTICIPATION HOME-BASED CARE WORKERS COUNSELLING

The intervention summary representation indicates the level of intervention required in order to meet the assessed needs of the community. Rothman (2003:201) suggests that utilizing the systems concepts as theory base for this multi-level intervention strategy as each level can affect the results at other levels.

The micro level will focus on the individual needs of the community members with disabilities as well as their immediate family members and caregivers. Intervention will mainly focus on personal empowerment, counselling and support. Zastrow and Kirst-Ashman (2007:22) recommend utilizing the guidelines for normal developmental milestones, which include biological, psychological, emotional, intellectual and social points of development that normally occur in a person’s lifespan, as guiding principles for the micro-intervention required. The meso level of intervention will be in the form of support group sessions for the already mentioned client group. The macro level intervention will benefit the community members with disabilities, but will mainly focus on the developmental and awareness domains of the Heuningvlei community and their service providers.

7.3 SUGGESTED PROGRAMME STRUCTURE

The micro-, meso- and macro intervention programme will be based on a 5-point continuum structure for a community-based disability programme based on the principles of empowerment as suggested by Wilson (2005:58) and illustrated in Table 14.

TABLE 14: Action steps in compiling a community-based disability programme.

<p>1. Personal action</p>	<ul style="list-style-type: none"> ☞ Build a sense of control in people’s lives and bring them together in small groups around issues of mutual concern = Skills training (Food garden) and physical handling training for all disability caretakers in the community.
<p>2. Small mutual groups</p>	<ul style="list-style-type: none"> ☞ Assist the community to identify and prioritise its problems, solutions to the problems and actions to resolve the problems = Support groups for community members with disabilities in the Heuningvlei community. ☞ Strengthen local leadership skills = Choose a Disability Representative to co-ordinate the services and advocate for community members with disabilities’ rights.

<p>3. Community organisations</p>	<ul style="list-style-type: none"> ☞ Strengthen organisational structures = <i>Involve the local community resources such as the clinics, school and the SAPS to assist with disability awareness.</i> ☞ Link organisations to resources and develop skills to identify, mobilise and access resources = <i>Disability Home-based carers to be linked with Department of Health for training and skills development.</i> ☞ Promote critical awareness = <i>Arrange Disability Awareness programme in partnership with role-players for yearly National Disability Day.</i>
<p>4. Partnerships</p>	<ul style="list-style-type: none"> ☞ To develop a shared agenda with other organisations and build local partnerships and alliances between groups = <i>Relevant service providers and government involvement crucial in the isolated rural community.</i> ☞ Provide access to resources outside the community = <i>Transport and road maintenance important to encourage service providers to visit the area and deliver much needed support.</i>
<p>5. Social and political action</p>	<ul style="list-style-type: none"> ☞ Provide legitimacy to the issues and concerns raised by the community by using their own expert power and political influence = <i>Motivate Chief Bareki and his family to improve the support and services for people with disabilities in their community.</i>

The action steps set out in the above table consists of five main focal points within the intervention model. The first focus point is based on personal action within the micro-intervention sphere. It consists of a personal approach to empowerment and gaining back control in people's lives. This could be through counselling or individual support. The second focal point is aimed at the meso-intervention sphere and is small support groups for people with disabilities and their immediate family members. Nichols and Jenkinson (2006:8) suggest that these support groups should include the following social support: interaction leading to increased self-esteem, support through the provision of information, social companionship and actual physical help.

The macro-intervention sphere is summarized in focal points three, four and five. These points include the creation of disability awareness, resource mobilization, development of partnerships and social and political action.

7.4 FACILITATING THE PROGRAMME

A programme or programme activity is “a medium through which the functioning of members can be assessed in areas such as interpersonal skills, ability to perform daily living activities, motor co-ordination, attention span and the ability to work cooperatively” (Toseland & Rivas, 2005:259).

In the context of this study, the programme is thus the procedure of activities, within certain time frames, to achieve set goals or objectives.

The following methods of teaching were utilized during the implementation of the programme. A group of ten community members who all indicated that they had some interest in disability matters were chosen by Chief Bareki, the Father (Roman Catholic Church) and the researcher. The group members volunteered to take part in the training and to become community-based disability group leaders.

7.4.1 Group work

Social group work can be defined as a goal-directed activity with small groups aimed at meeting socio-emotional needs and accomplishing tasks. This activity is directed at individual members of a group and at the group as a whole within a system of service delivery (Toseland & Rivas, 2005:12). Ross and Deverell (2004:294) continue by advocating that empowerment manifests in groups of people working together. The group work platform was utilized to train the community-based disability group leaders.

7.4.2 Practical sessions

Choosing appropriate programme activities requires a careful assessment of the needs of group members (Roux, 2002:186; Toseland & Rivas, 2005:259).

Toseland and Rivas (2005:261) indicate the procedure for selecting programme activities. The practical sessions during the group training session for this project included a number of practical examples in the programme, and the group participants experienced the exercises and physically engage in creating the low-cost assistive devices. The practical sessions will enable the group leaders to transfer the knowledge and skills to their own groups and sessions.

7.4.3 Visual aids

Each group member was provided with a copy of the programme as well as the presenter's guide. A translator was able to explain any queries to the group participants. Due to the limited resources in Heuningvlei, none of the traditional visual aids were utilized. No posters, photographs, overhead projection, slide presentations or videos were available.

7.4.4 Learning aids

In the Tshwaragano project, flip charts, exam pads and the printed programmes were used to allow members of the group to make group presentations and other activities during the sessions. Home-made paint, clay and plastic bags were utilized to construct low-cost activities and assistive devices.

8. PROGRAMME COMPOSITION

Guidelines for any community development programme or intervention is clearly outlined by the South African Department of Social Development's Integrated Service Delivery Model (ISDM) towards improved social services (South Africa, 2008a:12, 16, 18). Suggested programmes include youth development, socio-economic programmes, morale regeneration, development of women, women empowerment programmes, poverty reduction programmes, integrated empowerment programmes. It provides a framework and guidelines for the development process relevant to this study. Mehra (1997:137) suggests the sustainable livelihood approach, which will improve people's economic status and well-being through empowerment and improvements in their own lives. The participants will be given evaluation opportunities in different phases of the implementation process.

9. THE PROGRAMME (APPENDIX F)

The community-based disability programme layout is illustrated in Table 15.

TABLE 15: Layout of the community-based disability programme

MODULE	PROGRAMME CONTENT	GOAL	OBJECTIVES
1	<i>Getting to know one another.</i>	Life Skills	Relationship development To be aware of other people's needs and dreams
2	<i>Self-esteem</i>	Life Skills	Relationship development, assertiveness, conflict management Understanding the importance of self-esteem and how to make a PWD (Person with Disabilities) feel less isolated and excluded
3	<i>Health</i>	Prevention of illnesses and disabilities	Healthy lifestyles and the importance of timely immunizations.
4	<i>Stress management</i>	Life Skills	Awareness of internal and external causes of stress for a PWD (Person with disabilities)
5	<i>Healthy living and eating</i>	Prevention of illnesses and disabilities	Growing a food garden, nutrition awareness, First Aid
6	<i>Exercise</i>	Prevention of illnesses and disabilities	Exercise and relaxation programme development
7	<i>Tau strong</i>	Prevention of illnesses and disabilities	Awareness of the dangers of substance misuse and HIV, AIDS and STIs.
8	<i>Map of my life</i>	Life Skills	Setting of goals for your life
9	<i>Discrimination</i>	Disability awareness	Understanding discrimination against PWD and support resources Human Rights
10	<i>Disability care</i>	Disability management and care	Resources for Social Security grants, causes of disabilities types of disabilities, physical handling techniques

MODULE	PROGRAMME CONTENT	GOAL	OBJECTIVES
11	<i>Low-cost activities, evaluation and feedback</i>	Disability management	Child development and stimulation, creating low-cost assistive devices, creating low-cost creative activities
12	<i>Celebrating National Disability Day</i>	Disability awareness	Disability awareness event for the Heuningvlei community, including the relevant role-players and government departments

10. OPPORTUNITIES OF THE PROGRAMME

- ☞ This programme is based on intensive research in a rural community and is aimed at meeting very specific needs of a rural community. The bottom-up approach was utilized, developing and implementing a needs-based programme.
- ☞ Promoting social integration and fair integration are one of the major aims of the programme and will be achieved through the intervention on micro, meso and macro level.
- ☞ At micro level the intervention will include meeting individual needs through the mobilization of Disability Representative in the community. The roles and responsibilities of this individual/s will encompass linking people with disabilities with the appropriate resources in the community and outside the community. This could include the timely applications of social security grants, counselling and accessing assistive devices.
- ☞ At meso level the people with disabilities will participate in a needs-led support group and will address issues and concerns such as self-exploration, healthy living and eating, stress management, exercise, discrimination and practical disability management tips. Intervention with immediate family members and carers will include disability awareness and celebrating National Disability Day.
- ☞ At macro level the focus will mainly be on community awareness and involvement. This will also include the motivation and training of community home-based carers and other significant and influential role-players in the community to roll-out the community-based disability programme. Home-based care has been identified as a major need in the Heuningvlei community

- ☞ The practical sessions on disability management and establishment of food gardens will result in sustainable progress.
- ☞ Empowerment will include personal development, management of resources and relationships and the elimination of barriers to people with disabilities in the Heuningvlei community. Life can be lived in an unwavering, outgoing way with positive experiences and forward bearing, irrespective of any disability, but it is hard to see this in the isolation of your own home.
- ☞ The programme was presented to the group members in English, but an interpreter was utilized to answer all queries and to promote understanding. The programme has also been translated in the community's own language in order to further promote utilization and sustainability.

11. RECOMMENDATIONS

The following recommendations were made based on the implementation of the programme:

- ☞ The results of the research, conducted in the Heuningvlei community, clearly indicated that social work support, housing assistance, home care worker assistance and assistance to apply for grants are the major needs of the members with disabilities in this community. The community disability representative could therefore be assisted to contact the Department of Social Development, the Department of Rural Development, the Department of Housing as well as Department of Health in order to ensure effective and timely service delivery. The community disability representative will also be assisted to formally request the services of the allocated social worker to act as co-ordinator and to ensure that the multiple and complex needs of community members with disabilities are met in a holistic manner.
- ☞ Social workers, for example, can play a crucial role in this community intervention process. The role of teacher should involve the social worker providing new information to the community in order to assist them to cope with problem situations. A very important role is that of mediator. The social worker could assist community members with disabilities to resolve conflict and avoid aggression, violence, family abuse, substance abuse and even suicide. Lastly, and most important for this specific poverty-stricken community, is the role of advocate. The social worker could assist the community members to obtain benefits, services and other resources urgently

needed in order to address the needs of the people with disabilities and their family members.

- ☞ Due to physical barriers in the community such as dirt roads, lack of wheelchairs, lack of transport for the people with disabilities, the participation in a support group is a major challenge and careful planning is needed in order to ensure the success of this programme. A dedicated, disability co-ordinator is needed.
- ☞ Due to the fact that limited services and resources in this community, the food garden project could ensure healthy eating habits and prevention of certain disabilities.
- ☞ To ensure sustainability it would be advantageous for the disability care workers to receive some kind of an allowance to motivate them to care for the community members with disabilities.
- ☞ Community-based home-based care workers will play an active part in this process and could, according to the Policy on Financial Awards to service providers (South Africa, 2005:18), as part of a self-help group and cooperative, come together to learn certain skills or address certain needs with a view to improve the quality of their lives as well as the lives of other community members with disabilities. Van Rooyen (2007:213) continues to describe the importance of appropriate and continued training of community-based home-care workers, active participation of the community and the importance of support, supervision and accountability.
- ☞ The implementation of support groups, for people with disabilities as well as for their carers, parents and spouses, home-based care work support are all important aspects during the development of the community-based disability programme.

12. CONCLUSION

The research results of this project will be illustrated in this research article. The Heuningvlei community is extremely isolated, surviving on minimum resources and is in need of support, inclusion and development opportunities. This article focuses on and includes a workbook for the prevention, management and awareness of disability-related issues in a community.

The community-based disability programme is essential. The constitutional rights of people with disabilities and the government guidelines for service delivery to poor and

vulnerable client groups form the basis of this programme. Poverty, unemployment, malnutrition, poor sanitation and lack of essential services are clearly linked to the development of and contributing to the occurrence of disabilities. Therefore the most effective way of reducing the burden of increasing numbers of people becoming disabled and draining the social security system is to prevent the occurrence of disabilities in these rural areas through a needs-led community-based disability programme. Overall prevention of the occurrence of disabilities in any community is improbable, therefore monitoring, support and accommodation of people with disabilities will be veracity.

An absolutely crucial aspect to take into consideration with the development of a community-based disability programme is the different cultures of the person with a disability, the family, the community, society and other relevant role-players. The core of the community-based disability programme will be the development of the community through a people-centred approach of participation and empowerment.

This programme provides community members in isolated, resource-stricken and poor communities to gain insight into positive change and create motivation and encouragement for development and new challenges.

It was clearly evident through the research process that the people with disabilities in Heuningvlei were buoyant about development, support and empowerment. They incessantly requested activities and learning opportunities. An optimistic mindset, eagerness to participate and enthusiasm to contribute to your own and other people's development already contributes to the mêlée.

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ARTICLE 4
**THE EVALUATION OF A COMMUNITY BASED DISABILITY
PROGRAMME FOR RURAL AREAS**

ABSTRACT

In this article the community-based disability programme for the Heuningvlei community will be evaluated both qualitatively and quantitatively. The data were obtained by means of a questionnaire for the group participants, utilizing the standardized Facilitation and Assessment Scale (FAS) as developed by Weyers and Rankin (2007:92) as well as a focus group interview with local community experts. Although the FAS is an assessment scale it was utilized to evaluate the following two aspects: evaluation of the learning process and evaluation of the content of the programme. The focus group interview focused on the programme successes, programme content, educational/information value and programme impact. This article firstly contains the background and problem statement of this study. Secondly, the research methodology, ethical aspects, purpose and aims are discussed and thirdly, the evaluation results of the content and effectiveness of the programme. Fourthly, the value of this community-based disability programme for the Heuningvlei community was discussed. This includes the integration, development and care of the community members with disabilities as well as the utilization of community resources. The sixth and final discussion includes the advantages and challenges of the programme.

KEYWORDS:

Evaluation, Facilitation Assessment Scale (FAS), sustainability, community-based disability programme

1. INTRODUCTION

This project focused on the disability-related challenges, prevention of disabilities, available resources and the inclusion of people with disabilities in the greater Heuningvlei community. The aim of this article is to evaluate specific aspects of the intervention process (De Vos, 2005b:368). Mixed methods research included the utilization of two structured measuring instruments for quantitative and qualitative evaluation. This evaluation included the following aspects;

- ☞ The changes/improvements which took place after the implementation of the programme.
- ☞ The accomplishment of meeting the physical needs of the people with disabilities (PWD) in the community.
- ☞ An opportunity to evaluate the content of the programme and to address any additional requirements.
- ☞ The utilization of the community resources.
- ☞ The awareness created for the needs of the PWD in the community.
- ☞ Any recommendations or suggestions.

2. PROBLEM STATEMENT

Many rural communities in South Africa face substantial threats to health and sustainability due to extreme poverty. De Beer and Swanepoel (2000:7) describe people living in rural areas as poor, weak, isolated, powerless and vulnerable. Sharkey (2000:10) argues that community work should focus on all groups, including vulnerable groups such as older people, PWD, caretakers and people living with HIV and AIDS. The Tshwarogano project in the Northern Cape Province specifically focuses on empowerment programmes to build the capacity of the poor people living in the Heuningvlei community.

This specific part of the project focussed on the PWD in the Heuningvlei community.

The White Paper on the Integrated National Disability Strategy (South Africa, 1997:3, 15) states that people living in poor and rural areas, do not have accurate information concerning disability, its causes, its prevention and its treatment. This is because of a high illiteracy rate and poor knowledge regarding basic social, health and education services.

A disability-focussed research project was embarked upon and a community-based disability programme was implemented.

The Policy on Disability (South Africa, 2008b:14) states that children living in rural areas or in informal settlements are the most vulnerable to disablement and Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), more so as facilities for early detection, diagnosis and support are inadequate. Inadequate facilities inevitably lead to an increase in both the extent and severity of disablement. People with multiple disabilities, mental disabilities, visual disabilities, congenital disabilities and severe disabilities are groupings that require special attention. Mainstream services often do not address their social needs adequately. Lack of comprehension of their needs often leads to misunderstanding, exclusion and wrong conclusions on how their needs should be appropriately addressed and their rights promoted.

Disability-specific services should include promoting the inclusion and mainstreaming of people with disabilities in society. Service delivery should also focus on the rights of people with disabilities, awareness of disability issues and the accessibility of services. Community and public resources should discourage discrimination against people with disabilities; encourage programmes for the early identification of genetic disorders and awareness regarding the prevention of the transmission of genetic disorders. PWD could greatly benefit from life-skills- and capacity-building programmes and skills development services (South Africa, 2008b:41).

Chiu and West (2007:1915) advise that service for PWD should also include social structures or networks and they discuss the importance of social embeddedness. Kim and Fox (2006:481) state that community involvement, collaboration and relationships with others, such as family, friends, health-care providers, and the so-called disability communities or support groups, have a significant impact on health. Relationships with others are considered part of the social environment and are also one of the personal domains within the concept of health. Emotional and financial support from significant others give participants strength to deal with their disabilities. Involvement in disability communities or support groups offers opportunities to share a common understanding of experiences in relation to the environment as well as a chance to share specific strategies for living independently.

The community-based disability programme's foundation includes these mentioned aspects as well as the prevention of illnesses and disabilities. The White Paper on the Integrated National Disability Strategy (South Africa, 1997:10) states that one of the cornerstones of disability policy is prevention. The majority of disabilities are preventable. Prevention services are aimed at strengthening and building the capacity and self-reliance of the client. Early intervention (non-statutory) services should make use of developmental and therapeutic programmes to ensure that those who have been identified as being at

risk are assisted before they require statutory services, more intensive intervention or placement in alternative care (South Africa, 2008b:29). These key prevention requirements form the parameter for the community-based disability programme and form the directive for the primary, secondary and tertiary disability prevention approach.

Frank (2003:18) suggests that prevention services should be targeted and especially intended to strengthen the resilience and increase the life skills of specific individuals and groups. Ross and Deverell (2004:286) support this focus of intervention. Although the prevention of disabilities is a complex issue, it is possible. Sewpaul (1993:188) states that the prevention of mental disabilities requires a multidimensional bio-psycho-social approach and partnerships with government organizations and Non Government Organizations (NGOs) are crucial. This empowerment process should therefore be addressed through a co-ordinated approach which will maximize resources, end duplication of services and target areas of need.

A holistic approach as mentioned above would include the systemic therapy concepts as discussed by Nash, Munford and O'Donoghue (2005:33). Effective intervention requires a holistic approach, which should include the community member/s, their families, their community leaders, the relevant government agencies and all other community resources that could positively contribute to the development of this community. Rothman, Erlich and Tropman (2001:460) provide the guidelines for the procedures in organizing a new service or programme for a community. Zastrow and Kirst-Ashman (2007:24) finally reminds the community development worker/social worker that awareness of human differences and the effects thereof on human behaviour is momentous and should be taken into consideration during the planning and development of the community-based disability intervention programme.

The evaluation process was based on the following research question:

- How effective was the implemented community-based disability programme?

3. AIM AND OBJECTIVE

The following aim and objective forms the foundation for this article and will be explored thoroughly.

3.1 Aim

- To evaluate the community-based disability programme.


3.2 Objective

- To identify opportunities and limitations of the community-based disability programme and to make recommendations for improvement and further intervention.

4. RESEARCH METHODOLOGY

A summary of the research methodology for this article is illustrated in Table 16.

TABLE 16: Summary of the research methodology for this article

<p>PHASE 3</p> 	<p>Pilot test the interview schedule with 2 community members.</p> <p>Programme evaluation through a focus group session with experts and local key role-players and the FAS.</p> <p>Advanced development and dissemination.</p>
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4.1 RESEARCH MODEL

During this study the intervention research, design and development (D & D) model was utilized. “Intervention research is carried out for the purpose of conceiving, creating and testing innovative human services approached with a view to prevent or ameliorate problems or to maintain quality of life” (De Vos, 2005a:394). D & D is a phase model consisting of six phases (De Vos, 2005a:395). The fifth and sixth phases were conducted during this part of the study.

4.1.1 Evaluation and advanced development

This phase of the D & D model comprises the following operations (De Vos, 2005a:403):

- Selecting an experimental design
- Collecting and analysing data
- Replicating the intervention under field conditions
- Refining the intervention

4.1.2 Dissemination

Following the implementation, testing and evaluation of the community intervention, it is ready to be distributed to community organizations, relevant role-players and other target audiences. De Vos (2005a:404) provides guidelines for the implementation of the intervention or programme:

- Preparing the product for dissemination
- Identifying potential markets for the intervention
- Creating a demand for the intervention
- Encouraging appropriate adaptation
- Providing technical support to adopters

4.2 RESEARCH DESIGN

This exploratory and descriptive study utilized a combination of qualitative and quantitative research approaches: “Mixed method studies combine the qualitative and quantitative approaches into the research methodology of a single study of multi-phased study” (De Vos, 2005d:360). The concurrent embedded strategy was used in this study and is described by Creswell (2009:214) as the utilization of mixed methods simultaneously during one data collection phase. According to Nottel (1990:25), descriptive design is a way of establishing what the facts are in relation to a particular problem. Bless and Higson-Smith (2000:154) describe the aim of the exploratory research as formulating more specific research questions relating to a specific phenomenon in order to gather more information and to gain better insight into the phenomenon.

