

**THE CULTURAL BELIEFS OF PEOPLE WITH PHYSICAL
DISABILITIES IN A COMMUNITY REHABILITATION CENTRE IN
ONIIPA, NAMIBIA**

By

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DECLARATION

I hereby declare that: “The cultural beliefs of people with physical disabilities in a community rehabilitation centre in Oniipa, Namibia” is my own work, that all the sources used or quoted have been indicated and acknowledged by means of complete references, and that this dissertation was not previously submitted by me for a degree at another University.

Murisi Chokuda Zhou

Signature

Date:

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ABSTRACT

THE CULTURAL BELIEFS OF PEOPLE WITH PHYSICAL DISABILITIES IN A COMMUNITY REHABILITATION CENTRE IN ONIIPA, NAMIBIA

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Persons with physical disabilities are one of the excluded sections of society and they face a number of problems in their daily lives, owing to the cultural beliefs regarding disabilities in their communities. The study explores the cultural beliefs of people with physical disabilities in a community rehabilitation centre in Namibia. The study was informed by a concern that many community based rehabilitation programmes fail to recognise that cultural factors influence attitudes towards disability and rehabilitation.

The goal of the study was to explore and describe the cultural beliefs of people with physical disabilities in a community rehabilitation centre in Oniipa, Namibia. The researcher conducted this study from a qualitative approach. In this study, the life experiences of a purposive sample of people with physical disabilities are explored. Qualitative data was gathered by means of focus group discussions. A total sample of 21 participants was drawn from three constituencies under the Evangelical Lutheran Church Rehabilitation Centre in Oniipa.

The study's findings indicate that there are cultural beliefs that perceive disabilities as a result of witchcraft, punishment for wrongs done in the past, bad luck, or bad omens to the family, and also regard people with physical disabilities as useless and worthless. However, people with disabilities and their families have strong positive

views about disabilities, seeing it as a gift from God and they also believe the causes of disabilities to be diseases, accidents and natural causes.

The study concludes that even though communities hold negative cultural opinions about physical disabilities, which in turn inform community practices, the situation is changing especially in the immediate families of people with disabilities. Interventions and campaigns that build on these changing cultural beliefs are more likely to be acceptable and improve community integration and equalisation of opportunities. The study proposes creating an awareness of the social model to confront problems caused by disabling environments and cultures. To further ensure that programmes promote the inclusion of people with disabilities (PWDs), a key recommendation from the study is to develop programmes and evaluate their effectiveness with a view to adopt best practices that can be replicated in other communities.

KEY WORDS

Community integration and inclusion

Cultural Beliefs

Community Based Rehabilitation

Disability

Equalisation of opportunities

Physical disabilities

Rehabilitation

Social model approach

“Sustainable, equitable progress in the agreed global development agenda cannot be achieved without the inclusion of persons with disabilities. If they are not included, progress in development will further their marginalisation.”

- UN Inter-Agency Support Group, 2011 p 13

“I had to learn to be my own hero, my own role model – which is another way of saying that I had to learn to live with neither heroes nor role models.”

- Leonard Kriegel in his book *Flying Solo*, where he describes his fight with polio and the process of accepting his disability in a world that values able-bodiedness.

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TERMS AND DEFINITIONS

Ovambo – The people of Northern Namibia

Oshiwambo – The common and main language in Northern Namibia

Oshindonga and Oshikwanyama – The major ethnic groups in Northern Namibia

ACRONYMS

ATR – African Traditional Religion

AU – African Union

CBR – Community Based Rehabilitation

CRPD – Convention on the Rights of Persons with Disabilities

ELCIN – Evangelical Lutheran Church in Namibia

ICM – International Classification of Functioning

MDGs – Millennium Development Goals

PHC – Primary Health Care

PLWD – People living with Disabilities

PLWPD – People living with Physical Disabilities

SDH – Social Determinants of Health

SM – Social Model

UN – United Nations

UPIAS – Union of the Physically Impaired Against Segregation

WHO – World Health Organization

WPA – World Programme of Action

CHAPTER ONE:

GENERAL ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Mlenzana, Frantz, Rhoda and Eide (2013:1) state that according to the World Report on Disability (WHO, 2011), 15% of the population globally presents with disabilities, with physical disability being most prevalent. It is notable that 80% of those with disabilities live in low-income countries with inadequate access to health and rehabilitation services (Pechak & Thompson, 2007:5). The 2011 Population and Housing Census approximated that 5% of Namibians have a disability (Namibia Statistics Agency, 2014:1). The number of people with disabilities is increasing globally due to population growth, ageing, emergence of chronic diseases, and medical advances that preserve and prolong life (WHO, 2005:1). These trends create overwhelming demands for health and rehabilitation services, which are very far from being met, particularly in low-income countries (Pechak & Thompson, 2007:5).

Understanding the needs of people with physical disabilities may be a complex process as it involves understanding the person, the society in which he or she lives, and how these interact (Mlenzana et al., 2013:1). The situation of people with disabilities in developing countries is of concern for governments, non-governmental organisations (NGOs) and the international community. Nhiwatiwa, Fuller, Loeb and Eide (2001:1) assert that the rights of people with disabilities have long been the subject of much debate in the United Nations. However, as noted by Haihambo and Lightfoot (2010:76), for policies and programmes to be effective it is important that they take into account the cultural beliefs about disability that exist within their populations. The authors further argue that while certainly a developing country has limited resources available to fully implement all approved policies; there may also be socio-cultural factors that are affecting the implementation of these policies. They suggest that cultural myths and beliefs about disabilities are aspects to consider (Haihambo & Lightfoot, 2010:77). Khupe (2010:1) points out that one of the bedrocks on which discrimination against persons with disabilities is based is culture. People

often use culture to justify wanton discrimination against people with disabilities. The challenges facing people with disabilities must be at the centre of all international development discussions if attitudes towards disability are to change in Africa. This means that the voices of people with disabilities must be heard loud and clear (Dube, 2011:1-2; Kwenda, 2010:1-4). This study examined the cultural beliefs of people with physical disabilities about their disability.

The researcher conducted a study at the Evangelical Lutheran Church in Namibia (ELCIN) Rehabilitation Centre on the cultural beliefs of people with physical disabilities. This study was aimed at sensitising people with physical disabilities and the health care system of Namibia to the need to explore cultural beliefs systems in the health care provision. The study helped to identify barriers threatening inclusion and integration of people with physical disabilities.

The key concepts for the study are as follows:

- **Culture**

Eskay, Onu, Igbo, Obiyo and Ugwuanyi (2012:473) postulate that culture is the mechanism through which people learn their values, norms and beliefs. Culture is something which is shared by members of a society. It is transmitted from one generation to another through stories and fables, watching other people, and formal education. Culture defines behaviour, as people learn beliefs and also act upon them. In the study culture refers to the learned norms and beliefs about physical disabilities by people in the rehabilitation centre.

- **Cultural Beliefs**

Haihambo and Lightfoot (2010:77) argue that cultural beliefs about disability are related to their social beliefs about the causality of disability, the values and devalued attributes of people within that culture, and the anticipated adult status of a person with disability. Within the context of this study, cultural beliefs refer to what people with bodily impairments think constitute the causes of disabilities and their status in the community.

- **Disability**

Disability refers to any restriction or lack of ability (resulting from an impairment) to perform an activity in the manner or within the range considered normal for a human being (e.g. participation in a tug of war) (WHO, 2011:4, Ross & Deverell, 2010:15-16). In the study people with physical disabilities are considered from both a social and a physical environment perspective:

- Social environment refers to the beliefs, attitudes and behaviours that surround a person with disabilities (PWD), and that are communicated to a PWD as positive or negative messages.
- Physical environment refers to the natural and man-made physical structures that surround a PWD, and that limits (as barriers) or promotes (as assistive devices) his/her activities. In the study, these are considered to reflect the social environment (attitudes and beliefs), as well as the capacity of a community to modify the environment (WHO, 2011:4).

- **Rehabilitation**

The World Health Organization (WHO) (2011:4) defines rehabilitation as a goal-oriented and time-limited process aimed at enabling an impaired person to reach an optimal mental, physical and/or social functional level, thus providing her or him with the tools to change her or his own life. It can involve measures intended to compensate for a loss of function or a functional limitation. Within the context of the study, rehabilitation refers to measures intended to facilitate social adjustment or readjustment.

- **Community Based Rehabilitation**

M'kumbuzi (2002:6) states that community based rehabilitation (CBR) refers to:

...situations where resources for rehabilitation are available in the community... large scale transfer of knowledge about disabilities and of skills in rehabilitation to the people with disabilities (PWDs), their families and members of the community. There is also community involvement in the planning, decision making and evaluation of the programme...

- **Equalisation of Opportunities**

Equalisation of opportunities means the process through which the general systems of society, such as the physical and cultural environment, housing and transportation, social and health services, educational and work opportunities, and cultural and social life (including sports and recreational facilities) are made accessible to all (WHO, 2011:4).

- **ELCIN Rehabilitation Centre**

The ELCIN Rehabilitation Centre is a community based welfare organisation which started in 1990, is registered with the Ministry of Health and Social Services, and which works with people with physical disabilities in the Onandjokwe district. The Centre operates during the day and service users return to their homes after their rehabilitation sessions. This was done to promote integration of people with physical disabilities within communities. The study was done at the ELCIN Rehabilitation Centre, Oniipa constituency, Namibia.

1.2 LITERATURE REVIEW

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) (United Nations, 2008) facilitated the implementation of programmes and policies regarding the rights of people with disabilities in Namibia. However, it appears that there continues to be significant gaps in knowledge regarding the situation of people with disabilities, their families and their environment (Marsay, 2013:1). Thus opportunities for success are limited as noted by Eide & Ingstad (2013:1-7).

Although there is a highly progressive legislation and clear governmental commitment, the majority of persons with disabilities in Namibia still do not have access to opportunities for leading independent life like persons without disabilities (VSO International, 2010:1-2). The World Report on Disability estimates that over one billion people, or approximately 15% of the world's population, are living with a disability, yet many people with disabilities do not have equal access to healthcare, education, and employment opportunities, do not receive the disability related services that they need, and encounter exclusion from everyday activities (WHO, 2011:7-8).

Disability disproportionately affects vulnerable populations. Vulnerable groups may be defined as “social groups who experience limited resources and consequent high relative risk for morbidity and premature mortality” (Van Rooy, Amadhila, Mannan, McVeigh, MacLachlan & Amin, 2012:34), and may include children, the aged, ethnic minorities, displaced populations, people suffering from chronic illnesses and persons with disabilities. Importantly Eichler & Burke (2006:63-68) have recognized that the social discrimination and bias that arise based on such categories are the result of social hierarchies: similar exclusionary practices disadvantage and disempower different groups, undermining their human rights and their rights to health, other social services and to social inclusion – to being full participants in society.

Over the years, perceptions towards and beliefs regarding disabilities have varied significantly from one community to the other. Eskay et al (2012:1) state that the concept of disability has been examined from various cultural perspectives across the continent of Africa and found that in every culture, disability was perceived differently and such perception shaped the kind of services rendered. Limited literature however continues to pose a great challenge to students of disability studies in their endeavour to trace the development and formation of beliefs and perceptions towards people with disabilities (Munyi, 2012:1). It is towards this end that this study focuses on the cultural beliefs of people with physical disabilities.

Disability is a complex phenomenon. It involves people (both disabled and non-disabled) and their relationships as well as the social and physical environment of the person with a disability. It involves assistive technology, social reaction to people with disabilities, a myriad of impairments, public and private programmes and laws and a number of other things including people who work in the “helping” professions (Pfeiffer, Sam, Guinan, Ratliffe, Robinson & Stodden, 2003:132)

Many persons in the helping professions try to separate disability and people with disabilities, but such a separation is valid only if one looks at a specific person. The concept of a person with a disability embodies the phenomenon of disability and the two cannot be separated (Pfeiffer et al, 2003:132). This study is about the phenomenon of disability and the social group called people with disabilities and their cultural beliefs regarding disability.

In most poor communities, where everybody is struggling for survival, disability is not usually seen as a priority in development, except by persons with disabilities and their families (Coleridge, 2000:23). In particular it is rare for mainstream development planners to consider the impact of their plans on people with disabilities. But disability must be seen in the wider context of human development and social justice, and for this purpose all development workers need to have an understanding of disability issues. Those working in community disability programmes have a responsibility to research the local cultural factors affecting disabled people and to communicate their findings to the general development debate around them.

Wapling (2012:3) point out that redressing the effects of discrimination and exclusion are going to be very important if global progress is to be more equitably shared in the post millennium development goals framework. One of the ways in which this can be addressed is through a deliberate focus on inclusive development. The post-2015 framework could play a significant role in promoting more equitable development outcomes by ensuring that indicators of progress specifically target marginalized and vulnerable groups, such as persons with disabilities.

Cultural factors influence our attitudes towards most of the happenings around us, including our attitudes towards disability and rehabilitation (Groce, 2005:1-6). The term “handicap” is defined in relation to contextual factors that are predominantly cultural. Though the influence of cultural factors is great, many community based rehabilitation programmes fail to recognise them sufficiently. These programmes expose themselves to a higher risk of failure because they tend to conflict with the cultural factors of the host community.

Being actively included in the social life of one’s family and community is important for personal development. The opportunity to participate in social activities has a strong impact on a person’s identity, self-esteem, quality of life, and ultimately his/her status (WHO, 2010:1). Because people with disabilities face many barriers in society they often have fewer opportunities to participate in social activities. In the past, many CBR programmes focused on health issues and rehabilitations services, often ignoring the social needs of people with disabilities (Wapling, 2012:4). Even today, topics such as relationships, marriage and parenting may be seen as too sensitive or too difficult to address, while access to cultural, sporting and recreation activities and

to justice is seen as unnecessary (WHO, 2010:1). Thus there is need to highlight the importance of these issues in the lives of people with disabilities and the need for CBR programmes to address them.

Understanding disability in a socio-cultural context is a critically important subject that deserves serious consideration. Groce (2000:756-7) states that the knowledge of traditional beliefs and practices towards disability is of vital importance if we are to plan and implement programmes for individuals with disabilities that will make a real difference in their lives and the lives of the communities in which they live. Such knowledge can help establish what is universally true about disability and what is unique to specific cultures. When specific cultures have positive practices, these may provide models for more universal approaches to disability. When specific cultures have negative practices, change may be more effectively advocated when local people come to understand that their particular opinions and practices are not found world-wide.

A quick perusal of the available literature identifies the influence of cultural factors on disability and rehabilitation, especially during the implementation of CBR programmes. Yet CBR planners give little respect to these factors during policy development and planning risking failure of their projects. Decentralisation of rehabilitation services into the community and integration of persons with disabilities into their society, calls for closer interactions with cultural factors (Brown, 2002:34-50). Hence CBR policies require a greater understanding of the 'needs' of the community, which are in many instances biased by the traditional practices in that community. Groce (2005: 1-6) explains that a 'needs analysis' of a community's needs with regard to rehabilitation, highlights a community's understanding of the causation of disability, the prevailing attitudes, the present practices in rehabilitation, the readiness of the community to accept the services, the level of priority assigned by the community for rehabilitation and so on. Coleridge (2000:24) add that a community 'resource analysis' identifying the potential resources from the community, particularly traditional resources, along with the community's expressed needs, improves the relevance and efficiency of a rehabilitation programme.

Amidst the complexity there are some facts. First, cultures are not cast in stone: they have a past, a present, and a future. It is almost impossible to say what is

'indigenous' to a particular society because every country has been subjected to a continual process of cultural evolution and transformation throughout its history, and this process will continue indefinitely (Coleridge, 2000:24). Cultures are not intact and sealed forever by reference to an original, more or less mythical, state: they are being continuously influenced and changed by contacts of all kinds between various peoples. Secondly, cultures do not reflect consensus, but are to a large extent manifestations and often manipulations of power between different agents within a culture. Third, culture provides a key reference point for identity and fourthly and most importantly, to separate culture from development issues misses the point. Culture is the total manifestation of a people's aspirations, values and behaviour. As Coleridge (2000:24) put it "Culture is the web of significance man himself has spun". The development process, whether it involves outside agents or not, is part of the constantly evolving cultural process.

Nhiwatiwa et al (2001:1) point out that knowledge about cultural beliefs and the current situation of people with disabilities is important as a tool of advocacy and practical action. It is a prerequisite when agreeing on acceptable standards, setting priorities and planning for required improvements. Without the necessary knowledge, Governments and NGOs and International Organisations are more or less forced to work arbitrarily on a hit and miss basis.

Tradition, ethnicity and religion play a very important role in determining our behaviour in day to day life. These cultural factors influence our attitudes towards most of the happenings around us, including 'disability'. The term 'handicap', the most influential parameter for intervention in rehabilitation, is defined in relation to contextual factors that are predominantly cultural (Groce, 2005:1-6). The influence of cultural factors is so great, that many CBR interventions fail as a result of scanty recognition of these factors. Yet the fact is that we recognise culture as only an insignificant determining factor for success, while planning our programmes. Rehabilitation is a gradual and long process that cannot escape the influences of local cultural factors.

In conclusion, understanding cultural concepts and beliefs about disability are fundamental to our understanding of how to approach systems and how to foster productive change. If change is to be brought about, we must understand what is

good and build on it and what needs to be changed. It must also be remembered that all societies change over time and incorporate new ideas into a cultural whole. Having said this, one cannot simply list what the traditional beliefs and practices are. We need to understand beliefs, practices, customs and issues as part of a viable and interconnected set of systems that are closely linked and often evolving over time.

1.3 THEORETICAL FRAMEWORK

It is a basic tenet of humanistic philosophy that given the right environment people have an internal mechanism, called the self-actualisation tendency, by which growth can occur. This applies as much to people with disabilities as to the able-bodied. Consequently a foundation principle of all policies, programmes and interventions for people with physical disabilities should contribute to their growth and development, and actualisation of their potential (McAlpine, 2008:3). The social model emanating from the social theories of disability was utilised in the study. French (2001:7) notes that the social model also referred to as the barriers approach views disability not in terms of the individual's impairment, but in terms of environmental, structural and attitudinal barriers which impinge upon the lives of people with disabilities and which have the potential to impede their inclusion and progress in many areas of life unless they are minimised or removed.

Oliver and Barnes (2012:188) explain that the social model breaks the causal link between impairment and disability. The reality of impairment is not denied, but it is not the cause of people with disabilities' economic and social disadvantages. The model sees the issue of 'disability' as a socially created problem and a matter of the full integration of the individuals into society. In this model, disability is not an attribute of the individual, but rather a complex collection of conditions, many of which are created by the social environment. Thus management of the problem requires social action and it is the collective responsibility of society to make the environmental modifications necessary for the full participation of people with disabilities in all areas of social life. The issue is both cultural and ideological, requiring individual, community and large-scale social change. It is also worthy to note that from this perspective, equal access for someone with a disability is a

human rights issue of major concern and hence this model fit this study well (Tregaskis, 2004:65-82).

Oliver (2004a:18-31) asserts that the social model is an attempt to take the focus away from the functional limitations of individuals with an impairment and place it on the problems caused by disabling environments, barriers and cultures. The model also refuses to see specific problems in isolation from the totality of disabling environments; hence, the problem of unemployment for people with physical disabilities does not just entail intervention in the social integration of work and the operation of the labour market, but also in areas such as transport, education and culture. Thus, the social model is based on the understanding that once these barriers are removed, people with physical disabilities will not experience the problems of disability.

In many situations, impairment is used as the primary excuse for mainstream oppressive practices. Given the ongoing oppression of people with disabilities, further development of the social model theories to support persons with disabilities in their everyday struggles against social inclusion is essential. In seeking additional ways of furthering the agenda for inclusion, the social model explores the possibility of the people with disabilities forming strategic alliances with persons without disabilities (Tregaskis, 2004:65-82). Social change might best be achieved if people with disabilities and those without disabilities started working together more systematically to tackle exclusion in all its forms. This is part of a wider belief in social justice for all.

Tregaskis (2004:65-82) states that the process of “othering” has been used as a tool of political, social and cultural oppression by people without disabilities against persons with disabilities. Culturally society lets people with disabilities down because of the prejudiced views and negative shared attitudes of the non-impaired community towards people with physical disabilities. Prejudices are evident in language and the terminology used to describe people with physical disabilities, much of which is derived from medical labels. People are more than just a label, and describing a negative attribute and the stigma attached to those labels means that people with impairments are held back from achieving what they want to achieve. This model

was appropriate to this study as it advocates that if attitudinal barriers are removed, people with disabilities will realise their full potential.

The social model was propounded and developed by people with disabilities themselves. It is an inclusive model that realises the importance and need of people with disabilities to enjoy human rights as equals with non-disabled people. People with physical disabilities are subjected to economic, environmental and cultural barriers, hence the application of the social model in the study on the cultural beliefs of people with physical disabilities in a community rehabilitation centre programme. Unlike the medical and religious models that view persons with disabilities as patients and suffering people respectively, the social model seems to fit well with the purpose of the study as it advocates change within the families, communities and societies in which people with disabilities live. Thus, the above features and principles within the social model theory guided the study and it was applicable and appropriate to the study as it sought to understand the cultural beliefs of these people and then seek ways to change attitudes and encourage community involvement.

1.4 RATIONALE AND PROBLEM STATEMENT

Some development planners tend to regard culture, especially in conservative societies, as an impediment to 'development', but any development interventions which do not engage at a significant and not just superficial level with the local cultural context are bound to be short-lived (Coleridge, 2000:22). This is even truer of community level disability programmes, because disability is defined by culture and without an awareness of how disability is perceived in the target culture, a disability programme does not stand much chance of being relevant and sustainable. In addition, where people with disabilities are not seen as a priority for development or not included in mainstream development programmes, an awareness of cultural issues surrounding disability is a key part of the process of integrating disability into general development activities. Mlenzana et al. (2013:2) highlight that there is a need to understand the patient's view on service delivery and explore whether rehabilitation services acknowledge patient perspectives and make relevant adjustments. Haynes, Devereaux and Guyatt (2002:11-14) also highlighted the role

of patient preferences in disease management and considered it important that their views are heard. Van Til, Drossaert, Punter and Ijzerman (2010:598-604) highlighted the need to understand the barriers that patients experience in the field of rehabilitation and how these can be overcome. Their recommendation was to involve clients in decision-making regarding their rehabilitation so that clients can be part of the process. They further recommended that studies be conducted to explore cultural beliefs and barriers to rehabilitation and how to overcome them. While studies have sought the opinions of non-disabled people regarding their cultural beliefs on disability these opinions entrench discrimination. It is much better to seek the opinions of the “victims” themselves, hence this study was conducted.

Cott (2004:1411-22) postulates that a client centred and holistic philosophy takes into account the goals and expectations of the client and should consider the individual’s broader life circumstances. In the study, the researcher intended to consider the cultural beliefs of people with physical disabilities. This is also in line with the Primary Health Care approach (PHC), which highlights that “specific rehabilitative services should include a basic assessment of people with disabilities, followed by an appropriate treatment programme, in consultation with a person with a disability and his family” (Department of Health, 2000:43). Coleridge (2000:26) asserts that development activities that ignore culture as the sum total of people’s political, economic, social and spiritual aspirations will inevitably lead to alienation, exclusion, and a loss of identity, as well as the loss of a sense of community. Understanding the views of people with physical disabilities relating to their cultural beliefs will assist in identifying gaps in the rehabilitation services offered, as well as challenges in implementing inclusion policies. There is no current information on the cultural beliefs of people with physical disabilities. Most available information in literature is either outdated or sought the views of families and communities that care for people with disabilities. Of concern is that there is no study conducted which directly seeks the views of people with disabilities themselves. The researcher’s interest in the topic stemmed from his years of experience in the health sector which has developed his passion for advocating for vulnerable groups, especially people with disabilities. Thus, the study aimed to explore the cultural beliefs of people with physical disabilities in order to identify the barriers to accessing services and inclusion.

In addition the researcher hoped that the study would highlight the fact that cultural beliefs affect health outcomes and service provisions for people with physical disabilities, and hence need to be taken seriously. Oliver (2004b:21) asserts that the social model is an attempt to switch focus from the functional limitations of individuals with an impairment, to the problems caused by disabling environments, barriers and cultures. Thus it is important for people with disabilities to be aware of the social model so as to apply it in their daily lives.

Oliver (2004b:46) further states that the social model is founded on the notion that social and economic structures disable impaired people, excluding them from full participation in mainstream activities. Therefore the researcher points out that it is important for people with physical disabilities to recognise these structures. By doing so they can challenge these and advocate for full inclusion and participation.

This research might help to enhance the capacities of people with physical disabilities by helping them to sensitise communities about harmful cultural practices, thereby advocating for the rights of people with disabilities (Banerjee, 2005:10).

In conclusion it should be noted that people with physical disabilities should have an understanding of the social model, because the focus of the model is on removing barriers, promoting rights and anti-discrimination. Therefore the social model will help people with disabilities and health care providers sensitise communities, plan health programmes, and ground their understanding on how people with disabilities feel about their problems and issues.

The guiding research question for the study was:

- What are the cultural beliefs of people with physical disabilities in a community rehabilitation centre in Oniipa, Namibia?

1.5 GOAL AND OBJECTIVES OF THE STUDY

The research goal and objectives for the study are discussed below.

1.5.1 Research goal

The goal of the study was to explore and describe the cultural beliefs of people with physical disabilities in a community rehabilitation centre in Oniipa, Namibia.

1.5.2 Research objectives

- To contextualise physical disabilities according to the social model theory.
- To establish the cultural beliefs regarding disability among people with physical disabilities.
- To determine expressed beliefs in the cause of disability and the type of help sought (traditional or medical).
- To suggest strategies that will improve the community integration and inclusion of people with physical disabilities.

1.6 RESEARCH DESIGN AND METHODOLOGY

The following discussion is a brief overview of the research methodology utilised for the study. It is worthy to note, however, that a detailed description of the research methodology, including the research approach, type of research, research design, methodology, and the measures that were taken to ensure the trustworthiness of the data, as well as the ethical considerations of the study, will be presented in Chapter Three.

The researcher adopted a qualitative approach. A qualitative approach is more concerned with “what” questions, which was exactly what the study sought answers for (Fouché & De Vos, 2011:95). The qualitative approach enabled the researcher to obtain an in-depth understanding of the cultural beliefs from the point of view of the people with physical disabilities (Fouché & De Vos, 2011:95).

The research was exploratory in nature. More specifically, it was an applied research study, as it sought to help development practitioners address and solve immediate problems facing the professional practice and accomplish tasks regarding the inclusion and integration of people with disabilities.

A qualitative research design, more specifically the collective case study design, was utilised in the study (Rubin & Babbie, 2011:442). A collective case study enabled the researcher to gain insight and an understanding into the cultural beliefs of people with physical disabilities and how these affect integration and inclusion (Struwig & Stead, 2001:7).

The research population for this study included all the people with physical disabilities in the Onandjokwe district in the CBR programme. The researcher made use of the non-probability sampling technique, namely the purposive sampling method. The purposive sampling method was utilised to purposely seek typical and divergent data and to ensure that there was a good deal of variety in the sample of participants (Bryman, 2012:418; Strydom & Delpont, 2011:392).

The researcher made use of three focus group discussions to collect data. This allowed the respondents to be interviewed in a relatively unstructured way about their cultural beliefs (Bryman, 2012:503). In addition, it allowed the researcher to question several people with physical disabilities systematically and simultaneously (Rubin & Babbie, 2011:467). The researcher made use of a focus group guide to ask open-ended questions since the topic under study was exploratory in nature (Neuman, 2000:250). Focus groups were also inexpensive and generated speedy results (Rubin & Babbie, 2011:467).

1.7 LIMITATIONS OF THE STUDY

Although the study reached its aims, there were some unavoidable limitations. The study was undertaken three months after the presidential elections, during which period there had been strong advocacy for inclusion of people with disabilities in the electoral processes. The participants were also eager to let the newly elected party know about their “issues and challenges”, hence this could have influenced the participants and subsequently influenced the findings, conclusions and recommendations of the study. The findings, however, still reflect the participants’ views and experiences on cultural beliefs regarding disabilities in Oniipa. The sensitivity of the topic could have also influenced the participants’ responses and hence influenced the findings of the study. However, the selection of people aged 40

years and above minimised this as this mature group of people is less likely to give responses based on social desirability (Haihambo & Lightfoot, 2010:78). Finally, the findings of this study will probably not be generalised to the whole country, as it was carried out in one district. However, when conducting human scientific research and viewing the findings of an explorative study through a case study, it is important to note that every person's experience is important and relevant to understanding cultural beliefs and disability (Fouché & Schurink, 2011:311).

