

**INCLUSIVE HEALTH PROMOTION:
PUBLIC HEALTH REMEDY FOR PEOPLE WITH
DISABILITIES**

By

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DEDICATION

I dedicate this dissertation to the Lord who has blessed me with this achievement. To my beloved parents Shadi Ruth Mabaso, my late father, Hlupheka, “The Man”, Mabaso and my only brother Muzamani James Mabaso for my existence and their roles in shaping my life. To my beautiful children Thabang, Masana, and Naledi for their tireless support through this journey.

To all the people with disabilities and their families that continue to carry the burden of care in South Africa, the experiences expressed in this work are a lifelong dedication to the realization for their inclusion in mainstream activities of society.

DECLARATION

Student Number: 645-456-9

I declare that **INCLUSIVE HEALTH PROMOTION: PUBLIC HEALTH REMEDY FOR PEOPLE WITH DISABILITIES** is my own work and that the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any institution.

Rebecca Mabaso-Motlatla

Date

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This thesis is dedicated to people living with disabilities, the legendary activists who influenced the formations of disabled people of South Africa during the formative years. Their sacrifices served as the springboard for infusing disability in some aspects of life in South Africa. A case in point is inclusive Education and the establishment of the office on the status of people with Disabilities.

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ABSTRACT

The purpose of this study was to explore the views of adults with disabilities and their care providers with regard to extent to which health promotion implementation was facilitated within Protective Workshops across several service areas in South Africa. Quantitative and Qualitative Data was collected via a combination of data collection approaches that included the use of a descriptive survey, a self-administered questionnaire and a semi-structured interview. Structured questionnaires and an interview schedule were used to generate data from both the patient and care provider participants in each of the selected facilities. Participants with disabilities and care providers working in the Protective Workshops were identified and sampled through a multi-stage sampling procedure. Participants from 48 facilities participated in the study.

The findings revealed that health promotion in Protective Workshops was cursory and informal. Even though health education was provided whenever the need arose, it was neither individualized nor customized in accordance with reasonable accommodation of people with disabilities. There were provincial differences in terms of the levels of participation and organizational support for people with disabilities. In certain cases bureaucratic obstacles were identified during field work. Results show inconsistency regarding access to equal opportunities for people with disabilities, albeit some agreed to a lesser extent (30.5%), others moderately (21.5%) compared to only 22.6% who agreed, were exceeded by 25% of respondents who completely disagreed to the notion that equal opportunities existed for people with disabilities. The latter was confirmed by care providers. The study recommended an urgent need for the development of inclusive health promotion, the enforcement of the requirements for reasonable accommodation and adherence to policy and legal imperatives.

KEY CONCEPTS

Disability; Health Promotion; Inclusion; Prevention; Public Health; Protective Workshops.

DEFINITION OF RELEVANT TERMS

People with disabilities

People with disabilities include those who have a long-term physical, mental, intellectual or sensory impairment which in interaction with various barriers that may hinder their full and effective participation in society on an equal basis with others (UN Convention on the Rights of Persons with Disabilities, 2004).

Handicap

Handicap means a disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfillment of a role that is normal, depending on age, gender, social and cultural factors for the individual.

Impairment

Impairment is defined as a physical, intellectual, mental or sensory characteristic or condition, which places limitations on an individual's personal or social functioning in comparison with someone who does not have that characteristic or condition (VSO, 2002)

Health Promotion

The process of enabling people to increase control over their health and its determinants, thereby improving their health. A goal of health promotion is equity in health and reduction of differences in health status to enable all people to achieve their fullest health potential. Control of factors that determine one's health is needed for individuals to achieve their fullest health potential (WHO, 2009a).

Inclusive Health Promotion

Inclusive Health Promotion means to establish a common language for describing health and health related states in order to improve communication between different users such as health care workers, researchers, policy makers and the public, including people with disabilities.

Inclusion

Inclusive refers to the inclusion of all people in health and related activities irrespective of their age, gender, color, creed, and disability. Inclusivity is aimed at removing some

of the barriers to individual development and promoting active participation in matters that affect people in all spectrums of their lives.

Mainstreaming

Mainstreaming is the integration of people with disabilities in all aspects of societal developmental processes such as economy, health, politics, social, environmental etc, as in policy, programmes, projects and activities.

Disability Discrimination

Disability Discrimination includes any act, practice which has the effect of unfairly hindering or precluding any person or persons who have a disability from conducting their activities freely and which undermines their sense of human dignity and self worth and prevents their full participation and equal participation in society.

Public Health

Public health is a social and political concept aimed at improving health, prolonging life and improving the quality of life among whole populations through health promotion, disease prevention and other forms of health intervention (WHO (1978) Alma Ata Declaration).

Primary Health Care

Primary health care is essential health care made accessible at a cost a country and community can afford, with methods that are practical, scientifically sound and socially acceptable (WHO (1978) Alma Ata Declaration).

Medical Model of Disability

The Medical Model of Disability perceives people with disabilities as medical problems. As a result people with disabilities are expected to see their impairment as their problem, something they will have to make the best of and accept that there are many things they cannot do.

Social Model of Disability

The Social Model of Disability recognises that everyone is equal and demonstrates that it is society which erects barriers that prevent disabled people from participating and

restricts their opportunities.

Ubuntu

Ubuntu refers to the ethical and humane principle of how people relate to one another. It is based on the premise that a person is a person because of other people.

Empowerment

Empowerment refers to the process of "conscientisation" which builds critical analytical skills for an individual to gain self-confidence in order to take control of her or his life.

Diversity

Diversity means to be conscious and respect the differences in people's background and experiences.

Marginalization

Marginalization is a conscious act of social exclusion of certain individuals from the mainstream activities that should benefit them.

Stigmatisation

Stigmatisation refers to a negative label attached to certain people by society with the aim to condemn and exclude.

Prejudice

Prejudice is associated with the recognition of difference, and "disabled" people are not seen as normal in the eyes of "non-disabled" people.

Equity

Equity is the state, quality of being just and fair.

Equality

Equality means to be treated the same as other people.

Equality of opportunity refers to a fundamental human right embedded in the Constitution of South Africa.

Barriers

Barriers are obstacles that result in a restriction to achieve a particular objective and can be natural or manmade, e.g. access to services, etc.

Rehabilitation

Rehabilitation means a goal-orientated and time limited process aimed at enabling an impaired person to reach an optimum mental, physical and social functional level.

Prevention

Prevention means measures aimed at preventing the onset of mental, physical and sensory impairment (primary prevention) or at preventing impairment, when it has occurred from having negative physical, psychological and social consequences. Prevention of health conditions associated with disability is a development issue. Attention to environmental factors including nutrition, preventable diseases, safe water and sanitation, safety on roads and in workplaces can greatly reduce the incidence of health conditions leading to disability (WHO:2011).

Project

Project refers to the design of an implementation strategy of a plan of action geared towards achieving a particular goal.

Programme

Programme refers to a systematic action-oriented design of a plan of action towards achieving a particular goal.

A LIST OF ACRONYMS USED IN THE STUDY

ABET	Adult Basic Education and Training
AFUB	African Union of the Blind
AIDS	Acquired Immunodeficiency System
ARI	African Rehabilitation Institute
BBBEE	Broad Based Black Economic Empowerment
BCM	Black Consciousness Movement
CBR	Community-based Rehabilitation
Cc	Closed Corporation
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CMH	Cape - Mental Health Society
CRC	Convention on the rights of the Child
CREATE	Community-based Rehabilitation Education and Training for Empowerment
CRF	Community Rehabilitation facilitator
CSIR	Council for Scientific and Industrial Research
DeafSA	Deaf Federation of South Africa
DEC	Disability Employment Concerns
DEAT	Department of Environmental Affairs and Tourism
DoE	Department of Education
DICAG	Disabled Children Action Group
DOH	Department of Health
DoL	Department of Labour
DoSD	Department of Social Development
DPI	Disabled People International
DPO	Disabled People Organization
DPSA	Disabled People of South Africa
DSI	Danish Council of Organizations of Disabled People
DSM	Diagnostic and Statistical Manual of Mental Health
DWDE	Disability Workshop Development Enterprise
ECD	Early Childhood Development
EEFP	Economic Empowerment Framework programme
ESSA	Employment Services South Africa

ESCAP	UN Economic and Social Commission for Asia and the Pacific
EWPs	Education White Paper 6 on Special Needs Education
FET	Further Education and Training
GET	General Education and Training
INDS	Integrated National Disability Strategy
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
ICCD	Interdepartmental Co-coordinating Committee on Disability
ICF	International Classification of Impairment Disability and Health
ICIDH	International Classification of Impairment Disability and Handicap
ID	Intellectual Disability
INDS	White Paper on Integrated National Disability Strategy
ISGSA	Individual Scale for General Scholastic Aptitude
IUPHC	Institute of Urban Primary Health Care
LHR	Lawyers for Human Rights
MRC	Medical Research Council
MOU	Memorandum of Understanding
NCCD	National Co-coordinating Committee on Disability
NCPPDSA	National Council for Persons with Physical Disabilities South Africa
NCS	National Curriculum Statement
NDSD	National Department of Social Development
NEDLAC	National Economic Development Labour Council
NEPAD	New Economic Partnership for Africa's Development
NGO	Non Governmental Organization
NF	National Forum
NPO	Non Profit Organization
NPHE	National Plan for Higher Education
NWC	National Working Committee
OSDP	Office on the Status of Disabled People
OT	Occupational Therapy
PAFOD	Pan African Federation of the Disabled
PANSALB	Pan South African Language Board
Pty Ltd	Propriety Limited
PW	Protective Workshop
QASA	QuadPara Association South Africa

RURACT	Rural Disability Group
SABC	South African Broadcasting Co-corporation
SADI	South African Disability Institute
SAFCD	South African Federation Council on Disability
SAFOD	South African Federation of Organizations of the Disabled
SAHRC	South African Human Rights Commission
SAMH	South African Federation for Mental Health
SANCA	South African National Council for the Aged
SANCB	South African National Council for the Blind
SANEL	South African Epilepsy League
SAPS	South African Police Services
SAQI	South African Quality Institute
SASL	South African Sign Language
SASO	South African Student Organization
SAVE	Sexual Assault Victim Empowerment Programme
SDS	Society for Disabled Studies
SHAP	Self-Help Association of Paraplegics
SMME	Small, Medium and Micro Enterprises
SPSS	Statistical Package for Social Scientists
Stats	SA Statistics South Africa
UPLAS	Union of Physically Impaired Against Segregation
WHO	World Health Organization

ORGANIZATION AND STRUCTURE OF THE STUDY

- Chapter one:** This chapter focuses on the exposition of the problem, the research objectives and research questions; explanations of concepts and the research design.
- Chapter two:** This chapter covers a collation of literature from different sources related to the issue of disability both globally as well as nationally. Literature on disability exist but with limitations on integrating people with disability into the general societal developmental programmes and activities.
- Chapter three:** This chapter's thrust is on the theoretical framework and conceptualization of the study. The key concepts discussed include domains, social model of disability, health promotion model, protective workshop model, human rights, development, prevention, promotion, access, integration, mainstreaming, rehabilitation, health services, and people with disabilities, support and community. These concepts have been interlinked to conceptualize and understand their interestedness.
- Chapter four:** The crux of discussion in this chapter is constituted by research methodology, data gathering techniques, ethics of research and the attendant pilot study.
- Chapter five** Quantitative and qualitative findings are presented, data is analysed and interpretations of results are discussed with an evaluation of the study's strengths and limitations
- Chapter six:** The key discussion points relating to the study, the results, and recommendations are considered with the final evaluation of the contribution made to the study area.

LIST OF TABLES

Table 1.1: Protective Workshops by provinces and type of disability (National Data base, 2001: National Department of Social Development)	13
Table 1.2: Disability prevalence per province (1999).....	16
Table 1.3: Protective Workshops by provinces and type of disability	17
Table 2.1: Provides a summary of relevant literature reviewed by author, key findings and or key arguments and sources:	37
Table 4.1: Distribution of the sample size by province.....	118
Table 5.1: Demographic Characteristics.....	127
Table 5.2: Respondent's type of Health services Visited.....	136
Table 5.3: Respondent's Opinion on Health facility Disability Friendly	139
Table 5.4: Respondent's Opinion on Health Workers Disability Friendly.....	140
Table 5.5: Respondent's opinion on Treatment with Respect	141
Table 5.6: Respondent's Opinion on Appropriate Care	142
Table 5.7: Respondent's Opinion on Appropriate Referral	144
Table 5.8: Respondent's Level of Involvement in Health Related Activities	145
Table 5.9: Respondent's Opinion on the sufficiency of Health Promotion	146
Table 5.10: Respondent's Involvement in Health Promotion Activities.....	146
Table 5.11: Knowledge of Facilities catering for People with Disabilities.....	147
Table 5.12: Knowledge about the Frequency of availability of Health Services.....	147
Table 5.13: Age and Gender Cross-tabulation	149
Table 5.14: Chi-square test results for association: between the type of a disability and the extent to which people with disabilities relate with one other in the community.	151
Table 5.15: Chi-square test results for association: between the type of a disability and the extent to which health care facilities respond to the needs of people with disabilities	152
Table 5.16: Chi-square test results for association: between the type of a disability and the extent to which health workers are friendly towards people with disabilities	153
Table 5.17: Chi-square test results for association between the type of a disability and the extent to which people with disabilities receive appropriate health education.	154
Table 5.18: Chi-square test results for association between the type of disability and the extent to which people with disabilities receive services they need....	155
Table 5.20: Respondent's Population Group.....	158

Table 5.21: The target group of people with disabilities at facilities.....	158
Table 5.22: Socioeconomic Status and Geographic coverage Cross Tabulation	159
Table 5.23: Respondent's Educational Background and Gender of People with Disabilities Cross Tabulation	159
Table 5.24: Respondent's Recruitment Method	160
Table 5.25: Respondent's Opinion on opportunities for people with disabilities	161
Table 5.26: Respondent's Opinion on the sufficient the promotion of Health	161
Table 5.27: Extent of Involvement of People with Disabilities in Health Activities.	162
Table 5.28: Respondent's Opinion on the Efficiency of the Monitoring and Evaluation System.....	163
Table 5.29: Respondent's Opinion on the Efficiency of Health Promotion Topics.....	164
Table 5.30: Respondent's Knowledge about the Extent of Integration of Structures to promote equal opportunities	166
Table 5.31: Categories of the reasons for disability Status.....	167
Table 5.32: Respondent's opinions on the community view towards people with disabilities.....	172
Table 5.33: Showing thematic categories to the respondent's understanding of the term "health promotion".	173

LIST OF FIGURES

Figure 1.1:	Show the interaction of Poverty and Disability.....	9
Figure 1.2:	The Map of the Republic of South Africa (RSA)	14
Figure 1.3:	Delays in obtaining needed health care (target rate: 7%).....	21
Figure 3.1:	A Multilevel Approach.....	75
Figure 3.2:	An Inclusive Social Model of Health Promotion within Protective Workshops	91
Figure 5.1:	Respondent's Gender.....	129
Figure 5.2:	Respondent's Population Group.....	130
Figure 5.3:	Respondent's Age Group	131
Figure 5.4:	Respondent's Level of Education	131
Figure 5.5:	Respondent's Disability Status	132
Figure 5.6:	Respondent's Disability Type	133
Figure 5.7:	Respondent's Disability Rights	133
Figure 5.8:	Respondent's Opinion on Equal Opportunities for People with Disabilities	134
Figure 5.9:	Respondent's Opinion on Relationships with other People with Disabilities in the community	135
Figure 5.10:	Respondent's type of health services Visited	136
Figure 5.11:	Distance traveled to the nearest Health facility.....	137
Figure 5.12:	Respondent's Mode of Transport to the Health Facility	137
Figure 5.13:	Respondent's Opinion on Health Worker's knowledge about disability issues.	138
Figure 5.14:	Respondent's Opinion on Health facility Disability Friendly	139
Figure 5.15:	Respondent's Opinion on Health Workers Disability Friendly.....	140
Figure 5.16:	Respondent's opinion on Treatment with Respect	141
Figure 5.17:	Respondent's Opinion on Appropriate Care	142
Figure 5.18:	Respondent's Opinion on Appropriate Health Education.....	143
Figure 5.19:	Respondent's Opinion on Quality of Services	144
Figure 5.20:	Respondent's Level of Participation	148
Figure 5.21:	Respondent's Support Groups	148
Figure 5.22:	Respondent's Gender.....	157
Figure 5.23:	Respondent's Population Group.....	157
Figure 5.24:	Respondent's Extent of Involvement of People with Disabilities in Health Activities.	162

Figure 5.25: Respondent’s Knowledge of Supportive policies to increase access
to health promotion efforts for people with disabilities 165

Figure 5.26: Respondent’s opinion on equal rights for people with disabilities 170

LIST OF APPENDICES

Appendix A:	Interview Schedule for People with Disabilities	215
Appendix B:	Questionnaire for professionals working in the Area of Disability	223
Appendix C:	A National Sample of Protective Workshops.....	229
Appendix D:	Permission Letter to undertake study to the Department of Social Development.	232
Appendix E:	Approval response Letter from the Department of Social Development.	234
Appendix F:	University of South Africa 2008 Approval letter of Registration.	236
Appendix G:	University of South Africa Health Research and Ethics Committee (College of Human Sciences) Clearance Certificate	237
Appendix H:	Supervisor’s Letter of Support to gain access into the Research settings.....	238
Appendix I:	Permission Letter (Kwazulu-Natal) including Communication with the Province.	239
Appendix J:	Permission Letters: Free State Province (FS) including Communication with the Province.	243
Appendix K:	Permission Letters: Mpumalanga Province (MP) including Communication with the Province	246
Appendix L:	Permission Letters: North West Province (NW) including Communication with the Province	249
Appendix M:	Permission Letter: Eastern Cape Province (EC) including Communication with the Province	251
Appendix N:	Permission Letter: Gauteng Province (GP) including Communication with the Province	254
Appendix O:	Permission Letter: Limpopo Province (LP) including Communication with the Province	257
Appendix P:	Permission Letter: Northern Cape Province (NC) including Communication with the Province	259
Appendix Q:	Permission Letter: Western Cape Province (WC) Communication with the Province	261
Appendix R:	Request for Assistant with Statistical Analysis	266

Appendix S: Acceptance Letter to present work in process of the Thesis at the Biennial meeting of the International Network for Doctoral Education in Nursing on the 26-27 May 2007 at St Luke's College of Nursing in Tokyo.	267
Appendix T: Request Letter (DOH) for Sponsorship to attend the Biennial meeting of the International Network for Doctoral Education in Nursing on the 26-27 May 2007 at St Luke's College of Nursing, in Tokyo.....	268
Appendix U: Acceptance letter to submit the Thesis for examination	269
Appendix V: Thesis Revision 2012	270

TABLE OF CONTENTS

DEDICATION	i
DECLARATION	ii
ACKNOWLEDGEMENTS.....	iii
ABSTRACT	v
DEFINITION OF RELEVANT TERMS.....	vi
A LIST OF ACRONYMS USED IN THE STUDY	x
ORGANIZATION AND STRUCTURE OF THE STUDY.....	xiii

CHAPTER ONE

Overview of the Project.....	1
1.1 Introduction	1
1.1.1 The context of Public Health and Disability	1
1.2 Conceptualization of the thesis	5
1.2.1 Key Concepts Clarified.....	5
1.2.1.1 Health Promotion	6
1.2.1.2 Inclusive Health Promotion Model.....	6
1.2.1.3 Disability.....	7
1.2.1.4 Protective Workshops	8
1.2.2 Background to Health Promotion and Disability	9
1.2.3 A Political – Historical Perspective on Disability and Health	10
1.2.4 The Scope of the Study.....	12
1.2.5 Is Disability a Clinical Significant Issue – An analysis of the discourse background.	14
1.2.6 Primary argument of the thesis:	23
1.3 Problem Statement	25
1.4 Purpose of the Study.....	27
1.6 Research Questions.....	28
1.7 Significance of the study	29
1.8 Summary.....	30

CHAPTER TWO

Literature review.....	31
2.1 Introduction	31
2.2 Data Search Strategy.....	32

2.3	Sources of Literature and Search Tools.....	34
2.3.1	Justification	34
2.3.2	Inclusion and exclusion criteria	35
2.4	Systemic Literature Search	37
2.5	Thematic Review of the literature.....	50
2.5.1	Theoretical base of health promotion and disability	51
2.5.2	Conceptualization of key theories	56
2.5.3	Health and Human Rights perspective.....	63
2.6	Summary.....	68

CHAPTER THREE

	Conceptual Framework.....	70
3.1	Introduction	70
3.2	Theoretical base of the framework.....	72
3.3	Theoretical base of health promotion and disability	82
3.4	Conceptualization of the Framework.....	88
3.5	Model Exposition.....	89
3.5.1	Social Model of Disability Domain	91
3.5.2	Health Promotion Domain	92
3.5.3	Protective Workshop Service Domain.....	93
3.5.3.1	A case of Protective Workshops	94
3.6	Towards an Inclusive health promotion model for people with disabilities domain	100
3.7	Summary.....	104

CHAPTER FOUR

	Research Design, Research Methodology and Data collection Approaches.....	105
4.1	Introduction	105
4.2	Triangulation	105
4.3	Description of the Research Design.....	107
4.3.1	Research Design.....	107
4.3.2	Negotiating Entry.....	107
4.3.3	Triangulation of the Research Design	108
4.3.3.1	Data triangulation	108
4.3.3.2	Method Triangulation	109

4.3.3.3	Investigator Triangulation	109
4.4	The Research Setting and Sampling Procedure	110
4.4.1	Population	110
4.4.2	Sample Size	111
4.4.3	Inclusion Criteria	111
4.4.4	Exclusion Criteria	112
4.4.5	Ethical Considerations	113
4.5	Data Collection Approaches.....	114
4.6	Quantitative Data Collection.....	115
4.6.1	Questionnaire Formulation, Administration and Refinement.....	115
4.7	The Study Population and Sampling Procedure	116
4.7.1	Study Population	116
4.7.2	Sampling procedure	117
4.7.2.1	Simple Random Sampling Technique	118
4.8	The Pilot Study.....	119
4.8.1	The Setting.....	119
4.8.2	Target group.....	120
4.8.3	The Process	120
4.8.4	Key Findings	120
4.8.5	Generalisability	121
4.9	Ethical Considerations	122
4.9.1	Research-/ Researcher –Focused Ethical Consideration.....	122
4.9.2	Participant/Respondent-Focused Ethical Considerations	123
4.9.3	The Inviolable Principle of Human Dignity.....	123
4.9.4	The Principle of Justice	124
4.10	Summary.....	125

CHAPTER FIVE

	Data Presentation, Data Analysis and Interpretation	126
5.1	Introduction	126
5.2	Quantitative Data Presentation and Analysis	128
5.3	Data presentation and analysis of people with disabilities respondent type.....	129
5.3.1	Demographic Data	129
5.3.1.1	Gender	129
5.3.1.2	Population Group	130
5.3.1.3	What is your age group?	131

5.3.1.4	What is your educational background?	131
5.3.2	Awareness about Disability	132
5.3.2.1	What is the kind of your disability?	132
5.3.2.2	Disability Type.....	133
5.3.2.3	Do you think that people with disabilities have rights?	133
5.3.2.4	To what extent do you think that people with disabilities have equal opportunities compared to those without disabilities?	134
5.3.2.5	To what extent do you relate to other people with disabilities in your community?	135
5.3.3	Access to Health Services	136
5.3.3.1	Where do you go for health services?	136
5.3.3.2	How far is the nearest Health Facility?	137
5.3.3.3	How do you travel to and from a Health Facility?	137
5.3.3.4	Statement 1: The Health Workers are knowledgeable about disability issues.	138
5.3.3.5	Statement 2: The Health facility is Disability Friendly	139
5.3.3.6	Statement 3: Health Workers are friendly to People with Disabilities	140
5.3.3.7	Statement 4: People with disabilities are treated with Respect	141
5.3.3.8	Statement 5: People with Disabilities receive Appropriate Care.....	142
5.3.3.9	Statement 6: People with Disabilities receive Appropriate Health Education	143
5.3.3.10	Statement 7: People with Disabilities receive services they need. ...	144
5.3.3.11	Statement 8: People with Disabilities are referred appropriately	144
5.3.3.12	Statement 9: People with Disabilities are Involved in Health Related Activities aimed to Promote Health.	145
5.3.3.13	In your opinion, is Health sufficiently promoted amongst people with disabilities?	146
5.3.3.14	Are you still involved in Health Promotion Activities?	146
5.3.4	Availability of Support Structures and Mechanisms	147
5.3.4.1	Do you know of any facility in the community that caters for the health needs of people with disabilities?	147
5.3.4.2	How often are Health Programmes rendered at this facility?	147
5.3.4.3	What roles do people with disabilities play at those facilities?	148
5.3.4.4	Do you know of any Support Groups in your community for people with disabilities?	148
5.4	Further analysis of data.....	149

5.4.1	Cross tabulation of data	149
5.4.1.1	Age and gender.....	149
5.4.2	A Chi-Square Test Of Association.....	150
5.4.2.1	Association between the type of a disability and the extent to which people with disabilities relate with one another in the community.....	150
5.4.2.2	Association between the type of a disability and the extent to which health care facilities respond to the needs of people with disabilities.....	151
5.4.2.3	Association between the type of a disability and the extent to which extent to which health workers are friendly towards people with disabilities.	152
5.4.2.4	Association between the type of a disability and the extent to which people with disabilities receive appropriate health education.	153
5.4.2.5	Association between the type of disability and the extent to which people with disabilities receive services they need	154
5.4.2.6	Association between the type of disability and the extent to which people with disabilities are involved in health promotion activities ...	155
5.5	Data presentation and analysis of care providers/professionals working in the area of disability respondent type	156
5.5.1	Demographic Data	156
5.5.1.1	Gender	157
5.5.1.2	Population Group	157
5.5.1.3	What is the Target Population of people with disabilities for the programme?.....	158
5.5.1.4	Socio-economic status of people with disabilities served by your organization?.....	159
5.5.1.5	What is the educational background of people with disabilities utilizing the service/programme?.....	159
5.5.1.6	How are people with disabilities recruited to the Centre/ programme?.....	160
5.5.1.7	To what extent do you think that people with disabilities have equal opportunities compared to those without disabilities?	161
5.5.1.8	In your opinion, is health sufficiently promoted amongst people with disabilities?	161
5.5.1.9	What is the extent of Involvement of People with Disabilities in Health promotion?.....	162

5.5.1.10	To what extent is the Efficiency of the Monitoring System to identify high risk amongst people with disabilities?	163
5.5.1.11	In your opinion the Efficiency of Health Promotion activities for people with disabilities	164
5.5.1.12	Are there supportive policies to increase access to health promotion efforts for people with disabilities?.....	165
5.5.1.13	To what extent are these structures integrated to afford people with disabilities equal opportunities for quality services?	166
5.6	Qualitative data presentation and analysis.....	166
5.6.1	Introduction	166
5.6.2	Qualitative data analysis of people with disabilities.....	167
5.6.2.1	Awareness about Disability	167
5.6.2.2	Access to Health Services	173
5.6.2.3	Availability of Structures and Mechanisms.....	176
5.6.3	Qualitative data analysis of responses from care providers/professionals	178
5.7	Summary.....	183

CHAPTER SIX

	Conclusions and Recommendations.....	184
6.1	Introduction	184
6.3	Qualitative Findings.....	185
6.3.1	People with Disabilities Respondent Type– Emerging Themes	185
6.3.1.1	Awareness about Disability	185
6.3.1.2	Community relations with other people with disabilities	186
6.3.1.3	Community view towards people with disabilities.....	187
6.3.1.4	Understanding of the term “Health Promotion”	187
6.3.1.5	Exposure to Health Promotion Activities	188
6.4	Results from the assessment of Care-provider viewpoints	189
6.5	Naturalistic observation.....	192
6.7	Quantitative findings.....	193
6.7.1	Recommendation One	198
6.7.2	Recommendation Two	198
6.7.3	Recommendation Three.....	198
6.7.4	Recommendation Four.....	199
6.7.5	Recommendation Five	199

6.7.6	Recommendation Six	199
6.7.7	Recommendation Seven.....	199
6.7.8	Recommendation Eight.....	200
6.8	The unique contribution made to the research are.....	200
6.9	Conclusion	202
BIBLIOGRAPHY.....		203

CHAPTER ONE

OVERVIEW OF THE PROJECT

1.1 INTRODUCTION

1.1.1 The context of Public Health and Disability

Health is a vital asset and a fundamental right. The World Health organisation (WHO) have asserted the view that all people, including those with disabilities should be able to enjoy equal access to promotive, preventive, curative, long-term care and rehabilitative care (WHO,1978). This aspiration for equal access to care has presented particular challenges for many developing countries including South Africa. The South African experience of the burden of disease on those with disabilities is proving to be a particular test for prompting the health system to evolve beyond curative models of care but instead to focus more on preventive and promotive and rehabilitative care models. (Department of Health, NCD National Guidelines, 2006:8).

The disability sector in many developing countries including South Africa faces many challenges despite all the enabling legislative and policy environments. As early as 1992, the World Programme for Action on the care of Disabled People estimated that the percentage of people with disabilities who had secondary illnesses ranged from 20% to 50% of the total population of those with disabilities (World Programme of Action concerning Disabled People 1992:16). These rates of the prevalence of ill-health among those with disabilities set the background upon which several major risk factors exist with respect to the country's wellness and disease burden, particularly for people with disabilities and their families.

It is notable too, that those with disabilities have higher than average rates of poverty levels, greater difficulties in accessing quality health and social services and report increased exclusion from mainstream social activities (WHO, 2009a). These inequities exist despite of the World Health Organisation's well documented commitment to the promotion of all-inclusive health care delivery systems across the world. As with many developing countries, the South African public health sector faces unique challenges in

trying to ensure the delivery of the highest standards of care to those with disabilities (DOH 2011: 5).

Some studies including Vandenakker & Glass (2001) have confirmed that many individuals with disabilities including those with severe disabilities are living normal or near-normal life spans and as such, the provision of care for this group should be centred on the aspiration for the highest levels health and wellness possible. As is true across all health care spheres, Health Promotion is regarded as a strategic thrust and represents one of the most cost effective interventions that facilitate the continued improvement in the efficacy of health systems across the world and indeed within South Africa.

Recent prevalence studies by the World Health Organisation confirm that over a billion people, that is, about 15% of the world's population, have some form of disability (WHO, 2011:110). Within this, between 110 million and 190 million people have significant difficulties in functioning. Both these figures underscore the growing worldwide acknowledgement that the number of people with disabilities has grown rapidly. Factors contributing to growth of the population of people with disabilities include advances in health care and technology, survival of children and adults with acute and chronic illnesses and traumatic injuries including those associated with military, religious and ethnic conflicts around the world, and aging of the population (WHO, 2009a).

The current life expectancy of the South Africans is affected by four specific health imperatives including: (i) communicable diseases such as HIV, TB, malaria, respiratory infections and diarrhoeal diseases; (ii) high maternal and child mortality; (iii) increasing levels of non-communicable diseases such as hypertension, diabetes, cancer and cardio vascular diseases and as well as (iv), trauma related injuries. This is referred to as the quadruple burden of disease. In 2007, the South African population represented 0.7% of the world's population, but accounted for 17% (about 5.5 million people) of the global burden of HIV infections (The Lancet, August 2009). This disproportionate representation in the global burden of ill health raises the urgency with which South Africa must attend to the health challenges that face the country.

Bunker (2001:90) asserted that elimination of inequalities in health could increase the life expectancy of the most disadvantaged by up to 9 years, and if it were possible to then remove all 'unhealthy personal habits. Other views speak more specifically about the fact that health promotion and disease prevention activities targeting people with disabilities are crucial to both increasing years of healthy life for the whole population and to reducing health disparities.

Inequality in the health system is exacerbated by the fact that access to health care is unequal with the majority of the population relying on a public health care system that has a disproportionately lower amount of financial and human resources at its disposal relative to the private sector (DOH 2011:5). The Department of Health further recognises that while access in terms of reach has been achieved, more still needs to be done in terms of improving quality of care, human resources management, infrastructure and making services more available to all South Africans to ensure better health outcomes.

The health promotion approach advocates for a concerted effort and partnership building to tackle the burden of disease associated with disability. Focused interventions should be on the development of supportive environments, healthy public policies, access to health and social services, reorientation of health workers to promote the participation of people with disabilities and the community in shaping their own health. This view is supported by WHO (2009a) which argues that the primary goal of health promotion must be focused on equity in health and the reduction of differences in health status to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills, and opportunities for making healthy choices. Control of factors that determine one's health is needed for individuals to achieve their fullest health potential.

Even with these universal aspirations of equity, the World Health Organisation acknowledges, within the World Report on Disability (WHO 2011:xxi), that many people with disabilities do not have equal access to health care, education, and employment opportunities. They also receive inadequate disability-specific services that they require, and they often experience exclusion from everyday life activities.

These observed inequities have been documented by others including Watermeyer, Swartz, Lorenzo, Schneider and Priestly (2006) and the consensus across reports is that, people with disabilities have greater unmet needs and have greater health care needs than their counterparts without disabilities. For example, a recent survey of people with serious mental disorders, showed that between 35% and 50% of people in developed countries, and between 76% and 85% in developing countries, received no treatment in the year prior to the study (WHO, 2011). Health promotion and prevention activities seldom target people with disabilities. For example women with disabilities receive less screening for breast and cervical cancer than women without disabilities. People with intellectual impairments and diabetes are less likely to have their weight checked. Adolescents and adults with disabilities are more likely to be excluded from sex education programmes (WHO Fact sheet N°352 June 2011).

Since 1997, the South African government has demonstrated a commitment to ensuring that disability issues remain high in the country's developmental agenda. This commitment translated into institutional mechanisms that give higher priority to disability issues at the highest levels of government nationally, provincially and locally. For an example, the Office on the Status of Disabled Persons was established in 1997 to coordinate the integrated national disability strategy amongst others (Office of the Deputy President 1997:61). Current developments have seen this disability unit re-situated within the "Department for Women, Children and People with Disabilities" as an integrated government response to cater for vulnerable populations through the development of this high-intensity care-hub.

National frameworks such as the Bill of Rights in the Constitution of RSA and the advocate the principles of equality and dignity of people with disabilities. Other key provisions include the Integrated National Disability Strategy (1997) that address exclusion, discrimination and to advocate for the equalisation of opportunities for people with disabilities with the continuous support of the relevant International and Regional Conventions and Protocols that South Africa is signatory to. Despite all these measures, the WHO/27 (17 April 2002), acknowledges that continued limited participation of people with disabilities in health promotion programmes continues to present a serious challenge and accounts for the increasing and widening gaps within the health sector.

Driven by these observations, the current study offers an in-depth exploration of the gaps in scientific knowledge on inclusive health promotion for people with disabilities in the Republic of South Africa. More specifically, the study aims to explore and clarify the experiences that those with disabilities and their care providers have with regard to their engagement and participation in protective workshops. This aim will be achieved through a number of deliberate objectives that include :- describing participants' awareness of their disability and resulting needs (ii) describe the level of access participants have to inclusive health promotion services, (iii) describe the attitudes of service users and providers with reference to inclusive health promotion. (iv) assess existing structures for supporting inclusive health promotion and (v) develop an intervention model to address identified service shortcomings.

The study specifically looks at the gaps of knowledge within the context of protective workshops i.e. the respondents (both the professional care providers and the individuals with disabilities) will be asked to reflect on their knowledge, views and experiences as participants and recipients of care at a selection of protective workshops that have been facilitated across South Africa. Pursuant to this investigation, the study will utilise emergent findings to develop an intervention model to ensure that these gaps in the focus of health promotion programmes are addressed to benefit people with disabilities. In the long term, the study aims to provide initial impetus for an increase in access to preventive and health promotion services for those with disabilities.

1.2 CONCEPTUALIZATION OF THE THESIS

1.2.1 Key Concepts Clarified

Before engaging in in-depth meaningful dialogue regarding issues related to the inclusion of those disabilities within health promotion, there are key terms and words, whose use within the thesis will need to be specifically clarified. Ellis-Stoll and Popkess-Vawter (1998) draw attention to the likely difficulties that exist within academic discourse, as a result of poorly defined use of terms. The interchangeable use of terms within any paradigm often occurs with little explanation of the connotations and epistemological perspectives embedded within each term. This inconsistent use of language, as argued by Henderson (2003), poses notable difficulties in developing sound understanding of concepts being discussed. With this in mind, it is important to

re-conceptualise key related terms in an attempt to facilitate a meaningful and clearly directed dialogue. The key terms and concepts that are central to the current thesis are: Health Promotion; Disability; Protective Workshops and Inclusive health promotion.

1.2.1.1 Health Promotion

Health promotion is defined as the process of enabling people to increase control over their health and its determinants, and thereby improve their health (WHO, 2009a). A goal of health promotion is equity in health and reduction of differences in health status to enable all people to achieve their fullest health potential. Inherent in this definition is the concept of “empowerment” in which the focus of health promotion must be expressed as a commitment to giving power to the client population so they have greater control over issues related to the achievement of optimal health. This includes a secure foundation in a supportive environment, access to information, life skills, and opportunities for making healthy choices. Control of factors that determine one's health is needed for individuals to achieve their fullest health potential (WHO, 2009a).

For the purpose of this study Health Promotion encompass health related beliefs, attitudes and behaviour of health practitioners towards people with disabilities. Inclusive health promotion is about more than just health institutions, it has to do with transformation of the health care delivery system for eliminating barriers, established respect for human dignity, adopting a social development model and human rights approach. This is in agreement with international norms and conventions (WHO; United Nations; Gibson 2004; Sarkin 1998).

1.2.1.2 Inclusive Health Promotion Model

As discussed earlier, inclusive health promotion for the sake of this research include support for due process and health institutions and processes that make access and affordability universal, the health and basic respect for the dignity of people with disabilities. Institutions connected to human rights enforcement have not addressed health promotion.

The concerns is to determine the extent to which the health promotion endeavours widened and deepened public health for all, in particular people with disabilities – human rights protections: distinct but interrelated phenomena.

The primary argument of this study is to establish whether health promotion interventions are implemented within the Protective Workshops in South Africa. Based on the established facts, this study proposes a health promotion model for the inclusion of people with disabilities.

The basis of such an inclusive model would be guided by several factors, which are enabling for people with disabilities to achieve equality in life opportunities, including access to health care within the job market (protective workshops). It is important to note that the core service package of Protective Workshops DSD (2004:12) is in line with the Department of Health's Primary Health Care Service Package provision and their norms and standards DOH (2001:57-60). The core service package categories of Protective Workshops include the following:

- Promotion and prevention services
- Rehabilitative services
- Protection services
- Continuing services
- Mental Health

1.2.1.3 Disability

Supporting many other views of authors in both published and unpublished literature, this study is premised on the orientation that disability is extremely diverse. While some health conditions associated with disability result in poor health and extensive health care needs, others do not. However all people with disabilities have the same general health care needs as everyone else, and therefore need access to mainstream health care services. Article 25 of the UN Convention on the Rights of Persons with Disabilities (CRPD) reinforces the right of persons with disabilities to attain the highest standard of health care, without discrimination.

A disability may be physical, cognitive, mental, sensory, emotional, developmental or some combination of these. 'Disabilities' is an umbrella term, covering impairments, activity limitations, and participation restrictions and represents a complex phenomenon, reflecting an interaction between features of a person's body and features of the society in which he or she lives. The WHO (2009) point out that an individual may also qualify as disabled if they have had an impairment in the past or is seen as disabled based on societal norms. The discourse on the definition of "disability" has evolved over time to acknowledge that disability is more than just a physiological or medical diagnosis but rather is interplay between those medical factors and social norms and the effect of stigmatization in some cases such as with mental illness. The current study has adopted the most inclusive definitions of disability and within that, accepts that it may include physical, cognitive, mental, sensory, emotional, developmental or some combination of all these impairments.

1.2.1.4 Protective Workshops

This study is based on a service delivery model of the South African Department of Social Development, named protective workshops also referred to as supported environments. These facilities that are managed by Non Governmental Organisations (registered under the NPO Act and section 5 of the Social Assistance Act no 59 of 1992) and government. These facilities are funded and managed by the Department of Social Development (DSD). Protective workshops are regarded as access points that would benefit people with disabilities from preferential procurement, skills training and opportunities provided by various departments. The active participation of other departments therefore becomes imperative for the implementation of the Policy on the Management of Protective Workshops.

Protective Workshops are premised on the Policy Guidelines on the Management of Protective Workshops (DSD, 2004:12), which provide a framework to create enabling supportive environments within protective workshops for the promotion of an inclusive, accessible and integrated service delivery model for people with disabilities. The emphasis is on transforming disability as a developmental issue to ensure a more holistic and integrated approach to disability concerns into the mainstream of government responsibilities and service delivery.

1.2.2 Background to Health Promotion and Disability

Prior to 1991 no health promotion strategies had ever focused on matters related to disabilities (Makhubela-Nkondo 1993). Clinical programmes were funded to extend services to other groups, but not specifically to people with disabilities. The philosophical commitment to “Health for All by 2000” was also intended to include poor communities; however people made vulnerable by their disabilities were not given the expected level of attention and governmental focus. This exclusion is particularly alarming given the fact that those with disabilities, exhibit vulnerabilities both in terms of health related variables and also in terms material wealth. The latter relationship is elaborated on by Watermeyer et al (2006) in their relational model in which they offer an illustrative overview of the interaction between disability and poverty as cause and effect in increasing health vulnerability for people with disabilities.

Figure 1.1: Show the interaction of Poverty and Disability

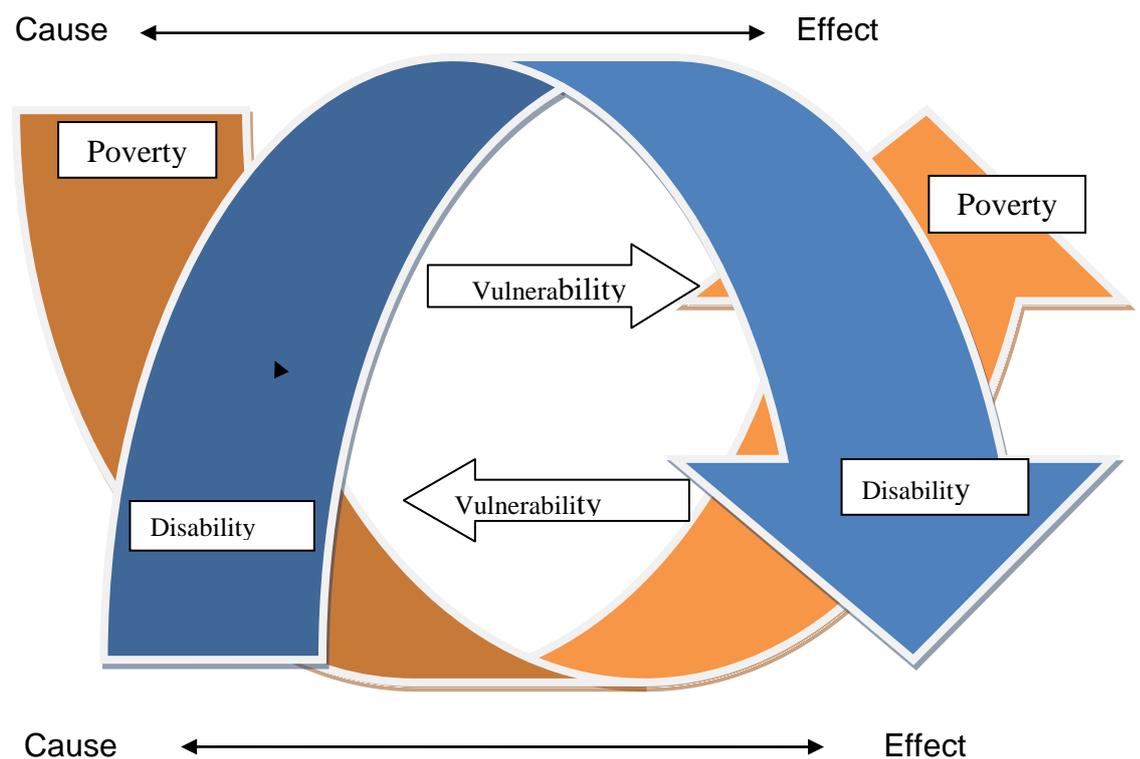


Figure 1.1 above offers an illustrative summation of Watermeyer et al (2006:208)'s model in which they suggest that disability increases vulnerability to poverty, while poverty creates the condition for increased risk of disability. This is especially noteworthy as poverty has been identified as one of the most persistent determinants of

poor health outcomes for populations (Makhubela-Nkondo, 1993). For example through poor nutrition, lack of access to health care, greater exposure to violence and unintentional injuries, lack of knowledge of prevention, etc. Ironically, being disabled is related with being exposed to high costs for the treatment of complications and that increases the risk of resulting financial difficulties for affected individuals. This understanding of cumulative disadvantage experienced by those with disabilities has helped the researcher to contextualize the study focus on inclusive health promotion in particular for people with disabilities especially in the context of how they utilise the support offered to them in protective workshops.

1.2.3 A Political – Historical Perspective on Disability and Health

In 1991, while under the auspices of Lawyers for Human Rights the Disabled People of South Africa launched a Charter that highlighted certain demands to help guide the inclusion of the historically marginalised; in particular the integration of people with disabilities (Watermeyer et al 2006: 57).

The conference with a Task Team of six people drafted the Charter on the issues addressed by the Drafting Committee. The charter was intended to accomplish the following goals; among many others:

- Create the knowledge base on inclusive health promotion as a public health strategy;
- Foster or increase understanding regarding basic human rights for people with disabilities;
- Enable people with disabilities to share experiences related to historical inequities and subjugation as a result of an existing disability;
- Facilitate discussions;
- Plan for the future,
- Create a forum where people with a diverse range of disabilities could meet;
- Deal with their historical injustices.

Health promotion is facing important challenges and in response, a number of governmental initiatives have been instigated over the last two decades. For example,

The Promotion of Equality and Prevention of Discrimination Act of 2000, the Employment Equity Act of 1998 and the Patients' Rights Charter, among other policies and legislative frameworks substantial transformation have served a pivotal role in focussing attention on the needs of those with disabilities. The United Nations Human Rights Commission has also raised concerns about the plight of people with disabilities, and has considered much of their marginalisation as a matter that relates to the principle of human rights. In this respect for example, the United Nations has been able to consolidate the principle that Human Rights are a matter of international concern and that international community is entitled to discuss and to protect human rights through the 1948 Universal Declaration of human rights and within this, the plight of those with disabilities remains central. In the African context, the OAU Charter served the first regional instrument that dealt with the protection of human rights in the continent and in that regard, instigated a need for a focus on those with disabilities (Ouguerouz, 2003).

The OTTAWA Charter (WHO: 1986) is regarded as the foundation for health promotion that recognises that "health" is created and lived by people within settings of their everyday life; where they learn, work and play. Importantly, the Charter identified the importance of Primary Health Care as the future of health care and that within this, Health Promotion and other preventive health strategies should form the basis of the direction that health care for all should take (WHO, 1986). Subsequent to the Ottawa Charter for Health Promotion several other charters were developed to shape health promotion in linking the economic, social and physical environment pathways.

A key milestone development of these conferences was a focus on "settings" approach in health promotion; the importance of placing health promotion at the centre of health development; building effective infrastructure by developing necessary skills; and addressing the social determinants of health. In this context, disability is regarded as an important setting for health promotion intervention.

In keeping with the Ottawa Charter emphasis, the South African health care system regards Primary Health Care Approach as the backbone and a key milestone in overhauling the health service delivery, which proposes a shift from curative services to put emphasis on individual and family centered preventive, promotive, and rehabilitative and referral services (DOH 2011:4; 89).

Considering disability within the context of Primary Health Care (PHC), the Alma Ata Declaration's approach to primary health care includes promotive, preventive, curative and rehabilitative care. It is believed that such an approach will increase access to comprehensive, extensive health care and psychological/psychiatric services. In this context, appropriate, accessible and affordable health services at primary, secondary and tertiary levels are essential to the equalization of opportunities for people with disabilities (Office of the Deputy President 1997:25). Primary health care is at the heart of the plans to transform the healthcare system in South Africa (DOH 2001:5). The primary health care programme provides accessible and affordable health care, which is in line with the global aim for all-inclusive comprehensive health care. However, actions to make health care delivery all-inclusive at all levels remain sparse with poor resources in the acquisition of medical equipment, facilities, training, and capital to support comprehensive health care programmes (DOH 2001).

Effective public health, health promotion, and chronic disease management programs help people maintain and improve health, reduce disease risks, and manage chronic illness. They can improve the well-being and self-sufficiency of individuals, families, organizations, and communities. Usually, such successes require behavior change at many levels, (e.g., individual, organizational, and community).

1.2.4 The Scope of the Study

To determine the scope of this study, the Author consulted two sources of information as provided that were obtained from the Department of Social Development (DSD) and they are:

- A national database of protective workshops which consisted of 235 facilities and;
- A resource dictionary on disability "*Building a caring society together*" was also used to distinguish between and locate protective workshops from other facilities that cater for people with disabilities such as Day Care Centres, Homes for the Disabled Persons, Schools for the Disabled; Self Help Groups and Social Work Services.

The methodology used to select a study sample from the 235 facilities will be discussed in chapter 4.

Table 1.1 below shows the distribution of the Protective Workshops as per the national database by province and within each province; they are distributed by the type of disability they cater for.

Table 1.1: Protective Workshops by provinces and type of disability (National Data base, 2001: National Department of Social Development)

Province	Facilities	PD	VD	HD	MD	ID	MUD	E	TB	N/S
Eastern Cape	14	4	0	0	1	2	7	0	0	0
Free State	15	4	0	0	3	0	8	0	0	0
Gauteng	59	16	1	1	16	0	4	2	1	18
Kwazulu-Natal	33	3	2	0	6	0	22	0	0	0
Limpopo	13	0	0	0	0	0	0	0	0	13
Mpumalanga	46	0	0	0	0	0	0	0	0	46
North West	9	0	1	0	1	1	4	0	0	2
Northern Cape	5	2	1	0	0	1	1	0	0	0
Western Cape	41	24	0	0	0	17	0	0	0	0
Total	235	53	5	1	27	21	46	2	1	79

**PD = Physical disability, VD = Visual disability, HD = Hearing disability, MD = multiple disability, ID = Intellectual disability, MUD = multiple disability, E= Epilepsy

A schematic presentation of the South African Map highlighting where the sample of Protective Workshop was drawn is shown below in figure 1.2:

Figure 1.2: The Map of the Republic of South Africa (RSA)



(Source: http://www.sa.venues.com/map/atlas/southafrica_province.gif: Date accessed 17/06/09).

1.2.5 Is Disability a Clinical Significant Issue – An analysis of the discourse background.

Based on 2010 global population estimates, more than one billion people (about 15% of the world's population) live with some form of disability (WHO 2011: xi; 261). Of this nearly 200 million are said to experience considerable difficulties in functioning. The report warns that in the years ahead, disability will be an even greater concern because its prevalence is on the rise particularly because of the ever-increasing ageing populations and the higher risk of disability in older people. The impact of this adds to the global burden of non-communicable diseases in countries including an increase in chronic health conditions such as diabetes, cardiovascular disease, cancer and mental health disorders. According to the World Health Survey (WHS: 2002-2004) around 785 million (15.6%) persons 15 years and older live with a disability, while the Global Burden of Disease (2004 update) estimates a figure of around 975 million (19.4%) persons. Of these, the World Health Survey estimates that 110 million people (2.2%) have very

significant difficulties in functioning. The Global Burden of Disease estimates that 190 million (3.8%) have “severe disability”, the equivalent of disability inferred for conditions such as quadriplegia, severe depression or blindness. Only the Global Burden of Disease measures childhood disability (0–14 years) which is estimated to be 95 million (5.1%) children of which 13 million (0.7%) have “severe disability” (WHO 2011:261-2).

These figures show considerable increase compared to the 2006 World Health Report estimates. The 2006 report estimated that about 600 million people lived with disabilities of various types. Similar predictions that the number was increasing due to the rise of chronic diseases, injuries, motor vehicle accidents, falls, violence and other causes such as ageing. The report further stated that of the 600 million people with disabilities, a total 80% lived in low socio-economic countries; most are poor and have limited or no access to basic services, including rehabilitation facilities (<http://www.int/nmh/a5817/en/index.html>) data accessed 11 February 2012.

A number of published and unpublished literary sources consulted, present evidence of an increasing prevalence of disability and the associated health implications on the burden of diseases. Growing evidence also shows a negative differential impact for people with disabilities than those without disabilities. According to (WHO: 2011: X11), across the world, people with disabilities have poorer health outcomes, lower education achievements, less economic participation and higher rates of poverty than people without disabilities. This is partly because people with disabilities experience barriers in accessing services that many have long taken for granted, including health, education, employment, and transportation as well as information.