The quantitative research design utilized was the single-system design as discussed by Strydom (2005c:145). The reason for choosing this design is based on the nature of this research project which was to implement the community-based disability programme and to evaluate the effectiveness thereof after a certain period of time. Strydom (2005c:145) states that this design is the ideal way to evaluate the effectiveness of treatment interventions. Ginsberg (2001:116) suggests that the measurements should be statistically validated, which enhances the link between research and practice. Another important aspect is to prevent factors other than the treatment from varying. This will enhance the quality and validity of the process and reduce the potential of confounding (Strydom, 2005c:145). The baseline for this single-system design is unique and ideal for this study because it involves the planned, systematic collection of data on the problem and this was achieved by means of individual interview sessions with key role-players and experts in

the community. This method of information gathering was also selected as it provided the researcher with an opportunity to explore the uniqueness of the Heuningvlei community in depth. The interview sessions not only provided general data for the research; it provided specific, heartfelt experiences, challenges and opinions which could be explored thoroughly in order to understand the baseline as best possible. To implement a valuable and relevant intervention (community-based disability programme) it is important to first understand the baseline or real desires of a community. These sessions also aided trust between the Heuningvlei community members and the researcher, which in return aided honesty, reliability, commitment and active involvement from the community members during the research process and the implementation of the community-based disability programme.

As suggested by McBurney (2001:316), a long enough time period should pass in order to obtain valuable data to compare against and to obtain a stable measurement. A period of six months was allocated during which the programme was implemented before the focus group evaluation session was conducted. The focus group method was selected for the evaluation process. The same participants interviewed during the initial phase of the project, again participated in the focus group session. This ensured validity and reliability as the only change which was implemented in the process, as previously suggested, was the community-based disability programme. The focus group session provided the researcher with supplementary source to obtain essential data. Greeff (2005:300) suggest that this method is useful to obtain multiple viewpoints or responses on a specific topic. It also provides an opportunity for informing, sharing, comparing and empowering local people. This process is described by Rothman, (2001:29) as locality development community intervention.

The final motivation for selecting the focus group method is because it provides a powerful way of exposing reality and or investigating complex behaviour and motivation (Greeff, 2005:301). The Heuningvlei community is extremely isolated and mired by limited resources and service delivery. This presents a complex situation and unique problem solving challenge. The expected coping mechanisms and resources available to PWD, and the rest of the community members, are not available in this setting. Resulting in a need for the local community members, resources and support structures to fulfil multi-dimensional and creative roles.

4.3 PARTICIPANTS

The Heuningvlei community consists of approximately four thousand households. The Tshwaragano project had already selected a non-probability sample population of a total

of two hundred and fifty four households from the Heuningvlei community in the Kagisano Municipal district. Exploratory questionnaires were completed with this sample population which were utilized during this study with the aim of compiling a community profile. The sample population for disability-related questionnaires were selected through the non-probability, snowball method (Strydom, 2005a:203). A total of 149 participants took part in this study.

During the qualitative evaluation part of the study the participants were selected according to the non-probability (purposive) sampling technique (Strydom & Delport, 2005:328). The criteria for inclusion were direct involvement with PWD in the Heuningvlei community or a genuine interest in PWD. A group of community experts and key role-players were selected and participated in individual interview session (Appendix B) during the initial phase of the research project. These same participants were selected to participate in a focus group evaluation session (Appendix C) during the final phase of the research project.

These participants were selected on the criteria of their involvement with and commitment to PWD in the Heuningvlei community. Each of the participants indicated that they had a sincere interest in disability matters and was involved with or responsible for PWD in their community.

Additionally, ten community members were selected and trained in the community-based disability programme. These same participants were selected to participate in the quantitative evaluation process by means of the FAS (Appendix H).

A summary of the participants, the aim of each phase and the data collection method is illustrated in Figure 5.

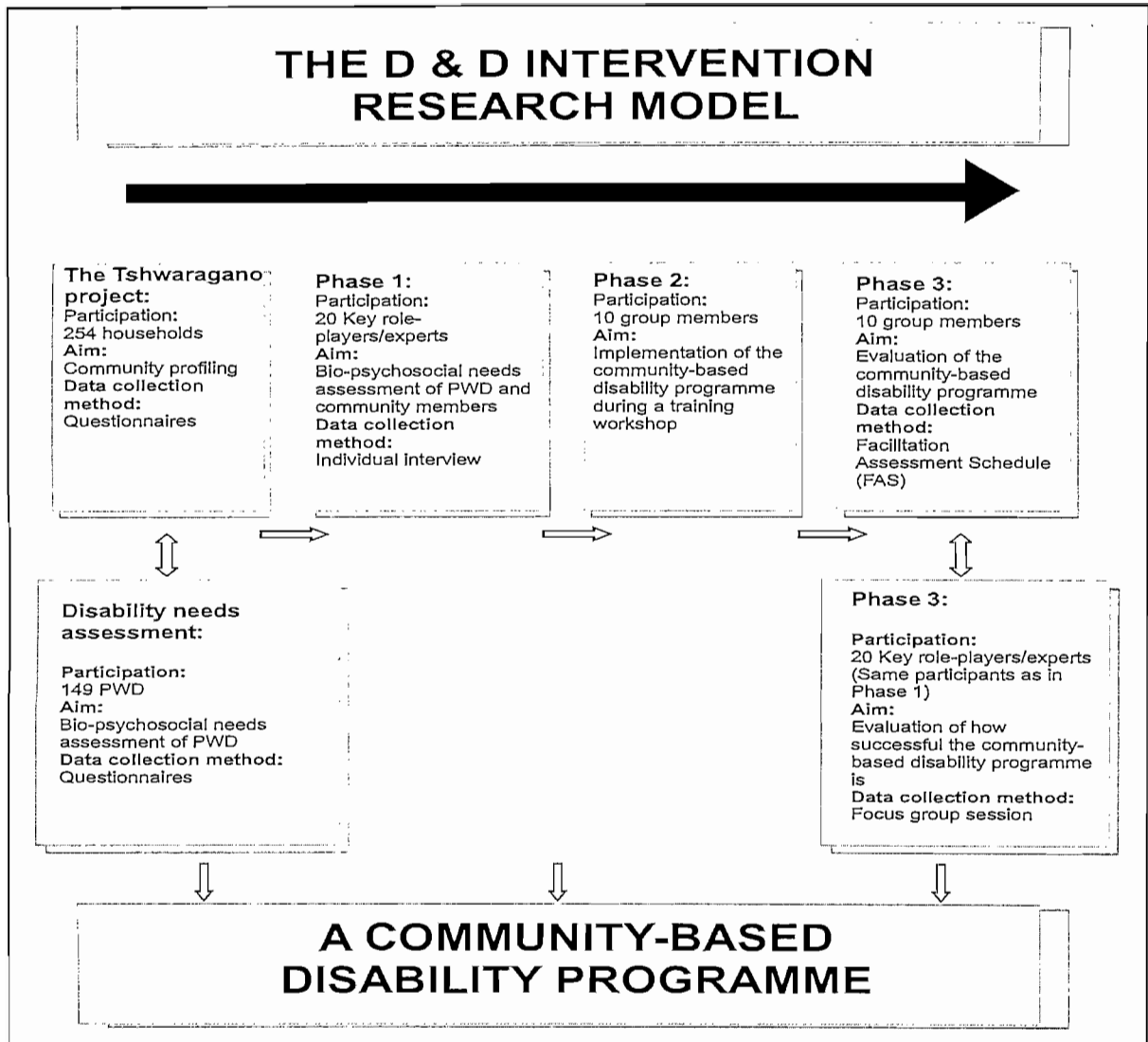


FIGURE 5: Participants and data collection throughout this study.

Figure 5 provides a summary of the participants, the aim and the data collection method of each phase. The data collected during a previous study, the Tshwaragano project, was utilized to compile a community profile. This information was linked to the disability-specific assessment. Phases 1, 2 and 3 completed the holistic view on the bio-psychosocial needs of the PWD in the Heuningvlei community.

4.4 DATA COLLECTION

In this study, a disability-specific questionnaire with open and closed-ended questions was utilized in order to assess the bio-psychosocial needs of the PWD in the Heuningvlei community (Appendix A). Initial individual interviewing sessions (Appendix B) with key role-players in the community during the initial phase of the study as well as an evaluative focus group session (Appendix C) with the same key role-players during the final phase of

welfare, well-living, utility, life satisfaction, prosperity, needs fulfilment, development, empowerment, capability expansion. The validity of the FAS and the focus group session is discussed based on the guidelines provided by Delport (2005:160) who states that validity has two important aspects to consider. Firstly, the instrument should measure the concept in question and secondly, that the concept should be measured accurately. The FAS was utilized to establish exactly how effective the content and process of the programme was as well as the feasibility of the implementation thereof. Babbie (2004:143) supports this view and states that in order to establish the validity of the evaluation instrument, it should reflect the concept it is intended to measure.

The reliability of the measuring instruments is explored according to the description provided by Delport (2005:162) who states that reliability implies the following: "The reliability of a measurement procedure is the stability or consistency of the measurement. This means that the same variable is measured under the same conditions". Strydom (2003:215) points out that one must also strive for the highest possible way of reliability.

Weyers and Rankin (2007:96) confirm that several studies proved the validity, reliability and effectiveness of the FAS instrument.

4.6 RESEARCH PROCEDURE

The procedures followed were:

- ☞ The researcher visited the Heuningvlei Community a month before the implementation of the programme and the participants were selected on the basis of their keen interest and volunteerism to participate in the community-based disability programme. Initial individual interviews were conducted with 5 experts and other role-players.
- ☞ The researcher visited the Heuningvlei community for a second time and the disability questionnaires were completed by the PWD in the community.
- ☞ The community-based disability programme was developed, based on the assessed needs.
- ☞ The researcher visited the Heuningvlei community for a third time when the programme was implemented.
- ☞ After a period of six months the Heuningvlei community was visited again and the community-based disability programme was evaluated.
- ☞ Data was analyzed, processed and presented.

4.7 DATA ANALYSIS

Data obtained from the FAS was computed on Excel. The results were interpreted, inferences pertinent to the research relations studied made and conclusions drawn. Data obtained from the focus group session (with open-ended questions) aims to identify areas

of common ground and differences (Laverack, 2005:94). The analysis process of the information gathered (field notes and transcribed interview) enabled the researcher to gain new insight into and confirmation of the phenomenon. The information was processed by the researcher in accordance with Tesch's data analysis approach. Poggenpoel (1998:343-344) provides the eight steps of Tesch's approach to consider in qualitative data analysis, namely:

- ☞ A holistic view and understanding of the phenomena is very important and the researcher could achieve this mental picture by carefully studying the transcripts and writing down some ideas and themes as they come into mind.
- ☞ Step two involves selecting one interview, perhaps the most interesting one and carefully studying it for further ideas and themes. The questions to keep in mind during this step are: "What is it about?" and "What is the underlying meaning of it all?"
- ☞ When the researcher has repeated this process for several respondents, a list could be made of the topics identified. Similar topics are clustered together and could be arranged into main ideas, unique ideas and not relevant.
- ☞ The researcher should then return to the data. The ideas are abbreviated as codes and the codes are written next to the appropriate paragraphs. New categories and codes could emerge and be added to the ideas list.
- ☞ The researcher then uses the most descriptive words for the topics and turns them into categories. The number of categories should be reduced to as few as possible in order to indicate the links between the categories.
- ☞ The researcher then makes the final decision on the abbreviation for each category and alphabetizes the codes.
- ☞ The information belonging to each category is assembled in one place and a preliminary analysis is made.
- ☞ The researcher recodes existing data if necessary.

5. ETHICAL ASPECTS

Ethical permission for this study has been granted by the Ethics Committee of the North-West University (Potchefstroom Campus), ethical application number: 06k07 - Tshwarogano Project. The necessary permission has also been attained from the Heuningvlei Chief, Chief Bareki. Overall ethical aspects which were attended to during this study were that the goal of the research project was clear and transparent. It was

made clear to the participants that participation was voluntary and that they were able to withdraw from the study at any stage. Written consent forms were signed in advance. Henn, Weinstein and Foard (2006:67) discuss the reasons for written consent. All information was kept confidential and anonymous. The results will be archived for five years. A written report will be given to Chief Bareki.

6. THE NATURE OF THE EVALUATION PROCESS

Rossi, Lipsey and Freeman (2005:16) define programme evaluation as the use of social research methods to systematically investigate the effectiveness of social intervention programmes and inform social action in order to improve social conditions. According to Babbie and Mouton (2001:337), evaluations have been commissioned for purposes of programme management, improvement and refinement, financial accountability, on public demand, to meet accreditation requirements, for purposes of quality assurance and control, and various other reasons. Potter (2006:411) defines programme evaluation as research that is concerned with establishing whether social programmes are needed, effective, and likely to be used.

Du Bois and Miley (2005:221-222) suggest that programme evaluation aims to establish whether the implemented programme has accomplished its goals. According to Toseland and Rivas (2005:390) there are several benefits of evaluation for social workers who do group work:

- ☞ Evaluation can satisfy the social workers' curiosity and professional concerns about effects of specific interventions they perform while working with a group.
- ☞ Evaluation can help the social worker in improving his/her leadership skills.
- ☞ The social worker can assess the progress of group members and determine whether the group and programme are accomplishing agreed on purposes.
- ☞ Evaluations allow group members to express their satisfaction and dissatisfaction with the group.
- ☞ Social workers can gather knowledge that can be shared with others who are using social group work as a method for similar purposes and similar situations.
- ☞ Social workers can systematize and make the covert hypothesis-generating and hypothesis-testing processes they routinely engage in as they practise.
- ☞ Evaluation can examine the cost-effectiveness of group work services.

Key policy areas which will also be kept in mind during the evaluation have been identified by the Department of Social Development (South Africa, 2006:17) and these include prevention, health care, rehabilitation, public education, barrier free access, transport, communications, data collection and research, education, employment, human resource development, social welfare and community development, social security, housing and sport and recreation. Guidelines for this evaluation process is provided by Jason, Keys, Suarez-Balcazar, Taylor and Davis (2004:4, 22, 44) who suggest that research increases citizen power and those community residents are the primary stakeholders in changing community behaviour. It engages citizens to participate as active partners in the creation and interpretation of findings and dissemination of products and research findings. In essence, it aims to empower citizens to re-establish power and control in their lives. They continue to discuss the importance of health promotion as part of the community development programme and states that optimal developments of competence pathways require an integrated approach, involving families, community resources at micro, meso and macro level.

The underlying principles for the evaluation process are provided by Jason *et al.* (2004:142):

- ☞ It aims to influence the quality of a programme by evaluating the programme's success.
- ☞ The power and responsibility for evaluation lies with the programme stakeholders, giving each role-player a voice in the decision-making process.
- ☞ It adheres to the evaluation standards and serves the information needs of the intended users.
- ☞ It demystifies evaluation by translating the evaluation process into specific questions.
- ☞ It emphasizes collaboration with programme stakeholders.
- ☞ It utilizes the evaluation in the spirit of continuous quality improvement. Positive results should be embraced and negative results should be improved upon.

It is also important to take cultural aspects into consideration during the evaluation process. Culture is not only the ethnic background, it is also the context in which individuals live or work and their shared interpretations of that context (Jason et al. 2004:177). They also suggest that methods should be developed to assess cultural identity as a strengths-based approach.

7. THE RESULTS

The results of the measuring instrument used (FAS), as well as data from the focus group session will be discussed.

7.1 FACILITATION ASSESSMENT QUESTIONNAIRE

Weyers and Rankin (2007:107) provide guidelines for the interpretation of the data and state that by comparing the averages for the different subscales it is possible to pinpoint the strong and weak elements of the workshop and facilitation process.

The results of the workshop evaluation questionnaire is discussed and aims to evaluate the learning process and the content of the programme which has been presented during a workshop training session to ten community members. The first discussion is the assessment of the learning process.

7.1.1 The assessment of the learning process

The workshop evaluation questionnaire's first question assessed the learning which took place during the workshop presentation. All the respondents indicated that they understood the purpose of the programme and that their initial expectations, which were discussed during the first phase of the workshop presentation session, were met during the training session. All the respondents indicated that the interpreter who was assisting the researcher during the presentation was useful. A combination of the absolute relevance of the programme content and the opportunity, through the interpreter, to explain the concepts of the programme in their own language contributed to the successful learning of the group.

The respondents were all able to understand the content and aim of the programme due to the uncomplicated presentation of the information in the programme. During the training session progress, learning and understanding was constantly monitored. Eight respondents indicated that they felt that the time allocated for the workshop was adequate. One respondent felt it was reasonable and one felt it was too short. It was difficult to allocate time to each presented module as the respondents varied in skills and abilities. The respondent who felt that the time allocated was too short had limited reading and writing abilities and could have benefited from a longer learning session.

All the respondents indicated "yes" to the question whether a follow-up workshop is required. A follow-up training session would enhance the learning process. All the respondents felt that they are able to successfully implement the content of the

programme in their community. The programme provided them with sufficient and relevant knowledge to do so. The ability to implement the programme is important and Laverack (2005:28) agrees with this viewpoint: "New knowledge without the means to carry out the prescribed actions can simply lead to people having a greater sense of powerlessness". This programme specifically focussed on information, but also incorporated practical sessions such as food garden development, stress management exercises and training in physical handling.

Based on the results of afore-mentioned evaluation, it can be concluded that strong elements of the workshop was the ability to meet the initial expectations of the participants through the comprehensive information provided. This successful learning process was aided by the utilization of the interpreter. The weaknesses identified by the evaluation were the length of the workshop; some respondents felt they needed more time in order to aid their learning process. Finally the need for a follow-up workshop was also identified - major challenge for this community-based disability programme to ensure sustainability of the programme and ongoing learning opportunities for the participants.

7.1.2 The assessment of the content of the programme

The assessment of the content of the programme provided the following data. The first question on the group participants' ability to assist someone to improve their self-esteem was positive with all of the participants indicating that they will be able to do it. The second module on self-esteem provided them with an awareness of one's self-concept. They successfully understood the importance and the impact of the way you think about yourself as well as positive feedback from other people. "Individuals with low self-esteem have an overall history of feeling rejected in their relationships with others, whereas high self-esteem individuals have a history of feeling accepted" (Sciangula & Morry, 2009:145). According to Baumeister, Campbell, Krueger and Vohs (2003:14), "...people with a high self-esteem report higher degrees of happiness, despite the presence of stress or other circumstances...they have less depression more optimism and fewer physical symptoms." The learning in this module was supported by practical life skills guidelines on communication, assertiveness and conflict management skills. These aspects aim to empower PWD to improve their self-esteem through improving their self-confidence.

All the participants indicated that they were able to identify the causes of disabilities as it was clearly explained and discussed in the programme. This module included aspects of healthy living, the importance of timely immunizations and the harmful effects of substance misuse and the wrong eating habits. This knowledge empowered the participants to identify harmful lifestyles and thus prevent disabilities. It is necessary for an

individual to make informed decisions based on knowledge, and facts on the causes of disabilities. Laverack (2005:49) supports this view and state that the ability to exercise control over health and safety decisions could be an important empowering tool.

All the participants indicated that they were able to present the stress management module. The programme assisted the participants to identify possible causes of stress for PWD in their community. The ability to identify the signs and symptoms of stress enables the participants to provide assistance and support to PWD and other community members suffering from stress. The programme also provided opportunity to discuss ideas for the mobilization of community activities in the form of social events and physical wellness events. Ungar (2005:235) states that social support and positive relationships are important when dealing with stress and adversity. Emotional support has a buffering effect on the impact of negative stressful life events (Siegel & Gorey, 1998:269). Laverack (2005:47) states: "Helping individuals to gain power ultimately involves their ability to make and carry out healthier lifestyle choices".

All the participants of the participants were of the opinion that the programme enabled them to advise community members on the negative effects of substance abuse, provide information on HIV, AIDS and STI'S and to assist the community members to say no to harmful substance misuse and dangerous sexual contact. Module 7 provided specific facts and enabled them to deal with myths and questions.

May (1998:111) stresses the importance of HIV and AIDS awareness as well as the impact of poverty, natural disasters, violence and social chaos on the disempowered status of most rural people. He states that these aspects form a fertile environment for the transmission of HIV infections.

Not all the respondents felt that the "Map of my life" module was relevant to their community. One respondent indicated that this module was useful. This module could be a way of discovering oneself and the effects that the disability has on oneself. Seven of the respondents indicated maybe. This module could assist PWD to form a picture of where they come from, what they want to achieve and who they need to assist them in this process. Laverack (2005:47) states that the purpose of this technique is to allow the individual to gain insight, through visual means, how they can build their skills from the existing position of strength". Herbst and De La Porte (2006:3) support this view.

However, it is important to note that one respondent indicated that it was not useful or realistic for a rural isolated community. Limited resources and lack of service delivery is interrelated to negative feelings, lack of planning and lack of goal setting, as these aspects are seen as irrelevant and pointless as nothing will change for this community.

All the respondents indicated that they were able to explain discrimination against PWD and offer emotional support to PWD and their family members. Any form of discrimination can interfere with the ability of a person to receive support from others (Corr, Nabe & Corr, 2003:546). "Eradicating oppression and asserting their rights to self-expression in a world they control, has become a key concern of people across the globe as they engage with one another to realise their hopes for a better tomorrow." (Dominelli, 2002:1).

The participants also found the module on low-cost activities and assistive devices (AD's) useful and can apply physical handling techniques, since the last session created an opportunity for a practical session which included making various assistive devices, toys for stimulation and actual practicing of lifting and handling methods.

7.2 SUMMARY OF THE FOCUS GROUP PROCESS AND RESULTS

The summary of the evaluation of the community-based disability programme is illustrated in Table 17.