1.8 DIVISION OF THE RESEARCH REPORT

The research report consists of four chapters namely:

Chapter One is the introduction and general orientation to the study, including a broad introduction of the research topic, the theoretical framework, rationale and problem statement, goal and objectives, a brief overview of the research methodology and the limitations of the study.

Chapter Two contextualises the disability phenomenon from a social model perspective. It also includes an in-depth discussion on the debates on cultural beliefs and disability, disabling barriers, as well as policy and the legislative framework for people with disabilities.

In **Chapter Three** the researcher outlines the research methodology used for the study. A detailed explanation of the research approach, type of research, research design, study population, sampling, data collection, data analysis, pilot study and ethical issues is included. The presentation and discussion of the research findings are also incorporated in this chapter.

Chapter Four is the last and final chapter of the report. The conclusions and recommendations of the study are outlined in this chapter. The researcher indicates how the goal and objectives of the study have been achieved. The key or major research findings from which conclusions were drawn are highlighted, resulting in the recommendations made.

CHAPTER TWO:

DISABILITY AND CULTURE: A LITERATURE REVIEW

2.1 INTRODUCTION

The focus of this chapter is on framing disability issues in local concepts and beliefs. Understanding disability in a socio-cultural context is a critically important subject that deserves serious consideration. The chapter will contextualise culture and disability from a social model perspective and look at the rationale and background of the cultural context of disability, as well as the significance of the cultural understanding of physical disability in Namibia. Current debates and studies regarding disability and culture will be investigated. There has been an increased awareness about the social construction of disability, particularly as beliefs about disability are examined in a cross cultural context. Thus the chapter explores the social model of disability with the notion that disability is a social construct that has been created by society and each society has its own understanding of disability depending on cultural beliefs. Thus cultural beliefs, myths and attitudes must be understood if nations are to plan and implement policies and programmes with the intent of making a difference in the lives of their citizens with disabilities.

Critically, disability policy and practice as well as national and international legal frameworks available to people with disabilities in Namibia are discussed. Throughout the chapter the key themes of the social model of disability, namely full participation, equalisation of opportunities, inclusiveness, empowerment, human rights, developmental approach, universal access, self-reliance, social integration, appropriateness, and accessibility are discussed to address challenges faced by people with physical disabilities. In the same vein, the role of social workers in policy implementation and service administration will be discussed.

2.2 RATIONALE AND BACKGROUND OF THE CULTURAL CONTEXT OF DISABILITY

2.2.1 Background

Disability: Evolution of the Concept

To understand how disability is currently viewed, it is helpful to look at the way the concept of disability has evolved over time. Historically, disability was largely understood in mythological or religious terms, for example people with disabilities are considered to be possessed by devils or spirits. Disability was also often seen as a punishment for past wrong doing (WHO, 2010:15). These views are still present today in many traditional societies.

In the 19th and 20th centuries, developments in science and medicine helped to create an understanding that disability has a biological or medical basis, with impairments in body function and structure being associated with different health conditions. This medical model views disability as a problem of the individual and is primarily focused on cure and the provision of medical care by professionals (Barnes, 2012:5).

Later, in the 1960s and 1970s, the individual and medical view of disability was challenged and a range of social approaches were developed. The social model of disability most notably emerged during this time. These approaches shifted attention away from the medical aspects of disability and instead focused on the social barriers and discrimination that people with disabilities face. Disability was redefined as a societal problem rather than an individual problem and solutions became focused on removing barriers and social change, not just on providing a medical cure (WHO, 2010:15).

Central to this change in the understanding of disability was the people with disabilities' movement, which began in the late 1960s in North America and Europe and has since spread throughout the world. The well-known slogan "Nothing About Us Without Us" symbolises the amount of influence the movement has had. Persons with disabilities' organisations are focused on achieving full participation and

equalisation of opportunities for, by and with persons with disabilities, which promotes a shift towards a human rights model of disability.

2.2.2 Rationale of the cultural context of disability

Munyi (2012:4) points out that a society reveals itself in the way it handles important phenomena. Disability is one such a phenomenon. Looking at disability from a cultural point of view starts with asking questions such as:

- What does disability mean in a certain society?
- How is the status of the person with a disability determined by the culture in which he/she lives?
- What are the most important issues when talking about disability in a certain society?

These questions are linked to the development of services for persons with disabilities in developing countries. Traditional beliefs have to be understood before implementing any kind of CBR. Understanding is the basis for dialogue between service providers and persons with disabilities in a local society. In such a dialogue people should be given a chance to discuss elements of their culture and reinterpret them. This understanding of culture, supplemented with skills of counselling and guidance, will give the service provider the ability to work with, and not necessarily against, culture.

One's disability and culture are central to determining the position or the status that the individual is given in a specific society. Eskay et al. (2012:475) noted that often if a person's disability conforms to social expectations the person is rewarded for that behaviour; culture tends to accept those who are willing to conform to given values, standards of behaviour, and ethical concerns. Culture imposes standards upon all citizens of that given culture. Disability has been defined by society and given meaning by culture, therefore there are various cultural perspectives of what disability is and how disability is perceived and treated in various cultures.

How we choose to define an issue shapes the responses we have to it. McConkey (2012:321-323) points out that disability is a contested term. Many authors see potential for the framework adopted by the International Classification of Functioning (ICF) (WHO, 2001) for viewing it as a continuous rather than dichotomous condition with intersecting personal, contextual and social factors contributing to the subjective as well as objective experiences of what is simplistically termed as “a disability”. Cultural influences create much unhappiness and isolation, not just for the person with the disability but also for the immediate family circle (Eide & Ingstad, 2011:231). This is a challenge as ill-informed beliefs about the causes of disability still remain in the folklore of modern technological societies and bringing about cultural evolution in perceptions of disability has to move beyond pages of academia and debates in conference halls to become a moral imperative for advocates and professionals, especially in multi-ethnic societies (MacLachlan & Swartz, 2009:280).

Pfeiffer, Sam, Guinan, Ratliffe, Robinson and Stodden (2003:132-149) point out that disability is a complex phenomenon as it involves people (both disabled and non-disabled) and their relationships, as well as the social and physical environment of the person with a disability. It involves assistive technology and social reaction to people with disabilities. A review of the literature shows that no one likes people with disabilities. Every major religion in the world (Ingstad, 2001:772-792; Braddock & Parish, 2001:11-68), every culture (Parmenter, 2001:267-296; Barton & Armstrong, 2001:693-710; Miles, 2000:603-618; Heyer, 2000a:105-133; Heyer, 2000b) with a few exceptions, every ethnic group (Van Ryn & Burke, 2000:813-828), every nationality (Crystal, Watanabe & Chen, 1999:91-111; Paterson & Jamieson, 1999:85-92), and each individual (it seems) views disability and people with disabilities in the most pejorative way possible.

Pfeiffer et al. (2003:132-149) note that disability is viewed as a tragedy, a disgrace, shameful, the result of sin, or a punishment from God. People with disabilities are repeatedly seen as objects of pity which produce guilty feelings in their family members and associates. They are frequently viewed as a burden to others, to their family, to themselves and to society. They are continually perceived to be useless and to behave in inappropriate ways. The answer is segregation and discrimination. If the person with a disability is a woman, it is even worse (Pfeiffer et al., 2003).

Groce (2000:2), in a review on the history of the “negative attitude” towards people with disabilities, concluded that “attitude towards persons with disabilities was not always negative and that historically it had been a mixture of tolerance interspersed with persecution.” These attitudes, however, influence the perception of the causation of disability, reaction towards people with disabilities, child rearing practices, education and vocational rehabilitation for persons with disabilities.

No culture is inherently fairer than any other when it comes to defining the place of people with disabilities (Coleridge, 2000:29). The author further states that the Christian ethic which inspired the Western notion of individual human rights also equates disability with sin, divine punishment and impurity. The notion of fairness and equality, and individual human rights may be very different in traditional societies, because their belief system gives prominence to such forces as fate and divine punishment which are beyond the reach of human intervention (Shuttleworth & Kasnitz, 2005:4). Thus the fact that some people have a disability may be regarded as the natural order of things, and attempts to redress the balance in terms of ‘equality’ may be seen as misguided. Both Western and traditional notions of equality have positive and negative features attached to them. Coleridge (2000:29) states that while Western industrialised societies may place fairness and equality at the top of their social agenda, a strong argument can be made for saying that what they actually espouse is uniformity and conformity. Either fit in or be excluded, hence pressure is placed on persons with disabilities to overcome their impairment and be like everyone else. In traditional societies the recognition and acceptance of intrinsic differences may actually lead to a more humane social life, while the passion for equality (or sameness) in the West brings repression and rejection.

Munyi (2012:2) sees societal perceptions and treatments of persons with disabilities from cross-cultural settings as a kaleidoscope of varying hues that reflect tolerance, hatred, love, fear, awe, reverence and revulsion. The most consistent feature in the treatment of persons with disabilities in most societies is the fact that they are categorised as “deviants” rather than “inmates” by society. From a cultural point of view, therefore, there are many specific circumstances that have influenced the living conditions of persons with disabilities, not to mention people’s attitudes towards them. History shows that ignorance, neglect, superstition and fear are social factors

that have exacerbated the isolation of persons with disabilities. Throughout Africa, persons with disabilities are seen as hopeless and helpless (Munyi, 2012:2). The African culture and beliefs have not made matters easier. Abosi and Ozoji, in Munyi (2012:2), found in their study that Nigerians in particular and of course Africans in general, attribute the causes of disability to witchcraft, sex-linked factors, and God/supernatural forces.

Though life with a disability is valuable, what makes it difficult is handicap. The priority, therefore, should be on the removal of the attitudinal, social, economic, educational, linguistic and cultural barriers and disadvantages our societies have created for disabled people (Brown, 2002:34-50). For too long these oppressive aspects have not been taken seriously, if not completely ignored. People with disabilities themselves as agents have taken the bold and historic initiative of changing the paradigm of disability from the “medical, charity and tragedy” to rights, culture and pride with the aim of creating a “society for all” (Brown, 2002:34-50).

The WHO (2011:9) identifies negative attitudes as one of the disabling barriers. Beliefs and prejudices constitute barriers to education, employment, health care and social participation. Some of these beliefs stem from culture, hence the importance of understanding the context in which people live in order to break the barriers.

In summary, the rationale to understanding the cultural context of disability is to ensure that the cultural construction of impairment and disability as a negative social response to impairment is understood and an open, diverse and embracing society where difference is valued and people are accepted for what they are regardless of their functional ability or appearance is promoted.

2.3 PREVALENCE OF PHYSICAL DISABILITIES

2.3.1 Questions around measurement of disability

Disability statistics in low-income countries has so far largely comprised impairment-based prevalence figures. Eide and Loeb (2005:iii) argue that prevalence in itself is of limited interest and that there is a need for data that can describe, analyse and

compare the situation among individuals with disabilities, as well as contribute to increased knowledge about the link between disability, poverty and cultural beliefs. They argue that in using the conceptual scheme inherent in the ICF (WHO, 2001), disability and health model, an alternative approach to disability statistics may be developed. As an alternative to dividing the population into persons with disabilities and persons without disabilities, activity limitation and restrictions in social participation can be measured as a continuous variable among all regardless of the presence of any impairment.

2.3.2 Disability: Global Figures

Mlenzana et al. (2013:1) state that 15% of the population globally presents with disabilities, with physical disability being the most prevalent. The numbers of people with a disability are increasing globally due to population growth, ageing, emergence of chronic diseases and medical advances that preserve and prolong life (WHO, 2011:8). About 80% of these live in low-income countries and of these, it is estimated that less than 5% have access to rehabilitation services (Pechak & Thompson, 2007:5). In certain developing countries nearly 20% of the general population has a disability in some way; if the impact on their families is taken into account, 50% of the population is affected (McAlpine, 2008:21). People with disabilities are among the world's most vulnerable and least empowered groups. All too often they experience stigma and discrimination with limited access to health care, education and livelihood opportunities. While they are entitled to the same rights as all other human beings, too often their lives are handicapped by physical and social barriers in society which hamper their full participation (WHO, 2010:11).

2.3.3 Disability: Namibian context

Namibia is a country in South-West Africa that achieved independence from South Africa in 1990. It has national level policies promoting community inclusion and inclusive education (Haihambo & Lightfoot, 2010:76). Despite these policies, people with disabilities are often excluded from schools and community life. The country has a small, diverse population of 2.4 million people, with roughly 67% living in rural areas, particularly in the northern part near the Angolan border. There are numerous

ethnic groups in Namibia, with approximately 50% belonging to the Ovambo group. Other ethnic groups include the Kavango (9%), Herero (7%), Damara (7%), Nama (5%) and the San Bushmen (3%). Namibia also has a sizeable population who identify as coloured and a population of people from German colonisers (Central Intelligence Agency, 2012). The vast majority of Namibians are Christians. The 2011 population and housing census revealed that approximately 5% of Namibians have a disability.

2.3.4 Classification of physical disabilities

Any impairment or disability which limits the physical function of one or more limbs and other facets of daily living is considered a physical disability. Examples include cerebral palsy, spinal bifida, amputation, spinal cord injury and dwarfism, although hearing and visual impairments may also be considered as physical disabilities (Ross & Deverell, 2010:15-16). A significant number of people with physical disabilities will require medical and rehabilitative services. These services can be in the form of physical therapy, orthopaedic and reconstructive surgery and orthopaedic workshops. The Physical Disability and rehabilitation Advisory Working Group (2007) noted the following 12 conditions as accounting for the majority of physical disabilities:

1. Cerebral Palsy
2. Neurologic and neuromuscular conditions
3. Osteomyelitis and septic arthritis
4. Clubfoot
5. Congenital limb deformity
6. Angular limb deformity
7. Burn contractures
8. Tuberculosis of the spine
9. Hydrocephalus and Spinal bifida
10. Cleft lip and palate
11. Developmental dislocation of the hip
12. Vesico-vaginal fistula

2.4 CURRENT DEBATES AND STUDIES ON CULTURAL BELIEFS AND PHYSICAL DISABILITIES

Over the years, perceptions and beliefs towards disability have varied significantly from one community to another. Limited literature in disability history however continues to pose a great challenge to students of disability studies in their endeavour to trace the development and formation of cultural beliefs towards persons with disabilities (Munyi, 2012:1). The concept of disability has been examined from various cultural perspectives across the continent of Africa and it has been found that in every culture disability was perceived differently and such perception shaped the kind of services rendered (Eskay et al., 2012:473-484). Monk and Wee (2008:94) posit that previous studies have examined the attitudes and beliefs of specific populations towards disability. They further add that many of these studies involved health workers and health care student populations while others included close relatives and other community members. Literature involving people with disabilities themselves is limited.

2.4.1 Social Construction of disability

Research of myths and beliefs about disability in sub-Saharan Africa has revealed varying myths about the causes and nature of disability, which relate to different understandings and meanings of disability (Haihambo, 2004; Munyi, 2012; Mpofu & Harley, 2002; Berinyuy, 2002, Brown, 2002:34-50; Monk & Wee, 2008). However, these beliefs about disability are not universal across Africa and there are various etiological beliefs regarding different categories of disability in Africa that vary from one cultural group to the next. This study will focus on one cultural group from Northern Namibia.

There has been an increased awareness about the social construction of disability, particularly as beliefs about disability are examined in a cross-cultural context. The whole notion underlying the social model of disability is that disability is a social construct that has been created by society (Pechak & Thompson, 2007:14). Under the social model, each society has its own way of understanding disability depending on their cultural beliefs. Cultural understandings of disability can influence the type of

services provided within a community, the likelihood that parents will seek out schooling or medical interventions for children with disabilities, and the degree of inclusion of people with disabilities (Haihambo & Lightfoot, 2010:77). In fact, cultural understandings of disability are so influential that Groce (2005:1-6) argues that people with disabilities are limited not so much by impairments or activity limitations, but more by the cultural interpretations of disability. Thus cultural beliefs must be understood if nations are to plan and implement policies that will make a difference for people with disabilities.

There is a growing body of research examining different understandings of disability, investigating how people from different cultures view the onset of disability, the nature of disability and appropriate interventions for disability (Gannotti, Handwerker, Groce & Cruz, 2001:1512-1523). Haihambo and Lightfoot (2010:77) argue that cultural beliefs about disability are related to their social beliefs about the causality of disability, the valued and devalued attributes of people within that culture, and the anticipated adult status of a person with disability. The authors give examples of some Asian countries that have cultural beliefs regarding reincarnation where disability is seen as temporary as well as a condition caused by events in a previous life. Similarly, in Turkey, mothers' understanding of disability was found to be greatly tied to the mother's religious beliefs (Diken, 2006:8-17). Thus, as cultures differ in regards to people's social beliefs, cultures will also have differing views of disability, hence the need to carry out this study in a community rehabilitation scheme of people from one cultural group.

In Namibia, like in any part of Africa, cultural reasons are often used successfully as convenient tools to deny rights to people with disabilities. On several occasions people use culture to justify wanton discrimination against people with disabilities. Each tribe or clan has its natural cultural norms or agreed policy on people with disabilities within the family or community (Khupe, 2010:1). But the ultimate result of that norm is to confine a person with a disability to a sub-human status. The author further points out that in some parts of Africa, Namibia included, people with physical disabilities (generally referred to as a crippled) are universally treated as if they are domestic animals such as a cat or a dog. People with a disability are specifically ostracised and segregated. For instance within some families in Africa, once a plate

or cup has been used by a person with a disability it becomes ritually unclean beyond redemption so that no other normal human being can use it. Such a utensil is only used to put out food for cats or dogs (Khupe, 2010:1).

Although attitudes towards people with a disability across Africa are starting to change, people with disabilities still face many challenges, from the additional costs for the healthcare services they need, where these even exist, to the stigma and discrimination they face (Dube, 2011:2). It is frequently assumed that because someone is disabled they will be a financial and social burden to their family, rather than someone to be proud of or someone that can, with some support, be an incredibly productive member of society.

In African traditional context, people with disabilities are generally associated with everything which is negative and evil. In many parts of Zimbabwe, it is believed by many people that the best witch doctors (wizards) or traditional black magicians with the most dangerous traditional medicine must be someone with a form of visible and queer disability (Khupe, 2010:1). The author further adds that such a person would be expected to be someone who has at least one or more of the following features: very ugly; black in complexion; less than five toes per foot; always dirty; walking with the aid of a dirty, decorated working stick; illiterate; deformed eyes; or unable to speak, stand or sit properly. Such myths about people with a disability have not been easy to remove from people's minds, particularly from followers of African Traditional Religion (ATR). According to traditional myths, people with disabilities are the natural hosts of bad spirits. As such, bad luck or incurable diseases must be deposited in the "disabled" via different forms of (often strange) rituals. One of the most common rituals involves having "extra ordinary sex with a disabled" (Khupe, 2010:2).

There are varied views among scholars on how cultural beliefs regarding physical disabilities are seen in Africa. For example, Mangaliso (2005:107) postulated that Africans in general believe that in spite of deviance, differences and abnormalities, their "humanness" still exists and hence all individuals are an integral part of the social being. According to the author, the Botho/Ubuntu concept as a cultural value places humans at the centre of the universe, without making them superior to all things. The Botho/Ubuntu concept is underpinned by collective existence and

experience, which translates to communalism. However, Abosi (2007:198) argues that an average African sees disabilities as a punishment for what one has done wrong. While the Botho/Ubuntu concept guides many if not all Africans, it can be argued that it is not wholly embraced, especially when one considers the struggles of people with disabilities for the equalisation of opportunities in education and employment, inclusion in all facets of life, as well as their fight against stigma and discrimination. The rise of the advocates of the social model of disability movement tends to lean towards agreement with Abosi that many people see disability as a punishment or a curse.

Social workers can harness the Botho/Ubuntu concept as it is in line with the principles of social work, namely acceptance, individuality and self-determination (IFSW, IASSW & ICSW, 2012). This can be done by educating communities on the values of Botho/Ubuntu, namely respect for human dignity, communalism and selflessness. These values do not discriminate and accept human differences and hence can help the cause of equality for people with disabilities.

In a study done in Turkey to understand how Turkish mothers found meaning in the disability of their children, Diken (2006:8) found that both traditional and modern (bio-medical) beliefs were held by most of the mothers on the causation of disability. The mothers identified traditional beliefs, especially the religious ones, as the most popular causal agents. The mothers who held strong traditional beliefs regarding the causation of the disability of their children held strong traditional treatment beliefs and valued more traditional treatment practices over bio-medical ones. This is important for social workers and other health professionals working with people with disabilities to understand and respect their belief systems and plan accordingly.

McConkey (2012:321-323) points out that how we choose to define an issue shapes our responses to it. He further notes that “the uniqueness of the disability perspective is that it has to do with poverty within poverty”. Cultural influences create much unhappiness and isolation, not for the person with disability alone, but also for the immediate family circle. Ill-informed beliefs remain in the folklore of modern societies. Bringing about cultural evolution in perceptions of disability has to become a moral

imperative for advocates and professionals, hence the need for this study to examine beliefs regarding disability.

Culture (including religion) is what gives meaning to people's lives, so to challenge it is to challenge their meaning system (Coleridge, 2000:22). On the other hand, where it is repressive it has to be challenged. Changing attitudes towards disability, because it is generally non-threatening, can be the starting point for leading people to adopt an inquisitive and questioning attitude towards their culture generally. The ultimate dilemma in development is how to stimulate change without undermining people's own sense of identity. Thus only people from within the culture (Coleridge, 2000:30) can attempt the task. Disability is defined by culture; what is regarded as a "disability" (that is, that which prevents someone from fulfilling the roles normally expected of him or her, especially regarding marriage) differs from one culture to another. Coleridge (2000:30) cites an example from the Tuareg people in Mali where freckles and small buttocks are counted as a serious impediment to marriage and could therefore be considered a disability. Thus, the way societies think about people with disabilities is determined by a variety of cultural variables, including the nature of the impairment. It is therefore essential for planners of community disability programmes to know and understand how physical disabilities are viewed in the target community in order to plan effective interventions. The study aims to explore cultural beliefs, especially since many programmes place changing attitudes among their main objectives.

The increasing awareness of the importance of understanding traditional beliefs and practices regarding disability call for increased knowledge about these beliefs (Haihambo & Lightfoot, 2010:78). This is necessary not only for increasing cultural understanding, but also for developing appropriate programmes and support. ELCIN Rehabilitation Centre is an interesting case study for examining cultural beliefs, as it is run by the Lutheran Church and is close to a district hospital, yet is also deep in the rural culturally conservative hub of the Oshiwambo people, the biggest ethnic group in Namibia. This study aims to gain an understanding of causes and treatment beliefs related to disability in Northern Namibia.

Disability must be considered within the context of the country's culture or the individual's sub-culture. This is so because culture will influence how people with disabilities are treated by families and society and how the person with disability perceives his/her situation (Pechak & Thompson, 2007:10).

2.4.2 Culture and Rehabilitation

The World Report on Disability states that people with disabilities have less access to health services than non-disabled people. While research shows that people with disabilities' need for inpatient and outpatient care is greater than their non-disabled counterparts, it is sad to note that in fact they are not receiving such services (WHO, 2011:9). Generally, the Social Determinants of Health (SDH) research clearly shows those who are poor, or who are most socially excluded and marginalised, find it harder to access appropriate and affordable health care services compared to those who are more affluent and socially integrated and, on average, live shorter lives and have higher levels of morbidity and mortality (Lang, 2013:6). The author further argues that there is a "social gradient" with regard to health inequalities as a result of the unequal power distribution in communities. Social and economic inequalities, including factors such as income, occupational category, socio-economic status, geographical location, level of education, and social capital result in health inequalities.

Rehabilitation research has traditionally been dominated by biomedicine and focused primarily on the clinical aspects and medical adherence. More recently, social science studies have emerged that focus on knowledge, beliefs, representations and experiences of people with disabilities. Late presentations at medical rehabilitation centres, healer shopping (between biomedicine, ethno medicine and faith healing), and poor self-care have been attributed to poor medical knowledge (De-Graft Aikins, Boynton & Atanga, 2010:5). According to the above authors, healer shopping within ethno medical systems is common and is implicated in avoidable complications and deaths. A dominant argument made in literature is that most chronic diseases which cause physical disabilities are attributed to spiritual/cultural causes and that these spiritual causal theories inform lay engagement with traditional healing systems.

A dominant argument made in literature is that chronic diseases are attributed to spiritual causes and that these spiritual causal theories inform lay engagement with traditional healing systems. However, a growing body of work in most African countries suggests that chronic illness beliefs are rooted in complex socio-cultural knowledge systems. De-Graft Aikins et al. (2010:5) identify the five sources from which rural and urban individuals draw knowledge on general health, pluralistic health systems, illness, chronic and rehabilitation as: social (family and friends), cultural (traditional handed-down knowledge), cross-cultural (through regional and international travel), institutions (pluralistic health professionals, mass media) and self (unique experiences of self in health and disease). These eclectic sources of knowledge inform multiple theories on help sought which encompass rehabilitation, witchcraft, or malevolent social actions. In the authors' study in Ghana the link between causal attributions to disability and health care choices was complex. This is so because firstly, concepts of illness chronicity and incurability differ within cultures and, secondly, concepts of medical pluralism are complex. Most people engage in four kinds of disability practices: biomedical management, spiritual action, cure-seeking and medical inaction. These forms of disability action highlight the complex and unpredictable relationship between knowledge, beliefs and health seeking behaviours

Pechak and Thompson (2007:12) point out that the impact of culture in the rehabilitation process should not be underestimated. A process of cultural competence must be incorporated into the design and implementation of rehabilitation services. The authors define cultural competence as a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations. For example, in some Asian countries that have cultural beliefs regarding reincarnation disability can be seen as both a temporary condition related to this particular incarnation, as well as a condition caused by events in a previous life (Haihambo & Lightfoot, 2010:77). Thus if an individual believes that he/she must suffer in this life for indiscretions in a past life, he/she may not see the need for rehabilitation. Thus social workers may need to find effective ways to approach rehabilitation.

In order for more positive outcomes to be achieved, rehabilitation depends primarily on the quality of the interactions between professionals working with people with disabilities and their families (Diken, 2006:8). A good understanding of families' socio-cultural background plays a crucial role in establishing positive interactions. The author further says that among families' socio-cultural background/characteristics, families and people with disabilities' beliefs or understanding of the disability seem to be the most important factor that directly influences their interactions with professionals and decisions regarding services to be provided. Thus without the knowledge of the socio-cultural background, social workers may not be able to have any meaningful dialogue and be change agents in the promotion of the rights of people with disabilities. The social model of disability advocates for forming alliances between disabled and non-disabled people in tackling structural barriers and developing a shared agenda for change resulting in a "win-win" situation (Tregaskis, 2004:65-82).

Some cultures do not value individual independence; rather the role of the individual in the family is of utmost importance. In this case instead of reaching functional independence, the rehabilitation team has to set goals with the client and family that reflect the client's value system through family-oriented culture (Pechak & Thompson, 2007:14). It can thus be noted that in order for the rehabilitation process to be both acceptable and successful, there is need to understand the culture in which the client lives.

Rehabilitation concepts and procedures must not be drawn only from developments in the western countries, neglecting the beliefs, practices and attitudes of the local culture. The notion that cultural beliefs are only barriers to development is changing. Traditional beliefs "have to be understood before implementing any kind of community based rehabilitation" (Coleridge, 2000:30). There are two important reasons for considering culture in CBR programmes. The first is that all development activities take place within a cultural context (Coleridge, 2000:22). Some development planners tend to regard culture, especially in conservative societies, as an impediment to development, but any development interventions which do not engage at a significant and not just a superficial level with the local cultural context are bound to be short-lived. What is true for development generally is even truer of

community level disability programmes, because disability is defined by culture and without an awareness of how disability is perceived in the target culture a disability programme does not stand a chance of being relevant or sustainable.