In South Africa, the 1995 October Household Survey that was conducted by the Central Statistical Services (CSS) revealed an estimation of a five-percent disability prevalence (United Nations Development Programme 1990:3). In 1992, the World Programme of Action concerning Disabled People estimated that the percentage of people with disabilities to be increasing as high as 20% and with families and relatives with a figure rising 50% of the total population (World Programme of Action concerning Disabled People 1992:16).

It was noted that although the definitions of disability differed and are not always explicit, the prevalence of disability reported in the 1996 South Africa Census data was

found to be typical of other similar countries which had an average prevalence of 6.6% of the generic population. However, despite the magnitude of the issue, both awareness of and scientific information on disability issues are lacking. There is no agreement on definitions and little internationally comparable information on the incidence, distribution and trends of disability (WHO 2011: XX1).

Regional estimates identify disability as a major public health concern in Africa with about 35 million disabled people constituting around 7% of the total African population. About 75%-80% of disabled people in African Region are in rural areas, where services for prevention and rehabilitation are either limited or unavailable (<http://www.afro.who.int/dpr/cbr.html>). Data accessed 11 February 2012)

According to (WHO 2011:275), the estimates of disability prevalence indicated by percentages (%) and of years of health lost due to disability (YLD) indicated that South Africa's disability prevalence (from WHS, 2006–2008) was at 24.2, that is the prevalence rate of 5.9% (12.2 measured as YLD per 100 persons in 2008).

Similar evidence was found in the country's national report (DOH: 2009) that confirmed the global prevalence rate for South Africa as shown in the table 2 below.

Table 1.2: Disability prevalence per province (1999)

Province	% of Population with Disabilities
Eastern Cape	8.9
Free State	5.8
Gauteng	5.2
Kwazulu-Natal	6.7
Limpopo	6.3
Mpumalanga	4.5
North West	3.1
Northern Cape	4.5
Western Cape	3.8
National	5.9

Source: (DOH, 1999)

(NB- No current data has since been provided by the Department of Health on disability and as such these statistics represent the most recent that are nationally available in South Africa).

WHO (2011: 22) affirms that gathered data need to be relevant at the national level and comparable at the global level, both of which can be achieved by basing their design on international standards, like the International Classification of Functioning, Disability and Health (ICF). Relating the above discussions to the current study, the background information and population profiles per type of disability within the Protective Workshops painted a picture of diverse skills provided by people with disabilities on a day-to-day basis (DSD, 2001).

Table 1.3: Protective Workshops by provinces and type of disability

Province	Facilities	PD	VD	HD	MD	ID	MUD	E	TB	N/S
Eastern Cape	14	4	0	0	1	2	7	0	0	0
Free State	15	4	0	0	3	0	8	0	0	0
Gauteng	59	16	1	1	16	0	4	2	1	18
Kwazulu-Natal	33	3	2	0	6	0	22	0	0	0
Limpopo	13	0	0	0	0	0	0	0	0	13
Mpumalanga	46	0	0	0	0	0	0	0	0	46
North West	9	0	1	0	1	1	4	0	0	2
Northern Cape	5	2	1	0	0	1	1	0	0	0
Western Cape	41	24	0	0	0	17	0	0	0	0
Total	235	53	5	1	27	21	46	2	1	79

(Source: SA National Data base. DSD, 2001)

**PD = Physical disability, VD = Visual disability, HD = Hearing disability, MD = multiple disability, ID = Intellectual disability, MUD = multiple disability, E= Epilepsy

Protective workshops fall under the category of supported employment providing a shift from sheltered employment to supported employments for people with disabilities. The concept of supported employment has a potential to integrate people with disabilities into the competitive labour market. Supported employment provides employment coaching, specialized job training, individually tailored supervision, transportation, and assistive technology, all to enable people with disabilities to learn and perform better in their jobs (United States Department of Labor, Office of Disability Employment Policy,

1993). Put differently to imply a transition from “train and place” to “place and train”. The idea is to employ people first, before they are trained, to help dispel beliefs that disabled people cannot perform a particular job (WHO 2011:243).

However, this transition has shown evidence of some inherent structural and operational challenges within Protective Workshops in South Africa such as the following issues:

- Inadequate resource allocation
- Overstretched and overburdened service providers,
- Overcrowding in protective workshop facilities,
- Dependency on social grants, and
- Lack of coordination and intersectoral collaboration in addressing issues of disabilities.
- The focus of protective workshops was limited to creating employment opportunities, care and social services excluded services of other departments, such as health services (DSD 2004:12).

According to Dube (2005), while support for the formulation and adoption of policy has been excellent, policy implementation remains a challenge. Of particular note is the fact that there are capacity constraints at programmatic level that limit the effective implementation of policy. Policy implementation issues are not addressed consistently, for various reasons, at different levels of government. These reasons include limited conceptual understanding, poor championing, inadequate or inappropriate institutional arrangements, and a general lack of capacity.

Globally, evidence showed that in many countries data on the employment of people with disabilities was not systematically available. Responses to an International Labour Organization (ILO) survey in 2003 showed that 16 of the 111 countries and territories responding had no data at all on employment in relation to disability (International Labour Organization, 2007). In low-income and middle-income countries, the availability of data continues to be limited, despite recent improvements (Montes & Massiah, 2002). And in many of these countries, a significant proportion of people works in the informal economy, and so do not appear in all labour market statistics. Nor are they covered by

employment legislation. Confirming the above statements, a World Bank Issue Brief on Disability (2005) cautioned that, “Prevented from working in decent paying jobs and estranged from the political process, disabled people tend to be the poorest of the poor within a global population of 1.3 billion people existing on less than one dollar a day.” (World Bank, 2005).

As discussed, for the purpose of this study, health promotion is indeed; health related beliefs, attitudes and behaviour of health practitioners towards people with disabilities, Inclusive health promotion is about more than just health institutions, it has to do with transformation of the health care delivery system for eliminating barriers, established respect for human dignity, adopting an integrative social development model and human rights approach. That is in keeping with international norms and conventions (WHO; United Nations; Gibson 2004; Sarkin 1998).

The Department of Social Development’s White Paper on Integrated National Disability Strategy (1997:1) recognizes a serious lack of reliable information on the nature and prevalence of disability in South Africa. Lack of reliable information is supported by the fact that in the past, disability was viewed primarily within health and welfare contexts with a consequent failure in integrating disability into government statistical processes.

The above evidence reflects a historical context of disability, which spans a century. Schneider (2006:6) attests that:

“Until the latter part of the 1900’s disability was understood to be entirely a problem of the individual, with the focus of the intervention thus being solely on specific individuals. This view is associated with the medical model of disability, or an individualistic perspective”

This excerpt by Schneider (2006) is supported by the Disabled People South of Africa’s Pocket Guide on Disability.

Schneider et al., (2003) argue that, disability can no longer be seen as a static feature of an individual but rather as a dynamic and changing nature of the environment. This change from focusing on individual to focusing on the environment has important implications for measuring and researching disability. In the context of this study

Protective Workshops serve as ideal supportive workplace environments for people with disabilities. This perspective is important to understand the complexity of the health care needs of people with disabilities.

WHO (2011:32) further points out that relationship between health conditions and disabilities are complicated. Whether a health condition, interacting with contextual factors, will result in disability is determined by interrelated factors. Often the interaction of several conditions rather than a single one contributes to the relationship between health conditions and disability. Co-morbidity, associated with more severe disability than single conditions, has implications for disability. Also the presence of multiple health problems can make the management of health care and rehabilitation services more difficult.

Supporting this perception, over recent decades, the disabled people's movement together with numerous researchers from the social and health sciences have identified the role of social and physical barriers in disability. The transition from an individual, medical perspective to a structural, social perspective has been described as the shift from a "medical model" to a "social model" in which people are viewed as being disabled by society rather than by their bodies (WHO 2011:3).

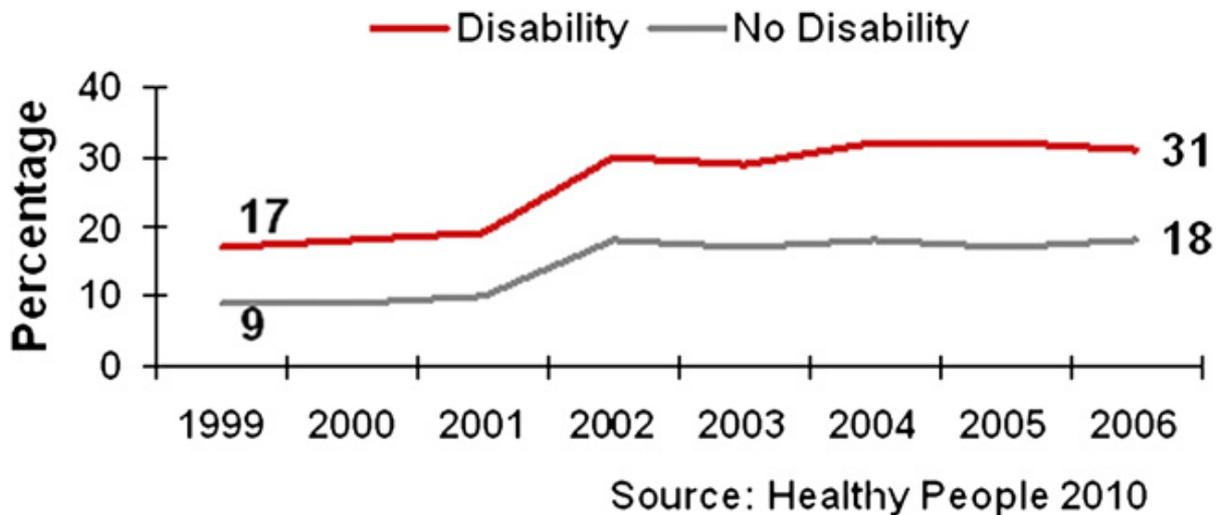
It is well documented that people with disabilities have less access to health care services and therefore continue to experience unmet health care needs (Queensland Government (2010); WHO (2011)). A publication of the Queensland Government (2010) revealed that people with disabilities have poorer health outcomes. People with disabilities and their caregivers reported that they do not have equitable access to health services across the continuum (preventative health care, primary health care, acute health care, rehabilitation or specialist health care) to meet their needs. Reasons for inequitable access included:

- The severity and range of their health needs
- A tendency to view health needs of people with disabilities as a part of their disability or as a result of premature ageing (e.g. people with Down syndrome suffering early onset dementia or cardiac disease)
- Lack of coordinated case management to address:

- their need to access multiple health services in a coordinated manner then they are in a very vulnerable and emotional state;
- the difficulty navigating such a complex health system and the interface with other social services.

Additionally, the gap has widened between people with and without disabilities as shown in Figure 1.3 below:

Figure 1.3: Delays in obtaining needed health care (target rate: 7%).



However, at the National Consultative Workshop on Protective Employment for people with Disabilities that was held from the 7-8 February 2008 in Gauteng Province, the provincial coordinators shared current developmental challenges and implementation experiences including emerging issues in protective workshops. A summary of key challenges included the following:

- The number of people with multiple disabilities is increasing with limited specialised workshops to meet their needs
- Rural/Urban disparity gap identified in terms of resource mobilisation and distribution, sustainability efforts, capacity and access to opportunities
- Poor remuneration of staff at protective workshops and poor management skills
- Management do not involve people with disabilities in decision making processes
- The operational focus within protective workshops is limited to employment, care, social and skills development

- Inadequate funding
- Access to government resources and services is always a challenge
- Good practice efforts not adequately documented and published.

The above stated challenges highlight a gap in legislation, policy and translation of that into actions. For an example, access to services and funding remains a major challenge when the policy and the Integrated National Disability Strategy 1997 advocated for an integrated response to service delivery.

According to the White Paper on Integrated National Disability Strategy (1997:01), several factors have been identified, which impact negatively on the prevalence of disability in South Africa due to unreliable statistics.

These include the following:

- There are different definitions of disability;
- The use of different data collection technologies on disability;
- Negative traditional attitudes towards people with disabilities;
- Poor service infrastructure for people with disabilities in underdeveloped areas, and
- Violence levels (in particular areas in particular places) impede the collection of data and affect the overall picture of disability.

However, some global and national statistical estimates on the prevalence of disability exist; some of these provide a useful picture for South Africa too. Reliable sources include the United Nations Development Programme (UNDP) estimates in 1990, that 5,2% of the world population was experiencing moderate to severe disability with a variation of 7,7% in developed countries to 4,5% in underdeveloped countries.

These observations further point out that people with disabilities are among the most disadvantaged people in the world and are over-represented among the poorest of the poor. That is why the relationship between disability and poverty has often been referred to as a vicious circle.

Yeo (2005) argued that this representation may obscure the similarities between the processes of marginalisation experienced by disabled people and poor people. There appears to be a widespread assumption in the disability sector that inclusion is necessarily good, with little assessment of the wider context. This leads to the bizarre situation where many community organisations are campaigning against, for example, the World Bank's poverty reduction strategies, claiming that the Bank's approach perpetuates poverty, while the disability sector fights for inclusion within the Bank's strategies. If the existing system is the cause of the problem, then inclusion within it cannot be the answer.

Wider assessment of the context is urgently required and alliances need to be built between marginalised people, if there is to be any real chance of creating a more humane and just society.

All these attributes also related to disability. When people with disabilities living in poverty are asked what their most pressing needs are, the answers are rarely impairment specific. In a survey of 108 people with disabilities affected by the Tsunami in Sri Lanka, only five asked for impairment-related aids. The others all mentioned issues related to housing, land, livelihoods, education or sanitation (Kett, Stubbs and Yeo 2005). Both disability and poverty are symptoms of the way that society is organised; marginalising and isolating certain groups of people.

The relationship between disability and poverty is often described as a vicious circle. It is argued that in fact, both disability and poverty are often manifestations of the same processes. If the commonalities are recognised then the need to build horizontal alliances becomes more apparent (Yeo, 2005). This indicates a knowledge gap in the subject area.

1.2.6 Primary argument of the thesis:

Who benefits from health promotion? The long-held pledge of "Health for All by the Year 2000" made this question seem obvious. The adoption of a Comprehensive Primary Health Care and community-based rehabilitation programme is embedded in this pledge. The delegates at the World Health Organisation of 1978 made the declaration without specifying the particular relevance to the health needs of those with disabilities.

Even so, people with disabilities have rightfully acknowledged this pledge in their call for “dignity and equal access to opportunities for their personal development”.

People with disabilities must necessarily be treated like any other person, gain access to mainstream health and social services and receive adequate support when needed. This is the general consensus shared by most of the scientific community. Technological advances and new scientific discoveries including the epidemiological profile on disability have increased the probability of survival of people with disabilities. This consensus has empowered the health and social scientists to argue against the opinions of those who believed instead that the health care needs of people with disabilities should only be oriented towards the “medical model” and compassionate care and support.

Current progress in health care technology and research brought great knowledge and improvement in the life of consumers (Callahan, 1990; Spiro et al., 1993). However, despite all these health care advances, relevant sources such as the World Report on Disability (2009; 2011) reveals that many people with disabilities do not have equal access to health care, education, and employment opportunities, do not receive the disability-related services that they require, and experience exclusion from everyday life activities. This situation is attributed to the existence of systemic barriers that prevent many people with disabilities from achieving optimal health and wellness. These barriers may be environmental, structural, and attitudinal in nature.

According to Dejong, Palsbo, Beatty, Jones, Knoll and Neri (2002:80), access to health care for people with disabilities is a particular public policy challenge. Although people with disabilities use health care services more frequently than other populations, formidable barriers continue to be commonplace. The risk profile shows financial and health plan coverage barriers are most significant. Furthermore, the physical, social, communication, and cultural barriers, however, are important and the evidence base less developed (Rixford 1997; Dejong 1989; 1997).

Although facilities that are used by individuals undergoing rehabilitative therapies are usually accessible, this is often not true of other clinical facilities, including some acute care hospitals, clinics, physicians' offices, and imaging centers. Across the globe,

people with disabilities tend to be disproportionately uneducated, untrained, underemployed, unemployed and poor (United Nations, 2009).

These factors individually and in combination serve as significant barriers to health and health promotion among people with disabilities. In addition, the historical context of disability spans a century. Schneider in Watermeyer et al (2006:6) attests that: "Until the latter part of the 1900's disability was understood to as entirely a problem of the individual, with the focus of the interventions thus being solely on specific individuals. This view is associated with the medical model of disability, or an individualistic perspective".

In the history of health promotion science, there has been a shift from an individual to a more ecological and strategic approach (MacDonald 2009). In the latter approach, health is viewed as a function of individuals and their environments, including families, social networks, organizations, and public policy context. This change in perspectives is generally pointed at as a change from health education interventions that focused on individuals and disease prevention, to health promotion interventions focusing on the individual as well as his/her environment. This is a shift to promotion of the broader scope of health and well being (World Population Foundation, July 2008).

1.3 PROBLEM STATEMENT

People with disabilities achieve minimal health benefits from the health care system, particularly in health promotion (WHO 2009; 2011). Evidently in the context of South Africa, the historical health inequity as well as exclusion has resulted in a disproportionately higher number of people with disability suffering more health problems. There are currently limited existing programmes to deal with the health promotion needs of people with disabilities and where they exist; services are often provided in an uncoordinated manner. There is a need to comply with policy and legislative imperatives regarding inclusion and integration in health promotion programmes.

To support this view, the World Report on Disability (WHO 2011) stated that the unmet needs of people with disabilities are still prevalent- fact evidenced by the observation that health promotion and prevention activities seldom target people with disabilities.

For example women with disabilities receive less screening for breast and cervical cancer than women without disabilities. People with intellectual impairments and diabetes are less likely to have their weight checked. Singer (2001) argues that, negative attitudes that lead to discrimination and exclusion at the community level mean that people with disabilities and particularly those with mental health problems can be marginalized economically, segregated and be prone to further mental health problems due to this exclusion and rejection.

In another study of the 2004 Canadian Attitudes Survey (Office of Disability Issues, Canada) there was broad agreement among people with and without disabilities that progress had been made towards including people with disabilities in Canadian society. However, respondents considered that people with disabilities still faced numerous barriers, first and foremost negative attitudes and prejudices of other people and society. Rosenthal et al (2006) cite studies including Brodwin et al (2002), Cook et al (1998), Livenh et al (1997) and Smart (2002) that demonstrate how negative social attitudes block the integration of people with disabilities into society. In addition to the above studies, Chen (2002) cites others that also demonstrate the constrictive effects of negative societal attitudes in preventing individuals with disabilities from "mainstreaming into society".

However, at the National Consultative Workshop on Protective Employment for people with Disabilities that was held from the 7-8 February 2008 in Gauteng Province, South Africa, the provincial coordinators and care givers shared current developmental challenges and implementation experiences including emerging service delivery issues within protective workshops. A summary of key challenges included the following:

- The number of people with multiple disabilities is increasing with limited specialised workshops to meet their needs
- Rural/Urban disparity gap identified in terms of resource mobilisation and distribution, sustainability efforts, capacity and access to opportunities
- Poor remuneration of staff at protective workshops and poor management skills
- Management do not involve people with disabilities in decision making processes
- The operational focus within protective workshops is limited to employment, care, social and skills development

- Inadequate funding
- Access to government resources and services is always a challenge
- Good practice efforts not adequately documented and published DSD (2008).

Another challenge identified was the focus of protective workshops on creating employment opportunities, care and social services excluded services of other departments, such as health services. Formal education contributed to fragmentation of services and defeats the aim of integrating people with disabilities into mainstreamed government activities.

The above stated challenges form a basis for understanding the environment under which the study is directed and assisted in determining the scope of the research project. These challenges highlight a gap in legislation, policy and translation of that into actions. For an example, access to services and funding continues to pose a major challenge despite the fact that the policy and the Integrated National Disability Strategy (1997) advocated for an integrated response to service delivery.

1.4 PURPOSE OF THE STUDY

First and foremost the human rights and social model allow all people; including people with disabilities to participate meaningfully in matters that affects them and educate the general public about disability and the need to prevent discrimination of people with disabilities. The purpose of this research project is to first establish whether inclusive health promotion occurs in South Africa and secondly, to investigate how health promotion programmes are implemented.

The terminal ambitions of the current study are to recommend a set of evidence based actions and activities for a national agenda to improve the health of people with disabilities. The emphasis is to contribute efforts on transforming disability as a developmental issue to ensure a more holistic and integrated approach to disability concerns into the mainstream of government responsibilities and health service delivery (DSD, 2004:12). The contribution of many authors including Patrick (2002) on this subject area attest to the need for effective and targeted activities for people with disabilities through the design and dissemination of culturally appropriate and accessible programs and policies, improved coordination of social and health care to

meet individual health promotion needs, and an improved evidence base on the effectiveness of personal and community prevention that is inclusive of people with disabilities.

Ultimately, this investigation should suggest concrete propositions for health promotion within institutions that serve people with disabilities using protective workshops as a model to contribute to the realization of inclusivity and harness healthy lifestyles. Furthermore, health promotion programme approaches will be honed to target people with disabilities and the citizenry as a whole for a sustainable, just and public health ethic as part of the county's development agenda.

1.6 RESEARCH QUESTIONS

The stated questions were formulated to determine the scope of the research process and guide the study purpose in understanding the factors of health promotion and disabilities. The application of questions and questionnaire construction considered two specific target groups, primarily people with disabilities and care providers/professionals working in protective workshops. The following key questions guided the study:

- What is the level of knowledge regarding health promotion among people with disabilities?
- What is the nature and extent of integration or inclusivity in health promotion endeavours for people with disabilities?
- Which of the governmental policies and programmes address disability issues?
- What is the scope of the integrated national strategy for people with disability in relation to public health programmes?
- What are the perceptions and attitudes of people with disability towards the current health promotion approach?
- What are the existing structures and mechanisms to support health promotion needs for people with disabilities?

1.7 SIGNIFICANCE OF THE STUDY

This is the first comprehensive study that focuses on disability and health promotion in the public health field within the South African context. Previous studies were conducted internationally and most of them focused mainly on specific disease prevention areas and or risk factors as entry points to introduce a health promotion model of disabilities. The study was initiated to contribute to building the body of knowledge and overcome a limitation of dearth of information in the area of disability and health studies.

This is also the first study in South Africa that attempts to apply Health Promotion practice to health related beliefs, attitudes and behaviour of health practitioners for people with disabilities in a setting such as the Protective Workshops. The application of inclusive health promotion in this study is about more than just health institutions, it has to do with transformation of the health care delivery system for eliminating barriers; established respect for human dignity; adopting a social development model and human rights approach. That is in consonant with the international norms and conventions (WHO; United Nations; Gibson 2004; Sarkin 1998).

The study constitutes a groundbreaking focus area and a combination of social science and health science methodologies. This includes exploring a social model of disability and the health promotion theories and principles to propose an inclusive model. A unique workplace setting of Protective Workshops for people with disabilities has been explored for the first time in South Africa.

Protective workshops are facilities that are managed by Non Governmental Organisations (registered under the NPO Act and section 5 of the Social Assistance Act no 59 of 1992) and government.

The use of participatory methodology in the current enquiry sets this study aside from others with the paradigm. Most specifically, the researcher involved people with disabilities both as participants and as field workers to collect data in some settings such as in Kwazulu- Natal Province, through focus group discussions and face-to-face interviews. That contributed important insights for inclusion of people with disabilities in designing and planning health promotion programs thus reinforcing the message of *“Nothing about us without us”*.

It is important to note that field workers with disabilities reported the prevalence of major barriers they experienced relating to attitudes of management and staff towards them and inaccessible buildings both physical and infra-structural. This offered initial insights about providing a barrier-free environment for people with disabilities as participants suggested a broad range of modifications and adjustments (reasonable accommodation) to facilitate access to health care services and the protective workshops facilities. Negative attitudes may be subtle but may result in a climate that is unwelcoming and discouraging to people with disabilities.

1.8 SUMMARY

Historical health inequities as well as exclusion have resulted in a disproportionately higher number of people with disability suffering more health problems. There is limited action and understanding of the barriers to inclusion in health promotion initiatives for this groups and this lack of knowledge has translated, in part to sparse programmes that deal with health promotion needs of people with disabilities and where they exist; services are often provided in an uncoordinated manner. The status quo is clearly unacceptable both in terms of the global commitment to equity in health and also from a human-social justice perspective. The current study explores the basis for this and recommends a number of actions to bring the health promotion needs of those with disabilities to the fore. The state of knowledge and dominant theoretical perspectives in relation to this study area are presented and discussed in the section on literature review.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter was a collation of literature from different sources related to the issue of disability and health promotion both globally as well as nationally. The literature search has shown that there was scarcity of specific literature on inclusive health promotion due to paucity of publications and historical dynamics in this specific field of study. Authors such as Mark Priestley contested that:

“Although there is a long history of academic research journals in the field of disability, until the emergence of the social model these titles were dominated by the clinical and therapeutic perspectives” (Watermeyer, et al 2006:27).

Priestley also highlighted that although more progressive approaches were evident in research on inclusive education, these only addresses one aspect of disabled individual's needs. To complement the stated limitation, adding depth in current knowledge, the researcher had to consider in the search, both published and unpublished work in the disability and health promotion domains dating back from the early 1980's to date.

In considering the orientation of the research topic and the stated research questions in the previous chapter, the researcher explored all topics related to the relationship between disability and health promotion. The literature search has been a continuous process from the initial conceptualisation of the study to a recent pre-submission review of the thesis. To ensure that this literature review explored the subject in a sound, inclusive and a reproducible manner, a systematic approach was undertaken to thoroughly search and explore all the sources of literature. The National Health Service (NHS) Centre for Reviews and Dissemination (1996:01) defines a literature review as:

“the process of systematically locating, isolating, appraising synthesising evidence from.....studies in order to obtain a reliable overview” (NHS Centre for Dissemination & Reviews, 1996: 01).

In other words, the purpose of a literature review is to demonstrate to the reader that one has a good grasp of the main published work concerning a particular topic or question in the identified field. According to Faulkenr & Thomas (2007) the review should not just be a description of what other people have published but a critical discussion that presents insight and an awareness of the different arguments, approaches and theories. Additionally, the same authors claim that the review and should link the researcher’s own purpose and rationale for carrying the review. Taking this into account, it could be argued that a literature review provides a new interpretation of old material or combines new with old interpretations. Furthermore, literature reviews allow the reviewer an opportunity to trace the intellectual progression of the field, including major debates about the interplay of disability literature and health promotion debates. An important outcome within any such process is the development of understandings that pave the way for new evidence upon which to base -practices in the ever changing climate of health care.

Parahoo (2006) suggests that before one starts a literature review, there are a number of key measures that need to be considered. Firstly, the formulation of a research question followed by establishing the search terms and taking into account where to search for the information. The research terms then need to be broken down into distinctive terms and concepts that can be searched separately. This is followed by the application of inclusion and exclusion criteria, selection of the items to review and then finally, but not least, an appraisal of the evidence with a view to offering recommendations.

2.2 DATA SEARCH STRATEGY

Initially the University library was used to search for books and journals that related to the topics of disability and inclusive health promotion. The use of libraries is seen as an excellent starting point as it allows the gathering of information and access to alternative sources (Guba & Lincoln, 2005)). Simultaneously, the use of electronic databases was also used to offer a wider range of literature. Henderson (2003) emphasises the

importance of the reviewer possessing the skills necessary to perform a comprehensive search of the available literature and to this end, private effort was given to gain familiarity with a range of health related databases.

Before engaging in the searches, a set of keywords was decided upon. In order to assemble the group of keywords that would be used in the search, a mind map was drawn so that core elements and arguments could be highlighted. Bell (2005) and Corner (2001) emphasise the use of a mind map to guide an initial understanding of the topic. The creation of a mind map to aid in the formulation of keywords and the focus question also helped to identify key search terms. Identifying keywords for the subject before initiating any literature search would ensure that correct results are obtained. In contrast, any omission of keywords may result in an incomplete and unfocused search (Burns and Grove, 2005).

Within the current enquiry the following search terms were used: -

- Disability and access to health.
- Inclusive health promotion and disability.
- Empowerment of those with disabilities in health and social care.
- Impairment /disability and health inequality.
- Exclusion of the disabled in health care.
- Marginalisation and disability.
- Primary health care and disability.

In this sorting process some literature was discarded while relevant sources that supported the study and provided answers to the research questions were retained and arranged accordingly. Each of the search terms were initially used individually, and then combined using Boolean operators AND, and OR. The use of Boolean operators allows a wider exploratory search of the literature (Bell 2005).

The resources that were available for the literature search were books, journals, which included both hardcopy and electronic databases. The initial hard-copy library search did not reveal many current sources, and therefore, primary focus was on searching various electronic databases as summarised below:-

- Unabridged Medline (Jan1976-Feb 2012)
- CINAHL- The Cumulative Index of Nursing & Allied Health Literature (Feb 1965-2012).
- OVID – an online database that searches across several medical and nursing online sources.
- Cochrane Database of Systematic Reviews (1996-2012).
- A hand-search of local South African Journals at the Local Health Authority library.

The University of South Africa's (UNISA's) vast array of library resources (including databases) were optimally utilised for local and international input through the ILL (inter-library loan) system. The latter enabled the researcher to obtain documentary and electronic information and data that are only available at other academic institutions and organisations to which the UNISA library is affiliated.

2.3 SOURCES OF LITERATURE AND SEARCH TOOLS

2.3.1 Justification

To gain an in-depth understanding of issues related to disability and health promotion, a practical and conceptual literature review was undertaken. The search observed that a considerable amount of published research and reviews in public health dealt with issues of disabilities, although most of these focused on specific disabling health conditions such as nutrition, physical activity, chronic diseases, mental health conditions, violence, HIV and AIDS and many more. Additionally, the researcher observed that most existing literature was limited to sources that focused on the international perspective with limited focus on the local South African context.

Both primary and secondary sources were consulted from a range of databases to facilitate a more systematic synthesis of the results into what is and is not known.

To facilitate an easy-to-follow review of relevant literature, relevant sources were grouped and arranged into themes so that the resulting review explored themes in the knowledge. The alternative approach would to group elicited literature chronologically or

through the progression of time. The latter approach has been criticised for oversimplifying the review process and by contrast the thematic grouping of literary sources is seen as a helpful way of gaining insights into the general debates that exist within a paradigm (Parahoo, 2006).

2.3.2 Inclusion and exclusion criteria

The initial search, using each of the primary search terms independently, identified over four hundred potential sources. However, the inclusion of other parameters, such as 'primary research' and 'English', led to an enormous reduction in the potential references of interest to 27. It is critical to highlight that not all of the 27 identified references were found to be relevant to the review question. This conclusion was reached when detailed inclusion and exclusion criteria, listed below, were applied to the literature or studies obtained for review.

- Inclusion criteria:
 - Studies that focused on disability and its impact on access to health issues.
 - Studies that focus on the impact of policies and politics on the development of health services for the disabled.
 - Studies that focused on inclusive health promotion and its interface with individuals with disabilities.
 - Studies published in English.
 - Given the difficulties that exist in authenticating data from the worldwide web (internet), only literature from validated academic databases such as Ebsco-Host and CINAHL were considered for inclusion within the review.
 - Furthermore, hard copy paper versions of studies retrieved from internet sources were manually sourced by the reviewer, as a means of validating their existence.
- Exclusion criteria:
 - Studies whose academic credibility could not be authenticated.
 - Studies written in languages other than English
 - Studies published before 1980.
- After applying each of the above criteria, only 27 literary sources (17 of which were original research) met the strict criteria for inclusion, and also satisfied the academic and scientific rigor expectations for inclusion in the review. The primary

research studies that fully satisfied the inclusion criteria are reviewed in the current chapter.

To determine the scope of this study, the researcher consulted two sources of information that were obtained from the Department of Social Development (DSD) and they are:

- A national data-base of protective workshops which consisted of 235 facilities and;
- A resource dictionary on disability "*Building a caring society together*" was also used to distinguish between and locate protective workshops from other facilities that cater for people with disabilities such as Day Care Centres, Homes for the Disabled Persons, Schools for the Disabled; Self Help Groups and Social Work Services.

Some of the available published and unpublished literature on disability in this chapter ranged from World Programme of Action Concerning Disabled Persons; Disability and Social Change; controversial debates and psychosocial perspectives – to World Health Assembly (WHA58.23) Approved Resolutions: On "Disability, including prevention, management and rehabilitation" calling upon member states to strengthen implementation of the United Nations (UN) Standard Rules on the Equalization of Opportunities for Persons with Disabilities; promote the rights and dignity of people with disabilities to ensure their full inclusion in society; promote and strengthen community-based rehabilitation programs; and include a disability component in their health policies and programs (WHO Disability and Rehabilitation Action Plan 2006-2011).

Table 2.1 below offers a summary of each of the primary and secondary research sources that were substantially reviewed within this literature review. Once identified for inclusion within the review, the process of reviewing each study was based on established and validated models of critical appraisal, such as those offered by Depoy and Gitlin (2005) and Crombie (2003). The decision to use a combination of frameworks is in keeping with guidance from Silverman (2008). He stipulated that different, or a mixture of appraisal frameworks, must be used for appraising qualitative and quantitative research sources, as these literature sources are inherently different in

terms of the quality of evidence they can offer. Although not wholly similar, each of these appraisal frameworks focuses on exploring a combination of methodological issues and the contribution each literary source made to the body of knowledge. In essence, the review of individual studies was weighted on the knowledge-contribution made to current understanding of disability, health promotion and inclusive health care. To be more specific, the studies were evaluated in terms of their rigour, validity, reliability, dependability and transferability to the practice context (Polit and Beck, 2008). Additional factors explored within the review process included the researcher(s) apparent clarity in their formulation of the study question(s), whether or not the methods of data collection adopted were scientifically sound and appropriate to the issue under investigation. Further attention was given to the handling of data within each of the reviewed sources, including how well researchers addressed potential limitations of their studies.

2.4 SYSTEMIC LITERATURE SEARCH

Table 2.1: Provides a summary of relevant literature reviewed by author, key findings and or key arguments and sources:

Author	Population Sample size/(N)/Design	Research Objectives	Facts/Findings/Recommendations
Bekker H (2006).	Adults with disabilities	Explored how health had been defined and measured for people with disabilities.	Study recommended need to: <ul style="list-style-type: none"> • Improve measurement of health among people with disabilities in clarifying conceptual and operational definitions of health with input from people with disabilities. • Modify environmental support for staying healthy and avoiding secondary conditions and population-based research on disability.
Block P, Skeels SE, Keys CB,	A cohort study of Community organizations and	To promote the health and empowerment of people with spinal cord injuries and	<ul style="list-style-type: none"> • The study concluded that project Shape-It-Up provides positive initial signs of the

Rimmer JH. (2005)	university researchers involved in a description of a model demonstration project called Project Shape-It-Up	related neurological disabilities	value of combining the resources of universities and community agencies.
Carmora RH, Cabe J McCabe J.(2005)	Adults with mental disabilities A random assignment 30 volunteers to the healthy lifestyles group or a control group	To determine the effect a health education and exercise program would have in limiting weight gain and in improving fitness and psychological parameters in adults with mood or psychotic disorders.	The study <ul style="list-style-type: none"> Findings: Intervention group evidenced greater weight loss than the control group, although not statistically significant. Significant differences were observed in rating of the general health ($p < .05$) and empowerment ($p < .01$). Key lessons: <ul style="list-style-type: none"> Exercise interventions may encourage weight loss, particularly if barriers to full participation can be addressed. Additionally, such interventions may contribute to “perceived” well-being even among those with subclinical participation.
Grönvik L (2009):	Study compared three different definitions of disability using six rather common variables: gender, age, living arrangements, education, labour market participation and	To analyze how different definitions of disability affect the outcomes of studies of disabled people’s living conditions.	Study Findings <ul style="list-style-type: none"> Recurrent differences between administrative definitions, on the one hand, and functional and subjective definitions, on the other, were found in relation to educational and labour force variables. People defined by an administrative definition were more likely to be younger and

	income.		<p>single than the people defined by the other two definitions.</p> <p>Recommended:</p> <ul style="list-style-type: none"> • Research on the impact of disability definitions was needed starting with improving the methodological awareness of disability researchers.
Morris, J., ed. (1996)	<p>Women with disabilities.</p> <p>N=100 women</p>	To establish the nature of disabled women's relationships with their general practitioners	<p>Study Findings:</p> <ul style="list-style-type: none"> • Disabled women's experience of general practitioners was a major area of concern for them. • GPs shape the environment disabled women live in through their ability to enforce a medical model of disability. Substantial power is vested in GPs (and other health professionals). • The pervasiveness of the medical model of disability is a major barrier for disabled people.
VSO, 2002. A handbook on Mainstreaming disability	<p>A book</p> <p>Publication</p> <p>Article</p> <p>Article</p> <p>N=135 disabled adults (aged 19–85 yrs) were administered questionnaires.</p>		<ul style="list-style-type: none"> • Provided a distinction in the definition between impairment and disability. Also contrasting disability within a social context. • Also highlighted some ways to can learn from such training programmes with particular regard to lessons, barriers and opportunities for their sustainability and for pursuing similar initiatives.

	<p>N= 44 nondisabled adults, Article Case Study 425 people participated in this study with physical, sensory and intellectual disability Publication</p>		
<p>Margot W Parkes, Jerry Spiegel, Jaime Breilh, Fabio Cabarcas, Robert Huish & Annalee Yassi . Public Health Review</p>		<p>To analyze how training programmes address the needs of marginalized populations and build capacity for addressing health determinants.</p>	<ul style="list-style-type: none"> • Study concluded that educational efforts focused on the challenges of marginalization and the determinants of health require explicit attention not only to the knowledge, attitudes and skills of graduates. • Lessons learned on effectively engaging the health settings and systems that will reinforce the establishment and retention of capacity in low- and middle-income settings where this is most needed.

<p>Queensland Government 2010, Queensland Health Disability Service Plan 2010–2011,</p>	<p>(Ministerial Committee)</p> <p>A sample of committee members specifically representing people with disabilities and their carers.</p>	<p>To develop a Plan on the role in advocating and responding to the Needs of people with disabilities in Queensland.</p>	<ul style="list-style-type: none"> • Study found that Peak advocacy groups reported that people with disabilities and their carers experience a ‘power imbalance’ when coming in contact with the health system. • This was evident in the use of clinical terminology; referring to the person’s condition rather than to the person on ward rounds; the clinician presenting themselves as ‘the expert’. • The Plan recommended a need to focus on the goals of the individual with a disability
<p>Karen Danna K and Griffin R.W</p>	<p>Document review on health and wellbeing</p>	<p>To review and Synthesis a number of literature that served to define health and well-being</p>	<ul style="list-style-type: none"> • Study found that Health and Well-being in the workplace have become common topics in the mainstream media, in practitioner-oriented magazines and journals and, increasingly, in scholarly research journals. • Highlighted the important future directions for future theory, research, and practice regarding health and well-being from an organizational perspective was provided
<p>Becker H, Stuijbergen A.K, and Sands D (1990)</p>	<p>Adult persons with disabilities</p> <p>Adult people without disabilities</p> <p>N=135 disabled adults (aged 19–</p>	<p>To describe the development of a tool to measure barriers to health promotion among persons with disabilities.</p> <p>To compare the Barriers to Health</p>	<p>Results:</p> <ul style="list-style-type: none"> • The BHADP yielded a Cronbach Alpha of .82 as a measure of internal consistency reliability. • In addition, t-test analyses demonstrated a significant difference in

	<p>85 yrs) were administered questionnaires.</p> <p>N= 44 nondisabled adults</p>	<p>Activities among Disabled Persons scale (BHADP) using a tool comprised of 16 items reflecting barriers to taking care of one's health identified from previous barriers literature and interviews with disabled persons.</p>	<p>scores between the disabled sample and a comparison group of suggesting the BHADP discriminate between these groups.</p> <ul style="list-style-type: none"> • The study recommended that BHADP may be useful in sensitizing health care providers to the wide range of barriers experienced by persons with disabilities, thereby enabling them to work more effectively with this special population.
<p>Manoj Sharma – Applying Freirian Model for Development and Evaluation of Community-Based Rehabilitation programmes</p>	<p>Adults with disabilities</p>	<p>To adopt the heuristics from Paulo Freire's model of adult education for possible application in development and evaluation of community-based rehabilitation (DBR) for people with disabilities.</p>	<p>Lessons learned:</p> <ul style="list-style-type: none"> • In the application of the mentioned constructs of Paulo Freire's model the "Dialogue" construct provides a two-way discussion between the educator and person with disability of their families in the community-based rehabilitation. • The second construct "Conscientisation" focuses on the difficulty experienced by the persons with disability, this enables the evaluators of community-based rehabilitation programmes to identify oppressive sources and the key issue influencing each person at a personal level. • The third construct "Praxis" is applied by providing persons with disability or their families with a joint project to plan,

	Adults with disabilities		<p>implement and evaluate collectively.</p> <ul style="list-style-type: none"> • This was by utilization of available resources in the community, transfer of knowledge about disability and skills in rehabilitation to people with disabilities, families and communities. • The fourth construct of the Freirian model is "Transformation" <p>The Limitations:</p> <ul style="list-style-type: none"> • The Freire model is criticized that his manner of writing and obscurantism makes interpretation difficult and measurement very complex. • The second is that Freire's viewpoints are utopian, there is excessive idealism in the description of knowing and for the learners and educators to participate as equals.
Boland M (2005)		<p>To assess health behaviours and health promotion need of people with disabilities attending residential, respite, day service or training facilities in the former East Coast Health Board Area.</p> <p>In this case study physical activity was classified as strenuous, moderate or mild.</p>	<p>This case found that one sixth of those with learning disability and a third of those with physical or sensory disability had done no physical activity at all in the last week only 2% of persons with physical/sensory disability participated in sports weekly.</p> <p>Of those with physical/sensory disability 44% did mild physical activity weekly, 18% carried out moderate physical activity and only 4% did weekly strenuous activity. Of those with learning disability 29% did mild physical</p>

			activity, 40% carried out moderate physical activity while 15% did weekly strenuous activity. 18% of those with a learning disability and 11% of those with a physical or sensory disability met with WHO physical activity recommendations.
National Disability Authority Murray P (2002) Inclusion		An exploration of the concept of inclusive education.	<p>Lessons learned:</p> <ul style="list-style-type: none"> • The concept of inclusive education, whether is it childcare/early childhood, primary education, secondary or tertiary education or ongoing professional education or adult education, is about taking into account the needs, strengths and weaknesses of each student. • Welcoming and accommodating people with diverse needs and focuses on removing environmental, attitudinal and institutional barriers to access and participate are crucial. • Facilitating appropriate participation i.e. the kind of participation wanted by the individual as most beneficial to him/her; participation according to need is crucial.
Beatty H Advancing the Inclusion of Persons with Disabilities:	Provincial and territorial governments	To describe Canada's knowledge base on disabilities and reviews of how progress toward inclusion is measured. This will be effectively applied by focus on the two objectives	<ul style="list-style-type: none"> • A recommendation of future reports would be a valuable first step in producing Advancing the Inclusion. Inclusive is the active involvement of provincial and territorial governments.

		of Inclusion and Governmental contribution.	
National Disability Authority – Shelley P (2002)	Children with disabilities. A survey on leisure opportunities for children with disability in Glasgrow City Council	To raise awareness and facilitate increased participation and increased quality in physical activity and sport opportunities.	Lessons learned: <ul style="list-style-type: none"> • Inclusion was about our “abilities, gifts and how to share them and NOT just a disability issue. • Inclusion should discuss the additional aspect being the inclusion of people with disabilities in our society, especially opportunities for involvement in community and political life, and recognition of rights in the justice system and by government. • The Government’s commitment to and future reports should include the additional outcomes such as, the living arrangements, family relationships, educational opportunities, accessibility of buildings, employment, and social and recreational opportunities, identified in consulting with organizations representing persons with disabilities.
National Disability Authority - Promoting the Participation of People with Disabilities in	Adult people with and without disabilities	To inform a wide audience on current provision of sport and physical activity opportunities for people with disabilities and on how participation in quality experiences might be	Study found that <ul style="list-style-type: none"> • Enormous benefits of physical exercise have been recognized but they need to be more widely experienced. • The pleasure as enjoyment that comes from physical

Physical Activity and Sport.		increased.	exercise and sport can be sufficient reason in themselves for participation.
Perkins, E.R, Simmet, I and Wright L 1999 – Evidence-Based Health Promotion	Book review	To provide evidence base on the theory and practice of assessing existing evidence, collecting new evidence and making decisions when evidence was imperfect.	
Davies, J.K and Macdonald, G 1998. Quality, Evidence and Effectiveness in Health Promotion: Striving for Certainties	Book review	The objective is the effectiveness of the studies through the application of a variety of evaluation methodologies, assess practice-based quality assurance programmes and provides examples of health promotion initiatives	Key themes that emerged: <ul style="list-style-type: none"> • Clinical outcomes, quality of care, patient satisfaction, and disease management, including health education, were being closely scrutinized by managed care, health maintenance, and other organizations redrawing the services picture.
Lyons, R.D and Langille, L 2000. Health Lifestyle: Strengthening the Effectiveness of Lifestyle Approaches to Improve Health		To examine and re-construct the concept of 'health lifestyle' so that the term can be applied to approaches in health promotion and population health.	Lessons; Key arguments <ul style="list-style-type: none"> • Healthy lifestyle is an adaption to one's social environment. Unless lifestyle is constructed (as a category of intervention) in concert with the way that lifestyle is experienced by target group(s), interventions is unlikely to succeed.
European Commission by the International Union of Health Promotion and Education, 2000	Book review	To identify the effectiveness of health promotion over 20 years, assessing the health, social, economic and political impacts of health promotion around the world.	Key lessons: <ul style="list-style-type: none"> • Significant evidence to show that mental health promotion strategies have reduced depression, reduced suicide rates and reduces behavioral problems.

			<ul style="list-style-type: none"> Interventions targeted towards help in the family have resulted in less domestic aggression, fewer learning problems with small children, and generally more positive environments in which they can grow and take up active and responsible citizenship.
http://www.york.ac.uk/inst/crd/wph/htm.Evidence from Systematic Reviews of Research Relevant to Implementating the 'Wider Public Health' Agenda	Children	To explore the affects of interventions in the field of social work, social welfare, encompassing social, public and fiscal policies, models of service delivery and interventions with individuals, groups and communities.	<p>Key lessons:</p> <ul style="list-style-type: none"> Programmes modify the school environment, and attempts to help children negotiate stressful transitions yield significant mean effects ranging from 0.24 to 0.93. In practical terms, the average participant in a primary prevention program surpasses the performance of between 59% to 82% of those in a control group, and outcomes reflect an 8% to 46% difference in success rates favoring prevention groups.
The Conference Board of Canada, 2002. Helath Promotion Programms at Work: A Frivolous Cost or a Sound Invetsment?	Health care managers	To discuss how managers can better understand taking a broad approach to integrating health promotion programs into corporate strategies and how these programs can contribute significantly to the achievement of organizational goals.	<p>Findings of the study:</p> <ul style="list-style-type: none"> Organizations tended to have introduced preventive measures in the physical work environment to address the health and safety of employees when performing job-related tasks. Over time, this focus on

			<p>preventative measures in occupational health and safety has helped to decrease the incidence of injuries and deaths in the workplace.</p> <ul style="list-style-type: none"> • Between 1970 and 1997, the incidence of workplace injuries in Canada fell from 11.3 to 6.4 workers, while the incidence of time-loss decreased from 4.3 to 3.2 per 100 workers.
<p>Craig, C.L, Beaulieu, A and Camerom, C. 1993. Active Living in the Workplace</p>	<p>Adult population in a workplace setting</p>	<p>The focus of this report was on physical activity programs in the workplace from an active living perspective. Focused on Trend comparison from 1986 to 1992 are made whenever possible.</p>	<p>Findings of the study:</p> <ul style="list-style-type: none"> • Overall, 71% of businesses indicate that both the employer and the employee share some responsibility for the employee's health. • An additional 18% indicate that the employee's health is at least a matter of interest and concern to the employer. In 10% of companies, health is considered to be the sole responsibility of the employee.
<p>Aldana, SG, 2001. Financial Impact of Health Promotion Programs: A comprehensive Review of the Literature</p>	<p>Adult population in a workplace setting</p>	<p>The study sought to answer the following questions:</p> <ol style="list-style-type: none"> 1) Do individuals or population with high health risks have worse financial outcomes than those with low health risks? 2) Do health promotion and fitness programs improve financial outcomes? 	<p>Findings of the study:</p> <ul style="list-style-type: none"> • High levels of stress, excessive body weight and multiple risk factors are associated with increased health costs and illness-related absenteeism. • Health promotion programs are associated with low levels of absenteeism and health care cost, and fitness programs are associated with reduced health care costs.

			<ul style="list-style-type: none"> Key lesson was that it seemed s that health promotion programs are associated with reduced absenteeism and health care costs, and health promotion programs should be considered a viable and effective method for helping employers reduce employee-related expenses.
<p>Lowe, G.S. 2003. Healthy Workplaces and Productivity: A Discussion Paper</p>	<p>Practitioners and policy makers</p>	<p>To examine two health issues of critical importance to practitioners and policy makers: What are the work environment and organizational; factors that positively influence workers health and well-being? And, Are organizations that support the achievement of good health for their employees also more productive?</p>	<p>Findings of the study ;</p> <ul style="list-style-type: none"> For employers, the paper's central message is that workplace wellness programs can yield cost savings and productivity payoffs. However, the underlying determinants of health and productivity can only be altered through changes to job design, organizational systems, human resource management practice, and the overall culture of the workplace.
<p>Ravesloot CH, Seekins T, Cahill T, Nary DE, White G (2006). Health promotion for people with disability program. Health Education Research Advance Azzes, October 10, [Epub</p>	<p>People with mobility impairments</p>	<p>To describe the participatory action research (PAR) methods we used to develop, implement and evaluate the Living Well with a Disability Program.</p>	<p>Findings of the study:</p> <ul style="list-style-type: none"> Logistic regression on outcomes controlling for demographic variables and pre-test measures indicated reductions in all three outcomes variables. People with mobility impairments who participate in the Living Well with a Disability program reported less limitation from secondary conditions, fewer unhealthy days and less health care utilizations

ahead of print]			
Block P, Skeels SE, Keys CB, Rimmer JH. (2005). Shake- It-Up: Health promotion and capacity building for people with spinal cord injuries and related neurological disabilities. Disability and Rehabilitation	People with spinal cord injuries and related neurological disabilities. community organizations that provide services to this population	To develop a description of a Model Demonstration for Project Shake-It-Up.	Key lessons: <ul style="list-style-type: none"> • Community organizations and universities researchers developed a successful partnership. • Individual members of the first cohort supported one another and benefited physically and psychologically. • Working together, these organizations can develop distinctive, multi-faceted programmes to support the health and empowerment of people with spinal cord injuries and other related neurological disabilities.

2.5 THEMATIC REVIEW OF THE LITERATURE.

According to Becker H (2006) the evolution of our understanding of health has profound implications for people with disabilities. A publication of the University of North Carolina (The Writing Center at UNC Chapel Hill: 2010-2012) states that thematic reviews of literature are organized around a topic or issue, rather than the progression of time. However, progression of time may still be an important factor in a thematic review. This understanding informed the choice of thematic literature review of this current study. A rigorous review of literature was done and both primary and secondary data were consulted to gather more in-depth knowledge of evidence related to the topic of health promotion and disabilities. On the basis of this literature two ‘grand-themes’ emerged and summarised as follows:

- Theoretical base of health promotion and disability
- Health and Human Rights perspective.

The above themes provide a review of evidence statements of arguments, common thinking and trends of both the current and old scholars. As a preamble to the review proper, the chapter offers a brief “scene-setting” exploration of topical issues such as

the burden of disease and disability (growing estimates on prevalence international regional and local); the unmet health care needs of people with disabilities, and the integrated service delivery challenges to address social exclusion of people with disabilities – the role of health promotion.

The theme “theoretical base of health promotion and disability” is based on a review of literature and critiques of key theories that grounds an understanding of the phenomenon of health promotion and disability. The third and last theme “Health and Human Rights perspective” provides a critical account of current understanding of disability and health as fundamental human rights issues.

2.5.1 Theoretical base of health promotion and disability

As indicated in the preceding chapters, one of the primary arguments in this study explores the extent to which people with disabilities benefit from health promotion. Highlighted as “Who benefits from health promotion?” The long-held pledge of “Health for All by the Year 2000” made this question seem obvious. The adoption of an indomitable Comprehensive Primary Health Care and community-based rehabilitation programme is embedded in the inaccessible clinical milieu.