TABLE 17: Summary of the results of the focus group session

FOCUS GROUP SESSION	SUMMARY OF THE RESULTS OF THE SESSION
OBJECTIVES	<ul style="list-style-type: none"> ☞ To make contact with the community experts/role-players. ☞ To explain the goals of the research project. ☞ To report on the progress of the intervention the past 6 months. ☞ To obtain informed consent from the participants. ☞ To evaluate the community-based disability programme and the changes after implementation thereof.
COURSE OF THE SESSION	<ul style="list-style-type: none"> ☞ This session was a contact/contract session. ☞ The researcher introduced herself and her assistant. ☞ The goals of the research project were stated. ☞ Written informed consent was obtained. ☞ The duration of the focus group session was discussed. ☞ Ethical aspects were clarified.
EMERGING THEMES	<ul style="list-style-type: none"> ☞ Acknowledgement for the need of the programme and a positive attitude towards the intervention process. ☞ Appreciation for the volunteers of the community. ☞ Acknowledgement for the lack of communication between the leaders of the community and the members of the community. Suggestions that training of the stakeholders (including the Chief) needed in order to promote ownership and involvement. ☞ Acknowledgement that changes in services are positive, but that certain required services are dependent on outside resources and commitment, e.g. transportation, housing, specialized schooling and access to the open labour market. ☞ Services which have improved include help with accessing disability grants, home-based care, help with identification of needs for AD and the application thereof. ☞ Social work counselling services are still needed, but social workers not available to deliver services. ☞ Disability awareness improved and suggestions of platforms for education/training were discussed. It includes school meetings, tribal gatherings, funerals, church gatherings, clinic sessions and the community radio (when available). ☞ Skills training, recreational activities and specialized schooling is still a major need.

	<ul style="list-style-type: none"> ☞ Home-based carers to be trained and they should assist with application of identity documents and birth certificates, support to the care-takers (support groups) and the PWD. These members should also consider Train-the-trainer sessions. ☞ Food gardens will assist with the malnutrition problem, but assistance from other agencies (including the North-West University) is needed with food garden project. ☞ Information, education and training will assist with meeting the needs of PWD in the community, but government involvement/NGO and other role-players are crucial in order to fully empower the people.
<p>RESPONSE EXAMPLES</p>	<ul style="list-style-type: none"> ☞ "The programme is accepted into this community with great excitement and has already made a difference in our community". ☞ "Ongoing support and input is needed in order to ensure a valuable service". ☞ "The impact of the programme is limited by the lack of communication in the community".
<p>CORRELATION WITH LITERATURE</p>	<ul style="list-style-type: none"> ☞ Cornes (1991:112) writes that new initiatives in education, rehabilitation, training and employment should seek to facilitate each person with a disability's independence and empowerment. ☞ Laverack (2005:4) advocates that empowerment is crucial during the independence process of any person or community that wishes to take control of their lives. He mentions that the steps are important to help individuals to increase their skills and competencies. ☞ De Beer and Swanepoel (2000:76) describe the importance of collaboration of all the role-players. ☞ Keskitalo (2004:12) suggests relevant partnership and resources that are vital to sustainable community policies, programmes and development. ☞ Ross and Deverell (2004:113) indicate that professional and community support has a valuable role to play. ☞ According to Northern (1995:9), most importantly, the positive change in bio-psychosocial functioning of individuals, changes in their families and groups and changes in the conditions in their environment to lessen obstacles and provide opportunities for satisfying social living.

7.3 THE LINKS BETWEEN THE QUALITATIVE AND QUANTITATIVE RESULTS

The combination of mixed methodologies proved the most effective strategy to achieve the objectives of this study and to discover the links between the evaluation results (Neuman, 2003:16). The following themes were identified:

7.3.1 Positive intervention

Results from both the FAS and the focus group session indicated that positive intervention is possible and has already been successful in the Heuningvlei community.

7.3.2 Expectations met

Results from both evaluations indicated that most of the expectations were met through the assessment, development and implementation process.

7.3.3 Ongoing support needed

The results indicated that ongoing support is needed in order to ensure sustainability and effective implementation of the programme.

7.3.4 Lack of service delivery

The lack of service delivery is still a major problem and remains a major challenge for this rural community. This programme has informed the participants of the rights of PWD, but it was felt that it was the responsibility of the Chief and other community leaders to address this problem and advocate for the rights of the PWD and the broader community.

7.3.5 Lack of community resources

The lack of community resources was another major obstacle in the management and prevention of disabilities – yet another responsibility for the community leaders.

7.3.6 Home-based care and physical assistance

The home-based care service was evaluated as crucial for this community, focussing on assistance with application for birth certificates, identity documents and disability grants.

7.3.7 Disability awareness

It was evaluated that this programme and service has improved the awareness with regard to disability matters and has overall been implemented successfully.

8. THE OPPORTUNITIES AND CHALLENGES OF THE PROGRAMME

The opportunities and challenges identified are based on the critical evaluation of the programme, guided by the “Domains approach” illustrated by Laverack (2005:9). This approach covers a range of social, political and economic factors relating to the level of control members of a community have over the influences on their lives.

The challenges and opportunities identified during this programme evaluation process include the following.

8.1 THE OPPORTUNITIES OF THE COMMUNITY-BASED DISABILITY PROGRAMME

- ☞ The content of the programme is based on the physical and educational needs identified by the community. Most of the information is supported by pictures and straightforward explanations which support the utilization of this programme for all levels of society.
- ☞ The nature of the programme also allows for other support workers or home-based care workers to be trained, resulting in a more flexible and sustainable programme.
- ☞ This programme aids empowerment in the Heuningvlei community that has been achieved through the education and training of the group participants as well as their ability to assist the Heuningvlei community by means of the stress management module, socializing opportunities, self-esteem development and disability awareness campaigns in the community.
- ☞ This programme guides the community members to utilize existing community resources such as the religious institutions, schools, clinics and the SAPS, minimizing their frustrations with regard to the lack of external resources and support.
- ☞ Disability awareness, advocating for equal opportunities and anti-discriminatory practices are advised. People with disabilities are often labelled,

pushed aside and forgotten. This programme focussed on discrimination and addressed this problem through the implementation of the disability home-care service.

- ☞ Support groups for PWD and their caretakers minimize isolation, depression, substance misuse and even suicide.
- ☞ Sustainable learning opportunities have been established through the utilization of the support groups and suggestions for skills development training.
- ☞ Social responsibility and future planning is encouraged through planning goals in module 8. This module includes important aspects such as planning for the future and coming to terms with personal struggles or challenges.
- ☞ Partnership development has been established during the focus group evaluation session. The establishment of social support networks is crucial in order to solve problems and effective service delivery.
- ☞ With this programme wider community involvement is achieved which is beneficial to the entire community's well-being.

8.2 THE CHALLENGES OF THE COMMUNITY-BASED DISABILITY PROGRAMME

The challenges identified are seen within the framework of poverty, isolation and limited resources.

- ☞ The first challenge is to ensure the sustainability of the project and to assist community members to create structures for it to operate within. The community-based disability programme (Appendix H) was written and presented in English but, due to the language limitations, the programme will be translated into Setswana and made available to the Heuningvlei community as soon as possible.
- ☞ The programme's content is complex at times and contains in-depth details of certain aspects. The programme presentation (training session) should be extended in order to provide the participants with more time to grasp the concepts.
- ☞ The need for ongoing support and training is evident and the participants should feel supported by further assistance and training.

9. RECOMMENDATIONS

The following recommendations are suggested for future research and intervention:

- ☞ **Government involvement:** An integrated strategy is clearly needed, since the concepts *poverty*, *health* and *disability* are closely related.
- ☞ **People-centred approach:** A people-centred approach promotes citizen participation and empowers people to sustain long-term development.
- ☞ **Holistic intervention:** In order to promote ownership and partnership working. Community resources and role-players should be engaged in this intervention process. The local school could for example be utilized as training venue, after school hours.
- ☞ **Advocacy:** The aim of advocacy in this rural community is to make sure the PWD know their rights, that their voices are heard and that they receive the services they need.
- ☞ **Home-based care:** The ultimate care provision, which at the moment seems to be a luxury instead of a necessity is the provision of personal assistance to all people with disabilities.
- ☞ **Activity centres:** The severe lack of opportunities for employment and alternative learning supports the need for activity learning centres, which would achieve various successes - activity centres for PWD who, due to the severity of their disabilities, are unable to engage in any meaningful economic activity. Services should include a range of options, which allow as independent a lifestyle as possible; promote full potential and dignity, and facilitate the involvement of families and communities in the provision of services.
- ☞ **Prevention strategies:** Involvement of the health professionals in this community is crucial in order to prevent disabilities in this isolated, resource-stricken community.
- ☞ **Sustainability:** Motivating community members to take responsibility and ownership of a development programme could, according to Jason et al. (2004:4, 12), be achieved through participation research approaches which increase citizen power and voices. They provide general principles for implementing this approach.
- ☞ **Decision makers' involvement:** Karger, Lyiani and Shannon (2007:81) remind the reader of the importance of multiple strategies which involve

engaging the correct and relevant decision makers, at the right time, at the right level as well as working through the power differentials, and especially empowering local communities if effective development is to take place. The community-based disability programme should first have been presented to Chief Bareki and the Royal Circle members in order to create awareness and to ensure endorsement of the programme and its goals.

- ☞ **Community action group:** Ross and Deverell (2004:296) stress the importance of including the relevant community leaders in a committee who will be responsible for the leadership of the intervention programme as well as the establishment of a community action group who will be responsible for the implementation of the intervention programme. Due to the political and power struggle in the community, the disability care workers will have to communicate with the community leaders and involve them in the intervention process.
- ☞ **Partnerships:** De Beer and Swanepoel (2000:xvii) suggest that significant role-players are important and states that authorities, Non-Government organizations (NGOs) and other role-players must play a supportive role, rather than the principal role, and that they should enable decision-making instead of making the decisions. Monaheng (2000:127) suggests that all the role-players should co-ordinate their efforts in order to maximize the impact of their efforts and to avoid superfluous duplication.
- ☞ **Ongoing support and advice:** It is finally suggested that ongoing support and advice from the North-West University would motivate the volunteers of this project and provide them with new knowledge and skills to execute their work more effectively.

10. CONCLUSION

The changes in South Africa the past few years have brought about major improvement in the care and management of PWD, but this field still offers fast opportunities for improvement and development. The combined micro-variables of family support, parental availability, positive family atmosphere and good role models could outweigh the negative effects of socio-economic restrictions. Based on this knowledge, total participation and acknowledgement of the community-based disability programme is needed in order to make a significant, large-scale contribution to the community.

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SECTION C
SUMMARY, CONCLUSIONS AND
RECOMMENDATIONS

1. INTRODUCTION

Based on the previous articles the most significant facts will be highlighted and discussed by means of to the research objectives.

SECTION A: ORIENTATION TO THE RESEARCH

This section covered the actuality of the research, the aim, objectives, theoretical assumption and definitions of key terms. The orientation initially focused on the preliminary exploration including the literature analysis, the utilization of experts and the initial exploration study. Thereafter, the empirical investigation including the research design, the population, the data collection instruments, procedures and ethical aspects. Finally the research results are presented in graphical- and table format, followed by the conclusions and recommendations.

SECTION B: THE JOURNAL ARTICLES

Article 1: **The interrelation between poverty, health and disability in a rural community.**

Article 2: **Developing a community-based disability programme: results of a situation-analysis in a rural community.**

Article 3: **A community-based disability programme for rural areas.**

Article 4: **The evaluation of a community-based disability programme for rural areas.**

SECTION C: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

SECTION D: APPENDIXES

SECTION E: CONSOLIDATED BIBLIOGRAPHY

2. SUMMARY OF THE MAIN ASPECTS OF THE RESEARCH PROCESS

Section B of this research report summarize the most important aspects, findings and conclusions of this research project.

3. AIM AND OBJECTIVES OF THE STUDY

3.1 Aim

- ☞ To develop and evaluate a community-based disability programme for poverty stricken families in a rural area.

3.2 Objectives




- ☞ To establish the interrelation between poverty-, health- and disability.
- ☞ To establish a community profile as well as the bio-psychosocial needs of the Heuningvlei community with regards to a community-based disability programme.
- ☞ To develop and implement a community-based disability programme.
- ☞ To evaluate the community-based disability programme.

4. RESEARCH METHODOLOGY

The mentioned goal and objectives of this study were researched by means of a social science research project (De Vos, 2005c:41), consisting of a literature study and an empirical study. Delpont and De Vos (2005:45) discuss the definition of professional research and professional practice which forms the foundation for this research process. Guidelines for the research process are provided by Fouché and Delpont (2005:79). Roos, Visser, Pistorius and Nefale (2007:102) and Strydom (2005a:57-67) provided ethical guidelines for this study.

The research methodology for this project is summarized in Table 18 and will be discussed in detail.

TABLE 18: The research methodology for the study

<p>PHASE 1</p> 	<p>Literature study.</p> <p>Conducting individual interviews with community expert and relevant role-players.</p> <p>Pilot testing the questionnaire with 2 community members.</p> <p>Survey: Doing a situation and needs analysis with community members with disabilities.</p>
<p>PHASE 2</p> 	<p>Pilot testing the programme with 3 community members.</p> <p>Programme implementation.</p>
<p>PHASE 3</p> 	<p>Pilot test the interview schedule with 2 community members.</p> <p>Evaluating the programme through a focus group session with experts and local key role-players and the FAS.</p> <p>Advanced development and dissemination.</p>

The research methodology for this study is summarized in Table 18 and was based on intervention research as defined by De Vos (2005a:394).

4.1 LITERATURE STUDY

The literature review was aimed at a clearer understanding of the nature and meaning of a certain phenomenon (Fouché & Delport, 2005:123). A collection of local and international books, scientific journals, thesis's and previous research were consulted. Data baseses that were utilized to identify applicable literature included EBSCO Host, Academic Search Premier, CINAHL, Emerald, Health Source: Nursing/Academic Edition, Master File Premier, MEDLINEA, ProQuest and PsycINFO.

The researcher also consulted with a psychologist, social worker, nurse, multi-professional team co-ordinator (United-Kingdom) and a communications officer of the SAPS. Each person is an expert in his/her field and contributed to the understanding of the phenomenon. The literature study led to a better understanding of the relevant data,

which in turn assisted with the development of the community-based disability programme and the empowerment of the people of the Heuningvlei community.

4.2 EMPIRICAL RESEARCH

The empirical investigation included the exploratory- and descriptive research designs, the population and sample selection, data collection instruments, procedures and ethical aspects.

☞ Research model

The process of intervention research, the design and development (D&D) model was utilized as discussed by De Vos (2005a:394). D & D is a phase model consisting of the following six phases: Phase 1 – Problem analysis and project planning, Phase 2 – Information gathering and synthesis, Phase 3 – Design, Phase 4 – Early development and pilot testing, Phase 5 – Evaluation and advanced development, Phase 6 – Dissemination.

☞ Research design

Both the exploratory and descriptive research designs were utilized including quantitative- and qualitative methods (Delpont, 2005:159-191; Fouché, 2005:267-285). Descriptive research assists us to understand the nature of a certain phenomenon more accurately (De Vaus, 2002:1). Exploratory research focuses on why questions and involves the explanations, causes and interrelations between concepts (De Vaus, 2002:2; Alston & Bowles, 2003:35).

☞ Participants

The Heuningvlei community consists of approximately four thousand households. The research participants were members from the Heuningvlei community in the Kgalagadi District of the Northern Cape Province.

☞ Sampling procedure

Exploratory questionnaires were completed by 254 households (selected through non-probability sampling) as described by (Strydom, 2005b:200) with the aim of compiling a community profile. The sample population for disability related issues were selected through the non-probability, snowball method (Strydom, 2005b:203).

The community experts (key role-players) for the individual interviews and evaluative focus group session as well the group participants were selected

according to the non-probability (purposive) sampling technique (Strydom & Delport, 2005: 328).

Data collection instruments & measuring instruments

In this study different data collection methods and measuring instruments were utilized in order to ensure the validity and reliability of the research process (Delport, 2005:160). A disability specific questionnaire (Appendix A) was utilized in order to assess the bio-psycho-social needs of the PWD in the Heuningvlei community. The community-based disability programme was developed based on the assessed needs of the PWD living in the community.

Initial individual interviews sessions (Appendix B) with key role players in the community during the initial phase of the study as well as an evaluative focus group session (Appendix C), (with same key role players utilized during the final phase of the study) were utilized to elicit data.

Local community members were recruited and trained on the programme, implementation thereof and the capability to train other interested community members. The FAS was utilized with this group of participants to evaluate the community-based disability programme ((Appendix H).

Data analysis

Qualitative and the quantitative methods were utilized for the data analysis. The qualitative data obtained from the interviews and focus groups were analyzed by means of Tesch's approach to data analysis (Poggenpoel, 1998:343-344). Central themes were identified and categorized.

The quantitative data was analyzed and interpreted in consultation with the Statistical Consultation Services of the North-West University (Potchefstroom Campus). The overall results of the research project were interpreted and presented in graphical format.

5. DISCUSSION AND INTERRELATION OF THE KEY CONCEPTS – POVERTY, HEALTH AND DISABILITY

The interrelation between poverty, health and disability has been thoroughly explored through a literature study and presented in major themes and ideas.

Problems do not originate *inside* people but as a function of the interaction between an individual and a particular context. Change in the context and social organisation can contribute to well-being in a community” (Visser, 2007:108).

Many families in South Africa are troubled by poverty which is characterised by crowded living conditions, chronic diseases, crime, violence, lack of employment, neglect, sex work, substance abuse and Human Immune Deficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), to mention but a few (Wessels, 2003:61; Mayekiso & Tshemese, 2007:156; Swart, 2007:194). “Malnutrition is the high prevalence of conditions such as malaria and bilharzias in poverty-stricken sub-Saharan Africa, which serve to further compromise the HIV-positive person’s immune system” (Van der Walt, Bowman, Frank & Langa, 2007:209).

Poverty is often accompanied by additional social problems such as family disintegration, substance abuse, adults and children in conflict with the law. Poverty also often goes hand in hand with low levels of literacy, lack of capacity to access economic- and social resources and a struggle to survive (Oliver, 2005:211). If the economic- and social resources were available, most health problems would be minimized (May, 2000:104). Lack of health care facilities leads to avoidable chronic diseases and disabilities and research by Vorster, Venter, Wissing and Margetts (2005:488) in the North-West Province indicated major differences in the health and general well-being of people living in rural areas and people living in urban areas. People in rural areas were found to have lack of knowledge about safe sex and primary health care, foetal malnutrition, childhood stunting, inactivity and nutritional facts.

Poverty makes people more vulnerable to ill-health and disability and disability can lead to isolation, lack of support and lack of resources. Many people still remain ill-fed, ill-housed, under-educated and defenceless to preventable diseases. There is interconnectedness between health, illness, risky behaviour and coping mechanisms. Diseases such as cholera, HIV and AIDS, malaria and tuberculosis are impacting negatively on the welfare of the people. Risk factors includes alcohol abuse as being interrelation to accidents, unsafe sexual behaviour, attempted suicide, liver disease, cardiovascular complications, stroke, cancer and neurological complications.

Poverty and health problems therefore have a profound influence on the vulnerable bio-psycho-social well-being of a PWD.

Due to the several of challenges associated with poverty, ill-health and disabilities in a rural community, the community-based disability programme focused on the available resources and community strengths which is defined by Roos and Temane (2007:281) as the unique combination of community resources that can enhance collective- and individual well-being through principles such as inclusiveness, respect, participation and equity.

6. THE COMMUNITY-BASED DISABILITY PROGRAMME

A summary of the module, programme content, goal and objectives of the community-based disability programme is illustrated in Table 19.

TABLE 19: The community-based disability programme

MODULE	PROGRAMME CONTENT	GOAL	OBJECTIVES
1	<i>Getting to know one another.</i>	Disability awareness	Relationship development To be aware of other people's needs and dreams
2	<i>Self-esteem</i>	Disability awareness Discrimination against PWD	Relationship development, assertiveness, conflict management Understanding the importance of self-esteem and how to make a PWD feel less isolated and excluded
3	<i>Health</i>	Prevention of illnesses and disabilities	Healthy lifestyles and the importance of timely immunizations.
4	<i>Stress management</i>	Disability management	Awareness of internal- and external causes of stress for a PWD
5	<i>Healthy living and eating</i>	Prevention of illnesses and disabilities	Growing a food garden, nutrition awareness, First Aid
6	<i>Exercise</i>	Prevention of illnesses and disabilities	Exercise- and relaxation programme development
7	<i>Tau strong</i>	Prevention of illnesses and disabilities	Awareness of the dangers of substance misuse and HIV, AIDS and STI'S.
8	<i>Map of my life</i>	Disability management	Setting of goals for your life

MODULE	PROGRAMME CONTENT	GOAL	OBJECTIVES
9	<i>Discrimination</i>	Disability awareness	Understanding discrimination against PWD and support resources Human Rights
10	<i>Disability care</i>	Disability awareness	Resources for Social Security grants, causes of disabilities types of disabilities, physical handling techniques
11	<i>Low cost activities, evaluation and feedback</i>	Prevention of illnesses and disabilities	Child development and stimulation, creating low cost assistive devices, creating low cost creative activities
12	<i>Celebrating National Disability Day</i>	Disability awareness	Disability awareness event for the Heuningvlei community, including the relevant role player and government departments

7. THE EVALUATION OF THE COMMUNITY-BASED DISABILITY PROGRAMME

Potter, Basson and Laauwen (2007:410) describe programme evaluation and state that the evaluation process should focus on whether the social programme is providing the appropriate service to individuals, organisations and communities.