The second reason is that in poor communities, where disabled people are not seen as a priority for development, nor included in most mainstream development programmes, an awareness of cultural issues surrounding disability is a key part of the process of integrating disability into general development activities. Thus development activities which ignore culture as the sum total of people's political, economic, social and spiritual aspirations will inevitably lead to alienation, exclusion, and a loss of identity, as well as loss of a sense of community (Coleridge, 2000:26).

The role of CBR is to work with all relevant stakeholders to ensure the full participation of people with disabilities in the social life of their families and communities (WHO, 2010:1). CBR programmes can provide support and assistance to people with disabilities to enable them to access social opportunities and can challenge stigma and discrimination to bring about positive social change. Community attitudes are particularly important because active community involvement is essential for the success and sustainability of a CBR programme (Monk & Wee, 2008:94). The community should be involved in all steps of the process, including programme planning, implementation and evaluation.

2.4.3 Biomedical versus bio-psychosocial approach

In the 1980s the WHO defined impairment from a biomedical understanding which did not take into account the social circumstances (Shuttleworth & Kasnitz, 2005:1). The WHO defined impairment as any loss or abnormality of mental, physiological, or anatomical structure or function. In this bio-medical understanding, impairment is viewed as separable from social circumstances and implies diminishment or limitation of an individual's neuromusculoskeletal capacity or functional ability measured against normative standard. The revision of the international classification of impairments, disabilities and handicaps to the international classification of functioning, disability and health presented a more holistic bio-psychosocial approach in 2001. Yet its definition of impairment remains similar to the spirit of the

biomedical understanding and its own earlier definition. Impairment remains both the underlying pathology and its manifestation as problems or deviations in cognitive, physiological or anatomical function. Deviation of norms, however, inherently refers to an evaluative system. “[N]orms, whether in some implicit or explicit form refer, to the real values, express discriminations of qualities in conformity with the polar opposition of a positive and a negative” (Shuttleworth & Kasnitz, 2005:2). The understanding of function in this evaluative way is not only the product of biomedicine, hence the need to explore the views of the physically disabled in this study. Cultures can have both positive and negative views of disability (Haihambo & Lightfoot, 2010:77). Groce (2005:1-6) asserts that cultures that hold positive views regarding disabilities are likely to display more positive attitudes towards universal principles to disability than those that hold negative views regarding disability. The author also warns that cross-cultural issues in the disability arena, as well as socially constructed concepts and beliefs about disability are constantly changing. Thus there is need to carry out a study to examine current trends in cultural beliefs.

Proponents of the social model of disability, such as Lightfoot (2004:455-456), reject the medical model as it does not consider the cultural differences of people with disabilities. The social model which emphasises the role of social factors, such as societal attitude, services and support rendered, challenges the clinical diagnosis of physical functioning which is based on some set standards and criteria without considering social circumstances. Thus, for this reason some institutions like the American Psychological Association propose a more developmental approach to classifying disabilities according to the intensity of personal support that an individual requires to attain quality of life (Lightfoot, 2004:455-456). This approach is developmental in that it de-emphasises impairment which medicalises disability and rather focuses on the level of societal support required by people with disabilities to obtain better quality of life.

2.4.4 The role of social work in working with people with physical disabilities

The United Nations Convention on the Rights of Persons with Disabilities recognises integration of disabled persons as a pertinent objective, particularly in developing countries where services for persons with disabilities are limited (UN Enable,

2009:16). The ICF model of disability describes the external factors that influence an individual's ability to participate in society as environmental factors. These include the individual and societal aspects of physical, social and attitudinal environments in a person's life (Monk & Wee, 2008:94). Identifying current attitudes and beliefs is a first step towards establishing an approach to promote the rights of people with disabilities through supportive environments. Full participation in the basic units of society, family, social groups and community is the essence of the human experience. The right to equality of opportunity for such participation is set forth in the Universal Declaration of Human Rights and should apply to all people, including those with disabilities (UN Enable, 2009). In reality, however, persons with disabilities are often denied the opportunities of full participation in the activities of the socio-cultural system of which they are a part. This deprivation comes about through physical and social barriers that have evolved from ignorance, indifference and fear.

Attitudes and behaviour often lead to the exclusion of people with disabilities from social and cultural life. People tend to avoid contact and personal relationships with those who are living with a disability. The pervasiveness of the prejudice and discrimination affecting persons with disabilities and the degree to which they are excluded from normal social intercourse produce psychological and social problems for many of them. Bayat (2014:3) postulates two notions that cause resentment towards people with physical disabilities. Firstly, the Western Judeo-Christians perceive creation as being "perfect" or "normal" and thus any deviation from normalcy is seen as evil or the result of sin. Secondly, African indigenous religions explain the world in context of interaction between various natural spirits: sky, water, forest, earth and ancestral. Problems and disharmony in life often means two or more spirits are in conflict. Illness or affliction is considered to occur as a result of the displeasure of one of the natural or ancestral spirits or as a result of possession of an evil spirit. Too often the professional and other service personnel with whom persons with disabilities come into contact with fail to appreciate the potential for participation by people with a disability in normal social experiences and thus they do not contribute to the integration of people with disabilities and other social groups.

Because of these barriers, it is often difficult or impossible for disabled persons to have close and intimate relationships with others. Marriage and parenthood are often unattainable for people who are identified as “disabled”, even when there is no functional limitation to preclude them. In some instances there could be unstable marriages and, in extreme cases, divorce due to accusations of evil spirits (Harper, Dyches, Harper, Roper & South, 2013:2). In patriarchal societies, as is the case in Namibia, women are usually blamed and are at the receiving end.

Many people with physical disabilities are not only excluded from the social life of their communities, but are in fact confined to institutions. Far too many people today are institutionalised when there is nothing in their condition to justify it. Bayat (2014:5) noted during his fieldwork that the conditions in institutions were suboptimal and that people with disabilities were ignored, not stimulated, and not being treated with any noticeable degree of humanity and respect.

Many persons with physical disabilities are excluded from active participation in society because of doorways that are too narrow for wheelchairs; steps that cannot be mounted leading to buildings, buses, trains and aircraft; telephones and light switches that cannot be reached; and sanitary facilities that cannot be used. Such barriers are the result of ignorance and lack of concern; they exist despite the fact that most of them could be avoided at no great cost by careful planning. The negative attitudes and cultural negativities towards people with physical disabilities go beyond just stigma and discrimination; they impede the general socio-economic development of communities through inhibiting social capital. Social capital incorporates key aspects of social organisation such as trust, norms and network and how access to and use of such resources benefit the individual’s actions (Turner & Nguyen, 2005:1694).

The rights of persons with disabilities to participate in their societies can be achieved primarily through political and social action. Social workers are better placed to advocate for steps to be taken to eliminate or reduce barriers to full participation and to advocate for the integration of persons with disabilities in the mainstream society.

Furthermore, social workers should demystify myths and misconceptions about disabilities by educating communities on the rights of people with disabilities as stipulated in the Convention on the Rights of Persons with Disabilities. These rights stipulate that persons with disabilities deserve to be respected as individuals with inherent dignity and worth, and that they should not be discriminated against on the basis of their impairments but deserve equal opportunities.

The core values of social work which include service, social justice, dignity and worth of persons, importance of human relationships, integrity and competence (IFSW, IASSW & ICSW, 2012) place social workers at a unique position to champion the rights of persons with disabilities just as they do with other vulnerable groups.

The social model of disability which is a result of activism and scholarship is integral to shifting perceptions regarding disability. Disability is now regarded in policy circles as not simply a medical issue, but also a human rights concern. A major catalyst for this development has been the social model's emphasis on the material and structural causes of disabled people's disadvantage (Barnes, 2012:21). Thus social workers can promote the inclusion of persons with disabilities in families, communities and indeed the whole society using the social model approach.

2.5 DISABLING BARRIERS FOR PEOPLE WITH PHYSICAL DISABILITIES

In the world report on disability, the WHO (2011:9) highlights the role of the environment in facilitating or restricting participation for people with disabilities. Negative attitude is one such barrier. Beliefs and prejudices constitute barriers to education, employment, health care and social participation. The attitudes of teachers, administrators, community members and even family members affect the inclusion of people with disabilities in mainstream life. There are misconceptions by some employers that people with disabilities are less productive than their non-disabled counterparts, and ignorance about available adjustments to work arrangements result in limited employment opportunities.

People with disabilities sometimes have difficulty doing things that other people may take for granted, such as travelling on public transport, climbing stairs or even using

some household appliances (Gobalakrishnan, 2013:489). However the greatest challenge has been society's misperception that they are a "breed apart" who need to be pitied, ignored, vilified and even hidden away in institutions (Gobalakrishnan, 2013:489). While people with disabilities have some abilities, needs and interests just as the rest of the population, it is unfortunate that discrimination continues to exist in certain important areas. Some employers are reluctant to take on or promote people with disabilities. Due to some cultural beliefs some landlords refuse to give land to them, as people with disabilities are considered the same as minors and also traditional courts deprive them of their basic rights, including custody of their children.

The people with physical disabilities face problems as they attempt to adjust to the demands of living in a social environment. Their problems are not only those caused by their disability, but also by adjustment to a world that has apathetic or hostile attitudes towards them, magnifying their troubles and threatening their very existence as human beings (Eide & Ingstad, 2013:1). They face psychological, educational, employment and social problems. Among these the most difficult is the adjustment to the hostile social forces in society that persons with disabilities suffer because of erroneous beliefs, which make them feel hopeless in their day-to-day way of life (Gobalakrishnan, 2013:490). It automatically generates a social resistance to accepting means of treating or ameliorating disability.

Cultural values and meanings represent established patterns for understanding and reacting to a phenomenon. We can identify established and culturally rooted discriminatory practices that affect individuals with disabilities and their families, for instance, gender imbalance as described by Ingstad, Baider and Grut (2011:3) in their study in Yemen. Segregation between men and women and male dominance play an important role in making girls and women with an impairment more disadvantaged than boys or men (Ingstad et al., 2011:148). More than anyone else, girls and women with disabilities living in low socio-economic status are bound by traditional family patterns and will easily be left isolated, uneducated and unmarried. Paradoxically, as they may face exclusion from the dominant and desired female role this also creates opportunities for a few girls and women who, due to a supportive family or other circumstances, may be able to get an education and live an active life

because the traditional barriers set up by entering into married life do not apply to them.

Oliver (2009), amongst others, speaks about the “disablist” attitude, which he describes as particularly disempowering. Due to negative cultural beliefs, people with disabilities cannot fully demonstrate their “ableism” in order to be recognised. Marsay (2014:8) argues that people may not be able to demonstrate their “ableism” if they struggle with self-esteem and are not encouraged and recognised to reach their potential. All people entering the world of work benefit from having self-knowledge and being able to identify their natural talents, accept their limitations, and acquire market related skills (Marsay, 2014:8). Many people who have disabilities can be competent members of the workforce if they are enabled to identify and develop their unique talent. Assisting people to establish positive self-regard, to see their intrinsic self-worth, and to know their strength and limitations is a priority. Wehmeyer and Little (2013:119) explain that people who are able to use accurate knowledge of themselves value themselves and those who know their strengths and weaknesses are able to capitalise on their knowledge despite the barriers imposed on them by culture.

Eide and Ingstad (2013) state that women with disabilities are worse off than men. Wehmeyer and Little (2013:125) describe findings of research studies which indicate that males show a higher degree of self-determination than females in many cultures and societies. Thus gender inequality may exacerbate the outcomes for people with disabilities, especially women, but all this is grounded on culture. Cultural patterns are not static, however, and not even homogeneous in a society, and are influenced by collective understanding and practices and by structural and social factors (Eide & Ingstad, 2013:4). Whilst poverty is largely the result of structural and often global forces, a situation of permanent poverty will affect social relations as well as attitudes and, over time, cultural beliefs and thus also how individuals with disabilities are treated. As described by Grut, Olenja and Ingstad (2011), discrimination against people with disabilities may easily be seen as a negative cultural practice, whilst another explanation may be that it is a forced reaction to poverty, largely a mechanism of survival or absence of options.

The WHO (2011:9) documents additional barriers as inadequate policies and standards, lack of provision of services, problems in service delivery, inadequate funding, lack of accessibility, lack of consultation and involvement, and lack of data and evidence. However, negative attitudes rooted in cultural beliefs regarding physical disability perpetuate discriminatory practices.

2.6 POLICY AND LEGISLATIVE FRAMEWORK FOR PEOPLE WITH PHYSICAL DISABILITIES

2.6.1 Disability strategies and plans of action

Strategies that set out a consolidated and comprehensive long-term vision for improving the well-being of persons with disabilities have continued to be sought. These strategies cover both mainstream policy and programme areas and specific services for persons with disabilities (WHO, 2011:18). The development, implementation, and monitoring of these strategies bring together a range of sectors and stakeholders. Policies and the legislative framework operationalise strategies by laying out concrete actions and timelines for implementation, targets, assigning responsible agencies, planning, and allocating needed resources. The development of policies has been influenced by the social model of disability. The model insists that in formulating and implementing policies, laws and services, people with disabilities should be consulted and be actively involved. The social model rejects the individual model which views disability as a personal tragedy and asserts that disability is an “externally imposed restriction” (Oliver, 2004a:18-31). While in the past the individual, medicalised model which views people with disabilities as “having something wrong with them” dominated disability policy and services provision, the social model has provided the necessary radical change in direction with an emphasis on addressing barriers and inequalities (WHO, 2011:12).

2.6.2 International Legal Framework

A major outcome of the International Year of Persons with Disabilities was the formulation of the World Programme of Action concerning Persons with Disabilities, adopted by the General Assembly on 3 December 1982, by resolution 37/521

(McAlpine, 2008:15). The World Programme of Action (WPA) is a global strategy to enhance disability prevention, rehabilitation and equalisation of opportunities, which pertains to full participation of persons with disabilities in social life and national development. The WPA also emphasises the need to approach disability from a human rights perspective. Equalisation of opportunities is a central theme of the WPA and its guiding philosophy for the achievement of full participation of persons with disabilities in all aspects of social and economic life. An important principle underlying this theme is that issues concerning persons with disabilities should not be treated in isolation, but within the context of normal community services (McAlpine, 2008:15).

This movement culminated the Convention on the Rights of Persons with Disabilities which was adopted in December 2006. The Convention does not create new rights; rather it specifies measures to ensure that people with a disability can equally access all of the fundamental rights already stated in previous international conventions. States that signed and ratified the Convention are obliged to implement these measures at a national level. This places member states under a legal obligation to promote and protect the rights of persons with disabilities. The Convention moves beyond the question of access to services, to broader issues of equality and elimination of legal and social barriers to participation, social opportunities, health, education, employment and personal development (Lightfoot, 2004:69). Thus, it can be noted that implementation of the Convention will only be effective if disability issues are mainstreamed in all development programmes.

The drafters of the Convention were clear that disability should be seen as the result of the interaction between a person and his or her environment. Disability is not something that resides in the individual as the result of some impairment. Disability resides in the society and not in the person. Thus as a result:

- A person in a wheelchair might have difficulties being gainfully employed not because of her/his condition, but because there are environmental barriers such as inaccessible buses or staircases in the workplace which obstruct her/his access.

- In a society where corrective lenses are available for someone with extreme myopia (near sightedness), this person would not be considered to have a disability. However, someone with the same condition in a society where corrective lenses were not available would be considered to have a disability, especially if the level of vision prevented the person from performing tasks expected of this person, such as shepherding, sewing, or farming (McAlpine, 2008:16).

The Convention recognises that disability is an evolving concept and that legislation may adapt to reflect positive changes within society. It marks a paradigm shift in attitudes and approaches to persons with disabilities. It takes the movement to a new height, from viewing persons with disabilities as “objects” of charity, medical treatment and social protection, to viewing persons with disabilities as “subjects” with rights, who are capable of claiming those rights and making decisions for their lives based on their free and informed consent, as well as being active members of society. There is a symbiotic relationship between the social model of disability and the Convention in as far as empowerment and self-determination of people with disabilities is concerned. Social workers can help foster these goals since they are at the heart of social work practice (Ife, 2001:53). In addition, social workers can also document and expose barriers to participation, lobbying decision makers, challenging institutions and creating alliances for the implementation of the Convention on the Rights of Persons with Disabilities.

The Convention is intended as a human rights instrument with an explicit social development dimension. It adopts a broad categorisation of persons with disabilities and reaffirms that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms (McAlpine, 2008:16). The social model of disability resonates with the principles of the Convention, as well as the practice of social work. The social development dimension expressed in the Convention constitutes developmental social work which invokes concepts of self-determination, participation, rights-based approach and empowerment meant to create a just society (Midgley & Conley, 2010:13). A just society is viewed as one in which there is commitment to equal rights and to an equitable distribution of wealth and power among citizens (Banerjee, 2005:10). Thus the primary responsibility of social

workers is to enhance people's well-being by helping them meet their developmental needs.

2.6.3 Regional and Continental Initiatives

The African Union (AU) developed a Plan of Action for Persons with Disabilities. Among other things, the plan recognises the need to integrate people with disabilities into society, and to empower and involve them in the formulation and implementation of social and economic development policies (Kwenda, 2010:4). It urges governments to allocate sufficient funds to ministries and departments dealing with people with disabilities and to establish national committees to coordinate all disability issues and include people with disabilities in their national programmes.

The plan proclaimed 1999 to 2009 the African Decade of Persons with Disabilities by the Continental body has seen activists clamouring for its extension, to match the timeline of the international community's Millennium Development Goals (MDGs), the world's blue print for reducing poverty and making other improvements in people's well-being by 2015. Across Africa many governments cite financial constraints as an impediment to promoting the rights of people with disabilities. But there have been some successes and improvements, including in Burkina Faso, Senegal and Togo. Namibia also falls in this category, as it has developed a policy on disability and offers disability grants as a way of uplifting the lives of people with disabilities. Ghana is a shining example. In 2006 Ghana's parliament passed the National Disability Act, intended to ensure that people living with disabilities enjoy the same rights as the able-bodied. The authorities disseminated the Disability Act more widely, including launching the Act's electronic version in 2009 in English and local languages. Most recently, the Government decided to incorporate disability issues into the country's national budget (Kwenda, 2010:5).

In a number of countries in Africa, there are NGOs that advocate for the welfare of people with disabilities, some focusing on those with specific needs, such as the blind, deaf, paralysed or mentally ill. Most groups challenge governments to implement policies for the rights of persons with disabilities. They want disability to be mainstreamed in all spheres of life.

While there are some bright spots, political will is sorely needed in most African countries, despite the existence of an international convention, the proclamation of an annual International Day of Persons with Disabilities (3 December) and other programmes. People with disabilities still face discrimination and receive little support across much of Africa.

2.6.4 National Legal Framework

Namibia, being a signatory to the Declaration on the Rights of People with Disabilities (1975), Convention on the Rights of the Child (1989), the Standard Rules on the Equalisation of Opportunities for Persons with Disabilities (1993), and the Convention on the Rights of People with Disabilities, has also domesticated these statutes into its national laws and policies.

2.6.4.1 National Constitution

The constitution of Namibia clearly outlines the fundamental human rights and freedoms due to all Namibian citizens. Article 10 on Equality and Freedom from Discrimination states that, “all persons shall be equal before the law” and that “no person may be discriminated against on the grounds of sex, race, colour, ethnic origin, creed or social or economic status” (Constitution of the Republic of Namibia, 1990). The vision for the national disability policy also states that nation building towards a “society for all” where all citizens can participate in a single economy can only take place if persons with disabilities are included in the development process. Thus while disability is not explicitly mentioned in the Constitution, the protection against discrimination guarantees the protection of people with disabilities.

By supporting non-discrimination, the constitution of Namibia views disability as a human rights and development issue. This is in contrast to the welfare model which created disempowered disabled people, and isolated and marginalised them from the mainstream society. The human rights and development approach has a better chance of creating equal opportunities, as the various systems of society and the environment are made available and accessible to all citizens.

Critics have argued that there is a need to specifically mention people with disabilities in national programmes. Dube (2011:1) and Antonio (2013:1) state that people with disabilities are central to any discussions on development. They cite the failure to attain the MDGs as a consequence of that. Dube (2011:2) further adds that while attitudes can be broken down, there is need for an approach that starts from the top so that at every level it is reinforced that with some assistance, people with disabilities can be active contributors to the community. Thus the post-2015 developments need to ensure that people with disabilities are not left out.

2.6.4.2 National Policy on Disability

The Government of Namibia came up with the National Policy on Disability in 1997 with a standpoint of addressing issues of disability as a human rights and development issue (Haihambo & Lightfoot, 2010:77). The vision of the policy states that the ultimate goal in development is an inclusive “society for all” which recognises and values individual differences and acknowledges common humanity and equality. The policy noted that the low level of understanding of disability issues, and the exclusion of persons with disabilities from the development process, necessitated the need to develop programmes focusing specifically on disability. The policy also states that the social model is more relevant in its implementation, as programmes would help to raise awareness, change attitudes, promote equal opportunities and find creative and practical means of adapting society to meet the needs of all its citizens, including those with disabilities. The policy boldly states that people with disabilities are a “natural and integral part of society” and in the interest of society as a whole, should have equal opportunities to contribute their experience, talents and capabilities to national development (Republic of Namibia, 1997:2).

Despite a well-meaning policy, marginalisation of people with disabilities continues to impede development (Antonio, 2013:1). A 2004 report by Save the Children Fund of Norway indicated that 87% of children needing special care in Zimbabwe are being sexually abused while more than half of them were HIV positive (Antonio, 2013:1). This can hardly be a society for all. The WHO (2011:8) reported that persons with disabilities are most at risk of neglect, exploitation and sexual abuse. People with disabilities often experience multiple deprivations, limiting their opportunities and marginalising them even further (Antonio, 2013:2). This is also true of Namibia,

where people with disabilities are often hidden behind closed doors or shut away in institutions and forgotten. Social workers can help to raise awareness and promote equal opportunities in communities.

The Disability Policy's mission is to improve quality of life through enhancing the dignity, well-being and empowerment of persons with disabilities. This is done by enabling them to achieve the essentials of life (equality, full participation, independence and self-determination through recognition of rights, prevention of causes, rehabilitation support, and universal accessibility). This is in order to achieve a full social integration of people with disabilities in society. The policy notes special target groups such as women with disabilities, children with disabilities, elderly with disabilities, and disabled people living in rural areas. Key areas for achieving a society for all are identified as: raising awareness; prevention; early intervention and health education; treatment; therapeutic aids and orthopaedic technical services; environmental accessibility; access to information, education, vocational guidance and training; family life and personal integrity; international cooperation; and the right of organisations and persons with disabilities to represent them at all levels (Republic of Namibia, 1997:4-7).

The policy also provides for a National Disability Council whose purpose includes monitoring the implementation of the National Disability Policy, advising people responsible for the enforcement of existing legislation which provides for equal opportunities for all people, and consulting with organisations representing people with disabilities regarding the implementation of the policy.

Through the National Policy on Disability (Republic of Namibia, 1997), the Government of Namibia considers disability as a human rights and development issue. In so doing, it was believed that this approach would enable the various sectors of the state to be made accessible to persons with disabilities and create equal opportunities. However, while this and other international policies ratified by the Government of Namibia are inclusive and progressive, research has reported that a "society for all" and the concept of inclusivity have been implemented at a slow pace (Zimba, Haihambo & February, 2004:3). Given the policy framework and political will, one is tempted to look elsewhere for a justification of the slow pace

regarding equal opportunities for persons with disabilities. Cultural beliefs about disabilities are one aspect for consideration in the slow implementation of these policies, hence the intention of this study to explore these cultural beliefs.

2.7 THE SOCIAL MODEL OF DISABILITY

People with physical disabilities have been represented in many ways by Western society over the years – as holy, special, and unfortunately also in many less respectful ways. Several models have characterised the history of disability: the religious model, the personal tragedy model, the medical/genetic model, and more recently the social/human-rights model (Barnes, 2012:1-2). These models or constructions of disability have had a powerful influence on setting the parameters for how people with physical disabilities are treated by society.

The social model of disability has been called “the big idea” of the disability movement (Shakespeare & Watson, 2002:3). Developed in the 1970s by activists in the Union of the Physically Impaired Against Segregation (UPIAS), it was given academic credibility via the work of Vic Finkelstein (1980, 1981), Colin Barnes (1991) and particularly Mike Oliver (1990, 1996). The social model has now become the ideological litmus test of disability politics, used by the people with disabilities’ movement to distinguish between organisations, policies, laws and ideas which are progressive and those which are inadequate (Shakespeare & Watson, 2002:3).

The starting point of the social model was the publication of *The Fundamental Principles of Disability* by the UPIAS in 1976. It stated that:

- “In our view it is society which disables people with physical disabilities. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded in society” (UPIAS, 1976:14).

This turned the understanding of disability completely on its head by arguing that it was not impairment that was the main cause of the social exclusion of people with disabilities, but the way society responded to people with impairments (Oliver, 2004b:19).

The proponents of the social model argue that it is massively important in two ways. Firstly it enables the identification of a political strategy, namely barrier removal. If people with impairments are disabled by society, then the priority is to dismantle these disabling barriers in order to promote the inclusion of people with impairments (Shakespeare & Watson, 2002:5). Rather than pursuing a strategy of medical cure or rehabilitation, it is better to pursue a strategy of social change, perhaps even the total transformation of society. In particular, if disability can be proven to be the result of discrimination (Barnes, 1991), then campaigners for anti-discrimination legislation can see civil rights as the ultimate solution.

The second impact of the social model is on the people with disabilities themselves. Replacing the traditional, “medical model” view of disability – in which the problems arose from deficits in the body – with a social model view – in which the problems arose from social oppression – was and remains very liberating for disabled individuals. Suddenly, people are able to understand that they are not at fault: society is. They don’t need to change: society needs to change. They don’t have to be sorry for themselves: they could be angry (Shakespeare & Watson, 2002:5). Thus disabled people think of themselves in a totally new way and become empowered to mobilise, organise and work for equal citizenship. Rather than the demeaning process of relying on charity and goodwill, disabled activists can demand their rights.

Oliver (2004b:21) describes the concept of the social model as an attempt to turn the focus away from the functional limitations of individuals with impairment onto the problems caused by disabling environments, barriers and cultures. Secondly, the social model refuses to see specific problems in isolation from the totality of disabling environments; hence the problem of unemployment does not just entail intervention in the social organisation of work and the operation of the labour market, but also in areas such as transport, education and culture. Thirdly the endorsement of the social model does not mean that individually based interventions in the lives of disabled people, whether they be medically or rehabilitative, educational or employment based, are of no use or always counter-productive (Oliver, 1996).

From a social model perspective, too much is invested in individually based interventions with ever diminishing returns. As a consequence, modifications to

environments tend to be neglected or under-resourced despite the greater potential benefits of such investments. The philosophical and cultural basis upon which the individualistic negative response to impairment rests is firmly entrenched in the foundations of Western culture (Barnes, 2012:1). For example, providing a barrier-free environment is likely to benefit not just those with a mobility impairment, but other groups as well (e.g. mothers with prams and pushchairs, porters with trolleys, etc.) whereas physical rehabilitation will only benefit those privileged enough to be able to access it (Oliver, 2004b:21). This is not a criticism of rehabilitation per se, but more about the efficient use of scarce resources.

Oliver (2004b:31) states that no person without a disability can represent well the likes and interests of people with disabilities. Proponents of the social model like Oliver and Shakespeare are themselves persons with disabilities and they are convinced the model is the most appropriate in viewing disability. Thus, this model is advocated by persons with disabilities and makes the model closer to persons with disabilities as opposed to the medical model. Oliver, in Shakespeare and Watson (2002:7), supplies a table in which two columns list the differences between the 'individual' and the 'social' model. In the first column there are words such as 'medicalisation', 'adjustment', 'prejudice', 'attitudes', 'care' and 'policy', and in the second column the alternatives representing the social model: 'self-help', 'affirmation', 'discrimination', 'behaviour', 'rights', 'politics'.