This section provides an analysis of applicable theories to the study and contextualizes the concept of inclusive health promotion for people with disabilities. Growing evidence show that there are a number of significant theories and models that underpin the practice of health promotion. It would be useful to make a differentiation between theories and models.

It is important to note that health behavior and health promotion theories draw upon various disciplines (social and behavioural sciences), such as psychology, sociology, anthropology, consumer behavior, and marketing. Many are not highly developed or have not been rigorously tested. Because of this, they often are called conceptual frameworks or theoretical frameworks (U.S. Department of Health and Human Services National Institutes of Health. 2005). In most instances these terms are used interchangeably.

However, authors such as Crosby & Noar (2010) argue that theory development has not proceeded at a pace commensurate with the evolution of health promotion practice. They cite at least three examples of this disparity that seem apparent: Firstly, that theory is developed in an evidence-based paradigm rather than a practice-based paradigm. Secondly, that a substantial majority of health behavior theories exist at the individual level, thereby neglecting contextual realities that shape behavior. Lastly, “accessibility” levels of theory to practitioners may be quite low in comparison to the growing demands to prevent disease through expanding health promotion practices.

The authors pointed that the challenges of health promotion demand a great deal more attention to developing theories that reflect the reality of broad influences on health behavior. One critical question that must be answered involves setting limits regarding the realistic role of behavioral interventions in public health practice. The evolution of theory should be practice-based, largely ecological in nature, and the resulting theories should be easily accessible to practitioners.

The theoretical implication of the above arguments could be associated with the medical model of disability. According to the growing body of evidence, the medical model of disability, which equates disability with illness, has been used extensively to organise and control the lives of disabled people. Focusing on an individualistic approach to disability, pathologising disabled people as problems, rather than recognising the structural oppression disabled people face, has blurred the distinction between illness and impairment. Consequently, on the one hand disabled people are having to challenge the relevance of a medical model of disability and advocate an understanding of disability based on attitudinal, environmental and institutional barriers; whilst on the other hand disabled people are also struggling to access appropriate health services. In the past, disabled people have challenged the medicalisation of disability and as a consequence anxieties about health needs have tended to be minimised. Concerns about the oppressive nature of medical treatment, and the fear of disability being construed as a catalogue of medical problems, has made disabled people wary of putting health issues on the public and/ or academic agenda (Watermeyer et al 2006). Whilst this may be an understandable response to the intrusive and often interventionist nature of the medical world there can be little doubt that disabled people, whether as a

result of impairment, or as a consequence of everyday illnesses, are consumers of health services. Lloyd (1992) points out:

‘.. the narrow definitions of disability in clinical terms results in an all-pervasiveness of doctors' power over disabled people's lives, in which the power to make decisions about fitness for work and entitlement to welfare benefits are but examples. This does not necessarily mean, however, that the medical aspects of their lives are unimportant for disabled people' (p. 211).

However, current thinking and arguments based on empirical validation of behavior health models related to HIV risk shed some light and offer interesting insights. Traube, Holloway and Smith (2011) argue that, in the presence of numerous health behavior theories, it is difficult to determine which of the many theories is most precise in explaining health-related behavior. New models continue to be introduced to the field, despite already existing disparity, overlap, and lack of unification among health promotion theories. In addition, the authors make a unique contribution to the HIV health behavior theory literature by moving beyond current health behavior theory critiques to argue that one of the field's pre-existing, but less popular theories, Social Action Theory (SAT), offers a pragmatic and broad framework to address many of the accuracy issues within HIV health behavior theory. The authors conclude this article by offering a comprehensive plan for validating model accuracy, variable influence, and behavioral applicability of SAT.

In a related review and synthesis of the literature by Karen-Danna and Griffin (2002) it became apparent that health and well-being in the workplace have become common topics in the mainstream media, in practitioner-oriented magazines, journals and increasingly in scholarly research journals. In their article, Karen-Danna and Griffin (2002) first review the literature that serves to define health and well-being. They then discuss the primary factors associated with health and well-being, the consequences of low levels of health and well-being, and common methods for improving health and well-being in the workplace. Finally, their discussion highlights important future directions for future theory, research, and practice regarding health and well-being from an organisational perspective. This perspective is associated with the social model of

disability. Pinder (1995) asserts that a more holistic definition of disability is needed, one which considers the way in which disability is intimately linked to other structural relationships which differentially disadvantage social actors. In Pinder's view, this is the hallmark of a Disability Movement which has truly come of age. The disabled sociologist Zola urged the Disability Movement to embrace a universal approach. He wrote:

'Only when we acknowledge the near universality of disability and that all of its dimensions (including the biomedical) are part of the social process by which the meanings of disability are negotiated will it be possible fully to appreciate how general public policy can affect this issue' (Zola, 1989: 420).

The dilemma for disability theorists is whether, in bringing into the fold 'experience at the margins', the political momentum can be sustained. According to WHO (1996:1) health is created by caring for oneself and others, by being able to make decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members (WHO 1996:1). Health is therefore not only seen as merely the absence of disease or infirmity but includes the state of physical, mental, spiritual and social wellbeing.

The social model of disability is viewed as the definitive way of representing the lived reality of disabled people as they struggle for social as well as political rights. It has become the means of explaining why disabled people fare so disproportionately poorly in the labour market, as in other areas of social life, such as education and housing (Oliver, 1990; Morris, 1991; Higgins, 1992; Swain et al., 1993). Firstly, disability is a problem of society, difficulties resulting from a disabling environment rather than from the defects or deficiencies of disabled people as individuals; and the term 'disablism' has been coined to give voice to the marginalisation, if not exclusion, of disabled people from mainstream society. Secondly, as society has 'manufactured' the problems in the first place, disability theorists argue, the onus is on society to change: impairment is, at most, a minor issue.

It is critical to note that disability does not only affect the disabled individual, but also the family and the immediate community (White Paper: 1997:49). Therefore, it is one's

opinion that strengthening health promotion approach will have benefits for the society to view people with disabilities as part of the population – a new paradigm of inclusivity. The inclusion of people with disabilities in a truly equal manner would necessitate questioning fundamental aspects of society. As Finkelstein puts it: “We cannot understand or deal with disability without dealing with the essential nature of society itself” (Finkelstein, 2001b:5).

According to the White Paper on Integrated National Disability Strategy (DSD 1997: 49), Social Development is recognized as a key role-player in enabling access to the service delivery system. It is acknowledged that fragmentation is a prevalent systemic challenge, which affects a holistic approach to the delivery of an integrated service. In view of this department’s service delivery improvement initiatives the Protective Workshops, a changing approach could be explored to move towards a holistic paradigm of inclusiveness and shared service delivery model, instead of regarding people with disabilities from a purely health and welfare issue to a primary human rights and developmental issue. The strategy makes recommendations for service providers to implement the Human Rights and the Development Model in the provision of services to People with Disabilities. It further recommends an integrated and collaborative approach between Departments in order to provide holistic and sustainable services to People with Disabilities (Department of Social Development 2008:5).

Goals of health promotion include the primary and secondary prevention of disease and health compromising condition. Many nations have embraced health promotion as an approach to extending and enriching the lives of their people. For example, in the US, the U.S. Department of Health and Human Services (2000) established two overarching goals: to increase the quality and years of healthy life, and to eliminate health disparities.

The above stated goals were regarded as ambitious and provided enormous challenges to the discipline of health promotion. However, advances in the development of behavioural and social science theory contributed extensively to enhance the ability to achieve the health promotion objectives of the ambitious country goals. Behavioural and social science theory provides a platform for understanding why people engage in

health-risk or health compromising behaviour and why they adopt health protective behaviour (Crosby, Kegler & DiClemente 2000).

For people with disabilities to be able to achieve this state of health, the health care system needs to develop inclusive strategies and programmes within their existing plans for comprehensiveness. The White Paper on Integrated National Disability Strategy (DSD 1997:21) identifies prevention as the cornerstone of disability policy because of a reality that most disabilities are preventable. The policy put emphasis on primary prevention of disease and injury, through the promotion of healthy lifestyles and ensuring protective measures to reduce risks to health. Secondary prevention is also promoted to prevent further complication that may result in disability through early management of diseases and injuries.

Another aspect of health promotion stated in the policy refers to that of public education and awareness raising on issues of disability. Disability is portrayed as a “problem”. People with disabilities are viewed as helpless and dependent; as ill and in constant need of care and medical attention, or as tragic victims (DSD 1997:23). As mentioned earlier in this discussion that negative traditional attitudes towards people with disabilities impact negatively on the concept of social exclusion and marginalization of people with disabilities, it is imperative that public education and awareness become central to changing societal attitudes to view people with disabilities as members of society.

Berkman's (1995) published article in the *Psychosomatic Medicine* journal on the role of social relations in health promotion contends that, there exists a substantial body of evidence that indicated that the extent to which social relationships were strong and supportive was related to the health of individuals who lived within such social contexts. A review of population-based research on mortality risk over the last 20 years indicated that people who were isolated were at increased mortality risk from a number of causes. For social support to be health promoting, it must provide both a sense of belonging and intimacy and must help people to be more competent and self-efficacious.

2.5.2 Conceptualization of key theories

Contemporary health promotion involves more than simply educating individuals about healthy practices. It includes efforts to change organizational behavior, as well as the physical and social environment of communities. Health promotion programs that seek to address health problems across this spectrum employ a range of strategies, and operate on multiple levels U.S. Department of Health and Human Services National Institutes of Health (2005:10). Similarly, authors Watermeyer et al (2006) contend that disability can no longer be seen as a static feature of an individual but rather as a dynamic changing experience determined by the changing nature of the environment. This change from focusing on the individual to focusing on the individual plus the environment has important implications for measuring and researching disability, as well as developing policies on disability.

Evidence has shown that it is at the individual/ intrapersonal level that the application of the medical model of disability gains dominance, particularly as the primary source of disabling factors is determined by the level of influence. An example of the level of influence includes Individual characteristics that influence behavior, such as knowledge, attitudes, beliefs, and personality traits. However, this could also be interpreted as a contribution to social exclusion of people with disabilities in the rest of the domains within the multilevel approach.

This view is supported by some including Oliver (1990); Morris (1991); Higgins (1992) and Swain et al (1993) who contested that disability is a problem of society and difficulties resulting from a disabling environment rather than from the defects or deficiencies of disabled people as individuals. As a result, the term `disablism' has been coined to give voice to the marginalisation, if not exclusion, of disabled people from mainstream society. Secondly, as society has `manufactured' the problems in the first place, disability theorists argue, the onus is on society to change: impairment is, at most, a minor issue.

Intervention mapping supports the socio ecological approach and serves as a planning framework in the development of a planned systematic and targeted intervention which enables each of the determinants of a desired behavior to be addressed (Reddy 2006; Bartholomew et al, 2011). The basis of intervention mapping involves a process of thorough needs assessment of quality of life, behavior and environmental conditions

and influencing determinants. Following a systematic, ecologic and systems approach, the following steps of intervention mapping are identified:

Step one: Assessment of the health problem, the behavioural and environmental causes of the problem and determinants of the behavioral and environmental causes;

Step two: Provides the foundation for the intervention by specifying who and what will change as a result of the intervention. The product of this step is a set of matrices of selected ecological levels at individual, interpersonal, community or societal that combines performance objectives at each level with selected determinants to produce change objectives;

Step three: Identification of theory-based methods and practical applications to change the determinants of health behavior, the behavior of environmental agents and to change organizational, community and societal factors to affect the environment.

Step four: focus on the scope and sequence of the intervention, completed program materials and program protocols

Step five: Focuses on program adoption and implementation including considerations of how the program could be maintained and disseminated after being evaluated, and;

Step six: Focuses on completion of the intervention

Although it is noted that the intervention mapping planning framework has not been applied to area of disability, there is evidence of its successes in other related topics such as nutrition and physical activity that also benefit people with disabilities. Additionally, the framework is based on a strong theoretical bases and logic models and regards the environment as key areas of influence to address health inequalities leading to social exclusion. This explains the reasons why the perspective have been built into the current study precisely to strengthen the knowledge-base that

However, from a public health perspective issues of health and wellness for people with disabilities are becoming prominent issues on the national health agenda (United States Department of Health and Human Services, 2000). New models of health and wellness specific to persons living with disability are attempting to understand and operationalize health and wellness within the disability experience. These models show what many people living with disabilities conceptualize that a person can be healthy and well and live long-term with disability (National Institute of Disability Rehabilitation Research, 2000; Institute of Medicine, 1991). Much of this shift in perspective stems from a new disability paradigm that views disability as a situational experience, a function of the relationship between the individual and the environments that surround that individual (cultural, social, natural and architectural) (NIDRR, 2000).

The White Paper on Integrated National Disability Strategy (DSD 1997) agrees with the above and indicates that the social model of disability implies a paradigm shift in terms of how we construct disability. The White Paper on Integrated National Disability Strategy (DSD 1997) highlighted the following principles of the social model:

- It is the stairs leading into a building that disable the wheelchair user rather than the wheelchair.
- It is defects in the design of everyday equipment that cause difficulties, not the abilities of people using it.
- It is society's lack of skill in using and accepting alternative ways to communicate that excludes people with disabilities.

Persons with disabilities have been largely overlooked in investigations of health and health behaviors. The primary purpose of this descriptive correlational study was to examine the usefulness of Pender's (1987) Health Promotion Model in explaining the occurrence of health-promoting behaviors among adults with disabilities. Hierarchical multiple regression analyses were used to analyze questionnaire responses from a sample of 117 adults with disabilities. Adults with disabilities were more likely to engage in a health-promoting lifestyle if they had higher specific self-efficacy for health behaviors, higher general self-efficacy, a wellness-oriented definition of health, required less mechanical assistance, and were female. Findings from this study suggested that interventions aimed at enhancing health promotion behaviors among persons with

disabilities would be strengthened by addressing perceived ability to master situations, particularly the ability to successfully carry out health-promoting behaviours (Research in Nursing & Health Volume 17, Issue 1, pages 3–13, February 1994. Date accessed 22 March 2012).

With regard to the public policy factors existing evidence in South Africa by Dube (2005: 4-6) investigated the effectiveness of disability legislation in South Africa. The findings of the study reveal that the national government has been successful in creating an enabling environment for policy development in the field of disability but implementation of such policies remains a challenge. Dube (2005: 3) cited the following factors that have contributed to poor implementation of policies on disability:

- Definition and nature of participation of people with disability have not been adequately reviewed and articulated;
- The policy requirements for disability mainstreaming are not adequately linked to performance management, thereby undermining commitment to implementation;
- Legislation and policies are not implemented, due to a lack of allocated fiscal resources and commitment.

Evidence of some Institutional or organizational factors is noted. In a study by Becker et al (1990) to describe the development of a tool to measure barriers to health promotion among persons with disabilities. A study involving 135 disabled adults living in two southwestern cities, the BHADP yielded a Cronbach Alpha of 0.82 as a measure of internal consistency reliability. In addition, t-test analyses demonstrated a significant difference in scores between the disabled sample and a comparison group of 144 nondisabled adults, suggesting the Barriers to Health Activities among Disabled Persons (BHADP) discriminate between these groups. The study findings revealed that subjectively-defined barriers to engaging in health promoting activities are one of the most important, yet least well operationalized, components in models of health promotion.

The Barriers to Health Activities among Disabled Persons scale (BHADP) is comprised of 16 items reflecting barriers to taking care of one's health identified from previous barriers literature and interviews with disabled persons. In a The

BHADP may be useful in sensitizing health care providers to the wide range of barriers experienced by persons with disabilities, thereby enabling them to work more effectively with this special population.

Another study by Benyamini et al (2000) found that people with disabilities and those without disabilities perceive health as a complex, multidimensional concept including in their definitions not only physical health, but being able to do what they want to do, and having a general feeling of well-being. Additionally, Jensen and Allen (1994) find that health for individuals living with disability is perceived within the context of the self and others. Influences on perceptions of health include life roles, choices, relations, abilities, beliefs, practices, social supports, interpersonal relationships, and culture. They conclude that interpersonal, intra-personal, and extra-personal dimensions affect the experience of wellness.

A qualitative study was undertaken by Stuifbergen, Alk, Rogers and Sharon (1997) to clarify an emerging explanatory model of health-promoting behaviors and quality of life in individuals with chronic disabling conditions. Twenty individuals (n=20) with multiple sclerosis shared their stories regarding health promotion, domains of quality of life, and factors that affected these domains. Health-promoting behaviors were viewed as essential to the process of rehabilitation and maintaining an acceptable quality of life. Important quality-of-life issues were related to domains other than function. Implications are that health promotion efforts need to be encouraged and supported in individuals with chronic disabling conditions.

Some of the interpersonal and community factors pertain to nurses as care givers have been explored in this literature. A study by Marion, Whitty-Rogers, and Joanne (2012) depicted some of the “harsh words” nurses sometimes unconsciously use, and it suggested alternatives. The study concluded that Influenced by an ethic of social justice and the ethic of relationship with others, an attempt would be made to explore nursing language with women and children. Nursing is grounded in communication with others, yet rarely are the words critiqued. Despite an ethical call to honor diversity, promote empowerment, and to do no harm, some of the language used in health care reflects historical prejudices, reductionism, and/or the overarching authority of medical or moral models Implications for nursing philosophy and practice became evident.

To support the above findings Falk-Rafael at the York University, Toronto stated that critical caring is proposed as a hybrid, midrange theory that builds on nursing science and critical feminist theories. As such, it has the potential to root public health nursing practice in an expanded nursing caring science that reincorporates the social justice agenda characteristic of early public health nursing practice but not featured prominently in contemporary nursing theories.

The World Health Organization's Press Release WHO/27 (17 April 2002) highlighted some of the key Ministerial discussions held regarding understanding the concept of health and disability during a World Conference in Trieste, Italy. The conference deliberations were based on the concept of 'Groundbreaking Classification' and focused on how everybody can live their full potential. Further discussions were for member states to be able to use a new groundbreaking tool to classify functioning, health and disability thus put disability as part of the wider health concept.

Subsequently, the 2002 groundbreaking tool was introduced in affiliated countries. However, there has been limited progress made to integrate disability into the wider health concept. Health promotion strategies were also aimed at making all people reach their full potential using different methodologies. Limited participation of people with disabilities in health promotion programmes continues to encounter a plethora of challenges. These include reporting mechanisms and implementation processes since 2002. Considering disability within the context of Primary Health Care (PHC), the Alma Ata Declaration's definition of PHC includes promotive, preventive, curative and rehabilitative care. The Declaration emphasizes three intervention levels, which are the primary, secondary and tertiary.

Since traditional health indicators are based on the population illness and death rates, the modern shift is based on the recognition and attention to the burden of diseases and proposes a focus to "Life", that is the preventive and promotive aspects. For people with disabilities, rehabilitation is crucial in improving their ability to participate in community activities (WHO: 1996:1). It is in this sense that health promotion can be seen as key in preventing further disability and improving the inclusion of people with disability in both health and social services, without adopting the medical model. However, one feels that

for that to happen, health promotion needs the support of other partners through service linkages, networks and coordinated programme efforts.

2.5.3 Health and Human Rights perspective

Health is a vital asset and a fundamental right. People with disabilities should be able to enjoy access to promotive, preventive, curative, long-term care and rehabilitation like everybody. As in other developing countries, the South African experience of the burden of disease and disability has prompted the health system to evolve beyond curative care models but to more urgently towards addressing the need to use long term preventive and promotion care models (DOH, NCD National Guidelines, 2006:8).

Author, Jonathan Mann as stated in the WHO's Health and Human Rights Publication Series No.1, July 2002:11 noted that, "Public health practice is heavily burdened by the problem of inadvertent discrimination. For example, outreach activities may "assume" that all population are reached equally by a single, dominant-language message on television; or analysis "forgets" to include health problems uniquely relevant to certain groups, like breast cancer or sickle cell diseases; a problem ignores the actual response capability of different population groups....." Integrating human rights in health require an adoption of a right-based approach as entrenched in the constitution of the Republic of South Africa and the Bill of Rights.

A rights-based approach to health refers to the processes of:

- Adopting human rights as a framework for health development;
- Assessing and addressing the human rights implications of any health policy, programme or legislation;
- Making human rights an integral dimension of the design, implementation, monitoring and evaluation of health related policies and programmes in all spheres, including political, economic and social (WHO July 2002:16).

Health promotion is facing important challenges. Hence Promotion of Equality and Prevention of discrimination of 2000, Employment Equity Act of 1998 and the Patients' Rights Charter, among other policies and legislative frameworks substantial transformation is critical. The United Nations Human Rights Commission has also

raised concerns about the plight of people with disabilities, therefore “transforming the practice of diseases such as disabilities”. In this respect, the United Nations has been able to consolidate the principle that human rights are a matter of international concern and that international community is entitled to discuss and to protect human rights through the 1948 Universal Declaration of human rights. In the African context, the OAU Charter was the first regional instrument that dealt with the protection of human rights in the continent Ouguergouz, F. (2003).

Official recognition of the rights of disabled people in international development work only really began in the 1980s. In 1983, the UN published its World Programme of Action Concerning Disabled Persons (UN 1983), in which it was stated that, “... particular efforts should be made to integrate the disabled in the development process and that effective measures for prevention, rehabilitation and equalization of opportunities are therefore essential.” This Programme of Action marked the beginning of the UN Decade of Disabled Persons (1983-92), which culminated with the UN adoption of the Standard Rules on the Equalisation of Opportunities for Persons with Disabilities in 1993. However, it was noted that these Rules are not legally enforceable, nor were many resources made available for promotion. They do, however, set an anti-discriminatory and inclusive international standard, which, together with other developments in the disability movement, have influenced many governments and organisations to take disability rights more seriously (Yeo K: 2005).

Within the context of this study, specific articles of the Convention on the Rights of Persons with Disabilities (CRPD) relating to specific rights are explored. Article 10: Right to life- reaffirms the inherent right to life of persons with disabilities on an equal basis with others. Article 25: Health - recognizes that persons with disabilities have the right to the enjoyment of the highest attainable standard of health, ensuring access for persons with disabilities to health services, including health-related rehabilitation, that are gender-sensitive, in their community and without financial cost. Article 26: Habilitation and rehabilitation - establishes the measures to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life, through comprehensive habilitation and rehabilitation programmes, in the areas of health, employment, education and social services. Article 27: Work and employment- recognizes the right of

persons with disabilities to work and to gain a living by participation in a labour market and work environment that is open, inclusive and accessible, including for those who acquire a disability during the course of employment (UN CRPD C/2/3 Nov 2009).

The above stipulations of CRPD affirm that human rights are indivisible and universal. Universality also means that all people have equal rights. In practice, it is often particular groups of people who cannot claim their rights in different areas of their lives. Policies and practices of governments, civil society and the private sector may discriminate on the basis of class, gender, age, ethnicity, disability or other social status. The consequent inequities in education health, employment, income and political representation perpetuate the powerlessness of the excluded.

Disability is a developmental and a human rights issue. A public health approach distinguishes three levels of prevention that is, the primary, secondary and secondary prevention. Prevention of health conditions associated with disabilities is a developmental issue and requires attention to environmental factors in disease prevention and risk reduction efforts in various settings including the work places (WHO 2011:8). Viewing disability as a human rights issue is not incompatible with prevention of health conditions as long as prevention respects the rights and dignity of people with disabilities, for example, in the use of language and imagery. Preventing disability should be regarded as a multidimensional strategy that includes prevention of disabling barriers as well as prevention and treatment of underlying health conditions (WHO 2011:8).

Paying attention to environmental factors in disease prevention and risk reduction efforts and respecting the rights and dignity of people with disabilities is a view that supports the ecological perspective discussed early in the text.

Constitution of the Republic of South Africa (No. 108 of 1996): Section 24 of the Bill of Rights (Chapter 2 of the Constitution) states that, “everyone has the right to have access to health care services, including reproductive health care, sufficient food and water, and social security”. This includes the right to a healthy environment and a protected environment for the benefit of present and future generations.

Furthermore, the Constitution of the Republic of South Africa (1996) makes provision for the promotion and protection of the equal human rights for people with disabilities in South Africa. All rights contained in the Constitution of the Republic of South Africa (the Constitution) are equally applicable to citizens with disabilities. However, the practical realisation of these rights remains one of government's greatest challenges and the majority of people with disabilities continue to be faced with discrimination, low literacy, unemployment and poverty. According to Dube (2005), the lack of effective grass roots implementation can be linked to a lack of capacity, limited budgetary allocations, negative societal attitudes and ignorance, as well as to procedural bottlenecks.

In 1991 while under the auspices of Lawyers for Human Rights the Disabled People of South Africa launched a Charter that highlighted certain demands to help guide the inclusion of the historically marginalised; in particular the integration of people with disabilities (Watermeyer et al 2006: 57).

The conference with a Task Team of six people drafted the Charter on the issues addressed by the Drafting Committee. The charter was intended to accomplish the following goals; among many others:

- Create the knowledge base on inclusive health promotion as a public health strategy;
- Foster or increase understanding regarding basic human rights for people with disabilities;
- Enable people with disabilities to share experiences related to historical inequities and subjugation as a result of an existing disability;
- Facilitate discussions;
- Plan for the future,
- Create a forum where people with a diverse range of disabilities could meet;
- Deal with their historical injustices.

Historically, the previous government despite their "Special Needs Education Programme – was also responsible for public health services peripherisation among people with disabilities. Failure to mainstream people with disabilities was compounded

by the medical model as opposed to the social development and human rights approach (United Nations 1982; World Health Organisation 1978, 2001; Watermeyer, et al 2006).

Authors Hoogeveen (2005); Yeo & Moore (2003); Harriss-White (1999) point out that If people with disabilities and their households are to overcome exclusion, they must have access to work or livelihoods, breaking some of the circular links between disability and poverty. There is also a need to articulate the government's policy frameworks such as the Constitution of RSA, Bill of Rights, White Paper on Integrated National Disability Strategy, international, regional obligations and instruments that are aimed at protecting the rights of people with disabilities and preventing discrimination and abuse. The National Disability Strategy for South Africa highlights the importance of integrating the needs of people with disabilities into all aspects of care, including learning, health, political and also calls for inclusive approaches to disability at all levels (ICCHNR 2005: 10).

In South Africa, Human Rights, Inclusivity and Social Justice are foregrounded in the Revised National Curriculum Statement the Department (RNCS) as a priority area that should be infused across all learning areas of Education. According to the Department of Education, Human Rights in education entail a whole school approach, and whose core-curricular programme is inclusive of different types of learning needs, orientations and abilities including disability. The programme focuses on Inclusive Education that pays special attention to the potential barriers to learning (Department of Education, no date provided).

In the light of all these enabling national policy frameworks, there is growing evidence that people with disabilities remain excluded and therefore disadvantaged in many of the country's mainstream activities related to health, education, socio-economic, labour, political issues. Some human rights approaches and statements emerged over the years from the voices of people with disability, strongly advocating messages of inclusivity such as "*Nothing about us, without us.*"

Discussions at the World Health Assembly's (WHA58.23) session on Disability, Including prevention, management and rehabilitation focused on ensuring equal opportunities and promotion of human rights for people with disabilities, especially those

who are poor. The WHA58.23 Resolution called on WHO to assist member States to develop policies on disability, which include community involvement and national rehabilitation programmes (WHO 2005:6).

As discussed in preceding chapters, this study is based on the service delivery model of the Protective Workshops for people with disabilities. Protective workshops are facilities that are managed by Non Governmental Organisations (registered under the NPO Act and section 5 of the Social Assistance Act no 59 of 1992) and government. The Protective Workshops are regarded as access points that would benefit people with disabilities from preferential procurement, skills training and opportunities provided by various departments (DSD 2004).

The approach of the Protective Workshops is grounded in human rights perspective, supported by such frameworks both at international and national levels. For example, Article 27 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD, 2006) “recognizes the right of persons with disabilities to work, on an equal basis with others; this includes the opportunity to gain a living by work freely chosen or accepted in a labour market and work environment that is open, inclusive and accessible to persons with disabilities”. Furthermore, the CRPD prohibits all forms of employment discrimination, promotes access to vocational training, promotes opportunities for self-employment, and calls for reasonable accommodation in the workplace, among other provisions.

In view of this context, continuing to leave disabled people out of mainstream systems of development by perpetuating discrimination and exclusion violates these rights. From a human rights perspective, development programmes can, therefore, no longer make excuses for not addressing disability, particularly as many development agencies now claim to be working within an explicit human rights framework. Amartya (2004) asserted that ‘overlooking or ignoring the plight of disabled people is not an option that an acceptable theory of justice can have.’

2.6 SUMMARY

This chapter dealt with literature from different sources relating to the issue of disability, from a global and national stand point. Literature on disability exists, but there are

limitations to available literature dealing integrating people with disability into the general societal developmental programmes and activities. The themes provided a review of evidence statements of arguments, common thinking and trends of both the current and old scholars. Firstly, the review explored the theme “health promotion needs for people with disabilities” as the basis of the study focus. The body built on topical issues such as the burden of disease and disability (growing estimates on prevalence international regional and local); the unmet health care needs of people with disabilities, and the integrated service delivery challenges to address social exclusion of people with disabilities – the role of health promotion.

The theme “theoretical base of health promotion and disability” was based on a review of literature and critiques on key theories that grounded an understanding of the phenomenon of health promotion for people with disabilities. The third and last theme “Health and Human Rights perspective” provided a critical account of understanding disability and health as fundamental human rights issues.

CHAPTER THREE

CONCEPTUAL FRAMEWORK

3.1 INTRODUCTION

In the previous chapter, the literature review process described the interconnectedness of different concepts and factors related to inclusive health promotion for people with disabilities. The understanding provided evidence for application within the supported environment of Protective Workshops. Additionally, a systematic view of the related concepts that considered public health, inclusive health promotion and disability phenomena was addressed. This was done to provide a framework within which data about people with disabilities and health could be collected and synthesized.

The previous chapter also addressed the theoretical background of some key evidence-base studies and provided examples of models supporting the different approaches and conceptualisation of inclusive health care of people with disabilities. It is important to note that most of these intervention studies were based on international experiences and tested models although most were grounded on internationally theoretical perspectives of the different disciplines such as social science, public health, disability studies and others.

Polit and Beck (2012:126) state that in designing research there needs to be a well deliberated conceptualization of people's behavior or characteristics on how these affects or are affected by interpersonal, environmental or biological forces. The authors stressed that in high quality research, a clear defensible conceptualization is made explicit. This section discusses the theoretical and conceptual contexts of inclusive health promotion for people with disabilities. A sound framework also identifies the various concepts being studied and the relationship between those concepts (Burns and Grove, 1997). Such relationships should have been identified in the literature. The research study should then build on this theory through empirical observation.

Authors such as Bassett and Bassett (2003) point out that following the identification of the research problem and the review of the literature the researcher should present the

theoretical framework. According to Polit and Beck (2012:148), the goal of theories and models in research is to;

- make findings meaningful;
- integrate knowledge into coherent systems;
- stimulate new research and explain relationship between them ;

According to Polit & Beck (2004), theoretical frameworks are implicit or explicit and identify study variables, propose relationships to be tested, and can guide the intervention protocol for an experimental study. However, Robson (2002) argues that theoretical frameworks are a concept that novice and experienced researchers find confusing. It is initially important to note that not all research studies use a defined theoretical framework. Conkin Dale (2005) clarifying on the uses of frameworks states that “A theoretical framework can be a conceptual model that is used as a guide for the study or themes from the literature that are conceptually mapped and used to set boundaries for the research (Miles and Huberman, 1994).

For the purpose of this study, it is important to clarify the use of terminology used throughout this chapter and indeed within the study. A Theory refers to an abstract generalisation that offers a systematic explanation about hoe phenomena is interrelated. A framework is a conceptual understanding of the study including an overall rationale and conceptual definitions of key concepts. A concept is a basic element of a conceptual model, but it is not linked in a logically ordered, deductive system. A conceptual model then provides context for scientific studies such as nursing studies. In the context of the current study this relates to an inclusive health promotion model for people with disabilities. (Polit and Beck 2012:127; 147; 148). ;

In this section the researcher considers a theoretical base for the development of a conceptual framework as supported by Polit & Beck (2004) statement that, theoretical frameworks are implicit or explicit and identify study variables, propose relationships to be tested, and can guide the intervention protocol for an experimental study. This is followed by the conceptualization of conceptual framework for people with disabilities, integrated model development and providing justification for the model domains towards an inclusive health promotion model for people with disabilities.

3.2 THEORETICAL BASE OF THE FRAMEWORK

Health is a vital asset and a fundamental right. People with disabilities should be able to enjoy access to promotive, preventive, curative, long-term care and rehabilitation like everybody. As in other developing countries, the South African experience of the burden of disease and disability has prompted the health system to evolve beyond curative care models but to more urgently towards addressing the need to use long term preventive and promotion care models (DOH, NCD National Guidelines, 2006:08).

Contemporary health promotion involves more than simply educating individuals about healthy practices. It includes efforts to change organizational behavior, as well as the physical and social environment of communities. Health promotion programs that seek to address health problems across this spectrum employ a range of strategies, and operate on multiple levels U.S. Department of Health and Human Services National Institutes of Health (2005:10). Similarly, some including Watermeyer et al (2006) contended that disability can no longer be seen as a static feature of an individual but rather as a dynamic changing experience determined by the changing nature of the environment. This change from focusing on the individual to focusing on the individual plus the environment has important implications for measuring and researching disability, as well as developing policies on disability.

There are other theories that explain change in communities and community action for health. Examples of such theories include the community mobilization (social planning, social action and community development) and diffusion of innovation. At organizational level, models that explain changes in organizational towards the creation of health supportive organizational practice is supported by the organizational change theory. This is based on the change theoretical orientation as explained above by the U.S. Department of Health and Human Services National Institutes of Health (2005).

It is against this background that the researcher identified the ecological perspective to provide an understanding of the theoretical context and evidence-based approaches to address social inclusion of people with disabilities and improving health outcomes. According to the U.S. Department of Health and Human Services National Institutes of Health (2005:10), the ecological perspective emphasizes the interaction between, and

interdependence of factors within and across all levels of a health problem. It highlights people's interactions with their physical and sociocultural environments.

Thus, in this sense it is important to note that several evidence-based theories and models have shown to be applicable. That is, the Health Behavior Theory (HBT) should describe what variables are most important and how the variables relate or interact.

In this context the HBT should explain differences across situations, contexts, populations with regard to different behaviors. Within the study of health behavior, theories have been proposed at a variety of levels, including the individual, interpersonal, group, organizational and community levels. Further, theories vary in their focus on individual as compared to environmental determinants of behavior and cognitive as compared to affective determinants (Glanz, K., Lewis, F.M. and Rimer, B.K. (eds) (1997b); Crosby et al, 2002).

Supporting this view the U.S. Department of Health and Human Services National Institutes of Health (2005:6) points out that because the social context in which behavior occurs is always evolving, theories that were important in public health education a generation ago may be of limited use today. At the same time new social science research allows theorists to refine and adapt existing theories. Two key concepts of the ecological perspective help to identify intervention points for promoting health: first, behavior both affects and is affected by multiple levels of influence; second, individual behavior both shapes and is shaped by the social environment (reciprocal causation).

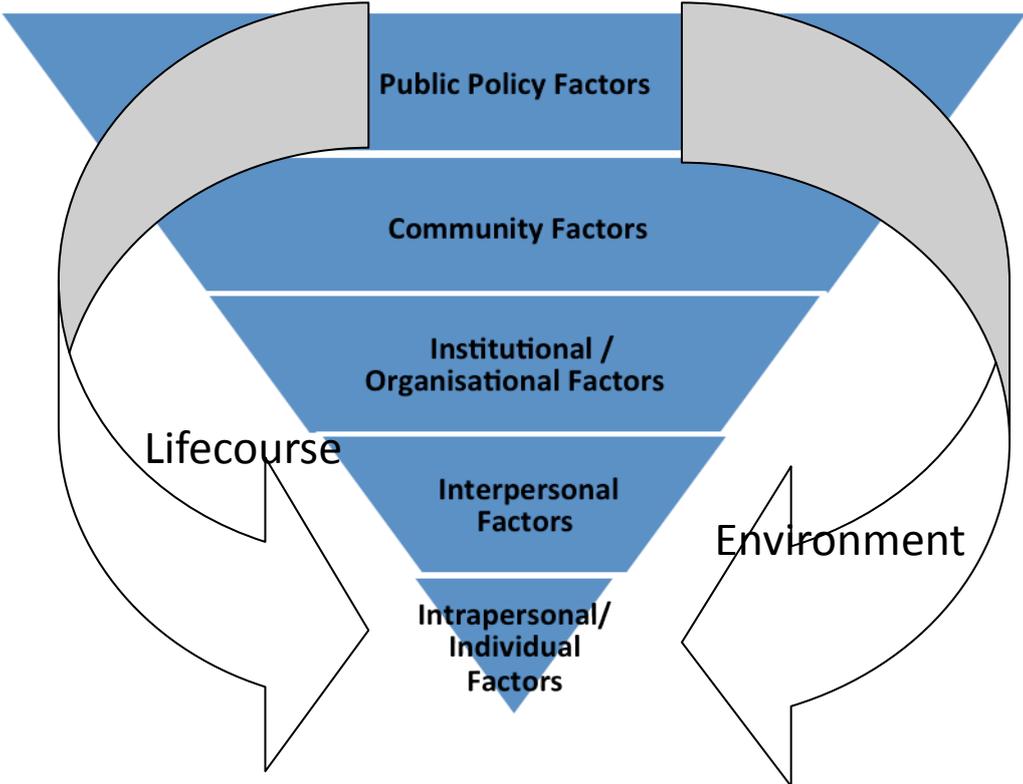
Within the context of this study, evidence from the recent WHO (2011) World report on disability supports the above points by the U.S. Department of Health and Human Services National Institutes of Health (2005). Evidence indicated a growing trend in the prevalence of disability and the increasing epidemiological transition due to technological advancement, which has an impact on the burden of especially non-communicable diseases. Factors contributing to growth of the population of people with disabilities include advances in health care and technology, survival of children and adults with acute and chronic illnesses and traumatic injuries including those associated with military, religious and ethnic conflicts around the world, and aging of the population (WHO, 2009a).

To explain the first key concept of the ecological perspective, multiple levels of influence, McLeroy and colleagues (1988) identified five levels of influence for health-related behaviors and conditions. These levels include the following concepts:

- (1) Intrapersonal or individual factors include Individual characteristics that influence behavior, such as knowledge, attitudes, beliefs, and personality traits
- (2) Interpersonal factors include Interpersonal processes and primary groups, including family, friends, and peers that provide social identity, support, and role definition
- (3) Institutional or organizational factors include rules, regulations, policies, and informal structures, which may constrain or promote recommended behaviors
- (4) Community factors include social networks and norms, or standards, which exist as formal or informal among individuals, groups, and organizations
- (5) Public policy factors include local, state, and federal policies and laws that regulate or support healthy actions and practices for disease prevention, early detection, control, and management.

The ecological perspective is applied in figure 3.1 below.

Figure 3.1: A Multilevel Approach



Adapted from Source: Smedley BD, Syme SL (eds.), Institute of Medicine. Promoting Health: Strategies from Social and Behavioral Research. Washington, D.C. National Academies Press, 2000.

Application of the above multilevel approach to the current study draws from a number of scholarly work some indicating that in a comprehensive review of the life course health development (LCHD) framework, Halfon and Hochstein (2002) argue that developmental trajectories and ultimately, health outcomes can be redirected (and improved) by appropriate, population based intervention in early childhood. Risk of serious diseases and disability in adulthood may be reduced if vulnerable children and young people are identified sufficiently early and given appropriate support and intervention. Relocating health services within all LCHD framework would require integration of clinical, public health and epidemiology services, and a long-term view on financing and investment in health (spend on prevention, save on treatment).

An ecological perspective shows the advantages of multilevel interventions that combine behavioral and environmental components. Based on this understanding and supporting evidence on the subject area, the researcher used the ecological perspective

to explore relevant literature that justify need to build evidence-based inclusive health promotion for people with disabilities. Some of these evidence statements and reviews are discussed below.

Supporting the ecological perspective, World Health Report on ‘Reducing Risks, Promoting Healthy Lifestyles’ (WHO: 2002), indicated that

“in recent years, a life-course approach to the study of health and illness suggests that exposure to disadvantageous experiences and environments accumulates throughout life and increases the risk of illness and premature death”.

This understanding has helped the researcher to contextualize the study subject area based on public health perspective health promotion in particular for people with disabilities. Key public health issues related to exploring the health needs of people with disabilities, the context of social determinants of health and the burden of disease and disability became critical. This approach also fully supports the ecological perspective discussed above.

On the basis of this study it is evident that it is at the individual/ intrapersonal level that the application of the medical model of disability gains dominance, particularly as the primary source of disabling factors determined by the level of influence. An example of the level of influence includes Individual characteristics that influence behavior, such as knowledge, attitudes, beliefs, and personality traits. However, this could also be interpreted as a contribution to social exclusion of people with disabilities in the rest of the domains within the multilevel approach.

Supporting evidence from the disability studies by Grönvik L (2009) states that functional limitations is a rather common way of identifying people as ‘disabled’. Grönvik L (2009) argued that this way of defining disability stems from a medical understanding of disability, where disability is understood as blindness, deafness or other kinds of changes in bodily structures. These are currently often labelled impairments (but not always). This understanding contributed to further exploring the extent of social exclusion basing debates on the effects of disability concepts on research outcomes.

Based on this perception of disability, Nagi (1965) introduced an understanding of disability as functional limitations in relation to which the effects of impairments on an individual's capacity to perform activities of daily living are regarded as disability. Varieties of this conceptualization are quite common (Hahn & Pool Hegamin, 2001); censuses as well as surveys all over the world start from this kind of definition (United Nations, 1996). Without much reflection on the impact of the choice of disability definition, it has also been used to compare occupational attainment and earnings between 'disabled' and 'non-disabled' in a Swedish context (Skogman Thoursie, 2004).

Following on the work of authors Barnes C and Mercer G in the early 1996 on '*Exploring the Divide: illness and Disability*', in which a direct link with the work of medical sociologists in facilitating and applying the World Health Organisation's International Classification of Impairments, Disabilities and Handicaps (ICIDH) (WHO, 1980) was highlighted. ICIDH scheme provided a framework for exploring how the effects of impairment or chronic illness 'create both activity restriction (disability) and social disadvantage (handicap)' (Bury, 1988, p. 91). The intention then was to conceptualise the consequences of chronic illness in such a way that practical and policy issues would be more easily identified. In practice, the widespread adoption of the WHO classification by medical sociologists stood in sharp contrast with its rejection by disability theorists.

This view is supported by Authors Oliver, 1990; Morris, 1991; Higgins, 1992; Swain et al., 1993 who contested that disability is a problem of society, difficulties resulting from a disabling environment rather than from the defects or deficiencies of disabled people as individuals; and the term 'disablism' has been coined to give voice to the marginalisation, if not exclusion, of disabled people from mainstream society. Secondly, as society has 'manufactured' the problems in the first place, disability theorists argue, the onus is on society to change: impairment is, at most, a minor issue.

The White Paper on Integrated National Disability Strategy (1997) agrees with the above and indicates that the social model of disability implies a paradigm shift in terms of how we construct disability. The White Paper on Integrated National Disability Strategy (1997) highlighted the following principles of the social model:

- It is the stairs leading into a building that disable the wheelchair user rather than the wheelchair.
- It is defects in the design of everyday equipment that cause difficulties, not the abilities of people using it.
- It is society's lack of skill in using and accepting alternative ways to communicate that excludes people with disabilities.

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With regard to the public policy factors existing evidence in South Africa by Dube (2005: 4-6) investigated the effectiveness of disability legislation in South Africa. The findings of the study reveal that the national government has been successful in creating an enabling environment for policy development in the field of disability but implementation of such policies remains a challenge. Dube (2005:3) cited the following factors that have contributed to poor implementation of policies on disability:

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- The policy requirements for disability mainstreaming are not adequately linked to performance management, thereby undermining commitment to implementation;

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Evidence of some Institutional or organizational factors is noted. In a study by Becker H, Stuifbergen A.K, and Sands D (1990) to describe the development of a tool to measure barriers to health promotion among persons with disabilities. A study involving 135 disabled adults living in two southwestern cities, the BHADP yielded a Cronbach Alpha of .82 as a measure of internal consistency reliability. In addition, t-test analyses demonstrated a significant difference in scores between the disabled sample and a comparison group of 144 nondisabled adults, suggesting the Barriers to Health Activities among Disabled Persons (BHADP) discriminate between these groups. The study findings revealed that subjectively-defined barriers to engaging in health promoting activities are one of the most important, yet least well operationalized, components in models of health promotion.

The Barriers to Health Activities among Disabled Persons scale (BHADP) is comprised of 16 items reflecting barriers to taking care of one's health identified from previous barriers literature and interviews with disabled persons. In a The BHADP may be useful in sensitizing health care providers to the wide range of barriers experienced by persons with disabilities, thereby enabling them to work more effectively with this special population.

Another study by Benyamini, Idler, Leventhal, and Leventhal (2000) found that people with disabilities and those without disabilities perceive health as a complex, multidimensional concept including in their definitions not only physical health, but being able to do what they want to do, and having a general feeling of well-being. Additionally, Jensen and Allen (1994) find that health for individuals living with disability is perceived within the context of the self and others. Influences on perceptions of health include life roles, choices, relations, abilities, beliefs, practices, social supports, interpersonal relationships, and culture. They conclude that interpersonal, intra-personal, and extra-personal dimensions affect the experience of wellness.

A qualitative study was undertaken by Stuifbergen, AIK, Rogers RN AND, Sharon MSN (1997) to clarify an emerging explanatory model of health-promoting behaviors and

quality of life in individuals with chronic disabling conditions. Twenty individuals (n=20) with multiple sclerosis shared their stories regarding health promotion, domains of quality of life, and factors that affected these domains. Health-promoting behaviors were viewed as essential to the process of rehabilitation and maintaining an acceptable quality of life. Important quality-of-life issues were related to domains other than function. Implications are that health promotion efforts need to be encouraged and supported in individuals with chronic disabling conditions.

Some of the interpersonal and community factors pertain to nurses as care givers have been explored in this literature. A study by Marion MN, Whitty-Rogers CNM, and Joanne MN (2012) depicted some of the "harsh words" nurses sometimes unconsciously use, and it suggested alternatives. The study concluded that Influenced by an ethic of social justice and the ethic of relationship with others, an attempt would be made to explore nursing language with women and children. Nursing is grounded in communication with others, yet rarely are the words critiqued. Despite an ethical call to honor diversity, promote empowerment, and to do no harm, some of the language used in health care reflects historical prejudices, reductionism, and/or the overarching authority of medical or moral models Implications for nursing philosophy and practice became evident.

To support the above findings Falk-Rafael at the York University [Sa], Toronto stated that critical caring is proposed as a hybrid, midrange theory that builds on nursing science and critical feminist theories. As such, it has the potential to root public health nursing practice in an expanded nursing caring science that reincorporates the social justice agenda characteristic of early public health nursing practice but not featured prominently in contemporary nursing theories. Critical caring transforms the curative processes of Watson's theory into 7 curative health-promoting processes that form the "core" of public health nursing practice and reflect the legacy and reality of public health nursing practice.

The World Health Organization's Press Release WHO/27 (17 April 2002) highlighted some of the key Ministerial discussions held regarding understanding the concept of health and disability during a World Conference in Trieste, Italy. The conference deliberations were based on the concept of 'Groundbreaking Classification' and focused

on how everybody can live their full potential. Further discussions were for member states to be able to use a new groundbreaking tool to classify functioning, health and disability thus put disability as part of the wider health concept.

Subsequently, the 2002 groundbreaking tool was introduced in affiliated countries. However, there has been limited progress made to integrate disability into the wider health concept. Health promotion strategies were also aimed at making all people reach their full potential using different methodologies. Limited participation of people with disabilities in health promotion programmes continues to encounter a plethora of challenges. These include reporting mechanisms and implementation processes since 2002.

Since traditional health indicators are based on the population illness and death rates, the modern shift is based on the recognition and attention to the burden of diseases and proposes a focus to “Life”, that is the preventive and promotive aspects. For people with disabilities, rehabilitation is crucial in improving their ability to participate in community activities (WHO: 1996:1). It is in this sense that health promotion can be seen as key in preventing further disability and improving the inclusion of people with disability in both health and social services, without adopting the medical model. However, one feels that for that to happen, health promotion needs the support of other partners through service linkages, networks and coordinated programme efforts.

According to WHO (1996:1) health is created by caring for oneself and others, by being able to make decisions and have control over one’s life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members (WHO 1996:1). Health is therefore not only seen as merely the absence of disease or infirmity but includes the state of physical, mental, spiritual and social wellbeing.

Health Promotion is a process of empowering people to take control over and empower their health. For people with disabilities to be able to achieve this state of health, the health care system needs to develop inclusive strategies and programmes within their existing plans for comprehensiveness. The White Paper on Integrated National Disability Strategy (21: 1997) identifies prevention as the cornerstone of disability policy

because of a reality that most disabilities are preventable. The policy put emphasis on primary prevention of disease and injury, through the promotion of healthy lifestyles and ensuring protective measures to reduce risks to health. Secondary prevention is also promoted to prevent further complication that may result in disability through early management of diseases and injuries.

Another aspect of health promotion stated in the policy refers to that of public education and awareness raising on issues of disability. Disability is portrayed as a “problem”. People with disabilities are viewed as helpless and dependent; as ill and in constant need of care and medical attention, or as tragic victims (White Paper on Integrated National Disability Strategy (23: 1997). As mentioned earlier in this discussion that negative traditional attitudes towards people with disabilities impact negatively on the concept of social exclusion and marginalization of people with disabilities, it is imperative that public education and awareness become central to changing societal attitudes to view people with disabilities as members of society.

3.3 THEORETICAL BASE OF HEALTH PROMOTION AND DISABILITY

As indicated in the preceding chapters, one of the primary arguments in this study explores the extent to which people with disabilities benefit from health promotion. Highlighted as “Who benefits from health promotion?” The long-held pledge of “Health for All by the Year 2000” made this question seem obvious. The adoption of an indomitable Comprehensive Primary Health Care and community-based rehabilitation programme is embedded in the inaccessible clinical milieu. This section provides an analysis of applicable theories to the study contextualize the inclusive health promotion for people with disabilities. Growing evidence show that there are a number of significant theories and models that underpin the practice of health promotion. It would be useful to make a differentiation between theories and models

According to U.S. Department of Health and Human Services National Institutes of Health (2005); a theory presents a systematic way of understanding events or situations. It is a set of concepts, definitions, and propositions that explain or predict these events or situations by illustrating the relationships between variables (Glanz et al., 1997a). Theories are applicable to a broad range of situations. Examples of such theories are Social Cognitive Theory, Theory of Planned Behaviour. Whereas, a model

is defined as subclass of a theory that provides a vehicle for applying the theory. Models do not attempt to explain the processes underlying learning, but only to represent them. An example of a model is the Health Belief Model.

It is important to note that health behavior and health promotion theories draw upon various disciplines (social and behavioural sciences), such as psychology, sociology, anthropology, consumer behavior, and marketing. Many are not highly developed or have not been rigorously tested. Because of this, they often are called conceptual frameworks or theoretical frameworks (U.S. Department of Health and Human Services National Institutes of Health 2005). In most instances these terms are used interchangeably.

However, authors such as Crosby and Noar (2010) argued that theory development has not proceeded at a pace commensurate with the evolution of health promotion practice. They cited at least three examples of this disparity that seemed apparent: Firstly, that theory is developed in an evidence-based paradigm rather than a practice-based paradigm. Secondly, that a substantial majority of health behavior theories exist at the individual level, thereby neglecting contextual realities that shape behavior. Lastly, “accessibility” levels of theory to practitioners may be quite low in comparison to the growing demands to prevent disease through expanding health promotion practices.

The authors pointed that the challenges of health promotion demand a great deal more attention to developing theories that reflect the reality of broad influences on health behavior. One critical question that must be answered involves setting limits regarding the realistic role of behavioral interventions in public health practice. The evolution of theory should be practice-based, largely ecological in nature, and the resulting theories should be easily accessible to practitioners.

The theoretical implication of the above arguments could be associated with the medical model of disability. According to Begum, the medical model of disability which equates disability with illness, has been used extensively to organise and control the lives of disabled people. Focusing on an individualistic approach to disability, pathologising disabled people as problems, rather than recognising the structural oppression disabled people face, has blurred the distinction between illness and impairment. Consequently,

on the one hand disabled people are having to challenge the relevance of a medical model of disability and advocate an understanding of disability based on attitudinal, environmental and institutional barriers; whilst on the other hand disabled people are also struggling to access appropriate health services.

In the past, disabled people have fought so hard to challenge the medicalisation of disability that anxieties about health needs have tended to be minimised. Concerns about the oppressive nature of medical treatment, and the fear of disability being construed as a catalogue of medical problems, has made disabled people wary of putting health issues on the public and/ or academic agenda. Whilst this may be an understandable response to the intrusive and often interventionist nature of the medical world there can be little doubt that disabled people, whether as a result of impairment, or as a consequence of everyday illnesses, are consumers of health services.