The findings indicate that the community-based disability programme has been received as positive and valuable. Empowerment through learning has been achieved and Van der Merwe and Dunbar-Krige (2007:304) suggest that people who are involved in community service learning should be encouraged to reflect on that learning in order to obtain a deeper learning that could be used in other situations. Even during the short operation time some positive changes have been reported and it was evident that the group members had indeed reflected on the learning process and were able to implement their skills in the Heuningvlei community.

Diale and Fritz (2007:319) remind the reader that indigenous knowledge and learning could contribute towards the empowerment of communities. During the focus group evaluation session these important aspects were confirmed by suggestions of awareness sessions during tribal meetings and discussions with the Chief and the elderly of the community.

The identified problems or challenges where no change or impact were reported on was identified as aspect outside of the support workers' arena of scope. These aspects

included transport problems, specialized schooling, government involvement and the creation of job opportunities. Linked to these last mentioned problems some of the respondents indicated that they feel so negative about their futures that they are not able to utilize the module on “Map of my life” as they feel they are not progressing and definitely have no goals or expectations for themselves or their children.

The overall evaluation indicated that this programme was considered to be beneficial to all PWD and their family members in the Heuningvlei community and an empowering instrument. Successful intervention as Swart and Bowman (2007:435) suggest that *research* must drive *action*.

8. CONCLUSIONS

This research project has endeavoured to highlight the interrelation between poverty, health and disability as a reality and a major challenge in rural areas.

- ☞ The stresses of poverty contribute to substance misuse, chronic diseases, HIV and AIDS, psycho-social difficulties, economic despair and disabilities.
- ☞ The lack of basic infrastructure such as transport networks, access to clean water and toilet facilities, specialized schooling, sport- and leisure activities are just some of the community resources challenges.
- ☞ Lack of resources and services in a community contributes to ill health and certain disabilities.
- ☞ Appropriate health care could prevent certain disabilities.

Housing conditions in the Heuningvlei community are poor and adapted housing facilities are only a myth. The majority of the community members are dependent on social security grants for survival.

The absence of a local health practitioner and nurse results in the occurrence of preventable health problems and stress for the community members. The lack of health care facilities is also linked to the inability to apply for disability grants, AD and the compulsory medication.

The aforementioned facts consequently directly impact on the functioning and the bio- psychosocial needs of the PWD, their care-takers and their family members.

9. TESTING THE CENTRAL THEORETICAL ASSUMPTION

By meeting the objectives and aims of this study the theoretical assumption that a community-based disability programmes can improve awareness, empowerment and support with regard to disability issues in a rural community has been proven correctly.

10. RECOMMENDATIONS

Based on the previous results and conclusions the following general recommendations/-improvements with regards to the community-based disability programme as well as more specific recommendations on national- , provincial- and local levels are presented:

General recommendations

- In order to ensure ownership of the community-based disability programme the Chief and the elderly of the community should be more involved in the development of the community-based disability programme.
- The community-based disability programme and the presenter's guide should be translated to Setswana.
- The trained disability home-based care workers should train other individuals in the community in order to effectively support all the PWD in the Heuningvlei community.
- Due to the lack of transport and the conditions of the roads a disability support groups is not viable at this stage. The community-based disability programme could however be utilized during a support group for the care takers of the PWD in the community.
- The community-based disability programme has been developed to be flexible and to meet various individual-, group- and community needs. Module 1 of the programme could be utilized during one-to-one sessions with PWD with the aim to build trusting relationships between the disability home-based care worker and the PWD.
- The community-based disability programme could be utilized for disability awareness in the wider community and practical guidelines for awareness could be included in the programme.
- Module 8 (Map of my life) does not seem relevant to this community as the PWD seems to have limited understanding of goals and future planning. A more culture appropriate technique such as the "River of Life" could perhaps be better utilized.

- The community-based disability programme could include a very basic, more comprehensive summary of the rights of a PWD.
- In order to ensure effective implementation and sustainability the language, culture and educational level of people in rural communities should be taken into consideration during the planning and development of a programme.

National Level:

- ☞ Nationally the government has a major responsibility in terms of disability rights, - prevention and –management in South Africa.
- ☞ A Chief-Directorate on the Monitoring and Evaluation of disability matters does exist and it is the responsibility of the Department of Social Development to take control and to monitor services for PWD in rural areas in South-Africa.
- ☞ All the disability related policies of the Department of Social Development include service delivery to rural areas. It is the responsibility of this Department to ensure effective service delivery in these isolated, resource-restricted rural areas.
- ☞ The Department of Trade- and Industry should provide relevant guidance and training for local business development and entrepreneurs.
- ☞ The Department of Health has a responsibility to ensure service delivery in the rural areas.
- ☞ The Department of Education should ensure education and training in rural areas.
- ☞ The Department of Labour should explore assisting the community members from rural areas to access the open labour market.
- ☞ The Department of Public works should provide accessible roads and running water in the rural areas.
- ☞ Professional disciplines such as social workers, psychologists, doctors, nurses, educators, police officers and trained volunteers should be working in partnership to meet the needs of PWD in rural areas
- ☞ Service delivery by these mentioned professional disciplines could include education and awareness training with regards to disability matters, community development projects and group work sessions for PWD.
- ☞ Government support and funding is crucial in rural areas.

- Further research could include the exploration of the successes and the challenges regarding the implementation of disability related policies in South Africa.

Provincial Level:

- It is recommended that the North-West University, and other Universities, continue to engage in research on rural areas and the bio-psychosocial situation of people living in these rural areas.
- The Provincial Disability co-ordinators for the Department of Social Development should continue to attend the training by the National Office of the Department of Social Development on the following disability related policies; The Policy on Disability, The Policy on Management and Transformation of Protective Workshops, The Policy on residential facilities and the Policy on the minimum standards for residential facilities. The Overall UN Convention for Persons with Disabilities also provides guidelines for effective service delivery to PWD.
- The roads leading to Heuningvlei are in appalling conditions and this seems to deter service delivery in the area. It is therefore recommended that the Provincial Department of Public Works improve these roads.
- The area lacks special education- and training facilities and resources. It is recommended that the Department of Education, the Department of Social Development and the Department of Health address this problem and provide the much needed services.
- Provincial social workers from the Department of Social Development have a major responsibility to actively engage in the care and development of PWD in rural areas. The social workers are qualified to deal with the challenges on micro-, meso- and macro levels.
- It is recommended that the allocated social worker for this area reach out to this community to assist with the assessed needs such as counselling, skills training and applying for disability grants and ADs.
- The Department of Health has a responsibility towards the PWD in this community. It is recommended that disability home-based carers are trained for each village. In order to ensure sustainability it is recommended that the home-based carers receive ongoing support, supervision and financial rewards.

- The various Departments could also employ family-centred service providers such as child- and youth care workers, assistant probation officers, community development workers, and auxiliary social workers. These resources and services could alleviate the pressure from thousands of families dependent on social security grants.
- Supervision, support and accountability of support workers could encourage and motivate them in the long run.
- Ongoing training to the support workers would ensure capacity building and assist them to manage the programme independently.
- The community-based disability care workers will establish a local community resource and create a basis for PWD to reach out to.
- Entrepreneur training and support will provide the taught individuals to create an income generating project and alleviate poverty.

Local Level:

- Assessment of the local needs and liaison with the local community members are crucial for the development of a relevant and sustainable programme.
- Permission from and endorsement by the Chief, his representatives and the elderly of the community is not only ethical, but also vitally important for the intervention process.
- Empowering group work sessions by the Department of Social Development could include the following themes; self-knowledge and self-esteem, health and wellness, general disability awareness and the causes of disabilities, management of disabilities, prevention of illnesses and disabilities, the link between substance misuse and disabilities, HIV/AIDS and disabilities, incest and disabilities, communication, skills training, AD and the application process, social security grants and the application process.
- The mobilization of relevant resources and services as well as endorsement by community leaders are only a few aspects which could improve the quality of life of PWD in rural areas.

11. CLOSING REMARKS

In drawing this study to a close the central themes from the findings that emerged from the research in the Heuningvlei community have confirmed that PWD and their community could greatly benefit from this programme, government involvement and community support. It can be argued that by implementing the community-based disability programme in a rural community there will be a high probability of improvement in preventing and managing disabilities in a rural area. It will also support and empower PWD and their family members in rural settings. The challenge remains to involve the government departments and significant other role players in order to meet the needs of the PWD living in rural areas in South Africa.

THE HEUNINGVLEI COMMUNITY

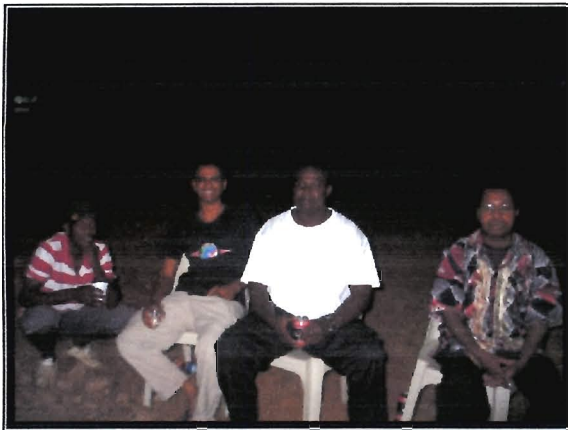
DISABILITY NEEDS ASSESSMENT



HOME VISITS



LIAISON WITH LOCAL KEY ROLE PLAYERS



INDIVIDUAL INTERVIEW SESSION



THE DISABILITY CARE WORKERS



LOW COST ACTIVITIES



THE DISABILITY WORKSHOP

THE FOCUS GROUP SESSION



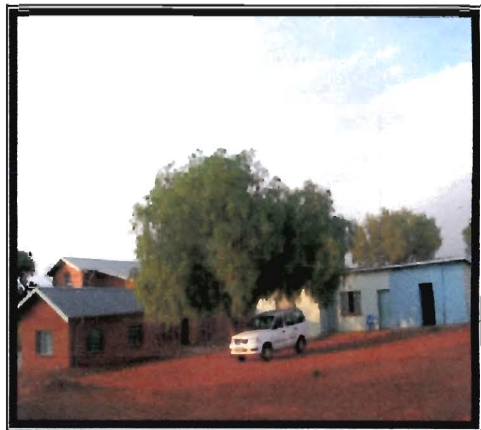
THE VEGETABLE GARDEN



THE TRAINING VENUE



THE WATER ACCESS POINT



THE END OF THE JOURNEY



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SECTION D
APPENDIXES




APPENDIX A






DISABILITY QUESTIONNAIRE:
TSHWARAGANO PROJECT GENERAL

1. Does anybody in your household have one of the following disabilities?

		Yes		No	
1.1	Physical disability. 		1		2
1.2	Hearing disability. 		1		2
1.3	Blindness 		1		2
1.4	Mental Impairment 		1		2

2. If yes, what was the cause of this disability?

		Yes		No	
2.1	Born with it. 		1		2
2.2	Illness. e.g. Polio, to fat or food. 		1		2
2.3	Shooting incident and violence. 		1		2

2.4	Genital illness. e.g. syphilis. 		1		2
2.5	General accident. e.g. Dangerous games, fire 		1		2
2.6	Poison. e.g. snake or paraffin 		1		2
2.7	Attempted to kill one-self. 		1		2
2.8	Substance abuse. .g. Drugs or Alcohol 		1		2
2.9	Other, specify:				

3. Does anybody in your household use a wheelchair, crutches, dentures or any other assistive devices?



Yes	1
No	2

4. Does anybody in your household receive a disability grant?



Yes	1
No	2

5. Do you know where and how to apply for the grant?

Yes	1
No	2

6. Do you know at what age children should be taken to the clinic to be immunized?

Yes	1
No	2

7. Do your family members have regular health check-ups?

Yes	1
No	2

8. What means of support do they need?

		Yes		No	
8.1	Regular visits and counselling		1		2
8.2	Helping to receive grants, information on resources.		1		2
8.3	Home based care and providing aids.		1		2
8.4	Other, specify.				

9. Do you know any other person with a disability?

Yes	1
No	2

APPENDIX B

QUESTIONS – HEUNINGVLEI INDIVIDUAL INTERVIEWS

QUESTION 1:	Name a few services you think the people with disabilities in your community need.

QUESTION 2:	What do you think are the physical needs of the people with disabilities in your community?

QUESTION 3:	What information/education should a community-based disability programme include for your specific community?

QUESTION 4:	Do you think your community members are aware of the needs, expectations and dreams of people with disabilities?

APPENDIX C

FOCUS GROUP QUESTIONS:
PEOPLE WITH DISABILITIES (PWD)



Review of initial questions and answers:

Name a few services you think the PWD in you community needs.

SERVICES REQUIRED

- Help with accessing disability grants
- Social work counselling
- Home-based care
- Assistive devices, such as wheelchairs, crutches and hearing aids
- Specialized schooling
- Socializing
- Protection
- Government housing assistance
- Transport
- Jobs
- Skills training

QUESTION 1:

Do you think that services identified (as mentioned above) during the initial phase of this project improved/changed after the implementation of the programme?

REVIEW OF INITIAL QUESTION AND ANSWERS.

What do you think are the physical needs of PWD in your community?

PHYSICAL NEEDS

- ☞ Comfortable and adapted housing Transport to the clinic, church and shops
- ☞ Home-based care
- ☞ Food
- ☞ Training for the caretakers in the physical care of a person with disabilities
- ☞ Comfortable and adapted housing

QUESTION 2:

Initially we explored the physical needs of the people with disabilities in your community. Do you think some of these needs have been met by the programme?

REVIEW OF INITIAL QUESTION AND PROGRAMME CONTENT.

What information/education should be included in a community-based disability programme for you community?

Module 1	Getting to know one another
Module 2	Self-esteem
Module 3	Health
Module 4	Stress management
Module 5	Healthy living and eating
Module 6	Exercise
Module 7	Tau strong
Module 8	Map of my life
Module 9	Discrimination
Module 10	Disability care
Module 11	Low cost activities, evaluation and feedback
Module 12	Celebrating National Disability Day

QUESTION 5:

Any recommendations/feedback?

THANK YOU FOR YOUR PARTICIPATION

LIZÉL PRETORIUS

APPENDIX D
PERMISSION LETTER

The Chief

2008-03-23

Heuningvlei

Dear Chief Bareki

RE: REQUEST TO CONDUCT RESEARCH – A COMMUNITY-BASED DISABILITY PROGRAMME FOR A RURAL AREA.

I am conducting a PhD research study, with the above mentioned title. The aim of this study is to empower and support community members with disabilities, their caretakers and their families, living in rural areas. The programme is aimed at prevention and management of disability related issues as well as disability awareness in the wider community. Partnership working and social change forms a vital part of the intervention.

I would be greatly appreciated if permission could be granted for community members of the Heuningvlei community to participate in this study. Research would include individual interviews with significant role players and experts, questionnaires filled in by community members with disabilities, group work with ten volunteers (with an interest in disability care in the community) and finally a focus group session with significant role players, experts, group participants and some members with disabilities.

Participation will be completely on a voluntary basis, participants will be informed of this. Participation will not lead to any financial benefits or academic qualification. Participants can withdraw from the study at any stage. They may refuse to comment or respond to any specific question or discussion, and request that a particular response not be used in the research report. With their permission, the focus group discussion will be audio/video-taped for purposes of transcription. These tapes will be kept locked in the researcher's office, alongside all the information gathered from this study. All relevant information will be destroyed after the completion of this study.

Confidentiality within the focus group cannot be assured. Participants will be requested to keep all discussions and information confidential, but they might choose not to adhere to this request. However, all information and contribution will be reported anonymously in the research report. No names will be disclosed and it will not be possible to link participants with any specific responses or data. The topics being discussed will be of an emotional nature, therefore the participants will be informed that follow-up counselling/debriefing will be available during the duration of the study (the researcher will provide this service) or additional counselling services will be requested from the relevant social worker (Department of Social Development) if requested.

The results will be presented in the form of a thesis which will be submitted to the North-West University (Potchefstroom campus). The results will be utilized for academic publication purposes only. This proposed study has been approved by the Department of Social Work (Faculty of Health Science) as well as the Ethics Committee of the North-West University.

If the request meets your approval the following dates are suggested for the research process.

Disability questionnaires	– September 2008
Individual interviews with experts	– September 2008
Programme implementation (Group sessions)	- March 2009
Focus group evaluation	- October 2009

If you have any questions or concerns, please contact the researcher. My contact details are as follows:

E-mail address: lizelsnyman@hotmail.com

Contact No: 0727843812

Yours Sincerely

L. Pretorius

Researcher

Dr. A.G. Herbst

Research Supervisor

HEUNINGVLEI : CONSENT FORM

**A COMMUNITY-BASED DISABILITY PROGRAMME
FOR RURAL AREAS.**

The aim of this study is to empower and support community members with disabilities, their caretakers and their families, living in rural areas. The programme is aimed at prevention and management of disability related issues as well as disability awareness in the wider community.

- I understand that participation in this project is on a voluntary basis and that I am able to withdraw at any stage.

- I understand that participation in this project is on a voluntary basis and that I am able to withdraw at any stage.

- I know that the information that I give will be used to develop a community-based disability programme for my community.

- I know that I can ask for assistance, counselling and support at any stage of the research process.

NAME: _____

DATE: _____

APPENDIX F
THE PROGRAMME

A community-based programme for rural areas



**PREVENTING DISABILITIES, DISABILITY MANAGEMENT & EMPOWERING OF
COMMUNITY MEMBERS WITH DISABILITIES.**

Complete the following programme and discuss the points in the group, on a voluntary basis. This will form the cornerstone of the empowerment process, fair and equal treatment and general well-being of every community member with a disability.

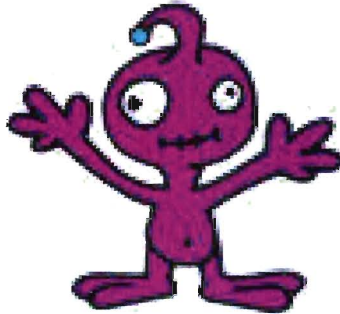
TITLE PAGE

1.	Module 1	Getting to know one another.
2.	Module 2	Self-esteem
3.	Module 3	Health
4.	Module 4	Stress management
5.	Module 5	Healthy living and eating.
6.	Module 6	Exercise
7.	Module 7	Tau strong
8.	Module 8	Map of my life
9.	Module 9	Discrimination
10.	Module 10	Disability care
11.	Module 11	Low cost activities, evaluation and feedback
12.	Module 12	Celebrating National Disability Day

MEET

PURPLE PULE

– THROUGHOUT THE PROGRAMME HE WILL BE PROVIDING
YOU WITH
USEFULL INFORMATION AND TIPS!!!!



MODULE 1:

GETTING TO KNOW ONE ANOTHER



”Cast your cares on the Lord and he will sustain you,
He will never let the righteous fall. “ Psalm, 55:22.



Objectives:

- ✓ To introduce the group members to each other and to start building trusting relationships
- ✓ To be aware of other people's needs and dreams



Important concepts to discuss before the module:



The best support should be built into everyday activities such as play, work, relationships, rest and adventure. We will learn how to be a therapist to ourselves in rural communities.

1. My name is...

2. My friends call me...

--

3. I amyears old.

--

4. I live in

--

5. Three things I like are...

6. Three things I don't like are...

7. What skills would you like to learn?



START BUILDING RELATIONSHIPS IN THE GROUP BY MAKING A VEGETABLE GARDEN.

These vegetables could be given to people with disabilities in your communities who are not able to travel to buy fresh food.



ALSO DISCUSS TRANSPORT ARRANGEMENTS AND ADDITIONAL REQUIREMENTS OF EACH MEMBER, IN ORDER TO ACCOMODATE AS MANY OF THEIR NEEDS AS POSSIBLE.



CONFIRM A DATE AND VENUE FOR THE NEXT MEETING.

MODULE 2:

SELF ESTEEM



“So do not be afraid of them. There is nothing concealed that will not be disclosed, or hidden that will not be made known.” Matthew 10:26.



Objectives:

- ✓ Get to know yourself
- ✓ To look at your everyday life
- ✓ Make yourself feel better



Important concepts to discuss before the module:

- ✓ **Self-esteem** is what you think about yourself and how you feel about yourself. You have a positive self-esteem if you like yourself. You have a negative self-esteem if you do not like yourself.
- ✓ **Improving yourself** is working on the points about yourself that you do not like and making yourself feel better and more loved.
- ✓ **Improve relationships** is working on getting on with your family members, friends and neighbours.