The social model of disability is based on five fundamental theses (Anastasiou & Kauffman, 2011:368). Firstly the social model, also referred to as the social constructional model (Anastasiou & Kauffman, 2011:368), makes a sharp distinction between impairment and disability. Impairment has been defined as lacking an organ or mechanism of a body leading to body dysfunction, while disability is the disadvantage or restriction of activity caused by contemporary social organisation, which takes little or no account of people who have impairments and thus excludes them from the mainstream of social activities (Oliver, 2004b:27). Harries and Enfield (2003:12) argue that people with disabilities may be socially excluded by attitudes of fear and ignorance on the part of non-disabled people, who may use negative and pejorative language to refer to them; or they may be excluded from society because of generally low expectations of what people with disabilities can achieve. Tregaskis

(2004:66-67) suggests that in furthering the agenda for inclusion the need to form strategic alliances with non-disabled people should be explored, as social change might be best achieved when disabled and non-disabled people work together more systematically to tackle exclusion in all its forms.

Oliver (2004b:33) points out that the social model supports the idea that disability is not a product of bodily pathology, but of specific social and economic structures. It is a reaction to the dominant medical model of disability which in itself is a functional analysis of the body as a machine to be fixed in order to conform to normative values. The social model identifies systematic barriers, negative attitudes and exclusion by society (purposely or inadvertently) which show that society is the main contributory factor in disabling people (Barnes, 2012:7). While physical variations may cause individual functional limitations or impairments, these do not have to lead to disability unless society fails to take account of and include people regardless of their individual differences. The medical model has some assumptions about “normality”, but “normality” is a contentious concept influenced by various historical, cultural and situational forces (Barnes, 2012:7). What is and what is not impairment is historically, culturally and socially variable. Handicap is therefore ideologically and culturally determined; neither ideology nor cultures are politically neutral. Thus, if families, communities and societies develop a positive attitude towards people with disabilities by shunning discrimination and removing physical and social barriers that inhibit people with disabilities from participating in mainstream activities, the problem of disability will be non-existent (Harries & Enfield, 2003:12).

Thirdly, Oliver (2004b:46) postulates that the social model is founded on the notion that social and economic structures disable people with disabilities, excluding them from full participation in mainstream activities. People labelled ‘disabled’ are viewed as economically and socially inadequate and in need of care (Barnes, 2012:8). This has resulted in the generation of a thriving and costly ‘disability’ industry comprised of state institutions, private businesses, charities and voluntary agencies staffed by vast armies of professional helpers. The result is that people with disabilities’ assumed inadequacy and dependence is reified and assured (Barnes, 2012:8). The social mode has thus played a crucial role in challenging existing power relations,

including increasing involvement of persons with disabilities in policy making on disability issues at local and national levels (Oliver, 2004a:18-31).

The social model of disability outlines that the political goal of the disability rights movement should be the removal of barriers imposed by social structures and attitudes. Tregaskis (2004:65-82) maintains that the majority of persons with disabilities have been so psychologically oppressed by society that their oppression has become internalised. Social oppression in turn gives rise to institutional discrimination. People with disabilities have been subjected to a multiplicity of oppressive social attitudes throughout history, which have included horror, fear, anxiety, hostility, distrust, pity, over-protection, and patronising behaviour. Such pejorative attitudes, coupled with an inhospitable physical environment, such as inaccessible buildings and unusable transport systems, are considered the real concerns of disability. It is therefore maintained that “people with disabilities live within a disabling world” (Oliver, 2004b:23). The social model presupposes that the goal of any disability movement should be to address issues of oppression and discrimination against people with disabilities, promoting inclusion of people with disabilities, creating a barrier-free society, and developing a positive identity for those with disabilities (Oliver, 2004b:44). Through lobbying and advocacy, organisations like the UPIAS have managed to bring issues affecting persons with disabilities to the fore, thereby liberating many persons with disabilities from physical and attitudinal barriers (Oliver, 2004b:12).

Last but not least, the social model affirms that disability is not a personal tragedy. For far too long the individual, medical model has dominated disability policy. The medical view of disability tends to regard people with disabilities as ‘having something wrong with them’ and hence the source of the problem (Oliver, 2004b:20). Oliver sees a paradox in that despite this view, people with disabilities are given a low priority when placed against the competing needs of other groups. The author further argues that if disability is seen as a tragedy, then people with disabilities will be treated as victims of some tragic circumstances which leads to policies that attempt to compensate the victims for the tragedies that have befallen them. The social model of disability continues to evolve and develop. Swain and French (2000:569-582) have outlined an ‘affirmation’ social model of disability which seeks

to 'celebrate the difference' that characterise the lives of persons with disabilities. It is therefore contended that persons with disabilities can be 'proud' of the fact that they are different from the majority of the population. By rejecting the personal tragedy conception, Swain and French maintain that it is not possible to make a stark distinction between those who with disabilities and those without, since all people, to some extent, have a degree of impairment but do not necessarily encounter the negative consequences of disability. Those who wear spectacles to compensate for low vision are a case in point.

In the broadest sense, the social model of disability is about nothing more complicated than a clear focus on the economic, environmental and cultural barriers encountered by people who are viewed by others as having some form of impairment – whether physical, sensory or intellectual (Oliver, 2004a:18-31). The barriers disabled people encounter include inaccessible education systems and working environments; inadequate disability benefits; discriminatory health and social support services; inaccessible transport, houses, public buildings and amenities; and the devaluing of disabled people through negative images in the media – films, television and newspapers. The cultural environment in which people grow up views impairment as unattractive and unwanted. Consequently, feelings towards and the treatment of persons with impairments are dependent upon what has been learned about disability from the world around them. Moreover, people who acquire impairment later in life have already been immersed in the personal tragedy viewpoint and it is not therefore surprising that many of these individuals find it difficult to know how to respond in any other way.

The social model of disability does not ignore questions and concerns relating to impairment and/or the importance of medical and therapeutic treatments. It acknowledges that in many cases the suffering associated with disabled lifestyles is due primarily to the lack of medical and other services. It is similarly recognised that for many people coming to terms with the consequences of impairment in a society that devalues disabled people and disabled lifestyles is often a personal tragedy (Oliver, 2004a:18-31). But the real misfortune is that society continues to discriminate, exclude and oppress people with impairments viewed and labelled as disabled.

The social model is a deliberate attempt to shift attention away from the functional limitations of individuals with impairments onto the problems caused by disabling environments, barriers and cultures (Barnes, 2012:11-12). It is a tool with which to provide insights into the disabling tendencies of modern society in order to generate policies and practices to facilitate their eradication. For advocates, impairment may be a human constant, but 'disability' need not and should not be. The general aim is to give expression to the experience of living with impairment in a disabling society and help generate a celebration of difference and positive disabled identity (Barnes, 2012:14).

The social model has had its fair share of criticism. The first is that the model ignores or is unable to deal adequately with the realities of impairment. Secondly, the other related criticism contends that the subjective experiences of pain of both impairment and disability are ignored by the social model. The third criticism of the social model states that it is unable to incorporate other social divisions like race, gender, ageing, sexuality and so on. A fourth criticism centres on the issue of 'otherness'. From this perspective it is not the physical and environmental barriers faced, but the cultural values that position disabled people as 'other'. The final criticism of the social model is that it is inadequate as a social theory of disablement (Oliver, 2004b:24-26).

The social model of disability should not be considered as a monolithic entity, but rather as a cluster of approaches to the understanding of the notion of disablement. Different variants of the model ascribe differing and relative importance to a multiplicity of factors that result in the oppression and discrimination that disabled people experience. However, common to all variants of the social model is the belief that at root, disability and disablement are socio-political constructions. It is therefore the inhospitable physical environment, in concert with the negative social attitudes, that disabled people encounter which results in the systematic oppression, exclusion and discrimination of people with disabilities.

It can therefore be appreciated that the consideration of the theoretical understandings of disability are not solely of semantic, academic interest. The manner in which disability is popularly perceived has a profound impact upon the way in which 'stakeholders' are considered (by persons with disabilities'

organisations, policy makers and voluntary organisations alike) to have a legitimate role in deciding how resources are distributed. Disability is situated in the wider, external environment and is not explicable as a consequence of an individual's physical and/or cognitive deficiencies. Thus, in focusing upon the manner in which disability is socially produced, the social model gives precedence to the importance of politics, empowerment, citizenship and choice. Furthermore, disability is the result of society's failure to provide adequate and appropriate services. Consequently, the needs of people with disabilities are not adequately accounted for within the contemporary social organisation of society. It is perceived in attitudinal terms – as a socio-cultural rather than a biological construct. A further central tenet of the social model is that, irrespective of the political, economic and religious character of the society in which they live, people with disabilities are subject to oppression and negative social attitudes that inevitably undermine their personhood and their status as full citizens.

In conclusion, the social model of disability sees the issue of 'disability' as a socially created problem and a matter of the full integration of individuals into society. In this model, disability is not an attribute of an individual, but rather a complex collection of conditions, many of which are created by the social environment. Hence, the management of the problem requires social action and is the collective responsibility of society at large to make the environment modifications necessary for the full participation of people with disabilities in all areas of social life. The issue is both cultural and ideological, requiring individual, community and large-scale social change. From this perspective, equal access for someone with an impairment/disability is a human rights issue of major concern. It should be noted however that the social model is a complementary tool to better understand disability and not cast in stone or a panacea to all problems (Oliver, 2004b:30).

2.8 SUMMARY

In summary, the evolution of the disability concept is traced and it was shown how some of the views are still present in many traditional societies. Understanding disability issues is a multi-faceted adventure requiring multi-sectoral and multidisciplinary approaches. Culturally, society lets impaired people down because

of the prejudiced views and negative shared attitudes of the non-impaired community towards people with physical disabilities. Prejudice is associated with the recognition of difference, and 'disabled' people are not seen as normal in the eyes of 'non-disabled' people (Oliver, 2004a:18-31). Prejudices are evident in language and the terminology used to describe people with impairments, much of which is derived from medical labels. People are more than just a label describing a negative attribute, and the stigma attached to those labels means that people with impairments are held back from achieving what they want to achieve.

The social model of disability is premised on the notion that disability is a social construct that has been created by society, hence the need to remove barriers, and promote citizenship rights (equality) and anti-discrimination legislation. Cultural understandings of disability can influence the type of services rendered to a community, whether people seek medical interventions, and the degree of inclusion of people with disabilities. In fact, cultural understandings of disability are so influential that Haihambo and Lightfoot (2010:77) argue that people with disabilities are limited not so much by impairments or activity limitations, but more from the cultural interpretations of disability. Thus, cultural beliefs must be understood in order to plan and implement policies and programmes with the intent of making a difference in the lives of citizens with disabilities.

At the heart of social work is social justice, empowerment, inclusiveness and human rights (Banerjee, 2005:10). Not only do social workers connect people to services but also they ensure that services are structured, organised and practiced in a way that respect human rights. Social workers may engage in such initiatives as mobilising people with disabilities, giving them information, linking them to resources and ensuring that services and resources are provided in accordance with the human rights convention (Ife, 2012:462). Thus there is a strong link between the social model of disability and social work practice as the social model is also driven by the same values.

Despite a very progressive legislation and a clear commitment from the Government, the majority of people with disabilities in Namibia still do not access the same opportunities of leading an independent life as non-disabled people do. Access to employment is extremely rare among people with disabilities, as only 10% are

employed (VSO International, 2010:1). Women with disabilities are worse off than men. Access to the education system for people with disabilities is limited. While the Ministry of Education is committed to Inclusive Education, physical and attitudinal barriers (among teachers, family and the community) prevent people with disabilities from attending adult literacy programmes. Access to rehabilitation services, which could help people with disabilities to access education and employment, is still very limited. There is a lack of rehabilitation staff within the Ministry of Health and Social Services, especially in rural areas. Studies show that only 26% of people that have a need for rehabilitation can access it and that 67% of people with disabilities express a need for assistive devices, although only 17% have access to such devices (VSO International, 2010:1). Similar figures exist for the need for counselling. Given the policy framework and the political will, one is tempted to look elsewhere for a justification for the slow pace regarding equal opportunities for people with disabilities. Cultural beliefs regarding disabilities is one aspect worth considering.

Therefore, improving access to mainstream education and access to rehabilitation services are priorities to ensure that people with disabilities are able to fully participate in society. The disability movement in Namibia identifies low awareness among decision makers and civil society as the root cause of the lack of coordination and prioritisation to offer inclusive education and rehabilitation services (VSO International, 2010:1). Social workers thus have a role in conducting research so as to document gaps, proffer solutions, and lobby and advocate for people with disabilities from an informed standpoint if the goal of empowering and supporting people with disabilities to fully participate in all aspects of society is to be realised.

The research methodology, ethical aspects, empirical findings and the summary will be presented in the next chapter.

CHAPTER THREE:

RESEARCH METHODOLOGY AND EMPIRICAL STUDY

3.1 INTRODUCTION

This chapter outlines the research methodology of the study and includes a discussion of ethical issues relevant to this study. The goal of the study is to explore and describe the cultural beliefs of people with physical disabilities in a community rehabilitation centre in Oniipa, Namibia. The objectives are as follows:

- To contextualise physical disabilities according to the social model theory.
- To establish the cultural beliefs regarding disability among people with physical disabilities.
- To determine expressed beliefs in the cause of disability and the type of help sought (traditional or medical).
- To suggest strategies that will improve community integration and inclusion of people with physical disabilities.

The research findings are later presented and discussed. The empirical study was guided by the following question: **What are the cultural beliefs of people with physical disabilities in a community rehabilitation centre in Oniipa, Namibia?**

3.2 RESEARCH METHODOLOGY

Creswell (2007:35-41) asserts that a qualitative research is concerned with non-statistical methods of inquiry and analysis of social phenomena. It draws on an inductive process in which themes and categories emerge through analysis of data collected by such techniques as interviews, observations, video tape, and case studies.

Samples in qualitative research are usually small and are often purposively selected (Rubin & Babbie, 2011:351). Qualitative research uses detailed descriptions of the research participants themselves as a means of examining specific issues and problems under study. In addition, qualitative approaches also have the advantage

of flexibility, in-depth analysis, and the potential to observe a variety of aspects of a social situation (Creswell, 2007:35-41).

The research methodology is organised under the following headings: the research approach, type of research, research design and methods, feasibility of the study, and ethical aspects.

3.2.1 Research approach

The research utilised a qualitative approach. There is no significant information on the cultural beliefs of people with physical disabilities in rural conservative communities. Thus this area required in-depth exploration. In light of this, the qualitative approach was the most suitable or appropriate approach for the study. Qualitative research is concerned with understanding the process and the social and cultural contexts which underlie various behavioural patterns, and the emphasis is on the quality and depth of information (Nieuwenhuis, 2007:51). A qualitative approach is more concerned with the “what” questions, which was exactly what the study sought answers for (Fouché & De Vos, 2011:95). In addition, the researcher sought to gain an in-depth understanding of the cultural beliefs and not to explain them, which was best fulfilled in a qualitative approach (Fouché & Delpont, 2011:65). Lastly, the qualitative approach enabled the researcher to report the cultural beliefs from the point of view of people with physical disabilities (Fouché & De Vos, 2011:95).

3.2.2 Research question of the study

The research question in this study is: **What are the cultural beliefs of people with physical disabilities in a community rehabilitation centre in Oniipa, Namibia?** Bryman (2012:9) defines a research question as a question that provides an explicit statement of what it is the researcher wants to know about. A research question must have a question mark at the end of it or else it is not a question. It must also be interrogatory. The research question stems from the research topic, makes the theoretical assumptions in the framework more explicit, and indicates what the researcher wants to know first and foremost (Welman, Kruger & Mitchell, 2005:52).

Fouché and De Vos (2011:80) point out that the research question has three important functions. It clarifies the intention of the research and determines exactly what motivated the investigation and what the researcher intends to find out. Secondly, the research question allows readers to evaluate the research by providing benchmarks against which to judge not only what the project aimed to achieve, but also what it did not set out to do. Lastly, a clear research question provides the researcher with a good platform from which to conduct the investigation.

The research question is extremely important in the research process, because it forces one to consider the most basic issues – what it is about your area of interest that you want to know (Bryman, 2012:10). The research question forces the researcher to consider the issue he wants to find out about more precisely and rigorously. Developing a research question is a matter of narrowing down and focusing more precisely on what one wants to know. Besides guiding the literature search for the literature review, the research question is both a signpost and a set of boundary markers: it sets the researcher on a specific path and defines the territory to be explored (Fouché & De Vos, 2011:80).

3.2.3 Type of research

The research was exploratory in nature and more specifically an applied research study. The research sought to solve policy problems regarding inclusion and integration of people with disabilities and sought to help development practitioners address and solve immediate problems facing the professional practice and accomplish tasks (Neuman, 2000:24). Applied researchers often try to solve problems, which include challenges in providing programmes that are “appropriate, timely, and according to clients’ wishes, family and peer involvement in the rehabilitation process, coordination and continuity within and across sectors, and outcomes that are meaningful to the client” (Cott, 2004:1418). The researcher used applied research, because it focuses on solving a problem in practice. It is used to find solutions to everyday problems rather than to acquire knowledge for knowledge’s sake. Bless, Higson-Smith and Kagee (2006:44) state that the goal of applied research is to improve the human condition. Therefore, the study would

establish knowledge and strengthen inclusion and integration of people with physical disabilities, contributing to their well-being.

3.2.4 Research design and methods

This section will elaborate on the research design and methodology used in the study.

3.2.4.1 Research design

Fouché and Schurink (2011:307) refer to a design as all those decisions a researcher makes in planning the study and a process of focusing on the purpose of a particular study. A research design focuses on the end product and all the steps in the process to achieve the outcome anticipated (Fouché, Delpont & De Vos, 2011:143). It is a step process that follows problem formulation and proceeds to data collection.

A qualitative design, more specifically the collective case study design was utilised in the study (Rubin & Babbie, 2011:442). A collective case study enabled the researcher to gain insight and understanding into the cultural beliefs of people with physical disabilities and how these affect integration and inclusion (Struwig & Stead, 2001:7). The design was utilised in the study in order to collect rich data in the natural settings of individuals without providing a pre-imposed framework (Fouché & Schurink, 2011:316). The case study described the meaning of the lived experiences, in the study the cultural beliefs of people with physical disabilities (Creswell, 2007:57). An explorative study through a case study enabled the researcher to gather detailed and rich in-context information on cultural beliefs and disability from the participants (Fouché & Schurink, 2011:311).

3.2.4.2 Research population, sample and sample method

Strydom (2011:223) states that the term sample always implies the simultaneous existence of a population of which a sample is a smaller section, or a set of

individuals selected from a population. Conversely, a population is a totality of persons, events, organisation units, case records, or other sampling units with which the research problem is concerned (Bryman, 2012:418).

3.2.4.2.1 Population

Strydom and Delpont (2011:223) indicate that population is a term that sets boundaries on the study units. It refers to individuals in the universe who possess specific characteristics.

In this study, the population of the study was all people with physical disabilities in Onandjokwe district served by the ELCIN Rehabilitation Centre based at Oniipa. The study was conducted at the ELCIN Rehabilitation Centre, a community based welfare organisation started in 1990 that works with people with physical disabilities (see Appendix 2 for permission letter). The organisation serves the entire Onandjokwe district. In total, at the time of the research, there were 150 people with physical disabilities in the district served by the rehabilitation centre. In a qualitative study it was not feasible to include the entire population (Sarantakos, 2000:139).

3.2.4.2.2 Sampling and sampling method

The researcher utilised a non-probability sampling technique to select a sample of 21 people with physical disabilities through purposive sampling. The three constituencies chosen make up the district which is served by the rehabilitation centre. The purposive sampling method allowed the researcher to purposely seek typical and divergent data (Strydom & Delpont, 2011:392; Bryman, 2012:418). This was important in order to ensure that there was a good deal of variety in the resulting sample, so that sample members differed from each other in terms of key characteristics relevant to the research question (Bryman, 2012:418). The researcher collected information until saturation point was reached (Kumar, 2011:192). The researcher came up with a sampling criterion to select 21 people with physical disabilities as follows:

- Willingness to participate in the study.

- Availability to participate in the study.
- Participants had to be 40 years old and above, because people over the age of 40 are assumed to be more vested in their belief patterns, know the cultural practices and expectations of their cultural groups, and are perhaps less likely to give responses based on social desirability (Haihambo & Lightfoot, 2010:78).
- Must have been in the CBR programme for at least two years.
- Based in Oniipa, Olukonda or Onayena constituencies.
- Both females and males were selected.

This type of sampling (purposive) was entirely based on the judgement of the researcher (Strydom & Delport, 2011:392) and the advantage was that it allowed the researcher to be in control of choosing the participants (Rubin & Babbie, 2011:355).

3.2.5 Data collection method

To extract in-depth information from 21 participants regarding the cultural beliefs of people with physical disabilities, the researcher made use of focus groups as the data collection method. A focus group guide was used to facilitate focus group discussions (see Appendix 1). The participants first filled in their demographic information on separate forms before the focus group discussions started. The participants' experiences in the "past" referred to what they heard from their parents and other elders as well as during the time of their childhood. The focus group typically emphasised a specific theme or topic being explored in-depth; in this study, cultural beliefs (Bryman, 2012:501). The researcher had three focus groups, as relying on one group was generally considered too risky since any one group could have been atypical (Rubin & Babbie, 2011:467). Each of the three groups comprised seven people with physical disabilities.

The selected sizes allowed the participants to say a lot, be involved, and be emotionally preoccupied (Bryman, 2012:507; Greeff, 2011:367). Three meetings lasting an hour each were scheduled for each focus group, the working assumption being that the greatest amount of new information will come out in the first two group

meetings, with considerable repetition after that (Greeff, 2011:367). However, data became saturated during the third focus group meeting.

The researcher recruited a fellow social worker who is experienced in group interviewing and able to operate recording equipment as an assistant facilitator. Her role was to operate a digital recorder, take comprehensive notes, and handle unexpected interruptions (Greeff, 2011:368). This kept the facilitator primarily concerned with directing the discussion and keeping the conversation flowing. The researcher transcribed the tape recordings after every focus group meeting, compared notes with the assistant facilitator, and got insights for follow-up matters. The researcher was the group moderator and guided the sessions, as he has adequate knowledge on the topic and is experienced in group dynamics and processes (Bryman, 2012:501; Rubin & Babbie, 2011:468).

The assistant facilitator recorded the proceedings and took down comprehensive notes simultaneously, while the researcher took down sketchy notes (Creswell, 2009:184). To aid the researcher to keep abreast of what was happening in the sessions and avoid disruptions, notes were written unobtrusively in the form of words and phrases (Rubin & Babbie, 2011:470). Field notes recorded by the assistant facilitator included comprehensive details on the seating arrangements and the order in which people spoke; this aided voice recognition during the playing of the recordings after the sessions (Greeff, 2011:372).

Focus group as a data collection method had the advantage that it allowed people who have had a disability experience to be interviewed in a relatively unstructured way about their cultural beliefs (Bryman, 2012:503). In addition, it allowed the researcher to question several people with physical disabilities systematically and simultaneously (Rubin & Babbie, 2011:467). The technique allowed the researcher to develop an understanding about why people feel the way they do. The participants were able to bring to the fore issues in relation to cultural beliefs that they deemed important and significant and it gave an opportunity to study the ways individuals collectively make sense of culture and disability and construct meanings around it (Bryman, 2012:504).

The focus groups were a powerful way of exposing reality and helped the researcher to understand the everyday experiences of the participants (Greeff, 2011:362). Moreover, “[f]ocus groups create a fuller, deeper understanding of the phenomenon being studied, and they stimulate spontaneous exchanges of ideas, thoughts and attitudes in the security of being in a crowd” (Greeff, 2011:374). The researcher made use of a focus group guide to ask open-ended questions since the topic under study was exploratory in nature (Neuman, 2006:250). While the focus groups were inexpensive and generated speedy results (Rubin & Babbie, 2011:467), they had the disadvantage of generating voluminous, unstructured and less systematic data, which was often very difficult and tedious to analyse (Rubin & Babbie, 2011:488). The researcher counteracted this by meticulously adhering to the process of qualitative data analysis.

3.2.6 Data analysis

The researcher utilised Creswell’s (2009) model of data analysis. The model states that “data analysis is always an on-going process that routinely starts prior to the first interview” (Creswell, 2009:184). Schurink, Fouché and De Vos (2011:403) further state that the process of data analysis and interpretation can best be represented by a spiral image – a data analysis spiral. The researcher noted that there was an inseparable relationship between data collection and data analysis (Schurink et al., 2011:403).

Schurink, Fouché and De Vos (2011:399) define qualitative data analysis as a process of inductive reasoning, thinking and theorising which certainly is far removed from structured, mechanical and technical procedures to make inferences from empirical data of social life. In addition, the authors explain that data analysis is a process of bringing order, structure and meaning to the mass of collected data. While qualitative data analysis is messy, ambiguous and time consuming, it is also creative and fascinating. Schurink et al, (2011:400) state the purpose of conducting a qualitative study as that of producing findings. This involves reducing the volume of raw information, sifting significance from trivia, identifying significant essence and constructing a framework for communicating the essence of what the data reveal.

Data was recorded using digital recorders. This had the advantage that it ensured verbatim recording and enabled the researcher to communicate, listen and probe participants attentively (Rubin & Babbie, 2011:468). Away from the field data analysis involved playing the recordings to develop transcripts, which were then read repeatedly and had memos and comments in the page margins (Creswell, 2009:184).

The researcher was then in possession of voluminous data, which he then compressed by generating categories, key themes and salient themes that appeared and reappeared among the three focus groups (Schurink et al., 2011:410). In analysing data, the researcher considered the words, the context, consistency, frequency of comments, extensiveness of comments, specificity of comments, and what was not said, as well as finding the “big idea” (Greeff, 2011:373). Once themes were identified, the researcher asked the assistant facilitator to do an independent coding of data to enhance trustworthiness and for easy retrieval of information. Coding entailed using a colour-coding scheme, where the assistant facilitator used a highlighter to show all the similar categories and patterns using one colour (Rubin & Babbie, 2011:480). The researcher then interpreted the data and finally presented and discussed it using a hierarchical tree diagram that depicted all the themes accordingly.

The following is the process that the researcher undertook to conduct data analysis:

- **Planning for recording data**

The researcher planned for the recording of data in a systematic manner that was appropriate to the setting and research participants and it also facilitated the analysis. The interviews were tape recorded with the permission of the participants and this helped the researcher to remember every detail of the interviews (Welman et al., 2005:75). The researcher planned a system to ease retrieval for analysis. The coding of notes, defining for data analysis, and planning further data collection and especially for writing the final product of the research was also planned (Schurink et al., 2011:404).

- **Data collection and preliminary analysis: The twofold approach**

The researcher applied data analysis in the field during data collection and away from the field after data collection. With the data analysis away from the field, the researcher sorted, retrieved, indexed and handled the data thereby dealing with the sheer amount of data that was created in the interview, field notes and tape recordings (Schurink et al., 2011:405).

The researcher applied data collection and analysis hand in hand and a coherent interpretation of the data was built. As qualitative data analysis is interpretive in nature, it is an ongoing process. This implies that data collection, processing, analysing and reporting are intertwined and does not occur in a 'recipe' like fashion (Welman et al., 2005:76). The researcher collected and checked data, saw what was emerging and identified hunches or ideas. These were subsequently pursued and information already collected was actively questioned. The researcher reflected on analysis, ethical dilemmas and on the frame of mind of the researcher (Schurink et al., 2011:406).

- **Managing the data (Transcribing)**

The researcher organised the data into computer files. Files were converted to appropriate text units, that is, a sentence for analysis by computer (Schurink et al., 2011:408). The researcher managed data by gathering all materials that were collected and filed them. Typing and organising handwritten field notes, cutting and pasting was done.

- **Reading and writing memos**

After organisation and conversion of data, the researcher read the transcripts in their entirety several times. This helped to get immersed in the detail and get a sense of the interview as a whole before breaking it into parts. Writing of memos in the margins of the field notes or transcripts was done. The analytic memo writing started shortly after the beginning of data collection until before the final research report was completed (Schurink et al., 2011:409).

- **Generating categories and coding the data**

The researcher brought meaning to the words by identifying themes and patterns, that is, concepts, behaviours, interactions, incidents, terminology or phrases used; and organised them into coherent categories that was summarised and brought meaning to the text (Schurink et al., 2011:410). The researcher reduced the data to a small, manageable set of themes and wrote into final narratives.

The researcher assigned abbreviated codes of a few words and placed them next to the themes and ideas that were found. This helped in the organisation of the data into categories and provided a descriptive name for each category created (Schurink et al., 2011:411). As the researcher categorised the data, other themes were identified that served as sub-categories. The researcher continued to categorise until relevant themes were identified and labelled (Schurink et al., 2011:411).