Lloyd (1992) points out:

‘.. the narrow defining of disability as clinical conditions results in an all-pervasiveness of doctors' power over disabled people's lives, of which the power to make decisions about fitness for work and entitlement to welfare benefits are but examples. This does not necessarily mean, however, that the medical aspects of their lives are unimportant for disabled people' (p. 211).

In a related review and synthesis of the literature by Karen Danna K and Griffin R.W it became apparent that health and well-being in the workplace have become common topics in the mainstream media, in practitioner-oriented magazines and journals and, increasingly, in scholarly research journals. In this article, we first review the literature that serves to define health and well-being. We then discuss the primary factors associated with health and well-being, the consequences of low levels of health and well-being, and common methods for improving health and well-being in the workplace. Finally, we highlight important future directions for future theory, research, and practice regarding health and well-being from an organizational perspective

This thinking is associated with the social model of disability. Pinder (1995) asserts that more holistic definition of disability is needed, of the way in which disability is intimately linked to other structural relationships which differentially disadvantage social actors. In Pinder's view, this is the hallmark of a Disability Movement which has truly come of age. The disabled sociologist Irving Zola urged the Disability Movement to embrace a universal approach. He wrote:

'Only when we acknowledge the near universality of disability and that all of its dimensions (including the biomedical) are part of the social process by which the meanings of disability are negotiated will it be possible fully to appreciate how general public policy can affect this issue' (Zola 1989:420).

The dilemma for disability theorists is whether, in bringing into the fold 'experience at the margins', the political momentum can be sustained. According to WHO (1996:1) health is created by caring for oneself and others, by being able to make decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members (WHO 1996:1). Health is therefore not only seen as merely the absence of disease or infirmity but includes the state of physical, mental, spiritual and social wellbeing.

The social model of disability, is viewed as the definitive way of representing the lived reality of disabled people as they struggle for social as well as political rights. It has become the means of explaining why disabled people fare so disproportionately poorly in the labour market, as in other areas of social life, such as education and housing (Oliver, 1990; Morris, 1991; Higgins, 1992; Swain et al., 1993). Firstly, disability is a problem of society, difficulties resulting from a disabling environment rather than from the defects or deficiencies of disabled people as individuals; and the term 'disablism' has been coined to give voice to the marginalisation, if not exclusion, of disabled people from mainstream society. Secondly, as society has 'manufactured' the problems in the first place, disability theorists argue, the onus is on society to change: impairment is, at most, a minor issue.

It is critical to note that disability does not only affect the disabled individual, but also the family and the immediate community (White Paper: 1997:49). Therefore, it is one's

opinion that strengthening health promotion approach will have benefits for the society to view people with disabilities as part of the population – a new paradigm of inclusivity. The inclusion of people with disabilities in a truly equal manner would necessitate questioning fundamental aspects of society. As Finkelstein puts it: “We cannot understand or deal with disability without dealing with the essential nature of society itself” (2001b:5).

According to the White Paper on Integrated National Disability Strategy 1997: 49, Social Development is recognized as a key role-player in enabling access to the service delivery system. It is acknowledged that fragmentation is a prevalent systemic challenge, which affects a holistic approach to the delivery of an integrated service. In view of this department’s service delivery improvement initiatives the Protective Workshops, a changing approach could be explored to move towards a holistic paradigm of inclusiveness and shared service delivery model, instead of regarding people with disabilities from a purely health and welfare issue to a primary human rights and developmental issue (White Paper: 1997:49).

The strategy makes recommendations for service providers to implement the Human Rights and the Development Model in the provision of services to People with Disabilities. It further recommends an integrated and collaborative approach between Departments in order to provide holistic and sustainable services to People with Disabilities (Department of Social Development 2008:5).

Goals of health promotion include the primary and secondary prevention of disease and health compromising condition. Many nations have embraced health promotion as an approach to extending and enriching the lives of their people. For example, in the US, the U.S. Department of Health and Human Services (2000) established two overarching goals:

- To increase the quality and years of healthy life, and
- To eliminate health disparities.

The above stated goals were regarded as ambitious and provided enormous challenges to the discipline of health promotion. However, advances in the development of

behavioural and social science theory contributed extensively to enhance the ability to achieve the health promotion objectives of the ambitious country goals. Behavioural and social science theory provides a platform for understanding why people engage in health-risk or health compromising behaviour and why they adopt health protective behaviour (Crosby, Kegler & DiClemente 2000).

For people with disabilities to be able to achieve this state of health, the health care system needs to develop inclusive strategies and programmes within their existing plans for comprehensiveness. The White Paper on Integrated National Disability Strategy (21: 1997) identifies prevention as the cornerstone of disability policy because of a reality that most disabilities are preventable. The policy put emphasis on primary prevention of disease and injury, through the promotion of healthy lifestyles and ensuring protective measures to reduce risks to health. Secondary prevention is also promoted to prevent further complication that may result in disability through early management of diseases and injuries.

Another aspect of health promotion stated in the policy refers to that of public education and awareness raising on issues of disability. Disability is portrayed as a “problem”. People with disabilities are viewed as helpless and dependent; as ill and in constant need of care and medical attention, or as tragic victims (White Paper on Integrated National Disability Strategy (23: 1997). As mentioned earlier in this discussion that negative traditional attitudes towards people with disabilities impact negatively on the concept of social exclusion and marginalization of people with disabilities, it is imperative that public education and awareness become central to changing societal attitudes to view people with disabilities as members of society.

Berkman L.F's published article (Psychosomatic Medicine, Vol 57, Issue 3 245-254, Copyright © 1995) on the role of social relations in health promotion contended that there was a substantial body of evidence that indicated that the extent to which social relationships were strong and supportive was related to the health of individuals who lived within such social contexts. A review of population-based research on mortality risk over the last 20 years indicated that people who were isolated were at increased mortality risk from a number of causes. For social support to be health promoting, it

must provide both a sense of belonging and intimacy and must help people to be more competent and self-efficacious.

3.4 CONCEPTUALIZATION OF THE FRAMEWORK

Many models of evidence-based have been developed including models that provide a framework for individual clinicians (Stetler model) and others for organization or teams (IOAW model) of evidence-based practice to promote quality of care). Amongst the widely used models is Roger's Diffusion of Innovation (Polit AND Beck 2012:46). The U.S. Department of Health and Human Services National Institutes of Health (2005) defines Diffusion of Innovations Theory as one that addresses how ideas, products, and social practices that are perceived as "new" spread throughout a society or from one society to another. Diffusion Theory has been used to study the adoption of a wide range of health behaviors and programs.

However, evidence show that issues of health and wellness for people with disabilities are becoming prominent issues on the national health agenda (United States Department of Health and Human Services, 2000). New models of health and wellness specific to persons living with disability are attempting to understand and operationalize health and wellness within the disability experience.

These models show what many people living with disabilities conceptualize that a person can be healthy and well and live long-term with disability (National Institute of Disability Rehabilitation Research, 2000; Institute of Medicine, 1991). Much of this shift in perspective stems from a new disability paradigm that views disability as a situational experience, a function of the relationship between the individual and the environments that surround that individual (cultural, social, natural and architectural) (NIDRR, 2000).

However, the current thinking and arguments based on empirical validation of behavior health models related to HIV risk shared some light. Authors Traube D; Holloway I; Smith L (2011) argued that in the presence of numerous health behavior theories, it is difficult to determine which of the many theories is most precise in explaining health-related behavior.

New models continue to be introduced to the field, despite already existing disparity, overlap, and lack of unification among health promotion theories. In addition, the authors make a unique contribution to the HIV health behavior theory literature by moving beyond current health behavior theory critiques to argue that one of the field's preexisting, but less popular theories, Social Action Theory (SAT), offers a pragmatic and broad framework to address many of the accuracy issues within HIV health behavior theory. The authors conclude this article by offering a comprehensive plan for validating model accuracy, variable influence, and behavioral applicability of SAT.

Persons with disabilities have been largely overlooked in investigations of health and health behaviors. The primary purpose of this descriptive correlational study was to examine the usefulness of Pender's (1987) Health Promotion Model in explaining the occurrence of health-promoting behaviors among adults with disabilities. Hierarchical multiple regression analyses were used to analyze questionnaire responses from a sample of 117 adults with disabilities. Adults with disabilities were more likely to engage in a health-promoting lifestyle if they had higher specific self-efficacy for health behaviors, higher general self-efficacy, a wellness-oriented definition of health, required less mechanical assistance, and were female. Findings from this study suggested that interventions aimed at enhancing health promotion behaviors among persons with disabilities would be strengthened by addressing perceived ability to master situations, particularly the ability to successfully carry out health-promoting behaviours (Research in Nursing & Health Volume 17, Issue 1, pages 3–13, February 1994. Date accessed 22 March 2012).

3.5 MODEL EXPOSITION

The conceptual framework for people with disability is based on the three domains are conceptualised to propose an inclusive service model for people with disabilities, that is; the Social, Health Promotion and the Protective Workshops. A common thread in the three model domains is that they are focussed on the common principles of social justice, redress, human rights and promoting inclusiveness through integrated/comprehensive approaches. Conceptual framework intends to respond to the study purpose that is to propose an integrated approach of health promotion within protective workshops to achieve inclusivity in promoting healthy lifestyles amongst

people with disabilities in environments where they live, work and play. This is based on strong theoretical evidence that serve as a basis for:

- Defining related concepts;
- Providing a frame of reference that is a for observations;
- Guiding the research design;
- Determining interpretations;
- Addressing potential generalization.

As mentioned earlier, the human rights and social model allow all people, including people with disabilities to participate meaningfully in matters that affect them. The model also aims to educate the general public about disability and the need to prevent discrimination of people with disabilities. The purpose of this research project was to first establish whether inclusive health promotion occurs in South Africa and secondly, to investigate institutions infuse health promotion.

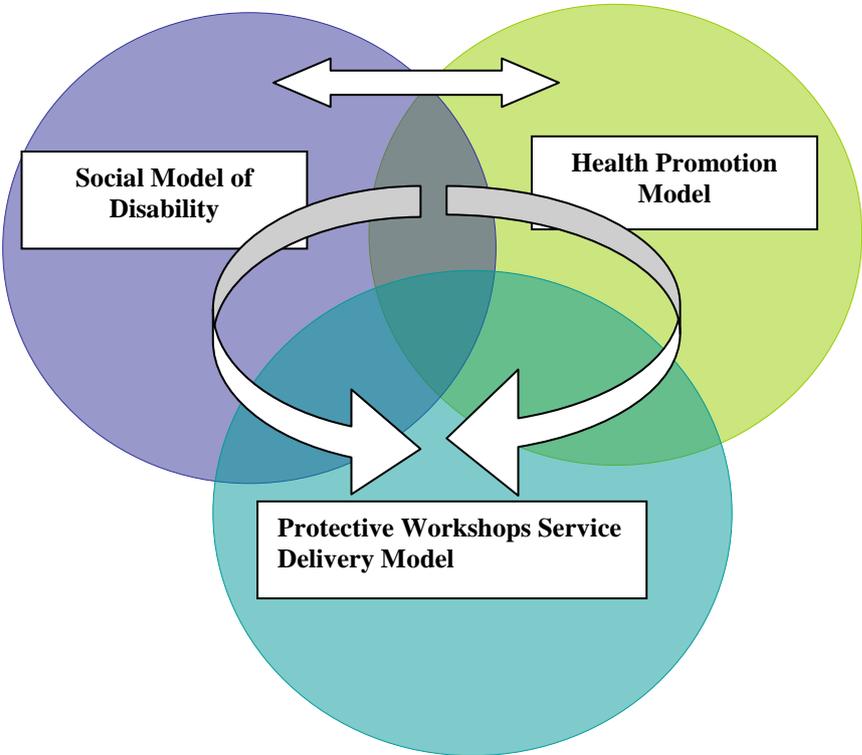
Ultimately, this investigation suggests concrete propositions for health promotion. Hopefully, institutions that serve people with disabilities should contribute to the realization of inclusivity and harness healthy lifestyles wherever people with disabilities live, work and play. Furthermore, the conceptual model demonstrate that health promotion programme approaches should be honed to target people with disabilities and the citizenry as a whole for a sustainable, just and public health ethic as part of the county's development agenda..

Evidence shows that the historical health inequity as well as exclusion have and continue to cause a disproportionately higher number of people with disability carry the burden of disease. However, the current and continuing limitations of existing programmes to deal with health promotion needs of people with disabilities has been of great concern and the fact that where such programmes exist, often the environments are often not conducive to promote the health and rights of people with disabilities.

The findings of this study revealed similar related experiences and suggested some strategies used to encourage greater participation of people with disabilities in health promotion efforts though compliance with policy and legislative imperatives regarding inclusion and integration in health promotion programmes. The development of this

framework has been guided by the literature review; respondent's expressed views and experiences during interviews and participant's observations.

Figure 3.2: An Inclusive Social Model of Health Promotion within Protective Workshops



3.5.1 Social Model of Disability Domain

The context of this domain on social model of disability has been widely expressed throughout the thesis through evidence statements and arguments to provide justification on the issue of inclusive health promotion for people with disabilities. Common theme that emerged from these debates revolve around social exclusion, social inclusion, access to health services, social barriers, discrimination, equal opportunities, reasonable accommodation. The contexts in which this theme was applied related to human rights, public health, and health promotion, and primary health care, protective workshops, applications of theories and models and also in evidence-based approaches including primary and secondary sources of literature reviews. This domain provided an important context for grounded theories on understanding the multifaceted and complex environments in dealing with issues of social exclusion. With supporting evidence from a variety of disciplines of social science, public health and disability studies human rights including anthropology and many more this created an

understanding of approaching social exclusion of people with disabilities from socioecological perspective in order to achieve better health outcomes. Lessons learned include the fact that depending on the level of influence there is a wide range of theories and models that could be applied to provide a systematic evidence-based behavior change and organizational change and remove the disabling factors in the social environment. This domain serves as the foundation for proposing an effective inclusive model as its successful implementation depends on the enabling safe and supportive environment through attention to legislative, policy, programmatic and communication mechanism.

Some of the supporting literature is discussed. Disability is a major health issue for the 21st century. The WHO 2002 report on reducing Risks, preventing diseases and promoting health identified the ten major health risks in the world and for South Africa five top risks contributed to mortality and morbidity trends. The approach is different in that it described the interrelatedness of the two main domains of the social model of disability and the health promotion model from a developmental and human rights perspective. Their relationship was then applied within the protective workshops service delivery model domain.

Growing evidence and experiences (revealed in this study finding) is that the health promotion needs of people with disabilities was insufficiently addressed, prompting the researcher to focus on this study to gain an in-depth understanding of factors in society that contribute to the exclusion of people with disabilities in mainstream service delivery programmes, such as protective workshops. This approach was further influenced by the Department of Social Development that had the mandate to develop and manage a national programme on protective workshops in collaboration with NGOs and key government stakeholders.

3.5.2 Health Promotion domain

This domain draws on the previous study in terms of evidence arguments and discussion throughout the study. As in other developing countries, the South African experience of the burden of disease and disability has prompted the health system to evolve beyond curative rate models but to move urgently towards addressing the need

to use long term preventive and promotion care models (Department of Health, NCD National Guidelines, 2006:8).

The health promotion approach advocates for a concerted effort and partnership building to tackle the burden of disease associated with disability with a focus on supportive environment, building healthy public policies, strengthening access to health and social services, reorientation of health workers into disability and promote participation of people with disabilities and the community in shaping their own health. Significantly the study contributes to increased access by people with disabilities to preventive and health promotion services as well as to increasing the ability of people with disabilities to take control of their own health, which is a basic human right.

3.5.3 Protective Workshop Service Domain

In understanding the context of this domain Protective Workshops, also referred to as supported environments are forms of a service delivery model exclusively employing people with disabilities. These facilities are funded and supported by the Department of Social Development (DSD) in South Africa and jointly managed by NGOs and DSD. In the context of this discussion, protective workshops are regarded as access points that would benefit people with disabilities from preferential procurement, skills training and opportunities provided by various departments. The active participation of other departments therefore becomes imperative for the implementation of the Policy on the Management of Protective Workshops.

The policy guidelines on the Management of Protective Workshops (Department of Social Development 2006) provides a framework to create enabling supportive environments within protective workshops for the promotion of an inclusive, accessible and integrated service delivery model for people with disabilities. The core service package categories of Protective Workshops include the following:

- Promotion and prevention services
- Rehabilitative services
- Protection services
- Continuing services

- Mental Health

The Primary Health Care Package of the Department of Health supports the core package areas of the Protective Workshops as mentioned above. The delivery of most of these services is dependant on the contributions of other departments such as health, social development, safety and security and many more to enable supportive environment within protective workshops.

For the purpose of this study, the researcher introduces some key areas for considerations that addresses the challenges affecting implantation of in protective workshops raised in preceding chapters. The purpose of this is to suggest improvement plans that protective workshops could adopt towards the development of an inclusive health promotion model for people with disabilities proposed in this study. This approach draws lessons from evidence-based studies and proven tools within public health system as guided by WHO's National Institute for Health and Clinical publication. Elements of improvement and application of public health systems with relevance to Protective Workshops could relate to the following sub headings:

- service design and service delivery
- targeting and tailoring
- life stage and setting
- mode of delivery
- partnerships and relationships
- creating resources
- service personnel and workforce development

3.5.3.1 A case of Protective Workshops

- **Service design and Service delivery**

It was established that the delivery of services within Protective Workshops is dependent on the contributions of other departments such as health, social development, safety and security and many more to enable supportive environment within protective workshops (DSD 2006). To achieve sustain health improvements, this is indicative of a need for evidence-based planning using a combination of integrated

organisational change theories and models of care such as ecological perspective, intervention mapping and evidence-based behavioural change models.

- **Targeting and tailoring**

In this context targeting and tailoring is seen as critical to address social exclusion, health care barriers and ensure equal opportunities for people with disabilities to mainstream health services. This is seen as a rights-based approach. Evidence from the White Paper on Integrated National Disability Strategy (1997:1), reflected several factors that impacted negatively on the prevalence of disability in South Africa due to unreliable statistics. These include the following:

- There are different definitions of disability;
- The use of different data collection technologies on disability;
- Negative traditional attitudes towards people with disabilities;
- Poor service infrastructure for people with disabilities in underdeveloped areas, and
- Violence levels (in particular areas in particular places) impede the collection of data and affect the overall picture of disability.

Additionally, growing evidence show the need for services, interventions and care providers within the health system to target and tailor activity towards those in most need. Needs assessment and or monitoring systems of clients or populations were a related construct.

- **Life stage and setting**

According to the White Paper on Integrated National Disability Strategy (1997) it is society's lack of skill in using and accepting alternative ways to communicate that excludes people with disabilities. The multilevel approach of the ecological perspective discussed earlier alluded to multiple evidence statements referring to services or interventions clustered around specific stages in the life course, within appropriate settings, which are applicable to the supported workplace environment (Protective Workshop) and homes for example. This emphasizes the 'wraparound' nature of health systems across life, and the need for service providers and service in these settings.

- **Mode of delivery**

Mode of delivery refers to the way in which an intervention or service is delivered, through which medium and by whom. This area is related to the sub theme of service delivery discussed above. As discussed, in the context of Protective Workshops, they are regarded as access points that would benefit people with disabilities from preferential procurement, skills training and opportunities provided by various departments. Critical to this is the active participation of other departments therefore becomes imperative for the implementation of the Policy on the Management of Protective Workshops. This approach creates a conducive environment to promote the health of people with disabilities in an integrated manner through a basket of services. Multisectoral approaches such as theories of organizational change, community development, communication and diffusion of innovation models are relevant.

- **Partnerships and relationships**

The successful implementation of an inclusive service delivery model of Protective Workshops depends on the contributions of other departments such as health, social development, safety and security and many more (DSD 2006). However some of the noted service delivery challenges earlier alluded to issues of service fragmentation, lack of integrated planning, coordination and funding mechanisms including lack of consultation of people with disabilities.

Some of the evidence to support this is discussed. Campbell (2006) reviewed recent UK initiatives to promote partnerships working, noting the increasing emphasis of interprofessional working and collaboration in UK health policy. She suggests that a combination of factors have driven this forward: Ever more complex health systems have meant that there is an increased need for coordination to improve advocacy, reduce duplication, promote sustainable projects and improve commissioning. The author proposes that effective partnerships may be developed through the development of clear partnership models, identification of appropriate collaborators (in consultation with stakeholders and communities), incorporation of good practice examples. However, no empirical evidence is presented for this approach.

Murphy (2005) reviews literature on citizens deliberation in setting healthcare priorities, focusing in particular on four recent UK studies. She concludes that the benefits of citizens involvement work two ways: citizens may benefit in terms of gaining insight into their experience and their own, or their communities, aspirations. Services and communities may benefit as citizens who share values such as respect, equality or generosity inform healthcare priorities that create opportunities for the wider community.

- **Creating resources**

The National Consultative Workshop on Protective Employment for people with Disabilities that was held from the 7-8 February 2008 in Gauteng Province, South Africa identified several challenges that put a strain on limited resources within Protective Workshops. These were noted as follows:

- The number of people with multiple disabilities is increasing with limited specialised workshops to meet their needs
- Rural/Urban disparity gap identified in terms of resource mobilisation and distribution, sustainability efforts, capacity and access to opportunities
- Poor remuneration of staff at protective workshops and poor management skills
- Management do not involve people with disabilities in decision making processes
- The operational focus within protective workshops is limited to employment, care, social and skills development
- Inadequate funding
- Access to government resources and services is always a challenge
- Good practice efforts not adequately documented and published.

Training and development of staff to promote effective services was a strong and consistent theme within the evidence statement. This area affects all other themes as resources determine planning and effectiveness of interventions in any planned course of action.

An example of a model applicable in this theme could be that of Diffusion of Innovations, which addresses how ideas, products, and social practices that are perceived as “new” spread throughout a society or from one society to another.

- **Service personnel and workforce development**

Evidence show that the role of appropriately trained personnel in delivering effective services within the system was a recurrent theme. NICE (2006) argue that the type of health professional who provides the advice is not critical as long as they have the appropriate training and experience, are enthusiastic and able to motivate, and are able to provide long-term support. However there is evidence of some conflict that surfaced in UPIAS' critique of the Disability Alliance and its dominance by non-disabled academics (UPIAS, 1976). The Alliance was regarded as a forum where others speak on behalf of disabled people, whereas UPIAS aimed for mass participation of the disabled community:

'We reject also the whole idea of "experts" and professionals holding forth on how we should accept our disabilities, or giving learned lectures about the "psychology" of disablement. We already know what it feels like to be poor, isolated, segregated, done good to, stared at, and talked down to - far better than any able-bodied expert....'(UPIAS, 1976) .

Some human rights approaches and statements emerged over the years from the voices of people with disability, strongly advocating messages of inclusivity such as "*Nothing about us, without us.*"

With regard to the public policy factors existing evidence in South Africa by Dube (2005: 4-6) investigated the effectiveness of disability legislation in South Africa. The findings of the study reveal that the national government has been successful in creating an enabling environment for policy development in the field of disability but implementation of such policies remains a challenge. Dube (2005:3) cited the following factors that have contributed to poor implementation of policies on disability:

- Definition and nature of participation of people with disability have not been adequately reviewed and articulated;
- The policy requirements for disability mainstreaming are not adequately linked to performance management, thereby undermining commitment to implementation;

Wise (2008) argues that investment, building evidence, building sector capacity, leadership by government, and incentive for health professionals to use effective health promotion strategies are all building blocks for improvement. He further identifies the need to redistribute political power and engage the whole population in political decisions as vital to engagement in health and behaviour change.

Additionally, in 2003, South Africa introduced free healthcare for people with disabilities of their life. According to DOH (2003), this move offered the best opportunity to the national health system to focus on the most vulnerable group of society. The focus of free health care for people with disabilities is on in-patient and out-patient hospital services such as diagnosis and treatment, specialised services, rehabilitation and provision of assistive devices. This is, according to DOH over and above promoting health care services already offered at clinics and community health centres for free. It has been established that most people with disabilities, particularly from Protective workshops and communities at the most utilizes the out-patient services and yet continue to experience unmet health care needs compared to those without disabilities.

The patterns of access to and exclusion from services have famously been described as the 'inverse care law' (Tudor Hart 1971). Tudor Hart argues that the need for care varies inversely with the care provided. In other words, those in most need receive the worst care, and those in least need the best. In this sense the systems have profound effects on health-related behaviour and on health outcomes.

Tudor Hart saw this as contributing significantly to health inequality. His observation is widely replicated in many healthcare settings, including those where there is no fee for service and care is free at the point of delivery, like the UK, and those based on social insurance as well as market based systems (Mackenbach 2006; Gilson et al. 2007; CSDH 2008). This understanding could be considered when assessing the extent to which the people with disabilities within protective workshops experiences health services. This is also important in defining their experiences in accessing health facilities such as hospitals and clinics.

3.6 TOWARDS AN INCLUSIVE HEALTH PROMOTION MODEL FOR PEOPLE WITH DISABILITIES DOMAIN

Inclusive health promotion for people with disabilities for the sake of this research include support for due process and health institutions and processes that make access, affordability and universal the health and basic respect for the dignity of the people who live with disabilities. This section provides a synthesis of all the evidence and arguments in order to justify the basis of an inclusive health promotion model for people with disabilities within the South African context.

The main thrust of this study was to address social exclusion of people with disabilities from accessing the mainstream health services as a constitutional right to health care. Research questions guided the study focus. To achieve this objective researcher explored different contexts of evidence-based approaches and empirical studies to develop an inclusive health promotion model for people with disabilities. It should be clarified that, however, this study was not intended to discuss context of disability but to explore the extent to which people with disabilities receive health services and to use that knowledge to improve their social inclusion and access to equal opportunities and participation in health promotion. As discussed earlier this view is supported by Polit and Beck (2012:148), the goal of theories and models in research is to make findings meaningful; integrate knowledge into coherent systems; stimulate new research and explain relationship between them.

Further, authors Griffith P and Bridges J (2010: 201;380) affirm that the need for evidence on which to base health care is growing as a result of many factors. It has been suggested that increased demand on health care service is a consequent of the ageing population, the expectation for accessible high quality services and for redress and compensation should there be a failure of these service. These factors highlight the importance of ensuring that only health care services that work are provided to consumers. In this context it implies that integrated service models could fit this description.

This synthesis provides an integrated model to benefit people with disabilities in three domains as indicated in the figure above. These domains are:

- The Protective Workshops, which are also referred to as supported environment (service delivery model) that is supported by the Department of Social Development (DSD) in South Africa and jointly managed by NGOs and DSD;
- Health Promotion, which refers to primary health care services managed by the Department of Health and health care partners to include within protective workshops for people with disabilities, and
- Social model, which encompasses approaches to address social exclusion of people with disabilities from Social Development, Human Rights, Employment, Organisations of people with disabilities' movements/activism including those for people with disabilities and people with disabilities' views.

It is well documented that people with disabilities have less access to health care services and therefore continue to experience unmet health care needs (Queensland Government (2010); WHO (2011). In view of this, an extensive body of knowledge supports that promoting health is a shared responsibility that requires the co-ordinated action of many sectors working together to improve wellbeing. Health systems can be defined as the sum of the people, institutions and resources arranged together (in accordance with relevant policies) to maintain and improve the health of the population they serve (WHO 2005: www.who.int/features/qa/28/en).

Moore et al. (2007:282) go further, suggesting that a health system encompasses:

“... the complex interaction and feedback occurring among global contexts, organisational capacities, inter-organisational relationships, institutional environments and population health”.

There is growing evidence to indicate that health systems have significant potential to change health behaviors and improve health. This is an addition to the potential for specific programmes and interventions delivered by health professionals to have a positive impact on health behaviour and health outcomes Fishbein, (2000). Harnessing and utilising health systems to prevent rather than, or in addition to, treating conditions and illnesses- may also lead to significant cost savings.

According to Fishbein, (2000), health systems are determinants of health in two distinct senses:

- Socially - because their existence has both intended and unintended effects on the health of individuals and populations.
- As agents themselves, since they make deliberate attempts to affect human behaviour. As 'agents', health systems further attempt to change the client group through the actions of the system, and by attempting to change its constituent parts- that is, by changing the behaviour of internal personnel and the way services are provided.

The theoretical Models explored earlier in the text at individual, community and organizational levels highlight the need to integrate their application as suggested by Fishbein (2000). The same understanding and growing evidence supports the Health Promotion Models and the need for paradigm shift to integrate the social model of disability in public health. This justification shows that strong theoretical base and health promotion are grounded on public health.

In terms of institutional mechanisms to support this integrated model for people with disabilities, it has been mentioned in preceding chapters that the disability sector is grounded in enabling legislative and environments at international, regional and national levels. It goes without saying that many of these prescripts and commitments regard social exclusion as a gross violation of the rights of people with disabilities. In addition they advocates for a change in thinking to promote social inclusion through strengthening integrated evidence based approach to disability at all levels of service delivery across the lifecourse. A sustainable public health approach, should adopt health promotion and disease prevention strategies for people with disabilities. The benefit of this is that health education and promotion goes along with empowerment model (equal opportunities, education for health) to keep people healthy while taking care of their health care needs (reasonable accommodation).

This perspective adds value to the health promotion practice and body of knowledge. At a greater level there is evidence of health and development gains in managed health care, decreased mortality and morbidity due to preventable diseases/ disabling

conditions including co-morbidity, reduced health care costs, increased life expectancy and quality of life and enhanced healthy lifestyles, primary prevention promoted and increased intersectoral collaboration. Through all this is the emphasis of the environment that disables people with disabilities the barriers it creates.

Supporting this belief, Schneider M (2006:8) asserted that disability can no longer be seen as a feature of an individual but rather as a dynamic and changing experience determined by the changing nature of the environment. Report of the WHO (2011:32) confirmed that the relationship between health conditions and disabilities are complicated. Whether a health condition, interacting with contextual factors, will result in disability is determined by interrelated factors. Often the interaction of several conditions rather than a single one contributes to the relationship between health conditions and disability. Co-morbidity, associated with more severe disability than single conditions, has implications for disability. Also the presence of multiple health problems can make the management of health care and rehabilitation services more difficult.

The behaviour of individuals including people with disabilities, communities and populations is one of the major determinants of their health outcomes. There is significant evidence that given the right approach and appropriate conditions health professionals, services or even governments may deliver services and interventions to individuals, communities or within populations in order to change health-related behaviors, reduce risk, and reduce levels of morbidity and mortality (Jepson et al. 2006). As noted by Watermeyer, Swats, Lorenzo, Schneider and Priestley (2006;2008) that disability is both a cause and a consequent of poverty. In this intersection, the authors explained that disability increases vulnerability to poverty, while poverty creates the condition for increased risk of disability. Poverty reduction strategies could receive attention through an inclusive model focus and be tackled to avert the associated vicious cycle implication by a number of service delivery partners.

Some the examples of supportive environments specific to this section are discussed.

Protective Workshops are premised on the Policy Guidelines on the Management of Protective Workshops (DSD, 2004:12), which provide a framework to create enabling supportive environments within protective workshops for the promotion of an inclusive,

accessible and integrated service delivery model for people with disabilities. The emphasis is on transforming disability as a developmental issue to ensure a more holistic and integrated approach to disability concerns into the mainstream of government responsibilities and service delivery. The delivery of most of these services is dependant on the contributions of other departments such as health, social development, safety and security and many more to enable supportive environment within protective workshops. This approach also create a supportive environment for this inclusive model.

3.7 SUMMARY

The chapter addressed interrelated concepts for a systematic view of the inclusive health promotion phenomena, so as to provide a framework within which data about people with disabilities and health could be collected and synthesized. Within this framework, the human rights and social model outlined the impact made first and foremost, after the Constitution of the Republic of South Africa, Act 108 of 1996, underscores the equality of all South Africans under the law stating that: Equality includes the full and equal enjoyment of all rights and freedoms. The human rights and social models facilitate meaningful inclusion and participation of people with disabilities in matters that affect them and dissemination of accurate and relevant information.

CHAPTER FOUR

RESEARCH DESIGN, RESEARCH METHODOLOGY AND DATA COLLECTION APPROACHES

4.1 INTRODUCTION

The preceding chapter dealt with the conceptual framework. This chapter will describe the research process, the rationale and describe triangulation procedures. Furthermore the data collection methods, the analysis of data including validity and reliability issues are considered. The problem statement, its purpose, the significance of the study and the interconnectedness of the research elements within inclusive health promotion, will also be addressed. This investigation should identify issues related to the nature and scope of inclusive health promotion; expand knowledge and describe how health practitioners can utilize scientifically proven data in ensuring that public health institutions, hospitals and clinics, meaningfully include people with disabilities in the delivery of health care services.

According to Polit and Beck (2004; 2012) a research design is the overall plan that the investigator has in their quest for answers to the research question. It is about selecting a specific design and identifying strategies to minimise bias. Furthermore, the authors refer to research designs as the architectural backbone of the study. Similar views by Burns and Grove's (2003:494) define research design as a system for undertaking an investigation that ensures optimal control over factors that could confound the credibility of the research findings. Whereas, Polit and Hungler (1999:166) earlier alluded to the significance of ensuring that the research process yields dependable research findings.

4.2 TRIANGULATION

The qualitative and quantitative approaches were viewed as complementary; using both was intended to minimise the effect of the weaknesses of each approach but at the same maximizing the impact of their strengths in the planned exploration of the phenomenon of inclusive health promotion with regard to those with disabilities. The methodological triangulation or rather, the combination of these two strategies involved a well-considered unification of the qualitative and quantitative approaches to better

understand the research area as an initial step towards recommending practice improvements (Sheppard 2004:215). The expressions yielded through the qualitative approach compensated for the deficits of the numerical data (Polit and Hungler 1999: 257-258). In support of a combination of approaches, many research theorists include Polit & Hungler (1999); Polit & Beck (2004) and Morse (1997:230) who suggest that, “substantive completeness” is acquired through this triangulation process. For Polit and Beck (2004:310) the merits of qualitative data in this research project had the benefit of substantiating and validating numerical findings. While the strength of quantitative data lies with its capacity for generalizability and precision, its shortcoming relates to limitations in offering in-depth narratives and perspectives of the situation under exploration.

Griffiths and Bridges (2010:430) describe an understanding of qualitative research as the non-numerical analysis of data gathered by distinctive methods such as in-depth interviews, focus groups and participant observations. They explain that qualitative data tends to take the form of narrative statements with themes and concepts as the analytical device. In addition, some form of the data is transformed into quantitative data and then subjected to standard statistical analysis. However, the author is cautious that such approaches are not what is usually meant by qualitative research. In this context, the qualitative research is meant to understand personal accounts for people with disabilities, manage the research while taking into consideration their motto; “Nothing about us without us” and the context of social exclusion. Leedy and Ormrod (2005:246) attest to the descriptive design’s dual characteristics of both qualitative and quantitative, of data generation in observation or interview techniques. The descriptive design may also be used to test hypotheses or research questions. Using a survey for data collection was a triangulation method utilised to give more meaning to the overall study design. A review of the health promotion activities for people with disabilities from a public health perspective. The process included examining different integrated models to determine if they improve the quality of health care service and support for people with disabilities in areas where they work, play and live. Different contexts (international and South African) supported this exploration.

4.3 DESCRIPTION OF THE RESEARCH DESIGN

4.3.1 Research Design

The study design was a quantitative approach, which used a descriptive survey to gain understanding of the phenomena of disability and social exclusion. This research design was combined with qualitative approaches. This triangulation of methods was intended to increase the study's reliability and validity (Polit and Beck 2004; Miles and Huberman 1994). The researcher identified the research setting and population. Hagu & Jackson (1996:76) elaborate that the research design gives direction to sampling procedures, level of measurement, frequency of measurement and data collection methods.

4.3.2 Negotiating Entry

To form the research design throughout the research process, there were preliminary measures such as establishing a rapport with the constituencies in the matter of disability issues. The researcher involved a number of stakeholders and gatekeepers in the areas of disability and health, in the government and civil society. A series of consultative meetings were conducted with different stakeholders in the area of disability and health practitioners, the Office on the Status of Disabled People (OSDP), Departments of Health and Social Development and Disabled People South Africa (DPSA). Understanding of the disability environment and dynamics associated require sensitivity of the issues involved. As stated earlier, descriptive data was complemented by qualitative data. The instrumentation questionnaire and tools were triangulated to ensure reliability and validity of the tools.

This study was conducted nationally within the disability environment using a Protective Workshop service model, which is a programme that is managed and supported by the National Department of Social Development. This service delivery model serves to create socio-economic opportunities by providing a diverse range of services, that include social and skills development, training and self-help programmes for people with disabilities (Social Development Consultative Workshop 2008:5).

4.3.3 Triangulation of the Research Design

Polit, Beck and Hungler (2001:472) refer to triangulation as the use of multiple methods or perspectives to collect data and interpret data about a phenomenon, so as to converge on an accurate representation of reality. Throughout the research process, the researcher used various complementary methods and sources.

The investigation included cross-referencing the current situation related to disability and health promotion for the enhancement of an inclusive health promotion model. Johnson and Christensen (2008:200) state that a method of cross checking information and conclusions through the use of multiple procedures or sources increases validity and reliability. Polit and Hungler (1999; 258) states that there are “problems with method and measures that are invariably fallible”, that are addressed by triangulation. In this study, the method of triangulation was elaborated on the following:

4.3.3.1 Data triangulation

The chapter on the review of literature explored various sources (primary, secondary and electronic) of data to describe complexities in health seeking behavior, the models of care and the level of involvement and participation of people with disabilities in health promotion to take control of their health. The methods were replicated to guide the research purpose and honed research questions that shaped the scope of the study design (Polit and Beck 2004).

The data collection process generated data comprising of both quantitative and qualitative information that allowed for data triangulation. Another source of data triangulation was through consultative meetings with various government and civil society stakeholders, including people with disabilities. The data analysis process yielded substantive and credible results. The qualitative field data was used to complement quantitative data sources such as participant observations and literature reviews which were blended to validate responses (Polit and Beck 2004).

4.3.3.2 Method Triangulation

Various methods of data collection were used in the study to enhance credibility. Individual in-depth interviews were held with all people with disabilities to collect data nationally. Various disability types amongst people with disabilities were considered as well as flexibility in terms of language barriers and translation (Sign and Braille). Local interviewers, some of which were people with disabilities themselves, were also employed at this stage. (Polit and Beck 2004).

During interviews there were no conflicts recorded in responses to questions by any particular type of disability. For example, there was harmony between respondents who were blind and those with other physical disabilities. This ensured greater corroboration of data. This confirms Polit and Hungler's (1999:429) assertion that the use of multiple methods and perspectives allows researchers an opportunity to sort out "true" information from "erroneous" information.

The qualitative data was analyzed differently from the quantitative data. The former involved themes, categories and patterns with narrative confirmation to nuance findings. Document review, participant observation and other sources of data supported the findings. Consultations were made with experts in the area of disability to discuss the questionnaire, tools and to address sensitivities with regard to acceptable use of disability language and the environment in general. This is also condoned as interdependent assessment (Polit and Beck 2012).

4.3.3.3 Investigator Triangulation

In this study the researcher utilized the services of a range of organizations serving people with disabilities to collect data, which played different roles in shaping the research project. The Office on the Status of Disabled People offices (OSDP) provided technical input and an orientation into the disability environment.

In most provinces survey administrators were recruited from organizations such as the Disabled People of South Africa (DPSA), the Association of people with Physical Disabilities (APD), The Mental Health Society (SFH), the Community-based Rehabilitation Centers (CBRC)' Health Promotion programs. Additionally, some of the

survey administrator themselves were living with a disability. Permission was requested from the University's Health Studies Research and Ethics Committee for clearance with regard to the research questionnaires (Polit and Beck 2004).

The researcher as a platform to share her research project and plan utilized several meetings of experts. In 2007 the researcher submitted an abstract of the research project to share at the International Nurses Doctoral Network (INDEN) Conference in Japan. This work was captured in the INDEN newsletter 2007. On the 7th - 8th February 2008 in Gauteng Province the researcher was invited by the Department of Social development to share her research project at the National Protective Employment for People with Disabilities Consultative Workshop. In 2008 at the Breast Cancer Awareness Seminar at UNISA organized by the Department of Health Studies the researcher presented a talk to women with blindness that were participants on the research project.

4.4 THE RESEARCH SETTING AND SAMPLING PROCEDURE

A national database of Protective Workshops provided an input to the study population and assisted in determining a sample for the study. A total number of Protective Workshops in the national data base was 235, the allocation of which varied from province to province and only those that were funded and managed by the Department of Social Development that were registered in the data base were targeted.

However, the sampling process revealed that some of the protective workshops no longer existed, while others had relocated and even changed names within the new management structures. The study also provided an input necessary for updating and revising the national database for Protective Workshops in South Africa.

4.4.1 Population

Out of a national sample of 70 facilities of protective workshops (Table 1.1, Chapter 1 above) only 48 facilities (Table 4.1, Chapter 4) responded to the study. These 48 facilities were spread across all provinces covering a diverse geographic area in urban, semi-urban and the rural settings. There were disparities amongst facilities of protective workshops in the sample in terms of structure (infrastructure, environment, location and

otherwise), management and staff capacity, resources (allocation, mobilization and distribution), range and conditions of services (basket), coordination and collaboration activities including recruitment of people with disabilities to the facility and their level of involvement in projects and in the decision making processes (Polit and Beck 2004).

Most urban-based facilities of protective workshops in provinces were found to be more developed than those that were based in rural parts of the same province. Some Protective Workshops provided a residential service as well as a workplace environment (eight hour daily) for people with disabilities, while others only provided a workplace service. In the latter situation, most of the protective workshops were serving people with disabilities from within its locality and from the neighboring communities who had been referred to the facility, which created problems such as transport to and from the facility and the conditions of service (Polit and Beck 2004).

4.4.2 Sample Size

A total of 286 people with different forms of disability (blindness, deafness, physical impairment, intellectual disability, etc.) participated in the study along with 68 care providers/ professionals. A diverse range of racial groups participated in the study and equally supported the research process. In terms of gender there was a greater representation of women than men in the sample, which mirrored the researcher's anecdotal experience in a disability services working environment.

In line with the purpose of the study and the research questions, the aim was to describe the range of activities that took place within the protective workshop service model and to better understand key elements associated with health enhancing behaviors, attitudes and perceptions of people with disabilities and care providers/professionals towards a strengthened inclusive model of health promotion.

4.4.3 Inclusion Criteria

Two categories of respondents or types of people with disabilities were identified in the sample, residents and day workers. This did not appear to affect their responses to the research questions about their knowledge, perceptions and experiences with regard to health related and health promotion activities promoted in the facility. Those that were

not residents came from different geographic locations and included a combination of individuals from relatively affluent, moderate and poorer backgrounds and from family structures that varied from large, medium and small. The Protective Employment for People with disabilities Consultative Workshop held on 7-8 February 2008 recommended that special attention should be paid to the needs of people with disabilities in rural areas and this representation was considered. The sampling technique used in this study afforded every person an equal chance of participation.

Language and educational background were not a factor for exclusion as translators and other forms of support were available. The province location and the community they come from determined the spoken language. Depending on the extent of their disabling factors, most people with disabilities obtained a primary level education, while a few progressed to secondary and very few had tertiary level education. This situation also has implications for health seeking behavior, as there is a relationship between education level and adoption of health promoting behavior. There is growing evidence that people who are educated are more likely to seek preventive and promotive health services such as getting themselves, their family and children immunized; seeking help and knowledge about where to locate social and health services and finally, in participating in health related activities. This was motivated by an acknowledgement that 'healthy people make good citizens' and as such, investment in their health is in fact an investment for the country (WHO 1995).

4.4.4 Exclusion Criteria

The category of care providers/ professionals comprised of staff members who were employed at the facility and excluded the support staff (domestic workers, gardeners, security and maintenance staff). The managers of the protective workshop identified staff members on a voluntary basis for participation in the study particularly in facilities where the staff allocation was more than two care providers. Some facilities that housed the protective workshops were managed by only one or two care providers and professionals, who were either facility-based or hospital/ district-based. In some of these facilities, the Rehabilitations Coordinators and other supplementary staff provided constant supervision.

People with disabilities did not manage most of the facilities. One of the recommendations of the Protective Employment for People with disabilities Consultative Workshop held on 7-8 February 2008 was the need to recognize people with disabilities in terms of management positions in protective workshops and to align the protective workshop service model with the United Nation's Convention on Employment of People with Disabilities. The sample of people with disabilities excluded those that were not affiliated with the Protective Workshops model and in other care facilities.

To negotiate entry into the research setting several steps were undertaken. Consultations with the Department of Health' Directorate: Chronic Diseases, Disability and the Elderly Persons Unit took place from April 2004 for technical guidance, to refine the research proposal and exploration of different departmental service models to identify the research setting for the study. The Office on the Status of Disabled People offices (OSDP) at the Presidency was consulted (October 2005) for the researcher to gain an understanding of the disability sector and to check the feasibility of undertaking such a study. (White Paper 1997).

4.4.5 Ethical Considerations

The researcher approached the Department of Social Development in the Disability Unit in 2007 to discuss the research project and to request permission to use the Protective Workshops Service Model for the proposed study. A formal letter was submitted to that effect stating the purpose of the study and the contribution that the study may make towards improving an inclusive and an integrated response model in line with the policy guidelines for the development and management of protective workshop prescript. A letter of response from the Department of Social Development to conduct the study in protective workshops was received on the 20 October 2007. Permission was requested and granted by the University's Health Study's Research and Ethics Committee Clearance with regard to the research. (Polit and Beck 2004).

The researcher was invited to present her research project at the Protective Employment for People with disabilities Consultative Workshop held on 7-8 February 2008, to lobby the support of provincial managers from government and Non-Governmental Organizations (NGOs) and consolidate relationships for entry into the sampled settings. The Employment Solution Protective Workshop in Pretoria, Gauteng

Province was approached to conduct the pilot study in 2007 with greater participation of the workers and staff. In planning for survey administration, the researcher sent out written communication letters and held several telephonic conversations with organizations in provinces such as the Office on the Status of Disabled Persons, the Disabled People South Africa, and Association for People with Disabilities, the Society for Mental Health and individual Protective Workshops to request permission for assistance with data collection. In eight provinces survey administrators were recruited by the same organizations, some of which were people living with a disability.

From early 2007 to late 2008, gaining the cooperation of some organizations in responding to the request took a long time. The researcher had to resend documents occasionally and some contacts were lost due to lack of interest in the process. Efforts of tracing lost contacts and identifying new contacts to gain access into the research setting and involving other partners such as the Department of Health paid dividend (Polit and Beck 2004).

An interesting challenge has been when permission was initially granted to conduct the study until the management realized that the survey administrator was a person with a physical disability who was then refused entry into the facility on the basis that the premises were not accessible to wheel chair users. As a result her appointments were repeatedly postponed until the researcher intervened to remedy the situation of resistance in the Protective Workshop in question. This practice confirmed the caution by the social model of disability, which asserted the view that 'it is society which erects barriers that prevent disabled people participating and restricts their access to equal opportunities (Southampton Centre for Independent Living Promoting Equality across the South, 2007).

4.5 DATA COLLECTION APPROACHES

According to Burns and Grove 2001:460, data collection is a process of selecting and gathering information from the research respondents. Mouton (2001:56) supports the use of different data collection techniques to answer the research questions. These were interviews, self-administered questionnaires, participant observations, consultations with key stakeholders in the area of disability and health and document

review. All of this information was triangulated to gain a broad perspective on the problem statement.

4.6 Quantitative Data Collection

A survey of 286 people with disabilities was conducted nationally with the aim of providing a descriptive picture related to their knowledge, attitudes and perceptions of health promotion among people with disabilities in protective workshops and other contexts. The data also formed the basis for interrogation for qualitative data. Structured questions (close ended and opinion statements) formed the basis of the instrument some of which contained opinion questions and probing questions (unstructured, open ended) to qualify responses to the question.

Survey administrators were appointed in provinces and trained in survey administration by the researcher to conduct the study. Survey administrators distributed and monitored the self-administered questionnaires for care providers/professionals in Protective Workshops sampled in most parts of the country. Survey administrators and the researcher interviewed people with disabilities in the sample in order to assist in the completion of the questionnaires. An interview schedule was used to collect data from people with disabilities (eighty (8) per facility) who were employed at the protective workshops.

Quantitative data was analyzed using the SPSS programme, translated into MS word format and Excel programmes for analysis. While qualitative data was analyzed manually to complement quantitative data. Observations were also noted and incorporated into the main findings of the study, as will be discussed in the next chapter.

4.6.1 Questionnaire Formulation, Administration and Refinement

The questionnaire items were formulated and honed to respond to the objectives of the investigation, these were guided by the broad stated research questions, a process which commenced in 2006. Research ethics were crucial in ensuring that the topic was researchable and followed ethical obligations.

Some opinion questions were developed to qualify responses, for example, a closed ended question number 9 in the questionnaire asked: *Do you think people with disabilities have rights? With a follow up question 10 stating: In your opinion, what are the rights of people with disabilities?* This process involved a range of consultations and discussions with experts in the area of disability and health, NGOs and research organization such as Human Science Research Council (HSRC), Medical Research Council (MRC) to assist with the formulation of researchable tools for data collection. Built into the actual data collection process was the observance of ethical considerations that was also shaped by the pilot project. Questions were adapted to clarify and remove ambiguous questions from the questionnaire.

Survey administrators in 8 provinces and the researcher in the remaining province of Gauteng facilitated data administration. Survey administrators were recruited from local organizations of people with disabilities and trained in survey administration by the researcher. Survey administrators had to distribute and monitor the self-administration of questionnaires by care providers/professionals in Protective Workshops.

Survey administrators and the researcher, to assist in the completion of the questionnaires, interviewed people with disabilities in the sample. An interview schedule was used to collect data from people with disabilities (eight per facility). Self administered questionnaires were distributed amongst care providers/professionals (two per facility), who were employed at protective workshops.

4.7 THE STUDY POPULATION AND SAMPLING PROCEDURE

4.7.1 Study Population

The study population comprised of all people with disabilities and the staff/professionals working in the Protective Workshops as per the national database, which was provided by the National Department of Social Development, 2001. The database only provided for those facilities that were supported by the National Disability Program of the Department of Social Development for the development and management of protective workshops.

A total number of 235 facilities of protective workshops formed the study population. The Department of Social Development compiled a Disability Resource Directory. A detailed national database of care facilities for people with disabilities and information on the types of services available is contained on it. Their management structures per province and location -- protective workshops, schools, residential areas (homes), day care centers, social work services was well documented (Disability Resource Directory: Department of Social Development).

The resource directory has been useful to further influence the choice and scope of the study population as it provided information (by province, specific locations, addresses and contact details) that assisted in locating the facilities of protective workshops sampled for the study necessary to negotiate entry into research settings and administer survey questionnaires. It is interesting to note that the organization of the resource directory also served an important function of facilitating better management and interventions for people with disabilities, such as schools, homes, protective workshops, etc., for people with disabilities across the country.

4.7.2 Sampling procedure

Multi-stage sampling was used to select the total number of individuals to be used in the study. The first stage was to determine a selection of sample facilities from the various provinces as verified by the national database. Clusters were the facilities within the protective workshop database, which became the study-sampling frame. The clusters were sampled using a simple random sampling procedure, whereby each cluster had an equal chance of being selected in the study. To determine the sample size of the clusters, equation (1), shown below, was used to calculate the sample size.

$$n = \frac{N}{1 + N(e)^2} \quad (1)$$

N is the population size of the clusters, e is the margin of error, and n the sample size for the clusters.

The clusters were selected with a margin of error of ± 0.10 for a confidence level of 90%. Of the 235 facilities, 70 facilities were selected using this formula, each being

treated as a cluster. Equation 2 below was used for the proportional allocation of the sample size to the provinces—ie, the larger the population, the larger the sample size. Table 4.1: below shows how the sample size was distributed. That is, the larger the population, the larger the sample size.

$$n_i = \frac{n}{N} \times N_i \tag{2}$$

Where n=70 and N1 is the number of facilities in provinces and N =235, therefore:

$$N1 = 70 \times 14 / 235 = 4$$

Table 4.1: Distribution of the sample size by province

Province	Facilities	Sample
EC	14	4
FS	15	4
GP	59	18
KZN	33	10
LP	13	4
MP	46	14
NW	9	3
NC	5	1
WC	41	12
Total	235	70

Within each cluster a simple random sampling method was used to select the number of individuals to be part of that sample. All the individuals in the selected clusters had an equal probability of being selected.