1. How would you describe yourself?

2. Do you work?

YES		NO	
-----	--	----	--

3. Are you interested in sport?

YES		NO	
-----	--	----	--

4. Is religion important to you?

YES		NO	
-----	--	----	--




5. Do you have friends?

YES		NO	
-----	--	----	--

6. Do you have a boyfriend/girlfriend/spouse/long-term partner?

YES		NO	

7. How would you describe your relationship? Choose one and mark with a X

Good			
Bad			
Up and down			

8. Is your family important to you?

YES		NO	
-----	--	----	--

9. Do you have any children?

YES		NO	
-----	--	----	--

10. Are you happy with the way you look?

YES		NO	
-----	--	----	--

11. Do you get on with your neighbours?

YES		NO	
-----	--	----	--

12. Do you think people talk about you behind your back?

YES		NO	
-----	--	----	--

13. What do you think they say about you?

14. How does it make you feel?
(write, draw, paste pictures from magazines or newspapers)?

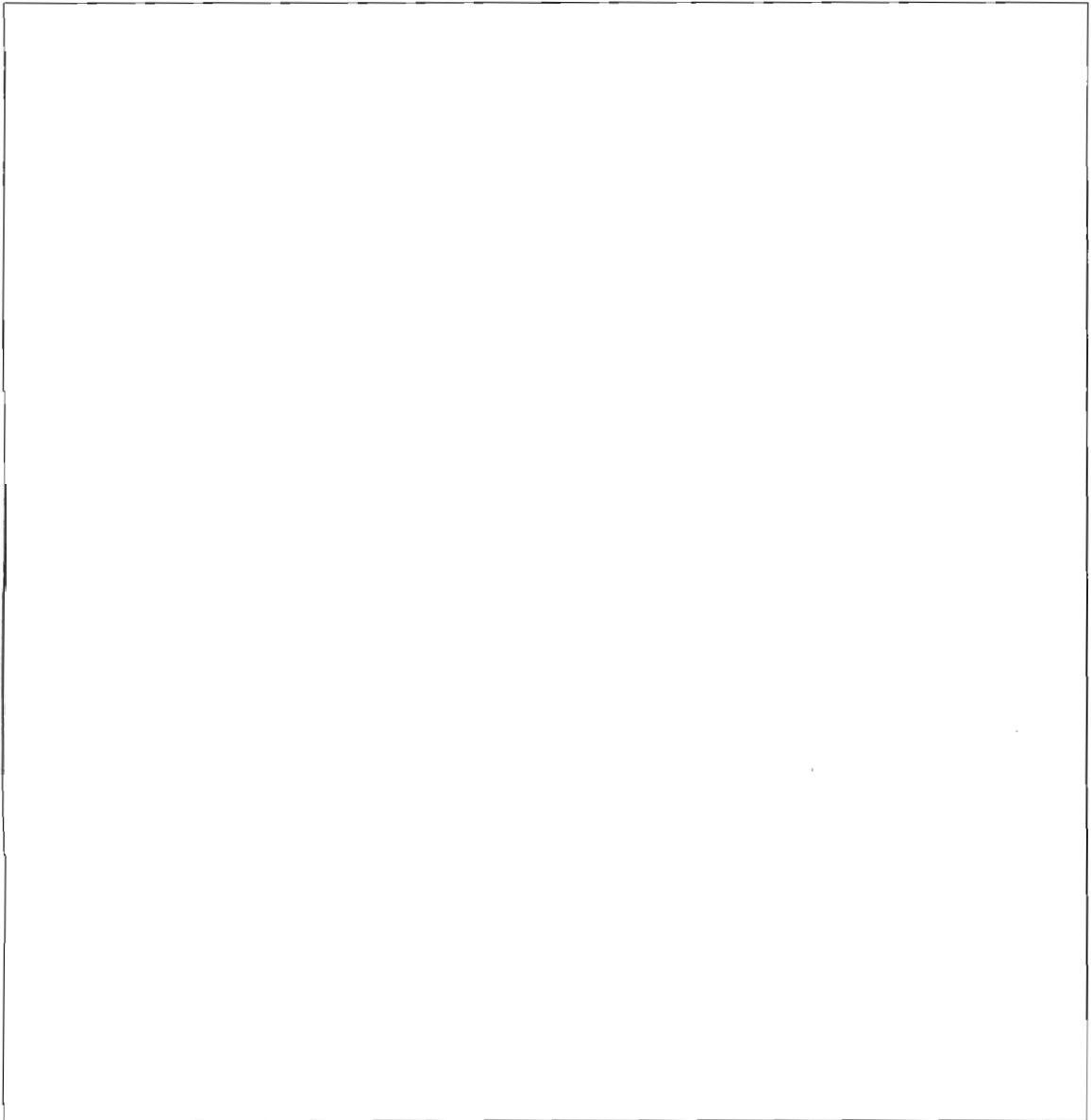
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You know yourself when:

- ✓ You accept yourself for who you are
- ✓ You accept and love other people
- ✓ You know what you do wrong and try hard to fix it

15. What can you do to make yourself feel better? (Write, draw, paste pictures from magazines or newspapers)



How to talk to people:

- ✓ Listen to the other person carefully
- ✓ Make sure you understand by asking if you heard correctly
- ✓ Don't attack the person self.
- ✓ Say what is bothering or hurting you
- ✓ Do not argue when you are angry, wait until you are calm



How to deal with an angry person:

- ✓ Do not get angry or aggressive back
- ✓ Give the other person the right to be angry
- ✓ Anger could be a sign of the person feeling helpless and sad
- ✓ Focus on the problem. Do not talk about things that is not relevant
- ✓ Show respect to the other person
- ✓ Show that you understand even if you do not agree with the person
- ✓ Show him/her how a person that is angry should behave
- ✓ Prepare for the argument and stay calm
- ✓ If you cannot control the situation. Look for help.



**Remember that loving yourself is needed before other people with
accept and love you.**

**Remember in order for you to deal with conflict and arguments
you must know yourself and what skills you have.**



Where can you go for help?

- ✓ OSDP: Office on the Status of Persons with Disabilities (012) 300 5486
 - ✓ DPSA: Disabled People South Africa (021) 422 0357
 - ✓ Social Workers – Department of Social Development
 - ✓ National Council for Persons with Physical Disabilities in South Africa (011) 726 8040
 - ✓ Circles of Support Hotline – 0860 222 777
 - ✓ Child Line – 0800 055 555
 - ✓ UNICEF – 012 338 5000
-



According to African culture there is a belief that if you raise your child correctly, the child will look after you in the future. This also means that community members should look after one another, but most people with disabilities are lonely and isolated. Relationships give meaning to life. Awareness of disability in your community could lead to acceptance and more friendships.



ALSO DISCUSS TRANSPORT ARRANGEMENTS AND ADDITIONAL REQUIREMENTS OF EACH MEMBER, IN ORDER TO ACCOMODATE AS MANY OF THEIR NEEDS AS POSSIBLE.



CONFIRM A DATE AND VENUE FOR THE NEXT MEETING.

MODULE 3: HEALTH



"There is nothing that enters a man from outside which can defile him; but the things which come out of him; those are the things that defile a man". Mark 7:15



Objectives



- ✓ To explore your knowledge with regards to important health issues
- ✓ To provide knowledge on the effect of your lifestyle and habits on your health
- ✓ To show the importance of living a healthy life
- ✓ To show you the harmful effects of the wrong eating and drinking habits



Important concepts to discuss before the module:

- ✓ **Assistive devices** include hearing aids, glasses, walking sticks, wheelchairs and crutches
- ✓ **Immunization** is the injections children should get at certain ages in order to prevent illness and disabilities
- ✓ **Highly infectious disease** is a disease which you can get from someone else by being in the same room with them



Start the session by weighing and measuring the group participants. Invite the Department of Health to work in partnership with this session. They could provide free testing. (Blood sugar diabetes, blood pressure, HIV).



WHAT DOES A HEALTHY PERSON LOOK LIKE?



- ✓ Not overweight and not too thin
- ✓ Smooth skin
- ✓ Strong teeth
- ✓ Clear eyes
- ✓ Healthy hair



Remember you must regularly visit your clinic for check-ups

1. What services can I expect from the clinic? (Draw, write or paste pictures).



Remember regular check-ups for your family can prevent disabilities and long-term illnesses



Most importantly, immunization at the right time can prevent disabilities



Immunization can prevent diseases like:

- ✓ TB (Tuberculosis)
- ✓ Tetanus (Lockjaw)
- ✓ Polio
- ✓ Whooping cough
- ✓ Measles
- ✓ Diphtheria



Did you know that measles is known as one of the most dangerous diseases of childhood?

It is spread when a person suffering from it coughs or sneezes.

2. Measles can cause the following:

- ✓
- ✓



Important facts:

- ✓ Children must be immunized to avoid getting measles
- ✓ Children can get immunized for measles at the age of 9 to 10 months of age and again at 18 months
- ✓ It is important to take the child to the nearest health facility as soon as measles is suspected
- ✓ People with measles should stay away from other people for at least 4 days
- ✓ Women should not get the vaccine when they are already pregnant or plan to get pregnant within three months after getting vaccinated.
- ✓ Immunization is given as an injection in the thigh or upper arm
- ✓ Contact your nearest clinic if you have any further queries.

3. Fill in the ages that you think immunizations are needed.



Children must be immunized at the following ages

AGE	IMMUNIZATION
	TB
	Polio, Diphtheria, Tetanus, Whooping cough and TB. Polio, Diphtheria, Tetanus and Whooping cough
	Polio, Diphtheria, Tetanus and Whooping cough
	Measles
	Polio, Diphtheria, Tetanus and Whooping cough
	Diphtheria, Tetanus
	TB



Most importantly immunization at the right time can prevent disabilities



Did you know that you can also keep yourself healthy by following a few easy steps:

- ✓ Wash your hands when you have been to the toilet
- ✓ Wash your hands before and after you have changed your baby's nappy
- ✓ Wash your hands before you work with food
- ✓ Wash your hands before you eat your food
- ✓ Only one person washes in a bowl of water
- ✓ Wash your clothes regularly
- ✓ If there is no clean water, boil the water first
- ✓ If there is no clean water you can also add a teaspoon of bleach to 20 litres of water to make it usable
- ✓ Wear sunglasses and a hat when you go outside
- ✓ Close your eyes tightly when dust is blowing around



If someone has severe burns, you can put bees' honey or sugar directly on the burn. The burn must be washed with boiled water, 2 to 3 times a day.



Complete the following questions and discuss it in your group:

4. What disability do you have?

--

5. How did you become disabled?

--

6. Do you use any assistive devices? What?

--

7. Do you know who can help you to apply for assistive devices?

--

8. Can having sex with a family lead to the conception of a baby with a disability?

YES		NO	
-----	--	----	--



Did you know that there are four ways to prevent pregnancy?

- ✓ The pill for woman. It must be taken every day of the month.
- ✓ Injections for woman. It must be injected at the Clinic every 2 to 3 months.
- ✓ The IUD (Loop) for woman. A doctor must put it in.
- ✓ The condom for men and woman. It must be worn every time you have sex.



Did you know you could get the following sexually transmitted infections when having more than one sex partner:

- ✓ Herpes
- ✓ Gonorrhoea
- ✓ Syphilis
- ✓ HIV and AIDS



To prevent this you must:

- ✓ Have ONE sexual partner
- ✓ Always use a condom
- ✓ Abstain from sex until you get married



ALSO DISCUSS TRANSPORT ARRANGEMENTS AND ADDITIONAL REQUIREMENTS OF EACH MEMBER, IN ORDER TO ACCOMODATE AS MANY OF THEIR NEEDS AS POSSIBLE.



CONFIRM A DATE AND VENUE FOR THE NEXT MEETING.

MODULE 4: STRESS MANAGEMENT



“My peace I give to you; not as the world gives do I give to you. Let not your heart be troubled, neither let it be afraid.” John. 14:27.



Objectives

- ✓ To understand how you feel about your disability and how this can cause you to stress
- ✓ To look at the causes of stress in your community and how to make it better
- ✓ To look at the symptoms of stress and how to make yourself feel better



Important concepts to discuss before the module:

- ✓ **Loss** is what you feel when you loose someone or something
- ✓ **Stress** is the tension that feel when you have to do something difficult
- ✓ **Stress management** is things you do to make yourself feel better



Traumatic events, smoking dagga and too much stress can also cause a mental disability!

1. Do you feel embarrassment or shame about your disability?

YES		NO	
-----	--	----	--

2. Do you feel that you have been cursed?

YES		NO	
-----	--	----	--

3. Do you try to hide your disability?

YES		NO	
-----	--	----	--

4. Do you feel as if you are already a burden to other people, you cannot ask favours of them?

YES		NO	
-----	--	----	--

5. Do you try to think of yourself as not having a disability?

YES		NO	
-----	--	----	--

6. Do you sometimes feel negative towards God about your disability?

YES		NO	
-----	--	----	--

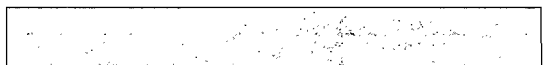
7. Do you think you are disabled because of your parents' sin?

YES		NO	
-----	--	----	--

8. Do you sometimes feel that you do not have the same opportunities as non-disabled people?

YES		NO	
-----	--	----	--

9. Having a disability can make you stress more. Discuss a few things that cause stress in your life and how you deal with it. Share this in the group





Symptoms of stress:

- ✓ Shaking hands
- ✓ Tense and stiff muscles
- ✓ Grinding teeth
- ✓ Lower back pain
- ✓ Moodiness – aggressive or quiet
- ✓ Not hungry or eating too much
- ✓ Not interested in sex or wanting more sex
- ✓ Using drugs or alcohol to feel relaxed
- ✓ High blood pressure
- ✓ Upset stomach
- ✓ Fainting
- ✓ Constipation or diarrhoea
- ✓ Very worried
- ✓ Feeling irritated with others and yourself
- ✓ Depressed

10. Discuss in your groups what the sources of stress in your community are and how you could fix it.

11. Who do you talk to when you are sad or lonely?

--



Did you know that you could talk to a social worker, friend, spiritual leader, neighbour or family member about your problems? This will make your stress and worries less and they could even help to solve your problem.

12. What can you do to make yourself feel better when you have a problem?



Use the next steps to cope with loss and stress:

- ✓ Be aware of the bereavement process you will go through when you lose someone or perhaps un-expectedly become disabled:
SHOCK, ANGER, DISBELIEF, NEGOTIATION, ACCEPTANCE
- ✓ Accept the situation. Do not blame others or God
- ✓ Cry and feel the pain - don't try to be brave for someone else
- ✓ Do not drink and smoke too much
- ✓ Talk to your friends and family
- ✓ Exercise, listen to music, play the drums, sing in a choir
- ✓ See a doctor if you can't sleep or eat
- ✓ Keep yourself busy with arts or crafts or gardening
Look at the work you can and cannot do and divide it equally in the family
- ✓ Be positive
- ✓ See a social worker or community care worker if you don't feel better



MY OWN PERSONAL STRESS MANAGEMENT PLAN:

(ACTIONS AND ATTITUDES)



ALSO DISCUSS TRANSPORT ARRANGEMENTS AND ADDITIONAL REQUIREMENTS OF EACH MEMBER, IN ORDER TO ACCOMODATE AS MANY OF THEIR NEEDS AS POSSIBLE.



CONFIRM A DATE AND VENUE FOR THE NEXT MEETING.

MODULE 5: HEALTHY LIVING AND EATING



“Teach me Your way, O LORD.” Psalms 27:11.



Objectives

- ✓ To look at healthy food and how you can make your own food garden
- ✓ To look at the cheapest ways to feed your family
- ✓ To look at the importance of breast feeding
- ✓ To look at healthy living and the prevention of illnesses





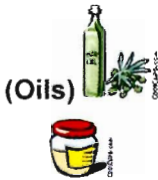

Important concepts to discuss before the module:

- ✓ **Carbohydrates** include food such as potatoes, bread, corn, nuts, stamp and pap.
- ✓ **Protein** include food such as meat, chicken, beans and fish
- ✓ **Fat** includes food such as cooking oil, lard, ghee and butter.


1. Good food knowledge is important. Please put the food in the correct food group box.

• Fish	Milk	Rice	Pork
• Porridge	Butter	Cooking oil	Banana
• Chicken	Broccoli	Bread	Goat
• Apple	Orange	Pap	Spinach
• Eggs	Marog	Potatoes	Tomato



CARBOHYDRATE 	PROTEIN 	FAT (Oils) 	FRUIT & VEGETABLES 

2. Name/ draw a few starchy food which will help you not to feel hungry

3 Starchy food should be the biggest part of each meal. True or false?

TRUE		FALSE	
------	--	-------	--

4 Meat, fish and chicken can protect us from certain illnesses. True or false?

TRUE		FALSE	
------	--	-------	--

5. Milk, sour milk, cheese and yoghurt can build healthy bones and teeth. True or false?

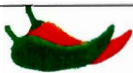
TRUE		FALSE	
------	--	-------	--

6. It is better to boil, stew, grill or braai meat than to fry it. True or false?

TRUE		FALSE	
------	--	-------	--

7. What do you normally eat in a day?

BREAKFAST	LUNCH	DINNER



It is important to eat at least one from each group each day.



You should eat plenty of fruit and vegetables, but they can be expensive, so take the following tips when shopping:

- ✓ Buy fruit and vegetables that grow in your area
- ✓ Buy more vegetables than fruit, it is cheaper
- ✓ Grow your own fruit and vegetables
- ✓ Mix your vegetables with dry beans, split peas, lentils, chicken, fish, meat or eggs.

8. Draw six reasons why it is important to eat fruit and vegetables?



Good eyesight	Fight colds and flu	Healthy body
Protect your heart	Healthy mind	Energy for the body











Breast feeding and introducing the correct food at the right age is an important aspect.


- ✓ Breast milk is the best food for a baby
- ✓ From 0-6 months breast milk is the best for your baby
- ✓ Continue to breastfeed your baby for the first two years – if you are HIV positive, please consult the nurse at the clinic about alternatives to breast feeding your baby
- ✓ Breast milk gives nutrients and energy to the baby
- ✓ Breast milk can help to fight infections
- ✓ Breastfeeding makes the baby feel safe and happy
- ✓ A baby cannot eat solid food before 6 months of age




ASK FOR ADVICE AND SUPPORT AT YOUR LOCAL CLINIC!

9. Your baby should not have the following food until they are one year old.


FOOD	TRUE	FALSE
✓ Honey (mamepe) 		
✓ Simba chips, chocolates, biscuits,  sweets, coke 		
✓ Food that can cause choking like sweets, peanuts, grapes, popcorn, raw carrots 		
✓ Fish and egg white 		
✓ Peanut butter 		
✓ More than one cup of fruit juice a day 		
✓ Rooibos tea 		



Vitamin A is extremely important to your child's health. It is important for good growth and good eye sight.



Public clinic provide Vitamin A capsules for free to woman within 6 to 8 weeks after giving birth and to children aged 6 to 60 months.



Facts of vitamin A deficiency:

- ✓ Difficulty seeing in dim light
- ✓ Measles and diarrhoea symptoms are much more serious
- ✓ Most important cause of child blindness
- ✓ Foamy white patches on the white part of the eye.

10. Too much fat in your diet can cause serious illness and disabilities.

TRUE		FALSE	
------	--	-------	--



If you eat too much fat you can get the following problems:

- ✓ Overweight
- ✓ High blood pressure
- ✓ Heart attack
- ✓ Stroke



You can eat dry beans, split peas, lentils and soya instead of meat. It is cheaper than meat and help to prevent heart disease and cancer.



Avoid the following fats and oil:

- ✓ Fat you can see on red meat, chicken skin
- ✓ Ghee, Lard, Butter, White cooking fat, Meat dripping
- ✓ Coffee creamers
- ✓ Chocolate, Biscuits, Ice cream, chips



Another illness which should be treated early is rheumatic fever. It usually starts with a sore throat, joint pain and fever without any signs of a cold or flu. Antibiotics could help to clear this up, but good hygiene and clean living conditions are crucial.



Remember that someone in a wheelchair often have difficulties moving. In order to prevent pressure sores and injuries, it is important that the person sits and lies on a soft mattress or cushion. Check the hips, knees and feet regularly for sores and take him to the clinic if he does need treatment. Move and exercise regularly to promote good flow of blood. The person must eat good food rich in protein, iron and vitamins.



Remember that someone in a wheelchair often have difficulties moving. In order to prevent pressure sores and injuries, it is important that the person sits and lies on a soft mattress or cushion. Check the hips, knees and feet regularly for sores and take him to the clinic if he does need treatment. Move and exercise regularly to promote good flow of blood. The person must eat good food rich in protein, iron and vitamins.



ALSO DISCUSS TRANSPORT ARRANGEMENTS AND ADDITIONAL REQUIREMENTS OF EACH MEMBER, IN ORDER TO ACCOMODATE AS MANY OF THEIR NEEDS AS POSSIBLE.



CONFIRM A DATE AND VENUE FOR THE NEXT MEETING.

MODULE 6:

EXERCISE AND RELAXATION



“Grace, mercy and peace from God the Father and from Jesus Christ, the Father’s Son, will be with us in truth and love.”
(2 John: 1:3)



Objectives

- ✓ To look at the importance of exercise
- ✓ To help you to look at local exercise options for your family and friends
- ✓ To help you to practice relaxation. (Group members can bring a pillow and towel/blanket)



Important concepts to discuss before the module:

- ✓ **Exercise** include walking, running, playing, cleaning the house and sports
- ✓ **Relaxation** is what you do to calm down and to rest



Did you know that exercise could help you lose weight, improve general health and increase your energy levels?



Exercise could also improve your self-image; reduce stress and aggression and improve concentration.



COMPLETE THE FOLLOWING EXERCISE IN YOUR GROUPS.



What exercise do you do? Write, draw or paste pictures from magazines/newspapers

What do you do to relax?



Relaxation can reduce general stress and body tension.



Do the following 5 minute exercise:

- Sit in a comfortable position
- Close your eyes
- Breathe slowly and deeply and keep your breath for 5 seconds
- Think about a nice place and imagine yourself being there
- Keep breathing slowly
- Tighten all your muscles and then slowly relax it again.
- Repeat and breathe slowly for 5 minutes
- Open your eyes and smile

What other activities can you arrange in your area to relax and enjoy life?

Give examples.

Group member lie down on the floor and close their eyes. The presenter would lead the following relaxation session.



ALSO DISCUSS TRANSPORT ARRANGEMENTS AND ADDITIONAL REQUIREMENTS OF EACH MEMBER, IN ORDER TO ACCOMODATE AS MANY OF THEIR NEEDS AS POSSIBLE.



CONFIRM A DATE AND VENUE FOR THE NEXT MEETING.

MODULE 7:

TAU STRONG



” The Lord is my light and my salvation; Whom shall I fear?”

Psalms 27:1.