- **Testing emergent understandings and searching for alternative explanations**

The researcher began the process of evaluating how things that were not in the data were important for analysis. This was done by searching through the data during which the researcher challenged the understanding, searched for the negative instances of the patterns, and incorporated these into larger constructs, as necessary. Evaluation of data for the usefulness and centrality was done (Schurink et al., 2011:415).

- **Interpreting data**

The researcher used themes and connections to explain the findings. Attaching meaning and significance to the analysis was done. The researcher developed a list of key points or important findings discovered as a result of the categorising and sorting data (Schurink et al., 2011:417).

- **Presenting the data**

The researcher presented data, a packaging of what was found in the text and wrote a final report (Schurink et al., 2011:418).

3.2.7 Trustworthiness of qualitative data

The researcher enhanced data credibility and trustworthiness through prolonged and repeated focus group sessions until data saturation occurred (Rubin & Babbie, 2011:448; Creswell, 2009:192). Prolonged engagement increased rapport leading to participants being more open in their interactions with the researcher (Lietz, Langer & Furman 2006:453). Furthermore, collecting additional data and spending more time with the participants increased the ability of the researcher to reach saturation point. Added to this, the researcher read interview transcripts numerous times to capture accurate descriptions of the cultural beliefs as reported by the people with physical disabilities. Subsequently, respondent validation was a crucial technique for establishing credibility. This entailed interpreting the information and then checking with the participants if the interpretation and thematic analysis was consistent, correct and congruent with their beliefs and experiences (Greeff, 2011:372). This allowed the participants to review findings from the data analysis in order to confirm or challenge the accuracy of the work. This was important in establishing trustworthiness, as it gave authority to the participants' perspectives, hence managing the threat of bias (Lietz et al., 2006:453). In addition to enhancing credibility, this was also critical in ensuring that the information was not subjectively interpreted (Rubin & Babbie, 2011:447).

The researcher engaged in reflexivity to increase rigor in the research. This was achieved through active acknowledgement by the researcher that his own actions and decisions could inevitably affect the meaning and context of the experience of cultural beliefs regarding disabilities (Lietz et al., 2006:447). The researcher involved the research assistant in the data analysis, and this helped to uncover hidden meanings in each narrative. The researcher also kept an audit trail throughout the data analysis process that clearly described the steps taken. This allowed the researcher to follow the research procedures consistently and helped the study to be open for critique by the research community, as the research procedures were fully described (Lietz et al., 2006:449).

The researcher also strived to provide rich and thorough information regarding the description of the research setting or context and observed transactions and

processes, and in-depth discussions of findings and themes as a way of ensuring rigor and transferability of data to other settings (Rubin & Babbie, 2011:450). Finally, but importantly, the researcher employed data neutrality as a way of safeguarding against preconceived ideas or own perceptions on the cultural beliefs of people with physical disabilities (Creswell, 2009:192). This was achieved through maintaining neutrality, avoiding being judgemental, and being mindful while becoming closely involved with the participants' cultural beliefs and experiences. In order for the research to reflect the thoughts, feelings and experiences of people with physical disabilities, the researcher made an effort to manage issues of reactivity and bias to describe data in a credible way (Lietz et al., 2006:444).

3.2.8 Pilot study

Bless et al., (2006:70) define a pilot study as a small study conducted in advance of a planned project, specifically to test aspects of the research design and to allow necessary adjustment before final commitment to the design. This small study is conducted prior to a larger piece of research to determine whether the methodology, sampling, instruments and analysis are adequate and appropriate. The ones who participate in a pilot study should not participate in the main inquiry (Strydom, 2011a:236).

The researcher conducted a pilot study prior to embarking on a more in-depth research process. The pilot study was conducted with four participants in order to try out the interview schedule and determine whether the exploratory themes were understandable. A recording device was also tested (Strydom & Delport, 2011:395).

The pilot study formed an integral part of the research process and its function was the exact formulation of the research, problem and a tentative planning of the modus operandi and range of the investigation (Strydom, 2011a:236). The participants in the pilot study were not included in the main study. The pilot study formed an integral part of the research process as it enabled the researcher to understand practical aspects, such as establishing access, estimating the time and costs, making contact, pre-empting the problems that may arise during the actual focus group discussions,

conducting interviews and becoming aware of the level of his interviewing skills (Strydom & Delpont, 2011:395).

The participants and the assistant facilitator gave input in the reviewing and final formulation of the focus group questions (Greeff, 2011:370). A pilot study had the advantage that it gave the researcher a taste and feel of what the study was going to be like. It was a revelation that enlightened the researcher on the feasibility of the proposed study in terms of financial resources, time and the willingness of the participants to be involved in the study (Strydom & Delpont, 2011:395). The focus group guide appeared to be suitable during the pilot focus group discussion and hence it was not necessary to consider another procedure for collecting data (Strydom, 2011a:243). The participants in the focus group and the assistant facilitator signed informed consent letters. The pilot study helped to increase the likelihood of success to the study and gave advanced warning about possible pitfalls. However, it should be noted that pilot testing group questions is difficult and the true pilot test is the first focus group with the participants (Greeff, 2011:370).

3.3 ETHICAL CONSIDERATIONS

This study was conducted in an honest and trustworthy manner. The researcher obtained permission to conduct the study from the University of Pretoria (see Appendix 3). The researcher was also granted permission by the ELCIN Rehabilitation Centre to conduct the study. Throughout the entire research process, from design to data collection and analysis to the publication of findings, the researcher paid due attention and adherence to the ethical issues discussed below.

3.3.1 Avoidance of harm

Bryman (2012:136) enjoins researchers to “anticipate, and to guard against, consequences for research participants which can be predicted to be harmful and to consider carefully the possibility that the research experience may be a disturbing one.” The goal of the study was to explore the cultural beliefs of people with physical disabilities and some emotional issues were bound to come out due to problems

caused by disability and community attitudes towards the same. The researcher did everything he could to ensure that the study did not harm the participants' development or self-esteem, or stress them (Bryman, 2012:135). To further minimise the risk of harm, the researcher informed the participants about the potential impact of the study and offered them the opportunity to withdraw from the study if they so wished without any negative consequences (Strydom, 2011b:115). The researcher explained fully the purpose of the study and had the participants sign informed consent forms as part of their willingness to take part in the study. Lastly the researcher referred those participants who needed professional help to the Onandjokwe Hospital's social workers.

3.3.2 Informed consent and voluntary participation

Inquiries involving human subjects should be based as far as practicable on the freely given informed consent of subjects (Bryman, 2012:138). In the study, the participants were given all the information on the goal and objectives of the study, the procedures to be followed during the focus group discussions, the possible advantages and disadvantages of the study, as well as the credibility of the researcher (Strydom, 2011b:117). The participants were also made aware of their entitlement to refuse participation at any stage for whatever reason. This is the principle of voluntary participation which they were entitled to (Neuman, 2006:96). The researcher explained as fully as possible and in terms meaningful to the participants what the research was about, why it was being undertaken, and how it was to be promoted. The researcher did not force or coerce anyone to participate in the study (Strydom, 2011b:116). The researcher asked the participants to sign consent forms before the research and key information regarding informed consent was repeated prior to the commencement of each focus group session. The researcher sought permission for the utilisation of digital recording and indicated in the informed consent letter that the data would be securely stored for a minimum of 15 years at the University of Pretoria. The researcher clarified and corrected misunderstandings. The researcher's assistant also signed a consent letter (see Appendix 5).

3.3.3 Deception

The research was not represented as something other than what it was (Bryman, 2012:143). Participants were not deliberately misled, the facts were not misrepresented and no information was withheld from participants in the study (Strydom, 2011b:118; Struwig & Stead, 2001:69). All the information regarding the research was shared with the participants.

3.3.4 Privacy, anonymity and confidentiality

Since the participants already knew each other and also met each other during the focus group discussions, anonymity could not be assured. However, the researcher asked the participants to keep the information shared during group discussions confidential. This was also indicated in the informed consent letters. The researcher informed the participants that tape recorders and field notes were going to be used to record data and their permission was sought for the use of these instruments to gather data. The participants were further informed that the researcher would compile a research report to be submitted to the University of Pretoria for academic purposes. The participants were informed and assured that while the research information would be shared with his supervisor, no information that directly identified their names, surnames or numbers would be included in the transcriptions, research report or other publications.

3.3.5 Compensation

The researcher did not offer any incentives in monetary terms for the participants to be involved in the study. The focus group discussions were held on a Friday morning and afternoon at the ELCIN Rehabilitation Centre conference room. However, the researcher compensated participants for transport costs and also provided refreshments during the focus group discussions, since they were not due to travel to the Centre during the time of the study (Strydom, 2011b:121). The researcher did not pay ELCIN Rehabilitation Centre to utilise its conference room (Greeff, 2011:371).

3.3.6 Actions and competence of researcher

The researcher was competent to undertake the proposed study, because the researcher is a qualified social worker with extensive research experience gained from his work, which entails carrying out research on various social issues. In addition, as part of the post-graduate studies, the researcher successfully completed a research methodology module. The researcher is also competent and experienced in group facilitation and possesses the necessary communication skills (Greeff, 2011:368).

3.3.7 Cooperation with contributors

The researcher dully acknowledged all those people who contributed to the research, that is the participants, the assistant facilitator for the focus group discussions, the management of the ELCIN Rehabilitation Centre, and the supervisor allocated to the researcher by the University of Pretoria (Strydom, 2011b:124-5).

3.3.8 Publication of findings

The researcher compiled a report as accurately and objectively as possible. The researcher ensured this by not manipulating the results (Strydom, 2011b:126). The researcher also mentioned the shortcomings and limitations of the study (Rubin & Babbie, 2011:84). The findings were also revealed to participants and management at ELCIN Rehabilitation Centre as a form of recognition and gratitude, and to maintain future good relationships with the community (Strydom, 2011b:126). The researcher also acknowledged the work of others which he consulted and correctly referenced to avoid plagiarism (Strydom, 2011b:126).

3.3.9 Debriefing of participants

The researcher offered the opportunity for participants to debrief after the focus group sessions. Participants got the chance to work through their experiences, as well as have the researcher answer their questions and remove misconceptions.

Through debriefing, problems generated by the research experience were corrected (Strydom, 2011b:122). As indicated by Strydom (2011b:122), a research process must always be a learning process for both participants and researcher, and this was the case in this study. The researcher referred participants to the ELCIN coordinator to further discuss some of the issues regarding disability. The researcher did not experience any situation where the participants needed therapy or counselling.

3.4 SECTION 1: EMPIRICAL FINDINGS

In this section, the research findings will be presented and discussed. The biographic data of participants will be provided, followed by the presentation of the themes and sub-themes as they emerged from the data. The biographic details of participants will first be presented in a narrative format and, where applicable, a graphic illustration of the findings will be given. The findings from focus group discussions will be discussed by means of themes and sub-themes, which will be presented in a table format to give a summary or overview of what emerged.

The discussion and analysis of the themes will be presented and these will be substantiated by direct quotes from the participants. Research findings will also be substantiated by literature where applicable. A total of 21 participants with physical disabilities took part in the focus group discussions.

3.4.1 Biographic profile

The study is focused on the cultural beliefs of people with physical disabilities in a community rehabilitation centre. The biographic profiles were constructed by drawing information from the participants on their age, gender, marital status, ethnic group, area of residency, sources of income, education level, number of dependents, age distribution of dependents, duration in the CBR programme, and the stage at which they acquired disability.

3.4.1.1 Age of participants

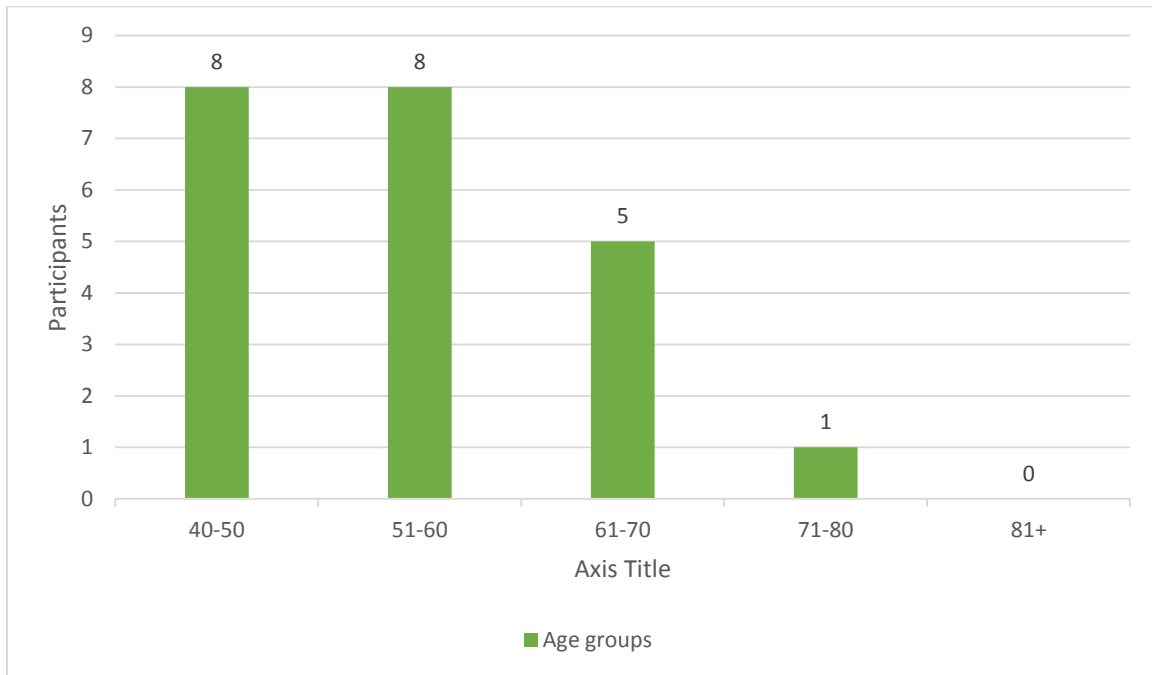


Figure 1: Age categories of participants

In Figure 2 above the x-axis shows the range of ages of participants and the y-axis shows the number of participants that took part in the study. The sum of participants on the y-axis shows the 21 participants that took part. Eight participants were between the ages of 40 and 50; seven participants were between the ages of 51 and 60; five participants were between the ages of 61 and 70; and one participant was between the ages of 71 and 80, while there was no one who was 81 years or above. These figures correspond with the Millennium Development Report which alluded to the fact that one household in every four contains a member with a disability.

3.4.1.2 Gender of participants

The pie chart below shows the gender of the participants.

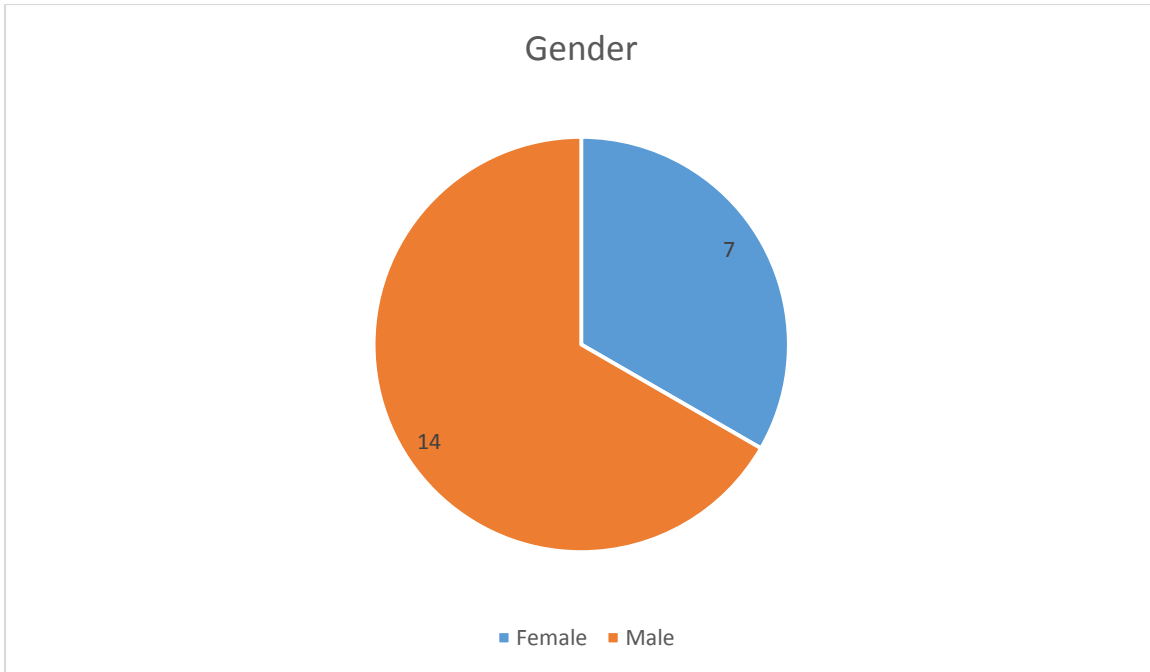


Figure 2: Gender of participants

Figure 2 above shows that out of the 21 persons with physical disabilities who participated in the study, seven were females while 14 were males. Wapling (2012:6) states that women and girls with disabilities experience double discrimination which means they face significantly more difficulties such as barriers in access to adequate housing, health, education, vocational training and employment. The global literacy rate for women with disabilities is believed to be as low as 1%. People with disabilities are also at higher risk of gender-based violence, sexual abuse, neglect, maltreatment and exploitation.

3.4.1.3 Marital status of participants

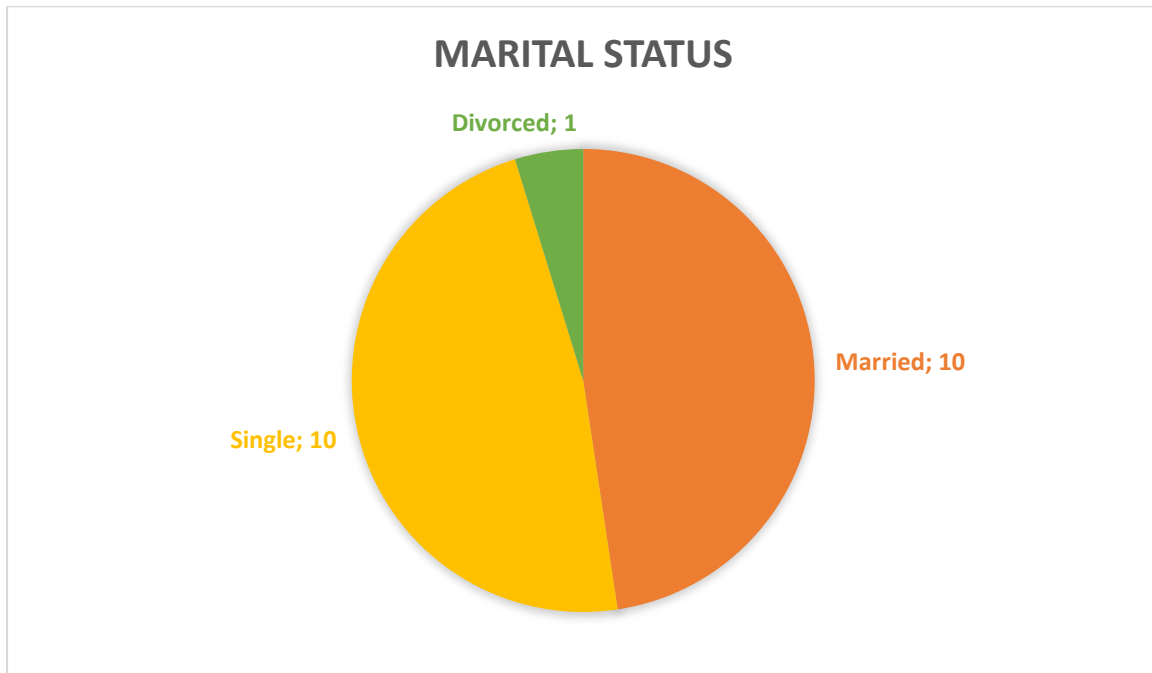


Figure 3: Marital status of participants

Figure 3 above demonstrates the marital status of the participants. A total of 10 participants were married, 10 participants were single and one participant was divorced.

3.4.1.4 Ethnic group of participants

Of the 21 participants, 20 were of the Oshindonga ethnic group and one was from the Oshikwanyama ethnic group. The fact that there are more people from the Oshindonga ethnic group is just a natural unfolding in terms of the geographic location and inhabitants dominant in the same.

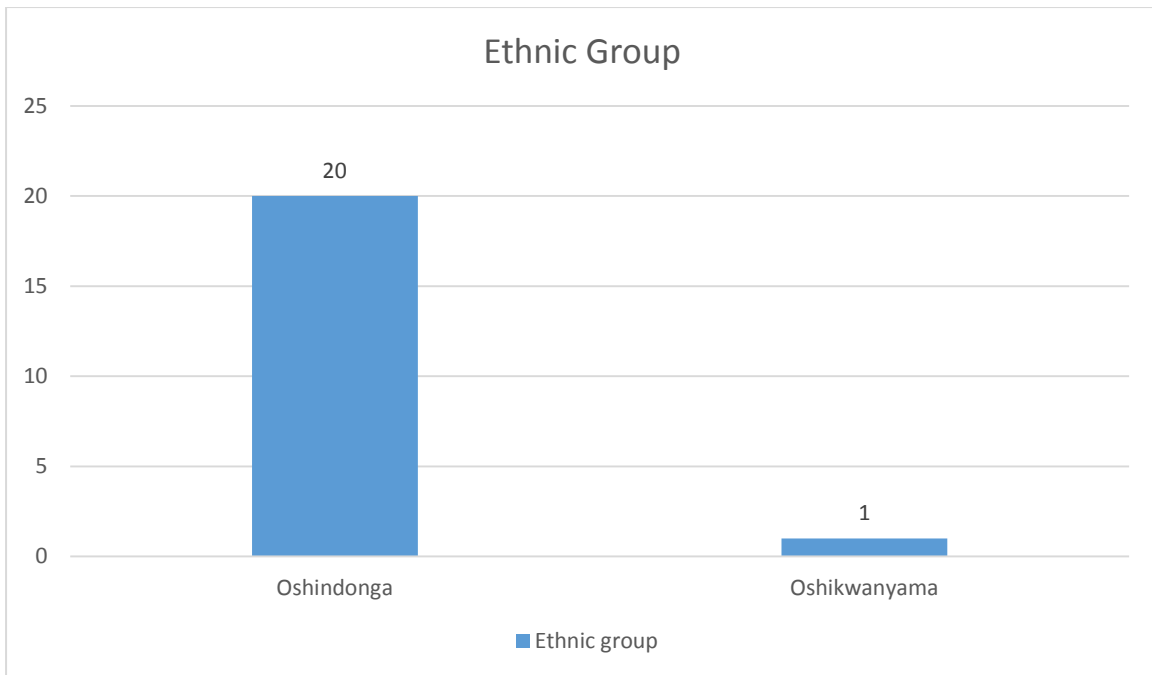


Figure 4: Ethnic group of participants

3.4.1.5 Area of residency of participants

Of the 21 participants, five were from Olukonda constituency; seven were from Oniipa constituency; and nine participants were from Onayena constituency. All the participants came from rural constituencies. Disability is more common among women, older people and poor households (Wapling, 2012:5). People with disabilities and their families who reside in rural areas are more likely to experience multi-dimensional poverty with fewer resilience options than their peers without disabilities or in urban centres.

3.4.1.6 Sources of income for the participants

Of the 21 participants, 16 indicated the social grant as their source of income, whilst four were formally employed and one relied on family members for income. This information is visually presented in the pie chart below.

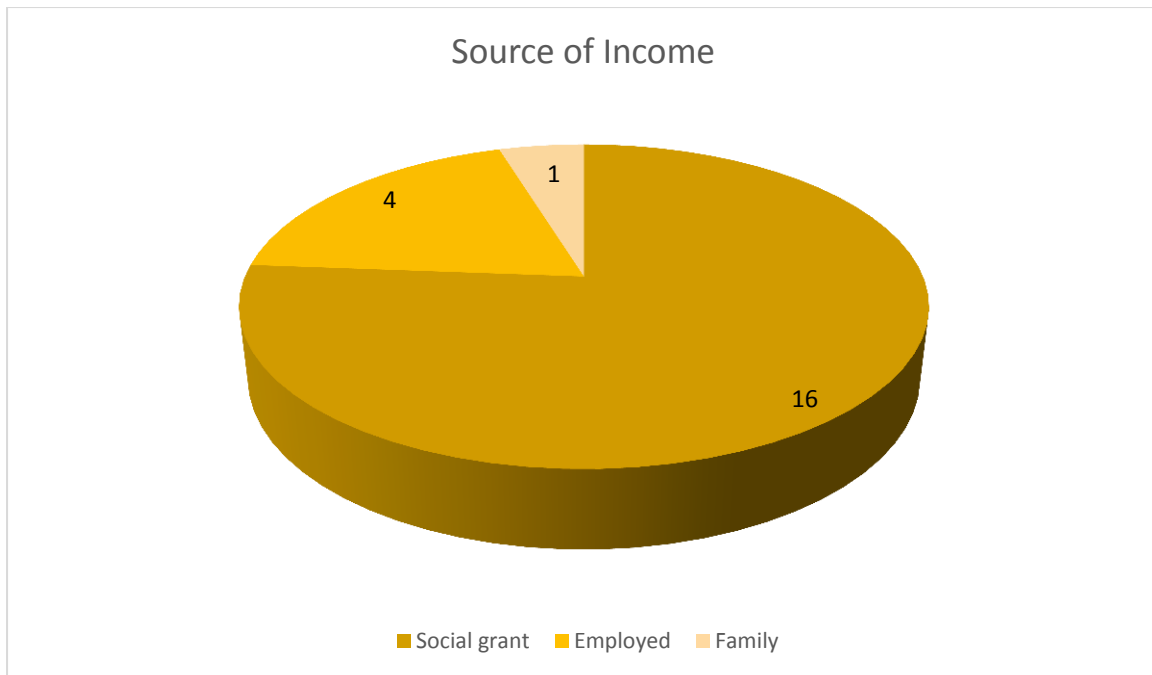


Figure 5: Sources of income for people with physical disabilities

The above findings indicate that most participants rely on the Government Social Disability Grant as their source of income. People with disabilities share the same problems as the poor without disabilities but they experience poverty more intensely (Wapling, 2012:4). Attitudinal and structural barriers limit their opportunities to escape poverty. A strong cycle of disability and chronic poverty exists – those who are poor are more likely to develop disabilities and those with disabilities are much more likely to be poor. They reinforce each other, contributing to increased vulnerability and exclusion (Wapling, 2012:4).

3.4.1.7 Educational level of participants

Grade	Number
Tertiary education	3
Secondary education	10
Primary education	8

Table 1: Educational level of participants

The table above demonstrates the participants who achieved various levels of education. Of the 21 participants, eight had primary education as their highest attained level, 10 had secondary education as their highest attained level, and three

had attained tertiary education. The 2010 MDG Report noted a strong link between disability and marginalisation in education. Having disabilities more than doubles the chance of never enrolling in school and in some countries it is a more significant factor in exclusion from education than gender. Having a parent who has a disability who is poor increases the likelihood of children never attending school.

3.4.1.8 Number of dependents per participant

Four participants had between one and two dependents; four participants had between three and four dependents; three participants had between five and six dependents; one participant had between seven and eight dependents; and nine participants had nine or more dependents. The above-mentioned information is presented in the graph below.