4.7.2.1 Simple Random Sampling Technique

This was stage two of the multistage sampling. To draw the simple random sample from a population under study, a random seven method was used to select a sample of people with disabilities and the care providers/professionals to participate in the study. A

simple random sampling was used to select 8 people with disabilities from each of the selected facilities and 2 care providers/professionals.

Eight questionnaires were administered to a random sample of people with disabilities, in each facility selected for the study in stage one. Two additional questionnaires were administered to a sample of professional care providers at each facility.

The sampling profile formed considered several factors to determine the inclusion criteria for people with disabilities in the study. These included the following:

- Participants should be employed or admitted at a facility of protective workshop in the sample.
- Anyone admitted to a selected workshop was eligible to be included in the study, irrespective of gender, age, race, language, and location.
- Male and female professional care providers working at a particular protective workshop were included, as per the employment criteria of the workshop (management, coordination, care giver.) Care providers/professionals were included irrespective of location, age, race, or language.
- Participation should encourage a representative mix of disabilities especially at facilities that cater for multiple disability types.
- The participant's type of disability (Blind, Deaf, Physical, Intellectual, etc) did not preclude them from participating in the study.

4.8 THE PILOT STUDY

4.8.1 The Setting

The pilot study was conducted at Employment Solutions Protective Workshop in Pretoria, Gauteng Province in 2007. The purpose of a pilot study was to test the research instrument for validity and reliability, The Employment Solutions Protective Workshop is urban-based and a self-reliant Protective Workshop able to generate its own resources through funding opportunities, and various sustainable projects.

4.8.2 Target group

A sample of 12 people (5 men and 7 women) with disabilities and two (male and female) care providers/professionals working at the facility participated in the pilot study based on voluntary participation. Of these, six people had a physical disability, two were blind, three were deaf and one person had an intellectual disability due to anxiety disorders. Gender and race was taken into consideration when establishing the sample.

4.8.3 The Process

Questions were clarified and ambiguity in question construction was removed and discussed with the statistician during refinement of the questionnaire. With regard to interpretation, volunteer interpreters were trained in questionnaire administration by the researcher and given support during interviews and there was no conflict on the issues of meanings, language barrier or the content of the question. This process provided an opportunity to test the questionnaire for reliability and validity and key findings were incorporated into the main study and ambiguous questions were clarified.

4.8.4 Key Findings

The pilot study results revealed the following key findings:

All twelve respondents attempted to complete the questionnaire with the assistance of the researcher and sign language interpreters who were themselves, individuals with disabilities.

All the respondents who took part in the pilot were aware about health issues and their rights to health care, but expressed concerns about:

- Discrimination, inaccessibility of health services, lack of involvement and participation in health matters, and health and social environments that were not considered user-friendly by them.
- The term “Health Promotion” was found to be relatively new to some although they related a range of health promoting activities to the term.
- All respondents expressed a need to get involved in health matters and to making a difference in society.

- The care providers/professional self administered questionnaire was completed with limited comments.

The protective workshop catered only for people with disabilities who were admitted through referrals from other organizations and also through self-interest. The workshop mainly focuses on skills development, training and entrepreneurship.

Health promotion activities that took place at the facility included health education sessions carried out by health workers visiting on an informal and irregular basis. Awareness campaigns during commemoration of a national and international day (such as world AIDS Day, International Day of people living with disabilities, Casual Day in support of people living with disabilities), fun days and educational excursions. There was no relationship with the local clinic or even the local hospital even though the facility was located next to a teaching district hospital. All respondents indicated an acceptable level of understanding of health issues and understood their rights to health care, amongst others.

4.8.5 GENERALISABILITY

Throughout the study careful considerations were made to ensure the generalisability of findings in terms of the design, measurement and the respondents. Firstly, a pilot study was conducted in a setting of a protective workshop, which was characterized by an environment and population that resembled that of the main study.

The pilot study results assisted to clarify and improve the questionnaire and observations made in anticipating the methodological and environmental research dynamics. Out of 70 facilities sampled for the study, at least 235 participated and the response rate of people with disabilities and care providers/professionals respondents was (354), which improves generalisability of the study findings to the whole population of people with disabilities in protective workshops.

Secondly, the pilot study results and amendments made, gave assurance that the research instrument was valid and reliable and applicable to a wide sample of people with disabilities and care providers/professionals in protective workshops. The study focus was based on the protective workshop service delivery model with a national

data-base of 235 facilities (sampling frame) and out of which 70 facilities sampled for the study.

A sample was selected using multi-stage sampling to select the total number of individuals to be in the study, a procedure that is fully explained in 3.5.2.2 (Sampling procedure) and statistical calculations, for example, sampling error was provided to ensure that the study results were useful and generalisable. A probability proportional to size sampling method was used to afford all the individuals in the selected clusters an equal probability of being selected in the study. With this probability, people with disabilities were randomly selected to participate in the study. Evidence shows that probability and randomness often justifies generalisability in most descriptive studies such as this current one but only if properly managed.

Lastly, two types of measurements were tested and employed to answer the research questions, a self-administered questionnaire for care providers/professionals at protective workshops and an interview schedule for people with disabilities with the assistance of a survey administrator.

The researcher conducted interviews, appointed and trained survey administrators in provinces to collect data. During the data collection process, there was constant supervision with field workers to clarify and discuss challenges between the researcher and field workers. In other provinces such as the Western Cape, respondents were paid an incentive per interview to encourage participation. The response rate, however, was lower than in all other provinces.

4.9 ETHICAL CONSIDERATIONS

4.9.1 Research-/ Researcher –Focused Ethical Consideration

- Approval was granted by the university and a Clearance Certificate was issued by the Ethics Committee in 2007 to proceed with the study.
- The National Office on the Status of Women was consulted to gain a deeper understanding of the disability environment and overcome the dynamics of such.

- Approval was granted by the Department of Social Development to undertake the study within their national programme of Protective Workshops to strengthen programme implementation through an integrated strategy.
- Approval of participation was also granted at provincial as well as facility level of individual protective workshops selected in the sample. At provincial level the Office on the Status of Disabled people in the Premier's offices were approached as a means of introducing the study purpose, the significance and negotiating entry into the research setting. Provincial offices of Disabled People South Africa were approached as well as Associations for People with Disabilities.

4.9.2 Participant/Respondent-Focused Ethical Considerations

Respondents were consulted and briefed about the study purpose to build rapport. Informed consent was obtained. Respondents were supported and treated with respect throughout all interviews conducted. To enable active participation and privacy, considerations were made to create a safe and supportive environment.

4.9.3 The Inviolable Principle of Human Dignity

- **The right to Self-Determination**

The type of disability or educational background did not deter participation in the interview as respondents were assured of freedom of expression of their views on the phenomenon, and were informed that there were no right or wrong answers. Appropriate means of assistance in the form of interpretation and transcripts were arranged to capture the expressions of respondent's.

- **The right to full Disclosure**

Respondents were assured that the information they share would be treated confidentially and be used only for the purpose it was intended for. They were informed of their right to withhold any information that they felt was sensitive and undermined their human dignity, and that they could withdraw from the interview at anytime if they wished.

- **Informed Consent**

Informed consent was obtained from individual respondents verbally and through written letters to Protective Workshops.

4.9.4 The Principle of Justice

- **The right to Privacy, Confidentiality and Anonymity**

In most workshops office space was specifically rearranged for interviewing to guarantee privacy and confidentiality of respondents. During interviews respondents were informed about the study's purpose and that their responses would be kept confidential and anonymous, including respondents who were assisted by interpreters verbally, or sign-language. Internal arrangements were made with the permission of respondent's who required a translator, for interpretation by colleagues or care professionals, who made respondents, feel at ease.

- **Voluntary Participation**

Respondents were informed about the sampling procedure and that the interview was based on voluntary participation and therefore they had a right to withdraw from the interview if at any time they felt uncomfortable.

- **Freedom from Exploitation**

Respondents were treated equally and fairly irrespective of colour, gender, and creed. They were assured that the information they shared was intended for research only, to inform and recommend service improvement for people with disabilities and not to exacerbate their disadvantage. The timing of interviews was at 10 minute intervals and made allowances for any language barrier, diversity and level of support required based on the type of a disability.

4.10 SUMMARY

A triangulation of data collection tools, research methods and questionnaire administrators were used. Consultative workshops and pilot projects were undertaken to hone the validation process. Protective workshops serve different people with disabilities and their needs. Ethical requirements for research among people with disabilities expect a stronger human protection element.

CHAPTER FIVE

DATA PRESENTATION, DATA ANALYSIS AND INTERPRETATION

5.1 INTRODUCTION

In the preceding section methodological issues related to inclusive health promotion were dealt with. The current chapter deals with management of field data. The data was generated from people with disabilities and care providers/professionals who were based in protective workshops environments. Data reduction, organization, presentation, analysis and interpretation were preceded by coding of raw data. This data was transcribed and packaged into a statistical computer program using coded variables. In this study, care providers/ professionals' respondents were asked to fill in the questionnaire and people with disabilities were assisted to complete the questionnaire by the researcher or by a survey administrator.

The decision by the researcher to simultaneously present, analyse and make interpretations from the study data represents a noteworthy deviation from the tradition of presenting each of these aspects as separate stand-alone processes and by inference, as stand-alone chapters. Carr (2004) and Polit & Beck (2009) acknowledge that research founded on the principles of participatory action enquiry may at times deviate from research traditions in pursuit of presentation formats that speak to the prioritization of 'active-participation' over 'adherence to research principles'. As such, they acknowledge that research processes play a secondary role to the researcher's interest in developing actions and interventions that meaningfully offer solutions to the subject under investigation. Within the current study, it was felt that the joint presentation of results, analyses and interpretations offered a more seamless progression from research findings to proposed practice actions than could have been achieved through separate presentation of each of these aspects. It is on this basis that the current chapter presents and analyses data in one chapter.

Data presented in this section emanates from two respondent sources that formed part of sample for the study, that is, people with disabilities as the main beneficiaries of the service and the care providers/ professionals who were service providers. A sample

survey of 870 all inclusive of people with disabilities and care providers/ professionals was conducted nationally with the aim of providing a descriptive picture of the respondent’s knowledge, attitudes and perceptions of people with disabilities in the protective workshops workplace environment about issues relating to disability and health promotion. Table 5.1 below show a population demographic in the study sample of people with disabilities.

Table 5.1: Demographic Characteristics

Population Group	Number of people with Disabilities in the Sample	% of respondents
Black African	212	77.4%
Colored	10	3.6%
Indian	22	8.0%
White	30	11.0%
Total	274	100%

The results show that a large number of respondents (77.4%) were Black Africans compared to other population groups, whites (11%), Indians (8%) and Colored’s 3.6%). This situation indicates that Black Africans are the most service users are in the most part facing the burden of disease and disabilities. Priority settings of government work have a long way to go when it comes to focusing health promotion resources to this population to balance the resource inequalities in an enabling manner to meet the needs of people with disabilities. A recent report of the Protective Workshop Consultative Meeting held in February 2007 revealed that there were disparities (in management including resource mobilization and other opportunities) in Black African managed protective workshops and those that were managed by whites and located in urban areas.

For the purpose of this study, two statistical computer programs were used alternatively to suit the statistician’s statistical package and familiarize the investigator with the software, the statistical packages were EPI Info, used to transfer and generate data set as well as the Statistical Package for Social Scientists (SPSS), Information from the data set created presentations; tables and graphs and pie charts for ease of analysis. Quantifiable raw data was presented numerically using the same charts, graphs, tables.

The qualitative section enhanced schemes with narrative statements to complement the quantitative section of analysis. The quantitative data will first be presented schematically using figures and tables, discussed and analyzed, subsequently.

The qualitative data was arranged with frequency tables to buttress narrative statements. Similarities, repetitions and related issues will yield to emerging themes.

Four stages of data preparation were conducted i.e. coding; the transfer stage, the computer entry stage and data cleaning stage to check for consistency and accuracy of the data. Further data management included cross tabulation and Chi-square test of association between variables. The section discusses participant's observations and also presented a brief description of qualitative data to complement personal accounts. The narratives were subsequently integrated with the quantitative data for ease of analysis and presented as frequency tables to facilitate interpretation.

5.2 QUANTITATIVE DATA PRESENTATION AND ANALYSIS

There were provincial differences regarding the level of participation and support by organizations for and of people with disabilities. One province resulted in a poor response rate despite all the means taken to provide incentives and renegotiate entry. The practical lessons learned by the researcher and survey administrator were related to attitudinal barriers by some management in some organizations, which became a threat to continue with research. To overcome this challenge, the researcher renegotiated entry and consulted extensively.

The targeted national sample size was 870 respondents as indicated in Table 5.1 of the methodology section; however, only 372 respondents (286 people with disabilities and 86 care providers/ professionals) who successfully completed the questionnaire. It is interesting to note that the results of the study have been displayed through tabulations and figuratively, also managed using Chi Square tests of association to test the hypothesis and further validate data and enrich the investigation. Cross tabulation of data was also done to determine the level of interaction and relationships of variables.

The section commenced with a presentation of the demographic data and then followed by the rest of the variables. This analysis was based on the collected data from two

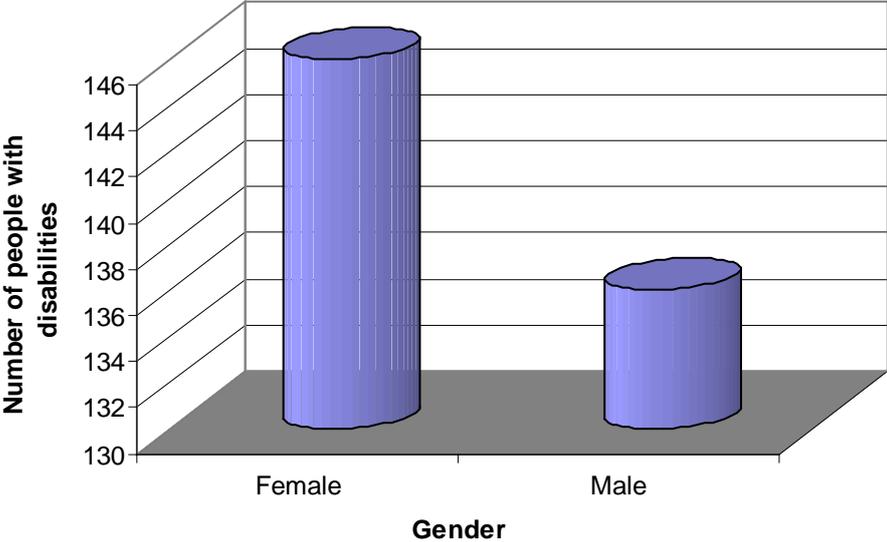
respondent types that were; the people with disabilities and care providers / professionals. Firstly, a description of data for People with Disabilities respondent type was managed and then followed by that of Care Givers/Professionals working in the area of disability.

5.3 DATA PRESENTATION AND ANALYSIS OF PEOPLE WITH DISABILITIES RESPONDENT TYPE

5.3.1 Demographic Data

5.3.1.1 Gender

Figure 5.1: Respondent’s Gender



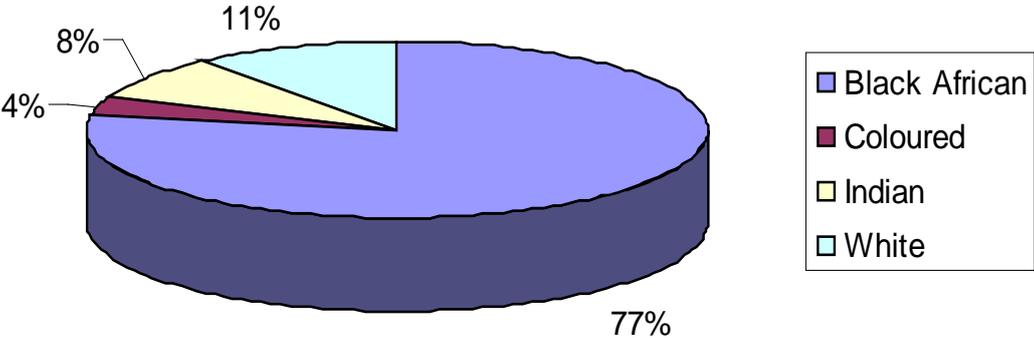
As shown above in Figure 5.1 female respondents (51.8%, n = 146) were in the majority compared to the males (48.2%, n = 136) whose representation was marginally lower. This representation by gender was an important variable particularly in the context of widely accepted views that isolate females living with disabilities, as having disproportionately wider care responsibilities than their male counterparts. Given ongoing aspirations towards achieving gender equality, women with disabilities bear the brunt of gender inequalities due to societal barriers in many aspects of life.

Women empowerment becomes imperative as a basic human right for people with disabilities to achieve good health outcomes. To promote exclusivity, a culture of equal sharing of responsibilities between women and men in all aspects of life including care

giving should be inculcated in the health promotion model including other models of care and supports.

5.3.1.2 Population Group

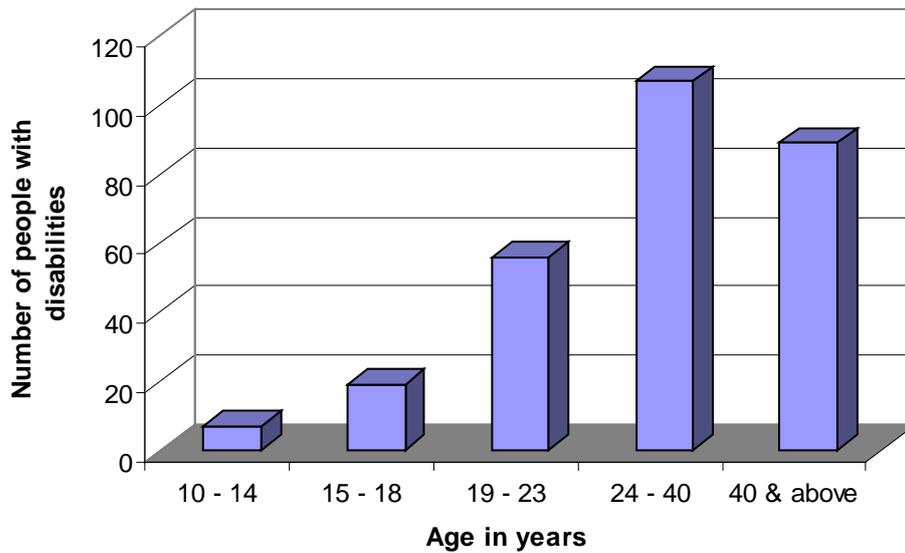
Figure 5.2: Respondent's Population Group



As confirmed in Figure 5.2 above, the representation of participants by race was proportionally similar to the that in the general population with the majority (77%) of respondents being Black Africans, while 11% were Whites, 8% were Colored's and only 4% were Indians. Figure 5.3. below, gives a representation by age within the group of respondents with disabilities.

5.3.1.3 What is your age group?

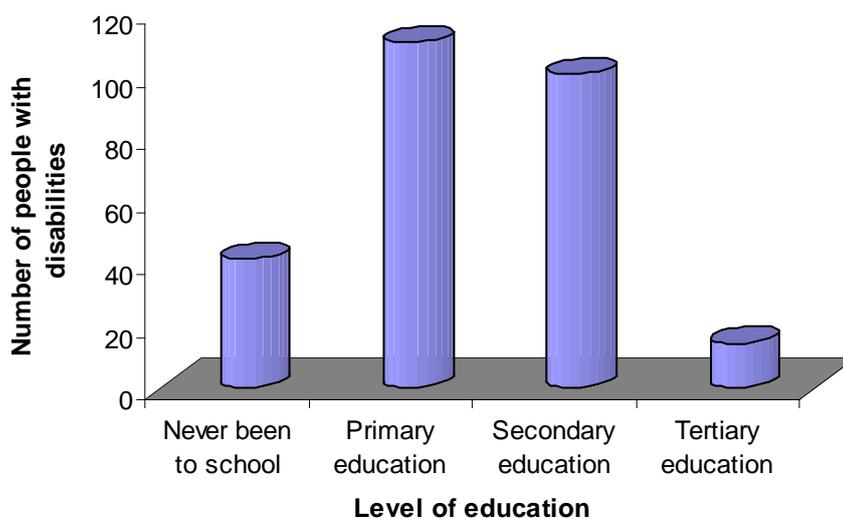
Figure 5.3: Respondent's Age Group



In the group of respondents who had confirmed having a disability, those aged 24- 40 years old were in the majority (37.4%, n=107) compared to those who were 40 years and above (31.1%, n=89); the 19-13 years (19.6%, n= 56); the 15-18 years (6.6%, n= 19) and the 10-14 years (2.4%, n= 2.4%).

5.3.1.4 What is your educational background?

Figure 5.4: Respondent's Level of Education



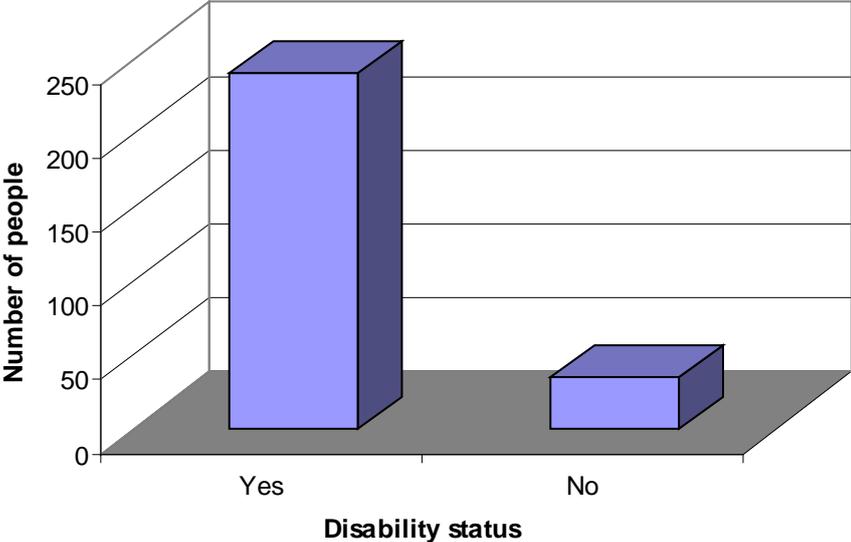
As shown by the Figure 5.4 above, respondents with confirmed disabilities were largely educated to primary level or had not attended school. A significant proportion (41.5%, n=110) of the respondents had attended primary school; 37.7% (n =100) had attended secondary school education. By contrast only 5.3% (n=14) were educated to tertiary education. 15.5% respondents said that they never went to school.

A Community Agency for Social Enquiry commissioned study (1999:22) revealed that the earlier the onset of a disability and the more disabilities a person has the more likely they are to have no education or reach only primary education. The stated statistical differences obtained for their variables were highly significant. Generally, the findings suggested that the area of disability was much neglected and should be targeted as a redress issue.

5.3.2 Awareness about Disability

5.3.2.1 What is the kind of your disability?

Figure 5.5: Respondent’s Disability Status



In the initial stage of identifying and differentiating between those with disabilities and those without, most of the respondents (87.6%, n= 245) respondents admitted that they were living with a disability. By contrast (12.7%, n = 37) said that they did not have a disability.

5.3.2.2 Disability Type

Figure 5.6: Respondent’s Disability Type

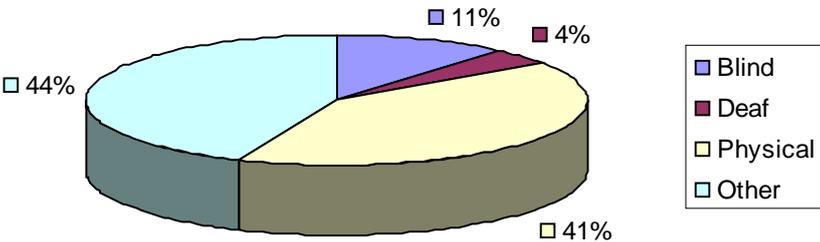


Figure 5.6 above reflects the different types of disability that existed within the 245 participants who confirmed that they had a formal diagnosis of a disability. Of these 11% (n=31) said that they were partially or total blindness and 4.4% (n=13) said that they were deaf. Nearly half i.e. 41% (n=113) had a physical disability compared to 43% (n=120) indicated that they other disabilities other than those that were categorised. The latter group included to forms of intellectual disabilities that were not specified in the questionnaire. It should be noted that people with disabilities are not a homogenous group requiring the same assistance, but individuals with particular and differing needs, beliefs and values. Therefore services should respond to these needs and recognize individual needs, strengths, weaknesses, abilities and opportunities (National Rehabilitation Policy: DOH p6, 2000)

5.3.2.3 Do you think that people with disabilities have rights?

Figure 5.7: Respondent’s Disability Rights

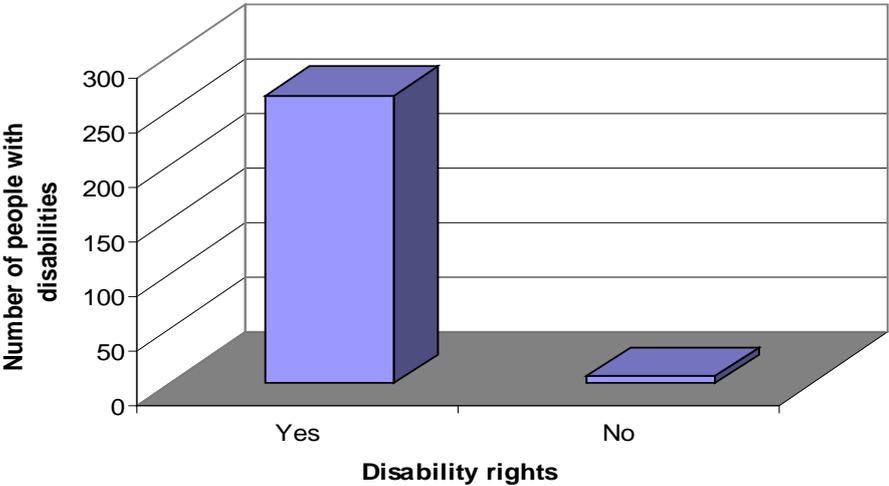
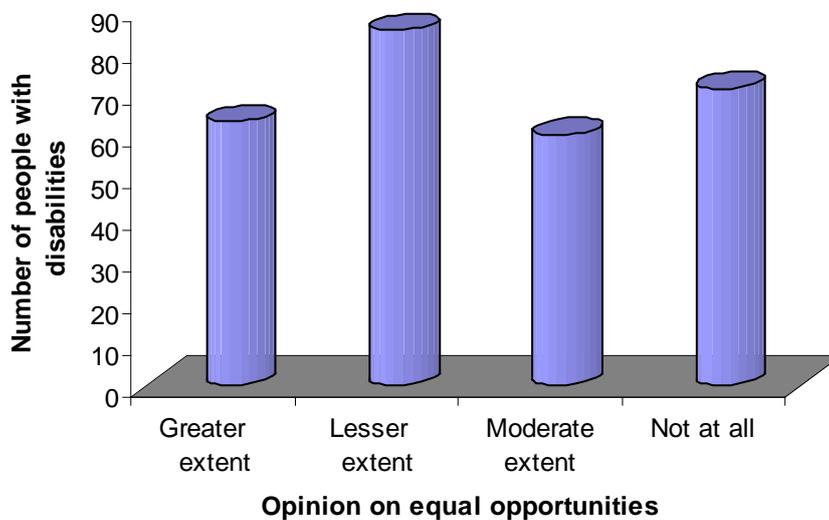


Figure 5.7 provides a pictorial overview the distribution of people by “their perceived awareness of their disability rights”. Overall, majority 97.8% (n= 272) of respondents show an increased level of awareness about the rights of people with disabilities, compared to 2.2% (n=10) that did not agree.

5.3.2.4 To what extent do you think that people with disabilities have equal opportunities compared to those without disabilities?

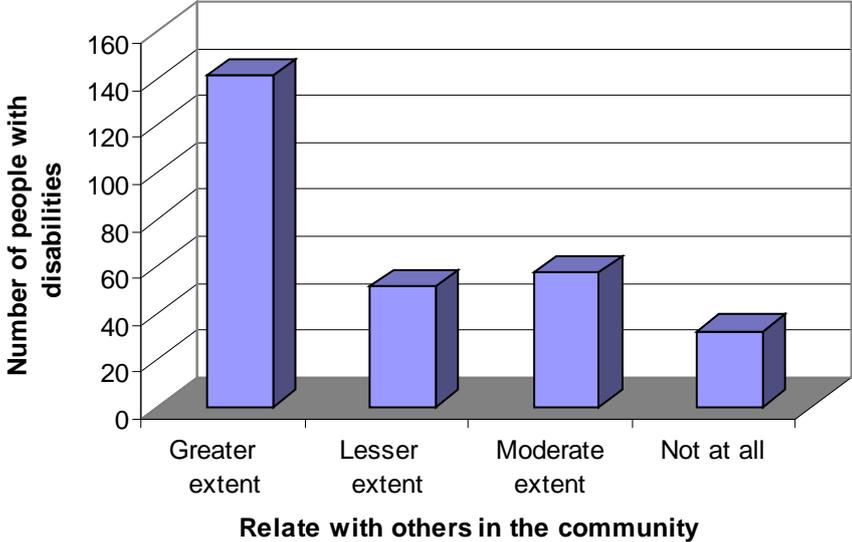
Figure 5.8: Respondent’s Opinion on Equal Opportunities for People with Disabilities



Most respondents tended to agree to a lesser extent (30.5%, n=86), moderate extent (21.5%, n= 61) and not at all 25% (n=72) that equal opportunities exist for people with disabilities compared to only 22.6% (n= 63) who agreed.

5.3.2.5 To what extent do you relate to other people with disabilities in your community?

Figure 5.9: Respondent’s Opinion on Relationships with other People with Disabilities in the community



One of the issues that were specifically explored related to the types of relationships respondents had with others in the community. Informed by literature e.g. Croxley (2010) that argued that those with disabilities were excluded from society and only maintained relationships with others that were similarly disabled, respondents were asked to comment on the types of relationships that they had within their communities of habitat. Figure 5.9 above shows that most respondents had social relationships with others with disabilities. More than half 50.2% (n=142) reported relating with others who had disabilities in the community to a greater extent; while 20.3% (n= 57) related to a moderate extent; 18.1% (n=51) lesser extent and 11.4% (n=32) said that they do not relate at all with other people with disabilities in the community.

5.3.3 Access to Health Services

5.3.3.1 Where do you go for health services?

Figure 5.10: Respondent’s type of health services Visited

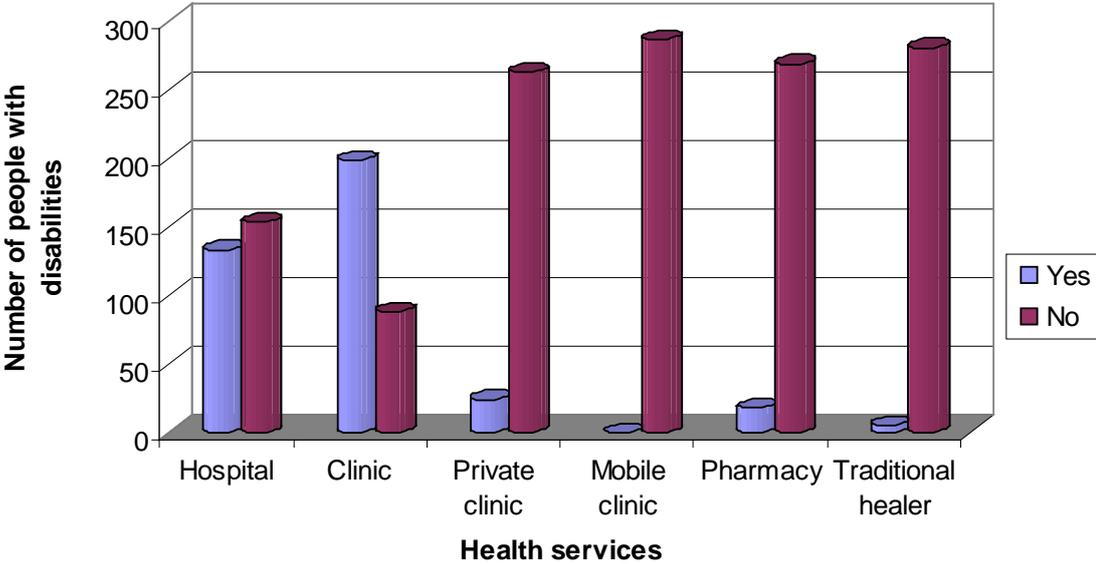


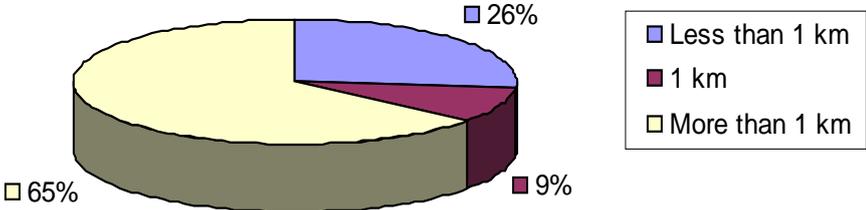
Table 5.2: Respondent’s type of Health services Visited

Health Services	Yes	No
Hospital	133	153
Clinic	198	88
Private Clinic	24	262
Mobile clinic		286
Pharmacy	18	268
Traditional Healer	5	280
Other		

Figure 5.10 and Table 5.2 shows the numbers of people living with disabilities by focusing on the type of health services they go to. Most respondents indicated more than one option as a reflection of a range and choice of services provided in the area. This is an interesting finding as the services of “others” related to those of the Private Health Sector and the Traditional Health Practitioners. To capture and quantify responses and prevent duplication, a Yes/No analysis was used.

5.3.3.2 How far is the nearest Health Facility?

Figure 5.11: Distance traveled to the nearest Health facility

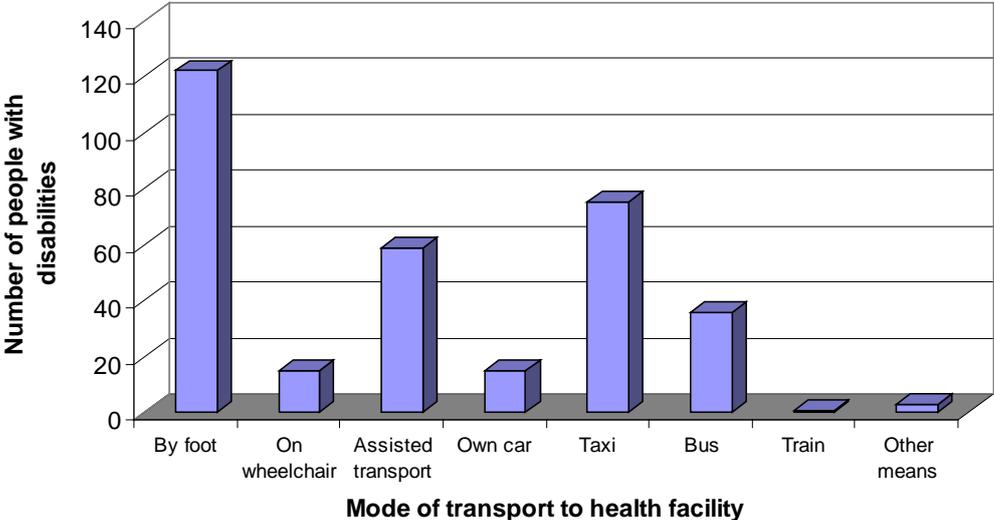


The remoteness of care facilities was a factor of interest in terms of its impact on the ease with which respondents perceived they could access supportive health care services. As indicated by Figure 5.11, more than half i.e. 64.3% (n=178) respondents said that they traveled more than 1kilometre to the health facilities, compared to only 26 respondents (n=9.4%) who had to travel less than a kilometer.

Article 25 (c) of the Convention on the Rights of Persons with Disabilities (UN 2006:23) obliges State Parties (Department of Health) to provide health services as close as possible to communities, including those in the rural areas of the country.

5.3.3.3 How do you travel to and from a Health Facility?

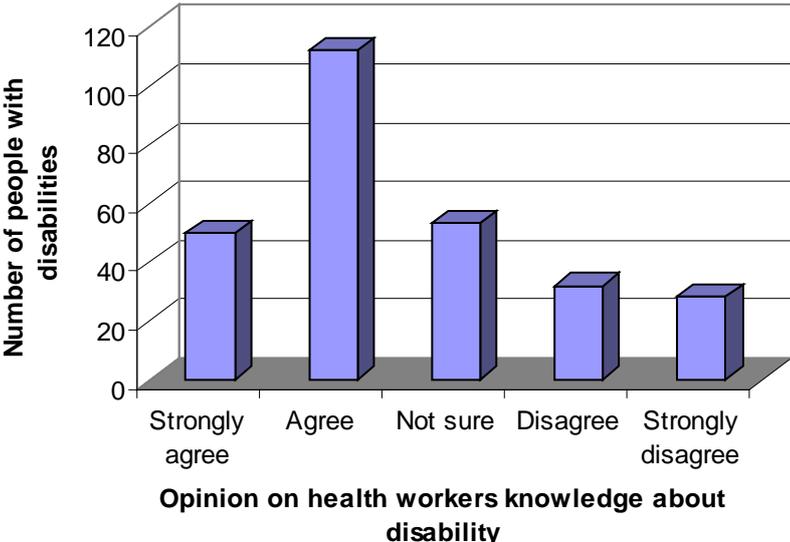
Figure 5.12: Respondent’s Mode of Transport to the Health Facility



In addition to eliciting the distance travelled by respondents to their nearest health care facilities, their mode of transportation was of particular interest as it played a role in determining the level of difficulty involved in accessing health care. By proportion, the majority (37.4%, n= 122) respondents traveled by foot to and from a health facility and while 23% (n= 75) respondents used a taxi. Some 18.1% (n=59) traveled by assisted transport, while others 11% (n=36) used a Bus. Only 4.6% (n=15) said they used their wheelchairs as mode of transport and a similar proportion of 4.6% (n=15) used their own transport. One (0.9 %) other respondent said they traveled by train. Other means were devised to include: 1 Hired car and a Bicycle.

5.3.3.4 Statement 1: The Health Workers are knowledgeable about disability issues.

Figure 5.13: Respondent’s Opinion on Health Worker’s knowledge about disability issues.



Confidence in the knowledge of health care professionals was an important consideration that related to respondents’ perceptions of their care services. Most (40.7% and 18.2%) respondents tended to strongly agree or agree that health workers had knowledge about disability. However, 19% were not sure about the statement and only (10.2 and 11.6%) either strongly disagreed or disagreed to the statement. Of the 275 respondents expressing an opinion, 27% (60 people) did not regard health workers as knowledgeable about disability.

5.3.3.5 Statement 2: The Health facility is Disability Friendly

Figure 5.14: Respondent’s Opinion on Health facility Disability Friendly

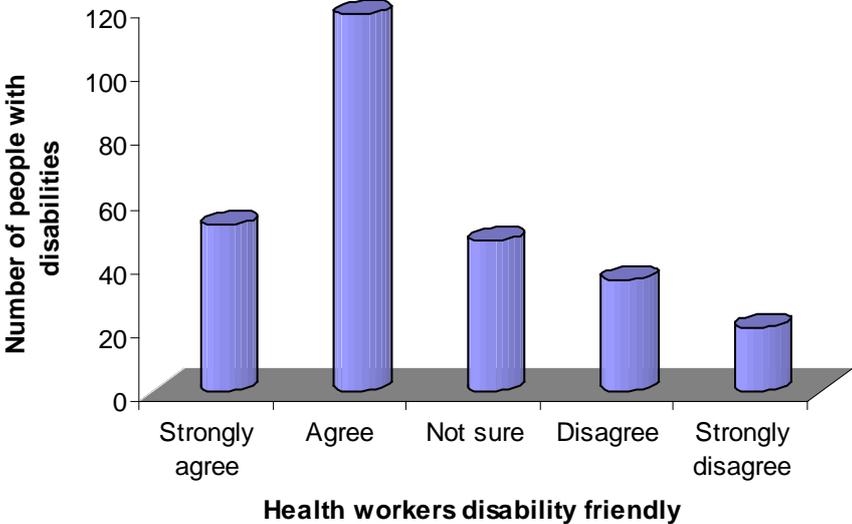


Table 5.3: Respondent’s Opinion on Health facility Disability Friendly

Health facility disability friendly	Number of people with Disabilities in the Sample	% of respondents
Agree	120	43.5
Disagree	31	11.2
Not sure	37	13.4
Strongly agree	56	20.3
Strongly disagree	32	11.6
Total	276	100

Most (43.5% and 11.6%) respondents tended to either agree or strongly agree that health facilities were disability friendly. However, 13% were not sure about the statement and only (11.2 and 11.6%) either disagreed or strongly disagreed to the statement. This indicates a need remove the physical/ architectural, attitudinal and service delivery (medical model approach) barriers and creating a disability friendly environment. Article 25 of the Convention on the Rights of Persons with Disabilities (UN 2006:23) recognises that people with disabilities have a right to attain the highest standards of health without discrimination on the basis of their disability and requires state parties to prevent denial of such a service.

5.3.3.6 Statement 3: Health Workers are friendly to People with Disabilities

Figure 5.15: Respondent’s Opinion on Health Workers Disability Friendly

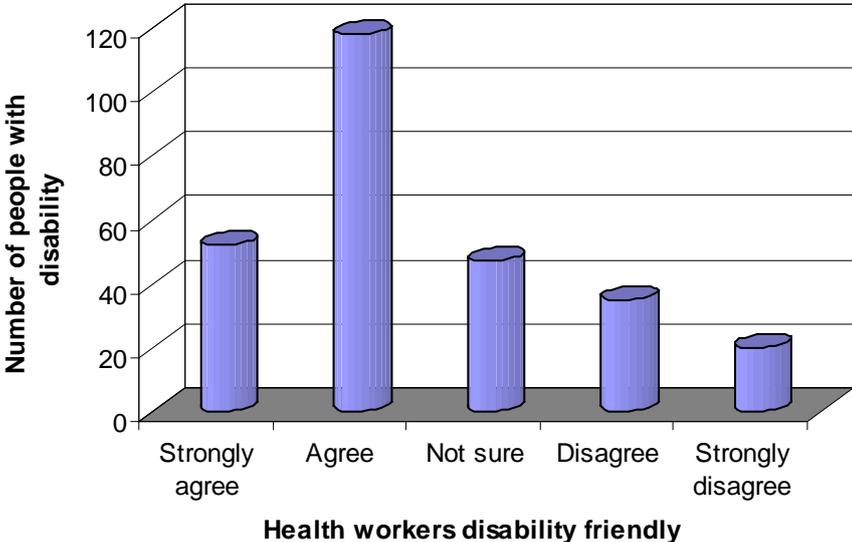


Table 5.4: Respondent’s Opinion on Health Workers Disability Friendly

Health Workers disability friendly	Number of people with Disabilities in the Sample	Percentage %
Agree	118	43.4
Disagree	35	12.9
Not sure	47	17.3
Strongly agree	52	19.1
Strongly disagree	20	7.4
Total	272	100

Most (43.4% and 12.9%) respondents tended to either agree or strongly agree that health workers were disability friendly. However, 17.3% were not sure about the statement and only (19.1 and 7.4%) either disagreed or strongly disagreed to the statement. Figure 5.12 and its accompanying table above confirm the findings of this statement. Evidence show that well trained health personnel are more likely to be friendly and supportive towards people with disabilities.

5.3.3.7 Statement 4: People with disabilities are treated with Respect

Figure 5.16: Respondent’s opinion on Treatment with Respect

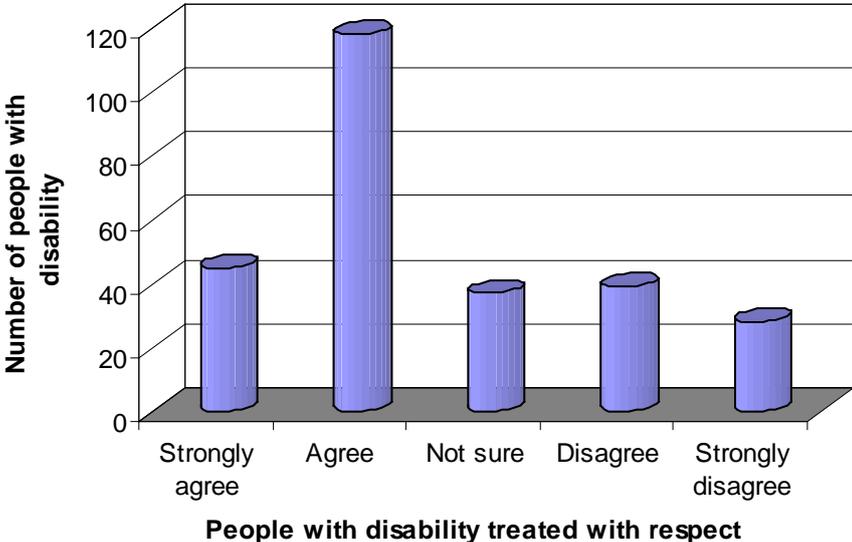


Table 5.5: Respondent’s opinion on Treatment with Respect

Treated with respect	Number of people with Disabilities in the Sample	% of respondents
Agree	116	43.4
Disagree	39	14.6
Not sure	37	13.9
Strongly agree	45	16.9
Strongly disagree	28	10.5
Total	267	100

These findings revealed a great percentage (43.4% and 10.5%) of respondents who tended to either agree or strongly agree that health workers treated them with respect. However, 13.9% were not sure about the statement and only (14.6 and 10.5%) either disagreed or strongly disagreed to the statement. The elements of respect and dignity are basic human rights issues as articulated in the RSA Constitution and the Bill of Rights, which should be enjoyed by every citizen. Attitudinal barriers could also be attributed to the question of respect, which should be addressed.

5.3.3.8 Statement 5: People with Disabilities receive Appropriate Care

Figure 5.17: Respondent’s Opinion on Appropriate Care

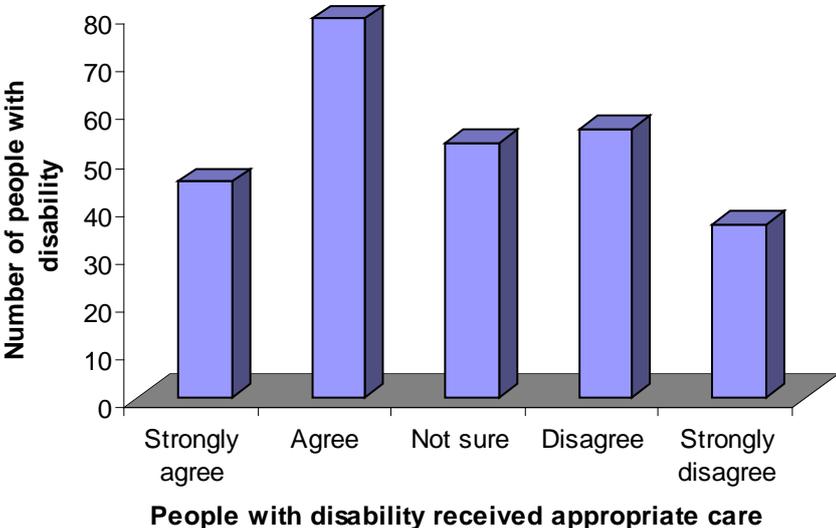


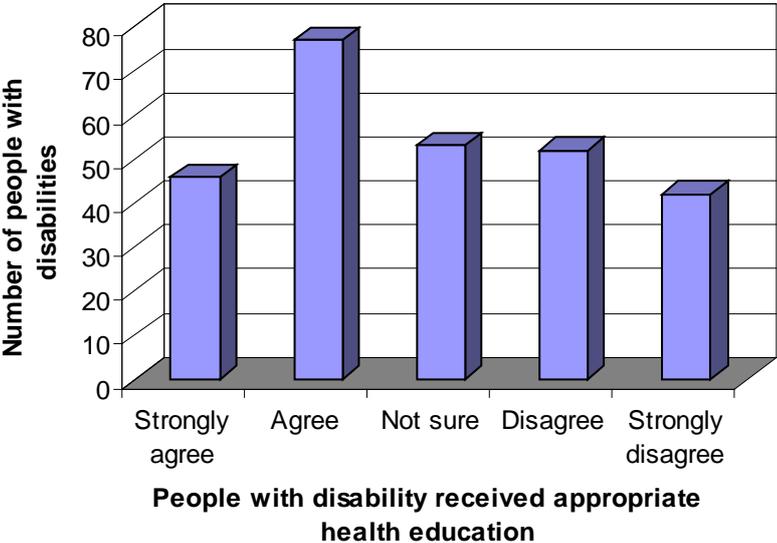
Table 5.6: Respondent’s Opinion on Appropriate Care

Appropriate care received	Number of people with Disabilities in the Sample	% of respondents
Agree	79	29.4
Disagree	56	20.8
Not sure	53	19.7
Disagree	45	16.7
Strongly disagree	36	13.4
Total	269	100

For many of the respondents (29.4% and 13.4%), they either agreed or strongly agreed that the health care facilities provided care that was appropriate to their needs. However, only 19,7% (n=53) said that they were not sure about the statement, while and other (20.8% and 13.4%) respondents either disagreed or strongly disagreed to the statement. This statement questions the extent of disability friendliness of health facilities.

5.3.3.9 Statement 6: People with Disabilities receive Appropriate Health Education

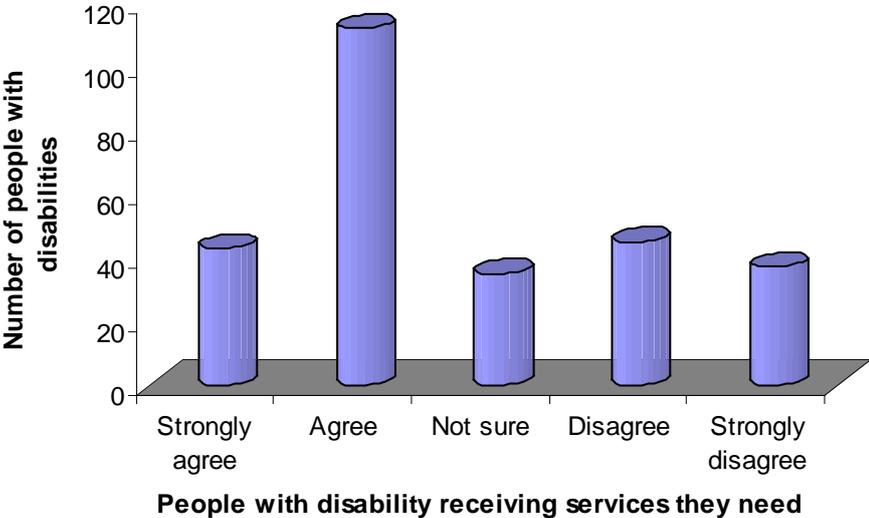
Figure 5.18: Respondent’s Opinion on Appropriate Health Education



As shown above, 28.5% (n=77) and 17%(n=46) respondents tended to either agree or strongly agree that people with disabilities receive appropriate health education at health facilities. However, 19.6% (n=53) said that they were not sure about the statement and only 19.3% (n=52) and 15.6%(n=42) either disagreed or strongly disagreed to the statement. One of the goals of health promotion is to increase health literacy. This is important for people with disabilities so they are able to take control of their own health and increase their health seeking behavior for preventive, rehabilitation and promotive care. It is also a constitutional right not to be denied access to health facilities and from a health perspective in terms of the Patient’s Rights Charter and the Batho Pele Principles.

5.3.3.10 Statement 7: People with Disabilities receive services they need.

Figure 5.19: Respondent’s Opinion on Quality of Services



As indicated above, 41.2% (n=112) and 15.8% (n=43) respondents tended to either agree or strongly agree that people with disabilities receive services they need at a health facility. However, 12.9% (n=35) said that they were not sure about the statement and only 16.5% (n=45) and 13.6% (n=37) either disagreed or strongly disagreed to the statement. The removal of barriers in health service delivery creates an enabling environment for people with disabilities to access and participate meaningfully in health care matters both as recipients of the service and as part of governance, for improvement in the quality of care.

5.3.3.11 Statement 8: People with Disabilities are referred appropriately

Table 5.7: Respondent’s Opinion on Appropriate Referral

Appropriate referral	Number of people with Disabilities in the Sample	% of respondents
Agree	100	37.9
Disagree	40	15.2
Not sure	48	18.2
Strongly agree	45	17.0
Strongly disagree	31	11.7
Total	264	100

Proportionally, most of the respondents (37.9% and 17%) either agreed or strongly agreed that people with disabilities receive appropriately referred across the health care delivery system and outside. However, 18.2% said that they were not sure about the statement and only (15.2% and 11.7%) either disagreed or strongly disagreed to the statement. These findings are confirmed by the statement of opinion on “appropriate care” discussed earlier above, which revealed an alarming percentage(19,7%) of respondents who said that they were not sure whether people with disability receive appropriate care and those that disagreed and strongly disagreed (20.8% and 13.4%). If they (people with disabilities) did not receive appropriate care, it would be less likely that appropriate referral took place, which constitutes missed opportunities in maintaining the continuum of care.