Objectives

- ✓ To look at the responsible use of alcohol
- ✓ To look at the negative effects of smoking and alcohol misuse
- ✓ To look at how to stay strong and say “NO” to keep yourself safe
- ✓ To look at healthy living with HIV and AIDS
- ✓ To understand what STI’s are and how to prevent it



Important concepts to discuss before the module:

- ✓ **Alcohol use**(having one or two beers/other alcohol) in a social setting is acceptable, but alcohol abuse (drinking more than two beers/ spirits, at a time, or until you pass out) is not acceptable
- ✓ **Drugs** include dagga, LSD, cocaine, heroin, tik and other illegal substances
- ✓ In order to keep yourself safe from drugs and alcohol, you will learn how to say “**NO**” and not let other people push you into doing something you don't want to do
- ✓ **HIV** stands for Human Immune Deficiency virus – You could have the virus, but not be sick
- ✓ **AIDS** stands for Acquired Immune Deficiency virus – You have the virus. It has attacked your immune system and you now are very ill
- ✓ **STIs** are sexually transmitted infections, which could lead to AIDS



SECTION 1: ALCOHOL AND DRUGS.

TODAY'S SESSION COULD BE CO-PRESENTED BY THE S.A.P.S. AS PART OF
THEIR SOCIAL CRIME PREVENTION STRATEGY.

1. How old do you have to be to legally drink alcohol?

2. How old do you have to be to legally smoke cigarettes?

3. Is it legal to smoke dagga?

4. Can you get the following illnesses from smoking?




ILLNESS	YES
1. Lung cancer	
2. Heart disease	

5. Is the following true or false?

QUESTION	TRUE	FALSE
Drinking too much alcohol can cause accidents?		
Drinking alcohol can make you feel stronger, braver and make you do dangerous things?		
Drinking too much alcohol can make you forget about sexually transmitted diseases like HIV and AIDS?		
If you don't drink with your friends they will not like you anymore?		
A major cause of death after drinking too much alcohol is choking on vomit?		
Dagga is not physically addictive, but it can cause serious mental health problems?		
You can die the first time you sniff solvents?		

6. Is smoking harmful to your body?

YES		NO	
-----	--	----	--

	Smoking also causes lung cancer, heart disease, ulcers, and cancer of the mouth, throat and kidneys.
	Pregnant woman who smoke usually have smaller babies. They also have a greater risk for miscarriages and stillbirths.
	Children of mothers who smoke often suffer from poor mental and physical development.

7. Is drinking too much alcohol bad for you?

YES		NO	
-----	--	----	--



The use of alcohol could lead to illness because your body's fighting skills are lowered.



Mixing alcohol with drugs, dagga and medication could kill you.



The following people should not drink alcohol at all!!

- ✓ Pregnant woman
- ✓ Breast feeding woman
- ✓ Children under the age of 18
- ✓ People taking medicine
- ✓ People who cannot stop drinking should look for help
- ✓ People planning to drive or operate machinery.

8. It is better to buy food for you and your family than to buy alcohol. True or false?

TRUE		FALSE	
------	--	-------	--

9. Is using dagga legal?

YES		NO	
-----	--	----	--



Did you know that smoking dagga could cause cancer and other lung diseases?



Short-term results are memory loss, lack of straight thinking and distorted sound, colour, distance and time.



Smoking dagga could cause fatal accidents.



CHOOSE SIX ACTORS. THREE OF THE ACTORS ARE BIG PLAYERS IN THE COMMUNITY AND IS DRINKING TOO MUCH ALCOHOL EVERY WEEKEND. THEY ARE NOW INFLUENCING THE 15-YEAR-OLD BOY TO DRINK BEER, BUT HE IS NOT SURE IF HE SHOULD. HE ALSO FINDS IT VERY DIFFICULT TO SAY "NO".

TWO ACTORS ARE NON-DRINKING CITIZENS AND IS ONLY HAVING ONE BEER BEFORE THEY GO HOME. THEY SEE THIS HAPPENING AND TELL THE DRUNKEN MEN TO LEAVE THE BOY ALONE. THE BOY IS GLAD TO BE SAFE NOW. HE GOES HOME AND NEVER GOES TO THE SHEBEEEN AGAIN.

WHAT LESSONS DID YOU LEARN?



You have the right to say that you do not want to do something and that you feel that it will make you stress.

How to say "NO":

- ✓ You have the right to say "NO".
- ✓ Say what you want to say without feeling guilty about it.
- ✓ Know why you say "NO" and stick with it
- ✓ You also have the right to change your mind
- ✓ Be strict and clear



SECTION 2:

LIVING STRONG AND HEALTHY WITH HIV OR AIDS.



A sexually transmitted infection (STI's) is an illness that is passed from one person to another during sex.

The signs are:

- ✓ Smelly fluids coming out of the penis or vagina
- ✓ Blisters, sores or warts on the vagina, penis or anus
- ✓ Pain in the lower stomach
- ✓ Pain or burning when passing urine
- ✓ Itching or redness around the vagina or penis
- ✓ Pain when having sex
- ✓ Pain in testicles
- ✓ Unusual swelling in the groin

10. Is a STI treatable at the local clinic?

YES		NO	
-----	--	----	--

11. You can protect yourself from an STI by washing after you had sex?

YES		NO	
-----	--	----	--

12. You can always see if someone has HIV or AIDS.

TRUE		FALSE	
------	--	-------	--

13. Anti-retroviral medication can help you to live a long and healthy life?

TRUE		FALSE	
------	--	-------	--



It is important to prevent passing the infection on to others. Use a condom to prevent STIs, HIV and AIDS and re-infection.



Take care of your health:

- ✓ Eat a healthy diet
- ✓ Exercise
- ✓ Stop smoking
- ✓ Only drink a little alcohol
- ✓ Get enough rest
- ✓ Get early treatment when you are sick



Remember that some people in wheelchairs are still able to have a loving and fulfilling sex life. Women with spinal cord injuries can fall pregnant and have normal babies.



ALSO DISCUSS TRANSPORT ARRANGEMENTS AND ADDITIONAL REQUIREMENTS OF EACH MEMBER, IN ORDER TO ACCOMODATE AS MANY OF THEIR NEEDS AS POSSIBLE.



CONFIRM A DATE AND VENUE FOR THE NEXT MEETING.

MODULE 8:

THE MAP OF MY LIFE



"He leads me in the paths of righteousness for His name's sake." Psalms 23:3.



Objectives

- ✓ To look at whom you are!
- ✓ To look at your goals and what you want to do in life
- ✓ To draw a map of your life's journey, the past, the present and how you see the future



Important concepts to discuss before the module:

- ✓ **Characteristics** are the things that make you different from other people. This could be that you are friendly, a good friend, honest or a Christian
- ✓ **Goals** are the things that you want to achieve

1. **Who am I? Write down your personal characteristics.**

2. My goals are:

SHORT TERM:

- ✓
- ✓
- ✓

MEDIUM TERM:

- ✓
- ✓
- ✓

LONG TERM:

- ✓
- ✓
- ✓

NAME & SURNAME

WITNESS



The map of life is your travelling from birth to death. Looking at different events, people, feelings, choices, problems and reactions. The following questions will help you to draw your own life's map. Focus on the past, the present and the future.

1. Who am I? Am I this body?
2. Where have I come from?
3. Where am I going?
4. How will I get there?
5. What help do I need?
6. What help do I need?
7. What will it be like when I get there?

DRAW YOUR MAP HERE

**CREATE YOUR OWN ART WORK. USE BOOKS, NEWSPAPERS, MAGAZINES
AND ANY OTHER PICTURES TO SHOW WHERE YOU SEE YOURSELF IN
THE FUTURE.**



**ALSO DISCUSS TRANSPORT ARRANGEMENTS AND ADDITIONAL REQUIREMENTS
OF EACH MEMBER, IN ORDER TO ACCOMODATE AS MANY OF THEIR NEEDS AS
POSSIBLE.**



CONFIRM A DATE AND VENUE FOR THE NEXT MEETING.

MODULE 9: DISCRIMINATION



Objectives

- ✓ To increase general awareness of the realities of disability and its existence in society
- ✓ To help you to make your voice heard
- ✓ To create community involvement in disability related matters



Important concepts to discuss before the module:

- ✓ **Stereotypes** is stereotyping is therefore beliefs and opinions about a certain group
- ✓ **Prejudice** is an attitude towards people and it is considered to be evaluative of the entire group
- ✓ **Discrimination** is defined as treating people differently from others based on their membership to a specific group, for example, people with disabilities.



The purpose of this exercise is to show you that what you think of a person when you first look at him/her might be right, but it might also be wrong.

The list could include:

- | | |
|--------------------------|-------------------|
| ✓ Happy | Likes to be alone |
| ✓ Does not like people | Friendly |
| ✓ Lazy | Loving |
| ✓ Likes to drink alcohol | Fun |
| ✓ Could be a good friend | Aggressive |
| ✓ Smart | |

Each person in the group must take the cards and give one to the person that he/she thinks will fit the word on the card. - Divide into groups of five people and discuss how it felt to be judged by people's first impressions of you.



The second part of the exercise is for volunteers to discuss if any of the labelling cards were right. Is there anybody that fits the description? Most people are usually wrong and judge people by the way that they look. This very often happens to people with disabilities.

1. Do you feel a valued member of your community?

YES		NO	
-----	--	----	--

2. Do you take part in any community activities?

YES		NO	
-----	--	----	--

3. Do you get support from a home based caregiver?

YES		NO	
-----	--	----	--

4. Do you receive regular medication and treatment from the clinic?

YES		NO	
-----	--	----	--

5. Do your family and friends support you?

YES		NO	
-----	--	----	--

6. Do you get transported to the places you need to be?

YES		NO	
-----	--	----	--

7. What do you think your rights as a person with a disability are? Discuss it in small groups and present it to the big group.

<p>7. What do you think your rights as a person with a disability are? Discuss it in small groups and present it to the big group.</p>			
--	--	--	--



Your rights include:



Divide into groups of four people each. Take a piece of paper and write down or draw two good things about each person in your group. Share your answers with the rest of the group.



Each person now thinks about three things that he/she is proud of - achievements or something for someone else. Share it with the group by moving to the middle of the group and telling them your story. After each person has finished, the group must clap hands for the speaker in order to make the person feel special, appreciated and valued.



Remember it is very important to trust. Trust is the basis of relationships, open communication and support. Even if you have been discriminated against and if you feel lonely. Make an effort to build a positive relationship with at least one person in this group and trust that person to support you and take care of you.



**SOCIAL SECURITY GRANTS APPLICATIONS,
YOU WILL NEED:**

- Your bar coded South African identity document.
- Proof of your income if you are employed (Salary slip/letter from employer).
- An affidavit (Police statement) saying that you are unemployed and to proof that you have no income.
- Your marriage certificate or divorce order to prove you are married, divorce or single.
- A birth certificate for the child you are applying for (This must have a 13 digit identity number).
- A death certificate if one or both of the child's parents are dead.



SOCIAL SECURITY GRANTS:

● CHILD CARE SUPPORT GRANT

- You must be a South African citizen who takes care of a child or children under the age of **7 years**. (The Government could extend this to children under 14 years).
- The children must also be South African citizens.
- You are not allowed to receive any other income for the children (Maintenance).
- You and your husband must have a joint (together) monthly household income of less than **R800** if you live in an **urban area** (city).
- You and your husband must have a joint (together) monthly income of less than **R1 100** if you live in a **rural area or an informal settlement**.
- If the child is not your own, you need to get an affidavit (statement) from the police to prove that you have permission from the parents to take care of the child.

● FOSTER CARE GRANT

- This is given to the caregivers of a child who is not the parent of the child by birth – **FOSTER PARENT**.
- This grant is given to children under the age of **18** years old. It can be extended to **21** year old if the child is still in school.

- Anyone can apply to become a foster parent, but you must be able to prove that the child's parents are **dead or not able to care** for the children.
- You can apply to become a foster parent at any **social worker** who will write a report which will go to the children's court for a decision.
- You must have a court order to foster a child.

● CARE DEPENDENCY GRANT

- This grant is paid to a parent/s that cares for a **child with severe disabilities and special needs**.
- They can be **parents/foster carers or caregivers**.
- You need a medical report stating what is wrong with the child.
- This grant is paid to children **between 1 and 18** years of age.
- Ask the social worker to help you to apply for this grant.

● DISABILITY GRANT – R960.00

- A disability grant is an income given to people who are physically or **mentally disable, unfit to work and unable to support themselves**. You get a permanent disability grant if your disability will continue for more than a year and a temporary disability grant if your disability will continue for a continuous period of not less than six months or for a continuous period of not more than twelve months.
- You must be a **South African citizen** or permanent resident.
- Between **18 to 59 years of age if female** and **18 to 64 years of age if male**
- submit a **medical or assessment report** confirming disability
- not be cared for in a State institution
- The applicant must not refuse to undergo medical treatment, unless if it life threatening.
- You may not be in receipt of another social grant in respect of yourself.

❖ **Steps to follow:**

- Complete a disability grant application form at your nearest social security office (**SASSA**).
- If you are too old or sick to go to the office, ask someone to **request a home visit** on

your behalf. The person should bring a letter from you or a doctor's note saying why you cannot visit the office.

- Complete the application form in the presence of a SASSA officer.
- Attend an interview and have your fingerprints taken.
- Submit the form with the following documents:
 - a **medical report** or functional assessment report confirming your disability
 - proof of **marital status** (if applicable)
 - an **identity document** (ID)
 - the following documents will be requested for applications where the **identity document and/or a birth certificate are not available**:
 - an affidavit commissioned by a Justice of the Peace. The affidavit must contain a clause which indicates that provision of incorrect or inaccurate information will result in prosecution in terms of Section 21 of the Social Assistance Act, 2004
 - a sworn statement by a reputable person who knows the applicant and the child. This may be from a councillor, traditional leader, social worker or minister of religion
 - proof that an application for a birth certificate or identity document has been lodged with the Department of Home Affairs
 - where applicable, a temporary identity document issued by the Department of Home Affairs
 - baptismal certificate
 - road to health clinic card
 - school report.
- **Please note: No application can be processed without the sworn statement/affidavit.**
 - proof of:
 - residence
 - income
 - explanation of all deposits going into your bank account
 - proof of private pension
 - bank statements for 3 consecutive months.
 - **After submitting your application you will be given a receipt.**
 - **Keep the receipt as proof of your application.**
 - The social security office will inform you in **writing** whether or not your application was successful.
 - If your grant is not approved, the social security office will state the reasons why

your application was unsuccessful.

- If you disagree with the decision, appeal to the Minister of Social Development or Member of Executive Council (MEC) in writing, explaining why you disagree.

Appeal within 90 days of receiving notification about the outcome of your application.

- Form Z970 - Disability Grant Application
- Form Z970A - Referral Letter
- Form Z970D - Recommendation by assessment committee



ALSO DISCUSS TRANSPORT ARRANGEMENTS AND ADDITIONAL REQUIREMENTS OF EACH MEMBER, IN ORDER TO ACCOMODATE AS MANY OF THEIR NEEDS AS POSSIBLE.



CONFIRM A DATE AND VENUE FOR THE NEXT MEETING.

MODULE 10:

DISABILITY CARE



Objectives

- ✓ Help and advice to caregivers or family members caring for the ill or disabled
- ✓ Identifying and treating contractures
- ✓ Identifying and treating pressure sores
- ✓ What is epilepsy and what to do when a person gets a seizure
- ✓ Wheelchair management and care
- ✓ How to perform transfers
- ✓ Maintaining health by improving endurance and muscle strength.



Important concepts to discuss before the module:

- ✓ **A contracture** is a muscle and the tissue that covers the muscle that has been hurt
- ✓ **Prevention** is things that you do to stop the disability to happen or get worst
- ✓ **Pressure sores** develop when you are lying or sitting in the same position for a long time, especially in a wheelchair.
- ✓ **Club feet** is when the balm of the foot is turned inwards and it does not get back into the normal position.
- ✓ **Epilepsy** is a condition where a person has brain seizures. This is a temporary disturbance to a person's brain.
- ✓ **Causes** of disabilities are the things that make a child disabled.
- ✓ **Concentration** is being able to sit still and listen to someone or being able to complete a task.
- ✓ **Distracted** is constantly looking around and thinking of other things.
- ✓ **Comprehension** is the skill to understand what someone is explaining to you.
- ✓ **Co-ordination** is being able to do a task without knocking into things and breaking things.
- ✓ **Emotional problems** are feeling un-able to talk to people, make friends and feel happy.

A contracture is a muscle and the tissue that covers the muscle that has been hurt. The person might not be able to move the joint of the body. Often found in the elbow, wrists, fingers, hips, knees and ankles. Look out for the following signs:

- ✓ Pain and unable to move the body. Muscles have become weak and cannot move
- ✓ If someone is cerebral palsied, had a stroke, rheumatoid arthritis, polio or was badly burned, the muscles can get very stiff
- ✓ A certain part of the body cannot be stretched out straightened.



Prevention:

- ✓ Position the injured part of the body correctly as suggested by the health care professional
- ✓ Wearing a splint as provided by the health professional
- ✓ Doing regular exercises as suggested by the health professional
- ✓ Early intervention.



PRACTICAL EXERCISES SUGGESTED BY THE HEALTH PROFESSIONAL.

You can draw pictures to remind yourself.



EPILEPSY:

Epilepsy is a condition where a person has brain seizures. This is a temporary disturbance to a person's brain. This can be caused by:

- ✓ Chemical imbalance such as low blood sugar
- ✓ Head injuries
- ✓ Certain toxic chemicals or drug abuse
- ✓ Alcohol withdrawal
- ✓ Stroke
- ✓ Birth injuries

Symptoms are:

- ✓ The person might cry out or make a sound. He may fall, get stiff for a few seconds and then move his arms and legs.
- ✓ The person's eyes are usually open
- ✓ The person will breathe deeply after the seizure
- ✓ The person will regain consciousness slowly within a few minutes
- ✓ The person may urinate during the seizure
- ✓ The person may become confused after a seizure.





Take the person to the clinic/hospital when:

- ✓ The seizure continues for more than 5 minutes
- ✓ The person has difficulty breathing
- ✓ The person stays confused or unconscious
- ✓ The person got injured during the seizure
- ✓ The person experiences a seizure for the first time

1. Which of the following should you do when a person is having a seizure?

STATEMENT	TRUE	FALSE
Put a cushion under the person's head		
Loosen any tight neck jewellery		
Turn the person on his side		
Do not place anything in his mouth or try to pull the teeth apart		
Take note of how long the seizure is, type of movement, the direction the eyes and head is turning		
Take note how often the person has a seizure		
Put something in the person's mouth		

2. Which of the following should you do to keep a child safe and prevent disabilities?

STATEMENT	TRUE	FALSE
 <p>Keep children away from open fires/ cooking fires and boiling water</p>		
 <p>Keep dangerous chemicals/ poison and other harmful materials locked away in a cupboard</p>		
 <p>Keep matches, lighters and fuel/ paraffin locked away in a cupboard</p>		
 <p>Make sure that you keep rats, mice and other animals out of your food</p>		

3. Can you name some of the causes of learning disabilities?

Internal Causes	External Causes

4. I should take a child to the doctor when I see the following problems with the child:

5. What can you do when your child has been diagnosed with a disability?



ALSO DISCUSS TRANSPORT ARRANGEMENTS AND ADDITIONAL REQUIREMENTS OF EACH MEMBER, IN ORDER TO ACCOMMODATE AS MANY OF THEIR NEEDS AS POSSIBLE.



CONFIRM A DATE AND VENUE FOR THE NEXT MEETING.

MODULE 11:

LOW COST ACTIVITIES & EVALUATION AND FEEDBACK



Objectives

- ✓ To look at low cost activities which you could use, to stimulate your child's development.
- ✓ To understand what rehabilitation is and how it can benefit your child with a disability.
- ✓ To get some practical guidelines and examples of how to create your own assistive devices in your house.
- ✓ To give you an opportunity to evaluate the **programme**.



Important concepts to discuss before the module:

- ✓ **Rehabilitation:** Getting better or helping someone with a disability to function better at home and in the community
- ✓ **Therapy:**
 1. Treatment for physical disabilities through improving positions, movement, strength, balance and control of the body.
 2. Treatment by helping a person with a disability to do useful or activities that they enjoy.
 3. Treatment to help the person with the disability to feel better about themselves and to live a happier life.

LOW COST ACTIVITIES FOR STIMULATION AND DEVELOPMENT

Finger paint

1 Cup of flower

1 Cup of sugar

1 Cup of cold water

3 Cups of boiling water

Mix the flower and the cold water.

Add the sugar.

Heat the mixture and stir until it's smooth.

Add the boiling water and heat until boiling point.

Take it off the stove and add food colouring.

Play Dough

1 Cup of water

2 spoons of oil

2 ½ cups of flower

1 cup of salt

Food colouring

Mix it all together

Salt Ceramics

½ Cup of salt

1 ½ Cup of flower

Mix it all together.

ASSISTIVE DEVICES

- Standing Frame
- Corner Chair
- Building Blocks
- Bubbles
- Universal Cuff
- Ball
- Baby Rattles
- Arm support for stroke patient
- Hammock
- Marabaraba game
- Home-made glue



DEMONSTRATIONS AND EVALUATIONS

NOTES:



ALSO DISCUSS TRANSPORT ARRANGEMENTS AND ADDITIONAL REQUIREMENTS OF EACH MEMBER, IN ORDER TO ACCOMODATE AS MANY OF THEIR NEEDS AS POSSIBLE.



CONFIRM A DATE AND VENUE FOR THE NEXT MEETING.

MODULE 12:

NATIONAL DISABILITY DAY CELEBRATION



“Grace, mercy and peace from God the Father and from Jesus Christ, the Father’s Son, will be with us in truth and love.”
(2 John: 1:3)



Objectives

- ✓ To look at the importance of exercise
- ✓ To help you to look at local exercise options for your family and friends
- ✓ To help you to practice relaxation. (Group members can bring a pillow and towel/blanket)

APPENDIX G
PRESENTER'S GUIDE

A community-based disability programme for rural communities



Presenters' guide and plan

GOAL:

This workbook provides guidelines for presenting the disability support group sessions. The goal of these groups are to support community members with disabilities and their immediate family members/ carers.