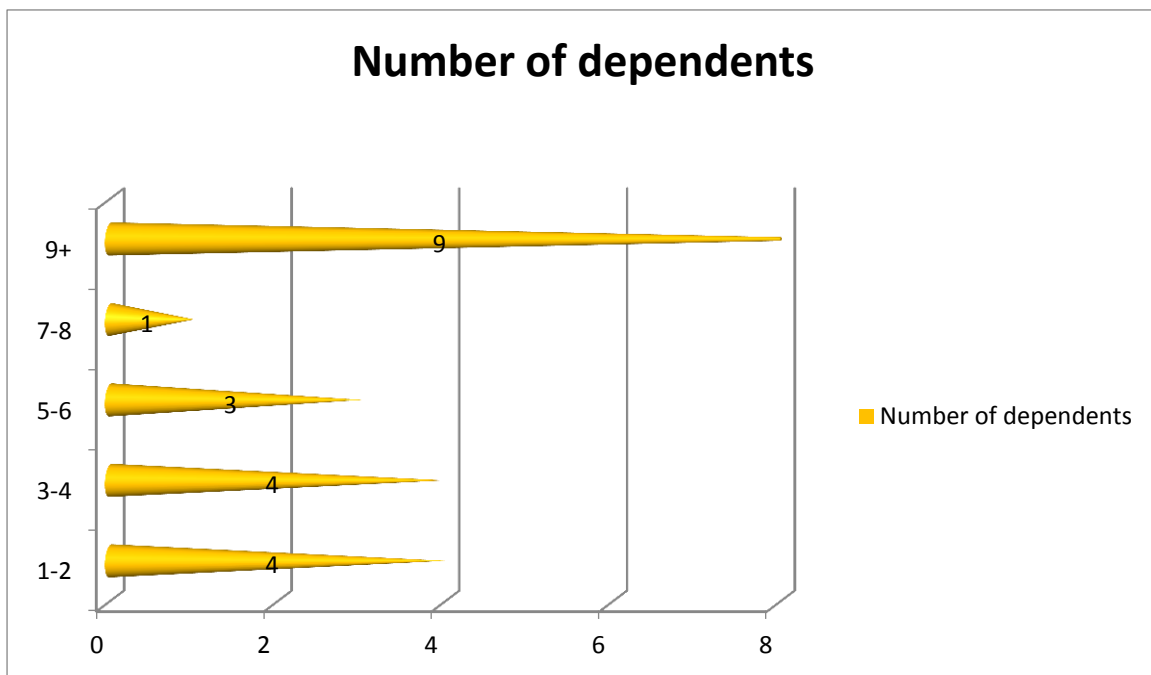


Figure 6: Number of dependents per participant

3.4.1.9 Age distribution of dependents

Six participants had dependents below one year old; 11 participants had dependents between the ages of one and four; 12 participants had dependents between the ages of five and nine; 12 participants had dependants between the ages of 10 and 14; 11 participants had dependents between the ages of 15 and 19; eight participants had

dependents between the ages of 20 and 21; and 13 participants had dependents aged 22 and above.

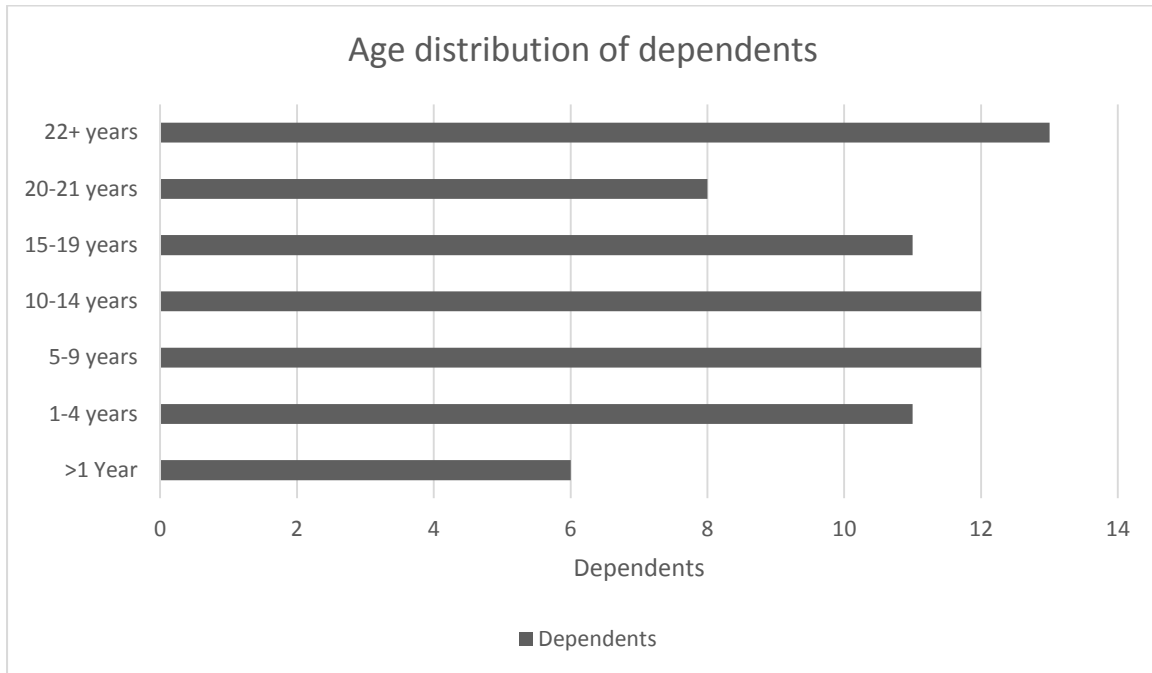


Figure 7: Age distribution of dependents

3.4.1.10 Duration in the CBR programme for the participants

Of the 21 participants, two had been in the CBR programme for two years, whilst the other 19 had been there for five or more years. The information on how long the participants had been involved in the CBR programme is presented in the table below.

Duration in the CBR programme	Number of participants
2 years	2
3 years	0
4 years	0
5 years or more	19

Table 2: Duration in the CBR programme

The findings indicate that most of the participants have been in the CBR programme for five or more years.

3.4.1.11 Period when disability was acquired by the participants

Of the 21 participants, two acquired disability at birth; five acquired disability during early childhood; five acquired disability during their teenage years; and nine acquired disability during their adulthood. The above information, pertaining to how disability was acquired is visually presented by the graph below.

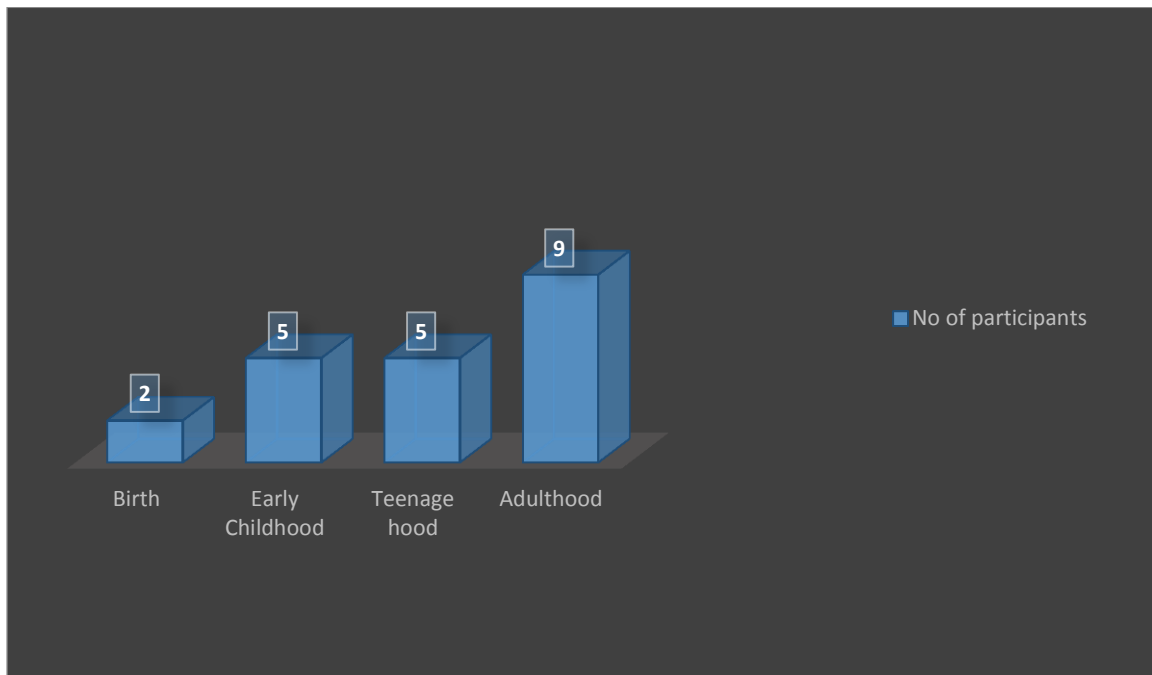


Figure 8: Period when disability was acquired

The findings show that most participants (nine) acquired disability during their adulthood. Five acquired disability during their teenage years and five during early childhood, while only two had a disability at birth.

3.5 SECTION 2: EMPIRICAL FINDINGS

As data was being processed and analysed, there were recurrent themes and sub-themes that were raised by the participants and specific trends and patterns emerged. These findings will be supported and substantiated by direct quotes in order to give voice to the views of the participants. The key findings will be highlighted and substantiated with literature in the final discussion of the chapter.

The researcher identified the following themes and sub-themes from the transcripts:

Themes	Sub-themes
Theme 1 General perceptions of disabilities	1.1. Institutional barriers 1.2. Negative attitudes 1.3. Lack of recognition of their rights
Theme 2 Perceived causes of disabilities	2.1. Accidents and falls 2.2. Diseases 2.3. Medical causes 2.4. Natural causes
Theme 3 Services sought after being diagnosed with a disability	3.1. Modern health facilities 3.2. Traditional healers
Theme 4 Cultural beliefs regarding disability	4.1. Witchcraft 4.2. Gift from God 4.3. Punishment for wrongs done 4.4. Curse or bad omen 4.5. Worthless and useless
Theme 5 Treatment of persons with disability in the past and its applicability in this period	5.1. Hidden and isolated 5.2. Pitied and not recognised as full beings 5.3. Views regarding the applicability of past treatment in this period
Theme 6 Community reactions to disability	6.1. Negative views 6.2. Positive views
Theme 7 Impact of disability socially and economically	7.1. Loss of livelihood 7.2. Loss of educational opportunities 7.3. Changed appearance and stature 7.4. Difficulty in adjusting to new condition
Theme 8 Support services received in dealing with a disability	8.1. Material support 8.2. Financial support 8.3. Medical support

	8.4. Psychosocial support
Theme 9 Strategies required to support people with physical disabilities	9.1. Ending discrimination against people with physical disabilities 9.2. Training role players involved in the lives of people with physical disabilities 9.3. Involving and consulting people with disabilities 9.4. Prioritising people with physical disabilities as a vulnerable group 9.5. Providing services and empowering people with physical disabilities

Table 3: Summary of the themes and sub-themes

Nine main themes, each with a number of sub-themes, were identified from the data. The first seven main themes focused mainly on the participants' perceptions, cultural beliefs and experiences regarding physical disabilities. The last two main themes focused on support services received and other strategies required to support people with physical disabilities.

3.5.1 Theme 1: General perceptions of disabilities

From the participants' responses with regards to their perceptions of physical disabilities, three main ideas emerged from this theme, namely institutional barriers, negative attitudes, and lack of recognition of their rights. These will be presented below in the next section as sub-themes.

Sub-theme 1.1: Institutional barriers

All the participants indicated that the society that they live in is not tailor-made for people with physical disabilities and this increased their hardships. Four participants indicated that there are difficulties that they encounter that made community "inclusion" and "integration" of people with physical disabilities an unfulfilled dream.

The following quotes demonstrate the sentiments of the participants regarding institutional barriers:

- *“There is need for the transport sector to think about us too... many times we are left stranded on the road as they have no time to fold our wheelchairs and help us into the car.”*
- *“We struggle to pass through the doors with our wheelchairs. Planners should always think about people with disabilities before starting their buildings.”*
- *“[In our town] most of the buildings are not accessible. Some of these buildings are even government owned [which should be public places] yet they exclude us.”*
- *“...I think only the government is employing people with disabilities...the private sector and charities must also start to recruit people with disabilities.”*

The institutional barriers mentioned by the participants include lack of accessibility to buildings and transport, as well as lack of employment opportunities. The WHO (2011:10) mentions that many built environments and transport systems, as well as information, are not accessible to all. Lack of access to transportation is a common reason for a person with disability to be discouraged from seeking work or prevented from accessing health care (Pechak & Thompson, 2007:14). Thus the authors point out that the whole notion underlying the social model is that disability is a social construct that has been created by society. People with disabilities sometimes have difficulty doing things that other people take for granted, such as travelling on public transport and using some household appliances (Gobalakrishnan, 2013:489).

Sub-theme 1.2: Negative attitudes

Four participants pointed out how the people’s views regarding physical disabilities made them feel. These views are not encouraging at all and they felt it increased their vulnerability as it takes away their self-esteem. Participants described these situations as follows:

- *“I think people should change their negative attitudes towards disability as it can happen to anyone and they must realise that people with disabilities have enormous potential.”*
- *“Societal attitudes are discouraging; they are not good at all.”*

- *“Some of our own friends make bad jokes about our disabilities, some only pretend to like us because of the disability pension we receive and not because of who we are and this needs to change...”*
- *“...people with disabilities need to be respected. Able-bodied people should know that we are just like them so we should be treated equally.”*

The above quotes highlight the fact that it is society that disables people with disabilities by the way they are isolated and excluded (Shakespeare & Watson, 2002:3). The participants mentioned numerous negative attitudes that they encounter. Due to negative cultural beliefs, people with disabilities cannot fully demonstrate their potential due to the “disablist” attitude which is disempowering (Oliver, 2009; Marsay, 2014:8). The WHO (2011:9) mentions that beliefs and prejudices constitute barriers to education, employment, health care and social participation. For example, the attitude of family and community members can affect the inclusion of people with physical disabilities in community programmes. Oliver (2004b:19) argues that it is not disability that is the main cause of the negative attitudes, but rather the way society responds to people with disabilities.

Participants further perceived disabilities within the realm of not recognising the rights of people with disabilities. This is discussed in the next section.

Sub-theme 1.3: Lack of recognition of their rights

Three participants viewed disability as a rights issue and explained that the lack of recognition of their rights hindered their contribution and their social standing in society. Participants mentioned the following:

- *“...there is need for a platform where everyone is represented including people with disabilities. We want equality for all and recognition [of rights]...”*
- *“...the rights of people with disabilities are violated with impunity...I think human rights must apply to all people and be enforced. Everyone must enjoy these rights.”*
- *“There are people or organisations that claim to represent people with disabilities yet they do not have time to visit us and see our living conditions and welfare...there is need to advocate and lobby” [for the rights of people with disabilities].*

Physical disabilities are perceived as leading to lack of recognition of the rights of people with disabilities (Wapling, 2012:8). Policy design does not always take into account the needs of people with disabilities, or existing policies and standards are not enforced (WHO, 2011:9). The participants' responses reflect on Oliver's (2004b:21) perception that the social model is an attempt to switch the focus from the functional limitations of individuals with impairment, to the problems caused by disabling environments, barriers and cultures.

The sub-themes in this section highlighted the perception on the interplay between a person's impairment and environmental, institutional and attitudinal barriers that create disabling conditions that most persons with disabilities experience. The perceptions can be related to the social model which serves as the theoretical framework for the study. The social model is an attempt to switch the focus from the functional limitations of individuals, to the problems caused by disabling environments, barriers and cultures (Oliver, 2004b:21). The above themes indicate how cultural perceptions of disabilities can negatively affect people with disabilities in all spheres of life. The effect of the social model is reflected by Wapling (2012:8), Oliver (2004b:19) and the WHO (2011:9), who state that the knowledge of perceptions regarding disability is important as it enables the identification of strategies for removing barriers and creating a positive and enabling environment for people with disabilities.

3.5.2. Theme 2: Perceived causes of disabilities

The most common expressed beliefs in the cause of physical disabilities were accidents and diseases. Accidents included natural calamities, as well as traumatic injury due to falls and motor vehicle accidents.

Sub-theme 2.1: Accidents and falls

Nine participants described accidents and falls as the cause of physical disability. They explained that these accidents and falls could be a result of being drunk or intoxicated by drugs, motor vehicle accidents, falling from trees or buildings, or as a result of gunshot wounds. Participants mentioned the following:

- *“Disability can be caused by drugs and alcohol abuse, leading to falls...”*

- *“In adults, disability can occur due to car accidents, wars or falling down from buildings.”*
- *“Disability can be caused by many things for example ... motor vehicle accidents, falling from a tree...”*
- *“Disability is caused by car accidents, injuries caused by gunshot wounds and also injuries caused as a result of alcohol abuse.”*

The participants' quotes are reflected in literature. The most common cause of physical disability is accidents and falls (Monk & Wee, 2008:97). These accidents could be due to motor accidents, or traumatic injury due to falls and conflict (McAlpine, 2008:23).

Sub-theme 2.2: Diseases

Nine participants verbalised that some diseases caused physical disabilities. Specific diseases such as polio, measles, diabetes and stroke were listed as causative factors in physical disability. Participants explained this as follows:

- *“Disability can occur when a pregnant woman is misusing alcohol and drugs leading to defects to the unborn child.”*
- *“Disabilities can be caused by diseases such as polio and measles.”*
- *“Sometimes physical disabilities are caused by stress related illnesses leading to a stroke.”*
- *“... diseases such as stroke can also cause disabilities.”*
- *“Disability can occur when a pregnant woman takes alcohol and drugs.”*

All the participants described diseases as a major cause of disability. Variations in the rates of disability across countries can be caused by chronic and infectious disease patterns, nutritional status and exposure to environmental risks (McAlpine, 2008:23). Diseases as a cause of disability were described by participants as having either a genetic, congenital or external aetiology. Maternal illnesses, such as alcohol and drug abuse during pregnancy, were thought to cause congenital disability. External causes of disease were associated mainly with poor health, infectious diseases, stroke and malnutrition (Monk & Wee, 2008:19). This finding corresponds with Monk and Wee's (2008:105) findings that some participants indicated that some disabilities arose from witchcraft and ancestral spirits, but explained that their own

disabilities were from a natural cause such as aging or natural diseases such as polio.

Sub-theme 2.3: Medical causes

Four participants expressed human error in the health care system as the cause of disability. The consequence of attending health facilities (hospitals and the rehabilitation centre) is that none of the respondents attributed the causes of disability to traditional or spiritual causes. Participants described these situations as follows:

- *“Some physical disabilities are caused by medical operations, for example amputations”.*
- *“...it [disability] can be caused by wrong medical prescription or treatment, for example one can be injected with wrong medication by inexperienced doctors or nurses.”*
- *“Some disabilities are caused by being given wrong medication or misdiagnosis...”*
- *“...in our area we have people who narrate how they were wrongly injected and this caused their disabilities.”*

The medical causes mentioned by the participants included mostly human error on the part of health workers which led to disabilities. Mishandling at birth and inappropriate medical treatment are indeed causative factors (McAlpine, 2008:24). Monk and Wee (2008:19) also mention that some people with disabilities distrusted the medical system as they reported knowing some people who got injected and ended up with a disability. Mistakes made by nurses during medical procedures were also mentioned by Diken (2006:12) as causal agents of disabilities. The information gained from the participants supported the descriptions in the mentioned literature.

Natural causes of physical disabilities that the participants felt did not fit in the above categories are discussed in the following sub-theme.

Sub-theme 2.4: Natural causes

Three participants described natural causes of disability relating to specifically to genetics. However, natural causes also encompassed various factors during

pregnancy leading to the birth of a disabled child. Participants mentioned the following:

- *“Disability is caused by many things, for example by natural causes, when you are just born with a disability...”*
- *“...it [disability] is caused at times by complications at birth.”*
- *“...complications during birth can cause physical disabilities.”*

Some participants described natural causes as leading to disabilities. The natural causes relate to genetics and also encompass various factors during pregnancy leading to the birth of a disabled child (Monk & Wee, 2008:98). External causes were associated with malnutrition and exposure to environmental risks (McAlpine, 2008:23). The information from the participants supported the descriptions in literature.

The sub-themes in this section show that the participants' beliefs on the causes of disabilities were varied. The primary causes described by the study participants were accidents, diseases, medical and natural causes. The participants' own beliefs were investigated, because it was postulated that perceived cause would affect attitude and the help sought and thereby have an effect on service provisions. These results correlate with a study in Kenya where the participants described the causes of disability as traditional causes, illness, accidents, natural causes, poverty and aging (Monk & Wee, 2008:104). In the study no participant blamed the people with disabilities for their impairment. While there were cultural beliefs, such as witchcraft, attributed to disabilities the people with disabilities themselves did not subscribe to them.

This can be related to the social model where the starting point is educating the community about causes of disabilities, as a barrier-free environment would benefit other groups without disabilities as well (Barnes, 2012:1). The participants distanced their disabilities from the cultural beliefs and had their own explanations regarding the disability, mostly a medical explanation just as in the Kenyan study (Monk & Wee, 2008:104).

3.5.3. Theme 3: Services sought after being diagnosed with a disability

From the participants' responses with regards to services sought in their communities after being diagnosed with a disability, the researcher identified two services, namely modern health facilities and traditional healers.

Sub-theme 3.1: Modern health facilities

A total of 10 of the participants stated modern health care facilities as their preferred source of help in the event of a disability occurring. These health facilities included clinics, hospitals and rehabilitation centres within the country and abroad. One participant mentioned the family as the first port of call for help before other avenues could be explored, while another spoke of special schools or institutions where people with physical disabilities are cared for. These all fall under modern health facilities. Participants stated the following:

- *“In our village, people get help from the hospital.”*
- *“Some people go to the social worker for counselling as it may be difficult to accept the disability.”*
- *“They also go to rehabilitation centres, apart from the hospitals ... in early childhood, a child may go to a specific school that caters for children with that specific disability or stay in institutions that house people that have that specific disability.”*
- *“These days they are referred to the government which in turn seek treatment for them in different countries. This is especially for those who suffer a stroke”.*
- *“People seek help at nearby hospitals and rehabilitation centres that are within their reach.”*
- *“In my community, help comes firstly from the immediate family members and the community in terms of first aid and any other needed assistance before one is taken to the hospital for further management.”*

Participants indicated that they found it helpful to go to health facilities after being diagnosed with a disability. Diken (2006:8) confirms that bio-medical treatment beliefs are the most held beliefs by persons with disabilities and their families. Monk and Wee (2008:105) mention that rehabilitation programmes are effective as a treatment choice in the community, as many people with disabilities prefer modern

health facilities. Most people draw knowledge on general health from institutions of health (De-Graft Aikins et al., 2010).

However as the next sub-theme indicates, ‘healer shopping’ within ethno medical systems is common. Some participants mentioned traditional healing as a preferred service to deal with a disability.

Sub-theme 3.2: Traditional healers

Three participants indicated that some people still sought help from the traditional doctors, as some would suspect the disability to have been caused by witchcraft while others sought spiritual help from church leaders. The opinions of participants regarding this theme are as follows:

- *“From the past people have gone to witch doctors or traditional healers ... even now people still go there...”*
- *“Some people get help from spiritual healers. They visit the homes and pray with the family members to support them.”*
- *“... people go to traditional healers...”*

The diagnosis of a disability resulted in participants seeking help from traditional healers. People who hold strong traditional beliefs regarding the causation of disability also hold strong traditional treatment beliefs and valued more traditional treatment practices rather than bio-medical ones, as confirmed by Diken (2006:8). De-Graft Aikins et al. (2010:5) also add that treatment beliefs are rooted in rooted socio-cultural systems.

The sub-themes in this section indicated that the majority of participants seek help from health facilities upon realising that they have a disability, while a few indicated traditional healers as a source of help. These findings correspond with what is stated in literature that healer shopping within ethno medical systems is common. This is so because most beliefs about disabilities are rooted in complex socio-cultural knowledge systems and draw knowledge from general health, pluralistic health systems, illness, chronic, and rehabilitation as: social (family and friends), cultural (traditional handed-down knowledge), cross-cultural, institutions of health, and unique self-experiences (De-Graft Aikins et al., 2010:5). This is important for social

workers and other health professionals working with people with disabilities to understand and respect their belief systems. Regardless of the causal beliefs Monk and Wee (2008:105) suggest that a rehabilitation programme could be effective as a treatment choice in the community, as aetiology did not correlate with treatment choices.

The study's findings also agree with the social model advocates who point out that the model does not ignore questions or concerns relating to impairment and/or the importance of medical and therapeutic treatments. It acknowledges that in many cases, the suffering associated with disabled lifestyles is due primarily to the lack of medical and other services (Oliver, 2004a:18-31).

3.5.4 Theme 4: Cultural beliefs regarding physical disabilities

A variety of cultural beliefs about physical disabilities were found. The participants revealed that cultural beliefs stem from the beliefs that physical disabilities are a manifestation of witchcraft; a gift from God; punishment from the ancestors; a curse or bad omen; or a predetermined occurrence, and that people with disabilities are worthless and useless. These beliefs will be discussed below as sub-themes.

Sub-theme 4.1: Witchcraft

A total of 11 of the research participants acknowledged a belief that any occurrence of disability was linked in some way to witchcraft. There were largely two beliefs regarding witchcraft and disability. The first was that disability could not just occur, one had to be bewitched, and the second was that the family with a member with a physical disability had tried to practice some witchcraft, especially to get rich, but failed to fulfil all the requirements of the witchdoctor. Because of the association of disability with witchcraft, persons with disabilities and their families tend to be isolated, rejected or even harmed. Some participants revealed that, many years ago, people with physical disabilities were killed because of this association with witchcraft. The following participants' views capture this theme as follows:

- *“Culturally, in my community people do not believe that disability can just occur, there must be a cause and disability occurs only when someone is bewitched.”*

- *“Some people believe that the person was trying to practice witchcraft and he/she did not manage to achieve the desired goals and it backfired. For example, if he/she was trying to get rich and was advised to apply some herbs in a certain manner but then failed to follow the instructions well, and then the person will end up disabled.”*
- *“Culturally, people with disabilities do not deserve respect and cannot be treated the same as other people. They are a product of witchcraft.”*
- *“Once people know or find out that you are now disabled, and because everyone assumes it has to do with witchcraft, then no one cares about you anymore, you cannot be treated as other normal people, that’s the belief.”*

Other participants noted that people with disabilities were pitied, because of the scourge of witchcraft. This is reflected by the following quotes:

- *“People believe that if disabilities occur to two or more people from the same household then the family is a family of witches.”*
- *“People believe a man with a disability cannot marry or look out for a woman to marry. This they believe will be difficult to achieve, because no family would accept a man who was bewitched and cannot do anything.”*

The findings show that most of the cultural beliefs regarding physical disabilities centre on witchcraft. This view is supported by Abosi and Ozoji, in Munyi (2012:2), who found in their study that Nigerians in particular and Africans in general attributed disability to witchcraft and supernatural forces. In addition, this finding is similar to studies done in other sub-Saharan African nations, such as Kenya, Zimbabwe (Monk & Wee, 2008) and Botswana (Dart, 2006) where the cultural beliefs were that supernatural causes such as witchcraft and improper relationships led to disabilities (Haihambo & Lightfoot, 2010:83).

Under the social model, each society has its own way of understanding disability depending on their cultural beliefs. Cultural understandings of disability can influence the type of services provided within a community, the interventions sought, and the degree of inclusion of people with disabilities (Haihambo & Lightfoot, 2010:77).

The study findings provide concrete evidence of why there should be renewed efforts to challenge repressive cultural belief systems. McConkey (2012:321-323) warns that cultural influences create much unhappiness and isolation not only for the person with a disability, but also the immediate family circle. Therefore, the study findings concur with Coleridge (2000:22) who points out that there is an urgent need to work towards changing people's attitudes towards disability and stimulating change without undermining people's sense of identity.

Sub-theme 4.2: Gift from God

Four participants indicated that there is a belief that disability is a gift from God. Many linked deformity and disability to a higher being beyond human control. This was mostly a belief coming from those with physical disabilities and their families. This was in contrast to and a clear move from the other themes such as witchcraft, punishment or curses. The following quotes demonstrate this:

- *“There are some beliefs that disabled people are a gift from God and hence people need to take care of them to avoid being cursed.”*
- *“When people are born naturally disabled, it is God's plan, there is no other way. God works in mysterious ways but whatever he gives it's a gift.”*
- *“People think that you are bewitched, but that is from God, you are created like that, that is God's creation.”*
- *“It is God's will and his hand (power) is shown through me.”*

The findings further show that there are cultural beliefs which regard physical disabilities as a gift from God. This is in contrast to views by authors such as Pfeiffer et al. (2003:132-149) who noted that disability was variously viewed as a tragedy, a disgrace, the result of sin, and a punishment from God.