5.3.3.12 Statement 9: People with Disabilities are Involved in Health Related Activities aimed to Promote Health.

Table 5.8: Respondent’s Level of Involvement in Health Related Activities

Involvement in health related activities	Number of people with Disabilities in the Sample	% of respondents
Agree	78	28.6
Disagree	52	19.0
Not sure	50	18.3
Strongly agree	47	17.2
Strongly disagree	46	16.8
Total	N=273	100

A significant proportion i.e. (28.6% and 17.2%) respondents either agreed or strongly agreed that people with disabilities were involved in health related activities. However, 18.3% said that they were not sure about the statement and only (19% and 16.8%) either disagreed or strongly disagreed to the statement. Involvement was limited to health campaigns such as the World AIDS Day activities and others, which justified the finding that most people with disabilities were passive or not actively involved in decisions made about their health.

5.3.3.13 In your opinion, is Health sufficiently promoted amongst people with disabilities?

Table 5.9: Respondent's Opinion on the sufficiency of Health Promotion

Health sufficiently promoted	Number of people with Disabilities in the Sample
Yes	147
No	135
Total	282

As illustrated by Table 5.9 above, 135 respondents said that health promotion was not sufficiently promoted within Protective Workshops compared to only 147 who agreed with the statement. The existence of 135 respondents who felt that health promotion was not adequately supported within the workshops indicates a need to strengthen awareness, coordination and integration of services. A recent Annual Report (2005/6) of the Association of Persons with Physical Disabilities (APD) in Kwazulu-Natal (31 March 2006: 4) revealed that coordination of programmes was an impediment to the efficiency of service delivery and whatever is done was far from satisfactory.

5.3.3.14 Are you still involved in Health Promotion Activities?

Table 5.10: Respondent's Involvement in Health Promotion Activities

Involvement in HP activities	Number of people with Disabilities in the Sample
Yes	129
No	153
Total	282

A number (129) of respondents said that they were involved in health promotion activities that are promoted at their Protective Workshops, compared to 153 who said that they were not involved. Similar findings confirmed that most people with disabilities were not involved in health related activities. The findings revealed that even if people with disabilities are involved in skills development activities offered by the Protective

Workshops, they experience a degree of exclusion in other activities that relates to their health and are only involved as recipients of the service by professionals.

5.3.4 Availability of Support Structures and Mechanisms

5.3.4.1 Do you know of any facility in the community that caters for the health needs of people with disabilities?

Table 5.11: Knowledge of Facilities catering for People with Disabilities

Knowledge of Facility	Number of people with Disabilities in the Sample
Yes	85
No	170
Total	N=255

As with some of the statements and questions posed, the response to the above statement was not completed by all possible respondents. Out of the 282 potential respondents, only 255 completed this. The reasons for non-completion were not elicited. Of the 255 respondents, the majority (n=170) respondents said that they were not aware of other facilities catering for people with disabilities compared to 85% who said that they were aware. There is a need to improve networking amongst disability and facilities in general and create opportunities for information and knowledge exchange, leisure and educational excursions for people working in Protective Workshops.

5.3.4.2 How often are Health Programmes rendered at this facility?

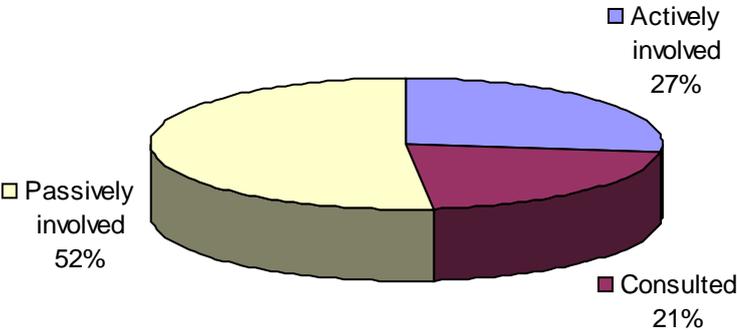
Table 5.12: Knowledge about the Frequency of availability of Health Services

Frequency of Health Services rendered	Number of people with Disabilities in the Sample	% of respondents
Always	4	7.5
Sometimes	10	18.9
Don't know	40	75.5
Total	53	100

It is interesting to note that the majority (75.5%) respondents did not know the timing of health services provided at their Protective Workshop, compared to 18.9% who said that health services were sometimes. However, only 7.5% said that health services were provided always. This finding indicates that the provision of a range of services requires a coordinated approach by all partners and there is a need to involve people with disabilities in the planning of such services.

5.3.4.3 What roles do people with disabilities play at those facilities?

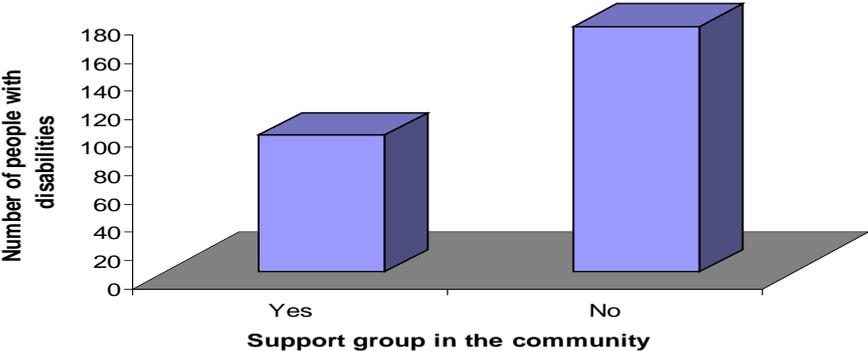
Figure 5.20: Respondent’s Level of Participation



More than half (51.6%, n= 111) respondents said that they participated passively in health promotion activities that are promoted at their Protective Workshops, compared to 21.4% (n=46) who said that they were consulted in health promotion activities. However, 27% (n=58) said that they were actively involved. The developmental social model of disability and the health promotion principles are rooted in community participation for social justice.

5.3.4.4 Do you know of any Support Groups in your community for people with disabilities?

Figure 5.21: Respondent’s Support Groups



As illustrated above, 174 of respondents did not know about support groups for people with disabilities in the community compared to only 97 respondents some of which were able to mention the location of such support groups in the communities. Protective Workshops were identified by most as a support group most people with disabilities associate with. However, that could mean only for those affiliated to them.

5.4 FURTHER ANALYSIS OF DATA

Cross tabulation was done to determine the relationship of the sex variable to other variables such as age, education and the kind of disability. Further analysis of data was done to test the hypothesis using chi-square tests of association. Both these techniques contribute toward validating and ensuring reliability of the data and enrich the investigation. Cross tabulation of data is presented below and then the chi-square of association.

5.4.1 Cross Tabulation of Data

5.4.1.1 Age and Gender

Table 5.13: Age and Gender Cross-tabulation

Age group	Sex		Total
	Female	Male	
10-14	2	5	7
15-18	10	9	19
19-23	29	27	56
24-40	58	48	106
41+	45	43	88
Total	144	132	282

Table 5.13 above compares the proportion of the target population by age group and gender in terms of participation in the study. The cross tabulated data revealed that almost all those in the age group 24-40 years (106) participated in the study followed by those in the age group 41years and above (88). The gender representation revealed that most of the age-group categories were represented by more females than males

with the exception of the 10-14 year olds. This supports the conclusion that Protective Workshops are mostly utilized by females with disabilities. There is a need to explore the influence of gender roles, gender division of labor and power relations within Protective Workshop through a gender analysis process. A gender integration program should form part of the mainstream activities.

5.4.2 A Chi-Square Test Of Association

The chi-square method was used in order to test the association between a variable and the type of disability. In this study a 5 percent level of significance was used for all statistical tests ($\alpha = 0.05$). The decision rule was to reject the null hypothesis (H_0) if the p-value of the test was less than alpha ($\alpha = 0.05$) and not to reject the null hypothesis if p-value of the test was greater than alpha ($\alpha = 0.05$).

5.4.2.1 Association between the type of a disability and the extent to which people with disabilities relate with one another in the community

The same frequencies and percentages used in Table 5.33 above of the cross tabulated data are used to test the association between the type of a disability and the extent to which people with disabilities relate with one another in the community. The computed value of $\chi^2 = 27.52$ is compared with the tabulated value of χ^2 with 9 degree of freedom. Since the calculated value is less than the tabulated we do not reject the null hypothesis (H_0), where

H₀: There is no association between the type of a disability and the extent to which people with disabilities relate with one another in the community.

H₁: There is association between the type of a disability and the extent to which people with disabilities relate with one another in the community

The p-value for the test is 0.0011, and less than 0.05. We conclude that there was association between the type of a disability and the extent to which people with disabilities relate with one another in the community. This shows that generally to a greater extent, people with physical disabilities relates well with one another in the community (135) despite societal barriers that they face including their exclusion in the mainstream societal activities. The type of disability influences relationships in the

community due to factors such as language, facilities for recreation, support structures, perceptions and attitudes of other people, etc. Those with physical disabilities relate even better compared to others with different types of disabilities such as those who are deaf and the blind including those with intellectual disabilities.

Table 5.14: Chi-square test results for association: between the type of a disability and the extent to which people with disabilities relate with one other in the community.

The extent of relationship	Disability type				
	Blind	Deaf	Physical	Other	Total
Greater extent	20	4	62	40	135
Moderate extent	2	2	27	24	55
Lesser extent	7	2	18	24	51
Not at all	1	4	4	22	31
Total	30	12	111	119	272
$\chi^2 = 27.52$, d.f. = 9 and p-value = 0.0011					

5.4.2.2 Association between the type of a disability and the extent to which health care facilities respond to the needs of people with disabilities

The computed Chi-square value in Table 5.35 below $\chi^2 = 21.30$ is compared with the tabulated value of χ^2 with 12 degree of freedom. Since the calculated value is less than the tabulated we do not reject the null hypothesis (H_0), where

H_0 : There is no association between the type of a disability and the extent to which health care facilities respond to the needs of people with disabilities.

H_1 : There is association between the type of a disability and the extent to which health care facilities respond to the needs of people with disabilities

The p-value for the test is 0.046, and less than 0.05. We conclude that there was association between the type of a disability and the extent to which health care facilities respond to the needs of people with disabilities. Although most respondents tended to either agree (115) or strongly agree (55) that health facilities are disability friendly, there

are differences in the extent of the experiences of friendliness by disability type. For an example, respondents who are deaf were less likely to either agree or strongly agree and almost not sure that health facilities were disability friendly.

This could be alluded to the factors such as the language barrier; lack of facilities to cater for their needs such as sign language literacy for health workers, schools and the communities including sign language interpreters, negative attitudes of health workers contributes to their exclusion and abuse. Respondents who were blind also indicated similar experiences.

Table 5.15: Chi-square test results for association: between the type of a disability and the extent to which health care facilities respond to the needs of people with disabilities

Health Facility disability friendliness	Disability type				
	Blind	Deaf	Physical	Other	Total
Strongly disagree	6	3	13	10	32
Disagree	1	0	20	10	31
Not sure	2	1	8	23	34
Agree	14	5	45	51	115
Strongly agree	7	3	21	24	55
Total	30	12	107	118	267
$\chi^2 = 21.30$, df. = 12 and p-value = 0.046					

5.4.2.3 Association between the type of a disability and the extent to which extent to which health workers are friendly towards people with disabilities.

The observed frequencies for the association between the type of a disability and the extent to which extent to which health workers are friendly towards people with disabilities are displayed together with chi-square test results in Table 5.15. The computed value of $\chi^2 = 16.25$ is compared with tabulated value of χ^2 with 12 degree of freedom. Since the calculated value is less than the tabulated value we do not reject the null hypothesis (H_0), where

H₀: There is no association between the type of a disability and the extent to which health workers are friendly towards people with disabilities

H₁: There is association between the type of a disability and the extent to which health workers are friendly towards people with disabilities.

The p-value for the test, 0.179, is greater than 0.05. Consequently there is no association between the type of a disability and the extent to which health workers are friendly towards people with disabilities. In other words, people with different disabilities experience the same treatment from health workers whether negative or positive. Depending on the model used at the health care facility for an example a medical model of care promotes attitudes and perceptions of people with disabilities as objects, sick and cases that require attention and treatment and therefore they are regarded as burdens. Whereas a facility that is oriented towards a social model is inclusive as it builds the esteem of people with disabilities through participatory and empowerment methodologies and pays attention to respect for their human rights.

Table 5.16: Chi-square test results for association: between the type of a disability and the extent to which health workers are friendly towards people with disabilities

Health Worker friendliness	Disability type				
	Blind	Deaf	Physical	Other	Total
Strongly disagree	2	2	8	8	20
Disagree	0	3	18	12	33
Not sure	8	2	14	22	46
Agree	12	3	50	47	112
Strongly agree	8	2	15	27	52
Total	30	12	105	116	263

$\chi^2 = 16.25$, df. = 12 and p-value = 0.179

5.4.2.4 Association between the type of a disability and the extent to which people with disabilities receive appropriate health education.

The observed frequency of the association between the type of a disability and the extent to which people with disabilities receive appropriate health education are displayed together with chi-square test results in Table 5.16. The computed value of

$\chi^2 = 25.28$ is compared with the tabulated value of χ^2 with 12 degree of freedom. Since the calculated value is less than the tabulated value we do not reject the null hypothesis (H_0), where

H_0 : There is no association between the type of a disability and the extent to which people with disabilities receive appropriate health education.

H_1 : There is association between the type of a disability and the extent to which people with disabilities receive appropriate health education.

Since the p-value of the test is 0.014 we therefore conclude that there is association between the type of a disability and the extent to which people with disabilities receive appropriate health education.

Table 5.17: Chi-square test results for association between the type of a disability and the extent to which people with disabilities receive appropriate health education.

Appropriate Health Education	Disability type				
	Blind	Deaf	Physical	Other	Total
Strongly disagree	9	2	18	11	40
Disagree	3	3	26	17	49
Not sure	2	4	17	28	51
Agree	3	3	26	37	69
Strongly agree	5	0	17	24	46
Total	22	12	104	117	255
$\chi^2 = 25.28$, df. = 12 and p-value = 0.014					

5.4.2.5 Association between the type of disability and the extent to which people with disabilities receive services they need

The observed frequency of the association between the type of disability and the extent to which people with disabilities receive services they need are displayed together with chi-square test results in Table 5.17. The computed value of $\chi^2 = 30.167$ is compared with the tabulated value of χ^2 with 12 degree of freedom. Since the calculated value is less than the tabulated value we do not reject the null hypothesis (H_0), where

H₀: There is no association between the type of disability and the extent to which people with disabilities receive services they need.

H₁: There is association between the type of disability and the extent to which people with disabilities receive services they need.

Since the p-value of the test is 0.003, we therefore conclude that there is association between the type of a disability and the extent to which people with disabilities receive appropriate health education.

Table 5.18: Chi-square test results for association between the type of disability and the extent to which people with disabilities receive services they need

Receive Services Needed	Disability type				
	Blind	Deaf	Physical	Other	Total
Strongly disagree	4	3	19	9	35
Disagree	2	5	23	14	44
Not sure	2	2	7	21	32
Agree	15	2	44	48	109
Strongly agree	7	0	12	24	43
Total	30	12	105	116	263
$\chi^2 = 30.167$, df. = 12 and p-value = 0.003					

5.4.2.6 Association between the type of disability and the extent to which people with disabilities are involved in health promotion activities

The observed frequency of the association between the type of disability and the extent to which people with disabilities are involved in health promotion activities are displayed together with chi-square test results in Table 5.18. The computed value of $\chi^2 = 32.46$ is compared with the tabulated value of χ^2 with 12 degree of freedom. Since the calculated value is less than the tabulated value we do not reject the null hypothesis (H₀), where

H₀: There is no association between the type of disability and the extent to which people with disabilities are involved in health promotion activities.

H₁: There is association between the type of disability and the extent to which people with disabilities are involved in health promotion activities.

Since the p-value of the test is 0.005, we therefore conclude that there is association between the type of disability and the extent to which people with disabilities are involved in health promotion activities.

5.5 DATA PRESENTATION AND ANALYSIS OF CARE PROVIDERS/ PROFESSIONALS WORKING IN THE AREA OF DISABILITY RESPONDENT TYPE

5.5.1 Demographic Data

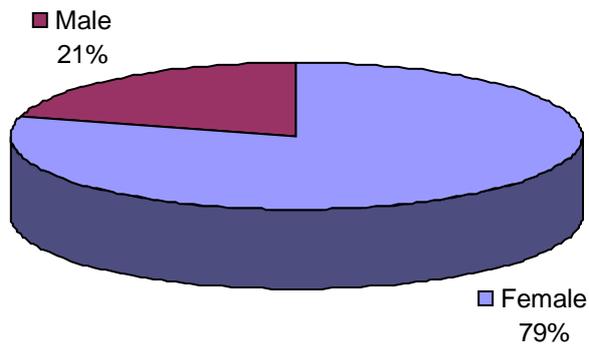
Table 5.19: Number of care providers/professionals in the sample per province

Province	Number of Professionals/Care providers in the sample	% Percentage
Mpumalanga	17	25%
North West	5	7.4%
Limpopo	8	11.8%
Northern Cape	1	1.5%
Eastern Cape	5	7.4%
Western Cape	3	4.4%
Free State	8	11.8%
KwaZulu Natal	11	16.2%
Gauteng	8	11.2%
Total	67	100%

Out of 68 only one respondent in the sample did not indicate the province they came from. It is important to note that not all Protective Workshops had care givers/professionals allocated at the care centre, but some were managing more than one centre depending on their staff establishment, location and other factors.

5.5.1.1 Gender

Figure 5.22: Respondent's Gender



Most of the care workers who were respondents (79.4%, n=54) were female compared to only 20.6% (n=14) male care givers/professionals. This indicates a noticeable gender disparity and the more prominent role of women in care work. A recruitment program to attract males into care giving responsibilities, including recognition and remuneration of care work is needed from government.

5.5.1.2 Population Group

Figure 5.23: Respondent's Population Group

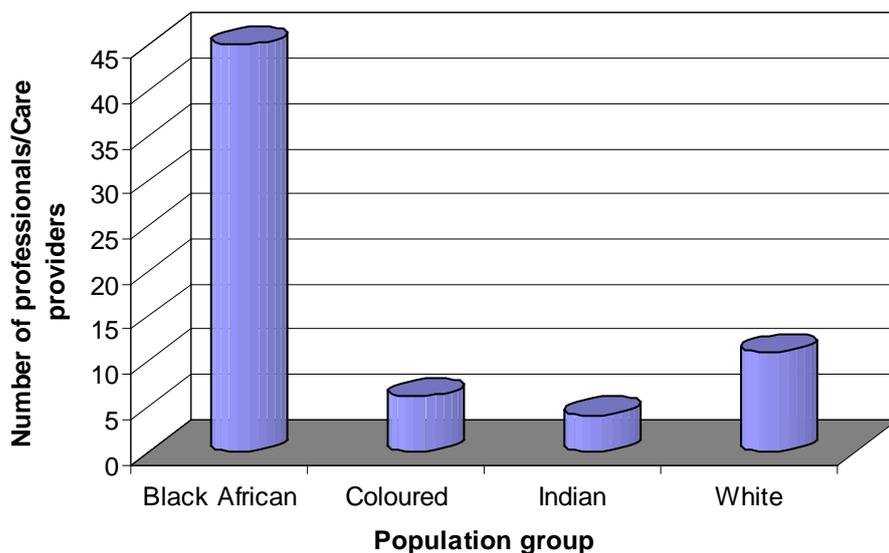


Table 5.20: Respondent's Population Group

Population Group	Number of Professionals/Care providers	Percentage %
Black African	45	66.2%
Colored	7	8.8%
Indian	4	5.9%
White	12	16.2%
Total	68	100%

Majority (66.2%, n=45) of respondents in the sample were black Africans compared to all others 16.2% (n=12) whites; 8.8% (n=7) coloreds and 5.9% (n=4) Indians. The demographics ranges from rural and urban with more of the Black Africans rurally-based and others mostly based in urban Protective Workshops. This has implications for lack resources, poverty and deprivation. It is important to note that most (79.4%) of them are females as revealed in figure 5.22 above.

5.5.1.3 What is the Target Population of people with disabilities for the programme?

Table 5.21: The target group of people with disabilities at facilities.

Target population N=68	Percentage %
Mean	76.76%
Standard Deviation	52.46%
Range (Min9 – Max 210)	9-210%

Out of a sample of 68 respondents, only 33 answered the question and 35 did not respond.

5.5.1.4 Socio-economic status of people with disabilities served by your organization?

Cross Tabulation data: Geographic Coverage by Gender.

Table 5.22: Socioeconomic Status and Geographic coverage Cross Tabulation

Socio economic Status	Geographic Coverage			Total
	Rural	Urban	Peri-urban	
Poor	14	14	12	40
Average	7	8	11	26
Good	1	3	2	6
Total	22	25	25	72

The findings revealed that amongst the people served by Protective Workshops poor socio economic status seemed to be a dominant factor of varying degree in all geographic areas and averagely so (26 responses). However, only six said that the socio economic status of people was good. There is a need to redirect the existing government poverty alleviation strategies and resources to meet the needs of people with disabilities through strengthened integrated approaches.

5.5.1.5 What is the educational background of people with disabilities utilizing the service/programme?

Cross Tabulation data: Educational Background and Gender.

Table 5.23: Respondent's Educational Background and Gender of People with Disabilities Cross Tabulation

Educational Background	Gender		Total
	Female	Male	
Never been to school	16	5	21
Primary education	20	7	27
Secondary education	10	1	11
Tertiary education	4	0	4
Total	50	13	63

Twenty respondents said that most people with disabilities served had only attended school until primary school, while 16 said they served people who had never attended school, and a few said some service users had secondary and tertiary education.

Missed opportunities for educational advancement could be attributed to factors related to barriers to learning. People with disabilities with potential and those possessing knowledge and skills should be encouraged to participate in governance issues and given opportunity for further education to enhance their abilities. Inclusive education and the education of the girl child should be promoted as well as continuing education as part of the Adult Basic Education.

5.5.1.6 How are people with disabilities recruited to the Centre/ programme?

Table 5.24: Respondent’s Recruitment Method

Recruitment Method	Number of Professionals/Care providers in the sample	Percentage %
Referral	51	75.5%
Self interest	34	50.0%
Other*	12	17.6%

Overall, 75% (n=51) of the respondents said that people with disabilities are recruited to the Protective Workshops. 50% (n=34) of the respondents said that some people affiliated with the Protective Workshops out of self-interest. However, 17.6% (n=12) of respondents said the recruitment of people with disabilities was based on “other” criteria. The inclusion criteria of people with disabilities varied from one Protective Workshop to another and also geographic differences existed.

5.5.1.7 To what extent do you think that people with disabilities have equal opportunities compared to those without disabilities?

Table 5.25: Respondent’s Opinion on opportunities for people with disabilities

Opinion on equal opportunities	Number of Professionals/Care providers in the sample	Percentage %
Greater extent	13	19.1%
Lesser extent	24	35.3%
Moderate extent	15	22.1%
Not at all*	14	20.6%
Total	66	100%

Table 5.25 above provides a summary of feedback from professional respondents with regard to whether they perceived that people with disabilities received comparable opportunities within health care settings as those without disabilities. The results, were evenly distributed across the continuum of viewpoints although the most expressed view was that professionals felt that individuals with disabilities received less opportunity than their non-disabled counterparts. It is interesting to note that 20.6% of care providers/ professionals in the sample did not seem to have a sense of awareness about opportunities available for people with disabilities they serve.

5.5.1.8 In your opinion, is health sufficiently promoted amongst people with disabilities?

Table 5.26: Respondent’s Opinion on the sufficient the promotion of Health

Health sufficiently promoted	Number of Care providers/ Professionals in the sample
Yes	27
No	39
Total	66

39 respondents indicated that they believed that health promotion was not sufficiently promoted within Protective Workshops compared to only 29 who agreed with the statement. This is a noteworthy difference when compared to the findings from the

exploration of views of respondents with disabilities, where 145 of them positively identified that health promotion was sufficiently promoted in Protective Workshops compared to 128 respondents who did not agree with the statement.

5.5.1.9 What is the extent of Involvement of People with Disabilities in Health promotion?

Figure 5.24: Respondent’s Extent of Involvement of People with Disabilities in Health Activities.

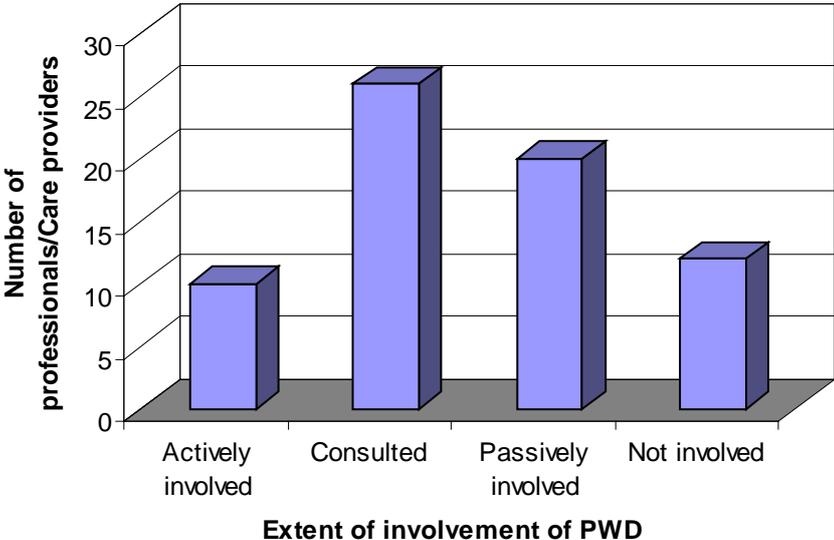


Table 5.27: Extent of Involvement of People with Disabilities in Health Activities.

Extent of Involvement	Number of Care providers/ Professionals in the sample	Percentage %
Actively involved	10	14.7%
Consulted	26	38.2%
Passively involved	20	29.4%
Not involved	12	17.6%
Total	68	100%

Table 5.27 provides a summation of professional views about the extent of involvement of people with disabilities in health promoting activities. Responses from the professionals indicated that they believed that those with disabilities were mostly consulted or passively involved (38.2% and 29.4% respectively) in their care with very

few being actively involved (14.7%). 17.6% (n=12) of the professional respondents said that people with disabilities were hardly involved.

5.5.1.10 To what extent is the Efficiency of the Monitoring System to identify high risk amongst people with disabilities?

Table 5.28: Respondent’s Opinion on the Efficiency of the Monitoring and Evaluation System

Efficiency of M&E systems	Number of care providers/professionals in the sample	Percentage %
High	12	17.6%
Moderate	25	36.8%
Low	18	26.5%
Don’t Know	12	17.6%
Total	67	100%

According to the findings provided in Table 5.28, not much (36.8% moderate; 26.5 low and 17.6% don’t know) had been done to monitor the activities of health and health promotion in particular and evaluate the programme. Only 17.6% respondents indicated the monitoring and evaluation systems were highly efficient. This indicates a need to develop and strengthen monitoring and evaluation of information management systems at protective workshops to improve the quality of care in Protective Workshops. Research and the development of good practice models should be encouraged.

5.5.1.11 In your opinion the Efficiency of Health Promotion activities for people with disabilities

Table 5.29: Respondent’s Opinion on the Efficiency of Health Promotion Topics

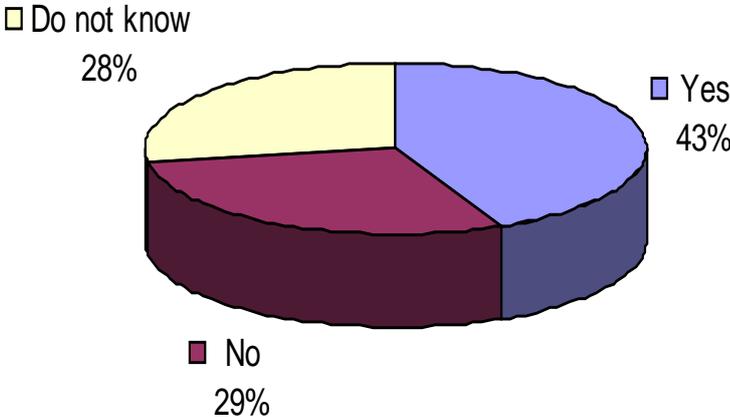
Efficiency of Health Promotion	Opinion					Total
	Strongly agree	Agree	Not sure	Disagree	Strongly Disagree	
Cover crucial preventive strategies	10	24	12	3	10	53
Rudimentary topics	5	16	15	4	4	44
Concise	6	17	13	4	3	43
Other	1	2	5	1	1	10

Responses on the efficiency of health services rendered at protective workshops were viewed differently by caregivers/professionals. Significantly, the majority (24 and 10 respondents) agreed and strongly agreed that the health promotion topics covered crucial preventive strategies, compared to those who disagreed. About 5 and 16 respondents said that topics covered are rudimentary, while others 17 and 6 said that topics are concise and did not make an impact.

On the contrary, it was found that most people with disabilities respondents disagreed that health promotion was sufficiently promoted within Protective Workshops. Evidence show that effective health promotion should move beyond campaigns and awareness to make a change into systems and processes of programmes; to be developmental and sustainable through a multispectral approach.

5.5.1.12 Are there supportive policies to increase access to health promotion efforts for people with disabilities?

Figure 5.25: Respondent’s Knowledge of Supportive policies to increase access to health promotion efforts for people with disabilities



As shown above, 41.2% (n=28) of respondents knew about the existence of supportive policies in their Protective Workshop compared to 27.9% (n=19) who said that such policies do not exist and 26.5% (n=18) who did not know whether they exist or not. There is a need to develop an integrated training and development plan and performance assessment of caregivers/professionals, also skills development should be linked to training needs, continuous education with expertise from partner organizations to orientate and keep them abreast with developments. The involvement of NGOs in training and development programmes is crucial.

5.5.1.13 To what extent are these structures integrated to afford people with disabilities equal opportunities for quality services?

Table 5.30: Respondent’s Knowledge about the Extent of Integration of Structures to promote equal opportunities

Extent of Integration	Number of care providers/professionals in the sample	Percentage %
Greater extent	11	16.2%
Moderate extent	17	25.0%
Lesser extent	27	39.7%
Not at all	10	14.7%
Total	65	100%

Table 5.30 above shows the respondent’s knowledge about the level of service integration in Protective Workshops, Most respondents tended to either agree that service integration takes place to a lesser (39.7%) or to a moderate extent (25%), or not at all (14,7%). However, 16.2% respondents said that there is a greater extent of integration taking place. There is more evidence to prove the benefits of an integrated approach to service delivery as it is an Endeavour to overcome fragmentation duplication and share limited resource for maximum capacity.

5.6 QUALITATIVE DATA PRESENTATION AND ANALYSIS

5.6.1 Introduction

The development of questionnaires focused on the two respondent types, which are people with disabilities and care providers/professionals. Questionnaire items of both contained a combination of closed and open-ended questions that were used complementarily to quantify responses on the demographics, knowledge, attitudes and perception of the respondents.

To gather a good response rate especially with regard to opinion questions, Survey administrators distributed and monitored the administration and completion of questionnaires of the care providers/professionals and conducted individual interviews to people with disabilities in the sample.

The qualitative data was analyzed differently from the quantitative data. The former involved themes, categories and patterns that gave a narrative confirmation to nuance findings of the latter. This analysis is supported by application of other sources of literature such as document review, participant observation to strengthen the study findings.

Qualitative data of both the respondent types was managed using a coding scheme and data reduced through allocating categories. Both opinion questions and statements were captured to justify issues commonly raised by respondents. Qualitative data of people with disabilities will be analyzed first and then followed by that of care providers/professionals.

5.6.2 Qualitative data analysis of people with disabilities

5.6.2.1 Awareness about Disability

- **Question 7.1: Please explain what led to your disability?**

Respondents were asked to explain how their state of disability occurred. Almost all (n=260) out of a total of 282 respondents were aware of their disabling factors and similarities were grouped as indicated in the following table:

Table 5.31: Categories of the reasons for disability Status

Common themes of Disabling Factors/Reasons	Categories of responses through Narrative Statements
Natural	"I was born like this" "Since Birth" "I was born Blind" "It is Congenital in our family"
Non-natural	" I was stabbed in the back with a knife" "I was involved in a car accident" "Had a spinal injury due to an accident" "I fell and injured my head when I was young"

	<p>“Paralysis due to Gunshot”</p> <p>“ Was beaten by a snake”</p> <p>“I drowned as a child and suffered brain damage”</p>
Childhood Illnesses	<p>“Cerebral palsy as a child”</p> <p>“German Measles”</p> <p>“Due to Meningitis when I was small”</p> <p>“ Had polio as a child”</p>
Health/Mental Health/Chronic Disease complications	<p>“Had a brain tumor”</p> <p>“Suffered a stroke”</p> <p>“Had Tuberculosis”</p> <p>“ Amputated due to Diabetes”</p> <p>“ I am Epileptic since I was young”</p> <p>“ I developed pneumonia and convulsions”</p> <p>“ Had an eye problem and was mostly damaged by an eye operation”</p> <p>“Has arthritis”</p> <p>“ I fell sick and became disabled”</p> <p>“I was unable to cope at school”</p> <p>“ Eye problems in 2006 leading to blindness”</p> <p>“ Drug Abuse”</p> <p>“ Depressed and Mental Illness”</p> <p>“Lost my hearing gradually”</p>
Other	<p>“I forget things”</p> <p>“Because of witchcraft”</p> <p>“After I lost one of my favorite clothes/outfit”</p>
Don't Know	<p>“I don't know”</p>

- **Question 8: In your own words, how would you define the term “disability”?**

Respondents were asked to define the term “disability”. Most of them related the term to their own experience of a disability, physical, intellectual, blind, deaf and mental.

The following narrative statements were expressed by respondents:

“A person who is physically challenged mostly due to accidents or born with it”

“People with visual impairment”

“People not coping to think properly and forgetful”

“If one cannot do anything for oneself”

“Unable to drive or work in the labour market”

“Being on a wheel chair”

“When one part of my body cannot function well”

Some of the respondents used language such as being “crippled”, “handicapped”, “in need” of assistance and social grants, “inability” to function, being different from “normal” people, people who are “not well”, “incapacitated”, something (a condition) that “never heals” and holds you back and makes you different, “not fit” to work.

However, others moved towards a broader understanding of disability as paraphrased below:

“Challenges, unable to perform daily activities due to various barriers”

“A situation that could happen to anyone due to accident and sometimes one could be born with the condition”

“An ability to do things differently with my limited ability”

“An environment around one that makes him or her feel disabled in many ways”

“Inability to participate in mainstream activities due to societal barriers”

“Disability is the disadvantages and restrictions of activity caused by society”

- **Question 9: Do you think people with disabilities have rights?**

This question on whether those with disabilities had rights was posed to further probe the “yes” or “no” quantitative responses elicited earlier in the quantitative data analysis. Most of the respondents felt that people with disabilities had the same rights as other people; a similar trend that emerged was that of “equal rights” or “all rights”. Elaborating on these rights, some respondents mentioned specific rights that were relevant to their contexts and they included the following:

- **Question 10: In your opinion, what are the rights of people with disabilities?**

Figure 5.26: Respondent’s opinion on equal rights for people with disabilities



- **Question 12: To what extent do you relate to other people with a disability in your community?**

Probing question:

Question 13: If not at all, please explain why?

Respondents were asked to explain the extent of their relationships with other people with disabilities in the community. 31 respondents indicated that relationships did not

exist (not at all). Amongst the reasons given, the issue of societal barriers was emphasized in areas such as and including lack of access to services and information, poor communication, the attitudes and stigma attached to people with disabilities, denial of ones disability status makes one to shun away from the community and lack of family support.

Most responses attributed direct blame on the society's failure to create an enabling environment for people with disabilities to relate with one another.

One respondent said:

"They are not caring and not assisting disabled people with resources and opportunities, they discriminated us"

Over protective attitudes by family were also identified as contributing toward increased stigmatization and isolation of people with disabilities.

Another respondent commented:

"My parents would not allow me to visit friends because all they do is laugh at me"

This is suggestive of the continuing ignorance, discrimination and lack of respect for people with disabilities in some communities contributing to disablement.

The quantitative data also revealed that people who are deaf and those who are blind were mostly affected. This could be associated with the fact that their disability renders them totally dependent on the support and guidance of significant others to be able to associate with others.

- **Question 14: In your opinion, how does the community view people with disabilities?**

Most respondents felt that the community view and treat them negatively, and only a few felt that there is a fair chance of community perception towards people with disabilities. The table below captured some of the respondent reaction to the question.

Table 5.32: Respondent’s opinions on the community view towards people with disabilities

Community Views	Responses	
	Negative	Positive
Perception	Stupid, fool, sick person, an outcast, nuisance, mentally retarded, dependent, view us as no total humans and the government and community takes decisions for us thinking they are making us a favor, ashamed of us, makes you feel unwanted.	Equal, strong people, community is fine and supportive, they understand my disability
Attitude	Bad attitude, poor communication, disrespectful, discriminate, takes us for granted, lack of support, no accepted as people, looked down upon, show lack of understanding of equal rights, Hidden agenda: the interest of community on benefiting than attending to the needs of people with disabilities, some hate us others love us, neglects us as there is no transport and services are not friendly to us, they think we cannot do anything for us	Caring and loving, others people show respect, increasingly there is awareness amongst community, they feel sorry for us, community accepts and appreciates us without critics, helpful,

One respondent raised an encouraging point that people do not know how to approach people with disabilities and it is just as much a responsibility of people with disabilities to reach out to the community. The respondent also acknowledged that, this required the creation of more receptive and enabling environments for people with disabilities.

5.6.2.2 Access to Health Services

- **Question 20: What do you understand by the term “health promotion?”**

Respondents were asked to give their understanding of the term Health Promotion. Thematic categories of their responses were paraphrased on Table 5.53 below:

Table 5.33: Showing thematic categories to the respondent’s understanding of the term “health promotion”.

Health service	Health awareness	Health education	Health Promotion
To take care of many people; Provides Medication that is not harmful;	Promoting awareness among people about illness; Information we receive about protective measures;	Health talks on diseases; Being taught how to protect self and how to deal with illnesses; To teach us about health; Teach people about health care services and to care about healthy food;	To improve your health; to provide proper implementation of programmes to improve community health; To do things to improve your health like sport, exercise healthy food go to clinics; To promote activities to the community to improve health status and the environment to users friendly to community; Health activities done to improve health environment where the community live; to promote our lives and disabilities; Doing activities in support with health development; To involve all stakeholders to participate to promote health activities.

The above four (4) categories are interrelated and their interconnectedness is briefly discussed. Health promotion takes place in different settings (including within Protective Workshops), and health education is a vehicle to assist in accomplishing health promotion. Awareness raises consciousness of individuals and communities to take appropriate decisions toward changing behavior.

Question 22: Please state what health promotion activities have you been exposed to?

Respondents were asked to state what health promotion activities they had been exposed to during attendance to their Protective Workshops.

Paraphrased narratives:

Almost all respondents identified HIV and AIDS education and awareness campaigns as a key activity provided by most Protective Workshops.

Most respondents identified the following activities that served as important entry points for health promotion:

Health activities

- Clinic services, on site or as a referral service;
- Health education,
- Special services such as Diabetic, Cancer and Tuberculosis days;
- healthy eating and take part in sport
- Drug abuse and mental health
- First aid training
- Oral Health care

Health related activities

- Road safety, prevention of road accidents

Campaign activities

- World Sight Day, World AIDS Day,
- International disability day,
- Worker's month for people with disabilities,
- World no Tobacco Day;
- Healthy Lifestyles campaign was identified by a few respondents;
- Woman and Child Abuse talks;

Social Support Services

- Counseling services;
- Support with Social Grants
- Mental Health and Substance Abuse
- Rehabilitation services

Leisure

- Exercise groups
- Sports
- Playing games

Education and training

- Attending Workshops
- Education on epilepsy, health and hygiene, HIV and AIDS and safety on using equipment
- Watching educational materials (DVDs) on AIDS, peer education, first aid courses and fire fighting courses.

However, a number of respondents said that they were not exposed to any health promotion activities.

- **Question 23: Who provided those activities? Please explain.**

Respondents were asked to identify people who provide health promotion related services in their Protective Workshop.

Paraphrased narratives:

Almost all respondents identified the following:

Health Promotion Service points

- The clinic identified as the main service points for health promotion and services.
- The government was said to be the primary service provider
- Non governmental organizations (NGOs) as supporting services
- Private sector was mentioned to a lesser extent.

- Community support structures were identified,
- Family and relatives in particular were regarded as foundations for care and support.

Health care providers

- Nurses (school Health Nurses, government)
- Government departments
- Social workers
- Educators
- Protective workshops management and staff
- Non Governmental Organizations (DPSA, Epilepsy SA, Deaf Society, etc)
- Doctors
- Pharmacists
- Parents

5.6.2.3 Availability of Structures and Mechanisms

- **Question 25: Do you know of any facility in the community that caters for the health needs of people with disabilities? (Please tick)**

Probing:

- **Question 26: If yes, please give names and their location.**

Respondents were asked to identify the community-based facilities that cater the health promotion needs of people with disabilities. It is interesting to note that out of a sample of people with disabilities, only 27 respondents could identify community-based organizations that provide services for people with disabilities and the rest did not know about their existence. There is a need to create awareness amongst people with disabilities on the range of services available in the community to increase their knowledge, interactions and access to a variety of services that addresses their needs.

- **Question 31: What health promotion activities do most support groups engage in?**

Respondents were asked to identify the health promotion activities that most support groups do. Common themes that emerged included the following: Health education and awareness campaigns activities; social support services; skills development. Health education and mostly campaign activities was said to be promoted by most support groups. HIV and AIDS health awareness and education seemed the most common activity promoted. Other health related activities included health education and prevention awareness sessions on cancer, eye care, and personal hygiene, and nutrition, tobacco and exercise/physical activity. Social support services included support group sessions for different needs, e.g., cerebral palsy; improve quality life of children with disabilities, moral support to the parents of the children with disabilities, care and guide orphans and social grants. Skills development activities included catering, cooking gardening, and income generating activities, educational activities and providing food parcels. However, there were those who were not aware of what support groups were doing.

- **Question 32: In your opinion, what support is needed for people with disabilities to participate actively in health promotion activities?**

Respondents were asked to identify what support they needed to enhance their participation in health promotion activities. Common themes that emerged included the following: Guidance, care and support; health education and integrated services; materials and equipments; active involvement and participation in health promotion activities; dedicated personnel and job opportunities. Another issue raised was that of accessibility of toilets and that the people attitude should change.

The following narrative statements are relevant:

“To raise awareness about disability issues”

“Someone to work with disabled people on a full time bases”

“We need to be taken in for any health promotion because we hardly participate in them”

“We need jobs, jobs, jobs”

“Give them strong wheelchairs and other equipments to be able to be active”

5.6.3 Qualitative data analysis of responses from care providers/professionals

- **Question12: in your own words, how would you define the term “disability”?**

Most respondents had limited the definition of disability to ‘a kind of impairment experienced by the person’.

The narrative statement below explains the view:

“Any type of impairment”

“No use of arms and legs”

Some of the respondents exhibited a limited understanding of the concept such as:

“A person who is unable to perform duties which are performed by normal people”

Others defined disability as:

“People who are unwell and unable to work in the open labor market”

“People who have had a relapse and are recovering”

These findings indicated that the orientation of some care providers/professionals was still on the medical model and a limited view of their knowledge to disability issues. Generally, compared to people with disabilities who were interviewed on the same question, respondents in this category have shown a low level of understanding and still promote the use of words such as “incapability”.

However, a few of the respondents believed disability to be:

“Any restriction or lack of ability to perform activities in the manner that is considered normal for a human being”

“It means differently able to what we know as able and doing things at own pace, time, etc”

“A person whose body functions is affected but can still do for him or herself”

The demographic data revealed disparities in terms of population, gender, geographical area of all respondent types. Skills development and opportunities for further education and relevant training should be considered to address the skills and knowledge gap in the protective workshops as well as in the public health including professional development of other disciplines.

- **Question 14: In your opinion what are the rights of people with disabilities?**

The right to education was raised by most respondents. Other rights included to support, love, care, employment, respect, protection, to make decisions, marriage, respect, access to resources, free from discrimination, dignity, fairness, etc. Ten of the respondents said that people with disabilities have the same rights as any other person.

- **Question 17: Please state the range of services that are rendered at the (Protective Workshop) Centre**

Most respondents were aware of the services rendered by their protective workshops, which included the following:

- Health services and education (treatment of minor ailment, promotion of health, first aid, rehabilitation); specialized health and social services including occupational therapy and physiotherapy, speech therapy and language therapy and audiologist;
- Basic health and hygiene such as bathing and brushing of teeth;
- Education programmes such as skills training and special educational programmes such as school for severely intellectually handicapped and Braille literacy and numeracy;
- Social services such as job creation, care and support, counseling; employment opportunities such as sheltered employment;
- Special projects such as business skills, Photostat, fax, E-mail, reprinting hall, computer training, funeral flowers' meat cutting, beadwork, sewing, food garden,

brick making, garden services, domestic work, car wash, art, glass cutting renting property etc;

- Sports and physical activity such as exercise, dancing, football
- Life skills such as independent living skills.

- **Question 18: What do you understand by the term “health promotion”?**

The term “health promotion was understood differently by respondents, most of whom viewed it as health education and awareness and by others as a service.

The following statements are paraphrased:

As health education and awareness the meaning was in the area of “giving talks”, “education to create awareness”, “making health workers known to the people with disabilities”, “provide them with the necessary information”, “campaign/awareness organized”, etc.

Health promotion as a service was seen as promoting the use of medication, treatment and rehabilitation; as a service to be brought to people with disabilities.

Health promotion was also understood by most to be about the promotion of food gardens, cleanliness (personal hygiene); generalised life improvement; empowerment of people to take care of their own health and the intervention of health professionals so that health activities are fulfilled in the prevention of diseases, and illness.

However, one respondent understood health promotion to be:

“A once off concentration of or a programme to promote health issues”

- **Question 19: Please state what health promotion activities are provided at the centre.**

Most respondents raised a combination of activities similar to the ones stated amongst people with disability respondent types earlier such as the following:

- Clinic services, on site or as a referral service;
- Mobile clinic services for outreach
- Health education,
- Special services such as Diabetic, Cancer and Tuberculosis days;
- healthy eating and take part in sport
- Drug abuse and mental health
- First aid training
- Oral Health care
- Life skills training
- Sports and exercise groups
- Exposing people with disabilities to various games
- Training workshops for people with disabilities
- Education health and hygiene, HIV and AIDS, cancer, etc.

In-service training sessions and information sessions were held on site in some settings as indicated below:

“Discussions and talks by staff and social workers”

- **Question 28: Please indicate resources available for Health Promotion.**

Most respondents identified the following as resources available for the promotion of health in protective workshops:

- Government hospitals and employees at the rehabilitation departments
- The media seen as a resource to promote the needs of people with disabilities
- Health campaigns and national commemorative days
- Protective Workshops with big space (grounds), which enables people with disabilities to walk and engage in sports activities.
- Dedicated staff to promote activities
- first aid kit and health centers on site
- Health Services such as clinic (washing teeth), eye check up,
- Local safety and security services such as policemen (woman and child abuse)
- Sports activities, life skills classes and healthy eating plan for residents
- Assistive devices such as wheelchairs and crutches

- Awareness in the form of pamphlets and booklets and videos. posters and talks
- Outreach by hospital therapist. Therapists visits once a month. social workers and mobile clinic
- Support groups
- NGO involvement

However one respondent said that there was no Braille literature at all. Another one said that their protective workshop is battling to get physiotherapy services, dentists and mobile services as well as assistive devices e.g., wheelchairs.

- **Question 20: Please indicate structures that are available to increase health promotion efforts for people with disabilities.**

Most respondents identified the following:

- A multidisciplinary team
- OSDP, NGOS
- Disability forum (not used by us), Society for Physically Disabled
- The disability desk by local government
- Social worker community
- School nurse, clinic and hospital
- Educators, staff, principal
- Schools, Corporate Business
- Full assistance is given by Welfare Officers
- Community -based workers and. hospital therapists
- Community-based rehabilitation outreach services by rehabilitation therapists

However, one respondent felt that:

“It was very difficult for structures to be sustained as departments are doing their own programmes and national must fund the organizations that are working to function properly”

- **Question 21: What qualities are essential for effective health promotion practice?**

Common issues that were raised by most respondents included a feeling that services providers need to have a passion to work with people with disabilities; to be sensitive to their needs, to be respectful to people with disabilities, warmth, love, caring, understanding, well informed person, offer emotional care and support. They should be able to make them feel free and accepted and also make them feel active everyday. Understanding of disability and use of simplifying terminology was emphasized. Efficient, capable, properly trained staff is needed and the Involvement of people with disabilities in mainstreamed activities. Networking between different departments and NGOs to promote the needs of people with disabilities and be empowering.

- **Question 22: In your opinion, what support is needed for People with disabilities to participate actively in health promotion activities?**

Most respondents raised similar issues relating to the support needs for people with disabilities. The need for collaboration with other partners was raised by most respondents. Service improvement in terms of resources and capacity (number and skills development) of service providers and partners was another issue. A strategy to remove all barriers to disability was raised by some in areas such as attitudes, transport; physical, infrastructure (toilet facilities).

5.7 SUMMARY

The current chapter dealt with management of field data. The data were generated from people with disabilities and care providers/professionals who were based in protective workshops environments. During the management of data, quality was retained and managed through an integrative process using various statistical soft wares, further data management included cross tabulation and Chi-square test of association between variables. The section discusses participant's observations and also presented a brief description of qualitative data to complement personal accounts. The narratives were subsequently integrated with the quantitative data for ease of analysis and were presented as frequency tables to facilitate interpretation.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

In May of 2005 the World Health Assembly (WHA58.23) endorsed a resolution that called upon Member States to include “a disability component in their health policies and programs...to intensify collaboration within the World Health Organization requesting the Director-General to produce a world report on disability and rehabilitation based on the best available scientific evidence” (World Health Organization Action Plan 2006-2011). This served as one of the drivers of the impetus behind the study exploring and probing the involvement of those with disabilities within health and in particular, their experience of protective workshops as vehicles of wider health promotion. Within the current study, a sample of facilities from all provinces within South African national databases was selected via a simple random selection procedure. All in all, a total number of seventy protective workshops across the nine provinces of South Africa were selected for review with a primary study purpose of determining the nature of health promotion that existed for people with disabilities within the context of protective workshops.

Both quantitative and qualitative data was sought from two participant groups, that is, those with disabilities who attended and took part in the protective workshops and secondly, the care providers/ professionals who facilitated and provided the protective workshops. This data was transcribed and packaged into a statistical computer program using coded variables. Qualitative data from both respondent groups was managed using a coding scheme and data reduced through allocating categories. Initial quantitative data collected via questionnaire was complemented by qualitative insights based on open-ended questions that had been posed to participants as part of the data collection process. The thematic categorization applied to the qualitative data was intended to complement the quantitative data which had been subjected to specific statistical analyses.

Analysis of data was done through Cross tabulation to determine the relationship of the sex variable to other variables such as age, education and the kind of disability. The chi-

square method was used in order to test the association between a variable and the type of disability. In this study a 5 percent level of significance was used for all statistical tests ($\alpha = 0.05$). The decision rule was to reject the null hypothesis (H_0) if the p-value of the test was less than alpha ($\alpha = 0.05$) and not to reject the null hypothesis if p-value of the test was greater than alpha ($\alpha = 0.05$). Both these techniques contributed toward validating and ensuring reliability of the data and enriched the investigations.

The results from this triangulated data collection process resulted in two distinct data types i.e. qualitative and quantitative data. As argued within this thesis and indeed by other researchers, the exploration of the topic area from these two differing perspectives offered unique insights that would not have been possible from the single-use of any one of the methodological approaches.

6.3 QUALITATIVE FINDINGS

6.3.1 People with Disabilities Respondent Type– Emerging Themes

Respondents' responses to the open-ended questions gave rise to a number of noteworthy themes. Even though the coordination of health promotion activity at the protective workshops seemed inadequate, participant feedback revealed collaborative efforts, which were observable among occupational therapists, social workers, health workers and educators. For example, all professional respondents were able to locate their own specialist role within wider health promotion aspirations and in so doing, also showed a sound awareness of how other professional disciplines contributed to their working within the delivery of protective workshops. There was clarity in the respondents' responses about who and what services were responsible for the different elements of care delivery even though this identification did not always translate to an appropriate use of specified services areas and expertise.