PROGRAMME:

DAY	PROGRAMME	PURPOSE
ONE	Getting to know one another	Ice breaker & building trust.
TWO	Self-esteem	Get to know yourself and improve!
THREE	Health	How to live healthy.
FOUR	Stress management	Relax, breathe and calm down.
FIVE	Healthy living and eating.	Mind, body and soul repair.
SIX	Exercise	Keeping fit and strong.
SEVEN	Tau strong	Keeping yourself safe.
EIGHT	Map of my life	Who am I? Where am I going?
NINE	Discrimination	I have rights and responsibilities.
TEN	Disability care	Disability awareness and care.
ELEVEN	Low cost activities, evaluation and feedback	Stimulation and prevention. Evaluation and feedback.
TWELVE	Celebrating National Disability Day	Community involvement and awareness.



Learning objectives

- Introductions, building trusting relationships and starting a food garden.
- Expand his/her knowledge with regards to important aspects of his/her personal life style and improve self-esteem.
- Become aware of how to live healthy.
- Become more aware of stress, relaxation and keeping calm.
- Manage healthy living and eating habits.
- The advantages of keeping fit and strong.
- Expand problem-solving skills and keeping yourself safe.
- Take charge and responsibility of who you are and where you are going.
- Become aware of disability related issues and appropriate care.
- Learning low cost activities for stimulation and the prevention of disabilities.
- Getting the community involved and celebrating National Disability day.



Important matters

- Welcome everyone and make a name list.
- Be open-minded and learn from one another
- Show respect for each other's point of view.
- Participate actively
- The duration of this programme is 12 months. It is important to attend a session once a month.
- The programme is for people with disabilities, but partners/care-givers can be invited to sessions which are relevant to them.
- **It is crucial to invite other significant role players in your community and with in partnership in order to ensure a holistic intervention strategy.**

TABLE OF CONTENTS

CONTENT	PAGE
1. GETTING TO KNOW ONE ANOTHER	
2. SELF-ESTEEM	
3. HEALTH	
4. STRESS MANAGEMENT	
5. HEALTHY LIVING AND EATING	
6. EXERCISE AND RELAXATION	
7. TAU STRONG	
8. THE MAP OF MY LIFE	
9. DISCRIMINATION	
10. DISABILITY CARE	
11. LOW COST ACTIVITIES, EVALUATION AND FEEDBACK	
12. NATIONAL DISABILITY DAY CELEBRATION	

INTRODUCTION

- Remember if you want to help someone to solve their problems you should be empathetic (understanding and none judgmental) and objective (not taking sides).
- The group leader must value personal change and growth.
- All information must be treated as confidential. You are not allowed to talk to anyone about it. Unless it is dangerous to the person/ community, then you can talk to the responsible social worker. If you need to tell someone, ask permission from the person self.
- It is very useful and therapeutic to discuss a problem with a friend who is an effective listener.
- In order to help someone they must get insight into the problem.
- Always show that you understand and do not judge them.
- Do not tell the group members what to do, they must decide for themselves.
- It is the group leaders' responsibility to arrange for group sessions including the place, transport and additional support workers, if needed.
- Remember to arrange with the relevant partners/guest speakers for sessions.
- Pursuit of the ultimate psychological peace combined with a recognition of the benefits of 'constructive emotional pain'.



**THROUGHOUT THE PROGRAMME I WILL BE PROVIDING YOU WITH
USEFULL INFORMATION AND TIPS!!!!**

MODULE 1:

GETTING TO KNOW ONE ANOTHER



Objectives

- ✓ To introduce the group members to each other and to start building trusting relationships
- ✓ To be aware of other people's needs and dreams

GOAL:

- ✓ To introduce the members to each other and to get to know each other.
- ✓ To be aware of people's needs and dreams. This will show all the group members that they are not the only one in the world with these problems. Other people understand and feel the same.

HOW:

- The group leader reads the questions out loud and explains it. Each person then fills in his own sheet. Group leader/ assistant can assist, if the member is not able to write himself/herself.
- Discuss the answers in the group. Each person gets a chance to tell his story. Everyone must listen
- Clap hands at the end of the session and thank everyone for their participation.
- The group leader will then show the members and their carers how to make a small vegetable garden.



ALSO DISCUSS TRANSPORT ARRANGEMENTS AND ADDITIONAL REQUIREMENTS OF EACH MEMBER, IN ORDER TO ACCOMODATE AS MANY OF THEIR NEEDS AS POSSIBLE.



CONFIRM A DATE AND VENUE FOR THE NEXT MEETING.

MODULE 2:

SELF-ESTEEM



“Grace, mercy and peace from God the Father and from Jesus Christ, the Father’s Son, will be with us in truth and love.”
(2 John: 1:3)



Objectives

- ✓ Get to know yourself
- ✓ To look at your everyday life
- ✓ Make yourself feel better

GOAL:

To discuss the following concepts:

- **Improve relationships** is working on getting on with your family members, friends and neighbours.
- **Self-esteem** is what you think about yourself and how you feel about yourself. You have a positive self-esteem if you like yourself. You have a negative self-esteem if you do not like yourself.
- **Improving yourself** is working on the points about yourself that you do not like and making yourself feel better and more loved.

HOW:

- **Always discuss the “Important concepts” first so that the group members understand the different concepts.**
- The group leader reads the **questions (1 to 13)** out loud and explains it. Each person then fills in his own sheet and explains how he/she is experiencing life. Each question will have a unique answer. There is **NO** right or wrong answers. Group leader/ assistant can assist, if the member is not able to write himself/herself.
- **Question 14:** The group member can draw or cut out pictures from magazines to explain how it makes him/her feel when other people talk about them. – Discuss this in the group when everyone is finished. This will show the group members that they are not alone and that there is other people that feel the same way as they do.

QUESTION 15:**Could have the following answers****ANSWERS**

- ✓ Making a choice to love yourself
- ✓ Praying
- ✓ Singing
- ✓ Playing sports
- ✓ Being nice to yourself
- ✓ Using your will power to say "NO" if you know it is wrong
- ✓ Replacing all the negative feelings about yourself with positive ones



- Read and explain Purple Pule's "How to talk to people".
- Read and explain Purple Pule's "How to deal with an angry person".
- Read and explain the "Where can you go for help?"
- Clap hands at the end of the session and thank everyone for their participation.

ADDITIONAL NOTES



ALSO DISCUSS TRANSPORT ARRANGEMENTS AND ADDITIONAL REQUIREMENTS OF EACH MEMBER, IN ORDER TO ACCOMODATE AS MANY OF THEIR NEEDS AS POSSIBLE.



CONFIRM A DATE AND VENUE FOR THE NEXT MEETING.

MODULE 3:

HEALTH



Start the session by weighing and measuring the group participants. Invite the Department of Health to work in partnership with this session. They could provide free testing. (Blood sugar diabetes, blood pressure, HIV).



Objectives

- ✓ To explore your knowledge with regards to important health issues
- ✓ To provide knowledge on the effect of your lifestyle and habits on your health
- ✓ To show the importance of living a healthy life
- ✓ To show you the harmful effects of the wrong eating and drinking habits

GOAL:

- ✓ **To explore the following concepts:**
- ✓ **Assistive devices** include hearing aids, glasses, walking sticks, wheelchairs and crutches.
- ✓ **Immunization** is the injections children should get at certain ages in order to prevent illness and disabilities.
- ✓ **Highly infectious disease** is a disease which you can get from someone else by being in the same room with them.
- ✓ How to stay healthy?

HOW:

- Always discuss the “Important concepts” first so that the group members understand the different concepts.
- What does a healthy person looks like? – Read out loud and discuss in the group.

QUESTION 3:**What services can I expect from the clinic?****ANSWERS**

- ✓ Family planning- When and how many children
- ✓ Advice on healthy eating
- ✓ Immunizations
- ✓ How to prevent disease
- ✓ Treatment of injuries and disease
- ✓ Weight loss
- ✓ Testing of blood pressure, blood sugar and diabetes
- ✓ HIV/AIDS and having a HIV - baby, even if you are HIV positive.

4. Measles can cause the following:**ANSWERS**

- ✓ High fever (hot to touch)
- ✓ Fine red rash
- ✓ Flu-like symptoms(cough, runny nose and watery red eyes)
- ✓ Pneumonia
- ✓ Infection of the middle ear which can cause deafness
- ✓ Blindness
- ✓ Malnutrition
- ✓ Brain damage
- ✓ Death

5. Fill in the ages that you think immunizations are needed –

AGE	IMMUNIZATION
New born baby	TB
3 Months	Polio, Diphtheria, Tetanus, Whooping cough and TB.
4-5 Months	Polio, Diphtheria, Tetanus and Whooping cough
6 Months	Measles
9-10 Months	Polio, Diphtheria, Tetanus and Whooping cough
18 Months	Diphtheria, Tetanus

5 Years	TB
---------	----

- THE GROUP LEADER READS THE FOLLOWING AND DISCUSS IT:
“Did you know that you can also keep yourself healthy by following a few easy steps?”
- DISCUSS QUESTIONS 4 – 6: IN THE GROUP. EACH PERSON ANSWERS THE QUESTIONS AND DISCUSSES IT IN THE GROUP. EVERYONE MUST LISTEN.

QUESTION 7:	Do you know who can help you to apply for assistive devices?
--------------------	---

- ANSWERS**
- ✓ Any Social Work Office
 - ✓ Any Social Security Office

QUESTION 8:	Do you know who can help you to apply for assistive devices?
--------------------	---

- ANSWERS** Yes
- Read the four ways how to prevent pregnancy.
 - Read the list of **sexually transmitted infections** (STI's) and show examples. (You can get additional information and pictures from the Department of Health).
 - Read the list of **how to prevent STI's** and discuss.
 - Clap hands at the end of the session and thank everyone for their participation.



ALSO DISCUSS TRANSPORT ARRANGEMENTS AND ADDITIONAL REQUIREMENTS OF EACH MEMBER, IN ORDER TO ACCOMODATE AS MANY OF THEIR NEEDS AS POSSIBLE.



CONFIRM A DATE AND VENUE FOR THE NEXT MEETING.

MODULE 4: STRESS MANAGEMENT



Objectives

- ✓ To understand how you feel about your disability and how this can cause you to stress
- ✓ To look at the causes of stress in your community and how to make it better
- ✓ To look at the symptoms of stress and how to make yourself feel better

GOAL:

To explore the following concepts:

- ✓ **Loss** is what you feel when you lose someone or something
- ✓ **Stress** is the tension that feel when you have to do something difficult
- ✓ **Stress management** is things you do to make yourself feel better

HOW:

- **Always discuss the “Important concepts” first so that the group members understand the different concepts.**
- Read and answer questions 1 – 9. Discuss the answers in the group.
- Read and explain the “**symptoms of stress**”.

QUESTION 10:

Discuss in your groups what the sources of stress in your community are and how you could fix it.

ANSWERS

- ✓ Un-employment – Develop a skill and create something to sell.
- ✓ Chronic illness - Prevent it by living healthy and taking medication.
- ✓ Lack of services for example: running water , housing, caring support at home, recreational activities (things to do), medical facilities, assistive devices, learning opportunities, employment opportunities and other community needs - Contact the relevant Social Worker and ask for support, advice and services.

QUESTION 11:

Who do you talk to when you are sad or lonely?

ANSWERS



Anybody as indicated by the group members

QUESTION 12:

What can you do to make yourself feel better when you have a problem?

ANSWERS



Anybody as indicated by the group members

- **READ AND DISCUSS THE STEPS OF HOW TO COPE WITH STRESS.**
- **ON PAGE 23 THE GROUP MEMBERS CAN DRAW OR WRITE THEIR OWN PERSONAL STRESS MANAGEMENT PLAN. WHAT THEY WILL DO WHEN THEY ARE FEELING STRESSED AND UPSET. FOR EXAMPLE: WHEN MY FAMILY MEMBER UPSET ME WITH SAYING SOMETHING BAD TO ME..... I SHALL KEEP QUIET AND THINK OF SOMETHING VERY NICE.**



ALSO DISCUSS TRANSPORT ARRANGEMENTS AND ADDITIONAL REQUIREMENTS OF EACH MEMBER, IN ORDER TO ACCOMODATE AS MANY OF THEIR NEEDS AS POSSIBLE.



CONFIRM A DATE AND VENUE FOR THE NEXT MEETING.

MODULE 5:

HEALTHY LIVING AND EATING



Objectives

- ✓ To look at healthy food and how you can make your own food garden
- ✓ To look at the cheapest ways to feed your family
- ✓ To look at the importance of breast feeding
- ✓ To look at healthy living and the prevention of illnesses
- ✓ To learn what to do when a person gets seriously injured

GOAL:





To explore the following concepts:

- ✓ **Carbohydrates** include food such as potatoes, bread, corn, nuts, stam and pap.
- ✓ **Protein** includes food such as meat, chicken, beans and fish.
 - **Fat** includes food such as cooking oil, lard, ghee and butter.
 - Important food groups.
 - The benefits of food.
 - Breast feeding
 - The importance of vitamin A.
 - Disability prevention.

HOW:

- **ALWAYS DISCUSS THE “IMPORTANT CONCEPTS” FIRST SO THAT THE GROUP MEMBERS UNDERSTAND THE DIFFERENT CONCEPTS.**

QUESTION 1:**The correct food grouping?**

CARBOHYDRATE	PROTEIN	FAT	FRUIT & VEGETABLES
		 (Oils)	
<ul style="list-style-type: none"> ➤ PORRIDGE ➤ Rice ➤ Bread ➤ Pap ➤ Potatoes 	<ul style="list-style-type: none"> ➤ Fish ➤ Chicken ➤ Eggs ➤ Milk ➤ Pork ➤ Goat 	<ul style="list-style-type: none"> ➤ Cooking Oil ➤ Butter 	<ul style="list-style-type: none"> ➤ Apple ➤ Broccoli ➤ Orange ➤ Marog ➤ Banana ➤ Spinach ➤ Tomato

QUESTION 2:**Name/ draw a few starchy foods which will help you not to feel hungry?****ANSWERS**

- ✓ Potatoes
- ✓ Sweet potatoes
- ✓ Pap/Porridges/Breakfast cereals
- ✓ Bread
- ✓ Oats
- ✓ Rice
- ✓ Pasta

QUESTION 3:**Starchy food should be the biggest part of each meal?****ANSWERS**

False

QUESTION 4:**Meat, fish and chicken can protect us from certain illnesses?****ANSWERS**

True

QUESTION 5:

Milk, sour milk, cheese and yoghurt can build healthy bones and teeth?

ANSWERS

True

QUESTION 6:

It is better to boil, stew, grill or braai meat than to fry it?

ANSWERS

True

QUESTION 7:

What do you normally eat in a day?

ANSWERS

EXAMPLE

BREAKFAST	LUNCH	DINNER
<ul style="list-style-type: none">➤ PAP➤ Milk➤ Tea➤ Fruit	<ul style="list-style-type: none">➤ Bread➤ Tomato➤ Tea➤ Fruit	<ul style="list-style-type: none">➤ Potatoes➤ Meat➤ Vegetables➤ Fruit

- Discuss the **shopping tips**. Remember home grown vegetables are the best nutritional value, value for money and easily available.

QUESTION 8:

Draw six reasons why it is important to eat fruit and vegetables? Own drawings or cut pictures from a magazine and paste it in the blocks.

ANSWERS

False

- Discuss **breast feeding**

QUESTION 9: Your baby should not have the following food until they are one year old?

FOOD	ANSWER
• Honey (mamepe)	• True
• Simba chips, chocolates, biscuits, sweets	• True
• Food that can cause choking like sweets, peanuts, grapes, popcorn, raw carrots	• True
• Fish and egg white	• True
• Peanut butter	• True
• More than one cup of fruit juice a day	• True
• Rooibos tea	• True

- Discuss the facts on **Vitamin A deficiency**.
- Discuss the facts on the **prevention of disabilities**.

QUESTION 10: Too much fat in your diet can cause serious illness and disabilities?

ANSWERS True

- Discuss the facts of too much fat in your diet.
- Discuss the facts on rheumatic fever.
- Discuss the facts on prevent pressure sores and injuries.
- Discuss the facts on the procedures in case of an accident; great care must be taken to prevent further damage to a person's back.

MODULE 6:

EXERCISE AND RELAXATION



Objectives:

GOAL:

To explore the following concepts:

- ✓ **Exercise** include walking, running, playing, cleaning the house and sports
- ✓ **Relaxation** is what you do to calm down and to rest

HOW:

- Always discuss the "Important concepts" first so that the group members understand the different concepts.
- Read the advantages of exercise on page 32.
- Question 1: What exercise do you do? The group members can write down, draw pictures or cut out pictures from a magazine or newspaper and paste it in.
- Question 2: What physical activities can you do with other people in your area to exercise? – Answers could be walking, running, playing soccer. There is no wrong answer, as long it involves some form of exercise.
- Question 3: What do you do to relax? – The group members can again write, draw or paste pictures of what they do to relax. It is recommended that alcohol abuse, drug abuse and any violent activity is not acceptable.
- The group leader asks the group to close their eyes and do the following:

5 MINUTE EXERCISE:

- ✓ Sit in a comfortable position
- ✓ Close your eyes
- ✓ Breathe slowly and deeply and keep your breath for 5 seconds
- ✓ Think about a nice place and imagine yourself being there
- ✓ Keep breathing slowly
- ✓ Tighten all your muscles and then slowly relax it again.
- ✓ Repeat and breathe slowly for 5 minutes

QUESTION 4:

What other activities can you arrange in your area to relax and enjoy life? – There are no wrong answers. The following are examples.

ANSWERS

- ✓ Playing games with a group of children from your area.
- ✓ Arrange a reading club. Someone who likes to read can read to the group.
- ✓ Gardening
- ✓ Singing
- ✓ Attending church
- ✓ Getting a hobby such as making shoes or handbags
- ✓ Participating in sports activities.

PREPARATION FOR RELAXATION:

- Find a quiet comfortable place where you won't be interrupted.
- Try to practice two to three times a day. By doing relaxation in different places to learn to relax no matter where you are.
- Make sure you are comfortable. Either sit in a chair or lie down. Do not cross your arms or legs.
- Have a relaxed attitude towards the exercise. Don't worry about thoughts, sounds or other distractions. Even if you can't relax at first, it will come with practice.

DEEP MUSCLE RELAXATION:

- **Tightening:** Tightening helps to focus attention on tension in the body. The degree of tightening needed will vary from person to person. If you are very tense you will have to tighten quite hard to notice the tension. Squeeze firmly but don't tense so hard that you get cramps or are in pain.
- **Relaxing:** Let go of the tension quickly so that the muscles are immediately loose and relaxed. Focus on the feeling of relaxation which may be heaviness or a warm glowing feeling. Compare the two feelings of tension and relaxation.
- **Breathing:** Breathing is automatic and you don't need to think about it. However, you can change your breathing to make it deeper and shallower. When you are tense you sometimes breathe shallower and faster. You can also feel tightness in the chest and stomach muscles. You must breathe slower and deeper.

DOING THE EXERCISE:

- Sit or lie down and close your eyes. Relax for a few minutes.
- Tense your right arm: make a fist, and then tighten your upper arm as if you were going to lift a heavy bucket. *Do not move your arm.*
- Hold the tension for 5 to 7 seconds.
- Release the tension on an "out" breath. Relax for 20-30 seconds.
- Now repeat the same exercise with the same arm.
- Tighten the left arm as before and hold the tension for 5 to 7 seconds.
- Let the tension go on an "out" breath. Relax for 20 – 30 seconds.
- Tense the chest, back and shoulders. Take a deep breath and hold it. Hold for 5 to 7 seconds.
- Breathe out and relax.
- Repeat the chest, back and shoulders exercise.
- Keep breathing the whole time.
- Slowly open your eyes and take a few minutes to become aware of everything around you.

MODULE 7:

TAU STRONG



Objectives:

- ✓ To look at the responsible use of alcohol
- ✓ To look at the negative effects of smoking and alcohol misuse
- ✓ To look at how to stay strong and say “NO” to keep yourself safe
- ✓ To look at healthy living with HIV and AIDS
- ✓ To understand what STI's are and how to prevent it

GOAL:

To explore the following concepts:

- ✓ **Alcohol use**(having one or two beers/other alcohol) in a social setting is acceptable, but alcohol abuse (drinking more than two beers/ spirits, at a time, or until you pass out) is not acceptable
- ✓ **Drugs** include dagga, LSD, cocaine, heroin, tik and other illegal substances
- ✓ In order to keep yourself safe from drugs and alcohol, you will learn how to say “**NO**” and not let other people push you into doing something you don't want to do
- ✓ **HIV** stands for Human Immune Deficiency virus – You could have the virus, but not be sick
- ✓ **AIDS** stands for Acquired Immune Deficiency virus – You have the virus. It has attacked your immune system and you now are very ill
- ✓ **STI's** are sexually transmitted infections, which could lead to AIDS

HOW:

- Always discuss the “Important concepts” first so that the group members understand the different concepts.



SECTION 1:
ALCOHOL AND DRUGS.

TODAY'S SESSION COULD BE CO-PRESENTED BY THE S.A.P.S. AS PART OF
THEIR SOCIAL CRIME PREVENTION STRATEGY.

QUESTION 1: How old do you have to be to legally drink alcohol?

ANSWERS 18 years old

QUESTION 1: How old do you have to be to legally drink alcohol?

ANSWERS 18 years old

QUESTION 2: How old do you have to be to legally smoke cigarettes?

ANSWERS 18 years old

QUESTION 3: Is it legal to smoke dagga?