Thus, the way societies think about people with disabilities is essential for planners of community disability programmes in order to plan effective interventions. This also increases self-esteem when people are viewed as a gift from God.

The participants' responses are in line with Diken's (2006:8-17) assertion that the person's understanding of disability is greatly tied to religious beliefs. In the author's study of Turkish mothers many saw their children's disabilities as a gift from God.

Similarly in this study the participants viewed their disability as a gift from God. The finding could also be tied to the participants being members of a rehabilitation centre for many years and the centre being run by the church which inculcates religious teachings. This finding is also in line with the social model which affirms that disability is not a tragedy. Swain and French (2000:569-582) add that the model seeks to celebrate differences.

Sub-theme 4.3: Punishment for wrongs done

Another common belief noted by four participants was that a family that had a member with a physical disability was being punished for the sins they committed. These sins ranged from not following a witchdoctor's instructions well, to wrongs done in the past by other departed family members. This punishment was also linked to witchcraft by some illustrating the complicated belief systems held by many. The participants' views are captured in the following quotations:

- *“This was because they believed that the sight of a person with disabilities would bring shame and further punishment to the family. They were supposed to be hidden to serve their punishments for the crimes they committed.”*
- *“This is shown by the derogatory names they label us in the vernacular language such as (shitiningili, shityofolo) which mock physical appearance, mental state of the person and imply that you are serving your punishment.”*
- *“People with disabilities used to be hidden from the rest of the people, as they had to be punished.”*
- *“Culturally disability is a punishment for the crimes committed in the past.”*

A finding in contrast to the one mentioned above shows that there are cultural beliefs which indicate that disability is as a result of punishment for the wrongs done by the affected person, their family or even their family members from earlier generations. The participants' responses are in line with the WHO (2010:15) which states that disability is seen as a punishment for past wrongs. While Pfeiffer et al. (2003:132-149) attributed some beliefs about disability to punishment from God, there was a variation with the findings of this study. Disability, if attributed to God, was seen as a gift and only when it was attributed to crimes committed was it seen as punishment. The findings are also in tandem with Abosi (2007:198) who stated that African

cultural beliefs regard physical disabilities as punishment for what someone did wrong.

Sub-theme 4.4: Curse or bad omen

Four participants noted a belief similar to that of punishment, namely that ancestors, elders in the family, evil spirits and the community can cause disability. This was also seen as generational, as some participants revealed that a family could be cursed for something that was done by their parents or their grandparents in the past or for not doing what was culturally expected of them in the community. Some believed that one could be cursed for disrespecting the elderly or disrespecting sacred places. The majority of the participants captured these views as reported in the following statements:

- *“During the era of our fore-fathers, people with disabilities were killed because it was believed that it was a bad omen in the family...”*
- *“They call me names such as (shingundu ngwee, shilema ngwee) meaning the cursed disabled one.”*
- *“...some believe that disabilities occur because of bad luck, while some believe that drinking water that is contaminated by evil spirits can cause diseases that lead to disabilities.”*
- *“In my culture, people believe that disability to a family member is a sign of bad luck...”*

A significant number of participants were of the view that there were strong cultural beliefs which viewed physical disabilities as a curse or bad omen. Thus physical disabilities were expressed in a negative way. This corresponds with what is stated in literature that people with disabilities are the natural hosts of bad spirits and as such bad luck or incurable diseases must be deposited to the “disabled” via different forms of often strange rituals (Khupe, 2010:2).

Munyi (2012:2) adds that most societies categorise people with disabilities as “deviants” rather than inmates. The person with a disability is confined to a sub-human status and in some parts of Africa, people with physical disabilities (generally referred to as crippled) are treated as if they are domestic animals and are

ostracised and segregated (Khupe, 2010:1). This leads to stigma and discrimination (Dube, 2011:2).

Sub-theme 4.5: Worthless and useless

Seven participants highlighted that culturally people with physical disabilities were seen as worthless and useless. This is what they had to say:

- *“Culturally people with disabilities do not deserve respect and cannot be treated the same as other people.”*
- *“In my community people believe that if a person is disabled, it means that he/she cannot do anything in life and even if a person is looking for a job, they don’t offer him/her because of being disabled.”*

The above statements are in line with what Khupe (2010:1) states, that culture is used to justify discrimination against people with disabilities and confine them to sub-human status. This adds to stigma and discrimination being perpetuated. Dube (2011:2) adds that the assumption that because someone is living with a disability he/she will be a financial and social burden to their family adds to these beliefs of viewing people with disabilities as worthless and useless.

Bayat (2014:3) asserts that attitudes and behaviour lead to the exclusion of disabled persons from social and cultural life. People tend to avoid contact and personal relationships with those with disabilities. This produces psychological and social problems leading to the notions of worthlessness and uselessness. The study findings show that identifying attitudes and beliefs can be the first steps in promoting the rights of people with disabilities through creating supporting environments.

The following are other views some participants gave on worthlessness and uselessness:

- *“In my culture people believe a person with a disability cannot do anything and even if you give simple instructions he/she will not be able to do it, because disability also affects the mental capacity to function well.”*
- *“People are different, some believe people with disabilities need help and should be helped with all the chores while others believe that a person with a disability cannot do any work and should therefore stay at home all the time.”*

- *“...some believe culturally people with disabilities are useless and shouldn’t be cared for.”*
- *“Culturally people with disabilities should be treated badly...”*

Monk and Wee (2008:94) indicate that persons with disabilities are often denied opportunities for full participation in the activities of the socio-cultural system of which they are a part. In addition, their problems are not only caused by their disability, but also adjustment in a world that has apathetic or hostile attitude towards them (Eide & Ingstad, 2013:1).

The study findings have shown that the above-mentioned attitudes may lead to psychological, educational, employment and social problems. Among these, the most difficult is the adjustment to the hostile social forces in the society, which make them hopeless and make their lives seem meaningless (Gobalakrishnan, 2013:490). The social model of disability regards disability not just as a medical issue, but also a human rights concern.

3.5.5 Theme 5: Treatment of persons with disability in the past and its applicability in this period

From the participants’ responses with regards to how people with physical disabilities were treated in the past, the researcher identified two aspects that characterised the treatment of people with disabilities in the past. These two aspects relate to how people with disabilities were hidden and isolated in the past and also how they were pitied and not recognised as full beings. The third aspect related to the views regarding the applicability of past treatment in the present period.

Sub-theme 5.1: Hidden and isolated

Five participants shared that people with disabilities were discriminated against in the past. They ascribed this to the shame that was associated with disabilities in families. The participants said:

- *“...families used to hide them. Even when there was an important function in the home the person would be kept away from the other people.”*

- *“People with disabilities used to be hidden from the rest of the people ... they were unfairly treated even by their own parents.”*
- *“People used to hide them and it was a shameful thing for a family to be known to have a member who is disabled. They had to be hidden away from visitors.”*
- *“Generally people with disabilities were hidden... the family would isolate [and] disown the person.”*
- *“They [people with physical disabilities] were also not allowed to share food with the rest of the family members. They were given separate plates and would eat alone.”*

People with disabilities used to get less attention, less stimulation and were always hidden (Munyi, 2012:2). The hiding and isolation of persons with disabilities was exacerbated by ignorance, superstition and fear influenced by culture. These misconceptions stem directly from the traditional systems of thought which reflect magical-religious philosophies that can be safely called superstition (Groce, 2005:1-6). Khupe (2010:1) mentions that hiding and isolating someone with a disability confines him to a sub-human status and affects the way an individual with disabilities sees himself and the world around him.

Participants further mentioned that in the past persons with disabilities were pitied and not recognised as full beings, as will be discussed in the next section.

Sub-theme 5.2: Pitied and not recognised as full beings

Five participants indicated that people with disabilities were not treated the same as other family members and were not given any opportunities in life. This made them objects of pity and ridicule. The following quotes provide the views of the participants on how persons with disabilities were pitied and not recognised as full beings in the past:

- *“...people used to pity people with physical disabilities as they were uneducated, poor and unemployed. They were not sent to school, nor were they given jobs to do. They did not have freedom to live independently.”*
- *“They were not recognised as members of the family ... they also suffered discrimination.”*

- *“They were not recognised as human beings...”*
- *“People with disabilities were not recognised at all. Only the able-bodied would be counted as the real family members...”*

The acts of pity and lack of recognition of people with disabilities mentioned by the participants include not sending them to school, discrimination, and lack of respect. Pity and lack of recognition is indeed characterised by viewing disability and people with disabilities in the most pejorative way possible as a tragedy, a disgrace and shameful (Pfeiffer et al., 2003:132-149). People with disabilities are seen as objects of pity which produce guilty feelings in their family members and associates (Munyi, 2012:3). Throughout Africa, persons with disabilities are seen as hopeless and helpless; they are categorised as deviants rather than “inmates” by society (Abosi, 2007:198). Just as in the quotes above, people with disabilities are categorised as “the unfortunate” and “the infirm” who evoke pity and this is used to deny them recognition as full human beings (Groce, 2000:2). Discrimination takes many forms and can include precluding men with physical defects such as amputations from becoming chiefs to avoid shame and rejection by the community (Munyi, 2012:2).

Sub-theme 5.3: Views regarding the applicability of past treatment in this period

All the participants expressed disgust and disdain with the way people with disabilities were treated in the past. They noted that although there are still challenges to be overcome regarding their treatment, there had been improvements over the years. Seven participants emphatically rejected maintaining the ways of the past in these present times. Participants voiced these sentiments as follows:

- *“No, I cannot support such cruelty.”*
- *“Not at all, in fact those still treating people like that must stop.”*
- *“I don’t agree with anything from the past and I say nothing should be taken or maintained as there was nothing good.”*
- *“No, because people with disabilities were treated like prisoners.”*

The above statements agree with Dube (2011:2) who states that attitudes towards people with disabilities are starting to change. The study has shown that people with disabilities are aware about treatment in the past and its applicability to the present.

It is therefore important that they take the bold and historic initiative of changing the paradigm of disability from the “medical, charity and tragedy” to rights, culture and pride, with the aim of creating a “society for all” (Brown, 2002:34-50). As stated by the social model, it is not impairment that is the main cause of social exclusion, but the way society responds to people with impairments (Oliver, 2004b:19).

The sub-themes in this section highlighted the treatment of persons with disabilities in the past and its applicability to this period. Given the above issues surrounding the treatment of people with disabilities in the past, the study has indicated that though life with a disability is valuable, what makes it difficult is handicap. Thus as stated in the social model, the priority should be the removal of attitudinal, social, economic, educational and cultural barriers and disadvantages societies have created against people with disabilities (Brown, 2002:34-50). The study findings indicate that for long these oppressive aspects have been ignored or not taken seriously.

3.5.6 Theme 6: Community reactions to disability

Participants were also asked about their community’s reactions to their disability. In general, participants discussed many more negative community reactions than positive reactions in their local communities. There was also a clear relationship between the cultural beliefs regarding disability and the community’s responses towards persons with disabilities.

Sub-theme 6.1: Negative views

A total of 10 participants revealed various forms of rejection of a person with a disability as common within their communities. This often led to emotional abuse. It was reported that members of the community felt pity, lacked respect for, and avoided people with disabilities and their families. Participants felt many community members felt uncomfortable in the presence of persons with disabilities. Participants mentioned the following:

- *“People feel pity for people with disabilities. They always give us light work just as a token to make us feel involved and respected, but you can see they feel pity.”*

- *“They call us mocking names...they call me the “chair man” because I am always in the wheelchair.”*
- *“The community treat us with no respect and we are called bad names.”*
- *“Only those who are employed or those who earn a disability grant are recognised and respected; if not there is no respect for you.”*
- *“They feel we are worthless and call us bad names because we did not go to school. We are uneducated, no one took us to school, and there were no opportunities when we were young.”*
- *“...they [community] still feel pity and I also sense I am a burden to them. On some social gatherings they don’t invite me yet I know if it was not for my condition they would have invited me.”*
- *“People in my community feel contempt and ridicule towards my disability. They call me names...”*
- *“The community feel pity at my appearance... they also feel my physical disability somehow makes me mentally disturbed too.”*

Physical disability is regarded negatively (Haihambo & Lightfoot, 2010:83), with no one liking people with disabilities (Pfeiffer et al., 2003:132-149). The negative views from the community may contribute to further marginalisation of people with disabilities. Research suggests that while community reactions to disability are negative, there is evidence that families of persons with disabilities do view them differently (Groce, 2005:1-6). This was the case with most participants in the study who indicated that even though the community had these negative views, their immediate families understood and accepted. It is recognised that these negative views affect the self-esteem and perpetuate the “disablist” attitude in people with disabilities (Marsay, 2014:8).

Sub-theme 6.2: Positive views

A total of 11 participants felt that community reactions to their disability had improved over time and they felt loved and respected. Some felt having stayed in the same community for so long with the disability, people had become used to them while others thought education and institutions like churches had helped. Participants mentioned the following:

- *“In our community people are very helpful and accommodative especially to us with physical disabilities.”*
- *“They really try to make us feel loved, they give us spiritual support.”*
- *“People in our community understand disabilities now and that it can occur to anyone.”*
- *“People in my community respect me and when there is certain work to be done or decisions to be made, I am consulted. They involve me.”*
- *“People in my community welcome people with disabilities and treat us fairly well.”*
- *“Generally people in my community respect people with disabilities. We take part in different activities like meetings and some get involved in sport. We also mix and mingle with different people with and without disabilities from all over the community freely.”*

The quotes above highlight the fact that attitudes towards people with disabilities have not always been negative, but tolerant (Groce, 2000:2). These attitudes influence the perception of the reaction towards people with disabilities and rehabilitation services. Munyi (2012:2) points out that societal perceptions and treatments of persons with disabilities reflect tolerance, love, awe and reverence. Mangaliso (2005) adds that in spite of the negative connotations, “humanness” still exists hence collective existence and experience which translates to communalism. The participants’ views are similar to those of Groce (2005:1-6) that a community with positive practices towards people with disabilities may provide positive models of intervention that are likely to be in line with what is universally accepted standards.

The sub-themes in this section have shown that people with physical disabilities are aware of community reactions to disabilities. It is therefore important to help clients with strategies to remove barriers, as stated by the social model, in order to promote the inclusion of people with impairments (Shakespeare & Watson, 2002:5). This will mean that instead of pursuing medical care and rehabilitation, only a strategy of social change and transformation of society will also be pursued.

The sub-themes have also shown that people with physical disabilities can build on positive community reactions. The social model states that it is a liberating feeling for

people to understand that they are not at fault, society is; they don't need to change, society needs to change; they don't have to be sorry for themselves (Shakespeare & Watson, 2002:5). Thus people with disabilities think of themselves in a totally new way and become empowered. This can be achieved through people with disabilities reaching out to communities to disseminate information about physical disabilities in order to help people change their perceptions.

3.5.7 Theme 7: Impact of disability socially and economically

With regards to participants' responses on the impact of disability on their lives, four main ideas emerged from this theme, namely loss of livelihood, loss of educational opportunities, changed appearance and stature, and difficulty in adjusting to new condition.

Sub-theme 7.1: Loss of livelihood

Five participants mentioned loss of their jobs and sources of income as a direct impact of their disability. Participants mentioned the following:

- *"I lost my job, I am now unemployed. What I used to get in terms of earnings, I cannot get it anymore."*
- *"I was a taxi driver before my disability... [now] I am grounded in one place."*
- *"I used to earn a salary as a secretary, but now it's gone. I used to supplement my salary by buying and selling goods, but now I don't have the strength to do it anymore."*
- *"... I cannot work anymore as I would do before the disability...what can I do in this wheelchair?"*

The impact of disability was that some participants lost their jobs and sources of income. People with disabilities are more likely to lose their jobs and experience multi-dimensional poverty with fewer resilience options than their peers without disabilities (Wapling, 2012:5). McConkey (2012:321-323) mentions that working age persons with disabilities are more likely to be unemployed than persons without disabilities. Additionally the WHO (2011:11) asserts that people with disabilities are more likely to be unemployed and generally earn less when employed. Due to the loss of livelihoods people with disabilities experience higher rates of poverty and are

more dependent on others (Wapling, 2012:6). The loss of livelihood can also stem from loss of educational opportunities as discussed in the following sub-theme.

Sub-theme 7.2: Loss of education opportunities

Four participants shared that they had to drop out of school and watch in agony as their peers went on to succeed in life. They ascribed their dropping out of school to their disabilities which made it difficult to remain in school, as they were constantly in hospitals seeking medical help and also had difficulties travelling the long distances to school. Participants reported that:

- *“Disability started when I was at school and this made me to drop out.”*
- *“Disability and deteriorating health due to illness made me to drop from school. I feel if it was not for the disability I could have gone far with my education and achieved a lot.”*
- *“I had to drop out of school, because my eyes would not see properly and my fingers were shaking such that I could not hold a pen to write. This negatively affected my career prospects.”*

Participants indicated that they had to drop out of school due to a disability and this affected their lives and it limited their opportunities. An estimated one third of all out of school children live with a disability and primary completion and literacy rates are consistently far below of those of non-disabled people (Wapling, 2012:5; WHO, 2011:11). People with disabilities are less likely to start school than their peers without disabilities and have lower rates of staying and being promoted in schools (Antonio, 2013:1). Education completion gaps are more profound among people with disabilities and being disabled more than doubles the chance of dropping out or never enrolling in school (Kwenda, 2010:1; UNESCO, 2010:184). This perpetuates poverty, as exclusion from school means future economic prospects will be severely restricted and children whose parents have disabilities are also at increased risk of missing out on education, as they take on support responsibilities within the household (Wapling, 2012:5).

Sub-theme 7.3: Changed appearance and stature

Three of the participants pointed out that disability changed their appearance and stature and this had a lasting effect on their lives and other people in their communities. Participants pointed out the following:

- *“Disability has changed my life firstly in terms of physical appearance and stature; I was not like his before.”*
- *“...without legs you miss out on everything...”*
- *“I had a promising career as a soccer player, but I cannot play anymore. My dreams we shattered. Other people go on to achieve more yet you remain behind because of disability.”*

Persons with disabilities find themselves in situations where they get affected by their appearance and stature (Dube, 2011:2). Appearance and stature play a significant role in the way people perceive people with disabilities. Khupe (2010:1) mentions that persons with physical disabilities are generally referred to as crippled with visible and queer disability and this forms the bedrock for negative and evil connotations that lead to discrimination. Participants further experienced the impact of disability as learning a new life of disability. Difficulty in adjusting to the new condition is discussed in the next section.

Sub-theme 7.4: Difficulty in adjusting to new condition

Five participants described the negative effects that physical disability had on their psyche and self-esteem. Some of the participants went on to explain how it was difficult during the earlier days of the disability to accept the new condition. Participants described these situations as follows:

- *“Yes it is very hard to accept especially if you were not born with a disability. Adjusting to the new life is difficult.”*
- *“All the friends I had no longer visit me as they used to do; at most they call once in a while just to check on me. I have lost all my friends and I feel isolated.”*
- *“... It [disability] affected my life as all the people I used to socialise with are no more there; I had to start to create new friends who understood my new condition.”*

- *“Yes disability changes life because it is difficult to adjust, it limits you, it is like you were once two but now you are one doing the same job. It changes the plans you had for the future and the success you can achieve is reduced...”*
- *“Many people used to call me to assist them with transport so I was never really broke. All those people no longer call me and I miss everything.”*

These findings confirm the views of Eide and Ingstad (2013:1) who assert that the people with physical disabilities face problems as they attempt to adjust to the demands of living in a social environment. Their problems are not only caused by their disability, but also by adjustment in a world that has apathetic or hostile attitude towards them and magnifies their troubles. As noted by Gobalakrishnan (2013:489), people with disabilities sometimes have difficulty doing things that other people take for granted, such as travelling on public transport, climbing stairs or even using some household appliances. However, the greatest challenge has been society’s misperception that they are a ‘breed apart’ (Munyi, 2012:4).

The sub-themes pointed out that disability impacted negatively on people with physical disabilities. The study findings indicate that many participants felt that their opportunities in life were limited by the disability. Given the above issues surrounding the impact of disability socially and economically, the study findings point to the fact that this results in established and culturally rooted discriminatory practices that affect individuals with disabilities and their families, as noted by Ingstad et al. (2011:3).

People with physical disabilities are negatively impacted by disability, and it is therefore important to assist them to establish a positive regard, see their intrinsic self-worth, and to know their strength and be able to capitalise on their knowledge despite the barriers imposed on them by culture (Wehmeyer & Little, 2013:119). As stated by the social model, Oliver (2009) speaks about the “disablist” attitude which he describes as disempowering. Marsay (2014:8) argues that people with physical disabilities need to reach out to communities and disseminate information about their abilities and potentials to help fight negative attitudes and show that they can be competent members of the workforce if accorded equal opportunities.

3.5.8 Theme 8: Support services received in dealing with a disability

From the participants' responses with regards to support services they received in dealing with their disability, the researcher identified four aspects that highlight the assistance obtained. These four aspects relate to support, namely material, financial, medical and psychosocial support.

Sub-theme 8.1: Material support

Four participants mentioned some of the things that they have received from various agencies to cushion them. Some of the participants received food aid while others received goats. In some instances some received crutches and artificial legs. Participants mentioned material support as follows:

- *“I have received food aid relief from the government as well as crutches from the hospital.”*
- *“I received 10 goats under the government and Germany partnership programme...”*
- *“From the government, I received artificial legs...”*
- *“I also thank the government for bringing the CBR programme as many people have obtained education on life-skills as well as self-help jobs.”*

Gobalakrishnan (2013:489) emphasises the importance of material support and providing tangible assistance. Wapling (2012:11) mentions that material support is vital as there are some very practical issues which need to be overcome. Thus material support can focus on things like food, housing and assistive devices to increase their active participation and well-being.

Sub-theme 8.2: Financial support

A total of thirteen of the participants stated the disability grant from the government as the support they received. Some also received money as compensation after being involved in motor vehicle accidents. Participants mentioned the following:

- *“I get [the] disability grant from the government.”*
- *“I have received ... financial support from the Motor Vehicle Accident (MVA) fund.”*
- *“I received the social grant from the government.”*

- *“Government help me with the social grant to sustain myself.”*

The above views are confirmed by Wapling (2012:11) who emphasises that costs need to be built into all programme budgets to ensure that people with disabilities are not excluded. The WHO (2011:19) advocates the provision of adequate funding and improving the affordability of services for people with disabilities, and further points out that over a lifetime of an individual person with a disability and their family, the actual costs of providing disability support becomes minimal, far outweighed by their contributions as economic, social and political participants in development.

Sub-theme 8.3: Medical support

Seven participants verbalised that they received free medical services at state hospitals and clinics. These ranged from free consultations and free examinations, to free drugs. Participants explained this support as follows:

- *“I should thank the doctors that treat me...”*
- *“I got help from the hospital. I received medical treatment and care...”*
- *“I get free medical services from the government.”*
- *“I received free rehabilitation services that helped me to move independently.”*
- *“I have received medical support from the MVA fund.”*

The above views on the value of medical assistance are reflected in literature. There a number of different support programmes currently taking place in Namibia. These include raising awareness, prevention, early intervention and health education, treatment, therapeutic aids and orthopaedic technical services, education, vocational training, and family life and personal integrity training (Zimba et al., 2004:3). Mlenzana et al. (2013:1-6) mention the value of medical support as improving the health outcomes of people with physical disabilities. Investing in health and rehabilitation services contributes not only to ensuring equality of opportunities and good quality of life for people with disabilities, but also promotes social participation and valuable contributions to society (Cott, 2004:1411-22).

Sub-theme 8.4: Psychosocial support

Four participants mentioned a form of support which was not mentioned by the other participants and seemed hidden. In other words, these participants felt that the moral

encouragement and support received from family members was usually understated, yet it was of equal importance. Participants explained this phenomenon as follows:

- *“I have received support from my family since childhood. This support has been mostly moral...”*
- *“My family have encouraged me and stood by me.”*
- *“...the church helped me spiritually and made me a Christian. They provided spiritual counselling and strengthened me to be resilient.”*
- *“...my family take care of me with kindness.”*

The participants' submissions in terms of positive support from families and the church correlate with the views of Dube (2011:2), who states that people with disabilities appreciate the first level of care at home and their social environment that emphasises empathy and allows them to work at their own pace.

The sub-themes in this section highlighted the support services received in dealing with a disability. These support services can be related to the social model. The Government of Namibia's national policy on disability addresses issues of disability as a human rights and developmental issue (Haihambo & Lightfoot, 2010:77). The vision of the policy states that the ultimate goal is development of an inclusive society for all which acknowledges common humanity and equality. Appropriate services must be advocated by persons with disabilities themselves so that all their needs are met. The themes point out that people with disabilities should be helped holistically. Psychosocial needs cannot be isolated from the financial or material needs; the total self has to be attended to and no person without a disability can represent well the likes and interests of people with disabilities (Oliver, 2004b:31).

3.5.9 Theme 9: Strategies required to support people with disabilities

The findings that were presented in the previous themes provide evidence of the cultural beliefs and community environments people with physical disabilities are exposed to. These have short-term and long-term effects on all aspects of their lives. It is therefore important that professional interventions are rendered to improve community inclusion and integration. The participants were asked to provide

suggestions on strategies in this regard. The suggestions made by the participants are discussed as the sub-themes in this section.

Sub-theme 9.1: Ending discrimination against people with physical disabilities

Four participants stated that they felt their efforts were hampered by the negative attitudes that people displayed towards them. The majority of the participants are of the view that changing people's attitudes towards people with disabilities and equal treatment for everyone will improve their social standing in society. The following quotes capture the sentiments of the participants regarding discrimination:

- *“There is need to come up with ways to end discrimination in all its forms. People who stay with persons with disabilities must change their attitudes towards them so that they feel valued and recognised as full members of the community. In this regard strategies to end discrimination must be sought and get implemented.”*
- *“I think that it must be made mandatory for people who make buildings to make them accessible to people with disabilities so that it is easier to enter and access services. For example, public buildings like churches, schools and hospitals must be accessible to those using wheelchairs.”*
- *“People with disabilities are discriminated against. Since independence it has been like that.”*

The findings show that the strategies that some participants have suggested to support people with physical disabilities relate to ending discrimination against them. Gobalakrishnan (2013:489) concurs that the greatest challenge has been society's misperception that people with physical disabilities are a “breed apart” who need to be pitied, ignored, vilified and even hidden away in institutions. Oliver (2009), amongst others, speaks about the “disablist” attitude which he describes as disempowering. Marsay (2014:8) argues that people may not be able to demonstrate their “ableism” if they struggle with self-esteem and are not encouraged and recognised to reach their potential. Many people with physical disabilities are not only excluded from the social life of their communities, but are in fact confined to institutions (Bayat, 2014:5) and to remote rural villages (Haihambo & Lightfoot, 2010:84). The study findings indicate that participants showed they are aware that

ending discrimination could go a long way in improving community inclusion and integration.

Sub-theme 9.2: Training role players involved in the lives of people with physical disabilities

All participants indicated that the family, the community, the government and the private sector should all have a role in improving the lives and services for people with disabilities. Community awareness and educating people to understand disabilities and people with disabilities was emphasised as the first step in working and living with persons with disabilities. All participants stressed the importance of learning more about the capabilities of people with disabilities so that the right message is sent out. They felt community leaders had a greater role to play as they have a larger following. The majority of the participants expressed the following views regarding this theme:

- *“I think that that the people in leadership positions, who have a lot of influence like the Councillors, the Headman and Church leaders are the ones who should be trained first as they are closer to us and also people listen to them and follow their lead. Once they are empowered, they transfer this knowledge and skills to the rest of the community.”*
- *“There is need for some awareness campaigns so that there is a better understanding of disabilities in the communities and in the country at large.”*
- *“The Government and communities need to raise awareness so that these people are brought forward and get registered to receive the grant and alleviate their suffering.”*
- *“There is need to enforce the laws and policies so that people with disabilities are empowered and also have equal access to employment.”*

The findings further show that most of the participants were of the view that community integration and inclusion can be addressed by involving non-disabled people so that they have a better understanding of disabilities and people with disabilities. The participants' responses are in line with Tregaskis' (2004:65-82) assertion that there is a need to form alliances between disabled and non-disabled people in tackling structural barriers and developing a shared agenda for change, resulting in a “win-win” situation. The WHO (2010:1) also points out that the role of

CBR is to work with all relevant stakeholders to ensure the full participation of people with disabilities in the social life of their families and communities. Monk and Wee (2008:94) further concur that community involvement challenges stigma and discrimination and brings about positive social change which is essential for the success and sustainability of CBR programmes.