6.3.1.1 Awareness about Disability

- **Disability Status**

Respondents were asked to explain how their state of disability occurred. Almost all (260) out of a total of 282 respondents were aware of their disabling factors

differentiated disability status primarily by whether disabling factors were “natural” or “non-natural” or a result of “childhood illness” and/or “chronic disease complications”. This understanding of disability in terms of “how it was caused” represented the most basic understanding of disability. Variance in perceptions of disability were borne out in respondents’ definitions of what disability was. Responses spoke primarily of physically observable impairments with little reference to the less observable forms of disability such as those that affect cognition and emotion. It was notable that respondent responses covered a wide continuum of understanding with some of the “non-professional” respondents expressing a broader understanding of disability which included seeing it as involving “the range of challenges that made them unable to perform their daily living activities. It was notable too that some of the conceptions about disability referred more specifically to the role played by the environment as a disabling factor, for example, some respondents saw their disability as the “Inability to participate in mainstream activities due to societal barriers” with others suggesting that “Disability is the disadvantages and restrictions of activity caused by society”

- **Disability Rights**

Almost all respondents (both those with disabilities and the care providers) felt that people with disabilities had the same rights as other people. Elaborating on these rights, some respondents mentioned specific rights that were relevant to their contexts to include equal protection legally, access to the same levels of care as others and not being exploited any more than their counterparts without disabilities. Closer analysis of respondents’ views drew attention to some of the less commonly expressed views such as, feelings by some that the care they received could have been improved on, particularly in terms of it being more accessible.

6.3.1.2 Community relations with other people with disabilities

Non-professional respondents were asked to explain the extent of their relationship with other people with disabilities in the community. A noteworthy proportion (n=31) believed that they did not have any relationships with other people that had disabilities and they attributed this a range of factors including socially determined barriers such as lack of access services to support their mobility, lack of information about potential social outlets, prevailing attitudes and stigma attached to people with disabilities and lastly,

but just as important, persistent denial of one's disability status such that they shunned away from the community. It was notable that many of the responses attributed the experience of being socially isolated to the failure by society at large and a generalized lack of enabling environments for people with disabilities to relate with one another. Additionally, over protection by family was also identified as a contributory factor to the continued stigmatization and isolation of people with disabilities. The quantitative data also revealed that people who are deaf and those who are blind were subjectively mostly affected. This could be associated with the fact that their disability required that they become totally dependent on the support and guidance of significant others to be able to associate with others.

6.3.1.3 Community view towards people with disabilities

Most respondents felt that the community viewed and treated them negatively, and only a few felt that there is a fair chance of community perception towards people with disabilities. The negative and positive responses included feeling that they were perceived as “mental retards”, “outcasts”, “sick people” and at times intellectually inferior. All the above expressed community perceptions, attitudes and views against people with disabilities constitute disability discrimination, abuse, exploitation, violation of their rights and creates barriers which compromise efforts towards integrated approaches. Public education campaigns, education and support to families and people with disabilities from discrimination and abuse should be considered. These perceived negative views were countered by more positive perceptions that included feeling that society at large was compassionate and empathetic to the needs of those with disabilities and viewed them as deserving of equal treatment. The above are health and development enhancing perceptions that should be reinforced through strength-based approaches including safety nets and supported to promote equality and equity principles among people with disabilities.

6.3.1.4 Understanding of the term “Health Promotion”

Non- professional respondents were asked to give their understanding of the term Health Promotion as the first step toward understanding how they perceived their access to promotive support. In their description of what they saw health promotion as, respondents believed it to include all actions that promote awareness about health and

illness; being taught about how to protect one's self from ill health; being taught about how to take medication and general health talks about disease prevention. Their understanding also included doing all things to improve their health like sport, exercise healthy food go to clinic; promoting activities within the community so as to improve their health status.

6.3.1.5 Exposure to Health Promotion Activities

Respondents gave accounts of the range of health promotion activities they had been exposed to during their Protective Workshops. Firstly, respondents identified HIV and AIDS education and awareness campaigns as a key activity provided by most Protective Workshops. They also identified a number of activities, which served as important entry points for health promotion such as diabetic, Cancer and Tuberculosis days; healthy eating, drug abuse and mental health support, First aid training and education on Oral Health care. A range of campaign activities and social support services were also reported including involvement in World Sight Day, World AIDS Day, International disability day, Worker's month for people with disabilities, World no Tobacco Day and Woman and Child Abuse talks. The social support services that were reported included access to Counseling services; Support with Social Grants and support with Mental Health and Substance Abuse issues.

Despite the reporting of access to a wide range of health promotion activities, a number of respondents said that they were not exposed to any health promotion activity.

In an effort to better understand the interface with health providers, the non-professional respondents were asked to identify people who provided health promotion related services in their Protective Workshops. Almost all respondents identified the following; *Health Promotion Service points such as clinics, Non governmental organizations (NGOs); Doctors; Nurses (school Health Nurses, government); Social workers; Educators; Protective workshops management and staff and their family members.* Respondents were asked to identify what support they needed to enhance their participation in health promotion activities. Common themes that emerged included the following: Guidance, care and support; health education and integrated services; materials and equipment; active involvement and participation in health promotion

activities; dedicated personnel and job opportunities. Another issue raised was that of accessibility of toilets and that the people attitude should change.

6.4 RESULTS FROM THE ASSESSMENT OF CARE-PROVIDER VIEWPOINTS

The second aspect of the study involved a review of the views of care providers with regard to their involvement as professionals within protective workshops. Out of 68 professional respondents, only one respondent in the sample did not indicate the province he/she come from. It is important to note that not all Protective Workshops had care givers/professionals allocated at the care centre, but some were managing more than one centre depending on their staff establishment, location and other factors. Most (79.4%) of respondents were female compared to only 20% male care givers/professionals. This indicates a noticeable gender disparity and the significant role of women in care work. A recruitment programme to attract males into care giving responsibilities, including recognition and remuneration of care work is needed so that those with males that are disabled can have access to more gender appropriate support as per need.

Majority (66.2%) of respondents in the sample were black Africans compared to all others (16.2% whites; 8.8% colored's and 5.9% Indians). The demographics ranges from rural and urban with more of the Black Africans rurally-based and others mostly based in urban Protective Workshops. This has implications for lack resources, poverty and deprivation. The findings revealed that amongst the people served by Protective Workshops, poor socio economic status seemed to be a dominant factor of varying the degree in all geographic areas and averagely so (26 responses). However, only 6 said that the socio economic status of people was good. There is a need to redirect the existing government poverty alleviation strategies and resources to meet the needs of people with disabilities through strengthened integrated approaches.

The method of initial engagement of people with disabilities in protective workshops was specifically explored with care provider respondents as part of the greater aim of gaining clarity on barriers to engagement that may have existed. With respect to this, the first question care-provider respondents were asked was to give their views about how service users with disabilities accessed their support. Overall, 75% of the care provider respondents said that people with disabilities were intentionally recruited to Protective

Workshops. 50% said that some people affiliated with the Protective Workshops out of self-interest and their specific reasons were unknown. However, 17.6% of respondents said the recruitment of people with disabilities was based on “other” criteria. The inclusion criteria of people with disabilities varied from one Protective Workshop to another and also geographic differences existed.

Care respondent’s opinion about the extent to which health promotion was supported within their workshops varied between respondents. Thirty nine (39) respondents said that health promotion was not sufficiently promoted within Protective Workshops compared to only 29 who agreed with the statement. There are differences in the findings of people with disabilities respondents, where 145 of them were positive that health promotion is sufficiently promoted in Protective Workshops compared to 128 respondents who did not agree with the statement.

One of the persistent criticisms of health promotion initiatives has been the fact that they adopted a top-down approach, which minimized opportunities for meaningful participation by those with disabilities. With regard to this, it was found that more (38.2% and 29.4%) respondents of care providers/professionals tended to consult and passively involve people with disabilities in health issues. 17.6% said that people with disabilities were hardly involved. However, only 14.7% said that there was active involvement of people with disabilities in health activities.

- **Respondent’s Opinion on the Efficiency of the Monitoring and Evaluation System**

According to these findings, not much had been done to monitor the activities of health and health promotion in particular and evaluate the programme, as revealed in figure and table (36.8% moderate; 26.5 low and 17.6% don’t know). Only 17.6% respondents indicated the monitoring and evaluation systems were highly efficient. This indicates a need to develop and strengthen monitoring and evaluation and information management systems at protective workshops to improve the quality of care in Protective Workshops. Research and the development of good practice models should be encouraged.

Responses on the efficiency of health services rendered at protective workshops were viewed differently by caregivers/professionals. Significantly, the majority (24 and 10 respondents) agreed and strongly agreed that the health promotion topics covered crucial preventive strategies, compared to those who disagreed. About 5 and 16 respondents said that topics covered are rudimentary, while others 17 and 6 said that topics are concise and did not make an impact. On the contrary, it was found that most people with disabilities respondents disagreed that health promotion was sufficiently promoted within Protective Workshops. Evidence show that effective health promotion should move beyond campaigns and awareness to make a change into systems and processes of programmes; be developmental and sustainable through a multispectral approach.

It was also important to get insights into the range of competencies that care providers perceived as important pre-requisites that enabled them to be effective health promoters for those with disabilities. Common issues that were raised by most respondents included a feeling that (beside being well trained), service providers needed to have a passion to work with people with disabilities; to be sensitive to their needs, respect to people with disabilities, warmth, love, caring, understanding, well informed person, offer emotional care and support.. Understanding of disability and the use of simplifying terminology was emphasized.

With regard to improving the level of active participation of individuals in health promotion activities, most care-provider respondents raised similar issues relating to the support needs for people with disabilities. The need for collaboration with other partners was raised by most respondents. Service improvement in terms of resources and capacity (number and literacy skills development) of service providers and partners was another issue. A strategy to remove all barriers to disability was raised by some, in areas such as attitudes, transport; physical, infrastructure (toilet facilities); positive attitude. This should greater sensitivity and protection of people with disabilities form unfair treatment.

6.5 NATURALISTIC OBSERVATION

During naturalistic observation which was an integral part of the investigatory process; some observations were made such as the absence of policy on health promotion. The Draft on Healthy Life-Styles Strategy was available and prominently displayed. The protective workshops that granted permission were physically visited for the purpose of data collection. The trained survey administrators (were recruited from the local organizations of people with disabilities) visited those that I did not visit physically. It seemed there was some degree of health promotion taking place within protective workshops; however these were not categorized as health promotion activities by staff.

Almost all respondents identified HIV and AIDS education and awareness campaign as a key activity provided by most Protective Workshops. Most respondents identified a number of activities, which served as important entry points for health promotion. These include a range of health activities such as Diabetic, Cancer and Tuberculosis awareness days, first aid training and information on the prevention of road accidents. Furthermore, social support services and leisure groups including education and training workshops were acknowledged as key entry points for health promotion.

Among other achievements, the participatory action research component of this investigation assisted the researcher to discern between study limitations and those of the models. According to the Department of Social Development (2008:37) the most current shortcomings of the Protective Workshops were that:

- The model does not clarify the process clearly enough and process flow should be explained
- Skills development falls under Social Development in the model. (A lead department must be clearly stipulated)
- Skills are limited and the model must address this matter.
- Sustainability must be guaranteed and it must be measurable
- No clear distinction is provided on the involvement of other stakeholders and the model should indicate their involvement

Other participatory action research and triangulation endeavors included several meetings attendance by the researcher as a platform to share her research project and plan. In 2007 the researcher submitted an abstract of the research project to share at the International Nurses Doctoral Network (INDEN) Conference in Japan. This work was captured in the INDEN newsletter 2007. On the 7th to the 8th February 2008 in Gauteng Province the researcher was invited by the Department of Social development to share her research project at National Protective Employment for People with Disabilities Consultative Workshop. The researcher addressed key workshop attendees comprising of provincial managers of the Protective Workshops from all provinces as well as partner organizations in line departments and the NGOs and the civil society. Again in 2008 at the Breast Cancer Awareness Seminar at UNISA organized by the Department of Health Studies the researcher presented a talk to women with Blindness who were participants on the research project.

6.7 QUANTITATIVE FINDINGS

Amongst the non-professional participants, female respondents represented a majority compared to their male counterparts, i.e. 51.8% compared to 48.2%. The responses to questions about their experiences of the protective workshops were broadly similar between the female and male respondents however, it has been noted in related literature that women have higher demands to provide care to others and as such it felt important to consider a recommendation that future protective workshops needed to give more focused support to women living with disabilities. Women empowerment becomes imperative as a basic human right for people with disabilities to achieve good health outcomes. To promote inclusivity, a culture of equal sharing of responsibilities between women and men in all aspects of life including care giving should be inculcated in the health promotion model including other models of care and supports.

Respondents aged 24- 40 years old were in the majority (37.4%) compared to those who were 40 years and above (31.1%); the 13-19 year olds (19.6); the 15-18 year olds (6.6%) and the 10-14 year olds (2.4%). As is evident from workshop membership, most (37.4% and 31.1%) of the people with disabilities who were recruited into the protective workshops are young adults and in their productive and reproductive years. There is a need for workplace healthy lifestyles programmes and strengthened sexual and reproductive health and mental health services to help them balance their work-life

responsibilities. Integrating Community-based Rehabilitation services will go a long way in facilitating social adjustment within protective workshops.

Further analysis of the Age and Gender data were Cross-tabulated and revealed that almost all those in the age group 24-40 years (n=106) participated in the study followed by those in the age group 41years and above (n= 88). The gender representation analysis revealed that almost all (except amongst the 10-14 age group) age groups were mostly represented by females. This indicates that Protective Workshops are mostly utilized by females with disabilities and all in their productive lives. There is a need to explore the influence that gender roles, gender division of labour and power relations play out within Protective Workshops. A gender integration programme should form part of the mainstream activities.

A large number of respondents (77, 4%) were Black Africans compared to other population groups, whites (11%), Indians (8%) and Colored's 3.6%). This representation by race indicates that Black Africans are the most represented service users and as such, have the greatest burden of disease and disabilities. Priority settings of government work have a long way to go when it comes to focusing health promotion resources to this population to balance the resource inequalities in an enabling manner to meet the needs of people with disabilities. A recent report of the Protective Workshop Consultative Meeting held in February 2007 revealed that there were disparities (in management including resource mobilization and other opportunities) in Black African managed protective workshops and those that were managed by whites and located in urban areas. It should be noted that people with disabilities are not a uniform group requiring the same assistance, but individuals with particular and differing needs, beliefs and values. Therefore services should respond to these needs and recognize individual needs, strengths, weaknesses, abilities and opportunities (National Rehabilitation Policy: DOH 2000:6).

Most (41.5%) of the respondents achieved primary education level; 37.7% achieved secondary education and only 5.3 achieved tertiary education. 15.5% respondents said that they never went to school. A further analysis through cross tabulated data revealed that a total of 99 people with disabilities (both males and females) attended secondary education level, compared to 41 who neither attended school and the same number

who only attended primary school education. This indicates the need to address barriers to learning through strengthened inclusive education and vocational skills development. The high levels of illiteracy within the client group indicate a need for the development of health promotion materials that are accessible across all educational groups. Health is a prerequisite for education and vice-versa. Evidence shows that education contributes to good health seeking behaviors and increases health literacy to modify risky behaviors especially when health is well promoted. More attention should be paid to increasing the education level of people with disabilities and inclusive education should be strengthened. Since protective workshops are offering ongoing skills development training, an integrated training and development approach is needed to increase education and health literacy for people with disabilities to contribute meaningfully into the country's developmental activities (economically, politically, socially).

With respect to disability rights, almost all (97%) of the respondents agreed that people with disabilities had equal rights as those who were not, compared to (2, 2%) who said that they believed that they had less rights than their non-disabled counterparts. The latter response could be attributed to the fact that more often people with disabilities experience discrimination, exploitation, and exclusion that affects their enjoyment of the right as enshrined in the RSA Constitution and the Bill of Rights. This also marginalizes people with disabilities and denies them opportunities to exercise their rights of access to services and meaningful participation in the country's development of inclusive health promotion. Public awareness campaigns and education about disability that will be facilitated by people with disabilities is needed. As stated above, emphasis should be put on increasing the education and health literacy levels of people with disabilities and to recognize (mainstream jobs markets) the skills and competencies of people with disabilities.

With respect to accessing equal opportunities with regard to life opportunities, most respondents tended to agree to a lesser extent (30.5%), moderate extent (21.5%) and not at all (25%) that equal opportunities existed for people with disabilities compared to only 22.6% who agreed. To achieve the goal of "full participation and equality" rehabilitation measures aimed at people with disabilities are not sufficient. Experience shows that it is largely the environment which determines the effect of an impairment or disability on a person's daily life (WHO 2002:7). Protective workshops are best suited to

afford people with disabilities equal opportunities if they can be strengthened through inter-sectorial and integrated coordination by different role players. An inclusive health promotion model is proposed that builds on the developmental of a social human rights model.

Relationships between those with disabilities and other members of the communities in which they lived were specifically explored. 50.2% of respondents tended to relate to a greater extent with others in the community; while 20.3% related to a moderate extent; 18.1% lesser extent and 11.45 said that they did not relate at all with other people in the community. This feeling of exclusion was a notable concern that needs to be addressed within future health promotion initiatives. Integrated public awareness campaigns and outreach programmes to expose people with disabilities to community empowerment activities should be created. Strengthening counseling services, family centered programmes and support groups and inclusive health promotion support programmes should be central to any health promotion strategy for those with disabilities living in the community.

In terms of the varied access to different promotive services, most respondents indicated more than one option as a reflection of a range and choice of health services provided. Notably, attendance to local clinics seemed to be the most (n=198 respondents) utilized followed by the hospital (n= 133). Ease of access to service providers was a noted difficulty with most respondents (n=178) indicating that they traveled more than 1kilometre to access their health facilities, compared to only 26 respondents who had to travel less than a kilometer. Most respondents (n=122) traveled by foot to and from a health facility with 15 respondents confirming that they had used wheelchairs as a mode of transport. 59 others traveled by assisted transport, while 79 respondents used taxi; 36 used Bus and 15 used own transport. One other respondent said they traveled by train. Collaboration should be forged to promote disability friendly service delivery with regard to improved transport means for people with disabilities (coupons, reliability, safety, convenience and assisted transport). Road traffic measures should support people with disabilities through foot paths, ramps enabling traffic lights and strengthening of traffic safety measures.

Most (43.4% and 12.9%) respondents tended to either agree or strongly agree that health workers were sensitive to their needs as disabled people and showed sound knowledge of their difficulties. However, 17.3% were not sure about the statement and only (19.1 and 7.4%) either disagreed or strongly disagreed to the statement. Evidence shows that well trained health personnel are more likely to be friendly and supportive towards people with disabilities. In light of this, it is important that service providers be engaged in continuous training so that they progress their expertise in working with different disabilities within protective workshops.

Most (28.5% and 17%) respondents tended to either agree or strongly agree that people with disabilities receive appropriate health education at a health facility. However, 19.6% said that they were not sure about the statement and only (19.3% and 15.6%) either disagreed or strongly disagreed to the statement. One of the goals of health promotion is to increase health literacy. This is important for people with disabilities so that they are able to take control of their own health and increase their health seeking behavior for preventive, rehabilitation and promotive care. It is also a constitutional right not to be denied and from a health perspective in terms of the Patient's Rights Charter and the Batho Pele Principles.

Most (41.2% and 15.8%) respondents tended to either agree or strongly agree that people with disabilities receive services they need at a health facility. However, 12.9% said that they were not sure about the statement and only (16.5% and 13.6%) either disagreed or strongly disagreed to the statement. The removal of barriers in health service delivery creates an enabling environment for people with disabilities to access and participate meaningfully in health care matters both as recipients of the service and as part of governance, for improvement in the quality of care.

Most (28.6% and 17.2%) respondents tended to either agree or strongly agree that people with disabilities are involved in health related activities. However, 18.3% said that they were not sure about the statement and only (19% and 16.8%) either disagreed or strongly disagreed to the statement. Involvement was limited to health campaigns such as the World AIDS Day activities and others, which justified the finding that most people with disabilities were passively or not involved in decisions about their health. Most (145) respondents were positive that health promotion is sufficiently promoted in

Protective Workshops compared to 128 respondents who did not agree with the statement. This indicates a need to strengthen awareness, coordination and integration of services.

6.7.0 RECOMMENDATIONS

Each of the above-mentioned excerpts from the findings of the study have been summarized and are presented below as a set of recommendations to promote more efficient delivery of health promotion to those with disabilities via the use of the protective workshop model.

6.7.1 Recommendation One

Education and Training

The first recommendation is that formal education and training programme should be established to include basic knowledge and implementation of health promotion activities. A special focus will be placed on inclusive health promoters who are able to implement reasonable accommodations to reach people irrespective to their type of their disability.

6.7.2 Recommendation Two

Disabled Mate Mentor

Peer groups among people with disabilities need training to help them manage all health related challenges including HIV and AIDS among the community of people with disabilities. This can be facilitated in the workplace, in institutions of learning, in the general community and even preschools and should be facilitated as a service priority.

6.7.3 Recommendation Three

Health Promotion as Essential Service

As an essential service, health promotion activities and services may have to be infused our policies and required by law. Perhaps have inclusive practitioners organize sessions that are currently in place such as HV/AIDS prevention programmes at the local clinics.

6.7.4 Recommendation Four

Area of Focus for Health Promotion

Health promotion activities and services may have to address misconceptions that are rife to even educate those not yet disabled about mundane issues; a case in point; sharing of facilities with a person with disabilities or HIV-positive.

6.7.5 Recommendation Five

Emergency care services as part of health promotion

The protective workshop supposed to have first aid kit in their working areas as required by Occupational Health and Safety Act No 85 of 1993, as amended.

6.7.6 Recommendation Six

Health promotion and HIV/AIDS

Confidential, counselling and voluntary testing seemed inadequate for the community of people with disabilities. There was no involvement in HIV testing. However; the idea that they still discriminated against people living with HIV AND AIDS means there was a need to educate the care providers and people with disabilities with regard to HIV and AIDS, the stigma attached to it and its control and prevention.

6.7.7 Recommendation Seven

Comprehensive Inclusive Health Promotion

According to the World Health Organization's May 2005 World Health Assembly (WHA58.23) resolution to include "a disability component in their health policies and programs...to intensify collaboration within World Health Organization requesting the Director-General to produce a world report on disability and rehabilitation based on the best available scientific evidence" (World Health Organization Action Plan 2006-2011):

- There was a need for inclusive health promotion workshops with health units.
- Health promotion practitioners to provide health promotion.
- Some of the people with disabilities were women. Issues such as woman abuse, HIV and AIDS and other women's health concerns need attention.

- There was scarcity of recreational facilities for people with disabilities. Health promotion is essential to divert attention from alcohol and other aberrant “recreations”.

6.7.8 Recommendation Eight

Legislation

- Legislation is the root of the problem. Revisions should be made to the Social Assistance Act, which is currently governing the protective workshops to ensure transformation mechanisms.
- Legislative provision must be made in Acts of other Departments to ensure the creation of employment and income generating opportunities for people with disabilities.
- Integrated National Disability Strategy and the Office on the Status of Disabled People’s monitoring should review progress and ensure mainstreaming of the issues (Department of Social Development 2008:37).

6.8 THE UNIQUE CONTRIBUTION MADE TO THE RESEARCH AREA.

The study of Health promotion and its utility among those with disabilities has received some attention globally and in that regard it represents a sparsely studied area. The studies in this area have tended to be within developed countries and focus has either been on accounts from those who are disabled or from their care providers but very limited work has offered a dual perspective or reviewed contributions from those with disabilities and their care providers in a single study. Furthermore the focus on a specific health promotion intervention, in this case, protective-workshops is even less presented within published literary sources. It must be noted that within South Africa, no other published study has focused on the specific aspects explored within the current study. As expected, this has exposed the study to a number of untested frontiers, which may be seen as representing possible sources of limitation. Firstly, the process of sampling across all regions in South Africa was especially difficult and resource intensive and could have been made more efficient by having a more locally based study approach. This was balanced against the potential of obtaining a more nationally representative viewpoint. The study presents a cross sectional assessment and it may have been more beneficial to have a longitudinal perspective so that long term

influences on the efficacy of health promotion interventions could be better understood. That said, the study offers many more benefits to the study area than it has limitations. As alluded to earlier, the current study is unique in a number of very specific and distinct ways.

- With respect to the methodology adopted here, the simultaneous collection of data from care providers and those with disabilities in a single study has not been previously done within the African context and this sets this study aside from all published work within the study area.
- Even though the efficacy of protective workshops as a vehicle for health promotion has been studied in the developed world, no published studies looking specifically at their health promotion contribution for those with disabilities, exist within the African context. This study explores the study area in a way not previously done in Africa and that represents an important and unique contribution to the subject area.
- Another notable area, in which the current study makes a unique contribution to existing knowledge within the topic area relates to the development of a theoretical framework as was developed here. The theoretical framework proposed in Chapter 3 helps to harmonise a number of theoretical perspectives so that the key considerations that relate to health promotion and disabilities work can be better understood

As already indicated, the opportunity made available to the researcher to compare the views of both those with disabilities and their care providers in one single study did in itself produce a range of findings not previously seen within the study area. There were notable differences between professional views and those of the respondents who were disabled especially in terms of attributions each gave for difficulties with effectively offering health promotion to those with disabilities. The non-professional respondents attributed much of the blame for this to barriers that existed within their social environments whilst care providers spoke more about inherent challenges that existed with treating people with disabilities. This pattern indicating some disagreement between different sources gave meaningful insights that can be integrated into future service planning.

6.9 CONCLUSION

As stated in the preceding chapters the purpose of this study centred primarily on developing insights into how inclusive health promotion interventions exist for people with disabilities. Specific focus was given to the nature and scope of the health promotion from both the perspectives of service recipients and care providers. The current study was conducted within the context of protective workshops across a wide geographical area in different regions within South Africa. Global findings from the investigation showed that inclusive health promotion was not explicitly experienced by participants and that their experiences showed a need for a more intensive focus on health promotion within the protective workshops. This set the backdrop against which a number of practice recommendations have been proposed based on areas of weakness as identified by both the individuals with disabilities and their professional carers. The range of recommendations proposed include a need for more directive legislation, a need for less discriminatory practices towards those with disabilities, and a range of practice changes designed to give higher and more equitable attention to the health promotion of those with disabilities. Both the study and the recommendations represent new knowledge within the South African context and as such, it is hoped that future practice will pursue suggested practice modifications. Even though the current study offers new guidance in relation to the care of those with disabilities, it must be acknowledged that this is a sparsely researched area in South Africa and there is need for further research to build on the work done here.

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APPENDIX A: INTERVIEW SCHEDULE FOR PEOPLE WITH DISABILITIES

AN INTERVIEW SCHEDULE

Health Promotion Questionnaire for People with Disabilities

Year of Study

2	0	0	
---	---	---	--

Interview date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Name of Interviewer

--

Name of Province

--

District

--

Respondent's number	
---------------------	--

Name and address of the organization:	
Province:	
District	

Interviewer: please observe and record the following in relation to the respondent:

Sex	01	Male
	02	Female
*Population Group	01	Black African
	02	Coloured
	03	Indian
	04	White

****Please explain to the respondent the reason why we are asking this question. In South Africa population group has been linked to socio-economic status. This, in turn, is closely linked to health.***

A. DEMOGRAPHY & SOCIO-ECONOMIC STATUS

1. Where were you born?

COUNTRY	01	South Africa	
	02	Other country – please specify	
If born in South Africa, in which PROVINCE	01	Eastern Cape	
	02	Free State	
	03	Gauteng	
	04	KwaZulu Natal	
	05	Limpopo	
	06	Mpumalanga	
	07	Northern Cape	
	08	North West	
	09	Western Cape	

2. What is your age group?

Age group	10-14	15-18	18-23	24-40	41 and above

3. What is the main language spoken at home?

1	Afrikaans
2	English
3	Ndebele
4	Sepedi
5	Sesotho
6	Setswana
7	Swati
8	Tsonga
9	Venda
10	Xhosa
11	Zulu
12	French
13	Other _____

4. How many people do you live with at home?

5. What is your educational background?

Never been to school	Primary school	Secondary school	Tertiary Education	Special Education

6. Do you receive a disability grant?

Yes	
No	

B. AWARENESS OF DISABILITY

7. What is the form/kind of your disability?

Blind	Deaf	Physical disability	Mental disability	Other

7.1 Please explain how your disability happened.

.....
.....

8. In your own words, how would you define the term “disability”?

.....
.....

9. Do you think people with disabilities have rights?

.....
.....

10. In your opinion, what are the rights of people with disabilities?

.....
.....

11. To what extent do you think people with disabilities have equal opportunities compared to those without disabilities?

Opportunities for people with disabilities	Not at all	Lesser extent	Moderate extent	Greater extent
Please Tick <input type="checkbox"/>				

12. To what extent do you relate to other people with a disability in your community?

Relationship with other people with a disability	Not at all	Lesser extent	Moderate extent	Greater extent
Please Tick <input type="checkbox"/>				

13. If not at all, please explain why?

.....

.....

.....

14. In your opinion, how do the community view people with disabilities?

.....

.....

.....

C. ACCESS TO HEALTH SERVICES

15. Where do you go for health services?

Health Services	Please Tick
Hospital	
Clinic	
Private Clinic	
Mobile Clinic	
Pharmacy	
Traditional healer	
Other, please specify	

16. How far is the nearest Health Facility?

Distance	
1 – 20 km	
21 – 40 km	
41 – 60 km	
60+	

17. How do you travel to and from a health facility?

Mode of Transport	Please tick
By foot	
On wheelchair	
Assisted Transport	
Own Car	
Public Transport	
Other means, please specify	

18. If public transport, which mode

Mode of Transport	Please tick
Taxi	
Bus	
Train	

19. For each of the items, please tick the number that best represents the extent to which you believe each statement is applicable to you at the health care facility.

Statements	Strongly disagree	Disagree	Not sure	Agree	Strongly agree
The health facility is disability friendly					
The health workers are knowledgeable about disability issues					

Health workers are friendly to people with disabilities					
People with disabilities are treated with respect					
People with disabilities receive appropriate health related information					
People with disabilities receive appropriate health education					
People with disabilities receive services they need					
People with disabilities are referred appropriately					
People with disabilities are involved in health related activities aimed to promote health					

20. What do you understand by the term “health promotion?”

21. In your opinion, is health sufficiently promoted amongst people with disabilities?

Opinion	Yes	No
Please tick		

22. Please state what health promotion activities have you been exposed to?

.....

23. Who provided those activities?

.....

24. Are you still involved in those health promotion activities? (Please tick)	Yes	
	No	

AVAILABILITY OF STRUCTURES AND MECHANISMS

25. Do you know of any facility in the community that caters for the health needs of people with disabilities? (Please tick)	Yes
	No

(If no, please proceed to question 28)

26. If yes, please give names and their location

.....

27. How often are health programmes rendered at this facility?	Always	1
	Sometimes	2
	Don't know	3

28. Do these facilities cater only for people with disabilities? (Please tick)	Yes
	No

29. What roles do people with disabilities play at these health facilities?

Actively involved in planning and implementation of activities	1
Consulted in most activities	2
Passive recipients	3

30. Do you know of any support groups in your community for people with disabilities? (Please tick)	Yes	
	No	

31. What health promotion activities do most support groups engage in?

.....

32. In your opinion, what support is needed for people with disabilities to participate actively in health promotion activities?

.....
.....
.....

THANK YOU FOR TAKING THE TIME TO ANSWER THIS QUESTIONNAIRE.

APPENDIX B: QUESTIONNAIRE FOR PROFESSIONALS WORKING IN THE AREA OF DISABILITY

A SELF ADMINISTERED QUESTIONNAIRE FOR PROFESSIONALS WORKING IN THE AREA OF DISABILITY

Topic: Inclusive Model of Health Promotion for People with Disabilities: A Public Health Remedy

Year of Study

2	0	0	
---	---	---	--

Interview date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Respondent's number	
Name and location of an Organization: Province: District	

Sex	01	Male
	02	Female
Population Group	01	Black African
	02	Coloured
	03	Indian
	04	White

A. DEMOGRAPHY

2. Where were you born?

COUNTRY	01	South Africa	
	02	Other country – please specify	
PROVINCE	01	Eastern Cape	
	02	Free State	
	03	Gauteng	
	04	KwaZulu Natal	
	05	Limpopo	
	06	Mpumalanga	
	07	Northern Cape	

	08	North West	
	09	Western Cape	

2. What is the target population of people with disabilities for the programme?

3. What is the socio-economic status of people with disabilities served by your programme? (How do we know the socio economic status) Please Tick	Poor	Average	Good

4. What is the educational background of people utilising the service/programme?

Never been to school	Primary school	Secondary school	Tertiary Education	Special Education

5. What is the geographic coverage of the programme? Please Tick	Rural	Peri urban	Urban

6. How are people with disabilities recruited to the centre/programme? Please Tick	Referral	Self Interest	Other (please specify)

7. How far do people with disabilities travel to the centre?

Distance	Please Tick
1 – 20 km	
21 – 40 km	
41 – 60 km	
61+	

8. What is the mode of transport used to travel to and from the centre?

Mode of Transport	Please tick
By foot	
On wheelchair	
Assisted Transport	

Own Car	
Public Transport	

9. If public transport, which mode

Mode of Transport	Please tick
Bus	
Taxi	
Train	

10. What is the main language spoken in the area?

1	Afrikaans
2	English
3	Ndebele
4	Sepedi
5	Sesotho
6	Setswana
7	Swati
8	Tsonga
9	Venda
10	Xhosa
11	Zulu
12	French
13	Other _____

11. How many people with disabilities at the centre receive disability grants:

B. AWARENESS OF DISABILITY

12. What is the form/kind of your disability?

Blind	Deaf	Physical disability	Mental disability	Other (please specify)

13. In your own words, how would you define the term “disability”?

.....

.....

14. Do you think people with disabilities have rights?

.....

15. In your opinion, what are the rights of people with disabilities?

.....

16. To what extent do you think people with disabilities have equal opportunities compared to those without disabilities?

Opportunities for people with disabilities	Not at all	Lesser extent	Moderate extent	Greater extent
Please Tick <input type="checkbox"/>				

C. ACCESS TO HEALTH SERVICES

17. Where do people go for health services?

Health Services	Please Tick
At the Centre	
Hospital	
Clinic	
Private Clinic	
Mobile Clinic	
Pharmacy	
Traditional healer	
Other, please specify	

18. Please state a range of services that are rendered at the Centre

.....

19. Who provides these services?

.....

20. What do you understand by the term “health promotion?”

.....

21. In your opinion, is health sufficiently promoted amongst people with disabilities?

Opinion	Yes	No
Please tick		

22. Please state what health promotion activities provided at the centre?

.....

23. What is the extent of involvement of people with disabilities in health promotion activities?

Actively involved in planning and implementation of activities	1
Consulted in most activities	2
Passive recipients	3
Not involved	4

24. To what extent is the efficiency of monitoring system to identify high risk among people living with disabilities.

Opinion	Low	Don't know	Moderate	High
Please tick				

25. In your opinion efficiency of health promotion activities for people living with disabilities

Opinion	Covers crucial preventative strategies	Rudimentary topics	Concise	Other
Strongly Agree				
Agree				
Not sure				
Strongly Disagree				
Disagree				

26. In your opinion, what is the adequacy of anticipatory health promotion?

Opinion	Significant	Minimal	Inadequate	Other
Please tick				

27. Are there any supportive policies to increase access to health promotion efforts for people with disabilities?	Yes
	No
	Don't know

28. If yes, please give examples of supportive policies

.....

.....

.....

29. Please indicate resources available for health promotion used among people with disabilities

.....

.....

.....

30. Please indicate structures available to increase health promotion efforts for people with disabilities

.....

.....

.....

31. To what extent are these structures integrated to afford people with disabilities equal opportunities for quality services?

Structural integration for people with disabilities	Not at all	Lesser extent	Moderate extent	Greater extent
Please Tick <input type="checkbox"/>				

33. What qualities are essential for effective health promotion practice among people with disabilities?

.....

.....

.....

34. In your opinion, what support is needed for people with disabilities to participate actively in health promotion activities?

.....

.....

THANK YOU FOR TAKING THE TIME TO ANSWER THIS QUESTIONNAIRE.

APPENDIX C: A NATIONAL SAMPLE OF PROTECTIVE WORKSHOPS.

NATIONAL SAMPLE FOR PROTECTIVE WORKSHOPS

TYPE OF DISABILITY	FACILITY	LOCATION
<p>1. <u>EASTERN CAPE</u> Interlectually physically challenged persons</p>	Fundukwenza Inqubela Ithembaletu Drosdy Workshop	Kwentana Location, East London New Brighton (Ferguson Road) Port Elizabeth Uitenhage, Port Elizabeth 21 William Street, Cotsworld, Port Elizabeth
<p>2. <u>FREE STATE</u> Mental Disabilities Multi Disabilities Multi Disabilities Mental Disabilities</p>	Mphatlalatsane Project SIH Sheet Metal Workshop Ithuseng Woprkshop Kroon Dagsorg	Rammulotsi Township, Viljoenskroon Bolokeng, Petrusburg Clarens Symondstraat, Kroonstad
<p>3. <u>Gauteng Province</u></p> <p>Physical Disabilities Physical Disabilities Epilepsy Mental Disability Physical Disability Physical Disability Mental Disability Mental Disability Physical Disability Physical Disability Mental Disability</p> <p>Physical Disability Physical Disability Deaf Mental Disability Integrated Disability</p>	Clunny Farm Centre Emmelang PW WAPD Epilepsy SA Workshop Alm Workshop Lebuwe Atteidgeville PW Workshop (APD) Sally's Workshop Shadvaal Takalani PW United Creative Enterprise Workshop for Disabled Vukani PW Eldorado Park Service Centre (APD) Elofsdal PW Harvey Cohen Workshop Jocod	Midrand, Sun Valley Rethabile Mars Mohlakeng Industria Saulsville Kisington, Parkview Atteridgeville Atteridgeville Hydepene Sebokeng Diepkloof Lenasia Senaone Eldorado Park Elofspark Newclare Lenasia
<p>4. <u>KZN</u></p> <p>Physical & mental Challenged Physical & mental Challenged Physical & mental Challenged Mentally Challenged and referred Physical & Mental Challenged & referred & Deaf</p>	APD Chesterville APC Ladysmith Ass for the physical challenged Challenge unlimited Durban North	Qualbert Ladysmith Pietermaritzburg Durban Phoenix

Physical & Mental Challenged Intellectual, Mentally Challenged and Physical Disability Epilepsy and Mentally handicapped Mentally Handicapped Deaf, Blind Hard Hearing	Challenge unlimited, Phoenix Challenge unlimited, Sherwood Durban Mental Health Epilepsy SA Inkanyezi Natal Deaf & Blind Society	Sherwood Sherwood Durban Sutherland Road, Imbali Lorne Street, Durban
5. <u>LIMPOPO</u>	Siloe After Care Centre Eeufees PW Tivanani Vatsinwa Workshop for the Disabled Letaba Aftercare Centre	Capricorn Capricorn Vhembe Nkowankowa Mopani
6. <u>MPUMALANGA</u>	Buhlebolwazi Self Help Group Ekujabuleni Activity Centre Epilepsy SA Dullstroom Pw Ithembelihle PW Moremela Disabled PW Motlatse Disabled Group Sizimisele Disabled People Sunfield Homes: Fortuna PW Thembelihle PW Thembelihle Zamani Disabled Group Zamokuhle Self Help Centre for the Disabled Zimeleni Disabled group Zamokuhle PW	Gert Sibande DOE old Book Store Room, Mpuluzi Ehlanzeni, Barberton Ekangala, Dullstroom Gert Sibande, Azalea Ehlanzeni Moremela Ehlanzeni Leroro Ehlanzeni Shongwe Mission Gert Sibande Balfour Ekangala, Kwaguga Ekangala Boekenhouthoek Ehlanzeni Hoyitrust Gert Sibande Leslie Gert Sibande Fernie Vlaklaagte
7. <u>NORTH WEST</u> Multi Disability	Triest Training Centre Jouberton Society	Southern Flamwood Southern Jouberton Township

All types of Disabilities	(Tekford) Itsoseng Handicap Centre	Central Itsoseng
8. <u>NORTHERN CAPE</u> Adults and Multiple Disabilities	Emmanuel	Steinkopf
9. <u>WESTERN CAPE</u> P Uys Intell Intell Intell Physical Physical Physical Physical Physical Intellectual Intellectual Physical	Unicraft W Athlone W Care Craft W Lansdowne Care Craft Wellington Jewish Sheltered Employment Centre Joyce Chevalier Kwa - Nonthuthuzelo Nonceba Ocean View Orion W Sanel (Knysna) Thembaletu	Beaufort W Cape Town Athlone Athlone Wetton Paarl Wellington Cape Town Gardens Wynberg Fishoek Athlone Gugulethu Khayelitsha Wynberg Ocean View Atlantis George Knysna Athlone Gugulethu

APPENDIX D: PERMISSION LETTER TO UNDERTAKE STUDY TO THE DEPARTMENT OF SOCIAL DEVELOPMENT.

11 Katz Street
Centurion
0158
20 October 2006

Ms Manthipi Molamu-Rahloa
Director: Disability
National Department of Social Development
Private Bag x901
PRETORIA
0001

Inclusive Model of Health Promotion: A Public Health Remedy Focussing on People with Disabilities

Dear Ms Molamu-Rahloa

Thank you for the opportunity to meet with you and share my research interest with the Department of Social Development, which is aimed at adding value to the area of disability studies. I'm currently registered with UNISA for Ditt Phil (Doctoral Degree) in the area of Health Sciences as well as five years working experience in Health Promotion at the Department of Health.

The focus of my proposed study is to contribute towards social change through an existing programme of Health Promotion to suggest an inclusive model for people with disabilities. A national study is proposed using participatory methodologies for the development of an inclusive model with people with disabilities.

Following consultations with my promoter, Prof Makhubela-Nkondo, including stakeholders such as the Disability Units at the Presidency (Mr Phadima), Department of Health (Ms Singh), Medical Research Council (Dr Levin), and the World Health Organisation AFRO (Dr Nyamwaya), I propose to work within your department's national programme of Protective Workshops and related networks. Since this in established programme with a supportive system in place, it creates an enabling environment for and this will contribute towards strengthening existing health programmes at the Protective Workshops. I also propose that an opportunity be created for coaching and providing an update on the progress should permission be granted.

I attach the following documents for your information;

1. Research Proposal
2. Draft questionnaires:
 - a. People working in the area of disability
 - b. People with Disabilities
3. Proof of Registration

My contact details are:
Ms Rebecca Motlatla
Proposed Sudy; Ditt Phil

University of South Africa
Student Number: 645 456 9
T 012 312 0183 or 082 908 7332

Hoping for a positive response.

Sincerely

Rebecca Motlatla
20 October 2006

APPENDIX E: APPROVAL RESPONSE LETTER FROM THE DEPARTMENT OF SOCIAL DEVELOPMENT.



social development

Department:
Social Development
REPUBLIC OF SOUTH AFRICA

Private Bag X 901, Pretoria, 0001, 134 Pretorius Street, HSRC Building, Pretoria
Tel: (012) 312 7400: Fax: (012) 312 7739 Enquiries: Ms Manthipi
Molamu-Rahloa

Ms. Rebecca Motlatla
11 Katz Street
Centurion
0158
17 November 2006

SUBJECT: Inclusive Model of Health Promotion: A Public Health Remedy focusing on People with Disabilities

Your letter dated the 20 October 2006 bears reference.

The Department of Social Development is funding 5 state run and subsidizes ± 300 protective workshops through the provincial departments. They are subsidized as part of the social welfare programs, to ensure the provision of appropriate developmental social welfare services to People with Disabilities whose vulnerability heightens the distress of poverty within their lives and those of their families.

The management of protective workshops have been established to provide protective, restorative, rehabilitative and educational programs to the vulnerable disability groupings, in collaboration with key stakeholders.

One of the programs that are being rendered in the workshops is health services. The Policy Guidelines on the Management of Protective Workshops, developed by the department, identified a lack in Health programs within workshops as a gap in service provision. Your participation and sharing of your work with the department and the protective workshops will indeed bring in understanding of how the programs could be started and also strengthen the existing ones.

The Department would, however, like to bring the following to your attention:

- All subsidized protective workshops are autonomous and you will be expected to establish a working relationship with them on your own accord. The department is not responsible to ensuring that a protective workshop works with you. The provision of this letter is our way of providing and showing our support.
- You will only be invited to meetings on protective workshops that would add value and are relevant to your field of focus

- The provincial disability co-ordinators, who are our contact and representatives at provincial level will be notified of your intentions and asked to give u all the support they can.
- You will be expected to provide feedback should any of the departmental principals require more information on your dealings with protective workshops

A copy of this letter will be sent to our communication unit, our national and provincial departmental Head of Departments as a way of informing them of your presence and intentions.

We wish you well.



ppDIRECTOR GENERAL
DATE:

APPENDIX F: UNIVERSITY OF SOUTH AFRICA 2008 APPROVAL LETTER OF REGISTRATION.



1148 MIRST

MOTLATLA R MRS
P O BOX 2455
ROOIHUISKRAAL
0154

STUDENT NUMBER : 0645-456-9

ENQUIRIES NAME : MADISENG LS
ENQUIRIES TEL : 429-2652

DATE : 2008-01-23

Dear Student

I wish to inform you that your registration has been accepted for the academic year indicated below. The relevant degree, the approved title for your projected dissertation/thesis, the name of the person appointed as your supervisor/promoter, etc appear below. Please check all the information carefully and let me know if you do not agree.

DEGREE : DLITT ET PHIL (HEALTH ST) (08907)
TITLE : INCLUSIVE MODEL OF HEALTH PROMOTION: A PUBLIC HEALTH REMEDY
SUPERVISOR/PROMOTER : Prof ON MAKHUBELA-NKONDO
JOINT SUPERVISOR : Prof CL OBI
ACADEMIC YEAR : 2008
TYPE: THESIS
SUBJECTS REGISTERED: DIS890B D LITT ET PHIL - HEALTH STUDIES

A statement of account will be posted to you shortly.

If you intend submitting your dissertation/thesis for examination, kindly note that notice of such intention must be given before 30 September (for the April/May graduation ceremony) or 15 April (for the September graduation ceremony). Submission must respectively take place BEFORE or on 30 November or 15 June. If submission takes place after 30 November, you will only graduate at the following September graduation ceremony and if submission takes place after 28 February, you will also have to reregister and pay the full tuition fees. Your supervisor's/promoter's written consent for submission must accompany your notice of intention to submit.

A guide on the studies for Master's and Doctor's degrees will be posted to you shortly.

PLEASE NOTE THAT IF A TITLE AND SUPERVISOR/PROMOTER ARE NOT INDICATED ABOVE, YOU MUST FIND A TITLE WITHIN YOUR FIRST YEAR OF REGISTRATION IN ORDER TO BE ELIGIBLE FOR REREGISTRATION.

Yours faithfully,


Prof. L. Molamu
Registrar



University of South Africa
Pretter Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

APPENDIX G: UNIVERSITY OF SOUTH AFRICA HEALTH RESEARCH AND ETHICS COMMITTEE (COLLEGE OF HUMAN SCIENCES) CLEARANCE CERTIFICATE

03/04/2006 12:24

0124296688

ADVANCING NURSING SCIENCE

PAGE 01/01

APPENDIX 6



**UNIVERSITY OF SOUTH AFRICA
Health Studies Research & Ethics Committee
(HSREC)
College of Human Sciences
CLEARANCE CERTIFICATE**

Date of meeting: September 2005 Project No: 0645-456

Project Title: Inclusive Health Promotion

Researcher: Ms. R.M. Motlatla

Supervisor/Promoter: Prof. O.N. Makhubela-Nkondo

Joint Supervisor/Joint Promoter: Not applicable

Department: Health Studies

Degree: D.Litt Et Phil.

DECISION OF COMMITTEE

Approved Yes

Conditionally Approved

Date: September 2005

A handwritten signature in black ink, appearing to read 'TR Mavundla'.

**Prof TR Mavundla
RESEARCH COORDINATOR: DEPARTMENT OF HEALTH STUDIES**

A handwritten signature in black ink, appearing to read 'SM Mogotlane'.

**Prof SM Mogotlane
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES**

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

APPENDIX H: SUPERVISOR'S LETTER OF SUPPORT TO GAIN ACCESS INTO THE RESEARCH SETTINGS.

4



TO WHOM IT MAY CONCERN

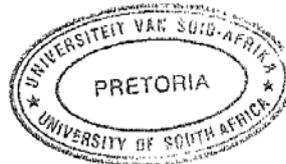
R.M. Motlatla
Student Number 645-456-9

This is to confirm that Mrs. R. Motlatla, has successfully completed her master's degree programme at the University of South Africa; her research project was conducted with utmost integrity. Mrs. R. Motlatla is currently a doctoral candidate at the same institution. It will be appreciated if she can be given the necessary support as she gathers data. She is in receipt of the clearance certificate and will produce the copy upon request. Please do not hesitate to contact me should you need additional information in this regard.

Sincerely

O.N. Makhubela-Nkondo (Prof.)
Supervisor

University of South Africa
TVW 7-151
Tel: 27-12-4296588
Fax: 27-12-4296688



APPENDIX I: PERMISSION LETTER (KWAZULU-NATAL) INCLUDING COMMUNICATION WITH THE PROVINCE.

NAME OF CLIENT: Mrs Rebecca Motlatla
INSTITUTION: UNISA

Student number: 645 456-9
TEL/CELL: 082 908 7332
Email Motla@health.gov.za
30 April 2008

DPSA KZN

To Programme Managers of the selected Protective Workshops:

KZN Selected Sample:

1. Association for People with Disabilities, Chesterville
2. Association for People with Disabilities, Ladysmith
3. Association for the Physical Challenged
4. Challenge Unlimited Durban North
5. Challenge Unlimited, Phoenix
6. Challenge Unlimited, Sherwood
7. Durban Mental Health
8. Epilepsy SA, Durban
9. Inkanyezi Protective Workshop, Durban
10. Natal Deaf & Blind Society, Durban

Dear Sir/ Madam

My name is Mrs Rebecca Motlatla, working for the National Department of Health in the Health Promotion Unit. I'm currently a UNISA doctoral student final year and in the process of collecting national data on the above topic "**Health Promotion Model For People With Disabilities – A Public Health Remedy**". The aim of my study is to propose an integrated approach to foster health promotion within Protective Workshops and other centres catering for People with Disabilities to increase their control of their own health through health information and education programmes.

The national Department of Social Development (Disability Desk) supports the study and the study is based on a national database of the Protective Workshops. Through a scientific sampling process, a national sample of 70 Workshops has been selected to participate in the study. Ten (10) Protective Workshops has been selected in KZN as indicated above. The KZN OSDP at the Premier's Office has been helpful to refer me to work through DPSA in the province. Ms Alzinah Zulu and Ms Sibongile Sibiya will be collecting data for the above study in some of the Protective Workshops and it will be appreciated if she can be granted permission collect data in your facility.

I appreciate your support

Yours Sincerely
Ms Rebecca Motlatla, R Motlatla

From: Rebecca Motlatla
To: mokoerad@durban.gov.za
Date: 2008/04/11 10:36 AM
Subject: Fwd: DATA COLLECTION IN KZN
Attachments: Draft Questionnaire for People with Disability March2007.doc; Ouestionaire 4 Prof disability Sept 2006.doc; NATIONAL SAMPLE FOR PROTECTIVE WORKSHOPS.doc; Sample size Determination.doc; Inclusive Model of HP Proposal Latest, latest April 08.doc

Dear Ms Mokoena

I have forwarded all information directly to you and to DPSA. Thanks for the support. I await your positive response.

Your in Research

Rebecca Motlatla
Doctoral Candidate
UNISA ST NO: 645 456-9
082 908 7332

Fax To: Rebecca Motlatla
Fax No: 012 3120876

P.O. Box 5292
DURBAN
4000
13 May 2008

Dear Rebecca:

It been an honour for me to be doing this for you although they we challenge in the way. I'm sure you would appreciate my effort to help you.

Epilepsy SA, do not run a protective workshop anymore due to the financial problem, so all the client the use to have have been referred to the other workshop.

So for these are the protected Workshop that I manage to interview:

1) APD-KZN
65 Benjamin Crescent
Woodhurst
Chatsworth

2) DCMH-KZN
50 DAARJCEANG ROAD
Mesebank

3) APD-KZN
313 LENHAM DRIVE
Phoenix

4) DCMH-KZN
3 HATTON ROAD
SHERWOOD

5) DCMH-KZN
24 Tuin Road
Wentworth

I'm sorry if I didn't meet up to your expectations
it was a hard work.