ANSWERS No

QUESTION 4:**Can you get the following illnesses from smoking?**

ANSWERS	ILLNESS	YES
	1. Lung cancer	Yes
	2. Heart disease	Yes

QUESTION 5:**Is the following true or false?**

QUESTION	TRUE	FALSE
Drinking too much alcohol can cause accidents?	X	
Drinking alcohol can make you feel stronger, braver and make you do dangerous things?	X	
Drinking too much alcohol can make you forget about sexually transmitted diseases like HIV and AIDS?	X	
If you don't drink with your friends they will not like you anymore?		X
A major cause of death after drinking too much alcohol is choking on vomit?	X	
Dagga is not physically addictive, but it can cause serious mental health problems?	X	
You can die the first time you sniff solvents?	X	

QUESTION 6:**Is smoking harmful for you body****ANSWERS**

Yes

QUESTION 7: Is drinking too much alcohol bad for you?

ANSWERS Yes

READ THE FACTS ON ALCOHOL TO THE GROUP AND DISCUSS IT.

QUESTION 8: It is better to buy food for you and your family than to buy alcohol?

ANSWERS True

QUESTION 9: Is using dagga legal?

ANSWERS No

- Read and discuss the facts on dagga.
- Arrange the following role play session. The group leader asks for 6 volunteers to play the following roles. The volunteers will be given an opportunity to prepare for the play. This could also be practiced and showed to various groups, especially young people at the local schools.
- Discuss which lessons have been learned from this session.
- **How to say "NO":** Read this section and discuss it in the group.

ROLEPLAY



MODULE 8:

THE MAP OF MY LIFE



Objectives

- ✓ To look at whom you are!
- ✓ To look at your goals and what you want to do in life
- ✓ To draw a map of your life's journey, the past, the present and how you see the future

GOAL:

- ✓ To explore the following concepts:
- ✓ **Characteristics** are the things that make you different from other people. This could be that you are friendly, a good friend, honest or a Christian
- ✓ **Goals** are the things that you want to achieve
- ✓ **Map of life** is the picture of your past, present and future life.

HOW:

- Always discuss the "Important concepts" first so that the group members understand the different concepts.

QUESTION 1:

Assist the group members to write down their personal characteristics. Examples could be:

ANSWERS Friendly Hard working
 Caring Positive
 Honest Lazy

QUESTION 2:

My goals are: Examples: Remember to sign this section!!!

SHORT
(1month)

TERM:

✓

Eat at least 2 vegetables each day

✓

Learn something today and share it with a friend/family member

MEDIUM (6 month)	TERM:	✓	Be friendly to a stranger
		✓	Drink 4 glasses of water each day
		✓	Contact the social worker for support
		✓	Learn a new skills or hobby
		✓	Make a new friend
LONG (5 years)	TERM:	✓	Sell my own fruit and vegetables to other people and make some money
		✓	Learn another skill or hobby
		✓	Become a group leader myself and do disability awareness in the community
		✓	Have a long-term partner



The map of life is your travelling from birth to death. Looking at different events, people, feelings, choices, problems and reactions. The following questions will help you to draw your own life's map. Focus on the past, the present and the future.

1. Who am I? Am I this body?
2. Where have I come from?
3. Where am I going?
4. How will I get there?
5. What help do I need?
6. What will it be like when I get there?

CREATE YOUR OWN ART WORK. USE BOOKS, NEWSPAPERS, MAGAZINES AND ANY OTHER PICTURES TO SHOW WHERE YOU SEE YOURSELF IN THE FUTURE.



ALSO DISCUSS TRANSPORT ARRANGEMENTS AND ADDITIONAL REQUIREMENTS OF EACH MEMBER, IN ORDER TO ACCOMODATE AS MANY OF THEIR NEEDS AS POSSIBLE.



CONFIRM A DATE AND VENUE FOR THE NEXT MEETING.

MODULE 9:

DISCRIMINATION



Objectives

- ✓ To increase general awareness of the realities of disability and its existence in society
- ✓ To help you to make your voice heard
- ✓ To create community involvement in disability related matters
- ✓ To give you information about the benefits (Social Security Grants) that you can apply for.

GOAL:

- ✓ To explore the following concepts:
- ✓ Stereotypes is stereotyping is therefore beliefs and opinions about a certain group
- ✓ Prejudice is an attitude towards people and it is considered to be evaluative of the entire group
- ✓ Discrimination is defined as treating people differently from others based on their membership to a specific group, for example, people with disabilities.

HOW:

- Always discuss the "Important concepts" first so that the group members understand the different concepts.
- The following exercise will show people that you need to give someone a chance by getting to know them better. Do not decide you don't like them, without even trying to build a relationship with them.



The purpose of this exercise is to show you that what you think of a person when you first look at him/her might be right, but it might also be wrong.

THE CATEGORY LIST SHOULD INCLUDE:

- | | | |
|---|------------------------|-------------------|
| ✓ | Happy | Likes to be alone |
| ✓ | Does not like people | Friendly |
| ✓ | Lazy | Loving |
| ✓ | Likes to drink alcohol | Fun |
| ✓ | Could be a good friend | Aggressive |
| ✓ | Smart | |

Each person in the group must take the cards and give one to the person that he/she thinks will fit the word on the card.

Divide into groups of five people and discuss how it felt to be judged by people's first impressions of you.

The second part of the exercise is for volunteers to discuss if any of the labelling cards were right. Is there anybody that fits the description? Most people are usually wrong and judge people by the way that they look. This very often happens to people with disabilities.

THE FOLLOWING QUESTION CAN BE ANSWERED BY EACH PERSON AND THEN DISCUSSED IN THE GROUP. IF THERE IS A "no" ANSWER THIS AREA/S SHOULD BE EXPLORED FOR SUPPORT.

QUESTION 1: Do you feel a valued member of your community?

ANSWERS Yes/No

QUESTION 2: Do you take part in any community activities?

ANSWERS Yes/No

QUESTION 3: Do you get support from a home based caregiver?

ANSWERS Yes/No

QUESTION 4: Do you receive regular medication and treatment from the clinic?

ANSWERS Yes/No

QUESTION 5: Do your family and friends support you?

ANSWERS Yes/No

QUESTION 6: Do you get transported to the places you need to be?

ANSWERS Yes/No

QUESTION 7: What do you think you rights as a person with a disability are? Discuss it in small groups and present it to the big group.

EXAMPLES

- Right to fair and equal treatment in the community
- Right to assistive devices
- Right to social security grants
- Right to dignity (someone to help you with the things you cannot do for yourself)
- Right to access to water
- Right to someone who will assist you with your emotional needs (Social Work Services)
- Right to education
- Right to employment



Divide into groups of two/three/four people each. Take a piece of paper and write down or draw two good things about each person in your group. Share your answers with the rest of the group.



Each person now thinks about three things that he/she is proud of - achievements or something for someone else. Share it with the group by moving to the middle of the group and telling them your story. After each person has finished, the group must clap hands for the speaker in order to make the person feel special, appreciated and valued.



THE FOLLOWING SOCIAL SECURITY GRANTS ARE AVAILABLE TO YOU THROUGH THE DEPARTMENT OF SOCIAL DEVELOPMENT:

<u>GRANT AMOUNTS</u>	<u>1 APRIL 2007</u>	<u>1 OCTOBER 2008</u>
-		
Grant for an aged person	R870	R 960
Grant for a disabled person	R870	R 960
War veterans' grant	R870 + R20	R980
Grant-in-aid	R200	R 230
Child support grant	R200	R 230
Foster child grant	R620	R 650
Care-dependency grant	R870	R 960

SOCIAL SECURITY GRANTS APPLICATIONS, YOU WILL NEED:

- Your bar coded South African identity document.
- Proof of your income if you are employed (Salary slip/letter from employer).
- An affidavit (Police statement) saying that you are unemployed and to proof that you have no income.
- Your marriage certificate or divorce order to prove you are married, divorce or single.
- A birth certificate for the child you are applying for (This must have a 13 digit identity number).
- A death certificate if one or both of the child's parents are dead.

● DISABILITY GRANT – R960.00

- A disability grant is an income given to people who are physically **or mentally disable, unfit to work and unable to support themselves**. You get a permanent disability grant if your disability will continue for more than a year and a temporary disability grant if your disability will continue for a continuous period of not less than six months or for a continuous period of not more than twelve months.
- You must be a **South African citizen** or permanent resident.
- Between **18 to 59 years of age if female** and **18 to 64 years of age if male**
- submit a **medical or assessment report** confirming disability
- not be cared for in a State institution
- The applicant must not refuse to undergo medical treatment, unless if it life threatening.
- You may not be in receipt of another social grant in respect of yourself.
- The applicant and the spouse must comply with the means test.

- You and your spouse must earn less than R26 928 if single and R53 856 if married.
- ❖ **Steps to follow:**
- 1. Complete a disability grant application form at your nearest social security office (**SASSA**).
- If you are too old or sick to go to the office, ask someone to **request a home visit** on your behalf. The person should bring a letter from you or a doctor's note saying why you cannot visit the office.
- Complete the application form in the presence of a SASSA officer.
- Attend an interview and have your fingerprints taken.
- Submit the form with the following documents:
 - a **medical report** or functional assessment report confirming your disability
 - proof of **marital status** (if applicable)
 - an **identity document** (ID)
 - the following documents will be requested for applications where the **identity document and/or a birth certificate are not available:**
- an affidavit commissioned by a Justice of the Peace. The affidavit must contain a clause which indicates that provision of incorrect or inaccurate information will result in prosecution in terms of Section 21 of the Social Assistance Act, 2004
- a sworn statement by a reputable person who knows the applicant and the child. This may be from a councilor, traditional leader, social worker or minister of religion
- proof that an application for a birth certificate or identity document has been lodged with the Department of Home Affairs
- where applicable, a temporary identity document issued by the Department of Home Affairs
- baptismal certificate
- road to health clinic card
- school report.

● **Please note: No application can be processed without the sworn statement/affidavit.**

- proof of residence and income
- explanation of all deposits going into your bank account
- proof of private pension
- bank statements for 3 consecutive months.
- **After submitting your application you will be given a receipt.**
- **Keep the receipt as proof of your application.**
- The social security office will inform you in **writing** whether or not your application was successful.

- If your grant is not approved, the social security office will state the reasons why your application was unsuccessful.
- If you disagree with the decision, appeal to the Minister of Social Development or Member of Executive Council (MEC) in writing, explaining why you disagree.

Appeal within 90 days of receiving notification about the outcome of your application.

- | |
|---|
| <ul style="list-style-type: none"> • Form Z970 - Disability Grant Application • Form Z970A - Referral Letter • Form Z970D – Recommendation by assessment committee |
|---|

● **CHILD CARE SUPPORT GRANT**

- You must be a South African citizen who takes care of a child or children under the age of **7 years**. (The Government could extend this to children under 14 years).
- The children must also be South African citizens.
- You are not allowed to receive any other income for the children (Maintenance).
- You and your husband must have a joint (together) monthly household income of less than **R800** if you live in an **urban area** (city).
- You and your husband must have a joint (together) monthly income of less than **R1 100** if you live in a **rural area or an informal settlement**.
- If the child is not your own, you need to get an affidavit (statement) from the police to prove that you have permission from the parents to take care of the child.

● **FOSTER CARE GRANT**

- This is given to the caregivers of a child who is not the parent of the child by birth – **FOSTER PARENT**.
- This grant is given to children under the age of **18** years old. It can be extended to **21** year old if the child is still in school.
- Anyone can apply to become a foster parent, but you must be able to prove that the child's parents are **dead or not able to care** for the children.
- You can apply to become a foster parent at any **social worker** who will write a report which will go to the children's court for a decision.
- You must have a court order to foster a child.

● CARE DEPENDENCY GRANT

- This grant is paid to a parent/s that cares for a **child with severe disabilities and special needs**.
- They can be **parents/foster carers or caregivers**.
- You need a medical report stating what is wrong with the child.
- This grant is paid to children **between 1 and 18** years of age.
- Ask the social worker to help you to apply for this grant.

MODULE 10:

DISABILITY CARE



Objectives:

- ✓ To help and advice to caregivers or family members caring for the ill or disabled
- ✓ Identifying and treating contractures
- ✓ Identifying and treating pressure sores
- ✓ What is epilepsy and what to do when a person gets a seizure
- ✓ Wheelchair management and care
- ✓ How to perform transfers
- ✓ Maintaining health by improving endurance and muscle strength.

GOAL:

To explore the following concepts:

- A contracture is a muscle and the tissue that covers the muscle that has been hurt
- Prevention is things that you do to stop the disability to happen or get worst
- Pressure sores develop when you are lying or sitting in the same position for a long time, especially in a wheelchair.
- Club feet is when the balm of the foot is turned inwards and it does not get back into the normal position.
- Epilepsy is a condition where a person has brain seizures. This is a temporary disturbance to a person's brain.
- Causes of disabilities are the things that make a child disabled.
- Concentration is being able to sit still and listen to someone or being able to complete a task.
- Distracted is constantly looking around and thinking of other things.
- Comprehension is the skill to understand what someone is explaining to you.
- Co-ordination is being able to do a task without knocking into things and breaking things.
- Emotional problems are feeling un-able to talk to people, make friends and feel happy.

HOW:

- Always discuss the "important concepts" first so that the group members understand the different concepts.
- Read and discuss the warning signs and prevention of a contracture.
- The members can now draw a picture of the prevention strategies.
- Read and discuss the warning signs and prevention of pressure sores.
- You can now assist the members to practice the prevention strategies in class. They can also make notes or draw pictures to remind themselves.





QUESTION 1:

Which of the following should you do when a person has a seizure? EXAMPLES:

STATEMENT	TRUE	FALSE
I. Put a cushion under the person's head	X	
II. Loosen any tight neck jewellery	X	
III. Turn the person on his side	X	
IV. Do not place anything in his mouth or try to pull the teeth apart	X	
V. Take note of how long the seizure is, type of movement, the direction the eyes and head is turning	X	
VI. Take note how often the person has a seizure	X	
VII. Put something in the person's mouth		X

QUESTION 2:

Which of the following should you do to keep a child safe and to prevent disabilities happening? EXAMPLES:

STATEMENT	TRUE	FALSE
 Keep children away from open fires/ cooking fires and boiling water		
 Keep dangerous chemicals/ poison and other harmful materials locked away in a cupboard		
 Keep matches, lighters and fuel/ paraffin locked away in a cupboard		
 Make sure that you keep rats, mice and other animals out of your food		

QUESTION 3:**Can you name some of the causes of learning disabilities?**

Internal Causes	External Causes
Injury to the brain	Abuse
Cannot hear or see	Neglect
Slower growth	Lack of opportunity because of poverty
Chemical imbalance in the body	Inexperienced parents

QUESTION 4:**I should take a child to the doctor when I see the following problems with the child. EXAMPLES:**

✓ The child starts to draw a picture, but never finishes it, because he/she wants to do something else.	✓ Child has difficulty concentrating; he/she cannot sit still and listen to the teacher in the class for long periods of time.
✓ He/she has difficulties talking and forming words	✓ Poor co-ordination and clumsiness. Always knocking things over and walking into things.
✓ Difficulties reading	✓ Very emotional, either very sad, or very happy and finding it very hard to make friends.
✓ Difficulties with spelling, handwriting and comprehension (understanding).	✓ The child is slower with reaching all his/her milestones, walking, talking, playing, drawing, running and writing.

QUESTION 5:**What can you do when your child has been diagnosed with a disability? EXAMPLES:**

✓ Speak to the teacher or principal about support in school	✓ Praise your child for every little thing that he/she achieves.
✓ Do not compare the child to friends/brothers/sisters. They must learn at their own pace.	✓ Give your child tasks to do like folding the washing or making the bed. Something that he/she can feel important to do.
✓ Everyday check if your child has homework and help him/her with it.	✓ Play games together, this will help co-ordination

✓ Accept them for who they are and encourage other people to do the same.

✓ Love, support and encourage your child.



ALSO DISCUSS TRANSPORT ARRANGEMENTS AND ADDITIONAL REQUIREMENTS OF EACH MEMBER, IN ORDER TO ACCOMODATE AS MANY OF THEIR NEEDS AS POSSIBLE.



CONFIRM A DATE AND VENUE FOR THE NEXT MEETING.

MODULE 11:

LOW COST ACTIVITIES, EVALUATION & FEEDBACK



Objectives

- ✓ To look at low cost activities which you could use, to stimulate your child's development.
- ✓ To understand what rehabilitation is and how it can benefit your child with a disability.
- ✓ To get some practical guidelines and examples of how to create your own assistive devices in your house.
- ✓ To give you the opportunity to evaluate the program and to suggest what else could be added to what information was not useful to you.

GOAL:

To explore the following concepts:

- ✓ Rehabilitation: Getting better or helping someone with a disability to function better at home and in the community
- ✓ Therapy:
 1. Treatment for physical disabilities through improving positions, movement, strength, balance and control of the body.
 2. Treatment by helping a person with a disability to do useful or activities that they enjoy.
 3. Treatment to help the person with the disability to feel better about themselves and to live a happier life.

HOW:

- Look at low cost activities and try it in the group session.
- Demonstration includes making the low cost assistive devices for your home. The Occupational Therapist can help you with this.

MODULE 12:

NATIONAL DISABILITY DAY



Objectives:

- ✓ Disability awareness
- ✓ Integration and participation
- ✓ Community involvement.



DISCUSS TRANSPORT ARRANGEMENTS AND ADDITIONAL REQUIREMENTS OF EACH MEMBER, IN ORDER TO ACCOMODATE AS MANY OF THEIR NEEDS AS POSSIBLE.



CONFIRM THE VENUE, ROLES AND RESPONSIBILITIES OF ALL THE ROLEPLAYERS FOR THE NATIONAL DISABILITY CELEBRATION DAY, IN PARTNERSHIP WITH YOUR LOCAL SERVICE PROVIDERS. ENJOY!!!!!!!!!!!!!!!!!!!!!!!!!!!!

ACKNOWLEDGMENTS

- ☞ Special thank you to our Heavenly Father for blessing this programme and opening all the right doors at the right time.

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Lizél Pretorius

APPENDIX H

FACILITATION AND ASSESSMENT SCALE

HEUNINGVLEI – A COMMUNITY-BASED DISABILITY PROGRAMME

Facilitation & Assessment Scale

1. INTRODUCTION

You have completed the community-based disability programme workshop. This programme has been developed for your community; therefore we must know how effective it was in meeting your needs and interests. For this we need ***your*** input. Please complete the following questionnaire honestly and in full – it will help to meet your needs.

2. GENERAL INSTRUCTIONS

- 2.1 Mark the answers **on this questionnaire** by making a **cross** in the appropriate blocks. The cross must not touch the outline of the block.
- 2.2 Mark only **one** answer per question.
- 2.3 Answer **all** questions.
- 2.4 Complete the questionnaire **honestly** and **on your own**.

By completing this questionnaire, you are giving permission that this data may be used for research purposes.

PART 1: WORKSHOP PARTICULARS

Presenter:

Lizél Pretorius

Date:

Office use

PART 2: ASSESSMENT OF THE *LEARNING PROCESS*

1. Did you understand the purpose of the workshop?	1. NO	2. Maybe	3. YES
2. Did the interpreter help you to understand in your own language?	1. NO	2. Maybe	3. YES
3. Did the programme meet all your expectations ?	1. NO	2. Maybe	3. YES
4. Was the time for workshop too short ?	1. NO	2. Maybe	3. YES
5. Do you want a follow-up workshop ?	1. NO	2. Maybe	3. YES
6. I will be able to use what I have learned in my community .	1. NO	2. Maybe	3. YES

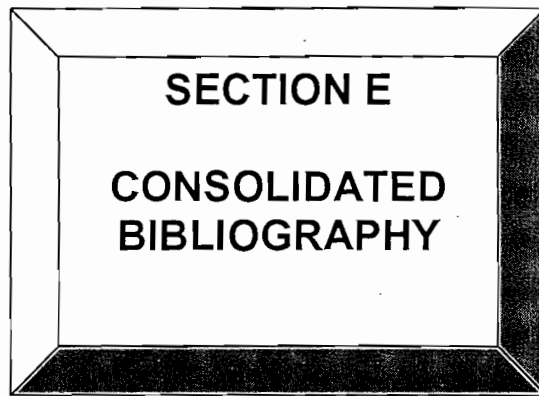
PART 3: ASSESSMENT OF THE *CONTENT OF THE PROGRAMME*

1. I know how to help someone with a disability to feel better about themselves?	1. NO	2. Maybe	3. YES
2. I understand that ill health and poor hygiene can lead to a disability .	1. NO	2. Maybe	3. YES
3. I can help someone to manage his/her stress better?	1. NO	2. Maybe	3. YES
4. I can help my community to become more active and to exercise .	1. NO	2. Maybe	3. YES
5. Are you now able to identify the negative effects of alcohol and drug abuse on a	1.	2. Maybe	3. YES

person's health?	<i>NO</i>		
6. I am able to advise someone about HIV, AIDS and STI's ?	1. <i>NO</i>	2. <i>Maybe</i>	3. <i>YES</i>
7. Is the section " Map of my life " useful for your community?	1. <i>NO</i>	2. <i>Maybe</i>	3. <i>YES</i>
8. I am able to explain discrimination against people with disabilities.	1. <i>NO</i>	2. <i>Maybe</i>	3. <i>YES</i>
9. I know how to show people physical handling techniques for people with disabilities.	1. <i>NO</i>	2. <i>Maybe</i>	3. <i>YES</i>
10. The low cost activities were useful practical ideas.	1. <i>NO</i>	2. <i>Maybe</i>	3. <i>YES</i>

PART 4: DO YOU HAVE ANY OTHER RECOMMENDATIONS?

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.



SECTION E

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BIBLIOGRAPHY**

CONSOLIDATED BIBLIOGRAPHY

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