Sub-theme 9.3: Involving and consulting people with disabilities

In order to effectively support people with physical disabilities, three of the participants stated the importance of learning more about the capabilities of people with disabilities in order to maximise their participation in the community and help them to achieve their potential. The participants also suggested that they should be consulted in matters that concern them, as no one could express their concerns better than they could themselves. The views of the respondents on the need to be involved and consulted are expressed in the following quotes:

- *“I need to be heard, for my opinions and views to be listened to starting from the family level up to the highest levels of Government and also those who seek to assist people with disabilities must listen to us.”*
- *“The best way to help people with disabilities in the community is to understand the person first, their disability and needs through talking to them.”*
- *“There are people or organisations that claim to represent people with disabilities yet they do not have time to visit us and see how we are living and our conditions and welfare. Some people are being abused, yet no one visits to investigate. There is need to advocate and lobby for services to be taken to the people in all communities including remote areas.”*

The participants were of the opinion that there is a need to consult and involve them in all matters and also that they needed to be prioritised as a vulnerable group in order to improve community integration and inclusion of people with physical disabilities. These findings are confirmed by Coleridge (2000:26) who states that where people with disabilities are not seen as a priority for development or included in most mainstream development programmes the end result is alienation, exclusion and a loss of identity, as well as loss of a sense of community. These findings also evoke the notion brought forward by Groce (2005:1-6) that a community with positive

practices towards people with disabilities may provide positive models of intervention that are likely to be in line with universally accepted standards.

Sub-theme 9.4: Prioritising people with physical disabilities as a vulnerable group

Five participants stated that support for people with disabilities can be addressed by prioritising people with physical disabilities as a vulnerable group, as currently they seem not to be prominently considered as vulnerable as other groups like women, youths, children, the elderly and people living with HIV/AIDS. The views of some of the participants in this regard are captured as follows:

- *“There must be a government arm or department solely focused on persons with disabilities. A dedicated office for people with disabilities is the way to go not to mix us with children, women, the elderly, and other vulnerable groups.”*
- *“People with disabilities need to be prioritised during the drought relief programme and all other developmental programmes.”*
- *“There is need to register all the people with disabilities so that they are known in terms of numbers, location and needs so that when there is some assistance available there will be correct targeting.”*
- *“I also want the government to increase the disability grant because these days things are expensive.”*
- *“People with physical disabilities should be provided with preferential treatment in hospitals in terms of quickly getting their medication, as they require assistance from other people. Their medication should always be available since it is expensive to buy in private pharmacies.”*

Despite representing a significant number of people, the economic and social potential of persons with disabilities to make significant contributions towards development has so far been lost (Wapling, 2012:2). The WHO (2011:9) adds that the implied inclusion of persons with disabilities has not resulted in their inclusion in development activities. Not only have persons with disabilities not benefited from much of the progress brought by the MDGs, but their living standards may have been declining in relative terms (Wapling, 2012:2). The information gained from the participants supported the descriptions in the mentioned literature.

Sub-theme 9.5: Providing services and empowering people with physical disabilities

A total of ten participants indicated that a practical strategy to improving community integration and the inclusion of people with disabilities can be through the provision of accessible services and also by empowering persons with disabilities to be self-reliant by forming self-help groups. Others noted the importance of material support as short- and long-term empowerment strategies. The views of the participants in this regard are reflected in the following quotes:

- *“There is need for a new system by the government to focus on empowerment and income generating projects rather than temporary hand-outs. We have potential and abilities which we want to utilise.”*
- *“We need to be trained in different skills which cater for our different forms of disabilities so that we are not just dependent on government, but can help grow the economy and employ others. We also want these training centres and rehabilitation centres to employ some people with disabilities they would have trained.”*
- *“I need help with agricultural inputs to cultivate in the fields. I am also into welding. I will appreciate if I can get more materials and funding to pay for the electricity costs until the business grows and sustain it-self.”*
- *“We need houses to be built for us as we cannot do it anymore on our own. It is difficult for us to look for shelter.”*
- *“We hear, the government is providing farming inputs and also resettling people into farming areas, we feel left out. We also want to be considered since we have families who can work on the land.”*
- *“I need a spare wheelchair to use when this one goes for repairs. Currently when the one I am using goes for repair it means I am grounded, I cannot go anywhere. I become a burden to my household members.”*

Lastly participants were of the opinion that support to people with disabilities could be addressed by providing services and empowering people with physical disabilities. Turner and Nguyen (2005:1694) noted that many persons with physical disabilities are excluded from active participation in society because of doorways that are too narrow for wheelchairs; steps leading to buildings, buses, trains and aircraft that cannot be mounted; telephones and light switches that cannot be reached; and

sanitary facilities that cannot be used. These authors continue to say that these services can be provided with careful planning and this will empower the socio-economic development of communities.

3.6 SUMMARY

Chapter Three focused on the research methodology and the ethical considerations that were followed during the research study. The empirical findings of the study were subsequently presented and discussed. The study was embedded within the social model which attempts to switch the focus from the functional limitations of individuals with disabilities, to the problems caused by disabling environments, barriers and cultures.

Nine themes emerged and these were: general perceptions of disability; causes of disabilities; services sought after being diagnosed with a disability; cultural beliefs regarding disability; community reactions to disability; impact of disability socially and economically; support services received in dealing with a disability; and strategies required to support people with disabilities. Themes and sub-themes that emerged from the transcripts acknowledged and represented the voices and perspectives of participants in the study. These were substantiated through direct quotations with integration of literature where applicable.

The key findings of the study will be discussed in Chapter Four. The chapter will also contain the conclusions and recommendations that are based on the key findings.

CHAPTER FOUR: CONCLUSIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

This chapter seeks to explain how the researcher achieved the goal and objectives of the study. The researcher will explain how the objectives were achieved by highlighting the main findings of the study. Conclusions will be drawn from the study and recommendations will be made on the key findings of the study.

4.2 GOAL AND OBJECTIVES OF THE STUDY

The goal of the study was to explore and describe the cultural beliefs of people with physical disabilities in a community rehabilitation centre in Oniipa, Namibia. Below is the research question on which the study was based:

What are the cultural beliefs of people with physical disabilities in a community rehabilitation centre in Oniipa, Namibia?

The goal was achieved through the attainment of the following objectives:

- **Objective 1:** To contextualise physical disabilities according to the social model theory.

This objective was achieved in Chapter One, especially sections 1.2 and 1.3; Chapter Two, sections 2.4.4., 2.5, 2.6, 2.7, 2.8; Chapter Three; and in this chapter especially in sections 4.3 and 4.4. The central focus of the social model is premised on the notion that disability is a social construct that has been created by society, hence the need to remove barriers, promote citizenship rights (equality), and do away with discrimination.

It is important for people with physical disabilities to understand the social model in order to influence the type of services rendered, whether people seek medical interventions and the degree of inclusion. The social model will

help people with physical disabilities to advocate for social justice, empowerment, inclusiveness and human rights. From the literature study, it is evident that the policy and legislative framework in Namibia is heavily influenced by the social model. In the empirical study, the majority of the participants did not manage to be elaborate in their contextualisation of physical disabilities from a social model perspective. In the greater study the participants largely perceived disability through medical, religious and charitable lenses and described their communities as using these same lenses with little evidence of a social model lens existing among community members. While some participants in the study were aware that disability is a social construct created by society, they accepted/lived with the conditions with little being done to remove the barriers.

- **Objective 2:** To establish the cultural beliefs regarding disability among people with physical disabilities.

This objective was addressed in the empirical study in Chapter Three, especially section 3.5.4. Participants' cultural beliefs regarding physical disabilities were different. Some stated that disabilities are seen as a product of witchcraft, a gift from God, punishment for sins committed, and also as a curse or bad omen. Others indicated that a person with disabilities is regarded as worthless and useless. In their own views, the people with physical disabilities (participants in this study) indicated that they did not concur with the cultural beliefs that society had about disabilities, except on the point that disabilities are a gift from God. They also indicated that it is important for correct information to be disseminated about the causes of disabilities as this will help people with disabilities to seek appropriate care services and also end stigma and discrimination.

- **Objective 3:** To determine expressed beliefs in the cause of disability and the type of help sought (traditional or medical).

This objective was addressed in Chapter Two (sub-section 2.4.2 to 2.4.3) where it became evident that cultural beliefs about disabilities are rooted in

complex socio-cultural knowledge systems. These beliefs systems lead to people either seeking help from traditional or modern health care providers. Alternatively, some seek help in both systems described as healer shopping, between biomedicine, ethno medicine and faith healing (De-Graft Aikins et al., 2010:5). Moreover it was noted that besides the use of modern treatment methods or prescriptions, traditional and religious treatment is also practised and is seen as helpful (Diken, 2006:14).

Furthermore, the third objective of the study was accomplished in the presentation of the study findings in Chapter Three (sub-section 3.5.2-3). The participants stated that upon realising a disability the majority of them seek help from medical health facilities, their families and institutions that cater for people with physical disabilities. However, a few participants indicated that they sought both medical and traditional assistance. It is important for people with physical disabilities to know the causes of disabilities and adopt positive health seeking behaviours. This could minimise the severity of some disabilities and improve functionality, independence and quality of life.

- **Objective 4:** To suggest strategies that will improve community integration and inclusion of people with physical disabilities.

This objective has been met in the empirical study in Chapter Three and Chapter Four. The participants proposed a number of strategies to improve community integration and inclusion of people with physical disabilities in all spheres of life. The main strategies suggested are as follows:

- Ending discrimination against people with physical disabilities.
- Training role players involved in the lives of people with physical disabilities.
- Involving and consulting people with disabilities.
- Prioritising people with physical disabilities as a vulnerable group.
- Providing services and empowering people with physical disabilities.

4.3 KEY FINDINGS OF THE STUDY

The researcher will present key findings and conclusions in this section in a sequential manner.

- The findings indicated that disability is largely perceived through religious, medical and charitable lenses with little evidence of social model lens existing among both people with physical disabilities and their communities.
- The findings revealed that there are cultural beliefs regarding disabilities. Most of these beliefs stem from the beliefs that physical disabilities are a result of witchcraft, punishment for wrongs done in the past, a curse or bad omen, as well as being a gift from God.
- Findings have established that physical disability is associated with a sense of worthlessness and uselessness and hence no need to invest in persons with disabilities, particularly at family and community level.
- The findings indicated that people with physical disabilities believed that physical disabilities are caused by diseases, accidents and natural causes as opposed to the causes attributed by cultural beliefs.
- The findings revealed that upon realising a disability, there are dual sources of help sought. These relate to seeking medical help at medical facilities, as well as seeking help from traditional healers. The study indicated that most of the participants held strong modern treatment beliefs and sought medical help, while a few sought help from both medical and traditional agents.
- Findings have shown that the treatment of people with disabilities was bad in the past and most of them think the way they are treated now is better, although things can still improve.

- Findings have established that despite the existence of an inclusive operating framework, the communities largely view people with physical disabilities from a religious and charity model perspective.
- The study findings have indicated that people with physical disabilities feel they have been disadvantaged socially and economically by the disability.
- Findings indicate that people with disabilities feel they have been inadequately supported by their communities and the Government. The negative cultural beliefs about people with disabilities appear to inform some community responses to people with disabilities. The community responses tend to be either negative or that of neglect. It was established that people with disabilities are referred to in a derogatory manner, neglected, and excluded from development and empowerment initiatives.
- The findings indicated strategies towards improving community integration and inclusion of people with physical disabilities which included: ending discrimination against people with disabilities; training role players involved in the lives of people with physical disabilities; involving and consulting people with disabilities; prioritising people with physical disabilities as a vulnerable group; and providing services and empowering people with physical disabilities.

In summary, the overall findings of the study revealed that cultural beliefs regarding disabilities and community responses were similar across like other regions. Underlying the various cultural beliefs was the perception that there were supernatural powers such as witchcraft, being cursed or punished, which led to disabilities. The study confirms the findings of Monk and Wee (2008); Dart (2006); Munyi (2012) and Haihambo and Lightfoot (2010) who carried out studies in other sub-Saharan African nations. These perceptions have strong negative connotations and affect the self-esteem of people with disabilities.

These findings evoke the notion brought forward by Groce (2005:1-6) that a community with positive practices towards people with disabilities may provide positive models of intervention that are likely to be in line with universally accepted standards. Equally, when communities hold negative views about disabilities, they may provide negative models of intervention. The author further suggests that in case of the negative perceptions, if change is to take place it should start with making local people understand that their opinions are not found worldwide and may need to be reviewed. The findings of the study suggest that most communities hold negative cultural opinions about physical disabilities and these inform community practices. However, it must be noted that there is evidence that the cultural beliefs are changing, especially in the immediate families of people with disabilities and a greater portion of the community, hence disability advocates must be aware of the changing cultural beliefs so as to design interventions and campaigns that are effective.

It is thus important for people with physical disabilities and disability advocates to understand the social model of disability in order to confront problems caused by disabling environments, barriers and cultures through social action and ensure the full participation of people with disabilities in all areas of social life (Shakespeare & Watson, 2002:5; Oliver, 2004b:19).

4.4 CONCLUSIONS

The following conclusions were derived from the literature review and empirical research findings of the study:

- It can be concluded that disability issues are understood from a medical and religious perspective despite the disability policy being based on the social model and focussing on community inclusion and integration.
- The researcher concluded that cultural beliefs continue to be significant in shaping people's perceptions about physical disabilities.

- The researcher concluded that cultural beliefs still play a major role in defining the place of people with physical disabilities within communities.
- The researcher has concluded that there is no common understanding between PWDs and their communities regarding the causes of disabilities. Therefore the study concludes that it is important to bridge this knowledge gap in order to foster community integration and inclusion of PWDs.
- It can be concluded that due to advances in knowledge about disability, many people seek help from medical facilities.
- The researcher has concluded that despite the challenges faced by PWDs, they feel that their situation has improved compared to the treatment of PWDs in the past. Most PWDs are now accepted and embraced by their families and communities.
- It can be concluded that disability limits potential and life opportunities. This can be worsened by internalised feelings of hopelessness, helplessness, inability to cope with the new condition, and a low self-esteem, as well as external conditions such as negative community attitudes and a disabling physical and social environment.
- People with physical disabilities and their families live within cultures that have negative views of disability. Many cultural perceptions of physical disabilities have an element of guilt and shame.
- It can be concluded that there is an urgent need to work towards changing people's attitudes towards disability and stimulating change without undermining people's sense of identity.
- Without the eradication of stigmatisation against PLWDs, negative attitudes will continue to hinder inclusion and integration outcomes. It can be concluded that dealing with stigmatisation through the material and structural causes of

people with disabilities will be a catalyst to addressing perceptions of worthlessness and uselessness.

- The researcher concluded that there are limited programmes to support people with disabilities in Namibia. In most cases, the available programmes only offer hand-outs which are temporary and promote dependency. As concluded in this study, the potential and skills of people with physical disabilities are not tapped into. The study therefore concludes that PWDs should be treated holistically and get empowered, as this would help remove barriers, negative beliefs and attitudes, and promote the rights, participation and inclusion of PWDs.
- It is concluded that people with physical disabilities understand the challenges that they face, as well as what could be done to address these challenges to effect the needed changes. However, it is not certain how empowered they are to implement the strategies and bring about the required changes.

It can be concluded that the social model attempts to explain the notion that disability is a social construct that has been created by society and thus there is a need to remove barriers and promote the rights of PWDs. The social model is ideal in health care programming and is used to promote social justice, empowerment, inclusiveness and human rights.

As mentioned in Chapter One, pages 9-11, PWDs are urged to understand the causal link between impairment and disability. While the reality of impairment should not be denied, it should be noted that it is not the cause of disabled persons' economic and social disadvantages. People with physical disabilities should see disability as a socially created problem and a matter of the full integration of the individuals into society. Disability is not the attribute of the individual, but rather a complex collection of conditions, many of which are created by the social environment. Thus to overcome the problem, PWDs require social action and it is collective responsibility of society to make the environmental modifications necessary for the full participation of PWDs in all areas of social life. Therefore the

study nestles into the social model, as it provides the consciousness and reawakens the PWDs to do something about negative cultural beliefs that inhibit their full participation. People with physical disabilities make up a significant part of the community, hence the social model helps them to realise the importance of them enjoying their rights and realising their full potential by removing negative cultural barriers through sensitisation programmes, health promotion and health education.

4.5 RECOMMENDATIONS

Based on the key findings and conclusions of the study, the following recommendations were respectfully made:

➤ **Ending discrimination against people with physical disabilities**

Redressing the effects of discrimination and exclusion are going to be important if people with physical disabilities are to enjoy their rights and get equal opportunities. A key factor is that any programme that attempts to change attitudes regarding disability must be developed in light of cultural and traditional notions of disabilities. Thus social workers, the department of marginalised communities in collaboration with other role players should be incorporated in this endeavour. Sensitisation programmes must address strong cultural and traditional views that people with disabilities are cursed. This must however be done without discounting traditional cultural values so that it is supported across all sectors. Education and health programmes need to frame the notion of disability in a positive manner that resonates with people's cultural beliefs and traditional values. Mainstreaming of disability must be done in all community programmes.

➤ **Training role players involved in the lives of people with disabilities**

The Government through the Ministry of Local Government and Rural Development must train traditional, religious and political leaders to address how disability is currently understood within communities and how the communities' understanding of disability impact on persons with disabilities and their families. Despite a sound policy framework promoting inclusion and integration, the findings indicated that communities largely operate from a

medical and religious model regarding their view of disability. Thus role players need to be trained to specifically address how disability is viewed and understood within communities. Sensitisation campaigns should enlist both religious leaders and traditional healers to help integrate beliefs and promote inclusion of people with disabilities. This is so because the study findings revealed that communities hold both traditional and modern beliefs about disability.

➤ **Involving and consulting people with disabilities**

There is need to involve people with disabilities and to consult them on interventions that target them and in other general community matters. People with disabilities need to become integral role players in their communities. Successful persons with disabilities need to be involved in sensitisation programmes or support programmes so that the notion that people with disabilities are useless and worthless will fade away. This will also help people with disabilities themselves who need positive role models. One of the reasons persons with disabilities don't benefit from programmes that target the most vulnerable is because unlike other socially excluded groups, there are some very practical issues which need to be overcome. Active participation does require that interventions consider the physical/sensory/cognitive and psychosocial needs of people with disabilities. Access costs need to be built into programme budgets to ensure that people with disabilities are not excluded on the basis of their impairment.

➤ **Prioritising people with disabilities as a vulnerable group**

People with disabilities and their families live within cultures that have negative views of disability. There is therefore a need for counselling programmes and support groups to help them cope. Many cultural perceptions regarding disabilities noted in the study have an element of shame and guilt. Many people feel that disability is a punishment for wrongs done, hence people with disabilities feel judged and shunned. These perceptions can make it difficult for people with disabilities and their families to develop positive self-worth and self-esteem, hence the need for these targeted support programmes.

➤ **Providing services and empowering people with physical disabilities**

For the integration and inclusion of people with disabilities to be successful there is a need to provide accessible services and communities will need to develop programmes that can address the unique cultural understandings about disability in an appropriate manner. These empowerment programmes should foster inclusion and acceptance of people with disabilities. A disability inclusive development approach should be used. This approach must ensure persons with disabilities are included in all mainstream programmes or initiatives from the consultation process through to design, implementation and monitoring. The approach should point out that persons with disabilities have a right to benefit from any programme or initiative; that persons with disabilities should be identified amongst beneficiary groups; and that barriers to their participation, such as those created by negative cultural beliefs and attitudes, should be identified and mitigated against.

➤ **Training people with disabilities and communities in the social model approach**

There is a need to train communities in the practical application of the social model approach. Once communities are trained, some barriers related to attitudes, beliefs and discrimination may fade away and then the process of integration and inclusion may begin. Additionally, for people with disabilities to know about the social model without applying it in their lives practically is not enough. Ways to apply it and improve their conditions should be sought.

➤ **Further research**

Further research is needed to develop programmes that promote community integration and inclusion within particular cultural beliefs, and evaluate their effectiveness with a view to adapt these models to other cultural groups.

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SEMI-STRUCTURED INTERVIEW SCHEDULE

Goal of this study

To explore and describe the cultural beliefs of people with physical disabilities in a community rehabilitation centre in Oniipa, Namibia

SECTION A: BIOGRAPHICAL DETAILS OF THE PARTICIPANTS

1. Age distribution

40-50		51-60		61-70		71-80		80+	
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2. Gender

Female		Male	
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3. Marital status

Single		Married		Divorced		Widowed		Living with partner	
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4. Ethnic Group

Oshindonga		Oshikwanyama		Other (specify)	
------------	--	--------------	--	-----------------	--

5. Area of residency

Oniipa		Onayena		Olukonda	
--------	--	---------	--	----------	--

6. Sources of income (mark all applicable)

Social grant		Employed		Partner		Other (specify)	
--------------	--	----------	--	---------	--	-----------------	--

7. Education level

Primary education		Secondary education		Tertiary education		Other (specify)	
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8. Number of dependents

1-2		3-4		5-6		7-8		9+	
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9. Age distribution of dependents

<1yr	1-4yrs	5-9yrs	10-14yrs	15-19yrs	20-21yrs	22yrs+
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10. How long have you been in the CBR programme?

2yrs		3yrs		4yrs		5yrs+	
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11. When did you acquire the disability?

At birth		Early childhood		Teenage hood		Adulthood	
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SECTION B: FOCUS GROUP QUESTIONS

1. What do you think are the causes of disabilities?
2. Upon a disability being realised where do people in your community seek help?
3. What are the cultural beliefs regarding disability in your community?
4. How were persons with disabilities treated in the past?
5. Do you think these ways used in the past must be maintained?
6. How does your community feel about your disability?
7. Has disability changed your life? (Socially, economically, practically etc.).
8. What support do you need and from whom?
9. What support have you received and from whom?
10. What new strategies can be employed to support people with disabilities in communities?
11. What are your general perceptions of the disability phenomenon in the context of the social model of disability?



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25 September 2014

Attention: Mr. M.C Zhou

RE: PERMISSION TO CONDUCT A RESEARCH STUDY AT ELCIN REHABILITATION CENTRE

Your letter dated 4 August 2014 refers. The management and board of ELCIN Rehabilitation Centre is pleased to inform you that permission has been granted to you and your research assistant to conduct focus group discussions with 21 members of our organization. We note that the selected participants (people with physical disabilities) will be asked to attend at least three meetings of approximately 60 minutes per meeting. We take note that the goal of your study is to explore and describe the cultural beliefs of people with physical disabilities in a community rehabilitation centre in Oniipa, Namibia.

The organization has granted your request to use our boardroom for the focus group discussions so as to have a conducive working environment for the study. We acknowledge that we will not receive any monetary benefits for the use of our facilities and that no incentives or material benefits will be offered to our members (the participants).

Thank you for choosing our organization. It is our hope that the study will contribute to a better understanding of disability issues especially with regards to development and inclusion.

Let us know when you are ready to commence with your study

I trust that all will go well

Yours faithfully

Lempie Ndatale Mwatala

PROJECT MANAGER

Appendix 3



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Research Ethics Committee

27 November 2014

Dear Prof Lombard

**Project: The cultural beliefs of people with physical disabilities in a community
Rehabilitation centre in Oniipa, Namibia
Researcher: MC Zhou
Supervisor: Ms NJ Bila
Department: Social Work and Criminology
Reference numbers: 13106092**

Thank you for the application that was submitted for ethical consideration.

I am pleased to inform you that the above application was **approved** by the **Research Ethics Committee** on 27 November 2014. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should the actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

The Committee requests you to convey this approval to the researcher.

We wish you success with the project.

Sincerely

Prof Karen Harris
Acting Chair: Research Ethics Committee
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: Karen.harris@up.ac.za

Research Ethics Committee Members: Dr L Blokland; Prof Prof M-H Coetzee; Dr JEH Grobler; Prof KL Harris (Acting Chair); Ms H Klopper; Dr C Panebianco-Warrens; Dr Charles Puttergill; Prof GM Spies; Dr Y Spies; Prof E Taljard; Dr P Wood



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Department of Social Work & Criminology

Date: 04/02/2015

INFORMED CONSENT FORM FOR PARTICIPANTS (People with Physical Disabilities)

Title of the study:

The cultural beliefs of people with physical disabilities in a community rehabilitation center in Oniipa, Namibia

Researcher: Murisi Chokuda Zhou

Contact details: 00264817152207 **Email:** mzchokuda@gmail.com

Purpose of the study:

Is to to explore and describe the cultural beliefs of people with physical disabilities in a community rehabilitation centre.

Objectives of the study:

- To contextualise physical disabilities according to the social model theory.
- To establish the cultural beliefs regarding disability among people with physical disabilities.
- To determine expressed beliefs in the cause of disability and the type of help sought (traditional or medical).
- To suggest strategies that will improve community integration and inclusion of people with physical disabilities.

Procedures:

I will be asked to partake in a focus group discussion which will be conducted at **ELCIN Rehabilitation Centre** and the duration will be approximately sixty (60) minutes. The focus group discussion will be tape recorded with my permission

Risks and Discomfort:

The focus group discussion will be conducted in a safe and secure environment. Any information provided during the interviews will be treated confidentially. I will not be required to furnish my personal details or particulars. I take note that there are no foreseen risks and discomfort involved however I am aware that if I need counselling as a result of this focus group discussion I will be referred to a social worker.

Benefits:

I understand that the researcher will not offer me any incentives for being involved in the study. I will benefit from the research in the long term if the disability services are improved as a result of this study.

Department of Social Work & Criminology
University of Pretoria
PRETORIA 0002
Republic of South Africa

Tel: Number 00 27 12 420 2325/2030
Fax: Number 00 27 12 420 2093

www.up.ac.za

Participant's Rights:

My participation in the research is on a voluntary basis. I may, if I wish to withdraw at any time that I want to or prefer. Upon my withdrawal, the information I provided for the research will be destroyed.

Confidentiality:

All information gathered for this research will be treated confidentially. The researcher and his supervisor will have access to the information. The thesis will be compiled reflecting the research results and my name will not be mentioned. I am aware that the researcher will use numbers or a letter of the alphabet in the report and this will enhance the confidentiality.

Data storage:

I am aware that the collected data will be stored for 15 years at the Department of Social work and Criminology according to the policy of the University of Pretoria and when necessary may be used for future research.

I, understand my rights as a research participant, and I voluntarily consent to participate in this study. I understand what the study is about and how and why it is being conducted.

Participant: _____

Date: _____

Signature: _____

Researcher: _____

Date: _____

Signature: _____



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Faculty of Humanities
Department of Social Work & Criminology

Date: 04/02/2015

INFORMED CONSENT FORM FOR THE RESEARCHER'S ASSISTANT

Title of the study:

The cultural beliefs of people with physical disabilities in a community rehabilitation centre in Oniipa, Namibia

Researcher: Murisi Chokuda Zhou

Contact details: 00264817152207

Email: mzchokuda@gmail.com

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- To determine expressed beliefs in the cause of disability and the type of help sought (traditional or medical).
- To suggest strategies that will improve community integration and inclusion of people with physical disabilities

Procedures:

I will be asked to partake in a focus group discussion as a research assistant to explore and describe the cultural beliefs of people with physical disabilities in a community rehabilitation centre which will be conducted at **ELCIN Rehabilitation Centre** and the duration will be approximately sixty (60) minutes. I am aware that I should attend at least three sessions and that I will be advised of the time and venue of the focus group meetings.

Risks and Discomfort:

I take note that there are no foreseen risks and discomfort involved in acting as a research assistant in the study.

Benefits:

I understand that the researcher will not offer me any incentives for being involved in the study as a research assistant.

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Confidentiality:

Information shared during the focus group discussion will be treated with strictest confidence. I will not divulge information from the focus group discussion to anybody else and I will, to the best of my ability prevent inadvertent disclosure of confidential information.

By signing this letter of consent, I confirm that I have read and clearly understood its contents. I do not give any legal right by signing this letter of informed consent.

Participant: _____

Date: _____

Signature: _____

Researcher: _____

Date: _____

Signature: _____