My full name is Sibongile A. Sibuya
And my bank account is - First National Bank
Bank Acc - 62045274777
Br. - Queen street

Don't hesitate to call me if there is any question,

Thank You

Yours faithfully
Sibongile Sibuya

N.B. Challenge Unlimited - Durban North - the client the
are mental disabled and they can't read & write.

APPENDIX J: PERMISSION LETTERS: FREE STATE PROVINCE (FS) INCLUDING COMMUNICATION WITH THE PROVINCE.

DATA COLLECTION FOR A DOCTORAL THESIS: "Health Promotion Model FOR PEOPLE WITH DISABILITIES – A Public Health Remedy"

NAME OF CLIENT: Mrs Rebecca Motlatla
INSTITUTION: UNISA
Student number: 645 456-9
TEL/CELL: 082 908 7332
Email Motla@health.gov.za

To Programme Managers of the selected Protective Workshops:

FREE STATE SAMPLE:

1. Mphatlalatsane Project - Rammulotsi Township, Viljoenskroon (056 343 0802)
2. Sheet Metal Workshop - Bolokeng, Petrusburg (0824790655)
3. Ithuseng Woprkshop - Clarens (058 2561946)
4. Kroon Dagsorg - Symondstraat, Kroonstad (056 2151500)

Dear Sir/ Madam

My name is Mrs Rebecca Motlatla, working for the National Department of Health in the Health Promotion Unit. I'm currently a UNISA doctoral student final year and in the process of collecting national data on the above topic "**Health Promotion Model For People With Disabilities – A Public Health Remedy**". The aim of my study is to propose an integrated approach to foster health promotion within Protective Workshops and other centres catering for People with Disabilities to increase their control of their own health through health information and education programmes.

The national Department of Social Development (Disability Desk) supports the study and the study is based on a national database of the Protective Workshops. Mr Paul Prins in the FS Office of the Status of the Disabled Persons (OSDP) has been consulted for guidance and support about the study purpose. Through a scientific sampling process, a national sample of 70 Workshops has been selected to participate in the study. Four (4) Protective Workshops has been selected in the Free State as indicated above.

Mr Chomane will be collecting data for the above study in some of the Protective Workshops and it will be appreciated if he can be granted permission collect data in your facility.

I appreciate your support

Yours Sincerely
Ms Rebecca Motlatla
30 APRIL 2008

DATA COLLECTION FOR A DOCTORAL THESIS: "Health Promotion Model FOR PEOPLE WITH DISABILITIES – A Public Health Remedy"

NAME OF CLIENT: Mrs Rebecca Motlatla
INSTITUTION: UNISA

Student number: 645 456-9
TEL/CELL: 082 908 7332
Email Motla@health.gov.za

To Programme Managers of the selected Protective Workshops:

FREE STATE SAMPLE:

1. Mphatlalatsane Project - Rammulotsi Township, Viljoenskroon (056 343 0802)
2. Sheet Metal Workshop - Bolokeng, Petrusburg (0824790655)
3. Ithuseng Woprkshop - Clarens (058 2561946)
4. Kroon Dagsorg - Symondstraat, Kroonstad (056 2151500)

Dear Sir/ Madam

My name is Mrs Rebecca Motlatla, working for the National Department of Health in the Health Promotion Unit. I'm currently a UNISA doctoral student final year and in the process of collecting national data on the above topic "**Health Promotion Model For People With Disabilities – A Public Health Remedy**". The aim of my study is to propose an integrated approach to foster health promotion within Protective Workshops and other centres catering for People with Disabilities to increase their control of their own health through health information and education programmes.

The national Department of Social Development (Disability Desk) supports the study and the study is based on a national database of the Protective Workshops. Mr Paul Prins in the FS Office of the Status of the Disabled Persons (OSDP) has been consulted for guidance and support about the study purpose. Through a scientific sampling process, a national sample of 70 Workshops has been selected to participate in the study. Four (4) Protective Workshops has been selected in the Free State as indicated above.

Mr Chomane and Mr M Nhlapo will be collecting data for the above study in some of the Protective Workshops and it will be appreciated if he can be granted permission collect data in your facility.

I appreciate your support

Yours Sincerely
Ms Rebecca Motlatla
30 APRIL 2008

From: Rebecca Motlatla
To: Paul Prins
Date: 2008/04/02 04:17 PM
Subject: Re: Sample
Attachments: PROTECTIVE WORKSHOPS DATABASE.xls

CC: Makhun@unisa.ac.za
Dear Paul **AN ATTACHMENT**

Thanks for your assistance. I suggest that we wait for those schools to reopen since they were selected according to a scientific sampling process. However, we can find a replacement for the Sheet Metal Workshop and i will deal with the situation in my methodology chapter. For your information, there is another workshop in the Northern Cape at Namakwa, that was found to have been closed in January this year, and this is the second case. Please help me identify another workshop we can include. I'm attaching a national database from the National Department of Social Development used for sampling. This information will contribute towards updating the DSD database as well.

I appreciate your support

Rebecca

>>> "Paul Prins" <prins@premier.fs.gov.za> 2008/04/02 03:26 PM >>>
Dear Rebecca

Because of the School Holidays Mphatlalatsane School is closed as well as Kroon Dagsorg. I tried to call them but there was no response. I don't know the Sheet Metal Workshop in Petrusburg. I called some of the organisations but they also don't know the workshop. I was at Ithuseng very recently. What I could observe is that there was only one deaf, one blind and one physically disabled person working there. It is a very small workshop where about five people are working.

Please advise.

Paul

--

This message has been scanned for viruses and dangerous content by MailScanner, and is believed to be clean.

APPENDIX K: PERMISSION LETTERS: MPUMALANGA PROVINCE (MP) INCLUDING COMMUNICATION WITH THE PROVINCE

From: Rebecca Motlatla
To: fomp@dpsa.org
Date: 2008/03/20 10:02 AM
Subject: DATA COLLETION IN MPUMALANGA
Attachments: Draft Questionnaire for People with Disability March2007.doc; Ouestionaire 4 Prof disability Sept 2006.doc; NATIONAL SAMPLE FOR PROTECTIVE WORKSHOPS.doc; Sample size Determination.doc; Inclusive Model of HP Proposal Rev 09 Feb 2007 Latest march2.doc

CC: Makhuron@unisa.ac.za
Dear Ms Thembi Sibeko

Thanks you very much for your support. I am in the process of collecting a national data on my topic and appreciates your support with the **Mpumalanga Sample**. My timeframe is the 15th April 2008. I have managed four provinces so far and hope to complete by the target date, negotiable. My proposal is to utilise the existing pool of fieldworkers for exposure and assistance with data collection. Proposed logistics are as follows:

1. My Research Topic is An Inclusive Health Promotion Model for people with Disabilities in Protective Workshops - A Public Health Remedy. A Two phased approach is adopted, **1.** Theoretical (aimed at assesing the status of health in the environment of PW, and **2.** Participatory approach, which aims at involving people with disabilities in developing an inclusive model based on the lessons of the first approach and other scientific theories. A Doctoral study with UNISA, final year. My research protocol and data collection instruments were approved by the ethics committee of the university. The Department of Social Development supports the study as the lessons learned will make a contribution towards strengthening the health component within the environment of PWs.

A copy of the proposal is enclosed for your information.

2. Research Methodology

Sampling process was guided by a national database of protective workshops (PWs) of the Department of Social Development. With the assistance of a statistician and using a multi-stage sampling procedure, a national sample of 70 PWs is drawn to participate in the study. **Within each protective workshop, 10 people will be interviewed, 8 of which will comprise people with disabilities (a fair mix of disabilities) and 2 will be people working within the protective workshops (mangement, caregivers,etc).**

- a) A copy of the Sample determination is enclosed for your information.
- b) A copy of a Questionnaire for People with Disabilities is enclosed for your information.
- c) A copy of A Questionnaire for Professionals Working with people with Disabilities is enclosed for your information.

3. Implications

> Kindly note that i am aware of the financial implication of data collection and as a student my study is not sponsored but i have put aside an amount of R1 500.00 from the University's Financial Aid funds towards questionnaire administration. Kindly advice.

> Through your advice, we can discuss other logistics for cost cutting purposes, such as questionnaire printing, courier services, ect, which could be arranged.

Lastly i would appreciate it if you can be my referee for the study to guide and support from your experience, so i can produce work that will make a difference in society.

Regards

Rebecca Motlatla
Doctoral Candidate
UNISA ST NO: 645 456-9



MPUMALANGA SAMPLE

NAME OF FACILITY	LOCATION NB! The province is vast and facilities are scattered
1. Buhlebolwazi Self Help Group	Gert Sibande District, DOE old Book Store Room, Mpuluzi
2. Ekujabuleni Activity Centre	Ehlanzeni District, Barberton
3. Epilepsy SA Dullstroom Protective Workshop	Ekangala District, Dullstroom
4. Ithembelihle Protective Workshop	Gert Sibande District, Azalea
5. Moremela Disabled Protective Workshop	Ehlanzeni District, Moremela
6. Motlatse Disabled Group	Ehlanzeni District, Leroro
7. Sizimisele Disabled People	Ehlanzeni District, Shongwe Mission
8. Sunfield Homes: Fortuna PW	Gert Sibande District, Balfour
9. Thembelihle Protective Workshop	Ekangala District, Kwaguga
10. Thembelihle	Ekangala District, Boekenhouthoek
11. Zamani Disabled Group	Ehlanzeni District, Hoyitrust
12. Zamokuhle Self Help Centre for the Disabled	Gert Sibande District, Leslie
13. Zimeleni Disabled group	Gert Sibande District, Fernie
14. Zamokuhle Protective Workshop	Vlaklaagte

From: Rebecca Motlatla
To: Mpumalanga Provincial Field Officer
Date: 2008/03/31 01:28 PM
Subject: Re: Budget for research

Dear Thembi

Thanks for considering my case. Kindly forward the amended version of the budget so i can process the invoice to UNISA.

Kind Regards

Rebecca Motlatla
645 456-9

>>> "Mpumalanga Provincial Field Officer" <fomp01@dpsa.org.za> 2008/03/30 08:26 PM >>>
Morning Rebecca

I am sending an invoice for the Mpumalanga research, please look it.

For more clarity please talk to me.

Thembi Sibeko
Provincial Field Officer
Community Based Rehabilitation Programme
Disabled People South Africa- Mpumalanga
Tel: 013-794 1711
Fax:086 514 8662
[email:fomp01@dpsa.org.za](mailto:fomp01@dpsa.org.za)

APPENDIX L: PERMISSION LETTERS: NORTH WEST PROVINCE (NW) INCLUDING COMMUNICATION WITH THE PROVINCE

From: Rebecca Motlatla
To: lenky@discoverymail.co.za
Date: 2008/04/02 02:06 PM
Subject: Fwd: DATA COLLETION IN THE NORTH WEST PROVINCE
Attachments: Draft Questionnaire for People with Disability March2007.doc; Ouestionaire 4 Prof disability Sept 2006.doc; NATIONAL SAMPLE FOR PROTECTIVE WORKSHOPS.doc; Sample size Determination.doc; Inclusive Model of HP Proposal Rev 09 Feb 2007 Latest march2.doc

CC: Makhuon@unisa.ac.za

Dear Ms Lenky

Thanks you very much for our communication this morning. My name is Rebecca Motlatla, currently working for the National Department of Health in the area of Health Promotion. I am a Doctoral student with UNISA, at final year of study, currently in the process of collecting a national data on my topic. Three facilities have been sampled in the North Westprovince (2 in Southern and one in Central). My timeframe is the 30th April 2008. I have managed six provinces so far and hope to complete by the target date, negotiable. My proposal is to utilise the existing pool of fieldworkers for exposure and assistance with data collection. Proposed logistics are as follows:

1. My Research Topic is "**An Inclusive Health Promotion Model for people with Disabilities in Protective Workshops (PW) - A Public Health Remedy**". A Two phased approach is adopted, **1. Theoretical** (aimed at assesing the status of health in the environment of PW, and **2. Participatory** approach, which aims at involving people with disabilities in developing an inclusive model based on the lessons of the first approach and other scientific theories. . My research protocol and data collection instruments were approved by the ethics committee of the university. The Department of Social Development supports the study as the lessons learned will make a contribution towards strengthening the health component within the environment of PWs.

A copy of the proposal is enclosed for your information.

2. Research Methodology

Sampling process was guided by a national database of Protective Workshops (PWs) of the Department of Social Development. With the assistance of a statistician and using a multi-stage sampling procedure, a national sample of 70 PWs is drawn to participate in the study. **Within each protective workshop, 10 people will be interviewed, 8 of which will comprise people with disabilities (a fair mix of disabilities) and 2 will be people working within the protective workshops (mangement, caregivers,etc).**

- a) A copy of the Sample determination is enclosed for your information.
- b) A copy of a Questionnaire for People with Disabilities is enclosed for your information.
- c) A copy of A Questionnaire for Professionals Working with people with Disabilities is enclosed for your information.

3. Implications

> Kindly note that i am aware of the financial implication for data collection and as a student my study is not sponsored but i have put aside an amount of R500.00 (Five Hundred Rands) from the University's Financial Aid funds towards questionnaire administration. Kindly advice.

> Through your advice, we can discuss other logistics for cost cutting purposes, such as questionnaire printing, courier services, ect, which could be arranged.

Regards

Rebecca Motlatla
Doctoral Candidate
UNISA ST NO: 645 456-9
082 908 7332

**DATA COLLECTION FOR A DOCTORAL THESIS: "Health Promotion Model
FOR PEOPLE WITH DISABILITIES – A Public Health Remedy"**

NAME OF CLIENT: Mrs Rebecca Motlatla
INSTITUTION: UNISA
Student number: 645 456-9
TEL/CELL: 082 908 7332
Email Motla@health.gov.za

To Programme Manager
Itsoseng Handicap Centre
Kokong Street
Itsoseng

Dear Mr Kgopetsi

My name is Mrs Rebecca Motlatla, working for the National Department of Health in the Health Promotion Unit. I'm currently a UNISA doctoral student final year and in the process of collecting national data on the above topic "**Health Promotion Model For People With Disabilities – A Public Health Remedy**". The aim of my study is to propose an integrated approach to foster health promotion within Protective Workshops and other centres catering for People with Disabilities to increase their control of their own health through health information and education programmes.

The national Department of Social Development (Disability Desk) supports the study and the study is based on a national database of the Protective Workshops. Through a scientific sampling process, a national sample of 70 Workshops has been selected to participate in the study.

Ten 3 Protective Workshops has been selected in the North West Province and your facility is one of them. The provincial DPSA Office, Ms Lenky has been helpful in advising with locations of most of these centres and communicating with some managers on my behalf.

I'm writing this letter to request for your permission and support with data collection. I have so far a limited timeframe of the 30 May 2008 to complete this process. Details of my study purpose and the methodology are attached for your perusal and attention.

I appreciate your support

Yours Sincerely


Rebecca Motlatla
UNISA ST NO: 645 456-9
Cell: 082 908 7332

**APPENDIX M: PERMISSION LETTER: EASTERN CAPE PROVINCE (EC)
INCLUDING COMMUNICATION WITH THE PROVINCE**

**DATA COLLECTION FOR A DOCTORAL THESIS: "Health Promotion Model
FOR PEOPLE WITH DISABILITIES – A Public Health Remedy"**

NAME OF CLIENT: Mrs Rebecca Motlatla
INSTITUTION: UNISA
Student number: 645 456-9
TEL/CELL: 082 908 7332
Email Motla@health.gov.za

**THE MANAGER
OFFICE OF THE STATUS OF DISABLED PEOPLE: EC
BISHO**

Eastern Cape Selected Sample:

Protective Workshop	Location
1. Fundukwenza	Kwentyana Location, Box 10070, Pefferville, East London Tel: 043-7221811
2. Inqubela	Ferguson Road, New Brighton, PE Box 7564, Newton Park Tel: 041-4541378
3. Ithembaletu	Community Development Jabavu 6242 Box 1400, Uitenhage Tel; 041 - 9773085
4. Drosdy Workshop	21 William Street, Cotsworld, Port Elizabeth Box 7564, PE Tel: 041-3650529

ATTENTION: Mr Sithembele

My name is Mrs Rebecca Motlatla, working for the National Department of Health in the Health Promotion Unit. I'm currently a UNISA doctoral student final year and in the process of collecting national data on the above topic "***Health Promotion Model For People With Disabilities – A Public Health Remedy***". The aim of my study is to propose an integrated approach to foster health promotion within Protective Workshops and other centres catering for People with Disabilities to increase their control of their own health through health information and education programmes. The outcome of this study will be an integrated health promotion model that will benefit people with disabilities through outreach programmes to increase health literacy, awareness and maximise their participation in health campaigns

The national Department of Social Development (Disability Desk) supports the study and the study is based on a national database of the Protective Workshops. Through a scientific sampling process, a national sample of 70 Workshops has been selected to participate in the study.

I would appreciate the permission and support of OSDP in the province with my study and assistance with data collection in the sampled Protective Workshops. My timeframe is the 15th May 2008.

I appreciate your support


Yours Sincerely
Ms Rebecca Motlatla
12 May 2008

From: Rebecca Motlatla
To: sithembele@starmail.co.za
Date: 2008/04/09 10:15 AM
Subject: Re: Fwd: DATA COLLETION IN THE EASTERN CAPE

Dear Sithembele

Thanks for the acknowledgement. I need assistance with data collection at the 4 sites. It would be best if i can be referred to any organisation working for or with people with disabilities locally, to collect data for me. Some organisations (DPSA, APDs, Mental Health Society, etc) have programmes that empower young people or adults to provide information and education on disability and other issues. That is why i was talking about fieldworkers because it is from those programmes, i think fieldworkers could be drawn for opportunities of exposure into the research environment. It is my wish to foster participation of people with and in the disability environment in this research as a health promoter and this approach promotes inclusivity. This is a perspective of my study. I need your guidance on how to approach this in the EC and then we can discuss other logistical implications related to the activity. Im attaching an **example** of an invoice from the Western Cape province for your information. As for the timeframe, the sooner we engage on the issue, the better time we will plan and agree on.

I appreciate you interest and support the Research Project.

Kind Regards

Rebecca Motlatla
083 908 7332

EASTERN CAPE PROVINCE SAMPLE

- | | |
|---------------------------|---|
| 1. Fundukwenza | Kwentana Location, East London |
| 2. Inqubela | New Brighton (Ferguson Road) Port Elizabeth |
| 3. Ithembaletu | Uitenhage, Port Elizabeth |
| 4. Drosdy Workshop | 21 William Street, Cotsworld, Port Elizabeth |

>>> <sithembele@starmail.co.za> 2008/04/08 05:46 PM >>>
Dear Rebecca

This serves to confirm receipt of your email with all the information. Yours is an interesting topic and such research will append value in liberating people with disabilities from the scourge of poverty and underdevelopment. Moreover, your findings will find expression in strengthening treatment mechanisms for people with disabilities in the PW.

Coming back to your communique, Im not sure exactly about the kind of assistance/ support you require from the Office... Is it about questionnaire administration??? If so, how??? When you talk of the pool of fieldworkers, who are you referring to and where are they???

In terms of data collection, it may be problematic to courier the staff and rely on individual administration as this approach may have interpretation flaws... We may need people who have basic understanding of data capturing. Looking at your time frame, the period is not friendly at all but anything is possible...

I hope you will consider these and come back to me... I suggest that we engage tomorrow at 10:00 to clarify these issues...

Regards,

APPENDIX N: PERMISSION LETTER: GAUTENG PROVINCE (GP) INCLUDING COMMUNICATION WITH THE PROVINCE

DATA COLLECTION FOR A DOCTORAL THESIS: "Health Promotion Model FOR PEOPLE WITH DISABILITIES – A Public Health Remedy"

NAME OF CLIENT: Mrs Rebecca Motlatla
INSTITUTION: UNISA
Student number: 645 456-9
TEL/CELL: 082 908 7332
Email Motla@health.gov.za

Dear Colleagues

My name is Mrs Rebecca Motlatla, working for the National Department of Health in the Health Promotion Unit. I'm currently a UNISA doctoral student final year and in the process of collecting national data on the above topic "**Health Promotion Model For People With Disabilities – A Public Health Remedy**". The aim of my study is to propose an integrated approach to foster health promotion within Protective Workshops and other centres catering for People with Disabilities to increase their control of their own health through health information and education programmes. The study contributes to the body of knowledge in the health promotion environment through evidence-based approaches.

The outcome of this study will be an integrated health promotion model that will benefit people with disabilities through outreach programmes to increase health literacy, awareness and maximise their participation in health campaigns. Successful Health Promotion work is evidence-based; the participation of health promoters in data collection will build more skills and a better understanding of the health promotion needs and experiences of people with disabilities for responsive integrated programming.

The national Department of Social Development (Disability Desk) supports the study and the study is based on a national database of the Protective Workshops. Through a scientific sampling process, a national sample of 70 Workshops has been selected to participate in the study.

I would appreciate the permission and support of Health Promotion in Gauteng Province though assistance with data collection in the sampled Protective Workshops. My timeframe is the 30th May 2008.

I appreciate your support


Yours Sincerely
Ms Rebecca Motlatla
12 May 2008

From: Rebecca Motlatla
To: pdcgp@dpsa.org.za
Date: 2008/04/10 09:36 AM
Subject: DATA COLLECTION GAUTENG - DOCTORAL THESIS UNISA
Attachments: Inclusive Model of HP Proposal Rev 09 Feb 2007 Latest march2.doc; NATIONAL SAMPLE FOR PROTECTIVE WORKSHOPS.doc; Questionnaire 4 Prof disability Sept 20 06.doc; Sample size Determination.doc; Draft Questionnaire for People with Disability March2007.doc

Dear Veni

My name is Rebecca Motlatla, currently working at the National Department of Health in the Health Promotion Unit. Mr Dominique Souchon at OSDP referred me to DPSA for assistance with data collection for my study. **This is the brief:**

I am a Doctoral student with UNISA, at final year of study, currently in the process of collecting a national data on my topic. 16 facilities have been sampled in Gauteng Province. My timeframe is the 9 May 2008. I have managed seven provinces so far and hope to complete by the target date, negotiable. My proposal is to utilise the existing pool of fieldworkers for exposure and assistance with data collection. Proposed logistics are as follows:

1. My Research Topic is "**An Inclusive Health Promotion Model for people with Disabilities in Protective Workshops (PW) - A Public Health Remedy**". A Two phased approach is adopted;
 - 1.1. Theoretical (aimed at assessing the status of health in the environment of PW, and
 - 1.2. A Participatory Approach, which aims at involving people with disabilities in developing an inclusive model based on the lessons of the first approach and other scientific theories.

My research protocol and data collection instruments were approved by the ethics committee of the university. The Department of Social Development supports the study as the lessons learned will make a contribution towards strengthening the health component within the environment of PWs.

A copy of the proposal is enclosed for your information.

2. Research Methodology

Sampling process was guided by a national database of Protective Workshops (PWs) of the Department of Social Development. With the assistance of a statistician and using a multi-stage sampling procedure, a national sample of 70 PWs is drawn to participate in the study. **Within each protective workshop, 10 people will be interviewed, 8 of which will comprise people with disabilities (a fair mix of disabilities) and 2 will be people working within the protective workshops (mangement, caregivers,etc).**

- a) A copy of the Sample determination is enclosed for your information.
- b) A copy of a Questionnaire for People with Disabilities is enclosed for your information.
- c) A copy of A Questionnaire for Professionals Working with people with Disabilities is enclosed for your information.

3. Implications

> Kindly note that i am aware of the financial implication for data collection and as a student my study is not sponsored but i have put aside an amount of R1 600.00 from the University's Financial Aid funds towards questionnaire administration (@ R15 per questionnaire). Kindly advice.

> Through your advice, we can discuss other logistics for cost cutting purposes, such as questionnaire printing, courier services, etc, which could be arranged.

Regards

Rebecca Motlatla
Doctoral Candidate
UNISA ST NO: 645 456-9
082 908 7332

APPENDIX O: PERMISSION LETTER: LIMPOPO PROVINCE (LP) INCLUDING COMMUNICATION WITH THE PROVINCE

From: Rebecca Motlatla
To: Mashimbye Lisebo
Date: 2008/03/14 12:43 PM
Subject: Data collection
Attachments: Questionnaire 4 Prof disability Sept 2006.doc; Draft Questionnaire for People with Disability March2007.doc; Sample size Determination.doc

Dear Sesi Lizzy

Thanks you very much for your support. I am in the process of collecting a national data on my topic and appreciate your support with the Limpopo Sample. My timeframe is March-15 April 2008. I have managed three provinces so far and hope to complete by the target date. Proposed logistics are as follows:

1. My Research Topic is An Inclusive Health Promotion Model for people with Disabilities in Protective Workshops - A Public Health Remedy. Two phased approach 1. Theoretical (aimed at assessing the status of health in the environment of PW, and 2. Participatory approach, which aims at involving people with disabilities in developing an inclusive model based on the lessons of the first approach and other scientific theories. A Doctoral study with UNISA, final year. My research protocol and data collection instruments were approved by the ethics committee of the university. The Department of Social Development supports the study as the lessons learned will make a contribution towards strengthening the health component within the environment of PWs.

A copy of the proposal is enclosed for your information.

2. Research Methodology

Sampling process was guided by a national database of protective workshops (PWs) of the Department of Social Development. With the assistance of a statistician and using a multi-stage sampling procedure, a national sample of 70 PWs is drawn for the study. Within each protective workshop, 10 people will be interviewed, 8 of which will comprise people with disabilities (a fair mix of disabilities) and 2 will be people working within the protective workshops (mangement, caregivers,etc).

- a) A copy of the Sample determination is enclosed for your information.
- b) A copy of a Questionnaire for People with Disabilities is enclosed for your information.
- c) A copy of A Questionnaire for Professionals Working with people with Disabilities is enclosed for your information.

3. Implications

> Kindly note that i am aware of the financial implication of data collection and as a student my study is not sponsored but have put aside an amount of six hundred rands, R600.00 + cost of printing questionnaires from the University's Financial Aid funds towards the work to be done in Limpopo. Kindly advice.

> Through your advice, we can discuss other logistics for cost cutting purposes, such as questionnaire printing, courier services, ect, which could be arranged. Please send me a quoutqtion as soon as possible so i can mobilise funds with the University. I have attached an example of an invoice from the WC for your information.

Lastly i would appreciate it if you can be my referee for the study to guide and support from your experience, so i can produce work that will make a difference in society.

Regards

Rebecca Motlatla
UNISA ST NO: 645 456-9
Cell: 082 908 7332

>>> Mashimbye Lisebo <mashimbyele@dhw.norprov.gov.za> 2008/03/14 12:01 PM >>>
I think so. The awaited document has not arrived yet

-----Original Message-----

From: Rebecca Motlatla [<mailto:motlar@health.gov.za>]
Sent: Friday, March 14, 2008 12:14 PM
To: Mashimbye Lisebo
Subject: RE: ISVIP Conference: 1st Announcement
Importance: High

** High Priority **

Ok, maybe i should separate my attachments and send them one by one to speed up the process. Hope it will work. What do you say Sis?

INVOICE FOR DATA COLLECTION OF A DOCTORAL THESIS: "Health Promotion Model – A Public Health Remedy"

NAME OF CLIENT: Mrs Rebecca Motlatla

INSTITUTION: UNISA

Student number: 645 456-9

TEL/CELL: 082 908 7332

Email: Motla@health.gov.za

SELECTED SAMPLE FOR DATA COLLECTION IN LIMPOPO:

1. Siloe After Care Centre : Capricorn District
2. Eeufees Protective Workshop: Capricorn District
3. Tivanani Vatsinwa Workshop for the Disabled: Vhembe District
4. Letaba Aftercare Centre: Mopane District

INVOICE

Description of Items	Total
A4 Envelopes sending questionnaires to workshops at R 6.04	R 48.32
Payment for completion of questionnaire to facilitators at R15.00 / questionnaire *40	R 600.00
400 Printing of Double sided 5 page questionnaire R0.50	R 200.00
1 Overnight Courier Service to Post Office 2kg Package (Completed questionnaires) at R 100.00	R 100.00
Telephone calls made to Managers of 4 different Workshops at R60.00	R 60.00
Total Vat@14%	R 1008.32

CONTACT DETAILS:

Ms Nkateko Eudora Lowane
Standard Bank
Branch : Braamfontein
Cheque account
Account number: 201111713

Name Signature Date

Thanks

APPENDIX P: PERMISSION LETTER: NORTHERN CAPE PROVINCE (NC) INCLUDING COMMUNICATION WITH THE PROVINCE

From: Rebecca Motlatla
To: socialwork@mweb.co.za
Date: 2008/03/26 02:57 PM
Subject: Fwd: DATA COLLETION IN NORTHERN CAPE PROVINCE
Attachments: Draft Questionnaire for People with Disability March2007.doc; Ouestionaire
4 Prof disability Sept 2006.doc; NATIONAL SAMPLE FOR PROTECTIVE
WORKSHOPS.d
oc; Sample size Determination.doc; Inclusive Model of HP Proposal Rev 09 Fe
b 2007 Latest march2.doc
CC: Makhuron@unisa.ac.za

>>> Rebecca Motlatla 2008/03/20 10:02 AM >>>
Dear Ms Leonie Taljard

Thanks you very much for your support. I am in the process of collecting a national data on my topic and appreciates your support with the **Northern Cape Sample**. My timeframe is the 20th April 2008. I have managed five provinces so far and hope to complete by the target date, negotiable. My proposal is to utilise the existing pool of fieldworkers for exposure and assistance with data collection. Proposed logistics are as follows:

1. My Research Topic is An Inclusive Health Promotion Model for people with Disabilities in Protective Workshops - A Public Health Remedy. A Two phased approach is adopted, **1**. Theoretical (aimed at assesing the status of health in the environment of PW, and **2**. Participatory approach, which aims at involving people with disabilities in developing an inclusive model based on the lessons of the first approach and other scientific theories. A Doctoral study with UNISA, final year. My research protocol and data collection instruments were approved by the ethics committee of the university. The Department of Social Development supports the study as the lessons learned will make a contribution towards strengthening the health component within the environment of PWs.

A copy of the proposal is enclosed for your information.

2. Research Methodology

Sampling process was guided by a national database of protective workshops (PWs) of the Department of Social Development. With the assistance of a statistician and using a multi-stage sampling procedure, a national sample of 70 PWs is drawn to participate in the study. **Within each protective workshop, 10 people will be interviewed, 8 of which will comprise people with disabilities (a fair mix of disabilities) and 2 will be people working within the protective workshops (mangement, caregivers,etc).**

- a) A copy of the Sample determination is enclosed for your information.
- b) A copy of a Questionnaire for People with Disabilities is enclosed for your information.
- c) A copy of A Questionnaire for Professionals Working with people with Disabilities is enclosed for your information.

3. Implications

> Kindly note that i am aware of the financial implication of data collection and as a student my study is not sponsored but i have put aside an amount of R150.00 (hundred and fifty rands) from the University's Financial Aid funds towards questionnaire administration. Kindly advice.

> Through your advice, we can discuss other logistics for cost cutting purposes, such as questionnaire printing, courier services, ect, which could be arranged.

Regards

Rebecca Motlatla
Doctoral Candidate
UNISA ST NO: 645 456-9
082 908 7332

APD

Association for Persons with Disabilities

Northern Cape Noordkaap



003-806 NPO
Partly funded by



Posbus/PO Box 928

Kimberley
8300

Tel: (053) 833-3315
(053) 833-3272

Fax: 053 8328431
socialwork@mweb.co.za

*Affiliated to
The National Council for Persons
with Physical Disabilities in South
Africa*

***Proudly hosting the 2008 Annual Conference and Business Meeting of the
National Association for Persons with Cerebral Palsy***



11 to 14 May 2008
Kimberley
Horseshoe Conference Centre
Tel. 053 - 8325267

The APD Northern Cape and Volksblad Photography competition photos will be on display during this conference.

Die APD Noordkaap en Volksblad Fotografie kompetisie se foto's sal tydens hierdie konferensie uitgestal word.

INVOICE

Name	APD Northern Cape
Address	PO Box 928, Kimberley, 8300
Tel/Cell	053 - 8333272
Fax	086511 8222
Email	socialwork@mweb.co.za

Date	07 April 2008
Contact	L. Taljaard
I.D.	6512200024089
Phone	083 455 8991
Fax	086 511 8222

Quantity	Description	Unit Price Ex VAT	Total Ex VAT
1	A4 Envelopes sending questionnaires to workshops	R6.04	R6.04
@ R10 per Questionnaire	Payment for completion of questionnaire to facilitators	R10.00	R100.00
	Printing of 10 Double sided 5 page questionnaire	R0.45	R22.50
1Parcel	Overnight Courier Service to your nearest Post Office 2kg Package (Completed questionnaires)	R32.00	R32.00
	TOTAL		R160.54

Banking Details:

Account Name: APD Northern Cape
 Bank: ABSA
 Branch Code: 500902
 Account Number: 048701191

APPENDIX Q: PERMISSION LETTER: WESTERN CAPE PROVINCE (WC) COMMUNICATION WITH THE PROVINCE

From: Rebecca Motlatla
To: udeglon@artefact.co.za
Date: 2008/02/27 01:36 PM
Subject: Data Collection: WC Protective workshops Sample
Attachments: PROTECTIVE WORKSHOPS DATABASE.xls; Sample WC.doc; Thesis Health Promotion
d
isability Proposal.doc; Draft Questionnaire for People with Disability Marc
h2007.doc; Questionnaire 4 Prof disability Sept 2006.doc; Sample size Determ
ination.doc

CC: Makhuron@unisa.ac.za
Dear Undere

Thanks you very much for your support. I am in the process of collecting a national data on my topic and appreciates your support with the Western Cape Sample. My timeframe is the 15th March 2008. I have managed three provinces so far and hope to complete by the target date. Proposed logistics are as follows:

1. **My Research Topic** is An Inclusive Health Promotion Model for people with Disabilities in Protective Workshops - A Public Health Remedy. Two phased approach 1. Theoretical (aimed at assesing the status of health in the environment of PW, and 2. Participatory approach, which aims at involving people with disabilities in developing an inclusive model based on the lessons of the first approach and other scientific theories. A Doctoral study with UNISA, final year. My research protocol and data collection instruments were approved by the ethics committee of the university. The Department of Social Development supports the study as the lessons learned will make a contribution towards strengthening the health component within the environment of PWs.

A copy of the proposal is enclosed for your information.

2. Research Methodology

Sampling process was guided by a national database of protective workshops (PWs) of the Department of Social Development, which i presented at the previous national workshop at KeptonPark, GP. With the assistance of a statistician and using a multi-stage sampling procedure, a national sample of 70 PWs is drawn to participate in the study. Within each protective workshop, **10 people will be interviewed, 8 of which will comprise people with disabilities (a fair mix of disabilities) and 2 will be people working within the protective workshops (mangement, caregivers,etc).**

a) A copy of the Sample determination is enclosed for your information.

b) A copy of a Questionnaire for People with Disabilities is enclosed for your information.

c) A copy of A Questionnaire for Professionals Working with people with Disabilities is enclosed for your information.

3. Implications

> Kindly note that i am aware of the financial implication of data collection and as a student my study is not sponsored but have put aside an amount of R1500.00 from the University's Financial Aid funds towards the work to be done. Kindly advice.

> Through your advice, we can discuss other logistics for cost cutting purposes, such as questionnaire printing, courier services, ect, which could be arranged.

Lastly i would appreciate it if you can be my referee for the study to guide and support from your experience, so i can produce work that will make a difference in society.

Regards

*Rebecca Motlatla
UNISA ST NO: 645 456-9
Cell: 082 908 7332*

21 May 2008

Dear Workshop Manager



REMINDER: To please fill in the Questionnaire and post back to: PO Box 22493, Fish Hoek, 7974. An honorarium of R10 per completed questionnaire will be paid to the workshop.

Rebecca Motlatla a Phd student came to DWDE for help with the collection of her data for her thesis. The following paragraph from Rebecca will describe what her research is about and what she expects.

Thanks you very much for your support. I am in the process of collecting a national data on my topic and appreciate your support with the Western Cape Sample. With the help of a statistical program 12 Workshops in the Western Cape have been chosen to participate in my research

My Research Topic is An Inclusive Health Promotion Model for people with Disabilities in Protective Workshops - A Public Health Remedy. Two phased approach

- 1. Theoretical (aimed at assessing the status of health in the environment of PW, and*
- 2. Participatory approach, which aims at involving people with disabilities in developing an inclusive model based on the lessons of the first approach and other scientific theories.*

This is a doctoral study with UNISA, final year. My research protocol and data collection instruments were approved by the ethics committee of the university. The Department of Social Development supports the study as the lessons learned will make a contribution towards strengthening the health component within the environment of PWs.

What we need from you the workshops.

Included in this envelope is a prepaid envelope addressed to DWDE and also 10 questionnaires. Two of the questionnaires need to be filled in by professionals working with people with disabilities and 8 questionnaires needs to be filled in by people with disabilities (a fair mix of disabilities).

Sampling process was guided by a national database of protective workshops (PWs) of the Department of Social Development, which I presented at the previous national workshop at

Kempton Park, GP. With the assistance of a statistician and using a multi-stage sampling procedure, a national sample of 70 PWs is drawn to participate in the study. Within each protective workshop, 10 people will be interviewed, 8 of which will comprise people with disabilities (a fair mix of disabilities) and 2 will be people working within the protective workshops (management, caregivers, etc).

Your participation in this vitally important research study is appreciated. We would like to ask you to please complete questionnaires as soon as possible and re-post back to DWDE to reach us by 5 May. There is a small amount of compensation available for interviewers that helped PwD to fill in there questionnaire (R10.00 per questionnaire).

Your efforts in helping us to know more about PwD will be greatly appreciated and your anonymity will be is held in great regard. Please answer as honestly as you can - your answers will be kept confidential.

Kind Regards
Dominique Brand
084 206 3949
(Research Assistant DWDE)

Underé Deglon
(CEO DWDE)

DISABILITY WORKSHOP DEVELOPMENT ENTERPRISE
Ground Floor, EBDEN HOUSE
Belmont Office Park
Rondebosch
7700

TEL: 021 685 0736

EMAIL: lmokhoro@telkomsa.net

APPENDIX G Rebecca Motlatla Timeline of activities

27 Feb 2008	Rebecca e-mailed Underé Deglon the first time
6 March 2008	Underé Deglon forwarded mail to Dominique Brand to assist Ms Motlatla
11 March 2008	Per request worked out a logistics plan for questionnaires and an detailed invoice for expenses. Invoice was for R1555.20
17 March 2008	Received a mail from Ms. Motlatla. Informing you that Unisa finance will be released by 20 March Thursday this week. I will then be able to deposit money into your account.
19 March 2008	E-mail from Ms Motlatla ("Yes, i'll do so as soon as i receive the money by Tuesday as promised.")
2 April 2008	E-mail from Ms. Motlatla Thanks the money is in my account and will be cleared by the 7th this month. I will make a deposit into your account as soon as possible.
8 April 2008	Ms Motlatla asked Dominique to confirm Banking Details. Dominique did do that the same day
8 April 2008	E-mail from D.Brand (Can you please just mail or fax me proof of payment fax 021-689 4107)
15 April 2008	E-mail from Ms Motlatla H(ope you are doing fine with data collection. My courier address is: Ms Rebecca Motlatla. PO Box 2455, Rooihuiskraal, 0154. I will appreciate if i can receive the completed questionnaire package by Friday this week. Pls call for clarity.)
16 April 2008	I replied on Ms. Motlatla request and informed her that we will not be able to send her completed questionnaires by 18 April Friday 2008
17 April 2008	Thembi Phoned workshop managers to confirm mailing address and inform them about research what we need from them and when it should be expected.
17 April 2008	Questionnaires was posted
17 April 2008	In my letter to the Workshop Managers I requested that they Fill in questionnaires and post back to reach DWDE BY 5 March 2008
22 April 2008	Thembi phone 12 workshops and check if they have received questionnaires and urge them to complete as soon as possible.
29 April 2008	Thembi phone workshops and remind them about 5 May date (post back to DWDE to reach us by 5 May 2008)
21 May 2008	As soOn as all Questionnaires are received post back to Ms. Molatla

From: "leboang mokhoro" <lmokhoro@telkomsa.net>
To: "Rebecca Motlatla" <MotlaR@health.gov.za>
Date: 2008/05/07 09:11 AM
Subject: Data Collection

Dear Rebecca

I have reminded all the workshops that Dominique has sent them the questionnaires, they have promised to make time to fill them in as they said they dont have time but promised to make time when I was making follow up calls, hopefully by the 5th of May as Dominique has stated which was on Monday they have posted them.I will keep you informed.

Kind Regards

Tembakazi Nxiba

ADMINISTRATOR
DISABILITY WORKSHOP DEVELOPMENT ENTERPRISE
GROUND FLOOR, EBDEN HOUSE
BELMONT OFFICE PARK
RONDEBOSCH
TEL: 021 685 0736
FAX: 021 689 4107
CELL: 082 749 0644
EMAIL: lmokhoro@telkomsa.net

"Our vision is to contribute to economic transformation of Protective Workshop and Self-Help Groups"

From: "Dominique Brand" <dwderesearch@telkomsa.net>
To: "Rebecca Motlatla" <motlaR@health.gov.za>
Date: 2008/04/24 02:42 PM
Subject: Just keeping you informed

CC: "Thembakazi Nxiba" <lmokhoro@telkomsa.net>

Hi Rebecca

Just want to let you know that your research is on its way. Hope you received the timeline I mailed to you. I am going to be out of office for a while but there will be somebody else at office that can assist you. Thembi Nxiba. I have briefed Thembi and she assisted me through the whole process. If you have any question I am therefore referring you to Thembi. Thembi's e-mail lmokhoro@telkomsa.net or send to this mail and in subject just address to Thembi.

Kind Regards

Dominique Brand

From: Rebecca Motlatla
To: Dominique Brand
Date: 2008/05/20 10:58 AM
Subject: Re: Questionnaires update

Dear Dominique

A kind reminder for data collection. This is exceedingly taking too long time as planned. Kindly assist and let me know the current status. I will appreciate it if i can receive questionnaires by Friday this week as they are the only outstanding for coding and data analysis.

Thanks

Rebecca

APPENDIX R: REQUEST FOR ASSISTANT WITH STATISTICAL ANALYSIS

From: Rebecca Motlatla
To: legesse.debusho@up.ac.za
Date: 2008/10/13 12:35 PM
Subject: Request for Assistance with Statistical Analysis
Attachments: Inclusive Model of HP Proposal Latest, latest April 08.doc; Draft Questionnaire for People with Disability March2007.doc; NATIONAL SAMPLE FOR PROTECTIVE WORKSHOPS.doc; Ouestionnaire 4 Prof disability Sept 2006.doc; Sample size Determination.doc

CC: Makhuon@unisa.ac.za

Dear Mr Debusho

Thanks for considering my request for assistance with the above subject matter. My name is Mrs Rebecca Motlatla, working for the National Department of Health in the Health Promotion Unit. I'm currently a UNISA doctoral student final year and in the process of analyzing national data on my research project "Health Promotion Model For People With Disabilities - A Public Health Remedy". The aim of my study is to propose an integrated approach to foster health promotion within Protective Workshops and other centres catering for People with Disabilities to increase their control of their own health through health information and education programmes.

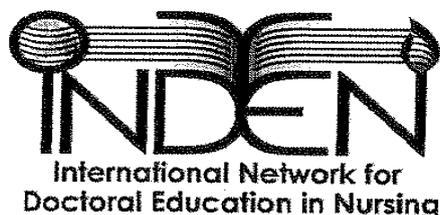
The national Department of Social Development (Disability Desk) supports the study and the study is based on a national database of the Protective Workshops. Through a scientific sampling process, a national sample of 70 Workshops has been selected to participate in the study. I am writing to you to request for assistance with data analysis and expertise in the finalization of my report. My timeframe for submitting the final draft is the 30th November 2008. Please find attached information including data collection tools that provides details of my research project for your attention and appropriate response. I can be contacted at 082 908 7332 and by E-mail.

Looking forward for a positive response

Sincerely

Rebecca Motlatla

APPENDIX S: ACCEPTANCE LETTER TO PRESENT WORK IN PROCESS OF THE THESIS AT THE BIENNIAL MEETING OF THE INTERNATIONAL NETWORK FOR DOCTORAL EDUCATION IN NURSING ON THE 26-27 MAY 2007 AT ST LUKE'S COLLEGE OF NURSING ,IN TOKYO.



May 3, 2007

Rebecca Motlatla
Department of Health Sciences
University of South Africa
Email: MotlaR@health.gov.za

Dear Rebecca Motlatla,

I am pleased your student poster and abstract, titled Inclusive Model of Health Promotion for People with Disabilities: A Public Health Remedy, was accepted by the review committee. You will present at the biennial meeting of the International Network for Doctoral Education in Nursing [INDEN], which will be held May 26-27, 2007 at St. Luke's College of Nursing, in Tokyo, Japan. We have an exciting program planned, which I know will interest you.

The INDEN 2007 meeting is being held prior to the Quadrennial Congress of the International Council of Nurses, to be held starting May 28, 2007, also in Tokyo. I hope you will be able to attend, and hope that you will encourage other colleagues and doctoral students to attend as well.

My best regards.

Sincerely yours,

Richard Redman, PhD
President of INDEN

RR/jm

APPENDIX T: REQUEST LETTER (DOH) FOR SPONSORSHIP TO ATTEND THE BIENNIAL MEETING OF THE INTERNATIONAL NETWORK FOR DOCTORAL EDUCATION IN NURSING ON THE 26-27 MAY 2007 AT ST LUKE'S COLLEGE OF NURSING, IN TOKYO.

PO BOX 2455
ROOIHUISKRAAL
0154
10 MAY 2007

MR FP NETSHIPALE **ATTENTION: MS G BROWN**
NATIONAL PROGRAMME MANAGER
EU: PDPHC PROGRAMME INCLUDING HIV AND AIDS
DEPARTMENT OF HEALTH
PRIVATE BAG X 828
PRETORIA
0001

Dear Mr Netshipale

REQUEST FOR SPONSORSHIP TO ATTEND AN INTERNATIONAL NETWORK FOR DOCTORAL EDUCATION IN NURSING (INDEN) CONFERENCE AND WORKSHOP IN TOKYO, JAPAN ON THE 26-28 MAY 2007.

My name is Rebecca Motlatla, a Doctoral student at UNISA and an employee of the Department of Health, based at the Health Promotion Unit. I have been invited to attend the above-mentioned Conference to present my work in progress, which was approved by the ethics committee of the conference early this month. This will be in the form of a poster presentation. My thesis is "*a Health Promotion Model for people with Disabilities in SA- A Public Health Remedy*" I have been granted a partial sponsorship by the conference, which covers registration and part of my accommodation to the value of US \$800.00.

I am writing to EU Partnerships for Health to request assistance with sponsorship of R10 000.00 to cover my travel cost to and from OR Tambo International Airport – Hongkong, including ground transport, from the 24-31 May 2007. The study is related to my work environment and attending this conference will add value to the department's programme through strengthening Health Promotion Research and supporting intervention evidence-based approach. Your assistance will grant me an opportunity to interact with fellow students from across the globe and contributes improved to health research in SA. I'm willing to share experiences with the department at relevant health forums.

Please find attached copies of information about the conference for your attention. For reference, my promoter is Prof O Makhubela-Nkondo at 012 429 6588, E-Mail: makhuon@unisa.ac.za.

Sincerely

Ms Rebecca Motlatla
UNISA Student Number: 645 456 9
Date:

APPENDIX U: ACCEPTANCE LETTER TO SUBMIT THE THESIS FOR EXAMINATION



Stud no/nr: 645-456-9
Navrae/Enq: M+D Eksamenkoördineerder
M+D Examination Coordinator
Tel: (012)429-2457/2643/3962/2658
Faks/Fax: (012)429-2429

Mrs R Motlatla
PO Box 2455
ROOIHUISKRAAL
0154

2009-01-12

Dear Mrs Motlatla

With reference to previous correspondence, I have pleasure in informing you that your promoter has consented to your submitting the thesis for examination.

I have also pleasure in informing you that the following amended title has been approved for your projected thesis for the degree of DLitt et Phil in Health Studies: **HEALTH PROMOTION MODEL FOR PEOPLE WITH DISABILITIES: "A PUBLIC HEALTH REMEDY"**.

For purposes of examination, **four** copies, bound between soft covers with a glued spine, must be submitted, as well as **four** copies of a scientific article. An electronic copy of your thesis in preferably PDF, Word or WordPerfect format must, if possible, sent on a CD to the same address as the paper copies. These copies are not to be confused with the (later) copies to be submitted after acceptance of a dissertation or thesis and in which any corrections have to be included. The copies must be addressed to The Registrar (Academic), for attention **Documentation, M & D section**, [Tel (012)429-3057, (012)429-3506, (012)429-3150 or (012)429-3486], or they may be handed in personally at the counter, Level 2 in Block B, Theo van Wijk Building (use the Gold Fields entrance)*.

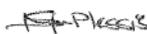
The enclosed *ProQuest Information and Learning (University Microfilms Inc)* agreement form must be completed in all its detail and must accompany the abovementioned examination copies.

Regarding submission dates the following rules apply:

- If submission takes place after 15 June a student will only graduate in April/May of the following year;
- if submission takes place after 30 November graduation will only take place in September of the following year;
- if submission takes place after 5 March a student will graduate in September and have to reregister and pay the full tuition fees;
- if you are not currently a registered student, submission will not be allowed.

Please note that, **after the examination has been completed** and after any corrections that the examiners might request have been effected, a student must, before the degree can be awarded, submit the text in **electronic format** and the same text in a further **three additional copies** of the accepted thesis, namely one unbound and two spine-glued hard cover copies, reflecting the full title of the thesis and your name on both the cover and spine of the bound copies. See * above for the address.

Yours faithfully


for REGISTRAR



University of South Africa
Pretter Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA, 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
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APPENDIX V: THESIS REVISION 2012

Title: Inclusive Health Promotion: Public Health Remedy for People with Disabilities

Name of Student: Rebecca Motlatla

Student Number: 645 456-9

The following table addresses the key issues raised in the Arbitrator's Summative Report in 2011 and the changes effected by the researcher to improve this thesis. During the thesis review, I considered step by step all the areas of weakness as well as the recommended cause of action to amend the thesis and presented them follows:

Schedule of amendments made from the Arbitrator's Summative Report in 2011

Issues identified as requiring changes	Cause of action	Amendments made	Reference chapter/page
Problem with conceptualization of the thesis.	Need to clarify primary argument for the thesis	The introductory chapter has been reworked to build a strong conceptual base. This involved a revision of certain subtitles and rewording, content re-arranging to strengthen the content and flow of information in conceptualizing the thesis. As recommended, the amendments made provisions to build into the thesis: conceptualization of the thesis and clarifying key concepts that area relevant to the study; Primary Arguments; Unique contributions to the study. Strengthened content on the perspective of health promotion and disability as the main focus of the study. New content on current arguments on the burden of disease was included with a focus on "Is	Chapter One was reconstructed to incorporate all the issues identified in the arbitrator's report without compromising the quality of the report.
Problems with conceptualisation of health promotion especially in the context of disabilities.	Need to discuss or operationalize health promotion		
Introduction focuses on public health and not enough on health promotion as a key concept within the study.	Need to outline the study thesis.		
Background structurally	Structurally needs to be revised and primary argument or problematic issues to be researched is unclear.		
Aim of the study not clearly articulated	Reference pages from the previous version of the thesis were given (7,8,26,27,31,32...130). It was recommended that these areas needed to be clarified and strengthened with a focus on		

	unique contribution to the study.	disability a clinical significant issue"- an analysis of the discourse background. Attention was taken to renew sources in the process of amending the thesis.	
Problem statement/ significance of the study not asserted clearly			
Definition of terms not complete. The definition of health promotion superficial and incomplete.	Need to look closely at definition for inclusion, mainstreaming, medical model of disability, social model of disability and		
Major grammar errors identified	Need to involve a language editor	The language editor was involved	
Ethical considerations	Need to be refined. Why was written consent not sought from participants at time of consent?		
Literature review chapter poorly expressed	Need total restructuring and additional literature integrated.	Chapter reconstructed, methods clarified. Evidence arranged in terms of systematic reviews and thematic reviews providing justifications thereof. Literature search strategies clarified and strengthened with most recent primary and secondary sources updates.	Chapter Two
Conceptual framework lacks depth and feels a little superficial		Conceptual framework strengthened to include the theoretical context as basis for the framework and applied within the context of health promotion and disabilities, examples of evidence based theories and models. An elaboration of the conceptual framework is provided in the relevant section.	Chapter Three
Design of study, data collection approaches and sampling approaches all deemed incongruent.		The section was amended for congruency	Chapter Four